OVERCOMING ADDICTION DISCRIMINATION

STATE EXPERTS AND POLICY-MAKERS
DEVELOP POLICY RECOMMENDATIONS

Promoting Addiction Treatment,
Prevention, and Recovery
Through Advocacy and Education

Public Policy and Information
Friends of Addiction Recovery-NJ
Care Coordination
The many New Jersey residents with an alcohol or drug addiction, as well as those who are in recovery from this disease, routinely encounter stigma and discrimination. Existing policies, laws, practices and misplaced perceptions undermine acceptance of addiction as a treatable disease and health condition and restrict access to appropriate health care, employment, housing, and public benefits.

According to a 2002 survey by the Eagleton Institute’s Center for Public Interest Polling, 90 percent of state residents view alcohol and drug addiction as a serious problem. The survey, which was commissioned by National Council on Alcoholism and Drug Dependence-New Jersey, also found that 75 percent know someone who has had a problem with alcohol or drugs. But the poll revealed inconsistencies indicative of stigma: almost half of New Jerseyans said they would be more guarded meeting someone in recovery than they would be in general.

Nearly one in three New Jersey residents report knowing someone in recovery from alcohol or drug addiction. However, the prevalence of people in recovery from this disease has not translated into broad public understanding. Forty percent of New Jersey citizens still view alcohol and drug addiction as a personal weakness instead of a health problem. This misunderstanding often leads to discrimination against individuals seeking treatment for and recovering from alcohol or drug addiction. In examining the issue of stigma, residents were divided almost evenly on whether addiction should be recognized as a health problem (41 percent) or attributed to personal weakness (40 percent). The closer the subject’s relationship to an addicted individual, the likelier they were to view addiction as a health problem.

This finding reflects how stigma continues to introduce doubts where addictive disease and recovery from it are concerned. Stigma and discrimination towards individuals seeking treatment and recovery creates unnecessary barriers and discourages them from obtaining necessary treatment and progressing in their recovery.

One of NCADD-NJ’s core principles is to confront the stigma surrounding alcoholism and drug addiction, and the agency remains firmly committed to this cause. In an effort to address these problems with meaningful action, NCADD-NJ convened a panel of state experts and policy-makers to examine this form of discrimination and to develop policy recommendations to overcome it. The New Jersey policy panel was prompted by the Eagleton Institute survey findings and is modeled closely after a 2003 report issued by the National Policy Panel of Join Together, a project of the Boston University School of Public Health, to address alcohol and other drug addiction discrimination on the national level.

As the findings in the 2002 Eagleton survey show and the testimony presented to the panel further illustrates, New Jersey still faces the challenge of confronting stigma and discrimination against those seeking treatment for or recovering from the disease of addiction.

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**Fundamental Principles of the Report**

**Principle 1:** Alcoholism and drug addiction are treatable and preventable diseases that society needs to accept as medical conditions from which people recover.

**Principle 2:** People seeking treatment for or recovering from alcohol or drug addiction should not be subject to discriminatory restrictions based upon their medical condition. They should be afforded opportunities for healthcare, employment, education, housing and public benefits equal to those provided to individuals with other chronic illnesses or disabilities as required by Federal and State law.

Policies, laws, and public perception that do not regard addiction as a treatable health condition are at the core of the problem. Addiction treatment research demonstrates that alcohol and drug addiction are treatable biopsychosocial illnesses that are similar to other chronic conditions such as asthma, diabetes or hypertension. Relapse and non-compliance are no more prevalent for people being treated for alcohol and drug addiction than among people with other chronic illnesses. Outcomes of treatment interventions for addiction are the same or better than those for hypertension, asthma and diabetes. Despite this research, many of New Jersey’s policies, laws, and public perceptions treat addiction as a moral or criminal weakness rather than as a chronic illness that can be effectively treated and managed like any other chronic illness.

Due to these misplaced perceptions, people with an alcohol or drug addiction seeking treatment or maintaining recovery are subject to policies and laws that restrict their access to appropriate health care, education, training, employment, housing, and public benefits. These obstacles can thwart the recovery process and prevent individuals from reclaiming their lives from addiction. Even after treatment is successful and leads to recovery from addiction, some existing laws continue to deny individuals certain rights by not allowing them to receive the support and opportunities available to people with other chronic illnesses and disabilities. These policies and laws exacerbate the misplaced perception of people with an alcohol or drug addiction and help perpetuate stigma and discrimination.

There is a remedy in state and federal law to challenge such disparate treatment and discrimination. The Federal Americans with Disabilities Act (hereafter ADA) and New Jersey’s Law Against Discrimination (hereafter LAD) prohibit the discrimination against anyone as a result of their disability. Alcoholism has long been recognized as a disability protected under these laws. Drug addiction is also recognized as a covered disability when the person is no longer using illegal drugs, has successfully completed or is participating in a drug rehabilitation program (including a methadone program), has otherwise successfully recovered, or is falsely believed to be engaging in such use.

**Overall Recommendation:**

1. Launch an ongoing public awareness campaign to educate the public and change attitudes and perceptions to de-stigmatize addiction and ensure its place in the public health realm. The awareness campaign should:
   - Focus on the disease of addiction and the effectiveness and positive outcomes of treatment, and the many cases of recovery.
   - Emphasize that public policy should reflect the long-held recognition of health professionals that addiction is a treatable medical condition from which many people recover.
   - Educate and develop a brochure for the public, businesses and lawmakers concerning addiction discrimination and outlining their rights, responsibilities and recourse under the ADA and LAD.
   - Encourage people to talk openly about their treatment for and recovery from addiction. Millions of Americans are living successful and productive lives in recovery from addiction and should not face unnecessary obstacles.

**Ending Stigma and Discrimination in Health Care**

Alcohol and drug addiction are chronic, often fatal diseases that can be effectively treated. Scientific research conducted over the past 10 years demonstrates that addiction to alcohol and drugs is a chronic biopsychosocial disease with similarities to diseases such as asthma, hypertension and diabetes. The research further shows that people treated for alcoholism and drug addiction have a higher compliance rate than do those treated for other chronic illnesses.
The outcome of addiction treatment is very favorable compared to the outcomes for treatment for those other diseases. Despite these findings, alcoholism and drug addiction treatment is not covered like other chronic illnesses.

The misguided approach to health coverage for addiction treatment is largely the product of the so-called managed care revolution that began in the early 1990’s. Under restrictions imposed by managed care organizations, New Jersey’s privately insured policy-holders who have an addiction have been forced to go without appropriate treatment or to rely on the public sector for treatment. This has caused unnecessary deaths, diminished addiction treatment capacity, cost businesses billions of dollars in increased health care expenditures and lowered productivity, and resulted in other deleterious effects on society.

Due to the stigma associated with addiction, individuals diagnosed with an addictive disease are not afforded the thorough medical attention that this chronic disease demands. The laws and regulations currently in place are not well-defined or adequately enforced to protect people with addictive illness from discrimination.

Although state law requires that insurance benefits for alcoholism “be provided to the same extent as for any other sickness under the contract,” such coverage has not been afforded those who need this treatment. The level of care, visits, and annual lifetime benefits are limited in a manner that does not meet the needs of the typical pattern of addictive behavior. The State Department of Health and Senior Services and Treatment Advisory Task Force concluded that where managed care organizations authorize treatment, care is of “insufficient duration and intensity to promote lasting recovery.” Unlike coverage for other chronic illnesses, managed care has not followed generally accepted treatment protocols that have been shown to produce positive outcomes.

Treatment producing positive outcomes follows a continuum of care encompassing brief interventions, outpatient, intensive outpatient, partial hospitalization, inpatient, residential, inpatient hospitalization, detoxification, and aftercare. This model has been almost non-existent since the advent of managed care.

Unlike coverage for other chronic illnesses, utilization review decisions regarding addiction treatment coverage are made in an arbitrary, capricious and unreasonable manner. New Jersey’s policy-holders are not provided with the coverage promised in their policy or that is required by New Jersey’s Administrative Code.

In many cases, HMO’s do not consider the severity of the disease but instead require recent failures in outpatient care before approving inpatient coverage. Failure in outpatient care is not required for other potentially fatal medical conditions when a physician finds that inpatient care is the medically appropriate course of care, nor is such a requirement based upon generally accepted medical or clinical standards.

Testimony provided to the panel showed the degree to which insurance companies fail to follow the treatment

“There appear to be many laws that need to be changed to reduce addiction discrimination in New Jersey, and yet underlying all of this is a political and public opinion issue that almost precedes changing any law …the need for attitudes to change.”

Victor Capoccia, Senior Program Officer, Robert Wood Johnson Foundation

OVERCOMING ADDICTION DISCRIMINATION
Promoting Addiction Treatment, Prevention and Recovery Through Advocacy and Education

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TRUE STORY | Bryan Shane Touches the Lives of Thousands

Bryan Shane was truly a gift from G-d. At five days old, this angelic child came into my life and changed not only me but eventually touched the lives of thousands. I believe he was a messenger. I often sang the song “Heaven must be missing an Angel,” not knowing that 22 years later his spirit would be felt most strongly from the heavens.

Keenly perceptive and intuitive, Bryan, at six years of age said, upon understanding of the word adoption, “Mom, you couldn’t have a son, and I couldn’t have a mom, and that’s why G-d put us together.”

As he grew, Bryan had mounting questions, anti-establishment views stemming from the many injustices in our world. He attached himself to peers who had similar thoughts and found solace in altering their feelings and existence with inhalants, marijuana and alcohol. This was the beginning of a downward spiral into addiction where the very freedom Bryan cherished was taken away. I often think about Bryan at age five, climbing a tree in the front of our home, and when asked where he was hiding, he replied, “my freedom tree.”

After one rehabilitation attempt, Bryan said, “I have exorcized the demon.” But his demon returned. Treatment for his addiction and a period of healing - gathering the necessary “tools for life” - couldn’t possibly happen in the 30-60 days that were allotted. Family visits with him during his treatment at a distant facility were rare, and education about his condition was sketchy. His treatment plans were not intensive enough, done on an “as needed” basis. How was recovery to happen? What is it going to take to exorcise this demon? How long?

My fear of living without Bryan was growing, but it could not conceivably become a reality. I attended Al-a-Non at Bryan’s suggestion. Guilt from hurting himself, his mom and other family members he loved dearly was overwhelming. He indulged in more drugs to numb his pain. Eventually, physically, emotionally, mentally and spiritually he became depleted. Bryan’s life was taken by a fatal dose of heroin and cocaine in the early morning hours of July 25, 1997.

Memories of his life, his love of nature, animals, music and quest for a better world free from addiction were recalled when I visited the beautiful Memorial Garden at the Daytop treatment facility that honors his memory.

I feel him smiling.

He is loved.

Story and photos provided by
Bryan Shane’s mother, Susan R. Foose
course of the health care professional’s assessing and evaluating a patient as to the nature and duration of treatment appropriate to the individual case.

New Jersey statutes require some group and individual policies sold by insurance companies to provide treatment for alcoholism when such treatment is prescribed by a doctor of medicine (IHC, SEH and HMO plans are not included in this mandate).

State law also provides that treatment include inpatient and outpatient services for alcoholism. New Jersey’s Administrative Code requires HMO contracts to provide a minimum of 30 days of inpatient addiction care, and many plans claim to provide 30 days of inpatient substance abuse services. Despite these provisions, state residents seeking treatment for addictive illness are unable to access these services. It is necessary to address the inconsistency that exists between language in health plans and the experience of individuals seeking to access those benefits.

There is no adequate means to enforce compliance with these plans. Policy-holders are not informed about the unwritten limitations on their drug and alcohol treatment benefits. During one panel discussion, Dr. Louis Baxter, Executive Medical Director of the New Jersey Medical Society’s Physicians Health Program, criticized the labyrinthine internal and external appeals process available to consumers as being of little real use. This multi-tiered process, Dr. Baxter said, is too complicated and takes far too long and in most cases results in the crisis that caused the individual to seek treatment to pass. The appeals process takes a minimum of 60 days.

The emergency provisions for appeals are no more helpful when dealing with alcohol or drug addiction. Typically, there is a small window of opportunity to engage the patient in the detoxification or treatment process. The five-day emergency process often results in the loss of this opportunity, leaving the addicted person without hope for recovery. Dr. Baxter recounted his being on the phone for three days trying to secure treatment for a patient. By the end of those three days, he said, the opportunity for treatment was lost as the patient went “underground.”

In addition to the above described discrimination, New Jersey is among the majority of states that still have a statute based on a model law written by the National Association of Insurance Commissioners (NAIC) over 50 years ago. The Uniform Accident and Sickness Policy Provision Law (UPPL) states that insurers can deny claims for injuries, illnesses or losses due to the insured being under the influence of alcohol or drugs not prescribed by a doctor. It applies to all types of insurance, including auto, health, and workers’ compensation.

The possibility of denied claims has a chilling effect on doctors and staff of hospital emergency rooms and trauma centers, who may be discouraged to screen injured patients for alcohol or other drug use. Approximately 50 percent of trauma patients have alcohol in their blood at the time of injury. Although NAIC adopted a resolution in March 2001 calling for the repeal of the UPPL, New Jersey has not amended its statute.

“The time has come for addiction to come out of the closet. The concept of anonymity served its purpose long enough. Once the shame and stigma of addiction are taken away, and the real numbers can be counted, those responsible for the discrimination will lose their power.”

Sue Shields, Mother, testimony before the Panel

**OVERCOMING ADDICTION DISCRIMINATION**

PROMOTING ADDICTION TREATMENT, PREVENTION AND RECOVERY THROUGH ADVOCACY AND EDUCATION

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Sue Shields, Mother, testimony before the Panel

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Recommendations

1. Insurance coverage for treatment of alcohol and drug addiction should be at parity with that for other chronic illnesses and disabilities, similar to asthma, hypertension or diabetes.

* Inform and educate the public, corporations and insurance companies about the social and economic benefits of utilizing established assessment and placement criteria and of covering treatment of alcoholism and other drug disease at parity with that for other chronic illnesses.

2. Utilization reviews should rely upon the recommendations of the health care professionals examining and evaluating the patient and be based on the best scientific protocols and standards of care.

* Require for the purpose of utilization management that “medically necessary” or “medical necessity” means as indicated in the most recent Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders published by the American Society of Addiction Medicine.

3. There needs to be a mechanism to safeguard that insured persons receive the health care recommended by their health care provider and promised in their plan, such as that provided by the Managed Health Care Consumer Assistance Program.

* Re-fund the Managed Health Care and Consumer Assistance Program established pursuant to P.L. 2001, c 14 and add a component that assists families in obtaining the alcohol and drug treatment benefits in their policy. The program’s activities should include a hotline to take calls from consumers who have been refused coverage, direct advocacy, legal assistance, assistance in filing complaints and appeals, and provide crisis support. The office should also monitor carrier compliance and work with the insurers to achieve successful resolution of insurance concerns in a timely manner.

* Establish an ombudsman’s position within the Office of Public Advocate to assist families in obtaining the alcohol and drug treatment benefits written into their health policies.

* Investigate filing a lawsuit patterned after the successful action against Blue Cross/Blue Shield in Minnesota, to determine if insurance companies are defrauding their customers by denying coverage in their policies.

4. Insurance companies should not be able to deny claims for injuries, illnesses, or losses due to the insured being under the influence of alcohol or drugs.

* Educate the public and lawmakers on the chilling effect and negative impact of New Jersey’s version of the Uniform Accident and Sickness Policy Provision Law (17B:26-27) and ask state legislators to repeal it.

Ending Stigma and Discrimination in Employment

Employment is an important factor for recovering people trying to rebuild their lives. New Jersey’s current drug laws and policies related to employment have only added to the difficulties of those recovering from addiction. Among the most serious barriers to employment someone with an alcohol or drug addiction could face is the bias and stigma associated with his/her alcohol or drug history. Many employers are reluctant to hire applicants with a history of alcohol or drug use because of stereotypes unrelated to his/her ability to perform the job.

People in recovery have been watched more closely, terminated from employment despite no work performance problems, or required to go through an arduous process prior to being licensed, including having the licensing board request confidential treatment records.
The ADA and LAD have been used successfully to prohibit discrimination against job applicants and employees because of their history of, or treatment for, alcohol or drug addiction. An individual who is currently engaging in the illegal use of drugs is not protected by the ADA and may be discharged or denied employment. But the ADA and LAD allow that a person who used drugs in the past, is in recovery from addiction, is participating in a drug program (including a methadone program) and not using illegal drugs, or is falsely perceived to have engaged in drug use is considered disabled and may not be denied employment or terminated as a result of this disability.

Despite these laws, legal restrictions continue to be placed on recovering people that can frustrate their efforts to remain alcohol- or drug-free. The restrictions are not related to the person’s qualifications or ability to perform the job and do not distinguish between those who currently use drugs and those who have used drugs in the past.

These restrictions only add to the stigma and discrimination. Many of these limits apply to people with drug convictions or the disease of addiction but not to people who have committed other more serious crimes or who have other chronic illnesses. Some of these restrictions are life-long and do not allow for demonstrated rehabilitation, thereby repeatedly punishing people for their addiction and not allowing them an equal opportunity to reclaim productive lives.

There are several categories of jobs that bar recovering people from obtaining employment. In New Jersey, people with a drug conviction, including possession of paraphernalia, regardless of the intervening time frame or rehabilitation, are statutorily barred from obtaining employment as aircraft/airport employees, school employees, including teachers, substitute teachers, teacher’s aide, school bus driver, cafeteria worker, secretary, clerical worker, or maintenance worker. There are also statutory restrictions that deny people employment or prevent them from obtaining certificates or licenses based solely on having an alcohol or drug addiction, even if they have been in recovery. These include but are not limited to administrators and supervisors of the Department of Conservation, parks and reservations, airfreightman, and longshoreman.

Richard Micewicz testified about a four-year-old marijuana conviction for possession of less than a gram (13/100s of a gram) and, after successfully completing probation that included over a dozen drug tests, being disallowed from bartending or even waiting tables. He had received a Bachelors of Arts in political science and a minor in psychology and obtained a job as a recreation coordinator and counselor for a social service program. He was later told that the FBI informed his boss that he could not work there because of his conviction. The only basis for appeal was if...
“It’s important to realize that when we’re talking about discrimination, it goes to all levels of society ... professional physicians, other health care professionals, to electricians, to carpenters, all the way down to the homeless on the street...we want to do whatever can be done to help get that eradicated.”

Dr. Edward Reading, New Jersey Medical Society
there was an error in the record. His rehabilitation was not considered.

The statutes and practices of disqualifying someone from employment based upon past drug use, addiction or alcoholism is contrary to the ADA, the LAD, licensing laws and the Rehabilitated Convicted Offender Act. It is difficult, if not impossible, to reconcile the laws that prohibit one from working in a particular occupation and laws that protect these people from such a prohibition.

**License Suspension**

In addition to the above obstacles, New Jersey law requires people convicted of drug offenses to forfeit their driver’s license for a period of not less than six months and not more than two years[^14]. A third DWI conviction leads to a 10-year driver’s license suspension. The law has no avenue for even a limited restoration, even after five years of recovery is documented. These same restrictions are not placed on people who have been convicted of other, perhaps more serious, crimes. In 2000, 17,543 licenses were suspended under the Comprehensive Drug Reform Act.

The loss of driving privileges is directly related to employability in New Jersey. Seventy-six percent of the people who use illicit drugs and thus risk forfeiting their license are employed. A percentage of these people will be unable to continue working or attend treatment under the current statute. Lack of employment, poverty, idleness, and the inability to attend treatment contribute to ongoing addiction. Meaningful employment and the ability to attend treatment not only contribute to recovery of addiction but may provide another avenue for drug testing and/or participation in treatment programs funded by the employee, the employee’s insurance, or the employee’s company.

New Jersey, unlike many other states, does not allow for a restricted license for work or treatment. For instance, New York statutes allow for a restricted license at the discretion of the commissioner of the Division of Motor Vehicles when evidence is presented that it is necessary for employment, education, or medical treatment. Washington law allows for occupational licenses for work, job training, seeking employment, attending treatment for alcohol or drug use or attending twelve-step group meetings if the program does not provide transportation.

A restricted driver’s license has the potential to assist people who have completed treatment transition back into the community, participate in treatment, be gainfully employed, and pursue an education, while still holding them accountable.

**Recommendations**

1. Educate employers about the disease of addiction, successful treatment outcomes and recovery. Emphasize that addiction treatment and expanded alcohol and drug benefits will benefit their workplace. Engage and make allies of associations such as NJBIA and local chambers of commerce to carry the message to employers and encourage them to seek such benefits and encourage their employees to participate in treatment.

2. Employees should be encouraged to seek and participate in alcohol and drug treatment and should not be subject to overt or covert discriminatory actions or termination for doing so.
   - Educate and inform applicants, employees and employers of their rights and responsibilities under the ADA, LAD, and RCOA, i.e., an employees’ rights pamphlet.

3. Urge licensing boards to have in place non-punitive mechanisms to support people seeking recovery, such as those in place for physicians and lawyers.

4. Past alcohol and drug use or alcohol- or drug-related convictions should not be used to disqualify otherwise qualified individuals from obtaining or maintaining employment.
   - Enact legislation to ensure that sentences are fair and proportionate to sentences imposed for other criminal offenses, including a mechanism by which people in recovery will not be repeatedly punished for the same offense with collateral consequences, such as those related to employment; i.e., amend statutes so they do not (1) exclude applicants based solely on their status as
an alcoholic or addict, or (2) disqualify individuals due to a previous non-violent drug-related offense(s) if they can demonstrate they are in recovery and/or are no longer using drugs.

5. People who have been convicted of a drug offense and are not currently using drugs should be able to apply for a restricted driver’s license for employment, education and recovery related activities. Judges should have discretion not to impose a driver’s license suspension on a person convicted of a drug offense under these and other compelling circumstances and to reinstate the driver’s license of a person who can demonstrate an extended period of recovery.

- Enact a law to allow those convicted of a drug offense to apply for a restricted driver’s license for employment, education, treatment, and self-help meetings.

**Ending Stigma and Discrimination in Education**

Title IV Financial Aid eligibility is suspended for a student convicted under any federal or state law for possession or sale of a controlled substance. Title IV Financial Aid includes: Pell Grant, SEOG, LEAP, FFEL Subsidized Loans (Stafford Student Loan, FFEL) and Unsubsidized Loans (Stafford Student Loan, PLUS Loans, College Work Study).

The period of ineligibility for Title IV assistance under the provision begins with the date of conviction. For a drug possession conviction, eligibility is suspended one year for the first offense, two years for the second offense, and indefinitely for the third offense. For a drug-sale conviction, eligibility is suspended two years for the first offense and indefinitely for the second offense. A person’s Title IV may be resumed before the end of the ineligibility period if the student completes a drug rehabilitation program and complies with criteria established by the secretary.

These restrictions serve to perpetuate stigma and discrimination. The limits are not placed on those convicted of more serious crimes or who have other chronic illnesses. While not all people convicted of a drug-related crime need treatment, only half of the adult residents in New Jersey who want treatment are able to access it. Thus, for those trying to rebuild their lives, these suspensions frustrate their efforts to begin recovery.

**Recommendations**

People with drug convictions but no current use should not be restricted from obtaining student loans. Repeal laws that bar those with drug-related histories from obtaining student loans if they can demonstrate they are not currently engaging in drug use.

**Ending Stigma and Discrimination in Housing Zoning**

Recovery houses and treatment centers have experienced persistent difficulties due to the stigma and discrimination associated with addiction. The panel heard testimony from a physician from South Jersey, Dr. James Manlandro, whose family practice included the treatment of alcoholics and drug addicts. His patients were harassed and efforts were made to force the practice to relocate, although no viable alternate site was available. A resolution as well as a “no stopping or standing” ordinance was enacted around his office, which made it more difficult for people to access treatment. The township claimed the patients being treated for addiction created a crime element in the county, although the physician testified there had been no crime resulting from their presence. Because of these measures and the stigma associated with the office, many addicted people were prevented from getting treatment.
New Jersey law provides that methadone clinics not be construed as ancillary or adjunct to a doctor’s professional office for zoning purposes and gives municipalities the authority to direct the location of methadone clinics to areas zoned exclusively for business or commercial use. No other type of medical practice is subject to such restrictions. Prior to this law, methadone clinics were treated as medical offices that could be sited in residential neighborhoods.

This new law was enacted due to the misperception and stigma associated with people being treated for an addiction or with methadone. In an effort to pass this law, claims were made that methadone clinics attract a drug subculture that is unsettling to those seeking treatment and to neighbors of the methadone clinics. The intent of the law was to direct methadone clinics to operate in business districts, in part because they are better policed, despite evidence that they do not need such policing.

This law and ordinance is contrary to the ADA and LAD, which protect people with an addiction who are not currently using drugs or who are currently in drug treatment and not using drugs, including those in a methadone program.

**Private Housing**

Medical facilities are not the only ones subjected to stigma and discrimination. The misinformed attitudes voiced by some officials and the public amid a debate over the proposed opening of a recovery house in the South Ward of Trenton were indicative of stigma and worse. An elected official was quoted equating a neighborhood with addiction recovery housing with a “dumping ground.” On April 13, 2004, a statewide radio station’s talk show host devoted a lengthy monologue to degrading people recovering from addictive illness and said, “I don’t think you should have recovering addicts and alcoholics in a community where there are children … nobody wants nine drug addicts and alcoholics moving into their neighborhood … I don’t think you’ll get any opposition to that … I’m not a believer in curing these people. I’d burn the house down with these people in or out of it.” He referred to people with addiction as “losers” and went on to sarcastically describe treatment and 12-step programs. This mentality contributes to the misperceptions of the facts about addiction and leads individuals and local governments to blatantly discriminate against individuals in recovery.

Although the federal fair housing law, the federal Rehabilitation Act, the ADA, and the LAD may protect those with addictive illness from regulatory discrimination, it cannot protect them from the attitudes and misplaced perceptions of people in New Jersey.

New Jersey protects tenants from being evicted without good cause. This provides little protection to people with the disease of addiction. A person who has been convicted, adjudicated delinquent, or found by a preponderance of evidence in a civil action of a drug-related offense committed within or upon the leased premises can be evicted under this statute if they have not successfully completed or been admitted to a drug rehabilitation program. This is discriminatory in that not everyone who is convicted of a drug-related crime needs treatment; some may use self-help groups and others may not have an addiction. For those who need and want treatment, only half will be able to access it. For those who can get it, there is often a long waiting list. A tenant can also be evicted for allowing someone else who has been convicted of a drug offense to occupy the premises. However, they must know that the person has been convicted.

**Public Housing**

Public Housing is more restrictive. Federal law allows housing authorities to disqualify applicants or have a lease provision prohibiting illegal use of controlled dangerous substances or other unlawful activity on or off the property. A public housing authority may evict a tenant when a member of the tenant’s household or guest engages in drug-related activity on or off the property, even if the tenant did not know of the drug-related activity. Once evicted, the tenants are banned from receiving federal housing assistance for three years. However, the housing authority is given
Right from the start it seemed too good to be true. Had I really found a job so soon after graduating college that would allow me to build on my recreation experiences while simultaneously utilizing my psychology education? I grew up playing in recreation leagues, spent college coaching and refereeing in one, and now I was being hired to take on a leadership and program development role in one of the most effective social service programs in New Jersey. My official title was Recreation Coordinator/Counselor. My employer was School Based Youth Services, an innovative social service program that operates out of numerous junior high and high schools throughout NJ. This program provides various services to schoolchildren in need, such as individual and family counseling, substance abuse counseling, primary and preventive health services, learning support, employment counseling, and what was my primary duty, recreational activities. Unbelievably, my job was to come up with diverse after school and weekend activities, such as basketball tournaments, soccer games, weight-training clubs, trips to pro sports matches and amusement parks. Whatever I wanted to lead and facilitate, I could create. There was no more ideal job out there for me being only one year out of college. I was ecstatic. Unfortunately this dream scenario was about to come to a screeching halt.

You see, one summer back in college, I was caught with some marijuana. Not much, 13/100ths of a gram to be exact, but enough to mean a criminal record. To make matters worse this infraction occurred out on Sandy Hook, a National Park, making mine a federal offense. I dutifully completed all conditions of my probation, which among others were over a dozen random drug tests, all of which came back negative for any illegal substances. I had been off probation for nearly a year when I received the job offer from the School Based Youth Services program that operates out of the Pinelands Regional School District. When filling out paperwork after being hired I found out that I would have to be fingerprinted for this job. I thought my background might become a hindrance, so I confided in my supervisor, about my past marijuana charge. She seemed unfazed, asking me several questions such as, “How long ago? How much was involved? and Did I still smoke marijuana?” I told her it happened three years ago, I was caught with 13/100ths of a gram, and that I stopped smoking upon being placed on probation and never restarted. She was satisfied with my responses and told me that I was still the right person for the job.

For the first two months everything was fine. I fit in perfectly and everyone was extremely satisfied with my work. Then one rainy Monday afternoon, I got a call to come to the district office and meet with the Superintendent. I figured it would just be an introductory meeting he has with all new employees. I was wrong. I met with the Superintendent, who proceeded to tell me that he received a phone call from the FBI who informed him that due to my previous criminal record, I would be unable to continue employment with them and I would have to leave the school grounds immediately. I was floored. Apparently, there is a state law that any school receiving public funding can not hire someone with a past marijuana charge. What makes this law even more bewildering is that there is no testing in place to determine if people working in the school system are currently using drugs.

Discrimination, double jeopardy, ineffective legislation, reactive mindset, those are all terms that come to mind when I think about what transpired during the fall of 2003. How do we expect someone to turn his or her life around after making a victimless mistake that could best be summed up as youthful indiscretion? What is to be gained by stigmatizing and ostracizing an intelligent compassionate young mind, who only wanted to bring recreational enjoyment to the lives of children who otherwise may find other, less productive, ways to spend their time after school and on weekends? Are the children really safer as a result of not having someone who smoked marijuana in college lead their after school recreational activities? These are questions that still torment me to this day. Nothing productive can come out of a law that refuses to do anything to address the problem of drugs and drug users in our school system. If lawmakers really wanted to do something about this perceived problem, they should implement random drug testing for school employees, not make discriminatory decisions based on an individual’s past. People, including those who have used drugs in the past, are capable of changing.

Story provided by
Richard Micewicz
discretion as to whether to evict someone, and such discretion should be used with common sense and compassion.

**Recommendations**

1. Treatment centers, sober housing, and methadone clinics should not be subject to discriminatory zoning regulations or attitudes that prevent them from being housed like other medical facilities and people.
   - Work to repeal ordinances that restrict the siting of methadone treatment.
   - Educate officials and the public about the disease of addiction, treatment, methadone treatment, the treatment gap, and recovery. Emphasize that methadone is a medical treatment and people seeking treatment and recovery do not pose a threat.

2. Private and public housing authorities should use their discretion with common sense and compassion and assist addicted individuals in obtaining treatment rather than merely evicting them.

**Footnotes**

1. 42 USC126 IV 12210.
2. N.J.S 17:48-6a; 17:48A-7a; 17:48E-34; 17B:27-46.1
4. N.J.A.C. 8:38-5.2(a) NJAC 8:38-8.1(b)(2)
5. N.J.S 17:48-6a; 17:48A-7a; 17:48E-34; 17B:27-46.1
8. 2A:168A et. seq.
9. 2A:168-4
10. N.J.S. 45:1-21
11. see e.g. N.J.S. 18A:6-7.1
14. NJS 2C:35-16 and NJS 2C36A-1
15. NJS 40:55D-66:10
16. NJS 2A:18-61.1

“People who are very smart and educated don’t realize that there is still this lingering stereotype of an alcoholic as being a skid row bum, or a drug addict as having a needle in their arm.”

James O’Brien, Executive Director, Addiction Treatment Providers of New Jersey
Panel Members

Louis E. Baxter, M.D., FASAM  
Executive Medical Director  
Physicians Health Program/Healthcare Professionals Program  
Medical Society of New Jersey

Victor Capoccia  
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NJ State Nurses Association

Shai Goldstein  
Regional Director  
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Deborah Jacobs  
Executive Director  
American Civil Liberties Union of NJ

William Kane  
Director, NJ Lawyers’ Assistance Program  
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Lynn Limato  
Past Chair  
Friends of Addiction Recovery—New Jersey

Michael Murphy  
McManimon & Scotland, LLC

James O’Brien  
Executive Director  
Addiction Treatment Providers of New Jersey

Mary Lou Powner  
Executive Director  
Governor’s Council on Alcoholism & Drug Abuse

Roseanne Scotti  
Director  
Drug Policy Alliance of NJ
“My daughter is dead because she had a life threatening illness that is treated differently than other illnesses… My daughter never chose to become a drug addict, any more than a smoker chooses to get cancer or a sedentary person chooses to have a heart attack …She begged me for inpatient care…but inpatient care was denied because she hadn’t overdosed. Katie had her first and last OD three months later. Dead at the age of 16.

Sue Shields, Mother, testimony before the Panel