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One Size Does Not Fit All: The Failure of Washington's Licensing Standards for Alcohol and Drug Treatment Programs and Facilities to Meet the Needs of Indians

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ONE SIZE DOES NOT FIT ALL: THE FAILURE OF WASHINGTON'S LICENSING STANDARDS FOR ALCOHOL AND DRUG TREATMENT PROGRAMS AND FACILITIES TO MEET THE NEEDS OF INDIANS

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Abstract: It is well recognized that culturally and spiritually relevant alcohol and chemical dependency treatment programs are most successful. Washington's licensing standards for such programs and facilities, however, fail to address the cultural and spiritual needs of Indians who they serve. The State's current one-size-fits-all approach offers no hope for improved treatment outcomes for Indians. This Comment demonstrates the inadequacy of Washington's current treatment facility and program licensing standards and examines the high costs of maintaining these standards. The Comment concludes with a proposal for specific legislation for the State of Washington.

Washington's licensing standards for alcohol and chemical dependency treatment facilities and programs fail to address cultural and religious diversity among those persons who use the services. Because a strong and direct link between cultural and religious relevance of treatment and successful outcomes is well recognized,[1] these standards are woefully inadequate. This Comment addresses the disparate impact on Indians[2] of Washington's failure to recognize cultural and religious needs in the treatment process.

Alcohol and chemical abuse treatment programs[3] that are not culturally relevant fail to serve adequately the needs of Indians who have strong cultural or religious ties to reservation life, the Native American Church (NAC), or other tribal/cultural practices.[4] Such failure leads to disappointing treatment success rates for Indians sentenced to complete programs following alcohol or drug-related offenses, as well as for those

1. Larry Dyer, *Problems of Definition*, in *Managing Multiculturalism in Substance Abuse Services* 33 (Jacob U. Gordon ed., 1994); Mary L. Robbins, *Native American Perspective*, in *Managing Multiculturalism in Substance Abuse Services* 169 (Jacob U. Gordon ed., 1994).

2. The term "Indian" is used to describe those persons who consider themselves to be Native American. For the purposes of this Comment, tribal membership, tribal recognition, and other legal distinctions are irrelevant.

3. For the sake of simplicity, throughout this Comment "alcohol treatment programs" will signify both alcohol and other chemical abuse treatment programs.

4. Because successful treatment opportunities must meet the cultural and religious needs of a broad spectrum of individuals, this Comment will not differentiate between Indians living on reservations and Indians living in urban environments. Such an approach would fail to recognize that many urban Indians have strong traditional beliefs and cultural ties.

in voluntary treatment efforts.[5] Many studies show a much higher success rate for Indians in culturally relevant treatment programs and a disappointing recidivism rate where cultural factors are not integrated.[6]

Despite this data, however, Washington's standards make it difficult for alternative treatment programs to gain state approval. The current system assumes that one size fits all. This assumption has numerous repercussions for Indians and for the state. Because studies show that alcohol is involved in as much as ninety-seven percent of crime among Indians,[7] a system that fails to address the unique treatment needs of this population fails everyone. Further, alcohol and chemical abuse frequently is implicated in family violence and neglect.[8] Fetal alcohol syndrome is another significant problem among many tribes that contributes to the multigenerational effects of the state's failure to treat adequately alcohol and drug addictions.[9] Indians who lose their children, who become incarcerated, or who are unemployed due to an ongoing cycle of alcohol or drug abuse and failure in treatment programs are both contributors to and victims of a vicious cycle. Repeated treatment failure increases the problem by diminishing the hopes of substance abusers, their children, and the tribes.[10] Dominant culture[11] stereotypes of the

5. Robbins, *supra* note 1, at 168.

6. *Id.* at 148–49; *see also* Dyer, *supra* note 1, at 33; Janine M. Lee, *Historical and Theoretical Considerations: Implications for Multiculturalism in Substance Abuse Services*, in *Managing Multiculturalism in Substance Abuse Services* 13–14 (Jacob U. Gordon ed., 1994).

7. Ronet Bachman, *Death and Violence on the Reservation: Homicide, Family Violence, and Suicide in American Indian Populations* 31 (1992).

8. *Id.* at 91.

9. Claire Dineen, *Fetal Alcohol Syndrome: The Legal and Social Responses to Its Impact on Native Americans*, 70 N.D. L. Rev. 1, 2–4 (1994). Fetal Alcohol Syndrome (FAS) results from maternal alcohol use during pregnancy. Its effects can include mental and physical handicaps and may be so debilitating that victims are unable to live independently. The effects also may be multigenerational because FAS interferes with the victim's ability to understand the connection between actions and consequences, such as drinking during their own later pregnancies, abuse, and neglect. *Id.*; *see also* Gilberto F. Chavez et al., *Leading Major Congenital Malformations Among Minority Groups in the United States, 1981–1986*, 261 JAMA 205, 208 (1989) (reporting that incidence of FAS among Indians is generally 33 times higher than among Caucasians).

10. *See* Robbins, *supra* note 1, at 155, 168.

11. As used in this Comment, the term "dominant culture" describes American society as it is infused with predominantly Anglo values and beliefs. *See* Lee, *supra* note 6, at 13–17 (stating that historically American society has emphasized assimilation of different racial and ethnic groups into dominant culture, wherein Western traditionalists hold balance of power, financial resources, and top positions in government, mass media, publishing industry, and schools, colleges, and universities).

"drunken Indian" also are perpetuated, further decreasing chances for treatment success.[12]

Culturally relevant treatment programs offer the most significant opportunity for change, but such programs are beyond the economic reach of most tribes and Indian substance abusers because state funding is available only to state-approved treatment facilities.[13] Further, court-ordered treatment is required to occur in state-approved facilities.[14] Therefore, to serve adequately Indian treatment participants, the State must alter its standards to treat alcohol and chemical abuse in a culturally relevant manner.

This Comment first reviews, in part I, the present law in Washington State that establishes standards for approved treatment facilities and programs. Part II examines the high cost of a system that fails to treat alcohol and chemical abuse successfully, and then discusses several reasons why inadequate treatment programs and facilities contribute to lower treatment success rates among Indians. Part II also examines treatment models that may be more successful than those currently in place. Standards for proposed reform are set forth in part III, and part IV proposes legislative reform in Washington to allow and encourage the licensing of alcohol and chemical abuse treatment facilities and programs that better address the needs of Indians.

I. THE LAW IN WASHINGTON STATE

The Legislature has announced that it is the policy of Washington State that alcoholics should be provided with a continuum of high quality services that will allow them to lead normal lives and be productive members of society.[15] To carry out this policy, the Legislature has authorized and funded the Department of Social and Health Services (Department or DSHS) to develop and provide treatment programs including a broad range of medical and counseling services.[16] The Department also is authorized to set licensing standards for treatment programs.[17] Approved programs may be either public or private.[18]

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12. Robbins, *supra* note 1, at 152, 160–61 (stating that stereotypes about Indian identity translate into behavior and destroy psychological well-being and self-confidence).

13. Wash. Rev. Code § 70.96A.045 (1996); *see also infra* note 23.

14. *See infra* notes 19–21.

15. Wash. Rev. Code §§ 70.96A.010–.011 (1996).

16. Wash. Rev. Code §§ 70.96A.030–.040 (1996).

17. Wash. Rev. Code §§ 70.96A.011, .020, .040 (1996). "Treatment" means a broad range of emergency, detoxification, residential, and outpatient services and care, including diagnostic

Like other Washington residents, some Indians come to alcohol treatment facilities voluntarily. Others come because of a court order resulting from criminal conviction,[19] determination of incapacitation by alcoholism or drug addiction,[20] or reported child abuse or neglect.[21] Those entering on an involuntary basis will, of course, be sent to a state-approved facility.[22] But even those seeking treatment on a voluntary basis are likely to seek a state-approved facility due to cost considerations, because only state-approved facilities may receive state funding.[23] Thus, for the vast majority of Indians seeking treatment in Washington, the conditions attached to state approval are crucial.

The Department's standards are set forth in Washington Administrative Code chapter 246-326. The stated purpose of the regulation is "to provide health and safety standards and procedures for the issuance, denial, suspension and/or revocation of licenses for facilities, other than hospitals . . . , maintained and operated primarily for receiving or caring for alcoholics."[24] Great power accompanies the regulations, as the Department is authorized to define "[a]ll adjectives and adverbs such as adequate, approved, competent, qualified, necessary, reasonable, reputable, satisfactory, sufficiently, effectively, appropriately, or suitable . . . ."[25] The ambiguity of many of these terms suggests that the Department has a fair amount of flexibility in deciding the standards to apply.

This apparent flexibility is offset, however, by other specific elements of the regulations that erect significant barriers to culturally relevant

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evaluation, chemical dependency education and counseling, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons. § 70.96A.020(21).

18. Wash. Rev. Code § 70.96A.040(2) (1996); *see also* Wash. Rev. Code § 70.96A.080(4) (1996) (authorizing Department to contract for use of approved programs).

19. *See, e.g.*, Wash. Rev. Code § 46.61.524 (1996).

20. Wash. Rev. Code § 70.96A.140 (1996).

21. Wash. Rev. Code § 26.12.170 (1996).

22. *See supra* notes 17–19. These statutes require that court-ordered treatment occur at an approved facility.

23. Wash. Rev. Code § 70.96A.045 (1996) ("All facilities, plans, or programs receiving financial assistance under RCW 70.96A.040 must be approved by the department before any state funds may be used to provide the financial assistance."). The statute makes no distinction between the state's own funds and any federal funds that may filter through the state. *See also* Wash. Rev. Code § 70.96A.040.

24. Wash. Admin. Code § 246-326-001 (1995).

25. Wash. Admin. Code § 246-326-010 (1995).

treatment programs. For example, personnel requirements demand adherence to a hierarchical system that may be at odds with social structures present in Indian cultures.[26] Another requirement, that medical staff must comply with Washington law for physician or nursing practice, impedes the provision of traditional Indian healing methods[27] either as the sole source of medical services or as a complement to Western medicine,[28] as does a requirement that anyone "administering medications and medical treatments to patients . . . be qualified by training and legally permitted to assume this responsibility."[29]

Two other elements prevent the incorporation or allowance of Native American Church practices in treatment facilities or programs approved by the State. First, a facility cannot be licensed if any individual named in the application has been convicted of a felony, and facilities may not permit, aid, or abet the commission of any illegal act on the premises of the facility.[30] Second, "[m]edications listed as controlled substances in

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26. Wash. Admin. Code § 246-326-030 (1995). The Code reads, in relevant part:

(1) Governing body.

(a) The alcoholism treatment facility shall have a governing body responsible for adopting policies related to the conduct of the alcoholism treatment facility in accordance with applicable laws and regulations.

(b) The governing body shall provide for the personnel, facilities, equipment, supplies, and special services . . . .

(2) Administrator.

(a) There shall be an administrator at least twenty-one years of age . . . .

. . . .

(c) The administrator shall establish and maintain a current written plan of organization including all positions and delineating the functions, responsibilities, authority, and relationships of all positions within the alcoholism treatment facility.

§ 246-326-030.

27. *See infra* note 108 and accompanying text; *see also* Vine Deloria, Jr., *God Is Red* 263–64 (1973) (stating that although "healing remains one of the major strengths of tribal religions," traditional Indian healers still face skepticism and often are regarded as "fakers and charlatans").

28. Wash. Admin. Code § 246-326-030(3)(i). Washington Administrative Code Section 246-326-050(3)(a) requires that a physician direct all medical aspects of the treatment program, including care of minor illnesses. Wash. Admin. Code § 246-326-050(3)(a) (1995). Although it is conceivable that a physician might approve traditional healing methods as an adjunct to Western medicine, a physician is clearly not directed to consider such options. Further, any traditional medical practitioner would have to practice under the direction of the physician. The concurrent practice of traditional and Western medicine is still not a common sight in Washington or elsewhere in the United States.

29. Wash. Admin. Code § 246-326-060(3)(a)(iv) (1995).

30. Wash. Admin. Code § 246-326-020 (1995).

Washington shall be prohibited."[31] These provisions bar the traditional, and distinctly nonabusive, sacramental use of peyote by members of the Native American Church while they are in treatment facilities.[32] Further, by preventing treatment centers from employing any members of the Native American Church who previously have been convicted for exercising this element of their religious practices, these provisions hinder Indians' ability to participate in a treatment program with personnel who share their beliefs and practices. The State certainly has a legitimate interest in preventing the use of controlled substances by persons in treatment facilities generally. The effect of these regulations, however, is to limit significantly the ability of members of the Native American Church to participate fully in and practice their religious beliefs while in treatment.[33]

The physical requirements for treatment facilities also may impede culturally relevant programs. These include detailed requirements for room size, sleeping arrangements, location of windows, lighting, temperature and heating systems, and furnishings.[34] Such requirements prevent the construction of many traditional structures that tribes might find better suited to the promotion of traditional healing methods.[35]

The regulations do state that facilities must provide a "reasonable opportunity to practice religious choice insofar as such religious practice

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31. Wash. Admin. Code § 246-326-060(2)(k) (1995). Peyote is listed as a controlled substance. Wash. Rev. Code § 69.50.204(c)(17) (1996).

32. *See infra* notes 99–103 and accompanying text. Though its use of peyote as a sacrament is controversial, the Native American Church has been proven to be a successful component in alcoholism treatment programs for Indians.

33. *See infra* notes 99–103 and accompanying text.

34. Wash. Admin. Code § 246-326-090 (1995). These regulations are highly detailed, reading like a building code. For example:

> No portion of a sleeping room having less than seven foot six inch ceiling height may be counted as part of the required area . . . . Only rooms having unrestricted direct access to a hallway, living room, outside, or other common-use area shall be used as sleeping rooms . . . . Sleeping rooms shall be outside rooms with a clear glass window area in a vertical wall not less than one-tenth of the required floor area . . . . Each patient shall be provided with a comfortable bed not less than thirty-six inches wide . . . . The alcoholism treatment facility shall be equipped with an approved heating system capable of maintaining a healthful temperature. Use of portable space heaters is prohibited unless approved in writing by the Washington state fire marshal . . . . Ventilation of all rooms used by patients or personnel shall be sufficient to remove all objectionable odors, excessive heat, or condensation.

§ 246-326-090.

35. *See, e.g.*, Philip Drucker, *Indians of the Northwest Coast* 71–72 (1963). Traditional structures, such as semisubterranean lodges and small, domed, mat-covered sweatlodges in which water is sprinkled over hot coals, are unlikely to be approved.

does not infringe upon rights and treatment of other patients or the treatment program in the alcoholism treatment facility: *Provided*, That a patient also has the right to refuse participation in any religious practice."[36] Providing a reasonable opportunity to engage in religious practices indicates some cultural sensitivity, but it fails to provide adequate assurance that individuals in treatment will not have to find their own ways to work around a dominant culture religious perspective that permeates the treatment process.[37] The provision also fails to ensure that treatment facility staff will be trained to respect and understand diverse cultural practices and beliefs and create an environment that supports and encourages such respect and understanding among those receiving treatment services.

Little case law exists interpreting the statute or regulations that govern state-approved treatment programs and facilities. One case, however, evaluated the adequacy of a program provided to inmates at the Walla Walla penitentiary, and held that the Revised Code of Washington section 70.96A.050(3) "cannot be reasonably construed as a legislative mandate that certain treatment modalities should be employed by DSHS."[38] Citing the Department's discretion, the court based its holding on the fact that "the alcohol treatment program consists of a variety of components, including the credibly successful Alcoholics Anonymous program . . . ."[39] The court neither cited data to support the effectiveness of the Alcoholics Anonymous (AA) program, nor made an inquiry into its relative effectiveness among various population groups. Thus, neither the statute, the regulations, nor any case law suggests a commitment by the Legislature or the Department to provide culturally and spiritually relevant treatment programs and facilities.

II. WASHINGTON SHOULD REFORM ITS STANDARDS FOR ALCOHOL TREATMENT FACILITIES

A. The Costs of Untreated Alcoholism Are High

The Legislature authorized the Department of Social and Health Services to create treatment programs and services because it found that

36. Wash. Admin. Code § 246-326-040(2)(b)(iv) (1995).

37. *See infra* part II.B and accompanying notes. The Christian beliefs and values upon which the dominant treatment model are based permeate the treatment process.

38. Aripa v. Department of Social & Health Servs., 91 Wash. 2d 135, 138, 588 P.2d 185, 187 (1978).

39. *Id.* at 141, n.8, 588 P.2d at 189, n.8.

alcohol and drug abuse constitute "a serious threat to the health of the citizens of the state of Washington."[40] A review of the effects of alcoholism and drug abuse on Indians not only illustrates the accuracy of the Legislature's concerns, but also demonstrates that special attention to the needs of Indian addicts is necessary.

Statistical and anecdotal information abounds describing the devastating and disparate impact of alcohol and drug abuse on Indians and Indian tribes. "Alcohol . . . 'is the single most serious health and social problem among American Indian people,'" contributing to poverty, disease, and crime.[41] In fact, evidence supports a strong correlation between early substance abuse and the onset of a pattern of juvenile and adult criminal activity leading to long-term incarceration.[42]

It is dangerous to use statistics to predict or describe conditions for any given tribe because variation among tribes is extreme.[43] On a national basis, however, some Indian communities have three to five generations of alcohol abusers, and the Indian Health Service estimates that significant drinking problems are experienced by about fifty percent of the population on some reservations.[44] Prospects for improvement in

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40. Wash. Rev. Code § 70.96A.011 (1996).

41. Robbins, *supra* note 1, at 151–52. For example:

1. Cases of terminal liver cirrhosis are 14 times greater among Indians than non-Indians between the ages of 25 and 34 . . . .

2. Death from heavy drinking is 6.5 times greater than the general population . . . .

3. Nearly one third of all outpatient visits to the Indian Health Service (IHS) involve alcohol abuse or dependence . . . .

4. Drug abuse and dependence are especially high among young Indians . . . .

7. Suicide rates are twice the national average and strongly linked to substance abuse . . . .

8. Alcoholism among young parents is on the rise with an accompanying increase in child abuse . . . .

9. The number of babies born with fetal alcohol syndrome is increasing . . . .

10. Accidental fatalities (estimated to be 75% alcohol related) are three times as high for Indians as for other ethnic groups and account for one fourth of Indian deaths . . . .

11. Most Native American crime is drug or alcohol related . . . .

Id.

42. *Id.*

43. Bachman, *supra* note 7, at 5. The Bureau of Indian Affairs recognizes 505 tribes in the United States, including 197 Alaska Native village groups. Today, approximately one-half of all American Indians live on reservations, and an equal share live in urban areas. There are about 304 federal Indian reservations in the United States. *Id.*

44. Robbins, *supra* note 1, at 154; *see also* R. Dale Walker et al., *Treatment Implications of Comorbid Psychopathology in American Indians and Alaska Natives*, 16 Culture, Med. & Psychiatry 555, 555–56 (1992/1993) (reporting that a recent study of 290 urban Indian families in the Pacific

future generations are dim because the rate of youth alcohol and drug abuse by Indians is more than twice the national rate, with little variation by tribe.[45] Thus, the effects of alcohol and drug abuse on Indians promise to worsen if treatment outcomes are not improved.

It is unclear why alcohol and drug abuse affects Indians more than other groups. The myth that Indians are biologically more susceptible to alcohol than are Whites has been largely dispelled.[46] One possible explanation is that, although Indians are subject to the same risk factors as other members of the population, they may experience greater exposure to many of these factors.[47] Risk factors include long-term alcohol or drug use, psychology, poverty, and family and social history.[48] Several of these factors play a greater role in more Indians' lives than in other segments of the population. For example, despite present variations among tribes in wealth and living conditions, all tribes have experienced similar economic and social disruptions of their communities and traditional family life since European contact began.[49] Economic deprivation often underlies the development of other risk factors, because it "can increase the likelihood of a number of pathologies, such as alcoholism, suicide, child abuse, and lethal violence. The psychological consequences of being poor are many. It engenders hopelessness, apathy, and anger."[50]

Indians face an important additional risk factor, often termed "acculturation stress," which results from the "stresses of living in a predominantly White culture that traditionally has not supported Native American identity."[51] The difficulties associated with straddling two cultures are exacerbated in the treatment environment, where a narrow "path" based in dominant culture beliefs is presented as the only means

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Northwest shows that 43% of Indian fathers and 30% of Indian mothers have a lifetime history of alcohol dependence).

45. Robbins, *supra* note 1, at 154.

46. *Id.* at 164 (reporting that although some individuals may be more genetically susceptible to alcohol than others, most studies show greater variation within ethnic groups than among them; noting that there is evidence that, on individual level, body's physiological stress response to alcohol consumption itself may enhance its negative effects).

47. A risk factor is defined as "a characteristic of an individual's environment that increases the potential for the individual to use substance abuse as a means to mediate life's stresses." Dyer, *supra* note 1, at 33.

48. Robbins, *supra* note 1, at 166–67.

49. Bachman, *supra* note 7, at 6.

50. *Id.* at 48.

51. Dyer, *supra* note 1, at 32.

of achieving and maintaining sobriety.[52] Another unique problem affecting Indians is that the prohibition on sales of alcohol to Indians on many reservations[53] appears to increase the practice of binge or explosive drinking patterns.[54] This all-or-nothing drinking format, in turn, brings Indians into conflict with dominant culture law enforcement agents by forcing off-reservation trips resulting in arrests for driving while intoxicated and other associated offenses.[55] In addition, empirical data suggest that negative stereotypes result in discriminatory treatment against Indians in the criminal justice system, including higher arrest rates and longer sentences.[56] This problem is compounded because Indians are also less likely than whites to be financially able to obtain adequate legal assistance.[57] The result of these factors is the presence of many Indians in treatment programs and facilities in Washington State. If treatment outcomes are not successful, negative stereotypes and discrimination will likely continue.

B. Treatment Models That Do Not Work Are Worse Than No Treatment at All

The dominant recovery model in the United States is Alcoholics Anonymous (AA), established in the 1930s by upper-middle-class white men with strong Christian backgrounds.[58] Although the Washington statutes do not require that treatment be based on the AA model, the statutes do not encourage, or even mention the importance of, developing alternative models that might better serve the goals established by the Legislature. Thus, the AA model dominates Washington's treatment

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52. Charlotte Davis Kasl, Ph.D., *Many Roads, One Journey: Moving Beyond the 12 Steps* 146–47 (1992). The title chapter of *Alcoholics Anonymous*, which sums up the approach of the dominant treatment method, states, "Rarely have we seen a person fail who has *thoroughly* followed *our* path. Those who do not recover are people who *cannot* or *will not* completely give themselves to this *simple* program . . . ." *See also* Deloria, *supra* note 27, at 254 ("Alcoholism and suicide mark this tragic fact of reservation life. People are not allowed to be Indians and cannot become whites.").

53. Robbins, *supra* note 1, at 166. The federal government prohibited the sale of alcoholic beverages to Indians from 1802 to 1953; 60% of reservations still restricted the sale and consumption of alcohol in 1991. *Id.*

54. *Id.*

55. *Id.*

56. Bachman, *supra* note 7, at 80–84. A longitudinal analysis of arrest and disposition rates for all individuals processed by the Seattle Police Department, for example, stated, "A potentially valid explanation for the alarming arrest rates for Indians may be as basic as anti-Indian bias on the part of the criminal justice system." *Id.* at 82.

57. *Id.*

58. Kasl, *supra* note 52, at 3–5.

programs and facilities as it does elsewhere.[59] Although the AA recovery method claims a long history of significant success,[60] it has proven less successful for many minorities, including Indians.[61] This disparity can be attributed to AA's dominant culture roots.[62] Two primary ways in which AA treatment models alienate members of nondominant cultures are by failing to meet diverse spiritual needs and by neglecting cultural differences such as communication styles and healing models.

The pervasiveness of AA's religious roots may distance people of other cultures whose spiritual beliefs are significantly different. Although it asserts itself as a primarily spiritual program capable of accommodating any religion, AA was conceived in a Christian framework and includes the Lord's Prayer at the end of meetings.[63] By encouraging non-Christian Indians and others to merely substitute their own higher power for the Christian God in order to participate in treatment programs modeled on the AA doctrine, AA demonstrates deep and incorrect cultural assumptions and ignorance.[64] Although few practicing Christians would likely be satisfied with attending a Muslim mosque or a Buddhist temple with the same instructions, non-Christian Indians pursuing treatment for alcohol or drug abuse are told such substitutions are sufficient to meet their spiritual needs.[65]

Although traditional Indian religious beliefs defy generalization, some prevalent practices and beliefs will help illustrate that the problem cannot be solved by mere substitution of key words or objects. Indian religious beliefs generally are pervasive, infusing all aspects of life with spiritual significance, especially the natural environment. Ceremonies, rituals, and

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59. Telephone Interview with Renee Anderson, Div. of Alcohol & Substance Abuse, Wash. Dep't of Soc. & Health Servs. (Oct. 29, 1996).

60. Alcoholics Anonymous Worldwide Servs., Inc., *Alcoholics Anonymous* at xi–xii (3d ed. 1976).

61. Kasl, *supra* note 52, at 3–7; *see also* Lee, *supra* note 6, at 14.

62. "Values are often unspoken components of culture that are so ingrained . . . that they are assumed rather than consciously chosen." Dyer, *supra* note 1, at 31. Thus, although AA sets out to accommodate persons with a variety of spiritual beliefs, the treatment model is flawed fatally by ingrained values that, like unfamiliar foreign customs, may alienate members of nondominant cultures.

63. *Id.* at 27.

64. *See* Kasl, *supra* note 52, at 150.

65. Jack Trimpey, *The Small Book: A Revolutionary Alternative For Overcoming Alcohol and Drug Dependence* 38 (1989); *see also* Kasl, *supra* note 52, at 146 ("When I say to people in the program that this sounds religious to me, they respond, 'Oh, anything will do for your Higher Power—a doorknob, a tree, your car.' That answer seems to trivialize the notion of a Greater or Higher Power.").

practices involve the use of sacred places, feathers, plants, stones, and other items, and are believed to be essential to the continued health of Mother Earth. Indian religions are rooted in a sense of oneness with the natural environment.[66] A central tenet of many Christian religions, by contrast, is that humans are distinctly separate from the natural environment, and should "have dominion over" and "subdue" the earth.[67] The practice of religion, especially many of the Indian religions, is not a piecemeal affair, but a holistic, lifelong experience.

Another reason why the AA model fails to meet the spiritual needs of many Indians is AA's assertion that there is only one road to sobriety: the acceptance and performance of the twelve steps.[68] For example, steps one and two state:

> 1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
>
> 2. [We c]ame to believe that a Power greater than ourselves could restore us to sanity.[69]

And, AA doctrine further states "[f]or our group purpose, there is but one ultimate authority—a loving God as He may express Himself in our group conscience."[70] AA claims that participants may trust their recovery to any higher power, but the entire context is deeply rooted in Christian values.[71] Mere substitution of another word for "God" is not equivalent to full accommodation of spiritual diversity.

It is common for Indians to incorporate both Christian and traditional Indian beliefs into a mixed spiritual practice. For example, it is congruous to many Indians to fully participate in a Catholic church and also practice their native beliefs.[72] A program, such as AA, which demands submission to one ultimate authority, may alienate persons whose beliefs do not fit within rigid confines. Those who are not

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66. *See generally* Deloria, *supra* note 27; *Touch the Earth: A Self Portrait of Indian Existence* (T.C. McLuhan ed., 1971).

67. Genesis 1:26–28. "[O]f all the major religions of the world, [Christianity] has been the most insistently anti-natural. In the mind of the average Christian . . . nature's chief function is to serve man's needs. . . . No religion . . . has been more rigid in excluding all but man from the real of the divine grace and in denying any moral obligation to the lower species." Donald Worster, *Nature's Economy: A History of Ecological Ideas* 27 (1977).

68. Kasl, *supra* note 52, at 7.

69. *Id.* at 144.

70. *Id.* at 157.

71. *Id.* at 139–40, 144–46.

72. Robbins, *supra* note 1, at 161.

completely alienated must struggle internally with conflicting spiritual beliefs because the program requires them to outwardly admit they are powerless and to submit to group beliefs that are touted as the only way to sobriety.[73]

AA's Christian basis has special repercussions for women and Indians.

> The twelve steps contain words like humility, character defects, shortcomings, and moral inventory, which follow traditional Christian teachings of sin and redemption . . . . If we take Bill Wilson's [AA's co-founder] idea of deflating the ego to its extreme we would have a crushed, nonexistent ego. That's what lots of women and minorities already have, which is not functional.[74]

A majority of treatment facilities also operate on an adult-male centered model.[75] This presents an additional barrier for Indian women and youth, who are significantly more likely than Caucasian women and youth to abuse alcohol and drugs.[76]

Dominant culture treatment programs also fail Indians by neglecting cultural differences in means of communication and healing models. Because an important key to successful treatment is teaching new ways of understanding and thinking about alcohol and drug use,[77] a treatment program that does not recognize Indian ways of learning and passing on knowledge is destined to fail as surely as one taught in a foreign language. This problem is exacerbated by treatment programs that ignore value differences between White and Indian cultures. There are significant differences between White and Indian professionals in value orientation regarding activity, relationships, time orientation, and the human relationship to nature.[78] A significant example is that in many Indian traditional healing models:

> Although healing rituals may take a long time to perform, results are usually expected immediately. . . . In a study . . . over 50% of Indian clients failed to return after the first visit, compared to a

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73. *See* Kasl, *supra* note 52, at 7, 139–46.

74. Kasl, *supra* note 52, at 17–18.

75. Helene M. Cole, *American Medical Association Board of Trustees, Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2669 (1990).

76. Robbins, *supra* note 1, at 154–55.

77. Dyer, *supra* note 1, at 31.

78. *Id.*

> 30% dropout rate for other groups. The counselor can improve these odds by preparing in advance for the first session with cultural knowledge.[79]

Cultural ignorance may take many forms, from mere insensitivity to overt racism, and the effects of historical racism and discrimination may impact the ability of Indian addicts to participate fully in treatment processes.[80] The following statement comes from an African American chemical dependency counselor, but just as easily could have been spoken by an Indian:

> You always sit there wondering, 'What is that white guy *really* thinking about me? Is he faking it? What does he say behind my back?' Class issues also arise: The rich white man is talking about his pain over losing his boat, and none of the poor men can relate. They never had a boat to lose.[81]

The road to treatment and long-term sobriety is fraught with numerous challenges and obstacles. It is not the time to require further submission to the dominant culture, nor to ask that those seeking help silently find their own way to work around racism and other impediments related to cultural ignorance.

It is important to remember that the problem is greater than the failure of a treatment outcome for any given individual. "[T]here is a general sense among Native American communities and individuals that problem drinking is inevitable and possibly untreatable . . . [in part because] treatment programs have been largely unsuccessful in dealing with Native Americans . . . ."[82] One person's failure to succeed in treatment is added to the failures of others, creating a cultural attitude that undermines individual efforts and creates barriers to community support for change.[83] An Indian prison inmate articulated the accepted belief that community support is crucial to long-term sobriety when he said:

> I've been in treatment for 5 weeks and I'm doing good, but I'm so scared to get back in the population . . . . I'm doing good now because I have support to do good, but put me back out with the

79. Robbins, *supra* note 1, at 158.

80. Dyer, *supra* note 1, at 29–30.

81. Kasl, *supra* note 52, at 243.

82. Robbins, *supra* note 1, at 168.

83. *Id.* at 154–55.

people that are saying, 'here bro, want to get high' or whatever, you know, and it won't last.[84]

Peer pressure is a concern for all persons leaving treatment, but the danger is increased in a community that has good reason to believe that treatment does not work.[85] Because twenty-five percent of Indian women in Washington State have been through treatment at least once,[86] messages about treatment are returning to tribes and other Indian communities on a regular basis. It is essential for the long-term success of both individuals receiving treatment and for tribes and communities as a whole that such messages are positive.

C. *The Department Should Encourage Alternative Treatment Models*

To be successful, treatment programs must offer all participants a culturally relevant and culturally sensitive environment. By authorizing DSHS to create licensing standards for alcohol treatment facilities and programs, the Legislature uniquely has empowered the Department to encourage such programs and facilities to meet better the spiritual needs of a diverse population. The authorizing statutes contain no provisions that prevent the Department from requiring treatment programs to include strong policy statements and training that will increase understanding and accommodation of diverse cultures and religions.

In addition to improving existing programs, the Department should reform its licensing standards to encourage the development of alternative treatment programs. Although little firm data exist, it generally is agreed that cultural relevance is a significant factor in successful alcohol and drug abuse treatment programs for Indians.[87] "A culturally sensitive approach to understanding abuse of alcohol and other drugs is founded on the premise that substance abuse is learned within a cultural context."[88] This concept is reflected in the growing trend toward a community-wide approach to drug and alcohol abuse treatment and prevention.[89]

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84. Bachman, *supra* note 7, at 55.

85. *Id.*

86. U.S. Dep't of Health & Human Servs., *Alcohol Use Among U.S. Ethnic Minorities* 214 (1985).

87. Dyer, *supra* note 1, at 33; *see also* Robbins, *supra* note 1, at 168 ("[T]reatment programs have been largely unsuccessful in dealing with Native Americans . . . since they are geared to the culture and needs of the Anglo middle class.").

88. Robbins, *supra* note 1, at 149.

89. *Managing Multiculturalism in Substance Abuse Services* at vii (Jacob U. Gordon, ed., 1994).

The community-wide approach provides greater support for recovering addicts by preceding and following treatment with support and healthy messages about drug and alcohol abuse. Important elements of such programs include recruiting and training within the community, educating about drugs and alcohol, teaching life skills, providing alternatives to substance abuse, developing and implementing policy, and promoting cultural self-esteem.[90] The community treatment model is intended to create a set of shared values and consistent messages among community members that encourage and support behavior change.[91] Such a model appears ideally suited to reservation communities, which may offer the opportunity for greater social cohesion than most people find upon leaving a treatment program.[92]

The most dramatic success story to date occurred in British Columbia, Canada. There, the Alkali Lake Band of Indians mobilized against alcoholism as a community. Beginning with one woman, an entire tribe whose adult alcoholism rate approached 100 percent became sober over a fourteen-year period.[93] "The essential component to the program's success seems to be the declaration that the community would no longer tolerate a high rate of alcohol abuse."[94] This tribe's success supports further development and use of community-wide programs.

Others cite the practice of traditional ceremonies including gourd dances and sweat-lodge ceremonies as highly successful in combating alcoholism among Indians.[95] Many traditional men's social organizations, such as Plains gourd clans or societies, require sobriety to participate in the ceremonies.[96] At least one prison psychologist has noted the stabilizing effect on Indian inmates of participation in traditional religious ceremonies.[97] This contention is illustrated by the statement of an Indian inmate who said: "I've seen what happens when people find themselves—find their identity and their heritage. You can take a drunken Indian and give him culture and self-esteem and watch him change for the better."[98]

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90. Lee, *supra* note 6, at 19.
91. *Id.*
92. Robbins, *supra* note 1, at 159.
93. *Id.* at 170–71.
94. *Id.*
95. *Id.* at 171.
96. *Id.*
97. Bachman, *supra* note 7, at 43.
98. *Id.*

Indian and alcohol literature demonstrates a growing belief that indigenous religious movements, such as the Native American Church (NAC) and the Indian Shaker Church, can successfully reduce alcohol and drug abuse.[99] For anyone who accepts the success with Whites of Alcoholics Anonymous, which is rooted in Christian values, the idea that Indians will have greater success with treatment programs rooted in their own spiritual beliefs makes perfect sense.

The NAC has demonstrated significant success in reducing substance abuse among Indians, but its use of peyote as a sacrament is controversial.[100] The NAC, which began around 1870 and now has about a quarter of a million members, combines Indian traditions with Christian ones to varying degrees.[101] Although peyote is included in weekly ceremonies, "[i]t is sacrilegious for a member to take peyote outside the Church ceremony. The general consensus that has emerged in the substance abuse literature is that 'usage by church members is legal and in no way constitutes a 'drug problem.'"[102] In addition to building cultural pride, the success of the NAC in preventing alcohol abuse is due to the fact that members are forbidden to use alcohol and may not participate in ceremonies if they violate this requirement.[103] The NAC thus provides both opportunity for increasing cultural self-esteem and strong motivation to become and remain sober.

There have been recent challenges to the Native American Church's use of peyote in religious ceremonies. In *Employment Division, Department of Human Resources v. Smith*, the U.S. Supreme Court upheld the denial of unemployment compensation to two employees of a private drug rehabilitation organization who were dismissed for their religious use of peyote.[104] The Court acknowledged that a state would prohibit the free exercise of religion in violation of the Constitution[105] if

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99. Robbins, *supra* note 1, at 169–70 ("The Shaker Church maintained 3,000 members as of 1986. About 76% of a study sample had problems with alcohol before they became Shakers as a last resort, and 92% of that group had at least 1 year of sobriety."); *see also* Bachman, *supra* note 7, at 133.

100. *See* Bernard J. Albaugh & Phillip O. Anderson, *Peyote in the Treatment of Alcoholism Among American Indians*, 131 Am. J. Psychiatry 1247, 1249 (1974); Paul Pascarosa & Sanford Futterman, *Ethnopsychedelic Therapy for Alcoholics: Observations in the Peyote Ritual of the Native American Church*, 8 J. Psychedelic Drugs 215 (1976).

101. Robbins, *supra* note 1, at 161.

102. *Id.* at 162.

103. Albaugh & Anderson, *supra* note 100, at 1248.

104. Employment Div. of Human Resources v. Smith, 494 U.S. 872, 874, 890 (1990).

105. U.S. Const. amend. I. The Amendment reads, in pertinent part: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof. . . ." *Id.*

it sought to ban the performance of, or abstention from, physical acts solely because of their religious motivation.[106] The Court held, however, that the constitutional provision does not relieve an individual of the obligation to comply with a law that incidentally forbids or requires the performance of an act that his or her religious belief requires or forbids, so long as the law is not directed specifically to religious practice and is otherwise constitutional.[107] Thus, through general criminal statutes prohibiting the use of peyote, states may bar the practice of the Native American Religion. It is not enough to answer that only one element of the religious practice is forbidden, leaving a large percentage of the religious practice intact. The practice of religion is not amenable to dissection by a group with different spiritual values.

In addition to religious practices and cultural pride, many tribes share a general healing model that, if harnessed, could be very useful in preventing alcohol and drug abuse. Though great variation exists, the following describes a common healing model:

> 1. "Health results from a harmonious relationship with nature." Breaking a taboo or ignoring a tradition can result in a state of disharmony that can be manifested as a disability, disease, or distress.
>
> 2. Nature is whole and seamless—it cannot be categorized. American Indians may perceive Western medical practitioners as artificially separating the natural world into physical, mental, and social parts. Traditional healers treat the afflicted individual with a focus on wholeness, interconnectedness, and complexity.
>
> 3. An individual's problem is assumed to be rooted in the community. Traditional healers do not treat individuals in isolation or in unfamiliar surroundings. Extended family, friends, and neighbors are mobilized to support the individual for reintegration into the group's social life.[108]

Many researchers support a combination of traditional religious, community-based, and chemical treatment modalities as offering the greatest chance for success.[109] This approach may, in part, be favored

106. *Smith*, 494 U.S. at 877.

107. *Id.* at 878–79.

108. Robbins, *supra* note 1, at 157–58 (citation omitted).

109. *See* Lee, *supra* note 6, at 19; Robbins, *supra* note 1, at 169, 172–73.

because of the reality that most Indians must find a way to straddle traditional and dominant culture experiences and values.[110]

Clearly Indian tribes possess many underutilized tools to combat alcoholism and drug abuse. The use of these tools should be encouraged and facilitated by removing barriers erected by dominant culture lawmakers.

III. STANDARDS FOR PROPOSED REFORM

One size does not fit all in alcohol and drug abuse treatment programs. The failure of state-approved facilities to reduce significantly alcohol and drug abuse among Indians is evidence that something new should be tried. Washington's regulations for state-approved drug and alcohol abuse treatment facilities should be modified to encourage improvement of existing programs and facilitate the development and implementation of alternative methods by removing barriers to such efforts.

Although the statute might recognize the successes of dominant treatment models among members of the dominant culture, it also should reflect an admission of the need to improve services to those persons not as well-served by the dominant culture modalities, including Indians, women, and youth. As a preliminary matter, the statute should include a strong statement recognizing that treatment programs are most successful when they are culturally relevant and respect diversity,[111] and should bolster this statement with a commitment to ensuring that these elements are central to any state-licensed programs. A statement that the Department recognizes the effects on treatment participants of societal and historical racism and discrimination also should be included. The Department should be required to counteract these effects on the treatment process by making all reasonable efforts to ensure a supportive environment that encourages cultural pride and spiritual freedom. Such an environment can be created only when both staff and fellow treatment participants are encouraged and enabled to recognize and move beyond prejudice and discrimination.

To carry out these goals and commitments, the statute should include several requirements. First, it should require that all treatment facility staff receive training in cultural diversity and receive information about the effects of cultural relevance on treatment success rates.[112] This

110. Robbins, *supra* note 1, at 162.

111. *See supra* notes 5–6 and accompanying text.

112. *See supra* notes 6, 60–62, 87–89, and accompanying text.

requirement would go a long way toward eliminating stereotyped responses to the failures of treatment recipients who are not members of the dominant culture.[113]

Second, the statute should require that all treatment programs be designed with sufficient flexibility to provide culturally relevant service to participants.[114] The statute should, therefore, require more than mere accommodation of non-Christian belief systems and nondominant cultural practices. Only a true willingness to respect and incorporate a wide variety of spiritual beliefs and cultural practices on an equal basis should satisfy this requirement.

Third, because of the disparate impact on Indians of cultural insensitivity in treatment programs,[115] the Department should be required to establish a committee that will consider the spiritual and cultural needs of Indians in treatment and recommend alternatives to existing programs. Committee membership should reflect the diversity of Indians involved in treatment, including representation of both genders, a variety of ages, and reservation and urban Indians from several tribes.[116]

Fourth, the statute also should require the Department to consider alternatives to mainstream treatment models and allow exemptions from regulations that create barriers to proven alternatives to the extent possible without risking the health or safety of patients. To this end, exemptions from personnel,[117] facility,[118] and medical[119] regulations should specifically be allowed, such as for variations in personnel hierarchy, alternative facility designs, and traditional healing modalities,. A special provision also is necessary to allow members of the Native American Church, both as staff and patients, to participate fully in their

113. "Stereotype" is defined, in the alcohol and drug treatment field, as "negative and derogatory assumptions about members of particular groups that limit the growth and development of both those holding the beliefs and the targets of these beliefs." Dyer, *supra* note 1 at 34. Through education, it is hoped that incorrect assumptions will be replaced with accurate knowledge. "[S]taff need to be taught how to understand the heritage (and biases) inherent in their own cultural background and to assess and meet the other cultures of their clients . . . ." *Id.* at 33–34.

114. *See supra* notes 6, 60–62, 87–89, and accompanying text.

115. *See supra* part II.B and accompanying notes.

116. *See* Robbins, *supra* note 1, at 171–72. Community-based treatment programs, to which researchers and program developers are increasingly turning, often rely on involvement and input from a variety of community members. *Id.* This provides a good model for state-wide efforts.

117. Wash. Admin. Code § 246-326-030 (1995); *see also supra* note 26 and accompanying text.

118. Wash. Admin. Code § 246-326-090 (1995); *see also supra* notes 34–35 and accompanying text.

119. Wash. Admin. Code §§ 246-326-030(3)(i), -050(3)(a) (1995); *see also supra* notes 27–29.

religious beliefs.[120] Both constitutional religious freedom rights[121] and this well-established organization's proven success rate in reducing alcoholism and drug abuse among its members[122] argue for such an exemption, despite the controversial nature of the peyote sacrament.

Finally, the statute should include a statement that, wherever possible, the Department should attempt to involve communities in the treatment process, so that support is available after participants leave treatment. This should include efforts to involve entire communities in the design and planning of treatment programs, as well as education to increase the understanding of alcoholism and addiction among community members. The State should commit itself to encouraging communities to build consistent and supportive values regarding alcohol and drug use.

IV. A PROPOSAL FOR LEGISLATIVE REFORM IN WASHINGTON

Using the standards proposed above, the following changes should be made to Washington's statute authorizing the Department of Social and Health Services to license alcohol treatment facilities.[123] The current statute begins with a definitions section, followed by licensing requirements. This section should be preceded by a new section that states the purposes to be served by the statute, and general requirements that underlie the Department's authority. This new section should read:

> Purpose and scope. The success of alcoholism treatment facilities and programs is difficult to measure, but the Legislature acknowledges the failure of dominant treatment methods to serve adequately the needs of many members of the population, including Indians, women, and youth. Because it is well-recognized that treatment programs are most successful when they meet the unique spiritual and cultural needs of participants, the State is committed to providing services with the flexibility necessary to meet these needs. Therefore, this statute is to be interpreted to allow utmost flexibility to encourage and support the creation of culturally and spiritually relevant programs and facilities. All regulations authorized by this statute are to be developed in accordance with

120. Wash. Admin. Code §§ 246-326-020, -060(2)(k); *see also supra* notes 30–33, 99–103, and accompanying text.

121. *See supra* note 105 and accompanying text.

122. *See supra* notes 99–100 and accompanying text.

123. Wash. Rev. Code §§ 70.96A.030–.040 (1996).

this commitment. Programs and facilities licensed under this statute and any subsequent regulations must not merely accommodate cultural, religious, gender, and age diversity, but must welcome, respect, and strive to meet the unique cultural and religious needs of each participant. Health care practices, personnel hierarchies, and building structures that are traditional to cultures served by treatment programs and facilities are to be incorporated wherever possible. All treatment participants must be allowed free spiritual and cultural practice and expression. Regulations adopted under this statute must include exemptions whenever necessary to allow programs and facilities to meet the cultural and spiritual needs of all treatment participants, so long as the health and safety of participants is not endangered.

The statute[124] should also be amended to include a new section to read as follows:

Every application for a license shall include:

(1) A policy statement that affirms the facility's commitment to encouraging, respecting, and nurturing cultural and spiritual diversity, and that states the means by which the facility will achieve these goals;

(2) A training plan that describes how facility personnel will be trained to encourage and protect treatment participants' rights to cultural and spiritual integrity, pride, respect, and freedom;

(3) A training plan that describes the materials and/or information facility personnel will receive describing the relationship between the cultural and spiritual relevance of treatment programs and successful treatment outcomes;

(4) A statement of the facility's treatment methods, describing how those methods will accommodate diverse treatment participant populations by, for example, addressing traditional medicine, dietary considerations, cultural and spiritual practices and expression, and physical plant considerations; and

(5) A statement of the facility's plan for involving communities in designing and evaluating the treatment process, for providing community education regarding drug and alcohol abuse, and for

124. §§ 70.96A.030–.040.

generating community support for individuals leaving the treatment facility.

VI. CONCLUSION

Providing culturally relevant treatment programs will not eliminate all of the risk factors that cause Indians to suffer disparate impacts of alcohol and drug abuse. Such programs will neither end societal racism and discrimination, nor erase the historical effects of such beliefs and acts. Indians still will struggle with the need to straddle two cultures, and cultural pride still will need to be developed. But, the proposed reforms to Washington's treatment facility approval statutes offer significant hope for long-term improvement in treatment outcomes.

If more individual Indians become sober, they will have achieved tremendous personal success unlikely under the current law. Their communities, families, and future generations will reap the benefits as well. Those who become sober will be less likely to commit alcohol or drug-related crimes, less likely to give birth to children with physical or mental defects, and less likely to create abusive or neglectful homes. They also will bring to their tribes and communities success stories that may help others overcome a sense of hopelessness in their own addictions or the addictions of people they care about. Indians who return to their communities sober will have a new source of personal pride, which others may seek to acquire for themselves, and which may help the tribe and its members to make other positive changes in their lives. Alcohol and drug abuse is not the cause of all problems among Indians, nor is sobriety the only solution. But successful treatment outcomes are a necessary component of any effort to improve the lives of Indians touched by alcohol or drug abuse.