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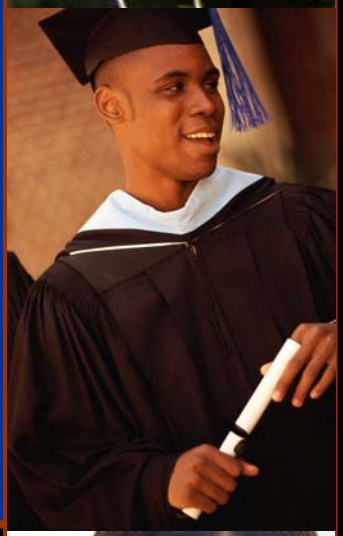
The Blue Ribbon Commission

Racial Disparities in Substance Abuse Policies

Report and Recommendations



NATIONAL AFRICAN AMERICAN DRUG POLICY COALITION
NAADPC
Promoting Health and Justice

September 2006

BLUE RIBBON COMMISSION ON RACIAL DISPARITIES IN SUBSTANCE ABUSE POLICIES

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September 2006

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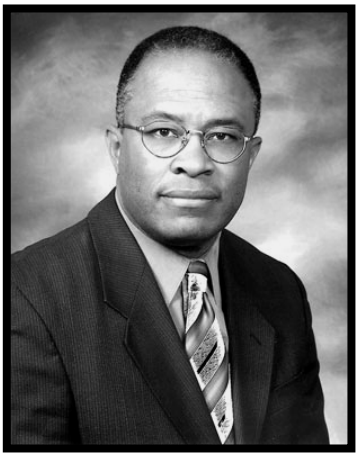
ACKNOWLEDGMENTS

The Commission wholeheartedly expresses its gratitude to Clyde E. Bailey, Sr. for his insight and wisdom - and for being the motivating force - not only in conceptualizing and creating the National African American Drug Policy Coalition, Inc., but also in seeing the need for a commission of African American professionals to gather and evaluate the facts and to propose solutions to deal with racial disparities in substance abuse policies and for choosing Senior Judge Arthur L. Burnett, Sr. as his agent to bring his dream to fruition. We dedicate this Report and the Recommendations to his genius and commitment to improve the quality of lives for African Americans, and indeed for all Americans.

The authors would like to give special thanks to the following individuals for advising, providing background information, and administrative support: Janice Ford Griffin, Consultant; Lisa Hill, Ph.D., Center for Drug Abuse Research; Rosalee Morris-Dailey, Center for Drug Abuse Research; and Ivory A. Toldson, Ph.D., Howard University.

FOREWORD



The Blue Ribbon Commission Report is an important achievement of the National African American Drug Policy Coalition, Inc., an organization established for the purpose of influencing the direction of the War on Drugs toward more of a public health focus than a criminal justice focus.

The organizations that are members of the Coalition are diverse in their makeup and in their charters. However, these groups of professionals recognize that the War on Drugs has a significant impact on their work whether it is in the classroom, the hospital, the courts or the correctional system. Each Coalition member organization brings a unique perspective to the issues involved in drug policy reform. The report of the Blue Ribbon Commission reflects the diverse interests and some common concerns of the individuals who represent the cross-disciplinary membership of the Coalition.

It is our hope that policy makers at the national and state level will consider carefully the important recommendations which the Blue Ribbon Commission has made. They include the following:

1. Access to Comprehensive Quality Health Services;
2. Increased Membership of African Americans on all Elected and Non-Elected Oversight Boards, Commissions and Task Forces;
3. Elimination of Racial Biases by Institutions and Individuals in Exercising and Implementing Policies and Practices; and
4. Increased Participation by African American Researchers in the Collection of Data, and in Analyzing, Evaluating and Developing Policies and Practices.

These recommendations are thoughtful and interrelated. The Commission firmly believes that adopting these recommendations will lead to more effective drug policy and will help improve the quality of life for all American citizens.

Heartfelt thanks go out to all the members of the Blue Ribbon Commission for their hard work on these issues. Member organizations of the National African American Drug Policy Coalition look forward to engaging in a national discussion of these recommendations.

Kurt L. Schmoke
Dean, Howard University School of Law
Chair, NAADPC, Inc.

CHAIR'S STATEMENT

Based on my extensive experience in law enforcement, in overseeing the federal government's drug policies as the Nation's Drug Czar, and as Mayor of a major urban city, serving, as Chair of the Blue Ribbon Commission on Racial Disparities in Substance Abuse Policies has been one of the most important events in my life. The extensive experience and expertise of the twenty-one (21) members of the Commission provided an all encompassing breadth of views on one of the most intractable domestic issues facing this Nation today. We have an extraordinarily high rate of illicit drug usage and addiction, abuse of prescription drugs and medications, alcoholism, and related co-occurring mental and emotional disorders. Illegal drug usage and drug trafficking, as well as alcoholism, have significantly contributed to this Nation having the highest rate of incarceration for criminal offenses of any Nation in the world.

This Commission represents the bringing together of a broad array of African American professionals to arrive at recommendations and solutions to one of the most pervasive problems in African American communities, resulting from the adverse and debilitating effects of illicit drugs and alcohol on the functioning of individuals in our Nation. The Commission viewed its charter as first investigating and evaluating the facts as to healthcare disparities affecting African Americans with respect to treatment for substance abuse, alcoholism and mental health issues generally, and second, the impact of the criminal justice system on African Americans with these afflictions, and how that system could be modified to treat these problems as diseases, requiring a medical and public health approach, as an alternative to criminal prosecution and incarceration in appropriate circumstances. The Commission sought to reach a consensus on a set of recommendations which would promote a greater public health approach to these issues, increase access to quality healthcare for these problems and eliminate healthcare disparities for African Americans, and at the same time increase the quality of health for African American citizens, reduce recidivism and crime, and make all of our communities safer for all citizens.

I emphasize that this Commission viewed its mission as being far more than achieving a "study" result. Thus, this Commission urges aggressive action be undertaken by the National African American Drug Policy Coalition, Inc. and its twenty-three member organizations to implement the four major recommendations made in this Report. These organizations represent nearly 255,000 primarily African American professionals in all of the professions and disciplines involved in dealing with drug abuse and addiction, alcoholism, and related mental/emotional health issues. They must educate the public as to what must be done to solve this major crisis in our Nation. To the extent we make progress, we will share our successes with the entire population of the United States to improve the quality of life for all our citizens.

Lee P. Brown
Chair, Blue Ribbon Commission on Racial Disparities in Substance Abuse Policies

REPORT AND RECOMMENDATIONS

Introduction:

In April 2005 the National African American Drug Policy Coalition, Inc. (The Coalition) convened a Blue Ribbon Commission to examine racial disparities in substance abuse policies and gain first-hand insight on drug abuse issues that were affecting African Americans and their communities across the United States. The Blue Ribbon Commission on Racial Disparities in Substance Abuse Policies (The Commission) is comprised of twenty-one individuals who have exceptional credentials and experience in dealing with substance abuse, alcoholism and mental health issues and who represent the different disciplines of the professional organizations which comprise the Coalition. Their names and professional affiliations are listed in Appendix 1.

The Blue Ribbon Commission met and had its first organizational meeting on April 25, 2005 following the conclusion of the Coalition's first Annual Summit Conference. Thereafter, plans were made to conduct hearings on racial disparities in substance abuse policies in several cities with a large African American population and a substantial drug abuse problem. The first hearing was held in Flint, Michigan on October 28-29, 2005, followed by a hearing in Washington, D.C. on December 6, 2005. The first hearing of 2006 was held in Barbados, West Indies on January 21, 2006 in connection with the Mid-Winter Meeting of the Board of Governors of the National Bar Association and its Judicial Council. Thereafter, further hearings were held in Houston, Texas on January 27-28, 2006, in Los Angeles, California on February 17-18, 2006 and finally in Washington, D.C. on March 10-11, 2006. In these 6 hearings, the Commission heard from ninety-three witnesses and received several written statements, reports, and studies on the use of illicit drugs, excessive use of alcohol, and co-occurring mental disorders.

"We in America have adopted policies which in substance treats drug abuse as a moral failure requiring eternal punishment, when a far better approach is to treat drug use as a public health problem…"

Martin Y. Iguchi, Ph.D. UCLA School of Public Health and RAND Corp.

The Commission approached its task with a focus on placing greater emphasis on treating drug addiction and alcoholism as diseases to be treated pursuant to a public health model. It recognized that this goal required changing public attitudes and convincing members of the public and policy makers that they should view addictions as any other chronic disease, and not by imposing a moral judgment on the afflicted individual's character. Concurrently, the Commission recognized the interrelationship between drug abuse and our criminal justice system and the need to shift our approach to the problems of drugs and alcohol from a criminal justice model to a public health model. Martin Y. Iguchi, Ph.D., Professor, UCLA School of Public Health and Senior Behavioral Scientist, RAND Corporation, in testifying before the Commission in Los Angeles, California cogently summarized the issues facing the Commission, noting that "we in America have adopted

policies which in substance treats drug abuse as a moral failure requiring eternal punishment, when a far better approach is to treat drug use as a public health problem, even to the extent of increasing the availability of drug treatment programs to users before they are arrested, increasing the availability of drug courts and related judicial mechanisms emphasizing treatment in lieu of incarceration and rehabilitation over punishment, and facilitating the re-entry of drug offenders into our communities upon release from prisons and jails after serving of a sentence."

The Commission recognizes that although African Americans are not the majority of substance users in the United States, they bear the heavy burden of criminal prosecution for drug related offenses.[1] Additionally, they are the least likely to get quality treatment.[2] The Commission took on the task of examining the reasons for these glaring disparities recognizing that earlier we treat persons with drug addiction and alcoholism problems, and for co-occurring mental/emotional disorders, and we do so effectively with the proper quality of care, the less costly our healthcare system will be in the future and concurrently we may significantly reduce crime in this Nation and make all of our communities safer for all its residents.[3] Finally, in the process we may restore many persons to healthy lifestyles, enabling them to become productive citizens.

Against the foregoing background and their collective expertise, the Commission has made four substantial recommendations for reform, changes and improvements in the nation's approach to addressing the problems of alcohol and drugs, with a special interest in the impact of those policies on African Americans. The recommendations are:

1. Access to Comprehensive Quality Health Services;
2. Increased Membership of African Americans on all Elected and Non-Elected Oversight Boards, Commissions and Task Forces;
3. Elimination of Racial Biases by Institutions and Individuals in Exercising and Implementing Policies and Practices; and
4. Increased Participation by African American Researchers in the Collection of Data, and in Analyzing, Evaluating and Developing Policies and Practices.

RECOMMENDATIONS

RECOMMENDATION 1: ACCESS TO COMPREHENSIVE QUALITY HEALTH SERVICES

Acknowledging documented disparities in healthcare in the United States, the Commission recommends that all persons, including those suffering from substance use disorders should have access to comprehensive quality health services in both the public and private sectors. Comprehensive quality health services for persons with substance abuse disorders include care for physical health and mental health needs, and pharmacotherapies, where appropriate.

Discussion: While focusing on African Americans and other minorities, the Commission took notice of the enormity of the problem of substance abuse and alcoholism in this Nation as a whole. A recent Gallup poll conducted April 27, 2006 to May 31, 2006 and reported on July 20, 2006 concluded that addiction affects 1 out of 5 persons, and when considering their families – spouses and children – some 40 million people in the United States. Addiction is thus endemic in American families.

The Institute of Medicine of the National Academies in its report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series,* noted that only a fraction of the people who need services get them in a timely manner and that more than 8 of every 10 Americans who need services for addiction to alcohol and other drugs are not receiving the professional help that they need to get well.[4] It further observed that this failure is overwhelmingly tied to the lack of private and public funding for addiction treatment services including discrimination by private insurers and managed care organizations.[5] It also noted that the lack of adequate funding and discriminatory policies means that for those individuals who do receive care, the assistance comes often in the late stages of illness and the quality is often variable and rarely lasts long enough, similar to other areas of healthcare.[6]

Parity Treatment of Substance Abuse by Insurers

The Commission recommends changes in laws in both the public and private sectors to require insurance companies to provide *parity* -- equal coverage for substance abuse treatment and mental health treatment to the same extent as physical disorders. Further, the Commission recommends that the law should require that the co-pay obligations, the extent of coverage, and duration of coverage should be the same as for physical illnesses.[7]

The National Policy Panel established by Join Together in its June 2006 Report stated that for the past decade, private insurance spending for substance use treatment has been declining, and as a result, States now pay for 60 percent of all alcohol and drug treatment with a combination of state and federal dollars even though they insure only about 25 percent of their populations. The Panel urged that States require private insurers to cover substance use treatment to protect themselves from this shift to the public sector, observing that only nine States currently require insurance parity for the treatment of alcohol and other substance use disorders, and even these States often have managed care restrictions that limit access to effective care.[8] Research proves that coverage does not

necessarily drive up costs and, in fact, can save insurers money in the long run.[9]

The Uniform Accident and Sickness Policy Provision Law (UPPL) adopted by many States permit insurance carriers to deny accident or injury claims if there is evidence that the claimant was affected by alcohol or narcotics (unless administered pursuant to direction of a physician) at the time of the injury. Emergency room physicians are often reluctant to screen patients or test them for alcohol or drug usage, because if detected, the patient's health plan may not reimburse the hospital and the doctor, or the patient for the services.[10] According to the National Policy Panel, the National Association of State Insurance Commissioners has called for the repeal of the UPPL to eliminate this problem and this practice.[11]

The Commission heard testimony that most often drug treatment occurs in connection with criminal charges pending against an individual or in connection with neglect and abuse or child dependency cases in the welfare system, and in a smaller percentage of cases where individuals are fortunate enough to have health insurance policies which cover substance abuse, alcoholism and mental health therapy. Several witnesses urged that substance abuse and mental health therapy should be available on demand under Medicaid or some other program established by a State for its impoverished citizens, where a preliminary screening clearly indicates the need for treatment.[12]

The Commission urges legislators and policy makers at the federal, state, and local levels to provide adequate financial support to assure the availability of comprehensive quality treatment for all persons with drug and alcohol addiction and other related problems.

Access to Treatment for Drug Offenders

The Commission recommends that every person entering the criminal justice system be screened for alcoholism, substance use disorders, and related mental health issues. If that screening suggests a problem, that individual should then be fully assessed with a diagnostic evaluation, provided with an intervention, and prescribed a patient-centered course of treatment.[13] Clients with a chemical dependency and co-occurring mental/emotional disorder should be treated with an approach that ensures their unique needs are met.[14] If a person is convicted and placed on probation under a therapeutic sentencing program, there must be an adequate drug treatment program with the necessary supportive services.[15] If that person is convicted and sent to prison, this course of treatment should be available to that person while in prison.[16] Quality substance abuse treatment should be available to each inmate during imprisonment in jails and prisons so that there is continuity of treatment and far less difficulty in readjustment upon release from prison. When that person is being considered for release back into the community, at least six months prior to the release date there should be preparation for a transition program, including a halfway house if other residential arrangements are not available, a referral for drug testing, and community-based recovery services to prevent relapse and to help the individual to reintegrate with his or her family, to an employment setting, and in the community to which he or she returns. There should be a strong program of aggressive prevention interventions to protect against recidivism and to assure stabilization of that person back into the community.

Healthcare Professional Recruitment and Retention

Both Federal and State governments should use their licensing and educational resources to increase, improve and retain both the prevention and treatment workforce in healthcare professions. The National Policy Panel observed that workforce instability is a major obstacle to effective prevention and treatment programs and that turnover rates among workers in many substance use treatment programs rival the fast-food industry, averaging 50 to 60 percent a year. It further noted studies that report that about half the treatment program directors have been in their job for less than one year and that few of them have specialized training for their position. The Panel further observed that fewer than half of the treatment programs in the country have even a part-time physician working with them which leads to a high percentage of clients who have undiagnosed physical problems and/or are unable to get medication supported treatment to help them recover. The Panel recommended that licensing and contracting standards for treatment programs include the active participation of physicians in the planning and providing of treatment for all clients.[17] Furthermore, the Commission recognizes that culturally competent treatment is significantly influenced by representation and participation of African Americans in all health professions, including physicians, dentists, pharmacists, nurses, nurse practitioners, therapists, mental health counselors, and substance abuse and addiction counselors and calls for an increased African American representation in these professions.[18]

RECOMMENDATION 2: INCREASED MEMBERSHIP OF AFRICAN AMERICANS ON ALL ELECTED AND NON-ELECTED OVERSIGHT BOARDS, COMMISSIONS AND TASK FORCES

Recognizing that the development and implementation of formal policy occurs through the interplay of statutes, executive orders, regulations, and practices, the Commission recommends aggressive action to assure and achieve increased membership and participation of African Americans on all elected and non-elected oversight commissions, boards, task forces, and other such entities at the national, state and local levels of government, as well as in the private sector where advisory groups influence policy and its implementation.

Discussion: To assure equal access to all healthcare resources and services for all segments of society, including African Americans and other minorities, the Commission concludes that it is imperative that African American professionals contribute to the development of the policies and implementation at all levels of services, and that they be represented on federal and state advisory panels, on state licensing and oversight commissions and boards, and even on zoning boards that determine the locations of facilities and programs providing alcohol and drug treatment services. They should be represented in sufficient numbers to make sure that the policies developed are culturally sensitive to the needs of all segments of the population to be served and that quality healthcare services are rendered equitably to all groups. Advisory councils must be vigilant in holding elected officials and executive branch appointed department and agency heads accountable for providing and implementing progressive policies for prevention and treatment.

In the course of its hearings, the Commission heard from a number of former drug users and addicts who had recovered and been "clean and sober" for a significant number of years. Some have earned an undergraduate or graduate degree and are now service providers treating and counseling recovering addicts. The Executive Director of Healthy African American Families II, Inc, a Los Angeles non-profit community service agency stated that her organization often invited recovering addicts for meaningful participation "in our research initiatives, often as layperson co-creators of the research itself…We witness profound ability, worth, and potential in recovering addicts on a daily basis."[19] The Commission concludes that we need to convince the public, legislators and other policy makers that a significant number of people do recover from alcoholism and drug addiction and go on to make major contributions to the quality of life in their communities. With reference to advisory commissions, boards, and task forces, the Commission urges appointing authorities to consider including representatives of the organized recovery community on these advisory bodies, for they have valuable insight and perspective on what works effectively and how to enhance drug and alcohol treatment programs.

"We witness profound ability, worth, and potential in recovering addicts on a daily basis…"

Loretta Jones, M.A., Healthy African American Families II, Inc., Los Angeles, CA

RECOMMENDATION 3: ELIMINATION OF RACIAL BIASES BY INSTITUTIONS AND INDIVIDUALS IN EXERCISING AND IMPLEMENTING POLICIES AND PRACTICES

Despite rules, regulations and guidelines, biases often enter and influence policy at all levels among institutions, practitioners, and individual providers. Thus, the Commission recommends that biases and, other acts of racial discrimination, be documented and used to develop policies and practices to change conduct that disproportionately affect African Americans and other minorities.

Discussion: Federal and state laws prohibit discrimination based on race, gender, socioeconomic class, sexual orientation, religion, or physical condition.[20] Bias is an attitude or point of view that colors judgment made by an individual.[21] It is not only a negative opinion or attitude towards an individual based on non-merit factors, but it also includes giving a person preferential treatment based on race, gender, socioeconomic class, religion, or physical condition.

Biases in Healthcare

The Commission calls for elimination of stereotypes or assumptions used in providing quality medical care to any individual. In the Commission's view, decisions regarding the diagnosis and course of treatment should be based on an independent evaluation of each individual's medical needs, totally uninfluenced by bias. The Commission considers it imperative that all persons in the United States have confidence in our healthcare system and its fairness, objectivity, and neutrality in the quality of healthcare services rendered.

Testimony from several witnesses revealed pervasive biases in selective drug testing in hospitals, and a range of other cross-sections between drug treatment and the law. A witness reported that African American mothers, who are welfare recipients, are frequently drug tested without their knowledge, but similarly situated Caucasian mothers are not tested for illicit drug use. In addition, witnesses observed the following: 1) Racial bias by police officers when dealing with disturbances caused by persons with mental and/or emotional disorders (e.g., African Americans being arrested, charged with assault and jailed while Caucasians are taken to the home of a relative or to a hospital); 2) Racially based assumptions that result in substandard treatment for the African American patient (e.g., an African American individual is a poor person without health insurance coverage or the financial means to pay for an extensive diagnostic procedure and course of treatment); and 3) Lack of quality care being provided to certain populations, such as insufficient ambulances in impoverished areas which can result in a poor patient dying before he or she can receive medical attention.

Additionally, several witnesses were concerned about selective drug testing in poor inner city public schools, based on the assumption that youth in urban areas use more drugs. However, household surveys show that white students, who are more likely to attend suburban private schools, use certain drugs more extensively than African American teenagers.[22] Federal policies that prescribe drug testing of students apply only to public schools. In the Nation's major urban public school districts, African Americans and other minorities comprise the majority of students, and are thus disproportionately affected by such policies.

Finally, witnesses reported biases in managed care programs decisions, which affect the extent and quality of care a patient may receive. Managed care programs therefore must develop practices and procedures to eliminate both actual bias and the perception of bias in dealing with their patients.[23]

Biases in Law Enforcement

The Commission took note of the burgeoning prison and jail population, which has resulted in the United States incarcerating more persons per 100,000 than any other nation in this world, with an estimate of 2.3 million people in prison and jails.[24] Two-Thirds of these 2.3 million prisoners are African American or Hispanic. [25]A report by The Institute of Medicine of the National Academies suggests that as many as 75 percent of the people involved in the criminal justice system have drug and alcohol problems.[26]

Drug Free Zones

Current drug free school zone laws disproportionately impact African American communities and other minorities living in high density inner cities, compared with low density suburban and rural communities. For example, the New Jersey Commission to Review Criminal Sentencing in a report released in December 2005 found that New Jersey's laws unfairly affected minorities, as 96% of all inmates in New Jersey whose most serious offense was a school zone violation were African American or Latino. It also found that only 2 out of 10 suburban or rural drug-distribution offenses occurred within school zones, compared to eight out of ten urban distribution offenses occurring within school zones. The Commission recommends reconsideration of Drug Free Zone

laws that disparately impact African Americans and other minority communities.

Restoration of Judicial Discretion

The Commission recommends changes in criminal justice policies with respect to mandatory minimum sentencing for drug offenses at both the federal and state levels of government. Such changes would give judges broader judicial discretion in sentencing so that they can tailor a sentence to the circumstances of the individual offender.

The Commission recognizes that unfettered judicial discretion could lead to wide variances in sentencing and unequal treatment of offenders. There is a need for sentencing guidelines, based on certain factors, to assure that people in like circumstances are treated in a like manner, and that there is no unlawful or invidious discrimination. The Commission concludes, however, that a degree of judicial discretion is necessary to meet the unique circumstances which may arise in individual cases, i.e., an offender's prior personal history and the degree of his or her moral culpability in the offense at issue. The Commission recommends that judges be given the authority to place eligible non-violent individuals who are drug addicts, suffering from what can medically be described as a disease, in a pretrial diversion program for treatment or on probation in a therapeutic sentencing program requiring treatment with supportive services.[27] The Commission urges the development and expansion of drug courts and the implementation of procedures for screening, brief intervention and referral to treatment wherever appropriate within the court system that it can be done without jeopardizing the overall public safety of the community.[28]

Crack Cocaine v. Powder Cocaine

The legal distinction between crack and powder cocaine is an example of the discriminatory impact of mandatory minimum sentences. Although, the chemical characteristics of both types of cocaine are the same, studies show that in 2003 the average sentence for crack cocaine offense, 123 months, was three and a half years longer than the average sentence for an offense involving the powder form of the drug, 81 months, and as a result African Americans now serve virtually as much time in prison for a drug offense, 58.7 months, as Caucasians do for violent offenses, 61.7 months.[29] In 2002, African Americans constituted more than 80 percent of the people sentenced under the harsh federal crack cocaine laws and served substantially more time in prison for drug offenses than did Caucasians,[30] despite the fact that more than two-thirds of crack cocaine users in the United States are Caucasian or Hispanic.[31]

The Commission supports the research and scientific studies that refute, contradict, and invalidate any rationale for policies requiring mandatory minimum sentences and the disparate sentences for crack cocaine versus powder cocaine, and recommends reconsideration of those policies.

Barriers to Re-Entry

The Commission recommends that barriers to financial aid for persons convicted of drug offenses in the past, who have fully recovered, be removed so that they may obtain additional education to prepare for meaningful employment and thus significantly removing the risk of recidivism. Barriers to welfare and other benefits denied solely because of drug convictions should be removed. Furthermore, barriers to certain

employment opportunities which would not endanger the public should also be removed.

Financial Aid

Before July 1, 2006 20 U.S.C. §1091(r) (1) restricted the access to financial aid to persons convicted of possession or sale of a controlled substance under any federal or state law, even if the conviction came prior to the person applying for financial aid.[32] The law now only places an ineligibility period on those persons who were enrolled in school and receiving any grant, loan, or work assistance under 20 U.S.C. §1091 (r) (1) at the time of the drug offense. The ineligibility period ranges from one year to indefinite for the possession of a controlled substance, and two years to indefinite for the sale of a controlled substance. Even if a student is convicted while in school he still has an opportunity to get financial aid once his ineligibility period is up and he meets certain criteria under 20 U.S.C. §1091(r) (2).

The amendment to 20 U.S.C. §1091(r) is the first step in the right direction in eradicating the barrier to financial aid that persons with criminal records face when they try to pursue higher learning, vocational education, and other training opportunities. However, there is still a need to consider removing additional obstacles to a rehabilitated individual obtaining financial aid to improve his or her skills for future employment, thus eliminating a substantial ground for recidivism.

Welfare Benefits and Housing

The Commission was especially concerned about the impact of the provisions of the welfare reform law on mothers with children, which bars convicted drug felons permanently from receiving food stamps and other benefits under the Temporary Assistance to Needy Families (TANF) Act.[33] The impact of denying people public benefits like TANF can lead to recidivism, disruption of families, and perpetuates a discriminatory system of imprisoning the poor, who are disproportionately people of color.

Current public housing policy permits housing authorities to consider substance abuse when making access and eviction decisions and as written, encourages consideration of rehabilitation and drug treatment options. However, in actual practice and implementation since 1996, public safety has been the overriding consideration, leaving convicted drug offenders and their families with few housing options. Community coalitions, civic organizations and churches must work with housing authorities to get them to be more reasonable in accommodating the housing needs of recovered drug addicts and users and their families.[34]

Employment

Many federal and state statutes place employment restrictions on ex-convicts by precluding them from certain types of employment and authorizing government agencies to revoke or suspend licenses or permits for conviction of a felony.[35] Florida Governor Jeb Bush on April 26, 2006 issued Executive Order No. 06-89 directing each Florida executive state agency to conduct a comprehensive inventory of their employment disqualifications affecting people with convictions and to report to him the reasons for any automatic disqualifications and any available procedures for waiver. He further directed the agencies to eliminate or modify such disqualifications that are not tailored to

protect the public safety and to create case-by-case review mechanisms to provide individuals the opportunity to make a showing of their rehabilitation and their qualifications for employment. The Governor also strongly encouraged other state agencies, counties, municipalities and political subdivisions of the State and private employers "to the extent they are able, to take similar actions to review their own employment policies and provide employment opportunities to individuals with criminal records."[36]

The Commission recommends that federal and state governmental authorities should conduct a comprehensive review of laws imposing employment disqualifications affecting people with convictions and eliminate automatic disqualification except where the conviction rationally indicates that the person is currently a threat to public safety. The Commission suggests that in lieu of automatic disqualification, there should be an administrative process on a case-by-case basis for an individual to make a showing of his or her rehabilitation and his or her qualifications for a particular job.

RECOMMENDATION 4: INCREASED PARTICIPATION BY AFRICAN AMERICAN RESEARCHERS IN THE COLLECTION OF DATA, AND IN ANALYZING, EVALUATING AND DEVELOPING POLICIES AND PRACTICES

The Commission recommends the establishment of policies and practices to assure increased representation and participation of African American researchers in all areas to provide culturally sensitive and appropriately relevant context, analysis, interpretation of data, evaluation, and conclusions.

Discussion: The disproportionate number of African Americans with low incomes influences the large numbers who receive services from the public sector. Without proper analysis this can result in generalizations being applied to all African Americans without regard to income. Thus, it is very important to provide appropriate analysis, interpretation, and extrapolation of data to specific segments of the population. The Commission also noted that there may be gaps in the research in the collection of data, secondary analyses, and evaluation because of the absence of researchers of color with unique and diverse perspectives of the culture and the environment of persons from whom the data is collected.[37]

CONCLUSION AND FUTURE CONSIDERATIONS

The absence of access to quality treatment for substance use disorders, alcoholism and mental health issues drives crime and has severe health consequences. There is a significant overlap and interrelationship between the criminal justice system and its disproportionate impact on African Americans and other minorities in dealing with illegal drug offenses and racial disparities in the healthcare. The two are inextricably tied to each other. Improved policies in one area will have positive consequences in the other.

The Commission acknowledges the magnitude and complexity of the myriad problems associated with alcohol and drug abuse. Though time and other limitations prevented the Commission from a thorough examination and review of all policies and issued presented to them, it recommends that the National African American Drug Policy Coalition, Inc. and its member organizations consider these issues by creating future Commissions or Task Forces to deal with them.

BLUE RIBBON DRUG POLICY COMMISSION MEMBERS

Name	Position & Affiliation
The Honorable Lee P. Brown (Chair)	Former Mayor, Houston, Texas & Former Director, Office of National Drug Control Policy
Beny J. Primm, M.D. (Vice-Chair)	Executive Director, Addiction Research & Treatment Corporation
Patricia B. Ayuk-Egbe, Pharm. D.	Associate Professor, Pharmacy Practice, Howard University, College of Pharmacy
Francis L. Brisbane, Ph.D.	Dean and Professor, School of Social Welfare, State University of New York at Stony Brook
James E. Cheek, Ph.D.	President Emeritus, Howard University
Betty Davis-Lewis, Ed.D., RN, FAAN	President, National Black Nurses Association, Inc., Diversified Health Care Systems
Julius Debro, Ph.D.	President Emeritus, University of Washington & President, JDAssociates (JDA)
Chief Clarence Edwards	Immediate Past President, National Organization of Black Law Enforcement Executives
C. Alicia Georges, Ed. D., R.N., FAAN	Past President, National Black Nurses Association, Inc., Lehman College, Department of Nursing
Vincent “Peter” Hayden, M.S.	President, National Black Alcoholism & Addictions Council, Inc.
Theorious M. Hickman, MSW, LICSW	Past President, National Association of Blacks in Criminal Justice
Glenn F. Ivey, Esq.	State’s Attorney, Prince Georges County, Maryland
Joy Jordan, D.D.S.	Past President, National Dental Association
Wilma A. Lewis, Esq.	Former United States Attorney for the District of Columbia; Partner, Crowell & Moring, LLP
Averette Mhoon Parker, M.D.	President/CEO, Access to Racial and Cultural Health Institute, Inc.
Winston Price, M.D.	Immediate Past President National Medical Association
Rev. Kwame Osei Reed, Ph.D.	United Church of Christ Central Atlantic Conference
Barbara T. Roberts, Ph.D.	Professor, Department of Psychiatry Georgetown University School of Medicine
The Honorable Martha Lynn Sherrod	District Court Judge, Huntsville, Alabama, Chair, Judicial Council, National Bar Assn.
Mavis Thompson, Esq.	Vice President, Regions & Affiliates, National Bar Association
Vernetta D. Young, Ph.D.	Assistant Professor, Department of Sociology and Anthropology, Howard University

HEARING WITNESSES

FLINT, MICHIGAN HEARINGS (OCTOBER 2005)

1. Stanette Amy, Social Worker and Attorney, Genesee County
2. Lee Bell, Coordinator, Flint Youth Violence Prevention Center
3. Erin Brodie, Transition House
4. Ronald C. Brown, Executive Director, Flint Odyssey House
5. Ken Byrd, Director, Woodward Counseling
6. Rory Cavette, Pastor, Church of God
7. Reginald Coleman, Prevention Specialist
8. The Honorable Wilce Cooke, Mayor, City of Benton Harbor, MI
9. Maurice Cox, Program Director, Woodward Counseling
10. The Honorable William Crawford, Judge, 68th Judicial District
11. Etta Walker Dotson, Retired School Principal
12. Lonie Gray, Therapist, Transition House
13. Wesley Gray, Acupuncturist, Woodward Counseling
14. Linda Itson, Social Worker, Delphi East
15. Bernadel Jefferson, Pastor, Faith Deliverance Center
16. Morris Kent, Attorney, The Manley Firm
17. Lieutenant Alvern Lock, Flint Police Department
18. Dennis Lovejoy, Community Member
19. Jon Manning, Deputy Director, Odyssey House
20. Tom McHale, Work/Family Coordinator, UAW Local 598
21. Agnes Napier, Community Activist, New Jerusalem FGBC
22. Sixto Olivio, Community Member
23. Rodney Pendelton, President, Genesee County Drug Court Alumni Assn.
24. Vera J. Perry, Treasurer, Flint Board of Ed., Flint Comm. Schools
25. Virlyn Poe, Co-Director, Above the Water House, Inc.
26. Robert Roper, Outreach Worker, Woodward Counseling
27. Stephen Sewell, Community Member
28. Minnie Sims, Asst. to City Manager, City of Benton Harbor
29. Lorita Ward, Flint Odyssey House
30. Ronnie Wiggins, Counselor, Living Christian Outreach Ministries
31. Woodward Stanley, County Commission, Genesee County Board
32. Trachelle Young, City Attorney, City of Flint

WASHINGTON, D.C. HEARINGS (DECEMBER 2005)

1. Paul A. Quander, Jr., Court Services and Offender Supervision Agency for The District of Columbia
2. Edward G. Singleton, Ph.D., Consulting Psychologist, Ips-Interactive Professional Services
3. Nkechi Taifa, Esq., Senior Policy Analyst, Open Society Institute
4. John Wilson Jr., Ph.D., John Wilson & Associates Consulting

BARBADOS, W.I. HEARINGS (JANUARY 2006)

1. The Honorable Sybil Elias, Judge, East Orange Municipal Court
2. Raphael Prevot, Esq., Labor Counsel, National Football League
3. Sharon Strickland, Esq., Former Vice President, National Bar Association
4. The Honorable Nathaniel Walker, Judge (Retired)
5. Taa Gray, Esq., Chair, Criminal Law and Juvenile Justice Section, National Bar Association (written statement)

HOUSTON, TEXAS HEARINGS (JANUARY 2006)

1. David L. Benson, Office of County Commissioner El Franco Lee
2. Gary Bledsoe, Esq., Texas State Conference of NAACP (written statement)
3. The Honorable Garnet F. Coleman, Texas State Representative, District 147
4. The Honorable Caprice Cosper, Judge, 339th Criminal Court, Harris County
5. Jimmie Dotson, National Organization of Black Law Executives (NOBLE)
6. The Honorable Mike Fields, Judge, Harris County Criminal Court at Law No.14
7. Dashiel Geyen, Professor, Texas Southern University (written statement)
8. The Honorable Ronald Green, City of Houston Council Member
9. Helen Taylor Greene, Professor, Texas Southern University
10. Kathryn Griffin, Exec. Dir. of Outreach, Office of Council Member Peter Brown At-Large
11. Gregory Harris, Board Chair, Johnson Institute
12. The Honorable Belinda Hill, Judge, 230th Criminal Court, Harris County
13. Sandra Massie Hines, Junior Achievers- Texas Youth Against Drugs and Crime
14. James Hollins, Student, Texas Southern University
15. The Honorable Shelia Jackson Lee, U.S. House of Representatives, Texas, 18th Congressional District
16. Robert Jefferson, Pastor and Special Projects Director (HMAC)
17. Dorian Jones, Student, Mickey Leland Congressional Intern, Texas Southern University
18. Jesse Lucas, President, Helping Non Profit
19. Aaron Mallory, Student, Texas Southern University
20. Ronald Nicholas, Attorney, Harris County Star Drug Court
21. James Goodwille Pierre, Region V Director National Bar Association
22. Christina Sanders, SGA President, Texas Southern University
23. Herbert Steptoe, Winners Circle Peer Support Network
24. Reverend Vernus C. Swisher, CEO, Career and Recovery Resources
25. The Honorable Senfronia Thompson, State Representative, Texas
26. Riley Venable, Texas Southern University
27. Eugene Waddis, Reintegration Counselor, Houston Area Urban League
28. Frank Wiley, Infinity Unit Management Group

LOS ANGELES, CALIFORNIA HEARINGS (FEBRUARY 2006)

1. Christopher Erving, M.D., National Medical Association
2. Juan Flores, Office of Assembly Member Jerome Horton
3. Scottie Gray, Executive Director, Hope 4 Life Foundation
4. Michael Guynn, President, National Association of Black Social Workers of Greater Los

Angeles
5. Martin Iguchi, Ph.D., Professor, UCLA School of Public Health; Senior Behavioral Scientist, RAND Corporation
6. James Lyons, President, California State University at Dominguez Hills
7. Eric Marts, Division Chief, Los Angeles County Department of Children and Family Services
8. John Robertson, Ph.D., National Black Alcoholism & Addictions Council
9. Bishop Edward R. Turner, Power of Love Christian Fellowship
10. The Honorable Michael Tynan, Judge, Los Angeles Superior Court
11. The Honorable Diane Watson, U.S. House of Representatives, California, 33rd Congressional District
12. George White, Assistant Director and Editor, UCLA Center for Communications and Community

WASHINGTON, D.C. HEARINGS (MARCH 2006)

1. Gail Christopher, D.N., Vice President, Joint Center for Political & Economic Studies
2. Miles Cameron, Executive Director, Maryland Juvenile Justice System
3. L. Natalie Carroll Dailey, M.D., Obstetrician/Gynecologist, Board Chair, Institute for the Advancement of Multi-Cultural & Minority Medicine
4. Darryl Colbert, Program Manager, Catholic Community Services
5. Marshawn Evans, Esq., Former Miss District of Columbia
6. Gene Guerrero, Senior Policy Analyst, Open Society Institute
7. Rosetta Kelly, Lead Parent Advocate, Rebecca Project for Human Rights
8. The Honorable Rufus King, III, Chief Judge, Superior Court of D.C.
9. Vincent Schiraldi, Director, D.C. Dept. of Youth Rehabilitation Services
10. Ivory A. Toldson, Assistant Professor, Howard University
11. Joseph B. Tulman, Professor, Univ. of District of Columbia David A. Clark School of Law
12. Nora Volkow, M.D., Director, National Institute on Drug Abuse

END NOTES

[1] See, U.S. Sentencing Commission. (1997). Special Report to Congress: Cocaine and Federal Sentencing Policy. U.S. Sentencing Commission: Washington, D.C. See also, Mauer, M. (2006). Race to Incarcerate. The New Press: New York.

[2] See, Institute of Medicine. (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academies Press: Washington, D.C.

[3] State governments now bear the financial burden of the consequences of drugs and alcohol in our nation, spending over thirteen percent of their budgets on problems related to drug and alcohol use. Less than four percent of this is spent on prevention and treatment, while more than 96 percent pays for the avoidable social and physical consequences that result from our failure to apply what we know about how to prevent and treat substance use problems. Between forty and eighty percent of families in the child welfare system have alcohol or other drug problems; and a majority of children in foster care come from families with drug or alcohol problems; more than half of all state prison inmates were under the influence of alcohol or drugs when they were arrested; nearly one in six state inmates committed their crimes to support a drug addiction; drunk driving is a major expense to the police, courts and emergency medical systems; about 20 percent of acute Medicaid expenditures pay for alcohol or drug related medical costs. See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts.

[4] In 2002-2004, approximately 23.5 million people age 12 or over needed treatment for an alcohol or illicit drug problem but only 2.3 million of these individuals in need of treatment actually received specialty treatment, leaving 21.2 million people still needing treatment. Ten percent of the care is consistent with scientific knowledge about addiction treatment, similar to other areas of health care. See, Institute of Medicine. (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academies Press: Washington, D.C.

[5] See, Institute of Medicine. (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academies Press: Washington, D.C.

[6] Ibid.

[7] Federal Medicaid guidelines now allow States discretion over whether, and to what extent, to cover substance use treatment programs. As a result, coverage for substance use treatment varies substantially from State to State. Thus, consideration should be given to whether Federal Medicaid legislation should be amended to mandate uniform coverage in all States and whether the requirement should comprehensively embrace all forms of substance abuse and alcoholism treatment, and related mental health treatment, both in-patient and outpatient. See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts.

[8] See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts.

[9] The federal government started covering mental illness and substance use disorder care for all federal employees in 2001, and subsequent evaluation has shown that the cost of insurance did not increase when parity for behavioral healthcare was implemented. See, Goldman, H., et al. (2006). Behavioral Health Insurance Parity for Federal Employees. New England Journal of Medicine 354(13), 1378-86. Indeed, early treatment of substance abuse problems or alcoholism may save the insurance carrier money in avoiding greater expenditures for physically related medical problems which might occur if the drug usage or alcoholism problem had not been treated. Aggravated

diabetes, increased liver ailment problems and blood circulation problems, for example, all may require greater medical expenses than otherwise would have occurred if there had been parity for treatment of the substance abuse disorder or alcoholism when it first appeared necessary that the client receive treatment. See, Harris, K., Carpenter, C., & Bao, Y. (2006).The Effects of State Parity Laws on the Use of Mental Health Care. Medical Care, 44(6), 499-505.; Study: Parity that Includes SA Does Not Spur Utilization, Cost (2006). Alcoholism & Drug Abuse Weekly.

[10] See, Chaput, L. (2002). Dual diagnosis: An Integrated Approach to Treatment. Journal of Social Work Practice in the Addictions, 2(2), 95-96; Kanwischer, R. (2001). Principles and Practice for the Screening, Diagnosis, and Assessment of Persons with Co-occuring Mental Illness and Substance Abuse. Psychiatric Rehabilitation Skills, 5(1), 29-51.

[11] See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts. See also, Gentilello, L., Donato, A., Nolan, S., Mackin, R., Liebich, F., Hoyt, D., & LaBrie, R. (2005). Effect of the UPPL on Alcohol Screening in Trauma Centers. Journal of Trauma, Injury, Infection, and Critical Care, 59(3), 624-631.

[12] The National Policy Panel in its June 2006 Blueprint for the States report recommended requiring all public and private health insurance programs to offer the same coverage and access for alcohol and drug treatment as they provide for other diseases. It also recommended expanding drug treatment resources, pooling of treatment funds and case management support from multiple State agencies into joint purchasing arrangements, and implementation of a memoranda of understanding to ensure use of a standard of treatment for all clients using best practices. Thus, where an individual has physical ailments such as diabetes and hypertension, a substance use disorder, alcoholism and mental health issues, the monies for all of these conditions could be pooled so as to provide an integrated treatment program for him. The Panel also recommended expanding Medicaid coverage to provide a range of alcohol and drug treatment services for all beneficiaries, and preventive services for high risk children, concluding that this was the fastest and most cost effective way to get critically needed services to low income parents and their children. See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts.

[13] Where that individual is placed on a period of probation supervision, he or she should be connected with treatment and recovery services needed to maintain abstinence. The National Policy Panel in its Blueprint for the States report noted that chief judges of courts should exercise leadership by ensuring that all other judges and judicial personnel are adequately trained to identify and act on substance abuse problems that affect the majority of people who enter the courts. See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts. Judge Nathaniel Walker (retired) of Selma, Alabama testified at the Barbados, W.I. hearings that these training programs should also include informing judges of all available resources in their communities and how to develop collaborative arrangements with agencies and churches to place offenders in available treatment programs.

[14] An example of an ideal treatment center is one with an interdisciplinary staff that provides detoxification and support services for those who are dual diagnosed with substance abuse and an emotional/mental disorder. The center would be staffed by a physician and certified addiction counselors who develop individualized treatment plans for the patients who also participate in 12-Step programs.

[15] The National African American Drug Policy Coalition, Inc.'s nine pilot sites (local coalition groups) are designed to serve as citizen advisory groups by bringing together local representatives of the member organizations to deal with individuals with substance abuse and mental health disorders. These groups advise courts of available resources in their communities and urge local policymakers to correct deficiencies in resources.

[16] In its 2002 Annual Report to Congress on substance abuse treatment programs in the Nation's federal prisons, the Federal Bureau of Prisons reported that 50 of the Bureau's prisons had a residential drug abuse treatment program in which inmates were housed together in a separate unit of the prison reserved for drug abuse treatment. In the fiscal

year 2002, more than 16,000 inmates participated in the in-prison residential drug abuse treatment programs and more than 13,000 participated in community transition drug abuse treatment. The Bureau asserted that rigorous analysis of these programs by it and the National Institute on Drug Abuse showed that these programs made a significant positive difference in the lives of inmates following their release from prison as they were substantially less likely to use drugs or be rearrested compared to other inmates who did not participate in the treatment programs. See, Federal Bureau of Prisons. (2003). Substance Abuse Treatment Programs in the Federal Bureau of Prisons: Fiscal Year 2002 Report to Congress. The Commission urges the expansion of this program.

[17] See, Rosenbloom, D., Leis, R., Shah, P., & Ambrogi, R. (2006). Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a National Policy Panel. Join Together: Boston, Massachusetts.

[18] See, Stanhope, V., Solomon, P., Pernell-Arnold, A., Sands, R., & Bourjolly, J. (2005). Evaluating Cultural Competence Among Behavioral Health Professionals. Psychiatric Rehabilitation Journal, 28(3), 225-233. See also, Gonzàlez Castro, F., & Garfinkle, J. (2003). Critical Issues in the Development of Culturally Relevant Substance Abuse Treatments for Specific Minority Groups. Alcoholism, Clinical and Experimental Research, 27(8 (Print)), 1381-1388.

[19] Letter from Loretta Jones, M.A., Executive Director, Healthy African American Families II, Inc., Los Angeles, California, dated March 3, 2006. On this issue, she concludes: "There still are valuable contributions to be made to society by the addict who is afforded capabilities for recovery."

[20] See, Bonastia, C. (2006). The Historical Trajectory of Civil Rights Enforcement in Health Care. Journal of Policy History, 18(3), 362-386.

[21] See, Snowden, L. (2003). Bias in Mental Health Assessment and Intervention: Theory and Evidence. American Journal of Public Health, 93(2), 239.

[22] See, Fritz, G. (2006). The Debate Over Drug Testing in Schools. Brown University Child & Adolescent Behavior Letter, 22(3), 8-8; Kroutil, L., Van Brunt, D., Herman-Stahl, M., Heller, D., Bray, R., & Penne, M. (2006). Nonmedical Use of Prescription Stimulants in the United States. Drug & Alcohol Dependence, 84(2), 135-143.

[23] Martin Y. Iguchi, Ph.D., Professor, UCLA School of Public Health and Senior Behavioral Scientist, RAND Corporation suggested ways to eliminate bias including, a quality assessment approach which includes involvement of all stakeholders, transparent and open exchange of information, collection of relevant data, clearly stated policies and procedures, report cards and performance measures, and data-driven decisions and interventions as effective means to deal with disparity.

[24] See, Prison Situation Among the States and in the Federal System, Mid-2003. (2005).World Almanac & Book of Facts. London, A., & Myers, N. (2006).

[25] Ibid.

[26] See, See, Institute of Medicine. (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academies Press: Washington, D.C.

[27] See, www.nasadad.org for recommendations on treatment programs. See also, The White House. (2005). National Drug Control Strategy.

[28] According to a new report from the Justice Policy Institute released on April 13, 2006, drug treatment legislation enacted in California was followed by a greater decrease in the number of individuals incarcerated for drug possession and drug charges than any other large state prison system. According to the Report "Proposition 36: Five Years Later," researchers found that since 2000, California reduced its drug-possession prison population by the largest number of prisoners (over 5,400) among the Nation's largest prison systems. California also experienced the largest numerical decline in the number of drug prisoners of the 10 largest states. Only New York saw a greater

percentage drop in the number of those imprisoned for drug crimes. Most significant was the finding that while opponents of the initiative warned that Proposition 36 might lead to an increase in violent crime, California's violent crime rate has declined since 2000 at a rate higher than the national average Finally, it is also significant to note that since 2000, spending on drug treatment in California has doubled, but Proposition 36 had saved the State hundreds of millions of dollars. The researchers of the Justice Policy Institute Report estimated that 140,000 fewer people were admitted to prison for drug possession due to Proposition 36. See, Ziedenberg, J., Ehlers, S. (2006).Proposition 36: Five Years Later. Justice Policy Institute; Fratello, D. (2006). Proposition 36: Improving Lives, Delivering Results: A Review of the First Four Years of California's Substance Abuse and Crime Prevention Act of 2000. The Drug Policy Alliance; Belenko, S. (2006). The Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers. Treatment Research Institute at the University of Pennsylvania.

[29] Bureau of Justice Statistics, Compendium of Federal Justice Statistics, 2003 (Washington, D.C.: October 2004) Table 7.16, p. 112.

[30] U.S. Sentencing Commission, Sourcebook (2002), Table 34.

[31] Substance Abuse and Mental Health Services Administration, 2004 National Survey on Drug Use and Health, Population Estimates 1995 (Washington, D.C.: September 2005), Table 1.43a.

[32] See, Dervarics, C. (2006). Lawsuit: Drug-Based Ban on Financial Aid Hurts Minorities. Diverse: Issues in Higher Education, 23(7), 6-7; Lawsuit Seeks to Repeal Financial Aid Drug Exclusion. (2006). Alcoholism & Drug Abuse Weekly; Leinwand, D. (n.d.). Drug Convictions Cost Students their Financial Aid. USA Today; Klein, A. (2006). Groups Challenge U.S. Ban On Aid for Drug Offenders. Education Week, 25(30), 33-33.

[33] See, Meara, E. (2006). Welfare Reform, Employment, and Drug and Alcohol Use Among Low-Income Women. Harvard Review of Psychiatry, 14(4), 223-232; Morgenstern, J., & Blanchard, K. (2006). Welfare Reform and Substance Abuse Treatment for Welfare Recipients. Alcohol Research & Health, 29(1), 63-67; Blanchard, K. A.; Sexton, C. C.; Morgenstern, J. (2005). Children of Substance Abusing Women on Federal Welfare: Implications for Child Well-being and TANF Policy. Journal of Human Behavior in the Social Environment, 12(2), 89-110. Report Attempts to Bolster SA's Inclusion in TANF Reauthorization. (Cover story). (2002). Alcoholism & Drug Abuse Weekly.

[34] See, Stinson, P. (2004). Restoring Justice: How Congress Can Amend the One-Strike Laws in Federally-Subsidized Public Housing to Ensure Due Process, Avoid Inequity, and Combat Crime. Georgetown Journal on Poverty Law & Policy, 11(3), 435-494.

[35] See, http://www.sentencingproject.org/rights_restoration/table6.html; Coppolo, G., Reinhart, C., Nelson, J. (2005). Consequences of a Felony Conviction Regarding Employment. OLR Research Report 2005-R-0311.

[36] See, State of Florida Executive Order Number 06-89.

[37] See, Bernal, G. (2006). Intervention Development and Cultural Adaptation Research with Diverse Families. Family Process, 45(2), 143-151; Hecht, M., & Krieger, J. (2006).The Principle of Cultural Grounding in School-Based Substance Abuse Prevention. Journal of Language & Social Psychology, 25(3), 301-319; Sue, S. (2006). Cultural Competency: From Philosophy to Research and Practice. Journal of Community Psychology, 34(2), 237-245; Fowler, D., DiNitto, D., & Webb, D. (2004). Racial/Ethnic Differences in Dually Diagnosed Anglo and Ethnic Minority Women Receiving Chemical Dependency Treatment. Journal of Ethnicity in Substance Abuse, 3(3), 1-16.