2007-2009

The Domino Effect:

A Business Plan for Re-building Substance Abuse Prevention, Treatment & Recovery

Prepared for:
Governor Kulongoski and Members of the Oregon Legislative Assembly
By The Governor's Council on Alcohol & Drug Abuse Programs

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Table of Contents

Table of Contents

Preface

The Governor's Council on Alcohol and Drug Abuse Programs is charged with assessing and reporting the economic and social impact of alcohol and drug abuse on Oregon to the Governor. The Council is required to assess effectiveness and recommend goals and priorities for prevention, treatment and recovery services, financed through sixteen state agencies. In order to prepare the 2006 report, the Governor's Council has taken a broad view, gathering information about Oregonians' perceptions regarding prevention, treatment and recovery services. The council visited five counties, met with tribal representatives, heard from 14 of 16 state agency department heads, listened to business leaders, elected officials, community coalition volunteers and other professionals across multiple disciplines. In addition, the Council has been an active participant on various task forces including:

- Methamphetamine Task Force
- OMHAS Evidence-based Practices Workgroups
- Oregon Leadership for Alcohol-Free Kids
- Oregon Business Plan Drugfree Workforce Task Group

The Council has active liaison relationships with:

- Commission on Children and Families
- Juvenile Justice Commission
- Association of Community Mental Health Programs
- Oregon Prevention, Education and Recovery Association
- Partners for Children and Families
- Juvenile Crime Prevention Advisory Committee
- Oregon State Police

"Substance abuse and addiction is the elephant in the living room of American society. Too many of our citizens deny or ignore its presence. Abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem our nation faces: crime, disease, AIDS, cirrhosis, child abuse and neglect, domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children, and poor schools and disrupted classrooms. Every sector of society spends hefty sums of money shoveling up the wreckage of substance abuse and addition. Nowhere is this more evident than in the public spending of states."

-~Joseph A. Califano, Jr., The National Center on Addiction and Substance Abuse,

This report will document the Council's findings and offer policy recommendations. The report illustrates the domino effect that occurs throughout society because of inadequate, inappropriate, and inefficient public policy for alcohol and drug prevention, treatment and recovery.

Some significant Oregon findings are:

- Foster care has increased by 45 percent in the past four years due to a huge increase in drug and alcohol related arrests.
- Accidents related to alcohol or drug intoxication were responsible for 40 percent of all traffic fatalities in 2003.
- Between 1999-2003, 77 percent of traffic fatalities under 16 years old were riding in cars with intoxicated drivers.
- Oregon's prison population is up 128 percent for women and 60 percent for men.
- Property crime committed by women has increased 279 percent in the past four years.
- Decreased health insurance coverage has led to an increase in emergency room contacts by 136 percent in 2003-2004.
- Hepatitis C accounts for up to 40-60 percent of liver disease with 70 percent of those having histories of IV drug abuse with no health insurance.
- Sexually transmitted diseases have increased an average of 25 percent over the past four years.
- Increase in underage drinking by girls is up from 3-7 percent in most areas except for North Coast which is up 13.6 percent for 8th grade girls, and 27 percent for 11th grade girls in four years.
- Nearly 4000 Oregonians need affordable drug free housing.

Additionally, over the past four years:

- Treatment access has been reduced by 18 percent.
- Alcohol and drug prevention activities in schools and communities have decreased.
- 40 percent of substance abuse treatment professionals are considering leaving the field.

Societal Costs

Child Welfare System
Forty-eighty percent of families involved in the child welfare system are impaired by alcohol or other drugs, directly correlating with the abuse and neglect experienced by their children. For every $113 spent on consequences of substance abuse JUST ON CHILDREN, only $1 is spent on prevention and treatment.
Hospital Admissions
Between 20-40 percent of all general hospital, patients are admitted for complications of alcohol or substance abuse.
Employment
Alcoholism accounts for 500 million lost work days per year.
Cost Analysis
Of every dollar spent on substance abuse, 96 cents goes to shoveling up the wreckage of impairment. Only 4 cents is spent on prevention and treatment.
Cost Per Tax Payer
Every American paid $277 per year in taxes to deal with consequential burdens of substance abuse, and $10 per year for prevention and treatment.
Justice System Burden for Substance Involved Offenders
States spend 4.9 percent of the budget on criminal justice systems, 10 times more than for prevention and treatment. States spent $30.7 billion on incarceration, probation, parole, juvenile justice, criminal and family court costs. Sixty-for percent of arrestees used substances in the days leading up to their crime.
Burden of Problem on Public Programs
States spent $77.9 billion on criminal justice, Medicaid, child welfare, mental health systems, highways, state payrolls, schools, and juvenile justice to deal with substance abuse.
Cost
Sates spent $81.3 billion to deal with substance abuse, which is 13.1 percent of state budgets.

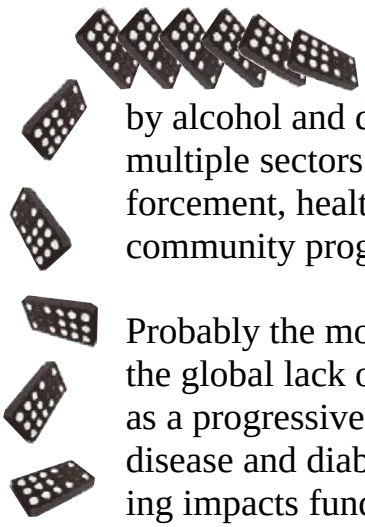
Treatment of Alcohol and Other Substance Use Disorders, What Legislators Need to Know, National Conference of State Legislators. January 2004

Executive Summary

"Drugs are a bet with the mind."

~Jim Morrison

Section I



The disproportionate share of revenue losses experienced by alcohol and drug services over the last three biennia is evident across multiple sectors and has lead to the domino effect in foster care, law enforcement, health care, child and family services, the Oregon Health Plan, community programs, mental health, criminal justice and the workforce.

Probably the most significant public policy finding made by the Council is the global lack of understanding about the nature of chemical dependency as a progressive, chronic, relapsing disease, in this way not unlike heart disease and diabetes, and its consequential costs. This lack of understanding impacts funding decisions, legislation, workplace policy, housing, social and legal services, education and financial services.

One aspect of the disease of chemical dependency that is least understood is relapse. Many equate relapse with treatment failure. An episode of congestive heart failure in a patient with heart disease is not a treatment failure. We intervene to correct the problem. Likewise we do not treat a rise in blood sugar in a diabetic as treatment failure. Nutrition experts do not recommend giving up on a diet or health regime because of a "slip" or relapse. Relapse can occur at any point in recovery. Parents, educators, child welfare workers and legislators need to intervene with the disease of chemical dependency as they would with any other disease.

While other chronic illnesses enjoy widespread understanding of risk factors, available treatment intervention including medications, and have financial investment and support, chemical dependency does not. The Council believes it is time to correct this problem by establishing public policy based on the principle that states addiction is a chronic, relapsing illness. Prevention, treatment and recovery services on demand are imperative.

The second most significant public policy finding made by the Council is the lack of support for the most significant and cost efficient step that could be taken: fully fund alcohol and drug prevention, treatment and recovery services. For every $1.00 spent on prevention and treatment $5.00 to $7.00 is saved in related costs ranging from health care, emergency room visits, law enforcement, and criminal justice (Finnigan, 1999).

Persons in recovery returning to the work force contribute taxes to the system. Funding prevention, treatment and recovery would lead to unprecedented returns on investment from both the offset of related costs and new tax payers entering the workforce. It is puzzling that this return on investment is widely ignored.

Findings From Communities

- Communities are working together to maximize the delivery of prevention, treatment and recovery services with inadequate funding. Small communities are particularly hard pressed given there are even more limited resources to access. Most struggle to offer even basic services. This situation is exacerbated by the methamphetamine epidemic. Their plea for help crystallized Council members' core understanding of the effects chemical dependency has on the community. Although Council members could not provide much hope given the extreme budget cuts and resultant reduction of services, the Council came away with a strengthened commitment to work toward establishing prevention, treatment and recovery services on demand and the necessary funding to support those services.

- Cuts over the last three biennia have significantly affected the infrastructure of the service delivery system. The Council finds a critical need for additional services across the full continuum including prevention, outpatient, intensive outpatient, day treatment, residential, detoxification, corrections treatment, case management and recovery services.

- Resoundingly the Council heard tremendous need for affordable, accessible, appropriate drug and alcohol free housing to support families in their recovery.

- Credit union fraud investigators, law enforcement officials, and business owners have identified the need to invest in prevention.

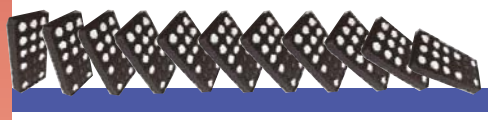
- During the past four years, treatment programs have nearly succumbed to the epidemic of methamphetamine use. Younger adolescents are drinking more and finding it increasingly easy to obtain alcohol, mostly from parents and other adults. These trends place enormous burdens on state agencies and local providers and are alarming to the Council.

- Stigma against substance abusers is severe and the Council recognizes it must be addressed to encourage early entry into treatment. Ultimately, the funding necessary to effectively address the drug epidemic must be obtained. The Council plans to work on a separate report addressing this issue in Spring 2006.

Recommendations

"If nothing ever changed, there'd be no butterflies."

~Unknown



Section II

The Council's assessment of the economic and social impact of alcohol and drug abuse on Oregon has led to the following recommendations:

A. *Capacity Needs*

1. Increase capacity for public substance abuse treatment by 20 percent in the 2007-2009 biennium, and an additional 13% in the 2009-2010 biennium.

2. Double the state prevention investment by allocating $4.5 million dollars during the next biennium.

3. Increase rates paid for substance abuse treatment services by 15 percent.

4. Support an increase of the number of state police officers in order to impact the drunk driving rate.

5. Conduct a workforce training initiative to elevate counselor expertise in evidence-based practices beginning with the 2007-2009 biennium; repeated each 2 biennia.

6. Support an increase in drug free housing by at least 2000 beds.

7. Support a 20% increase of substance abuse treatment for the prison population and recovery services for those released.

B. *Public Policy Initiatives*

1. Provide funding for a county-by-county Oregon Household survey at least every 4 years beginning with the 2007-2009 biennium.

2. Provide funding for the Healthy Teens Survey, to include sixth, eighth and eleventh graders every year beginning with the 2007-2009 biennium. Every two biennia, add homeless, home schooled and private schools students (sixth, eighth and eleventh grades) to the population surveyed, beginning with the 2007-2009 biennium.

3. Review and recommend changes in Minor in Possession (MIP) policy, particularly those which may be determined by the Attorney General's Task Force on Underage Drinking Laws.

4. Remove the Uniform Accident and Sickness Policy Provision (UPPL) from the Oregon Statute which allows insurers to deny coverage to individuals injured while under the influence of alcohol or narcotics beginning in the 2007-2009 biennium.

5. Support the Oregon Business Plan initiative to establish certified drug-free workplaces in 75 percent of Oregon businesses by 2008.

6. Create incentives for small business participation in drug-free workplace programs, including discounted workers' compensation premium rate to certified employers beginning with the 2007-2009 biennium. Other incentives such as decreasing workers' compensation and unemployment benefits for employees discharged for a positive test as well as tax credits should be investigated.

7. Establish public policy preventing the discrimination and stigmatization of persons in recovery beginning with the 2007-2009 biennium. Specific recommendations will be made by the Council following its May, 2006 Forum on stigma.

8. Establish public policy supporting the Behavioral Health Workforce Issues, which includes alcohol and drug abuse counselors, to become part of the Oregon Health Workforce Initiative beginning with the 2007-2009 biennium.

9. Reinstate the quota for the number of new distilled spirits licenses indexing additional licensees to the population beginning with the 2007-2009 biennium.

10. Initiate the distribution of any new funds across counties to establish equity per the levels determined by the Office of Mental Health and Addiction Services (OMHAS) beginning with the 2007-2009 biennium.

11. Fund a statewide public education program already developed by the Department of Human Services to ensure that persons infected or at risk for Hepatitis C Virus (HCV) are recognized, diagnosed, evaluated and treated.

C. *Funding Capacity Needs*

1. Designate 10% of distilled spirits revenue beginning with the 2007-2009 biennium, indexed to the cost of living thereafter for prevention, treatment and recovery services.

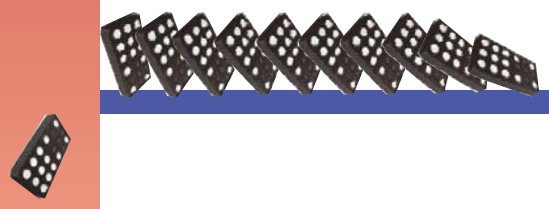
2. Increase medical marijuana card application and renewal fee to $150 and earmark revenue above the level required to administer the program for prevention, treatment and recovery services program beginning in the 2007-2009 biennium.

3. Raise the tax on beer and wine by ten cents per bottle beginning in the 2007-2009 biennium, indexed to the cost of living thereafter and designate the revenue to prevention, treatment and recovery services. Micro brews would have an exemption from the increase and wineries would continue to have an exemption as per Oregon Revised Statute, 473.050.

Funding of Services Domino

"Payment for recovery services means developing a way to make sure people can sustain their recovery."

~Pat Taylor
Faces and Voices of Recovery



Section III

Because the primary concern of the communities we visited was the need for more services, we will begin with a brief description of the reductions of treatment and prevention money over the last four years.

The legislature reduced revenues for treatment services by at least $45 million over the last four years, through a combination of General Fund cuts and Oregon Health Plan Standard reductions as Table 1 illustrates. The remaining programs funded by the General Fund have not received a cost of living increase since 2000 (Mercer, 2006). Consequently, the rates currently paid by the state are woefully inadequate.

Investing in drug treatment cannot be a substitute for competent policy development.

Table 1

Category of Service (COS)	Historical 2002 FFS Reimbursement Rate Per Unit	2002 FFS Unit Cost Benchmark	2006 FFS Unit Cost Benchmark
Hospital	$264.93	$345.49	$437.60
Physician	$51.44	$76.87	$85.67
Prescription Drugs	$45.40	$44.65	$51.20
Mental Health Inpatient	$244.98	$540.47	$672.15
Chemical Dependency	**$39.69**	**$58.14**	**$64.92**
DME/Supplies	$1.43	$1.41	$1.50
Dental	$31.69	$45.31	$52.51
Other Services	$31.99	$43.45	$47.69

Currently there are policy inconsistencies in funding addiction services. The Office of Mental health and Addictions Services (OMHAS) reports that Oregon dedicates a percent of the beer and wine tax revenues for alcohol and drug prevention and treatment, and a portion of lottery

revenues are designated for gambling addiction prevention and treatment services.

Oregon does not dedicate any revenue from the sale of distilled spirits revenue or medical marijuana fees to alcohol and drug prevention and treatment. According to the Oregon Liquor Control Commission, ten of the other 18 states that have state liquor control earmark a percentage to treatment. The highest earmark is 14.85 percent in Alabama, and the lowest of .05 percent in Michigan.

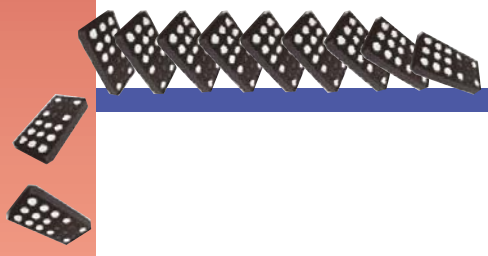
Oregon could join other states in earmarking a percentage of the revenue from the sale of distilled spirits to treatment and prevention in the budget or by changing the current OLCC statute to dedicate a percentage of the revenue to treatment and prevention services.

The Governor's Council was prepared to recommend that Oregon adopt legislation similar to the California model of instituting a surtax on taxpayers who have a gross income above $1 million. The Council learned that the Legislative Revenue Office had researched this issue. Unfortunately what we discovered is that Oregon does not have enough millionaires to make the proposal feasible. In fact, it would take a 5 percent surtax on taxpayers with income above $500,000 to generate about $28 million per year.

Treatment Access Domino

"The demand is so overwhelming, it's like someone having six tickets to a concert and 300 people rushing to get them."

~Carolann Alleva
Legislative & Community Liaison
Baltimore Substance Abuse Systems, Inc.



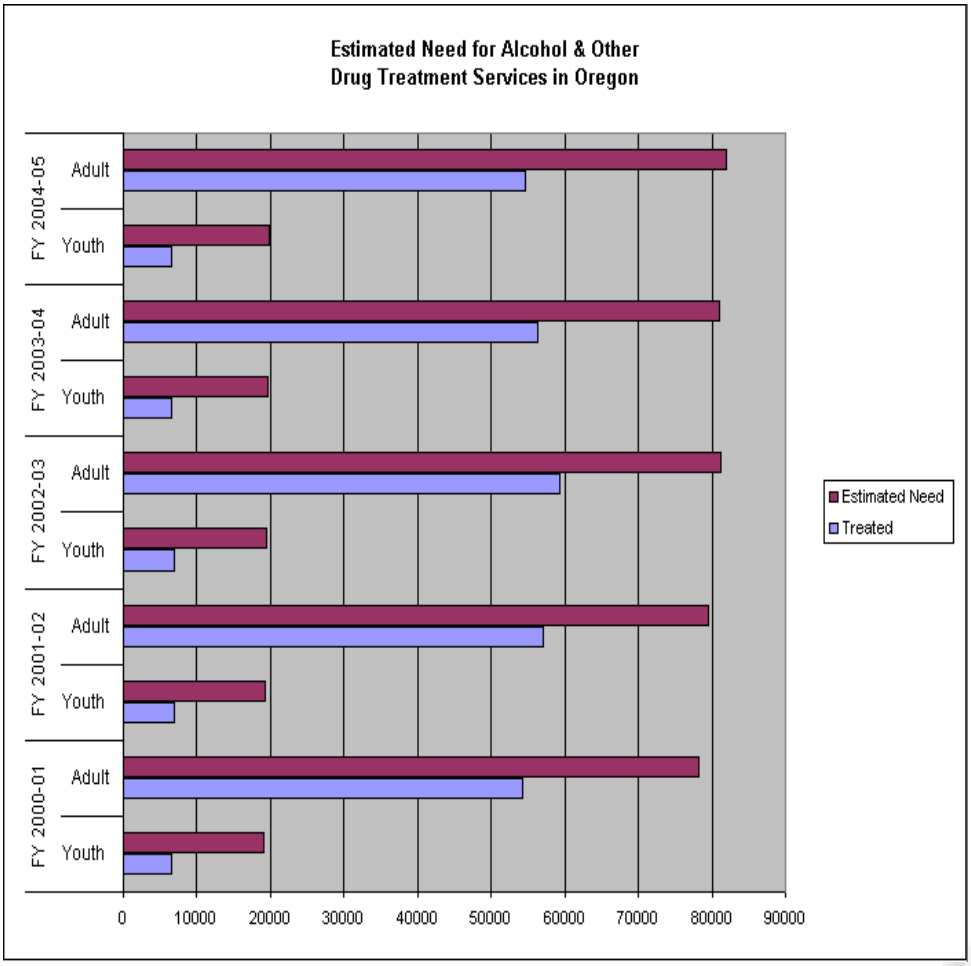
Section IV

As a result of severe reductions in funding and more Oregonians without health insurance, public treatment access has been reduced by 18 percent in the last four years (see Graph 1). In 2001-2002, Oregon served 71 percent of the estimated need for persons needing publicly funded substance abuse treatment. In 2004-2005, Oregon served 53 percent of those in need for publicly funded treatment. With the above reductions and 9.4 percent growth in state population, we estimate that services need to be increased by at least 43 percent to meet the needs of those who are ready for treatment.

"Last year, an estimated 2,300 people in Lane County—many convicted offenders-wanted treatment, but there was no room in the system for them."

~Lane County Public Safety Task Force Final Report, October, 2005

Graph 1

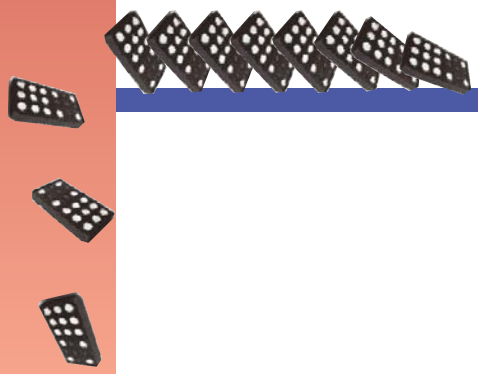


The need to stem the major hemorrhaging of both short term and long term societal costs is great. The human capacity to build safe and healthy communities for Oregon has been compromised.

Health Care Domino

"The greatest wealth is health."

~Virgil



Section V

Health Care Costs

The Oregon Medical Assistance Program (OMAP) demonstrated that health care costs rise when alcohol and other drug treatment capacity is reduced (Mercer, 2004). People requiring physical care services related to addiction showed up in emergency rooms. During 2003-2004, OMAP shows an increase of emergency care visits of 136 percent. Current statistics show that alcohol-related diseases and injuries account for 40 percent of hospital costs (Oregon Coalition to Reduce Underage Drinking, 2002).

"HIV is spilling over into the general population through injection drug users. We can still make a difference in Oregon by a dual strategy: provide effective drug treatment to those ready to quit and provide needle exchange to protect us all from HIV, Hepatitis C and higher health costs and encourage those still using to work towards drug treatment."

~Diane B. Lang, Executive Director of HIV Alliance

Mortality

Individuals diagnosed with both mental health and substance abuse disorders are 15.8 times more likely to die of poison, 8.2 times more likely to die of substance abuse related causes, and 4.5 times more likely to die of suicide than those who were not diagnosed with mental illness and substance abuse problems (Anteneh, 2005).

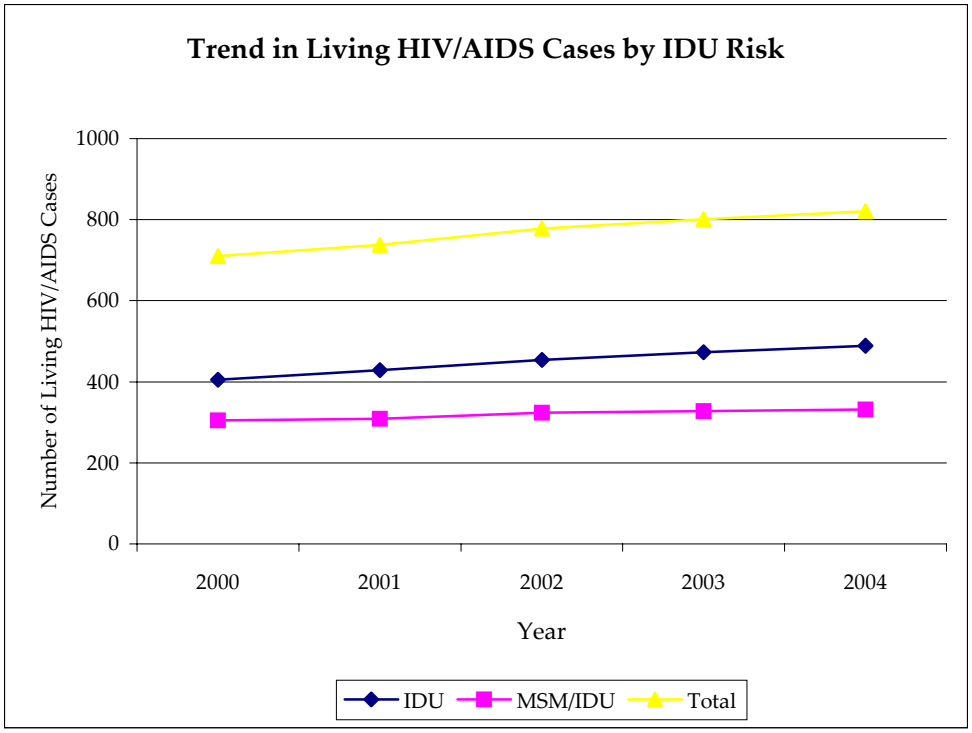
Hepatitis C

Hepatitis C is responsible for 40-60 percent of liver disease in Oregon (Oregon DHS, 2005). Complications from chronic Hepatitis C Virus (HVC) are expected to rise dramatically in the near future. By 2020, cirrhosis is projected to increase 16-32 percent, liver failure by 106 percent, liver cancer by 81 percent and liver-related deaths by 180 percent. The single strongest risk-factor for HVC is injection drug use. (Oregon Acute Communicable Disease Prevention, 2000). Persons receiving treatment for IV drug abuse require 26 percent longer treatment episodes because of the severity of the complicating health issues.

HIV/AIDS and Sexually Transmitted Disease

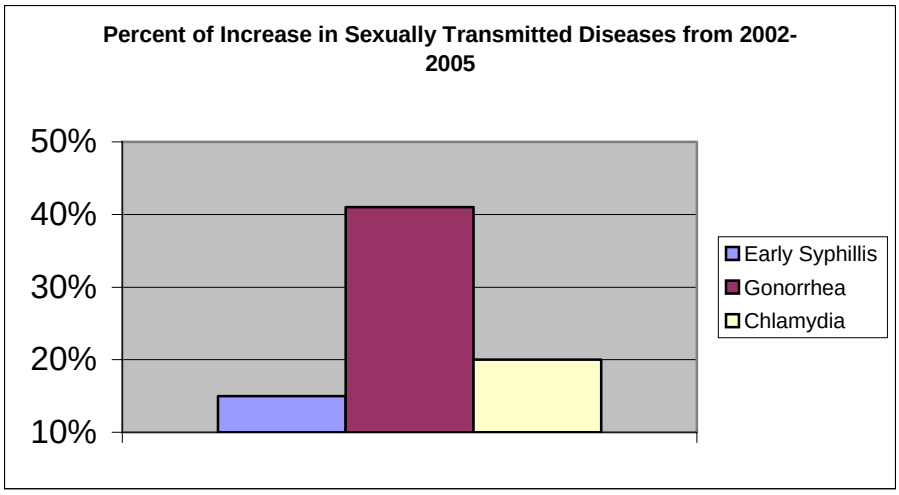
In 2003 there were 232 cases of AIDS reported in Oregon (Oregon HIV/STF/TB Program, 2004). The number of new AIDS cases was consistent with the trend over the past five years, during which time the number of AIDS cases has been over 200 per year and slowly increasing.

The most frequently reported risk behavior in 2003 was men having sex with other men (MSM) at 52 percent (Oregon HIV/STD/TB Program, 2004). Injection drug use (IDU) risk was reported among 24 percent of AIDS cases. Heterosexual risk made up 10 percent of AIDS cases. The remaining 24 percent were blood transfusions or transplants, heterosexual or "risk not specified" (see Graph 2). The most compelling information about risk for AIDS and IDU is that 44 percent of people diagnosed with HIV/AIDS between 2002–2004 and identifying their risk as IDU were either diagnosed with AIDS or progressed to AIDS within 12 months of their diagnosis.



The Department of Human Services Public Health reports an increase in Sexually Transmitted Infection over the past four years (Oregon STD Program, 1967-2005). Early syphilis has increased 15 percent, gonorrhea has increased 41 percent and chlamydia has increased 20 percent (see Graph 3).

Graph 3



Other Health Care Concerns

When trying to determine further cost impact on healthcare, the Council noted that Oregon law, Uniform Accident and Sickness Policy Provision law (George Washington University, 2006) allows health insurers to deny payment if an injury is a result of alcohol or narcotic use. Emergency care only notes alcohol or narcotic use in injuries if the person is covered by the Oregon Health Plan. Studies from George Washington University have shown that individuals who receive brief alcohol counseling in emergency rooms or trauma centers have 48 percent fewer admissions to hospitals. Patients who receive counseling have 28 fewer drinks per person per week. For every $1 spent on alcohol counseling for injured patients, hospitals can expect to save $3.81. By discouraging screening and treatment, the Alcohol Exclusion Law leads to more hospital admissions, related arrests, and injury-related hospital readmissions (Rosenbaum et al., 2005). This law reinforces the stigma of drug abuse and is in conflict with the recent passage of Oregon's parity legislation passed last session.

Medical Marijuana

The creation of the Medical Marijuana program has led to a paradox in Oregon. Marijuana is an illegal drug, yet is available as a medicine for those who qualify. Questions have been raised in discussions across service providers, workplaces, school districts and state agencies during public Council meetings. People who use marijuana as medicine and are employed create policy conflicts for employers. Attempts by employers to keep medical marijuana out of the workplace have led to several cases currently being litigated in a variety of courts. People who are in treatment for alcohol or other drug abuse disorders who are enrolled in the medical marijuana program create policy challenges for treatment programs. Alcohol and drug counselors report frustration working toward the goals of abstinence and recovery while clients in the medical marijuana program test positive for marijuana and continue to use an illicit drug. Further conflict created by the program involve the requirements and documentation that certifies patients for receiving a card. Despite attempts to clarify the program during the last legislative session, law enforcement continues to be hampered by operational issues such as caregiver definitions, cultivation definitions and parameters defining who can grow plants and for how many people.

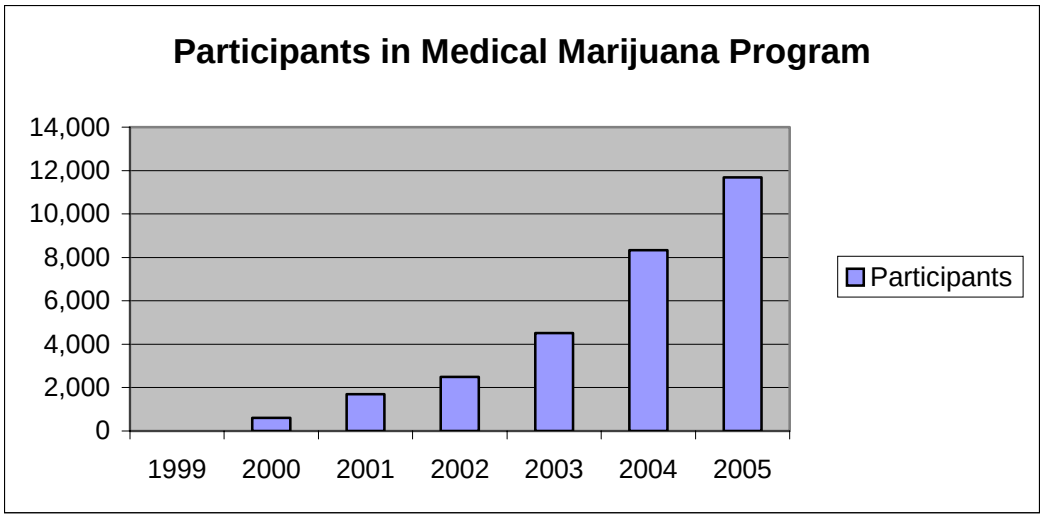
The medical marijuana program complicates prevention efforts in the schools. Youth receive clear messages from drug prevention that marijuana is a dangerous illicit drug, yet they know that it is prescribed for specified medical conditions. Well over 70 percent of card holders are given a card for pain (Oregon OMMP, 2006). Prevention specialists are discredited by these conflicting messages. Because the medical marijuana program is a complex issue, the program continues to require focused attention.

By September 2005, there were 11,680 medical marijuana card holders (Oregon OMMP, 2006). It is legitimate to question the consequences this program is having on our culture, our workplace, our school system and our youth. Current litigation will eventually sort out some of the workplace questions which may be helpful to school policy makers as well.

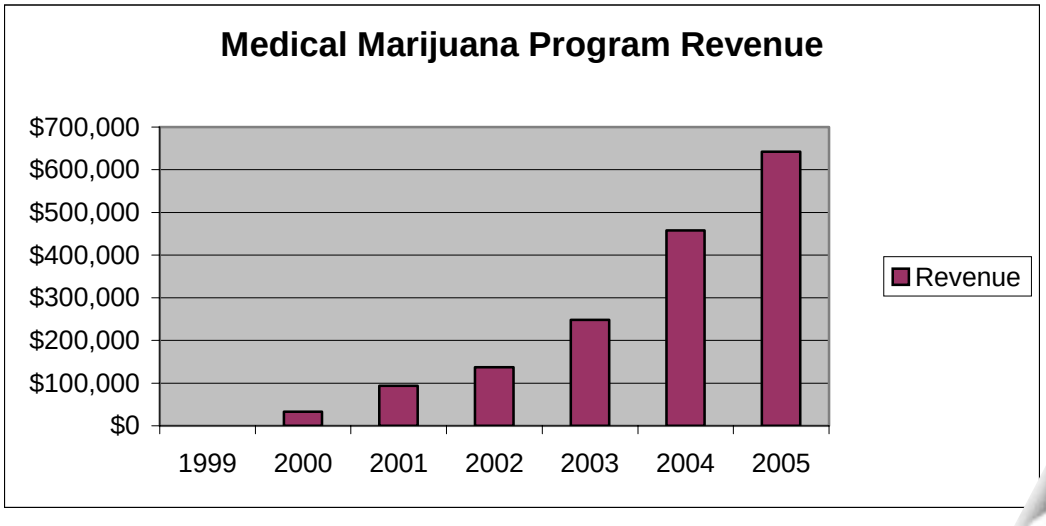
In the meantime, one way to help with the problems being created by this program is to utilize the revenue above that needed to administer the program for prevention, treatment and recovery services.

Oregon does not dedicate any of the medical marijuana fees to alcohol and drug abuse prevention and treatment. Graphs 3, 4 and 5 represent the participants and program revenue (Oregon OMMP, 2006).

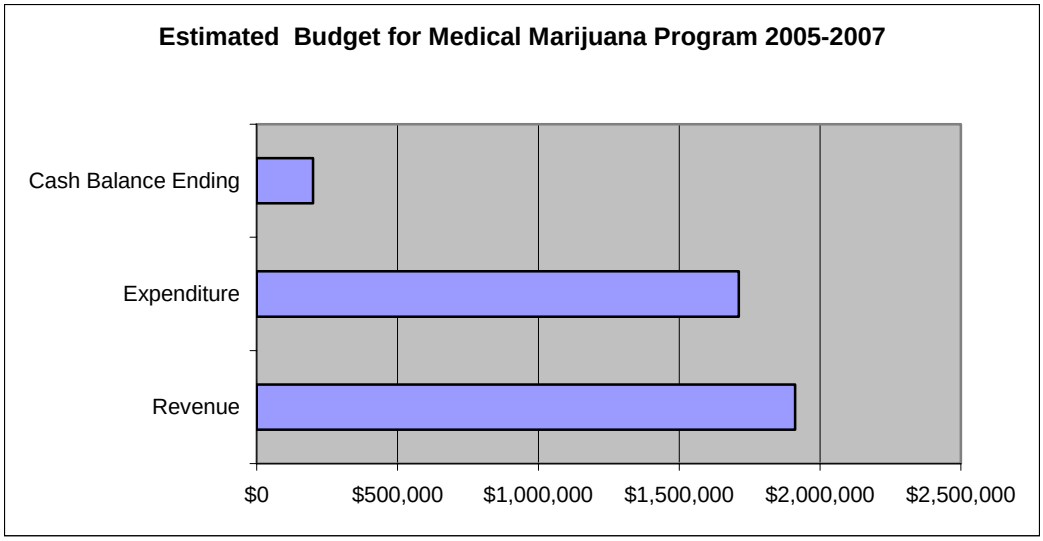
Graph 3



Graph 4



Graph 5



Mental Health

Co-occurring mental health and substance use disorders (COD) are common in the general adult population. Among adults with severe mental illness (SMI) in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent (CSAT, 2005). Among adults who used an illicit drug in the past year, 17.1 percent had SMI in that year, while the rate was 6.9 percent among adults who did not use an illicit drug.

Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition, however many individuals with COD go untreated (CSAT, 2005).

The rate of hospitalization for clients with both a mental and a substance use disorder was more than 20 times the rate for clients with substance abuse only, and five times the rate for clients with a mental disorder only (CSAT, 2005).

There is an increased prevalence of COD among people who are homeless and they are frequently involved with the criminal justice systems. Surveys by the Bureau of Justice Statistics found that 16 percent of State prison inmates, seven percent of Federal inmates, and 16 percent of those in local jails reported either a mental condition or an overnight stay in a mental hospital (CSAT, 2005).

Treating this population poses specific challenges for treatment providers. Because clients with co-occurring disorders seek treatment in both mental health and substance abuse treatment facilities it is necessary for alcohol and drug abuse counselors to acquire the competencies needed to work effectively with clients who have COD. Substance abuse treatment organizations need additional medial staff to provide the necessary comprehensive care for clients with co-occurring disorders.

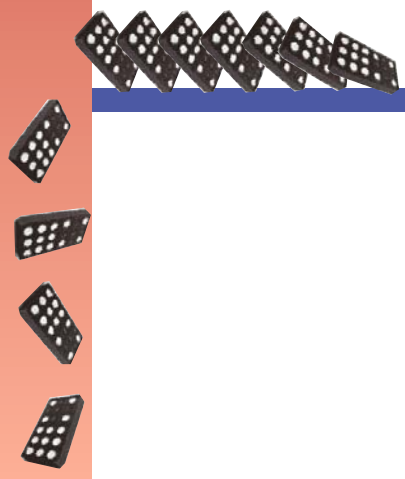
Oregon has a combined mental health and substance abuse office under the Department of Human Services. This merger has allowed Oregon to identify and track people with COD as they are served throughout the system of care. The Client Care Monitoring System (CPMS) is being updated to provide better data used to measure performance outcomes.

The Office of Mental Health and Addiction Services (OMHAS) provides training for counselors and clinicians to teach specific skills needed to effectively identify and treat people with COD. Additionally, Oregon is involved with a major behavioral health workforce development initiative with community partners, higher educational and research. This collaboration is designed to improve services for people with COD systematically.

OMHAS supports evidence-based practices for this population by disseminating the Substance Abuse and Mental Health Services Administration (SAMHSA) Toolkits and provides technical assistance to providers.

These efforts are a good start to improve services for people with COD, but without supportive funding, service enhancement is limited.

Tribal Services Domino



Section VI

Tribal services in Oregon present a unique and complex array of alcohol and drug abuse prevention, treatment and recovery challenges. Seven of the nine federally recognized Native American tribes in Oregon hold current outpatient Letters of Approval from the Office of Mental Health and Addiction Services (OMHAS) and four tribes receive state funding, leaving five tribes with no outpatient treatment dollars. Additionally, the Native American Rehabilitative Association (NARA) located in Portland, Oregon provides a full range of treatment services for urban Native Americans and Oregon Tribes.

> *"Not unlike other tribal members, I have lost so many brothers, sisters, aunts, uncles, parents and community members to Alcoholism."*
>
> *~Warm Springs Tribal Member*

A full continuum of care is necessary to improve treatment outcomes and sustain recovery. The tribal programs are not funded to provide a full continuum of addiction services. Detoxification services are not available on any of the reservations. Treatment providers do not accept clients until they are medically stabilized. Some of the tribes refer clients to psychiatric hospitalization services for alcohol or drug detoxification. Residential treatment is not offered on any of the reservations. Some tribes refer to and pay NARA for residential level of service.

Travel is often a barrier for tribal members seeking to access residential treatment. Wait lists for residential treatment services can be lengthy. Without residential treatment, those with the highest risk would be referred to intensive outpatient treatment, but again, limited funds restrict access to these services as well.

Drug-free transitional housing is not currently available on eight of the reservations. This resource, along with other recovery support services is needed for tribal members transitioning back to their communities from residential treatment. The lack of wrap around services such as housing, Native American fellowship, case management and local NA/AA groups are especially concerning for parolees from the Department of Corrections. Meaningful employment, particularly for males who are the

primary family provider, is limited on the reservations. Requirements to meet job-hunting quotas for unemployment benefits are difficult to fulfill for tribal members seeking jobs on the reservation.

Prevention efforts on the reservations have included Reservation Watch, summits held on alcohol and drug related topics, and other community watches. Native communities have also been active in conducting methamphetamine task forces and community coalitions to address community wellness. Base prevention funding of $50,000 per year or $100,000 a biennium is provided through OMHAS. This resource primarily supports population-based prevention strategies and environmental strategies aimed at changing cultural norms related to alcohol use on tribal reservations. Tribes need additional prevention resources to develop early childhood prevention programs and strategies.

The Oregon Indian Council on Addictions (OICA) identifies that a complete continuum of services for adults would include out patient, residential, transitional school and drug–free housing, and employment and job training. Youth have unique needs because of family connections. Many youth must leave their families to access residential treatment services. Continuum of services for youth would include prevention, foster and proctor homes, outpatient and residential located on the reservation or within the tribal services area. Regional residential services could be more cost-effective.

Because of one retail outlet located close to the Warm Springs reservation, the effects of alcohol abuse within the Confederated Tribes of Warm Springs are suffering a significant loss of life in their community. It is necessary for Oregon to protect their most vulnerable people. The Council will work with the Oregon Liquor Control Commission to ensure monitoring and enforcement of retailer liquor law violations in the vicinity of Warm Springs the same way they would elsewhere in Oregon.

Tribal programs find it challenging to select evidence-based practices or programs that have been culturally normed for application with the populations they serve. SB 267 passed during the 2003 legislative session requires OMHAS and four other state agencies to dedicate progressively increased proportions of their budgets to support evidence-based practices. Tribal programs need additional assistance documenting clinical outcomes and finding relevant research to support selection of practices and programs that are tailored to meeting the needs of the population they serve. For the Native American population, limited research on practices creates a special challenge. Evidence-based practices are frequently required for Federal grant money. The tribal treatment programs are at a disadvantage competitively for these monies as a result.

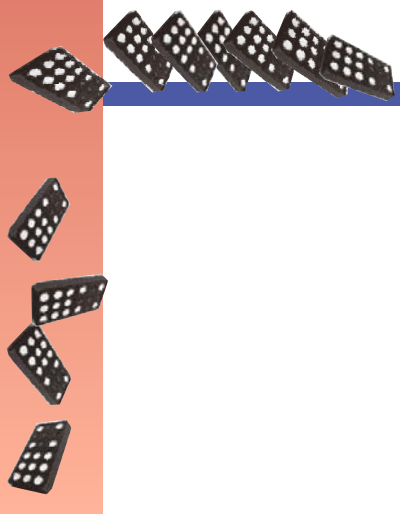
Other Culturally Based Services

The Tribes in Oregon are well organized and effectively represented by the Oregon Indian Council on Addictions. Consequently, information regarding levels of service, resource needs and gaps in services are readily available. The same is not true of other minority populations. There are Hispanic, Asian, African-American and Russian services providers but no single association or group representing these populations to which the Council can turn for information. Therefore, the Council will explore ways to represent these populations and convey their service needs and resources before the next plan is submitted.

Criminal Justice Systems Domino

"I'm convinced that every boy, in his heart, would rather steal second base than an automobile."

~Tom Clark



Section VII

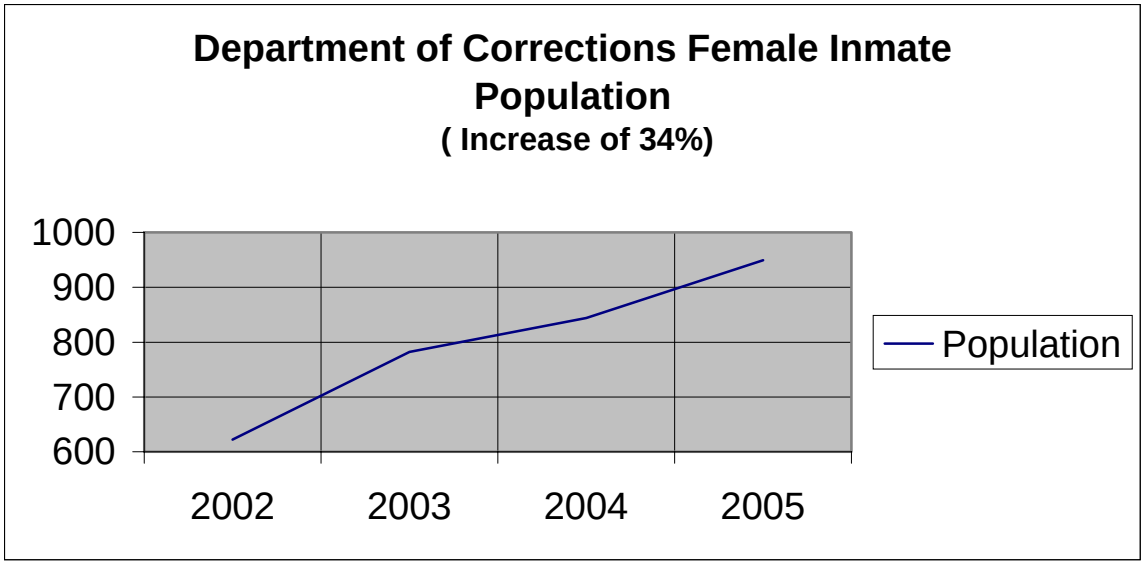
Both the Department of Corrections (DOC) and the Oregon Youth Authority (OYA) reported that between 70-82 percent of individuals involved with the Oregon criminal justice system have alcohol and other problems. The Department of Corrections offers six alcohol and drug treatment programs, and one Hispanic alcohol and drug treatment program within the corrections facilities costing $68 dollars per day per inmate. The Oregon Youth Authority, responsible for alcohol and drug treatment of incarcerated youth, is currently applying for letters of approval with OMHAS in compliance with House Bill 2500. Youth who are at highest risk receive comprehensive alcohol and drug services.

"Families break apart, health deteriorates, freedom is restricted and lives are lost. Economic costs of arresting, processing, incarcerating, police protection, increased insurance rates, and property loss are too great."

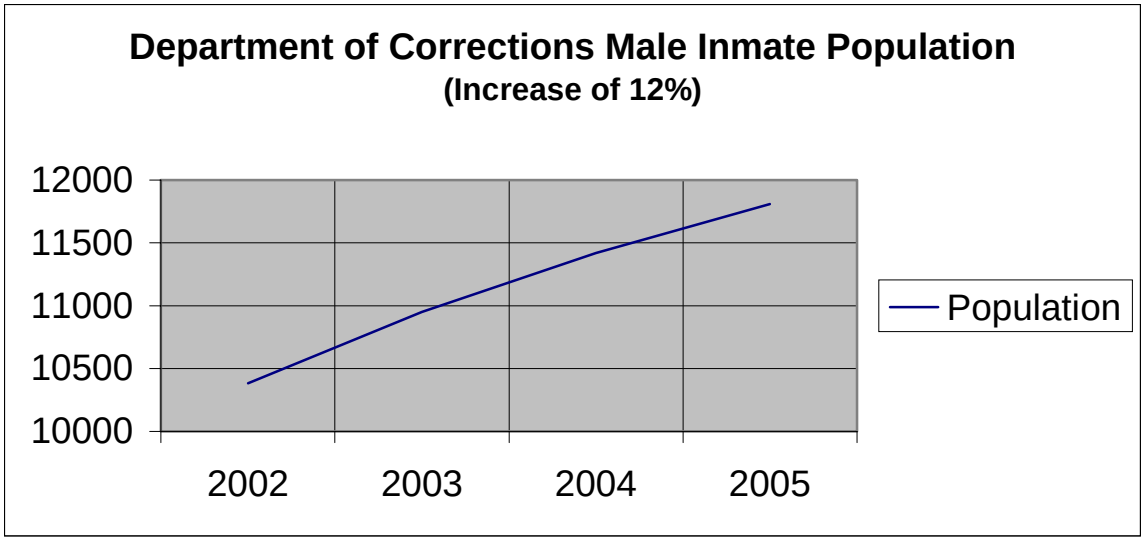
Convictions for felony drug offenses prohibit many ex-offenders from being eligible for student loans, public housing assistance and driver's licenses. This results in lifelong consequences for those who already have served their sentences for drug law violations (Coker, 2004).

There are grave differences between women and men involved in the Oregon criminal justice systems. The DOC reports that eighty percent of women who are incarcerated have a history of alcohol and other drug use while sixty-six percent of men in prison have substance abuse problems. Over the past ten years, the population of women inmates has grown by 128 percent compared to a 60 percent increase in men as illustrated in Graphs 6 and 7.

Graph 6

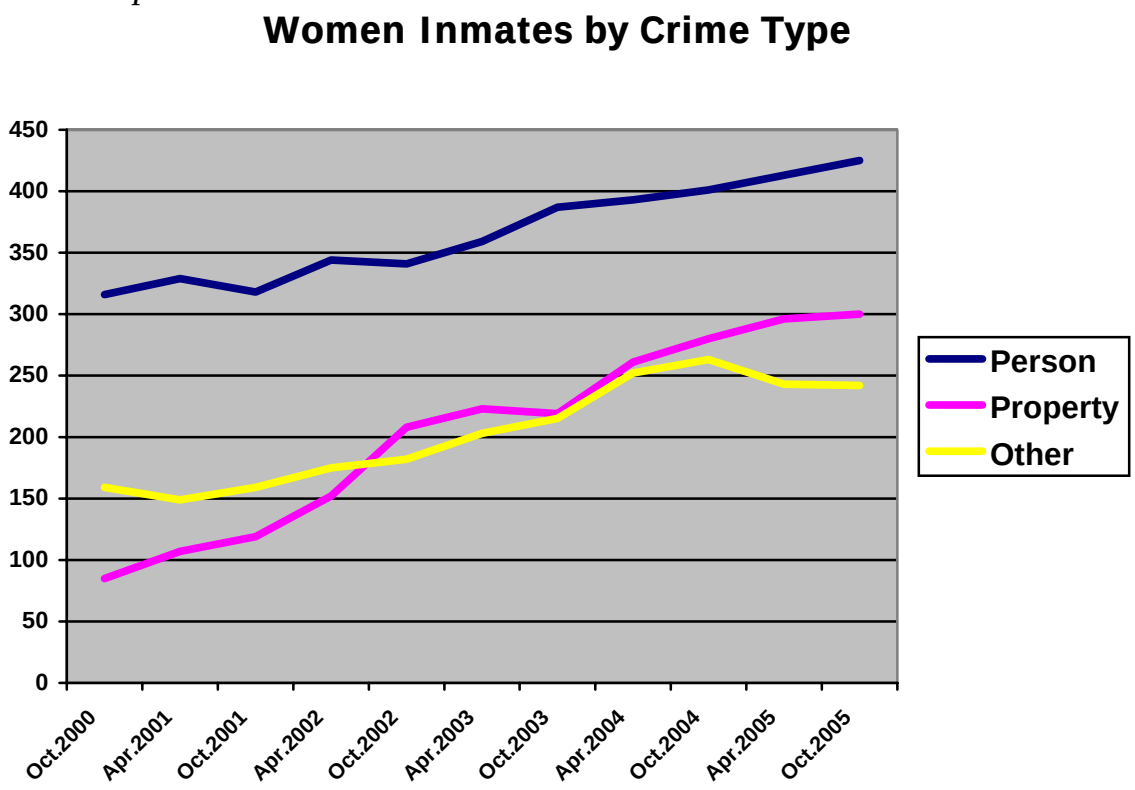


Graph 7



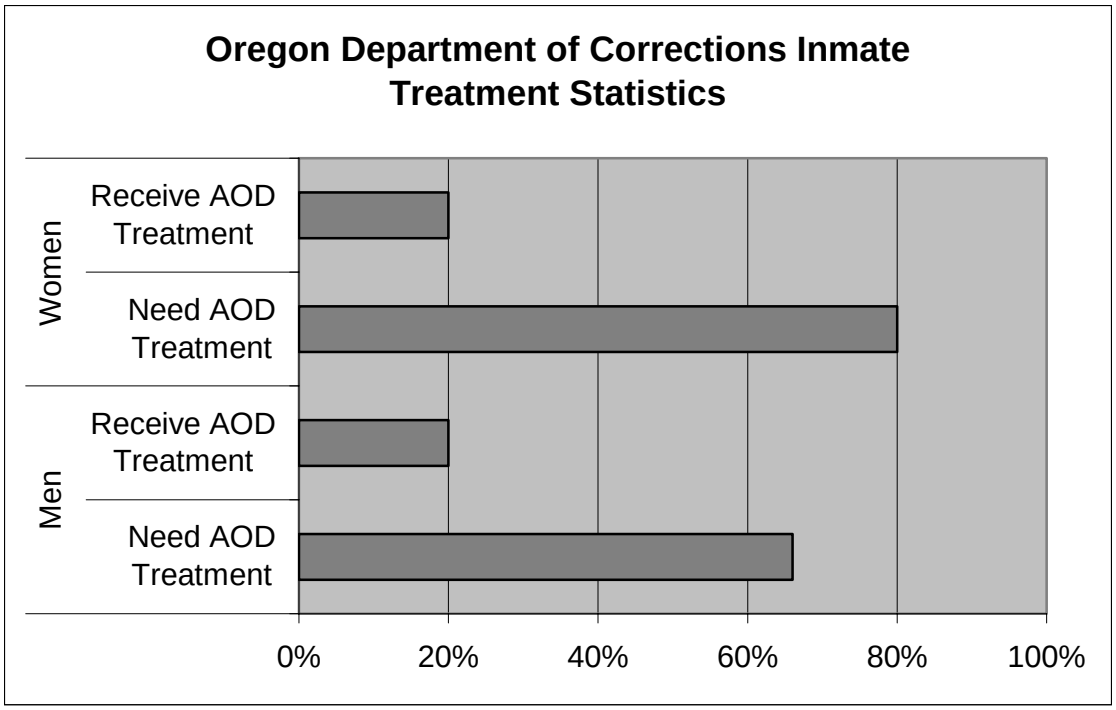
The DOC identifies that Methamphetamine is the primary drug of abuse for 63 percent of women and 43 percent of men in treatment in Oregon prisons. Their offenses are often directly related to their substance abuse. Sixty-eight percent of women in prison have children they were parenting prior to incarceration. The increase in property crimes by 279 percent committed by women since 2000 is driving the increase of women inmates. Theft convictions are by far the largest group of property offenses. This increase began in 2002. Graph 8 shows Oregon Department of Corrections women inmates by crime type.

Graph 8



There are 30,000 individuals on supervision or probation outside of Oregon correction facilities. (Oregon DOC, 2001). According to the Department of Corrections, a minimum of 20,000 adult probation or parolees need treatment or recovery support services, only twenty percent receive treatment while incarcerated as Graph 9 shows.

Graph 9

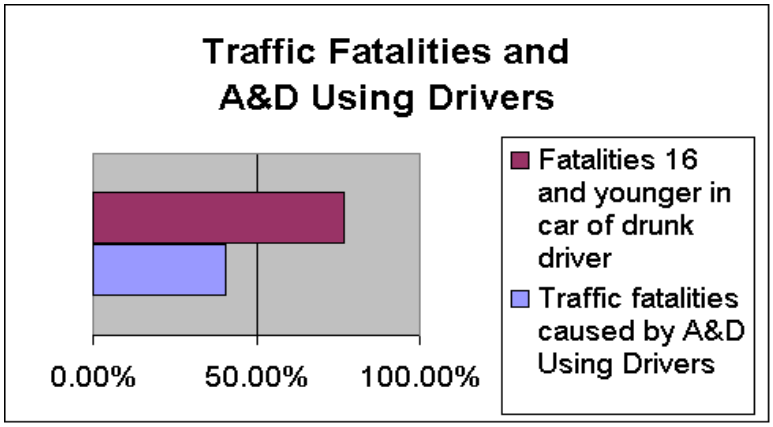


A prime opportunity to make a sustained and cost effective difference is being lost by not treating impaired individuals while incarcerated with a formal treatment and recovery services plan in place. One reason inmates are released without an intervention plan is a lack of adequate treatment resources in the community, particularly those designed for this specialized population. At a minimum, substance abuse assessments should be conducted while incarcerated and transition plans developed that involve community treatment providers. Inmates released into the community who have a history of addiction problems are at greater risk to relapse and re-offend when transition services are inadequate.

Traffic Safety/DUII

Alcohol continues to be the most common drug involved in a Driving Under the Influence of Intoxicants (DUII) and an overwhelming factor in fatal and injury crashes. Many substances other than alcohol affects an individuals ability to drive and the numbers of individuals being charged with DUII due to substances other than alcohol has continued to rise. The Oregon Department of Transportation (ODOT) Traffic Safety Performance Plan reflects that in 2003, 40 percent of all traffic fatalities were alcohol related (see Graph 10). It is very troubling to note that between 1999-2003, 77 percent of all fatally injured under the age of 16 were passengers in the car of a driver under the influence of intoxicants.

Graph 10



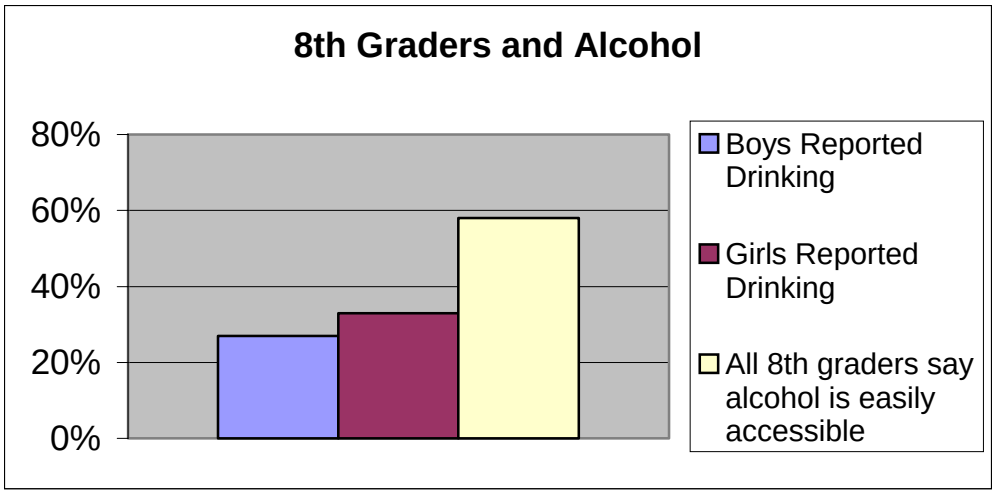
The Transportation Safety Division reports that each year since 2000-2002 there were 25,351 DUII offenses. Overall, DUII offenses have decreased 12.9 percent since 1993 according to the Oregon State Police. However, without controlling for fluctuations in the number of law enforcement, arrest efficiency, and population growth, it is impossible to determine if there has actually been a decrease in the number of impaired drivers, or a decrease in arrests. Comparing the number of arrests to DUII related fatalities reveals no significant changes since 1996, however, we could improve efforts related to DUII prevention. Many lives could be saved and societal costs reduced with strong public policy that supports DUII prevention and provides for enough law enforcement to fully enforce DUII related laws.

MIP and Underage Drinking

The Council understands there are logical consequences to any given policy decision made at the federal, state and administrative levels. The whole point of the Domino analogy used throughout this report illustrates the consequences of the revenue losses experienced over the last three biennia for prevention, treatment and recovery services. But perhaps no consequence has been as generally alarming as the overall rise in underage alcohol use and, more specifically, the alarming rise in underage alcohol use by 8th grade girls.

According to the 2005 Oregon Healthy Teens Survey, 27 percent of 8th grade boys and 33 percent of 8th girls are drinking alcohol (see Graph 11). And no wonder, 58 percent of 8th graders report it is "very easy" or "sort of easy" to obtain access to alcohol. Bear in mind these are 12 and 13 year old children. This level of use by those so young has extensive developmental, social, economic, workplace and educational implications.

Graph 11



Girls have unique pathways to addiction. Risk factors such as early puberty, history of abuse, frequent moving, low self esteem and unstable peer relationships contribute to early the substance abuse of girls. (Girls Incorporated of Oregon, 2004).

Usually girls obtain alcohol from friends who are under 21 or at parties. Highly disturbing is the fact that 12 percent of them obtain alcohol from their parents with permission. Boys usually obtain their alcohol from a friend be they 21 or not, at parties and from parents; again, with permission.

Last fall OMHAS sponsored a summit on underage drinking. Over 200 attendees identified five focus areas and developed strategies in each area. The focus areas are to develop a statewide adult-focused media campaign, foster community mobilization and leadership, cultivate relationships with law enforcement and criminal justice, address parenting issues, develop public policy and awareness, and conduct outcome studies through data collection and evaluation.

Recently, a policy decision was made to charge the Governor's Council with the responsibility of the Underage Drinking Task Force. The Council willingly accepts this new charge and will work with the Governor's Office and OMHAS toward a smooth transition. Prevention research for the last 15 years consistently shows that the longer we delay the onset of use, the less likely it is for problems to develop in adulthood. Clearly, Oregon has its work cut out if we are to reverse the trend of early onset.

Minorities

Disproportionate numbers of incarcerated people involve minority communities, particularly African Americans. At the beginning of the 1990's more African American men were under the control of the Criminal Justice System than enrolled in college (Coker, 2004). Imprisonment has led to fewer numbers of African American men available to care for children leading to higher rates of single-parent households and overall family disruption. The DOC reports that the prison population consists of 9.7 percent African American, 9.8 percent Hispanic, 2.2 percent Native American, 1.2 percent Asian and 77.1 percent White inmates. In all of the DOC population which includes probation, local control, prison, and parole, 7.5 percent of inmates are African American, 6.6 percent are Hispanic, 1.7 percent are Native American, 1 percent are Asian, 83.2 percent are White, and .2 percent unknown (Oregon DOC, 2001).

According to the US Census report, 2000, Oregon's population consists of 1.6 percent African American, 8 percent Hispanic, 1.3 percent Native American, 3 percent Asian and 86.6 percent White. The disproportion of minority population involved with the Oregon criminal justice system is apparent.

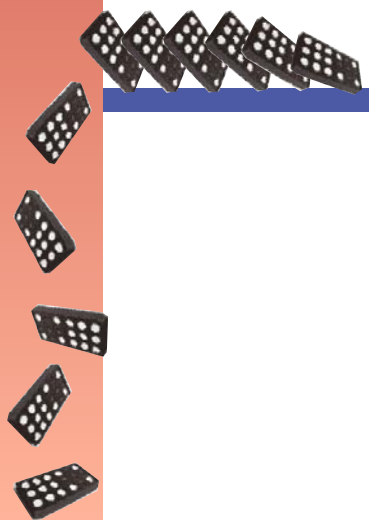
Liquor Control

In 1992, the quota on the number of liquor-licensed business was removed from the Oregon Liquor Control Commission (OLCC) rules. According to the OLCC, the number of licensed businesses has grown from 7310 to 11,763. This is a 60 percent increase when the total population has increased 21 percent. The OLCC needs more staff to monitor current licensees and increase the number of minor decoy operations. The Commission has only 32 staff statewide who monitor 9600 retail outlets and conduct undercover minor decoy and other operations designed to prevent underage use and the fraudulent use of identification. The state of Washington has 300 staff to monitor 11,000 retail outlets. Research consistently shows that underage use goes up exponentially with availability. The Council suspects a link in the dramatic rise in underage drinking by girls and the increased availability of various alcohol outlets. The OLCC's staffing level is inadequate in a state with 11,763 licensees to monitor.

Foster Care Domino

"Children are one third of our population and all of our future."

~Select Panel for the Promotion of Child Health, 1981

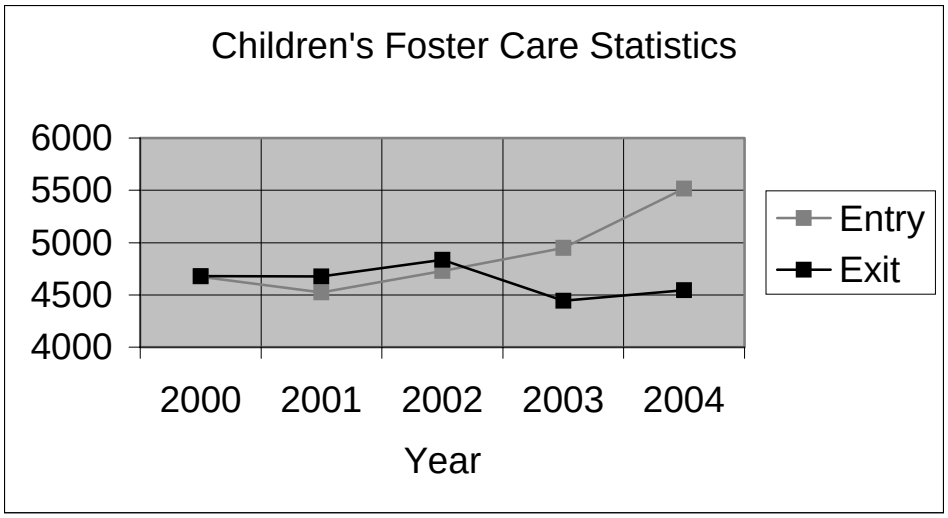


Section VIII

The increased demand for foster care is directly related to the methamphetamine epidemic in Oregon. There are growing foster care costs as parents, mostly women, are unable to complete the substance abuse treatment required to get their children back within the one year timeframe allowed by the Adoption and Safe Families Act (Oregon DHS, 1997). Even without time constraints, treatment is often not readily available due to resource reductions experienced at the program level. This situation has become even more critical with the reduction of the OHP Standard. Very few residential treatment beds are available to parents who are not eligible for the Oregon Health Plan. This policy has resulted in a huge increase in foster care enrollment over the last two years costing the state about $700 per child or $3,860,500 total in 2004 (Oregon CWS, 2004).

Parental Drug and Alcohol abuse continue to be a driving factor in the reasons why children enter foster care.

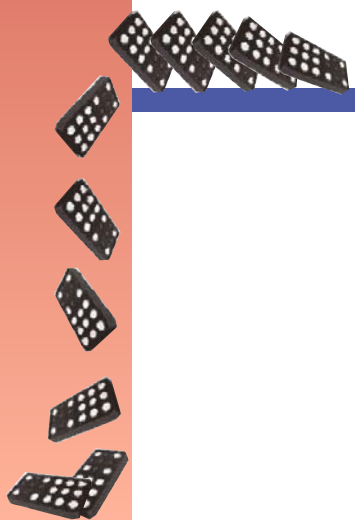
Graph 12



Additionally, Child Welfare costs have increased with the exacerbation of drug involved parents enrolling in the system. An example of this is the increase in spending for the required urinalysis testing (U.A.) over the past four years. In 2000, Oregon Child Welfare reported through Legacy Labs billing that $7000 per month was spent on U.A. testing. During 2005, they report spending $80,000 per month.

Education Domino

" Education is not preparation for life: Education is life itself."
~John Dewey



Section IX

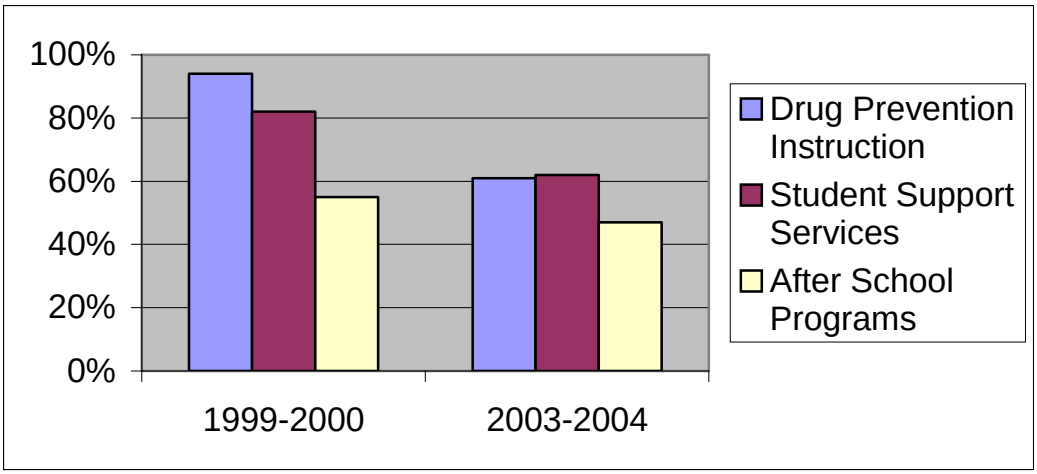
Historically, alcohol and drug prevention was primarily school-based. From the time of Nancy Reagan's "Just Say No" campaign through the DARE program and the beginnings of the Red Ribbon Week movement, education played a pivotal role in prevention. Oregon led the nation in shifting prevention from being almost solely school-based to being community-based with its Preparing for the Drug Free Years and Oregon Together campaigns. During the 1980s and 1990s, the Oregon Department of Education (ODE) was a primary partner in the delivery of a wide variety of alcohol and drug prevention services. Their mandate is to provide K-12 alcohol and other drugs education. Many schools collaborate with local prevention providers to support parent training, after-school programs, and participate in local community coalitions.

"In the 2003-04 school year, 3592 students were suspended from school due to alcohol, tobacco and other drug use and 1122 students were expelled for alcohol, tobacco, and other drug use."

~Oregon's Safe and Drug-Free Schools and Communities Act

The ODE reports that since 1999, the Federal Safe and Drug Free Schools funds have decreased 35 percent. In Oregon, drug prevention instruction has gone from 94 percent of funds to 61 percent. Funding for student support services has been reduced from 82-62 percent and after-school programs went from 55-47 percent. Special event funding was also reduces from 56-39 percent. (see Graph 13).

Graph 13



Oregon funds alcohol and drug prevention primarily utilizing federal funds from the Substance Abuse Prevention and Treatment (SAPT) block grant.

Despite the Oregon Administrative Rule for Standards for Prevention Education Programs in Drugs and Alcohol (OAR 581-002-0413), there is little indication of monitoring a district's compliance for teaching alcohol and drug education as required.

Drug-free Workplaces Domino

"Alcoholism and other addictive illnesses need to receive the same level of attention, funding and professionalism as any other medical condition."

~David Lewis, M.D.
Chairman of the National Council on Alcoholism & Drug Dependence

Section X

Drug-Free Workplace Programs

Oregon first recognized the link between the workplace and alcohol and other drugs in the 1980s. Few remnants of the original workplace initiative remain. One is a program working with various constituents to institute drug-free workplace programs and services. Another is a law that allows workers' compensation insurers to offer discounts to policyholders with drug-free workplace programs with the caveat that they file actuarial data showing plans are not discriminatory. This strategy has never been widely used and none exist today.

"The drug issue is beginning to impact our ability to recruit or expand industry in our region. Master Brand (Grants Pass) no longer can find employees to support their expansion."

~Monte Mendenhall, Chair, Southern Oregon Economic Development, Inc.

The most significant public policy issue affecting the workplace is the need for a systematic campaign to enlist business participation in drug-free workplace programs (Drug-Free Workforce Task Group, 2005). Results of a national workforce drug testing study show that there has been a steady increase of positive drug testing over four years from .25 percent in 2000 to .49 percent in 2004 (Quest Diagnostics, 2004).

The Council applauds the work conducted by the Oregon Business Plan Drugfree Workforce Task Group and supports their initiative to certify 75 percent of Oregon business's as Drug-Free Workplaces by 2008.

To be certified, an employer must conduct a pre-employment drug test, implement policy, train supervisors, educate employees and provide an Employee Assistance Program or Information and Referral Service. This initiative has the potential to be the most significant prevention initiative since the Oregon Together community coalition movement of the 1980s. The benefits to business, workers, communities and the economy have enormous potential. The return on investment cannot be over emphasized. Outcomes will be monitored as this initiative progresses. The Council will report findings in its 2008 report.

Treatment for Impaired Unemployed Workers

Reports by experts in the field, the employment division and the business community have enlightened the Council to the significant absence of drug free individuals to fill the employment needs. The Oregon Education Department (ODE) reported to the Council that many employers are discontinuing the practice of pre-hire testing in order to have an adequate job pool from which to hire. While employers worry about the message this sends to workers and the community they find it necessary to make the policy change to hire an adequate number of workers to fill positions. The Council is concerned about this emerging trend. Data supporting this statement is anecdotal but compelling none the less. For example, one lumber mill in Eastern Oregon who wanted to add a third shift drug tested 300 individuals and still couldn't find the 40 FTE needed to fully staff the new shift. A medium employer in Douglas County has discontinued the practice of pre-hire drug testing in order to maximize hiring. Several other medium to large employers throughout the Willamette Valley have discontinued the practice of pre-hire drug testing. National research consistently shows that employee alcohol and drug use is twice as prevalent in small businesses (Drug-Free Workforce Task Group, 2005). As a small business state, this trend should not be acceptable to Oregonians.

Additionally, there has been an increase in the number of workers who cannot afford employee contributions to health coverage if offered by their employer. This further limits workplace wellness and treatment options. Research consistently shows that 74 percent of those who use drugs and 80 percent that are heavy or binge drinkers are employed (Drug-Free Workforce Task Group, 2005). Treatment access is limited if an individual is unable to pay or does not have insurance including Oregon Health Plan. The demand for publicly funded treatment has grossly intensified since the reduction of Standard benefit into the Oregon Health Plan and exacerbates the business sector's struggle to find substance free workers.

Alcohol & Drug Services Domino

"We keep putting band aids on broken arms and think we have solved the problem."

~Mark Branlund, Council Member

Section XI

Evidence-Based Practices

The 2003 Legislature passed Senate Bill 267 (Oregon Legislative Bills, 2006). This bill requires that increasing amounts of state funds be spent on Evidence-Based Practices (EBP). For 2005-2007, the statute requires that at least 25 percent of state funds used to treat people with substance abuse problems who have a propensity to commit crimes be used for the provision of EBP's. In 2007-2009, the percentage of funds to be spent on EBPs increases to 50 percent and in 2009-2011 to 75 percent. Delivering services based on scientific evidence of effectiveness is a major shift for both the mental health and addiction treatment systems. The Office of Mental Health and Addiction Services (OMHAS) is working with stakeholders to develop a list of evidence-based practices. There are currently over one hundred practices identified on the OMHAS website (http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml). With the increase in methamphetamine use, clients require longer and more extensive treatment episodes (NACO, 2006). The number of clients waiting for treatment has increased. People become sicker during the wait period. Often they require a higher and more expensive level of care as a result. Evidence-based practices are imperative to work effectively with severe cases.

The Office of Mental Health & Addiction Services promotes recovery through culturally competent, integrated, evidence-based practice treatments of addiction, mental illnesses, and emotional disorders.

Prevention

OMHAS is working with prevention partners including county and tribal prevention, community coalitions, and the Oregon Commission on Children and Families to promote the adoption and implementation of evidence-based prevention strategies. OMHAS is developing a technical assistance process to assist prevention providers in making the changes necessary to meet the intent of SB267.

Although new resources have not been available to invest in alcohol and drug prevention services, the state continues to promote these services

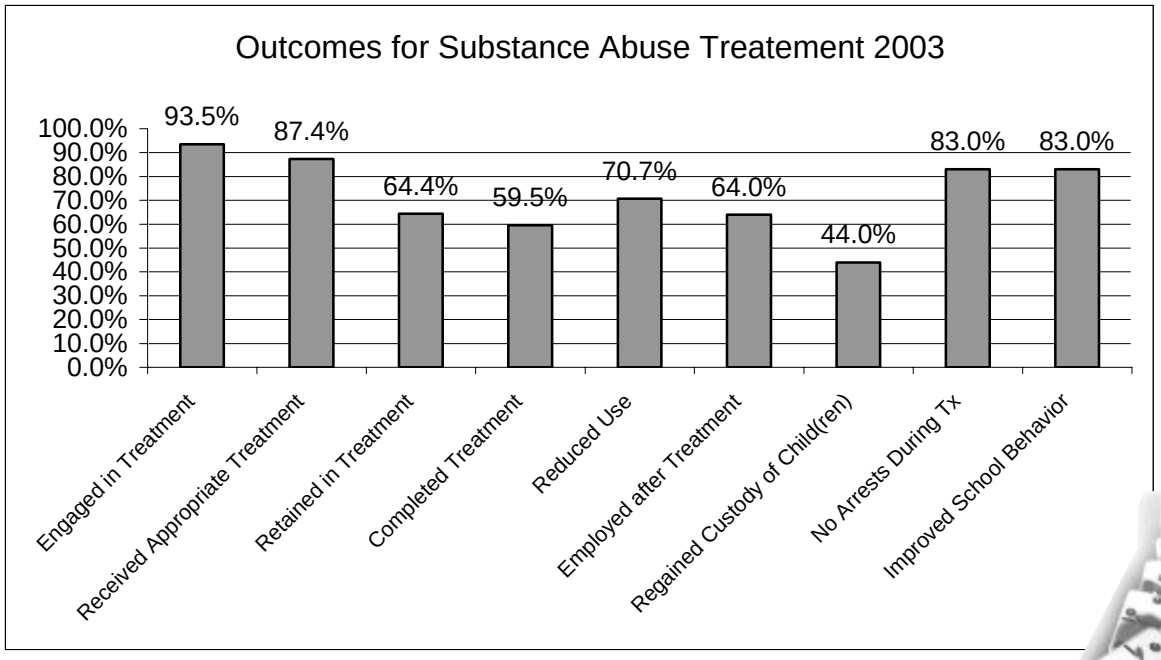
and work collaboratively with local communities, tribes and the counties. Available resources will be focused on strategies that have been proven effective in decreasing the risks of substance abuse and promoting the strength and resiliency of individuals and communities.

Treatment

The OMHAS distributes available treatment dollars to local counties. Funding inequity exists as population growth differs. Reduction in treatment dollars exacerbate the inequities of funding across counties. This inequity makes full continuum of care difficult at the local level, especially in rural areas. Clients may travel extremely long distances for treatment services appropriate to their level of care needs.

OMHAS tracks outcomes for substance abuse treatment. The graph below shows the results from 2003 (Graph 14). Although the outcomes are generally encouraging, current budget cuts and the complicating problems of severe drug abuse problems such as the methamphetamine epidemic create increasing challenges for the treatment system.

Graph 14



Workforce Development

The workforce required to provide alcohol and drug abuse treatment services is currently sparse, overworked, underpaid and needs additional training and supervision to meet the expected guidelines for evidence-based practices. According to the Addictions Counselor Certification Board of Oregon (ACCBO) 2002-2004 survey, 40 percent of certified counselors are thinking about leaving the field (ACCBO, 2004). There are 1103 certified counselors in the state of Oregon serving about 60,000 social service clients each year. The average years in the field is eleven with an average income of $37,000 per year. Most certified counselors have a college degree and job satisfaction is 3.96 based on a 1-5 scale. The survey validates concerns from community treatment providers. A strong workforce is imperative to provide a full continuum of treatment services. A budget package raising the current rates for a continuum of services should include increasing the number of counselors employed, increasing the salary standards, and training monies to ensure a professional workforce and increase longevity in the field.

The Northwest Addiction technology Transfer Center (NFATTC) funded by SAMHSA provides training for substance abuse counselors. The center works with Oregon and other northwest universities and community colleges to improve the counselor trainings and provides leadership in helping the field adapt to evidence based practices. This vital workforce training center helps improve knowledge and skills and deserves continued support.

Recovery Support Services Domino

"Drugs are not always necessary, but a belief in recovery is."

~Angel Cordero, Jr.

Section XII

The Office of Mental Health and Addiction Services (OMHAS) funds eight projects in 7 counties and one tribal community to support over 500 people per year in recovery from addictions to obtain stable Alcohol and Drug Free (ADF) housing as they transition to self-sufficiency. Prior to receiving this assistance, 65 percent were homeless.

"Don't try to drive the homeless into places we find suitable. Help them survive in places they find suitable."

~Daniel Quinn

Persons with psychiatric and/or addiction disorders should have access to and support for maintaining residential stability in the community housing of their choice. Affordable housing options are insufficient to meet the existing need for safe and decent living accommodations. Planning must take place that identifies areas of greatest need and prioritizes strategies within the scope of available resources. Homelessness is not an acceptable alternative. A preliminary report conducted by OMHAS indicates that of 27 counties reporting, 900 adults need structured/ specialized or residential treatment housing, 2002 need recovery housing and 1989 need affordable housing.

OMHAS contracts for two outreach coordinators who support the establishment of new Oxford Houses and other peer supported recovery housing. As of October 2005, there were 135 homes accommodating over 1,000 people recovering from alcoholism and drug addiction in 15 counties. Of the residents, 77 percent have been homeless for an average of nine months.

The importance of housing cannot be over-emphasized. A nationwide study of Oxford House from DePaul University demonstrated that 87 percent of residents remained alcohol and drug free after one year and 65 percent remained alcohol and drug free after two years (Jason et al., 2006).

Conclusion

Section XIII

Oregon stands at a public policy crossroads, with the Executive and Legislative branches facing a number of crucial choices. The economic recovery the state is now experiencing will make it possible to restore some of the vital services that have suffered grievously in recent years. When weighing these compelling demands, the Council hopes decision makers will realize that drug and alcohol prevention, treatment and recovery services have been among the most deeply eroded, as indicated by the evidence presented in this report. We have also documented the destructive, far reaching impacts of that erosion: higher crime, soaring child welfare caseloads, lost health and diminished economic productivity.

"Oregon should be re-established as a state on the cutting edge of prevention, treatment and recovery services and should be resourced adequately."

This report also underscores that the foundation of the system has been torn apart at the same time the methamphetamine epidemic has overwhelmed the ability to respond. While meth has uniquely destructive qualities, other drugs and alcohol also continue to claim their victims.

The time has come to curtail the domino effect. The downward spiral can be stopped with a public policy decision that treatment and recovery services on demand are fully funded. This will require a greater investment in the short run. But the return on that investment will begin immediately as case loads in various state agencies begin to plateau and then recede, allowing resources to be redirected to other critical needs. The Council recognizes this is a significant commitment that will take time to fully implement but believes it is an essential step.

The Council will also work to help fully fund prevention. A true and sustained commitment to prevention is sound public policy. It will build stronger, healthier communities and also produce a significant return on the investment.

As the Columbia University report cited in the opening of this report so aptly states: "Every sector of society spends hefty sums of money shoveling up the wreckage of substance abuse and addiction. Nowhere is this more evident than in the public spending of states." The time has come for Oregon to stop shoveling up the wreckage and begin building a healthier, more hopeful tomorrow.

Appendix A

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Appendix B

Governor's Council Duties

The Council is charged with implementing the legislative policy by:

- ❑ Describing the need for prevention and treatment services and strategies, and the method by which state and federal resources shall be prioritized;
- ❑ Setting forth principles guiding the purchase of services and strategies from local community providers;
- ❑ Identifying outcomes and a method for monitoring those outcomes;
- ❑ Identifying consistent standards for measuring prevention and treatment provision/success;
- ❑ Outlining a process for providing training and technical assistance to local providers, including special populations;
- ❑ Identifying how prevention and treatment link to other services and supports for children and families;
- ❑ Assessing the economic and social impact of alcohol and drug abuse on Oregon and report the findings and recommendation to the Governor by January 1st of each even-numbered year;
- ❑ Reviewing and make recommendations to the Governor on the goals, financing, priorities and a state plan for prevention, intervention and treatment of alcohol and drug abuse problems, which encompasses all appropriate state agencies by January 1st of each even-numbered year;
- ❑ Reviewing alcohol and drug abuse programs and making recommendations to the Governor on the effectiveness and priorities for improvements of all such prevention and treatment programs for alcohol and drug problems engaged in or financed through state agencies by January 1st of each even-numbered year;
- ❑ Ensuring that each state agency or other entity responsible for a component of the local coordinated comprehensive plan shall ensure that a biennial evaluation of the plan component is conducted according to a consistent framework;
- ❑ Working to ensure broad-based citizen involvement in the planning and execution of the alcohol and drug prevention and treatment plans at both the state and local level;

The Council is also directed by statute to:

- Assessing the economic and social impact of alcohol and drug abuse on the State of Oregon and reporting the findings and recommendations to the Governor by January 1 of each even-numbered year.

- Reviewing and making recommendations to the Governor on the goals, financing, priorities and a state plan for prevention, intervention and treatment of alcohol and drug abuse problems, which encompasses all appropriate state agencies, by January 1 of each even-numbered year.

- Reviewing alcohol and drug abuse programs and making recommendations to the Governor on the effectiveness and priorities for improvements of all such prevention and treatment programs for alcohol and drug problems engaged in or financed through state agencies by January 1 of each even-numbered year.

Appendix C

Contributors to the 2007-2009 Governor's Council Plan

County Site Visits:
- Union
- Marion
- Lane
- Burns-Piute

Oregon Indian Council on Addictions (OICA)

State Agencies:
- Department of Human Services
  - Children Adults and Families
  - Public Health
  - Office of Mental Health and Addiction Services
  - Office of Medical Assistance Programs
  - Seniors and People with Disabilities
- Department of Education
- State Commission on Children and Families
- Oregon Liquor Control Commission
- Employment Department
- Oregon State Police
- Oregon Department of Justice
- Oregon Youth Authority
- Department of Corrections
- Department of Motor Vehicles
- Department of Transportation
- Traffic Safety Division

Appendix D

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