



*Physician Leadership*  
on National Drug Policy

Position Paper on Drug Policy  
Physician Leadership on National Drug Policy

Physician Leadership on National Drug Policy  
PLNDP National Project Office  
Brown University  
Center for Alcohol and Addiction Studies

PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY

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Physician Leadership on National Drug Policy

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Position Paper*

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# introduction

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## HISTORY OF PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY

PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY (PLNDP) was started in July 1997 when thirty-seven of the nation's distinguished physicians, representing virtually every medical specialty, met and agreed on a Consensus Statement. This statement, which stresses the need for a medical and public health approach to national drug policy, has served as the underlying framework for all of the project's activities (see Consensus Statement on page 6). "Despite the best intentions of government policy makers and law enforcement officials, the current criminal justice driven approach is not reducing, let alone controlling drug abuse in America," said Lonnie Bristow, MD, the past President of the American Medical Association and PLNDP Vice Chair, at the outset of the project. "Our profound hope is that this group of distinguished physicians, because of their professional accomplishments and objectivity, will be able to help move us to a new national consensus," noted David Lewis, MD, PLNDP Project Director.

The thirty-seven PLNDP Members are physicians of high national standing and many have health policy responsibilities at the highest federal and state levels (see Appendix A for a list of PLNDP Members). Because of their wide range of backgrounds, there is no particular ideological or political perspective that dominates the group.

In March 1998, the PLNDP presented its first research report, "Addiction and Addiction Treatment." The report contained a review of more than 600 research articles as well as original data analyses that conclusively demonstrated that drug addiction is as treatable

as other chronic medical conditions, such as diabetes, asthma, and hypertension. The report also found that treating drug addiction is an effective anti-crime measure and is less costly than prison. Some of the most positive outcomes of treating drug addiction include: greatly reduced medical costs to society; returning drug addicts to their families, communities, and jobs; major crime reductions; and a reduction in funds spent on law enforcement. From this research, the PLNDP developed a videotape report, *Drug Addiction: The Promise of Treatment*, that was released in November 1998. The video has been very well-received and the feedback has been overwhelmingly positive. A wide variety of groups—including healthcare educators, practicing physicians, medical students, criminal justice professionals, judges, and those in the treatment field—have viewed the video and shared its message with others.

In November 1998, the PLNDP presented a second research report “Health, Addiction Treatment, and the Criminal Justice System.” The report was made up of a series of research studies on drug courts and drug treatment programs for prisoners, parolees, and teenage drug users and found that the best new programs reduce drug use, crime, and re-arrest rates. In analyzing this new level of success, a core component cited in the studies is the need for close collaboration among the criminal justice system, the community, public health agencies, cognitive and behavioral counselors, drug treatment specialists, health care providers, and employment specialists. The PLNDP’s second videotape report, *Trial, Treatment, and Transformation*, was generated from this research and was released in April 1999. The video presents evidence on the effectiveness of treatment programs as compared to incarceration and includes comments from a number of experts in the field. It also features the graduation of the Richmond, Virginia drug court as well as the stories of two former drug addicts who are now taking positive steps to turn their lives around.

For further information on these two videotape reports, please see Appendix C. Through foundation

support, we are able to offer complimentary copies of these videos to anyone with plans to use them for an educational purpose. Recently, a third videotape has been released for use on cable television.

The PLNDP has also expanded its efforts beyond the PLNDP Members by inviting physicians and medical students from across the country to become associates of the PLNDP. To date, there are nearly 6,000 PLNDP Physician Associates and several hundred PLNDP Medical Student Associates who have indicated that they are in agreement with the Consensus Statement and that they are interested in further educating themselves on drug policy.

In June 1999, the PLNDP leadership met at the Aspen Institute in Aspen, Colorado. An important goal of this meeting was to facilitate dialogue between various disciplines in order to arrive at shared goals and to articulate the necessary steps in national and local research and advocacy efforts. To this end, representatives from law, the enforcement community, business leaders, legislators, community coalition leaders, and experts in addiction medicine and addiction psychiatry were present (for a full list of participants, see Appendix B). The meeting was successful, with participants responding positively to the idea of working together to develop new approaches to drug policy. This position paper was presented in its draft form at the Aspen Institute meeting and much of the feedback received has been incorporated into the final document.

#### POSITION PAPER ON DRUG POLICY

Drug addiction is a medical and public health problem that affects all Americans, directly or indirectly. This report by PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY (PLNDP) demonstrates that a medically-oriented, public health approach to dealing with the problems of drug abuse will help improve the health of individuals as well as the health and safety of our communities and of our nation.

The focus of PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY has been on illicit drugs, although many of the policy recommendations in this report apply to all forms of substance abuse. This focus on illegal drugs was chosen by comparison to tobacco and alcohol policy because illicit drug policy is the area where there has been the least input and influence from medical and public health leaders.

The medical and public health oriented treatment policy recommendations in this report are based on evidence that:

- ▶ Drug addiction is a chronic, relapsing disease, like diabetes or hypertension.
- ▶ Treatment for drug addiction works.
- ▶ Treating drug addiction saves money. It helps people return to work, reduces the burden on emergency care, and decreases crime rates and incarceration costs.
- ▶ Treating drug addiction restores families and communities.
- ▶ Prevention and education efforts help deter our youth from substance abuse, delinquency, crime, and incarceration.

This report, “Physician Leadership on National Drug Policy: Position Paper on Drug Policy,” is structured in a similar way to public health strategy planning reports like *Healthy People 2000* and *Healthy People 2010*.<sup>1</sup> It is an outgrowth of two major PLNDP research reviews on “Addiction and Addiction Treatment” and “Health, Addiction Treatment, and the Criminal Justice System.”<sup>2</sup> Above all, this report is meant to outline some basic policy directions, rather than advocate any specific legislation or political agenda.

– David C. Lewis, M.D.

## ENDNOTES: INTRODUCTION

- 1 *Healthy People 2000* (Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 1990) <<http://odphp.osophs.dhhs.gov/pubs/hp2000/>>; Developing Objectives for *Healthy People 2010* (Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, September 1997).
- 2 Lewis DC, Physician Leadership on National Drug Policy: Advocacy for an Effective Drug Policy, *Medicine and Health/Rhode Island*, 82(3): 101-104 (March 1999).





# executive summary

## KEY POLICY RECOMMENDATIONS

- ▶ ***Reallocate Resources Toward Drug Treatment and Prevention***  
Increase the proportion of the federal drug control budget allocated to demand reduction (treatment and prevention) from 32.6% to 50% in the near-term, and thereafter to 65%.
- ▶ ***Parity in Access to Care, Treatment Benefits, and Clinical Outcomes***  
Increase the proportion of health insurance plans giving parity for substance abuse treatment.
- ▶ ***Reduce the Disabling Regulation of Addiction Treatment Programs***  
Adopt a simplified and shorter set of regulations effecting drug abuse treatment programs and rely more on the development of consensus treatment protocols to promote quality practice instead of rules to regulate treatment.
- ▶ ***Utilize Effective Criminal Justice Procedures to Reduce Supply and Demand***  
The federal government should initiate funding mechanisms for increased support for programs at the interface between the criminal justice and health care systems – community coalitions, community policing, drug courts.
- ▶ ***Expand Investments in Research and Training***  
Increase the research budgets (including research training) of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) with the goal of gradually attaining budgets more comparable with National Institutes of Health (NIH) research institutes whose activities are directed toward diseases with costs and impacts similar to alcoholism and drug addiction.
- ▶ ***Eliminate the Stigma Associated with Diagnosis and Treatment of Drug Problems***  
Increase the proportion of the public and of health professionals who believe that drug addiction is a treatable problem comparable to other chronic diseases.
- ▶ ***Train Physicians and Students to be Clinically Competent in Diagnosing and Treating Drug Problems***  
Substance abuse education should be a required element in the accreditation standards for all health professional schools.

# consensus statement ————— *July 1997*

## PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY

Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

We are impressed by the growing body of evidence that demonstrates that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs. These approaches offer great opportunities to decrease the burden on individuals and communities, particularly when they are integrated into multidisciplinary and collaborative approaches. The current emphasis – on use of the criminal justice system and interdiction to reduce illegal drug use and the harmful effects of illegal drugs – is not adequate to address these problems.

The abuse of alcohol and tobacco is also a critically important national problem. Alcohol abuse and alcoholism cause a substantial burden of disease and antisocial behavior which require vigorous, widely accessible treatment and prevention programs. We strongly support efforts to reduce tobacco use, including changes in the regulatory environment and tax policy. Drug addiction encompasses dependency on alcohol, nicotine, as well as illegal drugs. Despite the gravity of problems caused by all forms of drug addiction, we are focusing our attention on illicit drugs because of the need for a fundamental shift in policy.

### **As physicians, we believe that:**

- It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures that are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs.
- Concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.
- Physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area.
- Community-based health partnerships are essential to solve these problems.
- New research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training.

PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY will review the evidence to identify and recommend medical and public health approaches that are likely to be more cost-effective, in both human and economic terms. We shall also encourage our respective professional organizations to endorse and implement these policies.

# initiative 1

Addiction is a Chronic,  
Relapsing Disease

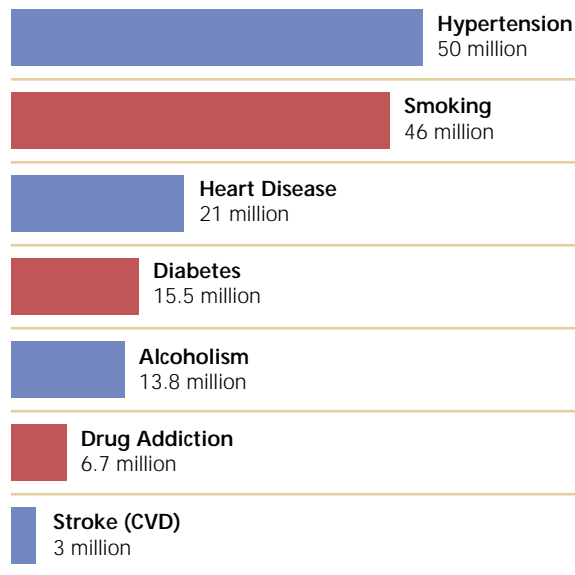
“Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements. We are impressed by the growing body of evidence that demonstrates that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs.”

## initiative 1 — *Addiction is a Chronic, Relapsing Disease*

### BACKGROUND AND REFERENCES

Drug addiction has not been considered to be a “real” medical disease by the public or, for that matter, by many physicians. One result of this attitude is that, while considerable scientific advancements have been achieved in the last twenty years in the understanding of addiction and addiction treatment, little of this knowledge has reached the general public or garnered application in clinical practice or public policy settings. Ignorance about the scientific facts of addiction has allowed drug abuse and addiction to be understood as social problems that should be handled by social institutions. Exacerbating this situation is the stigma surrounding drug use and addiction, which is discussed in greater detail in Initiative 7. Social stigma creates a simplistic dichotomy of morality, in which the user or addict is thought to

## Prevalence of Major Chronic Behavioral Health Problems

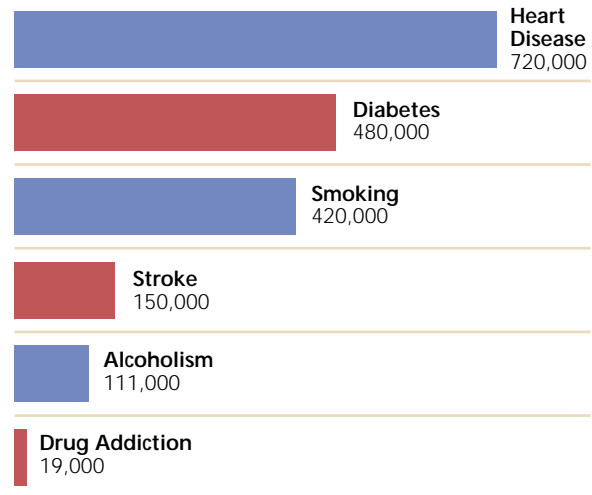


Large segments of the U.S. adult population have health problems with important behavioral aspects in both origin and management. For alcohol, on the order of 15% of the roughly 90 million current drinkers have problems with dependence or abuse. For drugs, up to half of current users (about 11 million) may meet clinical criteria for abuse or dependence. SOURCE: National Institutes of Health (Department of Health and Human Services), *Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update*, 1997. Data prepared by Henrick J. Harwood.

be bad or weak-willed, seeking gratification and pleasure without control or concern for the future. There is ample evidence to suggest that such a divisive framework is an inappropriate response to what is inherently a chronic, progressive, relapsing disease deserving of medical treatment and public health solutions.

In medical dictionaries, the definition of “disease” is so vague that “whether a particular condition is or is not designated a disease is as much a matter of cultural consensus as medical truth.”<sup>1</sup> In lieu of a fixed definition, more restrictive, biological models of disease have emerged. These rigid disease models often produce vague or overdetermined definitions which, if rigorously applied, would exclude many commonly accepted diseases such as coronary heart disease, essential hypertension, diabetes mellitus, and cancer.

## Total Annual Deaths for Major Chronic Behavioral Health Problems



The mortality toll from heart disease, diabetes, smoking, and stroke are all much higher than the loss of life from alcohol and drug disorders. Of course, one of the palpable concerns with respect to alcohol and drug abuse is that some deaths occur in non-users of alcohol or drugs through accidents and violence. SOURCE: National Institutes of Health (Department of Health and Human Services), *Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update*, 1997. Data prepared by Henrick J. Harwood.

Critics of the idea that drug addiction is a disease cite two major reasons for concern: the lack of clear, specific knowledge about the biological basis of addiction and the role of volition in drug use. Much scientific evidence has pointed to the biological basis of addiction, making it comparable to other conditions. National Institute on Drug Abuse (NIDA) Director Dr. Alan Leshner has cited research demonstrating the direct or indirect involvement of the mesolimbic reward system in the biochemical mechanisms of virtually all addictive substances.<sup>2</sup> Likewise, many researchers have noted that a variety of drugs cause significant long-term changes in brain metabolic activity, receptor availability, and gene expression. There are also data to support the presence of heritable elements predisposing individuals to addiction. Enough information has been collected for the American Psychiatric Association to codify criteria for the diagnosis of drug abuse and

drug dependence (DSM-IV)<sup>3</sup> and for researchers to identify the progression of addictive diseases.<sup>4</sup> Dr. Leshner concludes, “The common brain effects of addicting substances suggest common brain mechanisms underlying all addictions ... [making] it, fundamentally, a brain disease” (endnote 2).

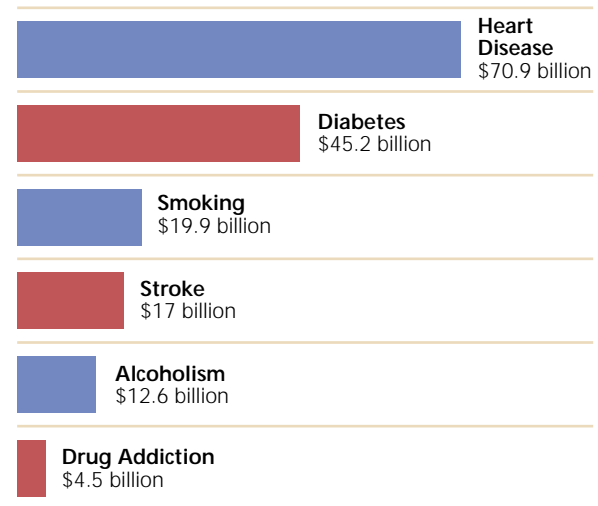
In fact, while the exact biological components of addiction and their relation to environmental factors are not precisely defined, addiction is no different than many other chronic, relapsing diseases in this matter. As Brown University Professor Dr. David Lewis points out, the etiology of coronary heart disease, a medically significant condition easily classified as a disease, is unknown—while the pathological basis is known to be arteriosclerosis, neither the etiology nor mechanism of plaque formation in arteries is clear. As for genetic predisposition, the evidence for addictions is at least as persuasive as it is for heart disease, diabetes, and hypertension. According to Lewis, “Chronic diseases in which the inherited biological defect is known are rare” (endnote 1).

Drug addiction and other chronic illnesses are also comparable in terms of volition. An individual’s behavior can influence the etiology and outcome of many medical conditions: cigarette smoking, hypertension, and obesity can influence the onset and prognosis of coronary heart disease; salt intake, cholesterol, and obesity impact essential hypertension; dietary controls are vital to manage diabetes; and drug abuse no doubt contributes to the onset of drug addiction. But no person eats fatty foods with the purpose of developing heart disease or hypertension, just as no drug user begins to use with the hope of becoming addicted. Dependence is essentially marked by the loss of consistent control over intake, a continuous desire for a drug in spite of possible harmful effects, and frequent relapses following periods of abstinence. Most people who drink alcohol or use illicit drugs never become addicted or develop an uncontrollable problem, just as poor diet does not always lead to health problems. In many cases, various environmental and biological factors significantly contribute to or trigger an illness or addiction.

In fact, people who do develop chronic, relapsing diseases are often no different in behavior or motivation than unaffected, healthy individuals. Voluntary control over behavior is as important and difficult an issue for a drug addict as it is for an obese hypertension patient. Policy differences between the two may be more an outcome of stigma and public perception than of medical fact.

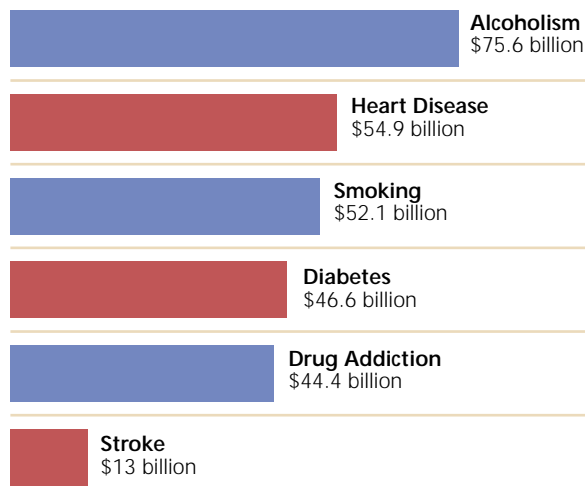
For many chronic diseases, the damage caused by the disease is often progressive, even with good management. In comparison with other chronic diseases, drug addiction is a manageable condition and, very frequently, robust health can be achieved

### Annual Expenditures on Major Chronic Behavioral Health Problems



**Heart disease and diabetes have total health expenditures many times greater than alcohol and drug disorders, while annual stroke and smoking health expenditures are somewhat greater.** In interpreting annual expenditures, disease prevalence should be accounted for. Analysis reveals per capita expenditures: \$5,667 for stroke, \$3,376 for heart disease, \$2,916 for diabetes, \$913 for alcoholism, \$671 for drug addiction, and \$432 for smoking. In addition to these differences, which may be appropriate, medically necessary health services for most behavior related disorders are routinely covered under private insurance as well as Medicare and Medicaid (including health problems caused by smoking), while treatment for drug addiction is not. SOURCE: National Institutes of Health (Department of Health and Human Services), Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update, 1997. Data prepared by Henrick J. Harwood.

## Productivity Losses Due to Major Chronic Behavioral Health Problems

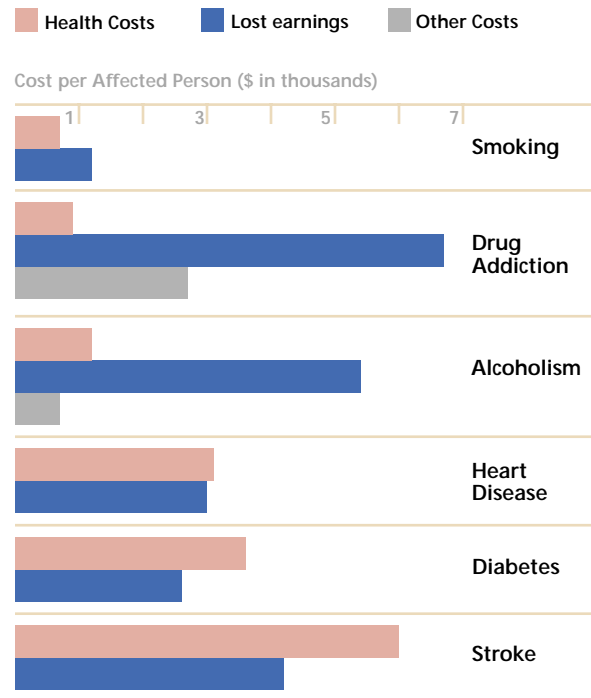


Aggregate productivity losses (employment and household productivity) from alcohol and drug disorders are comparable to those for other disorders with behavioral elements. A major part of the lost productivity for alcohol abuse is associated with alcoholics working at impaired levels of effectiveness, while drug abuse costs are elevated because a small number of drug addicts “drop out” of the legitimate labor market for crime careers. SOURCE: National Institutes of Health (Department of Health and Human Services), *Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update*, 1997. Data prepared by Henrick J. Harwood.

for individuals who are successfully treated. Finally, it should be noted that the management of addiction is generally less costly than the management of many other chronic diseases.

A series of Physician Leadership on National Drug Policy charts comparing addiction with other chronic diseases follows. Understanding the similarities between drug addiction and other chronic illnesses is vital for impacting medical practice and improving the health of individuals. Data for the charts was analyzed and compiled by Henrick J. Harwood, PhD of The Lewin Group. The phrase “chronic behavioral health problems” was chosen by Dr. Harwood to illustrate and emphasize the behavioral component of chronic diseases.

## Annual Cost per Affected Person of Major Chronic Behavioral Health Problems



Health costs per case of alcohol and drug abuse are materially lower than for heart disease, stroke, and diabetes.

The productivity losses per person are greater for alcohol and drug abuse than for the other three disorders, although the origin and nature of these costs are quite different from the other health behavior problems, involving costs typically outside of the health framework (i.e. property destruction and criminal justice system expenses). SOURCES: National Institutes of Health (Department of Health and Human Services), *Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update*, 1997; McGinnis M, Foege W, Actual Causes of Death in the United States, *Journal of the American Medical Association* 270(18): 2207-2212 (1993). Data prepared by Henrick J. Harwood.

### ENDNOTES: INITIATIVE # 1

- 1 Lewis DC, A Disease Model of Addiction, In Miller, N (Ed), *Principles of Addiction Medicine* (Chevy Chase, MD: American Society of Addiction Medicine, 1994): Chapter 7.
- 2 Leshner AI, Addiction is a Brain Disease, and It Matters, *Science*, 278: 45-47 (1997).
- 3 *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association, 1994).
- 4 Hazelden Institute, Addiction: A Disease Defined, *Research Update* (August 1998).



## initiative 2

### Reallocate Resources Toward Drug Treatment and Prevention

- ▶ **Increase the proportion of the federal drug control budget allocated to demand reduction (treatment and prevention) from 32.6% (Fiscal Year 1999) to 50% in the near-term, and thereafter to 65%.** Data source: Office of National Drug Control Policy budget

- ▶ **Each state should provide the number of publicly funded treatment slots indicated by that state's SAPT Block Grant Needs Assessment study.** Data source: Office of Applied Statistics, Center for Substance Abuse Treatment

“ It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention.”

## initiative 2 ————— *Reallocate Resources Toward Drug Treatment and Prevention*

### POLICY RECOMMENDATIONS

- **Increase the proportion of the federal drug control budget allocated to demand reduction (treatment and prevention) from 32.6% (Fiscal Year 1999) to 50% in the near-term, and thereafter to 65%.**

Data source: Office of National Drug Control Policy budget

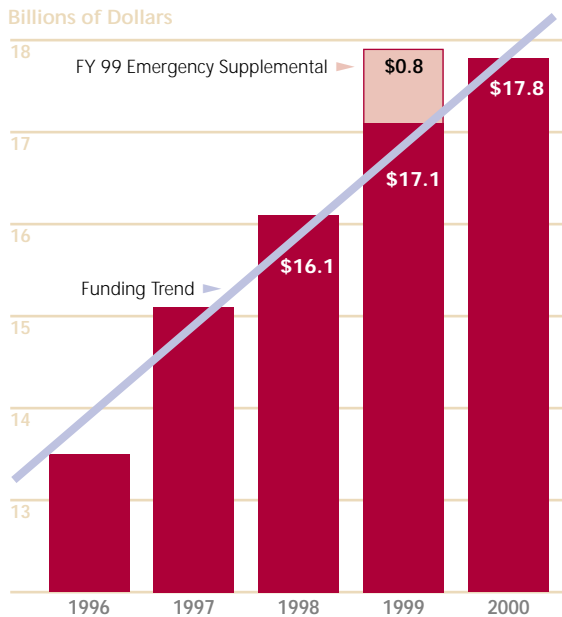
- **Each state should provide the number of publicly funded treatment slots indicated by that state's SAPT Block Grant Needs Assessment study.** Data source: Office of Applied

Statistics, Center for Substance Abuse Treatment

### BACKGROUND AND REFERENCES

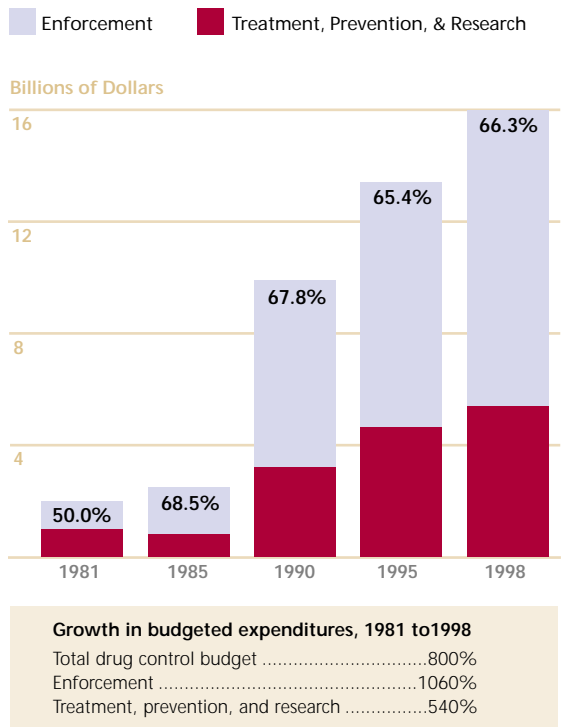
An estimated five million Americans are in need of treatment for drug abuse, and less than one-fourth of those needing treatment get it.<sup>1</sup> A major study commissioned by the US Army found that law enforcement costs fifteen times more than drug treatment to achieve the same degree of benefit in reduced cocaine consumption, reduced crime, and reduced violence.<sup>2</sup>

## National Drug Control Budget Funding Trend



**National Drug Control Budget Funding.** Adapted from: Office of National Drug Control Policy, *National Drug Control Strategy 1999*.

## Federal Drug Control Budget



**Federal Drug Control Budget.** Adapted from: Drucker E, Drug Prohibition and Public Health: 25 Years of Evidence, *Public Health Reports* 114(1): 14-29 (1999).

The nation's current drug control budget allocates two-thirds of its funding to law enforcement and interdiction efforts, twenty-two percent to treatment and twelve percent to primary prevention programs.<sup>3</sup> Despite steadily increasing expenditures, especially on enforcement, drug use has been remarkably resistant to change in all age groups,<sup>4</sup> drug availability has been unaffected,<sup>5</sup> and drug-related deaths have increased.<sup>6</sup> Increased funding for treatment and prevention may be justified in part because these approaches have been shown to have a cost-effective impact on drug problems in our communities.<sup>7</sup> The major emphases of the national drug control budget are evident in the Office of National Drug Control Policy (ONDCP) National Drug Control Strategy (see chart at left).<sup>8</sup>

A recent report by Join Together, an organization that helps communities battle drugs and crime, examined the current state of drug treatment and recovery. The report emphasized that there are large numbers of drug abusing or addicted individuals who are not offered treatment due to a lack of funding or resources, while there remains a heavy focus on supply reduction measures.<sup>9</sup> After providing a background on the efficacy of treatment and the potential savings for society, the report defined six recommendations for drug abuse policy:

- 1 Parity for addiction treatment
- 2 Creation of a broad-based national campaign to educate the public and build political support
- 3 Increased addiction and treatment research and increased accessibility of the results
- 4 Education and training on addiction and treatment for all health, mental health, social service, and justice system professionals
- 5 Monitoring of treatment programs by independent treatment managers to ensure efficacy

6 Integration of diagnosis, treatment, and long-term recovery into a coordinated, community-wide strategy dealing with substance abuse issues

Any “community-wide strategy” for “dealing with substance abuse issues” must begin by educating that part of our population who are most at risk: our youth. As one expert in the field of adolescent substance abuse notes, “From a public health standpoint, adolescent drug abuse has far-reaching social and economic ramifications, particularly when its onset is early. . . . Adverse consequences associated with problematic youth drug abuse include psychiatric comorbidity and suicidality, mortality from drug-related traffic crashes, risky sexual practices, and substantial direct health care costs.”<sup>10</sup> Studies like the National Household Survey on Drug Abuse<sup>11</sup> have found that adolescent substance abuse has begun to level off and, in some cases, decrease. However, youths continue to use both legal and illegal substances and, despite decreasing rates overall, the National Household Survey also reported increased rates for some substances. For example, in 1993, the number of youths 12-25 who began using heroin doubled from the previous year; by 1996, the number of youths initiating heroin use was more than five times as high as it had been from 1980-1992. In fact, in 1996, youths were initiating heroin use at the highest rate since the early 1970s. Such research suggests that further prevention efforts must continue to be a priority for all of our communities.

The Physician Leadership on National Drug Policy National Project Office (1998), with the assistance of Henrick J. Harwood, PhD, has analyzed the relative costs of treatment programs as compared to the cost of incarceration. That data is provided as a chart on the next page and explained below. Since a range of treatment modalities is required to address the different needs of drug dependent and abusing individuals, various programs have been included in the analysis.

The National Treatment Improvement Evaluation Study (NTIES), conducted by the Center for Substance Abuse Treatment, estimates the average cost of regular outpatient treatment to be \$1,800, based on \$15 per day, for 120 days.<sup>12</sup> Outpatient treatment at Level I, as defined by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, typically involves one or more group or individual sessions with up to 9 hours of services per week.<sup>13</sup> Charges for one group session can be as high as \$30 to \$50 and typically last from one hour to several hours. Intensive outpatient treatment, Level II of the ASAM criteria, ranges from 9 hours of structured services per week (as seen in some evening programs) to more than 20 hours for day programs. The average cost estimate of \$2,500 includes six months of weekly maintenance care group sessions after completion of the intensive phase of the treatment. The NTIES estimates a methadone maintenance cost of \$13 per day for an average of 300 days, or \$3,900 per person. Costs during the first year of methadone maintenance may be considerably higher due to additional assessments, closer monitoring, and group sessions that are required at the initiation of methadone treatment.

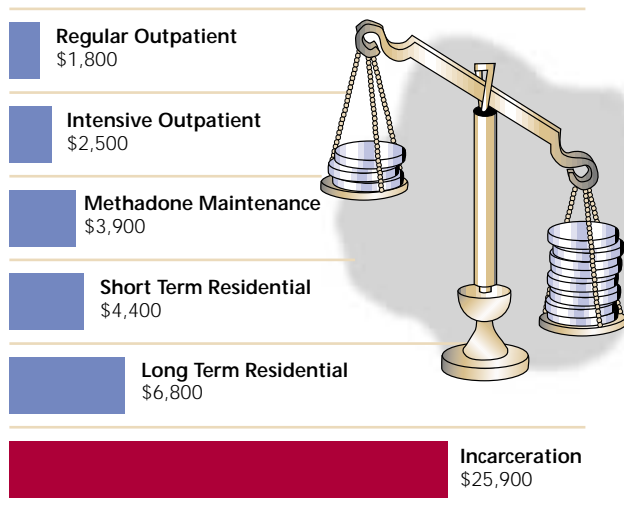
The average costs for short term residential care are \$130 per day, for 30 days, yielding a treatment cost of about \$4,000. An additional \$400 for 25 weekly group sessions is added to the NTIES estimate because research has shown that six months of ongoing care yields better outcomes. Charges for short term residential treatment vary widely depending upon the nature of the clients served and the total package of services provided. Private sector treatment programs include costs of service delivery plus indirect expenses such as capitol debt retirement and typically range from \$6,000 to \$15,000. These programs usually include up to a year of weekly maintenance care group sessions and/or provision of any other necessary service in the event of relapse. The NTIES estimates the average cost for long term residential care to be \$49 per day for an average of 140 days or a total of \$6,800.

The incarceration cost estimate of \$25,900 is based on a common cost estimation strategy. The total federal corrections budget of approximately \$3.2 billion minus construction costs (about 15% of the total budget) is divided by the number of federal inmates (currently about 105,000). Daily operating costs range from just over \$53 per day for low security inmates to over \$71 per day for high security prisoners. According to the Federal Bureau of Prisons, the average weighted operating cost for housing an inmate is \$59.83 per day, for an annual cost of approximately \$21,800. Capitol investments required for the construction of facilities result in amortized costs that must be added to the operating budget to account for all incarceration costs. Simply dividing the total budget for fiscal year 1997 by the number of inmates (which would yield a cost of over \$30,000 per inmate) is inaccurate because construction costs should be spread over the functional life of the facility. The cost estimate of \$25,900, which includes non-operational costs but excludes the current year's construction, is a reasonable estimate of total incarceration expense.

All of these cost estimates suggest that closing the gap between treatment need and treatment availability may be a feasible project. At the same time, it is important to be careful about simple-minded solutions to closing this gap.<sup>14</sup> The solution may not always be “more money” or “more beds/slots/-programs.” No matter how many “slots” are available, if some of the problems with the current funding system for substance abuse treatment are not fixed, many people who need treatment still will not receive it. Examples of problems with the current system include:

- ▶ Restrictions on where people can go to get treatment (e.g., those on Medical Assistance (MA) must go to hospital-based programs, which tend to be more expensive, because of the “IMD exclusion” which prohibits MA funds from being spent for services in “Institutions for Mental Diseases,” defined as any program outside a hospital that has more than 16 beds).
- ▶ Lack of insurance coverage or special limits, caps, and co-pays for substance abuse treatment.
- ▶ Lack of research-based criteria for client placement.
- ▶ Unequal cost-sharing or “match” requirements, making some types of placements in treatment programs more financially attractive to one level of government (even though it may be more expensive to the taxpayer overall).

## Weighing the Costs Annual Cost per Drug Addict



DATA SOURCES: Center for Substance Abuse Treatment 1997 *National Treatment Improvement Evaluation Study (NTIES)* (Rockville, MD: CSAT, 1997); Federal Bureau of Prisons. Data prepared by the Physician Leadership on National Drug Policy National Project Office.

There may be other ways to increase the cost-effectiveness of the substance abuse treatment system that will allow more clients to be treated for the same or less money. This may involve re-thinking the current system. When this action was undertaken in Minnesota by creating the Consolidated Chemical Dependency Treatment Fund, the state was able to:

- ▶ Treat 1/3 more clients for the same amount of money;
- ▶ Control costs (costs for the Fund increased less than 7% from 1989-1992 compared to 28% for other medical care);
- ▶ Increase access to specialized programs for those with special needs.

The Minnesota Department of Health combined all state, federal, and local funds into one Consolidated Fund that allowed “the dollar to follow the client” to the program that could best meet their needs, based on standard, uniform placement criteria administered by independent assessors. The local match was equalized for all placements, and state programs were placed in competition with private programs. The result was a 10% increase in the use of outpatient programs and a decrease in the use of expensive, hospital-based programs. Excellent client outcomes were maintained, at less cost per client.<sup>15</sup> Also, 80% of the cost of treatment was offset in one year by reductions in medical and psychiatric hospitalizations, detox admissions, and arrests.<sup>16</sup>

Another issue that needs further discussion and clarification is the relationship between treatment “need” and the “demand for treatment.” People often use these terms interchangeably, but they are not the same thing. Many people who clinically “need” treatment (i.e., meet accepted diagnostic criteria) do not “demand” it or access the system, even if slots and funding are available. Chemical dependency is an illness characterized by denial, and few people volunteer for treatment. Some form of coercion is usually involved (from an employer, family member, or the criminal justice system).

A recent survey in Minnesota<sup>17</sup> found that only one in four adults who need treatment receive it, even though that state has enough treatment capacity to accommodate them. The biggest barrier to getting treatment was people’s perception that they did not need it. Of those people identified to need treatment

who did not seek it, 9 out of 10 did not believe they needed help. Only 1 out of 10 cited practical barriers to treatment, such as lack of insurance or transportation.

These considerations need to be taken into account in implementing recommendations such as the one at the outset of this section: “Each state should provide the number of publicly funded treatment slots indicated by that state’s SAPT Block Grant Needs Assessment study.” Just providing more treatment slots may not be the answer to closing the gap between treatment need and actual access to treatment. Other approaches may be needed, either in addition to or instead of simply increasing treatment slots, such as re-thinking and changing the current funding system and its restrictions; helping people look critically at their behavior; more public understanding that treatment is available and effective; and improved screening in health care, social service, and criminal justice settings.

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## initiative 3

### Parity in Access to Care, Treatment Benefits, and Clinical Outcomes

- ▶ **A model state substance abuse parity act should be developed and endorsed by major organizations in the field of substance abuse treatment.** Data source: Legal Action Center
- ▶ **Amend the Mental Health Parity Act of 1996 or adopt new legislation to include substance abuse treatment services and to require parity with other chronic diseases in terms of service limits, limits on outpatient care, cost sharing and deductibles.** Data source: United States Code
- ▶ **Increase the number of states having adopted legislation requiring third party payers to provide parity of coverage for substance abuse.**  
Data source: Substance Abuse and Mental Health Services Administration
- ▶ **Increase the proportion of health insurance plans giving parity for substance abuse treatment.** Data source: Health Plan Employer Data and Information Set  
scorecard



“ Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.”

initiative **3** ————— *Parity in Access to Care, Treatment Benefits, and Clinical Outcomes*

POLICY RECOMMENDATIONS

- ▶ **A model state substance abuse parity act should be developed and endorsed by major organizations in the field of substance abuse treatment.** Data source: Legal Action Center
- ▶ **Amend the Mental Health Parity Act of 1996 or adopt new legislation to include substance abuse treatment services and to require parity with other chronic diseases in terms of service limits, limits on outpatient care, cost sharing and deductibles.** Data source: United States Code
- ▶ **Increase the number of states having adopted legislation requiring third party payers to provide parity of coverage for substance abuse.** Data source: Substance Abuse and Mental Health Services Administration
- ▶ **Increase the proportion of health insurance plans giving parity for substance abuse treatment.** Data source: Health Plan Employer Data and Information Set scorecard

## BACKGROUND AND REFERENCES

Health plans and third-party payers typically provide less extensive coverage for substance abuse treatment than for other general medical services. Some insurance companies provide no support for treatment benefits and programs. Offering equitable medical coverage would accord substance abuse “parity” with other chronic conditions in the provision of health care, making access to treatment more feasible. Private insurance coverage would also help to stimulate private sector developments of treatment programs, medications, and protocols, which are discouraged economically in the current system. The 1996 Mental Health Parity Act passed by Congress requires health plans to provide the same annual and lifetime benefits for mental health as already guaranteed for other aspects of health care.<sup>1</sup> No equivalent federal bill has been passed for substance abuse benefits, however.

A recent landmark initiative to provide mental health benefits to Federal employees did include substance abuse coverage. On June 7, 1999, President Clinton directed the Office of Personnel Management to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001. In addition, Clinton noted that the FEHBP’s action could serve as a model for other employers and insurance providers.<sup>2</sup> State action will also be important for achieving substance abuse parity, although to date only five states have passed substance abuse parity laws. At least forty states’ legislatures have considered mental health and substance abuse parity bills.<sup>3</sup>

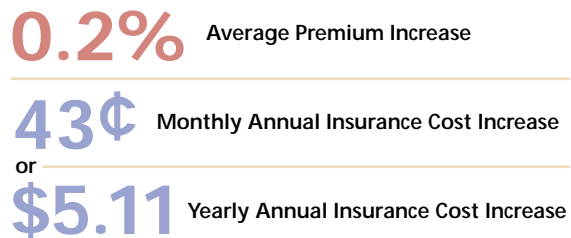
The primary argument against providing substance abuse parity is the fear that the cost to third-party payers will be too high.<sup>4</sup> Few seem to doubt the benefits of providing treatment for drug addiction, especially given the extensive favorable scientific evidence. However, many people do doubt the practicality of requiring insurance providers to cover the costs for substance abuse treatment. Many of these doubts have been addressed by studies that

examine the costs of parity for substance abuse treatment. In fact, a government study published in 1998 showed that the costs of substance abuse parity are small and that the demonstrable benefits to individuals, employers, and society are significant.<sup>5</sup>

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### Cost of Full Parity for Substance Abuse Treatment

Cost per Insured Individual



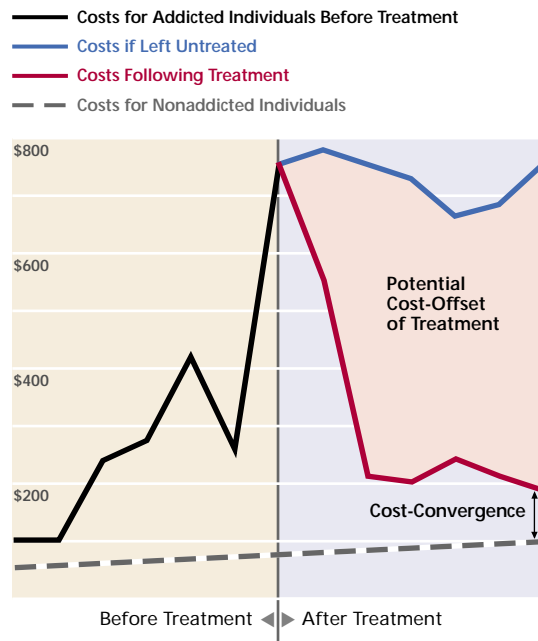
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SOURCES: Substance Abuse and Mental Health Services Administration, *The Costs and Effects of Parity for Substance Abuse Insurance Benefits* (Washington DC: SAMHSA, U.S. Department of Health and Human Services, 1998); Sturm, R, Zhang, W, and Schoenbaum, M, How Expensive are Unlimited Substance Abuse Benefits Under Managed Care? *The Journal of Behavioral Health Services & Research* 26(2): 203-210 (1999).

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The study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that offering full parity for substance abuse treatment would increase insurance premiums by only 0.2% (see table above). A more recent parity study, by the RAND Corporation, concluded that the cost for large corporations and HMOs to provide complete substance abuse benefits would be 43¢ per month or \$5.11 annually per employee.<sup>6</sup> The report also showed that, “Changing even stringent limits on annual SA [substance abuse] benefits has a small absolute effect on overall insurance costs under managed care, even though a large percentage of substance abuse patients are affected. Removing an annual limit of \$10,000 per year on substance abuse care is estimated to increase insurance payments by about 6 cents per member per year, removing a limit of \$1,000 increases payments by about \$3.40.” A 1998 survey by the actuarial firm Milliman &

## Monthly Healthcare Costs for Treated vs. Untreated Substance Abuse



**Treatment Cost Offset.** SOURCE: Langenbucher J, Offsets Are Not Add-Ons: The Place of Addictions Treatment in American Health Care Reform, *Journal of Substance Abuse* 6: 117-122 (1994).

Robertson Inc. found the additional cost for drug abuse treatment to be less than 1%.<sup>7</sup>

While comprehensive parity coverage comes at a small price, the potential cost offset produced by substance abuse treatment is significant. Health care utilization of a treated patient group is observed to fall dramatically and eventually, in most cases, will nearly converge to the level of the normative population. Only in cases where the physical damage done by drinking or drug use is permanent, or where the patient is no longer physically resilient, will significant convergence not be observed. Even in such cases, there may be attractive cost-offsets since medical problems are contained or at least brought under greater control. Currently, substance abusers are among the highest cost users of medical care in the United States, although only 5-10% of those costs are due directly to addiction treatment.<sup>8</sup>

One study, which followed 161 methadone patients, found that nearly half had at least one comorbid medical condition that required immediate treatment.<sup>9</sup> Eighteen percent required treatment for a sexually transmitted disease, 16% for tuberculosis, 15% for HIV/AIDS, and 7.5% for hypertension. A number of other medical conditions requiring treatment were noted in smaller numbers of patients including infections, liver disease, and anemia. Providing treatment for drug addiction results in more effective health care utilization for other medical problems by addicts and their families. A study from the Harvard School of Public Health computed the cost per year of life saved for a variety of behavioral, medical, and safety interventions, analyzing 500 different interventions.<sup>10</sup> Substance abuse treatments were found to be in the most favorable category of interventions, ranking in the top 10% for their savings in money and lives.

Public opinion around parity legislation may be largely connected to perceived cost. A 1998 survey about substance abuse and mental health benefits found that the majority of surveyed individuals did support expanding treatment benefits, but only if such expansion did not require extensive increases in taxes or health insurance premiums.<sup>11</sup>

Researchers for the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed a number of studies of states with parity laws and concluded:

- ▶ Most state parity laws are limited in scope or application and few address substance abuse treatment. Many exempt small employers from participation.
- ▶ State parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous baseline benefits.

- Employers have not avoided parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees. The low costs of adopting parity allows employers to keep employee health care contributions at the same level they were before parity.
- Costs have not shifted from the public to private sector. Most people who receive publicly funded services are not privately insured.
- Based on the updated actuarial model, full parity for substance abuse services alone is estimated to increase services by 0.2%, on average. This translates to an approximate cost of \$1 per month for most families.<sup>12</sup>

In another government report, researchers from the Center for Substance Abuse Treatment’s (CSAT) Office of Managed Care as well as the Center for Mental Health Services (CMHS) reviewed studies of five states with parity laws (California, Ohio, Oregon, Minnesota, and Washington). They found that the costs associated with substance abuse benefits tend to have little impact on premiums or the overall spending of insurance companies, and the initial costs are offset by the resultant social benefits of treatment.<sup>13</sup>

A recently published study of the costs and benefits of publicly-funded outpatient treatment services in the city of Philadelphia found similar results.<sup>14</sup> The average cost for treatment in an outpatient drug-free program was \$1,275 while the benefits gained by avoiding health care and crime costs were estimated to be \$8,408 per person. Even greater cost benefits were found for the outpatient methadone maintenance program: treatment cost slightly more, \$1,873 per person, but saved over \$34,000 through reduced medical costs, increased rates of employment, and decreased crime rates.

In addition, several major political and professional organizations have published statements of support

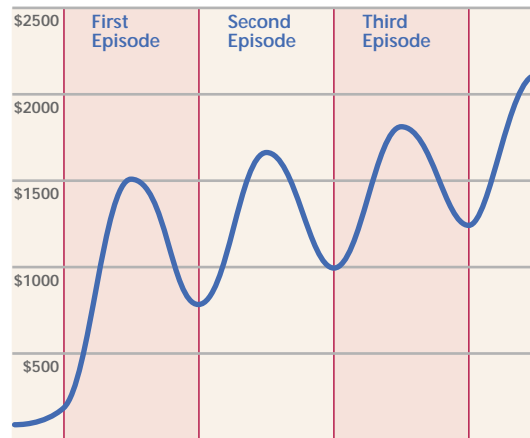
for parity legislation. The Office of National Drug Control Policy (ONDCP) cited four major reasons for its support of parity: 1) Parity will help to close the treatment gap, 2) Parity will correct discrimination, 3) Parity is affordable, 4) Parity will reduce the overall burden of substance abuse to society.<sup>15</sup>

Similarly, many medical and professional organizations have affirmed their support for parity for substance abuse, including: American Society of Addiction Medicine (ASAM), American Psychiatric Association (APA), American Academy of Addiction Psychiatry (AAAP), American Managed Behavioral Healthcare Association (AMBHA), and American Medical Association (AMA).<sup>16</sup>

A report on Vermont’s Mental Health and Substance Abuse Parity Act (Act 25) by the Vermont Department of Banking, Insurance, Securities and Health Care

## Healthcare Cost Profile of Untreated Addictive Diseases

Average Monthly Healthcare Costs



**Escalating costs of repeated relapse episodes of untreated drug addiction.** SOURCES: Blose J, Holder H, The Utilization of Medical Care by Treated Alcoholics: Longitudinal Patterns by Age, Gender, and Type of Care, *Journal of Substance Abuse* 3: 13-27 (1991); Langenbucher J, Prescription for Health Care Costs: Resolving Addictions in the General Medical Setting, *Alcoholism: Clinical and Experimental Research* 18: 1033-1036 (1994); Luce B, Elizhauser A, *Standards for the Socioeconomic Evaluation of Health Care Services* (New York: Springer-Verlag, 1990). Data compiled by James Langenbucher, PhD.

Administration details the implementation of the Act, measures taken to ensure compliance, comparisons between treatment conditions, and estimated impact on health insurance costs.<sup>17</sup> The key points of the report follow:

- ▶ Act 25 applies to all health plans (except self-insured plans) offered by Vermont insurance companies, including HMOs. The law went into effect in 1998 for all new insurance policies and upon the date of renewal for existing insurance policies, collective bargaining agreements, or employment contracts.
- ▶ Health insurance companies estimated that their premiums would increase, on average, in the 1–3% range. Generally, managed care companies filed the lowest percent of premium increase attributable to parity while indemnity insurers filed the highest.
- ▶ In most areas of Vermont, providers expressed a desire to learn how to effectively communicate and work with managed care organizations, and an ongoing need for managed care organizations to develop effective means of outreach to local providers.
- ▶ Companies (as of June 1998) had not moved in large numbers into self-insurance; there had been no major dropping of insurance by employers; there had been compliance by the health plans with the provisions of the law; and the stakeholders had together generated a common, “can-do” spirit of parity implementation.

In a like manner, many businesses have already found that managing the costs of treatment for drug addiction can easily be incorporated into their existing health care management procedures.<sup>18</sup> Many corporations, in order to examine their spending on health care benefits and the outcomes of medical treatments—for all medical problems, including

substance abuse—have assembled relational databases. These databases usually contain medical, surgical, psychiatric, substance abuse treatment, employee assistance, Worker’s Compensation, disability, and human resources data.

By using such relational databases, substance abuse treatment can be linked with drug testing and other factors to examine potential outcomes. These databases are used to evaluate existing programs with the goal of not only minimizing costs for employers, but also of maximizing benefits to employees. In other words, relational databases help employers and health insurance providers determine which treatment options are working best for its employees and which treatment options should be eliminated.

In the future, large companies with relational databases may consider consolidating their data to better examine potential outcomes. Such comparisons might be of further use to smaller companies or insurance providers who have not had extensive experience with substance abuse treatment options. In particular, while patient placement guidelines have been developed by ASAM and treatment guidelines have been developed by the APA, purchasers of health services still perceive a need for consolidated disease management protocols similar to those for other chronic diseases (e.g. diabetes or hypertension).

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## initiative 4

### Reduce the Disabling Regulation of Addiction Treatment Programs

- ▶ **Transfer authority for regulation of methadone treatment programs from the Food and Drug Administration to the Center for Substance Abuse Treatment.** Data sources: Federal Register, Health and Human Services
- ▶ **Adopt a simplified and shorter set of regulations effecting drug abuse treatment programs and rely more on the development of consensus treatment protocols to promote quality practice instead of rules to regulate treatment.** Data source: Federal Register

“ It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires... reducing the disabling regulation of addiction treatment programs.”

## initiative 4 ————— *Reduce the Disabling Regulation of Addiction Treatment Programs*

### POLICY RECOMMENDATIONS

- ▶ **Transfer authority for regulation of methadone treatment programs from the Food and Drug Administration to the Center for Substance Abuse Treatment.** Data sources: Federal Register, Health and Human Services
- ▶ **Adopt a simplified and shorter set of regulations effecting drug abuse treatment programs and rely more on the development of consensus treatment protocols to promote quality practice instead of rules to regulate treatment.** Data source: Federal Register

### BACKGROUND AND REFERENCES

There are a number of cases in which excessive regulation of medical practice have been documented to play a role in producing less than optimal (or even harmful) medical care. For example, there are numerous restrictions involved in the prescription of opioid pain medication to individuals seriously disabled from painful conditions or terminal illness.<sup>1</sup> Physicians have been shown to provide inadequate



analgesia in emergency situations to patients with preexisting medical conditions that require opiates to manage chronic pain. Often, opiates are either withheld completely or an inadequate dosage is given, which can result in needless withdrawal symptoms. These actions by physicians, which, in many cases are clearly detrimental to the patient, are undertaken in part due to lack of training and education but mainly to avoid the perception that a narcotic “addiction” is being encouraged. In other words, some physicians over-react to the excessive scrutiny of narcotic prescriptions such that they consider prescriptions of opiates to be inappropriate, even in cases when they are both appropriate and necessary to the patient. Various levels of regulation also govern the provision of methadone maintenance treatment.

Methadone maintenance has been proven to be a safe, effective, and low cost treatment<sup>2</sup> for heroin addiction, yet it remains subject to more restrictive controls than any other established medical treatment. In fact, although methadone was first approved by the FDA as an analgesic in 1947, the current federal regulations, in force since 1977, classify it as an investigative drug. Methadone is regulated by a unique three-tiered system of regulation by the Food and Drug Administration, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration, resulting in a nearly crippling snarl of paperwork and rules.

Unlike most approved medications, use of methadone has been confined to specialized treatment programs, which tend to be under-funded, punitive, and in short supply. Neither physicians in general medical practice nor psychiatrists in general practice are allowed to prescribe methadone. Methadone is not even stocked by community pharmacies.

In 1995, an Institute of Medicine study group concluded that the regulations were unnecessarily burdensome and that there was no medical justification for the special regulatory status of methadone (endnote 2). The panel recommended a number of

changes in the regulations which would have made them less obstructive.

Two years later, a consensus panel on medical treatment of heroin addiction appointed by the National Institutes of Health (NIH) found the situation unimproved and strongly recommended expanding access to methadone treatment by eliminating excessive federal and state regulations and increasing funding for methadone treatment.<sup>3</sup> The NIH consensus panel reported, “Existing Federal and State regulations limit the ability of physicians and other health care professionals to provide methadone maintenance services for their patients. Additionally, these regulations require excessive paperwork and impose burdensome administrative and oversight costs.”<sup>4</sup> The panel also recommended that these regulations be eliminated and that alternative means, such as accreditation, for improving the quality of methadone maintenance treatment programs be instituted. Panel chair Lewis L. Judd, MD stated, “We know of no other area of medicine where the Federal Government intrudes so deeply and coercively into the practice of medicine.... If extra levels of regulation were eliminated, many more physicians and pharmacies could prescribe and dispense methadone, making treatment available in many more locations than is now the case.”

Later in 1997, the American Medical Association (AMA) House of Delegates approved a recommendation from its Council on Scientific Affairs: “That the AMA encourage the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable.”<sup>5</sup> In this statement, the medical profession makes it clear that it considers opioid maintenance programs to be effective for those addicted to opiates. Further, the AMA indicates that the availability of opioid maintenance therapy is an important issue for its physicians.

Currently, new regulations<sup>6</sup> permitting more widespread prescribing of methadone are being developed, but the United States lags far behind developments

in other nations. Prescription of methadone by private physicians is the norm rather than the exception in the Netherlands and the British National Health Service is moving from clinic-based distribution of methadone to methadone prescription by general practitioners.

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- 5 Lundberg GD, New Winds Blowing for American Drug Policies, *Journal of the American Medical Association* 278(11): 946-947 (September 17, 1997).
- 6 Food and Drug Administration and Substance Abuse and Mental Health Services Administration, Health and Human Services, Proposed Rules – Narcotic Drugs in Maintenance and Detoxification of Narcotic Dependence; Repeal of Current Regulations and Proposal to Adopt New Regulations, *Federal Register* 64(140): 39809-39857, Docket No. 98N-0617, RIN 0910-AA52, 21 CFR Part 291, 42 CFR Part 8 (July 22, 1999).

## initiative 5

### Utilize Effective Criminal Justice Procedures to Reduce Supply and Demand

- ▶ **Initiate a systematic and coordinated program of research funded by the National Institute of Justice and other federal agencies aimed at identifying those law enforcement strategies and tactics which accomplish the greatest reductions in drug abuse and/or in the harm to users and society resulting from drug abuse.** Data

source: National Institute of Justice Annual Report

- ▶ **The federal government should initiate funding mechanisms for increased support for programs at the interface between the criminal justice and health care systems – community coalitions, community policing, drug courts.** Data sources: National

Institute of Justice, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

- ▶ **The federal government should provide increased support for evaluating the effectiveness of criminal justice procedures and programs in reducing drug abuse and crime.** Data source: National Institute of

Justice Annual Report

“ It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires... utilizing criminal justice procedures that are shown to be effective in reducing supply and demand.”

initiative 5

*Utilize Effective Criminal Justice Procedures to Reduce Supply and Demand*

POLICY RECOMMENDATIONS

- ▶ **Initiate a systematic and coordinated program of research funded by the National Institute of Justice and other federal agencies aimed at identifying those law enforcement strategies and tactics which accomplish the greatest reductions in drug abuse and/or in the harm to users and society resulting from drug abuse.**

Data source: National Institute of Justice Annual Report

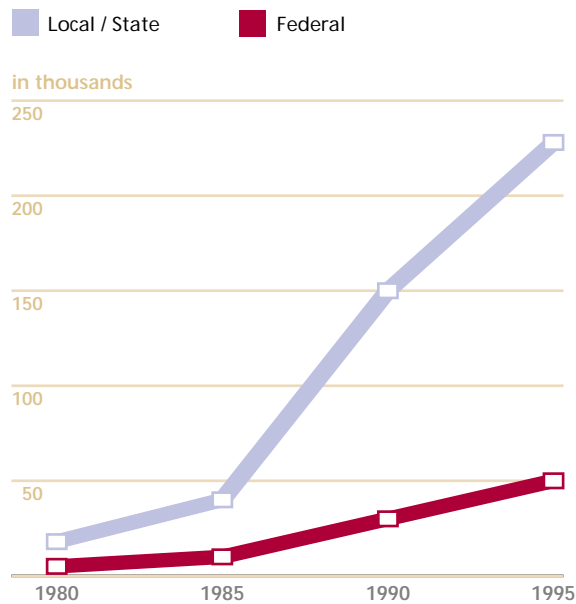
- ▶ **The federal government should initiate funding mechanisms for increased support for programs at the interface between the criminal justice and health care systems – community coalitions, community policing, drug courts.**

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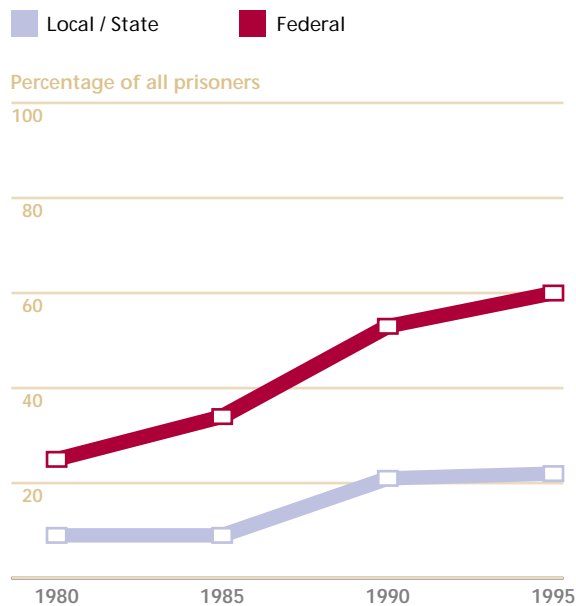
- ▶ **The federal government should provide increased support for evaluating the effectiveness of criminal justice procedures and programs in reducing drug abuse and crime.**

Data source: National Institute of Justice Annual Report

## Total Incarcerations for Drug Violations in Local/State and Federal Facilities



## Percentage of Incarcerations for Drug Violations in Local/State and Federal Facilities



**Incarcerations for drug violations in local/state and federal facilities.** Adapted from: Drucker E, Drug Prohibition and Public Health: 25 Years of Evidence, *Public Health Reports* 114(1): 14-29 (1999).

## BACKGROUND AND REFERENCES

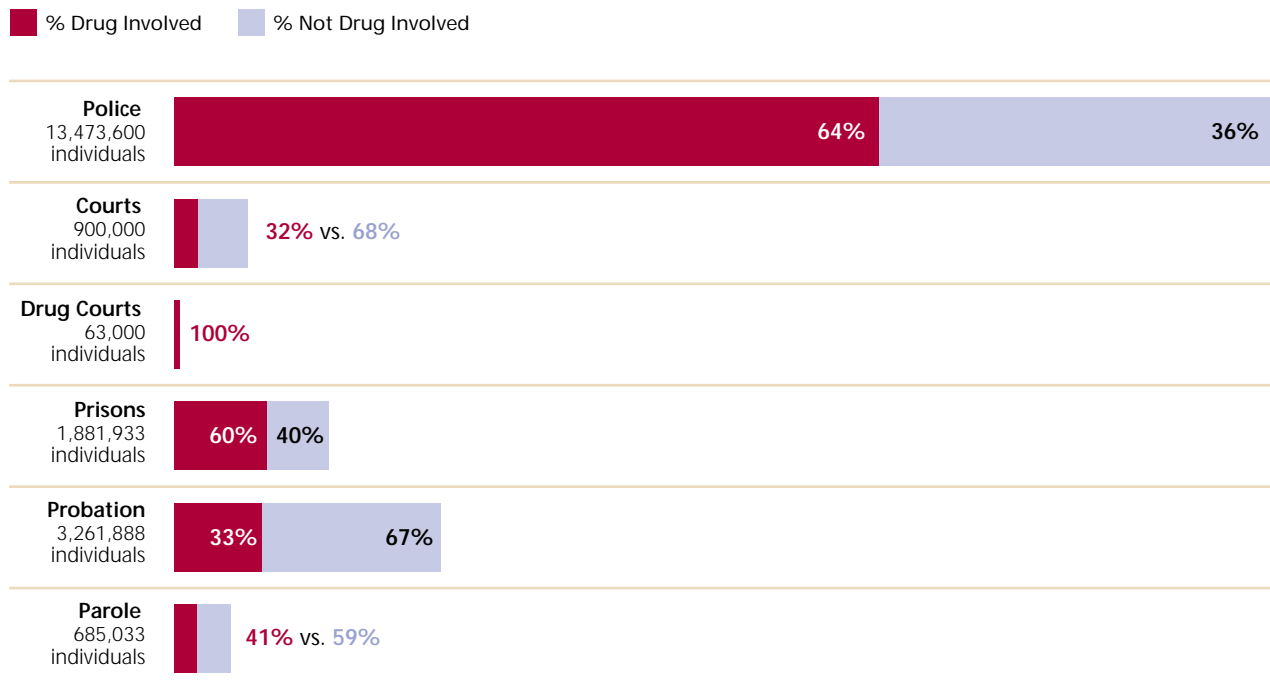
The body of research evaluating criminal justice approaches to drug addiction and their outcomes is not nearly as complete as the body of research on treatment outcomes. A major review of the preventive effect of criminal justice programs conducted for the National Institute of Justice (NIJ) in 1998 reinforced this conclusion. The review stated: “the current development of scientific evidence is inadequate to the task of policymaking.... Many more impact evaluations using stronger scientific methods are needed.”<sup>1</sup> Based on the available evidence, the NIJ report evaluated a number of programs and separated them into three categories: programs that *work* to prevent crime or reduce factors for crime, those that *do not work*, and those that *show promise*. Some examples of programs from each category are listed below:

- ▶ **Programs That Work:**  
rehabilitation programs for adult and juvenile offenders, drug treatment in prison, arresting domestic abusers
- ▶ **Programs That Do Not Work:**  
arrests of juveniles for minor offenses, increased arrests or raids on drug markets, correctional boot camps using traditional military training, “scared straight” programs
- ▶ **Programs That Are Promising:**  
community policing with meetings to set priorities, drug courts, intensive supervision and aftercare of serious juvenile offenders.

The importance of this review is clear given the large number of individuals incarcerated for drug violations (see charts at left).

Conclusions from reports like the NIJ’s should be drawn carefully because some supply and demand reduction measures tend to be oversimplified in public policy. For example, while the NIJ report cited some interdiction efforts in the “Do Not Work” category, it should not be assumed that all interdiction

## Estimated Percent of Drug Involved Individuals in the Criminal Justice System



efforts are equally ineffective. Interdiction is typically portrayed as involving baggage checks at country borders, but another important aspect of interdiction is control of international drug enterprises. The value of such controls has rarely been disputed since these controls have proven to be effective in reducing the supply of illegal drugs.

At the same time, reports such as the NIJ's have encouraged individuals typically supportive of harsh drug penalties to reconsider the wisdom of mandatory minimum laws, particularly in light of the effects these laws have had on non-violent drug users. This position was articulated by University of Pennsylvania Political Science Professor John DiIulio, who writes that he normally has "a kind word for imprisonment."<sup>2</sup> However, DiIulio has reevaluated this stance in the case of non-violent drug offenders. He explains in a recent article: "With mandatory minimums, there is no real suppression of the drug trade, only episodic substance-abuse treatment of incarcerated drug-only offenders, and hence only the most tenuous crime-control rationale for imposing prison term—mandatory or otherwise—on any of them."

### Estimated Percent of Drug Involved Individuals in the Criminal Justice System

DATA SOURCES: National Institute of Justice Research Report, *ADAM 1997 Annual Report on Adult and Juvenile Arrestees* (Washington, DC: US Department of Justice, Justice Programs Office, 1998); Langan P, Brown J, *Felony Sentences in the United States 1994*, *Bureau of Justice Statistics Bulletin* (Washington, DC: US Department of Justice, Office of Justice Programs, 1997); Mumola C, Bonczar T, *Substance Abuse and Treatment of Adults on Probation, 1995* (Washington, DC: US Department of Justice, 1998); Office of National Drug Control Policy, *Drug Treatment in the Criminal Justice System* (Washington, DC: Office of National Drug Control Policy, 1998); US Department of Justice, *Comparing Federal and State Prison Inmates, 1991* (Washington, DC: US Department of Justice, 1994); US Department of Justice, *Drugs and Jail Inmates, 1989* (Washington, DC: US Department of Justice, 1991); US Department of Justice, *Prison and Jail Inmates at Midyear, 1997* (Washington, DC: US Department of Justice, 1998); Adams W, Roth J, Scalia J, *Federal Offenders Under Community Supervision, 1987-96*, (Washington, DC: US Department of Justice, 1998).

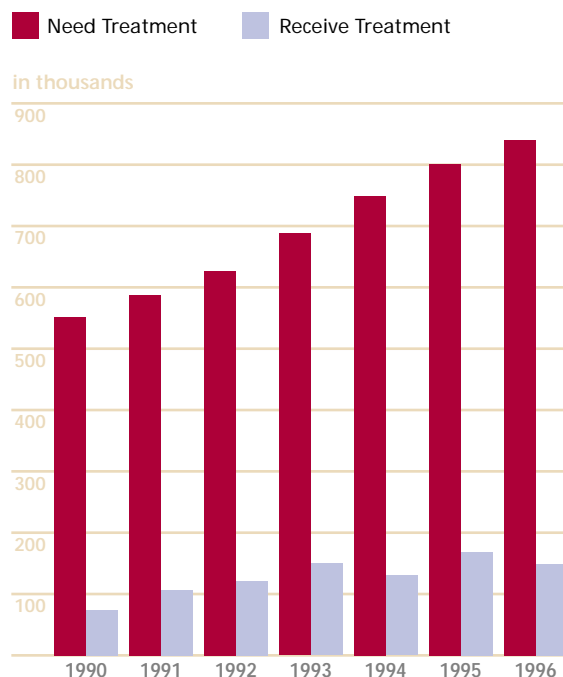
The PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY National Project Office (1998), with the assistance of Craig Love, PhD, has analyzed various data to reveal the percentage of individuals who are drug involved at every level of the criminal justice system. The results are provided in the chart above, "Estimated Percent of Drug Involved Individuals in the Criminal Justice System."

The estimate of problematic drug involvement among arrestees was drawn from the most recent data report of ADAM (Arrestee Drug Abuse Monitoring). The 64% at the “Police” stage was calculated by obtaining an average percentage of individuals with positive urine screens. Drug offenses represented 31.9% of all state and federal felony convictions in 1994; federal convictions were more likely to be for drug offenses (41.4%) than were state convictions (31.4%). Drug offenses here refer to both possession and trafficking charges. Although not explicitly stated in the available literature, it is reasonable to assume that all drug court participants are drug involved. While most drug court participants are substance abusers (alcohol and illicit drugs), it is also true that some participants are drug dealers

who do not abuse substances. Almost 47% of all state and federal probationers (including DWI) reported that they were under the influence of alcohol or drugs at the time of their offense. The estimated 59.6% of local jail and state and federal prison inmates who had ever used drugs regularly was based on an ONDCP (Office of National Drug Control Policy) report. It is assumed that these estimates, using the most recent available data, were conservative, given the increases in drug-related arrests and convictions from 1991-1997.

Though the medical and public health system and the criminal justice system may seem entirely different, they are not necessarily separate entities. There are many opportunities for collaboration. Treatment and public health measures and practices can be incorporated into the criminal justice setting. Likewise, the criminal justice system can inform and educate the treatment community. Examining the effects of America’s “tough” law enforcement-centered approach to reducing drug use and its associated problems in light of studies that the RAND Corporation has conducted for the federal government, long-time crime and public policy commentator Peter Reuter concludes: (1) Arresting and punishing drug users has little deterrent effect; (2) Vigorous enforcement against high-level dealers, smugglers, and refiners does not reduce availability and does little to raise the retail price, but contributes greatly to corruption in producer countries and American law enforcement; and (3) Intensified enforcement against dealers in street markets increases the level of violence associated with such trafficking without significantly affecting drug availability.<sup>3</sup> Reuter also suggests that policy-makers would be well advised to consider placing less emphasis on interdiction and law enforcement and greater emphasis on getting dependent users into treatment and making drug dealing less conspicuous, arguing that these measures would make drugs less available to novice users.

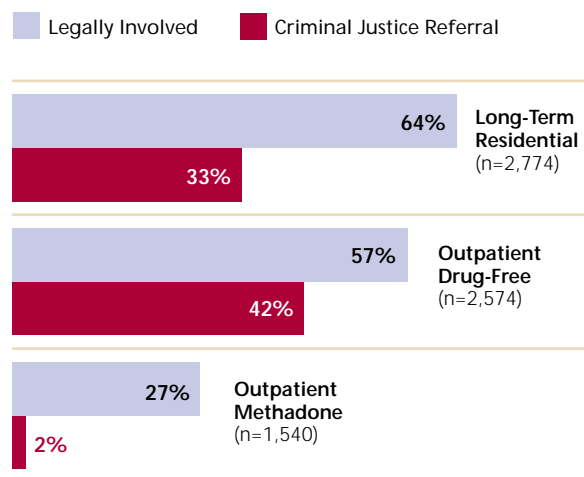
### State and Federal Inmates Needing vs. Receiving Substance Abuse Treatment



On average, states spend roughly 5% of their prison operating budgets on drug and alcohol treatment services. SOURCE: National Center on Addiction and Substance Abuse, *Behind Bars: Substance Abuse and America’s Prison Population* (New York: CSAT, 1998). Data analyzed by D. Dwayne Simpson, PhD and Kevin Knight, PhD.

In 1996, the state of Arizona established the Drug Treatment and Education Fund (DTEF) to divert nonviolent drug offenders from prisons to probation.

## Criminal Justice System Referrals to Community Treatment

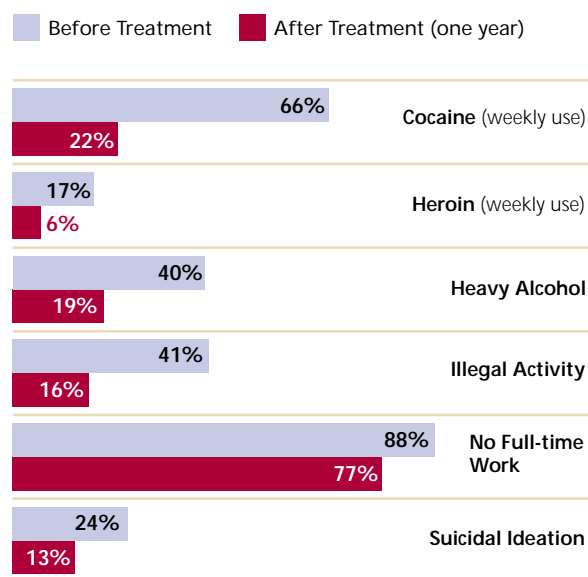


**NIDA's Drug Abuse Treatment Outcome Study (DATOS),** NIDA's 3rd National Treatment Evaluation (N=10,010; 96 Programs). Over half of all admissions to community-based LTR and ODF programs were on probation, parole, or awaiting trial. Note the almost total lack of criminal justice referrals to methadone maintenance treatment. SOURCE: Craddock S, Rounds-Bryant J, Flynn P, Hubbard R, Characteristics and Pretreatment Behaviors of Clients Entering Drug Abuse Treatment: 1969 to 1993, *American Journal of Drug and Alcohol Abuse* 23: 43-59 (1997). Data analyzed by D. Dwayne Simpson, PhD and Kevin Knight, PhD.

A recent evaluation of the program showed that 76.3% of probationers complied with substance use prohibitions, an extremely high level.<sup>4</sup> In addition, 61.1% completed a treatment program successfully. The total Fiscal Year 1998 cost savings for the citizens of Arizona was about \$2.5 million.

One example of an alternative to incarceration is the drug court. The success of drug courts<sup>5</sup> has acted as a catalyst for many programs involving substance abuse and addiction. However, the impact of substance abuse on the justice system is pervasive and can be found across a far wider spectrum of cases than are handled by specialty drug courts. Unified family courts provide one model of approaching substance abuse in a comprehensive manner. Such courts are based on the belief that a family's social and legal needs are best served when that family is assigned to one judge and one social services team who remain

## Effects of Long-Term Residential Treatment



**Long-Term Residential (LTR) Treatment Programs, DATOS** Sample (N=676). Note the significant changes in alcohol and drug use and illegal activity. SOURCE: Hubbard R, Craddock S, Flynn P, Anderson J, Etheridge R, Overview of First Year Follow-up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS), *Psychology of Addictive Behaviors* 11(4): 261-278 (1997); Simpson DD, Joe G, Broome K, Hiller M, Knight K, Rowan-Szal G, Program Diversity and Treatment Retention Rates in the Drug Abuse Treatment Outcome Study, *Psychology of Addictive Behaviors* 11(4): 279-293 (1997). Data analyzed by D. Dwayne Simpson, PhD and Kevin Knight, PhD.

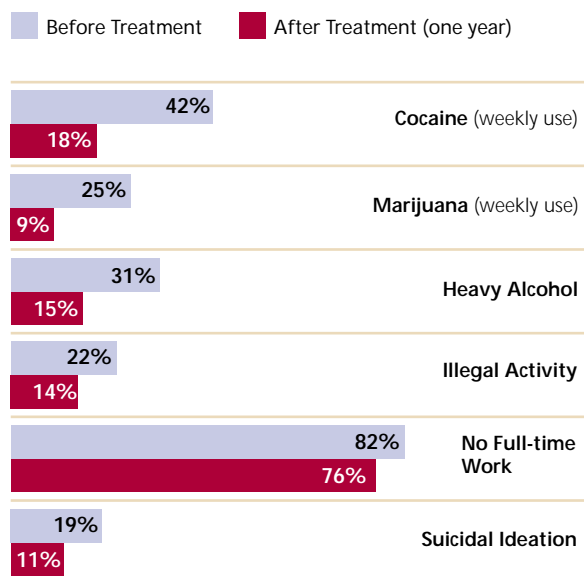
with the family during their entire relationship with the court.

A unified family court system combines the essential elements of traditional family and juvenile courts. Administrative, medical, legal, counseling, and enforcement services are available in or near the court building so that a family's interrelated needs can be served easily and quickly. Social and mental health counseling are also an integral part of the unified family court system.

Further evidence that incorporating medical and public health strategies into the criminal justice system is beneficial to communities can be found in the area of cost offsets. An effective reduction of substance abuse, which can be achieved by treating



## Effects of Outpatient Drug-Free Treatment

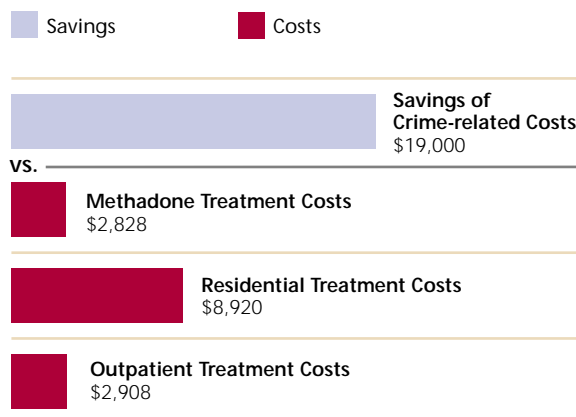


**Outpatient Drug-Free (ODF) Treatment Programs, DATOS Sample (N=764).** Admitted patients on average had less severe drug use histories and criminal activity than those admitted to LTR programs. Pretreatment rates for weekly cocaine use dropped in the year following ODF treatment; comparable reductions were found for weekly marijuana use and heavy drinking. Longer time in treatment was related to significantly better follow-up outcomes on a variety of behavioral criteria.

SOURCES: Hubbard R, Craddock S, Flynn P, Anderson J, Etheridge R, Overview of First Year Follow-up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS), *Psychology of Addictive Behaviors* 11(4): 261-278 (1997); Simpson DD, Joe G, Broome K, Hiller M, Knight K, Rowan-Szal G, Program Diversity and Treatment Retention Rates in the Drug Abuse Treatment Outcome Study, *Psychology of Addictive Behaviors* 11(4): 279-293 (1997). Data analyzed by D. Dwayne Simpson, PhD and Kevin Knight, PhD.

those who are addicted, leads to an associated reduction not only of illegal activity, but also of the costs related to crime. In other words, drug abuse treatment has a marked economic impact. A 1997 study found that the savings in crime-related costs (for each treated individual) in the year following treatment averaged more than \$19,000 per patient.<sup>6</sup> This compares quite favorably to the cost of providing treatment for addiction—\$2,828 for methadone maintenance, \$8,920 for residential treatment, and \$2,908 for outpatient drug-free treatment. Given the large number of individuals incarcerated as a result of their addictions, such savings can be immense.

## Crime-Related Cost Savings vs. Drug Treatment Costs



SOURCE: Rajkumar A, French M, Drug Abuse, Crime Costs, and the Economic Benefits of Treatment, *Journal of Quantitative Criminology* 13(3): 291-323 (1997).

### ENDNOTES: INITIATIVE # 5

- 1 Sherman L, Gottfredson D, MacKenzie D, Eck J, Reuter P, Bushway S, Preventing Crime: What Works, What Doesn't, What's Promising? *National Institute of Justice—Research in Brief* (Washington, DC: National Institute of Justice, 1998) <<http://www.ncjrs.org/works/whole.doc.htm>>.
- 2 DiIulio J, Against Mandatory Minimums, *National Review* 51(9): 46-51 (May 17, 1999).
- 3 Reuter P, On the Consequences of Toughness, In Krauss M, Lazear E (Eds), *Searching for Alternatives: Drug Control Policy in the United States* (Stanford, CA: Hoover Institution Press, 1991).
- 4 Administrative Office of the Courts (Arizona Supreme Courts), *Drug Treatment and Education Fund Legislative Report* (March 1999).
- 5 Belenko S, Drug Courts, *Physician Leadership on National Drug Policy* (1998); Belenko S, Research on Drug Courts: A Critical Review, *National Drug Court Institute Review* 1(1): (1998).
- 6 Rajkumar A, French M, Drug Abuse, Crime Costs, and the Economic Benefits of Treatment, *Journal of Quantitative Criminology* 13(3): 291-323 (1997).

## initiative 6

### Expand Investments in Research and Training

- ▶ **Increase the research budgets (including research training) of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) with the goal of gradually attaining budgets more comparable with National Institutes of Health (NIH) research institutes whose activities are directed toward diseases with costs and impacts similar to alcoholism and drug addiction.**

Data source: Federal budget

- ▶ **Priority in federal funding should go to treatment and prevention programs which have been scientifically evaluated and found to be effective in reducing drug abuse.**

Data sources: Institute of Medicine, Government Accounting Office, Substance Abuse and Mental Health Services Administration

- ▶ **Expand support for the clinical training of health professionals so that they may meet the current need for screening, diagnosis, referral, and treatment of drug and alcohol abuse and addiction.**

Data sources: Health Resources and Services Administration, Center for Substance Abuse Treatment, Center for Substance Abuse Prevention

“ New research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training.”

## initiative **6** ————— *Expand Investments in Research and Training*

### POLICY RECOMMENDATIONS

- ▶ **Increase the research budgets (including research training) of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) with the goal of gradually attaining budgets more comparable with National Institutes of Health (NIH) research institutes whose activities are directed toward diseases with costs and impacts similar to alcoholism and drug addiction.** Data source: Federal budget
- ▶ **Priority in federal funding should go to treatment and prevention programs which have been scientifically evaluated and found to be effective in reducing drug abuse.** Data sources: Institute of Medicine, Government Accounting Office, Substance Abuse and Mental Health Services Administration
- ▶ **Expand support for the clinical training of health professionals so that they may meet the current need for screening, diagnosis, referral, and treatment of drug and alcohol abuse and addiction.** Data sources: Health Resources and Services Administration, Center for Substance Abuse Treatment, Center for Substance Abuse Prevention

The Institute of Medicine’s Committee on Opportunities in Drug Abuse Research recently outlined a set of research priorities to guide the nation’s research efforts on drug abuse.<sup>1</sup> These priorities include: fundamental investigations in neuroscience on the molecular, cellular, and systemic levels; epidemiological research to allow for the assessment of a broader range of issues; multidisciplinary research on the combined effects of biological, psychological, and contextual factors as they relate to the development of drug use, abuse, and dependence; evaluation of universal versus targeted prevention programs with regard to effectiveness and cost-effectiveness; expanded research on injecting and non-injecting drug use and HIV transmission; continued research on the magnitude and extent of the effects of maternal drug abuse on the prenatally exposed infant and child over time as well as the effects of growing up in a drug-abusing household; research on violence, drug abuse, and co-occurring psychiatric disorders; research to improve and evaluate the effectiveness of drug abuse treatment; studies of the organization, financing, and characteristics of drug abuse treatment in the managed care setting; and policy-relevant studies of drug control within a comprehensive scientific agenda. The IOM Committee also urged that this

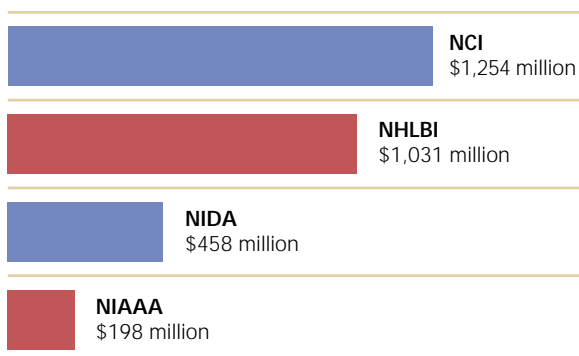
program of research should be undertaken in the context of a comprehensive public health framework.

Comparing the NIAAA and NIDA research budgets with other NIH institutes reveals significant differences.<sup>2</sup> In 1996, when total NIAAA expenditures were \$198 million and total NIDA expenditures were \$458 million, the National Heart, Lung, and Blood Institute (NHLBI) spent \$1.031 billion and the National Cancer Institute (NCI) spent \$1.254 billion (1996 comparative data). In comparing costs to society, total annual direct and indirect costs were \$98.6 billion for alcohol abuse and addiction, \$158.2 billion for drug abuse and addiction (\$66.9 billion for illicit drugs and \$91.3 billion for nicotine), \$133.2 billion for heart disease, and \$96.1 billion for cancer.

The charts below show the trends in NIDA and NIAAA funding and demonstrate: (1) incremental increased funding for both institutes; and (2) proportionally greater funding for NIDA, which was spurred by the AIDS epidemic.

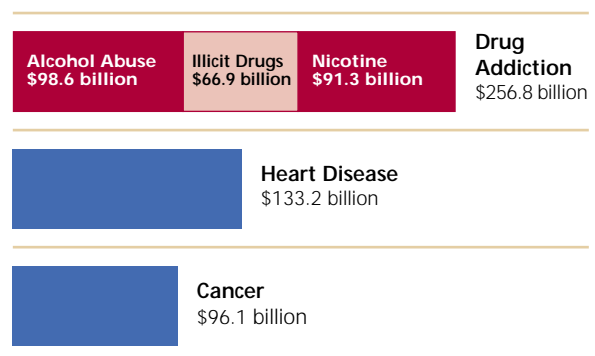
In addition to a lack of funding for research, there is a continuing shortage of personnel trained in the provision of drug abuse treatment. Primary caregivers who might best identify abusers at an early stage and direct them into treatment seldom

### Annual Budgets for NIH Institutes



SOURCE: Institute of Medicine, *Dispelling the Myths About Addiction: Strategies to Increase Understanding and Strengthen Research* (Washington, DC: National Academy Press, 1997): Chapter 2.

### Annual Costs to Society



SOURCE: Institute of Medicine, *Dispelling the Myths About Addiction: Strategies to Increase Understanding and Strengthen Research* (Washington, DC: National Academy Press, 1997): Chapter 2.

use recommended screening questions, rarely refer patients into formal treatment, and even more rarely offer treatment themselves. A recent study concludes: “diagnosis and treatment of these problems remains underemphasized, inconsistent, and, when performed, insufficient to conform with the recommended practices.”<sup>3</sup>

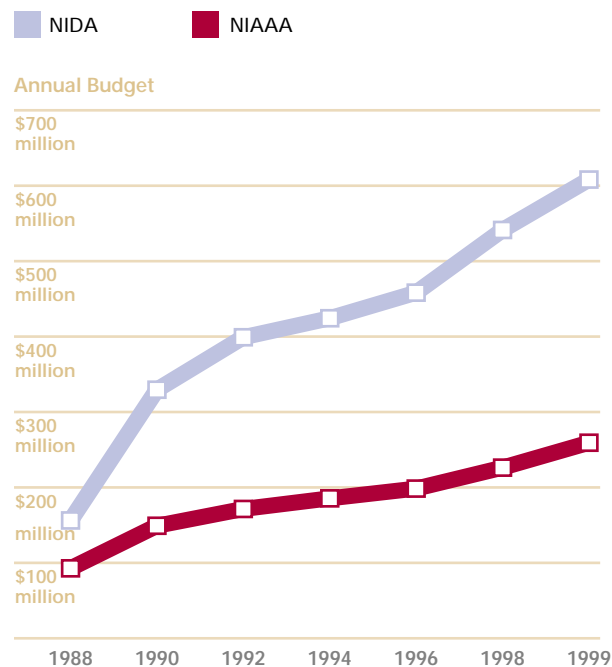
Another continuing problem in the treatment of addictions is the fact that a great deal of what research has shown us about effective treatment remains largely underutilized in community treatment settings.<sup>4</sup> The federal Center for Substance Abuse Treatment has undertaken a number of efforts to close this gap between research and practice, including the publication of Treatment Improvement Protocols and the establishment of a network of regional Addiction Technology Transfer Centers.<sup>5</sup> In its examination of this problem, the Institute of

Medicine Committee on Community-Based Drug Treatment points out that the problem is a two-way street with researchers often ignoring issues of great interest to clinicians and with much to be gained by both groups if researchers and clinicians communicated more fully.<sup>6</sup>

ENDNOTES: INITIATIVE # 6

- 1 Committee on Opportunities in Drug Abuse Research, Division of Neuroscience and Behavioral Health, Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research* (Washington, DC: National Academy Press, 1996) <<http://books.nap.edu/books/0309055334/html/>>.
- 2 Institute of Medicine, *Dispelling the Myths About Addiction: Strategies to Increase Understanding and Strengthen Research* (Washington, DC: National Academy Press, 1997): Chapter 2 <<http://books.nap.edu/books/0309064015/html/>>.
- 3 Friedmann PD, McCullough D, Chin MI, Saitz R, Screening and Intervention for Alcohol Problems: A National Survey of Primary Care Physicians and Psychiatrists, *Journal of General Internal Medicine* (In Press).
- 4 McLellan A, McKay J, The Treatment of Addiction: What Can Research Offer Practice? In Lamb S, Greenlick M, McCarty D (Eds), *Bridging the Gap Between Practice and Research*, (Washington, DC: National Academy Press, 1998): 147-185.
- 5 See <<http://www.samhsa.gov/csatsat.htm>> and <<http://www.nattc.org/>>.
- 6 Lamb S, Greenlick M, McCarty D (Eds), *Bridging the Gap Between Practice and Research*, (Washington, DC: National Academy Press, 1998) <<http://books.nap.edu/books/0309065658/html/>>.

NIDA and NIAAA Funding Histories



SOURCES: Institute of Medicine, *Dispelling the Myths About Addiction: Strategies to Increase Understanding and Strengthen Research* (Washington, DC: National Academy Press, 1997): Chapter 2; NIDA (1998, 1999); NIAAA (1998, 1999).

## initiative 7

### Eliminate the Stigma Associated with Diagnosis and Treatment of Drug Problems

- ▶ **Increase the proportion of the public that believes that drug addiction is a treatable problem comparable to other chronic diseases.** Data source:

National public opinion poll

- ▶ **Increase the proportion of health professionals who believe that drug addiction is a treatable problem comparable to other chronic diseases.**

Data source: National public opinion poll

“Concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential.”

initiative **7**

## *Eliminate the Stigma Associated with Diagnosis and Treatment of Drug Problems*

### POLICY RECOMMENDATIONS

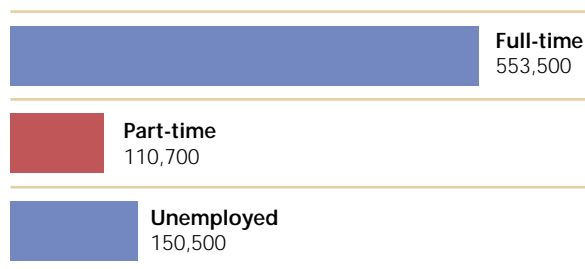
- ▶ **Increase the proportion of the public that believes that drug addiction is a treatable problem comparable to other chronic diseases.** Data source: National public opinion poll
- ▶ **Increase the proportion of health professionals who believe that drug addiction is a treatable problem comparable to other chronic diseases.**

Data source: National public opinion poll

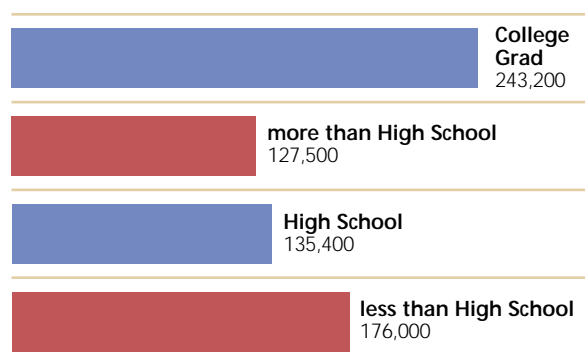
### BACKGROUND AND REFERENCES

Public perceptions of drug abuse and addiction generally lag behind scientific advances in knowledge. Data from two national surveys – the National Household Survey on Drug Abuse (performed by the Substance Abuse and Mental Health Services Administration) and the Youth Risk Behavior Survey<sup>1</sup> (performed by the Centers for Disease Control and Prevention) – provide revealing information which contradicts many popularly held views of substance abusers. That data was analyzed and prepared by Jeffrey Merrill, a researcher in the areas of treatment economics and policy (see charts on the next page).

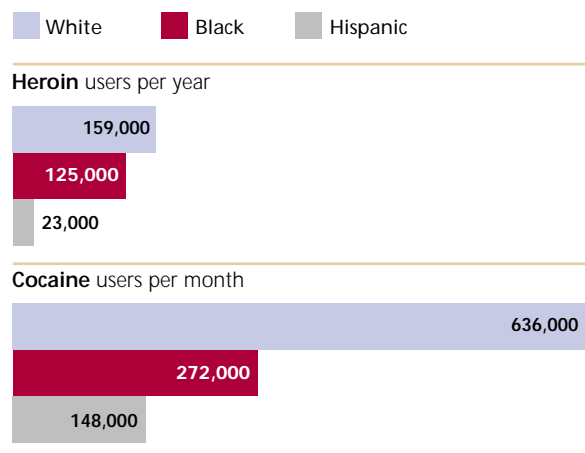
## Monthly Cocaine Users by Employment Status



## Number of Youths Who Used Cocaine in the Past Month by Father's Education Level



## Adult Heroin and Cocaine Use by Race



According to the 1996 National Household Survey on Drug Abuse, current rates for cocaine use among these racial groups have stayed relatively constant at 0.8% for whites, 1.0% for blacks, and 1.1% for Hispanics. Heroin use in that year was 0.2% for whites, 0.5% for blacks, and 0.6% for Hispanics. Absolute numbers of users are displayed in the charts. DATA SOURCE: 1996 National Household Survey on Drug Abuse. Data prepared by Jeffrey C. Merrill.

Understanding predominant viewpoints about addictions is vital for health professionals, leadership groups, and civic and political organizations. As reported in a recent Institute of Medicine publication, “Even after years of public statements that drug addiction is a disease, many continue to subscribe to a moralistic view of addiction and to see addicted people as immoral, weak-willed, or as having a character defect requiring punishment or incarceration.”<sup>2</sup> The compassion normally displayed by the public about chronic diseases and toward individuals suffering from such diseases is not extended to the disease of addiction. The popular prejudice is that substance abuse is simply not the same in either medical practice or treatment outcome. However, such a view is at odds with established science (see the chart on the next page).

Some argue that the stigma surrounding illicit drugs is instrumental in discouraging experimentation or even continued use. It is thought that public opinion and fear of the ramifications will help thwart desires for or curiosities about illegal substances. In the book *Body Count*, which understands drug use to be one of the “immediate causes of much of America’s moral poverty, the destruction of large parts of our inner cities, and its record-high crime rate,” the authors argue that a drug stigma works to deter casual use by children and adolescents.<sup>3</sup> The authors also suggest that drug use in these age groups is spread by their peers, rather than by adults. They justify this idea by referring to a national survey of high school students which found that individuals who reported that they “probably will not” or “definitely will not” use marijuana in the coming year state this for four major reasons: (1) lack of desire to get high (62.4%), (2) possible psychological damage (60.9%), (3) possible physical damage (59.7%), and (4) parental disapproval (58%). Fear of arrest was one of the five leading reasons in an equivalent survey about cocaine and crack. Based on such reports, the authors conclude, “The lesson is obvious: normalize drug use and more young people will take drugs, stigmatize drug use and there will be less of it.”



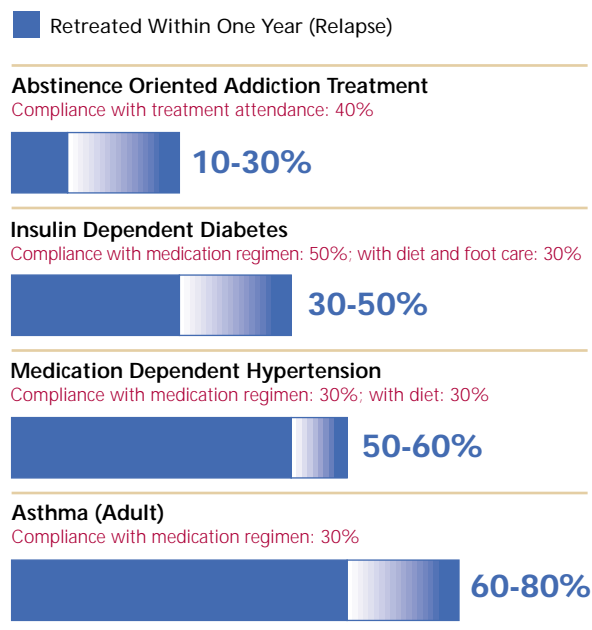
On the other hand, clinicians, patients, and families understand that disease stigmatization often prevents individuals from seeking or receiving the help they need. Stigma may also prevent usually reliable sources of support – like family, friends, and employers – from acknowledging a drug problem and urging an individual’s entry into a treatment program.

Carol Shapiro, the director of a multi-service community based program that works to support those struggling with addiction and their families, offers this perspective on the stigma around drug addiction and its treatment: “People experience shame and stigma which can severely impede the effectiveness of treatment and access to community based resources. Researchers hint at this unexpected problem, but community based treatment providers witness [them] directly.... [S]hame and stigma affect not only the substance abuser, but the family as well – preserving the tendency of external agencies to demonize poor families and create a greater gulf between them and their access to treatment assistance. Substance abusers, and by extension, their families, feel shame when their locus of control is removed and replaced by an external punitive entity.”<sup>4</sup>

Stigma may make even the existence of treatment programs or related insurance benefits, research, and staff training tenuous or largely unsupported. The Institute of Medicine report discussed earlier cites several specific examples of the general lack of funding for addiction research and the devalued nature of this area of study.<sup>5</sup> Drug stigmatization also has an impact on perceived truths. The stereotype, for example, that motivation alone is required to change abusive behavior grossly oversimplifies research pointing to multiple determinants of abuse and addiction behaviors. Such a viewpoint acknowledges substance use only as a willful action.

Some argue that drug stigmatization is the predominant force behind the opposition to the harm reduction approach, though from the perspective of public health and medicine, the concept of harm reduction is hardly controversial. Injury prevention

## Compliance and “Relapse” in Selected Medical Disorders



Comparison of compliance and relapse rates in substance abuse treatment to other chronic behavioral diseases (insulin dependent diabetes, hypertension, and asthma).

SOURCE: O'Brien CP, McLellan AT, Myths About the Treatment of Addiction, *Lancet* 347(8996): 237-240 (1996).

programs and strategies to improve air quality are but two examples of public health approaches to reduce harm. In medicine, much of the management of chronic disease is to reduce the harmful consequences of those diseases. Similarly, a great deal of psychiatric care focuses on improving function and reducing harm. However, when harm reduction is applied to the drug policy area, it becomes highly controversial. In an insightful analytical essay, University of California at Berkeley Public Policy Professor Robert MacCoun defines harm reduction as “a set of programs that share certain public health goals and assumptions... [including] the belief that it is possible to modify the behaviors of drug users, and the conditions in which they use, in order to reduce many of the most serious risks that drugs pose to public safety and health.”<sup>6</sup> Originating, in this context, as an outgrowth of interventions responding to the AIDS epidemic, harm reduction accepts the occurrence of

some adverse behaviors and devises interventions to reduce risks to both users and non-users.

Harm reduction has become controversial because it is associated not only with needle and syringe exchange, but also with methadone maintenance treatment and, to a lesser extent, the reform movement for drug decriminalization. In his essay, MacCoun observes, “The tone of the harm-reduction debate suggests that attitudes toward drug policies – on both sides – are influenced by deeply rooted and strongly felt symbolic factors that are largely independent of concerns about policy effectiveness per se.” In other words, despite the conclusions of scientific research, stigma often drives the drug debate.

Several public opinion surveys have measured various aspects of drug stigmatization. A recent paper in the *Journal of the American Medical Association* analyzed 47 national surveys conducted between 1978 and 1997.<sup>7</sup> According to the collected data, 82% of Americans considered illicit drug use a major problem in this country and 68% reported getting their information about illicit drug problems from the media, especially television. The number of people reporting drug problems in their own communities was significantly lower than their perceptions of the extent of the crisis nationwide.

The same study also found that the large majority of surveyed individuals were concerned about illicit drugs because of their link to high crime rates (73%), negative impacts on national character (72%), a fundamental decline of morality (50%), and harmful consequences to the user (89%). While 78% of the people believed that the War on Drugs has failed, most supported an allocation of resources in roughly the same policy direction as the current model (approximately two-thirds of resources toward interdiction and incarceration and only one-third toward treatment and research). Increased funding for treatment was given low priority and was strongly favored by only a minority (19%), although 59% of individuals believed that closely supervised treatment for first-time offenders could significantly reduce crime.

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## initiative 8

### Train Physicians and Students to be Clinically Competent in Diagnosing and Treating Drug Problems

- ▶ **The recommendations of the Physician Consortium on Substance Abuse Education and the Macy Conference on Training About Alcohol and Substance Abuse for All Primary Care Physicians should be implemented by all accredited medical schools and primary care residency review committees.**

Data sources: Association of American Medical Colleges, American Medical Association

- ▶ **Substance abuse education should be a required element in the accreditation standards for all health professional schools.** Data source: Health

Resources and Services Administration

“Physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area.”

initiative 8

*Train Physicians and Students to be Clinically Competent in Diagnosing and Treating Drug Problems*

POLICY RECOMMENDATIONS

- ▶ **The recommendations of the Physician Consortium on Substance Abuse Education and the Macy Conference on Training About Alcohol and Substance Abuse for All Primary Care Physicians should be implemented by all accredited medical schools and primary care residency review committees.** Data sources: Association of American Medical Colleges, American Medical Association
- ▶ **Substance abuse education should be a required element in the accreditation standards for all health professional schools.** Data source: Health Resources and Services Administration

BACKGROUND AND REFERENCES

A physician’s ability to recognize and treat substance abuse is severely compromised by a lack of medical education in the area of substance abuse. Only 8% of US medical schools offer a specific required substance abuse component of their curricula, and this coverage could range from a lecture course to a single grand

rounds.<sup>1</sup> Further, the Association of American Medical Colleges has found that just 80% of medical schools even offer electives in alcohol abuse or chemical dependency.<sup>2</sup> Dr. Barry Stimmel offers four possible explanations for the lack of substance abuse education: “a) the view that addiction is not a substantial problem; b) the lack of curricular time in medical school as well as during residency training to incorporate substance abuse education; c) the perception that this lack of knowledge on the part of physicians has a minimal effect on the quality of medical care provided; d) the belief that since such problems are self-inflicted and their effects confined to certain populations, they are not of sufficient importance to intrude on the already crowded curriculum or during the hectic pace of residency training.”<sup>3</sup>

Dr. Michael Fleming finds that family physicians, internists, and psychiatrists often never counsel or refer a patient to a substance abuse rehabilitation program due to their inability to recognize the problem.<sup>4</sup> It is of major concern that many physicians do not feel competent to handle substance abuse issues. Often, physicians are treating the acute medical conditions resulting from drug abuse and addiction, rather than recognizing and managing the underlying problem: chemical dependency.

A survey conducted in 1981 found that while 40% of surveyed generalist physicians felt prepared to offer substance abuse counseling to their patients, just 5% of those doctors who did offer counseling felt that their efforts were successful.<sup>5</sup> Repeated in 1994, the majority of physicians now felt competent to counsel patients with alcohol and tobacco problems but still less than half felt competent to counsel patients with illicit drug problems.<sup>6</sup>

The Physician Consortium on Substance Abuse Education – organized in 1989 to promote physician roles in prevention, early identification, and treatment of substance abuse – released its first policy report in 1991, noting the “markedly deficient” level of medical education and training in this field.<sup>7</sup> That report made several specific recommendations to

impact the areas of undergraduate medical education, graduate medical education, continuing medical education, multicultural issues, and adolescents and children. A subsequent 1998 policy report by the group defined steps to promote collaborative education and training efforts between medicine, other health professions, and the criminal justice system.<sup>8</sup>

Along similar lines, the concluding statement from the participants of a 1994 conference sponsored by the Josiah Macy, Jr. Foundation recommends: “primary care specialties should require all residents to be trained to develop and to demonstrate those skills necessary to prevent, screen for, and diagnose alcohol and other drug problems; to provide initial therapeutic interventions for patients with these problems; to refer these patients for additional care when necessary; and to deliver follow-up care for these patients and their families.”<sup>9</sup>

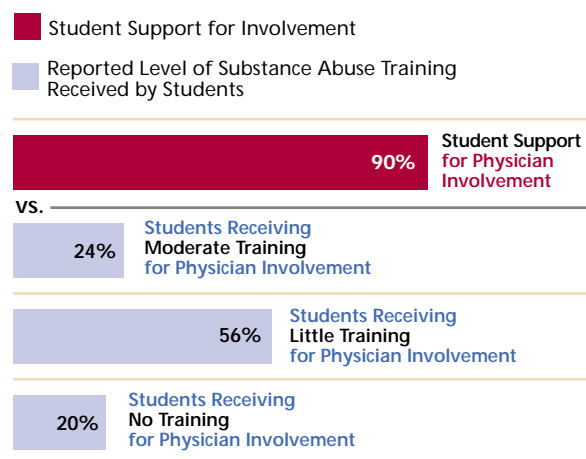
A set of guidelines released in May 1999 by the American Academy of Pediatrics clarified the role of primary care providers with regard to substance abuse and cited the need for improved education and clinical practice.<sup>10</sup> These guidelines established core competencies for three distinct levels of care: Level 1 defines the baseline or minimum specific knowledge and skills that should be required of all primary health care providers; Level 2 defines competencies for providers accepting responsibility for prevention, assessment, intervention, and coordination of care; and Level 3 sets guidelines for providers accepting responsibility for long-term treatment.<sup>11</sup>

A National Institutes of Health (NIH) consensus panel on effective medical treatment of opiate addiction concluded that one of the barriers to effective treatment was “the shortage of physicians and other health care providers who can competently treat heroin addiction.”<sup>12</sup> The panel recommended: “all primary care medical specialists, psychiatrists, nurses, social workers, psychologists, physician assistants, and other health care professionals should be taught the principles of diagnosing and treating patients with heroin addiction.”

Similarly, PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY member Dr. Harold Sox, as President of the American College of Physicians, urged internists to educate themselves in order to better treat their patients. Sox asserts, “the most important action is to rethink our attitudes toward addiction to illicit drugs and to recognize it as a chronic disease rather than a manifestation of psychological impairment.”<sup>13</sup>

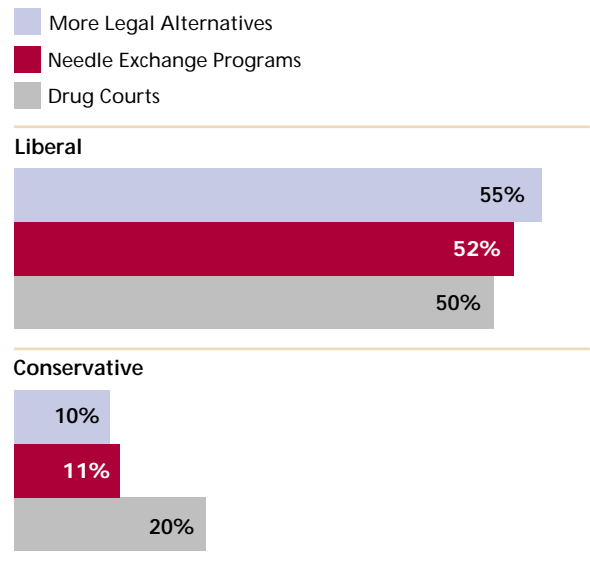
In February 1998, PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY Policy conducted a national survey to investigate medical student perceptions about drug treatment and policies related to drug problems. Few past surveys have explored student attitudes and beliefs concerning patients with addictions, especially on such a scale. PLNDP surveys were sent to first- and third-year students in a random selection of 15 medical schools in 14 states with 1,256 medical students responding.<sup>14</sup> Some results from this survey are illustrated by the charts shown on this page.

### Medical Student Support for Physician Involvement in Drug Policy Making vs. Student Training Received



SOURCE: Physician Leadership on National Drug Policy survey conducted by Norman G. Hoffman, PhD, Albert J. Chang, BS, and David C. Lewis, MD.

### Support for Selected Programs by Political Orientation



SOURCE: Physician Leadership on National Drug Policy survey conducted by Norman G. Hoffman, PhD, Albert J. Chang, BS, and David C. Lewis, MD.

The majority of survey respondents (76%) reported receiving little or no training in substance abuse issues in medical school, although 90% also indicated a strong desire for physician involvement in designing drug policy. This finding is corroborated by other surveys of medical students. In the “All Schools Report” by the Association of American Medical Colleges from the same year, students reported that their training in “Pain Management” was more “Inadequate” than their instruction in every other area except for alternative medicine.<sup>15</sup> In fact, 65.7% of students felt that their training in “Pain Management” was lacking.

Finally, analysis of the PLNDP survey data revealed that political identification was one of the most important factors in determining students’ policy orientations toward supply, demand (use), and harm reduction. The majority of self-identified conservatives favored increased supply reduction policies, while self-identified liberals favored increased treatment funding and were significantly more receptive to drug courts, needle exchange programs, and legal

alternatives to our current policies. Regardless of political orientation, however, most students were supportive of certain medical approaches to drug policy such as the legalization of medical marijuana and increased research funding.

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**Medical Student Support for Physician Involvement in Drug Policy Making vs. Student Training Received**

Hoffmann N, Chang A, Lewis DC, *Medical Student Attitudes Toward Drug Addiction Policy*, Currently under review for publication.

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**Support for Selected Programs by Political Orientation**

Hoffmann N, Chang A, Lewis DC, *Medical Student Attitudes Toward Drug Addiction Policy*, Currently under review for publication.

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Professor and Chair, Department of Psychiatry and Behavioral Sciences at the University of Louisville School of Medicine. President, American Psychiatric Association. President, American Association of Chairs of Departments of Psychiatry. Deputy Editor, *The Journal of Psychotherapy Practice and Research*.

**Donald D. Trunkey, MD**

Chair, Department of Surgery, Oregon Health Sciences University. Former Chief of Surgery at San Francisco General Hospital.

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*Participants at the Aspen  
Institute Colloquium*

**Hoover Adger, Jr., MD, MPH**

Associate Professor of Pediatrics;  
President, National Association for Children of Alcoholics;  
Former Deputy Director, ONDCP; Former President,  
Association for Medical Education and Research in  
Substance Abuse

**Lonnie Bristow, MD**

PLNDP VICE CHAIR  
Chairman, Board of Regents of the Uniformed Services  
University of Health Sciences; Past President of the AMA

**James Callahan, D.P.A.**

Executive Vice President and CEO American Society of  
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**H. Westley Clark, MD, JD**

Director, Center for Substance Abuse Treatment (CSAT),  
Substance Abuse and Mental Health Services Administration,  
(SAMHSA)

**Thomas A. Clark, JD**

Past President, American Judges Association (AJA); Member,  
Executive Committee, AJA

**Jennifer Collier-McColl**

Director of National Policy, Legal Action Center

**George D. Comerci, MD**

PLNDP MEMBER  
Clinical Professor of Pediatrics, University of Arizona College  
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Pediatrics and the Ambulatory Pediatric Association

**Richard F. Corlin, MD**

PLNDP MEMBER  
Speaker of the American Medical Association House of  
Delegates; Assistant Clinical Professor at the University of  
California- Los Angeles, School of Medicine; Past President  
of the California Medical Association

**Harlon L. Dalton, JD**  
Professor, Yale Law School, Yale University

**Gloria Danziger**  
Staff Director, American Bar Association

**Stephen Dilts, MD, PhD**  
President-elect, American Academy of Addiction Psychiatry

**Mathea Falco**  
President, Drug Strategies

**David S. Greer, MD**  
PLNDP MEMBER  
Dean and Professor Emeritus of the Brown University School of Medicine; Founding Director of International Physicians for the Prevention of Nuclear War

**Linda Hawes Clever, MD**  
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**Sally Hillsman, JD**  
Deputy Director, National Institute of Justice

**Robert Hunter, MD**  
Corporate Medical Director, Shell Oil Company

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**Alan I. Leshner, PhD**  
Director, National Institute on Drug Abuse, National Institutes of Health

**David C. Lewis, MD**  
PLNDP PROJECT DIRECTOR  
Director, Center for Alcohol and Addiction Studies, Brown University

**Robert J. MacCoun, PhD**  
Associate Professor, Goldman School of Public Policy, University of California at Berkeley

**David Mactas**  
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**Michael Massing**  
Author, *The Fix*

**June E. Osborn, MD**  
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Sixth President of the Josiah Macy, Jr. Foundation; Former Chair of the U.S. National Commission on AIDS; Former Dean, University of Michigan, School of Public Health

**Robert Potter**  
Director of Communications, Howard Hughes Medical Institute

**Susan Powers Lodge, JD**  
Attorney

**Anthony B. Radcliffe, MD**  
Chief of Staff, Chemical Dependency & Recovery Program, Kaiser-Permanente

**Elsbeth Revere**  
Director, General Programs, The John D. and Catherine T. MacArthur Foundation

**P. Preston Reynolds, MD, PhD**  
PLNDP MEMBER  
Associate Professor of Medicine, Vice Chair of the Department of Medicine, and Chief, Division of General Internal Medicine at Johns Hopkins University

**David Rosenbloom, PhD**  
Director, Join Together; Associate Professor of Public Health, Boston University; Former Commissioner of Health and Hospitals for the City of Boston

**Allan Rosenfield, MD**  
PLNDP MEMBER  
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**Gerald Rouse, JD**  
President-Elect, National Council of Juvenile & Family Courts

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Manager, Employee Assistance Program, American Airlines

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PLNDP MEMBER  
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**Kenneth Shine, MD**  
FACILITATOR  
President, Institute of Medicine, The National Academy of Sciences

**David E. Smith, MD**

President and Founder, Haight-Asbury Free Clinics; Former  
President, American Society of Addiction Medicine

**Christopher Stone**

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**Sharyn Sutton, PhD**

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**Donald D. Trunkey, MD**

PLNDP MEMBER

Chair, Department of Surgery, Oregon Health Sciences  
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**Cynthia Turnure, PhD**

Health Care Program Manager, Center for Health Statistics,  
Minnesota Department of Health; Former Executive Director  
of the Chemical Dependency Program, Division of the  
Minnesota Department of Human Services

**Kenneth D. Wells, MD**

Corporate Medical Director, Tenneco

**Hubert Williams**

President, Police Foundation

**John T. Young, M.Phil**

Research Specialist in the Harvard Opinion Research  
Program



## appendix c ————— *PLNDP Videotape Reports*

### Video 1 Drug Addiction: The Promise of Treatment

“The safety sought by and for the American family is elusive. That tragedy, and the growth in drug abuse among our children, for the first time has brought together a remarkably diverse group of national physician leaders to seek a new consensus on major new policy directions.”

*Lonnie Bristow, MD, Vice Chair,  
Physician Leadership on National Drug Policy  
Past President, American Medical Association*

- ▶ Introduces a new initiative in drug policy by the Physician Leadership on National Drug Policy (PLNDP). The PLNDP aims to bring their message to policy makers, medical and other health-related professionals, community leaders, the public, and to those recovering from addictions.
- ▶ Includes a portrayal of Steve — a dentist and recovering cocaine addict — who successfully participates in a treatment program in Maryland.
- ▶ Features interviews with leading physicians and researchers who discuss addiction as a disease, which must be treated like other chronic diseases. Interviews include (in order of appearance): Drs. June Osborn, James Callahan, Thomas McLellan, David Lewis, Richard Corlin, Ken Shine, Robert McAfee, Alan Leshner, Floyd Bloom, Peter Beilensen, Jerome Kassirer, and Lonnie Bristow along with Baltimore Police Commissioner Thomas Frazier.
- ▶ Reports the conclusions of research presented to the PLNDP concerning the cost and effectiveness of treatment as an anti-crime measure.
- ▶ Surveys research findings showing that substance abuse treatment is very similar to the treatment of other chronic illnesses like diabetes or hypertension.
- ▶ Profiles one community — Baltimore, Maryland — that is currently confronting a drug epidemic. This city has just instituted a new program that provides treatment to addicts when they need it.

- ▶ Presents the stories of a number of recovering heroin addicts who are treated at a Baltimore clinic.
- ▶ Shows the PLNDP working with policy makers on Capitol Hill for a fundamental shift in resources to support drug addiction treatment. Footage includes a selection from the Bill Moyers series *Close To Home* and from a PLNDP hearing before the Senate Labor and Human Resources Committee. In this testimony, research was presented confirming that insurance premiums would increase insignificantly if substance abuse treatment were covered by private insurers. Also includes comments from Rep. Jim Ramstad and Sen. Paul Wellstone.
- ▶ Concludes with a statement from the PLNDP's Project Director, David C. Lewis, MD suggesting that we take advantage of what research has shown us and begin acting for policy change at a local level.

**Produced for:**  
Physician Leadership on National Drug Policy (PLNDP)

**Supported by:**  
The Robert Wood Johnson Foundation and  
Brown University's Center for Alcohol and Addiction Studies

**Produced by:**  
Porter Novelli

**Running Time:**  
17:44

## Video 2 Trial, Treatment, and Transformation

“Although serious and violent offenders must be dealt with by the law, the vast majority of substance abusers and addicts threaten only themselves. Recovery is more likely if effective treatment is available.”

*Louis W. Sullivan, MD*  
*PLNDP Member*  
*President, Morehouse School of Medicine*  
*Former Secretary, Health and Human Services*  
*(Bush Administration)*

- ▶ Introduces the findings of a Physician Leadership on National Drug Policy (PLNDP) study that reviewed the research on addiction and the criminal justice system.
- ▶ Profiles two graduates of Richmond, Virginia's drug court and the effects the drug court has had on their lives. These drug court participants —Leslie and Rodney — chose the drug court as an alternative to prison.
- ▶ Features comments and conclusions of leading physicians, researchers, and community leaders who have found that treatment for substance abuse within the criminal justice system is not only effective for the drug offenders involved, but also cost-effective for their communities. Presentations by: Drs. Steven Belenko, Lonnie Bristow,

Douglas Lipton, Antonia Novello, Allan Rosenfield, D. Wayne Simpson, and Ken Winters, along with Jubi Headley of the U.S. Conference of Mayors and Carol Shapiro of La Bodega de la Familia.

- ▶ Interviews members of the judicial system involved with drug courts, including Judge Donald Lemons, who serves on the Virginia Court of Appeals, and Judge Margaret Spencer of the Richmond (Virginia) Circuit Court.
- ▶ Presents evidence on the effectiveness of treatment programs as compared to incarceration.
- ▶ Examines alternative approaches to combating juvenile drug use and relapse.
- ▶ Closes with a recommendation from PLNDP's Project Director, David C. Lewis, MD, that medical, criminal justice, community leaders, and other professionals begin to implement the findings of this report in order to start improving the health and safety of our communities.

**Produced for:**  
Physician Leadership on National Drug Policy (PLNDP)

**Supported by:**  
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**Produced and Reported by:**  
Jeff Levine

**Technical Support:**  
GVI Productions

**Running Time:**  
18:39

For more information on obtaining a copy of one or both PLNDP Videotape Reports, you may:

- 1 access the order form on our webpage  
<<http://www.caas.brown.edu/plndp/order.html>>
- 2 call the PLNDP National Project Office (401-444-1817)
- 3 email the PLNDP National Project Office  
<[plndp@brown.edu](mailto:plndp@brown.edu)>

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