# Report of the Task Force on Drug Addiction Treatment to the King County Bar Association Board of Trustees

**May 15, 2001**

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**Drug Policy Project**

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# Introduction

The Task Force on Drug Addiction Treatment of the King County Bar Association Drug Policy Project was formed to report to the Board of Trustees on issues relating to treatment for addiction to drugs whose possession and sale are prohibited by current law.[1] This report considers why, when and how the people of Washington should provide treatment for individuals who are addicted to such drugs,[2] and makes recommendations with a view toward promoting the development and implementation of a comprehensive addiction-treatment plan for Washington.[3] Task Force participants, including lawyers, judges, treatment professionals, and others with extensive academic and practical experience, gave their time to this effort in the hope of focusing the attention of public policy makers on ways to improve our societal response to drug addiction through the appropriate use of effective treatment strategies.

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[1] The decision to initiate a drug-policy project focused on drugs whose possession and sale are prohibited by current law responds to the fact that our society and our laws have made a strong distinction between alcohol and other addictive psychoactive chemicals. The drugs proposed as the enemy in the "war on drugs" have not, for better or worse, included alcohol. Alcohol is sold in state liquor stores, and the Washington State Department of Agriculture promotes the cultivation of alcohol-related crops. (For example, its Chemical and Hop Laboratory "grades hops for seed, stem and leaf content and analyzes hops for brewing value," according to the DOA web site as of April 2001.) The Washington State Legislature has declared: "It is the policy of this state that alcoholics and intoxicated persons may not be subjected to criminal prosecution solely because of their consumption of alcoholic beverages but rather should, within available funds, be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." RCW 70.96A.010. While, as some of the data presented in this report reveal, societal harm associated with alcohol use is greater in many respects than the harm associated with the use of other drugs, the social and political history of state and national policies concerning other drugs, and the present consequences of those policies, warrant separate treatment of the subject. At the same time, several of the Task Force's recommendations could apply, with little modification, to treatment for alcohol addiction.

[2] Our use of the expression "drug addiction" is consistent with its definition in RCW 70.96A.020: "a disease characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning." "Drug addiction treatment" and "drug treatment" are used interchangeably.

[3] Other task forces of the KCBA Drug Policy Project are addressing the uses of criminal sanctions, drug abuse prevention strategies, and disproportionate racial impacts of drug policies.

## Summary

Drug addiction is a source of serious problems in Washington, as it is elsewhere, and the societal costs associated with it are significant. Reliable evidence demonstrates that treatment can be effective both in reducing drug addiction and use, and in reducing the crime, violence, unemployment and economic dependence, family neglect and infectious disease that are associated with drug addiction.

Drug addiction treatment is available in Washington only to a small minority of those who need it, either through the criminal justice system or otherwise. Washington has not made a serious commitment to providing treatment to those who need it and cannot afford it. As a result, most people who need or could benefit from treatment do not get it, and most of the societal harm that could be averted by effective treatment strategies is not averted.

With a view toward promoting the development of a comprehensive drug treatment plan, the Task Force makes 19 recommendations. Four central recommendations are briefly stated as follows:

- Drug addiction treatment should be available on request to every Washington resident who wants and needs it. It should be available at public expense to those who cannot otherwise afford it.
- Drug treatment should be complemented by, and coordinated with, other needed treatment and assistance, including mental health treatment.
- Special efforts should be made to assure that drug treatment, including inpatient treatment, is promptly available to children who need it.
- The people of Washington should make a commitment to, and have a strategy for, the adequate funding of drug treatment.

## I. Drug addiction is a source of serious and costly problems in Washington.

The consequences of drug addiction are expensive and far-reaching. The "economic costs of . . . drug abuse in Washington" for the year 1996 were analyzed in a study sponsored and published by the Washington State Division of Alcohol and Substance Abuse. The total cost identified was *$2.54 billion.* Fifty-nine percent of the economic costs were attributable to alcohol and 41% to the use of other drugs.[4] The study also reported 16,000 hospital discharges in 1996 classified as drug-related, as well as 2,824 deaths. Of the deaths, 2,318 were alcohol-related and 506 were related to other drugs.[5]

The $2.54 billion dollar figure cited above includes both costs to Washington residents individually and costs reflected in the state budget. Focusing more narrowly on the impact of addictions on state budgets, a recent national report showed that public spending for 1998 to "shovel up the wreckage of substance abuse" cost the State of Washington $1.51 billion – more than 10% of the state budget.[6]

Harder to quantify, but no less significant, is the emotional and physical suffering attributable to drug addiction. The well-being of individuals and families is compromised. Drug addiction contributes to child abuse and neglect, family disintegration and divorce, teen pregnancy, poor school performance, homelessness and suicide. Health conditions associated with addiction range from accident-related injuries to HIV infection and AIDS.[7]

[4] Thomas Wickizer, *The economic costs of drug and alcohol abuse in Washington State* (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999). Dr. Wickizer is Rohm & Haas Professor of Public Health Sciences at the University of Washington. The $2.54 billion figure includes costs associated with crime ($541 million), direct costs for medical care resulting from drug overdoses or alcohol related automobile accidents and costs associated with substance abuse related diseases ($211 million), social welfare administration ($9 million), fire-destruction ($8 million), non-medical costs of motor vehicle accidents ($237 million), payments for private and publicly funded substance abuse treatment ($160 million), lost wages and housekeeping values from premature death ($929 million), and reduced productivity of wage earners and housekeeping values for in-home workers ($369 million). "Housekeeping values" represent "imputed market values for maintaining the home." *Id*. at 14.

[5] *Id*. at 18.

[6] *Shoveling Up: The Impact of Substance Abuse on State Budgets* 75 (National Center on Addiction and Substance Abuse at Columbia University, 2001). The report is available at the following on the Internet at the following address: http://www.casacolumbia.org. The state spending for Washington is broken down as follows: justice ($378,772,700), education (elementary/secondary) ($448,832,700), health ($273,679,800), child/family assistance ($139,655,900), mental health/developmentally disabled ($145,061,300), public safety ($1,144,300), regulation/compliance ($64,950,000), prevention, treatment and research ($57,198,000).

[7] Results of research that has attempted to quantify these and other harms are reported in *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State: 2001 Report* (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001). Copies of the report can be obtained from the Washington State Alcohol & Drug Clearinghouse (1-800-662-9111).

The relation of injection drug use to AIDS has been a particular cause for concern. "From 1982-1994, 18% of diagnosed AIDS cases in Washington State were traceable to possible exposure from injection drug users (IDUs). In 1999, this percentage had risen to 28%. Nationally, about two-thirds of new HIV infections each year are attributable to drug use."[8]

A look at illustrative numbers describing drug addiction among Washington residents arrested on criminal charges is revealing. More than 60% of people arrested for any crime in Seattle and Spokane in the period from July 1998 through June 1999, for example, tested positive for some drug use. Of those arrested in Spokane for drug possession crimes, 96% of men and 92% of women tested positive for drugs; of those arrested for drug sales 93% of men and 100% of women tested positive.[9]

Significantly, 43% of arrested men and 44% of arrested women (with drug or non-drug charges) in Spokane said they would like treatment. And, of those who tested positive for drugs, 60% of men and 55% of women reported that they had children at home. (What happens to these children? Many experience neglect and are consigned to an overburdened foster care system.[10])

The harmful effects of drug addiction on our society are often aggravated by the harmful effects of our responses to drug use and sale. In our efforts to rid our world of certain drugs, we have incarcerated unprecedented numbers of people for long periods of time, often for low-level involvement in the sale of small quantities of drugs.[11] Typically, as the data cited above concerning arrestees suggest, those incarcerated are addicted to drugs, and more often than not they have been incarcerated and released without treatment and without useful training or preparation for life in society.

Conspicuously, the harms associated with prosecution and imprisonment are not uniformly distributed across the population. African Americans are incarcerated for drug-related offenses in numbers that are ten times higher than their representation in the

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[8] *Id.* at 81 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001). For the conclusions reported in the quoted passage, the report cites the Washington State Department of Health, Infectious Disease and Reproductive Health Assessment Unit, HIV/AIDS Reporting System (1999) and the *Disease Prevention Fact Sheet: needle exchange* (Seattle-King County Department of Public Health, 1997).

[9] Spokane Quarterly Report, July 1999, Arrestee Drug Abuse Monitoring Program (ADAM). (The Spokane report lists some figures for Seattle as well as for Spokane.)

[10] This issue is discussed below at p. 18.

[11] "[Nationally,] in 1998, 1.6 million people were arrested for drug offenses, 3 times as many as in 1980, and 289,000 drug offenders were incarcerated in state prisons, 12 times as many as in 1980 (23,900)." *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* 2 (National Research Council 2001).

population at large.[12] The harmful effects of this high rate of incarceration (in conjunction with the low probability that those incarcerated will receive needed treatment) reverberate in the larger population, especially among the families and friends of those directly affected. And, while the causes of racial disproportionality are complex, the perception that something is not right casts a shadow over public servants in law enforcement and in the courts. In some quarters, respect for those institutions is diminished.

Respect for lawmakers, law enforcers and for the rule of law may also be compromised when many citizens view their government as failing to make appropriate distinctions among substances that are proscribed – in particular, between marijuana and other more highly addictive drugs.[13]

[12] The disparate impact of drug enforcement on different racial populations is the subject of another KCBA Drug Policy Project task force report. It is also the subject of a recent report by Human Rights Watch, entitled *Punishment and Prejudice: Racial Disparities in the War on Drugs* (May 2000). While African-Americans represent only 3% of the state population, they represented 34% of Washington prisoners serving time on drug charges in 1996. (These data are reported in Figures 2 and 7 in the Human Rights Watch report, citing United States Census data and 1996 data from the National Corrections Reporting Program.)

[13] The contrasting perspectives of large segments of the public on the one hand and of many public officials on the other are illustrated by the popular vote in favor of California Proposition 215, permitting the medical use of marijuana, and by federal action, in response, to enjoin distribution of marijuana under the initiative. (On May 14, 2001, the United States Supreme Court held that distribution of marijuana, including distribution for the medical purposes contemplated by the California initiative, violated the federal Controlled Substances Act, and that the Act allowed no medical necessity defense. *United States v. Oakland Cannabis Buyers' Cooperative*, No. 00-151.) The contrasting perspectives are also suggested by the relatively high rate of experimentation with marijuana by American teenagers – 28% of 10th graders have tried it, according to a World Health Organization report released in February 2001, described in *Study Finds Teenage Drug Use Higher in U.S. Than in Europe*, New York Times (February 21, 2001). We note also that the extent of domestic marijuana production is significant; in some states it is the number one cash crop. *See Kentucky Journal: Fighting Appalachia's Top Cash Crop, Marijuana*, New York Times (February 28, 2001). This may, but does not necessarily, reflect some degree of public tolerance.

## II. Society is justified in offering and, sometimes, in requiring drug addiction treatment.

The substantial societal harm associated with drug addiction warrants a serious societal response. Subject to important constraints, the people of Washington expect their state government to promote the public interests in health and safety. Those interests are engaged by the harms associated with drug addiction.[14]

When drug addiction treatment is accepted on a voluntary basis, society's interests may be furthered without curtailing individual liberty. So, when the provision of treatment on a voluntary basis is a practical strategy, it will generally be the preferred strategy in a society that values individual liberty.

By contrast, *requiring* individuals to participate in treatment involves a significant curtailment of individual liberty. Consequently, coercive treatment strategies must be carefully justified. Relevant considerations should include the specific harms associated with particular addictive substances, the effect of an addiction on others dependent on the addicted individual, and the probable efficacy of any proposed treatment. Obviously, coercion is involved when treatment is offered as an alternative to incarceration.[15] It is also involved, for example, when child custody or visitation decisions are made contingent on compliance with treatment requirements.

In principle, and sometimes in practice, carefully designed, coercive drug addiction treatment may be needed to further important public health and safety interests and may, therefore, be justified. The burden of justification is, however, a serious one.

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[14] Among the relevant constraints articulated in the Constitution of the State of Washington, Article I (Declaration of Rights), are the right not to be deprived of liberty without due process (§ 3), the right not to be disturbed in one's private affairs (§ 7) and the right to freedom of conscience in matters of religious belief (§ 11). *See, e.g., Robinson v. Seattle*, 102 Wn. App. 795 (Div. I 2000) (holding that a municipal ordinance requiring pre-employment drug testing was not narrowly drawn to achieve a compelling governmental interest as required by Constitution, Art. I, § 7). And, of course, federal due-process and fourth-amendment requirements also constrain the authority of state government. *See, e.g., Ferguson v. City of Charleston*, 121 S. Ct.1281 ( March 21, 2001)(holding that a state hospital's use of a diagnostic test to obtain evidence for law enforcement authorities of cocaine use by pregnant patients is unconstitutional if nonconsensual and not authorized by a valid warrant).

[15] Issues related to the use of criminal sanctions are the subject of a separate task force report.

## III. Drug treatment should have multiple objectives.

Not surprisingly, approaches to drug treatment may vary in their objectives. They may also vary in the way in which advocates of different approaches conceive of their projects. Contemporary discussions sometimes contrast approaches focused on reducing the prevalence of drug use (with *abstinence* as the objective) and approaches focused on decreasing the negative consequences of drug use (with *harm reduction* as the objective).

In many countries, including Canada, Australia, Holland and the United Kingdom, national drug policy is explicitly framed in harm-reduction terms.[16] Abstinence is not discounted as a treatment objective within a harm-reduction framework, but other strategies for reducing individual and societal harm are important as well. (Methadone-maintenance and needle-exchange programs, and educational programs that help students assess the effects of high-risk activities, are examples of harm-reduction approaches.[17])

In the United States, there is a noticeable difference between the approaches taken by the Office of National Drug Control Policy (ONDCP), on the one hand, and by such public health agencies as the Centers for Disease Control and Prevention (CDC), on the other. The *National Drug Control Strategy: 2001 Annual Report* of the ONDCP caricatures and dismisses "harm reduction" in two brief paragraphs.[18] At the same time,

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[16] G. Alan Marlatt, *Harm Reduction around the World*, in G. Alan Marlatt, ed., *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* 30 (The Guilford Press 1998).

[17] For a summary of the underlying principles and strategies of harm reduction, see G. Alan Marlatt, *Basic Principles and Strategies of Harm Reduction*, in G. Alan Marlatt, ed., *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* 49 (The Guilford Press 1998).

[18] According to the ONDCP report, "Harm reduction is a theory that says because use of illegal drugs cannot be controlled by law enforcement, education, public-health intervention or other methods, we can at least reduce some of the harms associated with inevitable drug use. According to the theory of harm reduction, dispensing clean needles to addicts, for example, can reduce the incidence of AIDS; maintaining heroin addicts on heroin can reduce the amount of crime they would commit to maintain their habit.

"The truth is that drug abuse wrecks lives. Addictive drugs were criminalized because they are harmful; they are not harmful because they were criminalized. If drugs were legalized, decriminalized or made more available through harm reduction policies, the costs to the individual and society would grow astronomically. It is shameful that more money is spent on illegal drugs than on art or higher education . . . ." *National Drug Control Strategy: 2001 Annual Report*, p. 56. The report is available on the ONDCP web site at the following address: http://www.whitehousedrugpolicy.gov/policy/ndcs01/strategy2001.pdf.

Critical readers of the ONDCP report will note that the question whether "dispensing clean needles to addicts . . . can reduce the incidence of AIDS," for example, is an empirical, not a theoretical, one. "Studies conducted or reviewed by the National Commission on AIDS (1991), General Accounting Office (1993), federal Centers for Disease Control and Prevention (1993) University of California (1993), National Academy of Sciences (1995), and the Office of Technology Assessment (1995) have all concluded that needle exchange programs reduce HIV transmission without increasing drug use." June 1999 statement of the Washington State Board of Health, reported in the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse publication *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State: 2001 Report*, p. 259.

the CDC, in its January 2001 *HIV Prevention Strategic Plan Through 2005*, endorses a strategy to "[i]ncrease comprehensive services for IDUs [injecting drug users], including . . . harm reduction programs to promote non-sharing of injection equipment and use of sterile injection equipment."[19]

Among Task Force members, there was a consensus that drug treatment should have multiple objectives. To the extent practicable, it should aim at helping individuals to overcome their drug addictions. At the same time, in view of the fact that for many addicted individuals overcoming addiction may be a very long-term process, or may not be an achievable outcome as a practical matter, treatment should aim at mitigating the harms associated with drug use, including crime, economic dependence, family distress and, in particular, the spread of HIV infection.

[19] *HIV Prevention Strategic Plan Through 2005* at 29. The plan is available on the CDC web site at the following address: http://www.cdc.gov/nchstp/od/news/prevention.pdf.

## IV. Treatment is an effective response to drug addiction.

There is a broadly accepted body of evidence for the proposition that *treatment programs can be highly effective in reducing the incidence of drug addiction and in mitigating the harms to drug-addicted individuals and to society that are associated with drug addiction.* One authoritative governmental source of research-based information on drug addiction treatment is the National Institute on Drug Abuse (NIDA), one of the National Institutes of Health. In 1999, NIDA published a report entitled *Principles of Drug Addiction Treatment: A Research-Based Guide*.[20] Among its conclusions are the following:

> [T]reatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. . . . Methadone treatment has been shown to decrease criminal behavior by as much as 50 percent. . . . [D]rug addiction treatment reduces the risk of HIV infection . . . . Treatment can improve the prospects for employment, with gains of up to 40 percent after treatment.[21]

Studies conducted in Washington State support similarly positive conclusions about the effectiveness of drug treatment. The Division of Alcohol & Substance Abuse (DASA) of the Washington State Department of Social & Health Services gathers information and reports annually on addiction-related problems and on the measurable effects of treatment. Its reports show that treatment is associated with dramatic decreases in crime, need for school discipline, illness, unemployment, accidents and low-weight births, among other things, and with corresponding decreases in costs to the state.[22]

According to the United States Department of Health and Human Services, Center for Substance Abuse Treatment, "treatment cuts medical costs." The Center cited data from Washington State showing that 39% of "substance abusers" need major medical care in the year before treatment and only 12% needed it in the year after. In addition, medical costs covered by Medicaid were $4,500 less for patients in the year following treatment, more than compensating for the $2,300 cost of the treatment.[23]

Assessing the cost-effectiveness of drug treatment, a 1994 RAND Corporation study, funded in part by the Office of Drug Control Policy and the United States Army, found that societal costs associated with crime and lost productivity were reduced by

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[20] The report is in the public domain and can be downloaded from the Internet at the following address: http://www.nida.nih.gov/PDF/PODAT.pdf.

[21] NIDA *Principles of Drug Addiction Treatment* at 15-16.

[22] *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State: 2001 Report* (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001). Copies of the report can be obtained from the Washington State Alcohol & Drug Clearinghouse (1-800-662-9111).

[23] *Treatment Cuts Medical Costs*, Substance Abuse in Brief 2 (Center for Substance Abuse Treatment, May 2000).

$7.46 as a result of every dollar spent on treatment. By comparison, the costs associated with crime and lost productivity were reduced by $0.52 for every dollar spent on domestic law enforcement and incarceration.[24]

The Washington State Institute for Public Policy has concluded, similarly, that the benefits of drug treatment outweigh the costs, and that drug courts, in particular, "can save about two dollars for every one dollar of taxpayer cost."[25]

Citing the RAND study, and some others, in a February 2001 statement to the Washington State Legislature, King County Prosecutor Norm Maleng drew a three-word conclusion: "Drug treatment works."[26] This is not, of course, to suggest that it works in every case, or that every program referred to as "drug treatment" is effective. But, as the National Institute on Drug Abuse reports, "[t]reatment of addiction is as successful as treatment of other chronic diseases such as diabetes, hypertension, and asthma."[27]

"We know that by expanding treatment options we can drive down illegal activity, illegal drug use, re-arrest rates, prostitution and homelessness," Edward Jurith, Acting Director of the Office of National Drug Control Policy, recently declared. "This is a key goal of the [national drug control] strategy."[28]

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[24] C. Peter Rydell & Susan S. Everingham, *Controlling Cocaine: Supply Versus Demand Programs* (RAND Corporation, 1994). *See also Treatment: Effective (But Unpopular) Weapon Against Drugs*, *RAND Research Review* (Spring 1995) (http://www.rand.org/publications/RRR/RRR.spring95.crime/treatment.html).

[25] Testimony of Steve Aos, Associate Director, Washington State Institute for Public Policy, to the Senate Ways and Means Committee, April 10, 2001. Drug courts are discussed below at p. 14.

[26] Norm Maleng, *Beyond the "War": Using the Criminal Justice System to Bring Addicts Into Treatment.* The statement is currently available on the web site of the King County Bar Association, http://www.kcba.org/. (Select "Drug Policy Project" from the choices on the home page.)

[27] *Principles of Drug Addiction Treatment: A Research-Based Approach* 15 (National Institute on Drug Abuse 1999).

[28] Edward H. Jurith, *Is Our Drug Policy Effective?,* Fordham Urban Law Journal 43 (October 2000). Goal 3 of the National Drug Control Strategy is to "reduce health and social costs to the public of illegal drug use by reducing the treatment gap." *National Drug Control Strategy: 2001 Annual Report*, p. 6.

## V. Some basic principles should inform the evaluation of treatment options.

"The past decade has seen a wealth of new research-based resources for drug and alcohol treatment providers . . . [and] consensus statements on the state of the science of drug treatment, produced by blue-ribbon panels of experts, convened by the Institute of Medicine . . . , the Office of National Drug Control Policy . . . , the American Psychiatric Association . . . , and the National Institutes of Health . . . . The National Institute on Drug Abuse [NIDA] (1999) recently produced an accessible 54-page guide to research-based principles of drug addiction treatment. The Center for Substance Abuse Treatment now distributes *Treatment Improvement Protocols*, providing best-practice guidelines for drug abuse treatment (see http://www.treatment.org/Externals/tips.html)."[29] To " review the substantive findings of the growing empirical literature on drug treatment outcomes" is beyond the scope of our task.[30] But because they provide a framework that is useful in assessing many (but not all) important components of a comprehensive treatment plan, the thirteen principles of effective treatment from the 1999 NIDA report referred to above, *Principles of Drug Addiction Treatment: A Research-Based Approach,* are quoted in full below.

**"[NIDA] Principles of Effective Treatment**

"**1. No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

"**2. Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment

[29] *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* 8-1 (National Research Council 2001). This report was prepared by the National Research Council of the National Academy of Science with a grant from the White House Office of National Drug Control Policy, and published in March 2001. While noting the "wealth of new research-based resources for drug and alcohol treatment providers," and without attempting "to review the substantive findings of the growing empirical literature on drug treatment," the report identified a particular "need for better information on the potential benefits and costs of drug treatment as an adjunct to, or an alternative to, traditional criminal justice sanctions and coerced treatment regimes." It further suggested that "randomized controlled trial has not yet been used to full advantage in treatment evaluation research." Id. at 8-1. The full report is available online at http://www.nap.edu. For an extensive review of the research on harm reduction strategies for responding to drug addiction, see Susan F. Tapert and others, *Harm Reduction Strategies for Illicit Substance Use and Abuse*, in G. Alan Marlatt, ed., *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* (The Guilford Press 1998).

[30] "We [the National Research Council Committee on Data and Research for Policy on Illegal Drugs] make no attempt . . . to review the substantive findings of the growing empirical literature on drug treatment outcomes." *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* 8-1 (National Research Council 2001). Washington has a legal framework for certification of approved chemical dependency treatment programs. *See* RCW 70.96A.090 and Chapter 388-805 WAC.

applicants can be lost if treatment is not immediately available or is not readily accessible.

"**3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

"**4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

"**5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs (see pages 13-51 [of the NIDA report]). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

"**6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. (Pages 37-51 [of the NIDA report] discuss details of different treatment components to accomplish these goals.)

"**7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of

treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.[[31]]

"**8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

"**9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use**. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (see pages 25-35 [of the NIDA report] ).

"**10. Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

"**11. Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.** The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

"**12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

"**13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment

[31] In its discussion of maintenance treatment with methadone and LAAM, Task Force members found the NIDA report's use of euphemism to be unhelpful. In it's discussion beginning on page 17, the report asserts as follows: "As used in maintenance treatment, methadone and LAAM are not heroin substitutes. They are safe and effective medications for opiate addiction that are administered by mouth in regular, fixed doses." In fact, methadone and LAAM, like heroin, are addictive drugs, and in maintenance programs, they generally *are* heroin substitutes. They are also very effective in reducing harm for addicts, their families and the rest of society.

episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help programs during and following treatment often is helpful in maintaining abstinence."

In September 1997, the Drug Policy Project of the Federation of American Scientists published a statement entitled *Principles for Practical Drug Policies*. While not limited to the issue of drug addiction treatment, three of the principles have important application to treatment policy:

- "Drug policies should be based on the best available knowledge and analysis and should be judged by the results they produce rather than by the intentions they embody. Too often, policies designed for their symbolic value have unanticipated and unwanted consequences.

- "Drug control policies should be designed to minimize the damage done to individuals, to social institutions, and to the public health by a) licit and illicit drug-taking, b) drug trafficking, and c) the drug control measures themselves. Damages can be reduced by shrinking the extent of drug abuse as well as by reducing the harm incident to any given level of drug consumption.

- "Because each substance has its own profile of risks and patterns of use, different substances call for different policies."[32]

[32] The quoted principles are respectively numbers 2, 3 and 8 in the published statement. The statement is available on the FAS web site at the following address: http://sun00781.dn.net/drugs/Principles.htm .

## VI. Washington has only an embryonic drug-treatment program.

In spite of the documented societal harm associated with drug addiction and the compelling evidence that drug treatment produces greater benefits than costs, Washington currently lacks the capacity to provide treatment to most of those who need it.

The failure is especially conspicuous as it applies to people arrested and charged with crimes.[33] As King County Prosecutor Norm Maleng explained to the Washington State Legislature in February 2001: "The exclusive currency of the justice system remains incarceration. . . . [T]he options for treatment within sentencing laws have been mostly illusory – they exist in theory and statute, but not in reality."[34]

A treatment option for a small percentage of those sentenced to terms in Washington prisons was authorized by the Legislature in 1995 in the Drug Offender Sentencing Act. Treatment may be provided as part of a "drug offender sentencing alternative" ("DOSA") for individuals who have been convicted of nonviolent felonies, including certain drug offenses involving "only a small quantity of the particular controlled substance as determined by the judge," and who have never been convicted of a violent offense or a sex offense. The alternative involves a reduced period of confinement in prison and a period of in-prison treatment followed by a period of treatment in "community custody" in a program approved by the DSHS Division of Alcohol and Substance Abuse.[35] As of December 31, 2000, there were 1,507 people participating in DOSA treatment. At that time there were 14,920 adults in the custody of the Washington State Department of Corrections, including 3,730 serving time only for drug offenses.[36]

Because of its budgetary constraints, the Department of Corrections is only able to provide addiction treatment to those offenders sentenced under DOSA, leaving the majority of drug-addicted prisoners without any treatment at all. In addition, the Department currently has no protocol for the treatment of the "co-occurring" disorders of drug addiction and mental illness, despite the fact that 15 percent of the male prison population and 20 percent of the female prison population have been diagnosed as "seriously mentally ill" under DSM-IV criteria.[37]

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[33] As noted reported on page 3 above, a large percentage of individuals arrested and charged with crimes both use drugs and want treatment.

[34] Norm Maleng, *Beyond the "War": Using the Criminal Justice System to Bring Addicts into Treatment* 2 (February 2001).

[35] Drug offender sentencing alternative provisions appear in RCW 9.94A.120(7).

[36] These numbers were obtained from the Department of Corrections Offender-Based Tracking System.

[37] Information about the Department of Corrections treatment program was provided by DOC staff in response to inquiries by Task Force members. Several members made a prison visit and and were given a briefing by staff involved in the DOC addiction treatment program.

In some counties, "drug courts" offer a treatment alternative to conventional prosecution and punishment for some individuals with drug addictions who are charged with certain nonviolent criminal offenses. Eligible individuals are offered the option of judicially-supervised treatment along with periodic drug testing and sanctions for non-compliance with treatment requirements;[38] participants waive certain rights in exchange for a dismissal of charges on successful completion of the program. Some transitional federal funding is available for drug-court treatment programs. After federal funds are exhausted, counties may seek an appropriation of state funds, which the county must match dollar for dollar.[39]

There are currently drug courts in 12 of Washington's 39 counties and in three tribal nations within the state. The largest program, in King County, had 900 cases referred to it in 2000, and had 432 active cases in December 2000. In 2000, 4,258 drug cases were filed in the King County Superior Court. Of these 1,281 were delivery cases and 2,607 were possession cases.[40]

An enhanced drug-court program sponsored by the United States Department of Justice has demonstrated great promise in several pilot sites, and is now being implemented in Pierce County. The program is called "Breaking the Cycle" ("BTC"). It involves extensive collaboration among law enforcement, pre-trial services, prosecutors, judges, probation and addiction-treatment services. Offenders on pre-trial release are admitted to the program, and comprehensive individual case plans are formulated. These address mental health treatment, family counseling, peer involvement, education and training, as well as issues more narrowly related to drug addiction. An essential component of the program is post-treatment follow-up by trained case managers.[41]

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[38] While testing in the drug-court context is generally associated with the application of punitive consequences for undesired results, another approach would use positive incentives to reward test results demonstrating compliance with a treatment program. For a discussion of research suggesting advantages of this approach in reducing drug-related harm, see Susan F. Tapert and others, *Harm Reduction Strategies for Illicit Substance Use and Abuse*, in G. Alan Marlatt, ed., *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* 165-66 (The Guilford Press 1998).

[39] Drug courts are departments or calendars of the superior court. They are authorized and described in RCW 2.28.170.

[40] These figures were supplied to the Task Force by the King County Drug Court program administrator.

[41] Following the drug court model, the BTC program uses a balance of sanctions and incentives to guide participants through treatment, with judicial oversight by specially-trained judges. Drug testing is used to guide treatment interventions and not to prove guilt or innocence, but sanctions for violations can ultimately result in confinement. The participants spend longer periods in treatment and follow-up than typical drug court participants; the program's initial research has shown that longer periods of treatment lower the chances of relapse to drug use. Implementing such a comprehensive program requires a flood of resources. Substantial resources are provided by the Department of Justice, but there are still significant resource problems, such as the extreme shortage of *inpatient* facilities and services. However, there are currently no other public programs in the nation that address drug addiction in such a comprehensive fashion. Although the BTC program has only been operating for a year in Pierce County, anecdotal

A "chemical dependency disposition alternative" for children, analogous to the adult drug offender sentencing alternative, is available for certain juvenile offenders who would otherwise be subject to "local sanctions" or confinement for 15 to 36 weeks. The alternative does not appear to be widely used.[42] There are juvenile drug courts in three counties: King, Kitsap and Clallum. Between July 1, 1999 and May 9, 2001, the juvenile drug court in King County had 70 participants. During the same period there were 819 drug charges against children in the county. (This number includes alcohol-related charges.)[43]

Lawyers, judges and treatment professionals in King County, interviewed by Task Force members, expressed several concerns about the addiction treatment currently available to children under the jurisdiction of the Juvenile Court. These include: insufficient inpatient treatment capacity, with associated long waits to get into appropriate inpatient programs (sometimes resulting in missed opportunities to provide treatment); a related occasional need to use treatment facilities at too great a distance from family members to involve them in a constructive way; inadequate provision for related mental health treatment when it is needed; and inadequate attention to the continuing needs of the child after formal treatment is concluded ("after care").[44]

Washington's failure to offer drug treatment to most of those residents who need it and cannot afford it does not only, or primarily, affect individuals charged with crimes or juvenile offenses. According to extensive research completed by the Division of Alcohol and Substance Abuse, only 18.3% of Washington residents who need treatment and whose income is under 200% of the federal poverty level can be served by the current treatment system with existing resources.[45] Need for treatment was assumed if an

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evidence suggests a significant reduction in drug arrests and drug use among program participants. For sources of information on the BTC program, see http://www.ojp.usdoj.gov/nij/brekprog.htm.

[42] The chemical dependency disposition alternative for juvenile offenders is provided in RCW 13.40.165. A bill passed by the Legislature in April 2001, SSB 5468, slightly expanded the eligibility criteria for the alternative, but it appears from the associated fiscal note that under the new criteria only approximately six additional juveniles would have completed the disposition alternative in FY 2000.

[43] These figures were supplied to the Task Force by the King County Juvenile Drug Court manager.

[44] Other problems mentioned to Task Force members included lack of transportation for juveniles to treatment agencies, lack of youth-oriented A.A. or N.A. meetings, and a need for assistance with reintegration in school when a student has completed an inpatient program. Task Force members were also told of treatment-access problems encountered by children addicted to heroin or methamphetamine who are not, and do not want to be, involved with the juvenile court system, but also are not living with responsible adults. If such children need and want inpatient addiction treatment, but cannot or will not involve a parent in the process, serious obstacles are encountered. The Task Force did not have enough information about this problem to fully characterize it or to recommend a solution. Members are aware that the problem is being studied elsewhere.

[45] *County Profile of Substance Use and Need for Treatment Services in Washington State* 13 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 1999). The County Profile report is available on line at http://psy.utmb.edu/dasa99/report/cntyrep/wa000/page01.htm. (Page references are to the online version.) The study on which the report was based assumed that people "living at or below 200% of the federal poverty guidelines . . . approximates people potentially eligible for

individual had a "past 18 month substance use disorder" or if certain other criteria were met.[46]

The Task Force heard testimony confirming the inadequate treatment resources for poor King County residents with opiate addictions from Task Force member Kris Nyrop, director of Street Outreach Services in Seattle. SOS, a non-profit agency,

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publicly funded treatment services." *Id*. at 4. If anything, this overestimates the availability of treatment for people who cannot afford to pay for it, since many people with income above 200% of federal poverty guidelines (in 2001 $1,432 a month is 200% of the federal poverty guideline for one person) would be unable to pay privately for addiction treatment.

[46] Because the concept "needs treatment" is important and not self-explanatory, the criteria used in applying it in the *County Profile* report are set out at length, followed by some comments. The report explains: "A respondent needs treatment during the past year if: [1] they have a past 18 month substance use disorder; OR [2] they 'ever had a problem or felt addicted to alcohol or drugs' AND used alcohol or drugs regularly during the past 18 months (i.e. they drank an average of 3 drinks per drinking day at least once per week OR they used marijuana 50 times or more OR they used any other illicit drug 11 times or more); OR [3] they have received licensed residential or outpatient treatment services during the past 12 months; OR, [4] they have maintained a very high level of alcohol or drug use during the past 18 months (i.e. they drank an average of 4 drinks per drinking day at least 3 to 4 times per week OR they used any illicit drug 50 times or more)." *Id*. at 4. The criteria for "substance use disorder" were those in the American Psychiatric Association's Diagnostic and Statistical Manual, Third Edition – Revised (DSM-III-R). The report notes that there have been some changes in the criteria with the release of DSM-IV, but observes that "those are unlikely to greatly affect the present findings." *Id*. at 3.

The report sets forth a list of symptoms from DSM III-R, three or more of which together indicate substance dependence. The list is as follows: "[1] Substance is often taken in larger amounts over a longer period than the person intended. [2] Persistent desire or one or more unsuccessful attempts to cut down or control substance use. [3] Great deal of time spent in activities necessary to get the substance, taking the substance or recovering from its effects. [4] Frequent intoxication or withdrawal when expected to fulfill major role obligations or when use is physically hazardous. [5] Important social, occupational or recreational activities given up or reduced because of substance use. [6] Continued use despite knowledge of having a persistent or recurrent social, psychological or physical problem. [7] Marked tolerance or markedly diminished effect with continued use of same amount. [8] Characteristic withdrawal symptoms. [9] Substance often taken to relieve or avoid withdrawal symptoms." The report continues with the following three definitions: "**DSM-III-R Lifetime Dependence**: A person is diagnosed with lifetime dependence if: [1] they have ever had three or more symptoms of dependence, and [2] at least two of those symptoms lasted a month or more or occurred repeatedly over a longer period of time" *and* "**DSM-III-R Lifetime Abuse**: A person is diagnosed with lifetime abuse if: [1] they do not have a lifetime diagnosis of substance dependence; [2] they have ever continued substance use despite having recurrent social, occupational, psychological or physical problems exacerbated by it OR used repeatedly in situations where use is physically hazardous (determined from a subset of questions used to assess dependence symptoms); and [3] at least one symptom lasted a month or more or occurred repeatedly over a longer period of time" *and* "**Past 18 Month Substance Use Disorder**: A person is diagnosed with a past 18 month substance use disorder if: [1] they have a diagnosis of lifetime dependence or abuse; [2] they have used a substance in the last 18 months, and [3] they have experienced a DSM-III-R abuse or dependence symptom in the last 18 months." *Id*. at 3-4.

The Task Force noticed that some people would question the use of criterion [4] ("they have maintained a very high level of alcohol or drug use during the past 18 months [i.e. they drank an average of 4 drinks per drinking day at least 3 to 4 times per week OR they used any illicit drug 50 times or more]") as demonstrating a need for treatment. A survey omitting it might produce results suggesting a somewhat lower level of unmet need. But even if the unmet need were decreased by 10%, treatment would not be available for most people who need it and whose income is less than 200% of federal poverty guidelines.

conducts street outreach to individuals with drug addictions. It operates a drop-in center for street youth, an infant mortality prevention project and a needle exchange program. Arranging for addiction treatment is an important part of its mission.

As of the end of March 2001, SOS had 185 individuals on a waiting list for methadone therapy. Ninety-nine had been on the list since 1999. The list had been closed to new applicants since October 2000. Mr. Nyrop reported that the Seattle-King County Health Department had a list of approximately 500 applicants, some of whom had been waiting since 1999. These lists did not reflect the full extent of demand, he noted, because (even when the lists are open to new applicants) many people do not bother to sign up, in light of the wait.[47]

In addition to budget constraints, there have been other constraints on the provision of methadone treatment in Washington. For one, individual counties have had the option of prohibiting methadone treatment within their borders, and all but four have done so. Also, clinics have not been permitted to serve more than 350 clients at a time. These constraints were modified by the Legislature this year, but the siting of methadone clinics will still face significant procedural hurdles.[48]

One task force member's informal survey of public defenders assigned to represent parents in dependency proceedings, and the direct experience of another member, who represents parents in custody proceedings, suggested significant difficulties in finding affordable treatment suitable for parents whose addictions interfere with their ability to care for their children. In the dependency context, these difficulties were thought to result in extended, avoidable placements in foster care in some cases.[49] State

[47] In other words, (1) we make the possession of heroin a crime, and are prepared to send individuals to prison for long periods for committing it (at a cost of many thousands of dollars a month), and (2) we deny treatment to people who are addicted to heroin and who ask for methadone treatment (at a cost of approximately $350 a month) that would allow them to comply with the law and attempt to function as productive members of their families and communities. Public funds for addiction treatment include state funds provided under the ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) program, county funds administered by county health departments, and Medicaid funds. The Medicaid program has some requirements, including a requirement that covered medical services be provided with reasonable promptness, that have been applied to require the State of California to mitigate delays in the provision of methadone treatment. *Sobky v. Smoley*, 855 F. Supp. 1123 (E.D. Cal. 1994). It is beyond the province of this Task Force to address disputed issues of law, and we do not address the issue of whether the current situation in Washington violates any provision of federal Medicaid law.

[48] In April 2001, the Legislature passed Substitute Senate Bill 5417, eliminating the county veto and the absolute 350-person lid, but various procedural hurdles to the siting and expansion of clinics remain. It is too early to assess their full significance.

[49] According to a September 1998 United States General Accounting Office survey report, entitled *Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers*, two thirds of the foster children in both California and Illinois had at least one parent who abused alcohol or other drugs – heroin, cocaine or methamphetamines, in most cases. *Id*. at 7. The report noted that "agencies face difficulties in helping parents enter drug or alcohol treatment programs," *id*. at 18, due in part to limited treatment availability, *id* at 20. The report also takes note of the special treatment needs of women with children: "Women with children often need intensive treatment because their fear of losing custody of their children often prevents them from seeking treatment on their own. As a consequence, by the time they

policy favors nurturing of the family unit,[50] and out-of-home placements may only be made if a court "finds that reasonable efforts have been made to prevent or eliminate the need for removal of the child from the child's home and to make it possible for the child to return home . . . [including] services . . . to the . . . child's parent."[51] Nevertheless, inadequate resources are allocated to providing addiction treatment to parents of children in dependency proceedings.[52]

Lengthy waits for treatment openings cause harm both to parents who need treatment and to their children. Addiction treatment may be required before a parent can resume parental responsibilities. If the treatment is not available, disruption of the family may be unnecessarily prolonged. Sometimes, unavailability results from funding obstacles. Parents may not meet need-for-treatment or other criteria of the programs that fund services, even if a judge has determined that treatment must occur before parental responsibilities can be resumed.[53] And some treatment programs fail to support the maintenance of contact between parents and children during the treatment process, the Task Force was told.

There is, of course, an array of services offered by private providers in Washington to those who can afford them. Private health insurance plans, including the plans of health maintenance organizations, are required to cover prescribed minimum amounts of drug addiction treatment. The requirement does not apply to plans offered by employers with 25 employees or fewer.[54] Under rules adopted in July 1999, minimum benefits were increased from $5,000 to $10,000 in a 24-month period, with an indexing provision. A provision that had permitted the imposition of a $10,000 lifetime maximum benefit was repealed.[55] In its notice published in May 1999 with its rulemaking proposal, the Insurance Commissioner's Office explained that the benefit provided under the

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come to the attention of the child welfare system their addiction is usually far advanced. In addition, according to HHS, informed sources generally believe that treatment for women must address issues unique to women, such as sexual abuse, domestic violence, child care, and health problems." *Id*. at 16. The report is available on the GAO web site at http://www.gao.gov.

[50] RCW 13.34.020.

[51] RCW 13.34.130(2).

[52] There are efforts under way in King County to improve the services provided to parents in dependency proceedings, including case management through TASC of King County.

[53] For example, a financially eligible individual who has been diagnosed as dependent on a psychoactive substance (other than nicotine) using DSM IV criteria, and who meets the incapacity standards for treatment under the state's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program, is ineligible for ADATSA treatment if he or she has "abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated," WAC 388-800-0055, even if a juvenile court order makes treatment a precondition for resumption of parental responsibilities.

[54] *See* RCW 48.44.023, RCW 48.46.066 and RCW 48.21.045.

[55] WAC 284-53-010.

$5,000 standard established in 1987 had "become almost illusory." It noted that "[a]ddiction treatment has outcomes that are comparable in efficacy to the treatment of other chronic conditions. Compliance rates for patients are higher for chemical dependency patients than for patients with diabetes, hypertension, and asthma, amongst other conditions."[56] It went on to explain the savings in overall health-care costs associated with the provision of addiction treatment:

> While treatment costs may rise for carriers, they will enjoy considerable cost-offsetting. Carriers may spend/pay less money on health coverage overall by providing the necessary chemical dependency coverage. Studies show that a mere 5% to 10% of the medical costs of a chemically dependent person are related to addiction treatment.[57] While chemical dependency users and their families are among the highest users of medical care, the cost of chemical dependency treatment is comparatively very low. The families of a drug or alcoholic dependent person use two to three times more health care services than a family without a chemically dependent person.[58] . . . The health costs drop dramatically after treatment.[59]

The Basic Health Plan, administered by Washington's Health Care Authority, still has benefit maximums of $5,000 in a 24-month period and $10,000 in a lifetime – the benefits characterized as "almost illusory" by the Insurance Commissioner's Office in 1999. The Task Force has not surveyed the coverage among self-insured entities not covered by the Insurance Commissioner's regulation.

Many primary care doctors do not routinely refer addicted patients to formal treatment programs, according to a recent national study.[60] The authors contrasted this result to what they characterized as a "consensus" view "favoring referral of drug-abusing patients to specialized treatment."[61] Doctors with patients who could benefit

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[56] Washington State Register 99-11-103.

[57] "Langenbucher, J.W., McCrady, B.S., and Esterly, R. *Socioeconomic Evaluations of Addictions Treatment: Prepared for the President's Commission on Model State Drug Laws*, Pisctaway, N.J. Rutgers University, 1993." The footnote is from the Insurance Commissioner's Office notice.

[58] *Id.*

[59] Washington State Register 99-11-103.

[60] Peter D. Friedman, Deirdre McCullough, Richard Saitz, *Screening and Intervention for Illicit Drug Abuse: A National Survey of Primary Care Physicians and Psychiatrists*, Archives of Internal Medicine,V. 161, No. 2(January 22, 2001). "In this national survey, 32% of primary care physicians and psychiatrists reported that they do not inquire routinely about illicit drug use. . . . Only 55% of physicians reported that they routinely recommend formal addiction treatment to drug-abusing patients, and a substantial minority reported that they do not regularly intervene at all . . . ." *Id.* at 249.

[61] *Id.* For the consensus view, the authors cited the *Guide to clinical preventive services: report of the U.S. Preventive Services Task Force*, 2nd ed., published in 1996 by the U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Disease Prevention and Health Promotion.

from opiate-substitution therapy are often faced with insurmountable obstacles. Treatment through a clinic may be unavailable, or may be inappropriate for a particular patient. And current law does not allow opiate-replacement treatment by individual physicians. These obstacles have produced a call for change from the Washington State Medical Association.[62]

For the fortunate minority to whom publicly-funded services are offered (the estimated 18.3% of those who need treatment and can't otherwise afford it), a broad menu of services is supported by public funds. The Division of Alcohol and Substance Abuse Services (DASA) provides diagnostic evaluation, alcohol/drug detoxification, outpatient treatment, methadone treatment for opiate addicts, intensive inpatient treatment, recovery house services, long-term residential care, youth residential and outpatient treatment, outpatient and residential treatment for pregnant and parenting women (with child care), and treatment for co-occurring disorders. Specialized contracted support services for eligible individuals include childcare, translation services, transportation assistance, youth outreach and case management, and cooperative housing support.[63] In a recent DASA Public Policy Forum attended by a Task Force member, Daniel Schecter, Acting Deputy Director for Demand Reduction for the Office of National Drug Control Policy, referred to Washington State as a "star" among the states for the comprehensiveness and quality of its drug treatment system. But the system is closed to a majority of those who need it.

Washington does have more needle exchange programs than any other state, with exchanges operating in 12 counties as of January 2000. The early implementation of needle exchange programs in Washington (which pioneered this HIV prevention method) may be associated with the much lower infection rates among injection drug users in

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[62] The following resolution was adopted by the WSMA House of Delegates in 1991: "The WSMA supports use of methadone maintenance as crucial in the treatment of opiate dependency and to decrease the spread of HIV infection. The WSMA supports legislation assuring rapid access to comprehensive methadone treatment for those who request or are referred for such treatment. The WSMA supports adequate funding for such therapy." Res. 9, C-91. In 1996, the following additional language was adopted: "The WSMA supports changes in laws and regulations which currently prevent physicians who are deemed qualified by the medical profession from providing treatment for opiate addicted patients." EC Rpt. J, A-96. The latter issue has also been addressed by the Washington State Pharmacists Association. In 1995, the WSPA Senate adopted the following resolution: "The WSPA resolves that the State of Washington reduce impediments to physician licensure to use opiate replacement therapy in the treatment of opiate addiction to the extent that such registration is practical and convenient for physician practitioners with valid narcotics licenses.

[63] Of the 32,000 Washington residents admitted for DASA treatment services in 1998, approximately 9,300 received inpatient services, 23,000 received outpatient services, and 1,700 received methadone maintenance. *County Profile of Substance Use and Need for Treatment Services in Washington State* 8 (Department of Social and Health Services, Division of Alcohol and Substance Abuse 1999). DASA's current annual budget is $55,000,000. The agency estimates that it would cost an additional $156 million a year to provide treatment to everyone with income at or below 200% of federal poverty guidelines who needs it. (This assumes treatment to another 84,188 people at an average rate of $1,853 per person.) Worksheet and Assumptions for Treatment on Demand Prepared Using Analysis -Expanding Publicly Funded Substance Abuse Treatment in Washington State, prepared by the Division of Alcohol and Substance Abuse, using population figures for 1998.

Seattle (2-4%) by comparison to the rates in cities that waited to implement such programs (New York and Miami at 40-60%).[64] In most Washington counties, however, needle exchanges are not available.

[64] *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State: 2001 Report* 259 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001), citing a June 1999 statement of the Washington State Board of Health for the comparative infection rates.

## Recommendations

If we as a society are serious about wanting to provide treatment to address the problems associated with drug addiction, we should have a comprehensive addiction-treatment plan. The plan should be based on effective treatment strategies, including strategies for reducing social and individual harm; it should contemplate a coordinated administration of addiction-treatment programs; and it should address both funding needs and funding sources.

With a view toward promoting the development and implementation of such a plan, the Task Force makes the following recommendations:

### AVAILABILITY AND ADEQUACY OF TREATMENT

1. **Drug addiction treatment should be available on request to every Washington resident who wants and needs it.** This will not always mean treatment at public expense. Individuals who can afford to pay privately for treatment may be expected to do so, although it may be in the public interest to offer incentives for pursuing treatment to those who might be influenced by them. But the important public interest in averting the economic costs and other societal harm associated with drug addiction warrants the expenditure of the public funds required to assure that appropriate treatment is available to anyone who needs it and cannot otherwise afford it.[65]

2. **Drug treatment should be complemented by, and coordinated with, other needed treatment and assistance, including mental health treatment.** The problem of inadequate mental health treatment resources for individuals with mental health diagnoses receiving drug treatment was raised repeatedly to Task Force members by professionals familiar with current treatment programs in adult prisons, programs available to juvenile offenders, and in other settings.[66] A program aimed at healing addicted individuals so they may assume roles as responsible citizens should not look exclusively at the symptoms of addiction. It should address physical and mental health issues, and should acknowledge individuals' needs to invest their lives with some meaning. It should promote stable housing, employment and social relations through housing assistance, vocational and civil-legal assistance, and family counseling, where appropriate. Treatment should also be available that is responsive

[65] Individuals who want treatment should be considered to need treatment if they meet criteria for either substance dependence or substance abuse as defined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV) of the American Psychiatric Association, or if treatment has been required as a condition of exercising some important right, for example, as a condition of retaining or resuming parental responsibilities.

[66] Addressing this issue, Principle 8 of NIDA's *Principles of Drug Addiction Treatment* declares: "Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way."

to the needs of women who have been subjected to sexual abuse or domestic violence, to the child-care related needs of parents, and to the special needs of children.

3. **A broad spectrum of drug treatment options should be available.** It should include treatment in residential treatment facilities and out-patient treatment, using treatment modalities that have demonstrated effectiveness based on such criteria as clients' ability to hold jobs, discharge family and community obligations, reduce health care costs and avoid criminal activity.

4. **Drug treatment capacity, over the broad spectrum of options, should be sufficient so that treatment is available promptly for individuals who need and want it.** "Promptly," in this context, will often mean "immediately" if an opportunity to intervene constructively in the life of a person in crisis is not to be missed. This may sometimes mean providing some form of transitional help until the appropriate treatment placement can be made. As previously noted, the Division of Alcohol and Substance Abuse has estimated that its $55 million dollar annual budget would have to be increased by $156 million to satisfy the unmet need for treatment among individuals at or below 200% of federal poverty guidelines. A significant additional investment of public funds for addiction treatment would be offset by significant savings, including savings in other health care costs.

5. **Special efforts should be made to assure that drug treatment, including inpatient treatment, is promptly available to children who need it.** Even more troubling than our failure to offer treatment to adults who want and need it is our failure to provide needed treatment to children. Waiting lists for inpatient drug treatment for children, including children under the jurisdiction of the juvenile courts, should be deemed unacceptable, as should the failure to provide needed mental health treatment or to provide needed ongoing help after an inpatient treatment program is finished.

6. **A coordinated system for the provision of drug treatment should include places where individuals in need of treatment can go (or can be referred) for assessment, to be matched with treatment programs and to get transitional help.** Staff should be available to follow the progress of an individual who has been matched with a treatment program and to provide additional assistance when appropriate. At the same time, the assessment function performed by such staff should not become an obstacle or a source of unreasonable delay in the provision of treatment. There should be alternative ways to enter the treatment system, and barriers to entry should be minimized.

7. **Treatment should continue to be available for those who need to re-enter it or to start a new program.** Planning should take into account that relapse is not uncommon in the course of recovery from drug addiction, and should be considered an expected temporary setback, rather than a failure resulting in exclusion from services.

8. **Obstacles to the effective use of opiate-replacement therapies should be removed.** Methadone-maintenance therapy has consistently been shown to reduce or eliminate the use of illegal opiates such as heroin, to reduce criminal activity and to improve the quality of life and health of opiate-addicted individuals and their families.[67] Currently, federal regulations require that methadone-maintenance therapy take place only in a methadone clinic setting, even when an individual has been stable for a long time, although the regulations allow for waivers of the clinic-setting requirement both on a case-by-case and on a programmatic basis. Treatment with methadone should be available to Washington residents regardless of where they live.[68] It should also be available in settings that work for those in need of treatment. The settings in which methadone therapy is offered should be expanded to include, where appropriate, public health facilities and the offices of qualified physicians.

9. **Needle exchange programs should be available throughout the state, and convenient referral to addiction-treatment programs, including programs offering opiate-replacement therapy, should be available at needle exchange sites.** Needle exchange programs have demonstrated their effectiveness both in reducing the spread of HIV infection and in serving as a gateway to treatment. They have been the leading source of drug-treatment referral in Washington.[69] In addition to increasing the likelihood that injecting drug users will use clean needles, reducing health risks to needle users and to others with whom they have contact, needle exchanges increase the likelihood of safe needle disposal, reducing public health risks associated with unsafe disposal. Consistent with these public health objectives, pharmacists should be allowed to sell clean needles, and their purchase and possession should be permitted.[70]

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[67] According to the National Institutes of Health, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity." *Effective medical treatment of heroin addiction: NIH consensus statement 1997*, National Institutes of Health (1997). The consensus statement calls for broader access to methadone maintenance programs, and recommends that physicians and pharmacies be allowed to dispense methadone.

[68] Until recently, state law has allowed individual counties to prohibit methadone treatment within their borders, and all but four have done so. In addition, clinics have not been allowed to serve more than 350 individuals at any one time. The Legislature lowered those two obstacles in the 2001 session. Substitute Senate Bill 5417 eliminated the county veto and the absolute 350-person lid, but various procedural hurdles to the siting and expansion of clinics remain. It is too early to assess their full significance.

[69] This conclusion was reported in a June 1999 statement by the Washington State Board of Health, reported in *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State: 2000 Report* 237 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2000).

[70] For a thoughtful analysis of the needle-deregulation issue, see *Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States*, American Bar Association AIDS Coordinating Committee (ABA 2001).

## TREATMENT IN PRISONS AND JAILS

10. **Drug treatment on request should be available to individuals in prison or jail.** While implicit in the recommendation that addiction treatment should be available on request to every Washington resident who wants and needs it, this point warrants separate comment. A great many people with drug addictions are currently incarcerated in Washington.[71] Once an individual who has a drug addiction and who wants addiction treatment has been incarcerated, the failure to provide such treatment makes no sense. The harm caused and experienced, both while incarcerated and after release, by addicted individuals who have been incarcerated and denied treatment is harm that should be preempted to the extent possible. This means not only that in-prison treatment should be available, but also that provision should be made to assure that needed treatment and related services are available after release.

11. **Opiate-replacement therapies should be available treatment options in correctional settings, to the extent practicable.** Available evidence suggests that methadone treatment in correctional settings reduces violence, reduces transmission of HIV and other infectious diseases (to others in the prison population and, ultimately, to the general public), and decreases recidivism rates after release.[72] Released opiate-dependent offenders in methadone maintenance treatment have reduced illegal drug use, reduced risky health behavior, and reduced future criminal behavior. In general, the longer a person is receiving methadone treatment, the higher the chances of ongoing treatment success. Engaging a prisoner in methadone treatment while in prison is the most successful way to increase the likelihood that the prisoner will enter a methadone treatment program on release from prison (if one is available). When an individual who is on a methadone maintenance program comes into a jail, that person should be permitted to continue receiving the medication. Task Force inquiries to individuals with responsibilities related to drug treatment in prison and elsewhere revealed a willingness to exploring the issue of methadone therapy, as well as an awareness of some administrative challenges in the implementation of methadone therapy in a correctional setting.[73]

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[71] Whether some of these people should be incarcerated is a question to be addressed by the Criminal Sanctions Task Force. Within the Treatment Task Force there would likely be some differing views on the appropriate use of the criminal law in relation to the possession, use and sale of drugs.

[72] Kate Dolan and Alex Wodak, *An International Review of Methadone Provision in Prisons*, Addiction Research 1996, Vol. 4, No. 1; Vincent Tomasino and others, The Key Extended Entry Program (KEEP): A Methadone Treatment Program for Opiate-Dependent Inmates, The Mount Sinai Journal of Medicine, Vol. 68, No. 1 (January 2001); Mark W. Parrino, *Methadone Treatment in Jail*, American Jails (May-June 2000).

[73] The range of issues addressed by providers outside of prison – from eligibility criteria and funding to delivery and storage of the methadone – would have to be addressed. A particular concern was whether a prisoner started on methadone in prison would have access to continued treatment on release.

## FUNDING AND ADMINISTRATION OF TREATMENT

12. **The people of Washington should make a commitment to, and have a strategy for, the adequate funding of drug addiction treatment.** One of the most significant obstacles to the implementation of an effective addiction-treatment plan is our failure to allocate sufficient funds to the project. The Task Force is not equipped to decide among potential funding sources, but has identified some that warrant consideration.[74] One source of funding that was a subject of intense discussion in the 2001 Legislative session is the generation of savings in prison-related costs by beginning to reduce certain drug-related criminal sentences.[75] Another is the use of a dedicated increased sales tax on a product such as beer.[76] A third source of expanded funding might be Medicaid. (One specific change that would allow for an expansion of the use of Medicaid funds is addressed in the next recommendation.) The mention of such funding sources is not meant to relieve us of responsibility to make a sufficient commitment of general state revenues raised from general taxes to fund treatment programs.

13. **An addiction-treatment exception should be made to the federal prohibition against use of Medicaid funds for services provided in institutions for mental diseases with more than 16 beds.** The policy against using federal funds to care for patients in institutions for mental diseases (IMD) dates back half a century. It is based on the notion that care of such patients has traditionally been and (therefore) should remain the responsibility of the states and not the federal government. Whatever the continuing merit of such a division of responsibility might be in general, in the area of addiction treatment it represents a significant obstacle to the pursuit of a national policy to reduce drug addiction. Washington spends approximately $30 million annually on residential addiction treatment programs. Medicaid funding covers less than 12% of the cost of these programs. The current IMD policy is one reason that Medicaid is such a limited addiction-treatment resource.[77]

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[74] By saying that they warrant consideration, the Task Force does not endorse any identified source of funding.

[75] E2SSB 5419, making modest reductions in prison sentences for certain drug-related offenses and providing for the allocation of certain related savings to addiction treatment, passed the Senate but failed to pass the House.

[76] While taxes on other alcoholic products in Washington are not low by national standards, beer is taxed at a relatively lower rate, unless its alcohol content by weight is more than 8%. RCW 82.08.150; RCW 66.04.010(22). It may be argued that tax revenues should compensate for the economic costs to the public associated with the product sold. According to Professor Wickizer, "[f]or every $1 that Washington State collected in tax revenue from alcohol sales in 1996, over $12 was spent as a result of alcohol abuse." *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996* p. xv (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 1999).

[77] *What is the IMD Exclusion?* Division of Alcohol and Substance Abuse paper, July 2000.

14. **The Division of Alcohol and Substance Abuse should have enhanced oversight responsibility for state addiction-treatment policy.** Currently, responsibility for addiction-treatment policy and its implementation is dispersed among various state agencies including the Department of Social and Health Services Division of Alcohol and Substance Abuse (DASA), the Department of Corrections, the Office of Community Development, the Department of Health and the Office of the Insurance Commissioner. While there is a need to involve various agencies in addiction treatment, a single office should articulate a unifying policy and vision, assess the availability, utilization and effectiveness of treatment options, certify treatment providers, assure smooth transitions between programs, and manage a uniform information base.[78] While significant coordination, planning and information gathering responsibilities are assigned to the Department of Social & Health Services under current law, [79] and while the DSHS Division of Alcohol and Substance Abuse has been widely regarded as effective in discharging the responsibilities assigned to it, those responsibilities have not included, for example, the assessment of treatment programs in prisons, the assessment of the availability and utilization of treatment options under private medical insurance, or the assessment of the effectiveness of primary health care providers in addressing addiction-related issues. The Task Force is not prepared to specify the scope of additional authority needed to enable DASA to provide optimal policy coordination. It recommends that the issue be reviewed by the Governor's office in consultation with representatives of affected agencies and others.

15. **Research-based investigation and reporting on the effectiveness of various approaches to addiction treatment and related issues should have continued support.** While addiction treatment has been the subject of important and useful research, both nationally and in Washington State, important research remains to be done as a basis for improved treatment approaches and wise policy decisions. By supporting investigation and reporting on the extent of various addictions, related societal costs, and the effectiveness of treatment in Washington, the Division of Alcohol and Substance Abuse has provided information of tremendous usefulness for the development of drug policy. That investigation and reporting should be expanded to address additional areas, including treatment in prison and the utilization and effectiveness of treatment provided through private insurance plans.

16. **Health insurance plans should provide broad coverage for drug addiction treatment; the Basic Health Plan and plans offered to employers of not more than 25 employees should have benefits at least at the levels required under WAC 284-53-010.** Substantial coverage (a minimum benefit of $10,000 in a 24-month period) is currently required for group insurance plans that are governed by WAC 284-53-010. No similar requirement applies to group plans offered to

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[78] Currently, for example, there is extensive information about utilization, and success, of public addiction-treatment programs, but scant comparable data on the utilization of treatment covered by private insurance. And, while DASA certifies treatment providers pursuant to RCW 70.96A.090 and Chapter 388-805 WAC, other agencies that provide addiction treatment do not uniformly use certified providers.

[79] RCW 70.96A.040 and 050.

employers of not more than 25 employees, or to self insurers. The Basic Health Plan, administered by the Washington State Health Care Authority, currently includes less coverage than is required generally for group insurance plans.

17. **Drug court programs should be offered as an alternative to trial on criminal charges for individuals with drug addictions whenever this alternative is not inconsistent with important public interests.**[80] Drug courts generally offer individuals with drug addictions who are charged with certain criminal offenses the option of treatment in place of conventional prosecution.[81] This option is currently available to only a small fraction of those who could benefit from it. A substantial expansion of the program is warranted.

## EXPANDING TREATMENT CAPACITY

18. **Drug addiction screening and intervention standards for health professionals should be established and appropriate training should be incorporated in academic curricula and in continuing education programs.** The Division of Alcohol and Substance Abuse should work with willing associations of health care providers to develop or promote the development of appropriate standards and training.

19. **Programs to attract and train addiction-treatment professionals should be supported and expanded.** If funds were available tomorrow to offer addiction treatment to all who need and want it, there would not be enough trained professionals to meet the demand. In fact, "service provider agencies [already] report increasing difficulties in recruiting and retaining chemical dependency professionals."[82] In designing training programs, attention should be paid to the special needs of Washington residents of different ages, language and cultural backgrounds and life experiences.

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[80] The issue of what acts should be defined as criminal offenses is to be addressed by the Sanctions Task Force. This is, once again, an issue about which opinions among Treatment Task Force members would likely differ. Where individuals with drug addictions *are* charged with crimes, however, the option of drug courts should be considered.

[81] See discussion on page 14 above.

[82] *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State: 2001 Report* 233 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001).

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