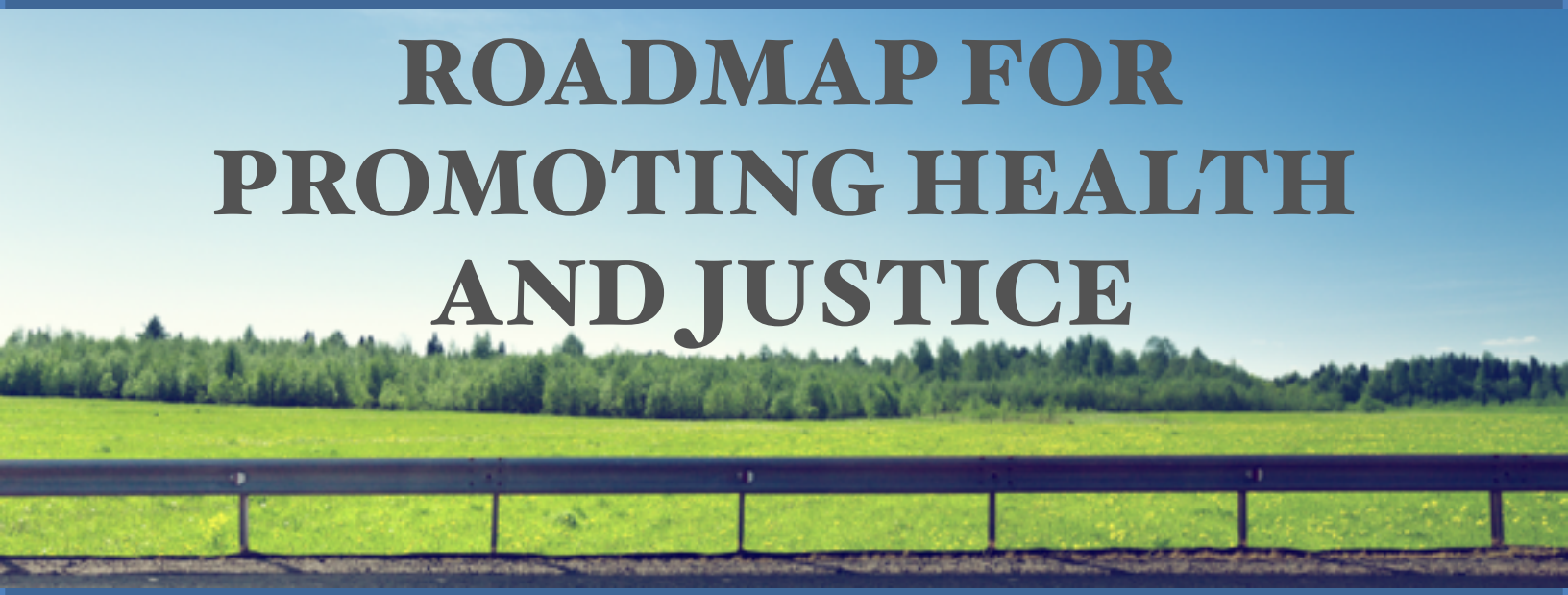
LEGAL ACTION CENTER

Arthur Liman Policy Institute

ROADMAP FOR PROMOTING HEALTH AND JUSTICE



A Smarter, More Effective National Drug and Alcohol Policy

January 2016

Legal Action Center is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas.

For four decades, LAC has worked to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

This report is a product of the Legal Action Center's Arthur Liman Policy Institute. We are deeply grateful to the Open Society Foundations, National Council of Behavioral Health and the Liman family for their support.

A list of the Legal Action Center's funders for the full range of our legal and policy advocacy can be found on our website.

Visit LAC's website at www.lac.org.

Letter from Legal Action Center President and Director Paul Samuels

Greetings,

Legal Action Center, the only nonprofit organization dedicated to fighting for the rights of people with drug and alcohol histories, criminal records, and HIV/AIDS, is pleased to release this *Roadmap for Promoting Health and Justice: A Smarter, More Effective National Drug and Alcohol Policy.* The *Roadmap* provides a comprehensive and detailed set of recommendations for improving our national drug and alcohol policies to improve health and public safety and save lives and resources. As we move into the 2016 election season, we hope this Roadmap will guide policymakers, thought leaders and campaigns in their decision-making and discussion of these issues.

In 2008, after consultation with leading stakeholders, Legal Action Center released the *Roadmap for Smarter and More Effective Alcohol and Drug Policies*. A number of the *2008 Roadmap's* major recommendations have become the law of the land. Our lead recommendation – inclusion of good coverage of substance use services in health care reform – was mandated in the Affordable Care Act. Our recommendation that government and the private sector roll back laws and practices that discriminate against people in recovery from addiction was included for the first time in the President's 2012 National Drug Control Strategy. The federal government and many states have taken important steps to reduce discrimination in employment, housing and higher education.

As a result of these historic reforms and earlier breakthroughs like passage of the Wellstone Domenici Mental Health Parity and Addiction Equity Act in 2008, the United States is poised to prevent and treat substance use problems and promote recovery much more effectively than ever before. We now have the best opportunity we will ever have to prevent young people from beginning unhealthy substance use, to make a major dent in the nearly 90 percent treatment gap between the 21.5 million Americans who need care and the 2.3 million who actually receive it, and to end discrimination against those who have overcome or still suffer from this terrible disease.

Strong partnerships with Presidents, Congress and states were integral to winning these victories, and continued bipartisan support will be key to further progress. It is exciting to see that in state after state, and in our nation's capital, there is constructive, bipartisan work on these issues. The tremendous need for reform, driven especially by the devastation of the heroin/opioid epidemic and other drug and alcohol addiction, alongside huge opportunities for improvement, have brought concerned Americans from many walks of life into the conversation. Improving our nation's drug and

alcohol policies will make our communities healthier, our families stronger, and our neighborhoods safer, and lift up people who were previously marginalized.

This Roadmap will advance two major goals:

1. Provide the full range of proven prevention, treatment, and recovery services to 1 million more Americans over the next five years.

2. Eliminate or modify the thousands of criminal record barriers that fall disproportionately on people with substance use disorders.

We look forward with great excitement to working with families, advocates, policymakers, service providers and other concerned Americans to greatly expand addiction prevention, treatment and recovery in the coming years.

Paul Samuels
President and Director
Legal Action Center

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Executive Summary

Introduction

An unusual bipartisan consensus is emerging to promote serious reform of America's drug policies and criminal justice system. Our nation has an unprecedented opportunity to transform its approach to people with substance use disorders (SUDs), shifting its primary focus from inflicting punishment and erecting discriminatory barriers to improving health. Such a reorientation will not only save lives; it will also relieve pressure on both the health care and criminal justice systems and free up resources for other national priorities.

The *Roadmap for Promoting Health and Justice: A Smarter*, More Effective National Drug and Alcohol Policy is a guide for policymakers who understand the urgent necessity to reshape the nation's drug and alcohol policies, in order to address SUDs as chronic diseases that can be treated and prevented. It provides a comprehensive, detailed set of recommendations for concrete steps that will accomplish the following goals:

1. Provide the full range of proven prevention, treatment, and recovery services to 1 million more Americans over the next five years.
2. Eliminate or modify the thousands of criminal record barriers that fall disproportionately on people with substance use disorders.

Why Drug and Alcohol Policy Should Focus on Health

The evidence supporting comprehensive reform that treats substance use disorders as a chronic disease could not be clearer. Addiction treatment has been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests by up to 64 percent.[1] Yet, even though an estimated 21.5 million Americans aged 12 or older need treatment for an alcohol or illicit drug problem, only 2.3 million received help at a specialty substance use treatment facility in the last year.[2]

The paucity of prevention initiatives and the unacceptably large gap between the need and availability of SUD treatment could not be occurring at a worse time. SUDs are the leading cause of injury-related deaths in the United

[1] The National Council for Community Behavioral Health, Preventing and Treating Substance Use Disorders: A Comprehensive Approach, https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf (last visited Jan. 7, 2016).

[2] U.S. Substance Abuse and Mental Health Services Administration, Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings (2015), at 3, http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf.

States[3] and among the most prevalent illnesses.[4] They cost over 100,000 lives and more than a third of a trillion dollars annually.[5] An epidemic of prescription opioid and heroin misuse and addiction is sweeping the nation, adding to the burdens created by other drugs as well as alcohol.[6]

> Addiction treatment has been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests by up to 64 percent.

Drug policies that emphasize punishment and discriminate against people with drug histories and criminal records are clearly not working. They have contributed to a huge growth in justice involvement that has resulted in criminal records for 70 million Americans. A criminal conviction exposes a person to barriers that make it more difficult to participate in educational opportunities, obtain employment, maintain suitable housing, receive quality healthcare, and access public benefits. Clearly, it is time for a change.

Building on Recent Progress

Fortunately, federal and state policymakers have taken important steps to change our health and criminal justice systems during the past seven years. The Legal Action Center (LAC) played an important role in this progress. In 2008, after consultation with many leading stakeholders, we released the *Roadmap for Smarter and More Effective Alcohol and Drug Policies*, which outlined public policy reforms needed to improve how our nation addressed substance use disorders.

Several of the 2008 *Roadmap's* major recommendations have become the law of the land. Our lead recommendation was that good coverage of substance use disorder prevention, treatment and recovery services should be included in health care reform. This concept was integrated into the Affordable Care Act (ACA), with consultation from LAC and our allies. The ACA includes several landmark reforms to help people with SUDs get insurance coverage and access to treatment.

Thanks to the ACA and others historic reforms, including the Wellstone Domenici Mental Health Parity and Addiction Equity Act, the U.S. has made huge strides toward providing SUD coverage in public and private health insurance and expanding access to care. At the same time, the federal government and some states have made efforts to reduce the discriminatory barriers that confront people with criminal records.

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[3] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

[4] See U.S. Substance Abuse and Mental Health Services Administration, Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings (2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf; Robert Woods Johnson Foundation, Substance Abuse: The Nation's Number One Health Problem (Feb. 2001), http://www.rwjf.org/content/dam/farm/reports/reports/2001/rwjf13550.

[5] U.S. National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction (revised 2010), https://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.

[6] U.S. Centers for Disease Control and Prevention, Today's Heroin Epidemic: More People at Risk, Multiple Drugs Abused, http://www.cdc.gov/vitalsigns/heroin/ (last visited Jan. 7, 2016).

Despite these gains, the work is unfinished. Laws and regulations designed to expand prevention and ensure greater access to SUD treatment and recovery supports and end discrimination mean nothing unless they are enforced. Following the recommendations in this new Roadmap will improve the health and wellbeing of millions of Americans, their families, their communities and the nation as a whole.

Recommendations to Strengthen the Health Responses to Addiction

Ensure that both private and public health insurance provide coverage for the full range of proven substance use prevention, treatment, and recovery support services

Private insurance

- The health insurance Marketplaces established under the ACA give states considerable flexibility to define Essential Health Benefits (EHBs) packages in qualified health plans. States should ensure that the EHBs include strong, specific coverage for the full range of SUD and MH services and medications.
- The Department of Health and Human Services (HHS) and states should ensure that private insurance plans meet the parity and anti-discrimination requirements of the Mental Health Parity and Addiction Equity Act, state parity laws and the ACA.
- The Marketplace should also ensure that enrollees can easily identify and choose the health coverage that is best for them. Finally, regulators should develop and enforce network adequacy standards to ensure timely access to SUD/MH services.

Public Insurance

- Individuals with SUD/MH who are eligible for Medicaid and Medicare must get access to the full continuum of needed services and medications.
- All newly eligible and traditional Medicaid beneficiaries should get coverage of SUD/MH services and medications at parity with other covered benefits.
- The federal government should modify the "Institution for Mental Disease" (IMD) exclusion, a serious roadblock to Medicaid beneficiaries receiving the level of SUD care that they need.
- All states should implement the Medicaid Health Home option and design systems to ensure that the SUD/MH needs of all enrollees will be addressed.
- Finally, federal and state governments should support and fund public education on overdose prevention, recognition, and response. Tools that are effective in preventing overdose death should be widely available. Federal and state governments should support evidence-based public health interventions, including syringe exchange programs, which increase access to health care and decrease transmission of HIV, viral Hepatitis, and other blood–borne diseases.

Prevent uninsured people with SUDs from falling through the cracks

Even after full implementation of the ACA in 2019, millions of people will remain uninsured, and not everyone with insurance will have adequate SUD coverage.

- It is essential to ensure that the current safety net, including the Substance Abuse Prevention and Treatment Block Grant, remains strong for people and services that remain uncovered by the ACA.

Invest in the SUD infrastructure and new models of care

Just as the federal government has made a meaningful investment in the community-based primary care infrastructure, it must make a serious commitment to an expanded SUD service infrastructure and new approaches to treatment. Specifically:

- The full continuum of SUD care must be available in every community. There must be investments in SUD treatment systems that are patient-centered and better reflect the chronicity of substance use disorders by promoting effective chronic disease prevention and management.
- Invest in building new treatment capacity and strengthening the infrastructure of the existing system.
- Assist SUD and MH providers to create needed health information technology.
- Increase investment in substance use education and training and initiatives to attract and maintain a diverse and culturally competent addiction workforce that is prepared for changes to the health care system.
- Assist SUD providers in adapting to changes in payment and reimbursement mechanisms.

Strengthen Substance Use Prevention

- Proven substance use prevention strategies and services should be brought to scale and incorporated into broader chronic disease prevention initiatives.
- Substance use screenings for youth and adults should be regularly conducted in a variety of settings. Brief interventions and referrals to treatment should be made when appropriate.

Reform our criminal justice system to focus primarily on the health and recovery of people with SUDs, rather than punishment and incarceration

The ACA has made possible an unprecedented expansion of health insurance coverage for justice-involved individuals, especially in states that have expanded Medicaid. This newly available coverage, combined with proven methods of diversion and early intervention, provide an opportunity to dramatically expand treatment and reduce recidivism.

- Each intercept of the criminal justice system--diversion programs, courts, jails, prisons, probation and parole departments, and reentry programs--should implement programs to ensure that justice-involved people are screened for and enrolled in appropriate health insurance coverage.
- Justice-involved people should be engaged in SUD and MH care as early as possible. They should be connected to crisis

intervention centers, community-based SUD and MH care, and other evidence-based services.

- Medication-assisted treatment (MAT) for SUD should be offered as a treatment option at all stages of the criminal justice system.
- The continuity of care for people returning to the community from the criminal justice system should be improved.

Expand SUD research

In recent years, researchers have made extraordinary advances in understanding the nature of addiction and developing new approaches to treating it. This progress cannot be allowed to stop.

- Federal resources for scientific research on SUD should be increased.

Recommendations to Eliminate Barriers Against People with Substance Use Disorders

Protect people in early recovery or entering treatment from discrimination

- The American with Disabilities Act, the Rehabilitation Act, the Fair Housing Act, and other anti-discrimination laws that cover people in early recovery should be fully enforced.

Remove barriers to public benefits and voting rights

- SSI/SSDI benefits for people with substance use disorders should be restored. The TANF and SNAP drug felony ban that limits access to nutrition assistance and cash support should be eliminated.
- The voting rights of people with criminal records should be restored.

Improve access to housing

- Statutory and regulatory barriers to housing for people with criminal records or histories of drug or alcohol misuse should be eliminated.

Promote educational opportunities

- Pell Grant eligibility should be restored for in-prison postsecondary education. The student aid ban for people with drug convictions should be eliminated.
- Post-secondary institutions should be encouraged to adopt admissions policies that don not discriminate against students with criminal records.

Increase employment of people with criminal records

- Laws and regulations that unreasonably prevent qualified people from working in certain industries should be eliminated.
- Background checks should be required to be fair, accurate, and complete. The fairness and relevance of criminal record checks should be improved by expanding sealing and expungement.
- Fair hiring policies should be implemented for people with criminal records, who

should receive specialized workforce services.

Relieve people of collateral consequences

- Unnecessary collateral consequences should be eliminated, and procedures should be offered to relieve people of collateral consequences.

Improve reentry and planning services

- The Second Chance Act federal reentry legislation should be reauthorized and fully funded.
- Effective prison and jail based recidivism reduction programming should be increased, including reentry planning.
- The federal Interagency Reentry Council should be made permanent.

Expand Alternatives to Incarceration

- The number of offenses for which Alternatives to Incarceration are a permissible or preferred sentencing option should be increased.
- Financial and career incentives should be offered to prosecutors who demonstrate a commitment to Alternatives to Incarceration and incorporate its use into their job performance measures.

Introduction

Drug policy and criminal justice reform are rare areas of public policy where a consensus has begun to form about the need for serious reform. In the states and at the federal level, from Left to Right, coalitions and reform efforts have taken root, achieved some important successes, and laid the ground work for changes that could dramatically reorient our health and justice systems to prevent, diagnose, treat, and manage substance use disorders in the same way as other chronic diseases. Such a reorientation will relieve pressure on corrections systems and law enforcement and free up resources for health, public safety, and other national priorities.

There is growing consensus about the evidence of dysfunction in the old approach to substance use from which we are departing and about the need for major reforms to improve health, reduce mass incarceration, and save and restore lives. There are also a number of different reforms that have been tried and met with success in different jurisdictions. But what has been missing is a comprehensive guide for overhauling the health and justice systems so that our nation's drug policies improve health, cost less, and do it in a more humane way.

The Roadmap for Promoting Health and Justice: A Smarter, More Effective National Drug Policy fills that gap. The Roadmap provides a comprehensive and detailed set of recommendations for improving our national drug and alcohol policy to focus on improving health and safety. Adopting these policies at the federal level and nationally would:

1. Provide the full range of proven prevention, treatment, and recovery services to 1 million more Americans over the next five years.
2. Eliminate or modify the thousands of criminal record barriers that fall disproportionately on people with substance use disorders.

Why Drug and Alcohol Policy Should Focus on Health

Public policy should be based on the best available evidence, and the evidence supporting a health approach to substance use could not be

clearer. Drug overdoses are the leading cause of injury death in the United States,[7] and substance use disorders are among of the most prevalent illnesses[8] even though they are chronic diseases that can be effectively prevented and treated. Substance use costs over 100,000 lives and upwards of half of a trillion dollars annually.[9] On top of high rates alcohol, cocaine and other drug problems, an epidemic of prescription opioid and heroin misuse is sweeping the nation.[10]

> Drug overdoses are the leading cause of injury death in the United States.

In addition to this tragic and often preventable loss of life, substance use disorders result in other high costs, especially to the health system. For example, according to the Agency for Health Research Quality, 25 percent of U.S. hospital admissions are directly related to mental health and/or substance use disorders.[11] A large body of evidence shows that treatment for substance use disorders is effective and results in remarkable cost savings to the health care, criminal justice, child welfare and social services systems.

Substance use disorder treatment has been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests by up to 64 percent.[12] Yet, according to the most recent Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH), 21.5 million Americans aged 12 or older needed treatment for an alcohol or illicit drug problem in 2014 but only 2.3 million received substance use treatment.[13]

Drug policies that emphasize punishment and discrimination are harmful and have failed to

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[7] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

[8] See U.S. Substance Abuse and Mental Health Services Administration, Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings (2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf; Robert Woods Johnson Foundation, Substance Abuse: The Nation's Number One Health Problem (Feb. 2001), http://www.rwjf.org/content/dam/farm/reports/reports/2001/rwjf13550.

[9] U.S. National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction (revised 2010), https://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.

[10] U.S. Centers for Disease Control and Prevention, Today's Heroin Epidemic: More People at Risk, Multiple Drugs Abused, http://www.cdc.gov/vitalsigns/heroin/ (last visited Jan. 7, 2016).

[11] Agency for Healthcare Research and Quality, Mental Health: Research Findings, http://www.ahrq.gov/research/findings/factsheets/mental/mentalhth/mentalhth3.html (last visited Jan. 7, 2016).

[12] The National Council for Community Behavioral Health, Preventing and Treating Substance Use Disorders: A Comprehensive Approach, https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf (last visited Jan. 7, 2016).

[13] U.S. Substance Abuse and Mental Health Services Administration, Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings (2015), at 3, http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf.

reduce substance misuse. They have contributed to the huge growth in justice involvement that has resulted in criminal records for 70 million Americans.[14] A criminal conviction exposes a person to barriers that make it more difficult to participate in educational opportunities, obtain employment, maintain suitable housing, receive quality healthcare, and access public benefits. Yet research shows that these are the very things that make successful reentry more likely. For example, a study by the American Bar Association Commission on Effective Criminal Sanctions shows that people with criminal records who are unable to obtain employment are three times more likely to return to prison than those individuals who are able to find work.[15]

See Appendix A: Just the Facts: The Clear Case for a Drug and Alcohol Policy that Promotes Health and Justice for more detail about the evidence for a national drug and alcohol policy that emphasizes health.

Looking Back on Seven Years of Accomplishments

Over the past seven years, the substance use disorder field has achieved tremendous success advocating for smarter drug and alcohol policies that will improve health outcomes, strengthen families and communities, and save huge amounts of money. Strong support from an alphabet of federal agencies -- HHS, SAMHSA, CMS, CCIIO, DOJ, DOL, and ONDCP, among others – Congress, and states was essential to this success. While there is much further to go, we have made huge strides toward increasing SUD coverage in public and private health insurance, expanding access to care, and eliminating discriminatory policies that harm people with substance use histories or criminal records.

In 2008, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) became law.[16] MHPAEA prohibits discrimination in health insurance coverage of substance use disorder (SUD) and mental health (MH) benefits. 113 million people have gained the protections of the federal parity law. The federal health reform law, the Affordable Care Act (ACA), includes SUD services and providers in virtually all of the law's major initiatives.

Bipartisan appropriators in Congress and the Administration have continued to support strong funding for the Substance Abuse Prevention and Treatment Block Grant program despite an extremely challenging fiscal environment. Since FY 2009, Congress has appropriated nearly $500 million in funding for critically important Second Chance Act reentry programming around the country.

Various policy documents of the Administration, including the National Drug Control Strategy and the annual federal budget, have clearly reflected the policy needs of people in recovery and those with criminal records.

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[14] Maurice Emsellem & Michelle Natividad Rodriguez, Advancing a Federal Fair Chance Hiring Agenda: Background Check Reforms in Over 100 Cities, Counties, and States Pave the Way for Presidential Action (Jan. 2015), http://www.nelp.org/content/uploads/2015/01/Report-Federal-Fair-Chance-Hiring-Agenda.pdf.

[15] ABA Commission on Effective Criminal Sanctions, Second Chances in the Criminal Justice System: Alternatives to Incarceration and Reentry Strategies at 27 (citing Rebuilding Lives. Restoring Hope. Strengthening Communities: Breaking the Cycle of Incarceration and Building Brighter Futures in Chicago. Final Report of the Mayoral Policy Caucus on Prisoner Reentry at 15 (2006)). (2007).

[16] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343.

The U.S. Attorney General established the Interagency Reentry Council, whose membership includes over twenty federal agencies, to coordinate and advance effective reentry policies and remove barriers to success.[17] The U.S. Attorney General directed the Department of Justice to reduce collateral consequences, promote alternatives to incarceration and place greater emphasis on successful reentry and recidivism reduction.[18] The U.S. Equal Employment Opportunity Commission (EEOC), Department of Housing and Urban Development, and Department of Education have all acted to reduce barriers for people with criminal records.

See Appendix B, Looking Back: Seven Years of Progress, for more information about the last seven years of drug policy reform.

Looking Forward to Work that Remains

Despite these tremendous gains, the work is unfinished and there is much more to do. Passage of the federal parity and health reform laws with strong addiction provisions, and the issuance of clear implementing rules and regulations, are just the beginning. Strong and unified advocacy will ensure that we achieve these goals: continue to expand access to provide the full range of proven prevention, treatment, and recovery services to 1 million more Americans over the next five years; and eliminate or modify the thousands of criminal record barriers that fall disproportionately on people with substance use disorders.

See Appendix C, Recommendations at a Glance, for a list of the recommendations in this report.

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[17] See Council of State Government Justice Center, Federal Interagency Reentry Council, http://csgjusticecenter.org/nrrc/projects/firc/, (last visitd Jan. 7, 2016).

[18] U.S. Dep't of Justice, Smart on Crime: Reforming the Criminal Justice System for the 21st Century, (Aug. 2013), http://www.justice.gov/sites/default/files/ag/legacy/2013/08/12/smart-on-crime.pdf.

Recommendations to Strengthen Health Responses to Addiction

Implementation of the Affordable Care Act (ACA) creates an unprecedented opportunity to address substance use disorders as the preventable, treatable, chronic health conditions that they are. Substance use disorders (SUD) must be addressed in a comprehensive way to transform our health care system into one that provides higher quality, better coordinated care. Such a system would improve health, prevent and effectively treat chronic diseases, and save money.

The ACA includes a number of landmark reforms related to substance use disorders and mental health (MH/SUD). Legal Action Center, the Coalition for Whole Health, and the SUD/MH fields are advocating for strong integration of SUD/MH in all aspects of health reform, beginning with the foundational issues of benefits, coverage, access, and delivery system reforms. The following are recommendations for dramatically expanding access to quality SUD and MH services in the critical years of health reform implementation.

Ensure Strong Coverage of and Access to SUD And MH Services and Medications in all Private Insurance plans in the Marketplace

A central component of the Affordable Care Act is the expansion of private insurance through the creation of state-based Health Insurance Marketplaces (also called "exchanges"). Health Insurance Marketplaces will allow individuals and small businesses to pool risk and purchase quality, regulated health insurance. It is through the Marketplaces that individuals and families with incomes below 400 percent of the federal poverty level will be able to receive federal subsidies to make insurance affordable. These small group and individual market insurance plans must cover all of the services in the essential health benefits package, including SUD/MH services, and meet the requirements of the federal parity law. Health plans will also have to meet non-discrimination and network adequacy requirements that, if well

implemented, will significantly improve access to SUD /MH services.

States should ensure Essential Health Benefits packages in all qualified health plans in insurance exchanges have strong and specific coverage for SUD and MH

The Essential Health Benefits (EHB) package, one of the most important consumer protections in the ACA, requires that all qualified health plans participating in the new Health Insurance Marketplaces, all non-grandfathered individual market and small group health plans operating outside of the Marketplaces, and Medicaid expansion plans include substance use disorder and mental health benefits. Full implementation of the ACA would result in approximately 70 million Americans having health coverage that is subject to the EHB requirements.

> Full implementation of the ACA would result in approximately 70 million Americans having health coverage that is subject to the EHB requirements.

While it was assumed that the Secretary of Health and Human Services (HHS) would develop an EHB package that would define the services to be covered in all states' plans, the Secretary instead gave states considerable flexibility to determine their own EHBs by selecting a "benchmark" plan. While HHS provided a framework to ensure that coverage for all required categories will be included, EHB requirements, including benefit requirements for MH/SUD, differ across states as a result of this approach.

For many states, the benchmark plan used to define their EHB was a plan from the small group market where coverage is generally less comprehensive than what is offered by large group plans. These plans also had not previously been subject to the requirements of the federal parity law. Coverage of certain prescription medications for SUD and MH, of "intermediate" SUD services such as residential and intensive outpatient treatment, and of care coordination and recovery supports similar to services for people with other chronic illnesses often have been excluded, inadequately covered, or more stringently managed by commercial insurance.

Coverage of SUD/MH should address the full continuum of care for these illnesses, from prevention, early intervention, treatment and rehabilitation to recovery supports. It should cover services to meet plan enrollees' multiple needs and all medications approved by the FDA to assist in the treatment of these disorders, and recognize that no single treatment is effective for all individuals. Everyone with SUD/MH treatment needs should receive the care that they need to get better, stay well, and lead healthy lives. To support adequate coverage of SUD/MH benefits in all states' EHBs, the Coalition for Whole Health, consisting of national, state, and local organizations, released recommendations for the minimum SUD/MH services states should include.[19] States should use the Coalition for Whole Health's recommendations as a guide for their EHBs.

HHS has implemented new regulations that generally continue the current benchmark approach through at least 2017. HHS should

[19] Coalition for Whole Health, EHB Consensus Principles and Service Recommendations.

conduct a comprehensive and transparent review of Essential Health Benefits in every state. Reviews should include both current EHB packages as well as proposals for the updated EHB to begin in 2017. Comprehensive EHB reviews should be done to ensure that current coverage is in compliance with the regulations and inform potential future changes in approach. If the EHB is not meeting the needs of all enrollees, HHS should make improvements.

HHS should pay special attention to categories that are traditionally insufficiently covered, including substance use disorder and mental health coverage, and work closely with states to identify and fill any gaps. Where the EHB as supplemented is still found lacking, HHS should use its authority to ensure adequacy of coverage by mandating certain services in a state, if those services are typically covered by large group and other employer plans.

HHS should pay special attention to categories that are traditionally insufficiently covered, including substance use disorder and mental health coverage, and work closely with states to identify and fill any gaps.

HHS and states should work closely together to ensure that coverage meets the parity and anti-discrimination requirements of the ACA and the federal parity law, including collecting the data required to ensure compliance and quality

The ACA requires that small group and individual insurance plans comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations to ensure that all enrollees are able to access the care they need.

With passage of MHPAEA in 2008, Congress sought to end the long history of insurance discrimination against those with SUD and MH that has prevented so many individuals from receiving the clinically appropriate type, level, and amount of care they need to get and stay well. While MHPAEA applies only to large group plans, the ACA extended its requirements to small group and individuals plans. To comply with the law, coverage of SUD/MH benefits may not be more restrictive than coverage of other medical/surgical benefits provided by the plan. The Secretary of HHS has made clear that all Qualified Health Plans (QHP) and coverage in individual and small group plans sold outside the exchanges must comply with these parity requirements.

The MHPAEA regulations state that financial requirements (co-pays, deductibles, co-insurance, and other out-of-pocket costs) and both quantitative treatment limitations (including day or visit limits or frequency of treatment limits) and non-quantitative treatment limitations (medical management tools) applied to SUD/MH benefits must be at parity. The regulations are clear that any limitations imposed on coverage of intermediate levels of SUD and MH care, such as residential treatment, intensive outpatient services and partial hospitalization, must be no greater than limitations imposed on other medical and surgical care.

Both the states and the federal government have the responsibility for ensuring that all covered large group, small group and individual plans fully comply with the requirements of parity, non-discrimination and other consumer protections in the laws. States should design robust SUD/MH benefits so that all enrollees can access the most comprehensive level of benefits that the framework established by HHS will allow. Plans that fall short of the requirements of state and federal law must be brought into compliance. HHS should require that plans make readily available on web sites and otherwise their coverage for MH/SUD, providers of MH/SUD services in their networks, and medical necessity and medical management criteria for MH/SUD as well as other conditions for parity comparison purposes. HHS should ensure that oversight and enforcement of parity for all covered plans is sufficient in every state.

HHS should also conduct a review of all EHB packages to ensure that they meet all of the requirements of MHPAEA and the ACA. If problems are identified, HHS should work with federal and state partners to enforce those requirements. To strengthen federal enforcement of the ACA and MHPAEA, HHS/CCIIO should 1) develop a mechanism for consumers, family members, and service providers around the country to report problems they experience with access to MH/SUD care without fear or risk of retribution; 2) take transparent corrective action to rectify identified problems with ACA and parity compliance; and 3) provide additional detailed guidance to insurers, consumers, providers, state regulators and others on what compliance with the MHPAEA, non-discrimination and other consumer protective provisions of the ACA requires. This includes working closely with insurance commissioners and other state regulators to clarify responsibilities. Where states are unable or unwilling to effectively guarantee parity compliance, HHS should ensure parity is enforced. Outcomes of EHB and MHPAEA compliance investigations should be made available on HHS and Department of Labor (DOL) websites, with names redacted where appropriate. Robust data collection will be extremely important to ensure that HHS, states, accrediting entities, consumers, and other stakeholders have the information required to enforce these protections, including ensuring that the SUD/MH benefits are provided in a way that is no more restrictive than the other benefits in the plan, consistent with parity. Congress should also pass into law HR 4276, the Behavioral Health Coverage Transparency Act, which would strengthen transparency, disclosure requirements and enforcement of the federal MH/SUD parity law.

HHS should also conduct a review of all EHB packages to ensure that they meet all of the requirements of MHPAEA and the ACA.

Health Insurance Marketplaces should ensure that enrollees can easily identify and choose the health coverage that is best for them

The Marketplaces should facilitate the enrollment in appropriate coverage of individuals with SUD/MH, since many will have difficulties navigating a complicated system. Therefore, a robust Navigator program—the central outreach and enrollment mechanism in

exchanges—and other application assistance and outreach efforts are critically important to ensuring maximum enrollment. HHS and states should ensure that all who may be eligible are aware of their eligibility, apply for coverage, and are promptly enrolled.

Protecting patient confidentiality is vital. All health plans, providers, Navigators, administrators and others who may have access to protected information should be trained on how that information may be shared in accordance with federal and state privacy laws.

Network adequacy standards that ensure timely access to SUD/MH benefits should be developed and enforced

As a result of strong advocacy by the SUD/MH community, the Exchange rule requires all qualified health plans to maintain a "network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay."[20] Properly enforced, this rule ensures enrollees in qualified health plans are able to access the care they need within a reasonable timeframe.

States and the federal government should ensure that the network adequacy requirements are enforced. Without strong enforcement and monitoring, it is likely that many plan enrollees will be unable to obtain the SUD/MH care they need. This is especially important considering the typical urgency of substance use and mental disorders and the need for treatment and other services to be readily available, without unreasonable waiting lists and other barriers.

Provide Strong Coverage of and Access to SUD and MH Services and Medications in Medicaid and other Publicly Funded Programming

The Affordable Care Act significantly expands Medicaid eligibility, including to childless adults and some higher income parents for the first time in many states. Under the law, the Medicaid expansion population will be guaranteed a package of benefits that includes SUD/MH benefits at parity with medical and surgical benefits. Medicaid expansion presents an unprecedented opportunity to address the SUD/MH needs of historically underserved low-income adults. Indeed, for the first time in the history of the Medicaid program, comprehensive SUD and MH coverage will be required for millions of adult beneficiaries.[21]

HHS and states should design Medicaid benefits and eligibility systems to ensure that eligible individuals with SUD/MH can enroll and access needed services and medications

The ACA expands Medicaid coverage by essentially eliminating categorical eligibility

[20] 45 CFR §156.230.

[21] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.

requirements for those under age 65 and setting an income eligibility floor for all individuals at or below 133 percent of the federal poverty level (FPL), or $14,856 for an individual and $30,657 for a family of four. As a result of the expansion, up to 16 million previously ineligible adults will gain Medicaid eligibility if all states expand, according to estimates by the Congressional Budget Office.[22]

The Medicaid expansion is an extraordinary opportunity for states to extend health coverage to some of their most vulnerable, underserved populations, and do so at very little cost to the state. All states should take full advantage of the opportunity to expand Medicaid coverage to all qualified adults below 133 percent of poverty. States should make full use of benefit flexibility and enhanced federal funding to provide the strongest possible SUD/MH coverage to the expansion population.

All Medicaid expansion plans, called the Medicaid Alternative Benefit Plans (ABP), must include SUD/MH benefits as one of the ten essential benefits, at parity with other illnesses.

HHS and states should ensure that all newly-eligible and traditional Medicaid beneficiaries receive comprehensive health coverage, including coverage for SUD and MH services and medications, at parity with other covered benefits

States have a considerable amount of flexibility to design benefits for the Medicaid expansion population, including the option to design an overall package of benefits that is more robust than the benefits currently provided to traditionally eligible enrollees. This is particularly true for SUD/MH benefits, which are often inadequately covered by Medicaid programs and, in the case of SUD, often not covered at all.

All Medicaid expansion plans, called the Medicaid Alternative Benefit Plans (ABP), must include SUD/MH benefits as one of the ten essential benefits, at parity with other illnesses. This means that financial requirements, quantitative treatment limitations, and non-quantitative limitations imposed on SUD/MH services and medications cannot be more restrictive than those applied to other covered medical and surgical benefits. State advocates should closely examine the SUD and MH coverage provisions of the ABPs alongside the coverage provisions of corresponding medical and surgical benefits. They should work with state Medicaid offices to ensure that the parity requirements are being met and that the clinically appropriate type and amount of care is accessible for consumers.

As states move forward with the Medicaid expansion, they should design the most comprehensive coverage allowed by Medicaid law and HHS, and should particularly design SUD/MH benefits in a way that will fully meet the needs of this underserved population. This includes, at a minimum, all of the MH/SUD services recommended by the Coalition for Whole Health.

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[22] Congressional Budget Office, Insurance Coverage Provisions of the Affordable Care Act— CBO's January 2015 Baseline, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf (last visited Jan. 7, 2016).

The ACA does not require states to provide SUD/MH benefits to beneficiaries receiving traditional Medicaid coverage. As states implement the Medicaid expansion, they should ensure not only that coverage for the expansion is as strong as possible for SUD/MH but also that those who are traditionally eligible for Medicaid receive the same SUD/MH benefits. Most large group plans cover SUD/MH services, and small group and individual market plans, as well as Medicaid expansion plans, are required to cover SUD/MH services. Those Medicaid beneficiaries that fall into traditional eligibility categories should also be guaranteed a comprehensive package of SUD/MH benefits. Providing the same benefits to both Medicaid populations will also avoid disruptions in coverage when an individual moves from one eligibility category to another and confusion among providers who treat traditionally eligible and newly eligible Medicaid beneficiaries.

States may not automatically enroll consumers with certain complex, chronic health conditions into ABPs, including chronic substance use disorders and serious mental health conditions. HHS should issue guidance to states on how to identify these medically frail individuals, including promoting policies that allow people to self-identify as medically frail. HHS should work with states to implement policies to assist people identified as medically frail and ensure they enroll in appropriate coverage for their needs.

Federal regulators should promptly finalize the recently proposed rule on the application of the federal parity law to Medicaid managed care, Medicaid Alternative Benefit Plans, and CHIP. Federal and state regulators should continue working to ensure that parity is fully implemented and enforced in these programs

The federal parity law applied its requirements to large group health plans and Medicaid managed care plans. Parity requirements have since been extended to the Children's Health Insurance Program (CHIP), small group and individual commercial markets, and Medicaid Alternative Benefit Plans (ABPs) through the ACA. CMS has repeatedly stated that parity applies to Medicaid managed care, ABPs, and CHIP, issued guidance to states on the application of parity to these programs, and continues to work with states to bring their programs into compliance with the law.

In April 2015, the Department of Health and Human Services issued proposed regulations governing how parity applies to Medicaid and CHIP. Under the proposed rule, all individuals enrolled in managed care, regardless of how the SUD/MH services are delivered, would receive the protections of MHPAEA, fulfilling a major intention of the law.[23] HHS should carefully consider the SUD/MH field's recommendations on the application of parity to Medicaid and CHIP plans and, as soon as possible, issue final regulations to ensure that parity is fully

[23] Coalition for Whole Health, Comments on Proposed Rule Applying Parity to Medicaid Managed Care, CHIP, and Alternative Benefits Plans (June 2015), http://lac.org/resources/substance-use-resources/parity-health-care-access-resources/coalition-for-whole-health-comments-on-proposed-rule-applying-parity-to-medicaid-managed-care-chip-and-alternative-benefit-plans/.

implemented in the coverage provided by these programs and fully enforced.

The federal government should modify the IMD exclusion to ensure that everyone with SUD/MH treatment needs can obtain appropriate care

The "Institution for Mental Disease" (IMD) exclusion is one of the most serious roadblocks preventing Medicaid beneficiaries from receiving the level of SUD care that they need. The IMD exclusion prohibits Medicaid from paying for any services for individuals between ages 18 and 64 who are patients in facilities that are determined to be IMDs. The intent of the IMD exclusion—to prevent Medicaid funds from going to mental hospitals—is wholly unrelated to cost-effective, community-based residential treatment for substance use disorders.[24] The IMD exclusion also raises parity concerns, since facilities that specialize in residential SUD/MH care are singled out for a payment exclusion that does not exist for facilities treating other illnesses and conditions. In fact, the final MHPAEA regulations make clear that coverage in private plans of intermediate services, including residential SUD services, must be at parity. The rule's explicit inclusion of residential treatment in the protections of the parity law means that more privately insured people may be able to access needed residential SUD treatment, while Medicaid plans continue to deny access.

CMS has recently taken encouraging steps toward improving access to this needed level of care. This includes release of a Medicaid Managed Care rule which proposes to increase flexibility to use substitute providers, including IMDs, under CMS's "in lieu of" policy and to permit a capitation payment for certain enrollees in an IMD for psychiatric or SUD crisis residential services. In addition, in a July 2015 State Medicaid Directors Letter, CMS stated that the agency would allow for federal financing of SUD services in IMDs through an 1115 demo, as part of a comprehensive, evidence-based, SUD system transformation. To improve access to the full range of SUD services for Medicaid beneficiaries, states should work closely with CMS to fully implement these new opportunities. Statutory changes may also be needed to ensure that providers of residential SUD services can remain financially viable.

All states should implement the Medicaid Health Home option and design systems to ensure that the SUD/MH needs of all enrollees will be addressed

One of the most important delivery system reforms in the ACA is the new health home state Medicaid option for beneficiaries with chronic conditions. Health homes build on the medical home model to create linkages to other community and social supports, enhance coordination of physical health, mental health and substance use care, and improve health outcomes for high-cost patients.

While some states have enthusiastically taken advantage of the health home option, many have been slow to begin implementation. Though optional, health homes hold significant promise to improve health and reduce the costs associated with chronic illnesses, including SUD/MH. All states should work closely with

[24] Legal Action Center, The Medicaid IMD: An Overview and Opportunities for Reform, http://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf (last visited Jan. 7, 2016).

SAMHSA and CMS to develop health homes, and they should design them to target enrollees with SUD/MH treatment needs and ensure they are able to access the full array of services and supports they need to improve and maintain health.

All Medicare enrollees with SUD/MH service needs should be able to access all medically appropriate care, including all approved medications, across the continuum of care for these illnesses, for an appropriate duration.

Linking people in the criminal justice system to health homes is an excellent opportunity to ensure they receive needed care. New York, in particular, has looked to its Medicaid health homes as an effective way to improve the health of many in the state's criminal justice population.

The full continuum of SUD/MH services and medications should be covered and fully accessible to people enrolled in Medicare

All Medicare enrollees with SUD/MH service needs should be able to access all medically appropriate care, including all approved medications, across the continuum of care for these illnesses, for an appropriate duration. Enrollees often face barriers to accessing the services and medications they need, and parity requirements for SUD/MH do not apply to Medicare. Congress should extend the consumer protections of the federal parity law to all people covered by Medicare. Medicare regulations governing which SUD/MH providers are eligible to participate in the program and receive reimbursement are unnecessarily restrictive, preventing many qualified providers from serving the Medicare population. Medicare rules should be reformed to allow SUD/MH treatment providers to more easily become Medicare providers.

Federal and state governments should support and fund public education on overdose prevention, recognition, and response, and tools that are effective in preventing overdose death should be widely available. Federal and state governments should also support evidence-based public health interventions, including syringe exchange programs, which increase access to health care and decrease transmission of HIV, viral Hepatitis, and other blood-borne diseases

Drug overdose deaths in the United States are at an epidemic level. According to the latest available data from the Centers for Disease Control and Prevention (CDC), drug overdose was responsible for over 47,000 deaths in 2014[25] and is the leading cause of injury-related

[25] U.S. Centers for Disease Control and Prevention, Drug Overdose Deaths Hit Record Numbers in 2014, http://content.healthaffairs.org/content/31/5/1000.full (last visited Jan. 7, 2016).

death.[26] Drug overdose caused more deaths among people 25 to 64 years old than motor vehicle crashes.[27] Overdose deaths involving prescription opioids have increased to almost 17,000 deaths a year,[28] which coincides with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain.[29]

In addition, as demonstrated by the situation in Scott County, Indiana, there is a clear link between injection drug use and the transmission of HIV, Hepatitis and other blood-borne diseases. A variety of interventions are needed to reduce HIV incidence among people using injection drugs and their partners, including HIV prevention education and access to SUD treatment. Public health agencies are currently restricted by law from using federal funds for one evidence-based approach: syringe exchange programs. Numerous scientific studies have established that when implemented as part of a comprehensive HIV/AIDS prevention strategy, syringe exchange programs are effective at preventing HIV infections and do not promote drug use. This position is confirmed by leading scientific experts including three former Surgeons General. Syringe exchange programs have been shown to prevent the transmission of Hepatitis C, another growing threat to the nation's health.

Numerous scientific studies have established that when implemented as part of a comprehensive HIV/AIDS prevention strategy, syringe exchange programs are effective at preventing HIV infections and do not promote drug use.

We are facing a major national public health crisis that requires a multi-pronged, coordinated, sustained response, including:

- Public education and other prevention strategies to reduce drug use initiation and prevent escalation to dependence and addiction;
- Increased federal support for mandated education of prescribers on evidence-based practices for the use of prescription opioids to manage pain and specific steps to prevent, identify and manage opioid overdose;
- Expanded access to addiction treatments, including the use of all FDA-approved medications;
- Improved education about where to obtain SUD treatment and recovery support;
- Repeal of the ban on federal funding for syringe exchange programs to allow interested states and localities the financial flexibility to implement evidence-based HIV prevention initiatives;

[26] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

[27] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

[28] U.S. Centers for Disease Control and Prevention, Opioids Drive Continued Increase in Drug Overdose Deaths (Feb. 2013), http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html.

[29] U.S. Substance Abuse and Mental Health Services Administration, Prescription Drug Misuse and Abuse, http://www.samhsa.gov/prescription-drug-misuse-abuse (last visited Jan. 7, 2016).

- Increased federal investment in public education and awareness on identifying the symptoms of overdose and steps to take if someone may be experiencing an overdose; and
- Increased funding for SAMHSA to help States, counties and localities purchase naloxone and to support other tools effective in preventing opioid overdose deaths.

Invest in the SUD Service Infrastructure

The prevention, treatment and recovery service infrastructure must be strong to ensure that people at risk or suffering from SUDs can access the quality care and supports they need to become and remain well. However, the current addiction service providers are not even close to having the infrastructure and capacity to help the millions of Americans who are currently un-served. The ACA's coverage expansions and required inclusion of SUD benefits likely will lead to many more of the 23 million Americans with untreated SUD seeking care. Every community must have the capacity to meet their needs with the full continuum of quality substance use disorder prevention, treatment services and medications, and recovery support services. Patient placement should be determined using the criteria developed by the American Society of Addiction Medicine. These services should be readily available to people who need them, whenever and wherever they are ready to receive them.

> The SUD service infrastructure must meet the needs of far more Americans and reflect the chronicity of the disease of addiction and support people over a lifetime. Treatment for SUDs that is based on the latest evidence with a focus on quality reduces costs and improves outcomes.

As the coverage expansions of the ACA are fully implemented and the health care system evolves to better meet the needs of health care consumers, the SUD service infrastructure must also transform to meet three enormous challenges:

(1) Bringing treatment capacity to scale, so that it can serve far more than the 10 percent of the 23 million Americans with SUDs who currently receive care;

(2) Ensuring that both existing and new treatment providers include the full range of quality services people with SUDs need and deserve; and

(3)Integrating prevention, treatment and recovery support effectively with mental and physical health care.

Just as the federal government has made a meaningful investment in the community-based primary care infrastructure, Congress and the administration must make a serious commitment to the national SUD service infrastructure. Without a renewed federal investment in the SUD service infrastructure, there will not be adequate capacity for children, youth, and adults with substance use disorders to receive the lifesaving care and supports they need.

Ensure that the full continuum of SUD care is available in every community, and invest in SUD treatment systems that are patient-centered and better reflect the chronicity of substance use disorders by promoting effective chronic disease prevention and management

Widespread discrimination against people with addictions led to severe underfunding of the SUD prevention, treatment and recovery support system and the development of SUD services and financing systems separated from the rest of health care that promote limited episodic care rather than prevention, treatment and recovery from chronic disease. Barely 10 percent of those in need of SUD treatment receive any specialty care, a penetration rate far below that of any other health issue even though SUD is one of the most prevalent and deadliest diseases in our nation.

SUD care should be patient-centered and integrated effectively with other health care to address all the patient's needs, not a "one-size-fits-all" approach.

SUD systems of care should be based on recognition that addiction is a chronic brain disease that can be prevented, treated, and supported successfully. Like other chronic diseases, SUDs are best treated through disease management rather than episodic care to deal with a crisis or other severe downturn, as is often the case now. Research led by Thomas McLellan found that relapse rates for addiction are comparable with those for other chronic diseases such as diabetes and hypertension. Policymakers and practitioners should look to chronic disease management lessons from other illnesses, including the importance of trust and person-centeredness to treatment success. Chronic disease management practices that keep families healthy will improve public safety as well as contain rising health care costs.

The SUD service infrastructure must meet the needs of far more Americans and reflect the chronicity of the disease of addiction and support people over a lifetime. Treatment for SUDs that is based on the latest evidence with a focus on quality reduces costs and improves outcomes. Moving the SUD system of care toward a chronic disease management model, with an overall goal of increasing the capacity of quality services, will require delivery system design changes, infrastructure improvements, modifications to regulatory/licensing standards, a skilled workforce, more self-management support, and new approaches to SUD treatment financing.

Every community should have access to the full range of quality SUD prevention, treatment, rehabilitation, and recovery support services to ensure that people receive the clinically appropriate level of care that is focused on long-term patient engagement, integrated with mental health and primary and other physical health care, and coordinated with a single point of accountability. The services should include:

- Preventive and wellness services
- Screening, assessment, and diagnosis
- Medication-assisted treatment
- Psycho-social treatment modalities

- Gender-specific, culturally competent, trauma-informed care
- Co-morbid chronic disease management services
- Skills training and other rehabilitation services
- Recovery coaching and support services
- Transitional/ recovery support housing
- Educational and vocational services
- Family counseling and support, including unification

> Working in the addiction field should come with the same workforce support and professional prestige that are part of working in the larger health field.

SUD care should be patient-centered and integrated effectively with other health care to address all the patient's needs, not a "one-size-fits-all" approach. The Recovery-Oriented Systems of Care (ROSC) approach promoted by SAMHSA, like other integrated care models, aims to provide patient-centered and comprehensive health care across a broad spectrum of services and providers in a culturally appropriate, evidence-based, accessible, and continuous manner. A number of innovative models for broader integrated healthcare delivery, such as health homes and collaborative care models, offer significant promise to improve healthcare delivery and reduce overall healthcare costs if they effectively integrate SUD and MH services, treat these disorders as chronic diseases and include providers that specialize in treating addictions and supporting long-term recovery.

People in need of care should be fully informed about treatment and support options, with access to, and reimbursement for, recovery coaches to help them navigate their health care options and manage their recovery. Care models should meet the multiple needs of the individual and recognize that, like other conditions, no single treatment for SUDs is effective for all individuals. Patient-centered care should include options for care that foster recovery and wellness through individualized community-based services and supports. Care providers should work with patients and their families to design service plans, including how and where services are delivered, and empower them to participate in the design, administration and delivery of services. Patients also need to be well-informed about why health information sometimes needs to be shared with the patient's other health care providers to improve the quality of care and about how the law continues to protect their privacy and the confidentiality of records related to addiction treatment.

Invest in building new treatment capacity and strengthening the infrastructure of the existing system

Our nation needs to substantially expand SUD treatment capacity to treat the millions more Americans in need of care. Recent increases in private investment in expanding SUD treatment is welcome and needed; government must assist those efforts by removing bureaucratic and sometimes illegal barriers to siting, building and opening new offices and clinics. The Obama Administration's recent investment in expanding the capacity of community health centers to address addiction also is an important step; it

must make sure that health centers provide, directly or by contract, the specialized addiction treatment services many will need. Federal, state and local governments must also invest in expanding the capacity of specialized SUD treatment.

SUD service providers' history of insufficient funding, lack of experience receiving reimbursement from Medicaid and commercial insurance, and isolation from the rest of health care has left many of them ill prepared to adapt to the rapidly changing health care environment. Service providers need assistance with billing, negotiating contracts with insurers, and other business skills to transition into the more managed and integrated health care environment. Government should continue to assist providers in improving these business practices to maintain and increase capacity. Private payors must come into compliance with federal and state requirements for contracting with and reimbursing SUD and MH providers.

Assist SUD and MH providers to create needed health information technology

Quality care, including effective integrated care, requires timely health information exchange so that patients and their health care providers have real-time access to health information that is relevant to their care. Electronic health information systems should be designed consistently with the requirements of the federal law and regulations governing confidentiality of alcohol and drug patient records to include records of treatment for alcohol and drug disorders and should be constructed to allow health care providers appropriate access. Integrated electronic health records can greatly improve the quality and coordination of care for SUD and MH as well as physical health conditions. However, these technologies require significant up-front expenditures to implement.

As the use of health information technology is expanded to further integrate care in our healthcare system, SUD/MH treatment providers must be eligible to receive grants for health information technology adoption, implementation, and training. Most SUD/MH service providers were not eligible for the $19 billion in health information technology funds allocated through the American Recovery and Reinvestment Act (ARRA) stimulus bill. As a result, fewer than half of SUD and MH providers possess fully implemented electronic health record systems, and information technology spending in those organizations represents only 1.8 percent of total operating budgets, compared with 3.5 percent for general health care.[30]

Congress should pass the Behavioral Health Information Technology Act which would make providers of lifesaving addiction and mental health treatment services eligible for these funds, thereby strengthening the infrastructure for cost-effective, quality care.

Increase investment in substance use education and training and initiatives to attract and maintain a diverse and culturally competent addiction workforce that is prepared for changes to the health care system

As documented by the Institute of Medicine and other public health experts, the addiction service field faces a serious shortage of workers, an

[30] Centerstone Research Institute, Behavioral Health/Health Services Information Systems Survey (June 2009), http://www.satva.org/documents/InformationSystemsSurveyReportFinal.pdf.

aging workforce, unacceptably low counselor salaries, the need for a more diverse, culturally competent workforce, and the continuing stigma associated with addiction.[31] SUD service providers are a part of the broader health care system. Working in the addiction field should come with the same workforce support and professional prestige that are part of working in the larger health field. Congress and the administration should renew their commitment to the SUD service infrastructure and demonstrate the importance of the addiction workforce by significantly increasing funding for:

- Educational and training for the addiction workforce. Initiatives to support training for the broader health workforce must have a specific, required focus on training and educational grant support for addiction workforce professionals. These initiatives should prepare addiction workforce professionals to integrate more effectively with the broader health care system. The federal investment in training and technical assistance for programs should be doubled to ensure that addiction professionals are utilizing up-to-date, evidence-based practices.
- Education and training for other health care professionals. Workforce development initiatives that are a part of national healthcare reform must ensure that all health professionals receive education and training about how substance use disorders are preventable, treatable chronic diseases and that millions of Americans are in long-term recovery from these diseases. All health professionals should receive the requisite education to recognize the symptoms and screen for mental illness and/or substance use disorders. These initiatives should also ensure that funding is provided to train health professionals to conduct brief interventions and ensure that people in need of treatment receive the appropriate level of care. Medical and nursing schools have a critical role to play in making sure health professionals are prepared to address addictions that often co-occur with other health disorders. Accrediting agencies should make sure schools that train medical professionals are adequately preparing them to meet the needs of their patients who have addictions.
- Career development within the addiction field. Congress should establish a loan forgiveness program for addiction workforce professionals and an increased pay scale that better compensates workers in this field. Adequate funds should be appropriated to support and incentivize career development activities including mentoring, apprenticeship, and career ladders for advancement within the field.
- A diverse and culturally competent workforce. Statutory and regulatory barriers that prevent people in recovery from working in the addiction services field should be eliminated. Congress should establish demonstration projects within the Department of Labor and the Department of Veterans Affairs to develop training institutes and career ladder opportunities for veterans and service corps members to become qualified addiction counselors. HRSA should work with SAMHSA to develop and infuse national addiction core

[30] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Improving the Quality of Health Care for Mental and Substance-Use Conditions (2006), http://www.ncbi.nlm.nih.gov/books/NBK19830/.

competencies and accreditation standards into academic curricula across medical, social service, and criminal justice disciplines.

Assist SUD providers in adapting to changes in payment and reimbursement mechanisms

SUD treatment, like much of health care, is currently financed largely through a fee-for-service model. As some payment systems begin to change to value-based systems (e.g., accountable care organizations, bundled payments, global payments and case rates),[32] providers will need assistance in developing the competence to navigate that transition. Many, if not most, SUD providers – again like much of the rest of the health care system – currently lack the data and analytic ability to calculate and negotiate value-based payments.

Federal, state and local governments should assist SUD providers in developing the capacity to shift to value-based payments, including the ability to:

- Cost out services
- Measure, contract for, and customize services to deliver clinical and financial outcomes and value-based services
- Understand how to utilize risk-bearing and risk-sharing financial models with respect to the contracting, delivery and billing of services

Every community must have sufficient capacity to ensure that children, youth, and adults receive the lifesaving substance use care and supports they need. Launching a significant, sustained federal investment in the SUD service infrastructure is more important now than ever.

Preserve the Safety Net for the Continuum of SUD Prevention, Treatment and Recovery Support Services

Ensure the safety net, including the Substance Abuse Prevention and Treatment Block Grant, remains strong for people and services that remain uncovered by the ACA

It is essential now and will remain essential in the future to maintain strong safety net funding, including for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Health care reform presents a great opportunity to help many more people with SUD prevention, treatment and recovery support needs to get what they need to become and stay well. However, it is clear that even after full implementation of the ACA in 2019, millions of people will remain uninsured, and not everyone with insurance will have adequate SUD coverage.

There will likely remain certain parts of the SUD services continuum that are not adequately covered through the ACA. Although the ACA will continue to dramatically expand coverage for SUD treatment, the same is not expected for substance use prevention. Coverage for certain

[32] The National Council for Behavioral Health, Creeping and Leaping from Payment for Volume to Payment for Value: An Update on Behavioral Healthcare Payment Reform (2014), http://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf.

preventive services will likely increase as a result of the ACA, but many community- and school-based substance use prevention strategies and services will not likely be adequately covered through the essential health benefit package. There is a strong need to maintain the requirement that the SAPT Block Grant fund substance use prevention to ensure that these services and strategies receive adequate funding.

Public and private plans are also unlikely to meet the treatment and recovery needs of every person with SUD. Although the ACA and the federal parity law will improve coverage of services that help people maintain their recovery, critically important recovery support services will likely not be fully funded. These services are analogous to management services covered for people with other chronic diseases such as diabetes, heart disease and hypertension.

States that have approached universal coverage have found that those who remained uninsured are disproportionately people with SUD needs, who continue to need a strong safety net.[33] To cover people who will remain uninsured and services that will remain uncovered, SAPT Block Grant and other safety net programs must continue to be strong through these interim years, full implementation of the law and beyond.

Strengthen Substance Use Prevention

Proven substance use prevention strategies and services should be brought to scale and incorporated into broader chronic disease prevention initiatives.

As health care reform is implemented and greater emphasis is placed on preventing chronic disease, the need to strengthen support for effective substance use prevention strategies and services is more critical than ever. Our nation must strengthen the existing substance use prevention infrastructure and ensure that substance use prevention strategies and services are fully included in broader chronic disease prevention initiatives through the Affordable Care Act and otherwise.

While a great deal of progress has been made in expanding the health responses to substance use and addiction, our nation suffered a significant setback when much of the funding for substance use prevention disappeared with the elimination of all funding for the Safe and Drug-Free Schools and Communities program. Despite the significant loss of federal funding and programs in recent years, there remains expertise around the country on a broad array of effective community- and school-based substance use prevention. However, the percentage of federal funding devoted to primary prevention is woefully inadequate. A significant federal investment is needed to return to a baseline where every school or community has a point person for youth substance use education and counseling. The current substance use prevention infrastructure, supported by a strong body of knowledge and expertise, needs strengthening to ensure that effective substance use prevention strategies and services are available across the lifespan.

> Substance use prevention should be fully incorporated into the new health care environment.

[33] Victor A. Capoccia et al., Massachusetts's Experience Suggests Coverage Alone Is Insufficient to Increase Addiction Disorders Treatment, Health Affairs (May 2012), http://content.healthaffairs.org/content/31/5/1000.full.

Existing substance use prevention strategies, interventions and services should be brought to scale. Prevention initiatives must include a blend of individually and environmentally focused efforts. Multiple strategies should be implemented across all sectors of a community to reduce drug and alcohol use. Prevention messages and strategies need to be directed toward youth, parents, schools – including colleges and universities –and communities.

Although coverage for certain preventive services will increase as a result of the ACA, most community- and school-based substance use prevention strategies and services are unlikely to be adequately covered in private or public insurance. In addition to continued mandatory substance use prevention funding through the SAPT Block Grant, SAMHSA should continue its strong focus on and investment in substance use prevention programming. The federal government should also support and fund a broad public health education initiative, particularly aimed at teens and parents, to reduce teen initiation of alcohol, opioids and other drugs. This type of initiative should be comparable to the effective, on-going public education campaigns to prevent smoking, to prevent drunk driving and to promote public health.

Substance use prevention should be fully incorporated into the new health care environment. The National Prevention Strategy[34] recognizes the importance of preventing substance use to improving our nation's health and wellness. There is greater understanding that substance use prevention services and strategies are effective not just in preventing use and the harms associated with use, but also in helping people avoid addiction and other co-occurring chronic diseases. As they are developed, initiatives aimed at promoting health and wellness and preventing chronic disease in schools, community health settings, the workplace, and other settings should focus on effective substance use prevention strategies and services. Inclusion in these initiatives of substance use screening and brief interventions for adults and youth, educational services for consumers, families and caretakers, health coaching, and wellness promotion will improve public health.

Substance use screenings for youth and adults should be regularly conducted in a variety of settings. Brief interventions and referrals to treatment should be made when appropriate.

Substance use disorders are preventable chronic diseases, and prevention, early identification, and treatment of these diseases are highly cost-effective.[35] Given the low risk, low cost, and high effectiveness of screening for alcohol and drug use (both illicit and prescription drug misuse) and the current state of knowledge about the consequences of untreated addiction, screenings should be done often to identify problem drinking and/or drug use and intervene early. These screenings should be covered by private and public insurance in all appropriate health, school and other community-based settings, and should be reimbursable when provided by any qualified practitioner. Screenings should be provided as often as appropriate, which may include at every

[34] Office of the U.S. Surgeon General, National Prevention Council, National Prevention Strategy (2011), http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf (last visited Jan. 7, 2016).

[35] See, e.g., Kaiser Permanente Medical Program Division of Research, Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis (Jan. 2001), http://www.ncbi.nlm.nih.gov/pubmed/11271969 (Healthcare costs declined by 39 percent, 35 percent, and 26 percent respectively after patients who suffered from alcohol or drug addiction received treatment.).

opportunity for people at higher risk for SUD. Screenings should be followed by brief interventions and/or referrals for treatment whenever that is the appropriate care.

Primary care professionals conducting these preventive services should receive adequate education and training on substance use disorders, effective screening and assessment tools, treatment, and recovery. This includes not just providers in traditional primary care settings, but also those in schools, juvenile justice facilities, and other primary care settings where prevention services related to substance use disorders are especially needed.

Provide Strong Coverage for and Access to Care for Justice-Involved Individuals

Untreated addiction is common among the criminal justice population and has been shown to contribute to criminal justice involvement and recidivism.[36] Prior to health reform, the justice-involved population disproportionately lacked health coverage to treat substance use disorders and other health needs. The majority could not afford private health insurance and was not in a category that would make them eligible for Medicaid or other public coverage.

Under the Affordable Care Act, that entire landscape has shifted, especially in states that have expanded Medicaid eligibility. In Medicaid expansion states, almost all individuals leaving jails and prisons or serving a term of parole or probation in the community are eligible to receive Medicaid benefits or purchase quality private health coverage that is subsidized to be affordable based on their income.

This expanded insurance eligibility presents an extraordinary and unprecedented opportunity in both health and criminal justice to provide lifesaving and life-changing substance use and mental health treatment and other health services to a large population of that has previously lacked access to such care. Substance use and mental health care will improve the health and well-being of justice-involved people and increase public safety by reducing recidivism.

By working to ensure that all eligible people are enrolled in health coverage and connected to healthcare, including appropriate treatment services and medications to address substance use disorders, practitioners can maximize this opportunity to improve health and justice.

Ensure all eligible justice-involved people are enrolled in appropriate health coverage

Health reform offers a great opportunity to ensure that justice-involved people are able to obtain health coverage to overcome one of the primary obstacles to SUD treatment: a lack of affordable coverage options to pay for medications and services. While many more people have become eligible for affordable coverage, there remain a large number of eligible individuals who are not enrolled in coverage. Many of them wind up in contact with the justice system. All intercepts of the criminal justice system —diversion programs, courts, jails, probation and parole departments, and those providing reentry services— should

[36] See U.S. Substance Abuse and Mental Health Services Administration, Criminal and Juvenile Justice, http://www.samhsa.gov/criminal-juvenile-justice (Last visited Jan. 7, 2016).

implement processes to ensure that people under their custody or supervision are screened for and enrolled in appropriate health coverage.

In addition to those who are eligible but not enrolled in Medicaid, many states unnecessarily terminate enrollees' Medicaid coverage when they are incarcerated, requiring them to reapply after they are released and often resulting in long gaps in coverage.[37] However, at least twelve states, including California, Iowa, New York, North Carolina, and Texas, currently have laws or administrative policies to suspend, not terminate, the Medicaid enrollment of incarcerated individuals. This allows Medicaid enrollees seamless or near seamless transitions in health coverage as they reenter the community.

There is an additional fiscal benefit for states to keep Medicaid enrollment active for people who are incarcerated. While federal Medicaid funds are not available for most care provided to incarcerated beneficiaries, states can be reimbursed by the federal government for inpatient care provided to incarcerated individuals in community-based settings. Maintaining enrollment facilitates access to Medicaid funds when allowed, which can save states and localities considerable amounts of money.[38] The potential for states to decrease their share of health care spending is another reason all states should adopt policies that keep Medicaid active during incarceration.

Justice-involved people should be engaged in SUD and MH care as early as possible. They should be connected to crisis intervention centers, community-based SUD and MH care, and other evidence-based services

Everyone should have access to the full range of substance use disorder and mental health services, whether they are incarcerated in prison or jail or participating in a community corrections or diversion program. Treatment for substance use disorders should be the preferred method for addressing drug use, and prison and jail should be reserved for cases where treatment will not be sufficient to address the public safety concerns raised by a person's conduct. For those individuals who do receive a term of incarceration or community corrections, the full range of treatment options should be offered and promoted at every opportunity.

> Untreated addiction is common among the criminal justice population and has been shown to contribute to criminal justice involvement and recidivism.

Federal, state, and local governments should expand the use of diversion programs to admit people into substance use disorder and mental health care. Diversion programs should not widen the criminal justice net by imposing more severe penalties and sanctions on people who do not immediately succeed in treatment. Relapse is often part of recovery. Programs that increase

[37] Council of State Government, Justice Center, Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System (Dec. 2013), https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

[38] Council of State Government, Justice Center, Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System (Dec. 2013), https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

the consequences for a defendant who enters treatment and then relapses by imposing more stringent penalties than they would have received if they did not agree to treatment fail to take this into account.

Diversion programs should divert defendants from the justice system as early as possible. People should be connected to crisis intervention centers, community-based substance use or mental health treatment, or other evidence-based services at every early justice-system intercept:

- Before arrest
- Before charging or booking
- Before a guilty plea or conviction

These programs should allow defendants to avoid receiving a criminal conviction if they are willing to participate in diversion programs that hold them accountable while also addressing their underlying health needs. Allowing people to avoid a conviction is critical since a criminal record makes life difficult for people long after they would have completed any term of incarceration or community supervision.

> All intercepts of the criminal justice system —diversion programs, courts, jails, probation and parole departments, and those providing reentry services— should implement processes to ensure that people under their custody or supervision are screened for and enrolled in appropriate health coverage.

Offer medication-assisted treatment (MAT) for SUD as a treatment option at all stages of the criminal justice system

Scientific research has firmly established that treatment of opioid dependence with medications (MAT) reduces addiction and related criminal activity more effectively and at far less cost than incarceration.[39] Notwithstanding the clear benefits of MAT, many parts of the criminal justice system prohibit the use of MAT to treat opioid dependence, even when it is prescribed by a treating physician.[40]

Federal and state courts, prisons, jails, community corrections settings, and diversion programs should offer MAT as a treatment option whenever a physician or other substance use treatment professional has determined that MAT is the appropriate treatment for a person's substance use disorder. Law enforcement, corrections, and court personnel should not interfere with a clinician's judgment about what is right for a patient's health. They should receive education and training on the nature, application, and implementation of MAT services.

Congress should pass the Comprehensive Addiction and Recovery Act of 2015, bi-partisan

[39] Substance Abuse and Mental Health Services Administration, Emerging Issues in Behavioral Health and the Criminal Justice System, http://www.samhsa.gov/criminal-juvenile-justice/behavioral-health-criminal-justice (last visited Jan. 7, 2016).

[40] Legal Action Center, Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System (Dec. 2011), http://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

federal legislation introduced in both the U.S. House and Senate, which would expand community-based opioid addiction treatment and intervention programs, and would support the expansion of MAT in jails and prisons. The White House Office of National Drug Control Policy's recently announced plan to prohibit drug courts receiving federal dollars from forcing people receiving MAT to stop taking their medications should be fully implemented and enforced.

Improve continuity of care for people returning to the community from the criminal justice system

Justice systems should promote continuity of care for the people transitioning from their custody or supervision into the community. Courts and corrections should work with other government agencies and community-based treatment providers to meet the health needs of people in transition without unnecessarily disrupting care they are receiving or delaying care they need.

> Scientific research has firmly established that treatment of opioid dependence with medications (MAT) reduces addiction and related criminal activity more effectively and at far less cost than incarceration.

Prisons and jails should provide every person leaving their custody with a reentry plan that includes initial appointments and contact information for substance use and mental health treatment services they need to receive in the community to stay healthy. Corrections personnel should work with community-based providers to arrange point-to-point transportation from the facility to the location of appointments and services.

States should use the Medicaid health home option. Its focus on ensuring that people with complex, varied health needs receive care and supports in a coordinated way is well designed to meet the health needs of formerly incarcerated people and others involved in the criminal justice system.

Expand Research on Substance Use Disorders

Scientific research led to the discovery that addiction is a disease of the brain.[41] As researchers continue to learn about alcoholism and drug addiction, their findings will continue to improve our understanding of addiction and inform policy-makers and practitioners about the preventative and therapeutic actions that can combat it. Groundbreaking research continually identifies more effective responses.

Over the past several years, the National Institutes on Drug Abuse (NIDA) and Alcohol Abuse and Alcoholism (NIAAA) have made extraordinary scientific advances in understanding the nature of addiction. Research on addiction has led to the development and testing of new science-based therapies.

Federal resources for scientific research on SUD should be increased significantly to address some of the most pressing questions about SUD

[41] U.S. National Institute on Drug Abuse, The Science of Drug Abuse and Addiction: The Basics, http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics (last visited Jan. 7, 2016).

prevention, treatment, and recovery. Expanded research could focus on:

- Medications development;
- Treatment and service delivery throughout the criminal justice system;
- Adolescent vulnerability and decision-making and resulting prevention strategies;
- Recovery and its nature, characteristics, and demographics.

With funding for expanding research and applying what is learned, the fields of substance use prevention, treatment and recovery can work collaboratively with policymakers, social service and government institutions, and community leaders to implement better informed, science-driven approaches to preventing and treating SUD.

Recommendations to Eliminate Barriers for People with Substance Use Disorders

Each year, over 11 million people cycle through our nation's jails[42] and over 600,000 people return home from prison,[43] roughly the same population as Louisville or Milwaukee. Over 70 million Americans, or one in three adults, have an arrest or conviction record.[44] For many of them, criminal justice involvement is related to a substance use disorder.[45]

When a person completes a criminal sentence, society expects them to return home, rejoin and recommit to their community, and begin to support themselves. But laws and policies deny people student aid, prohibit them from working in jobs even when they are qualified and pose no serious risk, and allow employers to rely on notoriously inaccurate criminal record information to make hiring decisions. They make it harder for people to find housing and live with their families, deny them the security of knowing they can rely on a safety net, and prohibit them from participating in representative government.

Protect People in Early Recovery or Entering Treatment from Discrimination

The Americans with Disabilities Act (ADA), prohibits discrimination against people with disabilities in employment, public benefits, public accommodations and other activities. Addiction is a qualifying disability under the law, and employers must accommodate people with addictions unless they are "currently engage[ed]

[42] U.S. Bureau of Justice Statistics, Jail Inmates at Mid-Year 2014, (June 2015), at 8, http://www.bjs.gov/content/pub/pdf/jim14.pdf.

[43] U.S. Bureau of Justice Statistics, Prisoners in 2013 (Sep. 2014), at Table 9, http://www.bjs.gov/content/pub/pdf/p13.pdf.

[44] Maurice Emsellem & Michelle Natividad Rodriguez, Advancing a Federal Fair Chance Hiring Agenda: Background Check Reforms in Over 100 Cities, Counties, and States Pave the Way for Presidential Action (Jan. 2015), http://www.nelp.org/content/uploads/2015/01/Report-Federal-Fair-Chance-Hiring-Agenda.pdf.

[45] See U.S. Substance Abuse and Mental Health Services Administration, Criminal and Juvenile Justice, http://www.samhsa.gov/criminal-juvenile-justice (Last visited Jan. 7, 2016).

in the illegal use of drugs."[46] While the ADA says that people who are not currently engaged in illegal drug use and are participating in or have completed drug treatment may not be discriminated against, courts have interpreted "current use"differently.

In some cases, "current use" has been conflated by the courts with risk of relapse so that people in early recovery can be denied the law's intended protections when an employer discriminates based on their addiction. Although there is no definitive time period, case law shows that the courts often will not apply the ADA unless a person has been in long and permanent recovery from use, creating a disincentive for people to seek treatment they need.

Ensure that the Americans with Disabilities Act protects people in early recovery and those who are willing to enter treatment

The conflation of current use with risk of relapse runs counter to that science and is inconsistent with both the letter and spirit of the law. Congress passed the ADA to ensure that people with disabilities, including addiction, could overcome the stigma and other barriers that prevent them from participating fully in society. Congress intended for the Act's protections to be construed broadly to achieve its goals. Research has established conclusively that addiction is a disease of the brain but there are successful treatments that enable those who are addicted to stop using and achieve long-term recovery.

The Department of Justice and EEOC, which share jurisdiction over ADA enforcement, should issue guidance or promulgate a rule clarifying that current use under the ADA means use of illegal drugs that is ongoing rather than use of illegal drugs in the recent past combined with a risk of relapse to active addiction.

If discrepancies in interpretation remain among the federal courts, Congress should pass legislation clarifying that the ADA applies to all people in early recovery or willing to enter treatment.

Ensure People with Histories of SUD or Drug Convictions Can Access Public Benefits

Restore SSI/SSDI benefits for people with substance use disorders

Substance use disorders can be as disabling as physical and mental conditions that are recognized as SSI/SSDI disabilities. The financial and medical benefits provided by SSI/DI are as important to people with SUD who are disabled as for those with other disorders. They enable people to avoid homelessness, receive healthcare, and, when possible, recover from their disabilities.

Addiction is preventable and treatable, just like most other chronic diseases. Similar to other chronic illnesses, health related to substance use disorders cannot be separated from overall health. In the years since Congress terminated SSI/SSDI benefits for people whose SUD contributed to their disabilities, science, policy and Congress have all moved towards this recognition. For example, in 2008 Congress passed the federal parity law, and in 2010 it

[46] 42 U.S.C. §12114

passed the Affordable Care Act requiring certain health plans to provide SUD benefits, at parity, for the first time under federal law. Congress should repeal the ban on disability eligibility for those whose addiction is a contributing factor to their disability.

However, since Congress may not change the law in the near term, the Social Security Administration should utilize its flexibility to consider what is in the best interest of SSI/SSDI applicants and beneficiaries. Current policy creates a disincentive for SSI/SSDI beneficiaries with SUD to be honest with their doctors and evaluators, knowing that if they talk openly about their addictions they may be putting their benefits at risk. Policy should not create barriers that may penalize people for seeking treatment for their illness. SSI/SSDI beneficiaries in need of addiction services should be able to access them as freely as they access other health services.

> Congress should repeal the drug felony ban on TANF and SNAP benefits and avoid creating new barriers that single out people with criminal records or histories of addiction and deny them access to public benefits.

Eliminate the TANF and SNAP drug felony ban that limits access to nutrition assistance and cash support

Federal law prohibits anyone convicted of a drug-related felony from receiving cash assistance through the Temporary Assistance to Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP, formerly food stamps). Although states may opt-out of or modify the ban, the law creates a lifetime ban for people with these types of convictions.[47] Congress has recently considered – but fortunately largely not acted on – proposals that would create additional barriers to receiving TANF, SNAP and even unemployment insurance benefits. These proposals would create barriers based on a person's criminal record or require drug testing as a condition for receiving benefits.

Congress should repeal the drug felony ban on TANF and SNAP benefits and avoid creating new barriers that single out people with criminal records or histories of addiction and deny them access to public benefits. As a first step, Congress should pass the REDEEM Act, which would eliminate the TANF and SNAP bans for certain drug crimes, and offer people with other crimes an opportunity to have their benefits restored.

The Departments of Health and Human Services and Agriculture should encourage states to opt out of the ban or modify it so their residents can receive the benefits they need. HHS and USDA should grant waivers to permit states to experiment with pilot projects to demonstrate the public safety, social, and other benefits of restoring eligibility for TANF/SNAP benefits in states that have adopted either the full ban or a modified version of it.

States should take advantage of the option to opt out of the TANF and SNAP drug felony ban or modify it to reduce its impact.

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[47] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, §115, 110 Stat. 2105.

Restore Voting Rights

Restore the voting rights of people with criminal records

Felony disenfranchisement laws, which vary from state to state, currently disqualify nearly 6 million American adults from voting. As a result of these laws, 1 in 13 African- Americans is prohibited from voting, including up to 1 in 5 in some states. 75 percent of the disqualified voters are not in prison, but are on probation or parole or living in the community after their conviction. The loss of voting rights is often imposed regardless of the nature or seriousness of the offense, and in some states the loss is permanent.[48]

Voting is a foundational democratic right and may contribute to successful reentry. A study by sociologists Christopher Uggen and Jeff Manza found that, among people with a prior arrest, "27percent of non-voters were re-arrested over a three-year period, compared with only 12percent of voters."[49] Voting rights should be restored for all otherwise eligible citizens with criminal records. Passage of the federal Democracy Restoration Act would permit people who are no longer incarcerated to vote in federal elections. It should be passed.

States that restrict them should completely restore voting rights for people with criminal convictions.

Improve Access to Housing For People With Criminal Records

Affordable, safe, and stable housing is a human necessity and cornerstone of participation in the community. Housing contributes to successful reentry.[50] Unfortunately, federal, state and local policies and practices, discrimination, and low income make finding suitable housing more difficult for people with criminal records that result from histories of addiction.

Federal housing laws give the Department of Housing and Urban Development (HUD), public housing authorities, and private landlords broad discretion to determine whether people with criminal records or histories of drug or alcohol misuse should be admitted into public or federally assisted housing. HUD has implemented regulations that exclude more people than required by law, and housing authorities and property owners use existing statutes and regulations to justify housing denials and evictions of people with drug addictions or criminal records even when the law does not require the denial or eviction.

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[48] The Sentencing Project, Felony Disenfranchisement: A Primer, (Aug. 2015), http://sentencingproject.org/doc/publications/fd_Felony%20Disenfranchisement%20Primer.pdf.

[49] Christopher Uggen & Jeff Manza, Voting and Subsequent Crime and Arrest: Evidence from a Community Sample, Columbia Human Rights Law Review, Vol. 36, No. 1, at 193-215, http://sociology.as.nyu.edu/docs/IO/3858/Voting_and_Subsequent_Crime_and_Arrest.pdf.

[50] Jocelyn Fontaine & Douglas Gilchrist-Scott, Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project (Aug. 2012), http://www.urban.org/research/publication/supportive-housing-returning-prisoners-outcomes-and-impacts-returning-home-ohio

Eliminate statutory barriers to housing for people with criminal records or histories of drug or alcohol misuse

People with substance use and criminal histories confront a number of statutory provisions that limit access to affordable housing. Congress should reduce or eliminate barriers that make it harder for people to find housing and prevent families from living together. States and localities should also limit use of criminal records in determining housing eligibility only to convictions – not to arrests that did not lead to conviction – and only to those convictions that are related to the individual's appropriate use of the housing.

Reduce regulatory barriers and discrimination that limit access to housing for people with criminal records or histories of drug or alcohol misuse

HUD should change policies and practices that prevent people with criminal records and addiction histories from accessing and remaining in affordable housing.

What Should Congress do to Eliminate Barriers to Housing?

- Create a mechanism for excluded people or households to receive a waiver or exception to their exclusion from public or federally assisted housing. The waiver should be available to people and families excluded or evicted from housing under statutory provisions at 42 U.S.C. 1437n(f) and 42 U.S.C. §§ 13661-63 as well as any other statutory or regulatory restrictions on access to public and federally-assisted housing.
- Amend 42 U.S.C. §13661(a) so that the duration of the ban on admitting people to public housing after they have been evicted for drug-related criminal activity is reduced to one or two years and current participation in drug treatment or a willingness to enter treatment warrants a waiver of the exclusion. Currently, people must complete drug treatment before the exclusion is lifted.
- Amend 42 U.S.C. §13661(c) to set a maximum limit for the "reasonable time" during which a person's criminal activity may be considered under that subsection to 1 year or less for drug-related criminal activity, and to the later of seven years from the date of the most recent relevant conviction or five years from the most recent release from incarceration for violent criminal activity.
- Amend federal law to provide maximum time limitations on the durations of statutory restrictions[51] on a person or household's eligibility for public or federally assisted housing. In no case should a person or household be restricted from public housing after the later of seven years from the date of the most recent relevant conviction or five years from the most recent release from incarceration.

[51] See, e.g., 42 U.S.C. §§1437n(f); 13661-63.

- With respect to statutory and regulatory provisions that, rather than compelling housing denials and evictions, provide PHAs and owners of federally assisted housing with discretion to admit or retain tenants,[52] Congress should set maximum time limitations for the consideration of a criminal record, providing PHAs' and owners' discretion to reduce but not to exceed those limitations.
- Create pilot projects to evaluate the feasibility and benefits of reuniting people with their families in public or federally assisted housing by waiving some of the criminal record barriers and providing wrap-around services to families that agree to participate.

What Should HUD do to Eliminate Barriers to Housing

- Amend its definition of "parole violator"[53] to exclude people with technical probation or parole violations who are not the subject of arrest or bench warrants; who have not fled; and whose conduct would not form the basis for criminal prosecution absent their status as parolee or probationer.
- Amend its regulations[54] so that PHAs and owners of federally assisted housing are required to consider evidence of rehabilitation when considering drug-related or other criminal activity in making admission or eviction decisions.
- Amend its regulations[55] interpreting 42 U.S.C. §13661(c)'s "reasonable time" during which an owner or PHA may consider a person's criminal activity to establish a maximum duration and permit PHAs and owners of federally assisted housing to reduce, but not increase, the time that they consider "reasonable" before admitting a person to housing.
- Amend its regulations so that an arrest that does not lead to a conviction cannot be considered.[56]
- HUD should amend its regulations[57] so that owners of federally assisted housing and PHAs are prohibited from denying admission to a person or family beyond the three-year bar created by 42 U.S.C. §13661(a).

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[52] See, e.g., 42 U.S.C. §§13661-62; 24 C.F.R. §§5.854-55; 24 C.F.R. §§960.203-04; 24 C.F.R. §982.553.

[53] 24 C.F.R. §§5.859(b)(2); 982.310(c)(2)(ii)(B).

[54] 24 C.F.R. §§5.854(b), 960.204(a)(2), 982.310(c)(1) and 982.553(a)(1)(ii).

[55] 24 C.F.R. §5.855(a) and (b).

[56] 24 C.F.R. §§5.861 and 982.310.

[57] 24 C.F.R. §§5.854(a) and 960.203(c)(3).

- Amend 24 C.F.R. §960.203(b) to eliminate the PHA assessment system incentive for PHAs that document their efforts to deny housing to certain people. The current subsection provides that PHAs that can document that "they successfully screen out and deny admission to certain applicants with unfavorable criminal histories receive points" under the PHA assessment system.
- Require housing authorities and owners of federally assisted housing to put in writing their admissions standards for people with criminal records and histories of illegal drug use or alcohol misuse. These policies should be made available to any person requesting them.
- HUD should require housing authorities and owners of federally assisted housing to provide all applicants with a summary statement of the screening policies and procedures being used and any appeal rights of rejected applicants.
- HUD should provide a right to appeal a housing authority or owner's decision to reject an applicant based on a criminal record or history of illegal drug use or alcohol misuse. The regulation should specify the agency to which an appeal should be made and the basic appeals procedures. Housing authorities and owners should be required to provide this information in writing to rejected applicants.
- HUD's Office of Fair Housing and Equal Opportunity should issue guidance similar to the EEOC's April 2012 criminal records guidance. This guidance should promote the fair use of criminal record information for housing purposes and identify the circumstances under which housing discrimination based on a criminal record might violate the Fair Housing Act, prompting enforcement activities against a housing authority or landlord.
- HUD should amend 24 C.F.R. §91.5 so the definition of homeless includes people leaving prisons or jails who were homeless prior to their incarceration without regard to the length of their incarceration.

Promote Educational Opportunities for People with Criminal Records

A number of federal statutes, regulations, and policies prevent people with criminal records from attending college or participating in training. The federal government could play an important leadership role for the states by reforming its policies to promote education and training for people with criminal records.

Unreasonably limiting educational opportunities does not improve public safety. A 2013 study supported by the U.S. Department of Education (DOEd) found that, on average, individuals who participated in correctional education programs had 43 percent lower odds of returning to prison than individuals who did not.[58] Restricting access to education for incarcerated individuals is counter-productive as it inhibits successful reentry and prevents people from maximizing their potential contribution to their families, the

[58] U.S. Dep't of Justice, Justice and Education Departments Announce New Research Showing Prison Education Reduces Recidivism, Saves Money, Improves Employment (Aug. 22, 2013), http://www.justice.gov/opa/pr/justice-and-education-departments-announce-new-research-showing-prison-education-reduces.

market and society. Congress and the DOEd should ensure that people with criminal records and those who are incarcerated have access to the broadest range of educational opportunities.

Restore Pell Grant eligibility for in-prison post-secondary education and eliminate the student aid ban for students with drug convictions

In 1994, Congress eliminated Pell Grant eligibility for adults in prison. Within three years, the number of college degree programs inside state prisons plummeted from about 350 to eight,[59] a devastating reduction in the number of educational opportunities available to incarcerated people. The administration's recently announced Second Chance Pell Pilot Program should be fully implemented by the Department of Education. Congress should also restore Pell Grant eligibility for in-prison post-secondary education by passing into law the Restoring Education and Learning (REAL) Act of 2015.

> A 2013 study supported by the U.S. Department of Education (DOEd) found that, on average, individuals who participated in correctional education programs had 43 percent lower odds of returning to prison than individuals who did not.

In 1998, the Higher Education Act was amended to prohibit anyone with a drug conviction from receiving federal financial aid for post-secondary education.[60] By 2005, the ban was modified to prohibit federal financial aid only for convictions for conduct that occurred while a student was receiving financial aid.[61] It is in society's best interest that people are educated. Congress should eliminate the student aid ban entirely.

Encourage post-secondary institutions to adopt admissions policies that do not unfairly discriminate against students with criminal records

Congress and DOEd should promote fair post-secondary education admission standards related to students with criminal records:

- Educational institutions that receive federal funding, including universities, colleges, and other post-secondary training institutions, should be required to implement fair admission policies for students with criminal records. Blanket policies that exclude students with criminal records should be prohibited. Students with criminal records should receive case-by-case assessments of their suitability for admission based on the nature of their offense, the amount of time that has elapsed since the offense was committed, and evidence of rehabilitation.
- Congress should prohibit the use of Workforce Investment Act funds to support services provided by community colleges or other institutions of higher education that

[59] The Pell Institute, Reflections on Pell (June 2013), at 86, http://www.pellinstitute.org/downloads/publications-Reflections_on_Pell_June_2013.pdf.

[60] 1998 Amendments to the Higher Education Act of 1965, Pub. L. No. 105-244, §483(f).

[61] Higher Education Reconciliation Act of 2005, Pub. L. No. 109-171, § 8021 (c).

have admissions policies or practices that create flat bans on admission for people who have arrest or conviction histories.

- The Department of Education should publish guidance on the appropriate use of criminal record information in institutional admissions decisions.

Increase Employment of People with Criminal Records

Eliminate or reduce the harmful impacts of laws and regulations that prevent qualified people from working in certain industries

Criminal record barriers prevent qualified workers in recovery from addiction who have histories of involvement in the criminal justice system from finding stable work to support themselves and their families. These barriers do not allow people to contribute their skills and energy to their community and the economy. Employment promotes public safety by reducing recidivism and lowers the associated economic and social costs of crime and unemployment. Employment barriers should be disfavored, and when they are needed to protect the public they should be tailored to cover convictions for conduct that is relevant to the job and provide an opportunity for people to demonstrate rehabilitation.

Employment barriers should be disfavored, and when they are needed to protect the public they should be tailored to cover convictions for conduct that is relevant to the job and provide an opportunity for people to demonstrate rehabilitation.

Governments should reduce barriers in laws and regulations that prevent people from obtaining particular types of employment, even though they are qualified and suitable for the job. For example, federal rules create numerous barriers to employment in the health care industry for people with misdemeanor or felony convictions, including convictions for most drug-related offenses.[62] These provisions permanently exclude people from employment in a health care office or institution that participates in any federal health care program such as Medicare, Medicaid, and state Block Grant programs. They apply to people who have paid their debt to society and are qualified for the job. They penalize people who have a substance use disorder that contributed to their criminal record and have participated in treatment and entered recovery.

Health care employment exclusions are not limited to jobs that require medical competency or fiduciary trust. For example, a person with a past misdemeanor drug conviction would be precluded from obtaining a maintenance job on the grounds of a health facility.

Congress and the Department of Health and Human Services (HHS) should change laws and regulations to limit these exclusions to positions requiring medical competency or fiduciary trust. Congress and HHS also should change the waiver process to consider the current job-

[62] 42 U.S.C. § 1320a-7(a) et seq.; 42 C.F.R. §1001.101 et seq.

relatedness of a person's conviction history, including the type of employment, nature of the offense, length of time since the offense occurred, and evidence of rehabilitation.

Other federal laws prevent qualified, suitable people with criminal records from obtaining employment in many other industries, including but not limited to commercial transportation,[63] finance,[64] and insurance.[65] Generally, these restrictions apply to too many types of crimes, restrict employment for too long, often permanently, and are not subject to reasonable, accessible, and effective waiver processes. Furthermore, barriers may be erroneously applied because of incomplete and inaccurate criminal record information in the FBI's criminal record database and other criminal record information repositories.

> Each year, over 11 million people cycle through our nation's jails and over 600,000 people return home from prison.

Congress and the Administration should reduce the impact or employment barriers in federal law. Existing employment bars for people with criminal records should apply to people with convictions for offenses that have some relationship to the type of employment regulated by the law, only remain in effect for a reasonable duration, and provide a waiver process for people to demonstrate that the barrier should not apply to them. Congress should pass a federal law codifying the EEOC guidance on the use of arrest and conviction histories for employment purposes.

Similarly, states should pass laws that only allow public and private employers to deny or terminate employment based on a criminal record if the worker has a criminal conviction that is related to the job. Employers should be required to examine factors like the nature of the job, the offense and its relationship to the job, the length of time since the offense occurred, and evidence of rehabilitation.

Require that background checks are fair, accurate and complete and expand opportunities for criminal record sealing and expungement

FBI background check records provided for employment purposes are far too often inaccurate and incomplete.[66] Except for positions related to public safety or national security, the FBI should be required to report complete and accurate criminal record information on background check reports it provides for employment purposes. If the disposition of a case cannot be determined with

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[63] 49 U.S.C. §44936 (related to air transportation); 46 U.S.C. §70105 *et seq.* (related to port worker TWIC cards).

[64] 12 U.S.C. §1829 (related to FDIC insured banks); Title V of the Housing and Economic Recovery Act of 2008, Pub. L. No. 110-289 §1501, 122 Stat. 2654, 2810, the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (SAFE Act) (related to mortgage lending).

[65] 18 U.S.C. §1033(e).

[66] National Employment Law Project, Wanted: Accurate FBI Background Checks, 3 (2013) ("[I]n 2006, the Attorney General revealed that roughly 50 percent of the records are incomplete and fail to provide information on the final outcome of an arrest."), http://www.nelp.org/content/uploads/2015/02/Report-Wanted-Accurate-FBI-Background-Checks-Employment-1.pdf.

reasonable confidence, the record should be excluded from the report.

Congress and the states should expand opportunities for criminal record sealing and expungement so people can find work and participate in other opportunities in the community. Expunged or sealed convictions should no longer impact a person's eligibility for employment, education, housing, public benefits and other opportunities. The Consumer Financial Protection Bureau should aggressively enforce the Fair Credit Reporting Act's requirements on employers and background screening companies that work with criminal records.

> Collateral consequences create lifelong burdens for people no matter how long ago their offense occurred or how serious it was.

Adopt fair hiring policies

Under 5 C.F.R. §731.202 (OPM's employment suitability rule), federal agencies rely on criminal records to determine suitability and on the EEOC factors private employers must follow to comply with Title VII of the Civil Rights Act as the "agency, in its sole discretion, deems any of them pertinent," in other words, whenever the agency's HR staff are willing to follow those rules. Because agencies may interpret the requirements of 5 C.F.R. §731.202 differently and because OPM has never provided documentation of how the various agencies interpret the employment suitability rule, it is unclear how the various federal agencies use criminal records for employment purposes. This leads to confusion and discourages workers with criminal records from seeking employment from the federal government. Current federal employment policies that violate Title VII may also result in litigation that is both costly and embarrassing for the government, as exemplified by the class action suit filed against the U.S. Department of Commerce for the Census Bureau's use of criminal records in the temporary hiring of over 1 million workers for the 2010 census.

Congress should require federal agencies hiring for positions that are not security-related to follow fair hiring practices for the use and consideration of criminal record information. These practices include postponing the inquiry into a criminal background check until the applicant has an opportunity to demonstrate their qualifications for the job (ban the box), considering only convictions that are relevant to the job, and weighing factors such as the amount of time since the conviction occurred, its seriousness, and evidence of rehabilitation.

At the federal level, the Office of Personnel Management (OPM) should fully implement the President's recently announced initiative to ban the box for federal employment purposes. States and cities should also "ban the box" and adopt other fair hiring requirements for public and private employers. Employers who comply with fair hiring laws should be protected from negligent hiring liability in the rare case where a worker with a criminal record harms a person or property on the job.

Offer specialized workforce services for people with criminal records

Workforce programs, especially Workforce Innovation and Opportunity Act programs (WIOA, formerly the Workforce Investment Act), should include specialized services for people with criminal records to help them identify and

overcome common employment barriers they face as a result of their criminal record. Provisions that became law in the 2014 reauthorization of WIOA[67] -- requiring workforce systems to focus on the needs of workers with barriers to employment and to measure their efforts to serve people with such barriers, including barriers resulting from a criminal record, are steps in the right direction and should be built upon.

Workforce programs in correctional settings should focus education and training opportunities as well as career placement services on high growth industries and occupations that have jobs available in the places people will return to after they complete their sentence. They should ensure they are not preparing people for jobs that are off-limits to people because of their criminal record.

Relieve People of Collateral Consequences

People who have paid their debt to society should be relieved of collateral consequences. Collateral consequences create lifelong burdens for people no matter how long ago their offense occurred or how serious it was. Justice, compassion, and reason require that these unfair and disproportionate burdens should be reduced. People with criminal records should have an opportunity to move on with their lives at some point.

Reduce unnecessary collateral consequences and impose them only as a part of sentencing

Congress and the states should create judicial mechanisms that are part of sentencing and require judges to opt in, or permit them to opt out of, collateral consequences that currently apply to defendants. Existing barriers limit the ability of people to work in certain industries, deny them public benefits or educational assistance, or make it harder for them to live with their family if they need public or federally-assisted housing or have an immigration status issue. The judicial mechanism would support truth in sentencing and should be available for all crimes.

Offer procedures for people who have completed their sentence to be relieved of collateral consequences

Congress and the states should offer processes for people who have completed their sentence to obtain judicial or administrative relief from collateral consequences, or receive a certificate from the courts or other agencies that signifies that they have paid their debt to society. People who receive relief should no longer be legally or otherwise burdened by their prior involvement in the criminal justice system. Many states provide certificates or other relief from collateral consequences. More states should do so.

Congress should pass the REDEEM Act,[68] bi-partisan federal legislation sponsored by Senators Rand Paul (R-KY) and Cory Booker (D-NJ), which would create ways for adults and

[67] Workforce Innovation and Opportunity Act of 2014, Pub. L. No. 113-128.

[68] Record Expungement Designed to Enhance Employment Act of 2015 (REDEEM Act), S. 675, H.R. 1672, 114th Congress (2015).

youth to have certain records for federal offenses sealed and expunged and provide incentives for states to adopt similar provisions.

Improve Reentry Planning and Services

Each year, over 11 million people cycle through our nation's jails[69] and over 600,000 people return home from prison.[70] Many return to communities lacking opportunities and adequate human services. They confront legal, policy, and social barriers that make reintegrating more difficult and recidivism more likely. Barriers to housing, public benefits, education and employment reduce their ability to support themselves and their families and lower their potential contributions to society. These barriers damage communities and waste human capital.

The Administrations of President Barack Obama and President George W. Bush have prioritized improved reentry and reduce recidivism as part of an effective and just approach to public safety. President Bush signed the Second Chance Act federal reentry legislation into law, and President Obama's Administration convened an Interagency Reentry Council to bring cabinet-level officials together to coordinate and improve federal reentry policies and programs and reduce criminal record barriers.

> Prisons and jails should expand substance use disorder treatment, employment support, family involvement, and other programs shown to reduce recidivism when people return home.

Nationally, state and local governments grappling with rising law enforcement and corrections costs are investing in community corrections, substance use and mental health treatment, and other interventions that cost less than incarceration, reduce recidivism, and keep communities safe. The time to build on these developments is now.

Reauthorize and fully fund the Second Chance Act federal reentry legislation

The Second Chance Act, enacted to combat unacceptably high recidivism rates around the country, provides funding to support recidivism reduction and enhance public safety. Among the services it supports are employment assistance, substance use disorder and mental health treatment, housing, family-based programs, mentoring, and other services proven to reduce recidivism. By funding innovative and evidence-based programs, the Second Chance Act enables communities to address public safety concerns with proven strategies and experiment with new ways of improving reentry.

Second Chance Act programs, which have been funded at levels ranging from $25-100 million annually, continue to face funding pressures that limit their ability to achieve the even greater recidivism reductions. Strong federal funding for the Second Chance Act should continue to support proven strategies and the development

[69] U.S. Bureau of Justice Statistics, Jail Inmates at Mid-Year 2014, (June 2015), at 8, http://www.bjs.gov/content/pub/pdf/jim14.pdf.

[70] U.S. Bureau of Justice Statistics, Prisoners in 2013 (Sep. 2014), at Table 9, http://www.bjs.gov/content/pub/pdf/p13.pdf.

of new ones to promote public safety and reduce recidivism. The Administration should continue to highlight the federal government's role in reentry by championing the Second Chance Act and highlighting successful programs. The Department of Justice, Bureau of Justice Assistance should use ongoing analyses to target funding to Second Chance Act grant applicants for activities that have the greatest impact on recidivism rates and innovative but promising programs that build on the available knowledge in the reentry services field. Congress should fully fund Second Chance Act programs and protect Second Chance funding from carve-outs for other programs.

The Second Chance Act authorizing legislation has expired; reauthorization would signify that reentry continues to be a priority of Congress. Congress should reauthorize the Second Chance Act with improvements based on several years of experience implementing the law.

Increase effective prison and jail based recidivism reduction programming

Prisons and jails should expand substance use disorder treatment, employment support, family involvement, and other programs shown to reduce recidivism when people return home. People who are incarcerated should receive incentives to participate in these programs, including time credit toward completion of their sentence. Offering people credit toward completion of their sentence will encourage them to participate and recognizes the contribution program participation makes to rehabilitation. The CORRECTIONS Act provides a good model for the federal system, and Congress should pass it.

Improve reentry planning

The federal government and state and local governments should improve reentry planning and preparation in corrections systems, including ensuring all individuals are enrolled in health coverage for which they qualify and performing a needs assessment toward the end of each individual's term of incarceration. Prisons and jails should provide every person leaving their custody with a reentry plan that includes initial appointments and contact information for substance use, mental health treatment and other health care services they will need to receive in the community to stay healthy and for community-based programs like employment and legal services that can help them address the collateral consequences of their conviction and meet the needs identified in their assessment. Corrections personnel should work with community-based providers to arrange point to point transportation from the facility to the location of appointments and services and follow-up with service providers to ensure the individual has attended.

Make the federal Interagency Reentry Council permanent and create state-level reentry councils

Established by Attorney General Eric Holder in January 2011, the federal Interagency Reentry Council represents an executive branch commitment to coordinate and improve reentry policy across federal agencies. Premised on the recognition that federal policies across many agencies have an effect on reentry outcomes, the council brings together a staff-level working group and secretaries and directors of over 20 federal agencies, including the Departments of Justice, Health and Human Services, Labor, Education, Housing and Urban Development, and Veterans affairs, among others. Congress

should make the Interagency Reentry Council a permanent part of the federal government by authorizing it in statute.

New York and other states have experiments with similar reentry councils. These efforts should be duplicated and given sufficient resources to be successful.

Expand the Use of Alternatives to Incarceration

Incarceration is a severe penalty that creates significant consequences beyond just the loss of freedom. People who are incarcerated are separated from their families and communities, often causing more harm than the modest increase in safety from removing people from the streets. As incarceration has soared, the public safety return on each new prison bed dwindles.[71] Prison and jails can act as school for criminal behavior, exposing people involved in low-level crime to more sophisticated and damaging criminal behavior. Incarceration is expensive. For example, since 1980, annual spending on the federal prison system has risen 595 percent, from $970 million to more than $6.7 billion, after adjusting for inflation.[72]

Alternatives to Incarceration are sentencing options that hold people accountable for their conduct without using expensive and counter-productive incarceration. Types of Alternatives to Incarceration including diversion programs that remove people from the criminal justice system and place them in services and programs that can address their behavior, problem-solving courts like drug courts and veterans' courts, and community corrections, like probation. These alternatives should be available for more types of crimes, and systems should incentivize the use their use.

Increase the number of offenses for which Alternatives to Incarceration are a permissible or preferred sentencing option

The federal and state governments should increase the number of offenses for which sentences other than incarceration are available. Incarceration should be reserved for only those defendants who pose an actual and serious risk of harm to the public that cannot be mitigated through treatment or other services or whose conduct has resulted in actual and serious physical harm or property loss for which the only appropriate retribution is the extreme deprivation of liberty that incarceration entails.

Provide funding incentives for U.S. Attorneys offices and other prosecutors' offices that prioritize Alternatives to Incarceration as sentences for defendants they prosecute

The federal and state governments should create funding incentives for prosecutors' offices that demonstrate a commitment to using Alternatives to Incarceration for most defendants and

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[71] Oliver Roeder, Lauren-Brooke Eisen & Julia Bowling, What Caused the Crime Decline?, Brennan Center for Justice (Feb. 2015), https://www.brennancenter.org/sites/default/files/analysis/What_Caused_The_Crime_Decline.pdf.

[72] The Pew Charitable Trusts, Federal Drug Sentencing Laws Bring High Cost, Low Returns: Penalty Increases Enacted in 1980s and 1990s Have Not Reduced Drug Use or Recidivism (Aug. 2015), http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/08/federal-drug-sentencing-laws-bring-high-cost-low-return.

reserving incarceration and scarce prison resources for defendants who have committed the most serious and harmful crimes. These offices create cost savings by reducing prison overcrowding and allowing people to stay in their community where they can work and contribute to their communities. They should receive some of the benefits of those cost savings.

Provide financial and career incentives for prosecutors who demonstrate a commitment to Alternatives to Incarceration and incorporate the use of Alternatives to Incarceration into their job performance measures

For prosecutors, career success is often measured in the number of years of incarceration they can secure against people they prosecute. To promote safety, justice, and efficiency, prosecutors should be evaluated not only on their ability to secure severe prison sentences for the most serious crimes but also for their efforts to secure community-based Alternatives to Incarceration for most defendants for whom incarceration is not the right outcome.

Pass the Sentencing Reform and Corrections Act

This year, Congress should pass into law the Sentencing Reform and Corrections Act, bipartisan legislation which has been approved by the Senate Judiciary Committee.

Key provisions of the bill would:

- Reduce the number of offenses (including several drug-related offenses) that would trigger mandatory minimum sentences and also reduce the required length of time of the sentence (including for people who have been convicted of past crimes);
- Make additional people (including people who have been convicted of certain drug-related crimes) eligible for the "safety valve" that allows judges in certain circumstances to issue a sentence that is shorter in duration than the mandatory minimum sentence otherwise required for that offense
- Allow the earning of good-time credits for activities including academic classes, occupational and vocational training, and recovery programming (including appropriate medication-assisted treatment) for people with addiction histories
- Allow for expungement and sealing of certain types of juvenile records; the bill would also establish processes for automatic expungement and sealing of certain juvenile nonviolent offenses
- Promote greater use of residential substance use disorder treatment through the federal Bureau of Prisons
- Authorize a pilot program aimed at reducing recidivism and helping more people enter recovery from addiction to alcohol and other drugs
- Authorize reentry demonstration projects which could include substance use disorder treatment services, including, if appropriate, addiction treatment medication, mental health treatment, occupational, vocational, and educational training, apprenticeships, recovery support and other types of programming to

promote effective reintegration into the community

- Expand the use of prerelease custody for certain individuals
- Allow courts to reduce a term of imprisonment for certain people who were convicted as adults for a crime committed before age 18 and have served 20 years in prison
- Expand the use compassionate release for older incarcerated adults
- Seek to improve the accuracy of federal criminal records

Passage of the Sentencing Reform and Corrections Act would make progress toward a broad range of the reforms outlined in this Roadmap and be an important step in making our criminal justice system more fair and better at improving public safety and health outcomes.

Conclusion

There is clear, broad consensus that reforming our nation's policies to expand the health responses to addiction and to eliminate discriminatory policies against people in recovery will make families and communities healthier and stronger and will save taxpayers huge amounts of money.

We now have the best opportunity we will ever have to prevent young people from beginning unhealthy substance use, to make a major dent in the nearly 90 percent treatment gap between the 21.5 million Americans who need care and the 2.3 million who actually receive it, and to end discrimination against those who have overcome or still suffer from this terrible disease.

We now have the best opportunity we will ever have to prevent young people from beginning unhealthy substance use, to make a major dent in the nearly 90 percent treatment gap between the 21.5 million Americans who need care and the 2.3 million who actually receive it, and to end discrimination against those who have overcome or still suffer from this terrible disease.

We must build on recent historic reforms by ensuring that all Americans have access to the full range of proven substance use prevention, addiction treatment, and recovery supports and that discriminatory criminal record barriers do not relegate tens of millions of our friends, neighbors, and family members to a permanent second-class status.

We have provided this Roadmap of detailed recommendations for moving forward, and urge policymakers to put them into practice as soon as possible. While the problems we seek to address here are complex, evidence shows they can be solved. The answers are readily available. The time to implement them is now.

Appendix A **Just the Facts: The Clear Case for a Drug and Alcohol Policy that Promotes Health and Justice**

Substance Use Disorders Are Costly in Lives

Drug overdoses are the leading cause of injury death in the United States[73] and substance use disorders are among of the most prevalent illnesses even though they are chronic diseases that can be effectively prevented and treated. Substance use costs over 100,000 lives and upwards of half of a trillion dollars annually.[74] On top of high rates of alcohol, cocaine and other drug problems, an epidemic of prescription opioid and heroin misuse is sweeping the nation.[75] In the 2014 annual survey of top health concerns conducted by the C.S. Mott Children's Hospital National Poll on Children's Health, adults across the nation rated drug abuse as the 3rd leading health concern for children in their communities; alcohol abuse came in 6th. If alcohol and drug abuse are combined, they easily come in first as the top health concern for children.[76]

Substance use disorders are preventable and treatable, just like hypertension, diabetes, and asthma.[77] A large body of evidence shows that treatment for substance use disorders is effective and results in remarkable cost savings to the health care, criminal justice, child welfare and social services systems. Substance use disorder treatment has been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests by up to 64 percent.[78] Evidence-based educational programs and environmental changes have significantly reduced underage

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[73] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

[74] U.S. National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction (revised 2010), https://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.

[75] See U.S. Centers for Disease Control and Prevention, Today's Heroin Epidemic, www.cdc.gov/vitalsigns/heroin/index/html http://www.cdc.gov/vitalsigns/heroin/ (last visited Ja. 7, 2016).

[76] See C.S. Mott Hospital National Poll on Children's Health, Top Ten U.S. Children's Health Concerns in 2014, http://mottnpch.org/blog/2014-08-29/top-10-us-childrens-health-concerns-2014 (last visited Jan. 7, 2016).

[77] U.S. National Institute on Drug Abuse, Treatment and Recovery, http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery (last visited Jan. 7, 2016).

[78] The National Council for Behavioral Health, Preventing and Treating Substance Use Disorders: A Comprehensive Approach, https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf (last visited Jan. 7, 2016).

drinking. Between 2002 and 2013, for example, current alcohol use among underage people (aged 12-20) declined from 28.8 percent to 22.7 percent, a drop of over 20% of the previous 2003 level.[79]

There is a tremendous unmet need for substance use prevention, treatment and recovery services.

Drug overdoses are the leading cause of injury death in the United States and substance use disorders are among of the most prevalent illnesses even though they are chronic diseases that can be effectively prevented and treated. Substance use costs over 100,000 lives and upwards of half of a trillion dollars annually.

According to SAMHSA's most recent National Survey on Drug Use and Health, 21.5 million Americans aged 12 or older needed treatment for an alcohol or illicit drug problem in 2014 but only 2.3 million received substance use treatment.[80]

The Institute of Medicine identified alcohol and other drug use in the armed forces as a public health crisis. The report found that there is substantial unmet need for substance use disorder treatment services as well as outdated policies and practices that serve as barriers to care.[81]

Federal data show that in a given month as many as 6.5 million Americans misuse prescription drugs.[82] The Centers for Disease Control and Prevention has found that narcotic painkiller overdoses kill 44 people every day in the United States, more than heroin and cocaine combined.[83]

The costs of untreated substance use disorders to the healthcare system are immense and growing.

According to the Agency for Health Research Quality, 25 percent of U.S. hospital admissions

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[79] U.S. National Institute on Drug Abuse, Drug Facts: Nationwide Trends (June 2015), http://www.drugabuse.gov/publications/drugfacts/nationwide-trends (last visited Jan. 7, 2016).

[80] U.S. Substance Abuse and Mental Health Services Administration, Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings (2015), at 3, http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf.

[81] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Improving the Quality of Health Care for Mental and Substance-Use Conditions (2006), http://www.ncbi.nlm.nih.gov/books/NBK19830/.

[82] U.S. National Institute on Drug Abuse, Drug Facts: Nationwide Trends, http://www.drugabuse.gov/publications/drugfacts/nationwide-trends (last visited Jan. 7, 2016).

[83] U.S. Centers for Disease Control and Prevention, Prescription Drug Overdose Data, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 7, 2016).

are directly related to mental health and/or substance use disorders.[84] Patients with alcohol problems spend an average of four times as many days in the hospital as non-drinkers, mostly because of drinking-related injuries.[85] The estimated annual health care expenditures for alcohol and illicit drug use is over $35 billion.[86] Untreated alcohol and drug addiction can aggravate or mask symptoms of medical conditions and complicate treatment effectiveness.[87] More than 5 million emergency department visits a year are associated with drug use.[88]

Addressing SUD through a health lens will result in huge cost-savings to the health care system

While the costs of untreated substance use disorders are enormous, evidence demonstrates that prevention and treatment of SUD results in significant cost-savings. For example:

- Inpatient, emergency room, and total healthcare costs decline by 39 percent, 35 percent, and 26 percent respectively after patients who suffer from alcohol or drug addiction receive treatment.[89]
- For patients with SUD-related medical conditions, integrating medical and SUD treatment services results in decreases in hospitalization rates, fewer days of inpatient treatment, and fewer emergency room visits. Total medical costs per patient per month are more than halved, from $431 to $200.[90]
- A Washington State study of the impact of a 2005 investment by the state in SUD treatment estimates a return on investment of 2:1 over the next four years in direct healthcare related costs; that is, for every dollar invested in expanded alcohol and drug dependence treatment the state saved at least two dollars in avoided medical and nursing facility costs.[91]
- A similar Washington State study concluded that much, if not all, of the

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[84] Agency for Healthcare Research and Quality, Mental Health: Research Findings, http://www.ahrq.gov/research/findings/factsheets/mental/mentalhth/mentalhth3.html (last visited Jan. 7, 2016).

[85] Robert Woods Johnson Foundation, Substance Abuse: The Nation's Number One Health Problem (Feb. 2001), at 58, http://www.rwjf.org/content/dam/farm/reports/reports/2001/rwjf13550.

[86] U.S. National Institute on Drug Abuse, Trends and Statistics, http://www.drugabuse.gov/related-topics/trends-statistics (last visited Jan. 7, 2016).

[87] See U.S. National Institute on Drug Abuse, Medical Consequences of Drug Abuse, http://www.drugabuse.gov/related-topics/medical-consequences-drug-abuse (last visited Jan. 7, 2016).

[88] Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network 2011: National Estimates of Drug-Related Emergency Department Visits (2013), at 21, http://www.samhsa.gov/data/sites/default/files/DAWN2k11ED/DAWN2k11ED/DAWN2k11ED.pdf.

[89] Kaiser Permanente Medical Program Division of Research, Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis (Jan. 2001), http://www.ncbi.nlm.nih.gov/pubmed/11271969.

[90] Medical Care, Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care (Mar. 2003), http://www.ncbi.nlm.nih.gov/pubmed/12618639.

[91] See Christine Vesta, States Gear Up to Help Medicaid Enrollees Beat Addictions, Huffington Post (Jan. 13, 2015), http://www.huffingtonpost.com/2015/01/13/states-medicaid_n_6463286.html.

cost to the state of providing SUD treatment to low-income adults is offset by increased earnings and the associated contributions to the state general fund, reduced medical costs among those who enroll in Medicaid, and reduced costs associated with fewer arrests.[92]

- According to a recent study by SAMHSA, every dollar spent on school-based substance use prevention efforts produces $18 in savings related to health, work loss, and other social costs.[93]

Ensuring that justice-involved individuals can access public benefits, housing, health care, education and employment will improve health and public safety, reduce crime and disease, and save money

A criminal conviction exposes a person to barriers that make it more difficult to participate in educational opportunities, obtain employment, maintain suitable housing, receive quality healthcare, and access public benefits. Yet research shows that these are the very things that make successful reentry more likely. For example:

- In addition to its practical function as a credential in the job market, participation in higher education has been shown to lower recidivism by 15 percent and 13 percent for people who earn an associate's or bachelor's degree, respectively.[94] By investing in post-secondary education for incarcerated people, the Correctional Education Association calculated that states experience a "return [of] at least $2 for every $1 spent in terms of saving in cell space on those who do not return to the system."[95]
- A study by the American Bar Association Commission on Effective Criminal Sanctions shows that people with criminal records who are unable to obtain employment are three times more

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[92] Melissa Ford Shah, et al., Washington Dep't of Social and Health Services, The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults (Nov. 2009), https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-79.pdf.

[93] U.S. Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis (2008), http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf.

[94] Open Society Institute Criminal Justice Initiative, Education as Crime Prevention: Providing Education to Prisoners *(*September 1997), http://www.prisonpolicy.org/scans/research_brief__2.pdf.

[95] Steve Steurer, Linda Smith & Alice Tracey, "The Three State Recidivism Study." (Sep. 2001), http://www.ceanational.org/PDFs/3StateFinal.pdf.

likely to return to prison than those individuals who are able to find work.[96]

- Stable housing is a critical component of successful reentry. Research indicates that both supportive housing and peer-led recovery residences are associated with reductions in recidivism.[97]
- A Yale Center for Interdisciplinary Research on AIDS study found that people with drug convictions who are denied government food benefits upon release from prison are "at greater risk of engaging in dangerous, sexual risk behaviors in order to obtain food" and that 37percent had gone an entire day without food in the past month. 25percent reported that their children had similarly gone without food fo r an entire day.[98] Other research shows that children who are denied public assistance are at greater risk of hospitalization and food insecurity.[99]

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[96] ABA Commission on Effective Criminal Sanctions, Second Chances in the Criminal Justice System: Alternatives to Incarceration and Reentry Strategies (Dec. 2007), at 27 http://www.americanbar.org/content/dam/aba/migrated/cecs/secondchances.authcheckdam.pdf (citing Rebuilding Lives. Restoring Hope. Strengthening Communities: Breaking the Cycle of Incarceration and Building Brighter Futures in Chicago. Final Report of the Mayoral Policy Caucus on Prisoner Reentry at 15 (2006)).

[97] Jocelyn Fontaine, Examining Housing as a Pathway to Successful Reentry: A Demonstration Design Process (Nov. 2013), www.urban.org/sites/default/files/alfresco/publication-pdfs/412957-Examining-Housing-as-a-Pathway-to-Successful-Reentry-A-Demonstration-Design-Process.PDF.

[98] Helen Dodson, Ban on food stamps leads to hunger, HIV risk among former drug offenders, Yale News, March 25, 2013, http://news.yale.edu/2013/03/25/ban-food-stamps-leads-hunger-hiv-risk-among-former-drug-felons.

[99] Children's Sentinel Nutrition Assessment Program, The Impact of Welfare Sanctions on the Health of Infants and Toddlers (Sep. 2002), http://www.childrenshealthwatch.org/upload/resource/welfare_7_02.pdf.

Appendix B **Looking Back: Seven Years of Progress**

Report card on progress made in achieving the reforms recommended in our 2008 Roadmap and a summary of what needs to be done next

Expand and Improve Health Responses to Addiction		
Objective	*Did the 2008 Roadmap recommendation contribute to reform?*	*What needs to happen to build on these accomplishments?*
Include Equitable and Adequate Substance Use Disorder Treatment and Recovery Support in All Public and Private Health Care Plans	The Affordable Care Act requires coverage of substance use disorder and mental health services as an essential benefit, at parity with other illnesses, in all Medicaid expansion plans and small business and individual insurance plans. As a result, for the first time in our nation's history, a large percentage of the 23 million Americans with substance use problems will have insurance coverage that will pay for substance use care.	These landmark reforms must be implemented so that they achieve their full potential. People in need of substance use care must be able to obtain it. Substance use prevention, treatment and recovery must be integrated effectively with the rest of the health care system and with the criminal justice system to maximize their potential for saving lives, improving health and public safety, and saving taxpayer dollars.
Promote Prevention, Early Intervention, Recovery, and Research	The Affordable Care Act includes substance use prevention in its prevention and wellness initiatives. However, funding for effective prevention, early intervention, recovery support and research remain woefully inadequate.	Our nation must greatly expand its investment in these lifesaving and cost-effective areas.

Expand Drug and Alcohol Treatment Services for an Additional One Million Americans	The Affordable Care Act's mandated coverage of substance use disorders at parity sets the stage for dramatic expansion of treatment capacity. Critically needed initiatives to assist service providers in adapting to the rapidly changing health care environment have begun. Strong bi-partisan support ensured the continuation of strong funding for the Substance Abuse Prevention and Treatment Block Grant despite an extremely challenging fiscal environment. However, there has been insufficient investment in building the infrastructure necessary to expand treatment capacity.	Our nation must invest in workforce, information technology, capital construction and other infrastructure needed to expand treatment capacity. These investments are vital to ensuring that care will be available for the millions more Americans with coverage who have substance use disorders, while maintaining critically needed safety net funding.
Eliminate Discrimination Against People in Recovery		
Repeal Discriminatory Laws and Policies	For the first times, the President's National Drug Control Strategy called for eliminating discriminatory barriers that violate the civil rights of people in recovery from addiction, and people with criminal histories who have paid their debt to society and are living productive and law-abiding lives. The U.S. Attorney General established the Interagency Reentry Council to advance policy reforms that help people in the criminal justice system successfully reenter society. The federal government and many states took positive steps to remove counter-productive barriers to employment, higher education and housing.	The federal government, states and the private sector should repeal or reform all remaining counterproductive, discriminatory barriers that make it difficult for people in recovery from addiction and those with criminal histories to obtain health care, housing, education, employment, public benefits and other necessities of life.

Seven Years of Progress

Over the past seven years, the substance use disorder field has achieved tremendous success advocating for smarter drug and alcohol policies that will improve health outcomes, strengthen families and communities, and save huge amounts of money. Strong support from federal agencies -- including HHS, SAMHSA, CMS, CCIIO, DOJ, DOL, and ONDCP – Congress, and states was essential to this success. While there is much further to go, we have made huge strides toward increasing SUD coverage in public and private health insurance, expanding access to care, and eliminating discriminatory policies that harm people with substance use and/or criminal histories.

- In 2008, the federal Mental Health Parity and Addiction Equity Act (MHPAEA)

became law.[100] MHPAEA prohibits discrimination in health insurance coverage of substance use disorder (SUD) and mental health (MH) benefits. 113 million people have gained the protections of the federal parity law. Since its passage, in response to the field's continued advocacy, the federal government has issued regulations and guidance designed to ensure that limitations on SUD and MH benefits are no more restrictive than for treatment of other illnesses.[101]

- The federal health reform law, the Affordable Care Act (ACA), includes SUD services and providers in virtually all of the law's major initiatives.
    1. SUD and MH services must be included in the essential health benefit package for most individual and small group health plans and for the Medicaid expansion population.
    2. All ACA plans must adhere to the federal parity law, which requires that SUD/MH benefits be equal to medical and surgical benefits.
    3. Individuals with chronic SUD who gain Medicaid eligibility under the ACA have the legal right to choose enrollment in the Medicaid program of their choice.
    4. Substance use prevention and mental health promotion is included in the ACA's chronic disease prevention initiatives.
    5. Initiatives to strengthen the health workforce include the SUD and MH workforce.
    6. All participating private health plans must include in their networks sufficient MH and SUD providers to ensure enrollee access without unreasonable delay.
- Bipartisan appropriators in Congress and the Administration have continued to support strong funding for the Substance Abuse Prevention and Treatment Block Grant program despite an extremely challenging fiscal environment.
- Since FY 2009, Congress has appropriated nearly $500 million in funding for critically important Second Chance Act reentry programming around the country.
- Various policy documents of the Administration, including the National Drug Control Strategy and the annual federal budget, have clearly reflected the policy needs of people in recovery and those with criminal histories. The 2012 National Drug Control Strategy was the first national strategy to include a section on eliminating barriers that limit the civil rights and liberties of people in recovery from addiction and/or people with criminal records.[102]
- The U.S. Attorney General established the Interagency Reentry Council, whose membership includes over twenty federal agencies, is coordinating and advancing

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[100] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343.

[101] Legal Action Center, Frequently Asked Questions on the Federal Mental Health Parity and Addiction Equity Act (Nov. 2013), http://lac.org/wp-content/uploads/2014/12/November_2013_Parity_FAQs_copy.pdf.

[102] Executive Office of the President of the United States, Office of National Drug Control Policy, 2012 National Drug Control Strategy (2012), https://www.whitehouse.gov/sites/default/files/ondcp/2012_ndcs.pdf.

effective reentry policies and removing barriers to success.[103]

- The U.S. Attorney General directed the Department of Justice to reduce collateral consequences, promote alternatives to incarceration and place greater emphasis on successful reentry and recidivism reduction.[104]

2. The Attorney General directed all those under DOJ jurisdiction to consider whether any proposed regulation or guidance may impose unnecessary collateral consequences on those seeking to rejoin their communities.[105]
3. The Attorney General instructed DOJ and U.S. Attorneys to identify and share best practices for enhancing the use of diversion programs – such as addiction treatment and community service initiatives – that can serve as effective alternatives to incarceration.
4. Consistent with the field's advocacy toward the adoption of a drug control strategy that places a greater emphasis on public health and less reliance on mass incarceration, the Attorney General has "mandated a modification of the Justice Department's charging policies so that certain low-level, nonviolent drug offenders who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences."
5. The Attorney General directed some U.S. Attorneys to examine sentencing disparities and to develop recommendations on how best to address them.

- The Equal Employment Opportunity Commission (EEOC) released important updated guidance on the use of criminal records for employment purposes and discouraged blanket bans against hiring people with criminal histories.[106]
- The Secretary of Housing and Urban Development issued guidance letters to all the housing authorities[107] and landlords and agents of federally assisted housing[108] highlighting their broad discretion to admit most people with criminal records into housing and encouraging them to look more favorably on tenants with a criminal record and their families.

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[103] See Federal Interagency Reentry Council, http://csgjusticecenter.org/nrrc/projects/firc/ (last visisted Jan. 7, 2016).

[104] U.S. Dep't of Justice, Smart on Crime: Reforming the Criminal Justice System for the 21st Century, (Aug. 2013), http://www.justice.gov/sites/default/files/ag/legacy/2013/08/12/smart-on-crime.pdf.

[105] U.S. Attorney General Eric Holder, Memorandum to Heads of Department of Justice Components and U.S. Attorneys on Consideration of Collateral Consequences in Rulemaking (Aug. 12, 2013), http://csgjusticecenter.org/wp-content/uploads/2013/09/DOJ-Collateral-Consequences-memo-8-12-13.pdf.

[106] U.S. Equal Emp. Opportunity Comm'n, Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964 (Apr. 25, 2012), http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm.

[107] U.S. Sec. of Housing and Urban Development Shaun Donovan & Assistant Sec. Sandra Henriquez, Letter to Public Housing Authorities Calling on Them to Exercise Discretion to Admit People with Criminal Records to Housing (June 17, 2011), http://csgjusticecenter.org/documents/0000/1130/HUD_letter.pdf.

[108] U.S. Sec. of Housing and Urban Development Shaun Donovan & Acting Assistant Sec. Carol Galante, Letter to Owners of Multi-Family Dwellings Calling on Them to Exercise Discretion to Admit People with Criminal Records to Housing, http://csgjusticecenter.org/documents/0000/1344/3.30.12_MFamily_properties_Reentry_memo_6__2_.pdf

- The Department of Education changed the FAFSA (federal student aid application) so that first-time student aid applicants are no longer asked whether they have been convicted of a drug crime. Previously, first-time applicants were asked this question even though only individuals convicted of a drug offense while receiving student aid can be penalized under federal law. This question likely deterred many eligible individuals from applying for aid.

Appendix C
Recommendations at a Glance

Introduction

The Roadmap for Promoting Health and Justice: A Smarter, More Effective National Drug and Alcohol Policy provides a comprehensive and detailed set of recommendations for improving our national drug and alcohol policies to improve health and public safety and save lives and resources. Here is a quick look at the recommendations in the report.

Recommendations to Strengthen the Health Responses to Addiction

Ensure Strong Coverage of and Access to Substance Use Disorder and Mental Health (SUD/MH) Services and Medications in Private Insurance

- States should ensure Essential Health Benefits packages in all qualified health plans in insurance exchanges have strong and specific coverage for SUD and MH
- HHS and states should work closely together to ensure that coverage meets the parity and anti-discrimination requirements of the ACA and the federal parity law, including collecting the data required to ensure compliance and quality
- Health Insurance Marketplaces should ensure that enrollees can easily identify and choose the health coverage that is best for them
- Network adequacy standards that ensure timely access to SUD/MH benefits should be developed and enforced

Provide Strong Coverage of and Access to SUD/MH Services and Medications in Medicaid and other Publicly Funded Programming

- HHS and states should design Medicaid benefits and eligibility systems to ensure that eligible individuals with SUD/MH can enroll and access needed services and medications
- HHS and states should ensure that all newly-eligible and traditional Medicaid beneficiaries receive comprehensive health coverage, including coverage for SUD and MH services and medications, at parity with other covered benefits

- Federal regulators should promptly finalize the recently proposed rule on the application of the federal parity law to Medicaid managed care, Medicaid Alternative Benefits Plans, and CHIP. Federal and state regulators should continue working to ensure that parity is fully implemented and enforced in these programs
- The federal government should modify the IMD exclusion to ensure that everyone with SUD/MH treatment needs can obtain appropriate care
- All states should implement the Medicaid Health Home option and design systems to ensure that the SUD/MH needs of all enrollees will be addressed
- The full continuum of SUD/MH services and medications should be covered and fully accessible to people enrolled in Medicaid
- Federal and state governments should support and fund public education on overdose prevention, recognition, and response, and tools that are effective in preventing overdose death should be widely available. Federal and state governments should also support evidence-based public health interventions, including syringe exchange programs, which increase access to health care and decrease transmission of HIV, viral hepatitis, and other blood-borne diseases

Invest in the SUD Service Infrastructure

- Ensure that the full continuum of SUD care is available in every community, and invest in SUD treatment systems that are patient-centered and better reflect the chronicity of substance use disorders by promoting effective chronic disease prevention and management
- Invest in building new treatment capacity and strengthening the infrastructure of the existing system
- Assist SUD and MH providers to create needed health information technology
- Increase investment in substance use education and training and initiatives to attract and maintain a diverse and culturally competent addiction workforce that is prepared for changes to the health care system
- Assist SUD providers in adapting to changes in payment and reimbursement mechanisms

Preserve the Safety Net for the Continuum of SUD Prevention, Treatment and Recovery Support Services

- Ensure the safety net, including the Substance Abuse Prevention and Treatment Block Grant, remains strong for people and services that remain uncovered by the ACA
- Strengthen substance use prevention

Provide Strong Coverage for and Access to SUD/MH Care for Justice-Involved Individuals

- Ensure all eligible justice-involved people are enrolled in appropriate health coverage

- Justice-involved people should be engaged in SUD and MH care as early as possible. They should be connected to crisis intervention centers, community-based SUD and MH care, and other evidence-based services
- Offer medication-assisted treatment (MAT) for SUD as a treatment option at all stages of the criminal justice system
- Improve continuity of care for people returning to the community from the criminal justice system

Expand Research on Substance Use Disorders

Recommendations to Eliminate Discrimination Against People with Drug/Alcohol and Criminal Histories

Protect People in Early Recovery or Entering Treatment from Discrimination

- Ensure that the Americans with Disabilities Act protects people in early recovery and those who are willing to enter treatment

Ensure People with Histories of SUD or Drug Convictions Can Access Public Benefits

- Restore SSI/SSDI benefits for people with substance use disorders
- Eliminate the TANF and SNAP drug felony ban that limits access to nutrition assistance and cash support

Restore Voting Rights

- Restore the voting rights of people with criminal records

Improve Access to Housing For People with Criminal Records

- Eliminate statutory barriers to housing for people with criminal records or histories of drug or alcohol misuse
- Reduce regulatory barriers and discrimination that limit access to housing for people with criminal records or histories of drug or alcohol misuse

Promote Educational Opportunities for People with Criminal Records

- Restore Pell Grant eligibility for in-prison postsecondary education and eliminate the student aid ban for students with drug convictions
- Encourage post-secondary institutions to adopt admissions policies that do not unfairly discriminate against students with criminal records

Increase Employment of People with Criminal Records

- Eliminate or reduce the harmful impacts of laws and regulations that prevent qualified people from working in certain industries
- Require that background checks are fair, accurate, and complete and expand opportunities for criminal record sealing and expungement
- Adopt fair hiring policies
- Offer specialized workforce services for people with criminal records

Relieve People of Collateral Consequences

- Reduce unnecessary collateral consequences and impose them only as part of sentencing
- Offer procedures for people who have completed their sentence to be relieved of collateral consequences

Improve Reentry Planning and Services

- Reauthorize and fully fund the Second Chance Act
- Increase effective prison and jail based recidivism reduction programming
- Improve reentry planning
- Make the federal Interagency Reentry Council permanent and create state-level reentry councils

Expand the use of Alternatives to Incarceration

- Increase the number of offenses for which Alternatives to Incarceration are a permissible or preferred sentencing option
- Provide funding incentives for U.S. Attorneys offices and other prosecutors' offices that prioritize Alternatives to Incarceration as sentences for defendants they prosecute
- Provide financial and career incentives for prosecutors who demonstrate a commitment to Alternatives to Incarceration and incorporate the use of Alternatives to Incarceration into their job performance measures

Pass the Sentencing Reform and Corrections Act