IS IT TIME TO END
THE WAR ON DRUGS?

AN EXAMINATION OF CURRENT LAW AND PRACTICE IN
DRUG ABUSE PREVENTION, DRUG ADDICTION TREATMENT
AND
THE USE OF CRIMINAL SANCTIONS

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ADOPTED BY THE BOARD OF TRUSTEES

November 20, 2001

PREAMBLE

For decades, our society has been prosecuting and incarcerating increasing numbers of people for possessing or selling small amounts of drugs. Today, no country in the world has so large a percentage of its population behind bars for this type of activity. Furthermore, the collateral damage caused by the excessive reliance on such criminal sanctions has been deeply troubling. Since the harsh use of criminal sanctions has been unsuccessful, we have concluded that it is time for a new approach.

We are not advocating the immediate dismantling of our criminal justice system as a means of controlling the flow and use of illegal drugs and the harm they cause unless and until an effective replacement system is securely in position. We are also not advocating that the dealers and distributors be given a free hand to engage in their trade with impunity. However, we do want to spark an open and honest discussion about the current criminal justice system’s inability to achieve the result that we all want: reducing the damage done by drugs while not creating more harm than the use of the drugs themselves.

Instead of relying primarily on criminal sanctions to deal with those who possess or distribute relatively small amounts of drugs, we should be moving decisively towards a public health model for those individuals. There have been some recent efforts in other states to use the public health model, and they appear to be successful. However, this model has not yet been tested over a long period of time, nor do we know what undesirable consequences might arise from the widespread use of the model. Hence, we believe that our society should promptly develop public health programs for these individuals while continuing to use the threat of criminal sanctions for the limited purpose of encouraging the participation of these individuals in the public health programs. It is our hope that, over time, the reliance on the threat of criminal sanctions will diminish as the success of the public health model demonstrates itself.

While we do not claim to have a complete vision of a well-formulated drug policy, we are confident that we must move boldly toward the provision of effective treatment, now offered to only a small fraction of those who need it, and away from an excessive use of the criminal sanctions that has caused more harm than good. Of course, the criminal law will always have a role to play to assure public safety. Behavior that puts others at risk, such as violent or other non-drug related criminal behavior where drug abuse was a factor, should not excuse the underlying crime. Moreover, driving under the influence of any mind-
altering drug should continue to be prohibited and punished. And, in our view, the
distribution of drugs (except by those who deliver small quantities to support their own
addiction) and, of course, giving or selling mind-altering drugs to minors, should continue to
be prohibited and criminally punished.

Finally, it is absolutely crucial that there be adequate funding for any public health
model. In order to have long-term success in dealing with the problem of drugs, our society
must make a commitment to pay for drug abuse prevention and drug addiction treatment
programs. Failure to do so will doom the public health model to the same sad fate as the
current criminal sanctions model.

CONCLUSIONS, RECOMMENDATIONS AND PRINCIPLES:

**DRUG ABUSE PREVENTION**

Washington’s overall drug abuse prevention goals should be:

a. to prevent or delay the use of alcohol, tobacco and other drugs
   among young people;

b. to reduce the harm from and curb the progression of alcohol, tobacco
   and other drug use among youth who have already begun;

c. to reduce the other problem behaviors that can co-occur with the use
   of alcohol, tobacco and other drugs; and

d. to increase the availability of school- and community-based prevention
   services, especially for vulnerable groups and high-risk individuals.

To achieve these goals, a working group of statewide experts should be convened
to improve on Washington’s comprehensive substance abuse prevention plan. This
special statewide panel, composed of state and local educational and health officials,
scholars, clinicians, parents, teachers and students, should build on the work already begun
by the State Division of Alcohol and Substance Abuse, and would be qualified to make
specific recommendations to improve the state’s comprehensive prevention plan. The plan
should incorporate state-of-the-art prevention programming that meets Washington’s needs.
As a guide to the experts on the recommended statewide panel, the effort to improve Washington's comprehensive substance abuse prevention plan should conform to the following broad recommendations:

1) Any effective drug abuse prevention strategy must address the social and psychological problems underlying drug abuse, so as to help give young people genuine opportunities to lead fulfilling lives. Drug abuse prevention should be part of a broader youth development strategy, reaching beyond mere drug education and helping young people to develop the needed social and self-management skills to make responsible decisions in the broader contexts of their lives.

2) To be most cost-effective, prevention programs should focus primarily on those youth who are most at risk of developing a range of problem behaviors, which include substance abuse, but also include poor school performance and low school attachment, delinquency, depression and suicidal behavior.

3) The appropriate outcome measure for prevention programming should not be drug use, but rather drug abuse, or more specifically, the harm resulting from excessive drug use. From this perspective, a core feature of Washington’s prevention strategy should be the prevention of alcohol and tobacco use among minors, especially early initiation of use.

4) Drug education programs should provide honest and complete information about alcohol and other drugs, carefully distinguishing between the degrees and types of harm and risk associated with the use of different drugs. Such programs should include a discussion of the appeal of drugs, as well as the physiological and psychological effects that can also lead to excessive and harmful use.

5) Abstinence-only programs in schools, while generally ineffective or counterproductive in preventing alcohol and other drug use, seem to be effective in preventing tobacco use; therefore, tobacco-only abstinence programs are highly recommended.

6) Adequate training and commitment of teachers, counselors and discussion leaders is essential for an effective school-based prevention program, as is commitment and support from administration.
DRUG ADDICTION TREATMENT

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.

2. Drug treatment should be complemented by, and coordinated with, other needed treatment and assistance, including mental health treatment.

3. A broad spectrum of drug treatment options should be available.

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.

5. Special efforts should be made to assure that drug treatment, including inpatient treatment, is promptly available to children who need it.

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.

7. Treatment should continue to be available for those who need to re-enter it or to start a new program.

8. Obstacles to the effective use of opiate-replacement therapies should be removed.

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.

TREATMENT IN PRISONS AND JAILS

10. Drug treatment on request should be available to individuals in prison or jail.

11. Opiate-replacement therapies should be available treatment options in correctional settings, to the extent practicable.
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.

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.

14. The Division of Alcohol and Substance Abuse should have enhanced oversight responsibility for state addiction-treatment policy.

15. Research-based investigation and reporting on the effectiveness of various approaches to addiction treatment and related issues should have continued support.

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.

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. The issue of what acts should be defined as criminal offenses is addressed elsewhere. If individuals with drug addictions are charged with crimes (including crimes for which the use or sale of drugs is not an element), the option of drug courts should be considered.

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.

19. Programs to attract and train addiction-treatment professionals should be supported and expanded.
THE USE OF CRIMINAL SANCTIONS

Principles regarding the use of criminal sanctions

1) The current use of criminal sanctions against those who possess or deliver relatively small amounts of drugs is an ineffective means to discourage drug use or to address the problems arising from drug abuse, and it is extremely costly in both financial and human terms, unduly burdening the taxpayer and causing more harm to people than the use of drugs themselves.

2) Rather than criminally punish persons for drug use per se, any state sanction or remedy should be aimed at reducing the harm directly caused to others by persons using drugs. For example, there should be more reliance on civil remedies, supported by a court’s contempt power, which are already available to be imposed on persons who use drugs to the detriment of others.

3) Criminal sanctions should continue to be imposed upon persons who commit non-drug criminal offenses, but those offenders should have the opportunity to receive drug treatment, especially if their crimes are related to chemical dependency.

4) The state should significantly expand its investment in drug addiction treatment, drug education and drug abuse prevention programs, which have consistently been shown to be much more cost-effective responses to the problems created by drugs in society. Funding for those programs could be obtained from the substantial cost savings that will accrue from the diminishing reliance on the use of criminal sanctions.

Principles for an alternative drug policy

The reform of drug policy should be guided by the following set of principles:

1) Any public policy toward drug use should seek to result in no more harm than the use of the drugs themselves;

2) Any public policy toward drug use should address the underlying causes and the resulting harms of drug abuse instead of attempting to discourage drug abuse through the use of criminal sanctions;

3) The state should regulate the use of drugs in a manner that recognizes a citizen’s individual liberties while answering the need to preserve public health, public safety and public order;

4) The state should regulate the use of drugs in a manner that uses scarce public resources as efficiently as possible.

5) Federal law should permit the states to develop their own drug control strategies and structures for individuals possessing or selling small quantities of drugs.
Introduction

The King County Bar Association established the Drug Policy Project in the fall of 2000 to examine current state and federal drug policies and to find more practical, effective and humane alternatives for reducing the harm caused by drug abuse. The project has also involved the participation of the King County Medical Association, the Washington State Bar Association, the Washington State Medical Association and the Washington State Pharmacy Association. The effort is intended to foster a more open and honest dialogue about drug policy among professionals, public officials and the public at large.

This report is the compilation of separate studies completed by three policy-oriented task forces of the Drug Policy Project. Task force participants included lawyers, judges, scholars, clinicians, educators and others with extensive academic and practical experience, who gave their time in the hope of helping to focus attention on ways to improve our societal response to drug abuse. Each of the task forces was formed to examine key drug policy issues and to formulate specific recommendations to address those issues:

The **Task Force on Effective Drug Abuse Prevention** was established to study and report on current drug abuse prevention research, policies and programs. The Prevention Task Force considered why young people begin to use drugs and reviewed measures that have been shown to prevent, delay or reduce the harm from such use, including some noteworthy examples developed in Washington State. Although there are many drug abuse prevention strategies, including the building of community coalitions, expanded after-school activities, social service referrals and public service announcements,\(^1\) the Prevention Task Force concentrated on the principal and most widely used drug abuse prevention strategy – drug education programs and other school-based substance abuse prevention programs.

The **Task Force on Drug Addiction Treatment** was formed to report on issues relating to treatment for addiction to drugs whose possession and sale are prohibited by current law. The Treatment Task Force considered why, when and how treatment should be provided to individuals who are addicted to such drugs, and it made recommendations with a view toward promoting the development and implementation of a comprehensive addiction-treatment plan for Washington State.

The **Task Force on the Use of Criminal Sanctions** examined current criminal sanctions, both in Washington and on the federal level, related to the non-medical use of drugs. The Sanctions Task Force was charged with assessing the effectiveness of criminal sanctions in reducing both illegal drug use and drug-related crime, and also assessing the public costs associated with the use of criminal sanctions. The Sanctions Task Force also evaluated the extent to which drug-related criminal sanctions are satisfying the objectives of the criminal law.\(^2\) Reviewing recent attempts to reform the prevailing drug policy, the Sanctions Task Force formulated a set of principles to guide the future development of alternative approaches to the problem of drug abuse that are more effective, less expensive and more humane.
**Definitions:**

In Sections II and III of this report, which deal respectively with addiction treatment and the use of criminal sanctions, the word “drugs” is generally defined to include the class of substances that is currently the target of the “War on Drugs.” Therefore, this report mainly discusses those drugs whose possession and sale are prohibited by current law.

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 target of 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. 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 this report’s recommendations could apply, with little modification, to the problem of alcohol abuse.

In Section II of this report, the use of the expression “drug addiction” is consistent with its definition under Washington law: “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.”

By contrast, Sections I and III of this report grapple with the elusive meaning of “drug abuse” and the policy challenges that arise from varying definitions of that term.

In the discussion of drug abuse prevention, the definition of “drugs” is necessarily more broad. Prevention science focuses particularly on drug use by children and adolescents, and therefore, “drugs” are defined to include alcohol and tobacco, because the use of all drugs is legally prohibited for minors, and because alcohol and tobacco use by minors is especially associated with drug abuse and other problem behaviors. The term “alcohol, tobacco and other drugs,” or “ATOD,” is often used by government agencies and by scholars in the prevention field, and that term is used interchangeably with the word “drugs” in Section I of this report. In addition, the terms “drug abuse prevention” and “substance abuse prevention” are used interchangeably in Section I, referring to those non-coercive interventions that are used both before and after the onset of any drug use by young people.
Conclusions and Recommendations

EFFECTIVE DRUG ABUSE PREVENTION

The prevailing approach to preventing drug abuse is not working. “Prevention” programs aimed at youth have been largely ineffective, based on the faulty premises that juvenile drug use can be completely eliminated, and that the chief concern is drug use \textit{per se} rather than the social forces that give rise to drug abuse and other problem behaviors.

Most youth pass through adolescence without experiencing any significant adverse consequences from drug use. However, more young people are beginning to use illicit substances at earlier ages. Although there is no cause-effect relationship, research shows that early initiation of drug use is associated with poor school performance, low school attachment and school dropout, antisocial and criminal activity, substance abuse and other problem behaviors. For those young people at risk of abusing drugs, who are not resilient enough to ward off other environmental risks, early intervention is essential. To the extent that children’s cognitive, physical and social development is compromised by the use of drugs, it is in the public interest for Washington to develop a more effective, statewide substance abuse prevention strategy.

Drug use by our youth should be strongly discouraged, but experimentation with these substances is inevitable for many adolescents. Prevention efforts should be focused on the harm associated with drug use, rather than merely the use of drugs. It is important to distinguish between varying degrees of harm associated with different substances and to develop a strategy that reduces the greatest potential for harm. From the public health perspective, therefore, Washington’s substance abuse prevention strategy must include alcohol and tobacco, because of alcohol’s close association with aggressive, irresponsible and criminal behavior and tobacco’s highly addictive properties and its well-known, serious damage to physical health. Although alcohol and tobacco are not targets of the War on Drugs, the effort to prevent our youth from using substances that \textit{are} targeted by the War on Drugs must nevertheless focus prominently on alcohol and tobacco. Investing in strategies to prevent their use by minors will yield significant health benefits and will help prevent many problem behaviors by our youth.

Some programs have shown modest success in preventing or delaying youth drug use. However, those programs focus principally on helping youth to cope with an array of societal influences and to develop an increased sense of self-worth, rather than on the hazards of drug abuse. Research indicates that programs targeting “high-risk” youth are more beneficial and cost-effective than universal drug education programs such as D.A.R.E., which often rely on fear as a motivating factor and overstate the dangers of certain drugs in comparison with alcohol and tobacco. As a matter of social policy, therefore, “prevention” resources should be devoted primarily toward programs that build and reinforce social and self-management skills, particularly for youth presenting a higher risk of problem behaviors.
Washington is a national leader in developing programs that target children and adolescents who are at higher risk of drug abuse and other problem behaviors. There appears to be an emerging structure in Washington for youth-focused prevention efforts, but that initiative is severely under-funded and is insufficient for the scope of the challenge. Furthermore, research is needed to help explain the causes of substance abuse among our youth, and there is a critical need for more data on the effectiveness of prevention programs.

A special, statewide working group should be formed to improve Washington’s comprehensive substance abuse prevention plan. A special statewide panel, composed of state and local health and educational officials, scholars, clinicians, parents, teachers and students, could build on the work begun by the State Division of Alcohol and Substance Abuse and would be qualified to make specific recommendations to improve the state’s comprehensive prevention plan. The work of the panel of experts should be guided by the following broad recommendations:

- Any effective drug abuse prevention strategy must address the social and psychological problems underlying drug abuse, so as to help give young people genuine opportunities to lead fulfilling lives. Drug abuse prevention should be part of a broader youth development strategy, allowing youth to learn the social and self-management skills needed to make responsible decisions in the broader contexts of their lives.

- Youth-focused prevention programs should aim to prevent and minimize the harm associated with the use drugs, which means:
  1) preventing the early initiation of alcohol, tobacco and other drugs, which is correlated with problem behaviors of youth;
  2) focusing attention on programs targeting “high-risk” youth rather than promoting universal drug education programs that are ineffective; and
  3) concentrating on preventing use of alcohol and tobacco, the substances that present the greatest risk of harm to youth.

- Drug education programs should provide honest and complete information about drugs, carefully distinguishing between the degrees and types of harm and risk associated with the use of different drugs. Such programs should include a discussion of the appeal of drugs, as well as the physiological and psychological effects that can also lead to excessive and harmful use.

For the people of Washington, investment in research-based prevention programs will help to avert the much higher costs of drug treatment, criminal justice and social and health services that would otherwise arise, estimated to be about $2 million for each young person who develops a long-term substance abuse problem. Shifting funding away from drug-related criminal enforcement and toward drug abuse prevention will also reflect the proper emphasis on substance abuse as principally a social and public health problem.
**DRUG ADDICTION TREATMENT**

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.

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.

The following recommendations should guide the development and implementation of an effective, statewide addiction treatment plan for Washington:

**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.

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 is widely acknowledged by professionals familiar with current treatment programs in adult prisons, programs available to juvenile offenders and in other settings. 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 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. 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. 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. 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.

**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. 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.\textsuperscript{14} 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. Individuals responsible for providing drug treatment in prison and elsewhere have 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.\textsuperscript{15}

### 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. A number of potential funding sources warrant consideration. 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.\textsuperscript{16} Another is the use of a dedicated increased sales tax on a product such as beer.\textsuperscript{17} A third source of expanded funding might be Medicaid. 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.\textsuperscript{18}
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. While significant coordination, planning and information gathering responsibilities are assigned to the Department of Social & Health Services under current law, 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 scope of additional authority needed to enable DASA to provide optimal policy coordination should 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 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.** Drug courts generally offer individuals with drug addictions who are charged with certain criminal offenses the option of treatment in place of conventional prosecution. 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.”\(^{21}\) 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.
Current Criminal Sanctions Related to Drugs

- Criminal sanctions imposed in Washington for the possession and sale of drugs are severe, more severe than in many other states.

- First-time, non-violent offenders convicted of selling any amount of heroin, cocaine or methamphetamine are subject to a two-year prison sentence in Washington, which is four times as long as sentences for some common violent offenses, such as second-degree robbery and assault, and longer than sentences for many other violent crimes and crimes against other persons.

- Non-violent drug offenders with prior drug convictions face especially long sentences because of unique sentencing rules in Washington that make drug-related penalties particularly harsh. Repeat drug offenders may receive a prison sentence of up to twenty years, even without any violent offenses in their conviction history.

- A large number of drug offenders now being sentenced to prison in Washington are indigent and homeless and are arrested for selling very small amounts of drugs to support their own drug dependency.

- At the federal level, mandatory minimum sentences for drug offenses have resulted in extremely long prison terms, longer on average than for any other federal offenses except homicide and robbery.

- Contrary to the presumption that federal drug control efforts focus on the most “serious” offenders, one third of federal drug offenders have never been previously arrested, two thirds of federal drug offenders have had no prior felony convictions, and 90 percent of federal drug convictions are for non-violent offenses. Only 11 percent of federal drug offenders are classified as high-level dealers.

- As a result of amendments to federal and state drug laws in the late 1980s, the average prison time served for many drug offenses has doubled, as has the percentage of prison inmates whose most serious charge is a non-violent drug offense.

- Alternative sentences for some drug offenders are now available in Washington, whereby prison time is reduced and addiction treatment is provided. However, fewer than 25 percent of all drug offenders receive that option, and thousands of drug offenders in Washington continue to be incarcerated without any treatment.
Assessing the Effectiveness of Drug-Related Criminal Sanctions

- In the last dozen years, since the toughening of drug-related criminal sanctions at both the state and federal levels, rates of drug use and drug abuse have either remained relatively steady or have increased.

- Rates of drug use, especially of marijuana and cocaine, actually declined before the recent intensification of drug-related law enforcement and incarceration, and then increased after the imposition of harsher criminal sanctions.

- Total public costs related to substance abuse in Washington have continued to rise over the last decade. However, alcohol is responsible for the greatest amount of public health and associated economic costs, accounting for the vast majority of emergency room visits and the incidence of disease and premature death (from overdose and motor vehicle accidents).

- Rising costs related to illegal drugs have been due to increased drug law enforcement and incarceration of drug offenders, not to any increased demand for medical or social services. Even after factoring in law enforcement and incarceration costs related to illegal drugs, alcohol continues to account for the majority – 59 percent – of the total economic costs in Washington for drug and alcohol use combined.

- Crime related to drugs, including the possession and sale of drugs and “acquisitive” property crimes resulting from the need to support drug dependency, has increased since the toughening of criminal sanctions over a decade ago. While arrest rates for other crime categories have held steady or risen only modestly over the last 15 years, arrests for drug offenses have increased by 345 percent in Washington.

- Violent crime is associated with alcohol far more than with any illegal drug, including cocaine, “crack” cocaine and heroin. Alcohol is a factor in over 40 percent of murders and over 50 percent of assaults; in Washington, alcohol-related assaults outnumber assaults related to other drugs by a thirteen-to-one margin.

- The cost of criminal justice in connection with the War on Drugs has skyrocketed in the last decade, including more than a doubling of the cost of incarceration for drug offenders in Washington during that period. Combined federal and state expenditures on an annual basis for drug law enforcement have risen from about $10 billion in the mid-1980s to about $35 billion today.

- The increasing arrest and incarceration of drug offenders and the lengthening of their sentences have not only failed to reduce the prevalence of drug use, the problem of drug abuse or the incidence of drug offenses and drug-related crime, but have also failed to satisfy the core objectives of the criminal justice system. The toughening of drug-related penalties has not resulted in enhanced public safety, nor has it succeeded in deterring drug-related crime or in reducing recidivism by removing drug offenders from the community (the “incapacitation effect”).
Collateral Harm from the “War on Drugs”

- The War on Drugs has promoted crime at the local, national and international levels. The drug trade is exempt from regulation and control, and high profits from inflated drug prices (reflecting the risk of having to evade law enforcement) create stronger incentives to continue doing business. Increased law enforcement efforts have spawned higher levels of violence. Even as retail prices have declined, especially for cocaine and heroin, the international business in illicit drugs generates about $400 billion in trade each year.

- The criminalization of drugs has undermined public health in many ways, including AIDS transmission through unclean needles, the distribution of impure and hazardous substances and the development of higher potency and synthetic substances that may be more easily concealed, but are much more harmful to health. In addition, the risk of criminal sanctions has, arguably, prevented drug users from seeking medical attention, especially for addiction, and physicians are inhibited from providing effective pain treatment due to federal auditing of prescribed controlled substances.

- Drug cases have clogged the courts and caused delay in the processing of other criminal and civil matters. At least half of King County’s criminal caseload is drug-related, and the recent increase in the active pending criminal caseload is due in significant part to controlled substances cases, which account for the highest number of pending criminal cases (even excluding drug court).

- The War on Drugs has taken a particularly hard toll on economically disadvantaged communities, both through the massive incarceration of poor young men and through the sense of danger and disorder brought about by heavy police presence, open-air retail drug sales and the threat of violent turf battles. Incarceration of drug offenders has disrupted their families, interfered with their educational and employment opportunities and deprived them of the right to vote, perpetuating and exacerbating the social conditions that gave rise to drug abuse in the first place.

- Citizens’ constitutional rights have been compromised as a result of stepped-up drug law enforcement, as street sweeps, wiretaps and home searches have impinged upon individual privacy. Persons convicted of drug offenses lose the right to vote, the right to hold public office and the right to serve as a juror, and getting those rights restored after completion of the sentence is very difficult. The U.S. now leads the world in per capita imprisonment, and many of those prisoners are non-violent drug offenders.

- Corruption among criminal justice officials has risen dramatically during the War on Drugs, as the payoffs are high and the risks are low. Enormous profits from the drug trade have also corrupted foreign nations, particularly where the raw materials for illegal drugs are cultivated and processed. U.S.-led efforts to eradicate crops and to fight drug enterprises have brought about political and economic destabilization and environmental destruction.
Current Drug Policy Reforms

- Citizens in Arizona and California have approved statewide initiatives that mandate treatment instead of incarceration for non-violent drug offenders. Evidence from Arizona reveals that mandating treatment as the primary response to drug use has resulted in significant cost savings to the state and has reduced recidivism rates; early estimates from California indicate the same encouraging trend.

- “Drug courts” have been an important part of the recent paradigm shift from punishment to rehabilitation that is beginning to take hold, as courts work with health and treatment providers to address offenders’ drug dependencies. Drug courts have saved public costs and reduced recidivism rates among their “graduates,” but only a small percentage of drug offenders (10% in King County) participate in these programs. Drug courts still operate firmly within the criminal justice system, using criminal sanctions as tools to try to modify behavior. Ultimately, the drug court model cannot resolve the underlying problems of treating drug use as a criminal matter rather than as a health matter.

- Some states have reduced the severity and expense of incarceration for some drug offenders, including Washington, which expanded its Drug Offender Sentencing Alternative program to reduce prison time and provide drug treatment for almost one quarter of all drug offenders. Other states have begun to roll back prison terms due to fiscal pressures, but no state, including Washington, has yet shifted the primary responsibility for addressing drug-related harms from the criminal justice system to the public health system.

These findings give rise to the following conclusions:

1) The use of criminal sanctions is an ineffective means to discourage drug use or to address the problems arising from drug abuse, and it is extremely costly in both financial and human terms, unduly burdening the taxpayer and causing more harm to people than the use of drugs themselves.

2) Rather than criminally punish persons for drug use *per se*, any state sanction or remedy should be aimed at reducing the harm directly caused to others by persons using drugs. Civil remedies, supported by a court’s contempt power, are already available to be imposed on persons who use drugs to the detriment of others.

3) Criminal sanctions should continue to be imposed upon persons who commit *non-drug* criminal offenses, but those offenders should have the opportunity to receive drug treatment, especially if their crimes are related to chemical dependency.

4) The state should significantly expand its investment in drug addiction treatment, drug education and drug abuse prevention programs, which have consistently been shown to be much more cost-effective responses to the problems created by drugs in society. Funding for those programs could be obtained from the substantial cost savings that will accrue from continued diminished reliance on the use of criminal sanctions.
Future Considerations – More Effective Regulation of Drugs

Although the vast majority of citizens acknowledge the failure of the War on Drugs, there is no consensus on any alternative policy. Furthermore, an impediment to any fundamental drug policy reform is the breadth of federal drug law. Federal law should permit the states to develop their own drug control strategies and structures, using the federal system to allow states to be laboratories for change and improvement of public laws and institutions. Allowing Washington and other states to experiment with different drug control strategies and systems will permit the development of more effective means to deal with the problems created by drugs in our society.

The following set of principles should guide state-level efforts to develop more effective drug control strategies and structures:

1) Any public policy toward drug use should seek to result in no more harm than the use of the drugs themselves.

2) Any public policy toward drug use should address the underlying causes and the resulting harms of drug abuse instead of attempting to discourage drug abuse through the use of criminal sanctions.

3) The state should regulate the use of drugs in a manner that recognizes a citizen’s individual liberties while answering the need to preserve public health, public safety and public order.

4) The state should regulate the use of drugs in a manner that uses scarce public resources as efficiently as possible.

Using these principles as a guide, the people of Washington can fashion a drug policy that is fiscally responsible and that effectively balances the exercise of civil liberties with the maintenance of public order, while also providing compassionate treatment to those in need.
SECTION I

EFFECTIVE DRUG ABUSE PREVENTION:
KEEPING OUR YOUTH OUT OF TROUBLE
“Drug abuse prevention” does not seem to be controversial at first, as no reasonable person would argue against the desirability of preventing drug abuse. However, the social policy debate around drug abuse prevention is fraught with controversy, perhaps more than the discussion of the use of criminal sanctions to discourage drug use. Numerous political problems hamper current prevention efforts, including the “abstinence-only” approach and the primacy of the criminal justice system in attempting to control drug use. Even beyond those obstacles, the drug abuse prevention issue is more difficult to address than other drug policy issues.

Because drug abuse prevention primarily concerns our children, the issue touches the heart of family and community life, sometimes calling into question how parents rear their children, how schools transmit and reinforce norms and how peer groups form and function. A danger in the discussion of drugs with children is the mirror it holds up to adult drug use – and the media reinforcement of that image – showing the example that many adults set for their children. In a recent national survey, most fingers seem to point to “bad parenting” and “hanging around the wrong kids,” two factors that public policy cannot easily address. The discussion of drug abuse prevention is controversial because the stakes seem so high.

The highly-charged issue of drug abuse prevention becomes even more unsettled because of the limits of social science to predict human behavior. It is not possible to determine which child will eventually fall into drug abuse, so the discussion of drug abuse prevention struggles for certainty. This is distinguished from the other drug policy issues, where it is easier, for instance, to ascertain the numbers being arrested, prosecuted and incarcerated for drug offenses and the numbers needing drug addiction treatment. Where prevention science is in flux, parents and teachers are left with little comfort, as they confront the frightening reality that adolescents inevitably experiment with many potentially harmful behaviors, including drug use.

In grappling with the uncertainty that underlies drug abuse prevention, only some very targeted programs seem to have any measurable effect on drug abuse. Looking at the reasons for the success of those programs, the wisest use of scarce resources should focus on the children who are most at risk and on the drugs that present the most potential for harm. Furthermore, the relatively unsettled state of prevention science requires more study and evaluation by experts in the field in order to improve drug abuse prevention strategies.

1. Youth Involvement with Alcohol, Tobacco and Other Drugs
Formal research studies of adolescents have consistently found that most illicit drug use does not evolve into persistent use, and that illicit drug use, along with other adolescent behaviors, is intermittent or transitory. A recent federal report by the U.S. Center on Substance Abuse Prevention concluded:

Adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their independence. For a significant number of adolescents, this rejection consists of engaging in a number of “risky” behaviors, including alcohol and other drug use…[which] may be a “default” activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner.

Although most youth successfully navigate through adolescence without developing substance abuse problems, some do use drugs excessively, which can undermine motivation, interfere with cognitive processes, contribute to debilitating mood disorders and increase the risk of accidental injury and death. Over three million American children between the ages of 10 and 18 are experiencing serious troubles with drugs, jeopardizing their chances of success in adulthood.

Children’s limited ability to make informed judgments renders them especially vulnerable to the adverse consequences of drug use, so a delay in their exposure to drugs gives them more opportunities to become socially competent and resilient to risk. Therefore, to the extent that children’s development is impaired due to drug use, devising an effective strategy to prevent or delay drug use is an important social policy objective.

**Current Trends in Washington and the Nation**

Ranked nationally, the prevalence of drug use by teenagers in Washington is higher than in a majority of other states. The latest data from the State Division of Alcohol and Substance Abuse reveal the following:

- The percentage of 8th, 10th and 12th graders in Washington who have ever used cigarettes, alcohol and marijuana is higher than the national average.
- The percentage of 8th and 10th graders in Washington who have used alcohol recently is higher than the national average.
- The rate of heavy drinking by 8th, 10th and 12th graders in Washington is higher than the national average.
- The percentage of 8th, 10th and 12th graders in Washington who have used marijuana and cocaine recently is higher than the national average.
- The percentage of high school seniors in Washington who have used marijuana in the past 30 days is at its highest point in the last 15 years.

Findings from across the nation indicate that juveniles are experimenting with drugs at younger ages. Particularly significant changes in drug awareness seem to be taking place between the ages of 12 and 13; surveys show, for instance, that 13-year-olds are three times as likely as 12-year-olds to know how to obtain marijuana or to know someone who uses illicit drugs. In the last decade, the rising prevalence of marijuana usage has been attributed to increased use by 12-to-17 year-olds, and there has been a slight upward trend in first-time cocaine and heroin use by the same age group.

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The latest findings from a federally-sponsored national survey of high school seniors’ drug use reveal the following:\(^\text{32}\)

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>last 12 months</th>
<th>last month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>73.2%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>36.5</td>
<td>21.6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Heroin</td>
<td>1.5</td>
<td>0.7</td>
</tr>
</tbody>
</table>

By senior year, about 80 percent of students have consumed alcohol, 63 percent have smoked cigarettes and 49 percent have used marijuana. The use of “hard” drugs, however, is extremely limited.\(^\text{33}\) The high prevalence of alcohol use in particular gives rise to potential short-term and long-term harm, because alcohol consumption by young people is especially linked with aggressive, irresponsible and criminal behavior.\(^\text{34}\)

Looking back ten years, increased marijuana use among youth has been especially pronounced. Since 1991, the percentage of 10\(^{th}\) and 12\(^{th}\) graders reporting use of marijuana in the last month has doubled, and the percentage has more than tripled for 8\(^{th}\) graders.\(^\text{35}\) During the same period, the fraction of students who believe people are at “great risk” of harming themselves with marijuana has declined from about 75% in 1991 to just over 50% today.\(^\text{36}\) By contrast, the percentage of high school students perceiving “great risk of harm” from cocaine and heroin has not declined, remaining at a high level of over 80 percent.\(^\text{37}\)

It is instructive to note that the increase in marijuana use has coincided with students’ changing perceptions of the risks of marijuana use. Through observation and experience, most youth who have tried drugs have generally chosen to use a more benign substance such as marijuana instead of “hard drugs.” As the figures above indicate, however, the primary drugs of choice for youth are still alcohol and tobacco, which government-appointed commissions in the United States and Europe have concluded are more harmful than marijuana from a public health perspective.\(^\text{38}\)

**Statistical Caution: Drug Use vs. Drug Abuse**

It is useful to review evidence of the extent of drug use by young people, because research shows that early use of these substances is associated with developmental difficulties, drug abuse and other problem behaviors. However, as described below, there is no cause-effect relationship. In addition, the extent of drug abuse cannot be properly ascertained merely by estimating the number of persons who use drugs. Recent research reveals, for example, that a very small percentage of children and adolescents account for the vast majority of alcohol and drugs that are used. Data from the 1997 National Household Survey on Drug Abuse indicate that less than 3 percent of 12 to 14-year-olds and 12 percent of 15 to 17-year-olds consume over 80 percent of the alcohol consumed by their age groups.\(^\text{39}\)

The National Academy of Sciences has recently highlighted the range of profound
methodological difficulties in estimating levels of drug abuse and in explaining the causes of drug abuse. Researchers have noted the importance of understanding differences in patterns of drug use among segments of the population, and of the need to distinguish between, for instance, the teenage marijuana user, the occasional cocaine user and the crack-or heroin-dependent person for whom drug use is “a career rather than an event.”

Although the bulk of formal research shows clearly that alcohol and tobacco present the greatest risk of harm to youth, official government reports frequently cite marijuana use as a prime indicator of serious problems. This assertion serves as a justification for continuing the policy of criminal enforcement as part of the “war on drugs.” The federal government’s focus on marijuana not only overstates the harms associated with its use compared with other substances, but also confuses use with abuse, thereby preventing any credible analysis of the comparable risks of all drugs as well as any rational formulation of priorities for drug control or drug abuse prevention.

It is difficult to determine whether the increasing juvenile involvement with drugs at younger ages will necessarily require more health-related intervention. However, a higher prevalence of drug use by children at younger ages at least increases the risk of drug abuse, and it is for this reason that the review of drug use statistics above is informative.

**Criminal Justice Contact – Increased Cost and Increased Harm**

During the same period when drug use has increased among youth, there has been an even sharper upward trend in drug-related arrests of youth across the nation. These arrests have taken place during a period of intensified law enforcement efforts as part of the “war on drugs.” Since 1990, the number of males under 18 arrested for drug offenses has increased by over 125 percent, and the number of females under 18 arrested for drug offenses has increased by almost 200 percent.

The last decade in Washington has also seen increasing numbers of youth running afoul of the law in connection with illicit drug use. In 1999, there were 2,732 arrests of juveniles for “drug abuse violations” in Washington, comprising about 14 percent of all such arrests (both juvenile and adult), compared with only 1,183 juvenile arrests in 1991, which comprised only ten percent of all such arrests at that time.

African-American high school students report using drugs at lower rates than their white counterparts. However, despite apparently lower levels of drug use, young African Americans and Latinos are arrested and incarcerated for drug offenses with a frequency that is grossly disproportionate to their levels of drug use. This is one of the most troubling aspects of the current drug control regime.

Even experimental or occasional use of drugs may, and often does, result in a youth’s contact with the criminal justice system. Such contact may, in itself, be the first slip in a downhill slope towards aggravated problems at home, poor school performance, drug abuse and the stigma of “delinquency.” Adolescents’ propensity to challenge authority is
evidenced by the fact that rising levels of juvenile drug use have occurred during the same period of increased law enforcement activity. In consideration of this trend, many observers have seriously questioned the deterrent effect of criminal justice enforcement related to drug use among our youth, and have concluded that the “War on Drugs,” with its emphasis on criminal justice enforcement, has been more harmful to youth than the use of the drugs themselves, and that that drug use and drug abuse should be treated as a social and public health problem rather than as a criminal justice problem.

Opportunity for Cost Savings

For society at large, drug abuse by young people does extract a cost in health care, educational failure, mental health services, addiction treatment and juvenile crime. A recent study concluded that each youth who drops out of school and falls into a life of drug abuse and crime will cost society from $1.7 to $2.3 million. This suggests the practical wisdom of a public policy that seeks to avoid those costs. The National Institute on Drug Abuse has found that “for every dollar spent on drug abuse prevention, communities can save four to five dollars in costs for drug abuse treatment and counseling.” Accordingly, increased investment in an effective drug abuse prevention strategy would be a prudent means of saving future public costs. Rather than “getting kids out of trouble,” it would be wiser to “keep kids out of trouble.”

2. Trying to Explain Juvenile Substance Abuse:
The findings above reveal that many young people experiment with drugs, but a relatively small number of youth develop serious problems when experimentation evolves into regular or habitual use, and then even further into dependence and addiction. It is, therefore, important to identify those children and adolescents who are most highly at risk of using drugs excessively, and fashion interventions that effectively prevent such abuse. To guide the development of such a prevention strategy, it is necessary to understand the interplay of factors related to juvenile substance abuse.

All children are vulnerable to the risks of substance abuse, regardless of ethnicity or social class, and it is difficult to predict with certainty which children will use drugs excessively. Poverty is one principal risk factor, but current research has shed light on the other risk factors that increase the likelihood of substance abuse, as well as the important protective factors that help to mitigate such problems. This research, much of which has been conducted by scholars from the University of Washington, is helping to guide the design of more effective strategies to prevent substance abuse among our youth.\(^\text{49}\)

**Risk Factors**

Children and adolescents are exposed to risks in many different domains, including in their homes, at school, with their friends and in the larger community. The various identified risk factors for substance abuse and other problem behaviors have generally been segregated into those domains for better analysis and policy planning:\(^\text{50}\)

**Community Domain\(^\text{51}\)**
- Availability of drugs
- Norms favorable to drug use
- Economic and social deprivation
- Community disorganization
- High level of neighborhood transition and mobility

**Family Domain\(^\text{52}\)**
- Parent-child conflict
- Family substance abuse and/or mental illness
- Family management problems

**School Domain**
- Early and persistent anti-social behavior (kindergarten to 3\(^{\text{rd}}\) grade)
- Poor academic performance in late elementary grades
- Low commitment and attendance
- Dropping out of high school
Peer/Individual Domain

- Rebelliousness and anti-social behavior
- Friends’ use of drugs
- Favorable attitudes towards drugs
- Perception of low risk from the use of drugs

While these risk factors are important predictors of substance abuse, the effect of any one risk factor can be blunted by other, more positive environmental influences in a child’s life (those “protective factors” are discussed below). However, exposure to two risk factors makes a child four times as likely to develop problem behaviors, and exposure to multiple risk factors substantially increases the likelihood that a child will move from drug experimentation to serious substance abuse by the teenage years.

Although it may seem obvious, it is important to recognize that one of the most prominent risk factors for substance abuse is the availability of drugs, both real and perceived. Recent state survey data from Washington show how students believe it is easy to obtain these substances:

| Percentage of Washington Students Reporting “Easy to Obtain” Illicit Drugs |
|-----------------------------|-------------------|-------------------|-------------------|-------------------|
|                             | 6th Grade | 8th Grade | 10th Grade | 12th Grade |
| Alcohol                    | 25%       | 53%       | 75%       | 83%       |
| Tobacco                    | 33        | 62        | 82        | 93        |
| Marijuana                  | 11        | 40        | 67        | 77        |

The figures above seem to confirm the frequently-stated anecdote that “kids know where to get drugs better than adults do.” Further, the survey data show that youth find some illegal drugs even easier to obtain than alcohol.

Based on this evidence, and despite decades of vigorous law enforcement in connection with the “War on Drugs,” the growing extent to which juveniles can obtain illicit substances further suggests the futility of the criminal justice response to juvenile drug use. The blanket prohibition of certain drugs has prevented their regulation by the state, causing their distribution and supply, purity and price to be controlled by organized crime and a pervasive black market. More effective regulation and control of those drugs by the state would go a long way toward achieving the goal of reducing their availability to minors.

Other risk factors in the community domain, such as economic deprivation and neighborhood disorganization, are extremely difficult to assess. However, the community domain is the most important arena for drug abuse prevention planning, because local attitudes, beliefs and standards establish the context for all other activities. Where schools, households, peer groups and individuals all exist within the community domain, prevention programs are either enhanced or undermined by factors present in the larger community. Understanding this, many states are promoting community-wide mobilization as a prevention strategy, which requires long-term planning, significant public investment and a considerable amount of patience.
**Protective Factors**

While a child is exposed to various risks, there may be other circumstances that help to dampen negative influences and help the child become more resilient, including:

- strong and positive bonds within a pro-social family
- consistent enforcement of clear rules of conduct within the family
- close parental monitoring
- successful school performance
- strong bonds with other pro-social institutions
- development of healthy norms about drug use.\(^{59}\)

In general, protective factors are those opportunities that allow the child to form attachments with others and to make commitments to people and projects. When youth form meaningful bonds with parents, teachers, mentors and peers, and when they receive consistent recognition and reinforcement of healthy behavior, they are better able to develop the skills needed to succeed.\(^{60}\) Opportunities to participate meaningfully in school activities and in responsibilities at home reduce the likelihood that youth will engage in drug use or develop substance abuse and other problem behaviors.\(^{61}\)

**Washington State Profile**

In 2000, the State Division of Alcohol and Substance Abuse completed an assessment of the risk factors and protective factors present in communities throughout Washington. Some of the most noteworthy findings from that study include the following:\(^{62}\)

- In recent years there has been a considerable increase in the percentage of students who perceive community laws and norms as favorable to drug use (about 50% of high school seniors and 42% of 10th graders).
- About 20 percent of retail liquor establishments sell liquor to underage customers, and a significant number of businesses sell tobacco to underage customers (from 15 percent to 30 percent, depending on the county).
- The percentage of students at risk because of low neighborhood attachment has increased in the last few years (about one third of all students).
- Almost 50 percent of high school seniors and almost 40 percent of 10th graders are at risk due to low commitment to school.

These findings suggest that the prospects for Washington’s adolescents are mixed at best. Our youth have inadequate opportunities for meaningful “pro-social involvement,” which could be more broadly available with greater public investment. Examples of such pro-social involvement, which research has shown to be associated with reduced levels of substance abuse and other problems, include:\(^{63}\)
• participation in music, art or performing arts programs
• attendance at religious services once a week
• ability to talk with parents and friends about problems (other than drugs)
• participation in youth groups, clubs or civic activities
• participation in athletic activities

These types of alternative activities provide young people with opportunities for creativity, personal expression and the strengthening of personal relationships.

**Co-Occuring Behaviors and the “Gateway Theory” Fallacy**

Research has consistently shown that youth involved with drugs also engage in illegal activities and other problem behaviors. However, it is extremely important to note that the mere co-occurrence of drug use and problem behaviors does not mean that drug use causes other problem behaviors. In fact, long-established research has shown that problem behaviors among youth often precede the use of drugs.\(^{64}\) The more effective drug abuse prevention programs reveal that drug use *per se* is not necessarily the most important indicator of higher risk. Instead, truancy, poor school performance and low school attachment, early sexual activity, depression and suicidal behavior, which are often accompanied by drug use, are often the principal focus for intervention.\(^{65}\) Considering these findings, merely trying to prevent or reduce alcohol or other drug use by itself will not significantly reduce the incidence of drug abuse and other problem behaviors, and that a more effective strategy would be to address the risk factors that are thought to underlie most problem behaviors, of which drug abuse is only one example.

Just as there is no cause-effect relationship between drug use and problem behaviors, no scientific or clinical research has shown any causal relationship between the use of any one drug and the use of another, including the assertion that marijuana use leads to the use of harder drugs.\(^ {66}\) The Institute of Medicine issued a report in 1999 on numerous aspects of marijuana, including the so-called “gateway theory,” and found no conclusive evidence that the drug effects of marijuana are linked to the subsequent use of other illicit drugs.\(^ {67}\) Over 72 million Americans have used marijuana, yet for every 120 marijuana users there is only one active, regular user of cocaine.\(^ {68}\) If there is any association between marijuana and other illegal drugs, it is the fact that it is illegal, and that exposure to other drugs when purchasing marijuana on the black market increases the opportunity to use other drugs.\(^ {69}\)

The substances most frequently used by minors are alcohol and tobacco.\(^ {70}\) Furthermore, adolescents who use alcohol and tobacco are more likely to use other illicit drugs.\(^ {71}\) Although the “gateway theory” is scientifically invalid and there is no cause-effect relationship between alcohol and tobacco use and the use of other illicit substances, their correlation strongly suggests any effective substance abuse prevention strategy should emphasize prevention of alcohol and tobacco use by minors.
3. The Promise and Perils of Drug Abuse Prevention Programs

Changing Approaches to Prevention

The history of drug abuse prevention has shown very limited success. The early days of drug abuse prevention focused on scare tactics and moral suasion, exemplified by *Reefer Madness*, a notorious film produced by the Federal Bureau of Narcotics in the late 1930s, which portrayed a “respectable” young man turned into a crazed criminal after taking one puff of marijuana. The prevailing attitude reflected in that film, however, did not lose credibility until the 1960s, when sweeping cultural change included a generalized challenge to authority, and youth stopped believing negative messages about drugs.\(^{72}\)

In the late 1960s, drug education programs in schools began to focus on the pharmacology, the psychological effects and the health hazards of drug use, targeting high school students as they began to experiment with drugs, but such programs had no measurable impact on drug use.\(^ {73}\) By the late 1970s, two principal theories had developed to guide school-based prevention efforts – “social learning” theory and “problem behavior” theory. “Social learning” theory proposes that adolescents learn by directly modeling the behavior of peers and adults and reinforce the beliefs, attitudes and behavior of those around them. School lessons designed to undermine adolescents’ misguided beliefs about substance use by their peers are the type of curriculum components informed by “social learning” theory.\(^ {74}\) By contrast, “problem behavior” theory posits that adolescents use illicit substances to fulfill certain needs and to cope with social anxiety, rejection, social isolation, boredom, low self-esteem, lack of self-efficacy, etc. Lessons designed to teach “life skills” and to foster “pro-social” development and social competency are the central curriculum components arising out of “problem behavior” theory.\(^ {75}\)

To this day, many drug abuse prevention programs are still based on either the “social learning” or “problem behavior” theories, as they attempt to impart social or life skills to youth and also attempt to dispel beliefs regarding the prevalence and frequency of drug use among peers. However, despite the popularity of these programs, their formal evaluation has revealed only limited effectiveness in preventing or reducing alcohol and other drug use among children and adolescents. The “problem behavior” theory has been called into question recently by research demonstrating that “a large proportion of persistent serious delinquents are not involved in persistent drug use,” challenging the notion that similar factors validly predict a wide range of problem behaviors.\(^ {76}\) Other rigorously-designed and large-scale evaluations of the “social learning” approach have also shown most such programs as ineffective in preventing substance use and/or abuse over the long term.\(^ {77}\)
The Failure of D.A.R.E.

The most widely implemented and well-known school-based “prevention” program is the Drug Abuse Resistance Education (D.A.R.E.) program, which consists of a series of lectures by uniformed police officers to 5th graders. The program focuses on information about the negative effects of drugs and on developing certain attitudes and values in making a moral commitment not to use drugs. The overall thrust of D.A.R.E. has been compared to the type of dogmatic indoctrination common in prevention programs from decades past, as the police use scare tactics in asking: “Do you know what drugs will do to you even if you mess around with them just once?” and “Do you know you must commit yourself to never trying them?”

The D.A.R.E. program has a contract with about 80 percent of the nation’s school districts. With multiple sources of revenue, including private contributions, government grants, special events and license royalties, D.A.R.E. has become a lucrative enterprise with its corporate officers earning six-figure salaries. With friends in Congress, the D.A.R.E. program is the only drug education program to receive non-competitive grants from the government, through special earmarks in federal appropriations bills. National estimates of the annual cost of the D.A.R.E. program are about $1 billion.

Despite the apparent popularity of the D.A.R.E. program, recent results from disinterested and objective evaluations have demonstrated that D.A.R.E. has not reduced drug use. Further, in some cases the D.A.R.E. program has been linked to increased drug use, particularly among suburban youth. School administrators, faced with a wide variety of federally-supported “prevention” programs, have often chosen the most aggressively marketed package, as D.A.R.E. has relieved schools of having to train teachers or administer the program. However, using police officers has divorced the program’s message from students’ daily learning, so the material has not been reinforced in regular classes, and in any event, the program’s “just say no” message has not been persuasive.

In response to criticism, D.A.R.E. officials are now planning a different approach. It remains to be seen whether the re-engineering of D.A.R.E. will render it any more effective, as it is being modeled after the Life Skills Training program (briefly reviewed in Appendix A of this report), whose own effectiveness has recently been partly discredited.

Searching for Effective Prevention Programs

Supportive families and communities are essential to helping children develop the skills needed to resist or postpone using drugs. As a matter of social policy, however, investment in school-based programs that reinforce those necessary social skills is an important complement. The challenge is to identify those programs that have been proven effective over the long term in reducing drug abuse. Appendix A of this report provides a brief review of some of the nation’s noteworthy prevention programs, including: the Child Development Project, developed in Oakland, California; the STAR Project, initiated in Kansas City; Project ALERT, developed at the RAND Corporation; and the widely-implemented Life Skills Training Program.
Prevention strategies have been designed to address varying levels of risk, and the “dose” of intervention needed depends on the constellation of risk and protective factors present in each situation. Universal programs target all youth without identifying those at particularly high levels of risk. Selective programs aim interventions at those youth who are deemed more vulnerable to drug abuse because of personal, family and community risk factors. Indicated programs are intensive efforts aimed at youth already abusing drugs and exhibiting other problem behaviors.\(^8^6\)

Evaluation of school-based drug education programs has generally shown that non-interactive, lecture-oriented programs that stress drug knowledge and/or focus on building self-esteem have not effectively prevented or reduced alcohol and other drug use by youth.\(^8^7\) Such non-interactive programs, including D.A.R.E., have not provided a means for students to acquire “refusal” skills, nor have they given students adequate opportunities to consider the costs and benefits of drug use to enable them to make rationally-informed decisions about drug use.\(^8^8\)

School-based drug education programs that are interactive and have a discussion-based format have been shown to be a somewhat more effective prevention strategy. The latest research indicates that students respond more favorably to interactive programs that place mental health clinicians or students’ peers as discussion leaders, rather than police officers or teachers without special training.\(^8^9\) This finding presents a valuable opportunity for schools, because although the cost of a mental health clinician in every school would be substantial, the use of peer leaders instead could be a cost-effective way to increase program effectiveness.\(^9^0\)

Interactive programs specifically targeting tobacco have been particularly effective, where youth see the message of lifetime abstinence as more reasonable than in the case of alcohol, where abstinence is urged only until the legal age is reached. The message of complete lifetime abstinence from tobacco is lost in a generalized prevention program dealing with the use of all substances; hence the need to develop and implement tobacco-only prevention programs.\(^9^1\) Based on this finding, wide implementation of tobacco-only prevention programs in the schools would be a wise public investment.

**Finding the Key Elements**

Despite the mixed findings from the evaluation of drug education programs, research has identified important features of a school-based substance abuse prevention strategy.\(^9^2\)

- Help students recognize internal pressures, like anxiety and stress, and external pressures, like peer attitudes and advertising, that influence them to use alcohol, tobacco and other drugs;
- Help students develop personal, social and refusal skills to resist these pressures;
• Teach that alcohol, tobacco and other drug use is not as pervasive as it seems, even if students believe “everyone is doing it;”
• Provide developmentally-appropriate material and activities, including information about the short-term effects and long-term consequences of using alcohol, tobacco and other drugs;
• Use interactive teaching techniques, such as role playing, discussions, “brainstorming” and cooperative learning;
• Actively involve the family and community; and
• Include instructor training and support, and provide material that is easy to implement and culturally relevant for students.

It is important to note that all of the above features are essential for an effective drug education program, particularly the necessary training and commitment of instructors and the active involvement of the family and community. Research has shown time and again that partial or selective implementation of the elements of a drug education program will render it ineffective.93

Although some school-based programs seem to have modest effects in preventing or reducing substance use among youth, recent research has shown that certain models are more appropriate with certain age groups than with others, and that certain models are more effective with regard to certain drugs. Applying the same intervention to different age groups could result in different outcomes; for example, teaching middle school students to conform to social norms might result in a reduction in alcohol use, whereas teaching high school students to conform to social norms might result in an increase in alcohol use (where drinking to get drunk is normative behavior at that age). These findings indicate the need for a more sophisticated understanding of the different stages of development of each grade level and the varying degrees to which students at different ages will be receptive to different approaches.

Measuring Use or Abuse?

Reviews of the major, school-based drug education programs have revealed their limited effectiveness in reducing drug use, particularly over the long term.94 Prevention programs’ seemingly marginal effectiveness can be explained largely by the fact that the outcome measure is drug use rather than drug abuse. Conflating drug use with drug abuse, as discussed above, can lead to the assumption that all drug use is harmful, and also deflects attention away from the proven hazards of alcohol and tobacco. If the outcome measure of prevention programs were substance abuse, or more appropriately, the harm caused by excessive substance use, the programs referred to above would be deemed very successful, as only a very small number of youth experience serious problem behaviors.95
Universal prevention programs generally fail to target the small number of youth who account for most of the alcohol and other drug abuse. Resources are now devoted to reducing the prevalence of use among the vast majority of youth who will never develop substance abuse problems, and inadequate resources are devoted to the small number of youth who presently have real problems. The “selective” and “indicated” programs, which focus on high-risk youth, appear to be a more cost-effective and efficacious strategy for preventing substance abuse.

Washington has exceptional resources available locally for the design and implementation of substance abuse prevention programs. Appendix B of this report provides a brief review of programs developed at the University of Washington that target “high-risk” youth, including the Reconnecting Youth program, the Incredible Years program and the Seattle Social Development Project. These programs have begun to be replicated nationwide. The Task Force believes Washington should capitalize on these resources in improving its own statewide, youth-focused, substance abuse prevention plan.
4. Improving Washington’s Drug Abuse Prevention Strategy

Prevention Goals

Washington’s overall prevention goals should be:

1) to prevent or delay the use of alcohol, tobacco and other drugs among young people;
2) to reduce the harm from and curb the progression of alcohol, tobacco and other drug use among youth who have already begun;
3) to reduce the other problem behaviors that can co-occur with the use of alcohol, tobacco and other drugs; and
4) to increase the availability of school- and community-based prevention services, especially for vulnerable groups and high-risk individuals.

Despite some progress in furthering the understanding of the factors associated with substance abuse, Washington has not come close to attaining any of the goals outlined above.

Prevention science is still in its infancy. The bulk of recent research, based on the “risk and protective factor” paradigm outlined in this report, has illustrated the need for youth to develop healthy bonds with peers and adults, to take on meaningful responsibilities, to be recognized and rewarded and ultimately, to develop an increased sense of self-worth and to make informed decisions. However, researchers are still struggling to explain what accounts for the success of prevention programs that “work.”

Furthermore, putting prevention theory into practice has been extremely difficult, as prevention programs have too often suffered from faulty design, insufficient resources, inadequate training and commitment of teachers and a lack of support from school administrators.

If Washington is to deal effectively with preventing and minimizing the harm from substance abuse, more resources should be allocated for research-validated, school-based and community-based prevention programs, and also for measures to ensure their proper implementation. Washington is just beginning to establish a statewide structure for implementing youth-focused substance abuse prevention programs. Appendix C of this report provides a summary of Washington’s current, state-sponsored substance abuse prevention initiatives.

The state’s current attempt to implement a substance abuse prevention strategy is hampered by limited resources and inconsistent results. The prevalence of alcohol, tobacco and other drug use by minors in Washington has not decreased, particularly among younger children, and therefore, the risks of substance abuse and other problem behaviors have not decreased.
The programs implemented under the State Incentive Grant, and also the Children’s Transition Initiative (each of which are summarized in Appendix C of this report), seem to be based on the kind of rigorous research that has been the foundation for effective prevention programs. Those programs should help to provide the state with more reliable data on the effectiveness of certain prevention strategies. Unfortunately, significant funding is still being devoted to abstinence-only programs that have been shown to be ineffective (particularly through the federal “Safe and Drug-Free Schools” program), and also to universal programs aimed at all youth rather than the more cost-effective and efficacious programs targeted at “high-risk” youth.

The effort to improve Washington’s prevention strategy is clearly in flux at the moment. For the people of Washington, an investment in research-validated programs to prevent, delay and reduce the harm from the use of alcohol, tobacco and other drugs will help to avert the much higher costs of drug treatment, criminal justice and social and health services that would otherwise arise. Reallocating funding away from drug-related criminal enforcement and toward substance abuse prevention will also reflect the proper emphasis on substance abuse as principally a social and public health problem.
SECTION II
DRUG ADDICTION TREATMENT:
THE NEED FOR RESOURCES
1. 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. 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.

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.

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.

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.”

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.

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.)
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. 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 population at large. 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.
2. 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.\textsuperscript{106}

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.\textsuperscript{107} 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.
3. 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. 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.)

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. At the same time, 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.”

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.
4. 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. 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.

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.

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.

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 $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.

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.”
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.” 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.”

“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.”
5. 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).”\(^{121}\) To “review the substantive findings of the growing empirical literature on drug treatment outcomes” is beyond the scope of our task.\(^{122}\) 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 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.[123]

“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 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.”
6. 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. 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.”

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. 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.

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.

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; 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.
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.\textsuperscript{132}

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.\textsuperscript{133}

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.\textsuperscript{134} 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.)\textsuperscript{135}

Lawyers, judges and treatment professionals in King County have 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”).\textsuperscript{136}

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.\textsuperscript{137} Need for treatment was assumed if an individual had a “past 18 month substance use disorder” or if certain other criteria were met.\textsuperscript{138}

There are inadequate treatment resources especially for poor King County residents with opiate addictions. Street Outreach Services in Seattle, a non-profit agency, 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. 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.139

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.140

An informal survey of public defenders assigned to represent parents in dependency proceedings, and the direct experience of another public defender 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.141 State policy favors nurturing of the family unit,142 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.”143 Nevertheless, inadequate resources are allocated to providing addiction treatment to parents of children in dependency proceedings.144

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.145 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.146 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.147 In its notice published in May 1999 with its rulemaking proposal, the Insurance Commissioner’s Office explained that the benefit provided under the $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.” 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. 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. The health costs drop dramatically after treatment.

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. The authors contrasted this result to what they characterized as a “consensus” view “favoring referral of drug-abusing patients to specialized treatment.” Doctors with patients who could benefit 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.

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

THE USE OF CRIMINAL SANCTIONS: HOW EFFECTIVE AND HOW APPROPRIATE?

The statutory underpinning of current drug policy in the United States is the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, popularly known as the “Controlled Substances Act.” Complementary state legislation, the Uniform Controlled Substances Act, drafted in 1970 by the National Conference of Commissioners on Uniform State Laws, was adopted by Washington on May 21, 1971. The Uniform Controlled Substances Act has been adopted by 45 other states.

The goal of the uniform federal and state controlled substances statutes is to prevent the “illegitimate manufacture, distribution and possession” of drugs, including the unauthorized and unregulated diversion of drugs from “legitimate” sources, i.e., pharmaceutical manufacturers. The statutes distinguish “improper” uses of controlled substances from uses that are “essential for public health and safety.”

The uniform controlled substances statutes are intended to provide a foundation for a coordinated system of drug control. However, although the statutes describe prohibited activities in detail, they allow for state discretion in prescribing specific fines and/or sentences, and thus the criminal sanctions for violating those statutes differ between the federal and state levels and among the states.

Drug Offender Sentencing in Washington State

The criminal sanctions imposed in Washington for the sale and possession of illegal drugs are severe, more severe than those imposed for drug offenses in many other states. Only the possession of 40 grams or less of marijuana is a misdemeanor.

Felony sentencing in Washington is governed by a determinate sentencing system intended to ensure that offenders who commit comparable crimes and have comparable criminal histories receive equivalent sentences. The discretion of sentencing courts is guided by a “grid” of standard range sentences, constructed with one axis representing the seriousness of the offense and the other axis representing the conviction history of the offender. The more serious the offense, and the more convictions in the offender’s criminal history (also known as the offender “score”), the longer the sentence. Courts are permitted to impose “exceptional” sentences outside the prescribed standard range, but in practice, 95 percent of all sentences fall within the standard range.

In Washington’s felony sentencing grid, the legislature has assigned “seriousness
levels” for some drug offenses that are significantly higher than for other, non-drug offenses, including some violent offenses. The following is a comparison of current sentence lengths for various offenses committed by first-time offenders:

<table>
<thead>
<tr>
<th>Offense</th>
<th>Seriousness Level</th>
<th>Standard Range* (midpoint)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine Manufacture (any amount)</td>
<td>X</td>
<td>5 years</td>
</tr>
<tr>
<td>Kidnapping 1º (“serious violent” offense)</td>
<td>X</td>
<td>5 years</td>
</tr>
<tr>
<td>Child Molestation 1º (violent offense)</td>
<td>X</td>
<td>5 years</td>
</tr>
<tr>
<td>Robbery 1º (violent offense)</td>
<td>IX</td>
<td>3 years</td>
</tr>
<tr>
<td>Heroin/Cocaine Delivery (any amount)</td>
<td>VIII</td>
<td>2 years</td>
</tr>
<tr>
<td>Arson 1º (violent offense)</td>
<td>VIII</td>
<td>2 years</td>
</tr>
<tr>
<td>Burglary 1º (violent offense)</td>
<td>VII</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Drive-by Shooting (violent offense)</td>
<td>VII</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Unlawful Possession of a Firearm</td>
<td>VII</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Incest 1º</td>
<td>VI</td>
<td>1.08 years</td>
</tr>
<tr>
<td>Robbery 2º (violent offense)</td>
<td>IV</td>
<td>6 months</td>
</tr>
<tr>
<td>Assault 2º (violent offense)</td>
<td>IV</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*assumes no conviction history and thus an offender “score” of 0.

As this comparison shows, the sentence for a first-time conviction for methamphetamine manufacture is ten times as high, and the sentence for delivery of heroin or cocaine is four times as high, as the sentence for second-degree robbery or assault, regardless of the amount of drugs involved in the drug offense. A first-time conviction in Washington for delivery of heroin, cocaine or methamphetamine in any amount will result in a longer prison sentence than a first-time conviction for bribery, second-degree child molestation, first-degree incest, intimidation of judges, juries and witnesses, theft of a firearm, first-degree extortion, vehicular assault and many crimes against other persons.

All offenders with prior convictions receive much longer sentences under Washington’s determinate system, but drug offenders with any prior drug convictions receive especially long sentences. The legislature has lengthened sentences for drug offenses by assigning multiple “points” for prior drug convictions, thus increasing the offender’s criminal history score. This is called “triple scoring.” For most offenses, a prior conviction counts for one point, but many drug offenses count for three points, which significantly ratchets up the sentence lengths for drug offenders.

For example, multiple convictions for heroin or cocaine delivery would prompt the following sentences, regardless of the amount of drugs involved in each case:
The standard statutory *maximum* sentence for drug offenses in Washington is ten years, but the statutory maximum is doubled upon the second conviction for a drug offense such as heroin or cocaine delivery. Thus, a non-violent drug offender may receive a sentence of up to twenty years in prison.¹⁶⁹

A number of systemic factors lead to sentence lengths that the Task Force believes are disproportionate to the social harm cause by drug offenses. Drug offenders, as a group, have the highest recidivism rate among all classes of offenders,¹⁷⁰ and therefore, are routinely exposed to “triple scoring.” In addition, the law imposes other drug offender sentence enhancements, often causing drug offenders to serve longer sentences than non-drug offenders, including violent offenders.

A look at some average sentences imposed in Washington reveals the following:¹⁷¹

<table>
<thead>
<tr>
<th>Offense</th>
<th>Avg. Sentence Length</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin/Cocaine Delivery w/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Zone Enhancement¹⁷²</td>
<td>5 years, 7.8 mon.</td>
<td>36</td>
</tr>
<tr>
<td>Methamphetamine Manufacture</td>
<td>4 years, 10.4 mon.</td>
<td>40</td>
</tr>
<tr>
<td>Arson 1º (violent offense)</td>
<td>4 years, 1.8 mon.</td>
<td>19</td>
</tr>
<tr>
<td>Heroin/Cocaine Delivery – repeat offense</td>
<td>4 years, 0.3 mon.</td>
<td>374</td>
</tr>
<tr>
<td>Child Molestation 1º (violent offense)</td>
<td>3 years, 5.1 mon.</td>
<td>120</td>
</tr>
<tr>
<td>Drive-By Shooting (violent offense)</td>
<td>2 years, 5.8 mon.</td>
<td>35</td>
</tr>
<tr>
<td>Heroin/Cocaine Delivery – first offense</td>
<td>2 years, 4.3 mon.</td>
<td>490</td>
</tr>
<tr>
<td>Robbery 2º (violent offense)</td>
<td>1 year, 9.4 mon.</td>
<td>276</td>
</tr>
<tr>
<td>Theft of a Firearm</td>
<td>1 year, 6.4 mon.</td>
<td>53</td>
</tr>
<tr>
<td>Assault 2º (violent offense)</td>
<td>1 year, 5.9 mon.</td>
<td>757</td>
</tr>
<tr>
<td>Residential Burglary</td>
<td>1 year, 4.9 mon.</td>
<td>714</td>
</tr>
</tbody>
</table>

This comparison shows how hundreds of drug offenders with a prior history of drug offenses are serving periods of incarceration considerably longer than those served by many violent offenders convicted of robbery and assault.

Non-violent offenders are eligible for “earned early release” from prison that can amount to a 33 percent reduction in confinement time.¹⁷³ However, even after their term of confinement, drug offenders are required to be supervised after their release for a nine- to twelve-month period.¹⁷⁴ This period of “community custody,” supervised by the state Department of Corrections, can include frequent reporting to community corrections officers, prohibitions on alcohol and other substance use, mandatory drug addiction...
treatment, drug testing and other conditions. Sanctions are imposed, including imprisonment, for violations of conditions of community custody.

According to numerous judges and attorneys, many drug offenders are indigent and homeless, and sell small amounts of drugs to support their own drug dependency. For those offenders the provisions of Washington’s sentencing law can be especially harsh. The combination of “triple scoring” for prior drug offenses, the school zone “enhancement” and the absence of any link between the amount of drugs sold and the severity of the criminal sanction results in extremely long prison sentences for many impoverished, drug-addicted individuals who are repeatedly arrested, convicted and sentenced for selling very small amounts of drugs.

**Federal Drug Offender Sentencing**

The federal sentencing system is similar to Washington’s, with determinate sentences imposed according to the seriousness of the offense and the conviction history of the offender. However, as distinguished from Washington, the types and amounts of drugs involved are considered in determining the seriousness of the offense and the sentence imposed. Federal law also provides for many more mandatory minimum sentences for drug offenses than Washington does.

Federal mandatory minimum sentences have long been criticized for their arbitrariness, especially from the federal bench. For drug offenses in particular, mandatory minimums were enacted by Congress in 1986 with no formal fact-finding: “No hearings were held …. No experts on the relevant issues, no judges, no one from the Bureau of Prisons or from any other office in the government, provided advice …. Only a few comments were received on an informal basis.” Examples of mandatory minimum sentences for federal drug offenses include the following:

<table>
<thead>
<tr>
<th>Drug Offense</th>
<th>Quantity</th>
<th>First Offense</th>
<th>Second Offense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>1 kg. or more</td>
<td>10 years</td>
<td>20 years</td>
</tr>
<tr>
<td>Trafficking</td>
<td>less than 1 kg.</td>
<td>5 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Powder Cocaine</td>
<td>5 kg. or more</td>
<td>10 years</td>
<td>20 years</td>
</tr>
<tr>
<td>Trafficking</td>
<td>less than 5 kg.</td>
<td>5 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Crack Cocaine</td>
<td>Possession</td>
<td>5 grams or more</td>
<td>5 years</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1,000 kg.</td>
<td>10 years</td>
<td>20 years</td>
</tr>
<tr>
<td>Trafficking</td>
<td>100-1,000 kg.</td>
<td>5 years</td>
<td>10 years</td>
</tr>
</tbody>
</table>

In addition to imprisonment, federal drug offenders can be fined in amounts up to $8 million for an individual or up to $20 million for organizations or enterprises.

Because of the lengthy mandatory minimum sentences for federal drug offenses, many non-violent drug offenders have served as much or more time in prison than violent offenders:
Average Time Served in Federal Prison – Selected Felonies (1997)\textsuperscript{182}

<table>
<thead>
<tr>
<th>Offense</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murder/Manslaughter</td>
<td>61.7 months</td>
<td>40.1 months</td>
</tr>
<tr>
<td>Robbery</td>
<td>59.9 months</td>
<td>50.5 months</td>
</tr>
<tr>
<td>Drug Trafficking</td>
<td>43.2 months</td>
<td>40.1 months</td>
</tr>
<tr>
<td>All Drug Offenses</td>
<td>42.5 months</td>
<td>40.0 months</td>
</tr>
<tr>
<td>Assault</td>
<td>28.2 months</td>
<td>18.3 months</td>
</tr>
<tr>
<td>Burglary</td>
<td>20.4 months</td>
<td>15.7 months</td>
</tr>
<tr>
<td>Auto Theft</td>
<td>19.1 months</td>
<td>15.7 months</td>
</tr>
</tbody>
</table>

The average period of imprisonment of drug offenders convicted in federal courts in Washington has been longer than the national average. In the U. S. District for Eastern Washington, the mean sentence length for drug offenders is about 54 months, while in the U. S. District for Western Washington, the mean sentence length is about 68 months.\textsuperscript{183} Consistent with national trends, average sentences for federal drug offenders in Washington are longer than for any other federal offenses except murder and robbery.

It might be assumed that sentences for federal drug offenses are so long because they are more “serious” than drug offenses under state law, or that they involve larger amounts of drugs and/or the involvement of hard-core criminals or organized criminal enterprises. However, a closer look at federal drug offender sentencing reveals a different picture. According to the U. S. Sentencing Commission, 55 percent of all federal drug defendants are low-level offenders, such as street sellers, and only 11 percent are classified as high-level dealers.\textsuperscript{184} In 1999, one third of federal drug offenders had never been previously arrested, and two out of three federal drug offenders had no prior felony convictions. Ninety percent of convictions on federal drug charges that year were for non-violent offenses.\textsuperscript{185}

Federal efforts at drug control have also not been confined to the most potent or deadly substances. In 1999, marijuana offenses accounted for 31% of all federal drug cases, compared with 28% for powder cocaine, 15% for crack cocaine, 15% for methamphetamine and only 7% for all opiates, including heroin.\textsuperscript{186}

**Legislative Amendments – Longer Sentences and Alternative Sentences**

The relatively long prison terms for drug offenses result, in part, from amendments
to the controlled substances statutes made during the 1980s. For example, the Anti-Drug Abuse Act of 1986 established the federal mandatory minimum sentences for drug offenses.\textsuperscript{187} In 1988 Congress established the same mandatory minimum sentences for those convicted of conspiring to commit a drug offense.\textsuperscript{188} In Washington, the Omnibus Drug Act of 1989 significantly lengthened sentences by raising the “seriousness level” of heroin and cocaine delivery offenses, adding the “triple scoring” provision for prior drug offenses and establishing the 2-year sentence “enhancement” for drug offenses in the vicinity of schools, parks and bus stops.\textsuperscript{189}

As a result of these statutory changes, the number of persons in prison for drug offenses has grown enormously, as has the average confinement time. Between 1984 and 1999, the average prison time served by federal drug offenders more than doubled.\textsuperscript{190} In Washington, the changes in the law also resulted in a doubling of some prison terms, including those for one of the most common drug offenses – heroin or cocaine delivery.\textsuperscript{191}

Since 1989, Washington’s prison population has increased by over 125 percent, far exceeding the 22 percent increase in the state general population during the same period. This population growth was fueled in significant part by increased prison admissions for drug offenses and property offenses related to drugs, as well as by the longer sentences served by drug offenders.\textsuperscript{192} According to the state Department of Corrections, a non-violent drug crime is the most serious charge for about 24 percent of current prison inmates, compared with about 17 percent of inmates in 1990.\textsuperscript{193}

Some recent amendments to the controlled substances statutes have had the effect of reducing prison time for some drug offenses. At the federal level, certain exemptions from mandatory minimum sentences have been created more recently in the recognition that low-level drug offenders are serving prison terms grossly disproportionate to the seriousness of their offenses. The Violent Crime and Law Enforcement Act of 1994 exempted certain first-time, non-violent drug offenders from statutory minimum penalties and also provided the opportunity for early release (up to one year) of eligible offenders who successfully complete a drug treatment program while incarcerated.\textsuperscript{194}

In Washington, recent changes have also reduced prison time for some drug offenses. In particular, the Drug Offender Sentencing Alternative (“DOSA”) was enacted in recognition of the close link between drug addiction and non-violent drug offenses, and of the need to address the drug dependencies that are thought to prompt those offenses.\textsuperscript{195} DOSA gives courts the discretion to cut in half the term of confinement and to mandate addiction treatment for eligible offenders.\textsuperscript{196} In the beginning, fewer than 50 offenders per
found by the court to have a chemical dependency directly related to their offense. In the last two years, over 2,500 drug offenders have been sentenced to the DOSA program, with over 1,000 coming from King County and almost 500 from Pierce County. This amounts, however, to less than 25 percent of all convicted drug offenders. Furthermore, offenders given the DOSA option still serve a considerable amount of prison time – an average of 15.7 months for male offenders and 13.6 months for female offenders.

A major recent innovation in the last decade has been the “drug court,” a local-option program of deferred prosecution coupled with court-supervised drug treatment. Drug court participants agree to waive certain rights in exchange for dismissal of criminal charges upon successful completion of drug treatment. Drug testing through urinalysis is used to ensure compliance. Discussed in greater detail below, drug courts are currently the principal drug policy reform being implemented.

Despite recent changes, imprisonment is still the fate of almost all convicted drug offenders. Ninety percent of all federal drug offenders still serve time in prison. In Washington, all offenders convicted of drug delivery charges continue to be incarcerated, irrespective of the amount of drugs involved in any case. Rehabilitative sentences, including drug treatment, are still only offered to about one quarter of all drug offenders in Washington’s prisons. In summary, despite the availability of alternative sanctions for some drug offenses, the vast majority of drug offenders in both the state and federal systems still serve long prison terms, most without any drug treatment.

2. How Effective Are Drug-Related Criminal Sanctions?

After thirty years of a confinement-intensive policy intended to reduce drug abuse,
and especially considering the recent increase in the number of drug offenders spending longer periods in prison, it seems both timely and important to evaluate whether criminal sanctions have served their stated purpose. It is essential to determine whether our heavy reliance on criminal sanctions has been effective in reducing drug abuse and its attendant costs. What follows is a review of available data from the last dozen years in an attempt to determine whether the increased penalties enacted in the late 1980s have been associated with any reduction in drug abuse or drug-related crime. Specific indicators include the levels and rates of drug use and abuse, the levels and rates of arrests and convictions for drug offenses, and changes in public costs related to drug abuse and drug-related crime:

**Drug Use, Drug Abuse and Drug Addiction**

Estimates of drug use are derived from survey data, a somewhat unreliable measurement tool because illegal activity tends to be under-reported. The National Academy of Sciences recently highlighted further, more profound methodological difficulties in measuring drug consumption and the cost of drugs, and how the inadequacy of current data hampers the analysis of the effectiveness of drug policy. Nevertheless, an examination of available data on drug consumption is important to help ascertain whether there have been any changes in drug use patterns, and whether those changes might be attributed to the recent toughening of drug-related criminal sanctions.

A snapshot from the 1999 National Household Survey on Drug Abuse compares illegal drug use in the United States with the use of legal drugs, i.e., alcohol and tobacco:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Ever Used</th>
<th>Past Year</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>180 million</td>
<td>138 million</td>
<td>105 million</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>159 million</td>
<td>67 million</td>
<td>57 million</td>
</tr>
<tr>
<td>Marijuana</td>
<td>76 million</td>
<td>19.5 million</td>
<td>11 million</td>
</tr>
<tr>
<td>Cocaine</td>
<td>25 million</td>
<td>3.6 million</td>
<td>1.5 million</td>
</tr>
<tr>
<td>Crack</td>
<td>6 million</td>
<td>1 million</td>
<td>413,000</td>
</tr>
<tr>
<td>Heroin</td>
<td>3 million</td>
<td>403,000</td>
<td>208,000</td>
</tr>
</tbody>
</table>

In a nation of more than 270 million people, it is difficult to characterize the extent of the use of “hard” drugs like cocaine, crack and heroin as anything other than slight. Frequent users of “hard” drugs constitute less than one percent of the general population, compared, for instance, with frequent alcohol users, who comprise about 40 percent of the U. S. population.

In Washington, the prevalence of alcohol and other drug use is similar to the national trends, as 92.4 percent of adults have used alcohol and 38.6 percent of adults have used marijuana at some time in their lives. As far as recent use is concerned, 56 percent of adults in Washington report using alcohol in the last 30 days, whereas only 4.7 percent of
adults in Washington report such recent use of marijuana.\(^{208}\)

The popularity of different drugs has varied over time. For instance, marijuana use peaked around 1978, declined markedly during the 1980s and has risen again since 1992. Cocaine use increased in the 1980s, peaking around 1985, and after declining has begun to rise again since 1993. By contrast, the prevalence of heroin use has remained low, although there has been a slight increase since the mid-1990s.\(^ {209}\) In general, illicit drug use has increased since 1992, reversing a decline that began in the late 1970s.

It is noteworthy that the apparent upward trend in drug use since the early 1990s occurred during the same period of intensified drug-related law enforcement and incarceration brought on by the amendments in the late 1980s to the state and federal controlled substances statutes. In fact, drug use generally declined before the toughening of criminal sanctions in the 1980s and has since risen after the increase in those penalties.\(^ {210}\) Considering these findings, criminal sanctions cannot be said to have reduced drug use in the general population.

Drug use is difficult to measure, but measuring drug *abuse* is even more problematic, beginning with the difficulty in defining it.\(^ {211}\) The federal and state controlled substances statutes refer merely to the “improper use” of drugs, avoiding the definitional issue by equating any use of proscribed drugs with abuse, apparently on the presumption that all illicit drug use causes harm.\(^ {212}\) The Task Force rejects this statutory approach and believes that the extent of drug abuse cannot be measured by estimating the number of persons using drugs.\(^ {213}\) Further, the Task Force believes the conflation of “use” with “abuse,” and the imposition of criminal sanctions for both, impairs a consistent and useful analysis of the relation of criminal sanctions to the problem of drug abuse.\(^ {214}\)

Not all drug users become drug addicts, and in fact, available data suggests that only a small percentage of drug users need addiction treatment. For instance, U. S. and international health agencies have reported that less than one percent of those who have ever used cocaine become daily users, and other scholars have found that most cocaine users are not regular consumers of the drug.\(^ {215}\) There are even a large number of heroin users who are not addicted, just as there is a large population of non-addicted drinkers.\(^ {216}\)

Over the past century, the percentage of the population experiencing serious drug addiction has remained very low, at or just above one percent.\(^ {217}\) Seen from this perspective, the problem of drug abuse and drug addiction in America is “narrow and static,” according to RAND Senior Fellow Peter Reuter:

No more than 2.5 million Americans have substantial problems with cocaine and/or heroin – less than one-fifth the number for alcohol.

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Those with problems are heavily concentrated in urban minority communities. Methamphetamine abuse remains a much smaller problem, while marijuana dependence, a real phenomenon involving many more people, has much less consequence for those who experience it.\textsuperscript{218}

By contrast, from a local perspective, the contemporary drug abuse problem can take many forms and appear more serious. For example, issues related to heroin and methamphetamine have recently aroused public concern in Washington. The Seattle-King County Health Department recently released the report of its Heroin Task Force, finding a growing prevalence of heroin use and a rise in heroin-related public health costs.\textsuperscript{219} Meanwhile, in Washington’s more rural areas there has been a proliferation of methamphetamine manufacture, with severe social and environmental consequences.\textsuperscript{220} From the perspective of economically disadvantaged urban communities, people seriously addicted to “hard” drugs face a narrow range of treatment options, which has been very costly in both human and economic terms in neighborhoods already struggling with poverty and social dislocation.\textsuperscript{221}

Once again, it seems significant that the lack of improvement, and even a worsening, in the rate of drug use and drug abuse in Washington and across the nation have occurred during the same period of increased criminal enforcement of drug laws. The increased arrest, convictions and incarceration of drug offenders and the lengthening of their sentences seem, at the very least, not to have stemmed the increases in drug use or drug abuse.

The Public Cost of Drug Abuse

As outlined in Section II above, the total economic cost of drug abuse, including alcohol, has been estimated at $2.5 billion annually in Washington\textsuperscript{222}. Public costs related to the abuse of alcohol and other drugs amount to about $1.5 billion annually.\textsuperscript{223} In 1998, Washington spent about $275 million on health care related to addiction, overdoses and drug-related diseases, about $140 million on social services related to economic and housing assistance and about $145 million on mental health services.\textsuperscript{224}

\textit{Alcohol} is the drug that causes most of public spending attributable to substance abuse. A recent study prepared for the state Division of Alcohol and Substance Abuse reported an increase during the 1990s in the cost of addiction treatment and medical care and an increase in the incidence of disease and death. That report shows that alcohol, not illegal drugs, give rise to the vast majority of economic costs related to substance abuse.\textsuperscript{225}

Public costs related to illegal drugs have also increased, but most of those increased costs have been due to increased law enforcement and incarceration of drug offenders, not from medical or other social service demands arising from the use of the drugs.\textsuperscript{226} Alcohol continues to be the major source of total economic costs \textit{even after factoring in the cost of}
law enforcement and incarceration of drug offenders. Alcohol accounts for 59 percent of the total economic cost of drug and alcohol abuse combined.\textsuperscript{227}

National data from hospital emergency room visits show an increasing “mention” of drugs such as cocaine, heroin, marijuana and methamphetamine,\textsuperscript{228} but alcohol still accounts for most emergency room visits, a total of about 40 percent of which are drug or alcohol-related.\textsuperscript{229} Tobacco use also gives rise to enormous public health costs, as does the misuse of and adverse reactions to prescription drugs. A survey of some of the causes of death in the United States reveals the following:

<table>
<thead>
<tr>
<th>Annual Causes of Death in the United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco (average from 1990 to 1994)</td>
</tr>
<tr>
<td>Alcohol (1996)</td>
</tr>
<tr>
<td>Adverse reactions to prescription drugs</td>
</tr>
<tr>
<td>Suicide (1998)</td>
</tr>
<tr>
<td>Homicide (1998)</td>
</tr>
<tr>
<td>Licit and illicit drug-induced deaths (1998)</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs (1992)</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
</tbody>
</table>

**Drug-Related Crime**

The term “drug-related crime” is another phrase that evades a standard definition. Two types of drug-related crime are generally distinguished from one another: 1) “drug-defined” offenses, comprising violations of laws prohibiting the manufacturing, sale or possession of illegal drugs; and 2) “drug-related” offenses, which include crimes resulting from the pharmacological effect of drugs, property crimes and drug sales to support drug addiction and violence associated with the illegal drug market.\textsuperscript{238}

While some drug users are involved in illegal activity beyond the mere possession or sale of drugs, property crimes (e.g., theft, forgery and low-level burglary) do not seem to account for most of drug users’ illegally-obtained income. Many drug addicts seem able to avoid having to commit such “acquisitive” crimes altogether, supporting their habits exclusively through drug sales, or through a combination of drug sales, pimping and prostitution. A significant number of drug addicts – possibly the majority – are legitimately employed.\textsuperscript{239} Criminologists and criminal justice officials acknowledge what seems to be a close link between illegal drug use and property crime, but the impact of drugs on the level of any particular crime is not theoretically predictable. Nevertheless, Washington’s prisons currently house a growing number – almost 1,000 – non-violent offenders who were convicted of both drug offenses and property offenses.\textsuperscript{240}
Just as it is difficult to show a causal relationship between drug use and property crime, there is no reliable way to show how the pharmacological effects of drugs cause criminal behavior, or any other specific behavior. The White House Office of National Drug Control Policy concedes that “it is impossible to say quantitatively how much drugs influence the occurrence of crime.” It is important to acknowledge that although a high percentage of crime is associated with drug use, the converse is not true – most drug use is not associated with crime.

While causation may be difficult to prove, it is useful, nevertheless, to observe the association of crime with certain substances. From that perspective, it is apparent that crime is linked with alcohol far more than any other substance. Alcohol is especially associated with violent crime much more than any illegal drug, including cocaine, crack cocaine and heroin. About 40 percent of all offenders at the state level were using alcohol at the time of the offense for which they were convicted, and alcohol is reported to have been a factor in more than 40 percent of murders and almost 50 percent of assaults at the state level. Data from 1996 in Washington reveals that 1,801 arrests for felonious assault were alcohol-related, while only 144 were related to other drugs (of a total of 6,003 arrests that year).

As distinguished from crime related to drug use, available data on drug offenses per se, including the manufacture, sale and possession of drugs, show marked increases over the last decade in arrests, convictions and incarceration at both the federal and state levels. At the federal level, over 80 percent of the increase in the federal prison population from 1985 to 1995 was due to increased drug convictions; and drug offenders in 1998 constituted over 58 percent of all federal inmates, a significant increase from the decade before. The number of drug offenders sentenced at the federal level more than doubled from 1990 to 1998, from 30,470 to 63,011.

At the state level, arrests for drug offenses nationwide increased by over 35 percent between 1990 and 1999. By contrast, during the same period there was a notable downward trend in arrests nationwide for driving while intoxicated (a 27 percent decrease). It is useful to note that drug offenses increased significantly after the toughening of drug-related criminal sanctions, whereas drunk driving seemed to decline during the same period, which featured a concerted community and media campaign to alter the norms around drunk driving, along with some increases in DUI-related penalties. This may suggest that social sanctions, such as the disapproval of peers and the stigma attached to potentially hazardous activities, have been more effective than criminal sanctions in reducing the harms related to substance abuse.

In Washington, the trends in arrests, convictions and incarceration over the last decade reveal a distinct divergence between drug offenses and other offenses. In 1989 and 1990, the state legislature not only increased sentence lengths for drug offenses, but also for many violent and sex offenses. Since the mid-1980s, arrests and convictions for homicide
have declined in absolute terms and arrests and convictions for rape, robbery and assault have risen, but at a rate roughly commensurate with the rate of increase in the size of the general population. However, arrests and convictions for drug offenses have continued to rise at a much faster pace.

Records of arrests for various offenses since 1985 reveal the following:\textsuperscript{251}

<table>
<thead>
<tr>
<th>Offense</th>
<th>1985 arrests</th>
<th>1998 arrests</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>220</td>
<td>204</td>
<td>- 7%</td>
</tr>
<tr>
<td>Robbery</td>
<td>1,346</td>
<td>2,172</td>
<td>+ 61%</td>
</tr>
<tr>
<td>Rape</td>
<td>839</td>
<td>948</td>
<td>+ 13%</td>
</tr>
<tr>
<td>Assault</td>
<td>4,280</td>
<td>6,400</td>
<td>+ 49%</td>
</tr>
<tr>
<td>Drug Offenses</td>
<td>7,802</td>
<td>26,902</td>
<td>+ 345%</td>
</tr>
</tbody>
</table>

Considering these figures, the increase in penalties for the most serious violent and sex crimes in Washington has arguably had some effect in holding steady the rate of incidence of those crimes, considering the significant population increase in Washington during the 1980s and 1990s. However, it is evident that the increase in drug crime penalties has been associated only with a continued and dramatic rise in drug offenses during the same period. While the drug-taking behavior of citizens has changed only marginally over time, expensive and time-consuming law enforcement activity related to drugs has intensified dramatically.

**The Cost of Criminal Justice**

The last twenty years have seen a 1,200 percent increase in the number of drug offenders in state prisons, and criminal justice costs have risen very sharply as a result.\textsuperscript{252} As noted above, Washington ’s costs related to illegal drugs have increased, but mostly due to increasing drug law enforcement and the incarceration of drug offenders, and not because of any dramatic rise in social service, health care or other, non-criminal justice costs.\textsuperscript{253} In 1996, the most recent year for which data are available, law enforcement costs related to illegal drugs, including investigation, arrest and interdiction amounted to $202 million. Legal and adjudication costs arising from drug cases that year amounted to $22 million, or 83 percent of all court costs related to drug and alcohol cases. The cost of incarcerating drug offenders in 1996 amounted to $36 million for local jails and more than $97 for state prisons, more than double the cost in 1990.\textsuperscript{254} These criminal justice costs have surely continued to rise since 1996 with the continued incarceration of more and more drug offenders.
The federal criminal justice system has also spent increasing amounts on the War on Drugs over the last dozen years. For example, since the enactment of mandatory minimum sentences for drug offenses, the budget for the federal Bureau of Prisons has increased by 1,350 percent, from $220 million in 1986 to over $3.2 billion today. 255 The federal budget for drug control is currently $18 billion (President Bush has requested $19.2 billion for the upcoming fiscal year), and combined federal and state expenditures for the drug control program now total approximately $35 billion annually, a 250 percent increase from the mid-1980s when combined federal and state spending for drug control totaled about $10 billion. 256

The cost of criminal justice related to drug control includes the explicit costs of law enforcement, prosecution, defense, courts and corrections. With the intensification of criminal sanctions related to drugs, the number of personnel employed in each of those agencies has risen markedly, especially in corrections and in special drug enforcement units in police and sheriffs departments and prosecutors’ offices. 257 Beyond these explicit costs, however, are significant implicit public costs, such as the opportunity cost of the courts and prisons and increased crime and corruption resulting from drug prohibition (discussed below in more detail). 258

Criminal sanctions have not proven to be cost-effective as a means to reduce the societal costs of drug abuse, including crime, violence, medical care and lost productivity. A recent study compared the costs and benefits of varying approaches to drug control, arriving at the following findings:

**Reducing Societal Costs of Cocaine Use** 259

<table>
<thead>
<tr>
<th>Investment of additional $1 in:</th>
<th>Societal benefit received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source-country control</td>
<td>a LOSS of 85 cents</td>
</tr>
<tr>
<td>Interdiction</td>
<td>a LOSS of 68 cents</td>
</tr>
<tr>
<td>Domestic Enforcement</td>
<td>a LOSS of 48 cents</td>
</tr>
<tr>
<td>Treatment</td>
<td>a GAIN of $7.46</td>
</tr>
</tbody>
</table>

The same study found that an investment in drug treatment reduces drug consumption by four times as much as spending the same amount on law enforcement and seven times as much as spending the same amount on longer prison sentences. 260 These findings, in addition to all the other findings outlined in this section, leave little, if any, room to dispute that current drug policy has been ineffective in achieving its objectives, as tough criminal sanctions for drug offenses have failed to reduce drug use, drug-related crime and their associated costs.

**Serving the Purposes of the Criminal Law**

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In addition to evaluating specific effects on drug use and drug crime, current drug policy should also be evaluated as to whether it has generally served the purposes of the criminal law. Even though drug-related criminal sanctions have failed to reduce levels and rates of drug use and drug offenses and the respective costs of each, other objectives such as the promotion of justice, specific deterrence, incapacitation and rehabilitation may nevertheless have been advanced and are worth examining. The following discussion touches upon each of the key objectives of the criminal law to determine whether current drug policy has satisfied them.

Public Safety

The promotion of public safety is an overriding objective of the criminal law, served by the deterrence, incapacitation and rehabilitation strategies outlined below. The authority to preserve public safety through law enforcement is founded on the traditional police power of the state – promoting “health, welfare, safety and morals.”

Law enforcement is intended to protect society from drug-related crime, e.g., property crime to support drug addiction, as well as the public disorder and violence that is associated with drug trafficking and illegal drug “markets.” Criminal law enforcement is also aimed at protecting society from crimes that result from drug use, which include drug-related violent crime, destruction of property and traffic injuries and fatalities. Finally, to the extent that the state is acting in loco parentis, enforcement of drug laws is intended to protect citizens from the adverse health, economic and social consequences of their own drug use. The rationale for governmental intervention is the belief that intoxication and addiction reduce capacities for self-control and rational behavior, and that drugs are different from other commodities in that drug users are “less capable of protecting their own interests.” This reasoning does not clarify, however, why the imposition of criminal sanctions is the most appropriate way to protect citizens who use or abuse drugs.

The findings in this report indicate that criminal law enforcement has not adequately protected society from the adverse effects of drugs. Drug use and abuse, drug offenses and drug-related crime have all increased during the recent period of intensified law enforcement. Drug abusers and their children continue to place inordinate burdens on social welfare and child protective services, and they contribute to the rising cost of health care. It is apparent that the use of criminal sanctions has failed to achieve the public safety goals of drug policy.
A core principle of Washington’s determinate sentencing is “just deserts,” or the notion that the “punishment should fit the crime.” From this perspective, given the relatively severe penalties assigned, drug offenses should be considered among the most serious crimes, i.e., those that cause a great amount of harm. However, a number of stakeholders in Washington’s criminal justice system have questioned whether the punishment related to drugs is in proper proportion to the seriousness of the conduct. Part of the difficulty in arriving at a comparatively just punishment is that, unlike most crimes, drug cases rarely have specific, unwilling “victims.”

The discussion of the proportionality of criminal sanctions to illegal drug activity is fraught with disagreement and confusion. Some consider drug-related punishment to be disproportionate to the offense, but prison or jail, as seen from other perspectives, is hardly threatening or punitive. Some may believe that the risk of arrest and incarceration is an unavoidable aspect of drug use and participation in the drug trade. Still others may consider indigent drug offenders to be “lucky” to have food, shelter, clothing, health service, recreation and relative levels of physical safety as an improvement over life in an environment of urban blight. Moreover, many low-level drug offenders may develop relationships with more experienced drug offenders while in prison, and may receive an education in “advanced drug trafficking” or other illegal undertakings. The retributive function of drug-related criminal sanctions could be seen as offset by the harm caused to society by the criminalization of non-violent or first-time drug offenders.

**Deterrence**

A central purpose of criminal law enforcement is deterrence, the notion that the risk of a criminal record and the loss of personal liberty are disincentives to crime. Deterrence is either specific (directed toward the particular offender) or general (directed toward the general population). In the context of drug crime, criminal sanctions are intended to ensure that the costs to the individual of the use or sale of illegal drugs will outweigh the benefits.

Among drug offenders, there is little evidence that the threat of criminal sanctions has much deterrent effect. Persons addicted to drugs are unlikely to be deterred from continued use by the threat of sanctions, because “their craving renders them incapable of a rational calculation of the costs and benefits of drug-taking behavior.” In addition, many hard-core drug addicts have little left to lose to threats of imprisonment, having already lost, or never had, stable families, employment or property.

A similar balancing of cost and benefit is likely undertaken by those involved in the sale of illegal drugs. For some, the financial benefit of selling drugs is not offset by the risk of arrest. For others, it is unlikely that the threat of criminal sanctions has sufficient influence to deter selling drugs where there is no other sufficiently well-paid means of earning a living. The same can be said of low-level drug sellers who are addicts themselves and who participate in the drug trade to support their own dependency.
An important recent study by the Washington Sentencing Guidelines Commission reported on the recidivism rates of various classes of offenders, finding that drug offenders have the highest recidivism rate. The report found further that drug offenders tend to re-offend quickly after release from confinement (within one year), and that 85 percent of the time their subsequent offense is another drug offense or a property offense that is usually assumed to be related to drug addiction. California drug offenders who receive treatment in lieu of incarceration under the new Proposition 36 guidelines (described below) have had an average of 16 previous arrests. Again, there is little, if any, room to dispute that drug dependence and addiction (along with poverty) nearly eliminate the deterrent effect of the threat of criminal punishment.

Casual drug users might be deterred to a greater extent than addicted drug users. However, there are millions of casual drug users in the United States, for whom the risk of being arrested for drug possession is very small. Furthermore, because drug addicts are estimated to consume over 80 percent of all drugs, any attempt to deter casual users neither diminishes overall demand nor deters most drug use.

**Incapacitation**

The intent of incapacitation is to remove an offender from the community to prevent that person from committing other offenses and to reduce the incidence of crime in the community. The “incapacitation effect” is measured by the effect of incarceration on recidivism rates.

In the 1980s the federal Drug Enforcement Administration attempted to shut down crack markets in New York’s Washington Heights neighborhood by arresting hundreds of drug sellers and by seizing the cars of over one thousand white drug buyers from the suburbs who came into the neighborhood to buy drugs. Incapacitating all of those buyers and sellers had no effect on the demand for or the availability of crack, however, because both buyers and sellers in the drug trade could not be arrested or imprisoned in sufficient numbers to make a difference in drug abuse or drug-related crime.

A more recent study in Los Angeles examined the arrest records of offenders convicted of drug trafficking, drug possession, robbery and burglary in an attempt to determine the number of crimes avoided through incarceration. A significant incapacitation effect was found with the robbery and burglary offenders, but not with the drug trafficking or drug possession offenders. Taking burglars and robbers off the street resulted in a decrease in burglary and robbery, but the incarceration of the drug offenders simply created more business opportunities for other drug sellers. Incapacitating drug offenders does not reduce the incidence of drug offenses because there is a continuous supply of potential drug offenders to take the place of those who are sent away to prison.

**Rehabilitation**
Rehabilitation is the process of changing or “reforming” the behavior of offenders so that they will not commit further offenses. Rehabilitation was at one time the primary goal of sentencing, but since the late 1970s the pendulum swung toward punishment and incapacitation.278 After the rapid proliferation of drug offenses in the 1980s and 1990s, the pendulum began to swing back again, as “drug courts” were established as an alternative to the incarceration of drug offenders. Drug courts defer prosecution to allow drug users to receive addiction treatment under criminal justice supervision, and the threat of criminal sanctions and a criminal record serve as leverage to compel illegal drug users to participate in treatment.

The emphasis on addiction treatment for drug offenders is currently the major drug policy reform being implemented in the United States (discussed in greater detail below). The initial hope for programs such as drug courts derives from their rehabilitative focus – concentrating on one behavior problem (addiction) that is causally related to crime committed by one group of offenders.279 Evaluations of court-ordered drug treatment have shown some reductions in drug use and recidivism, but no study has yet reliably demonstrated that drug courts “work.”280

Restoration

The concept of restoration involves the use of the criminal justice process to rebuild relationships between an offender, the victim and the community disrupted by crime. Offenders are to be accountable for their actions before the community and the victim and, as the harm to the victim and the community is repaired, the offender is rehabilitated.281

The “restorative justice” approach has been effective with some types of non-violent offenders, particularly juvenile offenders. However, its relevance and applicability to drug offenders is negligible, because drug offenses per se are “consensual” or “victimless” crimes and are therefore not amenable to the potential for healing and forgiveness between the perpetrator of a crime, the victim of the crime and the larger community. However, the concept of restorative justice does highlight the approach taken by civil courts to the harms associated with drug abuse. For example, it is common in family court proceedings for parties to be ordered to participate in drug treatment as a way of restoring family relationships.

Summary
William J. Bennett, a former White House drug “czar,” stated recently that the War on Drugs once worked and that it can work again. Bennett decried the increase in drug use in the 1990s, comparing it with the decline in drug use in the 1980s, which he attributed to “vigorous law enforcement and interdiction, coupled with effective prevention and treatment.” However, as the findings in this report convey, Bennett’s statement bears little relationship to what has actually occurred in the last decade. Drug-related law enforcement activity and the increasing incarceration of drug offenders did not slack off during the 1990s, when drug use was on the rise again. In fact, the last decade has seen unprecedented drug-related law enforcement activity and incarceration of drug offenders.

The increasing arrest and incarceration of drug offenders and the lengthening of prison sentences since the late 1980s has failed to reduce the prevalence of drug use, the problem of drug abuse, the incidence of drug offenses and drug-related crime and the related public costs. Furthermore, the increased criminal sanctions related to drugs have not satisfied any of the core objectives of the criminal justice system. The toughening of penalties related to drugs has not contributed to increased public safety, nor has it succeeded in deterring drug-related activity or reducing drug-related recidivism rates through incapacitation.

Recent rehabilitative options for drug offenders have largely been a reaction to the perceived ineffectiveness of criminal sanctions. Although some encouraging reports have come from the nation’s drug courts, there are still doubts about their long-term effectiveness. Meanwhile, the large majority of drug offenders at the state and federal levels continue to serve long prison terms, most without any rehabilitative component to their sentences. Drug offenders in Washington have more rehabilitative options than drug offenders in other states, but the majority of offenders in need of treatment still do not receive it. The people of Washington continue to spend hundreds of millions of dollars annually to confine repeatedly a class of non-violent offenders who have the highest recidivism rate because of their drug dependence. The cost of drug-related criminal sanctions has been high, but the promised benefit of this policy has not been realized.

3. Problems and Prospects for Current Drug Policy
Damaging Collateral Effects of the War on Drugs

The findings described in this report indicate that the War on Drugs has been ineffective in reducing levels of drug use, drug abuse, drug offenses or other crimes related to drugs. In addition, it has caused collateral damage that has rippled through America’s disadvantaged communities and the American economy at large, as well as the international economy and the drug-producing nations of the world. What follows is a brief summary of some of the most serious negative side effects of our current drug policy.

Promoting crime – trade unfettered by law

The War on Drugs has actually increased crime and enhanced the profits made in the black market drug trade. Those who produce, deliver and use illegal drugs commit crimes merely by engaging in those activities. Many drug users turn to other types of crime in order to afford drugs, which are made more costly because of drug prohibition. On the supply side, the prohibition of illegal drugs has exempted the drug trade from regulation and control, and the resulting black market in the distribution of drugs has spawned high levels of violence. Where there is no recourse to the law to settle disputes or to protect the trade from competitors, business is often conducted by force or threat of force. For example, somewhere between 20 and 40 percent of murders in the United States take place because of the black-market drug business.

For the larger-scale drug sellers who operate above the street level, very high profits from the drug trade are a strong incentive to make “easy” money in a market that is not regulated or controlled. The high profits are a direct result of government attempts to restrict the supply of illegal drugs. Interdiction and enforcement efforts that reduce drug supply thus have become tantamount to “taxpayer-funded price supports for organized crime.” At the same time, those interdiction efforts have failed to stop the flow of drugs needed to meet consumer demand.

Retail prices of illegal drugs have actually declined significantly in recent years. In the United States over the last decade, the price of cocaine has fallen by about 50 percent and the price of heroin has declined by about 70 percent. This indicates that the War on Drugs has not kept supply from outstripping increased demand. Despite the drop in retail prices, the international illicit drug business has continued to realize enormous profits, generating about $400 billion in trade each year.

Undermining public health

The War on Drugs has exacerbated the damage to health inflicted by drug abuse in a number of ways. First, AIDS and other diseases are transmitted by the use of contaminated
needles. Drugs are often injected rather than taken in a safer way because the drugs’ cost prompts users to attempt to achieve the same effect using less of the substance. Second, in the unregulated drug market, a substance may be diluted with chemicals more harmful than the drug itself. Third, in response to intensified law enforcement activity, the smuggling of purer and higher-potency drugs has increased, allowing substances to be transported in smaller, more easily concealed quantities. The combination of more potent drugs and more frequent adulteration of drugs has rendered the quality of the drug supply extremely unpredictable, making the consumption of drugs much more dangerous in terms of overdoses, poisoning and possibly their addictive potential.

In addition to the increase in the potency of known drugs, criminalization has also brought about the formulation of new, and often highly potent, synthetic drugs. For instance, powerful, synthetic opiates are produced with chemical compositions that can be changed by suppliers to avoid criminal punishment. Another health-damaging response to drug prohibition is the substitution of lower-priced for higher-priced illegal drugs. In Washington and elsewhere, the current proliferation of methamphetamine, which is produced in varying and unpredictable degrees of quality and potency, is an example of the synthesis of a new drug that is cheaper and often more potent than other drugs such as cocaine or other stimulants, and potentially much more hazardous to the user’s health.

The criminalization of drug use has arguably discouraged people from seeking medical attention to address their medical needs, including their drug addiction; and the risk of criminal sanctions has prevented or discouraged some drug users from taking necessary steps to protect themselves from disease. Drug abuse can lead some people to neglect their health, but it is also conceivable that the risk of detection and criminal prosecution is a disincentive to seeking medical care. There is also some indication that drug users are stigmatized and receive a lower standard of medical care when their illness is related to their known drug use.

The criminalization of drugs also impairs the ability of doctors to practice effective medicine. Primary care physicians and other health professionals who prescribe controlled substances, especially opiates, to treat pain are audited by the federal Drug Enforcement Administration. Even if a prescription meets the standards of the medical board that regulates the physician’s license, the DEA can determine that the federal license to prescribe controlled substances should be taken away. Although physicians are not subject to criminal sanctions, but only license revocation, in such instances, the criminalization of drugs has created an environment of fear that inhibits doctors from providing competent medical care.

**Slowing the wheels of justice**

The dramatic expansion of law enforcement activity related to drugs in the last dozen years has clogged the court system to such an extent that judicial attention has been diverted away from the processing of civil cases and non-drug criminal cases. The federal courts
have been so overwhelmed with drug prosecutions that Chief Justice Rehnquist has expressed exasperation at the burdening of federal courts with petty drug cases. In Washington’s courts, civil cases are unduly delayed because of the need to process the large bulk of drug cases, which have priority because they are criminal matters.

In the King County courts, the volume of drug cases has overloaded the dockets and consumed scarce resources that also must be devoted to other criminal and civil cases. Approximately 40 percent of the cases filed in King County courts each year – over 3,800 – are controlled substances cases. In addition, almost 20 percent are “acquisitive” property cases such as theft and burglary. Although impossible to determine the exact number, it is not unreasonable to assume that many, if not most, property cases are drug-related, and therefore, that at least half of King County’s criminal caseload is drug-related. Controlled substances cases (excluding drug court cases) also make up the largest share of pending cases – almost 900 – which partially explains why the active pending criminal caseload has been rising for the last five years.

Social dislocation and racial/class divisions

The War on Drugs has taken a particularly hard toll on disadvantaged communities, both as a result of intensified law enforcement activity in those communities and the incarceration of residents from those communities. The focus of drug enforcement on the poor and near-poor has resulted in a massive “prisonization” of disadvantaged young men, to the point that more poor people are now housed within the correctional system than in public housing. Law enforcement efforts to stop the drug trade in one location have only displaced “markets” from one neighborhood to another, and the combination of open-air retail drug sales, the threat of violent turf battles and heavy police presence have imposed a sense of disorder and danger on those neighborhoods.

Drug abuse (though not drug use) is closely related to the conditions of social deprivation and community breakdown not uncommon in disadvantaged neighborhoods. In addition to drug abuse, the increase in law enforcement and incarceration because of drugs has perpetuated and exacerbated the social conditions that help give rise to drug abuse in the first place. The effects of incarceration on the family structure have been particularly disruptive, imposing large and apparently unmanageable burdens on single-parent families and the foster care system. Two million minor children in America have at least one parent in jail or prison. Almost 70 percent of women in local jails and state prisons have minor children, and almost half of the women in local jails or state prisons are incarcerated on drug charges. Maintaining parent-child relationships is extremely difficult for many offenders in prison, as a significant majority of parents in state and federal prisons are held more than 100 miles from their last place of residence.

The incarceration of minorities and the poor has further eroded the economic security of families in those communities, resulting in the loss of educational, employment (through job disqualification due to criminal records) and training opportunities, as well as losses in seniority. Drug-related incarceration has also exacted an economic cost from poor

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communities through lost worker productivity. In Washington in 1996, impairment of gainful employment due to the incarceration of drug offenders resulted in over $70 million in lost worker productivity.309

The War on Drugs has also distorted the political, economic and civic cultures in poor communities. The loss of the right to vote of those in the custody of the corrections system has arguably deepened their political alienation and the sense of impotence in their local communities. The “normalization” of prison time and the strengthened links between prison and the street have also limited the chances of success in the regular economy for many of those who come out of prison.310

Erosion of civil rights

Another consequence of rising drug enforcement in the last dozen years has been the compromise of citizens’ constitutional rights, particularly the relaxation of standards for search and seizure and invasions of individual privacy. One example is the United States Supreme Court’s ratification of the use of highway drug courier profiles to justify random checkpoint stops.311 In addition, reasonable suspicion requirements have been waived for “street sweeps” by law enforcement, where flanks of police officers conduct intensive stops and searches in targeted areas of a city.312

No comparable law enforcement effort has involved more wiretaps, home searches and other encroachments on individual privacy than the War on Drugs.313 Nine out of ten police departments in the United States have paramilitary units that patrol urban areas and also serve drug-related search warrants, which are usually no-knock entries into private homes.314 The dedication of such a high level of resources toward drug-related law enforcement, along with the primary focus on drugs as a motive for vehicle and personal stops by the police, has put civil liberties at risk and has antagonized wide segments of our citizenry. The concentration on the War on Drugs has also drained police resources away from the fulfillment other public safety responsibilities.

One of the most controversial features of the War on Drugs is the authority of law enforcement to seize the assets of those arrested on drug charges. No conviction is required for an asset seizure, and some federal circuits have even upheld asset seizures despite the owner’s eventual acquittal of drug charges.315 Critics of the practice say it is “hardly distinguishable from punishment without trial,” in which people are deprived of their criminal procedural rights.316 Civil asset forfeiture is also available to law enforcement in Washington in connection with arrests for drug offenses. Although the provisions of the state asset forfeiture statute were amended recently by the legislature, it is still possible for a property owner’s assets to be seized without the owner being found guilty by a court of any wrongdoing.317 In addition, law enforcement agencies keep the assets they seize, which
creates a conflict of interest that allows them to distort law enforcement goals to maximize funding for their operations.\textsuperscript{318}

Persons convicted of felonies in Washington, including drug offenders, lose the right to vote,\textsuperscript{319} to hold public office\textsuperscript{320} and to serve as jurors.\textsuperscript{321} Convicted persons may also be disqualified from acting as a personal representative\textsuperscript{322} or guardian.\textsuperscript{323} In addition to formal consequences of criminal conviction, one of the harshest effects of a felony record is the social stigma that poses barriers to employment and can give rise to other unpleasant and embarrassing situations. A great deal of confusion surrounds the process of restoring civil rights after the completion of the sentence, and many offenders are unable to get their civil rights restored after release from custody, due to unpaid financial obligations in connection with their sentence.\textsuperscript{324}

Another “right” put in jeopardy during the course of federal drug law enforcement has been access to higher education. An amendment to the Higher Education Act of 1998 provided that students convicted of drug charges become ineligible for federal financial aid and guaranteed student loans.\textsuperscript{325} No other criminal offense renders students ineligible for student loans. Accordingly, a student convicted of robbery or murder is eligible for federal financial aid for college, but a student convicted of simple drug possession is not eligible. Thus far in 2001, over 35,000 students in the United States have lost their eligibility for educational financial assistance due to drug convictions. Critics of this provision assert that the rule is biased against the poor.\textsuperscript{326}

The extent to which drug law enforcement has impinged upon civil liberties is most evident in our prisons: the United States now leads the world in per capita imprisonment. By way of comparison, France imprisons about 95 per 100,000 population for all offenses, and the U. S. imprisons about 150 per 100,000 for drug offenses alone.\textsuperscript{327} As former federal drug “czar” Barry McCaffrey has stated, “We have created an American gulag.”\textsuperscript{328}

**Official corruption /abuse of power**

One type of crime that has risen dramatically during the War on Drugs has been corruption among criminal justice officials, even federal judges.\textsuperscript{329} Scandals involving corruption related to drug enforcement have been uncovered in police departments in at least a dozen major metropolitan areas, although not in Seattle or King County.\textsuperscript{330} About half of all police officers convicted in FBI-led corruption cases nationally between 1993 and 1997 were convicted for drug-related offenses.\textsuperscript{331} Corrupt practices include knowingly conducting unconstitutional searches and seizures, stealing money and drugs, selling stolen drugs, protecting drug operations and submitting false crime reports.\textsuperscript{332}

Corruption is more likely when the potential payoff is high and the risk of being detected is low. In this context, public officials have a host of opportunities to benefit secretly from the illicit drug trade, as the profitability of that trade has afforded drug traffickers the means to attempt to corrupt public officials. As the War on Drugs has
expanded and intensified, the opportunities for corruption have seemed to grow equivalently. The illicit drug trade has been described as “the most lucrative source of police corruption that has ever existed in the United States”\textsuperscript{333} While the integrity of local law enforcement in Seattle and King County has not been called into question in this regard, drug-related corruption among public officials has caused considerable damage in other communities in the United States.

\textbf{International destabilization}

The enormous profits and corruption brought about by the War on Drugs has had particularly adverse effects on developing countries, especially those countries where the raw materials for illegal drugs, such as coca and opium, are cultivated and processed. The resources at the disposal of illegal drug enterprises in those countries have allowed them to corrupt their own governments, or alternatively to create their own private armies to terrorize local officials into permitting continued drug production.\textsuperscript{334}

The United States has demanded the cooperation of the governments in drug-producing countries to prosecute the drug producers under their own laws, to eradicate poppy, coca and marijuana crops, to destroy drug processing facilities, and otherwise to make it costly for drug producers and exporters to operate. The current effort of the United States in Colombia and other Andean nations involves the spraying of herbicide on croplands as well as substantial financial and military assistance to governments fighting drug producers, left-wing rebel groups and right-wing militias, all of whom profit handsomely from the drug trade.\textsuperscript{335} The Colombian government is cooperating, although there have been vociferous objections to the spraying of chemicals near rural villages, and also some recent calls from Colombian elected officials for the legalization of drugs.\textsuperscript{336}

Unfortunately, source-country drug enforcement efforts by the United States have not had long-term success in halting drug cultivation and processing, but instead, have worsened local environmental conditions, corrupted and destabilized foreign militaries and disrupted foreign economies and cultures.\textsuperscript{337}

\textbf{Special Note on Drug Trafficking and International Terrorism:}

Since the catastrophic terrorist attacks in New York and Washington, D.C., the United States and its growing coalition of allies have been attempting to track down leading terrorists and their organizations in the effort to prevent any future incidents. A significant part of that effort has been to find and freeze the assets of terrorist organizations. There is considerable evidence that terrorist organizations throughout the world have been partially financing their operations with the use of funds derived from illegal drug trafficking. For instance, the heroin-producing poppy fields of Afghanistan have helped to fund Al-Qaeda, the network of terrorist groups led by Osama bin Laden.\textsuperscript{338}
The links between illegal drug producers, organized crime syndicates and terrorist groups are spread worldwide. With the assistance of local drug producers, insurgent and terrorist groups in source countries such as Colombia, Thailand and Pakistan have been supplying drugs to international criminal organizations in exchange for weapons, or for cash to purchase weapons. These groups have included the Shining Path in Peru and the M-19 rebels in Colombia. With the end of the Cold War and the financing of proxy wars by the United States and the Soviet Union, armed groups have turned to the illegal drug business for funding. Interpol’s chief drug control officer, Iqbal Hussain Rizvi, stated in 1994: “Drugs have taken over as the chief means of financing terrorism.”

**Collateral Harms – Summary**

Any public policy has the potential to bring about unwanted side effects, but the extent of the collateral harm arising from the War on Drugs raises fundamental questions as to whether its policy goals are attainable without unacceptable costs. The basic finding in this report is that the War on Drugs has been extremely costly and has totally failed to fulfill any of its major objectives. Not only are drugs cheaper, purer and more available, but drug use and drug dependence and addiction are all on the rise, as are drug offenses and other crimes related to drugs. Furthermore, the shortcomings of the current drug enforcement system are overshadowed by the devastating array of its harmful side effects outlined above. The time is ripe for reform of the current drug policy, but the question remains as to what kind of reform will be adequate to address the profound problems plaguing the current system.

**Reforming Drug Policy – Current Efforts**

An increasing number of jurisdictions have attempted in recent years to reform their drug laws. Most of these reforms have been effected at the state and local levels. At the federal level, the U.S. Department of Justice has provided assistance for local “drug courts,” but otherwise, changes in federal drug policy have been limited to increasing its severity.

Drug policy reforms have been in reaction to both the fiscal and the human costs of the War on Drugs. Public officials and the public at large have expressed increasing concern and discomfort over the continuing rise in the public expense of arrest, prosecution and imprisonment for drug law violations, as well as the disproportionate impact of the current system on racial minorities and the poor and the perpetuation of social decay that the drug laws were ostensibly meant to prevent.

Some public officials, including the King County Prosecuting Attorney, have stated publicly that incarceration itself does little to resolve the harm of individual drug abuse. In general, however, policymakers have had to confront the political risks, both perceived and real, of being outspoken on the need for drug policy reform, and this has slowed the
pace of change. The most forceful calls for reform have come from the more politically insulated public officials, such as the tenured judiciary and elected officials facing term limits. At this point, changes that have been enacted have not been truly fundamental reforms, but only measures relating to discrete issues within the existing drug control system.

**Replacing Incarceration with Treatment – State Ballot Initiatives**

Two of the most dramatic drug policy reforms have taken place in Arizona and California, where sanctions for drug law offenses were changed by voter initiative.\(^{343}\) In both cases, the electorate voted in favor of a system where treatment of drug addiction, and not imprisonment, is the primary response to illegal drug use.

Arizona’s Proposition 200, the Drug Medicalization, Prevention and Control Act, was approved in 1996 with 65 percent of the popular vote.\(^{344}\) Proposition 200 bars the incarceration of persons convicted of possession of a controlled substance, and instead mandates probation with treatment for the first and second such offenses. The measure further requires that all persons convicted and sentenced to prison terms for drug possession *before* the enactment of the new law be made eligible for parole, so long as they would have otherwise been eligible for probation under the statute.\(^{345}\)

To date, Arizona’s Proposition 200 is the only statute with a track record that mandates treatment as government’s primary response to drug use. By replacing incarceration with treatment, state officials estimate that Arizona saved more than $2.5 million in its first fiscal year.\(^{346}\) With resources made available under Proposition 200, 98.2% of probationers received drug treatment and 77.5 % of them tested negative for drug use in urine testing during fiscal year 1998.\(^{347}\) Reporting on the cost savings under Proposition 200, the Arizona State Director of Adult Probation stated that “probation with treatment works….The next step is to ensure that effective treatment is available to all who need it, with emphasis on attendance in and completion of court-ordered substance abuse treatment programs.”\(^{348}\) Some members of the Arizona judiciary have expressed similar opinions: "Opponents of Proposition 200 said this was a ‘pro-drug’ initiative," said Arizona Appellate Court Judge Rudy Gerber. "As it turns out, [the law] is doing more to reduce crime than any other state program, and saving taxpayer dollars at the same time."\(^{349}\)

The other significant drug policy reform enacted by statewide initiative was California’s Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, which garnered 61 percent of the popular vote. Similar to Arizona’s initiative, Proposition 36 mandates treatment in lieu of incarceration for first- and second-time drug possession offenses.\(^{350}\) A key feature of the California initiative is that successful completion of court-ordered treatment leads to dismissal of the criminal charges, as the defendant is “released from all penalties and disabilities resulting from the offense of which he or she has been
convicted.” Proposition 36 also directed the California legislature to allocate $120 million annually for drug treatment as an alternative to incarceration and, like Arizona’s Proposition 200, requires annual reports on the effectiveness of the measure in reducing crime and public expenditures.

While the effects of Proposition 36 are yet to be determined, the California Legislative Analyst's Office estimates a total net savings for the state and local governments of $140 million to $190 million per year, plus an estimated one-time cost savings of between $450 million and $550 million attributable to the avoidance of additional prison construction. The estimated savings do not include specific amounts from fees paid by offenders or savings in prosecution-related expenses, each of which are estimated to be potentially millions of dollars statewide.

Neither Arizona’s evaluation of its early fiscal savings nor California’s official estimates took into account the potential economic benefits of a reduction in recidivism, increases in employment of probationers and the avoidance of social welfare costs from not removing parents and wage-earners from the community. In addition, the prevention of social disruption and emotional harm to individuals and their families cannot be measured in objective economic terms.

Similar voter initiatives have been filed or are being considered in other jurisdictions, including in Washington.

Replacing Incarceration with Treatment – Judicial Reform

The most prominent drug policy reform effected at the local level has been the “drug court,” which has signaled the beginning of a paradigm shift away from a predominantly punitive orientation toward substance abuse and drug-related crime to a focus on treatment and investment in human potential. The drug court model involves a new working relationship between the criminal court and health and treatment systems, carried out within the boundaries of the criminal court’s jurisdiction.

There are currently more than 650 drug courts in the United States, with an additional 450 in the planning stage. By June 1999, when only 381 drug courts were in operation, an estimated 140,000 defendants had been involved in adult drug court programs and the participant retention rate was estimated at greater than 70%. All 50 States and a number of American territories now have drug courts operating or in the planning stage.

In Washington, there are at least 16 adult, juvenile and tribal drug courts in operation and another 15 are planned. The first drug court in Washington began in King County in August 1994. Under the rules governing the King County drug court, eligible defendants
can elect to proceed with traditional court process or they may participate in the program that gives them the opportunity to receive drug treatment in lieu of incarceration. Defendants who choose to participate in the program come under the court’s supervision and are required to attend treatment sessions, undergo random urinalysis and appear before the drug court judge on a regular basis. Defendants who meet the requirements of each of the three levels of the program graduate from the program and their charges are dismissed. Defendants who fail to make progress are terminated from the program and are sentenced on their original charge.

An initial evaluation of the King County drug court program completed in 1998 was encouraging, showing significantly lower recidivism and drug relapse rates among its participants, compared to other drug offenders who did not participate in the program. An ongoing study of Washington’s six major adult drug court programs has been underway since 1999, conducted by the University of Washington’s Alcohol and Drug Abuse Institute. The study has been evaluating re-offense, new conviction and re-incarceration rates of offenders eligible for drug court who declined to enter or who terminated treatment, compared with “graduates” of the drug court program. The study’s core findings show drug court “graduates” with fewer re-arrests following drug court than any of the other offender groups. Throughout Washington, the rate of imprisonment in the post-drug court referral period is near zero. In King County, the drug court graduation rate is 29 percent (number of graduates/number of offenders entering the program) and the retention rate is 41 percent [(graduates + active participants) / admissions].

Due to fiscal constraints and eligibility restrictions, a relatively small fraction of drug offenders have been diverted through the drug court program. Each year since the program’s inception in 1994, approximately 900 offenders, or 21 percent of all drug cases filed in King County in one year, have been found eligible and referred to the drug court. Of those who are eligible, approximately one third have chosen the drug court option.

A significant difference between the drug court model and the diversion programs established under Arizona’s Proposition 200 and California’s Proposition 36 is that drug courts retain more authority to sanction or terminate drug offenders’ participation for violation of required conditions, often resulting in incarceration. In order to be eligible for the drug court program, defendants must waive the right to a speedy trial and the right to confront witnesses, and they must also stipulate to the facts of the case as stated in the police report, essentially deferring a guilty verdict in the hope of successful completion of drug treatment. Drug court participants who fail to remain drug-free (which is not uncommon among drug-addicted individuals) may be incarcerated on the original charge without trial.

There is no way to demonstrate whether individual defendants who succeed in drug court could have succeeded in treatment without arrest and the threat of incarceration. For defendants less amenable to drug treatment – coerced or voluntary – addressing drug use through the criminal courts, rather than through the public health system, often results in
non-violent offenders facing lengthy periods of incarceration that may often compound the health and social problems associated with their addiction. Individual drug court judges are specially trained and especially sensitive to these pitfalls, but the drug court model still does not resolve the underlying problems created by a system that attempts to address drug use as a criminal justice matter rather than as a public health matter.

**Sentencing Reform – State Legislation**

Relatively recently, a few state legislatures have attempted to reduce the severity and expense of incarceration of drug offenders and to increase opportunities for drug treatment. In Washington, as mentioned above, the Drug Offender Sentencing Alternative program has been recently expanded, providing an abbreviated prison sentence and drug treatment to eligible offenders. No state has yet shifted the primary responsibility for addressing drug-related harms from law enforcement to the health system, but there has been some movement in that direction in various states, including New Mexico, Nevada, New York, Connecticut, Louisiana and Indiana.

New Mexico has made the most comprehensive attempt in the nation to reform its drug laws. In its 2001 legislative session, with the active support of Republican Governor Gary Johnson, ten drug policy reform bills were introduced. Five of those bills passed into law: syringe availability, anti-opioid overdose treatment, early release of prison inmates convicted of non-violent drug offenses, restoration of voting rights for ex-offenders and expanded funding for treatment for drug addiction.

Two bills that did not pass in New Mexico in 2001 related to medicinal use of marijuana and civil asset forfeiture. Three other bills that were considered but did not pass directly addressed the state’s system of criminal sanctions for drug related offenses. Senate Bill 317 would have provided for treatment instead of incarceration for first- and second-time drug offenders in cases involving one to eight ounces of marijuana or two grams or less of cocaine, heroin or other controlled substance. The criminal offense in such cases would have been reduced to a misdemeanor and resulted in conditional discharge (i.e., probation). New Mexico judges would have had discretion to require offenders to participate in drug treatment, thereby preserving limited treatment services for those truly drug-addicted.

Current law in New Mexico provides that if a prosecutor charges an offender as a “habitual offender,” the sentencing judge must apply an enhancement to the person’s sentence. The habitual offender statute in New Mexico would have been amended by Senate Bill 313 to restore judicial discretion in determining whether to try defendants as habitual offenders in cases involving past or present use or sale of controlled substances.

The third fundamental reform considered but not enacted in New Mexico in 2001 was Senate Bill 315, which would have decriminalized possession by adults of one ounce or less of marijuana. While marijuana would have remained illegal, there would have been no criminal penalty for its possession, but instead a $100 fine for a first violation and $500 fine for subsequent possession charges. A law enforcement officer could issue a warning or a
citation requiring the offender to pay the fine by mail or in person at a magistrate’s court. The person receiving the citation could also appear in magistrate’s court in a civil proceeding to contest the citation. Money collected from such citations would go into the state general fund.376

Although these three proposals that would have reformed criminal sanctions for drug offenses in New Mexico were not ultimately enacted, none lost a committee or floor vote. This alone evidences a significant shift in attitude among elected officials in that state, as does the mere fact that the bills were introduced and seriously considered.

In the 2001 session of the Washington Legislature, there was also an attempt to reform sentencing in drug offense cases. Senate Bill 5419, in its original form, was similar to California’s Proposition 36 and New Mexico’s SB 317 in that it mandated treatment instead of incarceration for non-violent drug offenders.377 The King County Bar Association endorsed this bill.378 However, a committee amendment to the bill removed all reference to treatment for non-violent drug offenders as an alternative to incarceration. In its place was substituted a provision that would slightly reduce the length of incarceration for some drug delivery offenses, retaining the basic policy of incarcerating drug offenders.379 Moneys saved by shortened prison terms were to be allocated to drug treatment programs.380

The drafter and primary promoter of the amended SB 5419 was the King County Prosecuting Attorney, who called for a new policy:

A new approach to drug policy must look to law enforcement and the criminal justice system to play three critical roles:

- First, to apprehend and incarcerate those who profit from the misery of drugs. This includes the importers, manufacturers and dealers.

- Second, the criminal justice system can provide an effective intervention point to leverage drug addicts into treatment. We have learned over the last decade that courts can coerce addicts into treatment. In many cases, it takes an arrest and the threat of incarceration to bring about the motivation and self-realization for an addicted person to confront the fact and consequences of their own addiction; and

- Third, our society must provide a consistent message to our youngest citizens that drug use is wrong and harmful. This message can be delivered in a variety of ways within a school curriculum. It must be reinforced by maintaining laws against illegal drug use.381

Observing that “drug treatment works,” the King County Prosecutor has lamented the inadequacy of addiction treatment opportunities, commenting that, “with the notable exceptions of drug courts … and the Drug Offender Sentencing Alternative … the criminal justice system has no treatment alternatives to incarceration.”382 Drug treatment, however,
is still supervised by the criminal justice system, rather than left in the hands of medical service providers and drug treatment specialists. While recommending a much-needed expansion of rehabilitative options for drug offenders, the latest reform proposal for Washington is still only intended to modify the current system of criminal sanctions.

Senate Bill 5419, as originally introduced, would have made drug treatment the primary response to drug use. Later versions of SB 5419 provided for some less harsh sentences and greater resources for treatment of drug offenders, but still reaffirmed the long-standing primacy of criminal sanctions in the attempt to discourage drug use. Even in its most conservative form, SB 5419 failed to pass the Washington State Legislature in 2001. As the 2002 legislative session approaches, there is still a high level of interest in drug policy reform, both because of the potential cost savings and because of the prospect of a more effective means to address the drug abuse problem. However, as this important debate continues, it remains to be seen whether the legislature will enact more fundamental reform or merely tinker around the edges of current drug policy.

4. Toward a More Effective Drug Policy
Any examination of criminal sanctions related to drugs should consider whether current drug policy is serving essential public policy objectives. Among the most important of those objectives are:

1. Enhanced public order and reduced crime
2. Improved public health
3. Protection of children
4. Efficient use of scarce public resources.

This report finds that the War on Drugs has not only failed to fulfill any of these objectives, but also has exacerbated the very problems it was designed to address.

Unfortunately, the findings in this report are neither new nor surprising. From the very beginning of the modern era of drug control, it was recognized that “law enforcement may not be the ultimate solution to the drug abuse problem.”\(^ {383} \) Many scholarly studies, including the work of other bar associations, have come to the same conclusion.\(^ {384} \)

The Shift from Criminal Justice to Public Health

Although the vast majority of citizens acknowledge the failure of current drug policy, there is no consensus about alternatives.\(^ {385} \) Furthermore, the polarization of the drug policy debate between the “prohibitionists” and the “legalizers” has prevented measured and dispassionate consideration of the complex issues surrounding criminal sanctions for non-medical drug use.\(^ {386} \) The lack of meaningful dialogue on drug policy has largely precluded the design of alternative means to enhance public safety and public health more effectively. In the search for more effective alternatives, it is essential to identify workable approaches that can help to build common ground between those who currently hold differing views on drug policy.

Any sanction related to drug use should result in less harm than the use of the drug itself. Accordingly, a shift from the current system of punitive drug control towards a system of regulatory drug control would greatly reduce the harm that has resulted from the use of criminal sanctions. As an alternative to the criminal justice response, a public health response to drug use would shift resources away from the expensive and ineffective practices of arrest and incarceration and more towards an expansion of addiction treatment, drug education and research. A more compassionate response to drug abuse, coupled with comprehensive and honest drug education for both youth and adults, should ultimately result in more well-informed and responsible attitudes towards drugs.

Drug use can result in significant harm to the drug user, although many, if not most, drug users do not experience serious adverse consequences from drug use. To the extent that drug use harms the user, a public health response is appropriate. However, drug use can result in harm to other persons or property. When that occurs, either criminal or civil
A major impediment to fundamental drug policy reform in Washington (and throughout the country) is the breadth of federal drug law. The existing system of drug control is a very costly failure, but federal regulation of drug use has been and is so pervasive as to "preempt the field," inhibiting the development and testing of alternatives. Yet, one or more such alternatives are clearly needed.

Federal law should permit the states to develop their own drug control strategies and structures, using our federal system to allow the states to be laboratories for change and improvement of public laws and institutions. Allowing Washington and the other states to design and build (and, as appropriate, redesign and rebuild) legal and regulatory structures for drug control will enable the experimentation with strategies and systems in search for an effective means to deal with the problems that accompany drug use. Our present system is a failure, and there is no widespread agreement about what system would be best. Experimentation is necessary, and the states should be free to do it. Hopefully, the experimentation will produce successful strategies and structures that all the states could adopt.387

In the context of greater state control over drug policy, it is instructive to consider a range of long-term options for reform, including the notion of developing of a new, state-level regulatory structure for controlled substances. Under such a structure, an extensive network of laws and regulations would govern manufacturing, sale, labeling and advertising, and strict licensing requirements would apply to those dispensing controlled substances. Revenue from taxation could cover the cost of regulation and contribute to the cost of addiction treatment and drug abuse prevention. In addition, replacing the punitive system with a regulatory system would create a different incentive structure that would help encourage drug addicts to seek treatment.

The regulatory approach could be particularly appropriate at this time for marijuana, for which the cost of current criminal sanctions far outweighs any societal benefit received. If marijuana were regulated and taxed in the same manner as alcohol, including tight control over manufacture and sale, strict prohibition of availability to minors and restrictions on advertising, numerous societal benefits would accrue, including: 1) a separation of the market for marijuana from the market for other more harmful drugs; 2) severely curtailing or eliminating the black market for marijuana, thereby putting out of business those dealers who sell to youth; and 3) a reduction in the consumption of more harmful drugs, such as alcohol and cocaine.

Any reform of drug policy will likely be incremental, not only to allow for the phasing in of new measures, but also to provide opportunities to evaluate their effectiveness.
Other, more fundamental reforms may be developed and implemented at a later stage, particularly after a sufficient infrastructure for the delivery of drug treatment services is in place.

Where criminal sanctions are an ineffective and inappropriate means to address the problems that arise from drug abuse, it is instructive to look to Washington’s current policy toward alcohol use, articulated by the general proposition in RCW 70.96A.010:

*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.*

It is possible for the people of Washington to fashion a similar general policy with regard to other drugs, a fiscally responsible policy that would carefully balance the exercise of individual civil liberties with the effective preservation of public order, while also providing compassionate treatment to those in need. There is also a critical need for comprehensive education of the public and open-minded dialogue about the very complex and serious issues addressed in this report. Both inside, but especially outside, of government, very bright lights should be shone on the failure of our drug policies and the tremendous costs, both human as well as financial, they have exacted on our society and on the societies of many other nations. Change is sorely needed, and its form should be widely debated and implemented with all deliberate speed.
APPENDICES

APPENDIX A
Universal Drug Education Programs in Schools: Some Noteworthy Programs from Around the Nation

“System-Wide Change”

Of all the universal, school-based prevention programs, the most effective have followed the “system-wide change” model, which involves a wholesale transformation of the school atmosphere, engaging students more fully and involving the students’ families and community, while attempting to alter the social norms and expectations. One of the most celebrated of these comprehensive prevention programs is the Child Development Project, established in Oakland, California in 1981.

The Child Development Project is a research-based school improvement initiative intended to transform elementary schools into “caring communities of learners.” The principal goal of the project is to enhance pro-social characteristics in children that allow them to resolve conflicts with greater skill, and that give them an increased sense of social competence. With participation of parents and extended families, and with training and a high level of commitment of teachers and school administrators, the Child Development Project focuses on building a strong sense of community in school and further promotes change in classroom climate, curriculum and teaching style. The program is based on the assumption that the risks of substance abuse can be reduced by nurturing a student’s desire to learn, by cultivating supportive relationships and by promoting a sense of common purpose. Formal evaluation of the program has revealed a decrease in the early use of alcohol and tobacco and, as distinguished from other “prevention” programs, the positive effects have been found to continue for many years afterward.

The “system-wide change” approach recognizes the importance of culture in changing behavior and of the utility of involving the larger community in reinforcing classroom instruction and discussion. The strategy requires competent and committed school leadership as well as significant commitments from community and family members, so it would be difficult to replicate in many locations. Nevertheless, the few examples of “system-wide change” have been shown to reduce early initiation of alcohol, tobacco and marijuana, thereby helping to reduce youth substance abuse and other problem behaviors. It is worth considering whether the “system-wide change” model could be successfully implemented in Washington, perhaps in a strategically selected neighborhood in Seattle.

“Social Influences” and “Comprehensive Life Skills”

In addition to the “system-wide change” model, there are two other types of universal school-based prevention approaches that are easier to implement, although they
have shown less promise, especially over the long term. One is the “social influences”
model and the other is the “comprehensive life skills” model. Each is aimed at youth
exhibiting “normative” adolescent behaviors such as experimental drug use.391

The “social influences” programs inform students about the negative short- and long-
term consequences of drug use, provide information to change the perception that “everyone
is doing it,” and examine pro-drug media influences. In an interactive setting, students use
role-playing, rehearsals, immediate feedback and positive reinforcement from peers to build
a set of “refusal” skills.392

One of the most comprehensive prevention efforts using the “social influences”
approach is the STAR Project, initiated in Kansas City in the mid-1980s and replicated
in Indianapolis. The STAR Project involves schools, mass media, parents, community
volunteers and health policymakers. Classroom sessions seek to teach resistance skills and
to clarify misperceptions about drug use. Classroom teaching is reinforced with community
prevention efforts (such as better monitoring of convenience stores and other outlets for
alcohol) and media campaigns, and also with structured at-home discussions between
parents and their children about alcohol and other drugs.393 Formal evaluation of the STAR
program showed reductions in tobacco and marijuana use among middle school students,
including among “high-risk” students.394 The classroom instruction was deemed the most
essential element of the program, as the media and community prevention efforts would
have had little effect without “high-quality prevention teaching.”395 This suggests that the
classroom setting might be the most effective environment for drug education, at least for
middle school students.

Another noteworthy program following the “social influences” model is Project
ALERT (Adolescent Learning Experiences in Resistance Training), developed at the
RAND Corporation, and replicated in many locations. The ALERT program provides a
two-year period of classroom lessons in a specific sequence taught by trained teachers and
counselors to middle school students. Parent involvement is included through a home-
learning program. The program emphasizes resisting pro-drug social influences and
attempts to show that students overestimate the frequency and/or quantity of drug use by
their peers.396 Evaluation of Project ALERT has shown some beneficial effects on alcohol
use, but no effect on tobacco use.397

The “comprehensive life skills” programs are similar to the “social influences”
model, but in addition to helping foster students’ interpersonal skills (such as refusal skills),
the “comprehensive life skills” programs attempt to impart a broader spectrum of skills such
as assertiveness, decision-making, coping, communicating and goal setting – skills built on
the more intrapersonal sense of competence.398

The most well-known and long-standing “comprehensive life skills” program is the
Life Skills Training (LST) program, developed more than 20 years ago at Cornell
University and implemented in many school districts across the country. The LST program reports marked decreases in alcohol, tobacco and marijuana use among participating youth, but those findings have lately been called into question, particularly because of the evaluation methodology. Recent independent analysis has shown the LST program yielding some beneficial effects with regard to teen tobacco use, but no favorable long-term effects with alcohol use. The D.A.R.E. program, in its current attempt to refashion itself as a more interactive program, is borrowing pages from the LST playbook, but this Task Force is skeptical about the prospects for the new D.A.R.E. model because of the questions surrounding the effectiveness of the LST program, among other reasons.

APPENDIX B
Unique Opportunities in Washington State – Targeted Programs

Washington is a national leader in the current effort to design and implement prevention programs intended for higher-risk youth. Three programs developed at the University of Washington have been recognized by the National Institute on Drug Abuse, the U. S. Department of Education, the U. S. Department of Health and Human Services and the Office of National Drug Control Policy as some of the most promising strategies in the country aimed at preventing substance abuse and other problem behaviors:

**Incredible Years**

The Incredible Years program is designed for pre-school and elementary school settings, focusing on children who are experiencing conduct problems, such as aggression, non-compliance and defiance, behaviors that are predictive of delinquency, violence and other antisocial behavior. The training series includes separate curricula for parents, teachers and children, all with the goal of promoting children’s social adjustment and competence. Workshop leaders are trained and certified and there is extensive collaboration with school administrators, day care facilities and clinicians. Formal evaluation of the program has shown reduced levels of aggressiveness, impulsiveness and defiance, particularly for children who live in conditions of deprivation and/or in distressed family situations, including divorce and child abuse and neglect. The federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) has noted an increase in conduct problems among more children at earlier ages and has expressed particular concern over escalating aggression in pre-school and elementary school. OJJDP has highlighted the Incredible Years program as a model prevention strategy for such children, and the program has been adopted by hundreds of agencies serving youth in 43 states.

**Reconnecting Youth**

Developed at the University of Washington School of Nursing, the Reconnecting Youth program is a high school dropout, suicide and substance abuse prevention program, featuring a semester-long curriculum designed to promote school performance, to decrease involvement with alcohol and other drugs, and to improve mood management. Taken as a separate class in school, the program offers opportunities for healthy activities, including parent involvement. Evaluation of the program has shown significant results with improved school performance and decreased drug involvement, depression, anger and aggression and suicidal and self-destructive behaviors.

**Social Development Research Group**

Established in 1981 at the University of Washington School of Social Work, the
Social Development Research Group has been conducting the Seattle Social Development Project as a research-based program to reduce school failure, delinquency and substance abuse. The program is designed to be a universal prevention program, although the research on which it is based – the seminal work on the risk factor/protective factor paradigm – was originally focused on high-risk children.\textsuperscript{405}

The Seattle Social Development Project is intended for an elementary classroom setting, including all grades from first through sixth. The program’s instructional curriculum aims to strengthen bonds between children, families and schools. Children are taught to work in cooperative learning groups, parents are taught to monitor, reward and discipline their children, and teachers are specially trained in classroom management techniques so as to resolve conflict and maintain order. Initial evaluations of the project showed reductions in school expulsions, delinquent behavior and alcohol use, and girls in the program delayed their alcohol, tobacco and other drug use.\textsuperscript{406} More recently, the Washington State Institute for Public Policy conducted an independent cost-effectiveness analysis of the Seattle Social Development Project and found that the program would save the taxpayer $3,268 for each participant, the difference between the cost of the program and the estimated avoided criminal justice costs.\textsuperscript{407

APPENDIX C

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State of Washington: Current Prevention Strategies and Programs

Washington State’s 1994 Violence Prevention Act created the Community Public Health and Safety Networks and directed them to focus efforts on eight, specific at-risk youth behaviors, including: teenage pregnancy, suicide, substance abuse, dropping out of school, violence, child abuse/neglect, domestic violence and out-of-home placements. Relevant state agencies also address these same concerns through many of their programs and activities.

The State Division of Alcohol and Substance Abuse (DASA) is the primary state agency designated to develop drug abuse prevention strategies. Its two main prevention goals are to delay the onset of use and to reduce the misuse of alcohol, tobacco and other drugs. DASA has adopted a “risk and protective factor” approach as the cornerstone of its efforts to prevent alcohol and other drug abuse by children and adolescents in Washington State. DASA’s prevention programs include the following:

- **DASA Prevention Services**

  Prevention services are designed to reduce the incidence of new chemical dependency and early intervention of early users. DASA primarily contracts with 36 counties and has government-to-government agreements with tribal nations. Services are tied to risk factors. Additionally, DASA provides funds for individual training events on reducing risk factors and increasing protective factors. One of the primary performance measures for this program is to increase the number of 6th, 8th and 10th graders who abstain from using alcohol, tobacco or marijuana for a 30-day period. DASA also passes funds to the Office of the Superintendent of Public Instruction for substance abuse prevention services for grades K-12. Funding for all of these services totaled almost $16 million for the 1999-2001 biennium.

- **Children’s Transition Initiative (CTI)**

  Based on statewide risk and protective factor data, and prevalence data collected through the 1998 Washington State Adolescent Health Behavior Survey, DASA has begun piloting a new Children’s Transition Initiative (CTI), the goal of which is to prevent children, ages 9-16, from using alcohol, tobacco and other drugs. Through CTI, existing county programs will identify discrete youth populations at high risk for drug initiation. Prevention programming will be specifically tailored for each group, depending on their individual risk factors, protective factors and assets. To date, more than 100 children and families have been enrolled into CTI services in Clark, Ferry, Lewis, Pierce, Columbia, Spokane and Grant counties. The DASA budget for CTI for the 2001-2003 biennium is $380,000.

- **Drug Information Clearinghouse**
DASA contracts with the Washington State Alcohol & Drug Clearinghouse to provide communities, schools and individuals with access to information about alcohol, tobacco and other drugs. Available resources include videos, posters and written materials. The budget for this program for the 2001-2003 biennium is $380,000.

· **Community Prevention Training System**

DASA provides training support and funds to county and tribal prevention programs through DASA’s Regional Prevention Managers. This program, established in 1994, was budgeted at $340,000 for the 1999-2001 biennium.

· **Washington State Substance Abuse College Task Force**

The mission of the task force is to provide support for the development and continuation of substance abuse prevention programs on all college and university campuses in Washington through networking, technical assistance and an annual conference. The program was established in 1985, and since 1988 has been funded by DASA for travel, training, and administrative assistance. The 2001-2003 budget is $40,000.

Other state-sponsored prevention programs and activities are conducted by the Department of Community, Trade and Economic Development and the Office of the Superintendent of Public Instruction, including the following:

· **Community Mobilization Against Substance Abuse and Violence**

This program makes grants to local communities to develop and implement comprehensive strategies to reduce the demand and supply of illegal drugs and the misuse of alcohol and tobacco by minors. The program received $6 million in funding during the 1991-2001 biennium.

· **Prevention and Intervention Services Program (PISP)**

PISP is a school-based drug and alcohol abuse prevention and early intervention program. Intervention specialists assist K-12 students to overcome problems of substance abuse and strive to prevent the abuse of and addiction to alcohol and other drugs, including nicotine. The goal of the program is to provide prevention and intervention services in schools to enhance the classroom environment for students and teachers and better enable students to realize their academic and personal potentials. This program received funding of $10.2 million during 1999-2001 biennium.

· **Safe and Drug-Free Schools**
This program provides tobacco, alcohol and other drug and violence prevention activities in schools throughout the state. A variety of programs focused on increasing safety and improving school climate are funded through this program. Funding amounted to $10.6 million during the 1999-2001 biennium.

· Alcohol Awareness and Parent Training

Eight school districts have been awarded grants for the purpose of providing training for parents regarding how to communicate effectively with their children. Grades K through 3 are especially targeted. Funding for this initiative amounted to $300,000 during the 1999-2001 biennium.

· State Incentive Grant

In July 1998, Washington State received a 4-year, $8.9 million State Incentive Grant (SIG) from the federal Center for Substance Abuse Prevention to fund initiatives to reduce use of alcohol, tobacco, marijuana and other drugs, to reduce factors that put youth (grades 4-10) at risk for substance abuse and to enhance factors that provide protection for youth against these risks. DASA is the lead agency for managing this grant, with the Department of Social and Health Service’s Research and Data Analysis Division as the primary evaluator. In March 1999, the Governor issued a Washington State Substance Abuse Prevention Plan, and state agencies participating in SIG are engaged in the process of changing the system by which substance abuse prevention services are planned, funded, delivered and monitored in this state. 18 community projects in 15 counties are currently receiving SIG funding.

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ENDNOTES

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Introduction

1 See, e.g., U.S. Department of Health and Human Services (1999), Understanding Substance Abuse Prevention, Toward the 21st Century: A Primer of Effective Programs, monograph, Center for Substance Abuse Prevention (CSAP), Washington, D.C., p. 7. CSAP also includes limitations on tobacco and alcohol advertising as a prevention approach, but such measures have been invalidated recently by the U.S. Supreme Court. See Lorillard Tobacco Company et al. v. Reilly, Attorney General of Massachusetts et al., 121 Sup. Ct. 2404, 533 U.S. ___ (2001).

2 As a guide to its analysis, the Sanctions Task Force looked to the stated purposes of Washington’s Sentencing Reform Act, which include:
   1) proportionality of punishment to the seriousness of the offense;
   2) promotion of justice and respect for the law;
   3) commensurate treatment of similarly-situated offenders;
   4) protection of the public;
   5) opportunities for offenders to improve themselves;
   6) frugal use of state and local resources; and
   7) reducing the risk of re-offending in the community.

   See RCW 9.94A.010.

3 The word “drug” has been defined in its most general sense as “any substance other than food, which by its chemical nature affects the structure or function of the living organism.” See Raymond P. Shafer et al. (1973), Drug Use in America: Problem in Perspective, Second Report, National Commission on Marijuana and Drug Abuse, USGPO, Washington, D.C., p. 9. For the purpose of public policy analysis, the word “drug” has been more narrowly defined as “any psychoactive substance capable of being used recreationally.” Franklin E. Zimring and Gordon Hawkins (1992), The Search for Rational Drug Control, Cambridge University Press, Cambridge, p. 31. These definitions make no distinction between licit and illicit substances, because of the confusion inherent in attempting to make legality a criterion for classifying a substance as a “drug.” Ibid, p. 32. However, for purposes of the discussion in Sections II and III of this report, the word “drug” should be understood in an even narrower sense, as any psychoactive substance whose sale and possession are prohibited by current law. This, essentially, describes those substances that are the focus of the “War on Drugs.”

4 See RCW 70.96A.020.

5 Among scholars and public officials who work every day in the field, the term “prevention” is a term of art that is understood to mean youth-oriented intervention to prevent or delay drug use, not preventing adult drug use through law enforcement or other coercive means. The “War on Drugs” could be colloquially understood as an effort to prevent drug use, but prevention science is well established as a discipline aimed at problem behaviors of youth. Specific programs aimed at “preventing” adult drug abuse, particularly employer-sponsored “employee assistance programs,” fall more into the category of drug addiction treatment rather than preventing or delaying the initiation of drug use, and therefore fall outside the scope of this report.

6 As “legal” drugs available to adults, alcohol and tobacco are not targeted by the War on Drugs (which is the principal focus of the King County Bar Association’s Drug Policy Project). However, the research highlighted in Section I indicates that alcohol and tobacco use by children and adolescents is highly associated with the use and abuse of other drugs, as well as low academic achievement and school dropout, early pregnancy and parenthood, stealing and other delinquent behavior and the use of predatory and domestic violence. The Prevention Task Force found that any discussion of drug abuse prevention must prominently include alcohol and tobacco.

Conclusions and Recommendations

7 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.

8 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
The consensus statement calls for broader access to methadone maintenance programs, and recommends that physicians and pharmacies be allowed to dispense methadone.

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.

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 (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2000), p. 237.


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.


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 is whether a prisoner started on methadone in prison would have access to continued treatment on release.

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 in the 2001 session.

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. “For 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, (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 1999), p. xv.

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

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.

Section I  Effective Drug Abuse Prevention: Keeping Our Youth Out of Trouble

These two pillars of current drug policy provide the framework for the most widely used prevention program, the D.A.R.E. program (discussed at length in this section), in which police officers attempt to convey the “abstinence-only” message to school children.


See, e.g., D. Huizing, R. Loeber et al. (2000), Co-occurrence of Delinquency and Other Problem Behaviors, U.S. Department of Justice, Washington, D.C., p. 2. Other studies that have followed the development of youth over time have even concluded that adolescents who experiment with illicit drugs are “psychologically


26 Added to the immediate risks of juvenile drug abuse are the longer-range implications for youths who continue to abuse alcohol and other drugs into adult life, including higher risks of adult lung cancer and coronary disease, HIV/AIDS, violent crime (especially related to alcohol), child abuse and neglect, and unemployment. See the landmark study by J. David Hawkins et al. (1992), “Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention,” Psychological Bulletin, vol. 112, no. 1, p. 64.


28 The heightened risks associated with early substance use by children have been illustrated recently by a number of researchers, including Nels Ericson (2001), in Substance Abuse: The Nation’s Number One Health Problem, U.S. Department of Justice, Washington, D.C., who found that more than 40 percent of youth who start drinking alcohol at age 14 or younger develop alcohol dependence, compared with 10 percent of youth who begin drinking at age 20 or older. See also Bridget Grant and Deborah Dawson (1997), “Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence,” Journal of Substance Abuse, 9, who demonstrate that each year of avoiding alcohol use significantly decreases the risk of future dependence, at p. 103. See also Phyllis Elickson et al. (1998), “Does Early Use Increase the Risk of Dropping Out of High School?” in Journal of Drug Issues, vol. 28, no. 2, who reveal that early use of tobacco by Caucasian, African-American and Asian-American students is a predictor of dropping out of school and that early use of marijuana by Latino students is a predictor of dropping out of school.


33 Nels Ericson (2001), op. cit., p. 2.


36 University of Michigan (2000), Monitoring the Future, op. cit.

37 Ibid.


42 The federal government presents many statistics related to illegal drug use as support for its drug law enforcement policy, but a close inspection reveals those statistics to be “soft facts.” As the statistician Joel
Best states: “They are basically guesses and, because having a big drug problem makes the agencies’ work seem more important, the officials’ guesses tend to exaggerate the problem’s size….When it is difficult to measure a social problem accurately, guessing offers a solution; and there usually are advantages to guessing high.” Joel Best (2001), Damned Lies and Statistics: Untangling Numbers from the Media, Politicians and Activists, University of California Press, Berkeley, CA, p. 38.


Only 30 percent of African-American students reported using marijuana in the last year, compared with 40 percent of white students. In addition, white students were seven times more likely than African Americans to have used cocaine in the past year and three times as likely to have ever tried heroin. See Office of Juvenile Justice and Delinquency Prevention (1999), Juvenile Offenders and Victims, 1999 National Report, U. S. Department of Justice, Washington, D. C., pp. 58-59, 70-71.

African-American youth account for a disproportionately high 29 percent of all arrests for “drug abuse violations.” Although the same is thought to be true for Latino youth, there is no reliable data because Latinos are not classified separately from “whites.” See Federal Bureau of Investigation (2000), op. cit., pp. 230-232.

Office of Juvenile Justice and Delinquency Prevention (1999), Juvenile Offenders and Victims, op. cit., citing a study by Mark Cohen estimating the external marginal costs imposed on society by the average career criminal, heavy drug abuser and high school dropout. For drug abuse, the present value (i.e., the amount needed to be invested today to cover the future cost) is between $150,000 and $360,000. This figure does not include costs associated with drug-motivated and other drug-related crime, estimated at between $220,000 and $600,000 per youth, discounted to present value.


The risk factor-protective factor approach has been developed by J. David Hawkins, Richard Catalano and associates from the Social Development Research Group at the University of Washington. The U. S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration) and the National Institute on Drug Abuse, as well as the Washington State Division of Alcohol and Substance Abuse, have each incorporated this concept into their programs, including needs assessments and the development and evaluation of drug abuse prevention programs.


Levels of risk in the community are assessed by measures such as the number of alcohol retail and tobacco sales licenses, the community perception of the availability of illegal drugs, the numbers of children receiving free lunch at school, the number of food stamp recipients, the number of low birthweight babies born, the level of unemployment, the number of community members in jail and prison, the level of residential vacancy and the percentage of households in rental properties.

In addition to harsh and arbitrary parenting, risk factors in the family domain include domestic violence and divorce, unstable foster care arrangements and other situations where children live away from their parents.


Linda Becker, Ph.D., Maija Sandberg, Vera Barga and Monica Stanley (2000), Risk and Protection Profile for Substance Abuse Prevention Planning in Washington State, Division of Alcohol and Substance Abuse, Olympia, WA, p. 22.

For example, the Center on Addiction and Substance Abuse reports that teenagers consider marijuana easier to obtain than beer. See Luntz Research (1996), National Survey of American Attitudes on Substance Abuse II: Teens and Their Parents, National Center on Addiction and Substance Abuse, Columbia University, New York.

The King County Bar Association’s Task Force on the Use of Criminal Sanctions surveyed alternative models for drug control, including state regulatory regimes that would more effectively reduce the availability of alcohol, tobacco and other drugs to minors.


Ibid.

See J. David Hawkins, Richard Catalano et al. (1992), Communities That Care, op. cit. “Pro-social” institutions include civic and religious organizations, scouting groups and school clubs and athletic teams.
A key to preventing problem behavior in children is teaching them self-control. A more child-centered approach to teaching problem solving and conflict resolution, whereby children learn to control their own behavior, has proven more effective than direct adult control of children’s behavior.

See, e.g., P. Reuter, R. MacCoun and P. Murphy (1990), Money from Crime: A Study of the Economics of Drug Dealing in Washington, D.C., RAND, Washington, D.C., who found that most individuals first engage in criminal activities, including theft, as juveniles, a year or two before they become drug users.

For example, the Reconnecting Youth program (briefly reviewed in Appendix B of this report), developed by the University of Washington School of Nursing, is an intervention that focuses on preventing drug abuse and high school dropout. 40% of the youth in that program have also been very depressed and/or thinking about suicide. By dealing simultaneously with multiple problem behaviors that tend to co-occur, the Reconnecting Youth program has shown significant results in suicide prevention as well as drug abuse prevention. See L. L. Eggert and B. P. Randell (forthcoming), “Drug Prevention Research for Youth at High Risk,” in W. J. Bukoski and Z. Sloboda, Handbook of Drug Abuse Theory, Science and Practice, Plenum Books, New York; and also L. L. Eggert et al. (forthcoming), “Reconnecting Youth to Prevent Drug Abuse, School Dropout, and Suicidal Behaviors Among High-Risk Youth,” in E. Wagner and H. B. Waldron, eds., Innovations in Adolescent Substance Abuse Intervention, Elsevier Science, Oxford, England.

Alcohol use is prevalent particularly among adolescent males, and tobacco use is most prevalent among adolescent females. Nels Ericson (2001), op. cit., p. 2.

According to a 1999 national survey, more than 40 percent of youth cigarette smokers report using illicit drugs in the past month, compared to less than 6 percent of non-smokers. Similarly, almost 67 percent of juveniles who regularly drink alcohol report illicit drug use in the past month, compared to less than 6 percent of non-drinkers. Substance Abuse and Mental Health Services Administration (2000), Summary of Findings from the 1999 National Household Survey on Drug Abuse, U.S. Department of Health and Human Services, Rockville, MD, p. 15. The same survey revealed that alcohol and tobacco use by minors generally occurs earlier than the use of other illicit substances – the mean age of first cigarette use was 15.4 years old and the mean age of first alcohol use was 16.1 years old, compared to the mean age of first marijuana use at 17.2 years old.

For a comprehensive review of earlier school-based prevention programs, see Gilbert J. Botvin (1990), Substance Abuse Prevention: Theory, Practice and Effectiveness, in Michael Tonry and James Q. Wilson, eds., Drugs and Crime, University of Chicago Press, Chicago, pp. 461-519.


Huizing et al. (2000), op. cit., p. 5.


Section II  Drug Addiction Treatment:  The Need for Resources

97 Thomas Wickizer (1999), 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. 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.” Ibid., at p. 14.

98 Ibid., at p. 18.
99 Shoveling Up: The Impact of Substance Abuse on State Budgets (2001), National Center on Addiction and Substance Abuse, Columbia University, New York, p. 75. 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).
100 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).
101 Ibid., at p. 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).
102 Spokane Quarterly Report, July 1999, Arrestee Drug Abuse Monitoring Program (ADAM). (The Spokane report lists some figures for Seattle as well as for Spokane.)
103 “[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 (2001), National Research Council, p. 2.
104 The disparate impact of drug enforcement on different racial populations is 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.)
105 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.
106 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. 1 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).
107 Issues related to the use of criminal sanctions are the subject of a separate task force report.

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.

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.

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.

NIDA Principles of Drug Addiction Treatment at 15-16.


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


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.

Norm Maleng, *Beyond the “War”*: Using the Criminal Justice System to Bring Addicts Into Treatment. The statement is 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.)


*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 Marlett, ed., *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* (The Guilford Press 1998).

“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.”

In its discussion of maintenance treatment with methadone and LAAM, Treatment 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.

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.

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

Norm Maleng, Beyond the “War”: Using the Criminal Justice System to Bring Addicts into Treatment 2 (February 2001).


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

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 were given a briefing by staff involved in the DOC addiction treatment program.

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).

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

These figures were supplied by the King County Drug Court program administrator.

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 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.

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.

These figures were supplied by the King County Juvenile Drug Court manager.

Other problems mentioned to Treatment 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. Treatment 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 Treatment 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.

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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
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 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).”

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.

139 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. Seeooky 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.
Preventive Services Task Force

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treatment a precondition for resumption of parental responsibilities.

ineligible for ADATSA treatment if he or she has “abstained from alcohol and drug use for t

licensure to use opiate replacement therapy in the treatment of opiate addiction to the extent that such

following resolution: “The WSPA resolves that the State of Washington reduce impediments to physician

profession from providing treatment for opiate addicted patients.” EC Rpt. J, A-96. The latter issue has also

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HIV infection. The WSMA supports legislation assuring rapid access to comprehensive methadone treatm

children often prevents them from seeking treatment on their own. As a consequence, by the time they come to

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


140 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.

141 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 come to

the attention of the child welfare system their addiction is usually far advanced. In addition, according to HHS,

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women, such as sexual abuse, domestic violence, child care, and health problems.” Id. at 16. The report is


142 RCW 13.34.020.

143 RCW 13.34.130(2).

144 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.

145 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.

146 See RCW 48.44.023, RCW 48.46.066 and RCW 48.21.045.

147 WAC 284-53-010.

148 Washington State Register 99-11-103.

149 “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, Piscatway, N.J. Rutgers University,

1993.” The footnote is from the Insurance Commissioner’s Office notice.

150 Id.

151 Washington State Register 99-11-103.

152 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.

153 Id. For the consensus view, the authors cited the Guide to clinical preventive services: report of the U.S.


Services, Office of Public Health and Science, Office of Disease Prevention and Health Promotion.

154 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.

155 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.

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.

Section III  The Use of Criminal Sanctions:
How Effective and How Appropriate?

157 Pub.L. 91-513, Oct. 27, 1970, 84 Stat. 1236. The stated premise for passage of the legislation was that “the
illegal importation, manufacture, distribution, and possession and improper use of controlled substances have a

158 1st Ex. Sess., c. 308, Laws of 1971; codified in chapter 69.50 RCW.


160 Drug-related criminal penalties are most harsh in New York, Michigan, Nevada, Louisiana and other states
in the South, and Washington's drug laws also impose stiff penalties. For example, the possession of small
amounts of illegal drugs is a misdemeanor under federal and most state laws, but drug possession offenses in
Washington are felonies irrespective of the amount of drugs possessed.


162 Washington sentencing “grid” may be found at RCW 9.94A.510, Table 1 and felony sentences are ranked
by their level of seriousness in RCW 9.94A.515, Table 2. The rules for “scoring” an offender’s criminal
history are found in RCW 9.94A.525.


164 For technical reasons related to sentencing calculation, the term “drug offense” is defined under Washington
law to exclude possession of controlled substances and forged prescriptions. RCW 9.94A.030(20)(a).
However, in this report, unless otherwise stated, the term “drug offense” should be understood, by its plain
meaning, to include all drug crimes, including the manufacture, sale and possession of illegal drugs.

165 Both second-degree robbery and assault are classified as violent offenses, and both are also included on the
list of offenses that constitute “strikes” in an offender’s criminal history record, under Washington’s “three
strikes and you’re out” law (c. 129, Laws of 1995). The “three strikes” provision requires life imprisonment
without the possibility of release after three convictions of “most serious offenses,” which includes Robbery 2º
and Assault 2º, but not drug any offenses. Nevertheless, an individual conviction of Robbery 2º or Assault 2º
carries only a six-month jail sentence for a first-time offender.

166 See the felony rankings in RCW 9.94A.515, Table 2.

167 Along with drug offenses, violent and sex offenses are assigned more than one point per conviction. Prior
violent offenses such as robbery and assault earn two points and prior “serious violent” offenses, such as
Murder 1º and Rape 1º, count for three points, as do most prior sex offenses. Otherwise, most offenses score
only one point. See RCW 9.94A.525.

168 “Manufacture, Delivery or Possession with Intent to Deliver Heroin or Cocaine,” RCW 69.50.401(a)(1)(i).

169 RCW 69.50.408. A drug offender could receive such a long sentence in cases where other prior felony
convictions result in a higher criminal history score and where the offender in concurrently convicted and
sentenced for one or other felonies.

170 A recent study by the Washington Sentencing Guidelines Commission found not only that drug offenders
have the highest recidivism rate, but also that they tend to commit further drug offenses and non-violent property offenses, rather than crimes of violence. See State of Washington, Sentencing Guidelines Commission (2000), Recidivism of Offenders Targeted by the Offender Accountability Act, Olympia, WA.

The "school zone enhancement" does not require the defendant to be accused of selling drugs to minors. That is a separate offense. This "enhancement"lengthens the prison term for drug offenses committed near schools, as well as school bus stops and public parks. RCW 69.50.435(a)(3). The use of the school zone enhancement is available for prosecutors to use against accused drug offenders in almost every part of Seattle, since there are very few areas, if any, that are not within a designated "protected" zone. Task Force members expressed particular concern about the school zone enhancement, noting that there is little or no notice of the physical boundaries of such zones and that the sentence enhancement applies even during non-school hours and days. Task Force members noted that the possible addition of 2 years to a defendant’s sentence is often used by prosecutors to induce a plea agreement, even when the accused has an available defense but must avoid the risk of receiving the sentence enhancement, should the state prevail at trial.

RCW 9.94A.728
Chapter 437-20 WAC, Community Custody Ranges.
RCW 9.94A.715; RCW 9.94A.720.
RCW 9.94A.737
Public Broadcasting System (2000), Frontline program entitled “Snitch.” Comment from Eric Sterling, counsel to the U.S. House Judiciary Committee when the mandatory minimum drug sentences were enacted.
Federal law distinguishes between powder cocaine and "crack" cocaine, with a 100-to-1 ratio in the severity level between the two substances, so that the penalty for five grams of crack cocaine, for instance, is equivalent to the penalty for half a kilo of powder cocaine. Currently a federal offender convicted of simple possession – not trafficking – of five or more grams of crack cocaine is subject to a five-year minimum sentence. This controversial provision has long been criticized as having a disproportionately adverse effect on the inner-city poor and racial minorities. However, even in the face of equal protection and due process challenges, the law has been upheld in the federal courts. See, e.g., U.S. v. Frazier, 981 F.2d 92 (3d Cir. 1992), cert denied, 113 S. Ct. 1661 (1993); U.S. v. Harding, 971 F.2d 410 (9th Cir. 1992), cert. denied, 113 S. Ct. 1025 (1993); and U.S. v. Watson, 953 F.2d 895 (5th Cir. 1991), cert. denied, 112 S. Ct. 1989 (1992).
Ibid.
Before 1989, first-time offenders convicted of heroin or cocaine delivery faced a 12- to 14-month prison sentence. Today, such first-time offenders are subject to a 21- to 27-month prison term. More recently, the legislature has also increased penalties for other drug offenses. For instance, a first-time conviction for manufacturing methamphetamine now calls for a five-year prison sentence. HB 2628, c. 290, Laws of 1998.
State of Washington, Caseload Forecast Council (1999), Inmate Population Forecast, Olympia, WA.
Washington Department of Corrections, Offender-Based Tracking System report, as of December 31, 2000
DOSA offenders are sentenced to serve the first half of their sentence in total confinement and the second half in “community custody,” supervised by the Department of Corrections, and are required to complete a
program of drug treatment that begins in prison and is continued in the community setting. Offenders failing to complete drug treatment are returned to prison to serve the remainder of the original sentence. See RCW 9.94A.607.

Information obtained from the DOSA Program Manager at the Washington Department of Corrections.

U.S. Department of Justice (2001), op. cit. In 1999, 21 percent of federal drug offenders were exempted from mandatory minimum sentences, but were still sentenced to multi-year prison terms.

Drug delivery offenders are ineligible for the “First-time Offender Waiver,” a discretionary option for non-violent offenders that allows an alternative to incarceration. See RCW 9.94A.650(1)(b),(c) and (d).

According to the Washington Department of Corrections, about 2,500 inmates have participated in the DOSA program, of whom about 1,000 have been released. Today, there are about 750 DOSA participants in prison, out of about 3,175 drug offenders in prison. The county-level drug courts have diverted a much smaller percentage of offenders away from jail or prison – only about 10 percent in King County, for example. In the county jails themselves, there are very few opportunities for drug treatment.

The Washington Department of Corrections estimates that only about one-fifth of all offenders needing drug treatment actually receive it. Meanwhile, both in prisons and county jails, virtually no non-drug offenders with chemical dependency problems receive any treatment. The issue of lack of treatment opportunities for incarcerated persons is discussed at length in the report of the King County Bar Association’s Task Force on Drug Addiction Treatment.

Task Force members acknowledge that the “effectiveness” of criminal sanctions cannot be assessed in any scientifically valid manner, but believe that statistics related to drug use, drug-related crime and the direct and indirect costs of law enforcement are, at the very least, instructive in considering the utility of drug-related criminal sanctions.

National Research Council (2001), Informing America’s Policy on Illegal Drugs: What We Don’t Know Keeps Hurting Us, National Academy Press, Washington, D.C. The report found that, in the absence of reliable data on drug consumption, it has been difficult to assess whether criminal enforcement of drug laws has had any effect in reducing the overall problem. The chair of the National Research Council panel that issued the report, economist Charles F. Manski, stated: “It is unconscionable for this country to continue to carry out a public policy of this magnitude and cost without knowing whether it is having the desired result.” National Research Council news release, March 29, 2001


Ibid. Although no data are available from Washington regarding past 30-day use of “hard” drugs, 4.3 percent of adults in Washington report having used “hard” drugs in the last year. Ibid., p. 47.

Executive Office of the President, Office of National Drug Control Policy (1999), Drug Use Trends, p. 3.

The phenomenon of a decline in drug use prior to the imposition of criminal sanctions has occurred before in the United States. Opium consumption declined significantly in the first decade of the 20th century, in advance of the passage of the Harrison Narcotics Act of 1914. The growing public understanding of the harmful effects of opium seemed to have more effect on use than criminal penalties. See David F. Musto, M.D. (1987), The American Disease: Origins of Narcotic Control, p. 3; and David Courtwright (1982), Dark Paradise: Opiate Addiction in America Before 1940, Harvard University Press, Cambridge, MA.

From a public health perspective, drug abuse has been defined as the “regular or compulsive ingestion of illicit drugs taken in substantial doses or concentrated form.” Diana R. Gordon (1994), The Return of the Dangerous Classes: Drug Prohibition and Policy Politics, W. W. Norton & Co., New York, p. 9. Other definitions of drug abuse include the notion of addiction and dependence, whereby drug use “assumes a functional importance for the individual concerned, such that it renders his or her other social roles and preferences increasingly unimportant.” Franklin E. Zimring and Gordon Hawkins (1992), op. cit., p. 32.

Federal regulations that predate the Controlled Substances Act express the assumption that the non-medical use of controlled substances is, ipso facto, abuse, stating that “a substance has the potential for abuse [if]…individuals are taking the drugs on their own initiative rather than on the basis of medical advice.” 21 C.F.R. § 166.2(e)(3) (repealed).


The Sanctions Task Force discussed at length how the blurred line between drug use and drug abuse under the law raises fundamental normative and moral questions that are at the center of the debate over current drug
policy, highlighting the tension between the exercise of individual liberties and the coercive power of the state. 


This does not include the five or more percent of the population addicted to alcohol. David F. Musto, M.D. (1987), op. cit., p. 261.


Seattle-King County Department of Health (2001), Confronting the Problem of Heroin Abuse in Seattle and King County, Heroin Task Force Report, Seattle, WA.

Washington ranks second in the nation behind California in methamphetamine manufacture. According to the Washington State Department of Ecology, almost 1,500 methamphetamine “laboratories” and dump sites were reported in Washington in 2000, a 30-fold increase in the last decade. These sites present a danger to human health and cause extensive environmental damage, especially in King and Pierce counties.

See Elliott Currie (1993), Reckoning: Drugs, the Cities, and the American Future, Hill and Wang, New York, p. 20. Although drug abuse is a serious concern among minorities and the poor, the notion that such problems are concentrated in urban communities is not well founded. Recent data from Washington’s Division of Alcohol and Substance Abuse shows a higher incidence of drug use among those who are employed and/or living above the poverty line. David H. Albert (2001), op. cit., pp. 41, 44, 47 and 48.

Thomas Wickizer (1999), The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996, Department of Social and Health Services, Division of Alcohol and Substance Abuse, Olympia, WA., p. 63.

National Center on Addiction and Substance Abuse (2001), Shoveling Up: The Impact of Substance Abuse on State Budgets, Columbia University, New York, p. 75.

Ibid., p. 75. There are also non-public costs related to drug abuse that are harder to measure, such as increased health insurance premiums related to drug abuse and the loss of and damage to property. Community fragmentation, fear, isolation and other “quality of life” concerns are even less tangible, though no less real. The report of the King County Bar Association’s Task Force on Drug Addiction Treatment more thoroughly examines the costs related to drug abuse.

Thomas Wickizer (1999), op cit. For example, alcohol accounted for 80 percent of diseases resulting in economic loss and 70 percent of premature deaths (overdoses and motor vehicle accidents) and 95 percent of non-medical motor vehicle accident costs (insurance, administration, vehicle damage). pp. 17, 22 and 62.

Thomas Wickizer (1999), op. cit., p. 41.

Ibid., p. ix.


The District of Columbia recently reported that most of the drug and alcohol-related emergency room visits are related to alcohol and not to other drugs. Its survey also revealed that seven percent of the population of the District was addicted to alcohol, compared with 1.8 percent addicted to cocaine and 0.6 percent addicted to heroin. Public Broadcasting System (2001), interview with Dr. Larry Siegel from the D.C. Department of Health, All Things Considered, September 21, 2001.


National Institute on Alcohol Abuse and Alcoholism (1999), “Number of deaths and age-adjusted death rates per 100,000 population for categories of alcohol-related mortality,” Alcohol Epidemiologic Data System, Rockville, MD.


Ibid.

Ibid., pp. 1, 10. “Drug-induced” causes of death include not only deaths from the use of legal drugs (excluding alcohol and tobacco) and illegal drugs, but also poisoning from prescribed and other drugs. Accidents, homicides and other causes indirectly related to drug use are not included.

Police power and individual rights in America date back a century. Washington courts have defined police power as an "essential element of the state's power to govern which cannot be surrendered, in exercise of which the state may prescribe laws intended to promote health, peace, morals, education, good order and the welfare of the people, and the only limitation upon which is that it must reasonably tend to correct some evil or promote some interest of the state, and not violate any direct of positive mandate of the Constitution." [emphasis added] Peden v. City of Seattle, 510 P.2d 1169, 9 Wash.App. 106 (Div. 1, 1973), review denied 82 Wash.2d 1010.

Information obtained from the Washington Department of Corrections’ Offender-Based Tracking System. See, e.g., R. Room and G. Collins, eds. (1983), Alcohol and Inhibition, National Institute of Alcohol Abuse and Alcoholism, Washington, D.C.

Executive Office of the President, Office of National Drug Control Policy (2000), manuscript in publication.


Washington State Caseload Forecast Council (2001), adjusted arrest data from the Washington Association of Sheriffs and Police Chiefs. 1998 is the last year for which arrest data are currently available.

Nationwide, 236,000 drug offenders were sent to state prisons in 1998, compared to only 19,000 in 1980. See Anne M. Piehl, Raymond V. Liedka and Bert Useem (2001), The Crime Control Effects of Incarceration, manuscript in publication.

Thomas Wickizer (1999), op. cit., p. 27.


Ibid. DUI arrests nationwide declined from 1,021,753 to 749,454 during the 1990s.

See especially E2SSB 6259, c. 3, Laws of 1990, which increased criminal penalties for Assault 1º and other “serious violent” offenses, increased the mandatory minimum term for Rape 1º, established “triple scoring” of prior sex offenses in criminal history and reduced the amount of earned early release time available for “serious violent” and Class A sex offenses, among other measures.

Washington State Caseload Forecast Council (2001), adjusted arrest data from the Washington Association of Sheriffs and Police Chiefs. 1998 is the last year for which arrest data are currently available.

Nationwide, 236,000 drug offenders were sent to state prisons in 1998, compared to only 19,000 in 1980. See Anne M. Piehl, Raymond V. Liedka and Bert Useem (2001), The Crime Control Effects of Incarceration, manuscript in publication.

Thomas Wickizer (1999), op. cit., p. 68.

Ibid., pp. 27-36.


Peter Reuter (2001), op. cit., p. 16


Mark Thornton (1991), The Economics of Prohibition, University of Utah Press, Salt Lake City, p. 143.

C. P. Rydell and S. S. Everingham (1994), Controlling Cocaine, RAND Corporation, Santa Monica, Cal., p. xvii. “Societal benefits” include reductions in crime, violence, medical costs and productivity losses.

Ibid., p. 1.

“Police power” has been defined by the Washington courts as an “essential element of the state’s power to govern which cannot be surrendered, in exercise of which the state may prescribe laws intended to promote health, peace, morals, education, good order and the welfare of the people, and the only limitation upon which is that it must reasonably tend to correct some evil or promote some interest of the state, and not violate any direct of positive mandate of the Constitution.” [emphasis added] Peden v. City of Seattle, 510 P.2d 1169, 9 Wash.App. 106 (Div. 1, 1973), review denied 82 Wash.2d 1010. Discussions of the shifting balance between police power and individual rights in America date back a century. See Ernst Freund (1904) Police Power, Public Policy and Constitutional Rights, Callaghan & Co., Chicago, IL; and more recently, Richard A. Epstein (1993), Bargaining with the State, Princeton University Press, Princeton, NJ.


See the statement of purpose in Washington’s Sentencing Reform Act, which states that the punishment

No deaths have ever been recorded as having been directly induced by marijuana. See Janet E. Joy, Stanley J. Watson, Jr. and John A. Benson, Jr. (1999), Marijuana and Medicine: Assessing the Science Base, Institute of Medicine, Division of Neuroscience and Behavioral Research, National Academy Press, Washington, D.C.
must be proportionate to the seriousness of the offense and to the offender’s criminal history. RCW 9.94A.010(1).

Washington’s Sentencing Guidelines Commission is considering whether some punishments for drug offenses are out of proportion to the seriousness of those offenses, and is examining whether a new approach is necessary to deal with drug crime in general. The Commission is considering making new distinctions between different types of drug crimes and drug offenders, including the concept of a sliding scale or a series of degrees of drug crime. State of Washington, Sentencing Guidelines Commission (2000), The Sentencing Reform Act at Century’s End, Olympia, WA, pp. 5-6.


Ibid., p. 371.

Diana R. Gordon (1994), op. cit., p. 106. Similarly, Mark Kleiman has also asserted that the “bite of conscience and the fear of punishment are the two great deterrents,” but that drug use “quiets the conscience and dims foresight,” reducing the deterrent value of shame or punishment. Kleiman (1992), op. cit., p. 47.


The chance of being arrested for drug possession has been estimated at about 1 in 2400. Steven B. Duke and Albert C. Gross (1993), op. cit., p. 226.

Ibid., p. 10


Ibid, p. 3.


David R. Henderson (1991), “A Humane Economist’s Case for Drug Legalization,” 24 U. California, Davis. L. Rev. 3, p. 659. As discussed in the previous section of this report, non-drug crime committed by drug users is difficult to measure, but it is a very real phenomenon. Researchers have found explicit empirical evidence that drug prohibition is directly related to crimes other than illegal drug sale and use. See, e.g., B. D. Johnson, P. J. Goldstein et al. (1985), Taking Care of Business: The Economics of Crime and Heroin Abusers, Lexington Books, Lexington, MA.


Peter Reuter (2001), op. cit., p. 22. The so-called “profit paradox” has been highlighted as one of the fundamental flaws in current drug control strategy, whereby the high cost of illegal drugs – a reflection of the risk of having to evade law enforcement – leads to higher profits, which, in turn, create stronger incentives to continue doing business in illegal drugs. See Eva Bertram, Morris Blachman et al. (1996), Drug War Politics: The Price of Denial, University of California Press, Berkeley, CA, pp. 11-31.

In the 1970s, seizures of up to 200 pounds of heroin were considered impressive, but recently there have been individual seizures of over 15 tons of cocaine. At least three-quarters of all drug shipments would have to be intercepted in order to reduce the profitability of the international drug trade, but it is estimated that current efforts only intercept about 13 percent of heroin shipments and between 28 and 40 percent of cocaine shipments. See U.N. Office for Drug Control and Crime Prevention (1999), Global Illicit Drug Trends 1999, New York, p. 51.

Ibid., p. 86.


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A special exception to the trend of injection-related transmission of HIV/AIDS applies to Washington State, and to Seattle-King County in particular. Washington was a pioneer in the early 1990s in allowing for needle exchanges, which has dramatically reduced the rate of injection-related AIDS transmission to about 4 percent, the lowest in the nation. David H. Albert (2001), op. cit., p. 259.

For instance, the mean purity level of heroin was around six percent in 1987, but up to 37 percent by 1997, and as high as 60 percent in New York City. U.N. Office for Drug Control and Crime Prevention (1999), op. cit., p. 86.

Mark Thornton (1991), op. cit., pp. 89, 145. The relationship between prohibition of drugs and the reduced quality and higher potency of drugs was evident during Prohibition in the 1920s, when bootleggers sometimes used wood alcohol or other substances that resulted in a “powerful poison.” Ibid., p. 105.

Injection drug users have frequently been arrested for possession of syringes that they obtained or intended to return to needle exchange sites. See, e.g., “Manhattan: Needle Suit Can Proceed,” New York Times, Metro Briefing, August 1, 2001.

A highly-regarded physician who is a pain treatment specialist recently stated that “one of the primary reasons for the ineffective treatment of pain is a palpable level of fear among physicians about potential loss of their state medical licenses or federal registrations to prescribe controlled substances….Practitioners prescribe controlled substances in ways that will reduce the likelihood of investigation.” Howard Heit, M.D., F.A.C.P., F.A.S.A.M., letter to U. S. Senator Ron Wyden, September 29, 2001.


The King County Executive recently estimated a $41 million budget shortfall for the upcoming fiscal year, including a $10 million cut to criminal justice and the courts.


United States v. Sokolow, 109 S. Ct. 1581 (1989). In a related development, the Drug Enforcement Administration recently persuaded rail carrier Amtrak to grant computer access to passenger records, which most passengers likely assume to be held in confidence by Amtrak. As reported in the news media, Amtrak’s incentive is a ten percent share of any cash or property seizures made from its customers who fit a “drug courier profile.” Such profiles have been shown in other contexts to be based on invidious criteria such as an individual’s race. See “Amtrak: the great American snitch train,” St. Petersburg Times, June 24, 2001.


See, e.g., U.S. v. Currency in the Amount of $228,536, 895 F.2d 908 (2d Cir. 1990).


Substitute House Bill 1995, enacted in the 2001 legislative session, directed that the state bears the burden.
of proving whether seized assets were derived from illegal drug activity. Previously, this had not been the case with personal property (cars, cash, boats, etc.). SHB 1995 also provided for the award of attorneys’ fees to parties who successfully challenge the government’s forfeiture action. Finally, the bill called for a legislatively-created work group to study further possible changes to Washington’s drug forfeiture statutes.

319 WASH. CONST. art VI, § 3 (amended 1988): RCW 29.01.080.
320 WASH. CONST. art. II, § 7: Id. at art. III, § 25; see also RCW 29.65.010(3).
321 RCW 2.36.070(5).
322 RCW 11.36.010.
323 RCW 11.88.020(3).
324 According to the Washington Department of Corrections, over 3,000 offenders were officially “discharged” in 2000, whereby their civil rights were restored; but about 10,000 offenders were “terminated,” unable to get their civil rights restored because of unpaid legal financial obligations.
327 Peter Reuter (2001), op. cit., pp. 16-17.
329 Official corruption related to drugs has even touched the federal bench, resulting in the impeachment and removal from office of U.S. District Court Judges Nixon (Miss.), Hastings (Fla.) and Aguilar (Cal.).
331 Ibid., p. 35
332 Ibid., p. 8.
334 Steven B. Duke and Albert C. Gross (1993), op. cit., p. 6; see also Kevin Jack Riley (1996), Snow Job? The War Against International Cocaine Trafficking, Transaction Publishers, New Brunswick, NJ, for an account of the corruption of foreign nations that arises from the War on Drugs.
338 Evidence that Osama bin Laden was replenishing his coffers with money from drug trafficking was first reported by CBS News on May 31, 2000.
341 In a number of cases, federal criminal penalties related to drugs have continued to increase. For instance, the United States Sentencing Commission has recommended that equivalency value for the substance MDMA, commonly known as “Ecstasy,” be raised from 35 grams to 1 kilogram of marijuana – a 2857% increase over prior sentencing valuations. The proposed amendment treats Ecstasy as being of comparable seriousness to heroin and with heavier sanctions than powder cocaine. United States Sentencing Commission (2001), Proposed Amendments to the Sentencing Guidelines, January 24, 2001, p. 2.
342 See Norm Maleng, King County Prosecuting Attorney (2001), Beyond the ‘War’: Using the Criminal Justice System to Bring Addicts Into Treatment, A Bold New Approach to Fighting Drug Abuse, testimony before the 2001 Washington State Legislature.
343 Other drug policy reform measures have likewise passed by voter initiative. Eight states – Washington, Alaska, Arizona, Colorado, Oregon, California, Nevada and Maine – have enacted medical marijuana statutes by voter initiative. Similarly, citizen initiatives in Utah and Oregon have been enacted that restrict the civil forfeiture of assets in connection with drug enforcement.
344 Arizona Secretary of State, 1996 election results. Presidential votes in 1996 were split almost evenly between Bill Clinton and Bob Dole – with nearly 8% of the popular vote in Arizona going to Ross Perot.
Following the passage of Proposition 200, the Arizona State legislature passed House Bill 2518, which partially reversed the ballot initiative by barring physicians from prescribing schedule I drugs, such as marijuana, without the approval of the federal Food and Drug Administration and the U. S. Congress. Popular response to this move by the Arizona legislature came in 1998 in the form of Proposition 300, which, by a 57% to 43% margin, invalidated HB 2518 and restored Proposition 200. Opposition to Proposition 300 came largely from law enforcement and pharmaceutical interests, while statements in support came largely from judges, attorneys and physicians.

Arizona Proposition 300.


Ibid.


California Penal Code § 1210.1(d).

California Penal Code § 7

California Legislative Analyst's Office (November 2000), Proposition 36: Drug Treatment Diversion Program Initiative Statute, Figure 1.

Ibid.


Drug Court Clearinghouse and Technical Assistance Project (2001), Summary of Drug Court Activity by State and County, Justice Programs Office, The American University, Washington, D.C., p. 34.

Drug Court Clearinghouse and Technical Assistance Project (1999), Drug Court Activity Update: Summary Information, Justice Programs Office, The American University, Washington, D.C., § II.

Drug Court Clearinghouse and Technical Assistance Project (2001), Summary of Drug Court Activity by State and County, op. cit.

Ibid., p. 33.

King County Superior Court Clerk's Office, King County Drug Diversion Court Program, April 12, 2001.

Ibid.

Evaluation of King County’s drug court in 1998 showed an annual cost avoidance of $522,000 (including costs that would have occurred if the cases had been adjudicated in the traditional manner, as well as savings associated with reduced recidivism). Nine percent of drug court “graduates” were re-arrested for a felony, compared to 33 percent of offenders who opted not to participate in the drug court program. See M. M. Bell, Inc. (1998), King County Drug Court Evaluation: Final Report, Seattle, WA. Statewide, drug courts have been estimated to save Washington taxpayers approximately $2.45 for each dollar spent. See Washington State Institute for Public Policy (1999), Can Drug Courts Save Money for Washington State Taxpayers?, Olympia, WA.


Information provided to the Task Force by the King County Drug Diversion Court program administrator.

4,258 drug cases were filed in King County in 2000, of which 1,281 were drug delivery cases and 2,607 were drug possession cases. Figures provided by the King County Drug Diversion Court program administrator.


Nevada recently reduced penalties for marijuana possession.

There have been efforts to ameliorate New York State’s mandatory minimum sentences known as the “Rockefeller drug laws,” although no measure has yet been enacted.

Connecticut Public Act No. 01-99, Substitute Senate Bill No. 1160, gives judges discretion to waive the state’s mandatory minimum sentences for drug offenders in individual cases.

Louisiana Senate Bill 239, enacted this year, reduced sentences for drug offenses and other offenses.

House Enrolled Act No. 1892, Indiana General Assembly, 112th Indiana General Assembly (2001), permits drug-dependent defendants charged with or convicted of drug law violations to receive treatment instead of prosecution or imprisonment with “the consent of the authorities concerned.”

Senate Bill 317, New Mexico, 45th Legislature, First Session 2001.

Ibid.
public to be “more compassionate than condemnatory,” as a majority of Americans (52 percent) believe that drug use should be treated as a disease, compared to 35 percent who favor treating it as a crime. The Pew Research Center for the People and the Press, *Drug War Report*, March 21, 2001.

There are actually more sophisticated distinctions between interest groups in the drug policy debate, characterized by one commentator as the “progressive legalizers,” the “progressive prohibitionists,” the “reactionary prohibitionists” and the “hardcore libertarians.” Although the latter two groups are not amenable to compromise, considerable common ground could be found between the other two factions. See Ethan A. Nadelmann (1992) “Thinking Seriously About Alternatives to Drug Prohibition,” *Daedalus*, Journal of the
The notion that states should assume more authority over drug control seems to be gaining ground, at least in the western United States. The Western Governors’ Association, of which Washington in a member, issued the following policy statement in June 2000: “States, rather than the federal government, are in a better position to understand the substance abuse problem confronting them. The federal government needs to work closely with the states to provide the resources necessary to meet the individual and unique needs of each state rather than approaching the issue in a one-size-fits-all manner.” Western Governors’ Association (2000), Drug Policy in the West, Governors’ Policy Statement, Denver, CO, p. 2.

A central recommendation of the Bar Association of the City of New York in 1994 also presupposed the end of federal control over drug policy and “permitting states to devise alternatives to prohibition…[A] new approach to drug policy should leave state and local governments free to employ the full panoply of coercive penal sanctions when drug use is relevant to conduct affecting others.” Bar Association of the City of New York, Committee on Drugs and the Law (1994), “A Wiser Course: Ending Drug Prohibition,” op cit., p. 572.

### Appendices


392 Ibid., p. 318.


402 Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice, Washington, D. C.


Bottom Line: Cost Effective Interventions per student, but the estimated to save taxpayers an estimated $3,068 per student in avoided criminal justice costs and an estimated $3,991 per student from associated crime victim costs (1997 dollars).

Washington State budgeted approximately $162.8 million during the 1999-2001 biennium for prevention programs related to the 8 outcomes identified in the 1994 legislation. About 60% of these monies were from state sources, 36% from the federal government, and 4% from other sources. See Washington State Institute for Public Policy (2001), How Much Money Does Washington State Spend on Prevention Programs for Youth?, Olympia, WA.