United States Sentencing Commission
Regional Hearings on the Twenty-Fifth Anniversary of the Passage of the Sentencing Reform Act of 1984
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Thank you very much for the invitation to testify at today's hearing marking the 25th anniversary of the passage of the Sentencing Reform Act of 1984. I am not an expert on the sentencing guidelines, but I do know that drug crime is a major concern of the U.S. Sentencing Commission. Since I have worked in the field of alcohol and drug problems for 35 years, I welcome this opportunity to speak with you. My involvement began as a social worker in a detoxification center, halfway house, and outpatient chemical dependency treatment program, and since that time, I have devoted much of my work to education and research about substance use, abuse, and dependence and better ways to address these problems.

Though alcohol remains the primary drug of abuse and dependence in the United States, illicit drug abuse and dependence also pose serious problems for millions of Americans, and substantial numbers of people have both alcohol and drug disorders (Office of Applied Studies, 2009). Unfortunately, at least as far back as the Harrison Act of 1914, U.S. laws have been conflating drug addiction and drug crime, creating an underclass of people who, because they have a drug addiction (or in the terminology of the American Psychiatric Association [2000], are dependent on drugs), are labeled criminals and often become mired in the criminal justice system. The U.S. Congress, state legislatures, the criminal justice system, and groups like the U.S. Sentencing Commission can do much to untangle these problems and return drug abuse and dependence to the category of public health problems that are best addressed by health, substance abuse, and mental health professionals.

I have grouped my remarks today under four headings that represent action steps to address drug problems and their intersection with crime and that I am sure will be familiar to you: (1) treat offenders in prison and upon release using evidence-based practices; (2) divert as many individuals with drug problems as possible from prison into treatment and other needed services; (3) end discrimination against people with drug problems, including drug offenders, both during and after their involvement with the criminal justice system; and (4) increase community-based treatment and social welfare services as a means of reducing drug use and drug-related crime.

Treat Drug Offenders in Prison and Upon Release

Reports from the Bureau of Justice Statistics and other sources paint a picture of the pervasive drug involvement of those involved in the criminal justice system. For example, in 2004, 46% of those in federal prison for drug possession and 59% for drug trafficking had used a drug in the month before their offense, and 21% and 34%, respectively, were using at the time of the crime (Mumola & Karberg, 2007). Most drug offenders in federal prison are incarcerated for trafficking (including intent to distribute), and the figures I just cited indicate that a higher percentage of those convicted of trafficking rather than possession were recent drug users. In addition, 18% of all federal inmates and one-quarter of those imprisoned for drug offenses said they committed the offense to get money for drugs. More important for my remarks today, of all federal prisoners regardless of their offense, 64% were regular drug users (up from 57% in 1997), and 45% met the criteria for drug abuse or dependence, with the majority (29%) meeting the criteria for the more serious diagnosis of dependence. These figures are particularly astonishing given that the Substance Abuse and Mental Health Services Administration reports that less than 3 percent of Americans aged 12 and older met the criteria for drug abuse or dependence in 2008 (Office of Applied Studies, 2009).

Clearly, the federal criminal justice system is dealing with substantial numbers of people convicted of drug crimes or other crimes who abuse or are dependent on drugs. Two primary reasons that drug abuse and dependence are critical issues for the federal justice system are that (1) federal inmates who meet the criteria for drug abuse or dependence are substantially more likely to have a prior criminal history (75%) than other federal inmates (57%) (Mumola & Karberg, 2007), and (2) offenders who do not receive appropriate treatment are more likely to reoffend (see, for example, National Institute on Drug Abuse, 2007).

Virtually all federal prisons report providing some type of substance abuse services to inmates (Office of Applied Studies, 2002), but this does not mean that all incarcerated individuals in need get substance abuse services or that they get the type and intensity of services they need. The number of federal inmates who had used drugs in the month prior to their offense and participated in some type of drug abuse program while in prison has increased slowly, from 39% in 1997 to 45% in 2004 (Mumola & Karberg, 2007). This includes self-help groups, peer counseling, drug abuse education, and treatment by a qualified professional. However, there was no increase in the percent treated by a professional, which remained at 15%. Of those who met the criteria for drug abuse or dependence, 49% participated in some type of drug program, with about one-third participating in drug abuse education and one-fifth in self-help or peer counseling, but only 17% received treatment from a professional. Thus, in 2004, less than half of federal prisoners who may have needed treatment received any help and less than one-fifth received professional help. I hope these numbers have increased substantially since the 2004 data were collected.

No single treatment modality will be effective for all people with substance use disorders (National Institute on Drug Abuse, 2007, 2009). Combinations of evidence-based psychosocial treatments outlined by organizations such as the National Institute on Drug Abuse (NIDA) may be necessary. The incorporation of medications such as methadone

or buprenorphine used for opioid addiction or medications with different types of actions like naltrexone and acamprosate that may reduce alcohol cravings or prevent people from continuing alcohol or drug use if they initiate use should also be available when indicated. As evidence-based treatment approaches such as Motivational Interviewing (Miller & Rollnick, 2002) also tell us, and as social work practitioners have long recognized, patient involvement and choice in the types of interventions to be used is also important.

Though the education, self-help group, and other lower-intensity services that those in prisons and jails are most likely to get (Mumola & Karberg, 2007; Whitten, 2009) can be beneficial, evidence-based treatment by qualified professionals may also be necessary for recovery from drug problems. For example, the Federal Bureau of Prisons (2009) revised its Residential Drug Abuse Treatment Program (RDAP) based on evidence of effectiveness of a cognitive behavioral therapy treatment model. The National Institute on Drug Abuse publications *Principles of Addiction Treatment: A Research-based Guide* (2009) and *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (2007) are highly instructive in describing what it is needed to best assist individuals involved in the criminal justice system and to increase public safety.

Despite substantial information on treatments that can help individuals recover from substance use disorders and substantial evidence that the criminal justice system can motivate individuals to take advantage of treatment, many incarcerated individuals apparently do not receive the type and level of services that can help make a positive difference in their lives and the lives of their family members and also increase public safety. Findings from the National Criminal Justice Treatment Practices Survey reinforce the point that while nationally about half of offenders have drug problems, "less than 10 percent of adults and about 20 percent of juveniles with substance abuse problems in the Nation's jails, prisons, and probation programs can receive treatment on a given day" (see Whitten, 2009, p. 4).

In addition to increased availability of treatment for incarcerated individuals, substance abuse treatment professionals and the federal correctional system also recognize the critical role of substance abuse treatment services as inmates make the transition from prison to the community upon release. Across local, state, and federal correctional systems, much more must be done to reach incarcerated individuals and to continue to assist them upon return to the community. As Nora Volkow (2009), Director of the National Institute of Drug Abuse, continues to reiterate:

> Addiction is a chronic disease. Epidemiological evidence clearly shows that while science-based treatments are effective, many patients achieve long-lasting recovery only after years of therapy, often including multiple treatment episodes…. Continuity of care is key. Without it, patients are less likely to accumulate the sequential gains that ultimately result in long-term, stable control over their condition.

Chemical dependency treatment professionals further emphasize that the long-term assistance that some people with drug dependence need is similar to the situation of those who have other chronic medical illnesses in which genetic and environmental factors also play a part, such as type 2 diabetes, hypertension, and asthma, where relapse, i.e., nonadherence to treatment and spells of illness are common (McLellan, Lewis, O'Brien, & Kleber, 2000).

Divert People with Drug Problems from the Criminal Justice System

Legitimate questions can be raised about whether the criminal justice system is the most appropriate venue for addressing drug abuse and dependence. If we believe that drug dependence has genetic, psychological, and environmental origins, and is not by itself a moral failing or crime, then the current approach to imprisoning so many people who have drug problems, and imprisoning them for long periods of time, must be re-examined. The 2008 National Survey of Drug Use and Health (Office of Applied Studies, 2009, Table G.11) indicates that nearly half (47%) of Americans have used an illicit drug at some point in their lifetime. Given this figure, illicit drug use is more a normative rather than a deviant experience among the American population. Many people experiment with illicit drugs without long-lasting harm while others become addicted. However, anyone who has ever possessed an illicit drug has committed a crime and risked arrest.

I am sure the Sentencing Commission does not need a review of the following facts, but for the record, by 2006, drug arrests for adults were 5.25 times (more than 500 percent) higher than in 1970 and more than two times (200%) higher for juveniles (Bureau of Justice Statistics, 2008). In 2007 alone, the Federal Bureau of Investigation reported more than 1.8 million drug arrests; nearly half (47%) or about 873,000 were marijuana arrests (Bureau of Justice Statistics, 2009a). Of the more than 1.8 million drug arrests in 2007, 1.5 million (82%) were for possession and 322,000 (18%) for sale or manufacture (Bureau of Justice Statistics, 2009b). By 2000, estimates were that 57% of federal inmates and 21% of state inmates were incarcerated for a drug offense, while only 10% of all federal inmates compared to 49% of state inmates were incarcerated for a violent offense (Bureau of Justice Statistics, 2007). In 2007, the most serious crime of more than half (53%) of federal inmates continued to be drug offenses (West & Sabol, 2009, Appendix Table 12).

Given the large numbers of federal prisoners incarcerated for drug crimes and non-violent crimes, it seems that the federal justice system could do more to divert offenders to community-based treatment rather than prison. However, according to a recent report of the U.S. Sentencing Commission (2009), in 2007, only a very small percentage of U.S. citizens convicted of federal drug crimes were even eligible for alternative sentencing (including a combination of prison and community confinement), and only two-thirds of those eligible received an alternative sentence. Thus, substantial changes in policies and practices would be needed to make better use of alternatives to incarceration in the federal system. These alternative models include "drug courts, diversion programs, pretrial release programs conditional on treatment, and conditional probation with

sanctions" so that "offender[s] can participate in community-based drug abuse treatment while under criminal justice supervision" (National Institute of Drug Abuse, 2007, p. 16). I know the Commission has spent a good deal of time considering these alternatives and that many alternatives being used throughout the country with offenders who have drug problems were discussed extensively at the Commission's 2008 Symposium on Alternatives to Incarceration.

The National Institute on Drug Abuse (2009) has synthesized results of studies on the cost effectiveness of addiction treatment saying that:

> According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and to society also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths. (p. 13)

Community-based treatment does more than provide cost benefits. For many reasons, I agree with the conclusions of the Justice Policy Institute that "though drug treatment in a prison setting is helpful, drug-involved people are better served…in the community. Community-based drug treatment programs encourage successful transition to communities, which reduces the chance that a person will become involved in crime or the criminal justice system in the future" (Natarajan, Petteruti, Walsh, & Ziedenberg, 2008, p. 16). In addition to reduced crime, community treatment increases the chances that offenders will pursue gainful employment, maintain ties with family and other stabilizing community entities, improve parenting skills, and unless contraindicated, maintain relationships with their children and retain custody of children who might otherwise be placed in foster care. I believe this last statement is very much consistent with the sentiment expressed in the concluding paragraph of the U.S. Sentencing Commission's (2009) report on alternative sentencing.

End Discrimination Against Drug Offenders and Others with Drug Problems

People convicted of drug crimes are punished by the criminal justice system and punished again in other venues both during the time they are paying the price through the criminal justice system and after. Though many of these issues are not the purview of the Sentencing Commission, they are relevant to those convicted of drug crimes. For example, in addition to fleeing felons, probation and parole violators, and persons convicted of fraudulently receiving welfare in two or more states simultaneously, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also known as "welfare reform," singles out convicted drug felons by allowing states to ban them from ever receiving Temporary Assistance for Needy Families (TANF). TANF is the public assistance or welfare program for families with minor children. It also bans drug felons from ever receiving food stamps (now called the Supplemental Nutrition Assistance Program [SNAP]). Children are still eligible for TANF and SNAP benefits,

and many states have either opted out of, or limit, the ban for adults convicted of drug felonies (Legal Action Center, 2009). There are good reasons for states to opt out. Welfare payments are generally minimal to begin with, and subtracting the amount otherwise due the parent punishes children by leaving the family with less cash or food assistance. Another reason is that since TANF enrollments have been slashed, those adults remaining on the program often face substantial barriers to employment. Among those with the most substantial employment barriers are recipients with alcohol and drug problems (see, for example, Goldberg, 2002). Families headed by individuals who have alcohol and drug problems may be most likely to need TANF, SNAP, and the associated services like employment services and childcare these programs may provide. When adults with drug convictions are repeatedly singled out for discriminatory treatment, they may face almost insurmountable barriers to supporting themselves and their children, and they may be deterred from or unable to participate in services that can be helpful to them and their children.

The Higher Education Act (HEA) also singles out students convicted of drug crimes, as anyone who has gotten to question 31 on the Free Application for Federal Student Aid (FAFSA) can attest. Depending on the type and number of convictions, students with adult drug convictions (any possession or sale charges) can be denied federal financial aid for varying lengths of times, including forever. In 2006, the law was changed to apply only to convictions during periods when federal financial aid was being received, and completing an approved rehabilitation program may reduce the length of ineligibility (U.S. Department of Education, 2009). However, drug crimes remain the only crimes that can disqualify a student from financial aid (see Common Sense for Drug Policy, 2009). The drug conviction provision in the HEA makes it more difficult for those convicted of drug offenses to engage in productive activity through a college education and is another form of double jeopardy for those who have already made retribution through the criminal justice system.

Other erosions of the social welfare system also punish those with serious alcohol and drug problems and have been associated with increased drug crime. Supplemental Security Income (SSI) is the federal government's cash public assistance program for people who are disabled and have very low incomes because they are unable to work or eke out a minimal existence. States often supplement the federal SSI payment. When SSI began in 1974, those under age 65 with an alcohol or drug disability had to have a representative payee and get chemical dependency treatment. Twenty years later, in 1994, SSI benefits for people with alcohol or drug disabilities were limited to three years. Since welfare reform in 1996, those with alcohol or drug disabilities are no longer entitled to any SSI or Social Security Disability Insurance (SSDI) program benefits unless they have another disability in addition to alcohol or drug addiction. Those who lost SSI or SSDI benefits were also cut from the Medicaid and Medicare health insurance programs. Without health insurance, it can be difficult to get adequate treatment for alcohol or drug problems. Participation in substance abuse treatment declined substantially among former SSI recipients with alcohol and drug disabilities (Swartz, Campbell, Baumohl, & Tonkin, 2003).

Studies also showed that those with alcohol or drug disabilities who lost their SSI benefits were less likely to receive mental health and medical care (e.g., Podus, Barron, Chang, Watkins, Guydish, & Anglin, 2003), had higher rates of substance abuse, and were more likely to commit drug-related crime compared to those who retained their SSI benefits because they had a disability in addition to alcohol or drug addiction (Swartz, Martinovich, & Goldstein, 2003).

America's obsession with drug crime extends even further than those who use or traffic in illicit drugs. People who do not use drugs and have not committed drug crimes but who know people engaged in illicit drug use such as their children, grandchildren, or caretakers can also be punished. For example, in 2002, the U.S. Supreme Court declared in *Department of Housing and Urban Development (HUD) vs. Rucker* that people can be evicted from public housing if these other individuals engage in drug-related crime on, or in many cases, near the premises, even if the tenant did not know these individuals were using or selling drugs or could not control their actions (Dale, 2002).

Increase Community-based Treatment and Services to Reduce Drug Use and Crime

The Justice Policy Institute (JPI) notes that "states with a higher drug treatment admission rate than the national average send, on average, 100 fewer people to prison per 100,000 in the population than states that have lower than average drug treatment admissions" (p. 2). Though correlation does not necessarily imply causation and other factors may enter into the equation, I think we can all agree with JPI's conclusion "that the initiation of drug treatment prior to involvement with the criminal justice is the most beneficial and effective means of delivering services to drug-involved people" (Natarajan et al., 2008, p. 16; see also Potter, 2007). Rather than prosecute and incarcerate first and treat later, we should treat first. However, accessing needed treatment can be difficult. According to the Substance Abuse and Mental Health Services Administration, in 2008, 37% of those who said they wanted treatment for an illicit drug problem and made an effort to get it, but did not get it, said it was because they had no health insurance or could not afford treatment (Office of Applied Studies, 2009). About half of people with substance use disorders also have mental health problems that often go untreated (Kessler, Nelson, McGonagle, Edlund, Frank, & Leaf, 1996). Effective treatment often requires access to both mental health and chemical dependency treatment services, especially programs that treat these problems simultaneously (DiNitto & Webb, 2005).

As the United States engages in the debate over health care reform, we must insist that all children and adults have a source of health care that includes treatment for alcohol, drug, and mental health problems because the current system of publicly supported treatment is inadequate to meet the demand or need for treatment. Many times, apart from access to mutual-help groups like Narcotics Anonymous, people with drug problems have limited access to treatment, particularly high-quality, evidence-based treatment, and especially inpatient or residential care that people with the most severe problems may need (see, for example, Galanter, Keller, Dermatis, & Egelko, 2001). Medications that can be useful to people with alcohol and drug problems and people with mental health problems are often unavailable to those receiving publicly supported treatment because these programs cannot afford to pay for them. Those in private treatment may also not get these

medications because their insurance does not cover them or because the medications are in a high-cost sharing tier of their prescription drug plan and co-pays are beyond what the patient may be able to afford (Horgan, Reif, Hodgkin, Garnick, & Merrick, 2008). Patients paying for treatment out-of-pocket may also be unable to afford these medications. New federal mental health and substance abuse parity legislation will take effect January 2010. This is the first federal parity bill to include substance abuse treatment. However, because of exceptions in the law, many people will still not have access to substance abuse treatment ("The New Mental Health Parity Act," 2009).

I also want to emphasize the importance of auxiliary or adjunctive services in the treatment of people with substance use disorders that address employment, education, family, legal, and other problems (McNeece & DiNitto, 2005, chapter 6). It is generally the publicly supported treatment programs that do the best job of providing these services (see Delany, Shields, & Roberts, 2009; Mulatu, 2007), but publicly supported programs often struggle to meet the demand for their services.

I am also realistic about the barriers to addressing drug problems posed by stigma, ambivalence, insufficient funding for treatment, and what we still need to learn about more effective means of preventing and treating drug problems and motivating people to address drug problems. In addition to lack of insurance, substantial numbers of people do not get treatment because of fear of negative repercussions at work or other stigma (Office of Applied Studies, 2009). Others with alcohol and drug problems admit they are not ready to stop using, and many more do not get treatment because they do not perceive they have a problem or that they need treatment (Office of Applied Studies). The criminal justice system has helped people with drug problems by directing them to treatment, but only one-third of the federal drug control budget has gone to treatment and prevention (Office of National Drug Control Policy, 2009). Two-thirds has gone to law enforcement and interdiction, though law enforcement and interdiction by themselves do nothing to address the underlying problems of drug abuse and dependence. We must do more to help individuals with drug problems obtain appropriate drug education and treatment services and the adjunctive services they need and to encourage scientific testing of alternatives to incarceration that can better serve those with drug problems, their families, and their communities.

Conclusion

The Harrison Act of 1914, the Controlled Substances Act of 1970, and the Anti-Drug Abuse Act of 1986 were watershed events in U.S. efforts to control drugs that have potential for abuse or dependence. These laws, however, put in motion forces that have had severe consequences for individuals who abuse or are addicted to drugs, their families, and their communities. We need equally dramatic policies and practices to undo years of over-incarceration of Americans and underutilization of effective treatment and social service alternatives and move the United States closer to treating drug abuse and dependence as health or public health problems. I ask the U.S. Sentencing Commission to help the criminal justice system move further to ensure fair and equitable treatment of those who have drug problems by encouraging the justice system to provide necessary education and treatment and alternatives to incarceration based on a clear understanding

of the problems of drug abuse and dependence and the most effective methods for addressing them.

Thank you again for the opportunity to speak with you today. If I can be of further assistance to the Commission, please let me know.

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