SB

100

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

REPORTED OUT
APR 18 2007
SENATE FINANCE COMMITTEE

DATE: 3/30/07

FURTHER:

DATE TURNED IN TO OFFICE: 18April2007

Finance Committee considered SENATE BILL NO. 100

SB 100 SUBSTANCE ABUSE/MENTAL HEALTH PROGRAMS

"An Act relating to substance abuse and mental health disorder prevention and treatment programs; and relating to long-term secure treatment programs for persons with substance abuse or co-occurring substance abuse and mental health disorders."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS SB 100 (FIN)

[ ] adopt previous [ ] SCS or [ ] CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS Behavl. health admin.	4/17/07			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS Medicaid	3/19/07		✓/-		#18

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas	✓			
	Dyson	✓			
	Huggins	✓			
	Olson	✓			
Co-CHAIR:	Hoffman	✓			
Co-CHAIR:	Stedman	✓			

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB100-DHSS-DBH3-04-7-07
Bill Version: CS SB 100(FIN)
( ) Publish Date:
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: SUBSTANCE ABUSE/MENTAL HEALTH PROGRAMS
RDU: Behavioral Health
Component: Behavioral Health Administration

Sponsor: ELLIS
Requester: SENATE (FIN)
Component No.: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CSSB 100 25-LS0151\R updates current statutes to include language that supports the department's efforts to implement evidence-based, research-based, or promising practices when and where available; give treatment priority to pregnant women; and provide non-discrimination against faith-based approaches. Furthermore, the bill conceptually supports the department in its efforts to provide prevention and treatment for co-occurring disorders. There is no fiscal impact to the department.

Prepared by: Stacy Toner, Acting Director
Phone 465-2817
Division: Division of Behavioral Health
Date/Time 04/16/2007
Approved by: Karleen Jackson, Commissioner
Date 04/17/2007
Agency: Department of Health and Social Services

ADOPTED

25-LS0151\R
Mischel
4/16/07

CS FOR SENATE BILL NO. 100( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS ELLIS, French

A BILL

FOR AN ACT ENTITLED

"An Act relating to substance abuse and mental health disorder prevention and treatment programs; and relating to long-term secure treatment programs for persons with substance abuse or co-occurring substance abuse and mental health disorders."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

FINDINGS AND INTENT. (a) The legislature finds that a substantial number of persons have co-occurring substance abuse and mental health disorders and that identification and integrated treatment of co-occurring disorders is critical to successful outcomes and recovery.

(b) It is the intent of the legislature to

(1) support the Department of Health and Social Services in its efforts to implement programs that accurately identify and provide appropriate treatment for persons with substance abuse or co-occurring substance abuse and mental health disorders;

(2) increase treatment availability to persons with substance abuse or co-occurring substance abuse and mental health disorders;

(3) improve treatment outcomes by expanding evidence-based, research-based, and consensus-based treatment practices and removing barriers that prevent implementation of those practices.

* **Sec. 2.** AS 47.37.030 is amended to read:

Sec. 47.37.030. Powers of department. The department may

(1) plan, establish, and maintain programs for the prevention and treatment of alcoholism, drug abuse, and misuse of hazardous volatile materials and substances by inhalant abusers;

(2) make contracts and award grants necessary or incidental to the performance of its duties and the execution of its powers, including contracts with the grants to public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics, intoxicated persons, drug abusers or inhalant abusers; to the maximum extent possible, contracts and grants must be for a period of two years; contracts under this paragraph are governed by AS 36.30 (State Procurement Code);

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) administer or supervise the administration of the provisions relating to alcoholics, intoxicated persons, drug abusers, and inhalant abusers of state plans submitted for federal funding under federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism, drug abuse, and inhalant abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies for the treatment of alcoholics, intoxicated persons, drugs abusers, and inhalant abusers, and for the common advancement of alcoholism, drug abuse, and inhalant abuse programs in this and other states;

(6) keep records and engage in research and the gathering of relevant

statistics;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics, intoxicated persons, drug abusers, and inhalant abusers; however, the department shall encourage local initiative, involvement, and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the department; contracting and construction under this paragraph are governed by AS 36.30 (State Procurement Code)**:**

(9) strengthen and enhance the process for identifying people who have co-occurring mental health and substance abuse disorders;

(10) establish a secure enhanced detoxification and treatment center for persons involuntarily detained because they are likely to inflict physical harm to self or others; in this paragraph, "enhanced" means the ability to treat co-occurring mental health and substance abuse disorders;

(11) develop and implement a substance abuse treatment system using evidence-based best practices or, if evidence-based best practices do not exist, research-based practices, that includes a procedure for adapting the practices to new situations and for collaboration with consumer-based programs; if research-based practices are not known or available, the department may include consensus-based or, if funds are available, promising practices; a practice must promote independence, recovery, employment, education, ongoing community-based treatment, housing, and other aspects of harm reduction.

* **Sec. 3.** AS 47.37.040 is amended to read:

Sec. 47.37.040. Duties of department. The department shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and drug abuse and treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism, drug abuse, and inhalant abuse, and treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers;

(3) cooperate with the Department of Corrections in establishing and conducting programs to provide treatment for alcoholics, intoxicated persons, drug abusers, and inhalant abusers in or on parole from penal institutions;

(4) cooperate with the Department of Education and Early Development, school boards, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of alcoholism, drug abuse, and inhalant abuse, and treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers, and preparing curriculum materials for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and drugs, and the misuse of hazardous volatile substances;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers that includes the dissemination of information concerning the nature and effects of alcohol, drugs, and hazardous volatile substances;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers, and establish standards for training paraprofessional alcoholism, drug abuse, and inhalant abuse workers;

(8) sponsor and encourage research into the causes and nature of alcoholism, drug abuse, and inhalant abuse, and the treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers, and serve as a clearinghouse for information relating to alcoholism, drug abuse, and inhalant abuse;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated,

frequency of admission and readmission, and frequency and duration of treatment;

(10) conduct program planning activities approved by the Advisory Board on Alcoholism and Drug Abuse;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcoholics, intoxicated persons, drug abusers, and inhalant abusers;

(12) assist in the development of, and cooperate with, alcohol, drug abuse, and inhalant abuse education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) use the support and assistance of interested persons in the community, particularly recovered alcoholics, drug abusers, and inhalant abusers, to encourage alcoholics, drug abusers, and inhalant abusers to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Transportation and Public Facilities in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of an alcoholic beverage, inhalant, or controlled substance, and develop and approve alcohol information courses required to be taken by drivers under AS 28.15 or made available to drivers to reduce points assessed for violation of traffic laws;

(15) encourage hospitals and other appropriate health facilities to admit without discrimination alcoholics, intoxicated persons, drug abusers, and inhalant abusers and to provide them with adequate and appropriate treatment;

(16) encourage all health insurance programs to include alcoholism and drug abuse as a covered illness;

(17) prepare an annual report covering the activities of the department and notify the legislature that the report is available;

(18) develop and implement a training program on alcoholism and drug abuse for employees of state and municipal governments, and private institutions;

(19) develop curriculum materials on drug and alcohol abuse and the

misuse of hazardous volatile substances for use in grades kindergarten through 12, as well as a course of instruction for teachers to be charged with presenting the curriculum;

(20) develop and implement or designate, in cooperation with other state or local agencies, a juvenile alcohol safety action program that provides alcohol and substance abuse screening, referral, and monitoring of persons under 18 years of age who have been referred to it by

(A) a court in connection with a charge or conviction of a violation or misdemeanor related to the use of alcohol or a controlled substance;

(B) the agency responsible for the administration of motor vehicle laws in connection with a license action related to the use of alcohol or a controlled substance; or

(C) department staff after a delinquency adjudication that is related to the use of alcohol or a controlled substance;

(21) develop and implement, or designate, in cooperation with other state or local agencies, an alcohol safety action program that provides alcohol and substance abuse screening, referral, and monitoring services to persons who have been referred by a court in connection with a charge or conviction of a misdemeanor involving the use of a motor vehicle, aircraft, or watercraft and alcohol or a controlled substance, referred by a court under AS 28.35.028, or referred by an agency of the state with the responsibility for administering motor vehicle laws in connection with a driver's license action involving the use of alcohol or a controlled substance;

(22) whenever possible, apply evidence-based, research-based, and consensus-based substance abuse and co-occurring substance abuse and mental health disorders treatment practices and remove barriers that prevent the use of those practices;

(23) collaborate with first responders, hospitals, schools, primary care providers, developmental disability treatment providers, law enforcement, corrections, attorneys, the Alaska Court System, community behavioral treatment providers, Alaska Native organizations, and federally funded

programs in implementing programs for co-occurring substance abuse and mental health disorders treatment.

* **Sec. 4.** AS 47.37.045 is amended by adding new subsections to read:

(f) In addition to the priority given under (d) of this section, the department shall grant a priority to a proposed program or project under (c)(5) of this section if the proposed program or project provides prompt substance abuse treatment for a pregnant woman by advancing the woman on a waiting list for the program or project and by streamlining paperwork for admission of the woman to the program.

(g) In addition to the priorities given under (d) and (f) of this section, the department shall grant a priority to a proposed program or project under (c)(5) of this section if the proposed program or project

(1) creates alternatives to incarceration for nonviolent offenders;

(2) provides rehabilitation services to prisoners who have substance abuse problems;

(3) measures and demonstrates a high rate of harm reduction for participants;

(4) is based on scientifically sound principles of prevention and treatment;

(5) provides job training or employment opportunities after completion of substance abuse treatment;

(6) provides youth treatment;

(7) focuses on drug and alcohol abuse prevention;

(8) addresses alcohol or substance abuse in targeted populations that have statistically higher incidences of alcohol or substance abuse problems; or

(9) addresses co-occurring mental health and substance abuse disorders.

(h) The department may not fund a proposed program or project that has been previously funded under this section unless the applicant provides satisfactory evidence of success of the program or project.

(i) The department may not deny funding for a program under this section solely on the basis that the program relies on faith-based strategies so long as the

strategies are effective for preventing or treating substance abuse.

* **Sec. 5.** AS 47.37.120 is amended by adding a new subsection to read:

(b) The comprehensive program carried out under this section must include a strategy for expanding substance abuse treatment services and reducing waiting lists for eligible participants in a substance abuse prevention or treatment program and must include one or more of the factors listed under AS 47.37.045(g).

* **Sec. 6.** AS 47.37.130(b) is amended to read:

(b) The program of the department must include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment;

(4) outpatient and follow-up treatment; [AND]

(5) standards for alcohol safety action programs; the standards may vary in their requirements and stringency according to the population, price level, remoteness, access to transportation, and availability of ancillary services of the area to be served; a program must meet the applicable standards before it is approved by the department as an alcohol safety action program; the standards required under this paragraph shall be established in a manner that provides protection of the health, safety, and well-being of clients of the affected programs and protection for the affected programs from exposure to malpractice and liability actions;

(6) the priorities created under AS 47.37.045(f) and (g); and

(7) standards that are consistent with scientifically sound principles for measuring outcomes.

* **Sec. 7.** AS 47.37.140 is amended by adding a new subsection to read:

(g) The standards established for facilities under this section must be based on scientifically sound evidence and be consistent with the priorities created under AS 47.37.045(f) and (g).

SENATE FINANCE COMMITTEE

4 /17/ 2007 COMMITTEE ACTION

Bill Number	SB 100			
Amendment				
Motion	Adopt CS "R"			
Motion by	Hoffman			
Objection by	Elton			
Removed	✓			
Second Objection by				
Committee Member	Y	***Vote***		N
Senator Elton				
Senator Huggins				
Senator Olson				
Senator Thomas				
Senator Dyson				
Co-Chair Hoffman				
Co-Chair Stedman				
Tally				
Yea				
Nay				
Absent				
MOTION				

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

FAX COVER SHEET

DATE: 18 April 2007 TIME: 9:15 am

TO: Legal Services

NUMBER OF PAGES, INCLUDING COVER SHEET: 1

FROM: MINDY ROWLAND
SENATE FINANCE COMMITTEE SECRETARY
PHONE: 465-4935
FAX: 465-2187

NOTES: Final Please!
CS SB 100(FIN) 25-LS0151\R
Mischel 4/16/07

No changes

Thx

mindy

FINAL delivered
10:10 AM

Senate Labor and Commerce Committee, Chair
•
Legislative Budget and Audit Committee
•
Senate Rules Committee
•
Committee on Committees

ALASKA STATE LEGISLATURE

While in Session
State Capitol, Rm. 9
Juneau, AK 99801
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SENATOR JOHNNY ELLIS

MEMORANDUM

DATE: March 30, 2007

TO: Senator Bert Stedman, Co-Chair
Senate Finance Committee

FROM: Senator Johnny Ellis

RE: Explanation of Changes CSSB 100 (STA)

The Senate State Affairs Committee adopted a CS that addressed the Department of Health and Social Services concerns that the state might have to pay for an expansion of community services in order to coordinate with the pilot program proposed in SB 100. The language in the CS made clear that the pilot program must coordinate with "existing" community services. *See page 9, lines 14-17.*

ALASKA STATE LEGISLATURE
Senator Johnny Ellis

Sponsor Statement

SB 100 Substance Abuse Bill

Addiction is taking a heavy toll on Alaska's people, culture and economy. Alaska ranks #1 in the nation in alcohol-related deaths and Alaskans with substance abuse problems, or co-occurring mental and substance abuse disorders, are more likely to be homeless, spend time in correctional facilities, and become involved in child protective service proceedings. Substance abuse tears apart families; in 2004, 81% of all reported harm against a child cases involved illicit drugs. The financial impact of addiction is staggering, costing the state an estimated $738 million a year in health care costs, accidents, lost productivity, criminal justice and correctional facilities. Something must change.

At the same time, Alaska is falling behind in providing treatment to those who need help in overcoming their addiction. According to the 2002 Integrated Substance Abuse Treatment Needs Assessment for Alaska, only 15.6% of Alaskans in need of substance abuse treatment received it. We can, and must do better.

Senate Bill 100 proposes several common sense changes to Alaska's statutes regarding drug and alcohol abuse in order to improve the quality of and access to treatment and prevention. The legislation:

- Mandates priority treatment for pregnant women seeking help in overcoming addiction. Reducing the incidence of Fetal Alcohol Spectrum disorders will save large sums of money.
- Creates a pilot program in a secure setting for involuntary commitment cases. This small, but enormously expensive group of persons with addictions or co-occurring substance abuse and mental health disorders chronically recycle through non-secure treatment services and as a result present a danger to themselves and others. This population draws heavily on law enforcement, corrections, the court system, and community services.
- Gives priority to state grantees who utilize evidence-based programming, as well as programs that address substance abuse prevention, addiction within prisons, among youths, and in rural Alaska.
- Encourages the Department of Health and Social Services to develop a process to identify people with co-occurring mental and substance abuse disorders, so that this population can be better served.
- Ensures that effective faith-based strategies for treating substance abuse are not discriminated against in statute.

Most Alaskans have been touched by substance abuse, whether it is a personal struggle with addiction, or watching a friend or relative battle with this deadly condition. I ask you to support for SB 100 and its common-sense steps to strengthen the fight against drugs and alcohol abuse in our state.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
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Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 6, 2007

SUBJECT: SB 100 Sectional Analysis (Work Order No. 25-LS0151\V)

TO: Senator Johnny Ellis
Attn: Kate Herring

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Provides legislative findings and intent supporting treatment programs for persons with substance abuse and co-occurring substance abuse and mental health disorders.

Section 2. Amends the powers of the Department of Health and Social Services to add specified co-occurring substance abuse and mental health treatment programs.

Section 3. Amends the duties of the Department of Health and Social Services to require specified types of treatment and collaborations for co-occurring substance abuse and mental health disorders.

Section 4. Modifies and establishes priorities for grant programs related to substance abuse and mental health treatment.

Section 5. Establishes standards for the comprehensive program developed and implemented by the Department of Health and Social Services for the treatment and prevention of substance abuse.

Section 6. Adds standards pertaining to priorities listed in sec. 4 of the bill for the Department of Health and Social Services' comprehensive program for the treatment and prevention of substance abuse.

Section 7. Requires that standards established for public and private treatment facilities

be based on scientifically sound evidence and be consistent with priorities established under sec. 4.

Section 8. Establishes within the Department of Health and Social Services a pilot project to integrate crisis response and involuntary treatment of adults incapacitated by alcohol or drugs, including persons with co-occurring substance abuse and mental health disorders.

JMM:ljw
07-114.ljw

LEGAL SERVICES

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MEMORANDUM April 2, 2007

SUBJECT: Constitutionality of funding faith-based strategies for the prevention and treatment of substance abuse (SB 100)
(Work Order No. 25-LS0151\V)

TO: Senator Johnny Ellis
Attn: Kate Herring

FROM: Jean M. Mischel
Legislative Counsel

You have asked for a legal analysis of possible constitutional problems that would arise if SB 100 includes, as drafted, a provision allowing for the funding of faith-based strategies for the prevention and treatment of substance abuse. That provision, at AS 47.37.045(i), as proposed, states:

> The department may not deny funding for a program under this section solely on the basis that the program relies on faith-based strategies so long as the strategies are effective for preventing or treating substance abuse.

The primary constitutional issue implicated by this provision is the establishment clause of the first amendment to the constitution of the United States, which provides that "Congress shall make no law respecting an establishment of religion." This clause is made applicable to the states through the fourteenth amendment. Article I, section 4 of the Constitution of the State of Alaska includes a similar provision. According to the Alaska Supreme Court, "the establishment clause stands independently as a barrier to government action which favors religion over non-religion." *Bonjour v. Bonjour*, 592 P.2d 1233, 1241 (Alaska 1979).

The United States Supreme Court described a three-part test in *Lemon v. Kurtzman*, 403 U.S. 602 (1971), which held that in order for a challenged statute to survive scrutiny under the establishment clause, it must 1) have a secular legislative purpose, 2) its principal or primary effect must be one that neither advances nor inhibits religion, and 3) the statute must not foster an excessive government entanglement with religion.

Establishment clause jurisprudence has evolved from the test set forth in *Lemon v. Kurtzman*. Two additional establishment clause tests have been identified: the endorsement test in *Allegheny County v. Greater Pittsburgh ACLU*, 492 U.S. 573, 593-94 (1989), and the coercion test in *Lee v. Weisman*, 505 U.S. 577 (1992).

Under the endorsement test, which is sometimes described as an elaboration on the second prong of the Lemon test, government is prohibited from appearing to take a position on questions of religious belief. *Allegheny*, 492 U.S. at 593-94.[1]

In *Lee v. Weisman*, 505 U.S. 577 (1992), the court described the coercion test and found that having a rabbi deliver a non-denominational prayer at a middle school graduation ceremony violated the establishment clause, because even those students who objected to the religious exercise were in a sense compelled to take part.

When reviewing state subsidies or payments, other than those to religious schools that involve a separate constitutional principle not at issue here, courts have generally applied the *Lemon* test, with an emphasis in the first prong regarding secular purpose. Judicial review of governmental purpose is deferential. "A religious purpose alone is not enough to invalidate an act of a state legislature . . . . [T]he religious purpose must predominate." *Edwards v. Aguillard,* 482 U.S. 578, 599 (1987) (Powell, J., concurring) (citations omitted). Thus, a statute is invalid only if it "does not have a *clearly secular* purpose." *Wallace v. Jaffree,* 472 U.S. 38, 56 (1985) (emphasis added); *see, e.g., Church of Scientology v. Commissioner,* 2 F.2d 1514 (11th Cir. 1993) (cert. den. 513 U.S. 807 (1994)).

Inquiry into legislative purpose begins with interpreting the law itself. "The plain meaning of the statute's words, enlightened by their context and the contemporaneous legislative history can control the determination of legislative purpose." *Aguillard,* 482 U.S. at 594 (citations omitted). If the legislature's stated purpose is not actually furthered by the enactment then that purpose is disregarded as being insincere or a sham. *Id.*, 482 U.S. at 586-87. Even if the proffered purpose is not a sham, the court must evaluate the effect of the statute's provisions and "consider[] the historical context of the statute . . . and the specific sequence of events leading to [its] passage . . . ," *id.*, 482 U.S. at 595 (citations omitted); *see, e.g., Jaffree,* 472 U.S. at 59-60; *Valente,* 456 U.S. at 253-55; *see also, Village of Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252, 267 (1977).

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[1] In the *Allegheny* case, in a plurality opinion, the court held that a creche standing on its own on the grand staircase of the county courthouse with a banner over it reading "Gloria in Excelsis Deo!" had the effect of endorsing "a patently Christian message" and was therefore unconstitutional. *Id.* at 601. In the same case, however, the court found that the display of an 18-foot menorah next to a 45-foot Christmas tree at the City-County office building, a block away from the courthouse, could not be understood to "result in the simultaneous endorsement of Christian and Jewish faiths," but rather conveyed "the city's secular recognition of different traditions for celebrating the winter-holiday season." *Id.* at 620. Display of the menorah, the court held, was not unconstitutional.

In *Bowen v. Kendrick*, 487 U.S. 589 (1988), the U.S. Supreme Court upheld a federal law known as the Adolescent Family Life Act (AFLA).[2] Under the AFLA, the federal Department of Health and Human Services gives grants to public and nonprofit private organizations for services for the care of pregnant adolescents and adolescent parents and for prevention of adolescent pregnancy. Religious organizations are eligible for AFLA grants, and all grant applicants must show how they will involve religious organizations in the services provided under the grant.[3] The services provided under an AFLA grant may include child care, counseling, and health services.[4]

The Court had no problem with finding that the AFLA was motivated primarily, if not entirely, by a legitimate secular purpose: eliminating or reducing social and economic problems caused by teenage sexuality, pregnancy, and parenthood. It made this finding despite the fact that the Act amended previous laws to increase the role of religious organizations in the provision of the services funded by the Act.[5]

The Court noted that it was "sensible" of Congress to recognize "the important part that religion or religious organizations may play in resolving certain secular problems." It went on to say that "to the extent that this congressional recognition has any effect of advancing religion, the effect is at most "incidental and remote."[6]

The Court approved of the fact that a wide spectrum of organizations was eligible to receive funding under the AFLA, and said:

> [N]othing on the face of the Act suggests it is anything but neutral with respect to the grantee's status as a sectarian or purely secular institution . . . . In this regard, then, the AFLA is similar to other statutes that the Court has upheld against Establishment Clause challenges in the past. In *Roemer v. Maryland Board of Public Works*, 426 U.S. 736 (1976), for example, we upheld a Maryland statute that provided annual subsidies directly to qualifying colleges and universities in the State, including religiously affiliated institutions. As the plurality stated, "**religious institutions need not be quarantined from public benefits that are neutrally available to all.**" Id., at 746 (discussing *Everson v. Board of Education*, 330 U.S. 1(1947) (approving bussing services equally available to both public and private school children), and *Board of*

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[2] 42 U.S.C. 300z *et seq.*

[3] 42 U.S.C. 300z-5(a)(21).

[4] 42 U.S.C. 300z-1(a)(4)(K).

[5] *Bowen*, 487 U.S. at 603-604.

[6] *Bowen*, 487 U.S. at 607.

> *Education v. Allen*, 392 U.S. 236 (1968) (upholding state provision of secular textbooks for both public and private school students)). Similarly, in *Tilton v. Richardson*, 403 U.S. 672 (1971), we approved the federal Higher Educational Facilities Act, which was intended by Congress to provide construction grants to "all colleges and universities regardless of any affiliation with or sponsorship by a religious body." Id., at 676. And in *Hunt v. McNair*, 413 U.S. 734 (1973), we rejected a challenge to a South Carolina statute that made certain benefits "available to all institutions of higher education in South Carolina, whether or not having a religious affiliation." Id., at 741. . . . **[T]his Court has never held that religious institutions are disabled by the First Amendment from participating in publicly sponsored social welfare programs.**

(emphasis added)

The Court specifically refused to presume that aid to a religiously affiliated institution would be used in a way that would have the primary effect of advancing religion.[7]

Most of the Court decision concerned the counseling services that could be funded under the AFLA.[8] The Court found them to be one of the "facially neutral projects authorized by the AFLA." It found that

> pregnancy testing, adoption counseling and referral services, prenatal and postnatal care, educational services, residential care, child care, consumer education, etc. are not themselves "specifically religious activities," and they are not converted into such activities by the fact that they are carried out by organizations with religious affiliations.[9]

The Court specifically rejected the lower court's reasoning that public aid to a religiously affiliated institution to carry out a secular function created an impermissible "symbolic link" between the government and religion.[10]

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[7] *Bowen*, at 612. The Court distinguished the AFLA services from the indoctrination inherent in parochial schools. Previous court decisions have found public aid to parochial schools to be unconstitutional under the Establishment Clause. *Bowen* does not overturn those decisions.

[8] The Court focused on the counseling services because religious indoctrination is much more likely in a counseling session than in a health care or child care setting.

[9] *Bowen*, at 613.

[10] *Bowen*, at 614.

The Court was not bothered by the fact that there was no provision in the AFLA that prevented use of the government funds for religious purposes. More important to the Court was the fact that the AFLA expressly defined the uses to which the federal funds *could* be put, including providing care and prevention services to eligible individuals. The Court was satisfied that the Act, by implication, would not permit use of funds for religious purposes.[11]

The Court also declined to find excessive governmental entanglement caused by monitoring of the use of grant funds.[12]

In sum, the U.S. Supreme Court, in *Bowen v. Kendrick*, sustained Congress' judgment that religious organizations can constitutionally be given government funds to accomplish a strong secular purpose like caring for adolescent parents.

Under the Lemon and Bower analyses, I think it is very likely that a court would sustain the Alaska Legislature's judgment that religious organizations can constitutionally be given government funds to accomplish a strong secular purpose like the prevention and treatment of substance abuse. The authorization to find faith-based strategies among other strategies does not have a primary effect of advancing religion or foster excessive government entanglement.

Compared to the federal program upheld in *Bowen*, the secular purpose of the state's substance abuse treatment grant program is very similar in that mental health and substance abuse issues were being addressed. In addition, the availability of funds under the state program is even more neutral than under the federal program because other priorities must be present and faith-based strategies are only one component of treatment and prevention. Furthermore, funding is not directed at a religious program but those programs are not being specifically excluded.

Without the provision allowing for grant funding of faith-based programs in SB 100, the funding could be distributed in such a way to intentionally exclude religious or faith-based programs that may run afoul of the free exercise clause of the First Amendment, and the equal protection clause of the Fourteenth Amendment.

For these reasons, the provision cited does not appear to create constitutional problems for SB 100 and may, in fact, protect the grant program from them.

If I may be of further assistance, please advise.

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[11] *Bowen*, at 615 and note 13.

[12] *Bowen*, at 617.

The Partnership for a Drug-Free America™

13 MYTHS ABOUT DRUG ABUSE & TREATMENT

3/13/2006 10:39:32 AM

Myth #1: Drug addiction is voluntary behavior.
A person starts out as an occasional drug user, and that is a voluntary decision. But as times passes, something happens, and that person goes from being a voluntary drug user to being a compulsive drug user. Why? Because over time, continued use of addictive drugs changes your brain -- at times in dramatic, toxic ways, at others in more subtle ways, but virtually always in ways that result in compulsive and even uncontrollable drug use.

Myth #2: More than anything else, drug addiction is a character flaw.
Drug addiction is a brain disease. Every type of drug of abuse has its own individual mechanism for changing how the brain functions. But regardless of which drug a person is addicted to, many of the effects it has on the brain are similar: they range from changes in the molecules and cells that make up the brain, to mood changes, to changes in memory processes and in such motor skills as walking and talking. And these changes have a huge influence on all aspects of a person's behavior. The drug becomes the single most powerful motivator in a drug abuser's existence. He or she will do almost anything for the drug. This comes about because drug use has changed the individual's brain and its functioning in critical ways.

Myth #3: You have to want drug treatment for it to be effective.
Virtually no one wants drug treatment. Two of the primary reasons people seek drug treatment are because the court ordered them to do so, or because loved ones urged them to seek treatment. Many scientific studies have shown convincingly that those who enter drug treatment programs in which they face "high pressure" to confront and attempt to surmount their addiction do comparatively better in treatment, regardless of the reason they sought treatment in the first place.

Myth #4: Treatment for drug addiction should be a one-shot deal.
Like many other illnesses, drug addiction typically is a chronic disorder. To be sure, some people can quit drug use "cold turkey," or they can quit after receiving treatment just one time at a rehabilitation facility. But most of those who abuse drugs require longer-term treatment and, in many instances, repeated treatments.

Myth #5: We should strive to find a "magic bullet" to treat all forms of drug abuse.
There is no "one size fits all" form of drug treatment, much less a magic bullet that suddenly will cure addiction. Different people have different drug abuse-related problems. And they respond very differently to similar forms of treatment, even when they're abusing the same drug. As a result, drug addicts need an array of treatments and services tailored to address their unique needs.

Myth #6: People don't need treatment. They can stop using drugs if they really want to.
FACT: It is extremely difficult for people addicted to drugs to achieve and maintain long-term abstinence. Research shows long-term drug use actually changes a person's brain function, causing them to crave the drug even more, making it increasingly difficult for the person to quit. Especially for adolescents, intervening and stopping substance abuse early is important, as children become addicted to drugs much faster than adults and risk greater physical, mental and psychological harm from illicit drug use.

MYTH #7: Treatment just doesn't work.
FACT: Treatment can help people. Studies show drug treatment reduces drug use by 40 to 60 percent and can significantly decrease criminal activity during and after treatment. There is also evidence that drug addiction treatment reduces the risk of HIV infection (intravenous -drug users who enter and stay in treatment are up to six times less likely to become infected with HIV than other users) and improves the prospects for employment, with gains of up to 40 percent after treatment.

MYTH #8: Nobody will voluntarily seek treatment until they hit 'rock bottom.'

FACT: There are many things that can motivate a person to enter and complete substance abuse treatment before they hit "rock bottom." Pressure from family members and employers, as well as personal recognition that they have a problem, can be powerful motivating factors for individuals to seek treatment. For teens, parents and school administrators are often driving forces in getting them into treatment once problems at home or in school develop but before situations become dire. Seventeen percent of adolescents entering treatment in 1999 were self- or individual referrals, while 11 percent were referred through schools.

MYTH #9: You can't force someone into treatment.
FACT: Treatment does not have to be voluntary. People coerced into treatment by the legal system can be just as successful as those who enter treatment voluntarily. Sometimes they do better, as they are more likely to remain in treatment longer and to complete the program. In 1999, over half of adolescents admitted into treatment were directed to do so by the criminal justice system.

MYTH #10: There should be a standard treatment program for everyone.
FACT: One treatment method is not necessarily appropriate for everyone. The best programs develop an individual treatment plan based on a thorough assessment of the individual's problems. These plans may combine a variety of methods tailored to address each person's specific needs and may include behavioral therapy (such as counseling, cognitive therapy or psychotherapy), medications, or a combination. Referrals to other medical, psychological and social services may also be crucial components of treatment for many people. Furthermore, treatment for teens varies depending on the child's age, maturity and family/peer environment, and relies more heavily than adult treatment on family involvement during the recovery process. "[They] must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences)."

MYTH #11: If you've tried one doctor or treatment program, you've tried them all.
FACT: Not every doctor or program may be the right fit for someone seeking treatment. For many, finding an approach that is personally effective for treating their addiction can mean trying out several different doctors and/or treatment centers before a perfect "match" is found between patient and program.

MYTH #12: People can successfully finish drug abuse treatment in a couple of weeks if they're truly motivated.
FACT: Research indicates a minimum of 90 days of treatment for residential and outpatient drug-free programs, and 21 days for short-term inpatient programs to have an effect. To maintain the treatment effect, follow up supervision and support are essential. In all recovery programs the best predictor of success is the length of treatment. Patients who remain at least a year are more than twice as likely to remain drug free, and a recent study showed adolescents who met or exceeded the minimum treatment time were over one and a half times more likely to abstain from drug and alcohol use 4 However, completing a treatment program is merely the first step in the struggle for recovery that can extend throughout a person's entire lifetime.

MYTH #13: People who continue to abuse drugs after treatment are hopeless.
FACT: Drug addiction is a chronic disorder; occasional relapse does not mean failure. Psychological stress from work or family problems, social cues (i.e. meeting individuals from one's drug-using past), or their environment (i.e. encountering streets, objects, or even smells associated with drug use) can easily trigger a relapse. Addicts are most vulnerable to drug use during the few months immediately following their release from treatment. Children are especially at risk for relapse when forced to return to family and environmental situations that initially led them to abuse substances. Recovery is a long process and frequently requires multiple treatment attempts before complete and consistent sobriety can be achieved.

SOURCES (unless otherwise noted): Principles of Drug Addiction Treatment: A Research-Based Guide. (October 1999). National Institute on Drug Abuse, National Institute of Health; Alan I. Leshner, Ph.D., former Director of the National Institute on Drug Abuse (2001)

DSHS Research and Data Analysis Division Fact Sheet 4.42

Substance Abuse Treatment and Arrests: Analyses from Washington State

Washington State Department of Social and Health Services

Research and Data Analysis Division and Northwest Crime and Social Research

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Lijian He, Ph.D.
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March 2002

Brief Summary

This fact sheet used administrative data (treatment records from the Division of Alcohol and Substance Abuse linked with arrest records from the Washington State Patrol), to examine the criminal justice involvement of persons before and after receipt of publicly funded substance abuse treatment. 10,284 persons were studied.

Major Results

There were three prominent findings in this study.

- **A reduction in the number of clients arrested following treatment.**

  There was a 21% decline* after treatment in the number of persons being arrested (felony or gross misdemeanor). This is true even though the persons included here are a mix of treatment completers, dropouts, and those staying in treatment a very short time.

- **A reduction in the number of arrests for felony offenses following treatment.**

  There was a 33% decline in the number of arrests for felony offenses in the year after treatment, when compared with the year before.

- **Reduced risk of felony arrests for clients that complete treatment and for those with longer stays.**

  Completion: Completing an episode of treatment was associated with a 21% reduction in the probability of a felony related arrest in the 18 month following treatment discharge (compared with not completing treatment).

  Length of Treatment: Having a treatment episode lasting 90 days or longer was associated with a 32% reduction in the probability of felony arrests in the 18 months following treatment discharge (compared with having a shorter treatment episode).

  Reduced risk, regardless of prior criminal justice involvement: Regardless of whether clients had multiple arrests, one arrest or no arrests prior to treatment, completing treatment and staying in treatment longer were associated with reduced risks for felony arrests.

* 39% before compared to 31% after.

Statistical Controls: Reductions in the probability of arrest were estimated using a statistical model that controlled for the impact of personal characteristics, arrests prior to treatment and employment prior to treatment.

Background

The association between substance abuse and crime has been well documented (Amaro 1999). In 1996, Wickizer et al. (1999) found that alcohol and drug-related crime cost $541 million, a 39% increase over costs in 1990. Nationally, Harwood (et al. 1984) estimated that crime accounts for almost forty per cent of the total economic cost of drug abuse in the United States.

Research has shown that publicly funded treatment for substance abuse can have beneficial effects on both substance use and criminal behavior (Hubbard et al. 1989). However, much of that research was based on self-reported data. The results in the present report were based on administrative records of arrest kept by the Washington State Patrol (WSP).

This Report

Our study population was 10,284 clients between the ages of 18 and 64, who began and ended an episode of publicly funded treatment in 1995. These treatment records were obtained from the Washington State Division of Alcohol and Substance Abuse (DASA).

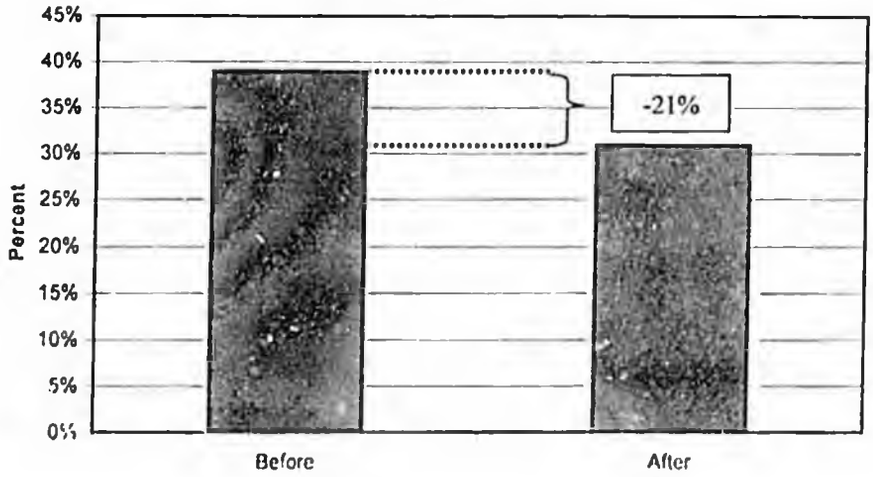
Arrest records came from the Washington State Identification System (WASIS), which is maintained by the Washington State Patrol (WSP). In Washington, all adults and juveniles, arrested for offenses classified as felonies or gross misdemeanors, are to be fingerprinted, and the fingerprints are to be submitted to WSP within 72 hours. Fingerprint and offense data, along with demographic information, are then entered into the WASIS database.

Arrests for felony offenses were the focus of most analyses, as opposed to arrests for lesser crimes. Felonies have been deemed more serious by the legislature and involve more punitive sanctions. They are more costly than other crimes, both to the criminal justice system and to victims, and for that reason were the focus of most analyses.

Results

What percent of clients were arrested for any offense (either a felony or gross misdemeanor) in the year before and after treatment?

Fig. 1: Percent of clients arrested for any offense (felony or gross misdemeanor) in the year before entering treatment and in the year after leaving treatment.



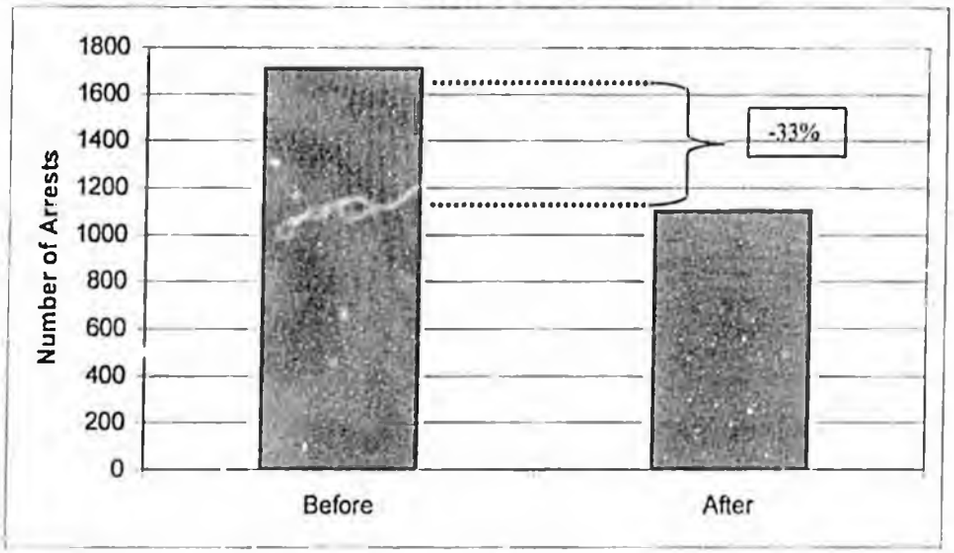
Main Points

- In the year prior to entering treatment, 39% were arrested for either a felony or gross misdemeanor.
- In the year after discharge, 31% were arrested for either a felony or gross misdemeanor. This represents a relative 21% decline in the number of these arrests.

Note: Since we cannot compare this decline to a comparison group of similar persons who did not get treatment, this decline cannot strictly be attributed to treatment.

How many arrests for felony offenses were there in the year after treatment, compared to the year before?

Figure 2: The Number of Felony Arrests in the Year Before and One Year After Treatment



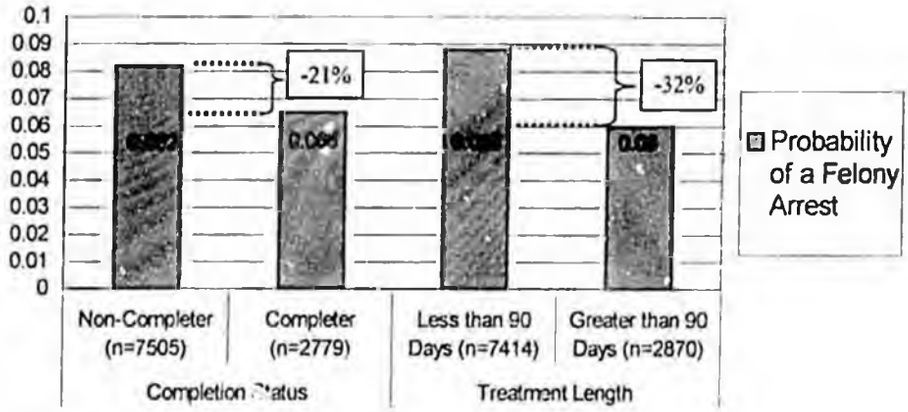
Main Points

- In the year before treatment, clients in the study population had 1710 arrests for felony offenses.
- In the year after treatment, clients in the study population had 1141 arrests for felony offenses, a decline of 33% when compared to the year before.

Note: Since we cannot compare this decline to a comparison group of similar persons who did not get treatment, this decline cannot strictly be attributed to treatment.

In the 18 months after treatment, were there differences in felony arrests among clients with different treatment experiences?

Fig. 3: Statistically Adjusted Probability of a Felony Arrest by Completion Status and Length of Treatment*



* Statistically adjusted probabilities were obtained from a logistic regression model which controlled for the impact of differences between groups in measured background characteristics of clients and their experiences prior to treatment, including prior arrests and treatment.

Main Points

Two primary treatment variables, completion of treatment and length of stay, were both associated with felony arrests

- The probability of an arrest for a felony offense was 21% lower for clients completing treatment, when compared to clients that did not complete.
- For clients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than clients with shorter treatment episodes.
- Regardless of whether clients had multiple arrests, one arrest or no arrests prior to treatment, completing treatment and staying in treatment longer were associated with reduced risks for felony arrests.

Conclusion

The analyses presented here were designed to address a key issue: whether treatment can reduce the impact of substance abuse on the criminal justice system. For all clients, arrest rates fell after treatment when compared to before, and completers and those in treatment 90 days or more were less likely to be arrested for a felony than non-completers or those spending less than 90 days in treatment.

Technical Note

Statistical model used for statistical adjustment of probabilities of felony arrests:

Table 1: Logistic Regression Analysis Predicting Felony Arrests
in the Eighteen Months Following Discharge from Treatment

Treatment Variables	Parameter Estimate	Std. Error	P-Value	Odds Ratios
Completed Treatment Episode	-0.2507	0.0832	0.0026	0.778
Length > 90 Days	-0.4195	0.0882	<.0001	0.657
Had Treatment in the Year Prior	0.1332	0.0823	0.1057	1.142
Inpatient Treatment Only (compared to Outpatient Only)	0.0734	0.083	0.3762	1.076
Both Inpatient and Outpatient in TX Episode (compared to Outpatient Only)	0.313	0.0904	0.0005	1.368
Client Characteristics				
Age 18-29 (compared to age > 45)	0.4833	0.1591	0.0024	1.621
Age 30-45 (compared to age > 45)	0.2684	0.1591	0.0915	1.308
Male	0.5395	0.0756	<.0001	1.715
White (compared to non-White)	-0.4651	0.0684	<.0001	0.628
Married	-0.1695	0.1063	0.1108	0.844
Employed in the Year before Treatment	-0.2555	0.0671	0.0001	0.775
Mental Health Problem	-0.0348	0.1085	0.7488	0.966
Hard Drug User (heroin, cocaine, amphetamines v. alcohol and marijuana)	0.9118	0.0681	<.0001	2.489
Arrested in Prior Year	1.3125	0.0693	<.0001	3.715
Intercept	-3.3152	0.178	<.0001	

Association of Predicted Probabilities and Observed Responses:
Percent Concordant Pairs: 74.4% (10,615,680 pairs)

Technical Note

Because the groups being compared were naturally occurring, and not based on random assignment, they could have differed on characteristics that were not measured. Group differences in unmeasured characteristics might have had an effect on the results of the statistical model, to the extent that they were independent of demographic and other characteristics already accounted for.

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Wickizer, T. 1999. The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996. Olympia, WA: Department of Social and Health Services

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DSHS Research and Data Analysis Division, 11.120fs

Chemical Dependency Treatment Reduces Emergency Room Costs And Visits

WASHINGTON STATE SUPPLEMENTAL SECURITY INCOME RECIPIENTS

Washington State
Department of Social
& Health Services

Research & Data Analysis
Division

ER

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Kenneth D. Stark, Director
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JULY 2004

Does Chemical Dependency Treatment Really Make a Difference?

In a previous study we found that most aged and disabled Medicaid clients who are frequent visitors to the hospital emergency room (ER) have an alcohol or other drug use disorder, a mental illness, or both.[1] However, fewer than one in six of the most frequent ER visitors in need of chemical dependency (CD) treatment actually received publicly funded CD treatment in Fiscal Year 2002.

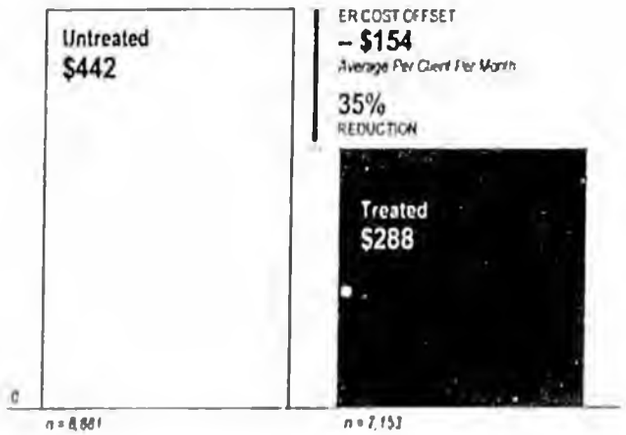
In this study we examine whether CD treatment reduces ER costs and ER visits for Supplemental Security Income (SSI) clients, compared to SSI clients who need CD treatment but do not receive it. **We find that there is a significant reduction in ER costs when CD treatment is provided to SSI clients who need it:**

- The average monthly ER cost is $442 for SSI clients who need CD treatment but do not receive it. These costs are reduced to $288 per month for SSI clients who receive CD treatment – **an ER cost offset of $154 per client per month.**[2] *(See chart below)*
- This represents a **35 percent reduction** in average monthly ER-related medical costs for SSI clients who receive CD treatment, compared to SSI clients who need but do not receive CD treatment.

In the following pages we provide more information about the effect of CD treatment on ER costs, frequency of ER visits, and the extent to which SSI clients "wander" from ER to ER to receive care.

Monthly ER Costs Are 35 Percent Lower For SSI Clients Receiving CD Treatment

ER costs per client per month



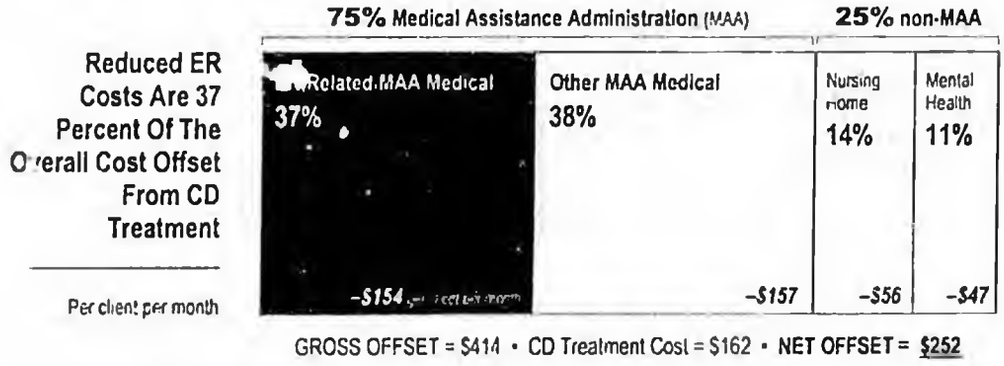
[1] Mancuso, David, Ph.D., Nordlund, Daniel J., Ph.D., Felver, Barbara E.M. (2004). *Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness.* Washington State DSHS, Research and Data Analysis Division, Olympia, WA. Updated June 2004

[2] Cost offsets can be interpreted as costs avoided for clients already receiving CD treatment, as well as potential savings that might be realized by treating those who now go untreated. Cost offsets were estimated using regression models in which the effects of covariates (age, gender, race/ethnicity, baseline ER expenditures) were controlled.

Reduced Emergency Room Costs Are Almost Half Of The Overall Medicaid Cost Offset From Chemical Dependency Treatment

In a previous study we found the overall "gross" Medicaid cost offset from providing CD treatment to SSI clients to be $414 per client per month. After accounting for the cost of CD treatment, the "net" cost offset is $252 per client per month.[3] **Reduced ER costs are a significant component of the overall Medicaid cost offset:**

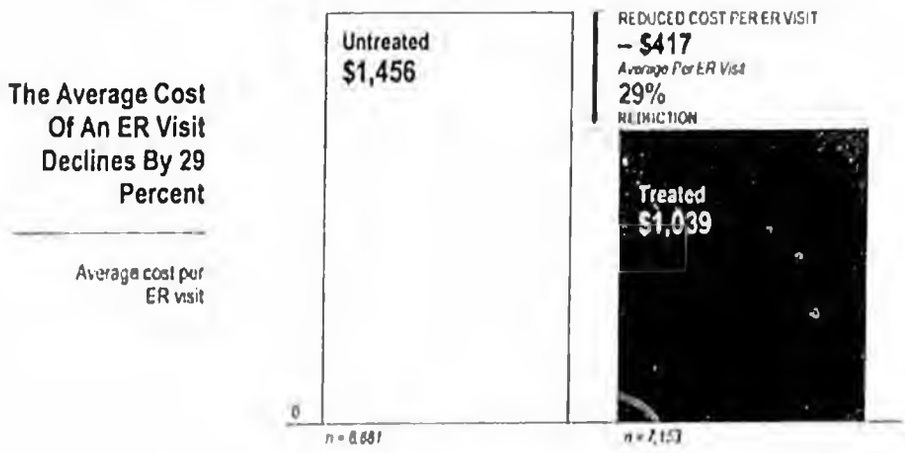
- The $154 per client per month ER cost offset accounts for more than one third – **37 percent** – of the $414 per client per month overall "gross" Medicaid cost offset from providing CD treatment to SSI clients.
- **Reduced ER costs alone almost completely offset the $162 per client per month average CD treatment cost.**



Chemical Dependency Treatment Reduces The Average Cost Per Emergency Room Visit

Providing CD treatment to SSI clients reduces per client per month ER costs in part by **reducing the average cost of an ER visit:**

- The average cost per ER visit is $1,456 for SSI clients who need but do not receive CD treatment. The average cost per ER visit is reduced to $1,039 for those who receive treatment – **a reduction of $417 per visit.**

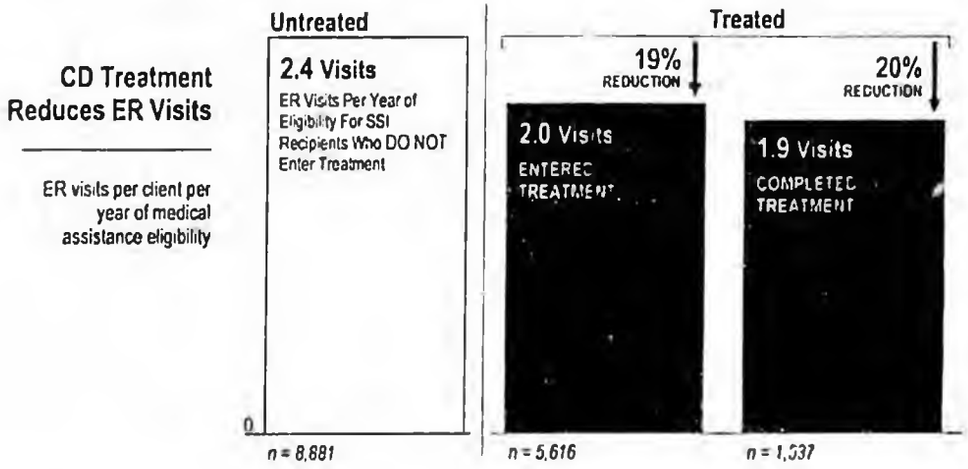


[3] Estee, S. and Nordlund, D. (2003). *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report.* Washington State DSHS, Research and Data Analysis Division, Olympia, WA. February 2003.

Chemical Dependency Treatment Reduces Subsequent Emergency Room Visits

CD treatment also reduces per client per month ER costs by **reducing the number of ER visits** made by SSI clients. Here we distinguish between clients who enter but do not complete CD treatment and those who complete CD treatment, to determine whether completing treatment has additional beneficial effects.

- The number of ER visits per year of medical assistance eligibility is reduced by **19 percent** for SSI clients who enter but do not complete CD treatment.
- ER visits are reduced by about the same degree – by **20 percent** per year – for SSI clients who complete CD treatment.



Chemical Dependency Treatment Reduces "Wandering" to Multiple Emergency Room Providers

Visiting multiple ERs – or "wandering" – may be an indication of drug-seeking behavior. We examined the effect of CD treatment on "wandering" by assessing the impact of CD treatment on the number of different ER providers visited.[4]

- The number of different ERs visited is reduced by **20 percent** for clients who enter CD treatment but do not complete treatment.
- The number of different ERs visited is reduced by **30 percent** for clients who enter and complete CD treatment.

[4] This analysis is restricted to SSI clients who had (1) at least one ER visit prior to the point at which their need for CD treatment was identified in administrative records, and (2) at least 12 months of medical assistance eligibility in the follow-up period.

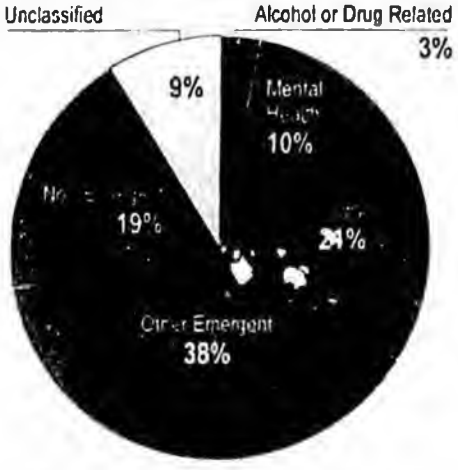
Why SSI Clients Needing Chemical Dependency Treatment Visit Emergency Rooms

Over the entire study period, only **3 percent** of ER visits by clients needing CD treatment had a primary diagnosis that was alcohol or other drug (AOD) related.[5] In contrast:

- **10 percent** of ER visits had a primary diagnosis of mental illness, such as schizophrenia, a bipolar disorder, or depression.[6]
- **21 percent** of visits were to treat injuries. The most common injuries were sprains, contusions, and open wounds.
- **38 percent** of visits were to treat other "emergent" conditions, such as abdominal pain, bronchitis, asthma, or congestive heart failure.[7]
- **19 percent** of visits were to treat non-emergent conditions. Headache was by far the most common non-emergent condition.

Distribution Of ER Visits By Primary Diagnosis

Among SSI Clients Needing CD Treatment



ER Visit Classification

"Billings" classification scheme groups the primary diagnosis from ER visits into mutually exclusive categories. Developed by John Billings, New York University Center for Health and Public Service Research.

Is my condition?

- Alcohol or Drug Related
- Mental Health Related
- An Injury
- Other Emergent
- Non-Emergent
- Unclassified

Typical Conditions

AOD related
- Alcohol or drug abuse, dependence, or psychosis

Mental health related
- Schizophrenia
- Bipolar disorders
- Depression

Injury
- Sprains
- Contusions
- Open wounds

Other emergent
- Abdominal pain
- Bronchitis
- Asthma
- Congestive heart failure

Non-emergent
- Headache
- Dental disorders
- Eye exams

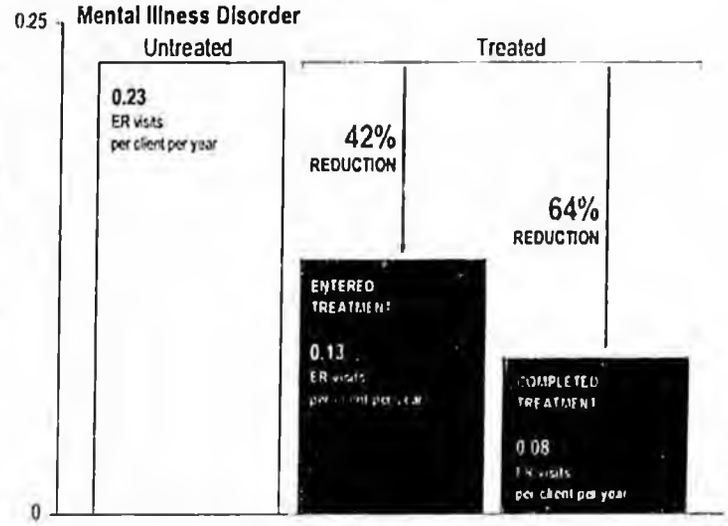
[5] An additional 5 percent of ER visits had a secondary diagnosis indicating the visit was alcohol or drug related.
[6] An additional 5 percent of ER visits had a secondary diagnosis of mental illness.
[7] Emergent conditions are those determined to require medical attention within 12 hours, based on the patient's initial complaint, vital signs, medical history, and age. For a more detailed discussion, see Billings, J., Parikh, N., Mijanovich, T. (2000). *Emergency Department Use in New York: A Substitute for Primary Care?* The Commonwealth Fund, New York, NY. November 2000.

Chemical Dependency Treatment Reduces Subsequent Emergency Room Visits With A Primary Diagnosis Of Mental Illness

We next examine the effect of CD treatment on the frequency of specific types of ER visits.[8] Subsequent ER visits with a primary diagnosis of mental illness are reduced by **42 percent** for clients who enter but do not complete CD treatment, and by **64 percent** for clients who complete CD treatment, when compared to untreated clients.

CD Treatment Reduces ER Visits With Primary Diagnosis Of Mental Illness

ER visits with a primary diagnosis of mental illness, per client per year of medical assistance eligibility

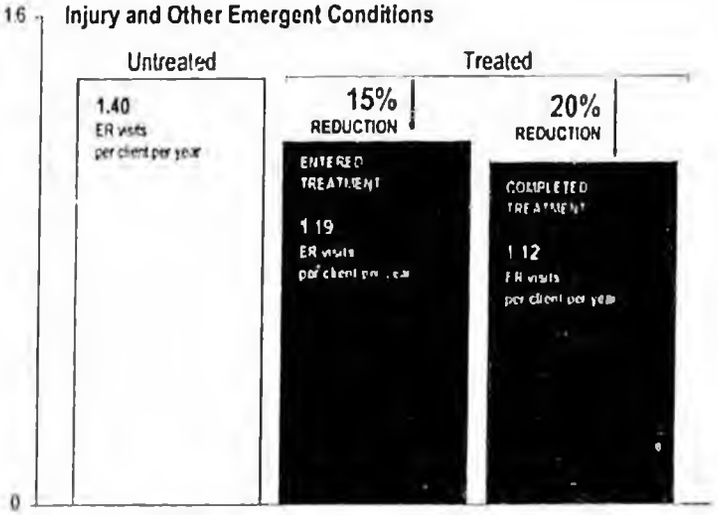


Chemical Dependency Treatment Reduces Subsequent Emergency Room Visits To Treat Injuries Or Other Emergent Conditions

Subsequent ER visits with a primary diagnosis of injury (sprains, contusions) or another emergent condition (abdominal pain, bronchitis, asthma) are reduced by **15 percent** for clients who enter but do not complete CD treatment, and by **20 percent** for clients who complete CD treatment, when compared to untreated clients.

CD Treatment Reduces ER Visits To Treat Injuries And Other Emergent Conditions

ER visits with a primary diagnosis of injury or other emergent condition, per client per year of medical assistance eligibility



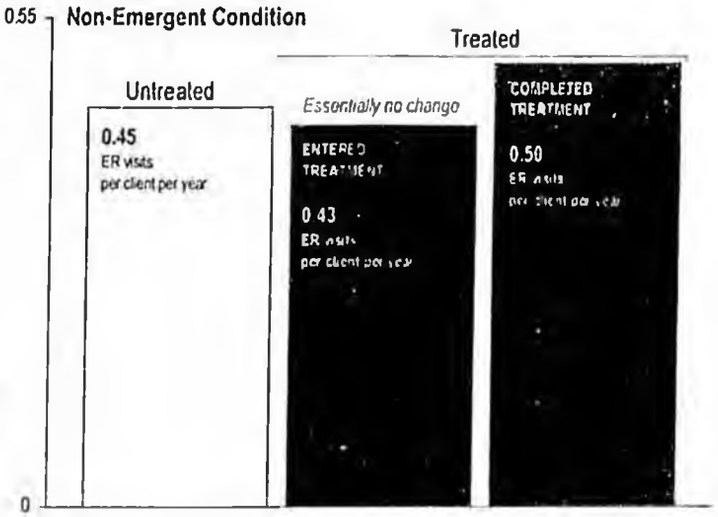
[8] Our analysis framework does not lend itself to analyzing pre/post changes in the frequency of AOD-related ER visits. This is because AOD-related ER visits by definition cannot occur before the "index date" when a client's need for CD treatment is first identified. Consequently, we do not report on the effect of CD treatment in reducing AOD-related ER visits. As previously noted, ER visits with an AOD primary diagnosis are rare, even among SSI clients who need CD treatment.

Chemical Dependency Treatment Does Not Affect Subsequent Emergency Room Visits For Non-Emergent Conditions

Treated and untreated clients average about half an ER visit per year to treat non-emergent conditions such as headaches or dental disorders. Use of the ER to treat non-emergent conditions may reflect problems with access to primary medical care for SSI clients. If this is the case, it is not surprising that CD treatment does not affect ER use for non-emergent conditions.

CD Treatment Does Not Affect ER Visits For Non-Emergent Conditions

ER visits with a primary diagnosis of a non-emergent condition, per client per year of medical assistance eligibility



Summary of Key Findings

This study has shown that CD treatment has significant beneficial effects in reducing ER costs, the frequency of ER visits, and the extent to which SSI clients "wander" from ER to ER to receive care:

- CD treatment reduces ER costs for SSI clients by **$154 per client per month.** Reduced ER costs alone almost completely offset the **$162 per client per month** average CD treatment cost.
- CD treatment reduces the number of ER visits made by SSI clients by about **20 percent.**
- CD treatment reduces the number of different ERs visited by **20 percent** for clients who enter CD treatment but do not complete treatment, and by **30 percent** for clients who enter and complete CD treatment.
- Subsequent ER visits with a primary diagnosis of mental illness are reduced by **42 percent** for clients who enter but do not complete CD treatment, and by **64 percent** for clients who complete CD treatment.
- Subsequent ER visits with primary diagnoses of injury or other emergent conditions are reduced by **15 percent** for clients who enter but do not complete CD treatment, and by **20 percent** for clients who complete CD treatment.

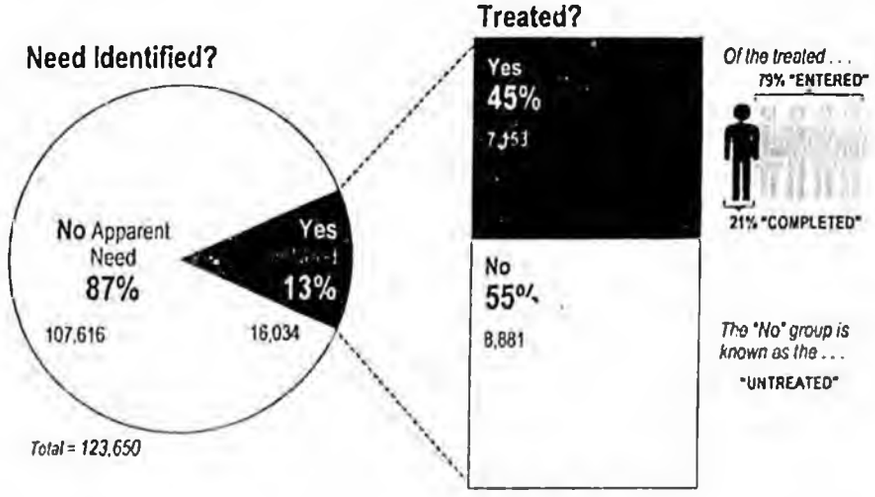
About the Study Population

This study examined 123,995 individuals who received SSI between July 1997 and December 2001. The SSI program provides assistance to persons with little or no income who are unable to work due primarily to physical or mental disability. SSI clients were first grouped into two broad categories:

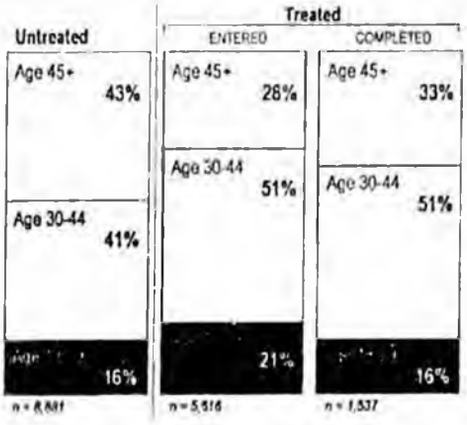
- Those with apparent need for CD treatment based on information in administrative records, and
- Those without an indication of need for CD treatment.

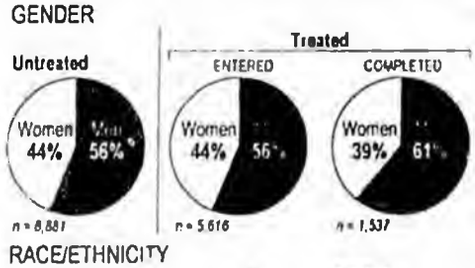
Of all SSI recipients, 13 percent were identified as needing treatment based on information in administrative records, including Medicaid-paid claims, Washington State Patrol arrest records, and Division of Alcohol and Substance Abuse service records.

- Among those identified as needing substance abuse treatment, we further distinguish between those who actually received treatment (45 percent of those in need), and those who needed treatment, but did not get it (55 percent of those in need). Finally, among those entering treatment we distinguish between those completing treatment (21 percent of those entering treatment) and those who enter but do not complete treatment (79 percent of those entering treatment).[9]



Demographics





RACE/ETHNICITY

	Untreated	Treated: ENTERED	Treated: COMPLETED
White	75%	73%	73%
African American	11%	12%	13%
Asian	1%	1%	1%
Native American	6%	7%	6%
Hispanic	3%	3%	4%
Other	4%	4%	3%

[9] A conservative definition of treatment completion was used in this study. If clients participated in a continuum of care, successive admissions and discharges were linked to construct treatment "episodes." For example, if a client participated in residential treatment and subsequently participated in outpatient treatment, the two admissions were linked to form a single treatment episode as long as the client entered outpatient treatment within 30 days of being discharged from residential care. For this study, a client needed to complete the last discharge in the episode in order for the episode to be considered as complete.

TECHNICAL NOTES

This paper examines "cost offsets" – costs avoided for clients already receiving treatment or potential savings that might be realized by treating the untreated – of ER-related medical costs among clients receiving CD treatment. ER-related medical costs include the cost of all Medicaid-paid medical claims with a first date of service falling within the first and last dates of service of the institutional ER claim. The paper also examines the effects of CD treatment on the number and type of ER visits and the number of different ER providers visited.

The study population included clients who received SSI benefits at some time between July 1997 and December 2001 and who were identified as having a substance abuse problem based on administrative records. The SSI program provides cash and medical assistance to persons with little or no income who are unable to work due primarily to disability. Results of the original study[10] examining the effect of CD treatment on overall Medicaid medical, mental health, and nursing home costs, along with separate analyses of the effects of treatment for stimulant drug abuse[11] and those who participated in methadone treatment,[12] are also available from the authors.

The need for CD treatment for these clients was identified using information from medical diagnoses or procedures; detoxification, assessment, or chemical dependency (CD) treatment encounters; and arrests for drug or alcohol-related offenses. Clients were included in the analysis only if they had at least one month of medical assistance eligibility both before and after the "index event" indicating a need for CD treatment. The "wandering" analysis was further restricted to clients who had (1) at least one ER visit prior to the point at which their need for CD treatment was identified in administrative records, and (2) at least 12 months of medical assistance eligibility in the follow-up period.

Average monthly ER costs incurred following the identification of need for CD treatment were compared between SSI clients receiving CD treatment and SSI clients needing CD treatment who remained untreated. The effect of CD treatment on ER costs in the follow-up period were estimated using a regression model to control for the effects of factors such as age, gender, race/ethnicity, and the baseline propensity to incur ER costs. The effect of CD treatment on ER costs is presented in comparison to the average monthly ER costs for untreated clients in the follow-up period. Differences-in-differences regression models were used to estimate the impact of CD treatment on the number of ER visits (by type) and the number of different ER providers visited per 12 months of medical assistance eligibility.

[10] Estee, S. and Nordlund, D., 2003. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report.* Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2003.

[11] Nordlund, D., Estee, S. and Yamashiro, G., 2003. *Treatment of Stimulant Addiction Including Addiction to Methamphetamine Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients.* Washington State Department of Social and Health Services, Research and Data Analysis Division, December 2003.

[12] Nordlund, D., Estee, S., Mancuso, D. and Felver, B. 2004. *Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions: Washington State Supplemental Security Income Recipients.* Washington State Department of Social and Health Services, Research and Data Analysis Division, March.

Additional copies of this fact sheet may be obtained from the following websites:
http://www1.dshs.wa.gov/RDA/ or http://www1.dshs.wa.gov/dasa/
or through the Washington State Alcohol/Drug Clearinghouse by calling 1-800-662-9111 or 206-725-9696 (within Seattle or outside Washington State), by e-mailing clearinghouse@adhl.org, or by writing to 6535 Fifth Place South, Seattle, Washington 98108-0243.

Department of Social & Health Services
Research and Data Analysis Division
Report Number 11.120fs

DASA Treatment Expansion Update

Expanding access to alcohol/drug treatment

Doug Allen, Division Director, Department of Social and Health Services, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse

JANUARY 31, 2007

Background

SENATE BILL 5763, The Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005 provided expanded funding for chemical dependency treatment of approximately $32 million for adults and $6.7 million for youth. The adult expansion was targeted for adults on Medicaid and General Assistance and was funded primarily by assumed savings in medical and long-term care costs. Youth expansion funds were earmarked for adolescents in households with income below 200 percent of the federal poverty level. No offsetting savings were budgeted for the youth treatment expansion.

Actual cost savings per treated client are better than expected

Medical Savings

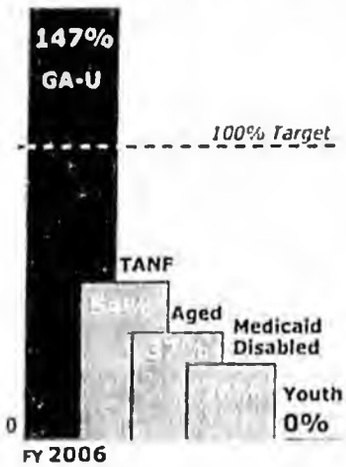
Medical savings per treated client are exceeding the original budget assumptions.

- For adult **Medicaid Disabled** clients, **medical savings** are now estimated to be **$289** per treated client per month, compared to $199 in the original appropriation.
- For adult **Medicaid Disabled** clients, **nursing home savings** are estimated to be **$115** per treated client per month, compared to $58 in the original appropriation.
- Actual **medical savings** for **GA-U clients** are estimated to be **$138** per treated client per month, compared to $117 in the original appropriation.
- Potential savings in other areas including criminal justice and child welfare costs have not been estimated.

FISCAL YEAR 2006	Assumed	Actual	Difference
Disabled – Medical Savings	$199	$289	+ $90
Disabled – NH Savings	$58	$115[1]	+ $57
GA-U – Medical Savings	$117	$138	+ $21

Treatment expansion ramp-up has been slower than expected

Percent of Goal Achieved



For most target populations, the number of additional clients in treatment has fallen short of the originally budgeted targets.

For the key Medicaid Disabled population, the 2005-07 Budget assumed that 4,386 additional clients would be in treatment in FY 2006. The actual expansion for Medicaid Disabled clients in FY 2006 was 1,129 – 26 percent of the original goal.

The expansion has also fallen short of the goals for other Medicaid target groups, but has exceeded the treatment targets for GA-U clients. Treatment levels for youth have not increased significantly above baseline levels.

- **The Bottom Line: Despite greater-than-anticipated savings on a per-client-treated basis, total savings in the 2005-07 biennium will be lower than originally budgeted due to the slower than expected ramp-up of treatment.**

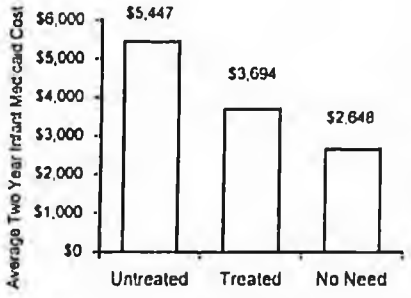
[1] Estimate to be reviewed by the Caseload Forecast Council long-term care technical workgroup.

Washington State Department of Social & Health Services
Division of Alcohol and Substance Abuse

Fact Sheet

Public Alcohol/Drug Treatment Reduces Future Medical & Psychiatric Costs in Washington State

Providing Treatment to Substance Abusing Pregnant Mothers Reduces Health Care Costs of Their Drug Exposed Infants



Alcohol/Drug (AOD) Treatment Results in Significant Medicaid Savings

Persons with Co-Occurring Disorders (Chemical Dependency & Mental Health) Had Lower Medical and Psychiatric Costs after Treatment

Providing Treatment to Substance Abusing Pregnant Mothers Reduces Health Care Costs of Their Drug Exposed Infants

- Average Medicaid costs for an infant's medical care during the first two years of life was 1.4 times greater for mothers with untreated substance abuse compared to those who received treatment in the prenatal period ($5,447 versus $3,694) and more than twice that for infants of other, non-substance abusing Medicaid women ($5,447 versus $2,648).
- The average expenditure for inpatient Neonatal Intensive Care Unit care for infants of substance abusers who received prenatal treatment for substance abuse ($832) was half that for infants of substance abusers diagnosed prenatally who did not receive treatment prior to delivery ($1,858) and was only slightly greater than that of infants of other Medicaid women ($755) (Cawthon & Schrager, 1995).

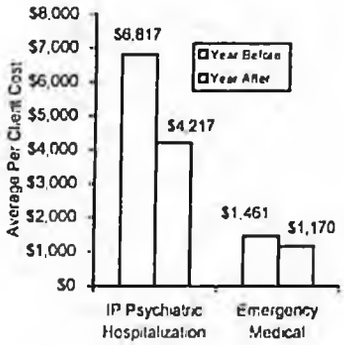
Medicaid Medical, Mental Health, and Nursing Home Costs Were Dramatically Reduced after Addicted SSI Recipients Received Chemical Dependency Treatment

- Untreated chemically dependent Supplemental Security Income (SSI) recipients (n=10,572) had $414/month higher Medicaid medical, mental health, and nursing home costs than treated (n=10,380) recipients--$252/month after adjusting for the cost of chemical dependency treatment.
- If an additional 30% of the 10,572 untreated SSI clients in need of alcohol/drug treatment got it, the annual cost savings could amount to roughly $9.6 million. (Estee & Nordlund, 2003).

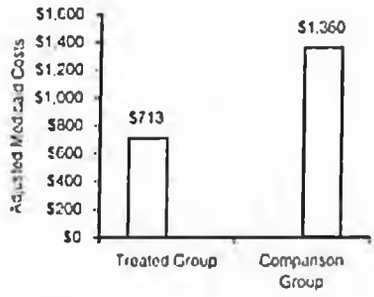
Persons with Co-Occurring Disorders (Chemical Dependency & Mental Health) Had Lower Medical and Psychiatric Costs after Treatment

- In a study of 534 patients discharged from a residential chemical dependency treatment program for persons with co-occurring disorders (chemical dependency and mental health), overall Medicaid-paid medical and psychiatric services decreased by 44%, from almost $5 million in the year before treatment to $2.8 million in the year after treatment.
- Individuals who completed treatment were less likely to receive costly, acute care services (Maynard et al, 1999).

Persons Involuntarily Committed to Chemical Dependency Treatment Had Decreased Medical and Psychiatric Costs in Year after Discharge



Significant Cost Savings Are Realized When Addicted Indigent Persons Are Provided Chemical Dependency Treatment



For more information on chemical dependency treatment studies described in this fact sheet, contact.

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Website: www1.dshs.wa.gov/dasa/

Persons Involuntarily Committed to Chemical Dependency Treatment Had Decreased Medical and Psychiatric Costs in Year after Discharge

- In a study of 735 patients discharged from a residential chemical dependency involuntary commitment program, the cost of their Medicaid-paid medical and psychiatric services decreased from $3.8 million in the year before admission to $2.7 million in the year following discharge.
- Average per client psychiatric hospitalization costs went from $6,817 in the year before treatment to $4,217 in the year after treatment (Maynard et al, 2000).

Health Care Savings Continued Five Years after Treatment

- Over a 5-year follow-up period, ADATSA[1] clients who received chemical dependency treatment had medical costs that were $4,540 less than those of the average untreated client.
- Treatment produces the largest savings for those who had Medicaid medical expenses prior to chemical dependency treatment. These clients cost, on average, $7900 less than a similar group of untreated clients over a five-year follow-up period (Luchansky & Longhi, 1997).

Significant Cost Savings Are Realized When Addicted Indigent Persons Are Provided Chemical Dependency Treatment

- The average ADATSA client who participated in chemical dependency treatment incurred an estimated $713 in (adjusted) Medicaid costs compared to $1,360 for the untreated comparison group. Approximately two thirds ($422 of $647) of the cost reduction represented a reduction in inpatient hospital costs (Wickizer & Longhi, 1997).

References

Cawthon, L., & Schrager, L. (1995). Fact Sheet: *"First Steps Database. Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State."* Olympia, WA: Office of Research and Data Analysis, Department of Social and Health Services.

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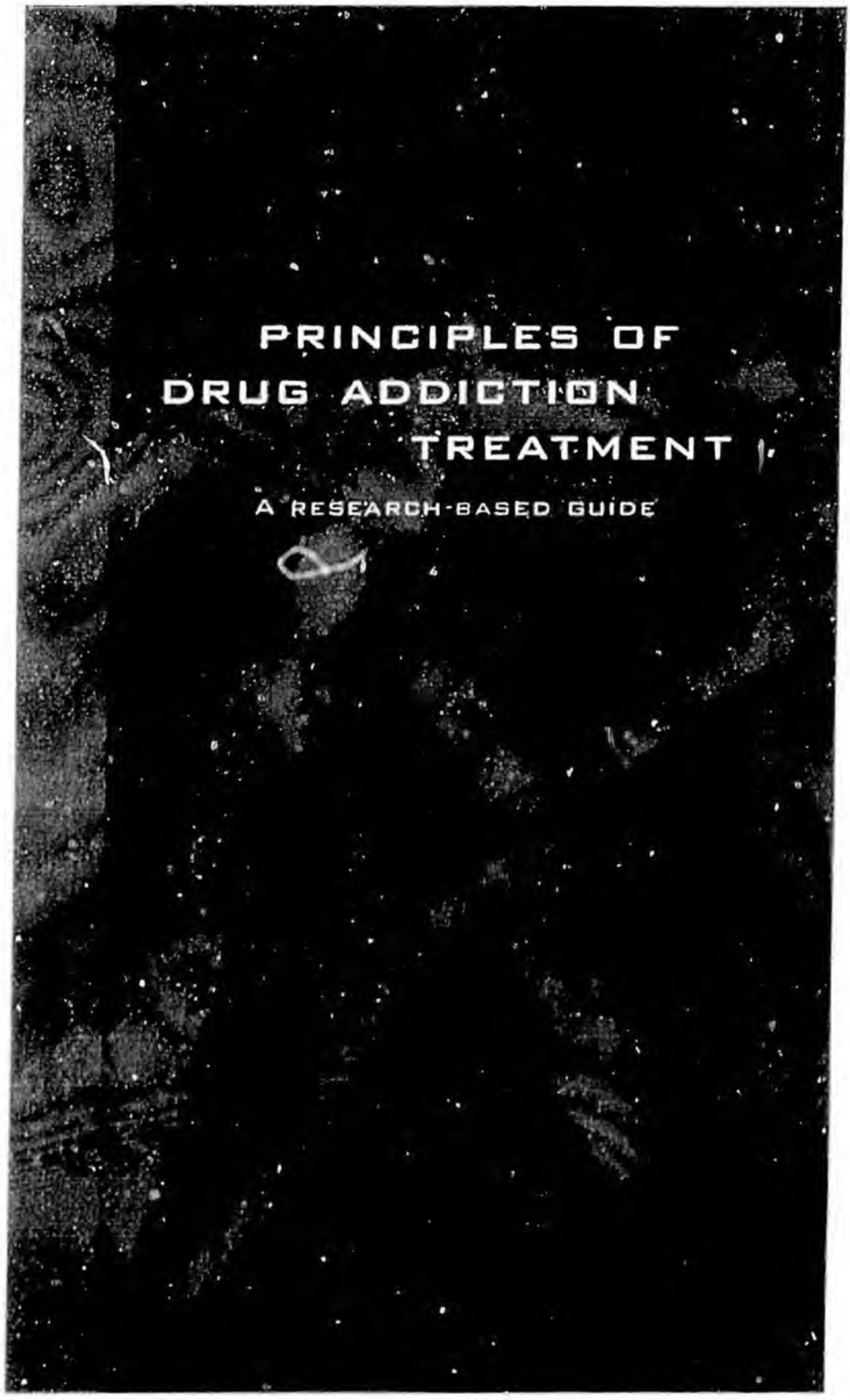
Luchansky, B., & Longhi, D. (1997). Briefing Paper: *"Cost Savings in Medicaid Medical Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State. A Five Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)."* Olympia, WA: Research and Data Analysis, Department of Social and Health Services.

Maynard, C., Cox, G. B., Krupski, A., Stark, K. (1999). Utilization of services for mentally ill chemically abusing patients discharged from residential treatment. *The Journal of Behavioral Health Services & Research, 26*, 219-228.

Maynard, C., Cox, G. B., Krupski, A., & Stark, K. (2000). Utilization of services by persons discharged from involuntary chemical dependency treatment. *Journal of Addictive Diseases, 19* (2), 83-93.

Wickizer, T., & Longhi, D. (1997). *Economic Benefits and Costs Associated with Substance Abuse Treatment Provided to Indigent Clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) Program.* Olympia, WA: Division of Alcohol and Substance Abuse, Department of Social and Health Services.

[1] ADATSA is a state funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.


PRINCIPLES OF
DRUG ADDICTION
TREATMENT
A RESEARCH-BASED GUIDE

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 [illegible] medical services, family therapy, parenting instruction, [illegible] 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). 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 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 an 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.

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).

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 support programs during and following treatment often is helpful in maintaining abstinence.

The Origins of Commitment for Substance Abuse in the United States

Kathleen Thomsen Hall, MD, and Paul S. Appelbaum, MD

Policymakers in the United States have long been perplexed by how to deal with substance abuse. As attitudes shifted in the 19th century toward viewing substance abuse as a medical problem akin to insanity rather than as a moral failing, greater emphasis was given to the potential for treatment. Thus, by the middle of the 19th century, states began developing substance abuse commitment codes and institutions to which substance abusers could be committed. Public ambivalence over whether substance abusers should be seen as having an illness or a weakness of will, however, was reflected in the lack of sustained support for these efforts, in contrast to support accorded systems for commitment of the mentally ill. Contemporary policymakers are faced with the same ambivalence, as they struggle with the extent to which substance abusers ought to be subjected to involuntary treatment. The legacy of the early years of substance abuse commitment lives on.

J Am Acad Psychiatry Law 30:33–45, 2002

Substance abuse has captured the concern of physicians, social reformers, the legal community, and policymakers in the United States for two centuries. In the face of perennial debates over when society should intervene, how best to do so, and how to fund these interventions, legal mechanisms for substance abuse intervention took several forms in the United States in the 19th century. Habitual drunkards, dipsomaniacs, opium addicts, and cocaine inebriates were incarcerated, placed in workhouses, committed to almshouses, subjected to inquisitions leading to guardianship, and committed for treatment to inebriety asylums and related facilities. This article records one aspect of substance abuse intervention history: the evolution of the first identifiable substance abuse commitment codes.

Social Underpinnings

The post-Revolution United States was a hard-drinking place. Alcohol, the "good creature of God,"[1] was the universal remedy. Americans drank at almost three times the present rate, with per capita consumption of ethanol reaching 7.1 gallons annually by 1830. In the face of this prodigious intake, problems related to the use of alcohol became a serious concern for civic leaders, law enforcement officers, and physicians.[1–3] *Status ebrietas* accounted for the majority of arrests and incarcerations, overwhelming courts, jails, and houses of industry.[3,4–8] In a perpetual circuit between the streets, jail, and other public facilities, recidivist habitual drunkards became known as "police court rounders."[9] Common drunkards were moral offenders whom the police could arrest without warrant in public places; even private drunkenness was criminalized in Massachusetts.[7,10]

Efforts to counter substance abuse originated with the temperance movement in the late 18th century. Temperance advocates collectively opposed the abuse, and eventually use, of alcohol. With ardent speeches and religious fervor, they sought to educate the public, reform the drunkard, and sway legislatures. Even with vigorous medical leadership, both punitive and reformative threads were found within the temperance movement, and temperance writers characterized intemperance sufferers as victims.[7,11–14] It is also in the temperance literature that

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the suggestion that alcohol is irresistable first occurs, ushering in the controversy surrounding the role of volition that shapes discourse on interventions to this day.[15–17]

Despite medical involvement in the formative years of the temperance movement, reformation as envisioned by temperance advocates typically involved mutual-aid fellowships of individuals devoted to abstinence, such as the Washingtonians and subsequent fraternal temperance societies.[3] Later in the century, the increasingly moralistic focus had shifted to prohibition, for "only evil-disposed persons and fools fall victims to the alcoholic excesses."[18] Temperance advocates succeeded in enacting a wave of prohibition statutes, starting with Maine in 1851. Fifteen states soon followed suit. Prohibition statutes were short-lived, however; some were ruled unconstitutional[19] and the remainder, declared the U.S. Brewer's Association, were "not sustained by the will of the people."[20]

Despite prohibition's failures and the decline of the short-lived Washingtonian movement, mounting intolerance of public drunkenness fomented social and religious pressures to aid, treat, and contain the dependent and deviant. Embraced by the great social welfare and public health movements of the 19th century, efforts to correct or reform drunkards preoccupied authorities and reformers. Public health officials warned that intemperance was an enormous evil, and the cause of a vast amount of suffering, endangering the public and the offspring of intemperate parents.[15,21–23]

The Medical Community Responds

For centuries, physicians had warned of dangers to health and mind from excessive consumption of alcohol. Although such influential physicians as Thomas Trotter, Samuel Woodward, and Benjamin Rush characterized habitual drunkenness as a disease of the mind, they represented a minority viewpoint at the dawn of the 19th century. Temperance-movement physicians were responsible not only for developing and advancing the disease concept of alcoholism among physicians, temperance advocates, and the general public, but were among the earliest advocates for medical treatment of drunkards.[2,24–28] They were not entirely successful: Early temperance literature referred to intemperance, variously, as a disease, or productive of a disease, or an evil.[5,29] Perhaps Boorstin got it right, arguing that when evil was encountered, Jeffersonian ideas led to naturalization into a disease.[15] This was a time of conspicuous intemperance among physicians, who faced declining public confidence, censure, and admonishment for prescribing alcohol as a remedy.[2,27,30,31] In any case, the abundant dangers, or evils, were often lethal. They included suicide, delirium tremens, lunacy, congenital idiocy, and incurable maladies stemming from the habit of drunkenness.[20,23,26,33–39] Dipsomania, declared inebriety pioneer J. Edward Turner, was America's "national disease."[40]

No nomenclature for substance abuse existed before the 19th century.[41] The newly proposed disease, however, was accompanied by an enthusiastic nomenclature, and diagnostic, descriptive, and etiologic categories abounded. Among the many diagnoses used were methyskomania, mania à potú, oinomania, mania ebriosa, narcomania, absinthe imbecility, and dipsomania. Dipsomania, a morbidly uncontrollable propensity for paroxysmal bouts of drunkenness, was one of the most commonly used diagnoses, and physicians engaged in ill-fated efforts to distinguish it from habitual drunkenness. Medical causation theories included J. E. D. Esquirol's partial insanity or monomania, Thomas Crothers' physical disease, George Beard's theories of social evolution leading to nervous exhaustion and neuroasthenia, James Prichard's concepts of moral insanity, Charles Palmer's moral typology of inebriates, phrenologic explanations, and Benedict Morel's theory of cumulative hereditary degeneration.[34,42–47]

Despite these medical theories of a generally biological basis for inebriety, the disease theory remained controversial in the medical community.[48,49] Even insane asylum superintendents were unable to agree on whether inebriety was a disease or a vice. Physicians agreed, however, that for those "deprived of volition," involuntary institutional care was a necessary intervention, declaring that inebriates should be restrained on grounds of moral depravity, detained as diseased requiring treatment, or committed as *non compos mentis*.[50]

Throughout the 19th century, physicians urged medical alternatives to incarceration of inebriates.[40,51] Blaming incarceration practices for increased crime, the Connecticut Medical Society in 1830 characterized penal discipline as degrading and injurious, impolitic and cruel.[52] Thomas Crothers declared that prosecution of the inebriate as wicked was analogous to prosecution of the insane as devil-

possessed.[51] Mason warned of medical dangers when a seriously intoxicated person was taken to jail, stating, "The average policeman is not a good diagnostician."[8]

While temperance advocates became preoccupied with moral arguments, punitive measures, and restrictive approaches such as prohibition, physicians devoted to the medical treatment of inebriety were increasingly occupied with "rational" and "scientific" methods and discounted the role of volition.[44] Enfield declared, "The science of medicine has commenced a new war against an old but recently discovered disease."[53] In 1870, the American Association for the Cure of Inebriety (AACI) was founded. Composed primarily of physicians affiliated with institutions for the treatment of inebriety, the AACI ranks included such highly regarded medical leaders as the founder of the American Medical Association. The AACI held annual scientific meetings, founded a journal, encouraged legislative advocacy, and endeavored to reach a consensus regarding the etiology and treatment of inebriety. Albeit with some dissension, the AACI promoted the concept that inebriety was a true medical disorder and thus most appropriately treated in special hospitals. Promoting involuntary treatment and strict public regulation of treatment institutions, AACI physicians strove to avoid moralistic approaches. They also advocated for the absence of volitional control in substance abuse insanity defenses,[54–56] arguing that mentally diseased inebriates were "moral paralytics."[41] Even Isaac Ray, the father of American forensic psychiatry, characterized alcoholic craving as an "unutterable agony of spirit, the resistless impulse by which he is driven."[42] Why, wondered physicians such as Louise Thomas, did the temperance movement no longer call on medical science?[57]

Remedies Proposed

Decades before the emergence of identifiable substance abuse commitment codes, many states developed civil mechanisms to intervene with habitual drunkards. These mechanisms included guardianship and commitments to almshouses and workhouses. Thus emerged civil mechanisms to confine or reform the habitual drunkard, who could be sent for treatment by order of his or her committee.[58,59] Case law clarified that guardianship proceedings could be instituted against a habitual drunkard who had no estate, and a therapeutic agenda was added to the guardian's custodial responsibilities. The court affirmed that power over the person was complete and should be used to effect a reformation by kind and humane treatment.[60] The court reasoned, "The protection of property is of but little consequence in comparison with the salvation of its deluded owners, who may properly be considered as morally deranged. . . ."[61]

Physicians, who were more familiar with involuntary treatment of the mentally ill, actively sought legislation that would permit commitment of substance abusers for institutional treatment. The models to which they looked were developed in the second quarter of the 19th century, as states began to construct public facilities for the care of persons with mental illness. Before that time, most hospitalization of the mentally ill occurred on an informal basis, with family members and physicians deciding when admission and discharge were indicated. With the development of the state asylums (only two existed before 1830), enabling legislation generally preserved this approach. Thus, patients could be hospitalized at the initiative of their families or, if they were paupers, by the overseers of the poor, when they required care and treatment. The hospital superintendent's concurrence was necessary, but there was no judicial review of the admission decision. Patients retained the right to trigger a court hearing by invoking a writ of *habeas corpus*, although this was an infrequent event.[62,63]

Physicians' recommendations for commitment laws for substance abusers reflected a similar paternalistic ethos. As early as 1812, Benjamin Rush had proposed that intemperate persons be examined by a physician and magistrate for court commitment to a sober house hospital.[25] Other measures to date had been inadequate, physicians argued, and involuntary treatment was needful and merciful.[13,17,23,25,26,28,34–36,64,65] Commitment would permit the environment change, medical supervision, and vigilance required for treatment, for inebriates in the throes of uncontrollable craving were thought to use extreme deception and cunning. Furthermore, treatment was the salvation of the morally dead inebriate, who became a morally responsible being.[40] Protection of the inebriate demanded involuntary treatment due to the risks of self-ruin, squandering property, medical complications, and suicide. Inebriates were also considered a contaminating influence, thus dangerous to others.[66,67]

Invoking "preventive justice"[37] and social preservation, physicians reasoned that prevention of crimes, cost-savings to be gained by treatment, and prevention of the hereditary transmission of the "inebriate diathesis" would be served by commitment.[66] Inebriates were also a crucial disposition issue for superintendents of asylums for the insane, who supported substance abuse commitment when paired with recommendations for inebriety asylums.[68] Because the state had created the disease by permitting legal sales of alcohol, the state was responsible to pay for treatment, opined one asylum proprietor.[40]

Amid the therapeutic and paternalistic rationales for involuntary treatment, an occasional physician acknowledged a role for the inebriate in his or her own recovery process. For example, in 1855, Wilson reminded physicians that part of the cure depends solely on the drunkard himself.[17] Most, however, viewed treatment as a medical procedure. Some medical advocates of involuntary treatment even declared that claims of self-cure were fraudulent,[69] resorting to circular arguments such as that by Enfield: "Because it is a disease, it is therefore curable. . . . Being a disease, its cure rests with the physician."[53]

Benjamin Rush's 1812 response to liberty concerns set the tone for the remainder of the century:

> Let it not be said, that confining such persons in a hospital would be an infringement upon personal liberty, incompatible with the freedom of our governments. We do not use this argument when we confine a thief in jail, and yet, taking the aggregate evil of the greater number of drunkards than thieves into consideration, and the greater evils which the influence of their immoral example and conduct introduce into society than stealing, it must be obvious, that the safety and prosperity of a community will be more promoted by confining them, than a common thief (Ref. 25, pp 267–8).

Subsequent physician advocates of involuntary treatment similarly dismissed legal concerns with individual liberties as both dangerous[11,70] and "merest nonsense."[71] A committee of the Massachusetts legislature formed to evaluate the need for commitment of inebriates held a similar view.[72] Physicians viewed such abstractions as of little significance when compared with the realities of inebriety: "There is one liberty which the humane would desire to see denied to every class of people: the liberty of making themselves slaves."[17] However the matter of detaining inebriates for treatment past their initial "paroxysm" represented a conflict of duties for some physicians.[64] Isaac Ray said, "I do not see how we can help compromising either the happiness of families or the rights of the individual."[3]

How did the physicians who advocated commitment of inebriates propose to treat them? With patience, compassion, and what corrections physician Lucy Hall described as "absolute and unremitting control and protection."[12] The principles of therapeutic intervention were first outlined by Thomas Trotter and consisted of managing withdrawal, a controlled environment, physical restoration, and education.[26] Later physicians, styling the treatment as rational and scientific, emphasized remedying the preinebriate condition, manual labor, probation, and time.[18,51,73,74] Reformation was a matter of growth and development, not a "presto-chango" affair.[75]

Physicians who urged legislative mechanisms for commitment of substance-abusing patients also advised development of institutions for the treatment of inebriates. American proposals for institutional care began with Benjamin Rush's proposal for a sober-house hospital in 1812. Soon thereafter Samuel Woodward[28] and the Connecticut Medical Society (1830) called for the founding of medical asylums to treat inebriates. Woodward frankly referred to this proposal as "an experiment in treating inebriety."[13] Jailers and state hospital superintendents joined in.[50,76] Thomas Crothers, proprietor of the Walnut Lodge in Hartford, Connecticut, went so far as to state that some individuals were sane "only when confined in an asylum."[11] Treatment with chemical restraints such as chloral, bromides, and opium at home was excessively dangerous, he warned, and prolonged the duration of the disease. The structure and discipline of the institutional setting were crucial, for recovery required alternation of restraint and freedom applied with "military exactness."[77]

The first "embryo asylum" was Boston's Washingtonian Hall, founded in 1845. By 1893, the AACI reported that more than 50 U.S. inebriety hospitals and medical facilities for treatment of inebriates were in operation, including homes, "faith cure" halls, and lodging houses; another account for the same year counted 118 proprietary cure institutes affiliated with the Keeley Foundation (see Case Study 3, to follow).[1,76,77] Inebriety hospitals or asylums often provided involuntary treatment to committed inebriates. Eventually, smaller institutions formed by temperance fellowships devoted to voluntary reformation such as the Washingtonian Home in Chicago

and the San Francisco Home shifted toward coerced treatment and enforced abstinence. Police court diversions to these otherwise voluntary facilities became commonplace.[78,79]

Debate about commitment procedures reflected the class concerns that simmered among those who treated inebriates. Inebriety physicians distanced themselves from "vicious drunks" of the "criminal classes," arguing that persons should be of "good character" to be eligible for the commitment process.[3] Generally, American physicians who worked at public facilities were prone to favor broader definitions of inebriety. Those at private institutions styled dipsomania and the neurasthenic inebriate affliction of upper-class and "refined" professions as the true diseases in need of medical treatment, whereas "vicious drunks" were characterized as ignorant, degraded, and of the criminal classes.[14,46,55,76,80] U.S. physicians collaborated with British efforts to enact substance abuse commitment; the resultant Habitual Drunkards Act was heavily class oriented. The exasperated physician John Bucknill responded, "I anticipate with some repugnance the duty of carrying out its provisions for treating the rich drunkard as if his conduct were the uncontrollable result of disease, while upon the poor and ignorant wretch I must still impose the penalty of vicious excess."[81]

Opponents of commitment statutes argued that the proposed treatments were costly, ineffective, and applied to conditions about which the medical community disagreed. More precisely, they pointed out that compulsory abstinence was not cure.[49] Moralists, noting disinterest by the temperance community, criticized the abdication of voluntary treatment approaches that fostered individual responsibility and moral heroism.[48,55,78,82] Pragmatists expressed skepticism regarding superintendents who wanted to take only those inebriates who desired treatment and concerns about facilities where only brief treatment was provided. Furthermore, it would be impossible to provide such a large group with industrial employment, an important aspect of rehabilitation recommendations.[73]

The legal community expressed doubt about a dubious certification process and concerns about wrongful detention and contended that morality could not be legislated. Doctors and family were suspected of sinister motives; examiners were suspected of pecuniary interests.[83] Although the medical community paid little heed, attorneys on both sides of the Atlantic took notice when a New York statute was ruled unconstitutional (discussed later, in Case Study 1). After all, if they were truly suffering from a mental disease, why not treat dipsomaniacs under insanity laws? And what possible rationale could justify detention during periods of sobriety? Furthermore, English common law had long held drunkards to be *voluntarius daemon*, thus affording no excuse for crimes committed when intoxicated. If inebriety was a disease requiring commitment, the English practice of holding a drunkard responsible could be eroded.[40,48,82–90]

Hard-line social reformers favored prison sentences because they were shorter, cheaper, and more severe.[73,55] The disease approach represented a "fundamental challenge to the rising organizational effectiveness of the social reform of the latter part of the 19th century."[55] Commitment, opponents implied, was an extreme response to a widespread problem.[79] Declared British opponents: "Here is the project of an Act for making us all sober with a vengeance. . . . Imprisonment may come from a picnic."[38]

Statutes Are Enacted

Despite this opposition, at least 14 U.S. states as well as many other countries succeeded in enacting substance abuse commitment codes during the last half of the 19th century. American, Canadian, British, and European advocates exchanged testimony and efficacy figures; opponents did likewise. U.S. statutes covered commitments to public facilities (e.g., Refs. 91–95) and a variety of private facilities (e.g., Refs. 96–100). Many of the earliest statutes hybridized guardianship and commitment (e.g., Refs. 92,101–107). Some incorporated criminal diversion procedures and mechanisms for voluntary commitment. Other jurisdictions enacting similar substance abuse commitment codes included Australia, Austria, Belgium, most Canadian provinces, England, Germany, Ireland, New Zealand, Norway, Russia, and Switzerland. In France, a guardianship-based procedure permitted involuntary treatment for inebriates and the mentally ill.[8,37,43,71,108–110] Closely tracking U.S. legislative activities, efforts to enact a substance abuse commitment code in England began early in the 19th century, although limitation in knowledge about the disease of inebriety and the difficulty in knowing the appropriate duration for detention were the primary difficulties with enacting legislation when Laycock wrote in

1855.[35,36] Legal commentators, shrewdly observing that temperance activists and medical entrepreneurs were the primary proponents of substance abuse commitment, declared that although involuntary treatment of substance abusers was not in conflict with the moral sense of the nation, it must involve support from more than teetotalers to enact.[111] England's Habitual Drunkards Act of 1879 consisted of a much-maligned voluntary commitment procedure, although an 1898 revision finally permitted involuntary treatment.[38,112–114]

Although the medical community urged the development of commitment procedures for decades before the first facilities were founded,[13,115] as with commitment for "lunacy," substance abuse commitment codes generally accompanied the founding charter of an institution. Their evolution tracked the course of the facilities they served, beset by social pressures, medical debates, and financial woes. The facilities involved included hospitals, asylums, reformatories, charitable institutions, and even a workhouse.[40,116] Some commitment statutes reflected the rejection of small, voluntary programs that were so reluctant to use coercion that they failed to protect patients, their families, and the public or to impose discipline when they received court-ordered inebriates.[79,97,98] In the transformation and demise of the San Francisco Home, for example, Baumohl noted "a failing faith in moral suasion and a growing conviction that those who repeatedly failed the test of the pledge needed prolonged and enforced separation from alcohol, whether in jail or in an asylum under medical management."[82]

With a petition or complaint alleging habitual intemperance, most statutes permitted any inebriate, dipsomaniac, or habitual drunkard to be committed. Some required the inebriate to have lost the power of self-control—a volitional standard that emphasized the person's need for treatment. Although the AACI's model legislation proposed dangerousness to self or others as a basis for commitment in 1872, only two New York statutes used this standard.[117,118] Legal theorists such as Christopher Tiedeman[119] argued that forcibly subjecting the inebriate to medical treatment could only be justified when individuals were insane or dangerous. British law reviewers opined:

> As a cause of forfeiture of the right to bodily freedom, drunkenness probably stands on much the same footing at common law as madness. It is probable that any person may justify at common law such restraint of a drunken man as may be necessary for preventing him from doing an injury to himself or to others if there is reasonable cause to believe that such injury will be done (Ref. 90, p 691).

Due process provisions were noticeably absent from most of the earliest statutes,[94,96–98,104] although litigation changed this picture. Some specified, vaguely, "due inquiry" by the court.[120] The court also adopted due process principles from insanity commitment litigation (e.g., *In re Wellman*) regarding the need to provide notice to the alleged inebriate of the impending proceedings. Excepting Maryland, most states avoided jury trials, despite their basis in common law.[92,121]

How long to treat an inebriate was a matter of considerable debate. Most physicians advised commitment for six months to three years or until patients were able to resist temptation and thus were cured.[8,13,77,112,122] As they gained experience committing inebriates, however, physicians revised their recommendation for discharge, first to restoration of sound mind and sober habits, and finally to "medical readiness."[14,123] Those physicians who supported shorter stays argued that delirium—the feature that most closely resembled temporary insanity—resolved within days.[82,124,125] Furthermore, abstinence due to enforced restraint was entirely different from "eradicating the morbid tendency."[18] Release, if terms were specified, was typically by court order or when the committed individual was no longer "subject to dipsomania or habitual drunkenness."[95]

The history of these statutes can be illustrated by exploring their courses in three states: New York, a colorful piecemeal; Massachusetts, a public sector story; and Minnesota, a tale of jittery taxpayers at the public-private interface.

Case Study 1: The New York Story

The nation's first identifiable substance abuse commitment code accompanied the granting of the charter of the New York State Inebriate Asylum. Billed as the world's first hospital dedicated to the treatment of substance abusers, the impressive Binghamton facility opened its doors in 1864 after decades of promotional efforts by inebriety pioneer and entrepreneur J. Edward Turner. The private facility was funded by shareholders, among whom numbered ex-presidents, former supreme court justices, and other political luminaries. Turner's grand designs refer to a "castellated gothic" structure with a

chapel seating 500, a winter garden, bowling rooms, and Russian baths. Despite concerns that commitment could become "an instrument of oppression by confining persons not drunkards in the true meaning of that word without power of redress,"[40] the legislature empowered the superintendent to accept and retain all inebriates who entered the asylum, initially both voluntary patients and those who entered by "orders of the committee" of any habitual drunkard, and later by judicial commitment. Commitment required evidence in the form of *ex parte* affidavits that the drunkard was lost to self-control or unable, because of inebriation, to attend to business or was dangerous to remain at large. Despite legal challenges and vigorous opposition by liquor proprietors, Turner succeeded in getting further legislative refinements, making it a misdemeanor to sell or give alcoholic stimulants, tobacco, or opium to asylum patients, and in adding police force protection to the facility.[117] Predictably, detainees filed writs of *habeas corpus*. The courts held that the legislature had failed to pass a law that conferred authority to detain voluntary patients.[126] Furthermore, the law depriving persons of their liberty for a considerable period of time without being heard, or having the opportunity to be heard, was repugnant to the state and U.S. constitutions, and the use of *ex parte* affidavits violated due process principles.[119,127] Although the empowering statute was voided, the facility continued to receive voluntary patients. Turner was ousted within a few years by trustees who objected to his coercive measures and questioned his financial management. In 1878, the inebriate asylum was taken over by the state and turned into an asylum for the insane.[77]

Brooklyn's Kings County Inebriates Home was founded in 1867, and a second series of facility-specific New York commitment codes ensued. Responding to pressures of law enforcement, corrections, and the medical community, New York became one of several states in the post-Civil War era to permit inebriates in police custody and prison inmates confined for substance abuse-related charges to be transferred to treatment in lieu of incarceration.[93,97–99,120,127] At a time when the prevalence of addiction had risen to an estimated two to four percent of the population,[129] the 1875 King's County statute led the nation by recognizing the increasingly troubling problem of narcotic addiction.[118]

In 1882, the third series of New York substance abuse commitment statutes originated, improbably, from criminal diversion efforts with prostitutes.[99,100,130] Women with intemperate habits could be detained in charitable institutions such as the Magdalen Female Benevolent Asylum, the Home of Fallen Women, and St. Saviour's Sanitarium. Like the overturned New York Inebriate Asylum statute, the St. Saviour's statute permitted the forcible retention of voluntary inebriates. Yet again, the court held that proceedings under the act lacked due process and were invalid, in that they depended on the discretion of those who detained the patients, and that although the object of the act appeared protective rather than penal, the deprivation of liberty produced by the act was penal in effect. Furthermore, New York's effort to evade due process shortcomings by expressly permitting application for writs of *habeas corpus* was unsuccessful because this was a right detainees already possessed in common with every other citizen of New York.[131] Although not unwilling to permit involuntary hospitalization for substance abuse treatment, the New York courts were vigilant in insisting on strict procedural safeguards.

Case Study 2: The Massachusetts Story

The Massachusetts story began when state insane asylum superintendents implored the legislature to found an inebriety hospital. They, along with their colleagues in the American Association of Medical Superintendents of Asylums for the Insane, viewed inebriety asylums as the best possible way of relieving overcrowded insane asylums of the burden of caring for inebriates. Instead, Massachusetts enacted a statute in 1885 permitting just what the superintendents had "always earnestly protested against"[132]: the commitment and treatment of dipsomaniacs and inebriates at state insane asylums. The Massachusetts experience was discouraging. The dipsomaniac was to be held until no longer subject to dipsomania or habitual drunkenness or until confinement was no longer necessary for public safety or the patient's welfare. State hospitals were already overflowing with cases of ordinary insanity.[68] With the influx of inebriates, the superintendent's position degenerated into that of a policeman trying to maintain order in a crowd of inebriates and the mentally ill.[132] Judges disregarded the requirement that satisfactory evidence be furnished that the person was not of bad repute or bad character. Although committing magistrates con-

strued the statute as also applying to private asylums for the insane, the state hospitals were quickly overrun.[95]

State officials eventually responded to these concerns by opening the Massachusetts Hospital for Dipsomaniacs and Inebriates in 1893; a special inebriety hospital did not solve the management problems, however. From the outset, trustees reported ongoing difficulties managing committed inebriates, handling escapees, and excluding incorrigible patients. And then there were the disgruntled patients, who believed they had been misled about the duration of their two-year commitments. Punitive commitments by family members who relented once the inebriate had been "punished enough" further compromised efforts to maintain a therapeutic program. Trustees also reported indiscriminate or inappropriate commitments of confirmed drunkards, medically ill individuals, inebriates who were past the age of possible cure, and "vicious inebriate" criminals of bad character.[14,123] Eventually, a procedure for early release was enacted whereby trustees were required to certify that the patients would no longer be subject to dipsomania or inebriety or would not be benefited by further treatment, thus permitting problematic patients to be culled.[133]

Massachusetts detainees were a litigious lot. As early as 1834, Samuel Woodward, superintendent of the state's insane asylum in Worcester, had anticipated that individuals detained in inebriety asylums might seek redress for false imprisonment, and he recommended a hold-harmless arrangement with family, friends, and guardians. Congruent with the disease model that underpinned these statutes and in parallel with procedures for committing the insane, Massachusetts was one of several states that required a physician's examination and certificate.[95,100,103,117,120,134,135] Theodore Fisher, superintendent of the Boston Lunatic Asylum, gained experience in defending an action for improper certification and was of the opinion that ambiguity in the 1885 statute could lead physicians to certify inebriates who were actually of sound mind. In *Niren v. Boland*, a tort case against two physicians alleged to have negligently certified a patient for commitment to the Massachusetts Hospital for Dipsomaniacs, the appeals court affirmed the importance of the examining physicians. Characterizing their role as quasi-judicial, the court indicated that the privilege that attaches to parties and witnesses in other judicial proceedings should attach to examining physicians.[136]

In Fisher's address to the Massachusetts Medical Society, "Insane Drunkards," he further characterized the difficulty of retaining a committed insane drunkard, whose prominent symptoms were transient. "In a surprisingly short time he is on his feet, under perfect control, looking around for a lawyer to help him swear that his confused recollection of the circumstances of his commitment is the true version."[137] When the statute was revised, adding procedural due process protections, the burden of proof was placed on the patient, who was required to show cause why he or she should not be committed.[123,138] Massachusetts' experience highlights the tendency for statutes originally developed for therapeutic purposes to be turned into overt mechanisms for social control, with the apparent acquiescence of the judiciary.

Case Study 3: The Minnesota Story

The Minnesota story is one of concern for financial outlays. Admission into the Minnesota Inebriate Asylum in 1875 required a judicial certificate of inability to defray expenses (thus limiting public expenditures to care for the indigent), a finding of incompetence, and guardianship on account of excessive drinking. The Inebriety Asylum was subsumed by Rochester State Hospital, and before the century was over, Minnesotans prohibited treatment of inebriates at their state hospitals. With proprietary facilities booming, Minnesota county governments were then required to take on financial responsibility for the court-enforced "voluntary" treatment of inebriates. These commitments required habitual drunkards to petition for their own commitment and demonstrate a desire to be cured.[94,103,139,140] The Minnesota statute even specified, briefly, that inebriates could be committed by the counties to Keeley Cure "reputable double chloride of gold institutes."[1] The most popular of these were the franchised facilities founded by Dr. Leslie Keeley, where his patent remedy for inebriety was administered. Keeley facilities, and the supportive "Keeley Leagues" of cured or recovering individuals, were powerful enough to enact similar voluntary commitment laws in Colorado, Louisiana, Maryland, North Dakota, and the Oklahoma Territory.[1,141–145] The counties, however, were loathe to pay for such treatment, and the court held that "so-called commitments under this statute

were unconstitutional, assigning judges powers beyond their constitutional jurisdiction."[146] A subsequent revision applied only to residents of populous counties and was also found unconstitutional, because the provisions of the act thus discriminated between urban and rural drunkenness.[147] Minnesota's courts, in contrast to New York's, had concerns about commitment for substance abuse treatment that extended beyond the procedural to encompass the substantive basis for deprivation of liberty.

Impact

Inebriety physicians generally retained a hopeful outlook for the institutional (and often involuntary) treatment of inebriates. They based their opinions of efficacy on long-term follow-up surveys of thousands of patients. The published results were positive enough to generate some skepticism: Thirty-five percent of 3,000 patients from Boston's Washingtonian Home were reported temperate and well 8 to 12 years after treatment; 42 percent of inebriates treated at the Massachusetts Hospital for Dipsomaniacs and Inebriates were doing well 2 to 14 months later; and 61 percent of 1,100 patients treated at the New York State Inebriate Asylum were deemed by relatives to be temperate and well after 5 years. Other asylum proprietors quoted similarly promising results, although in none of these reports are the outcomes classified according to whether the patient was voluntary or involuntary.[68,123,148]

The evangelical tone of physicians promoting institutional treatment of inebriates became tempered as the decades passed, for their central problem was never resolved: how to treat the accumulation of refractory inebriates, the same incorrigibles who clogged courts, jails, and workhouses. As physicians endeavored to confront this issue, their tone became increasingly strident. They recommended state guardianship. They proposed long-term and even life-long detention in industrial hospitals, or emigration to a temperance island.[54,67,75,122] Dr. Clark, a police surgeon, proposed trying the Scottish system "of sending inebriates to certain islands in the Frith of Clyde and would deport to the Pacific Islands our growing and hereditary class of inebriates."[113]

Statutes serving both public and private facilities were enacted throughout the last half of the century. Although intolerance of public drunkenness provided the constituency that permitted their enactment, skeptical legislators were loathe to fund inebriety treatment. Not until the 1890s did public funding for inebriety treatment become routine in statutory language—and this only in the wave of voluntary commitment statutes requiring county funding. Their formula took advantage of societal ambivalence by removing patient language and by reintroducing voluntarism, requiring evidence that the habitual drunkard was willing to obtain treatment. This time, advocates were not medical scientists but medical entrepreneurs of the 1890s.

Commitment statutes were rarely problem-free. Physicians succeeded in influencing the revision process not only by requiring physicians' certificates but by developing admission screening criteria such as "fit subject for treatment," a determination made by physicians. They sequestered inebriates away from insane asylums (except in Maryland), asserted physician discretion over discharge or conditional discharge procedures, developed transfer procedures between facilities, and modified duration.

Physicians who promoted commitment for institutional treatment of inebriates had a significant impact in fostering the scientific study of substance abuse and developing concepts of addiction as a form of psychological or neurologic disease. Limiting this impact, however, were the incongruities of inebriety as an inheritable yet treatable condition and a disease theory that never satisfactorily addressed the matter of volition. Furthermore, a treatment philosophy focusing solely on intervention meant a failure to develop a philosophy of prevention. Thus, inebriety physicians failed to ally with the public health movements or to develop an environmental approach or a social theory of the disease.[38] Public policy interests in social control ultimately prevailed over medical interests in scientific treatment measures, even when treatment was provided in the context of legal mandates.[149]

Nineteenth-century substance abuse commitment practices faded from use with closure of inebriety asylums in the wake of prohibition of alcohol and criminalization of narcotics. Not until the 1960s did the states again enact substance abuse commitment statutes. International and federal initiatives spurred this process, as did a series of U.S. Supreme Court decisions that decriminalized alcoholism and addiction.[150–153] The majority of states now have a mechanism for involuntary civil commitment of substance abusers, and involuntary treatment mechanisms in the criminal justice system (e.g., "drug courts") have

proliferated in the past decade.[154–156] Does the history of substance abuse commitment in the 19th century hold any lessons for contemporary policy?

With all the caution that must be taken in extrapolating across disparate historical epochs, we suggest that the early years of U.S. experience with involuntary treatment of substance abuse appears to point to three conclusions. First, unless a societal consensus can be achieved regarding the desirability and legitimacy of involuntary treatment, such programs as are established will be undercut by judicially imposed restrictions, the reluctance of the public—acting through their legislators—to provide adequate funding, and the unwillingness of family members or doctors to commit patients to these programs. Attempts to achieve broad social support before implementation of involuntary programs are crucial for their success and probably require some resolution of societal ambivalence over whether substance abuse should be viewed as willful misconduct or the consequence of an unwilled affliction. Second, in the absence of effective models of treatment, support for coercive interventions with substance abusers will wane. Substance abusers will be left on their own to bear the burdens of their behavior or will be relegated to the mercies of the criminal justice system. Thus, research that demonstrates efficacy has critical importance for public policy, as well as clinical, purposes. Finally, the temptation to use systems of involuntary treatment for purposes other than those for which they were created will always be substantial. Carefully crafted eligibility criteria and due process protections are needed to minimize the risk that involuntary treatment mechanisms will be used to serve other than therapeutic ends related to social control.

Conclusions

The story of substance abuse commitment codes is that of using law to solve complex human problems. Substance abuse commitment in the 19th century did not live up to the restorative or curative potential promised by its medical advocates, who failed to solve the problem of the chronic recidivist patients that ultimately overwhelmed treatment facilities. Nineteenth-century debates over the role of coercion, the nature of the underlying disease, and the efficacy of treatment are stunningly similar to present-day policy arguments, and the dilemmas faced by our medical forebears are decidedly familiar. Nevertheless, hope is to be found in this story of the enduring nature of the medical community's ethical and scientific motivation to intervene.

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Un-Motivated Drug Users

- **Svikis** et al. Johns Hopkins
  146 Cocaine Abusing, Pregnant Women
- Seeking Pre-Natal Care - Not Treatment
- 100 Received - 1-Week Residential Tx.
- 46 Received - Standard Pre-Natal Care
- Costs and Complications of Delivery

Cocaine + Urine at Delivery

• Treated Women	• Untreated Women
*37%	63%

Weight and Gestational Age

• Treated Women	• Untreated Women
*2939 gms	2534 gms
*39 wks	34 wks

NICU Stay and Costs

• Treated Women	• Untreated Women
*7 days	39 days
*$14,500	$46,700

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FRIDAY

State Edit

Anchorage Daily News

Friday, March 23, 2007 BREAKING NEWS AT ADN.COM Alaska's Newspape

Ellis

COMPASS: *Points of view from the community*

Senate bill offers effective approach to substance abuse

By MARGARET LOWE

Addiction is taking a heavy toll on Alaska. Our state ranks No. 1 in the nation for alcohol-related deaths, and every day this newspaper reports on the sad consequences of alcohol and substance abuse. Alaskans with substance abuse problems, or co-occurring mental and substance abuse disorders, are more likely to be homeless, spend time in correctional facilities and become involved in child protective service proceedings. Sadly, this epidemic breaks down the very fabric of our state, tearing apart families, depriving children of mothers and fathers and truly harming the next generation of Alaskans.

During the time that I was commissioner of Health and Social Services, some new insights and treatment systems were becoming prominent in the field. We became more efficient in recognizing the co-occurrence of mental health problems combined with addiction. Twelve years later, the state has adopted the "behavioral health" model, combining mental illness and substance abuse under one division. This approach enhances treatment for many individuals.

We worked very hard to get funding for prevention, and we realized that lengthy inpatient programs would not work for mothers who had children to care for; the first programs that had the children in the residence with mothers were initiated. We saw a very positive movement throughout Alaska Native associations to develop treatment programs and prevention efforts, promoting "wellness" for all Alaskans.

Unfortunately, since that time, Alaska's substance abuse problem has only grown, and the resources to combat the problem have only been reduced. Addiction to alcohol and other drugs costs the state almost $800 million a year in law enforcement, corrections, health care and child protective services, among others. Yet over the last five years, funding for substance abuse treatment and prevention has been cut by 56 percent. This has led to a severe reduction in services; in 2004, 35,000 Alaskans seeking help were unable to find treatment. I believe many of us have decided that enough is enough and it is time to do something. That is why I am excited to support Senate Bill 100, legislation sponsored by Sen. Johnny Ellis, D-Anchorage, who hopes to lead the bipartisan effort against addiction in Alaska.

SB 100 proposes several incremental commonsense changes to Alaska's statutes regarding substance and alcohol abuse. It would require state-run treatment facilities to move pregnant women to the top of waiting lists, to reduce the number of Alaskan children born with fetal alcohol syndrome disorders. The bill also directs the Department of Health and Social Services to use evidence-based and research-based programming and to target their efforts toward populations with higher incidences of substance abuse, so we can focus our resources on those who need help most.

Over the last five years, funding for substance abuse treatment and prevention has been cut by 56 percent. This has led to a severe reduction in services; in 2004, 35,000 Alaskans seeking help were unable to find treatment.

Finally, SB 100 proposes an innovative pilot program to create a secure setting in a treatment facility to address involuntary commitment cases. The program will target persons with addictions or co-occurring substance abuse and mental health disorders who often present a danger to themselves and others and chronically recycle through existing nonsecure treatment services. This group draws heavily on law enforcement, corrections, the court system and community services and could be better served by a secure detoxification facility, where they could then continue into a treatment setting. I believe it will save money in the long term, by reducing the draw on community, medical and law enforcement resources.

Sen. Ellis' bill is only part of the solution. We must aggressively pursue adequate funding for substance abuse treatment and prevention. Over the last few years, treatment facilities have seen sweeping cuts to funding, which has resulted in a startling reduction in services. Wait lists for some programs can be several months long, and people who recognize that they need help are not able to receive it. This only puts the financial burden on prisons, hospitals and law enforcement. Alaska can, and must, do better. I urge you to call legislators and ask them to support substance abuse treatment and prevention, and Senate Bill 100.

■ Margaret Lowe is a former commissioner of the Department of Health and Social Services.

Providence | Alaska Medical Center

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April 12, 2007

The Honorable Johnny Ellis
Alaska State Senate
State Capitol, Room 9
Juneau, AK 99801-1182

Dear Senator Ellis:

I write today in support of Senate Bill 100 relating to substance abuse and mental health disorder prevention and treatment programs. Providence applauds your efforts on this important issue.

As I know you are aware, there are a substantial number of Alaskans with co-occurring substance abuse and mental health disorders. The majority of patients seen in Providence's Psychiatric Emergency Room suffer from this co-occurring condition which contributes to the devastation in their lives and has a significant negative impact on their families, friends, and the community at large.

Providence wholeheartedly supports this piece of legislation which we believe is a small, but significant step toward caring for patients who are suffering from untreated substance abuse in our state. Again, thank you for bringing this important issue to the forefront.

Sincerely,

Laurie Herman

Laurie Herman
Regional Director
Government Affairs

Municipality of Anchorage

4501 Dimgow Street • Anchorage, Alaska 99507-1581 • Telephone (907) 786-8500 • http://www.muni.org

Mayor Mark Begich

Anchorage Police Department

Honorable Johnny Ellis
State Senate
Alaska State Capitol, Room 9
Juneau. Alaska 99801-1182

Dear Senator Ellis:

I appreciate your efforts regarding Senate Bill 100, which proposes some common sense changes to state statutes involving substance abuse. Mandating treatment for pregnant women who seek help in overcoming addiction, supporting DHHS in their efforts to more effectively deal with citizens who are doubly afflicted with mental and substance abuse disorders, and ensuring collaboration with and support of effective faith based efforts that deal with substance abuse are all noteworthy and doable.

As first responders, the specter of substance abuse and mental illness is prevalent throughout our daily contacts with citizens from all walks of life. Any effort by the state to ensure a better manner for addressing these problems, particularly in regard to a program focused on and supportive of involuntary commitments of those persons saddled with substance abuse and mental health disorders who pose a risk to themselves and others, is appreciated.

Once again, I am in support of SB 100 and appreciate your efforts.

Sincerely,

Rob Heun
Chief of Police

Municipality of Anchorage

P.O. Box 196650 • Anchorage, Alaska 99519-6650 • 825 "L" Street • http://www.muni.org

Mayor Mark Begich

Department of Health and Human Services

March 16, 2007

Senator Johnny Ellis
State Capital, Room 9
Juneau, Alaska 99801

Subject: SB 100

Dear Senator Ellis:

I applaud your efforts regarding SB 100. The Department of Health and Human Services here in Anchorage is engaged in an ongoing struggle with the issues of drug and alcohol abuse.

The changes that you are recommending to SB 100 will do nothing but help not only our efforts but those of 100's of dedicated professionals and service providers across the state. Our statistics in Alaska for Domestic Violence, Fetal Alcohol Syndrome, and DUI, to name a few, are alarming. All of these, and more, have direct links to drug and alcohol abuse and co-occurring mental disorders.

Other issues, like the effective use of AS Title 47 with respect to Involuntary Commitments have proven to be especially difficult here in Anchorage due, in part, to the lack of effective secure facilities for alcohol commitments.

Again, I appreciate everything you are doing in this area. Please do not hesitate to call me directly at 343-6300 or 343-6718, if I can be of assistance in any way.

Sincerely,

Diane Engle for

Beverly Wooley
Director

Senator Johnny Ellis
State Capitol, Rm 9
Juneau, AK 99801-1182

March 19, 2007

Dear Senator Ellis,

Covenant House supports SB 100, a bill to expand access to broader substance abuse treatment options, targeting certain populations with higher incidences of addiction. Covenant House is primarily a shelter for homeless and at-risk youth between the ages of 13-20, located in Anchorage. Additionally, Covenant House has transitional living program serving youth ages 18-20, which includes 10 beds for moms with babies and pregnant young women. Finally, Covenant House has a non-residential Community Services Center which provides educational and job skills services to youth.

One of the frustrations that we face as service providers is finding space in treatment programs for our clients. There are very few programs that specialize in providing substance abuse treatment to youth and those that do exist have long wait lists. Oftentimes those youth in greatest need of help are turned away from programs because there is no space available. Implementing a system that prioritizes certain populations and increases and broadens treatment options will prevent some of the most vulnerable among us from getting stuck in a cycle of addiction.

Identifying certain groups and providing priority treatment for them is an important step forward in controlling the substance abuse epidemic in Alaska. Many young Alaskans in need of treatment are ignored and go untreated only because there are no adequate resources available for these individuals who want help and want to improve their lives.

Thank you for introducing this legislation. Please let us know how we can help to ensure its continued support. I can be reached at (907) 339-4205 or nicole.thibodeau@covhouse.alaska.com.

Sincerely,
Nicole Thibodeau

Senator Johnny Ellis
State Capitol Room 9
Juneau, Alaska 99801

March 15, 2007

Dear Senator Ellis,

On behalf of our all-volunteer Board of Directors and professional staff, we are writing to extend Boys & Girls Clubs' support for Senate Bill 100, legislation designed to help prioritize evidenced-based substance abuse prevention programs. As a second-year grantee with SAMHSA Drug Free Communities program, Boys & Girls Clubs will again co-lead Anchorage's youth substance abuse prevention campaign with the Alaska Red Ribbon Coalition. Senate Bill 100 will empower Coalition partners to leverage existing resources with state grants to make a marked difference in youth substance use and abuse. We applaud your vision for healthier young Alaskans.

As you are aware, Boys & Girls Clubs also advocates for public awareness of youth development and substance abuse problems facing today's youth through its associations with United Way, America's Promise, The Center for Missing and Exploited Children and Alaska Suicide Prevention Council. Club professionals contribute their personal and professional time and resources to ensure that a consistent and collaborative voice and vision reach policymakers and the general public. The development of a statewide substance abuse prevention plan, as mandated in Senate Bill 100, will provide further direction for Boys & Girls Clubs and our partnering agencies.

Again, thank you for sponsoring this legislation. Boys & Girls Club appreciates your support of our prevention programs and your commitment to Alaska's youth.

Sincerely,

Alan Budahl
Board of Directors, Chair

John P. Oates
President and Chief Executive

Main Office
2300 W. 36th Avenue
Anchorage, Alaska 99517
Tel: 907-248-5437
Fax: 907-248-0047

President & CEO
John P. Oates
Tel. 907-770-7337
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joates@bgcalaska.org

Investing in Alaska's most valuable resource - our children.

Providence | Alaska Medical Center

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

March 7, 2007

Kate Herring
Office of Senator Johnny Ellis
Capitol Building, Rm. 9
Juneau, AK 99801
(907) 465-6704

Dear Senator Ellis:

Thank you for the opportunity to read the Senate Bill NO. 100 and give an opinion. I whole-heartedly support SB 100.

For the last five years I have been Medical Director of the Providence Psychiatric Emergency Room, and during this time also worked at the Salvation Army's Clitheroe Enhanced Detox Unit for 3 years. I see SB 100 as a small, yet significant step-in-the-right-direction in caring for the vast number of patients who are suffering from untreated substance abuse in Alaska. The majority of my emergency room psychiatric patients (and we see over 4000/year) have co-existing chemical dependency ("dual-diagnosis"), which certainly contributes to the devastation in their lives. Unfortunately, there are only 8 beds for me to refer patients to (which is a key part in getting onto the path of recovery) in Anchorage. These beds are usually full.

In short, the need in the community is high, the resources low, and the wreckage of the illness on patients (and their families, friends, community) are significant. So it is without reservation, I support SB 100, which addresses the call for for added treatment options for Alaskan patients, and suggest some creative solutions, such as the Pilot Project mentioned in section 8. Please feel free to contact me with any questions.

Sincerely;

Marc D. Pellicciaro, M.D.
Medical Director, Psychiatric Emergency Room
Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99508
Phone: (907) 273-7851
Fax: (907) 261-2807
E-Mail: mpellicc@provak.org

AARP Alaska

March 15, 2007

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capital, Room 30
Juneau, AK 99801-1182

RE: SB 100 (Ellis)—Support

Dear Chair Davis:

On the behalf of the members of AARP Alaska, we encourage you and your colleagues on the Senate Health, Education and Social Services Committee to support SB 100, authored by Senator Johnny Ellis.

There are three main reasons why AARP is concerned with substance abuse. The first two reasons involve abuse or neglect cases that stem from substance abuse and how they impact seniors directly. The third reason deal with the impact substance abuse has on seniors indirectly.

First is the classic case in which the person committing the abuse or the neglect has a substance abuse problem. A national study examining "elder abuse" case files from agencies around the country found that severe drinking bouts by the abuser led to harmful incidents in senior abuse cases.

The second case (which is probably as common), is where the older adult has a substance abuse problem. For some older adults it is alcohol; for others it is psychoactive medications. For many it is both. For these individuals getting treatment is very difficult because there is little access to treatment and prevention. In Anchorage, there is only one treatment center at which older adults may seek treatment (Ernie Turner Center).

The third reason why we support this bill has to with grandparenting. Grandparenting is sometimes called the most spiritual of all relationships because it links people entering the world with those on their way out. Grandparenting today, however, is not all Bible stories, sugar cookies and fun. Increasingly, grandparents are rearing their children's children when drug addiction and mental illness make parents unavailable.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

AARP is the world's largest organization of grandparents. Our 89,000 AARP members in Alaska are concerned about the impact substance abuse is having on their grandchildren. There are 8,188 grandchildren living with grandparents Alaska. In addition, there are 5,419 grandparenting headed household, which means that 1.5 children are living with their grandparents.

We believe that SB 100 is a substantive bill because it address the concerns of a lot of our members, as well the concerns of others. Furthermore, we believe that providing assistance to those who need help in overcoming their addiction is a good public policy for Alaska.

Therefore, AARP request an "AYE" vote on Senator Ellis's SB 100.

Should you have any questions about our position, please feel free to contact me (586-3637) or Pat Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator John Cowdery
Senator Kim Elton
Senator Fred Dyson
Senator Johnny Ellis

Municipality of Anchorage

P.O. Box 196650 • Anchorage, Alaska 99519-6650 • http://www.muni.org
100 East Fourth Ave. • Anchorage, Alaska 99501 • Telephone: (907) 267-4936 • Fax: (907) 267-4977

Mayor Mark Begich

Fire Department

STATEMENT OF SUPPORT
Substance Abuse Treatment and Prevention

Addiction is taking a heavy toll on Alaska's people, culture and economy. Alaska ranks #1 in the nation in alcohol-related deaths and Alaskans with substance abuse problems, or co-occurring mental and substance abuse disorders, are more likely to be homeless, spend time in correctional facilities, and become involved in child protective service proceedings. The financial impact of addiction is staggering, costing the state an estimated $738 million a year in health care costs, accidents, lost productivity, criminal justice and correctional facilities.

Something must change. We support updating Alaska statutes to promote expanding access to a wide spectrum of treatment, identifying those with co-occurring mental health and substance abuse disorders, and addressing substance abuse among youth and populations with higher incidences of addiction.

Please add my name/organization to the list of supporters.

Name Craig Goodrich
Organization Anchorage Fire Department
Title Fire Chief

Signature [signature]
Address 100 E. 4th Ave. Anchorage, AK 99501
Phone 907-267-4960 Fax 907-267-4977
Email goodrichcp@muni.org Website www.muni.org/fire1/index1.cfm

I/We would also be willing to:

✓ Publish an article in our newsletter
✓ Participate in media events
✓ Mobilize our membership
✓ Contact legislators

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Substance Abuse Treatment and Prevention

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Please add my name/organization to the list of supporters.

Name Susan M. Bomalaski
Organization Catholic Social Services
Title Executive Director
Signature [signature]
Address 225 Cordova St Anchorage AK 99515
Phone 907-297-7742 Fax 907-272-7370
Email Susan.bomalaski@CSSalaska.org Website www.cssalaska.org

I/We would also be willing to:

X Publish an article in our newsletter
X Participate in media events
__ Mobilize our membership
__ Contact legislators

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

STATEMENT OF SUPPORT
Establishing Education Savings Accounts for Foster Children in Alaska

Children in the foster care system face significant challenges when they age out of state care. Often, these children do not have a plan or the means to access job training or post-secondary education. With a program in place whereby concerned organizations and citizens can establish savings accounts in the names of foster children, these children will have opportunities beyond high school.

Alaska's foster children deserve a program that invests in their potential. Alaska should create a program designed to give children in foster care the opportunity to pursue education and job training past the age of 18.

Please add my name/organization to the list of supporters.

Name Drenda Tigner
Organization Presbyterian Hospitality House
Title
Signature Drenda M. Tigner Executive Director
Address 269 Forty Mile Ave Fairbanks AK 99701
Phone 907-456-6445 Fax 907-456-6402
Email DrendaTigner@aol.com Website WWW.PHHalaska.org

I/We would also be willing to:

- X Publish an article in our newsletter
- X Participate in media events
- X Contact legislators
- X Mobilize our membership
- X Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Substance Abuse Treatment and Prevention

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Something must change. We support updating Alaska statutes to promote expanding access to a wide spectrum of treatment, identifying those with co-occurring mental health and substance abuse disorders, and addressing substance abuse among youth and populations with higher incidences of addiction.

Please add my name/organization to the list of supporters.

Name Anne Dennis - Choi
Organization The Salvation Army Clitheroe Center
Title Executive Director
Signature Anne Dennis-Choi
Address 1709 Bragaw Suite B. Anchorage, Alaska. 99508
Phone (907) 770-8804 Fax (907) 770-8841
Email _____ Website http://www.salvationarmy.org/Clitheroe
anne_choi@us.salvationarmy.org

I/We would also be willing to:

✓ Publish an article in our newsletter (maybe)
✓ Participate in media events
✓ Mobilize our membership
✓ Contact legislators

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Substance Abuse Treatment and Prevention

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Please add my name/organization to the list of supporters.

Name Joseph P. Burns
Organization Nugen's Ranch
Title Night Attendant.
Signature Joseph P. Burns
Address 4006 Steven Dr. #8 Wasilla, AK 99654
Phone 373-7542 Fax
Email joeburns@mtaonline.net Website

I/We would also be willing to:

__Publish an article in our newsletter
__Participate in media events
__Mobilize our membership
__Contact legislators

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Something must change. We support updating Alaska statutes to promote expanding access to a wide spectrum of treatment, identifying those with co-occurring mental health and substance abuse disorders, and addressing substance abuse among youth and populations with higher incidences of addiction.

Please add my name/organization to the list of supporters.

Name GREG R. PEASE
Organization GASTINEAU HUMAN SERVICES CORPORATION
Title EXECUTIVE DIRECTOR
Signature
Address 5597 AISEK ST JUNEAU AK 99801
Phone 907 780 3011 Fax 907 463 3535
Email greg_pease@ghscorp.org Website www.ghscorp.org

We would also be willing to:

__Publish an article in our newsletter
/Participate in media events
__Mobilize our membership
/Contact legislators

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

GASTINEAU HUMAN SERVICES
CORPORATION
"A Chance For Change"

5597 Aisek Street
Juneau, AK 99801
Phone: (907) 780-3011
Fax: (907) 463-3535
Email: greg_pease@ghscorp.org

Greg Pease
Executive Director

Mission Statement
To serve individuals, their families and the community by providing structured residential treatment and employment program opportunities with an emphasis on those persons who are criminal offenders and/or substance abusers.

Kate Herring

From: Anna Sappah [annasappah@hotmail.com]
Sent: Wednesday, March 21, 2007 9:37 AM
To: Sen. Con Bunde; Sen. Lesil McGuire; Sen. Lyda Green; Sen. Gary Stevens; Sen. Hollis French
Cc: Kathryn L Craft; Angela Salerno; Kate Herring
Subject: SB100

Dear Senators,

I am writing today to voice my support of SB100 that was introduced by Senator Johnny Ellis. This piece of legislation can help to save the lives of Alaskans.

I am a recovering heroin addict. I have been clean for over 11 years. The reason that I am clean today is because I was able to receive appropriate treatment for my disease. Available treatment is the key to addicts being able to stop using long enough to learn the life skills they need to live without the use of drugs, including alcohol.

When I was using, I was a drain on my community and on the resources of our State. I collected welfare & medicaid and was unable to support myself or raise my children without assistance. I was a victim of domestic violence on numerous occasions. As a result of completing treatment, I have become a productive member of my society. I am able to parent my own children. I work full time and I am co owner of a family business. I attend APU full time seeking a double bachelors degree. I serve on the Advisory Board for Alcohol and Drug Abuse and volunteer for the Substance Abuse Directors Association, Meeting the Challenge Program and am a board member of the Narcotic Drug Treatment Center in Anchorage.

SB 100 can reduce the occurrence of FAS/FAE, reduce expenditures in Corrections and court costs and better serve people with co-occurring disorders.Addicts do recover and treatment is effective. Please support SB 100. Help to end the cycle of addiction that is killing Alaskans.

Respectfully,
Anna Sappah

1711 Logan Street
Anchorage, AK 99508
907-277-8796

STATE OF ALASKA

Sarah Palin, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

P.O. BOX 110608
JUNEAU, AK 99811-0608
PHONE: (907) 465-8920
FAX: 465-4410

Research Shows Effectiveness of Involuntary Substance Abuse Treatment

Involuntary Treatment of Alcohol-Dependent Patients: A Study of 17 Consecutive Cases of Civil Commitment. (2001) Department of Psychiatry, University Hospital, Lausanne, Switzerland.

This four-year study completed a cross-sectional comparative analysis of alcohol-dependent patients being treated under civil commitment. The study included 15 patients who were civilly committed to alcohol treatment and a comparative group of 34 randomly selected age- and sex-matched patients. Pre- and post-assessment included the patient's medical condition, social status, patterns of alcohol use, type and duration of residential treatment as well as their perceptions of commitment.

Results: The average duration of commitment was 29 weeks. At the time of follow-up, 14 out of 15 patients were alive, and 10 agreed to be interviewed. Eight of these reported complete abstinence, and 9 considered their alcohol problem as less severe than before. The majority of patients considered commitment as having been justified and useful. Health-related quality of life was good on average and better that that usually reported by other cohorts of alcoholics undergoing treatment.

Conclusions: Residential civil commitment is useful and successful for treating certain severely impaired alcohol-dependent patients. This study suggests that civil commitment not only may save the lives of endangered patients but could also be a heath-promoting measure that allows for recovery from dependence. In addition, the study showed that civil commitment is well accepted by many patients who considered the commitment decision as having been justified and useful.

Utilization of Services by Persons Discharged from Involuntary Chemical Dependency Treatment

Charles Maynard, PhD
Gary B. Cox, PhD
Antoinette Krupski, PhD
Kenneth Stark, MBA, MED

ABSTRACT. This report compares services utilization pre-admission and post-discharge in 735 consecutive persons involuntarily committed to a chemical dependency treatment program in Washington State. Patients entering treatment were in their late 30s, had multiple health problems, previous arrests for misdemeanors or felonies, and minimal structured daily activities. Post discharge, there were decreases in the use of costly acute care services including detox, psychiatric hospitalization, and mental health crisis services. Patients who completed the program were less likely to use acute care services and were more likely to participate in outpatient treatment after discharge. The overall death rate of 29.4 per 1000 persons per year was 4 times greater than the age adjusted death rate for the US adult population. Further studies of other involuntary chemical dependency treatment programs are needed to evaluate the results of this report. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com <Website: http://www.haworthpressinc.com>]*

Charles Maynard is affiliated with the Department of Health Services, University of Washington, Seattle, WA, and Health Services Research and Development, Department of Veterans Affairs, Seattle, WA.

Gary B. Cox is affiliated with the Alcohol and Drug Abuse Institute, University of Washington, Seattle, WA.

Antoinette Krupski and Kenneth Stark are affiliated with the Department of Social and Health Services, Olympia, WA.

Address correspondence to: Charles Maynard, ADAI, 3937 15th Avenue NE, Seattle, WA 98105 (E-mail: cmaynard@u.washington.edu).

Journal of Addictive Diseases, Vol. 19(2) 2000

KEYWORDS. Services, substance abuse, involuntary commitment, civil commitment

Little is known about what happens to individuals who are discharged from involuntary treatment of alcohol or substance abuse problems.[1,2] Depending on the jurisdiction, involuntary commitment of persons with alcohol or substance dependence is used by the courts in numerous ways, and may serve as an alternative to or diversion from incarceration.[3] Commitment may be part of both civil and criminal proceedings[4] and is employed to force treatment for a limited period of time and to protect the general society. Civil commitment and court diversion programs targeting intravenous drug users have been employed to reduce the number of users at risk for transmitting or contracting the AIDS virus.[5]

The purpose of this paper is to compare services utilization pre-admission and post-discharge in patients who were involuntarily committed to a chemical dependency treatment program in Washington State. A second objective is to ascertain if program completion was associated with decreased use of acute care services and increased use of outpatient treatment. In Washington State involuntary commitment is part of civil proceedings and can be used as a substitute for incarceration.

METHODS

Patient population. This study included all patients (n = 735) who were involuntarily committed to a single residential treatment facility between July 1, 1994 and January 29, 1997 and were discharged prior to March 1, 1997. The facility includes 65 beds for patients involuntarily committed. A second 65-bed unit for clients who are mentally ill with alcohol and/or substance abuse problems will not be considered here. For those entering the involuntary program for the first time, treatment is 60 days in duration and offers case management, counseling, education, activity, and vocation programming services, as well as continuing care and discharge planning. Details of the court proceedings that led to commitment were not available.

Baseline characteristics. The residential treatment facility's information system provided detailed data on patient demographic and

medical characteristics, substance abuse diagnoses, and program completion status. Alcohol and substance disorder diagnoses at admission and discharge were available for about half of individuals discharged from the program. Status at discharge was defined as complete or not complete; the reasons for non-completion included relapse, leaving treatment against medical advice, disengagement from therapy, or non-compliance.

Utilization of services. As this study examined existing databases, it was necessary to match identifiers from the residential treatment facility's client database to those in the databases used to track utilization of services. An inventory of the databases follows.

The Treatment and Assessment Report Generation Tool from the Division of Alcohol and Substance Abuse of the Washington State Department of Social and Health Services was used to examine alcohol and substance abuse services received from July 1, 1993 through May 31, 1997. Services were categorized according to the following modalities (1) residential, (2) intensive inpatient, (3) MICA residential, (4) outpatient, (5) detox, and (6) methadone. The Community Mental Health Information System, administered by the Mental Health Division of the Department of Social and Health Services, reported utilization of community mental health services from January 1994 through August 1997. The monthly number of treatment hours for crisis services and all outpatient services were obtained, although details concerning other treatment modalities were not available.

Information concerning health services paid for by Medicaid from July 1, 1993 through July 25, 1997 was obtained from the Medical Assistance Administration. Services were categorized as: (1) emergency medical, (2) psychiatric hospitalization, (3) general in-patient medical hospitalization, (4) medical outpatient, (5) prescription drugs, and (6) nursing home. The first 3 acute care services were of particular interest. The amount reimbursed for each service was calculated in 1997 dollars, and the total amount for all services was calculated.

Vital status. Vital status of individuals committed to the program was determined from 2 sources: first, death records for 1994 through 1996 obtained from the Washington State Department of Health, Center for Health Statistics, and second, hospitalization records for 1993 through 1997 obtained from the Medicaid Management Information System. Death records did not contain information on individuals who died out of state or those who died in 1997.

Statistical methods. We used the chi-square statistic to assess the univariate association between program completion status and categorical variables including baseline characteristics and utilization. The t-test was used to determine if age and length of stay differed by completion status. We used stepwise logistic regression to determine if program completion was associated with utilization after controlling for all other predictors of utilization. All statistically significant ($p < 0.05$) variables were allowed to enter the model and at the final stage, completion status was forced in the model to determine its association with the particular measure of utilization.

Age adjusted rates of death were calculated using the direct method of standardization. Total deaths for the 1996 United States population were reported by the National Center for Health Statistics.[6] The age distribution of the 1990 US population was used as the standard population.

RESULTS

Patient characteristics. Individuals who were involuntarily committed had multiple medical problems, despite being relatively young (Table 1). Prior to admission, nearly 60% had been arrested for misdemeanors, and over 30% had felony arrests. Information about admission diagnosis was available for 48% of patients. Over 90% had alcohol dependence; other dependencies included cannabis (41%), cocaine (36%), opioids (34%), and amphetamines (22%); many individuals had more than one chemical dependency.

Vital status. There were 29 deaths; 12 were due to injury including accident, homicide, or suicide, and 17 were due to medical conditions associated with substance abuse. The age adjusted death rate was 29.4 per 1000 persons per year and was 4 times higher than the age adjusted death rate of 7.4 per 1000 for the general US population, ages 15 through 80.

Alcohol, substance abuse, and community mental health services. There was a decline in the use of detox services from 63% in the year before admission to 30% in the year after discharge (Table 2). The proportion of patients in outpatient treatment increased slightly from 28% prior to admission to 31% after discharge. In the year after discharge, 41% of individuals with significant chemical dependencies did not receive alcohol or substance abuse services. Due to differential

TABLE 1. Patient Characteristics and Program Completion

Characteristic	Complete (n = 552)	Not complete (n = 183)	Chi-square	P
Age at Admission (years)	40 ± 10	36 ± 10	4.55	<0.0001
Women	30%	27%	0.64	0.42
Race			2.89	0.58
Black	6%	4%		
White	85%	85%		
Hispanic	1%	2%		
Native American	8%	8%		
Arrest Prior to Admission				
Misdemeanor	59%	61%	0.34	0.56
Felony	28%	39%	7.15	0.008
Marital Status			4.57	0.21
Single, never married	46%	52%		
Separated	12%	10%		
Divorced	30%	30%		
Married	13%	8%		
Medical History				
Diabetes	4%	4%	0.009	0.92
Pancreatitis	8%	6%	0.60	0.44
Ulcers	21%	21%	0.00	0.98
GI bleeding	17%	21%	2.33	0.13
Seizures	33%	30%	0.47	0.49
Cardiac	20%	13%	5.02	0.025
Liver disease	46%	31%	13.04	<0.0001
Respiratory disease	22%	18%	1.04	0.31
Malnutrition	28%	29%	0.03	0.86
Number Medical Conditions			3.29	0.19
None	26%	31%		
One	19%	23%		
Two or more	54%	46%		
Activity Level Prior to Admission			10.40	0.015
Full time employment	7%	4%		
Part time employment	6%	1%		
Day treatment	5%	8%		
No structured activities	82%	87%		

* t-test

follow-up, the number of individuals declined from 735 in the year after discharge to 577 in the 2nd year after discharge. Differential follow-up refers to the fact that an individual discharged in 1994 had 3 years of follow-up, whereas one discharged in 1997 had only a year.

Community mental health services utilization was similar in the year prior to admission and the year after discharge, although crisis services were used less often in the year after discharge (Table 2). For clients receiving services, the median annual number of hours of all services but crisis increased from 17.0 in the year prior to admission to 18.2 in the year after admission, and ultimately decreased to 13.1 in

year 2 and 10.2 in year 3. For those who received mental health crisis services, the median annual number of hours changed from 2.0 in the year prior to admission to 2.2 in the year after and to 2.9 and 2.5 in years 2 and 3, respectively. The proportion of clients receiving crisis services declined steadily from the year prior to admission to 3 years after discharge. However, the mean number of hours of crisis services increased for those receiving services.

Medicaid services. From the year before admission to 3 years after discharge, the utilization of Medicaid services declined significantly (Table 3). There were decreases in the use of the relatively costly acute

TABLE 2. Utilization of Substance Abuse and Community Mental Health Services

Service	Year before admission	1 year after discharge	2 years after discharge	3 years after discharge
Substance Abuse (n)	735	735	577	355
Detox	63%	30%	20%	16%
Mentally ill chemically abusing residential	6%	4%	2%	0.4%
Other residential	15%	20%	10%	4%
Intensive inpatient	8%	3%	2%	1%
Methadone	0.7%	0.7%	0.9%	0.7%
Outpatient	28%	31%	15%	10%
Differential diagnosis	2%	0.4%	0.2%	0%
None	21%	41%	66%	75%
Mental Health (n)	735	735	577	355
All but crisis	37%	38%	32%	18%
Crisis	33%	22%	16%	11%
None	52%	57%	65%	78%

TABLE 3. Utilization of Medicaid Services

Service	Year before admission	1 year after discharge	2 years after discharge	3 years after discharge
(n)	735	735	577	355
Emergency Medical	56%	51%	32%	21%
Prescription Drugs	64%	69%	53%	41%
Psychiatric Hospitalization	16%	9%	7%	3%
General Medical				
In-patient hospitalization	31%	22%	15%	10%
Outpatient	62%	65%	44%	30%
Nursing home	2%	2%	2%	1%
Any Service	74%	78%	60%	47%

care services, including emergency department visits, psychiatric hospitalization, and in-patient hospitalization.

Mean and median reimbursements for services paid for by Medicaid are shown in Table 4, which displays the actual dollars paid to providers, with the N column indicating the numbers of patients who received services during the time period. From the year prior to admission to the year after discharge, there were significant declines in median reimbursements for emergency medical services, medications, psychiatric hospitalization, outpatient medical services, and for all services. However, increases with respect to in-patient hospitalization and nursing home care costs for clients receiving these services were

TABLE 4. Reimbursement for Medicaid Services

Service	Mean($)	SD($)	Median($)	N
Emergency Medical				
1 year before	1461.13	2291.99	704.80	406
1 year after	1169.71	1932.42	578.21	362
2 years after	1253.70	2704.94	533.23	182
3 years after	1021.09	2319.83	379.10	68
Medications				
1 year before	851.61	1346.58	411.08	467
1 year after	869.97	1485.09	384.68	507
2 years after	937.83	1364.78	453.48	289
3 years after	605.18	837.97	258.10	125
Psychiatric Hospitalization				
1 year before	6817.15	7251.90	4348.90	120
1 year after	4217.53	2900.58	3935.59	55
2 years after	4184.11	3891.71	3893.19	22
3 years after	3817.14			1
Inpatient Medical Hospitalization				
1 year before	4006.60	8964.77	1496.17	225
1 year after	4543.58	7663.78	2130.40	155
2 years after	4894.55	8912.57	1853.55	74
3 years after	6062.10	7811.08	2074.03	25
Outpatient Medical				
1 year before	1696.50	3636.01	477.03	455
1 year after	1461.41	3124.21	387.42	479
2 years after	989.93	1708.09	279.53	241
3 years after	592.32	1133.46	164.22	101
Nursing Home				
1 year before	5633.79	6280.81	3810.76	13
1 year after	7517.57	9760.10	3941.47	12
2 years after	6814.60	5997.63	5748.21	6
3 years after				0
All				
1 year before	7065.47	10534.32	3343.62	544
1 year after	4768.42	8023.33	2057.10	571
2 years after	3920.04	6975.39	1752.85	326
3 years after	2458.79	4889.16	607.35	149

also apparent, although the proportion of patients hospitalized decreased.

The total cost of all Medicaid services in the year prior to discharge was approximately $3.8 million; in the year after discharge it was $2.7 million, a 29% reduction. Of note were large decreases from pre-admission to post discharge for psychiatric hospitalization ($0.8 to $0.3 million); there were also declines for emergency medical services ($0.6 to $0.4 million) and in-patient hospitalization ($0.9 to $0.7 million).

Combinations of services. In the year prior to admission, 94% of patients used one or more services categorized as chemical dependency, community mental health, or Medicaid, and in the year after admission, 88% did. The combination of chemical dependency and Medicaid services was provided to 62% of clients in the year prior to admission and 57% in the year after discharge. Less than 10% of patients used only a single service during the 2 time periods.

Program completion and service utilization. The mean length of stay for all patients was 65 ± 30 days, with a median stay of 59 days. Overall, 75% completed the program; the mean length of stay was 71 ± 28 days for those who completed the program and it was 47 ± 27 days for those who did not. The most common reasons for failure were non-compliance, disengagement from therapy, and leaving against medical advice.

The utilization of key services in the year after discharge was compared for those completing and not completing the program (Table 5). Clients who completed the program were less likely to be hospitalized for medical reasons and were also less likely to receive mental health crisis services. Those who completed the program were more than twice as likely to receive outpatient chemical dependency treatment than their counterparts who did not complete treatment. Program completion was not associated with the use of detox, emergency medical services, or psychiatric hospitalization. The proportions of deaths in the 2 groups were similar; 4.4% in the in the group not completing treatment, and 3.8% in the group completing treatment. We used logistic regression to examine the association between program completion and utilization. Variables in Table 1 as well as whether the service of interest was received in the year prior to admission were covariates. For most services, the univariate and multivariate odds ratios and 95% confidence intervals were similar.

TABLE 5. Program Completion Status and Service Utilization in the Year Following Discharge Odds Ratio and 95% Confidence Intervals

Service	Completed (n = 552)	Not completed (n = 183)	Univariate odds ratio	Multivariate odds ratio
Detox[1]	30%	32%	0.91 (0.64-1.31)	0.91 (0.61-1.33)
Chemical dependency outpatient[2]	32%	18%	2.19 (1.44-3.34)	2.33 (1.51-3.60)
Mental health crisis[3]	20%	30%	0.58 (0.40-0.85)	0.67 (0.45-1.01
Emergency medical[4]	50%	54%	0.86 (0.61-1.20)	0.97 (0.67-1.41)
Psychiatric hospitalizations[5]	9%	11%	0.79 (0.46-1.38)	0.89 (0.50-1.61)
Inpatient medical hospitalization[6]	15%	23%	0.60 (0.40-0.91)	0.56 (0.36-0.88)

[1]Adjusted for in order of entry, use in the previous year, history of seizures, and presence of ulcers.
[2]Adjusted for in order of entry, number of illnesses at baseline, female gender, and use in the previous year.
[3]Adjusted for in order of entry, use in the previous year and race.
[4]Adjusted for in order of entry, use in the previous year and history of seizures.
[5]Adjusted for use in the previous year, only.
[6]Adjusted for in order of entry, use in the previous year, history of seizures, race, and absence of prior felony arrests.

DISCUSSION

In this evaluation of service utilization and expenditures in individuals discharged from involuntary treatment for substance abuse, the overall death rate for those discharged from treatment was four times higher than that of the general US population. Patients entering treatment tended to have multiple health problems, previous arrests for misdemeanors or felonies, and minimal structured activities. Overall, from the year before admission to up to three years after discharge, there were declines in the cost and utilization of all services, including costly acute care services. Patients who completed the program were less likely to use acute care services and more likely to participate in outpatient treatment after discharge.

Even though more than 60% of states have programs for involuntary chemical dependency treatment, there are few, if any, published evaluations of these programs.[3,7] Most of the existing literature on involuntary treatment has considered legal aspects of civil commitment or coercive versus voluntary treatment, with almost no attention paid to treatment outcomes.[1,7] Involuntary treatment for alcohol or substance disorders has been characterized as a hybrid of medical and legal approaches.[7] The program evaluated in this report included case

management, counseling, educational, activity, and vocational programming services, as well as continuing care and discharge planning.

The results of this study must be considered in the light of several limitations. The tracking of utilization relied on administrative data sources and the ability to link those data with the treatment facility's database. It was not possible to identify services paid for by other organizations, most notably the Department of Veterans Affairs. For these reasons, the cost and utilization of services are likely to have been underestimated. Several important types of data were also missing or deficient. For example, we were unable to obtain information about felony or misdemeanor arrests in the time after discharge. Given the significant proportion of patients with a history of misdemeanor or felony arrests, there most likely was some arrest activity after discharge. These events can be costly, particularly when they result in judicial proceedings and/or incarceration. If program completion was associated with fewer arrests, considerable savings could be incurred. Also, there was no information on alcohol consumption or substance use in the post discharge period. Finally, little was known of the circumstances of commitment and whether they influenced outcome.

Another weakness of the study was the absence of a control or comparison group. For a variety of reasons, including ethical ones, it would be next to impossible to conduct a randomized trial of involuntary treatment, although it may be feasible to identify a group of individuals comparable to those undergoing involuntary treatment. Such a study design could not control for all differences between the 2 groups, but it would at least provide a basis for making comparisons. Without having a comparable group of patients who were not committed, it is difficult to say that treatment resulted in improved outcomes. Individuals may have improved despite not receiving treatment, although given the life circumstances of these individuals, this is highly unlikely.

Despite these limitations, this report demonstrated a significant decline in service utilization after discharge, as well as an association between program completion and services reduction. Hopefully, other states will evaluate their involuntary treatment programs, so that the results of this study can be placed in perspective. In conclusion, completion of involuntary treatment by individuals with severe substance abuse disorders may result in lower health care costs, primarily through reduced use of emergency department, hospital, and other acute care services.

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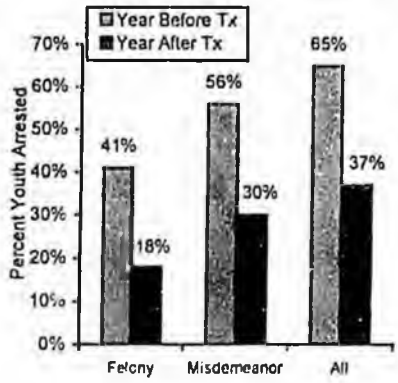
Washington State Department of Social & Health Services
Division of Alcohol and Substance Abuse

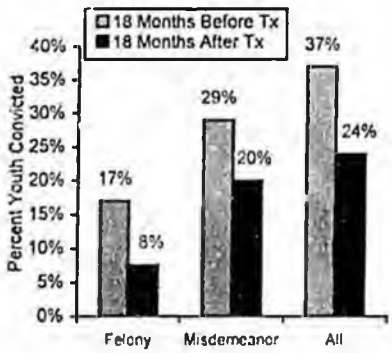
Fact Sheet

Chemical Dependency Treatment Reduces Crime in Washington State

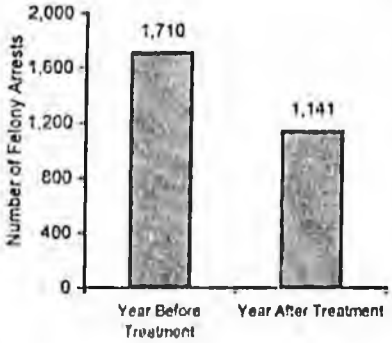
Youth Arrests Declined Significantly After Inpatient Treatment



Youth Convictions Declined Significantly After Treatment



Adult Felony Arrests Declined by 33% in the Year After Treatment



Arrests and Convictions Decreased After Treatment in Chemically Dependent Youth

- A study of over 450 chemically dependent Washington State youth showed that felony arrests decreased 56% (from 41% to 18%) between the year before and the year after treatment for inpatient clients and 54% for outpatient clients (from 41% to 19%). Misdemeanor arrests decreased by 46% in inpatients (from 56% to 30%) and by 40% in outpatients (from 47% to 27%) (New Standards, Inc., 1997).
- A recent study of almost 6,000 Washington State youth, 14-17 years of age, revealed significant declines in convictions: 56% decline in felonies (from 17% in the 18-months before treatment to almost 8% in the 18-months after treatment) and a 30% decline in misdemeanors (from 29% to 20%). (Luchansky, He, Longhi, Krupski, & Stark, 2003).

Arrests and Participation in Illegal Activities Declined After Treatment in Chemically Dependent Adults

- There was a 33% decline in the number of arrests for felony offenses in the year after treatment (compared to the year before) in a study of over 10,000 adult publicly-funded clients (Luchansky, He, & Longhi, 2002).
- Illegal activity declined 85% in a study of almost 600 adults discharged from publicly-funded chemical dependency residential treatment (from an average of 4.1 days engaged in illegal activities in the 30 days prior to treatment admission to 0.6 days in such activities in the 30 days prior to the 6-month follow-up). Average 30-day earnings from illegal activity declined 93%, from $485 at admission to $32 at follow-up (Carney & Donovan, 2000).
- Pregnant and parenting women who received chemical dependency treatment (n=763) had a decrease of more than 50 percent in arrest rate in the two years after treatment (Cawthon, 2004).
- In a study of over 20,000 chemically dependent Supplemental Security Income (SSI) recipients it was found that the likelihood of being arrested in the year after treatment was 16 percent lower when clients received chemical dependency treatment. The likelihood of a felony conviction was reduced by 34 percent (Estee & Nordlund, 2003).

Clients Who Stayed in Treatment Longer Had Better Criminal Justice Outcomes

- Treatment episodes over 90 days in length were associated with a 32% reduction in the probability of a felony arrest in the 18 months following discharge. Completing a treatment episode was associated with a 21% reduction the probability of an arrest (n=10,284) (Luchanksy, He, & Longhi, 2002).
- A recent study of almost 6,000 Washington State youth, 14-17 years of age, showed that clients completing treatment had a 29% reduction in risk of a felony conviction and a 17% reduction in the risk of any conviction (Luchansky, He, Longhi, Krupski, & Stark, 2003).

For every dollar spent on Drug Court, taxpayers receive roughly $2.45 in benefits to the criminal justice system.

Persons addicted to drugs need not be internally motivated at the outset of treatment to benefit from it. In fact, such persons legally pressured into treatment often have better outcomes than voluntary clients.

For more information on outcome studies of chemical dependency treatment, contact:

Research Investigator
Division of Alcohol & Substance Abuse
Department of Social & Health Services
PO Box 45330
Olympia, WA 98504
Phone: (360) 438-8200, or toll-free at (877) 301-4557

Website: www1.dshs.wa.gov/dasa/

- A recent study of 135 persons admitted to opiate substitution treatment found that those clients participating in treatment for at least 170 days reported less time in jail and fewer days engaging in illegal activity at 6- and 12- months following discharge compared to clients who stayed in treatment for less than 170 days (Carney, 2003).

Drug Court Participation Was Associated With Fewer Re-Arrests and Cost Savings to the Criminal Justice System

- Drug Court participants who completed a full course of chemical dependency treatment (n=297) were significantly less likely to be re-arrested in the 25 months following admission than the combined group of individuals who failed, dropped out, opted out, or were ineligible for the Drug Court Program (n=788).. (Cox et al 2001).
- A study of drug courts conducted by the Washington State Institute for Public Policy estimated that, for every dollar spent on Drug Court, taxpayers receive roughly $2.45 in benefits to the criminal justice system (Washington Institute for Public Policy, 1999).

Coerced Treatment Is Effective

- A conclusion of a recent review of the national literature is that persons addicted to drugs need not be internally motivated at the outset of treatment to benefit from it. In fact, such persons who are legally pressured into treatment often have better outcomes than voluntary clients because they are likely to stay in treatment longer and are more likely to graduate (Satel, 1999).
- Another review of literature reached a similar conclusion, stating that coerced addiction treatment typically results in favorable outcomes among criminal populations, with coerced convicts complying as well as those not mandated to treatment (Miller & Flaherty, 2000).

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SENATE COMMITTEE REPORT

DATE: 3/21/07

FURTHER: Finance

DATE TURNED IN TO OFFICE: 3/29/07

State Affairs Committee considered SENATE BILL NO. 100

SB 100 SUBSTANCE ABUSE/MENTAL HEALTH PROGRAMS

"An Act relating to substance abuse and mental health disorder prevention and treatment programs; and relating to long-term secure treatment programs for persons with substance abuse or co-occurring substance abuse and mental health disorders."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS SB 100 (STA)

[ ] adopt previous [ ] SCS or [ ] CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	03/21		✓		2
HSS	03/21	✓			1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	French	X			
	Stevens			X	
Ruby Green	Green			✓	
C Bunde	Bunde		✓		
CHAIR:	McClure			✓	

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/28/07

FURTHER: (State Affairs)
Finance

Date of 5-Day Notice: 3/15/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/19/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 100

SB 100 SUBSTANCE ABUSE/MENTAL HEALTH PROGRAMS

"An Act relating to substance abuse and mental health disorder prevention and treatment programs; and relating to long-term secure treatment programs for persons with substance abuse or co-occurring substance abuse and mental health disorders."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	3/15/07	✓			1
HSS	3/15/07		✓		2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Ellis	✓			
	Thomas	✓			
	Cowdery			✓	
	DYSON	✓			
CHAIR: Betty Davis	DAVIS	✓			

4/17/07

My name is Suey Linzmeier and I am the mother of an alcoholic and an addict. I strongly support SB 100, and urge those of you with doubts to do a bit more research on alcoholism and drug dependency.

Alcoholism is a disease. Without intervention, treatment, education and on-going support, most alcoholics and addicts are unable to control their habit... which means they are incapable of knowing when they have had too much.

My son struggled with drugs and alcohol for 7 years. He learned about drugs in the Juneau School District and obtained them there. It took him the last two years of extremely overwhelming addiction issues to ask for treatment support. If I could have forced him into a program sooner, I would have. But that method of treating is usually ineffective unless the program is holistic in dealing with the victim.

The Russian Orthodox Priest Father Michael Oleksa, who regularly counsels prisoners around the state, said that when he asks men in the Alaska prison system (because 85% of the people in prison are male) what led them to commit the crimes that put them in jail, 90% say they were drunk or high at the time they committed their crime. They may be locked up, but their disease is not being treated and they most likely will be repeat offenders.

My son was fortunate that our family has medical insurance and we could get him to a non-profit program in Washington with some of the best success rates in treatment in the nation (they're actually ranked third). There he, and our entire family, learned about the diseases of alcohol and addiction, and new methods of coping and being healthy. He will always be an addict and an alcoholic, but now he has learned how to find support wherever he is through the AA network and other community venues, and most

importantly that being an addict and alcoholic means never drinking a drop again.
(empire)
This boy was not so lucky. He is the same age as my son, and also started experimenting with drugs and alcohol in seventh and eighth grade. His mandatory court 'treatment' was at a local facility with a not-so-successful rate for helping young addicts and alcoholics. I am confident that if he were sentenced to treatment at the program my son went to, he would not be in this situation today.

The state of Washington offers their DUI offenders the option of prison or treatment. I wish that were an option in our State, because as we all know, the disease of alcohol knows no economic or social barriers. A 21-day treatment bill is $4,200 with all expenses paid including family therapy.

In that program we also saw pregnant women. They looked like they had many hard times behind them, but they also had a glow and happiness about them that made me suspect that their children will have a better life.

Thank you for your time, please get any questions about recovery that you have answered before you vote on this important topic, and thank you for supporting SB 100.