THE WHITE HOUSE

PRESIDENT'S COMMISSION ON MODEL STATE DRUG LAWS

Treatment

December 1993

President's Commission on Model State Drug Laws

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OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

December 1, 1993

Dear Colleague:

Drug use and drug trafficking have affected virtually every town, city, and State in America. Nearly every family has been touched in some way by illegal drug use and the violence it spawns.

The drug problem pervades all aspects of American life. In response, the President's National Drug Control Strategy calls for a broad-based crusade to reduce the demand for drugs, restrict their availability, and deter drug-related crime and violence. A fundamental principle of this Strategy is the idea that the most effective drug control programs are those designed and carried out at the State and community levels.

In recent years States and localities have responded creatively and energetically to the threat posed by illicit drugs, in part by enacting a broad range of codes and statutes. The President's Commission on Model State Drug Laws, a bipartisan group of distinguished Americans with extensive experience in law enforcement, drug treatment, and prevention, has spent the past year reviewing these codes and statutes.

Based on this review, the Commission has developed a comprehensive package of legislative initiatives, with specific recommendations that address not only the need for more effective criminal laws but also, and just as important, the need for legislation to empower and mobilize communities to confront the drug problem. In addition, the Commission's recommendations provide innovative civil remedies to supplement our criminal codes; facilitate the development of comprehensive educational and prevention tools by which to teach our children to resist the temptation of drugs; encourage businesses and their employees to work cooperatively by establishing effective workplace initiatives and employee assistance programs; and enhance our ability to provide drug treatment to those who need it.

The package of State legislative initiatives compiled by the President's Commission is a valuable resource for State legislators, local officials, and other concerned citizens who are seeking additional ways to confront and overcome the problems created by drug trafficking and drug use. I encourage your careful review of these initiatives.

Lee P. Brown
Director

Executive Director's Preface

Alcohol and other drug addiction erodes the vitality of our nation in ways we do not even realize. Drug-trafficking crimes and crack babies grab headlines, but as a society we fail to acknowledge, and public policy fails to reflect, that many of the other major problems of our day have their roots in widespread substance abuse.

Health care costs, for example, are driven up dramatically by untreated addiction; the average alcoholic or other drug addict is conservatively estimated to be using ten times the medical services of a non-addict. The disease of addiction destroys the body in many ways not commonly known, and all of us pay the costs of treating this physical breakdown through higher taxes or higher insurance premiums. Until the health care system provides sufficient access to effective treatment, as recommended in the Commission's model legislation, health care costs will remain unacceptably high no matter how the health care system is redesigned.

Crime and prison overcrowding is another example. Sixty to eighty percent of criminal defendants are addicted. Those who are convicted and jailed continue their habits in prison, where alcohol and drugs are readily available despite regulations and enforcement to keep them out. Offenders not imprisoned for life or executed will ultimately be released into society, still addicted and still dangerous. It is hardly surprising that crime rates remain high even though the number of people imprisoned in America has increased 168 percent since 1980.

Offenders entering the criminal justice system are in the perfect place at the perfect time to be assessed for addiction and referred to treatment. The burglaries, assaults, thefts, rapes and murders committed by that addicted sixty to eighty percent are closely connected to their alcohol and drug problems. Crime and prison overcrowding will not diminish to an acceptable level until the criminal justice and treatment systems are integrated, as recommended in the Commission's Model Criminal Justice Treatment Act. It will take years before every person arrested is assessed for substance addiction and where appropriate referred into treatment, but our country cannot afford to do anything but begin this transition.

Productivity in the workplace (which affects our global economic competitiveness) is another area where substance abuse has tremendous impact. Untreated addictions cost American businesses from $50 billion to $100 billion each year in increased medical claims and disability costs from illness and injuries, theft, absenteeism, and decreased productivity. These costs are comprehensible when one considers that fully two-thirds of all drug abusers in America are in the workplace.

The workplace is also a highly effective point of intervention for adult abusers. While much of the attention to drug-free workplaces in recent years has focused on drug testing, testing is only one tool to address the problem. A comprehensive drug-free workplace program is essential: written

policy statements, employees assistance programs and rehabilitation resources, employee education programs, supervisor training programs, testing, and confidentiality protections. Employers consistently report that these bring tremendous cost savings.

As staggering as are the obvious economic costs of alcohol and other drug abuse, the costs in human suffering are even greater. Millions of American babies are born into families ruined by the disease of addiction. The neglect, the cruelty and the abuse they suffer rob them of their innate innocence, hope, spontaneity and enjoyment of life. The bewilderment of children who can't count on a rational, nurturing, secure framework to grow up in causes incalculable emotional and spiritual damage.

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Those who offer solutions for our country's drug problems have traditionally misunderstood each other. Many law enforcement officials, for example, have been suspicious of those advocating treatment for criminal offenders. They believe that treatment advocates do not care about making criminals pay for their crimes, that they are cavalier about protecting public safety, and that treatment is just a "soft," easy alternative to the hard prison time that serious offenders should be serving. Many treatment advocates, on the other hand, have countervailing suspicions. They believe the law enforcement community is myopically focused on punishment without looking at the broader picture of how to create a safer society by changing addicted offenders' lives.

The President's Commission on Model State Drug Laws was a microcosm of the diverse viewpoints on the drug crisis. The law enforcement perspective was well represented, with three state attorneys general, five big city prosecutors, and two police chiefs. Those representing the treatment and prevention disciplines, though fewer in number, were not deterred from persuasively championing their own perspectives.

The challenge of reaching consensus initially seemed insurmountable to many of us. But after hundreds of hours of frank, honest exchanges about goals, priorities, concerns and doubts, both during formal meetings and hearings, and informally during off hours, something remarkable happened. Virtually every Commissioner learned that the "other" perspectives were not in opposition to his or her own.

Law enforcement Commissioners learned that treatment providers actually need the support of tough law enforcement; that instead of "special breaks," addicted offenders have to be held responsible for their actions like everyone else. Indeed, some treatment providers complained that the criminal justice system too often is not tough enough, and undermines treatment programs by not carrying out their recommendations to jail criminal justice clients who are not cooperating with the course of treatment.

Similarly, the treatment Commissioners found that prosecutors and police are not opposed to treatment per se. They learned that prosecutors' hesitations have sprung primarily from the public misperception that treatment does not work. When presented with compelling evidence that treatment can be effective in substantially reducing both recidivism and relapse, and thereby protects public safety, law enforcement Commissioners unanimously supported the expansion of treatment resources within both the criminal justice system and the public and private health care systems.

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The model legislation this Commission created integrates an unprecedented diversity of credible approaches into a single, comprehensive proposal. Bringing together leading professionals from different fields to address a common problem, and seeking to broaden the understanding of each by all the others, is itself a model for effective change.

By opening their minds to the broad picture of drug problems and solutions, these Commissioners were able to contribute to a richer whole than any of us thought possible in the beginning. By sincerely striving to understand approaches and perspectives they weren't always familiar with, they helped to create a package of legislation that will finally, and truly, make a difference.

Gary Tennis
Executive Director

Table of Contents

Introduction

The 1988 Anti-Drug Abuse Amendments created a six month bipartisan presidential commission to develop state legislative responses to the drug problem. Funded in 1991, the 23 member Commission was sworn in on November 16, 1992. Twelve Democrats and eleven Republicans, the Commissioners included an urban mayor, a superior court judge, state legislators, a child advocate, a housing specialist, state attorneys general, police chiefs, treatment providers, district attorneys and private practice lawyers. The Commission's mission was:

> to develop comprehensive model state laws to significantly reduce, with the goal to eliminate, alcohol and other drug abuse in America through effective use and coordination of prevention, education, treatment, enforcement, and corrections.

To facilitate its mission, the Commission held public hearings around the country to gather information on five broad topics:

- Economic remedies against drug traffickers
- Community mobilization and coordinated state drug planning mechanisms
- Crimes code enforcement against drug offenders
- Alcohol and other drug treatment
- Drug-free families, schools, and workplaces

The treatment hearing was held on March 10 1993 in Philadelphia, Pennsylvania. Wide-ranging testimony was presented by a diverse group, including: representatives of the criminal justice system, researchers, lawyers, treatment specialists, and individuals recovering from addiction. Witnesses discussed the effectiveness and affordability of treatment, treatment for the criminal offender, substance abuse involving juveniles, managed care issues, and treatment for pregnant addicted women and women with dependent children.

Six months of review, analysis and drafting have culminated in the following model treatment acts recommended by the Commission and discussed in Volume IV of the Commission's Final Report:

- Model Addiction Costs Reduction Act
- Model Medicaid Addiction Costs Reduction Act
- Model Family Preservation Act
- Model Managed Care Consumer Protection Act
- Model Early and Periodic Screening, Diagnosis and Treatment Services Act
- Model Health Professionals Training Act
- Model Criminal Justice Treatment Act
- Caregiver's Assistance Policy Statement

Treatment
Policy Statement

> "The problem of alcoholism and other drug addiction is a most serious health problem in the United States; [it is] the fourth major illness; and [it] has the third highest major disease fatality rate."[1]

If the contribution of alcohol and other drug abuse and addiction to accidents, injuries and a wide array of illnesses is considered, then alcohol and other drug abuse and addictions may well be the "No. 1 cause of morbidity and mortality in America."[2]

Like other chronic illnesses, addictive diseases are progressive and move along a continuum of deterioration and severity. Also, as in treatment of other illnesses, addiction treatment reflects the progression of the illness and moves along a continuum of service. Intensity and duration of treatment depends on how early in the disease progression diagnosis and intervention occurs.[3]

As with other illnesses, early identification and appropriate treatment enhance the likelihood of recovery. Treatment early in the disease progression is generally less intense, less expensive and of shorter duration than when diagnosis and treatment are delayed.

With these principles in mind, the Commission began the process of examining the existing national treatment system to identify gaps in the continuum of care, problems in obtaining needed treatment and methods to increase early intervention and treatment.

As a result, model state legislation is being proposed in seven areas specific to treatment. This proposed legislation calls for:

(1) Provision of a continuum of treatment for addiction in the health insurance plans of insurers and health maintenance organizations;

(2) Provision of a continuum of treatment for addiction under state Medicaid plans;

(3) Provision of addiction coverage through state implementation of the federal Early and Periodic Screening, Diagnostic and Treatment Program for Medicaid eligible children;

(4) Provision of residential treatment programs for pregnant women and girls and parents with dependent children;

(5) Provision of consumer protection requirements for managed care firms working with alcohol and other drug abusers and addicted individuals and families;

(6) Provision of training in alcohol and other drug abuse and addiction, early detection and intervention in medical school curriculum and as part of continuing medical education;

(7) Provision of addiction diagnosis, screening and treatment as part of involvement with the criminal justice system.

An additional proposed law that would give assistance to responsible caregivers of children deserted by addicted parents is still under development.

The first five proposed bills involve establishing and maintaining a full continuum of treatment services through insurance, health maintenance organizations and through the Medicaid system. Many states have pieces of the continuum in place, none have the full array of needed treatment services.

Proposals 6 and 7 provide for the development of improved intervention skills in two systems where alcohol and other drug abusing and addicted people and their families appear and are over-represented.

Repeated contact with the health care system is demonstrated dramatically by the following quote:

> "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12 months before treatment, the alcoholic's costs are close to 300% higher..."[4]

Even with this repeated contact with the health care system, people in need of treatment for an addiction are only "identified less than 5% of the time."[5] The Model Health Care Professionals Training Act will routinely provide health care professionals with basic skills needed to seize the opportunity created by this repeated contact with the health care system. It is an opportunity to both alleviate family suffering and to avert additional health care problems and expenditures.

People with alcohol and other drug abuse and addictions are also over-represented in the criminal justice population. The model statute proposed here provides for routine intervention through systematic screening and referral to treatment as part of criminal justice proceedings. Statutes implemented here should lead to reductions in criminal recidivism and should lead to reductions in spending on this population in both the criminal justice and health care systems.

In addition to the model laws proposed here, the Commission urges states to seek appropriate changes in policies of the Health Care Financing Administration to provide matching Medicaid dollars for long term residential rehabilitation. Such changes would greatly assist in the provision of inpatient treatment needs of pregnant addicted girls, women and parents with dependent children and criminal justice populations.

And finally, the Commission urges that the nation's alcohol and other drug problem be seen and addressed in terms of the full continuum of prevention, intervention, treatment and law enforcement.

"SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT" - A RUTGERS UNIVERSITY STUDY

Anticipating questions about the costs of untreated addiction to the health care, criminal justice systems and to the workplace and the costs of providing treatment for the illness, the Commission developed a contract with a research team from Rutgers University. The contract called for an extensive review of the existing research literature to determine the cost of untreated addictions to society and any potential cost benefit in providing addiction treatment for the following populations:

(1) Insured and Medicaid

(2) Workplace

(3) Criminal justice

(4) Pregnant addicted women and girls

The Rutgers' study is the first to integrate research on the costs of untreated addiction in all of these domains with the research on savings when proper treatment is provided.

The research demonstrates both the high financial drain of untreated addiction on the nation's economy and the reductions in cost that can be realized where appropriate treatment is provided. Since the Rutgers' study was completed, the Center on Addiction and Substance Abuse (Columbia University) published a report entitled "The Cost of Substance Abuse to America's Health Care System." This report provides additional research and data on the costs of untreated addiction to the Medicaid system and is recommended companion reading to this report.[6]

A few samples from some of the research in each of the delineated areas:

GENERAL POPULATIONS - INSURED AND MEDICAID

Prior to addiction treatment, "On the average, untreated alcoholics incur general health care costs that are at least 100% higher than those of nonalcoholics..."[7]

After treatment of the addiction, reductions in days lost to illness, sickness claims and hospitalization dropped by around 50%.[8]

WORKPLACE POPULATIONS

Prior to referral for addiction treatment, a high rate of worksite problems are in evidence: "...sick-benefit claims 120% the normal level, days absent 335% of normal, disciplinary actions 235% of normal..."[9]

After addiction treatment, worksite indicators showed over "... a 56% reduction in disciplinary actions, a 55% reduction in absenteeism and a 53% reduction in days on disability ..."[10]

CRIMINAL JUSTICE POPULATIONS AND NARCOTICS USERS

"Virtually all economic measures show that the burden of crime and other economic consequences of drug abuse are lower after treatment than before ..."[11]

Post-treatment decreases in illegal income (73%) appear to track post-treatment decreases (71%) in expenditures on drugs. "...the implication is clear that, as drug abuse treatment suppresses demand for illicit drugs, less predatory crime is committed and income from that crime declines."[12]

Cost savings during treatment alone more than recoup the cost of providing treatment, i.e., "Post-treatment gains are virtually an economic bonus."[13]

PREGNANT ADDICTED WOMEN AND GIRLS

Neonatal intensive care hospital costs range from $20,000 to $40,000 per drug-exposed infant.[14]

Overall hospitalization costs for drug-exposed infants and fetal alcohol syndrome create an annual economic loss to the country of $0.6 to $3.3 billion.[15]

SIX RECURRING THEMES

In addition to the cost data requested, the Rutgers research team unearthed six recurring themes key to understanding both the impact of addiction and of treatment. These themes are at work in most of the populations studied.

(1) "Ramping Up" (Rapid Increase) of Costs to Society Prior to Treatment.

People with alcohol and other drug problems use health care at rates well above comparison groups prior to treatment. This already high spending on health care accelerates dramatically in the 12 months before treatment by both insured and Medicaid populations.

Criminal justice populations show the same type of sharp increases — "ramping up" — in illegal activities prior to treatment.

A similar pattern emerges with workplace populations as well. Although already involved in higher that the norm sick leave use, absenteeism and disciplinary problems, there is a "ramping up" of these problems right before treatment.

After treatment, each of these groups shows a similar, marked "ramping down" in health care use, criminal activities and workplace problems.

Without such intervention and treatment, reductions in costs in these three areas is unlikely.

(2) Durability of Treatment Effects.

The research team located numerous studies that attest to the durability of treatment effects in health care, in the workplace and in the criminal justice system for years after treatment has taken place. Durability is demonstrated by post-treatment reductions in health care utilization, reductions in work place problems, and reductions in criminal activity.

(3) Duration of Treatment.

Success in treatment with insured and with criminal justice populations appears to be related to duration of treatment.

For the insured population:

"...only 21% of those patients who completed a 22-30 day treatment were readmitted to the hospital for any reason (including relapse)... In comparison, 48% of those treated for seven days or less were readmitted within a year."[16]

For criminal justice populations:

"...time in treatment is among the most important predictors of positive outcomes."[17]

"Time spent in treatment was among the most important predictors of posttreatment drug abuse for all types of drugs... In contrast to prior studies, however, we found the time in treatment necessary to produce positive outcomes was relatively long: 6 to 12 months."[18]

"...even changes that are initially observable in drug-taking and criminal behavior do not become stabilized in patients who remain in treatment for less than three months."[19]

(4) Additivity of Treatment Effects.

The research team found some indication that treatment effects with criminal justice populations are "additive" and cumulative in nature.

"Even while addicts are no longer in treatment or are between treatment episodes, these treatment effects are still apparent."[20]

However, research on this point must be balanced with the findings on duration of treatment. Individuals in treatment less than several months appear to do no better than "detox-only or intake-only groups."[21]

(5) Collateral Effects of Addiction and of Treatment.

The research indicates that addiction in a family drives up the health care use not only of the addicted individual but also the health care use of the family members as well. The health care use of the family members also "ramps up" prior to the treatment of the addicted individual. After treatment of the addicted individual, the level of health care used by family members is reduced and converges to the control groups. These collateral effects also appear to be durable and persistent over time.

The research team points to the need for investigation of other collateral effects. An untreated addicted person in the workforce may well have measurable impact on the health care use of co-workers. Similar collateral effects may occur regarding crime with a criminally involved addicted person involving family and co-workers as well.

Considering just the issue of collateral health care cost-offsets:

"The potential savings here, though, is enormous, much larger that those accruing from cost-offsets

from reduced health care utilization of treated alcoholics and addicts themselves, since the target group for these collateral cost-offsets - their families - is many times larger than the core group of substance-impaired individuals."[22]

(6) Effects of Coerced Treatment.

Criminal justice populations who are coerced into treatment do as well as and in some areas better than those with whom no coercion was applied.[23] However, considering the importance of duration of treatment to success:

"...the effect of court involvement, once thought to hopelessly compromise the privacy of the patient and his/her ability to form a good therapeutic alliance, appears if anything to keep patients in treatment longer and help them to achieve a more favorable and stable outcome."[24]

(7) Patient Matching.

The Rutgers research repeatedly underlines the importance of newly developing patient placement tools. These tools, such as one recently developed by the American Society of Addiction Medicine (ASAM), provide for standardized assessments and matching of patient profiles to treatment types and needed lengths of stay.

However, this necessary development of diagnostic and treatment protocols in the addictions continues to be held back by the lack of a fully developed continuum of needed treatment services.

Although estimates of the cost of untreated addiction run as high as $172 billion annually, dollars directed to supporting prevention and treatment amount to less than 1% of the annual cost of untreated addiction.[25]

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Model Addiction Costs Reduction Act (ACRA)

Table of Contents

Model Addiction Costs Reduction Act Policy Statement

HISTORICAL PERSPECTIVE AND SUMMARY

During the time period from 1973 to 1989, 43 states and the District of Columbia enacted laws requiring health insurance policies to cover treatment of alcohol and drug problems. Eight states have no such coverage.

As a result of these laws, in 26 of the states inclusion of addiction treatment coverage is automatic in health insurance policies. In another 17 states, laws mandate that coverage for drug and alcohol problems be offered to purchasers of insurance.

In 26 of the states, the coverage includes both alcohol and drug problems. In another 17, only alcohol is included.

Reflecting the time of origin, local politics and the evolution of the treatment field, the coverages vary widely. Some provide for the treatment of alcoholism only, some mandate only outpatient, some exclude individual policies and some attempt to cover a continuum of treatment services. In 15 states, Health Maintenance Organizations are excluded from the requirements established for health insurance.[1]

COST BENEFITS OF ADDICTION TREATMENT

Supporting the evolution of these state laws is a growing body of research on the costs of untreated alcohol and other drug addictions to the workplace, to the insurers and to the criminal justice system.

Study after study from business and industry, from health insurers and universities demonstrates, on the one hand:

(a) High health care utilization by the untreated alcoholic and addict prior to addiction treatment for a wide array of addiction related illnesses, accidents and injuries.

- "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12 months before treatment, the alcoholic's costs are close to 300% higher than costs of comparable nonalcoholics."[2]

(b) High health care utilization by the families of untreated alcoholics and addicts prior to addiction treatment of the addicted individual.

- "Policyholders in alcoholic families used roughly twice the (health care) services of non-alcoholic families."[3]
- One study compared these expenditures in monthly dollar amounts for families of addicted individuals and families without an addicted member. Families with an addicted member used inpatient health services at a cost of $27.00 a month compared to $6.50 a month for families without an addicted member.[4]

(c) High rates of accidents, absenteeism and sick benefit claims by untreated alcoholics and addicts in the workforce prior to addiction treatment.

- "The average alcoholic, it was found, lost 32 days to illness per year, almost one day in ten, prior to intake.[5]
- Another study found prior to addiction treatment, "... sick benefit claims 120% the normal level, days absent 335% of normal, disciplinary actions 235% of normal ... "[6]

On the other hand, after addiction treatment occurs, study after study finds:

(a) Marked reductions in health care use by the now treated addicted individual.

- In one study, "In general, rates of hospitalization for treated alcoholics declined by nearly 50% at three of four sites ..."[7]
- Another study found a 49% reduction in health care claims after addiction treatment.[8]
- In another study, health care expenditures by the now treated addicted person dropped from about $100.00 a month prior to treatment to $13.34.[9]

(b) Marked reductions in health care use by the family members.

- One study found the decline in health care utilization by the family after treatment of the alcoholic or addict was just over 50%.[10]
- Before treatment, health care utilization by the family of an addicted person is two to three times higher than for comparison families. After treatment of the addicted person occurs, health care utilization by their families drops to the same as the control group.[11]

(c) Marked reductions in workplace accidents, absenteeism and sickness claims.

- In one study, after treatment - workplace reprimands declined by 75% after six months and days lost to illness declined by 50% at the 18 month follow-up.[12]
- In another study describing after treatment work and health records, "Days sick or absent from work declined by fifty percent throughout this period..."[13]
- And still another study found after treatment reductions in disciplinary actions of 56%, absenteeism of 55%, days on disability of 53%.[14]

Without such treatment through insurance, the individual with an addiction will continue to deteriorate in a downward spiral eventually losing employment, insurance, health and becoming dependent on public funding. When this occurs, high health care utilization caused by untreated addiction shifts to welfare, to Medicaid, to Medicare and to the taxpayer.

Even with the more deteriorated addicted individual on Medicaid, the studies find the same patterns at work as with the insured. High health care use prior to treatment is followed by marked reductions in health care use after treatment of the addiction has occurred. In addition, other benefits accrue here in savings to the state from reductions in welfare cash grants, food stamps, etc. as many individuals in recovery find jobs and move back into self-sufficiency.

Similar cost benefit and cost offset data is available for criminal justice populations. Studies and research with narcotics and criminal justice populations show similar results. Criminal justice activity is markedly reduced after treatment of the alcohol/drug addiction.

The cost benefits for health care and other data on cost offsets presented here and in "Socioeconomic Evaluations of Addictions Treatment" prepared for the Commission by the Center of Alcohol Studies at Rutgers University, clearly establish alcohol and other drug treatment as a key component vital to any serious state strategy to contain health care costs or to address alcohol and other drug related crime.[15]

The data are clear - treatment of the alcohol and other drug problem is cost beneficial with any cost for addiction treatment more than offset by savings in other health care spending, accidents, welfare and criminal justice costs.

RELATIONSHIP TO NATIONAL HEALTH INSURANCE PROPOSALS

Along the way to passage of drug and alcohol insurance laws, 43 states have developed carefully crafted compromises between many competing interests. As noted, over the last 15 years, these compromises have resulted in coverage for addiction treatment in 43 states.

The federal debate over national health insurance has just begun. In the meantime the laboratory of the states goes onward. The daily devastation of families wrought by addiction will continue unless states quickly implement effective treatment policies.

Fifteen years of delicate political negotiations provide a solid foundation on which to build national health insurance proposals. Individuals developing national health insurance proposals can significantly benefit from the state experience. Accordingly, they will want to draft proposals which complement rather than detract from the compromises found in existing state laws.

MANDATED INSURANCE COVERAGE VERSUS MANDATED OPTION

Of the 43 states with mandated insurance laws, 26 provide coverage for drug and alcohol problems automatically with the policy. Since alcohol and other drug problems are among the top 5 leading disease killers in the United States, exclusion from the basic matrix of health care would seem illogical.

However, another 17 states require insurers to offer the coverage to the purchaser of insurance. Given the level of stigma and denial about alcohol and other drug problems, it is unrealistic to expect individuals or companies to anticipate having the problem personally or in the workforce.

Over the years, there has been some movement on this issue. Some mandated option states have switched to mandated coverage automatic in the policy. There has been no shifting in the other direction.

Key Components

Throughout the process of gathering treatment ideas, the need to update and further refine existing insurance laws was brought repeatedly to our attention.

With these goals in mind, states without insurance coverage for drug and alcohol problems may wish to put these laws in place. States with laws already on the books may wish to ensure that the full continuum of treatment services is available. Some of the treatment services needed to fill out many of the existing insurance laws include: drug treatment, family and co-dependency treatment, intervention services and intensive outpatient.

These coverages, in combination with workplace alcohol/drug education, alcohol/drug policies and employee assistance programs (EAPs) are critical in early intervention with chemical dependence. Intervention while the individual still has a job and a family is humane but also pays dividends in reduced workplace accident claims and high health insurance utilization for other related illnesses and injuries. Without such intervention, families and jobs are lost and additional health care dollars are expended. Many addicted people find themselves trapped on welfare and dependent on limited public funding for treatment. Some get involved in crime. At this point, the treatment needs of the individual are more intense and more extensive. In general, the longer the individual deteriorates, the longer and more intense the treatment will need to be to break the cycle of chemical dependence.

Full Continuum of Treatment

The continuum is usually defined as including at least the following treatment coverages:

Alcohol and Other Drug Intervention

Intervention includes services such as drug and alcohol assessment, diagnosis, family intervention, employee assistance and student assistant services and referral.

Alcohol and Other Drug Detoxification

Detoxification is "The process whereby a drug or alcohol intoxicated or dependent patient is assisted through the period of time necessary to eliminate by metabolic or other means, the presence of the intoxicating substance, while keeping the physiological or psychological risk to the patient at a minimum. This process should also include efforts to motivate and support the patient to seek formal treatment after the detoxification phase."[16]

This service is provided in a hospital or non-hospital residential setting.

Lengths of stay vary depending on the drug or combinations of drugs and alcohol in use, severity of addiction and an array of physical complications.

Many state insurance laws provide 7 to 15 days coverage.

Alcohol and Other Drug Inpatient Rehabilitation

Rehabilitation often follows detoxification or referral from an outpatient program. Many of these intensive programs are based on a therapeutic community model. Everything in the patient's living environment is organized and arranged to assist in the patient's therapy. The programs also

typically involve extensive education on alcohol and drug abuse and addiction, group and individual counseling and work with the family.

This service is provided in a hospital or a non-hospital residential setting.

Depending on the needs of the patient, inpatient rehabilitation can be short or long term. "In general, for employed individuals who are not in a deteriorated condition, the length of stay is about 30 days. Longer stays can be anticipated for young people, for the more deteriorated and for those with more attendant life trauma and complications. These individuals may need a year or more in residential treatment to deal successfully with the addiction. Patients leaving inpatient rehabilitation will generally be expected to continue treatment in an outpatient clinic."[17]

Many state insurance laws provide for 30 to 45 days in short term rehabilitation. Most of these insurance laws do not provide coverage for long term rehabilitation or for halfway houses.

Alcohol and Other Drug Outpatient Treatment and Intensive Outpatient

Addicted individuals access outpatient and intensive outpatient services in several ways: "A number of addicted individuals will first go to inpatient detoxification programs and, upon completion of that treatment, will move on to an outpatient setting...Many people go to outpatient clinics to explore a potential drug and alcohol problem or to discuss the problem of a loved one."[18] Enrollment in outpatient or intensive outpatient treatment often follows these exploratory first steps toward help. "Inpatient facilities also routinely refer program graduates to outpatient treatment as the next step in the continuum of healing."[19]

"Lengths of treatment will vary greatly for this modality and depend on the patient. In general, the outpatient involvement can be expected to last for up to a year. Programs typically involve educational and therapeutic components, group and individual counseling and work with the patient's family."[20] Some programs provide counseling coupled with methadone maintenance.

> "Frequency of appointments is worked out on an individual basis, although a typical pattern may involve one to three hour sessions a week in the beginning of the process. Some programs and states offer intensive outpatient approaches that run two to five hours during the day or after work, several times a week."[21]

Vigorously developed early intervention programs such as family intervention, student assistance programs (SAPs) and EAPs can reach people with addictions earlier in the disease progression and can lessen the need for inpatient treatment services. Sadly, intervention often comes so late in the disease progression that both outpatient and inpatient treatment are necessary.

State insurance laws typically provide coverage of 30 to 60 outpatient sessions but do not provide for the more recently developed intensive outpatient benefit.

Family and Co-Dependency Treatment

These programs can be provided on an outpatient or inpatient basis and are intended to address the needs of children of alcoholics and addicts, adult children of alcoholics and addicts, families and others significantly impacted by the alcohol and other drug abuse or addiction in the family. These programs are key in breaking the multi-generational cycle of addiction.

These services are rarely covered under state insurance laws. Where they are covered, they are usually listed under the general outpatient or inpatient benefits.

Other Treatment

There are other components in the continuum of services not listed here. These services tend to be less utilized by people who are still employed and who have health insurance coverage. These include quarterway houses, halfway houses, therapeutic communities, pharmacotherapeutic interventions, case management, etc. These components are generally not covered under state insurance laws.

SUMMARY

The Model Addiction Costs Reduction Act reflects a full continuum of treatment services for alcohol and other drug abuse and addiction. Many components of the continuum are already in place around the country however, most are missing both intensive outpatient coverage and family treatment.

ENDNOTES

1. All data in this subpart has been taken from: Goldman, Marshall, and Muszynski, P.C., STATE REQUIREMENTS ON PRIVATE HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AND/OR DRUG DEPENDENCY TREATMENT SERVICES (National Association of Addiction Treatment Providers (NAATP), 1989).
2. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4*, in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT 11 (Center of Alcohol Studies, Rutgers University, 1993).
3. *Id.* at 19.
4. *Id.* at 26.
5. *Id.* at 13.
6. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment in Workforce Populations, Chapter 5*, at 13.
7. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at 13. 7.
8. *Id.* at 25.
9. *Id.* at 26.
10. *Id.* at 26.
11. *Id.* at 27.
12. *Id.* at 13.
13. *Id.* at 14.
14. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 6.
15. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTION TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).
16. Pennsylvania Office of Drug and Alcohol Programs, PENNSYLVANIA LICENSING STANDARDS FOR DRUG AND ALCOHOL SERVICES, Chapter 157, 157.2 (February 13, 1990).
17. *The War on Drugs,* NATIONAL CLEARINGHOUSE REVIEW, Special Issue (1990).
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.*

Highlights of the Model Addiction Costs Reduction Act

- Requires all group health insurance and health maintenance organizations providing health care coverage in the state to provide coverage of a full continuum of alcohol and other drug abuse and addiction treatment services including:
  1. Detoxification
  2. Inpatient rehabilitation
  3. Outpatient
  4. Intensive outpatient
  5. Family treatment
- Establishes minimum levels of coverage within each modality of treatment.
- Limits provision of service to facilities and programs licensed by the single state authority on alcohol and other drugs.
- Allows deductibles and copayments if applied similarly to other physical illnesses in the policy.
- Disallows deprivation of coverage in the event of identification and referral from the legal or criminal justice system.

Model Addiction Costs Reduction Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Addiction Costs Reduction Act."

Section 2. Legislative Findings.

(a) The Alcohol, Drug Abuse and Mental Health Administration has estimated the annual cost of alcohol and other drug problems to business in America to be almost $100 billion.[1] Such estimates typically include calculations of factors such as increased medical claims, medical disability costs, decreased productivity, injuries, theft and absenteeism.

(b) Alcohol and other drug addicted individuals covered by health insurance use medical benefits at rates as high as ten times greater than the remaining population.[2] The many babies whose future lives are compromised by being born exposed to alcohol and other drugs will also use many times more medical benefits in their lifetimes than their more fortunate counterparts. Failure to provide sufficient insurance coverage for the complete continuum of alcohol and other drug addiction treatment leads to higher health insurance costs for all health insurance consumers.

(c) The cost of addiction treatment in reduced benefit utilization alone can be recovered within one to three years, based on studies of health care utilization pre- and post-addiction treatment.[3] Those cost benefits are further enhanced by increased productivity, reduced accidents, reduced crime, reduced absenteeism, and healthier parenting.

(d) One in ten Americans who use alcohol and other drugs will become an alcohol or drug abuser or will become addicted.[4] One out of four families in American are impacted by alcohol and other drug abuse.[5]

(e) Alcohol and other drug treatment is a cost effective means of achieving significant social and fiscal goals including: health care cost containment, restoration of health, restoration and healing of families, prevention of child abuse and fetal alcohol\drug syndrome, reduction in deaths on the highways, workplace savings, reduction in illegal drug trafficking, theft, and other crimes, with their attendant criminal justice system and prison costs, and removal of a major obstacle to successful re-employment and tax-paying self-sufficiency.

(f) Health insurance that fails to cover a sufficient level of alcohol and other drug treatment to provide a reasonable prospect of recovery is medically and fiscally unsound, and inconsistent with general insurance practices in other areas of coverage.

COMMENT

The high cost of untreated alcohol and other drug abuse and addiction to the nation is reflected disproportionately in the health care system as people repeatedly seek medical treatment for a wide array of addiction related accidents and illnesses. This spending can be markedly reduced by providing a full continuum of alcohol and

[1] Small Business Administration, U.S. Department of Labor, and Office of National Drug Control Policy, WORKING PARTNERS: CONFRONTING SUBSTANCE ABUSE IN SMALL BUSINESS, National Conference Proceedings Report 6 (July 13-14, 1992).

[2] Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986); Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). For additional information on the use of health care benefits by people with untreated alcohol and other drug problems, see also the Policy Statement for the Health Care Professionals Training Act.

[3] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2.

[4] U.S. Department of Health and Human Services, ALCOHOL AND HEALTH, Seventh Special Report to the U.S. Congress 7 (January 1990).

[5] Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE 104, 213 (1988); NCADD, FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY).

other drug treatment services. Expenditures made on treating the disease directly are generally recouped in savings in health care alone within a one to three year period. For this reason, early intervention and referral of untreated alcoholics and addicts is a sound investment in both workplace safety and in the health of employees. If savings in reductions in workplace accidents and absenteeism and increases in productivity are factored in, dollars spent on treatment are offset even more rapidly.[6]

Where intervention and appropriate treatment is not provided, for many the result is loss of job and a process of deterioration devastating to both the addicted individual and the family. For many, damage to health progresses with accelerating health care utilization and eventual dependency on the welfare system and other public funding streams. Some become involved with crime.

At this point of deterioration, longer term and more intensive treatment will be needed to break the cycle of addiction. The treatment services described in the [Model Medicaid Addiction Costs Reduction Act] reflect precisely this reality. Like other chronic progressive illnesses, failure to intervene early or failure to provide sufficient treatment early in the disease progression leads to more expense than proper treatment of the illness in the first place.

Until such treatment is provided, the alcohol and other drug problem will stand in the way of restoring the individual to re-employment and self-sufficiency.

Section 3. Purpose.

The purpose of this [Act] is to ensure that medical insurance beneficiaries are provided a level of alcohol and other drug treatment benefits sufficient to meet the minimum requirements of care necessary to provide effective alcohol and other drug treatment for health insurance policy subscribers and their families. This will increase the rate of successful treatment and reduce the disproportionately high utilization of medical insurance benefits by untreated alcoholics and other drug addicts.

COMMENT

Over the last 30 years, many states have passed insurance laws requiring some form of coverage for addiction. Treatment provided under these statutes varies greatly. Some include drug and family treatment. Some require treatment only for alcoholism. Others provide only inpatient care and exclude intensive outpatient services. Treatment requirements vary depending on local politics and when in the evolution of drug and alcohol treatment they became law.

The purpose of this statute is to delineate and provide for a full continuum of treatment services for alcohol and drug abuse and addiction. Provision of the full continuum will maximize recovery of alcohol and other drug abusers and maximize cost savings in health care.

Section 4. Definitions.

As used in this [Act]:

(a) "Alcohol and other drug abuse" means any use of alcohol and/or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

(b) "Drugs" means addictive substances, and substances of abuse scheduled in the [state controlled substances act].

(c) "Detoxification" means the process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the [single state authority on alcohol and other drugs] through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

(d) "Hospital" means a facility licensed as a hospital by the [state health department], the [state welfare department], or operated by the state and conducting an alcoholism and other drug addiction treatment program licensed by the [single state authority on alcohol and other drugs].

(e) "Inpatient care" means the provision of medical, nursing, counseling or therapeutic services 24 a day in a hospital or non-hospital facility, according to individualized treatment plans.

[6] Langenbucher, J.W., McCrady B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment in Workforce Populations, Chapter 5.*

(f) "Non-hospital facility" means a facility, licensed by the [single state authority on alcohol and other drugs] for the care or treatment of alcohol and other drug abusing and addicted persons, except for transitional living facilities.

(g) "Non-hospital residential care" means the provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol and other drug abuse or dependency in a short-term or long-term residential environment, according to individualized treatment plans.

(h) "Outpatient care" means the provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.

(i) "Partial hospitalization or intensive outpatient care" means the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility or intensive outpatient program licensed as an alcoholism and other drug addiction treatment program by the [single state authority on alcohol and other drugs], designed for a patient or client who would benefit from more intensive care than is offered in outpatient treatment but who does not require inpatient care.

COMMENT

To ensure quality, accountability and proper use of health care dollars, any treatment service provided under the terms of this statute must be licensed by the [single state authority on alcohol and other drugs].

Section 5. Mandated Policy Coverages and Options.

(a) All group health or sickness or accident insurance policies providing hospital or medical/surgical coverage in this state and all group subscriber contracts or certificates issued by any entity subject to this [Act], [cite statute relating to hospital plan corporations] or [cite statute relating to professional health services plan corporations], [cite state Health Maintenance Organization Act] or [cite state fraternal benefit society code] providing hospital or medical/surgical coverage in this state, shall in addition to other provisions required by this [Act] include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in Sections 6, 7, 8, 9, and 10.

(b) The benefits specified in subsection (a) may be provided through a combination of such policies, contracts or certificates.

(c) The benefits specified in subsection (a) may be provided through prospective payment plans.

(d) The provisions of subsection (a) shall not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies, such as, but not limited to, cancer insurance, polio insurance, dental care and similar policies as may be identified as exempt from this section by the insurance commissioner.

(e) No individual insured by a policy, group subscriber contract or certificate described in subsection (a) shall be deprived of alcohol and other drug treatment or coverage due to identification of an alcohol and other drug problem that occurs as a result of contact with the criminal justice or legal system.

COMMENT

As described in subsection (a), the policy coverages outlined in the statute are required for all group health insurance plans including those provided by health maintenance organizations.

In subsection (e), few people with alcohol and other drug problems reach a decision to seek help on their own without some kind of intervention. Typically, an accumulation of outside pressure drives that decision. For many, the process of recovery begins with an intervention by an employee assistance program, a student assistance program, a family member or the criminal justice system. The language in subsection (e) will ensure that the type of intervention employed is not used as grounds to deny treatment and that criminal justice interventions are welcomed as an opportunity to assist the individual, to reduce health care costs, to cut crime and to meet other goals consistent with both the needs of managed care and the needs of society.

Section 6. Inpatient Detoxification.

(a) Inpatient detoxification as a covered benefit under this [Act] shall be provided either in a hospital or an inpatient non-hospital facility which has a written referral agreement with a hospital for emergency, medical and psychiatric or psychological support services, and is licensed by the [single state authority on

alcohol and other drugs] as an alcoholism and other drug addiction treatment program.

(b) The following services shall be covered under inpatient detoxification:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Diagnostic X-ray;

(4) Psychiatric, psychological and medical laboratory testing; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered for a minimum of 15 days in any calendar year unless medical complications require additional days.

COMMENT

This section delineates the services that are reimbursable within an inpatient detoxification setting licensed by the [single state authority on alcohol and other drugs].

The process of detoxification can be life threatening and requires medical monitoring. At the point of admission, it is often impossible to discern who will have a problem free withdrawal and who will experience severe medical complications. Often, the individual is unable to remember or provide medical history or information on types and quantities of alcohol and other drugs consumed.

The length of detoxification typically depends on such factors as: the types, quantities and combinations of alcohol and other drugs consumed over a specific period of time, length and severity of addiction, age of onset of addiction and general physical health. Uncomplicated detoxification generally ranges from 1-7 days in duration with detoxification from certain kinds of prescription medications taking 15 days or longer.

The detoxification process is similar to stabilizing a diabetic in crisis. For both illnesses, failure to provide treatment after initial stabilization will result in an additional medical crisis and expenses as the individual is admitted for additional detoxification or other medical problems.

During the course of detoxification, an assessment of the need for ongoing alcohol and other drug treatment is made and preparation for referral to treatment occurs. Assignment to, or length of stay in outpatient or inpatient care will vary with the needs of the individual and is dependent on the degree of chronicity, deterioration of the individual's health, strength of support systems such as the family, the employer and others and many other factors. Sophisticated patient matching to care is critical to this process. This is accomplished by use of alcohol and other drug diagnostic criteria combined with personnel skilled in making these determinations.

An additional factor affecting patient matching to level of treatment and length of care, is the degree of denial by the patient. In fact, denial of the alcohol and other drug problem by both the patient and the family is one of the symptoms of alcohol and other drug problems. Like patient and family denial of other serious illnesses, denial must be addressed vigorously as part of the treatment recommendation and process. Dealing with denial is critical to opening the patient and family up to full participation in the recovery process. In general, the more severe the denial, the more intense the level of treatment will need to be and the longer the length of that treatment.

Other factors influencing treatment recommendations are public safety, high suicide rates of untreated alcohol and other drug abusers and high utilization of health care if the primary illness is left unaddressed.

Given the cost to society of untreated or inadequately treated alcohol and other drug problems, provision of and access to the full continuum of treatment services is essential and in the interest of the national economy. Failure to intervene or undertreatment at this point is likely to result in the alcohol and other drug addicted person returning to the health care system without a job, and now dependent on public funding.

No part of the continuum of treatment services described below can fill the role of the other. Some individuals will need every component of the entire continuum while others may not. However, some generalities can be made. As with other illnesses, where intervention occurs late in the addictive disease process, the individual is more likely to need longer and more intense levels of care. Early interventions result in less intense care over shorter periods of time.

Unfortunately, denial and the lack of understanding of this problem by the individual, the family, the employer and even the physician is such that intervention, if it occurs at all, tends to be late in the progression of the disease.

A companion bill in this package, the [Model Health Professionals Training Act] is intended to address this issue. Since untreated addicted people enter the health care system repeatedly for alcohol and other drug related accidents and illnesses, training of health care professionals to do early intervention and treatment is a key starting point. Such early intervention should assist in reducing health care utilization and could reduce some of the need for more intensive alcohol and other drug treatment.

Section 7. Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of thirty (30) days per calendar year for residential care.

COMMENT

This section delineates the services that are reimburseable within a residential rehabilitation setting. Nothing in this section bars provision of the services in an inpatient hospital setting. In fact, many insurers already provide such treatment in hospital settings.

Inpatient residential treatment ranges commonly from 28-32 days, depending on patient need. Many who do well in this form of treatment are still employed or may be unemployed but have been identified early in the disease progression, have some remaining support systems and good health. More deteriorated individuals will generally need more intensive, longer term care.

Throughout the 3-5 week treatment cycle, the individual is immersed in intensive patient education about addiction, in therapy and is exposed to support tools such as Alcoholics Anonymous and Narcotics Anonymous. As with other chronic life threatening illnesses, denial is normal and must be handled as part of the treatment process. Denial is often quite intense in the first weeks of treatment and must be approached with care. For this reason, program staff work to develop strong relationships with the individual and to create an environment where it is safe to move out from behind the walls of denial. As denial diminishes, patient therapy and education intensify. Inappropriately confronted, denial can lead to the development of psychological problems or drive the individual to leave the treatment program prematurely.

Education on addiction and other work with the family and support system occur while the addicted individual is in treatment. At the appropriate time, therapy and education with the individual, family, support system and others is combined as the individual is prepared to re-integrate with his/her family and community.

From the inpatient setting, the individual and family is referred to outpatient and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous to continue the growth process and to maintain and reinforce recovery.

As with other illnesses, the more deteriorated alcohol and other drug abusers and addicts will generally need longer lengths of stay than provided here in short term rehabilitation. Programs specializing in treatment of the more deteriorated patient are prepared to handle an array of complex medical, psychological, interpersonal, vocational and socioeconomic problems. The treatment needs of many of these individuals can be provided under the provisions of the [Model Medicaid Addiction Costs Reduction Act].

Section 8. Outpatient Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an outpatient alcohol and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per calendar year.

Section 9. Intensive Outpatient or Partial Hospitalization Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by [single state authority on alcohol and other drugs] as an intensive outpatient or partial hospitalization alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 intensive outpatient, full-session visits or days of partial hospitalization per calendar year.

COMMENT

Sections 8 and 9 delineate the services reimburseable under outpatient, intensive outpatient or partial hospitalization alcohol and other drug treatment services.

Many addicted individuals enter outpatient or intensive outpatient and in group and individual sessions, learn about addiction and develop the skills to stay sober. In general, these are individuals for whom intervention and referral occurs relatively early in the disease progression.

In addition to the group cited above, other addicted people require detoxification or detoxification and inpatient care. Upon completion of the inpatient programs, they will progress to an outpatient setting for ongoing treatment.

Outpatient or intensive outpatient or combinations of the two are generally recommended for at least a year. Intensive outpatient is recommended for those in need of a more structured treatment experience than can be provided in a traditional outpatient setting but who are not in need of inpatient treatment.

Here too, the more deteriorated alcohol and other drug abusers and addicts will generally need more intense levels of outpatient services over a longer period of time.

Outpatient and intensive outpatient as well as inpatient treatment programs encourage involvement with self-help groups such as Alcoholics Anonymous and Narcotics Anonymous as well.

Section 10. Family Codependency Treatment.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed

physician or licensed psychologist must certify the insured as a family member suffering from codependency as a result of an alcohol and other drug abuse or dependency within the family, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests;

(5) Prevention services for children; and

(6) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per calendar year.

COMMENT

This section delineates the services reimburseable under the family codependency treatment section.

Treatment for the families of addicted people has only become available in the past decade. Until recently, newly recovering individuals returned from outpatient and inpatient treatment to families made dysfunctional by the addiction, anger and blame.

In addition, there is emerging research demonstrating that families of addicted individuals also use health care at rates higher than found in the general population. After treatment of the addicted individual, health care spending by the family members is reduced.[7] Direct treatment of the overall family in distress may well have additional positive and measurable benefits for the emotional and physical health of all concerned.

Family treatment increases the likelihood of recovery by the alcohol and other drug abusing individual and addresses the needs of family members and children at risk of developing alcohol and other drug problems.

Section 11. Deductibles, Copayment Plans and Prospective Pay.

(a) Reasonable deductible or copayment plans, or both, after approval by the insurance commissioner, may be applied to benefits paid to or on behalf of patients during the course of alcohol and other drug abuse or dependency treatment. No deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

(b) Under a prospective payment plan, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

COMMENT

This section bars discriminatory practices in regard to chemical dependency and the use of deductibles, copayments and prospective payment plans. It ensures that addictive diseases will be handled on the same basis as other illnesses.

Section 12. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the purposes, objectives and policies set forth in Sections 2 and 3 of this [Act].

Section 13. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 14. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

[7] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at 42-43, 48-50.

Appendix A

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Model Medicaid Addiction Costs Reduction Act (MACRA)

Table of Contents

Model Medicaid Addiction Costs Reduction Act

Policy Statement

Alcohol and other drug abuse and addiction treatment have been demonstrated to reduce health care spending on addiction related illnesses and accidents. In addition, such treatment can remove a major barrier to re-employment and self-sufficiency and work to reduce alcohol and drug related crime.[1] Despite the obvious appeal of cutting down on crime, health care and welfare rolls, the full continuum of alcohol and other drug treatment services is rarely available for Medicaid eligible individuals and families.

State Medicaid coverage of alcohol and other drug abuse and addiction treatment services varies widely around the country and tends to be limited to those services where federal matching monies are available. Federal Medicaid does provide matching funds for limited hospital detoxification and for limited outpatient services.

Missing components of the treatment continuum in many places are: intensive outpatient and residential rehabilitation and family treatment including residential rehabilitation.

Lack of availability of particularly the residential treatment component limits service to pregnant addicted women, addicted parents with dependent children and severely limits the ability of the criminal justice system to access treatment for addicted people. Given the costs to society of fetal alcohol and other drug syndrome and alcohol and other drug related crime, additional effort to address the unmet treatment needs of these populations will yield immediate cost benefits. Such treatment represents a sure investment in our nation's future as well.[2]

There is ongoing discussion with the federal Health Care Financing Administration (HCFA) about re-interpretating federal Medicaid language to include these services. Such a re-interpretation would put the HCFA in the position of leading the national effort to expand treatment capacity to address the needs of these populations.

As part of this and other health care reform discussions, there have been some attempts to pit prevention and treatment, outpatient services, and inpatient and the hospital and non-hospital treatment sectors against one another. Since the treatment needs of addicted people and their families vary greatly, this is a destructive exercise. Advancing one form of treatment at the expense of another will result once more in an incomplete continuum of treatment service available to addicted people and their families.

The proposed Model Medicaid Costs Reduction Act provides for a full continuum of alcohol and other drug abuse and addiction treatment services for addicted individuals and families and calls for aggressive pursuit of federal matching funds by state alcohol and other drug authorities.[3]

ENDNOTES

1. See Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). See, in particular, chapters 4-6 on addiction treatment, insurance, and the workforce.
2. *Id.* at Chapters 6-7, on addiction treatment, crime and pregnancy.
3. For a quick read on opportunities to maximize the use of federal monies in this area, see Gates, D. and Beck, D., *Prevention and Treatment: The Positive Approach to Alcoholism and Drug Dependency*, CLEARINGHOUSE REVIEW, Special Issue 478-486 (1990); Gates, D., MEDICAID FINANCING OF ALCOHOL AND OTHER DRUG DEPENDENCY TREATMENT (U.S. Department of Health and Human Services, TA Pub. Series, July 1991).

Highlights of the Model Medicaid Addiction Costs Reduction Act

- Requires state Medicaid to provide a full continuum of alcohol and other drug abuse and addiction treatment services including:
    1. Detoxification
    2. Short-Term Inpatient Rehabilitation
    3. Long-Term Inpatient Rehabilitation
    4. Outpatient
    5. Intensive Outpatient
    6. Family Treatment
- Establishes minimum levels of coverage within each modality of treatment.
- Limits provision of treatment services to facilities and programs licensed by the [single state authority on alcohol and other drugs].
- Disallows deprivation of coverage in the event of identification and referral from the legal or criminal justice system.
- Encourages aggressive pursuit of federal funding and matching dollars.
- Includes a non-supplantation clause.

Model Medicaid Addiction Costs Reduction Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Medicaid Addiction Costs Reduction Act."

Section 2. Legislative Findings.

(a) Alcohol and other drug addicted individuals use medical benefits at rates as high as ten times greater than the remaining population.[1] The babies whose future lives are compromised by being born exposed to alcohol and other drugs in utero will also use many times more medical benefits in their lifetimes than their unimpaired counterparts. Failure to provide sufficient insurance coverage for the complete continuum of alcohol and other drug addiction treatment leads to increased medical assistance costs for the public.

(b) The cost of addiction treatment in reduced benefit utilization alone can be recovered within one to three years, based on studies of health care utilization pre- and post-addiction treatment.[2] Those cost benefits are further enhanced by increased employment, increased productivity, reduced accidents, reduced violent crime, reduced prostitution, reduced drug trafficking, reduced child abuse and healthier parenting.

(c) One in ten Americans who use alcohol and other drugs will become an alcohol or drug abuser or will become addicted.[3] One out of four families in America are impacted by alcohol and other drug abuse.[4]

(d) Alcohol and other drug treatment is a cost effective means of achieving significant social and fiscal goals including: cost containment of Medicaid costs, restoration of health, restoration and healing of families, prevention of child abuse and fetal alcohol\drug syndrome, reduction in deaths on the highways, increased transfer of addicts in recovery from welfare assistance to the workplace, reduction in illegal drug trafficking, theft, prostitution and other crimes, with their attendant criminal justice system and prison system costs, and removal of a major obstacle to successful re-employment and tax-paying self-sufficiency.

(e) Medical assistance that fails to cover a sufficient level of alcohol and other drug treatment to provide a reasonable prospect of recovery is medically and fiscally unsound and inconsistent with general medical assistance practices of providing sufficient resources to secure recovery where possible.

COMMENT

The high cost of untreated alcohol and other drug abuse and addiction to the nation is reflected disproportionately in the health care system as people repeatedly seek medical treatment for a wide array of addiction related accidents and illnesses. This spending can be markedly reduced by providing a full continuum of alcohol and other drug treatment services. Expenditures made on treating the disease directly are generally recouped in savings in health care alone within a one to three year period. Costs of addiction treatment are offset still more rapidly if the calculus is broadened to include not only reductions in Medicaid spending but also factors such

[1] Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986); Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4*, in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). For additional information on the use of health care benefits by people with untreated alcohol and other drug problems, see also the Policy Statement on the Health Care Professionals Training Act.

[2] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1.

[3] U.S. Department of Health and Human Services, ALCOHOL AND HEALTH, Seventh Special Report to the U.S. Congress 7 (January 1990).

[4] Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE 104, 213 (1988); NCADD, FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY).

as: reductions in use of welfare cash grants, food stamps, prevention of fetal alcohol and other drug syndrome and reductions in crime.

In addition, with proper treatment, many recovering individuals disappear entirely from the welfare rolls. They go back to school, to work and to become self-sufficient, taxpaying members of our society.

The relationship between alcohol and other drug abuse and addiction and crime has been well described in the literature. Prison research finds that at least half of those incarcerated have an alcohol and other drug abuse problem.[5] Studies also show that without alcohol and other drug treatment, criminal recidivism and re-arrest can be expected.

Like other chronic progressive illnesses, there are no shortcuts here. Failure to intervene early or failure to provide sufficient treatment early in the disease progression results in high costs to society and in the need for longer term, more intensive treatment.

Until such treatment is provided, the alcohol and other drug problem will firmly block the path to re-employment and self-sufficiency.[6]

Section 3. Purpose.

The purpose of this [Act] is to ensure that medical assistance recipients are provided a level of alcohol and other drug treatment benefits sufficient to meet the minimum requirements of care necessary to provide effective alcohol and other drug treatment. This will increase the recovery rate for successful treatment and reduce the disproportionately high utilization of medical assistance benefits by non-recovering alcoholics and other drug addicts.

COMMENT

Coverage of alcohol and other drug addiction treatment through state Medicaid varies greatly from state to state. State Medicaid reimbursed treatment is scarce in some states. Coverage for intensive outpatient, for family and for long term residential treatment is rare. At this time, federal matching funds are limited to outpatient, hospital detoxification and hospital rehabilitation. As a result, many states provide only the alcohol and other drug treatment services that can draw these matching monies into the state.

The purpose of this statute is to delineate and provide for a full continuum of treatment service for alcohol and other drug abuse and addicted individuals through state Medicaid and to maximize the use of federal funds and federal matching monies to achieve this goal. The continuum of treatment services delineated seeks to reflect the complex treatment needs of individuals and families deteriorated with an addiction to the point of eligibility for welfare and Medicaid.

Providing the full continuum will maximize recovery of addicted individuals while simultaneously reducing other health care spending for addiction related accidents and illnesses. In addition, such care will reduce crime and work as a crime prevention tool.[7]

Section 4. Definitions. As used in this [Act]:

(a) "Alcohol and other drug abuse" means any use of alcohol and/or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

(b) "Drugs" means addictive substances and substances of abuse scheduled in the [state controlled substances act].

(c) "Detoxification" means the process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the [single state authority on alcohol and other drugs] through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol and other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

(d) "Hospital" means a facility licensed as a hospital by

[5] Bureau of Justice Statistics, DRUGS AND CRIME FACTS, 1992 6,8.

[6] For material on the costs of untreated alcohol and other drug problems in terms of health care, crime and the workplace, see Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).

[7] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Addictions Treatment in CJS Populations and Narcotics Users, Chapter 6.*

the [state health department], the [state welfare department], or operated by the state and conducting an alcoholism and other drug addiction treatment program licensed by the [single state authority on alcohol and other drugs].

(e) "Inpatient care" means the provision of medical, nursing, counseling or therapeutic services 24 hours a day in a hospital or non-hospital facility, according to individualized treatment plans.

(f) "Non-hospital facility" means a facility, licensed by the [single state authority on alcohol and other drugs] for the care or treatment of alcohol and other drug abusing and addicted persons, except for transitional living facilities.

(g) "Non-hospital residential care" means the provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol and other drug abuse or dependency in a short-term or long-term residential environment, according to individualized treatment plans.

(h) "Outpatient care" means the provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.

(i) "Partial hospitalization or intensive outpatient care" means the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility or intensive outpatient program licensed as an alcoholism and other drug addiction treatment program by the [single state authority on alcohol and other drugs], designed for a patient or client who would benefit from more intensive care than is offered in outpatient treatment but who does not require inpatient care.

COMMENT

To ensure quality, accountability and proper use of health care dollars, any treatment service provided under the terms of this statute must be licensed by the [single state authority on alcohol and other drugs].

Section 5. Medical Assistance Coverage.

(a) Medical assistance shall in addition to other provisions required by this [Act] include benefits for alcohol and other drug abuse and dependency as provided in Sections 6, 7, 8, 9, 10 and 11.

(b) No medical assistance recipient shall be deprived of alcohol and other drug treatment or benefits due to identification of an alcohol and other drug problem that occurs as a result of contact with the criminal justice or legal system.

COMMENT

Under this section, alcohol and other drug treatment cannot be withheld because the alcohol and other drug problem was identified as a result of contact with the criminal justice or legal system.

Few people with alcohol and other drug problems reach a decision to seek help on their own without some kind of intervention. Typically, an accumulation of outside pressure drives that decision. For many, the process of recovery begins with an intervention by an employee assistance program, a student assistance program, a family intervention or a drinking and driving arrest and/or pressure by the criminal justice system. The language in subsection (b) will ensure that the type of intervention employed is not used as grounds to deny treatment and that criminal justice interventions are welcomed as an opportunity to assist the individual, to reduce health care costs, to cut crime and to meet other goals consistent with both the needs of managed care and the needs of society.

Section 6. Inpatient Detoxification.

(a) Inpatient detoxification as a covered benefit under this [Act] shall be provided either in a hospital or an inpatient non-hospital facility which has a written referral agreement with a hospital for emergency, medical and psychiatric or psychological support services, and is licensed by the [single state authority on alcohol and other drugs] as an alcoholism and/or drug addiction treatment program.

(b) The following services shall be covered under inpatient detoxification:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Diagnostic X-ray;

(4) Psychiatric, psychological and medical laboratory testing; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered for a

minimum of 15 days in any calendar year unless medical complications require additional days.

COMMENT

This section delineates the services that are reimbursable within an inpatient detoxification setting licensed by the [single state authority on alcohol and other drugs].

Particularly for these more deteriorated patients, the process of detoxification can be life threatening and requires medical monitoring. At the point of admission, it is often impossible to discern who will have a problem free withdrawal and who will experience severe medical complications. Often, the individual is unable to remember or provide medical history or information on types and quantities of alcohol and other drugs consumed.

The length of detoxification typically depends on such factors as the following: the types, quantities and combinations of alcohol and other drugs consumed over a specific period of time, length and severity of addiction, age of onset of addiction and general physical health. Uncomplicated detoxification generally ranges from 1-7 days in duration with certain kinds of prescription medications taking 15 days or longer. Addicted people at this level of deterioration tend to have numerous complicating medical problems, use a wide variety of alcohol and other drugs and are susceptible to a more troublesome withdrawal process.

The detoxification process is similar to stabilizing a diabetic in crisis. For both illnesses, failure to provide treatment after initial stabilization will result in an additional medical crisis and expenses as the individual is admitted for additional detoxification or other medical problems.

During the course of detoxification, an assessment of the need for ongoing alcohol and other drug treatment is made and preparation for referral to treatment occurs. Assignment to, or length of stay in outpatient or inpatient care will vary with the needs of the individual and is dependent on the degree of chronicity, deterioration of the individual's health, strength of support systems such as the family, the employer and others and many other factors. Key here is sophisticated patient matching to care. This is accomplished by use of alcohol and other drug diagnostic criteria combined with personnel skilled in making these determinations.

An additional factor affecting patient matching to level of treatment and length of care, is the degree of denial by the patient. In fact, denial of the alcohol and other drug problem by both the patient and the family, is one of the symptoms of alcohol and other drug problems. Like patient and family denial of other serious illnesses, denial must be addressed vigorously as part of the treatment recommendation and process. Dealing with denial is critical to opening the patient and family up to full participation in the recovery process. In general, the more severe the denial, the more intense the level of treatment will need to be and the longer the length of that treatment.

Other factors influencing treatment recommendations are public safety, homelessness or drug infested living quarters, high suicide rates of untreated alcohol and other drug abusers and high utilization of health care if the primary illness is left unaddressed.

Given the cost to society of untreated or inadequately treated alcohol and other drug problems, provision of and access to the full continuum of treatment services is essential and in the interest of the national economy. Failure to intervene or undertreatment at this point is likely to result in the alcohol and other drug addicted person returning to the health care system without a job, becoming dependent on public funding and, for some, increasing criminal activity.

No part of the continuum of treatment services described below can fill the role of the other. Some individuals will need every component of the entire continuum while others may not. However, some generalities can be made. As with other illnesses, where intervention occurs late in the addictive disease process, the individual is more likely to need longer and more intense levels of care. Early interventions result in less intense care over shorter periods of time.

Unfortunately, denial and the lack of understanding of this problem by the individual, the family, the employer, the physician, the caseworker and the criminal justice system is such that intervention, if it occurs at all, tends to be late in the progression of the disease.

The [Model Health Professionals Training Act] and the [Model Criminal Justice Treatment Act] attempt to address just this issue. The [Model Health Professionals Training Act] sets up training in early intervention and treatment for health care professionals and the [Model Criminal Justice Treatment Act] attempts to address some of the training needs of criminal justice personnel. Such intervention should assist in reducing health care utilization and could reduce some of the need for more intensive alcohol and other drug treatment.

The [Model Medicaid Addiction Costs Reduction Act] calls for longer and more intense treatment than provided in the [Model Addiction Costs Reduction Act] for individuals with insurance coverage. This difference reflects the chronicity and severity of the addiction of these more deteriorated individuals.

Even with this more intense treatment, costs of care will be quickly recouped in savings through a decrease in health care costs and a reduction in crime.

Section 7. Short Term Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of thirty (30) days per calendar year for residential care.

COMMENT

This section delineates the services that are reimbursable within a residential rehabilitation setting. Nothing in this section bars provision of the service in an inpatient hospital setting.

Section 8. Long Term Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of 18 months in a residential program.

COMMENT

Depending on the needs of the individual entering Medicaid supported addiction treatment, residential rehabilitation can range from 30 days to over 1 year. Most who enter this treatment are deteriorated in the addiction, have few positive support systems, little family contact and some impairments to health.

Many individuals appropriate for extended rehabilitation, have long term chronic addictions, lengthy records of detention, crime and hospitalization. Many got involved with alcohol and other drugs in adolescence, have limited or no work experience and little pre-addiction success to recall or to resume. The alcohol and other drug abuse and addiction settled in early and hard. Many come from troubled, unsettled homes with few role models of successful adulthood. Some are the children of alcoholics and other addicts. Some dropped out of school, have learning deficiencies and are unable

to read. Some have simply given up all hope of recovery.

For the reasons cited above, in addition to immersion in education on alcohol and other drug abuse and addiction and therapy, treatment here must go much further and address the wide array of factors complicating the recovery. The extended rehabilitation programs tend to be highly structured, sometimes confrontational, always emphasizing and teaching personal responsibility and basic life skills.

In addition to treating the addiction, many other health, educational and vocational goals must be addressed as well.

Many treatment programs select and train diverse personnel to match the patient population served. This is done purposefully with an eye to encouraging identification with successful recovering people working professionally in the field. Such identification is often key in the restoration of hope for people who have given up.

The process delineated here is generally called habilitation in contrast to the more commonly known concept of rehabilitation.

These most vulnerable-to-relapse individuals will need ongoing care in intensive outpatient and/or outpatient programs for some time after leaving the inpatient setting. By providing an ongoing support system with positive role models of successful recovery, Alcoholics and Narcotics Anonymous and other self-help groups will continue to play a critical role in the ongoing recovery process as well.

Like other diseases addressed late in the disease progression and where treatment has been delayed, recovery here will be more time consuming and more resource intensive than for people for whom intervention came early. However, an analysis of the cost of illness projections for untreated addictions and similar calculations of costs to the criminal justice system, persuades one of society's financial reward for treating such individuals.[8]

Section 9. Outpatient Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an outpatient alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency, and refer the insured for the appropriate treatment.

(b) The following services shall bc covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 72 outpatient, full-session visits per calendar year.

Section 10. Intensive Outpatient or Partial Hospitalization Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an intensive outpatient or partial hospitalization alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall bc covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

[8] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Cost-of-Illness Studies of Addictions, Chapter 3,* and *Addictions Treatment in CJS Populations and Narcotics Users, Chapter 6.*

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 72 intensive outpatient, full-session visits or days of partial hospitalization per year.

COMMENT

Sections 9 and 10 delineate the services reimbursable under outpatient, intensive outpatient or partial hospitalization alcohol and other drug treatment services.

Many addicted individuals entering outpatient or intensive outpatient programs and group and individual sessions learn about addiction and develop the skills to stay sober. In general, these are individuals for whom intervention and referral occurs relatively early in the disease progression.

Other addicted people require detoxification or detoxification and inpatient care before entering outpatient or intensive outpatient treatment. Upon completion of the inpatient programs, many will progress to an outpatient setting for ongoing treatment.

Outpatient or intensive outpatient or combinations of the two are generally recommended for at least a year. Intensive outpatient is recommended for those in need of a more structured treatment experience than can be provided in a traditional outpatient setting but who are not in need of inpatient treatment.

Here too, the more deteriorated alcohol and other drug abusers and addicts will generally need more intense levels of outpatient services over a longer period of time.

Outpatient and intensive outpatient as well as inpatient treatment programs encourage involvement with self-help groups such as Alcoholics Anonymous and Narcotics Anonymous as well.

Section 11. Family Codependency Treatment.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a family member suffering from codependency as a result of an alcohol and other drug abuse or dependency within the family, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests;

(5) Prevention services for children; and

(6) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per year.

COMMENT

This section delineates the services reimbursable under the family codependency treatment section.

Treatment for the families of addicted people has only become available in the past decade. Until recently, newly recovering individuals returned from outpatient and inpatient treatment to families made dysfunctional by the addiction, anger and blame.

In addition, there is emerging research demonstrating that families of addicted individuals use health care at rates higher than found in the general population. After treatment of the addicted individual, health care spending by family members can be expected to be reduced.[9] Direct treatment of the overall family in distress may well have additional positive and measurable benefits for the emotional and physical health of all concerned.

Family treatment increases the likelihood of recovery by the alcohol and other drug abusing individual and addresses the needs of family members and children at risk of developing alcohol and other drug problems.

[9] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Cost-of-Illness Studies of Addictive Disorders, Chapter 3,* and *Addictions Treatment in General Clinical Populations, Chapter 4.*

Section 12. Minimum Level of Medical Assistance Coverage for Alcohol and Other Drug Treatment.

Notwithstanding any other provision in this [Act], alcohol and other drug treatment coverage under state medical assistance shall not be less, in any respect, than coverage required by the state in the policies of health insurance companies or health maintenance organizations.

Section 13. Maximizing Use of Federal Resources.

The [insert executive of state agency administering welfare and Medicaid programs] shall aggressively pursue federal funding and matching funds available through Medicaid, through the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program, SSI and all other appropriate federal sources. In addition, the [insert title of executive] shall pursue federal matching funds through Medicaid for non-hospital residential alcohol and other drug treatment services from the federal Health Care Financing Administration.

COMMENT

A number of federal funding streams are available to provide federal match or support to states for the alcohol and other drug treatment of Medicaid recipients. For example, the federal program entitled, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, can provide federal financial support for diagnosis and treatment of young people with alcohol and other drug problems who are under age 21.

Section 14. Non-Supplantation of Addiction Treatment Funding.

No medical assistance funding or increase in such funding for alcohol and other drug treatment shall be used to supplant or replace existing municipal, county, state or federal funding or resources for alcohol and other drug treatment. The provisions of this [Act] shall in no way be construed to limit access to or funding of alcohol and other drug treatment services currently available.

Section 15. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the remedial purposes, objectives and policies set forth in Sections 2 and 3 of this [Act].

Section 16. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 17. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

Appendix B

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Model Family Preservation Act

Table of Contents

Model Family Preservation Act Policy Statement

Pregnant addicted girls and women and parents with dependent children face many obstacles when seeking treatment for addiction. Although outpatient services are generally available, there is a severe shortage of alcohol and other drug addiction residential treatment programs designed to serve the inpatient treatment needs of this population.

Across the country there are a range of outpatient and inpatient drug and alcohol addiction treatment programs. Although the numbers of programs and geographic accessibility of programs vary widely in the states, some of these programs are available to accommodate the treatment needs of adolescents, adults and pregnant addicted women and girls. However, few inpatient programs are physically constructed or programmatically structured to handle the needs of mothers with newborns and parents with dependent children.

In recognition of the changing roles in society, services developed to address this gap in the continuum of care will want to consider the needs of pregnant girls and women and the needs of men as well as women who have dependent children.

Although gender roles are changing, girls and women still handle the bulk of the responsibility for the care of infants and young children. For this reason, the shortage of facilities also able to accommodate dependent children primarily affects girls and women when there is need for inpatient treatment.

Stigma and negative stereotyping surrounding addiction is intense for both men and women. This leads to delays in seeking help and reinforces the denial of even the existence of the problem. However, stigma for girls and women is generally more intense and is in part, responsible for delaying identification and referral until later in the progression of the disease.

Compounding the problem of stigma, a woman in need of inpatient care is often faced with a decision to give up her children to gain access to treatment. The children often represent her last vestige of self-respect and self-esteem. In addition, once a woman has identified her addiction and sought addiction treatment, she is likely to have trouble maintaining or regaining custody of the children after treatment is concluded. Fearful of losing custody of her children, going to treatment becomes a choice few women are prepared to make.

This primary barrier to care can be averted by the development of residential rehabilitation centers prepared to address the inpatient treatment needs of girls, women and men with dependent children. In addition to addressing the addiction, these programs need to be structured to teach parenting, nutrition, and other life skills as well as to provide preparation and linkage to educational and vocational programs.

The best way to help the drug-exposed child is to help the parent recover from addiction. Treatment must be comprehensive and provided in an environment where the multivariate needs of parents and children can be addressed. A key element of the comprehensive service model is a continuum of family-oriented services directed at numerous risk factors and available at a single site.[1]

Since children of alcoholics and addicts are at high risk of developing addictions themselves, another necessary component of care is age appropriate prevention and education for them. In addition, intervention and counseling for the children is often needed to resolve the problems of living with an untreated alcohol and/or drug addicted parent.

The cost benefits to society are obvious even if measured only in the prevention of fetal alcohol and drug effect and syndrome.[2] For drug-exposed infants, hospital costs alone are 4 times higher than they are for non-exposed infants.[3] Heavy alcohol use during pregnancy is a leading cause of birth defects associated with mental retardation. Fetal alcohol syndrome is the leading known environmental cause of mental retardation in the western world.[4]

In addition to reducing health care costs to society, effective treatment with this population also lessens the social and economic costs of decreased productivity, accidents and crime.

These programs do far more than prevent fetal impairment. They hold out hope of healing the fractured families of addiction and of breaking the multi-generational cycle of alcohol and other drug abuse.

ENDNOTES

1. Kandall S., et. al., TREATMENT IMPROVEMENT PROTOCOL (TIP): DRUG-EXPOSED INFANTS, THE RECOMMENDATIONS OF A CONSENSUS PANEL (Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, 1992).

2. Langenbucher, J.W., McCrady B.S., Brick, J. Esterly, R., *Addictions Treatment with Pregnant Women, Chapter 7,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).

3. U.S. General Accounting Office, DRUG EXPOSED INFANTS: A GENERATION AT RISK (B-238209, June 1990).

4. National Institute on Alcohol Abuse and Alcoholism, 8th SPECIAL REPORT TO THE UNITED STATES CONGRESS ON ALCOHOL AND HEALTH (U.S. Department of Health and Human Services, Washington, DC, 1993).

Highlights of the Model Family Preservation Act

- Encourages the establishment of residential addiction treatment programs for pregnant addicted girls and women and parents with dependent children.
- Establishes program elements that are family-centered in focus.
- Establishes program elements that are addiction oriented.
- Provides for an array of support services attuned to the needs of addicted people with dependent children.
- Provides for educational and vocational counseling and services geared to re-entry and restoring self-sufficiency.
- Requires data collection and annual reporting to the governor and legislature.
- Establishes a training program for related health and human services to enhance identification and referral for help.

Model Family Preservation Act

Section 1. Title.

The provisions of this [Act] shall be known and may be cited as the "Model Family Preservation Act."

Section 2. Legislative Findings.

(a) An epidemic of alcohol and other drug abuse among women of childbearing years is destroying the lives of countless women, young children, and babies.

(b) In addition to the obligation of society to protect young lives, fiscal responsibility alone requires that the skyrocketing costs to society of lifetime care for children and families affected by alcohol and other drugs be addressed. To avoid or reduce these costs, alcohol and other drug treatment programs for all women of childbearing years and parents in need of such programs must be provided.

(c) There is a serious shortage of such alcohol and other drug treatment resources for women of childbearing years.

(d) Women with small children and pregnant women are further inhibited from seeking treatment by being forced to give up their children to enter inpatient treatment care and by the threat that they will lose long-term custody of their children if they seek treatment.

(e) Children raised in families with an addicted parent are at a high risk to develop the disease of addiction as they grow older.

(f) Impaired parenting by addicted parents may place the children at risk of developing social, emotional, and scholastic problems.

(g) Treatment of parents which includes the counseling of dependent children allows the parent(s) to maintain custody or contact and increases the likelihood of a successful recovery and the interruption of the cycle of addiction.

(h) Whenever consistent with and appropriate to the recovery of the parent and child in treatment, the non-custodial parent shall be included in parenting skills training, treatment, family counseling and other relevant activities.

COMMENT

The chapter entitled Addictions Treatment with Pregnant Women, from the Rutgers University study SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT, provides a sense of the substantial costs to society of fetal alcohol and other drug effect and syndrome. The ongoing costs of not addressing this problem are higher that providing addiction treatment.

Section 3. Residential Alcohol and Other Drug Treatment Programs for Women in Childbearing Years, Pregnant Women, and Parents and Their Dependent Children.

(a) The [single state authority on alcohol and other drugs] shall [provide][have the power to provide] directly or through grants to residential alcohol and other drug treatment and related services for women in childbearing years, pregnant women, parents and their dependent children and parents who do not have custody of their children where there is a reasonable likelihood that the children will be returned to them if the parent participates satisfactorily in the treatment program. Grant moneys shall be used for treatment and related services provided to residents of this state by alcohol and other drug treatment programs licensed by the [single state authority on alcohol and other drugs] which provide the following services:

(1)Residential treatment services for women and their children, subject to reasonable limitations on the number and ages of the children, provided in a therapeutic community setting and including, but not limited to:

(A) On-site family centered addiction and alcohol and other drug abuse education, counseling and treatment;

(B) On-site individual, group and family counseling including both parents where appropriate;

(C) On-site alcohol and other drug prevention and education activities for children approved by the [single state authority on alcohol and other drugs];

(D) On-site intervention and counseling that is attuned to the developmental and special needs children of alcoholics and other addicts;

(E) Involvement with Alcoholics Anonymous, Narcotics Anonymous, support groups for children of alcoholics and other addicts, and other family support groups; and

(F)Activities which enhance self-esteem and self-sufficiency for parent and child;

(2)On-site parenting skills counseling and training designed specifically for parents in recovery from alcohol and other drug abuse;

(3)Access to school for children and parents where appropriate, including, but not limited to, securing documents necessary for registration;

(4)Job counseling and referral to existing job training programs;

(5)On-site therapeutic day care for children when the parent is attending counseling, school or a job training program and when the parent is at a job or looking for a job and at other times as appropriate;

(6)Referral and linkage to other needed services including but not limited to health care and special therapy for children;

(7)On-site structured reentry counseling and activities;

(8)Referral to continuing care and treatment upon discharge from the residential program; and

(9)Referral to transitional housing appropriate for the family and its ongoing recovery.

(b) The [single state authority on alcohol and other drugs] shall require programs receiving funds under this section to collect and provide to the department information concerning the number of parents and children denied treatment or placed on waiting lists and may require such data and other information as the agency deems useful. Confidentiality of records regarding identifiable individuals enrolled in treatment programs funded under this section shall be maintained.

(c) The [single state authority on alcohol and other drugs] shall annually convene a meeting of all recipients of funds for programs funded under this section and other interested parties so that the agency may receive input regarding ways to improve and expand treatment services and prevention activities for women in childbearing years, pregnant women, parents and young children.

(d) The [single state authority on alcohol and other drugs] shall report annually to the governor and the general assembly as to its activities and expenditures under this section, the activities of recipients of funds under this section, the number of women and children denied treatment or placed on waiting lists, the recommendations in summary form made at the annual meeting provided for in subsection (c) and the recommendations of the department.

(e) As used in this section, the term "therapeutic community setting" means an alcohol and other drug-free, residential, non-hospital treatment program using therapeutic community principles as the underlying philosophy.

COMMENT

The goal of this legislation is to foster the growth of these needed residential treatment services. For those unlikely to recover through outpatient and Alcoholics and Narcotics Anonymous alone, inpatient programs that can accomodate pregnancy and the care of infants and children on site needs to be made available.

Services delineated in subsection (a) are designed to provide comprehensive prevention, education, treatment and counseling and to provide for vocational and educational goals as well. Services called for are specifically tailored to the needs of addicted people and their children and are family-oriented in nature. Any cost of service will be offset by savings in reduced need for treatment of fetal alcohol and other drug effect and syndrome and in financial reductions in other areas.

It is crucial that skillful provision of addiction treatment take precedence over other programming until the foundations of recovery are established. Parenting, educational, vocational and other services must be anchored in a solid addiction treatment and recovery program.

Failure to accomplish this primary goal will result in relapse, more suffering and trauma to already distressed families and children and additional wasted resources.

The data gathering discussed in subsection (b) will assist the state in its planning and needs assessment process.

Sharing information with the governor and general assembly through the mechanism provided in subsection (d) will alert policymakers to progress and problems on a routine, annual basis.

Given the high and typically irretrievable costs of fetal alcohol and drug effect and syndrome and the potential for prevention of addiction in the at risk children, highlighting this issue through the annual reporting process is sensible public policy.

Section 4. Staff Training and Referral Mechanisms.

The [single state authority on alcohol and other drugs] shall have the power, and its duty shall be:

(a) To establish on a demonstration basis, programs to train the staff of child protective services agencies, counseling programs and shelters for victims of domestic violence, recipients of funds under the High Risk Maternity Program or the Federal Maternal and Child Health Block Grant and community or state health care centers in order to identify pregnant women and parents in those programs who are in need of alcohol and other drug treatment. This proposed cross training program will lead to earlier identification and referral of addicted pregnant women and parents and should avert family suffering and disruption while reducing health care costs; and

(b) To establish referral networks and mechanisms between these agencies and appropriate alcohol and other drug treatment programs.

Section 5. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the purposes, objectives and policies set forth in Section 2.

Section 6. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 7. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

Appendix C

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Model Managed Care Consumer Protection Act

Table of Contents

Model Managed Care Consumer Protection Act

Policy Statement

During the last 30 years, a number of companies and some insurers, recognizing cost benefits to employers and workers alike, moved forward and instituted alcohol and other drug treatment coverage in company and insurance health plans.

As awareness of the cost of untreated alcohol and other drug problems to health care and to the workplace grew, some state legislatures responded by enacting laws requiring coverage for addiction treatment in health insurance policies.

In response to these new laws and workplace policies, workers were encouraged by co-workers and employee assistance programs (EAPs) to come forward and seek help. Skilled employees were salvaged and able to keep their jobs. Research on pre- and post-effects of treatment on workplace alcohol and other drug problems and on health care utilization accelerated.

The research on the cost benefits of addiction treatment became increasingly available to business and policy makers which in turn led to the passage of still more laws requiring coverage for this illness through health insurance policies.

Cost offset and cost benefit studies demonstrate that untreated addicted people and their families use health care at rates much higher than for general populations. The results of some of these studies are summarized below.

COST BENEFITS OF ADDICTION TREATMENT

Supporting the evolution of these state laws is a growing body of research on the costs of untreated alcohol and other drug addictions to the workplace, to the insurers and to the criminal justice system.

Study after study from business and industry, from health insurers and universities demonstrates, on the one hand:

(a) High health care utilization by the untreated alcoholic and addict prior to addiction treatment for a wide array of addiction related illnesses, accidents and injuries.

- "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12

months before treatment, the alcoholic's costs are close to 300% higher than costs of comparable nonalcoholics."[1]

(b) High health care utilization by the families of untreated alcoholics and addicts prior to addiction treatment of the addicted individual.

- "Policyholders in alcoholic families used roughly twice the (health care) services of nonalcoholic families."[2]
- One study compared these expenditures in monthly dollar amounts for families of addicted individuals and families without an addicted member. Families with an addicted member used inpatient health services at a cost of $27.00 a month compared to $6.50 a month for families without an addicted member.[3]

(c) High rates of accidents, absenteeism and sick benefit claims by untreated alcoholics and addicts in the workforce prior to addiction treatment.

- "The average alcoholic, it was found, lost 32 days to illness per year, almost one day in ten, prior to intake.[4]
- Another study found prior to addiction treatment, "... sick benefit claims 120% the normal level, days absent 335% of normal, disciplinary actions 235% of normal ... "[5]

On the other hand, after addiction treatment occurs, study after study finds:

(a) Marked reductions in health care use by the now treated addicted individual.

- In one study, "In general, rates of hospitalization for treated alcoholics declined by nearly 50% at three of four sites ..."[6]
- Another study found a 49% reduction in health care claims after addiction treatment.[7]
- In another study, health care expenditures by the now treated addicted person dropped from about $100.00 a month prior to treatment to $13.34.[8]

(b) Marked reductions in health care use by the family members.

- One study found the decline in health care utilization by the family after treatment of the alcoholic or addict was just over 50%.[9]
- Before treatment, health care utilization by the family of an addicted person is two to three times higher than for comparison families. After treatment of the addicted person occurs, health care utilization by their families decreases to the same as the control group.[10]

(c) Marked reductions in workplace accidents, absenteeism and sickness claims.

- In one study, after treatment - workplace reprimands declined by 75% after six months and days lost to illness declined by 50% at the 18 month follow-up.[11]
- In another describing after treatment work and health records, "Days sick or absent from work declined by fifty percent throughout this period ..."[12]
- And still another study found after treatment reductions in disciplinary actions of 56%, absenteeism of 55%, and days on disability of 53%.[13]

Without such treatment through insurance, the individual with an addiction will continue to deteriorate in a downward spiral eventually losing employment, insurance, health and becoming dependent on public funding. When this occurs, the high health care utilization caused by untreated addiction shifts to welfare, to Medicaid, to Medicare and to the taxpayer.

Even with the more deteriorated addicted individual on Medicaid, the studies find the same patterns at work as with the still insured. High health care use prior to treatment is followed by marked reductions in health care use after treatment of the addiction has occurred. In addition, other benefits accrue in savings to the state from reductions in welfare cash grants, food stamps, etc. as many individuals in recovery find jobs and move back into self-sufficiency.

The end result of this process of legislation and research is that 43 states have now put laws into effect requiring the coverage of addiction treatment.

THE NEED FOR CONSUMER PROTECTIONS

Despite the widespread passage of laws requiring coverage of addiction in insurance plans, denial and stigma - in fact intense shame - continues to surround addictive diseases and works to keep utilization of the treatment benefit extremely low. Utilization of the benefit by subscribers has been stalled at the rate of less than 1% of subscribers for many years. A survey by MEDSTAT Systems, Inc., a health care information company, showed only one-third of one percent (9,000 people) of three million insured people received inpatient substance abuse treatment in 1989.

This under-utilization perpetuates the health care spending on addiction related accidents and illness and limits capturing of health care savings through treatment of the primary illness.

Denial and stigma keep the employee out of treatment but also prevent employers from realizing the full benefit in reductions in health care spending, in reduction in workplace accidents and disciplinary problems.

Presently, a new development in health care is further complicating this picture. Responding to the high costs of health care and the need to control spending, many health maintenance organizations and insurers have begun to subcontract the administration of some health benefits, including alcohol and other drug treatment to managed care firms.

Because of the recent emergence of this industry, managed care is presently almost entirely unregulated in the 50 states and by the federal government. Although the state and federal government regulate health maintenance organizations, health insurers and alcohol and other drug treatment providers, there are few such regulations governing the activities of managed care firms.

In the absence of regulation, managed care firms often lack staff with specific skills and training in alcohol and other drug diagnosis and referral and often fail to use acknowledged alcohol and other drug criteria to assist in diagnosis and placement decisions. In addition, many have financial arrangements that can create incentives to undertreat, combined with grievance procedures that are run in-house to the company in question.

One result of the absence of regulation is that individuals seeking alcohol and other drug treatment are having increasing difficulty accessing the alcohol and other drug treatment benefit already provided and paid for in the health insurance policy.

Other difficulties in accessing help revolve around managed care policies regarding admissions to detoxification. Alcohol and other drug addicts in need of admission to a detoxification center often can neither understand nor wait out the managed care approval process to obtain care. Delays in approval for admission to detoxification lead to relapse, further damage to health and sometimes to job loss. Yet admission to detoxification, when properly handled, is a medical crisis that presents a window of opportunity to recovery for the individual and an opportunity for health care savings as well.

Many managed care firms are not available after 5:00 p.m. or on weekends, making pre-approval requirements all the more difficult.

The practical effect is obvious. These services, already paid for by the insured or the insured's employer, may not be available at the point in time when they are most needed.

Cost shifting is also occurring here. In some cases, treatment already covered by insurance and paid for by the patient or the patient's employer is being shifted to public funding sources such as Medicaid, block grant monies and other state funding. Others go untreated altogether with the predictable societal costs of increased medical expenses, lost jobs with resulting unemployment and welfare costs, broken families and ultimately, crime.

Without consumer protections in place, this combination of factors is potentially dangerous and likely to lead to still further reductions in utilization of alcohol and other drug treatment benefits. As has been discussed at length elsewhere, this failure to treat causes still higher health care spending on addiction related illness and accidents and eventually lead to job loss.

The managed care consumer protections included in this Act, are designed to protect consumers from the problems previously discussed.

The Act establishes the use of acknowledged alcohol and other drug diagnostic criteria, establishes standards for the alcohol and other drug credentialling of managed care assessment personnel, addresses potential conflicts of interest by removing fiscal incentives that may affect clinical decision-making, establishes a clear and accessible grievance procedure, and requires that subscriber materials be written in clear and simple language. In addition, the [Act] sets up a system of accountability including reporting procedures and performance standards.

The Act provides for immediate care of individuals under the influence of or in withdrawal from alcohol or other drugs by classifying detoxification as an emergency service. The emergency service provision would allow the treatment of the patient to go forward immediately, subject to concurrent, retrospective review and the grievance procedure. This allows the dispute over who pays for treatment to go on after the patient is safe and medically stabilized.

This Act additionally recognizes the role of employee assistance programs (EAPs) and student assistance programs (SAPs) that do alcohol and other drug abuse and additional assessments, referrals and follow-up for businesses and schools. These programs are, in effect, managed care for the businesses and schools. Employee assistance and student assistance professionals, unlike either traditional managed care providers or treatment providers, have no potential financial conflict of interest in their professional assessments and referrals, have direct contact with the alcohol or other drug troubled person, and can provide follow-up, support and accountability to the employer, or school. Where these programs are in place, the [Act] allows them to override the decisions of a

managed care firm, subject to the managed care firm's right to appeal using the grievance procedure ordinarily available to the aggrieved insurance policyholder.

The same authority to override the denial of benefits by managed care providers is provided to criminal justice officials responsible for treatment and referral for criminal defendants.

Responsible managed care firms are already moving in the direction of many of the provisions of the Act. They are looking at diagnostic criteria and staff credentials and at the potential harm of fiscal incentives that may lead to denial of needed care. As a result, these managed care firms are providing the full continuum of needed alcohol and other drug treatment services and find themselves at a competitive disadvantage with managed care firms that continue less responsible practices.

In summary, the Act provides reasonable protections that are intended to permit insurance policyholders to receive the benefits they paid for and are entitled to. It also will ensure that responsible managed care firms can carry out their worthy functions without finding themselves at a competitive disadvantage with firms whose lack of training and skills and fiscal incentives lead to the appearance of cost savings when in fact, cost shifting to the public health system has occurred.

ENDNOTES

1. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT 11 (Center of Alcohol Studies, Rutgers University, 1993).
2. *Id.* at 19.
3. *Id.* at 26.
4. *Id.* at 13.
5. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Addictions Treatment in Workforce Populations, Chapter 5,* at 13.
6. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 13.
7. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 25.
8. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 26.
9. *Id.*
10. *Id.*
11. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 13.
12. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 14.
13. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 5.
14. National Association of Addiction Treatment Providers (NAATP), TREATMENT IS THE ANSWER - THE COST EFFECTIVENESS OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT, White Paper (March 1991).

Highlights of the Model Managed Care Consumer Protection Act

- Requires the use of alcohol and other drug abuse and addiction criteria when doing assessments.
- Establishes a method to approve alternative alcohol and other drug assessment criteria.
- Establishes credentials of personnel doing alcohol and other drug assessments.
- Bars conflict of interest by clinical decision-makers.
- Establishes procedures for handling emergency and non-emergency admissions.
- Allows employee assistance programs, student assistance programs and officers of the court the ability to override managed care decisions subject to the grievance procedure.
- Establishes a grievance procedure.
- Sets standards for recruitment practices.
- Sets rules for disenrollment and establishes performance standards.
- Bars discrimination against individuals referred to treatment as a result of a contact with the legal or criminal justice system.
- Establishes reporting requirements.
- Requires consumer materials to be reviewed for simplicity and clarity of language.

Model Managed Care Consumer Protection Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Managed Care Consumer Protection Act."

Section 2. Legislative Findings.

(a) The Alcohol, Drug Abuse and Mental Health Administration has estimated the annual cost of alcohol and other drug problems to business in America to be almost $100 billion.[1] Such estimates typically include calculations of factors such as increased medical claims, medical disability costs, decreased productivity, injuries, theft and absenteeism.

(b) Alcohol and other drug addicted individuals covered by health insurance use medical benefits at rates as high as ten times greater than the remaining population.[2] The babies whose future lives are compromised by being born exposed to alcohol and other drugs will also use more medical benefits in their lifetimes than their unimpaired counterparts.[3] Delays or denials in providing treatment leads to higher health insurance costs for all health insurance consumers.

(c) The cost of prompt addiction treatment in reduced benefit utilization alone can be recovered within one to three years, based on studies of health care utilization pre- and post-addiction treatment.[4] Those cost benefits are further enhanced by increased productivity, reduced accidents, reduced crime, reduced absenteeism, and healthier parenting.

(d) One in ten Americans who use alcohol and other drugs will become an alcohol or drug abuser or will become addicted.[5] One out of four families in American are impacted by alcohol or other drug abuse.[6]

(e) Alcohol and other drug treatment is a cost effective means of achieving significant social and fiscal goals including: health care cost containment, restoration of health, restoration and healing of families, prevention of child abuse and fetal alcohol/drug syndrome, reduction in deaths on the highways, workplace savings, reduction in illegal drug trafficking, theft, and other crimes, with their attendant criminal justice system and prison costs, and removal of a major obstacle to successful re-employment and tax-paying self-sufficiency.

(f) In spite of the widespread prevalence of this disease, addiction treatment policies are utilized by one percent of policyholders, as a result of the denial and family embarrassment that is part of the disease of alcohol and other drug dependency.

(g) Any delays or obstacles to obtaining alcohol and other drug treatment can cause people in need of care or seeking care for a loved one to suffer serious, adverse consequences or to draw on public health funding sources.

[1] Small Business Administration, U.S. Department of Labor, and Office of National Drug Control Policy, WORKING PARTNERS: CONFRONTING SUBSTANCE ABUSE IN SMALL BUSINESS, National Conference Proceedings Report 6 (July 13-14, 1992).

[2] Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986); Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). For additional information on the use of health care benefits by people with untreated alcohol and other drug problems, see also the Policy Statement for the Health Care Professionals Training Act.

[3] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment with Pregnant Women, Chapter 7.*

[4] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2.

[5] U.S. Department of Health and Human Services, ALCOHOL AND HEALTH, Seventh Special Report to the U.S. Congress 7 (January 1990).

[6] Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE 104, 213 (1988); NCADD, FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY)..

(h) Sound and reasonable consumer protection legislation will ensure that such delays and obstacles will not occur.

(i) The streamlining of managed care will assure timely access to skilled assessment and treatment. Such access assures managed care practices that are medically, socially and fiscally sound. This streamlining advances the goals of cutting health care costs, reducing fetal alcohol and other drug syndrome, reducing accidents on the highways and in the workplace and reducing demand for drugs, all of which should promote the general welfare of the people of this state.

COMMENT

This section identifies the high cost of untreated alcohol and other drug abuse and addiction to the health care and criminal justice systems and to the business community. Although the prevalence of the problem is approximately 1 in 10 in the population who use drugs or alcohol, denial is widespread and alcohol and other drug abuse treatment benefits are chronically underutilized.[7] To avoid relapse and continued health care expenditures, managed care firms dealing with people with alcohol and other drug problems must be prepared to respond with skill, clarity and timeliness. Any delays in assessment and treatment will contribute to the economic losses cited here.[8]

Skilled identification, intervention and referral while the individual is employed and has insurance coverage will save money in health care and will reduce the likelihood of deterioration to the point of dependency on the welfare system. Once this deterioration has occurred however, the need for longer term, more intensive treatment is increased and the cost of any such treatment will be shifted to Medicaid. (See the [Model Medicaid Addiction Costs Reduction Act]). Because of this downward spiral of addiction, delays and missteps must be avoided if cost reductions in health care are to be realized. Addressing addiction early and thoroughly is key to conserving both insurance and Medicaid monies.

Section 3. Purpose.

Health maintenance organizations and managed care firms doing business in this state shall fully satisfy the requirements of the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment]. It is therefore the purpose of this [Act] that health maintenance organizations and managed care firms doing business in this state shall make benefit coverage decisions in an open, professionally sound, and ethical manner and shall satisfy all requirements of this [Act].

COMMENT

The purpose of the [Act] is to establish standards and rules for the professional operation of health maintenance organizations and managed care firms in regard to the provision of alcohol and other drug treatment services. Although insurers, health maintenance organizations and alcohol and other drug treatment programs are subject to state and federal regulations and other mechanisms providing for accountability, very few states regulate managed care firms handling alcohol and other drug assessments.

Managed care firms that have already established rules on credentialing of staff, diagnostic criteria and fair and timely grievance procedures will encounter no difficulty complying with the provisions of the [Managed Care Consumer Protection Act.]

Section 4. Establishment and Disclosure of Criteria for Treatment.

(a) Every health maintenance organization and managed care firm doing business in the state shall disclose the specific criteria used by that health maintenance organization, any primary care physician and the utilization, review, and appeal personnel to determine the type, level, and course of treatment that will be available for any member suffering from alcohol and other drug abuse or chemical dependency. Criteria shall be filed with and maintained by the [state agency that regulates health maintenance organizations]. Health maintenance organizations that subcontract any alco-

[7] National Association of Addiction Treatment Providers (NAATP), TREATMENT IS THE ANSWER - THE COST EFFECTIVENESS OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT, White Paper (March 1991).

[8] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).

hol and other drug abuse or chemical dependency services shall file criteria with the state [agency that regulates health maintenance organizations] for each of their subcontractors. Filing of the criteria with the [agency that regulates health maintenance organizations] shall occur within 60 days of the effective date of this [Act] and within 60 days of issuance or renewal of any contract thereafter. The existence and name of the criteria shall be disclosed to members in each health maintenance organization's member contract, and the criteria shall be provided immediately and at no cost to the member by the health maintenance organization upon request.

(b) Health maintenance organizations, their subcontractors or personnel involved in patient interviewing or assessment and utilization and review shall utilize criteria established by the American Society of Addiction Medicine (ASAM) or criteria established by the Cleveland Clinic (Cleveland Criteria). In addition, with the approval of the [single state authority on alcohol and other drugs], nationally recognized alcohol and other drug diagnostic criteria or alternative alcohol and other drug diagnostic criteria may be used. Health maintenance organizations may utilize the criteria beginning 60 days after submission, pending approval or disapproval by the [single state authority on alcohol and other drugs]. Disapproval shall be provided in writing by the [single state authority on alcohol and other drugs] based on the adequacy of the criteria to protect the health of subscribers of the health maintenance organization.

(c) Any changes to ASAM or Cleveland Criteria, by their respective organizations, will not require review by the [single state authority on alcohol and other drugs]. Any changes to all other criteria shall be submitted to the [single state authority on alcohol and other drugs] for approval or disapproval.

(d) In addition to the assessment criteria established in subsection (b), certain complicating factors affecting the determination of type, level of care and course of treatment shall also be considered and addressed within the limitations of the health maintenance organization in developing alternative criteria. These factors shall include, but not be limited to:

(1) Job safety and job security;

(2) Public safety;

(3) Alcohol and other drug use by the immediate family;

(4) Alcohol and other drug use by the extended family;

(5) Alcohol and other drug use within the environment of the member;

(6) Length and severity of addiction;

(7) Age of onset;

(8) Drug or combination of drugs and alcohol;

(9) Employer standards for alcohol and other drug use relative to employees;

(10) Pressures for the creation of drug-free workplaces;

(11) Geographic availability of treatment programs; and

(12) Supportiveness of living and work environment and other complicating factors.

COMMENT

This section assures that health maintenance organizations and managed care firms doing business in the state use assessment criteria appropriate to alcohol and other drug abuse and addiction. Two commonly known assessment criteria are specified for use. In addition, the section provides procedures for the approval of alternative criteria. Minimum factors to be included in any such alternative assessment criteria are also delineated to guide in criteria development. Alcohol and other drug assessment criteria selected or developed by health maintenance organizations or managed care firms must be filed with the state and disclosed to subscribers.

Use of proper alcohol and other drug diagnostic criteria will enhance early identification and aid in treatment placement appropriate to the needs of the individual. Failure to diagnose or failure to appropriately treat people with alcohol and other drug problems often costs more than providing appropriate treatment in the first place. Use of proper diagnostic and placement criteria are thus critical in reducing the health care spending of untreated alcoholic and other addicts for a wide array of addiction related accidents and illnesses.

Section 5. Minimum Standards for Decisions and Assessments; Minimum Qualifications of Decision-Making Personnel.

(a) All decisions and assessments using the approved

criteria for alcohol and other drug treatment and reviews of individuals, including counseling and intervention, provided to families with alcohol and other drug problems shall be completed in accordance with the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment] by trained personnel with acknowledged certification in the area of alcohol and other drug abuse or chemical dependency.

(b) Acknowledged certification as described in subsection (a) shall mean:

(1) Certification by ASAM in the area of alcohol and other drug treatment;

(2) Certification as a certified addiction counselor (CAC);

(3) Certification under any alcohol and other drug program recognized by ASAM; or

(4) Certification by any three-year training program in a facility licensed by the [single state authority on alcohol and other drugs] or equivalent out-of-state facility.

COMMENT

This section ensures that personnel doing alcohol and other drug abuse and addiction assessments for health maintenance organizations and managed care firms have skills appropriate to the task.

Alcohol and other drug addicted individuals can be difficult to diagnose and refer. Denial is intense and family members and friends often assist in minimizing the problem. Special training and skills are needed both to diagnose and to gain the individual's acceptance and ensure follow-through on treatment recommendations.

Although untreated addicted individuals frequent the health care system for treatment of addiction related illnesses, the primary illness at work usually escapes identification. Presently less than 5% of untreated addicted people already in the health care system have that addiction identified. For this reason, the [Model Health Professionals Training Act] is a critical companion to the [Model Managed Care Consumer Protection Act]. With skilled professionals doing the diagnosis and placement, the primary illness will be identified and treated. At this point, significant health care savings in alcohol and other drug related illnesses and accidents will become available to the health maintenance organizations, managed care firms and insurers. Such health care cost reductions cannot be realized without these highly skilled assessors.

Section 6. Conflict of Interest by Decision-Makers.

No health maintenance organization, managed care firm, employee assistance program or treatment program shall provide or establish contracts or arrangements to complete initial patient interviews, assessments, pre-certification, concurrent review or any subsequent review where direct compensation, or any specific part of compensation to individual or clinical decision makers or managed care firms depends on the determination of type or course of treatment, length of stay or level of care for an individual patient or groups of patients, whether the individual is an individual subscriber or a subscriber in a group plan.

COMMENT

This section bars health maintenance organizations, managed care firms and others from establishing arrangements that tend to create financial incentives to deny or reduce care.

Where these arrangements exist, the managed care firm's duty to ensure proper treatment may be in direct conflict with its financial interests. National and state law is replete with provisions established to avoid such conflicts of interest. These laws appear to reflect a national consensus and policy direction that conflicts of interest in legal, medical and other fields are against the public interest.

Section 7. Denial of State Requirements for Alcohol and Other Drug Treatment.

Health maintenance organizations and managed care subcontractors shall be required to fulfill the conditions of the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment]. Nothing in this [Act] shall prohibit health maintenance organizations or managed-care subcontractors from subcontracting with alcohol and other drug treatment programs licensed by the [single state authority on alcohol and other drugs].

COMMENT

This section assures that both the health maintenance organization and managed care subcontractors fall under the requirements of the existing state insurance

laws establishing coverage for the treatment of alcohol and other drug problems. The section also clarifies that the health maintenance organization and managed care firm may subcontract the assesment process to alcohol and other drug treatment programs licensed by the [single state authority on alcohol and other drugs].

Section 8. Standards and Review Procedures for Treatment Coverage Decisions.

(a) When a patient has begun treatment with a program licensed by the [single state authority on alcohol and other drugs], the health maintenance organization or subcontractor shall not intercede in treatment until the mandated minimum lengths of stay established by the program and the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment] have been satisfied unless otherwise indicated based on the criteria approved under subsections (a) through (d) of Section 4 of this [Act].

(b) Alcohol and other drug, or alcohol and other drug detoxification shall be considered an emergency condition pursuant to the emergency provisions of the [insert state statute regulating health maintenance organizations].

(c) All non-emergency assessments for care must be completed within 48 hours or the patient shall be permitted to access service for care, pending an assessment and subject to retrospective or concurrent review and grievance procedures.

(d) Where there is a dispute between an employee assistance program, a student assistance program or [insert title of official designated by the court to oversee addiction treatment for criminal defendants] and a health maintenance organization or managed care firm regarding the treatment of an alcohol and other drug abusing or addicted person, services shall be provided in accordance with the recommendation of the employee assistance program, student assistance program, or [designated court official]. Under such circumstances, the health maintenance organization or managed care firm shall have the right of appeal in the same manner as provided to a subscriber for whom benefits have been denied.

(e) Nothing in this [Act] interferes with the right of the health maintenance organization to concurrent and retrospective review and to request documentation on the progress of the individual at reasonable intervals, as provided in the licensure standards of the [single state authority on alcohol and other drugs]. Concurrent and retrospective review of care shall be based on the approved criteria for care and shall be subject to the applicable grievance procedure.

COMMENT

Under this section, health maintenance organizations and managed care firms are barred from interceding in treatment unless otherwise indicated by the assessment criteria selected by the health maintenance organization or managed care firm. Health maintenance organizations and managed care firms are not responsible for payment for treatment that is not indicated by the health maintenance organization's own assessment criteria and concurrent and retrospective review.

This section also recognizes the emergency nature of detoxification and calls for it to be treated like other medical emergencies. Since detoxification can be life threatening and requires medical monitoring, admission to treatment is permitted. (See the [Model Addiction Costs Reduction Act], Section 6, Inpatient Detoxification, for a discussion of the process of detoxification). Here again, the health maintenance organization or managed care firm is not responsible for payment unless indicated by the diagnostic and placement criteria of the health maintenance organization or managed care firm. In addition, all admissions are subject to concurrent and retrospective review and appeal through the grievance procedure.

Subsection (c) establishes a 48 hour response time for non-emergency assessments. When pressure from family, friends, employers or police create a crisis, the opportunity must be seized. Fast response here is critical and also consonant with the nature of addiction and denial. In addition, rapid response focuses on the larger goals of society: health care cost reduction, crime reduction, and preservation of families.

Subsection (d) allows disinterested parties serving managed care functions for business, for schools and for the criminal justice system to recommend and place the alcohol and other drug abuser in treatment. This subsection streamlines present practice where the employee assistance program for a business does an intervention and assessment and then may have to refer the individual to a managed care firm to do an additional assessment before treatment can begin. The streamlining eliminates the double handle and potential for delays, relapse and job loss while awaiting re-evaluation.

When the health maintenance organization or managed care firm disagrees with the assessment of the employee assistance program, student assistance program, or official designated by the court, the managed care firm may appeal through the grievance procedure.

Section 9. Notice of and Statement of Reasons for Denial of Treatment Coverage.

Any time a health maintenance organization or managed care subcontractor denies access for specific covered treatment or treatment modality or denies continuation of existing treatment, the denial shall be provided in writing to the patient, the referral source and the alcohol and other drug facility providing treatment and shall set forth the specific reasons for denial and the name of the individual making that decision.

COMMENT

This section requires the health maintenance organization or managed care firm to notify the patient, the referral source and the treatment program if payment for treatment is to be denied. In addition, denials are to be provided in writing and will include the reason for denial and the name of the decision-maker.

Denials in writing will clarify miscommunications about treatment between managed care subscribers, treatment programs and referral sources such as the employer and will ensure that all parties involved are aware of the denial and the need to begin discharge planning, initiate the appeal process or seek alternative funding.

On occasion, the denial of treatment by the managed care firm reinforces the denial of the alcohol and other drug problem by the subscriber and leads the subscriber to leave or delay treatment. These actions have both health care and potential public safety ramifications. With both the referral source and treatment program alerted to the denial of treatment, steps can be taken to counteract this problem.

Section 10. Grievance Procedures for Complaints.

(a) The state [agency that regulates health maintenance organizations] shall establish a grievance procedure to handle complaints and grievances regarding the provision of alcohol and other drug treatment services. These procedures shall be reviewed and jointly approved by the [single state authority on alcohol and other drugs] and the [state agency that regulates health maintenance organizations] to assure appropriateness for use with individuals and families afflicted with alcohol and other drug abuse and chemical dependency.

(b) Because of the physical and psychological nature of alcohol and other drug abuse with the potential for accidents, impairment, withdrawal and danger to the public safety, complaints and grievances regarding alcohol and other drug treatment shall follow a one-level grievance procedure and shall be resolved in 30 days from submission of the complaint.

(c) At the point of an inquiry requiring corrective action or a complaint regarding alcohol and other drug treatment services, subscribers shall be advised of the one-step grievance procedure.

(d) Health maintenance organizations and managed care firm shall routinely advise subscribers of the grievance procedure and how to initiate the process.

(e) At the point of denial of requested alcohol and other drug treatment, the health maintenance organization or managed care firm shall re-advise the subscriber of the grievance procedure and of how to initiate the process.

(f) There shall be established an Alcohol and Other Drug Grievance Review Committee which shall consist of three persons appointed by the governor. The Committee shall consist of: a member of the American Society of Addiction Medicine, or a certified addiction counselor selected from a list provided by the [state's professional association of health maintenance organizations], a representative of an alcohol and other drug treatment program selected from a list provided by the [insert name of state's association of licensed alcohol and other drug programs], and a past consumer of addiction treatment service selected from a list provided by the [single state authority on alcohol and other drugs]). The governor may return any list to the submitting organization for inclusion of additional names.

(g) The subscriber may not be excluded from the grievance review. The subscriber may be represented or assisted by counsel, a representative from an employee assistance program, student assistance program, alcohol and other drug treatment program, physician, family member or other persons designated by the subscriber. The subscriber or person designated by the subscriber shall be afforded the opportunity to present the case at any grievance review.

(h) The state [agency that regulates health maintenance organizations] shall compile and maintain records on inquiries requiring corrective action, complaints and grievances regarding alcohol and other drug treatment services.

COMMENT

This section calls on the state to establish a grievance procedure that is timely, involves personnel skilled in dealing with alcohol and other drug abuse problems and is independent of the health maintenance organization, the managed care firm and the alcohol and other drug treatment provider. In addition, the state will compile records on grievances regarding provision of alcohol and other drug treatment services.

This process offers complaint and grievance procedures common in other processes for products, health care and employee grievances. These procedures typically include: representation by all parties to the dispute including the consumer, experts on the problem, a disinterested third party and the public.

These components offer protection for the health maintenance organization and managed care firm as well as for the consumer. The process will ensure that timely and appropriate treatment decisions are made and may eliminate unnecessary litigation.

Section 11. Disenrollment.

(a) Termination of coverage may occur only after full transfer to the next health insuring organization has occurred or after alcohol and other drug treatment has been completed.

(b) During the course of alcohol and other drug treatment, if a subscriber enters an alcohol and other drug inpatient facility, for the purposes of health insurance coverage, the subscriber's residence shall be construed to be his or her residence prior to beginning the course of treatment.

COMMENT

In subsection (a), subscriber coverage for alcohol and other drug treatment may not be terminated once authorized treatment has begun. Patients being transferred from one health maintenance organization or managed care firm to another can encounter lengthy disenrollment procedures with neither organization accepting responsibility for care.

Subsection (b) clarifies that when referral for treatment places the patient in residence outside the geographic area of the health maintenance organization or managed care firm, the individual remains, the responsibility of the referring managed care firm.

Section 12. Non-Discrimination in Treatment Coverage and Provision of Treatment.

No subscriber of a health maintenance organization shall be deprived of alcohol and other drug treament or coverage due to identification of an alcohol and other drug problem that occurs as a result of contact with the legal or criminal justice system.

COMMENT

Few people with alcohol and other drug problems reach a decision to seek help on their won without some kind of intervention. Typically, an accumulation of outside pressures drive that decision. For many, the process of recovery begins with an intervention by an employee assistance program, a student assistance program, a family member or the criminal justice system. The type of intervention employed should not be used as grounds to deny treatment but should instead be used as an opportunity to assist the individual, to reduce health care costs, cut crime and meet other goals consistent with the needs of society.

Section 13. Recruitment Standards.

The [agency that regulates health maintenance organizations] shall establish standards governing the subscriber recruitment practices of health maintenance organizations and methods for evaluating those practices including but not limited to consumer surveys and complaints. Health maintenance organizations shall submit recruitment plans to the [agency that regulates health maintenance organizations] for review and approval.

COMMENT

This section calls on the state agency with responsibility for regulating health maintenance organizations and managed care firms to establish standards to govern recruitment practices and a method to evaluate those practices.

This section will have no impact on managed care firms that have developed sound policies defining responsible recruitment practices.

Section 14. Performance Standards.

(a) As part of registration with the [agency that regulates health maintenance organizations], the health maintenance organization shall submit a plan, which shall include but not be limited to:

(1) An estimate of prevalence of chemical dependency in the subscriber pool;

(2) An estimate of the need for each type of alcohol and other drug treatment service and lengths of stay in each year;

(3) A follow-up plan to ensure continuing care;

(4) An outreach plan setting goals to increase identification and treatment of subscribers with alcohol and other drug problems, methods of access to assessment and treatment displaying timeliness and appropriateness for handling alcohol and other drug affected individuals;

(5) A proposed program network demonstrating the full continuum of care, geographic availability, cultural sensitivity and planning for special needs populations; and

(6) A method to provide measures of performance within each of these categories.

(b) Plans will be reviewed and approved by the [state agency that regulates health maintenance organizations].

(c) Each health maintenance organization and managed care firm doing business in this state shall include in its annual report an assessment of its success in meeting the goals established in its plan.

COMMENT

Here health maintenance organizations are required to register with the state and submit an annual plan and a method to measure performance against that plan. The performance standards delineated here assure that health maintenance organizations and managed care firms consider measures of success in addition to reductions in spending and units of service provided.

The performance standards described are similar to those employed by other managed care entities like employee assistance programs, student assistance programs and others. Responsible managed care firms have already taken steps to measure performance in ways similar to those being proposed.

Section 15. Reporting Requirements.

(a) As part of its annual reporting requirements to the [state agency that regulates health maintenance organizations] each health maintenance organization shall report its ownership status, whether a parent organization or a subsidiary organization, and if a subsidiary organization, then its parent organization; each health maintenance organization shall fully disclose its financial arrangements and considerations between it and any managed care organization performing work for that health maintenance organization; and each health maintenance organization shall include, for itself and its subcontractors, the following information: the total number of members, the numbers receiving alcohol and other drug treatment benefits, the alcohol and other drug treatment benefits provided by type of service, the level of care, the length of stay within each type of service, the names and addresses of all subcontracting organizations handling this benefit and the names of all alcohol and other drug treatment facilities utilized within the reporting year. In addition, the [state agency that regulates health maintenance organizations] shall submit copies of all plans and reports relating to alcohol and other drug abusers to the [single state authority on alcohol and other drugs] for review and comment. The [state agency that regulates health maintenance organizations] shall review these annual reports for general compliance and to determine that the health maintenance organization and managed care firms are providing treatment to its members and are providing the full continuum of services as required under the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment].

(b) The [state agency that regulates health maintenance organizations]shall submit these reports with a summary to the legislature at the end of two years on the extent to which health maintenance organizations are providing treatment for alcohol and other drug abuse to their members as required in the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment].

COMMENT

This section sets up annual reporting requirements by health maintenance organizations to the state that include: disclosure of ownership status, disclosure of financial arrangements with managed care firms, num-

bers of subscribers using each of the alcohol and other drug abuse treatment benefits and modalities and length of stay required by the state and the names of all facilities and programs providing treatment services in the network. This reporting will simplify the task of monitoring for compliance with state laws requiring health maintenance organizations to provide coverage for alcohol and other drug treatment. Because of the importance of alcohol and other drug treatment in reducing health care costs, workplace problems, family stress and crime, the section calls for an additional report to the legislature.

This section provides reporting requirements and systems of accountability by managed care firms similar to those required of insurers, health maintenance organizations and alcohol and other drug treatment programs.

Section 16. Plain Language Requirement; Promulgation of Rules and Regulations Generally.

The [state agency that regulates health maintenance organizations] shall promulgate rules and regulations to implement this [Act]. The [state agency that regulates health maintenance organizations] shall specifically require health maintenance organizations subject to this [Act] to submit for departmental review and approval as to simplicity and clarity of language all subscriber forms, benefit handbooks or other material setting forth rights and duties. The [state agency that regulates health maintenance organizations] shall establish filing fees for health maintenance organizations and subcontractors required under this [Act] at a level adequate to support all costs of implementing this [Act].

COMMENT

This section sets up review of subscriber materials to assure ease of comprehension of benefits, rights and grievance procedures. Presently, some of the material provided to subscribers is difficult to read and comprehend - particularly at a moment of crisis or illness.

Section 17. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the purposes, objectives and policies set forth in Section 2 and 3 of this [Act].

Section 18. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 19. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

Appendix D

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Model Early and Periodic Screening, Diagnosis, and Treatment Services Act

Table of Contents

Model Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Act

Policy Statement

The Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) was enacted by Congress in 1967 and was seen as a far reaching effort to provide comprehensive preventive health and treatment services to Medicaid eligible children under age 21.

Under the statute, the states were required to provide at least the following services:

- A comprehensive health and developmental history including an assessment of physical and mental health development
- Physical examinations
- Appropriate immunizations
- Laboratory tests
- Vision services
- Dental services
- Hearing services

OBRA '89 Modifications of the EPSDT Program.

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified existing regulations and made a number of changes to the 1967 statute.

Although the EPSDT program addresses the health care needs of Medicaid eligible children in general, OBRA '89 brought with it some modifications of particular significance to those in need of alcohol and other drug screening, counseling and treatment for themselves and their families.

These changes include the addition of health education to the list of required services and the definition of health education to include "anticipatory guidance". This latter change is discussed in "The Explanation of the Energy and Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs":[1]

> "The Committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counseling to both parents and children."[2]

This language may well be interpreted to allow for inclusion of drug counseling in the EPSDT program.

For those in need of alcohol and other drug screening and treatment services, an even more significant modification of the 1967 law calls for the addition to the EPSDT program of:

> "Such other necessary health care, diagnostic services, treatment and other measures described in 1905 (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[3]

According to the Children's Defense Fund: this is "The most dramatic EPSDT change in OBRA '89 with great promise to improve the health of poor children".[4]

Alcohol and Other Drug Abuse: Impact on Children and Adolescents.

The effects of alcohol and other drug abuse and addiction on children and young people have been well documented over the years. This impact can be drastic, interfering with educational and maturational development, causing damage to the individual, to the family and to the greater society. The toll of alcohol and other drug abuse on children and young people includes: learning impairments, truancy, high drop-out rates, unwanted teen pregnancy, school vandalism, crime, car accidents, death on the highways and suicide.

The importance to families and to society of addressing alcohol and other drug problems at this young age is impossible to overstate. Intervention early in the abuse cycle will prevent permanent damage to health, family and to educational and career goals.

With this in mind, the EPSDT program presents an important opportunity for states to augment screening and treatment efforts geared to this age group. Through EPSDT, federal matching monies can be marshalled to address the needs of these high risk young people.

Summary: The Opportunity.

Modifications made to the Early and Periodic, Screening, Diagnosis and Treatment program by OBRA '89 present an opportunity to include alcohol and other drug abuse and addiction screening and treatment in this federally matched health effort targeted to children under 21.

Encouraging states to include these alcohol and other drug services as part of the implementation of the federal program will assist states in reaching positive preventive health goals for Medicaid eligible children while at the same time, maximizing the use of federal resources.

As with adults, alcohol and other drug abuse and addiction leads to high utilization of health care and increases criminal activity. Routine screening and treatment of alcohol and other drug problems with young people can be expected to reduce health care costs and alcohol and other drug-related crime.

ENDNOTES

1. Commerce Clearing House, Inc., EXPLANATION OF THE ENERGY AND COMMERCE AND WAYS AND MEANS COMMITTEES AFFECTING MEDICARE-MEDICAID PROGRAMS, Omnibus Budget Reconciliation Act of 1989, H.R. 3299, No. 596, page 399 (October 5, 1989).

2. 163 HEALTH ADVOCATE 4 (Winter 1990).

3. 42 U.S.C. 1396d(r)(5).

4. Children's Defense Fund, MEDICAID PREVENTIVE SERVICES FOR CHILDREN - THE EPSDT PROGRAM, Analysis of 1989 Federal Legislation (January 1990).

Model Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Act

(Amendment to State Welfare Code)

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Early and Periodic Screening, Diagnosis and Treatment (ESPDT) Services Act".

Section 2. Inclusion of Treatment in EPSDT Programs.

For the purposes of state implementation of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services program, all alcohol and other drug abuse screening, counseling and treatment services other than those provided in an Institution for Mental Disease, shall be included.

Section 3. Non-Supplantation.

Funding provided through the EPSDT services program shall not be used to supplant other state or federal resources.

Section 4. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the purposes, objectives, and policies set forth in Sections 2 and 3.

Section 5. Severability.

If any provisions of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the [Act] which can be given effect without the invalid provisions or application, and to this end the provisions of this [Act] are severable.

Section 6. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

COMMENT

Under the provisions of this program, the state can enhance its ability to provide alcohol and other drug abuse and addiction screening and treatment for Medicaid eligible children under the age of 21.

Federal financial participation is available for screening and for outpatient and inpatient treatment services except for those provided in an Institution for Mental Disease with 16 or more beds.

Appendix E

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Model Health Professionals Training Act

Table of Contents

Model Health Professionals Training Act Policy Statement

Prevalency of People with Untreated Alcohol and Other Drug Problems in the Health Care System.

> "The problem of alcoholism and drug addiction is a most serious health problem in the United States; [it is] the fourth major illness; and [it] has the third highest major disease fatality rate."[1]

Since death certificates may reflect any of a variety of addiction related or aggravated medical conditions, these numbers may well be underestimates. In any case, if alcohol and other drug related accidents and injuries are factored in, then alcohol and other drug abuse and alcohol and other drug addictions become the leading killers of Americans.[2]

Awareness of the alcohol/drug involvement in many illnesses, injuries and accidents causes some to conclude that it is the "No. 1 cause of morbidity and mortality in America."[3]

Research and surveys find that individuals with untreated alcohol and other drug problems appear frequently in the health care delivery system for a wide array of addiction related illnesses and injuries.

Some of these illnesses, medical complications and disease sequelae are: hypertension, stroke, diabetes, cirrhosis, cancers of the liver, larynx, esophagus, stomach, colon, and breast, heart attack, damage to the brain, pancreas and kidneys, ulcers, colitis, fetal alcohol and drug effects and syndrome, other birth defects, infections, damage to the immune system, AIDS, respiratory illnesses and edema.

The prevalency of untreated addicted individuals within the health care delivery system is quite high:

- Up to 50% of all general hospital admissions are alcohol and drug related.[4]
- 15% of all visits to doctors may be alcohol-related.[5]
- 30%-40% of inpatient hospital admissions are alcohol-related.[6]
- At least 15% of ambulatory patients are alcohol and other drug related.[7]
- 50%-60% of emergency room admissions are alcohol-related.[8]
- "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12 months before treatment, the alcoholic's costs are close to 300% higher than costs of comparable nonalcoholics."[9]

- Families of untreated alcoholics and addicts also use health care two to three times higher than the general public.[10]

Diagnosis and treatment of addictive diseases is clearly critical to proper patient care and to an effective health care cost containment strategy.

Despite these repeat contacts with the health care system, the alcohol and other drug abuse problem is diagnosed less than 5% of the time.[11]

Again, according to Dr. Otis Bowen, then Secretary of the U.S. Department of Health and Human Services:

> Up to 50% of all general hospital admissions are related to alcohol and other drugs, but many of these patients leave the hospital with their problem undiagnosed.[12]

Despite repeated contacts with health and medical services, the primary illness at work is rarely identified.

> Two of the country's leading doctors - Otis Bowen, Secretary of Health and Human Services and James Sammons, Executive Vice President of the American Medical Association - recently joined in a report saying 15 percent of all visits to doctors may be alcohol-related but only 2 to 3 percent are usually so diagnosed. Drug abuse, less familiar to most doctors, is probably diagnosed even less often.[13]

In sum, this is an illness that is greatly over-represented in people who appear in the health care system; that causes repeated use of health care; that may be the leading cause of morbidity and mortality in this country, and yet: it is diagnosed less than 5% of the time.[14]

With preparation and proper education in addiction, the health care system can learn to provide intervention early in the disease progression before permanent and costly health impairment has occurred. Those interventions are humane, medically appropriate and will also lead to reduced spending on alcohol and drug related accidents, injuries and illnesses.

History of Medical Education in Alcohol and Other Drug Abuse and Addiction.

Despite the high prevalence of people with untreated alcohol and other drug addictions in the general health care system, medical education and training in addictions continue to be sparse and in need of development.

Prior to the 1970s, medical education "virtually ignored alcohol and other drug abuse as a major concern."[15]

Partially in response to the drug abuse of the 1960s and growing focus on health care cost containment, interest in medical education in alcohol and other drugs increased in the early '70s. Meetings, conferences and federal support (National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA)) led to the development of the Career Teacher Training Program in the Addictions.

Results of the Career Teacher Program continue to be promising but evaluations ten years after it started found: "...the percentage of required teaching hours on alcoholism and drug abuse remained well under 1%, a level far out of proportion to the extent of the public health problem"(emphasis added).[16]

Fortunately, the effort did not end here. In 1976, the Career Teacher network founded the Association of Medical Education and Research in Substance Abuse (AMERSA). From here substance abuse programs were instituted in several medical schools. In addition, medical schools, the federal government and foundations teamed up to develop model medical curriculum, guidelines and resources for undergraduate, resident and post graduate school programs.

In 1985, at AMERSA's 9th annual conference, conferees agreed that primary care doctors including general internists, pediatricians, psychiatrists and family physicians should have proficiency in alcohol and other drug abuse in each of these areas at a minimum:

(1) Epidemiology, including knowledge of the natural history of substance abuse and risk factors;

(2) Physiology and biochemistry of dependency and addictions;

(3) Pharmacology, including knowledge of the effects of commonly abused drugs and drug-drug interactions;

(4) Diagnosis, intervention and referral;

(5) Case management, including short and long-term consequences of abuse and dependency; and

(6) Prevention through health promotion, early identification and patient education.

The conferees went on to add "primary care physicians should identify and assess their own personal and professional attitudes toward alcohol and drug abuse."[17]

Since the early 1970s, NIDA and NIAAA have also provided financial support and awards to a number of medical speciality organizations such as the American College of Emergency Physicians, the Society for Teachers of Family Medicine and the American College of Obstetricians and Gynecologists.

Despite these developments in medical school education in alcohol and other drug abuse, Lewis et al note:

> A common response to pressure to include substance abuse training in medical school or postgraduate education has been to provide one or more elective courses or a limited exposure as part of preclinical training. But this limited exposure ... virtually ensures that physicians will not be exposed to the range of problems and opportunities for successful intervention that substance abuse entails[18]

Can Physician Intervention and Attitudes Make a Difference?

A poll completed in 1982 by the American Medical Association found that 71% of physicians "felt either incompetent or ambivalent about treating alcoholism."[19] Nonetheless, 90% of patients surveyed indicated that "they would like their physician to recognize and participate in the treatment of their alcohol and drug problems."[20]

Other research suggests that even minimum physician intervention appears to make a difference in whether or not an alcohol and other drug addicted individual seeks treatment for this health problem.[21]

Despite this high potential for successful intervention, Dr. John Chappel, in an article entitled "Physician Attitudes and the Treatment of Alcohol and Drug Dependent Patients", cautions that physician attitude may stand in the way of diagnosis, intervention and treatment of alcohol and other drug problems:

> Studies of diagnostic practice indicate that the pervasive attitude among physicians is that 'It is better to suspect illness than not - better safe than sorry.' Yet, in the case of chemically-dependent persons, that traditionally positive physician attitude is often reversed. It seems safest NOT to diagnose alcoholism or drug dependence...[22]

In addition to this, "... many physicians have a stereotype of the alcohol-dependent patient as a derelict ... The result is delay (in diagnosis) until the condition has reached an advanced stage."[23]

The delay then leads to diagnosis only when late stage physical pathology is in evidence. This, in turn, reinforces physician stereotypes about addicted people, blocks intervention earlier in the disease progression, discourages referral to treatment and encourages physician and patient pessimism about the prospects for recovery.

Surveys of members of Alcoholics Anonymous confirm this tendency and find physicians last on the list of referral sources to this critical part of recovery, as noted in the following chart:

Factors Responsible for Coming to Alcoholics Anonymous.[24]

Factor	1977	1980	1983
A.A. member	44%	42%	37%
"On my own"	33%	27%	27%
Family	22%	21%	20%
Couns. & rehab	19%	26%	31%
Doctor	10%	9%	7%

Considering the attitudes blocking diagnosis and intervention, Chappel recommends the regular use of questionnaires for all patients at risk and notes that one such effort "increased the detection rate of alcoholism by nine times in one year."[25]

Summary

Training in alcohol and other drug abuse and addiction for physicians and other health care practitioners will enhance early identification and referral and has high potential to reduce health care expenditures as well as human misery.

State statutes requiring routine medical school education on alcohol and other drug abuse are critical components of proper patient care and any effective health care cost containment strategy. Such statutes will result in better, more humane care of untreated addicted people and their families.

ENDNOTES

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2. *Id.* at 1, 13.
3. *Recognizing and Treating the Alcoholic,* BEHAVIORAL MEDICINE 14 (January 1980).
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5. Bowen, O., and Sammons, J., *Why Doctors Miss the Warning Signs,* The Washington Post, December 27, 1988.
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9. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Population, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT 11 (Center of Alcohol Studies, Rutgers University, 1993); Holder, H.B. and Hallen, J.B., MEDICAL CARE AND ALCOHOLISM COSTS AND UTILIZATION: A FIVE YEAR ANALYSIS OF THE CALIFORNIA PILOT PROJECT (National Institute on Alcohol Abuse and Alcoholism, December 1981).
10. *Id.* at 19.
11. THE ALMACAN, *supra* note 6; Bowen, O., and Sammons, J., *supra* note 5.
12. Bowen, O., *supra* note 4.
13. Bowen, O., and Sammons, J., *supra* note 5.
14. THE EMPLOYEE ASSISTANCE PROGRAM DIGEST, *supra* note 6.
15. Lewis, D.C., Niven, R.G., Czechowicz, D., and Trumble, J.G., *A Review of Medical Education in Alcohol and Other Drug Abuse,* 257(21) J.A.M.A. 2945 (June 5, 1987).
16. *Id.* at 2946.
17. *Id.* at 2947.
18. *Id.* at 2948.
19. *Id.* at 2945.
20. *Id.*
21. 261 J.A.M.A. 407 (January 20, 1989).
22. Chappel, J., *Physician Attitudes and the Treatment of Alcohol and Drug Dependent Patients,* 10(1) JOURNAL OF PSYCHEDELIC DRUGS 27 (January-March 1978).
23. *Id.*
24. A.A. SURVEYS ITS MEMBERSHIP: A DEMOGRAPHIC REPORT (Box 459, Grand Central Station, New York, N.Y. 10163, Fall 1984).
25. Chappel, J., *supra* note 22.

Model Health Professionals Training Act

Accreditation and curriculum statutes for medical schools, nursing schools, paramedic schools, and schools training other health professionals shall be amended to add the following language:

> Curriculum requirements under this section shall mandate a minimum of 30 hours of study of alcohol and other drug abuse and addiction. The program for the study of alcohol and other drug abuse and addiction shall be approved by the [single state authority on alcohol and other drugs] in consultation with the American Society of Addiction Medicine and the state medical society and shall include, but not be limited to, diagnosis of addictive diseases, early warning signs of alcohol and other drug abuse, identification and referral skills, treatment approaches and appropriate use of support groups for affected individuals and for the families of affected individuals.
>
> Further, the practice act in this state shall require that all practitioners who apply for periodic relicensure shall present evidence of completion of a minimum of ten hours of continuing education of alcohol and other drug abuse and addiction. Such courses shall include, but not be limited to the subjects listed above.

COMMENT

Experts report that addictive diseases constitute the single most neglected public health problem in the United States. Although physicians and other health professionals are able to address secondary organ damage with considerable energy and expertise, many are remiss in recognizing the patient's primary health care problem - substance abuse and addiction.[1]

Presently, responsibility for addressing educational needs in this area has fallen largely to professional associations and speciality societies on a voluntary basis.

Many health professional associations and specialty societies have identified core bodies of knowledge for their members. For example, the American Medical Association has developed "Guidelines for Physician Involvement in the Care of Substance-Abusing Patients." Similar guidelines have been developed by the American Nurses Association, the American Psychological Association and a number of speciality groups.

More broadly, a federally convened Physicians' Consortium on Substance Abuse Education worked for three years developing consensus statements (1991) on the needs of practitioners at all levels of training.

What has been lacking to this point, is a method of translating these voluntary efforts into reality for medical practitioners. The [Model Health Professionals Training Act] will provide the impetus through the established mechanism of professional training.

[1] Valiant, G.E., *Alcoholism and Drug Dependence,* in THE HARVARD GUIDE TO MODERN PSYCHIATRY (Nicholi, Jr., A.M. ed. 1978); Bowen O., and Sammons, J., *Why Doctors Miss The Warning Signs,* The Washington Post, December 27, 1988; Lewis, D.C., Niven, R., Czechowicz, D., and Trumble, J.G., *A Review of Medical Education in Alcohol and Other Drug Abuse,* 257(21) J.A.M.A. 2945-2948 (1987).

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Model Criminal Justice Treatment Act

Table of Contents

Model Criminal Justice Treatment Act

Policy Statement

The Drug Use Forecasting System and other studies reveal that most drug and non-drug crimes are committed by persons who are under the influence of alcohol and illicit drugs. Drug abusing and addicted offenders thus account for a significant percentage of all crimes committed throughout the United States.

Substance abuse and addiction is related to crime rates in a number of ways. Many property offenses, for example, are committed by persons who need to raise money to support their drug habit. Substance abuse can also induce or accelerate criminal behavior. Persons who crave or are under the influence of a mind or mood altering drug, for example, may be unable to empathize with a potential victim, and at least certain drugs reduce an offender's inhibitions and actually seem to stimulate violence.

Moreover, a person under the influence of an intoxicating substance is typically much less able or willing to anticipate future consequences. This, in turn, undermines the concept of general deterrence — the notion that criminal behavior can be discouraged by threatening the swift, certain imposition of some form of punishment.

A comprehensive, systemwide effort to identify and to treat alcohol and other drug abuse and addiction will reduce both violent and property-related crime. Enhancing the ability of the criminal justice system to provide meaningful treatment opportunities is an effective crime prevention strategy.

Recent empirical studies confirm that drug treatment works for offenders who are compelled to engage the treatment process as a condition of pretrial release, sentence, probation or parole. It simply makes sense to use the criminal justice system to constructively induce substance abusing and addicted offenders to accept help and to enter and to stay in treatment for as long as necessary to deal effectively with their drug problem.

Because of the nature of addiction, few drug abusing or addicted persons "volunteer" for treatment on their own initiative. Typically, the decision to undergo treatment and to engage the rehabilitative process is a result of pressure or coercion brought to bear by others, including family members, friends, employers, school officials, medical and health care professionals or by the criminal justice system, including law enforcement and prosecuting agencies and court. State legislatures must recognize that in many if not most criminal cases, the necessary coercion will have to come from courts and law enforcement agencies, precisely because addicts are often in denial and may perceive little incentive to initiate the difficult rehabilitative process.

Arrests can serve as critical opportunities for intervention. This can only occur, however, when the criminal justice system has in place realistic policies, procedures and resources to identify sub-

stance abusing and addicted offenders and to motivate these offenders to overcome their denial, to accept help and engage the treatment process.

The Model Criminal Justice Treatment Act attempts to marshal and unify all of the resources and legal tools available within the criminal and juvenile justice systems so as to make the best possible use of these resources in reducing the incidence of substance abuse and addiction, and thereby reducing the incidence of crime. These important resources upon which the Model Act relies include individuals in recovery from alcohol and other drug abuse and addiction. Input from this population is explicetly provided for in sections on reporting and implementiation, and training for criminal justice and juvenile justice professionals. The Model Act embraces the following general principles, which should be adopted in one form or another in every criminal justice system throughout the nation:

EARLIEST POSSIBLE INTERVENTION

In order for treatment to be as effective as possible, identification and intervention resources should be provided to substance abusing and addicted offenders at the earliest possible opportunity within the criminal justice process. Accordingly, the decision to require an offender to undergo some meaningful form of treatment should not wait for a final conviction or adjudication. Rather, diagnostic assessments and treatment services should be provided as soon as possible following the arrest, and should continue throughout the dispositional process.

UNIVERSAL DRUG TESTING

Each jurisdiction should establish a comprehensive program for testing all persons who enter the criminal justice or juvenile justice systems as soon as possible following a felony arrest. Such testing should be done in a safe and reliable manner designed to produce accurate results which can then be used to determine whether and to what extent further diagnostic assessment is necessary to determine the offender's need for alcohol or drug treatment services.

COMPREHENSIVE DIAGNOSTIC ASSESSMENTS

Although drug testing remains a useful if not indispensable tool in identifying offenders in need of alcohol and other drug treatment services, courts and other actors within the criminal justice system should not rely entirely on drug test results. For one thing, such tests cannot reliably reveal whether the defendant is drug dependent. Each jurisdiction must therefore establish a comprehensive program for providing a professional alcohol and other drug diagnostic assessment of selected defendants to determine the scope and nature of their substance abuse or addiction problem. It is critical to note that not all substance abusing offenders are drug dependent. Some drug profiteers, for example, are motivated by greed, rather than an addiction to alcohol or illicit drugs. It is therefore essential to establish a system by which to reliably distinguish on a case-by-case basis those offenders who are profiteers, and those who are truly drug dependent and who might benefit from participation in an alcohol and other drug treatment program.

MATCHING INDIVIDUAL TREATMENT NEEDS TO AVAILABLE PROGRAMS

As part of the diagnostic assessment process, each jurisdiction should establish a system by which to ensure that defendants in need of some form of alcohol and other drug treatment are placed in an appropriate licensed program to ensure the most appropriate use of available resources. To accomplish this, the program conducting the individual diagnostic assessment should make specific recommendations to the court or other appropriate dispositional authority concerning the type of treatment program and length of stay which is both necessary and available to address the offender's individualized needs. These assessments and resulting recommendations should be based upon objective medical diagnostic criteria established by some appropriate authority, such as the single state authority on alcohol and other drugs.

ENSURING THAT LEGAL DECISIONS ARE BASED ON OBJECTIVE, PROFESSIONAL RECOMMENDATIONS

Although the decision to order a defendant to participate in some form of licensed treatment program is ultimately a legal one to be decided by a court or other appropriate agency, such as a parole board, such decisions should be based upon the specific recommendations of licensed alcohol and other drug treatment and diagnostic programs. In other words, while courts should never abdicate the responsibility to impose an appropriate sentence or disposition, they should defer or at least accord considerable weight to the recommendations of licensed professionals. Accordingly, a statutory "presumption" should be established whereby the court or parole authority should ordinarily rely upon and follow the case-specific recommendations of the program which conducted the individual diagnostic assessment. Where the court or other authority for any reason elects to disregard or depart from the specific recommendations of the assessment program, the court or parole authority should be required to state the reasons for its decision on the record. Moreover, copies of these statements of reasons should be compiled and provided to some appropriate government authority, such as the single state authority on alcohol and other drugs, to enable it to determine the extent to which courts and parole authorities throughout the jurisdiction are following the recommendations of treatment professionals.

HOLDING DEFENDANTS ACCOUNTABLE

For the criminal justice system to maintain credibility, all drug abusing or addicted offenders must be held accountable for their past and future actions. Offenders ordered to undergo alcohol and other drug treatment should be subject to careful monitoring, which should include but not be limited to periodic drug testing. These defendants should be subject to realistic, escalating sanctions which would be imposed in the event of a violation of any term or condition of the treatment program. The consequences for violations should be both realistic and predictable, to deter such violations. In developing a realistic continuum of sanctions, policymakers must recognize that an occasional relapse is often part of the difficult recovery process. Such sanctions might include, but need not be limited to, withholding privileges, requiring defendants to submit to more intensive or frequent monitoring and supervision requirements, or returning the person to a traditional form of incarceration.

DEFINING ROLES AND RESPONSIBILITIES

The roles and responsibilities of all of the professional actors within the criminal justice system must be carefully defined. It is important, for example, to distinguish the function of monitoring an offender's compliance with court-ordered terms and conditions on the one hand, from the responsibility actually to provide treatment services on the other hand. Similarly, it is important, to the extent possible, to distinguish the function of providing a professional diagnostic assessment or evaluation from the function of providing treatment services. Where the availability of licensed programs allows, the treatment and assessment services should be provided by different programs. This helps avoid potential conflicts of interest and the appearance that a given diagnostic assessment program might profit by determining that an offender is in need of the particular form of treatment that the assessor happens to provide.

However, the Commission recognizes that in many areas, the number of qualified, licensed programs is limited. It may therefore be necessary for the same program to undertake both the assessment and treatment functions. In such instances the single state authority on alcohol and other drugs should implement necessary monitoring procedures.

TREATMENT SERVICES PROVIDED BY LICENSED PROGRAMS

All diagnostic assessment and treatment services should be provided by programs which are licensed by the appropriate authority outside the traditional criminal justice or correctional system, namely, the single state authority on alcohol and other drugs. This should be done with respect to services provided to defendants awaiting trial or final disposition of the charges, those who are sentenced to any form of probation, those who are under parole or post-incarceration supervision, and even those who are serving a term of imprisonment in a traditional correctional facility. Where necessary, government agencies should enter into contracts with licensed professional programs to refer clients or provide in-house services. This is necessary to ensure that all treatment services meet current medical and therapeutic standards and to ensure that limited fiscal resources are at all time used to obtain the most effective services. This approach would not preclude and would actually make it easier for a defendant management agency (such as probation or parole agency or TASC program) to supervise each defendant's progress or lack thereof and to "broker" available services, that is, to make certain that each defendant is linked up with an appropriate treatment program.

EMPOWERING TREATMENT PROGRAMS TO EXERCISE APPROPRIATE CONTROL

In order for defendants to take alcohol and other drug treatment programs seriously, they must understand that the recommendations of treatment programs will carry great weight with courts, parole authorities and defendant management agencies. Legislation should also make clear that treatment programs will be supported by the criminal justice system in holding offenders accountable for rule infractions, and that these programs are free to expel offenders who fail to satisfactorily engage the treatment process or who threaten to disrupt the operations of the treatment program.

MANDATORY TREATMENT

Legislation should make clear that once an offender has been diagnosed with the disease of alcohol or drug abuse or addiction, the court or appropriate parole authority should, in the absence of special circumstances, be required to order the offender to participate in some appropriate licensed treatment program. As a general proposition, no offender diagnosed as drug or alcohol dependent should be permitted to exit the criminal justice system until he or she has undergone an appropriate form of treatment. The decision whether that treatment is to be provided in prison or elsewhere should be made by the courts based not only upon traditional sentencing criteria, but also upon the professional diagnostic assessment of each offender and the specific recommendations of the assessment program. The addict in denial should be given few choices. If, for example, he or she is unwilling to accept treatment and rigorous monitoring instead of imprisonment, than the court should oblige him or her by providing that treatment during a term of incarceration. Where the substance abusing or addicted offender refuses to engage the treatment process during a term of incarceration, he or she should remain ineligible for parole, early release or any other benefits afforded prisoners in good standing until he or she has made satisfactory progress in the treatment program. Under such a comprehensive statutory scheme, in other words, the offender should not have the option of choosing "passive" or "idle" incarceration in lieu of the rigors of a meaningful treatment program. In this way, the criminal justice system can be used constructively to motivate offenders to positively accept treatment and to engage the treatment process.

AFTERCARE AND SUPPORT SERVICES

It is an axiomatic that persons who are addicted to alcohol and other drugs who engage in the treatment process will face a lifelong struggle to remain substance free. That is why treatment professionals refer to persons who are "recovering," rather than to persons who have "recovered." While it is appropriate and necessary to require substance abusing or addicted defendants to undergo treatment during a term of confinement which may be imposed as part of the dispositional process, it is no less essential to provide persons diagnosed pursuant to this Act as drug or alcohol dependent with adequate aftercare and support services upon their release into the community following a term of court-ordered residential treatment or incarceration. Accordingly, this Act is designed to require such services, supervision and monitoring as a continuing condition of probation or parole following release.

PROGRAMMATIC EVALUATION

A rational statutory scheme would make certain not only that individual offenders are carefully monitored and held fully accountable for their actions, but also that treatment programs are held accountable and are subject to rigorous empirical evaluation. Such objective, outside monitoring and evaluation is necessary to ensure the credibility of the entire system, to educate the public that treatment works with respect to the offender population and to develop further information about effective approaches to treatment. In conducting a thorough evaluation, treatment programs and defendant management and monitoring agencies should be required to maintain accurate data and statistics. Moreover, in developing an appropriate research methodology, evaluators should use sufficiently sophisticated and sensitive measures of short and long-term impact, such as the number of substance-free and crime-free days while under supervision, relative decreases in the

amount of substances abused, the relative time to re-arrest, the number of days engaged in gainful employment, vocational or educational programs and other information concerning the long-term effect of court-ordered interventions.

DETERMINING SYSTEM-WIDE RESOURCE NEEDS AND EDUCATING INDIVIDUALS WORKING IN THE CRIMINAL JUSTICE SYSTEM

In most jurisdictions, those working within the criminal justice system complain, with justification, that there are inadequate resources dedicated to provide treatment services. However, all too often, these individuals may not be aware of all that they can do to take full advantage of those resources which do exist. Accordingly, an education program should be established for courts, probation and parole departments, prosecutors, defense attorneys and other individuals within the criminal justice system so that they have at least a rudimentary understanding of the different methods and modalities for assessing and treating alcohol and other drug abuse and for taking full advantage of those public and private resources and programs which are available within the jurisdiction. Moreover, the single state authority on alcohol and other drugs can play a key role in monitoring the use of the rehabilitative provisions of the Model Criminal Justice Treatment Act to make certain that available resources are used in the most appropriate manner.

Highlights of the Model Criminal Justice Treatment Act

GOALS

- To reduce violent and property-related crime by creating a systemwide effort to identify and treat alcohol and other drug abusing and addicted offenders.
- To use the criminal justice system to constructively motivate substance abusing and addicted offenders to enter and stay in treatment for the necessary duration to deal effectively with their alcohol and other drug abuse problem.
- To develop a criminal justice system which embraces the following principles:

  (1) early intervention for more effective treatment;

  (2) universal drug testing;

  (3) comprehensive diagnostic assessments to determine treatment needs;

  (4) matching individual treatment needs to available programs;

  (5) mandatory treatment for offenders diagnosed with a substance abuse problem or addiction;

  (6) reliance on licensed assessment and treatment programs to provide services which meet current medical and therapeutic standards;

  (7) clearly defined roles for programs providing assessment and treatment services;

  (8) holding offenders accountable for their criminal actions;

  (9) support for treatment programs by holding offenders accountable for program rule violations;

  (10) empowerment of treatment programs through the right to discharge offenders who fail to constructively engage in the treatment process or are disruptive;

  (11) adequate aftercare services for offenders who are released into the community;

  (12) programmatic evaluation to ensure program accountability and improvement; and

  (13) education of criminal justice professionals about alcohol and other drug abuse and available resources and programs.

DRUG TESTING

- Requires mandatory drug testing of individuals arrested for felonies and specified misdemeanors to assist in identifying persons with substance abuse problems.
- Requires a defendant management and monitoring agency to conduct the drug testing. e.g., pretrial services agency, Treatment Alternatives to Street Crime (TASC) program.
- Requires drug testing to be a condition of pretrial release, probation, or parole or similar release from a correctional facility.

ASSESSMENTS

- Requires designated arrestees to undergo an assessment to determine whether the person is drug or alcohol dependent, or otherwise in need of substance abuse or addiction treatment. An assessment is mandatory if:

  (1) the person refuses to undergo a drug test;

  (2) the drug test results reveal the unlawful presence of a controlled substance or the abuse of alcohol;

  (3) the person requests an assessment or admits to unlawful use of a controlled substance or alcohol abuse in the year preceding the arrest;

(4) the present or a pending charge involves illegal drugs or driving under the influence of alcohol or other drugs; or

(5) the person has within the last five years had a conviction involving illegal drugs or driving under the influence of alcohol or other drugs, or been granted a conditional discharge, or been sentenced to treatment during incarceration.

- Requires a court to also order an assessment if the court for any reason believes the person is drug or alcohol dependent or would otherwise benefit from an assessment.
- Requires an inmate, under specified circumstances, to undergo an assessment before receiving a grant of parole or other release from a correctional facility.
- Requires an assessment program providing services under the Model Act to be licensed by the single state authority on alcohol and other drugs.
- Requires an assessment to be a condition of pretrial release or probation.

USE OF DRUG TEST RESULTS OR ASSESSMENTS

- Provides drug test results or assessments to the court, prosecutor, person who underwent the test or assessment, appropriate parole authority, and assessment and treatment programs.
- Allows limited use of the test results or assessment, including determining a person's suitability for conditional discharge, the conditions of pre-trial release, the appropriate sentence, or the conditions of parole or other similar release from a correctional facility.
- Authorizes use of test results or assessments in a prosecution for contempt or perjury.
- Requires any information learned by an assessment or treatment program to be kept confidential pursuant to 42 U.S.C. §290dd-3.

COST OF DRUG TESTS OR ASSESSMENTS

- Requires a person who undergos a drug test or assessment to pay, consistent with the ability to pay, reasonable fees to cover the cost of the test or assessment.
- Exempts from the payment requirement individuals acquitted of the charges, against whom the charges were dropped, or who satisfy other particular qualifications.
- Requires drug testing fees to be forwarded to the defendant management and monitoring agency.
- Requires assessment fees to be forwarded to the appropriate assessment program.

COURT-ORDERED TREATMENT

- Requires the court to immediately order a person to participate in a treatment program recommended by an assessment program if the court agrees with the recommendation.
- Requires the court to state on the record any reasons or disagreement with the recommendation, and provide notice of the decision and reasons to the single state authority on alcohol and other drugs.
- Authorizes the court to refuse to order the recommended treatment despite court agreement with the recommendation if extraordinary and compelling reasons exist. e.g., a person is serving a mandatory life sentence or is subject to capital punishment.
- Requires treatment to be a condition of pretrial release, probation, or parole or other release from a correctional facility.
- Requires the court to designate a treatment program which must be licensed by the single state authority on alcohol and other drugs.
- Permits a treatment program to refuse a referral pursuant to the Model Act if the program administrator deems the person inappropriate for admission to the program.
- Allows a treatment program to immediately discharge an individual who fails to comply with program rules and treatment expetations or who refuses to constructively engage in the treatment process.

CREDIT FOR TIME SERVED

- Allows credit for time served for each day a person is committed to residential treatment if the treatment program so recommends based upon the person's satisfactory progress.

MITIGATING FACTOR

- Establishes satisfactory progress in a treatment program, as determined by that program, as a mitigating factor for purposes of sentencing, probation, or parole.

SANCTIONS

- Requires development of a schedule of presumptive sanctions to be imposed upon violation of any court-ordered term or condition of the defendant's participation in a treatment program.

REPORTING REQUIREMENTS

- Requires the defendant management and monitoring agency to report periodically to the court on a person's compliance with court-imposed terms and conditions.
- Requires a treatment program to notify the defendant management and monitoring agency if a person fails to comply with program rules and treatment expectations; terminates participation in treatment; or refuses to constructively engage in the treatment process.
- Requires every agency or program that provides services or issues an order pursuant to the Model Act to report monthly on activities and other designated information. Every agency or program shall keep case specific records, aggregate data and statistics as required by the single state authority on alcohol and other drugs.

DUTIES OF THE SINGLE STATE AUTHORITY

- Requires the single state authority on alcohol and other drugs (SSA):
  - (1) to report annually to the legislature and govenor regarding the need for and implementation of the Model Act;
  - (2) to establish an advisory board of state and local enforcement, judicial, and corrections officials, defense attorneys, assessment and treatment programs, and past consumers of treatment services;
  - (3) to convene, within two years, a conference to develop recommendations concerning improved and enhanced implementation of the Model Act;
  - (4) to establish and maintain a substance abuse educational program for police, prosecutors, judges, corrections officer, and private and public defense attorneys. The program shall discuss the causes, effects, indicators, and treatment of illegal drug use and dependency, and alcoholism.;
  - (5) to promulgate rules and regulations for implementation of the Model Act.
  - (6) to draft standards to ensure the full continuum of care for persons ordered to undergo treatment pursuant to the Model Act;
  - (7) to designate assessment and treatment programs with special skills in providing services to criminal or juvenile justice referrals; and
  - (8) to aggressively pursue all federal funding and matching funds through federal sources and programs to support the assessment and treatment services provided pursuant to the Model Act.

IMMUNITY FROM CIVIL LIABILITY

- Grants licensed assessment and treatment programs immunity from civil liability for damages caused by services provided in a good faith, non-negligent manner. The immunity extends only to actions taken in accordance with the Model Act.
- Grants qualified persons immunity from civil liability for damages caused by taking a specimen of breath, blood, urine, or other bodily substance in a non-negligent, medically accepted manner. The immunity extends only to actions taken in accordance with the Model Act.

Model Criminal Justice Treatment Act[1]

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Criminal Justice Treatment Act."

Section 2. Legislative Findings and Purpose.

(a) A growing body of research demonstrates the destructive impact of alcohol and other drug abuse or addiction on personal health and health care costs, the spread of communicable disease, educational performance and attainment, work force participation, safety and productivity in the workplace, and financial stability. These indicators of social erosion are in turn related to crime in many obvious but hard to measure ways. Given the recognized relationship between crime and substance abuse and addiction, it is necessary and appropriate to use, adapt, and expand the resources and remedies available within the criminal justice and juvenile justice systems to intervene to address the problem of substance abuse dependency and thereby to help reduce the demand for illicit drugs and to reduce drug-related crime.

(b) Studies, such as the Drug Use Forecasting studies conducted by the National Institute of Justice, reveal that a large percentage of persons arrested for both drug and non-drug offenses (such as thefts, burglaries, robberies, assaults, rapes and homicides) test positive for recent drug use. Many offenses are committed by adults and juveniles who are under the influence of a controlled substance or alcohol, or are committed in order to raise revenues to support the person's drug habit. Some mind and mood altering drugs, moreover, seem to induce criminal and often violent behavior, reducing the person's inhibitions as well as his or her ability to anticipate future consequences, thereby undermining the deterrent thrust of the criminal law. Some drugs may also reduce an offender's ability to empathize with a potential victim, resulting in episodes of seemingly mindless violence. Finally, some crimes, including crimes of violence, are committed in the normal course of conducting illicit drug businesses and enterprises. These include strong arm robberies and "rip-offs", violent retaliations for such offenses, and efforts to protect markets and "turf" by means of intimidation and terrorism directed against would-be competitors and drug purchasers who patronize competing drug distributors.

(c) Research has demonstrated that substance abuse and addiction is treatable within the offender population and that appropriate actions by criminal justice professionals can foster the effectiveness of treatment. This research further demonstrates that the effectiveness of substance abuse treatment is directly related to the length of stay in treatment. The threat of criminal justice sanctions, in turn, can motivate offenders to enter treatment to stay in treatment for as long as necessary to effect positive change. Court-ordered treatment must be of sufficient duration and intensity, must be supported by periodic comprehensive drug testing to maintain program integrity, must be provided by professional staff who have received adequate training and who continue to receive training and adequate supervision, and must provide for the continued collection and analysis of program data to allow for both process and impact evaluation. Moreover, the drug and alcohol treatment programs must be licensed by the [single state authority on alcohol and other drugs],

[1] The text of the Model Criminal Justice Treatment Act employs terminology typically used in state criminal justice systems to refer to adult defendants. The Commission strongly believes that the remedial and rehabilitative principles, policies and procedures recommended in the Model Act should apply to underage persons who enter the juvenile justice system. Accordingly, each state legislature should amend the text of this Model Act as necessary to encompass juveniles who are taken into custody for an act which if committed by an adult would be a felony or misdemeanor, or who are adjudicated delinquent.

and must be appropriate in type, duration, and intensity based upon the length and level of treatment derived from an alcohol and other drug assessment of each individual's needs, balanced with the public's right for protection.

(d) The purpose of this [Act] is to establish a comprehensive system for identifying at the earliest possible opportunity those adults and juveniles who enter the criminal justice and juvenile justice systems who actively abuse a controlled substance or alcohol, who are drug dependent, or who are otherwise in need of substance abuse treatment and monitoring. It is the intent of this [Act] to provide a continuum of care to address these offenders' needs. It is also the purpose of this [Act] to afford realistic, meaningful and cost-effective substance abuse assessment, treatment, and monitoring services; to ensure the effective management of persons undergoing court-ordered substance abuse treatment; and to hold substance abusing offenders accountable for their past and future actions by means of an effective combination of rewards, threats and swiftly imposed punishments and sanctions designed to take full advantage of the coercive influence of the criminal justice and juvenile justice systems.

(e) Few addicts voluntarily seek help for a substance abuse problem. Many drug dependent persons deny that they have a problem. Consequently, the decision to participate in treatment typically is the result of pressure brought to bear by others, including family members, friends, co-workers, employers, medical and health care professionals, school officials or by courts or law enforcement agencies. Since a significant percentage of referrals for substance abuse treatment come from courts and law enforcement agencies, the judiciary and the law enforcement community act as a major point of entry to the substance abuse treatment system. It is in the public interest to use the coercive powers of the courts and their jurisdiction over persons charged with committing crimes to constructively influence substance abusing and addicted offenders, and to provide strong incentives for these offenders to accept help and to participate and remain as long as necessary in meaningful treatment and monitoring programs.

(f) Most substance abusing and addicted offenders who are convicted of serious crimes and who are sentenced to terms of imprisonment will eventually be released back into the community on parole or at the expiration of their sentence. Without proper treatment, the offender is likely to continue to be drug dependent and to commit new offenses, resulting in further injury to victims, loss of property and the expenditure of scarce resources to identify, apprehend, prosecute and return him or her to confinement. In these circumstances, the overriding need to protect the public safety requires that all substance abusing and addicted offenders receive appropriate treatment and monitoring services, based on the individual's need as determined by the alcohol and other drug assessment, either in lieu of or during the course of traditional imprisonment, and should continue to receive needed treatment or appropriate aftercare or support or monitoring services as a condition of parole or release from confinement.

(g) Persons charged with a crime who actively abuse or are addicted to a controlled substance or alcohol and who are not undergoing appropriate treatment and monitoring pose a proportionately greater risk of criminal recidivism, missed court appearances and flight. It is therefore appropriate, and consistent with the traditional criteria for setting bail and conditions of pretrial release, that substance abuse assessment, treatment and monitoring services be provided to persons who are awaiting trial on serious criminal charges.

(h) It is imperative to provide judges at the earliest opportunity with accurate and detailed information concerning an arrestee's use of or addiction to a controlled substance or alcohol and the nature and extent of his or her need for some appropriate form of substance abuse treatment and court monitoring. Although the decision to compel some form of substance abuse treatment and court monitoring as a condition of pretrial release, conditional discharge, probation or final sentence is a legal one to be decided by the court in accordance with statutory criteria, it is essential that the court be provided with an accurate diagnostic assessment based on a thorough and comprehensive evaluation performed by programs or facilities which are licensed by the [single state authority on alcohol and other drugs], which evaluations should be conducted in accordance with medical standards and recognized alcohol and other drug abuse diagnostic criteria.

(i) For treatment and intervention services to be most effective, it is imperative to provide substance abuse assessment, treatment and monitoring at the earliest possible opportunity. In ordering persons who are subject to the jurisdiction of the criminal court to participate in any given course of treatment, the court should rely upon and give appropriate weight to the specific recommendations of programs licensed by the

[single state authority on alcohol and other drugs] with respect to both the type, intensity, and length of treatment which is necessary to address each offender's needs. Moreover, courts in enforcing the terms and conditions of release, probation or conditional discharge must be realistic, and must always be mindful that the difficult process of recovery may be punctuated by an occasional relapse. For this reason, courts in determining what sanctions should be imposed upon a violation should consider the violation in relation to the offender's overall progress or lack of progress made in the ongoing course of treatment, and should give appropriate weight to the recommendations of the licensed treatment program. It is the policy of this state to hold all persons subject to the jurisdiction of the court fully accountable for their actions through comprehensive monitoring and the swift and predictable imposition of realistic sanctions which are designed to motivate offenders so as to achieve long term success.

(j) In order to ensure uniformity and the best possible use of limited resources, the [single state authority on alcohol and other drugs] is to develop and enforce licensing and operational standards for all programs, whether public or private, which provide substance abuse diagnostic assessment, or treatment services to adults or juveniles subject to the jurisdiction of the criminal courts, including but not limited to those services provided to inmates in correctional institutions and facilities.

(k) For treatment and intervention services to be most effective, alcohol and other drug abusing and addicted offenders must be assured that information provided during the course of treatment and counseling is kept confidential in accordance with the provisions of 42 U.S.C. §290dd-3 and 42 C.F.R. Part 2, which govern the confidentiality of alcohol and other drug abuse treatment records. Without such protections, an offender in need of alcohol and other drug treatment services may be discouraged from constructively engaging in the treatment process. Preserving the confidentiality of treatment information and records is not inconsistent with the vital goal of holding alcohol and other drug abusing and addicted offenders fully accountable for their past and future actions. The responsibility for managing offenders and monitoring compliance with court-imposed terms and conditions of pretrial release, sentence, probation or parole should be separate and distinct from the responsibility to provide professional treatment services.

COMMENT

This section, a declaration of legislative findings and policy, is divided into paragraphs which summarize the necessity for adopting a comprehensive treatment act to deal with alcohol and other drug abusing or addicted offenders who enter the criminal justice system. It is hoped that this declaration, by identifying the purposes to be achieved by this reform initiative, will aid courts, administrative agencies, treatment and assessment programs and other interested persons and entities in interpreting and implementing the specific provisions of the [Act].

A detailed declaration of legislative findings and policy is especially important with respect to this [Act] because this section provides a general framework and outlines in some detail the essential principles necessary to establish a comprehensive system for identifying and providing an appropriate continuum of care for those persons who come within the jurisdiction of the criminal courts who have a drug or alcohol problem. The Commission recognizes that all states already have in place laws, court rules and procedures concerning bail and the conditions of the pre-trial release, pre-trial intervention and similar diversionary programs, probation, parole and sentencing.

In the circumstances, it is simply not feasible in model treatment legislation to cover in detail all aspects of the criminal justice process or to resolve all issues which might arise with respect to the handling of alcohol and other drug abusing or addicted offenders. This [Act] instead is designed to define in general terms the essential characteristics of any comprehensive system to use limited resources to address these offenders' needs, to provide a full treatment regimen and to ensure the interests of public protection. The declaration of legislative findings and policy thus establishes a basic framework for adapting existing systems and procedures to meet modern demands. See also the accompanying Policy Statement to the [Model Criminal Justice Treatment Act].

Section 22 provides that the provisions of the [Act] are to be "liberally construed to effectuate its remedial and rehabilitative purposes." It is expected that in all cases involving questions of statutory interpretation or construction, the declaration of legislative findings and policy would be consulted so as to reliably determine the precise nature of these remedial and rehabilitative objectives.

Section 3. Definitions.

As used in this [Act]:

(a) "Controlled substance" shall have the same meaning as that term is defined in [state controlled substances act].

(b) "Assessment" means a diagnostic alcohol and other drug evaluation to determine whether and to what extent a person is drug or alcohol dependent within the meaning of this [Act] or otherwise needs and would benefit from some form of substance abuse or addiction treatment. The assessment shall be conducted by an assessment program as defined by this [Act] in accordance with the standards, procedures and alcohol and other drug diagnostic criteria designated or established by [single state authority on alcohol and other drugs] to provide the most cost-beneficial use of available resources.

(c) "Assessment program" means a not for profit corporation, government agency or other entity which is licensed by [single state authority on alcohol and other drugs] to conduct an assessment pursuant to this [Act].

(d) "Drug or alcohol dependent" means in a state of physical or psychological dependence, or both, arising from the use of a controlled substance or alcohol on a continuous basis. Drug or alcohol dependence is characterized by behavioral and other responses, including but not limited to a strong compulsion to take the controlled substance or alcohol on a recurring basis, regardless of consequences, in order to experience its psychotropic effects, or to avoid the discomfort of its absence. The [single state authority on alcohol and other drugs] may establish standards, procedures and alcohol and other drug diagnostic criteria to determine whether and to what extent a person is drug or alcohol dependent within the meaning of this [Act].

(e) "Substance abuse or addiction treatment" means any type of drug or alcohol treatment ordered by a court, or [parole board or other appropriate authority] to address a person's drug or alcohol dependence or other substance abuse or addiction treatment.

(f) "Test" or "Drug test" means a test conducted in a medically safe and appropriate manner to determine the presence or absence of controlled substance metabolites or otherwise to determine the recent or historical use of a controlled substance by the subject of the test. The test shall be of a type approved for such purposes by the [single state authority on alcohol and other drugs].

(g) "Treatment program" means any governmental agency or other entity which is licensed by the [single state authority on alcohol and other drugs] to provide substance abuse or addiction treatment on a residential or outpatient basis.

COMMENT

This section provides the definitions of key terms which are used throughout the [Act]. Some of these definitions deserve special note.

The definition of the term "assessment" provides that such diagnostic alcohol and other drug evaluations must be conducted in accordance with standards, procedures and alcohol and other drug diagnostic criteria established by some appropriate authority outside the traditional criminal justice system, such as the [single state authority on alcohol and other drugs]. Reliance upon such criteria designated or established by the [single state authority] will ensure professionalism and the highest standards of competence. The [single state authority] is uniquely qualified to develop criteria so as to achieve the most appropriate and cost-beneficial use of limited available resources.

The definition of the term "assessment program" makes clear that any entity or agency conducting an assessment must be licensed by the [single state authority]. See also Section 19, concerning the licensure authority of the [single state authority on alcohol and other drugs]. Nothing in this definition would preclude a government agency from being assigned the responsibility to conduct a diagnostic assessment, provided, however, that any such government agency must submit to licensure procedures established by the [single state authority on alcohol and other drugs]. This licensing feature is designed to minimize the problems which can arise when traditional criminal justice actors (such as pre-trial services agencies, probation departments, parole agencies and local and state correctional agencies) decide on their own to enter into the business of providing drug and alcohol diagnostic assessments or treatment without being subject to some form of monitoring or licensing requirements established by an appropriate agency which has professional experience in this field.

This [Act] distinguishes the critical function of monitoring an offender's compliance with court-ordered terms and conditions from the responsibility to provide professional diagnostic or treatment services. Thus, a distinction should be drawn between a forensic drug test to determine whether a defendant has violated a

condition of pre-trial release or probation, as compared to a therapeutic or diagnostic assessment to determine whether and to what extent a given defendant is in need of and would benefit from professional treatment services, and to determine what specific program or treatment modality is appropriate to respond to the individual's needs. The former drug test can easily and reliably be performed by a defendant monitoring and management agency and need not be subject to the strict licensure provisions associated with diagnostic assessments. However, as discussed below and in Section 4, the [Act] does prescribe minimum standards for drug testing, whether such tests are used to determine compliance with court-ordered conditions or to support a diagnostic assessment.

The definition of the term "drug or alcohol dependent" is designed to make certain that the rehabilitative services prescribed in this [Act] are afforded to persons who genuinely need them. This [Act] is not designed to provide mitigating options, for example, to drug dealing profiteers, who are driven by greed rather than an addiction to alcohol or an illicit substance.

The [single state authority on alcohol and other drugs] is authorized to establish standards, procedures and designate drug and alcohol diagnostic criteria to determine whether and to what extent a person is drug or alcohol dependent within the meaning of this [Act]. Compare Section 18, which expressly authorizes the [single state authority] and any other appropriate agency or agencies to promulgate and periodically review and revise rules, regulations, guidelines, directives, standards and protocols necessary to implement the provisions of this [Act]. See also Section 19, which directs the [single state authority]to develop certain licensure standards. This formulation confirms that a determination as to whether and to what extent the person is drug or alcohol dependent is essentially a medical one to be determined by licensed professional programs in accordance with criteria established within the medical profession.

The definition of the terms "test" or "drug test" will allow the [appropriate state agency] to take into account new and emerging technologies. This definition does not attempt to provide detailed guidance concerning the procedures and protocols for drug testing, the handling of specimens in order to maintain the chain of custody, and similar legitimate concerns involving due process considerations and the civil liberty interests of persons required to submit to drug testing. Rather, these issues are left to be decided either in other model statutes or by rules and regulations promulgated by the [appropriate government agency]. See also discussion of Section 4.

The definition of the term "treatment program" makes clear that all such programs must be licensed by the single state authority. See also Section 19. This requirement applies to all substance abuse or addiction treatment programs, whether residential or out patient, which are operated by private corporations or by government entities.

Section 4. Mandatory Testing of Arrestees.

(a) A person who has been arrested for a felony [or misdemeanor] [or misdemeanor involving specified offenses including those under the Model Driving Under the Influence of Alcohol and Other Drugs Act and Model Underage Consumption Reduction Act, or for which the Model Revocation of Professional or Business License for Alcohol and Other Drug Convictions Act applies,] shall be required to submit to a drug test.

(b) The [defendant management and monitoring agency], as defined in this [Act], shall perform the test in accordance with pre-trial drug testing standards, rules or regulations promulgated by the [appropriate governmental agency] which ensure fair, accurate, and reliable testing procedures and protect the chain of custody. The sample or specimen used in the drug test shall be provided by or taken from the person in a medically safe and appropriate manner.

(c) The test shall be performed as soon as practicable after arrest, and where feasible, prior to the release of the person. If the person has not undergone a drug test at the time of his or her release, submission to a drug test shall be a condition of the person's release pursuant to Section 9.

(d) A person who refuses to submit to a drug test shall be required to undergo an assessment pursuant to Section 5.

COMMENT

This section, which outlines one of the key provisions of the [Act], provides for universal drug testing of all persons arrested for felonies and certain designated non-felony (i.e., misdemeanor) offenses. Universal drug testing should become an important part of a comprehensive program for beginning the process of identifying those defendants who abuse or are addicted to alcohol or controlled substances.

Subsection (b) provides that the test will be performed by a designated [defendant management and monitoring agency]. Although this term is not defined, it represents a critical concept which is used throughout the [Act]. The [defendant management and monitoring agency] might be a pre-trial services agency, probation department or Treatment Alternatives to Street Crime (TASC) program.

Subsection (b) further provides that any such drug test must be conducted in accordance with pre-trial drug testing standards, rules or regulations promulgated by some appropriate government agency, such as the [single state authority on alcohol and other drugs]. Such rules and regulations must be designed to ensure fair, accurate and reliable testing procedures and to protect the chain of custody. Moreover, the [Act] provides that the sample or specimen must be provided or taken from the defendant in a medically safe and appropriate manner. See also Section 21(b), which affords immunity from civil liability for persons taking or obtaining drug test samples.

The provisions of subsection (c) ensure that drug test results can be taken into account in developing appropriate conditions of pre-trial release and is consistent with a the [Act's] goal to provide intervention services at the earliest possible opportunity within the criminal justice process.

Subsection (d) recognizes that a person arrested for a serious offense who refuses to submit to a drug test may be attempting to conceal an alcohol or drug problem — a typical characteristic of denial, which is often associated with substance abuse or addiction. This feature is designed to ensure that no substance abusing or addicted offender can evade the identification and intervention services afforded pursuant to this [Act].

Section 5. Criminal Justice Referrals for Substance Abuse or Addiction Treatment.

(a) A person arrested for a felony [or misdemeanor] [or specified misdemeanors] shall be required to undergo an assessment if:

(1) the person refuses to undergo a drug test required under Section 4;

(2) the results of the drug test conducted pursuant to Section 4 reveal the presence of a controlled substance for which the person has no lawful prescription or order, or the abuse [use] of alcohol;

(3) the person requests an assessment;

(4) the person admits to unlawful use of a controlled substance within the year preceding the arrest for the present charge, or admits to alcohol abuse or alcoholism;

(5) the present charge involves a violation of [controlled substances act] or [Model Driving Under the Influence of Alcohol and Other Drugs Act or similar state law];

(6) the person has any other pending charge in this state, any other state, or federal court involving a violation described in paragraph (5), or an attempt or conspiracy to commit a violation described in paragraph (5);

(7) the person has within the past five years been convicted in this state, any other state, or a federal court of a felony or misdemeanor involving a violation described in paragraph (5);

(8) the person has within the past five years been granted a conditional discharge pursuant to the [state conditional discharge law], any similar or predecessor law of this state or any other state, or federal law; or

(9) the person has within the past five years been sentenced to probation or treatment during incarceration pursuant to this [Act], any similar or predecessor law of this state or any other state, or federal law.

(b) Notwithstanding the requirements of subsection (a), the court shall order a person to undergo an assessment if the court has reason to believe the person is drug or alcohol dependent, or would otherwise benefit by undergoing an assessment.

(c) If a person required or ordered pursuant to this section to undergo an assessment has not undergone the assessment at the time of the person's release prior to trial or on probation, submission to an assessment shall be a condition of the person's pre-trial release or probation pursuant to Section 9.

(d) If a person required or ordered pursuant to this section to undergo an assessment has not undergone an assessment at the time the person is granted a conditional discharge pursuant to [state conditional discharge law], submission to an assessment shall be a condition of the person's discharge.

(e) An inmate confined in a state or county correction-

al facility shall undergo a pre-release assessment before receiving a grant of parole or other release from the correctional facility if:

(1) the person was at any time ordered to undergo an assessment pursuant to this [Act];

(2) the person would have been statutorily required or ordered by a court to undergo an assessment pursuant to this [Act] had this [Act] been effective at the time the person was arrested or indicted for the offense for which he or she is presently serving a term of incarceration;

(3) the person at any time during his or her term of incarceration committed an institutional infraction or violation which involved the use or possession of a controlled substance or alcohol; or

(4) the [parole board or other appropriate authority] otherwise has reason to believe that the inmate is drug or alcohol dependent within the meaning of this [Act], or would otherwise benefit from substance abuse or addiction treatment or related support services.

(f) An assessment required pursuant to subsection (e) shall occur within 60 days of the inmate's scheduled parole or other release from the correctional facility

COMMENT

This section recognizes that while drug testing remains a useful tool in beginning to identify offenders who abuse or are addicted to alcohol and other drugs, courts and other actors within the criminal justice system cannot rely exclusively on drug test results. Rather, there is a need for a more comprehensive system for conducting diagnostic assessments to be performed by licensed programs using approved diagnostic criteria and methodologies.

For example, drug test results, including positive results, cannot reliably reveal whether the defendant is drug dependent and in need of treatment services. Moreover, the drug test cannot provide much guidance with respect to the specific type of program or treatment modality which would be appropriate to address the substance abusing defendant's needs.

Not all substance abusing offenders are drug dependent. Some drug distributing profiteers, for example, are motivated by greed, rather than an addiction to illicit drugs or alcohol. It is therefore essential to establish a system by which to reliably distinguish on a case-by-case basis those offenders who are profiteers from those who are truly drug or alcohol dependent and who might benefit from participation in a drug or alcohol treatment program.

By the same token, given the scarcity of resources available to support professional treatment services, it is essential that the provision of such services be limited to those who are genuinely in need and who might benefit therefrom. The establishment of a comprehensive diagnostic assessment system is necessary to ensure the most appropriate and cost-beneficial use of limited treatment resources.

Not every person entering the criminal justice system need undergo a professional diagnostic assessment. Accordingly, subsection (a) establishes certain objective criteria or circumstances from which it must be presumed that a diagnostic assessment is indicated and appropriate.

The nine criteria set forth in subsection (a) are objective, that is, can be reliably determined from known attendant circumstances and thus need not be decided by a court exercising discretion. The criteria detail those circumstances which by their nature suggest the distinct possibility that the defendant is drug or alcohol dependent, thus warranting a professional diagnostic assessment to confirm or dispel that suspicion.

Subsection (b) requires the court to order a person to undergo a diagnostic assessment where the court has reason to believe that the person is drug or alcohol dependent or would otherwise benefit by undergoing the assessment. It should be noted that while this subsection depends upon a judicial finding (as opposed to the automatic criteria set forth in subsection (a)) the provisions of this subsection are nonetheless mandatory. Accordingly, a court would have no discretion to decline to order the person to submit to a diagnostic assessment where the court has been presented information from which it can reasonably conclude that the person is drug or alcohol dependent. Note that the provisions of this subsection have been left intentionally broad so as to allow the court to consider the widest possible range of circumstances or behavioral characteristics which might reasonably suggest the possibility of drug or alcohol abuse or addiction.

Subsection (c) ensures the earliest possible intervention, and is in accord with the legislative finding that in order for treatment to be as effective as possible, identification and intervention resources must be provided to substance abusing and addicted offenders at the earliest possible opportunity within the criminal justice

process. Diagnostic assessments and resultant treatment services should be provided as soon as possible following the arrest, and should continue throughout the adjudicative and dispositional process. Such assessment and treatment should not be delayed until after conviction or adjudication.

Subsection (e), which outlines one of the major features of this [Act], specifies the timing for a diagnostic assessment which occurs not prior to the disposition of criminal charges, but rather after a conviction and before the person is released from any custodial confinement which may have been ordered as part of the sentencing process. In addition to the goal of achieving the earliest possible intervention, this [Act] clearly sets forth the proposition that no person should be allowed to exit the criminal justice system unless any drug or alcohol problem has been identified and addressed.

Subsection (e) identifies the specific criteria which must be used to determine whether the inmate must submit to a new diagnostic assessment before receiving a grant of parole or other release from the correctional facility. The first three factors are objective, that is, can be determined reliably from the inmate's institutional record and do not involve any exercise of discretion or judgment by parole authorities. These objective, automatic criteria are as follows:

1) The person was at any time ordered to undergo a diagnostic assessment pursuant to this [Act]. Accordingly, any person ordered to undergo a diagnostic assessment while awaiting trial who is subsequently convicted and is sentenced to a term of imprisonment must undergo a second diagnostic assessment, which must occur prior to his or her release from confinement.

2) The person would have been statutorily required or ordered by a court to undergo an assessment pursuant to this [Act] had the [Act] been in effect at the time the person was arrested or indicted for the offense for which he or she is presently serving a term of incarceration. In essence, this feature ensures the retroactive application of the rehabilitative features of the [Act], and would require parole authorities to consider the objective circumstances set forth in subsection (a) which, had they been in effect, would have mandated the defendant to undergo a pre-trial diagnostic assessment.

3) The inmate has at any time during his or her term of confinement committed an institutional infraction or violation which involved the use or possession of a controlled substance or alcohol. This objective factor is established only where a violation or infraction has been substantiated in accordance with applicable due process requirements governing the prosecution and adjudication of institutional violations. However, even where the institutional infraction was not substantiated, the facts concerning an allegation of drug or alcohol possession or use in violation of institutional rules might still be considered by the parole board or other appropriate authority in the exercise of its discretion pursuant to subparagraph 4, discussed immediately below.

In addition to these three objective or automatic criteria, subsection (e) (4) also mandates a pre-release diagnostic assessment where the parole board or other appropriate authority has reason to believe that the inmate is drug or alcohol dependent within the meaning of this [Act] and would otherwise benefit from substance abuse or addiction treatment or related support services. This feature is similar to the provisions of subsection (b), except that in this instance, the factual determination is to be made by the appropriate parole authority, rather than by a sentencing court.

The language in this section is left intentionally broad to account for unforeseen factors or indications which might suggest the possibility of drug or alcohol abuse or addiction.

Subsection (f) specifies the timing for a pre-release assessment required pursuant to subsection (e). The term "or other release from the correctional facility," as used throughout this [Act], refers to any type of program which is essentially similar to parole, and would include but not be limited to an intensive supervision program, furlough, work release program, placement in a half-way house, or any other program which involves placing the inmate outside the walls of a correctional institution and back into the community. The purpose of this feature is to ensure that any substance abusing or addicted inmate will be diagnosed and provided adequate treatment and support services before being removed from the confines of a prison environment. Once released into the community, it will be far more difficult to prevent access to alcohol or illicit drugs. Drug testing can then only reveal drug use "after the fact."

Section 6. Providing Drug Test Results or Assessment.

(a) Unless otherwise ordered by the court, the drug test results and assessment of a person shall be provided as soon as practicable to the court, or [parole board or other appropriate authority] in the case of an inmate, the prosecutor, the person who submitted to the test or assessment, and to the extent applicable, to the assessment and treatment program.

(b) The assessment shall include recommendations concerning:

(1) the person's need for substance abuse or addiction treatment; and

(2) an appropriate and available course of treatment necessary to address the person's needs.

(c) Unless otherwise ordered by the court, anyone receiving test results or an assessment under subsection (a) shall keep that information confidential in accordance with the requirements of 42 U.S.C. §290dd-3.

COMMENT

Subsection (b) provides that all diagnostic assessments conducted pursuant to the recommendations concerning an appropriate and available course of treatment in subsection (b)(2) should not be limited to describing the type or modality of treatment, but should also specifically refer to treatment services that are available within the jurisdiction.

Section 7. Use of Drug Test Results or Assessment.

(a) Except as provided in subsection (c), results of a person's drug test required or ordered under this [Act] shall only be used to determine:

(1) whether the court shall order an assessment;

(2) appropriate conditions of pre-trial release or disposition of pending charges;

(3) the person's suitability for conditional discharge and the terms and conditions of such discharge;

(4) an appropriate sentence or disposition in the event of a conviction;

(5) appropriate conditions of parole or other release from a correctional facility; or

(6) an appropriate sanction for violation of a court-ordered term or condition of the person's participation in a treatment program imposed pursuant to Section 11 of this [Act] or any other law.

(b) Except as provided in subsection (c), an assessment shall only be used for purposes listed in subsection (a)(2)-(a)(6) and to provide background information about an inmate to any person or agency conducting a pre-release assessment pursuant to Section 5.

(c) Nothing in this [Act] shall be construed to preclude the state from using an assessment in a prosecution for contempt, or an assessment or drug test results in a prosecution for perjury.

(d) Any information learned by an assessment or treatment program, including positive drug tests, as a result of the performance of an assessment shall be kept confidential in accordance with the requirements of 42 U.S.C. §290dd-3.

COMMENT

In order for treatment and intervention services to be most effective, drug and alcohol abusing and addicted offenders must be assured that information provided during the course of treatment and counseling is kept confidential. Without such assurances, an offender in need of drug or alcohol treatment services might be discouraged from constructively engaging in the treatment process. See Section 2 (k).

Subsection (c) makes clear that nothing in the [Act] would preclude a prosecutor from using the results of a diagnostic assessment in a prosecution for contempt or perjury. Thus, for example, a defendant should not be permitted to take the witness stand at trial and deny ever having used drugs where the court is in possession of a reliable positive drug test or diagnostic assessment indicating that the defendant admits to drug abuse.

The provisions of this subsection are necessarily subject to the provisions of subsection (d), which confirms that all information derived from drug tests, assessments or participation in a treatment program is subject to the requirements of federal confidentiality laws. These laws impose strict limitations on when such information may be used in a criminal investigation or prosecution. Nothing in this [Act] should be construed to authorize the use of information in violation of these confidentiality laws, which, in any event, necessarily preempt and supersede state laws, rules and regulations.

Section 8. Court-Ordered Treatment.

(a) Except as provided in subsection (f), a court shall immediately order a person to participate in a treatment program if:

(1) the assessment program recommends that the person participate in the treatment program; and

(2) the court has reason to believe that participation in the recommended program will benefit the person by addressing his or her drug or alcohol dependency or other substance abuse needs.

(b) Where the court determines pursuant to subsection (a) that participation in the treatment program will not benefit the person notwithstanding a recommendation by the assessment program that the person participate in such treatment program, the court shall state the reasons for its determination on the record and shall provide notice of the decision and the reasons therefor to the [single state authority on alcohol and other drugs].

(c) The court shall designate a treatment program as defined by this [Act] to provide the recommended treatment to the person. However, nothing in this [Act] shall prevent a treatment program from refusing to accept a criminal justice referral under this [Act] if the program administrator deems the person to be inappropriate for admission to the program. Additionally, a treatment program shall retain the right to immediately discharge any individual who fails to comply with program rules and treatment expectations or who refuses to constructively engage in the treatment process.

(d) If a person is released prior to trial or on probation, or granted parole or other release from a correctional facility, participation in the treatment plan shall be a condition of the person's release, probation, or parole pursuant to Section 9.

(e) If a person is granted a conditional discharge pursuant to [state conditional discharge law], participation in the treatment plan shall be a condition of the person's discharge.

(f) Upon a finding of extraordinary and compelling reasons on the record, the court may refuse to order the person to participate in a treatment plan as recommended by the assessment program even though the court has reason to believe that such participation will benefit the person. The court shall provide a copy of the findings to the [single state authority on alcohol and other drugs].

COMMENT

This section establishes a mandatory treatment policy, requiring persons diagnosed to be drug or alcohol dependent to participate in some appropriate treatment program. It makes clear that once an offender has been diagnosed as suffering from drug or alcohol abuse or addiction, the court or appropriate dispositional authority is required, in the absence of special circumstances, to order the offender to participate in some appropriate treatment program.

The decision whether that treatment is to be provided in prison or elsewhere should be made by courts based not only upon traditional sentencing criteria, but also upon the professional diagnostic assessment of each offender and the specific recommendations of the assessment program. An addict in denial should be given few choices. If, for example, he or she is unwilling to accept treatment and rigorous monitoring instead of imprisonment, then the court should mandate treatment during a term of incarceration. Where the substance abusing or addicted offender refuses to engage in the treatment process during a term of incarceration, he or she should remain ineligible for parole or early release until there is satisfactory progress in the treatment program.

Under this comprehensive statutory scheme, the offender should not have the option of choosing "passive" or "idle" incarceration in lieu of the rigors of a meaningful treatment regimen. In this way, the [Act] is designed to use the criminal justice system constructively to motivate offenders to accept treatment and to engage in the treatment process.

Subsection (a) requires the court immediately to order the defendant to participate in treatment following the required findings and recommendations. This provision thus implements the legislative policy of providing the earliest possible intervention; the decision to require an offender to undergo some meaningful form of treatment should not wait for a final conviction or adjudication. Treatment services should be provided as soon as possible following the arrest, and should continue throughout the adjudicative and dispositional process.

Although this section provides unambiguously that the court must "immediately" order the person to participate in a treatment program, this provision would not necessarily be violated where the defendant is placed on a waiting list. It is the responsibility of the assessment program in accordance with the provisions of Sec-

tion 6 (b) (2) to make specific recommendations concerning an appropriate course of treatment which is "available." In addition, other provisions of this [Act] are designed to enable the [single state authority on alcohol and other drugs] to take steps to ensure that limited and scarce treatment resources are distributed equitably and in an appropriate, cost-beneficial manner. See, e.g, Section 16(c) and Section 17.

Subsection (a) essentially establishes a presumption whereby the court should ordinarily follow the recommendations of the assessment program with respect to whether the defendant is in need of substance abuse treatment and would benefit thereby. When the assessment program recommends that the person participate in treatment, it has essentially made an initial determination not only that the person is in need of treatment, but that he or she necessarily would benefit from participating in such a treatment program by addressing his or her drug or alcohol dependency.

The reporting requirement in subsection (b) is not intended to provide a basis for an appellate remedy. This feature is only intended to provide the [single state authority]with the flow of information to enable it to perform its critical oversight function with respect to the entire treatment services system. The [single state authority] should be kept apprised of such determinations on a system-wide basis so that it can determine how the [Act] is being implemented and how often persons who have been diagnosed by professionals to be in need of treatment are not receiving treatment as a result of judicial findings to the contrary.

Under subsection (c) the treatment program administrator may refuse admission to persons deemed inappropriate for admission to the program. Such decisions by the program administrator would not be subject to judicial review pursuant to this [Act].

Similarly, this subsection makes clear that the treatment program retains the right immediately to discharge any individual who fails to comply with program rules and treatment expectations or who refuses to constructively engage in the treatment process.

Subsection (f) establishes the limited circumstances where a court may decline to order a defendant to undergo treatment notwithstanding the assessment program's recommendation of treatment and the court's belief is satisfied that participation in the recommended treatment program would in fact benefit the person by addressing his or her drug or alcohol dependency or other substance abuse needs. Specifically, the court in those circumstances may only refuse to order the person to participate in treatment as recommended by the assessment program upon a finding on the record of extraordinary and compelling reasons. Although the court ultimately retains responsibility for imposing conditions of pre-trial release, probation, conditional discharge or sentence, it is expected that the court will give substantial weight to the professional recommendations of the assessment program.

Such extraordinary and compelling circumstances might exist where the defendant is facing capital punishment or a mandatory term of life imprisonment, and the court determines that it would be inappropriate to dedicate limited treatment resources to address such a defendant's needs, since it would be unlikely that he or she would ever be released back into the community.

As noted above, the [single state authority] would not be authorized under this [Act] to review or overrule the court's decision. However, it is ultimately the responsibility of the [single state authority]to monitor and oversee all determinations affecting the distribution and use of limited treatment resources.

Section 9. Conditions of Pre-Trial Release, Probation, or Parole or Other Release from a Correctional Facility.

(a) If a person is released on bail, bond, personal recognizance, or to the custody of any person or public or private agency pending trial or disposition of the pending charges, the person shall agree as a condition of release:

(1) to submit to an initial drug test as required by Section 4;

(2) to submit to subsequent random periodic drug tests to be performed by the [defendant management and monitoring agency];

(3) to undergo an assessment as required by Section 5 and to cooperate fully with the assessment program;

(4) to participate in a treatment program as required by Section 8 and to cooperate fully with the treatment program;

(5) to satisfactorily fulfill any other terms and conditions ordered by the court, including:

(A) periodic telephone contact or office visits to a designated person or agency;

(B) periodic unannounced visits by a designated person or agency to the person's home or place of commitment;

(C) a curfew or restricted travel and associations;

(D) electronic monitoring; or

(E) pre-trial work or school release;

(6) to cooperate fully with the [defendant management agency's] monitoring of the person's compliance with court imposed terms and conditions of release;

(7) to pay drug testing and assessment fees in accordance with .

(b) If a person ordered pursuant to Section 8 to undergo treatment is placed on probation following a conviction for the present offense, the person shall agree as a condition of probation to the terms set forth in paragraphs (a)(2)-(7).

(c) If an inmate who has been ordered pursuant to Section 8 to undergo treatment, or has been assessed to be in need of alcohol and other drug treatment pursuant to Section 5(e), is granted parole or other release from a correctional facility, the inmate shall agree as a condition of parole or other release to comply with the terms set forth in paragraphs (a)(2), and (a)(4) - (a)(7). For the purposes of this subsection, the functions of the [defendant management and monitoring agency] under subsection (a) shall be performed by the [appropriate parole monitoring agency].

(d) The person shall acknowledge as a condition of pre-trial release, probation, or parole or other release from a correctional facility, that failure to comply with the terms set forth in subsections (a), (b), or (c) may result in the court's modification of the conditions of pre-trial release or probation, or the [parole board's or other appropriate authority's] modification of parole or other release.

(e) Nothing in this [Act] shall preclude a person from petitioning the court to modify the person's conditions of pre-trial release or probation, or the [parole board or other appropriate authority] to modify the person's parole or other release from a correctional facility.

COMMENT

This section establishes certain basic terms and conditions which courts or other appropriate authorities must impose upon defendants who are subject to the mandatory treatment policy set forth in Section 8.

This section is intended only to establish minimum standards. Nothing in this [Act] would preclude the court or other appropriate authority from imposing such additional requirements or conditions as may be appropriate in the circumstances and as may be authorized by law. Many states already have laws or court rules concerning appropriate terms and conditions of pre-trial release, conditional discharge, probation or parole. This [Act] is intended to supplement but not necessarily to supplant any such other existing laws or rules.

Individuals who enter the criminal justice system who actively abuse or are addicted to a controlled substance or alcohol and who are not undergoing appropriate treatment and monitoring pose a proportionately greater and undue risk not only of criminal recidivism, but also of missed court appearances or flight. It is therefore appropriate that substance abuse assessment, treatment and monitoring services should be provided to persons who are awaiting trial on serious criminal charges. See Section 2(g). As noted throughout the [Act], in order for treatment to be as effective as possible, identification and intervention resources must be provided to substance abusing and addicted offenders at the earliest possible opportunity within the criminal justice process.

This section does not specify the sanctions which could or ought to be imposed upon a defendant who refuses to accept or consent to the conditions of pretrial release. See discussion of Section 9(d). State laws and procedures vary with respect to the authority of courts to compel specific performance. Nothing in this [Act] would preclude a finding of criminal or civil contempt, and, at a minimum, a defendant's unwillingness to comply with the statutorily required terms and conditions should be taken into account in determining the likelihood of flight, missed court appearances, potential for criminal recidivism and other factors relevant to the release decision and the fixing of an appropriate bail or bond.

Finally, with respect to defendants awaiting trial, it should be noted that the requirement for "immediate" treatment established pursuant to Section 8 would apply to persons who are, for any reason, detained while awaiting trial. In other words, this [Act] would generally require that some appropriate treatment and intervention services be provided to defendants found to be in need of such services pursuant to Section 8 who are unable to make bail or who are otherwise not released on bail, bond, recognizance or to the custody of another while awaiting trial or disposition of the pending charges.

Subsection (b) provides that persons ordered pursuant to Section 8 to undergo treatment who are placed on probation following a conviction must agree as a condition of probation to the terms set forth in paragraphs (a)(2-7). Where the defendant refuses to agree to such required minimum conditions of probation, it is expected that the court would revoke the probationary sentence and that the defendant would instead be sentenced to a term of incarceration or imprisonment. This feature is designed to provide powerful incentives to accept and engage in the treatment process. A defendant who refuses to accept and comply with these minimum terms of probation would be required to undergo and accept treatment prior to release from confinement pursuant to subsection (c).

Subsection (c) deals with convicted defendants who have been sentenced to a term of imprisonment and who are now facing the prospect of release from custodial confinement by means of parole or any similar release program. (See discussion of the phrase "or other release from the correctional facility" in the commentary to Section 5(f)) Subsection (c) makes clear that the inmate must agree as a condition of such release to accept the minimum requirements set forth in paragraphs (a) (2-7). Where an inmate refuses to accept any or all of these minimum required terms and conditions, the inmate would remain ineligible for release from custodial confinement before the expiration of his or her full term notwithstanding any other law governing parole, release, or the calculation of earned time, "good time," work or "commutation" credits.

The provisions of subsection (c) are designed to implement the policy that no drug or alcohol dependent person should be permitted to exit the criminal justice or correctional systems unless and until he or she has undergone an assessment and had his or her treatment needs identified. See also Section 5(e), which requires a pre-release diagnostic assessment of certain inmates. Note in this regard that where an assessment conducted pursuant to Section 5(e) reveals that the inmate is in need of drug or alcohol treatment, participation in a treatment program would become a statutorily required condition of parole or other form of release. In these circumstances, the parole authorities would not have the discretion to conclude that the inmate does not require some from of appropriate treatment or support services. However, the parole board would be authorized to determine which program the inmate would be required to participate in as a condition of parole or other form of release.

Subsection (e) confirms that this [Act] is not meant to limit the authority of the court or parole authorities to modify terms and conditions of pre-trial release, conditional discharge, probation or parole on petition of the defendant, the prosecutor, correction authorities, probation agencies, treatment programs or any other interested persons or organizations. However, the provisions of this subsection should not be construed to authorize a court or parole board to circumvent the provisions of this [Act] which mandate participation in an appropriate treatment program. This subsection not authorize a court or parole board to decline to order a defendant to participate in an appropriate treatment program, where such participation is required pursuant to the provisions of Section 8 or any other provision of this [Act].

Section 10. Report on Progress in Court-Ordered Treatment and Compliance with Court-Imposed Conditions.

(a) If a person has been ordered pursuant to Section 8 to participate in a treatment program, the designated treatment program shall report periodically to the [defendant management and monitoring agency] on the person's progress in the treatment program. The [defendant management and monitoring agency] shall periodically forward information about the person's progress and compliance with any court-imposed terms and conditions to the court.

(b) The designated treatment program shall promptly notify the [defendant management and monitoring agency] if the person:

(1) fails to comply with program rules and treatment expectations; or

(2) refuses to constructively engage in the treatment process; or

(3) terminates his or her participation in the treatment program.

Upon such notification, the [defendant management and monitoring agency] shall promptly report the person's actions to the court [or other appropriate authority].

COMMENT

Pursuant to Section 14, where a defendant has been ordered to participate in a residential, inpatient treatment program and he or she leaves the premises of the program facility without authorization, such act of absconding constitutes the criminal offense of "escape,"

and this especially serious violation must be promptly reported to appropriate authorities.

Section 11. Sanctions.

(a) Each agency responsible for monitoring and supervising a defendant's participation in a treatment program pursuant to this [Act] [or, where appropriate, the administrative office of the courts] shall in accordance with [state administrative procedures act] develop and publish a schedule of presumptive sanctions to be imposed upon violation of any court-ordered term or condition of the defendant's participation in the treatment program. The schedule of presumptive sanctions shall be designed to hold all defendants accountable for their actions and to ensure a proportionate, predictable and uniform response to all violations. The schedule shall account for the seriousness of the violation, the defendant's record of prior violations and his or her overall progress or lack of progress in the course of treatment, as determined by the treatment program's report. Authorized dispositions may include but need not be limited to imposing new terms and conditions of supervision; requiring a defendant to submit to more frequent drug tests or more intensive forms of monitoring or supervision; extending the term of supervision, temporarily suspending or permanently revoking a defendant's participation in the treatment program; or any other sanction or combination of sanctions as may be authorized by law.

(b) Every person ordered pursuant to Section 8 to participate in a treatment program shall be provided a copy of the published schedule of presumptive sanctions promulgated pursuant to subsection (a) of this section, and shall acknowledge in the writing the receipt thereof.

(c) Upon a positive drug test or any other significant violation of any term or condition of a defendant's participation in a treatment program ordered pursuant to this [Act], the court [or other appropriate authority] shall immediately impose such sanction or combination of sanctions as are prescribed in the appropriate schedule developed pursuant to subsection (a) of this section, unless the court [or other appropriate authority] is clearly convinced that the presumptive sanction is inappropriate in the circumstances and that the need to depart from the presumptive sanction clearly overrides the need to deter the defendant and others from committing future violations. Notwithstanding the foregoing or any other provision of law, in the absence of compelling and extraordinary circumstances, the court [or other appropriate authority] shall not impose a lesser sanction or sanctions than that prescribed in the appropriate schedule except upon the recommendation of the treatment program. Where the court [or other appropriate authority] elects not to impose a presumptive sanction, the court [or appropriate authority] shall make a written finding setting forth the reasons for its decision, and a copy of such written finding shall be provided to the [single state authority on alcohol and other drugs].

COMMENT

This section prescribes the appropriate sanctions to be imposed upon a violation of any terms or conditions of a defendant's participation in a treatment program. For the criminal justice system to maintain credibility, all drug abusing and addicted offenders must be held accountable for their past and future actions. The failure to hold these persons fully accountable would be tantamount to "enabling," that is, the failure to take appropriate actions to discourage and condemn continued substance abuse.

Individuals ordered to undergo alcohol and other drug abuse treatment must be subject to careful monitoring, which should include but not be limited to periodic drug testing. These defendants must also be subject to realistic, escalating sanctions which would be imposed in the event of a substantiated violation of any term or condition of the treatment program. The consequences for violations should be both realistic and predictable, so as to deter such violations to the greatest extent possible.

This section does not discuss the specific procedures for prosecuting or adjudicating violations, or for ensuring due process. It is assumed that such enforcement actions would be conducted in accordance with established state laws and procedures governing pre-trial release, probation and parole revocation proceedings.

Subsection (a) authorizes appropriate judicial or administrative agencies to develop and publish a schedule of "presumptive" sanctions to be imposed upon a finding of a violation. Most if not all states have in place laws or "guidelines" which limit sentencing discretion and provide guidance to sentencing courts with respect to whether to impose a term of incarceration as opposed to a probationary or non-custodial sanction and with respect to the length of any custodial or probationary term. Many jurisdictions also prescribe certain bare minimum conditions of probation, such as a require-

ment that the offender refrain from committing any new crime and that he or she periodically report to some [defendant management and monitoring agency]. Few states, however, have in place laws or entities akin to sentencing commissions to establish guidelines concerning the appropriate sanctions to impose upon a given violation of probation or parole. The benefits of predictability, uniformity and consistency apply not only to initial sentencing proceedings, but also to parole or probation violation hearings.

The schedule of presumptive sanctions should be designed to hold all defendants accountable and to ensure a proportionate, predictable and uniform response to all violations. The schedule of presumptive sanctions must account for the seriousness of the violation, the defendant's record of prior violations and his or her overall progress or lack of progress in the course of treatment, as determined by the treatment program's report. State judicial or administrative authorities should develop such a schedule according to local needs and resources. Also pursuant to Section 17(b), the [single state authority on alcohol and other drugs] should assist in the development and refinement of the schedule of presumptive sanctions.

Subsection (a) lists a number of authorized dispositions in the event of a finding of a violation, ranging from requiring the defendant to undergo more intensive monitoring to revocation of probation or parole and placement of the offender in prison. This list of authorized dispositions is not exhaustive and is not intended to limit the range of sanctions or options which might be available to courts or parole authorities under state law.

This subsection provides that the court or other appropriate authority enforcing the violation should defer to the determination of the treatment program with respect to the degree to which the defendant has satisfactorily engaged in the treatment process and has made progress in the course of treatment. In order for defendants to take drug treatment programs seriously, they must understand that the recommendations of treatment programs will strongly influence the decisions made by courts, parole authorities and [defendant management and monitoring agencies], and these agencies in turn will support treatment programs in holding defendants accountable.

Subsection (b) requires that all defendants ordered to undergo treatment pursuant to this [Act] must receive a copy of the schedule of presumptive sanctions. See also discussion of Section 9(d). This feature is designed to promote the specific deterrence of persons ordered to undergo treatment. One of the principal objectives in developing a schedule of presumptive sanctions is to ensure predictability to encourage compliance to the greatest extent possible. Persons ordered to undergo treatment pursuant to this [Act] are admonished that they will be held accountable, and are entitled to know what will happen to them if they violate the terms and conditions of their participation in the treatment program.

Subsection (c) establishes the general rules that upon a finding of a violation, such as a positive urine test, the court must immediately impose the sanction (or combination of sanctions) as are prescribed in the schedule developed pursuant to subsection (a), unless the court is clearly convinced that the imposition of such sanction or sanctions would be inappropriate in the circumstances. The schedule developed pursuant to subsection (a) thus prescribes a "presumptive" sanction which the court or appropriate parole authority should ordinarily impose in the absence of special aggravating or mitigating circumstances not otherwise accounted for in the schedule.

It should be noted that the section expressly provides that the sanction be imposed "immediately" upon a finding of the violation. If the court or other appropriate authority were to suspend imposition or execution of the sanction, or otherwise hold the proceedings in abeyance, such decision would effectively constitute a "lesser sanction" than that prescribed in the schedule. Any such departure must be justified in accordance with the legal standards set forth in this section and discussed immediately below.

A departure from the schedule of presumptive sanctions would only be authorized where the court is clearly convinced not only that the prescribed sanction is inappropriate, but also that the need to depart from the schedule of presumptive sanctions "clearly overrides the need to deter the defendant and others from committing future violations." This feature recognizes that the strict enforcement of the published schedule serves a vital systemic function, that is, to further the goal often referred to in the context of substantive criminal law as "general deterrence." Under this approach, the court or appropriate parole authority must consider the effect of the departure from the published schedule not only on the defendant at bar, but also on all other persons who have been ordered into treatment and who might view a more liberal departure policy as some form of license to violate the terms and conditions of participation in the treatment program.

To emphasize this point, this subsection provides that where the court intends to make what is in essence a "downward" departure from the schedule of presumptive sanctions (i.e., to impose a lesser sanction than that prescribed in the schedule), the court must also find the existence of compelling and extraordinary circumstances "except upon the recommendation of the treatment program." It is expected that any such finding of extraordinary and compelling circumstances would only rarely be made.

If the treatment program does recommend a "lesser sanction" than the one prescribed in the published schedule of presumptive sanctions, the court or appropriate parole authority will still be required to find that the presumptive sanction is both inappropriate in the circumstances and that the need to depart from the presumptive sanction clearly overrides the need to deter the defendant and others from committing future violations. While this represents a substantial burden, it is nonetheless a far lesser standard than the finding of "compelling and extraordinary circumstances" which the court would be required to make in the absence of the affirmative recommendation of the treatment program to impose any such lesser sanction.

This section is silent with respect to the right of a prosecutor to appeal the imposition of a lesser sanction. It is thought that such matters are best left to existing state law and procedures.

Section 12. Drug Testing or Assessment Fees.

(a) Except as provided in subsection (c), the court, or the [parole board or other appropriate authority] in the case of an inmate, shall impose upon a person reasonable fees to cover the cost of:

(1) any drug test of the person required or ordered under this [Act]; and

(2) any assessment of the person required or ordered under this [Act].

The fees shall not be less than the administrative costs of a drug test or assessment and shall not exceed [ ]. The fees may be deducted from any income an inmate has received as a result of labor performed at the correctional institution or any type of work release program.

(b) Upon a finding of indigence, the court, or the [parole board or other appropriate authority] in the case of an inmate, shall require the person to pay as much of the fee as is consistent with the person's ability to pay.

(c) The person shall not be required to pay any fee if:

(1) the drug test results are negative for the presence or use of alcohol or a controlled substance;

(2) the person is acquitted of the present charge or charges; or

(3) the present charge or charges are dismissed for any reason other than the granting of a conditional discharge.

(d) All fees collected pursuant to (a)(1) shall be forwarded to the [defendant management and monitoring agency] for payment of costs associated with the agency's pretrial drug testing program.

(e) All fees collected pursuant to (a)(2) shall be forwarded to the assessment program for payment of costs associated with the provision of assessments.

COMMENT

This [Act] generally does not detail the procedures for collecting the fees ordered to be assessed pursuant to the section. Rather, such procedures and available remedies in the event of a failure to pay are left to existing laws and rules governing the collection of fines, fees and penalties in criminal actions.

Section 13. Credit for Time Served in Residential Treatment.

A person ordered by a court pursuant to this [Act] to participate in substance abuse treatment on a residential, inpatient basis while awaiting trial or other disposition of pending charges shall be entitled to credit for time served for each day during which he or she has been committed to such residential treatment, provided that the person has made satisfactory progress in the substance abuse treatment program as determined by the treatment program's report. No such credit shall be earned except upon the recommendation of the treatment program, certifying that the person has satisfactorily complied with court-imposed terms and conditions and that he or she has satisfactorily engaged the treatment process.

COMMENT

The right to "credit for time served" would only apply in the case of a person who has been committed pursuant to this [Act] to a residential, inpatient drug rehabilitation program, that is, one where the person is not free to

leave the residential facility or grounds without specific permission or authorization. See also Section 14 concerning the applicability of the criminal offense of escape. The person need not be placed in a government owned or operated facility. A person may be entitled to credit for time served pursuant to this section where he or she has been placed in a privately owned or operated drug rehabilitation program or facility which has, for example, entered into a contract with an appropriate criminal justice agency to provide residential treatment services to persons referred pursuant to this [Act].

This provision represents an important innovation — the concept of contingent credit, that is, credit subject to a condition. This feature provides a powerful, tangible incentive for defendants who are awaiting trial to cooperate with and engage in the treatment process, thus advancing the goal of providing meaningful treatment incentives and opportunities at the earliest possible point in the criminal justice process. Compare Section 15, which also rewards defendants who make satisfactory pretrial progress in treatment by establishing an express mitigating factor to be considered at the sentencing proceeding.

The [Act] is silent with regard to the right of a defendant to challenge in court the determination by the treatment program that he or she has not satisfactorily engaged the treatment process. Nor does the [Act] set out the standard by which the court would review any such determination made by the treatment program. As noted in the discussion of Section 11, the specific procedures for adjudicating alleged violations and for providing due process of law are left to other statutes and court rules of general applicability.

All determinations and recommendations by the licensed treatment program should be made by reference to clinical therapeutic standards and criteria accepted within the profession or expressly designated or adopted by the [single state authority on alcohol and other drugs]. See Section 18. Furthermore, it is intended that very wide latitude would be granted in the administration of such a program and that recommendations by the program concerning whether the defendant has engaged the treatment process are presumed to be reasonable and soundly based.

In many jurisdictions, other statutes or court rules determine whether a defendant is entitled to credit for time served where he or she has been placed in a state operated hospital or other medical facility while awaiting trial. This section is designed to supersede any other less specific state statute or rule.

In most jurisdictions, the determination of earned credits is made by reference to statute and does not involve a constitutional question. In some jurisdictions, however, a question may arise under the state constitution whether a person who has been confined to a residential treatment facility may be denied or, in this case, "divested" of credit for time served. The resolution of this issue may depend upon whether the person was "confined" or was in "official detention," as opposed to being placed in a medical or therapeutic facility in lieu of detention. Pursuant to Section 14, a defendant who has been ordered to participate in a residential, inpatient drug treatment program is deemed to be subject to "official detention" for the purposes of prosecution for the crime of escape. This provision is designed to deter defendants from unilaterally disengaging the treatment process. It is not intended to equate residential treatment with traditional confinement or detention for all purposes.

Finally, with respect to any constitutional question, the effect of this provision is to re-affirm that the defendant has an affirmative duty to comply with the court order to engage in the treatment process. The defendant must truly earn credit for time served by complying with the court order, which in this context is not achieved merely by the fact that the defendant has not "escaped." (It goes without saying that under the laws in every jurisdiction, a defendant would not be entitled to credit for "time served" during any period during which he or she has absconded from custody). Rather, the defendant must also actively engage in the treatment process.

Section 14. Escape from Residential Treatment Facility.

A person placed into a residential treatment facility or program pursuant to this [Act] shall be deemed to be subject to official detention for the purposes of a criminal prosecution for violation of [criminal law defining the crime of escape].

COMMENT

This section is designed not only to ensure public protection, but also to underscore the point that a defendant must at all times comply with the terms and conditions ordered by the court, as well as the rules and regulations established by the treatment program, including rules and regulations which would prohibit the person from leaving the grounds of the facility without proper prior authorization.

The phrase "official detention" is taken from the Model Penal Code definition of the crime of escape. Jurisdictions which do not follow the Model Penal Code formulation should revise this section to account for the exact language used in the state law definition of the crime of escape, absconding or similar offense.

It is not necessary under this section that the residential treatment facility be owned or operated by the government. This section would thus also include unauthorized absconding from a privately run or operated facility, provided that the defendant had been ordered to undergo residential, in-patient treatment in that facility pursuant to this [Act].

Nothing in this section is intended to preclude prosecution for criminal or civil contempt or a proceeding for a violation of a term or condition of pre-trial release, probation, conditional discharge or parole. This section is designed to enlarge, not to limit, prosecutorial and enforcement options in the event that a defendant ordered into residential treatment pursuant to this [Act] leaves the facility or grounds without prior authorization.

If the treatment program in its discretion pursuant to Section 8(c) expels or discharges a defendant, such defendant would not be guilty of the crime of escape. However, in that event, it would be the responsibility of the treatment program promptly to notify the [defendant management and monitoring agency], court or other appropriate authority regarding its decision to expel or discharge the defendant.

Section 15. Satisfactory Progress in Treatment as Mitigating Factor.

A person's satisfactory progress in a substance abuse treatment program as determined by the treatment program's report shall be considered a mitigating factor and evidence of the person's amenability to treatment for purposes of sentencing, terms and conditions of probation, or parole or other release from a correctional facility.

COMMENT

This [Act] prescribes an effective combination of rewards and punishments to motivate defendants to overcome denial and to participate fully in treatment. Compare Section 13, which authorizes credit for time served in residential treatment while awaiting trial dependent upon the defendant's satisfactory participation in the treatment program.

In most jurisdictions, penal statutes or sentencing codes list the aggravating and mitigating factors which a court may consider in imposing an appropriate sentence upon conviction. This section is designed to supplement existing sentencing law, and establishes the policy that a defendant's progress in treatment is a mitigating circumstance and persuasive evidence that the defendant can continue to make progress in court-ordered treatment imposed as part of the sentencing process.

This section is not intended to preempt or supersede laws which otherwise govern the sentencing process or which prescribe a given sentencing outcome. Thus, this section is not intended to create an exemption to any mandatory minimum term which may be required to be imposed by law.

It is the responsibility and authority of the treatment program in its report to determine whether and to what extent the defendant has made "satisfactory progress" in treatment. This feature is designed to enhance the credibility and authority of drug treatment programs by making certain that defendants understand that the recommendations of treatment programs will strongly influence the decisions to be made by the court.

Ultimately, however, the sentencing court must determine the weight to be accorded this mitigating factor in balancing the aggravating and mitigating circumstances within the statutory sentencing scheme.

Nothing in this section should be construed to preclude the court from considering other pieces of information or evidence concerning the defendant's participation in the treatment program in addition to the report and conclusions of the treatment program. Thus, the court would be permitted to consider any record of infractions, violations and sanctions imposed upon the defendant during his or her participation in the treatment program.

Section 16. Reporting and Implementation.

(a) Every substance abuse diagnostic assessment program, treatment program, court, pretrial services agency, probation department, correctional facility and parole agency which provides services pursuant to this [Act] or which otherwise supervises or issues an order pursuant to this [Act] shall keep such case-specific records and aggregate data and statistics as may be required by the [single state authority on alcohol and other drugs], and shall provide to such agency on a

monthly basis a report of activities and required information on forms to be developed and prescribed by the [single state authority on alcohol and other drugs].

The [single state authority on alcohol and other drugs], in conjunction with corrections officials and addiction treatment programs, shall identify data to be collected, mechanisms for data collection, and funding sources to support data collection.

(b) The [single state authority on alcohol and other drugs, or other appropriate agency(ies)] shall report on an annual basis to the legislature and to the governor its findings concerning the need for and implementation of the various provisions of this [Act], which report shall include a synopsis of such information or data necessary to determine the impact, utility and cost-benefits of the provisions of this [Act].

(c) The [single state authority on alcohol and other drugs] shall establish an advisory board which shall be comprised of judges, prosecutors, defense attorneys, probation officials, parole officials, correctional officials, substance abuse diagnostic assessment programs, substance abuse treatment programs and individuals working in licensed alcohol and other drug treatment facilities who are past consumers of treatment services. The advisory board shall meet periodically to discuss the provisions, implementation, and evaluation of this [Act] and to make recommendations to the [single state authority on alcohol and other drugs].

(d) Within two years of the adoption of this [Act], the [single state authority on alcohol and other drugs] shall convene a conference of judges, prosecutors, defense attorneys, probation officials, parole officials, correctional officials, substance abuse diagnostic assessment programs and treatment programs, and individuals working in alcohol and other drug treatment facilities who are past consumers of treatment services, concerning the implementation and evaluation of this [Act]. The conference shall make recommendations to the legislature and to the governor concerning ways to improve and enhance the provisions and implementation of this [Act] and the availability and quality of services, remedies and sanctions for substance abusing offenders. Nothing herein shall be construed in any way to prevent or preclude the [single state authority on alcohol and other drugs] or any other public or private agency from at any time convening a meeting, conference seminar or training session concerning any provision of this [Act] or its implementation or evaluation.

(e) All data, information or records kept or compiled pursuant to this section shall be deemed to be public records for the purposes of [insert citation to appropriate public information or right-to-know law], provided however that any record, document or information which identifies a specific defendant or juvenile shall be kept confidential in accordance with the provisions of 42 U.S.C. §290dd-3 and shall not be disclosed except as may be authorized by law.

COMMENT

The provisions of this [Act] are designed to make certain not only that individual offenders are carefully monitored and held fully accountable for their actions, but also to ensure that treatment programs and [defendant management and monitoring agencies] are held accountable and are subject to rigorous empirical evaluation. Such objective monitoring and evaluation is necessary to maintain the credibility of the entire system and to educate the public that treatment works with respect to the offender population. Such thorough evaluations, however, are not possible unless treatment programs and defendant management and monitoring agencies are required to maintain accurate data and statistics.

Accordingly, this section carefully defines the responsibilities of diagnostic assessment programs, treatment programs, courts, pre-trial services agencies, probation departments, correctional facilities and parole agencies to maintain appropriate records and statistics.

It is thought that it would inappropriate for model legislation to list specifically all of the types of data and statistics which should be kept in order to ensure an appropriate evaluation and monitoring of the implementation of this [Act]. Accordingly, the [single state authority]for Drug and Alcohol Abuse or other appropriate designated agency is authorized and required to identify the specific types of information and data which must be kept and transmitted to the [single state authority]or other appropriate authority. See Section 18.

In developing an appropriate research methodology, it is imperative that evaluators use sufficiently sophisticated and sensitive measures of short and long term impact, such as the number of substance-free and crime-free days while under supervision, relative decreases in the amount of substances abused, the relative time to re-arrest, the number of days engaged in gainful employment, vocational or educational programs, and other information concerning the long-term effect of court-ordered interventions. See Section 2(l). Ultimate-

ly, it is the responsibility of the [single state authority]to compile and study data and statistics so as to ensure the most appropriate use of the limited diagnostic assessment and treatment resources available throughout the state.

The purpose of the conference in subsection (d) would be to make recommendations to the legislature and to the governor concerning ways to improve and enhance the provisions and implementations of the [Act] and to enhance the availability and quality of the services, remedies and sanctions for dealing with substance abusing offenders. See also proposed community mobilization legislation concerning the need to enlist community support and to provide opportunities for a wide range of interests and constituencies to provide information and advice to the [single state authority on alcohol and other drugs] or other appropriate coordinating agencies.

Subsection (e) ensures that public monies spent on substance abuse diagnostic and treatment programs are well spent and that all programs are carefully and objectively evaluated. This subsection makes clear, however, that any record, document or information which identifies a specific defendant or juvenile must be kept confidential in accordance with the provisions of applicable federal confidentiality laws.

Section 17. Training for Criminal Justice and Juvenile Justice Professionals.

(a) The [single state authority on alcohol and other drugs] shall establish and maintain, in cooperation with the attorney general, local prosecutors, municipal and county police, state police, sheriffs, the courts, the department of corrections, the state bar association, licensed substance abuse diagnostic programs, licensed treatment programs, individuals working in alcohol and other drug treatment facilities who are past consumers of treatment services, and other appropriate public and private agencies, a program for the education of police officers, prosecuting agencies, court personnel, judges, probation and parole officers, public and private attorneys who represent adults and juveniles charged with crimes, correctional personnel, and other law enforcement personnel, with respect to the causes, effects, indications, treatment and monitoring of drug use, drug dependency and alcoholism. The program of education shall identify the different methods and modalities for assessing and treating drug and alcohol abuse, for identifying court-involved juveniles and adults who are alcohol or drug abusers, and shall also discuss those public and private resources and programs which are available within the state. The program of education shall stress the need for prompt assessment, early intervention and referrals for substance abuse and addiction diagnosis.

(b) The [single state authority on alcohol and other drugs] shall serve in a consulting capacity to such public and private agencies as described in subsection (a) and shall foster and coordinate a full range of services and programs which will be available for assessment, treatment and monitoring of drug and alcohol abuse and dependency. The [single state authority on alcohol and other drugs] shall assist such public and private agencies in developing rules, regulations, directives, guidelines, policies, programs or procedures for implementing and enforcing the provisions of this [Act] and for achieving the benefits, goals and objectives set forth herein.

COMMENT

In many jurisdictions, the individuals working in the criminal justice system complain, usually with justification, that there are inadequate resources dedicated to provide substance abuse diagnostic, intervention and treatment services. These individuals may not be aware of all that they can do to take full advantage of those limited resources which do exist. Accordingly, this section establishes a training program for courts, probation and parole departments, prosecutors, defense attorneys and others working within the traditional criminal justice system so that these individuals have at least a rudimentary understanding of the different methods and modalities for assessing and treating alcohol and other drug abuse and so that they will be able to take full advantage of those public and private resources and programs which are available within the jurisdiction.

This section sets forth the legislative policy that courts, prosecutors, police departments, probation and parole agencies and correctional agencies should cooperate and consult with the [single state authority] with respect to the development, revision and implementation of all policies, procedures, rules and regulations which relate to providing substance abuse diagnosis, intervention and treatment services.

Section 18. Rules and Regulations.

The [single state authority on alcohol and other drugs, and other appropriate agency (ies)] shall within 120 days

of the adoption of this [Act] promulgate in accordance with [state administrative procedures act] such rules and regulations, and shall develop and periodically review and revise such guidelines, directives, standards and protocols, and shall take such other actions as are necessary and appropriate to implement the provisions of this [Act].

Section 19. Licensure and Standards.

All programs providing alcohol and other drug treatment or diagnostic assessment services pursuant to any provision of this [Act] shall:

(a) be licensed by the [single state authority on alcohol and other drugs]; and

(b) be designated by the [single state authority on alcohol and other drugs] as having special skills in providing treatment and assessment services to persons involved in or referred from the criminal or juvenile justice systems.

The [single state authority on alcohol and other drugs] is further directed to develop program standards to ensure the provision of the full continuum of care for persons ordered to undergo treatment pursuant to this [Act]. Such standards shall address but not be limited to the following: defining the continuum of care; matching persons to appropriate treatment programs and facilities including voluntary and involuntary referals and the use of minimum security facilities; recruiting and hiring practices representative of the population to be treated including individuals in recovery from alcohol and other drug abuse and addiction; and addressing issues of conflict of interest.

COMMENT

This section is somewhat more specific than the provisions of Section 18, which in general terms authorizes the [single state authority]and other appropriate agencies to promulgate rules and regulations and to develop and periodically review and revise guidelines, directives, standards and protocols which may be necessary and appropriate to implement the provisions of this [Act].

Section 20. Funding Sources.

(a) In order to support and augment the diagnostic assessment and treatment services provided pursuant to this [Act], the [single state authority on alcohol and other drugs] shall aggressively pursue all federal funding and matching funds available through Medicaid, the Early and Periodic Screening, Diagnosis, and Treatment Services program, SSI, and other federal sources and programs. In addition, the [single state authority on alcohol and other drugs] shall pursue all available federal matching funds through Medicaid for non-hospital residential alcohol and other drug treatment services from the Health Care Financing Administration (HCFA).

(b) Where the person to whom alcohol and other drug diagnostic assessment or treatment services are provided pursuant to this [Act] is a member of a health maintenance organization or is otherwise covered by any contract or program for health insurance, every reasonable effort shall be made to ensure that the cost of diagnostic assessment and treatment services are defrayed by the health maintenance organization or insurer. Notwithstanding any other provision of law, where the health maintenance organization, insurer or managed care contractor disputes the treatment recommendation accepted by the court [or other appropriate authority] pursuant to this [Act], such recommendation shall prevail and shall be deemed to be reasonable and appropriate.

COMMENT

This section is designed to ensure that all possible funding sources are made available to support the alcohol and other drug diagnostic and treatment services to be provided pursuant to this [Act].

Section 21. Immunity from Liability.

(a) Any licensed alcohol and other drug diagnostic assessment program and treatment program which, in good faith, provides services pursuant to this [Act] shall not be liable in any civil action for damages as a result of any acts or omissions in providing such services, provided the skill and care given is that ordinarily required and exercised by others in the profession. The grant of immunity provided for in this subsection shall also extend to all employees and administrative personnel of the licensed program.

(b) Any qualified person who withdraws or otherwise obtains, in a medically accepted manner, a specimen of breath, blood, urine, or other bodily substance pursuant to any provision of this [Act] shall not be liable in any civil action for damages for so acting, provided the skill and care exercised is that ordinarily required and exercised by similar programs or others in the profession.

Section 22. Statutory Construction.

The provisions of this [Act] shall be liberally construed to effectuate its remedial and rehabilitative purposes.

COMMENT

This section makes clear that the provisions of this [Act] are to be liberally construed to effectuate the [Act]'s remedial and rehabilitative purposes. In identifying those purposes, courts and administrative agencies should review the declaration of legislative findings and policy set forth in Section 2.

Section 23. Severability.

If any provision of this [Act] or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 24. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date] document

Appendix G

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Caregiver's Assistance Policy Statement

The most innocent and tragic victims of America's alcohol and other drug crisis are its children. Children are victimized by drugs in many ways; one common scenario is repeated abandonments by addicted parents. Often, a child's father is absent altogether, while the mother may disappear periodically or provide inadequate care due to drug or alcohol binges.

Neighbors, friends, and extended family have reached out to these abandoned children, providing shelter, food, and other forms of parental support that children need, until the child's parent returns. These same individuals also take care of the children when the addicted parent leaves to seek treatment.

This response often creates a significant strain on the benefactors, who may be as financially troubled as the family they are helping. Under present law, these caregivers often receive inadequate financial support to offset the expenses of taking care of these children. Aid to Families with Dependent Children (AFDC), while available to relatives, may be inadequate to meet the sometimes extreme special needs of the children, as well as to prepare the home for the unexpected new members. While foster care resources technically may be available, the formalized requirements the foster care system places on its providers are inappropriate to these much more informal and fluid circumstances. The family next door may be willing to take care of the children for a few days or weeks until their parent returns. They generally will not be able, and cannot be expected, for example, to remodel their house or make other extensive changes to meet foster care system requirements.

The Commission recommends that legislation be formulated and adopted to provide appropriate financial and other assistance to caregivers in these instances. The Commission recommends that such legislation also contain the following features:

- The assistance must be expeditious.
- The terms and conditions of the assistance must balance the need to avoid additional burdens for the caregivers with the need to ensure that the care given meets standards acceptable to society.
- The legislation must take into account federal law, which does not permit AFDC and other assistance drawn from federal funds to follow the child under the circumstances envisioned here.
- There must be protection against fraud. A sufficient level of monitoring is needed to avoid the exploitation of children for financial gain. Again, it is critical that this not be burdensome for neighbors providing care for a few days.

- The unintended impact of caregivers' assistance on the nuclear family must be carefully considered. For example, care must be taken not to create a financial disincentive against parent/child reunification. In the words of a leading child welfare legal expert: "The welfare laws of the 1960's have been criticized as having helped push fathers away from their families. We must be sure not to drive mothers away too."

The Commission has attempted to draft legislation to implement its general policy recommendation, but upon closer examination has concluded that its initial attempts inadequately address the complex range of child welfare issues implicated by this problem. Due to this complexity, combined with the short time-frame and the ambitious scope of the rest of the Commission's task, the Commission does not present draft legislation in this area. Rather, it calls upon the nation's leading child welfare legal experts to convene as soon as possible to draft model legislation to address this widespread and pressing problem.

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Witnesses

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Graduates of Gandenzia, Inc. directed by Mike Harle, and of Abraxas Inc. The Commission expreses deep gratitude to these individuals for sharing their personal stories so the Commission could better understand addictions and the recovery process.

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American Methadone Treatment Association

American Society of Addiction Medicine

Employee Assistance Professionals Association

Legal Action Center

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National Association of Adult Children of Alcoholics

National Association of Attorneys General

National Association of Counties

National Association of Drug and Alcohol Abuse Directors

National Black Caucus of State Legislators

National Certification Reciprocity Consortium/ Alcohol and Other Drugs

National Coalition of State Alcohol and Drug Treatment and Prevention Associations

National Conference of State Legislatures

National Consortium of TASC Programs

National Council on Alcoholism and Drug Dependence

National Governors Association

National Highway Association

Office of National Drug Control Policy

Office of Treatment Improvement

President's Advisory Council

Society of Americans for Recovery

Therapeutic Communities of America

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RAMONA L. BARNES, of Alaska. Speaker Barnes is Speaker of the Alaska State House of Representatives. She has served as a Member of the Alaska State House of Representatives since 1979. She has served as Chairman of the Alaska House Judiciary Committee, as a member of the Corrections Finance Sub-Committee, and as Chairman of the Legislative Committee. Ms. Barnes is also a member of the Governor's Task Force on State-Federal Tribal Relations, the Citizen's Advisory Commission on Alaska Lands, the Alaska Representative State's Rights Coordinating Council, and the Alaska Delegate Council of State Governments.

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