GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

Office of the Senior Deputy Director
for Substance Abuse Services

THE U.S. SENTENCING COMMISSION
Public Hearing on Federal Cocaine Sentencing Policy

November 14, 2006

ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

The Addiction Prevention and Recovery Administration (APRA) is the District of Columbia's single state agency (SSA) on alcohol, tobacco and other drug abuse prevention and treatment. APRA plans and implements the public substance abuse prevention and treatment initiative for the Department of Health (DOH) and is the primary provider and/or funding agency for substance abuse services for indigent (uninsured or underinsured) District residents at risk or living with a substance use disorder. The DOH Senior Deputy Director for Substance Abuse Services/APRA Administrator provides oversight on all APRA activities.

MISSION:
Building resilience and enabling recovery for DC residents at risk or living with substance use disorders.

VISION:
A healthy and drug free District of Columbia

PHILOSOPHY:
Substance abuse and/or use disorders are associated with biological, psychological and social factors. Therefore substance abuse and addiction are multi-domain concerns and "biopsychosocial" in nature. Thus, prevention and treatment must address these components of the user or person at risk in order to meet the needs of the whole person. Effective prevention efforts build resilience against initial or continued use while treatment is matched to the clinical and social profile of the user through care plans that are based on standard of care and individual profile. Effective planning considers the cofactors to and impact of substance use on the individual and collective (familial and societal levels as well as the efficiency and effectiveness of current efforts.

CRITICAL SUBSTANCE ABUSE TRENDS IN THE DISTRICT:

- The overall illicit drug use rate of 9.6%, 52% higher than the nationwide rate of 6.3%
- Approximately 60,000 residents – nearly 1 in 10 – are addicted to illegal drugs or alcohol.
- There are between 26,000-42,000 individuals with a co-occurring substance abuse and mental health disorders – at least 40% of the street-bound homeless population has a co-occurring disorder.
- 27% of the cumulative AIDS cases are related to injection drug use.
- The social cost of alcohol and drug abuse is estimated to be more than $1.2 billion.

Through a Mayoral appointed Interagency Task Force on Substance Abuse, Prevention, Treatment and Control, APRA is responsible for leading the development and implementation of the City-Wide Comprehensive Substance Abuse Strategy.

As the substance use disorders treatment experts for the Nations Capitol, following are our collective responses to the very thought provoking questions raised in preparation for setting Cocaine sentencing policy:

1. **When a person using cocaine comes to treatment, what are the symptoms that you typically see? Do the symptoms vary depending on whether the patient abuses Crack versus powder cocaine and, if so, how? Do they vary depending on the route of administration and, if so, how?**

    - Addiction is a brain disease with biopsychosocial implications. While overall symptomatology for cocaine use is similar, clearly nuances are evident between clients presenting for treatment of their addictive disorder. Generally, at admission Crack and powdered Cocaine users present with symptoms indicative of depression. Intermittent binge use of crack cocaine and cocaine is common. The withdrawal symptoms of both agents are similar. The withdrawal symptoms after a 2-3 day binge are different from those that occur after chronic, high dose use. Following regular use the withdrawal syndrome consists of the following: dysphasia, irritability, difficulty sleeping and intense dreaming. These symptoms usually subside after 2 to 4 days of drug abstinence. This is due, in part to the depletion of certain neurotransmitters, which were highly active during the period of Cocaine use. Crack Cocaine enters the brain quickly, with an instantaneous pleasurable effect on the reward pathway of the brain. However, the decline of the effect occurs quickly as well. Hence, the desire to experience the intense feeling of pleasure intensifies cravings and compulsions to obtain more of the drug. Because of the lower price new users of Crack Cocaine often perceive their resources as infinite. This perception changes as they become caught in the cycle of: obsession, compulsion, loss of control over their use and continued use despite adverse consequences. At this juncture, many Crack Cocaine users present for treatment in a state of despair, dejection and destitution. Clearly, this scenario does apply to many users of powdered Cocaine as well. However, given the route of administration and the cost, the inevitable “end” might be merely prolonged. Many users of powdered Cocaine move from “snorting” to injecting and/or smoking

Cocaine. This pattern is indicative of the desire to achieve a more intense level of euphoria and a willingness to adapt behaviors to accomplish this goal. Snorting and/or injecting drugs have the effect of substance dilution that smoking the drug does not have. Hence, a Cocaine addicted person soon realizes that in some ways they are wasting money and diminishing the effect and start using Crack Cocaine.

2. **What is a typical treatment plan for a cocaine abuser and does it vary depending on either the form of the drug (Crack versus powder) or the route of administration (smoked, injected, or snorted)? Do the treatment plans use different or greater treatment resources (for example, is medical detoxification more likely required for users of one form of the drug compared to than other form of the drug); is there a different likelihood of successful completion of the treatment program based on the form of the drug or route of administration; is there a different risk of relapse?**

- All treatment plans designed for persons with addictive disorders must be based on the strengths, needs, abilities and preferences of the client (SNAP). Treatment providers aim to create an environment in which the clients can begin to embrace recovery, based on their assessed needs. When this occurs, treatment works. From this perspective no singular plan of care can address every user of Cocaine admitted to a treatment setting. The best plan for determining the appropriate level of care is the use of the patient placement criteria (PPC) developed by the American Society of Addiction Medicine (ASAM). This is especially important in that many users of Cocaine, in any form, rarely use Cocaine alone. Many are polysubstance users, which could include the use of Heroin, Alcohol, prescription narcotics and or tranquilizers and other licit and/or illicit drugs. Their Alcohol use could require a medically supervised detoxification. An important distinction centers on the debilitative level of the admitted client. Medically supervised detoxification is used to assisted client which are experiencing physical withdrawal that is life threatening. Clearly, all users of Cocaine do not require a medically supervised detoxification. Some users of Crack and or powdered Cocaine do require a period of stabilization found in a Social Model Detoxification placement. Placement at this level of care serves to stabilize the client within an integrated system of care that addresses their biopsychosocial needs as the drug withdraws from their body. Clients with a dependence on Cocaine, admitted to any level of care, often present for treatment with depressive affects that must be evaluated and monitored. Recognition of the issue of possible mood disorders, most notably depression, in the treatment of persons with a dependence on cocaine is vital to their successful care and subsequent outcome. First, the treatment must include plans for the prevention of self-harm, a factor often evident when people in a prerecovery state experience depression. As alluded to in the first question, the withdrawal affects of Cocaine are exacerbated by depletion of the neurotransmitters that produce, in the person, a sense of well being. Second, in all likelihood, the Cocaine addicted person has not slept nor eaten. They come out the euphoric state physically drained, emotionally depressed, hopeless and to some degree, guilt ridden over their behavior and/ or losses. Combined, the potential for self-harm and relapse

are high. The primary goal of the treatment process remains the same. The client must be educated about their addiction and the process of recovery. They learn to see the addictive disease in themselves, by learning to self-diagnose. Clients learn about recovery resources and how to use them to their advantage. Further, they learn that they have the primary responsibility for continued treatment of their addictive disorder. Added emphasis on craving management is helpful to persons addicted to Cocaine in any form. Because addiction is a brain disease, with Cocaine users, there is a continued sensitivity to the effect of the drug within the reward pathways of the brain. Therefore, the addicted individual, although in recovery, can still experience intense cravings long after their last use. These are called triggers. They can be environmental i.e. passing through an old neighborhood; or social i.e. seeing or talking to a friend they shared drugs with in the past or personal. This area speaks especially to the consequences of Crack Cocaine. Many persons addicted to Crack Cocaine who present for treatment have experienced trauma as a result of their drug seeking behavior and suffer PTSD. To be sure, the end point of continued addiction is personal deterioration of one sort or another. With Crack Cocaine the end point appears more pronounced.

3. **Have there been any changes since the Commission issued its 2002 report on federal cocaine sentencing policy that should be considered by the Commission?**

    - Since the changes instituted by Federal guidelines in sentencing there is a great disparity in the numbers of African Americans and other minorities incarcerated for longer periods of time.

4. **From your perspective is there a difference in harms associated with the use/trafficking of Crack versus powder cocaine:**

    - With all drugs of abuse and dependence a clear harm to the individual and society is evident. To place one harm above the other because of type not cause appears counter productive. Having stated that, the end result of Crack Cocaine use is devastatingly pronounced for some individuals, treatment for the addicted persons creates healthy productive citizens and a stronger community. What comes to mind is the question as to whether a Crack addicted mother who neglects to feed her child is worse than a drunk driver who kills a child at a crosswalk. Harm is reduced through new ways of thinking and behaving. This is the process of active recovery, and is just as potent in a positive manner as active addiction is in a negative manner. Addiction is a treatable brain disease. The concomitant harm associated with this disorder is the result of obsession, compulsion, loss of control and continued use despite adverse consequences. Through the use of proven best practice approaches the disease of addiction can be placed in remission, with demonstrated observable behavior changes evident in the “treated person”. Moreover, the neighborhood shares in the recovery and benefits from an improved community spirit.

If there is a difference, should trafficking in one form of the drug be punished more severely than trafficking in the other form of the drug?

If a difference exists but they should be punished identically? Please explain.

If a difference exists and they should be punished differently, what should that specific difference be, and what is the justification for that specific difference?

- Trafficking sentencing should be considered equal for Cocaine regardless of the form. However, it is important to consider in any sentencing structure that a significant number of those who sell these drugs do so to support their addiction. Addiction is a brain disorder that research has shown responds to treatment. In many cases those individuals who are incarcerated for possession or sale of illicit drugs can benefit from diversion to treatment rather than prison sentences. Without adequate treatment these same individuals will re-offend and add to the incarceration rate of high recidivism. Any federal sentencing policy that does not take into account the value of diversion and treatment will fail not only the individual with a substance use disorder but the community at large.