Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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APRIL 17, 18 & 19, 2007 BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30
Saturday, 10:00 AM, Channel 29
Sunday, 11:00 AM, Channel 30
Tuesday, 8:00 PM, Channel 29

Produced through MetroEast Community Media
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Tuesday, April 17, 2007 - **9:00 AM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners will meet in Executive Session Pursuant to ORS 192.660(2)(d),(e) and/or (h). Only Representatives of the News Media and Designated Staff are allowed to attend. News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Session. No Final Decision will be made in the Session. Presented by County Attorney Agnes Sowle. 15-30 MINUTES REQUESTED.

Tuesday, April 17, 2007 - **9:30 AM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

B-1 Review Co-Chairs' Budget and Implications to County Services. Presented by Gina Mattioda, Joanne Fuller, and Steve Liday. 30 MINUTES REQUESTED.

B-2 Evidence Based Treatment Practices. Presented by Commissioner Lisa Naito, LPSCC Chair; Eric Martin, Director of Addiction Counseling and Certification; Dennis McCarty, OHSU; Michael Finigan, NPC, and Invited Others. 90 MINUTES REQUESTED.

Wednesday, April 18, 2007 – **9:00 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

PUBLIC HEARINGS

[Please Note: Any action taken by the Board on the following Measure 37 Claims will be ratified at the April 19th Board Meeting.]

PH-1 Public Hearing to consider and possibly act upon a Measure 37 Claim by Alfred Feller for compensation or relief from regulations to allow for the development of a single family residence on property located north of 34242 SE Smith Road, Corbett. [1S, R4E, Sec 03B, TL 400] (Case File T1-06-077)

PH-2 Public Hearing to consider and possibly act upon a Measure 37 Claim by Martha Glaser for compensation or relief from regulations to allow the development of a single family residence on property located west of 13801 NW Charlton Road, Portland. [T2N, R1W, Sec 16C, TL 600] (Case File T1-06-093

PH-3 Public Hearing to consider and possibly act upon a Measure 37 Claim by Robert and Cheryl Wiley for $225,000 in compensation or relief from regulations to allow the development of a single family residence on property located west of 13801 NW Charlton Road, Portland. [T2N, R1W, Sec 16C, TL 500] (Case File T1-06-078)

Thursday, April 19, 2007 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
DEPARTMENT OF COMMUNITY SERVICES

C-1 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to BOBBY A. BERG

C-2 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to CREIGHTON TONG

C-3 Ratification of an ORDER in the matter of the Measure 37 Claim by Alfred Feller for compensation or relief from regulations to allow for the development of a single family residence on property located north of 34242 SE Smith Road, Corbett

C-4 Ratification of an ORDER in the matter of the Measure 37 Claim by Martha Glaser for compensation or relief from regulations to allow the development of a single family residence on property located west of 13801 NW Charlton Road, Portland

C-5 Ratification of an ORDER in the matter of the Measure 37 Claim by Robert and Cheryl Wiley for $225,000 in compensation or relief from regulations to allow the development of a single family residence on property located west of 13801 NW Charlton Road, Portland

REGULAR AGENDA
PUBLIC COMMENT - 9:30 AM

Opportunity for Public Comment on non-agenda matters. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

DEPARTMENT OF COUNTY MANAGEMENT – 9:30 AM

R-1 PROCLAMATION Proclaiming the week of April 22 through April 28, 2007 ADMINISTRATIVE PROFESSIONALS WEEK in Multnomah County, Oregon

DISTRICT ATTORNEY'S OFFICE – 9:35 AM

R-2 PROCLAMATION Proclaiming the week of April 22, through April 28, 2007 as NATIONAL CRIME VICTIMS' RIGHTS WEEK in Multnomah County, Oregon

NON-DEPARTMENTAL - 9:40 AM

R-3 PROCLAMATION Proclaiming April 15 through April 21, 2007 as MULTNOMAH COUNTY VOLUNTEER WEEK and April 25, 2007 as a SPECIAL DAY OF RECOGNITION FOR MULTNOMAH COUNTY VOLUNTEERS

R-4 Chair Ted Wheeler's Executive Budget Message for Fiscal Year 2008

R-5 Public Hearing and Consideration of RESOLUTION Approving the Chair's Proposed Fiscal Year 2008 Budget for Submittal to the Tax Supervising and Conservation Commission as Required by ORS 294.421

R-6 First Reading and Proposed Adoption of ORDINANCE Repealing Ordinances 1055 and 1060 to Delete the Real Property Compensation Law (Ballot Measure 37) Subchapter from the Multnomah County Code (§§27.500 – 27.565), and Declaring an Emergency

R-7 Sustainable Development Commission Annual Report. Presented by Commissioner Jeff Cogen, Sustainable Development Commission Chair Pamela Brody and Invited Others. 25 MINUTES REQUESTED.

DEPARTMENT OF COUNTY MANAGEMENT – 10:50 AM

R-8 RESOLUTION Certifying an Estimate of Expenditures for Fiscal Year 2007-2008 for Assessment and Taxation in Accordance with ORS 294.175

DEPARTMENT OF COUNTY HUMAN SERVICES – 10:55 AM

R-9 Budget Modification DCHS-19 Increasing the Mental Health and Addiction Services Appropriation by $1,853,919 to Reflect State of Oregon Funding Revisions, Increased Oregon Health Plan Premiums, and Increasing County General Contingency by $37,550

DEPARTMENT OF COMMUNITY JUSTICE – 11:00 AM

R-10 Budget Modification DCJ-17 Appropriating $3,750 in U.S. Department of Justice Funds to Support Collaboration between the Department of Corrections and the Community for Re-entry Programs for Offenders that are Released from Institutions to Multnomah County

DEPARTMENT OF HEALTH – 11:05 AM

R-11 NOTICE OF INTENT to Apply for Grant Funding through the Northwest Health Foundation to Support the Community Coalition to Address Childhood Obesity in North Portland Project

R-12 Budget Modification HD-14 Appropriating $49,534 Grant Funding from the Oregon Research Institute to the Health Department for Research and Evaluation Services

R-13 Budget Modification HD-20 Appropriating $13,962 in Additional Revenue for the Health Department, Community Health Services from a Grant Award from the Robert Wood Johnson Foundation

R-14 Budget Modification HD-26 Appropriating $50,000 from the Northwest Health Foundation to the Health Department for MultiCare Dental Services

BOARD COMMENT – 11:15 AM

Opportunity (as time allows) for Commissioners to provide informational comments to Board and public on non-agenda items of interest or to discuss legislative issues.

Lonnie Roberts
Multnomah County Commissioner
District 4

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MEMORANDUM

DATE: April 16, 2007

TO: Chair Ted Wheeler
Commissioner Maria Rojo de Steffey, District 1
Commissioner Jeff Cogen, District 2
Commissioner Lisa Naito, District 3
Board Clerk Deb Bogstad

FROM: Sam Peterson
Staff Assistant to Commissioner Lonnie Roberts

RE: Notice of Meeting Excuse

Commissioner Roberts will not be attending the April 17, 2005 Executive Session and Broad Briefing because of a doctors appointment. Thank you.

4.17.07 EXECUTIVE SESSION
NOT NEEDED

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST (short form)

Board Clerk Use Only	
Meeting Date:	04/17/07
Agenda Item #:	E-1
Est. Start Time:	9:00 AM
Date Submitted:	04/11/07

Agenda Title: **Executive Session Pursuant to ORS 192.660(2)(d),(e)and/or(h)**

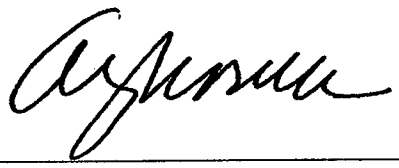
Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Requested Meeting Date:	April 17, 2007	**Amount of Time Needed:**	15-30 minutes
Department:	Non-Departmental	**Division:**	County Attorney
Contact(s):	Agnes Sowle		
Phone:	503 988-3138 **Ext.** 83138	**I/O Address:**	503/500
Presenter(s):	Agnes Sowle and Invited Others		

General Information

1. **What action are you requesting from the Board?**
   No final decision will be made in the Executive Session.
2. **Please provide sufficient background information for the Board and the public to understand this issue. Please note which Program Offer this action affects and how it impacts the results.**
   Only representatives of the news media and designated staff are allowed to attend. Representatives of the news media and all other attendees are specifically directed not to disclose information that is the subject of the Executive Session.
3. **Explain the fiscal impact (current year and ongoing).**
4. **Explain any legal and/or policy issues involved.**
   ORS 192.660(2)(d),(e)and/or(h)
5. **Explain any citizen and/or other government participation that has or will take place.**

Required Signature

Elected Official or Department/ Agency Director: 

Date: 04/11/07

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

Board Clerk Use Only	
Meeting Date:	04/17/07
Agenda Item #:	B-1
Est. Start Time:	9:30 AM
Date Submitted:	04/11/07

Agenda Title: **Review Co-Chairs' Budget and Implications to County Services**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Date Requested:	April 17, 2007	**Time Requested:**	30 minutes
Department:	**Non-Departmental**	**Division:**	**Public Affairs Office**
Contact(s):	Gina Mattioda		
Phone:	503.988.5766 **Ext.** 85766	**I/O Address:**	503/6
Presenter(s):	Gina Mattioda, Joanne Fuller, and Steve Liday		

General Information

1. **What action are you requesting from the Board?**

   Direction from the BCC on the co-chairs' budget and communication with the Oregon Legislature.

2. **Please provide sufficient background information for the Board and the public to understand this issue. Please note which Program Offer this action affects and how it impacts the results.**

   The Public Affairs Office provides governmental affairs services and lobbies the Oregon State Legislature on behalf of the Board of County Commissioners. The co-chairs' budget was released earlier this month and contains many cuts to county programs. This briefing will provide funding and client details on county programs.

3. **Explain the fiscal impact (current year and ongoing).**

   DCHS and DCJ are in the process of reviewing the co-chair's budget and creating a document which includes ramifications to county programs.

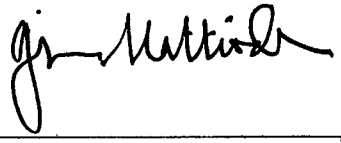
4. **Explain any legal and/or policy issues involved.**

   N/A

5. **Explain any citizen and/or other government participation that has or will take place.**

   N/A

Required Signature

Department/ Agency Director:  **Date:** **04/11/07**

Impact of the Ways and Means Co-Chairs' Budget
on programs managed by Multnomah County
Department of Community Justice and Department of County Human Services

*The Multnomah County share for the asterisked items was calculated based on an assumed 25 percent allocation of state funds.

Funding Program	Governor's Proposed Biennial Budget (Statewide 2007-09)	Governor's Budget (annualized)	Co-Chairs' Budget (annualized)	Difference (annualized)	Impact of Co-Chairs' Budget
DCHS Oregon Project Independence (OPI)	$16 million	$1,411,000 ***in Multnomah County funds***	$1,020,000 ***in Multnomah County funds***	($391,000) ***in Multnomah County funds***	Co-Chairs' reduction is equivalent to: • Operating at pre-2003 cut levels, including no ability to assist individuals currently on the wait list. • Needs of growing senior population continued unmet. • Additionally, the Co-Chairs' budget finances OPI with a temporary funding source which was originally intended to finance an OPI expansion and modernization.
DCHS Addiction Treatment Access with Oregon Liquor Control Commission (OLCC) funding	$10.4 million	$1.3 million ***in Multnomah County funds****	$0	($1.3 million) ***in Multnomah County funds****	Co-Chairs' reduction removes funds for new treatment capacity. The county currently serves 8,000 treatment episodes. The Governor's recommended budget would provide a capacity for an additional 2,000-4,000 individuals. Current estimates of need in Multnomah County are 14,000-16,000 individuals/year.

Funding Program	Governor's Proposed Biennial Budget (Statewide 2007-09)	Governor's Budget (annualized)	Co-Chairs' Budget (annualized)	Difference (annualized)	Impact of Co-Chairs' Budget
DCHS Equitable Alcohol and Drug Treatment	$4 million	$500,000 ***in Multnomah County funds****	$0	($500,000) ***in Multnomah County funds****	Co-Chairs' reduction equivalent to: • A 40 percent reduction in funds the state provides the county for alcohol and drug treatment. • A major reduction of services including the likely closure of some smaller treatment agencies.
DCHS AAA-D Equity	$11,546,000	$1,443,250 ***in Multnomah County funds****	$776,250 ***in Multnomah County funds****	($667,000) ***in Multnomah County funds****	Co-Chairs' reduction equivalent to: • Waiting lists increase to over a month. • Delays in timely responses to health and safety needs and benefits processing. • 14 FTE positions eliminated.
DCHS Early Assessment and Support Team (EAST)	$4 million	$500,000 ***in Multnomah County funds****	$0	($500,000) ***in Multnomah County funds****	If the county were successful in an RFP, between 54-108 clients would receive early identification, support and treatment for their mental illness. The Co-Chairs' reduction will eliminate this enhanced capability.

Funding Program	Governor's Proposed Biennial Budget (Statewide 2007-09)	Governor's Budget (annualized)	Co-Chairs' Budget (annualized)	Difference (annualized)	Impact of Co-Chairs' Budget
DCJ Gang Transition Services	$3,682,494	$1,841,247 ***in Multnomah County funds***	$1,291,832 ***in Multnomah County funds***	($549,415) ***in Multnomah County funds***	Co-Chairs' reduction equivalent to any one of these programs: • Culturally competent case management for 110 high-risk youth. • Secure shelter as detention alternative for over 50 youth.
DCJ Juvenile Crime Prevention (JCP) Basic	$11,126,362	$991,846 ***in Multnomah County funds***	$867,657 ***in Multnomah County funds***	($124,189) ***in Multnomah County funds***	Co-Chairs' reduction equivalent to: • Psychological assessment and treatment/care coordination for 21 high-risk delinquent youth with drug abuse and mental health problems.
DCJ Oregon Youth Authority (OYA) Diversion	$9,499,494	$846,820 ***in Multnomah County funds***	$752,861 ***in Multnomah County funds***	($93,959) ***in Multnomah County funds***	Co-Chairs' reduction equivalent to: • Intensive, multi-systemic therapy for 15 families of high-risk youth with drug and mental health problems.
DJC Adult Community Corrections	$239,253,801	$17,590,465 ***in Multnomah County funds***	$16,636,843 ***in Multnomah County funds***	($953,622) ***in Multnomah County funds***	Co-Chairs' reduction equivalent to any one of these programs: • 15 beds of residential treatment. • Londer Learning Center (which provides literacy and GED prep to 1,000 offenders). • Supervision of 600 offenders.

Impact of the Ways and Means Co-Chairs' Budget on programs managed by Multnomah County

*The Multnomah County share for the asterisked items was calculated based on an assumed 25 percent allocation of state funds.

Funding Program	Governor's Proposed Biennial Budget (Statewide 2007-09)	Governor's Budget (annualized)	Co-Chair's Budget (annualized)	Difference (annualized)
MCSO Community Corrections	$239,253,801 for all state community corrections	$9,225,695 ***in Multnomah County funds***	$8,725,547 ***in Multnomah County funds***	($500,148) ***in Multnomah County funds***
DCJ Community Corrections *(this DCJ information is also reported in the DCJ/DCHS matrix)*	$239,253,801 for all state community corrections	$17,590,465 ***in Multnomah County funds***	$16,636,843 ***in Multnomah County funds***	($953,622) ***in Multnomah County funds***
LPSCC	$239,253,801 for all state community corrections	$222,974 ***in Multnomah County funds***	$213,250 ***in Multnomah County funds***	($9,724) ***in Multnomah County funds***
Health Department Public Health addition	$5 million	$625,000 ***in Multnomah County funds****	$0	($625,000) ***in Multnomah County funds****
Healthy Kids	Funding level dependent on tobacco tax	Funding level dependent on tobacco tax	$0	The Governor's proposal predicts serving an additional 102,000 kids
Commission on Children and Families	$16 million	$8 million ***in Statewide funds***	$3,275,000 ***in Statewide funds***	($4,725,000) ***in Statewide funds***

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST (short form)

Board Clerk Use Only	
Meeting Date:	04/17/07
Agenda Item #:	B-2
Est. Start Time:	10:00 AM
Date Submitted:	04/11/07

Agenda Title: **Evidence Based Treatment Practices**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Requested Meeting Date:	April 17, 2007	**Amount of Time Needed:**	90 minutes
Department:	Non-Departmental	**Division:**	LPSCC
Contact(s):	Judy Shiprack		
Phone:	503 988-5894 **Ext.** 85894	**I/O Address:**	503/600
Presenter(s):	Commissioner Lisa Naito, LPSCC Chair; Eric Martin, Director of Addiction Counseling and Certification; Dennis McCarty, OHSU; Mike Finigan, NPC, and Invited Others		

General Information

1. **What action are you requesting from the Board?**
   Informational briefing only.
2. **Please provide sufficient background information for the Board and the public to understand this issue. Please note which Program Offer this action affects and how it impacts the results.**
   The purpose of the briefing is to update the Board on current research into Evidence Based Treatment Practices.
3. **Explain the fiscal impact (current year and ongoing).**
   In Oregon every dollar invested in treatment saves $5.60 in other costs.
4. **Explain any legal and/or policy issues involved.**
   Evidence based treatment practices are currently being utilized in Multnomah County. This briefing will highlight some of those programs as well as programs being implemented elsewhere, and will describe their impacts on Public Safety and Human Services.

5. **Explain any citizen and/or other government participation that has or will take place.**

The Legislature is currently considering its budget package that will directly impact Multnomah County's ability to provide treatment. Many of the invited presenters have addressed these issues and reasons to support treatment programs before legislative committees this session.

Required Signature

Elected Official or Department/ Agency Director: J Shumack **Date:** 04/11/07

BOGSTAD Deborah L

From: SHIPRACK Judith C

Sent: Tuesday, April 17, 2007 12:32 PM

To: Carol Metzler (carolm@ori.org); Eric Martin (eric@accbo.com); Dennis McCarty (mccartyd@ohsu.edu); 'Michael Finigan'

Cc: NAITO Lisa H; BOGSTAD Deborah L; WESSINGER Carol M

Subject: Treatment Works Power Point Presentations

Eric, Carol, Mike and Dennis—

Thank you all for your presentations to the Multnomah County Board this morning!

Please send me your power point files, and I will forward them to our County Clerk, Deb Bogstad, who has offered to make new copies for the Board, as well as for our public records.

Again, thanks. The messages and research you share about treatment effectiveness and public policy is timely, important and was powerfully delivered!!!

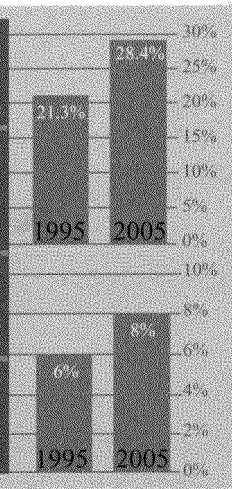
Judy Shiprack
Director, Local Public Safety Coordinating Council
503-988-5894
503-988-5262 fax
501 SE Hawthorne Blve., Suite 624
Portland, Oregon 97214

2006 Oregon Research Brief
on Addiction Treatment Effectiveness

Produced by Eric Martin, M.A., CADC III, Edited by Michael Finigan, Ph.D., and Pat Gold, B.A., CADC II

Oregon's young women have reached a state of crisis due to few prevention & treatment resources

1995	21.3% of all Oregon probationers were female
2005	28.4% of all Oregon probationers were female
1995	6% of all Oregon inmates were female
2005	8% of all Oregon inmates were female



(Oregon Department of Corrections, 2006)

- Oregon 8th Graders abuse alcohol 80.5% higher than the national average. Oregon 8th Graders abuse illegal drugs nearly twice the national average and use methamphetamine more than 4x's the national average. (Oregon Healthy Teens 2005 & Monitoring the Future 2005)
- Oregon ranks 2nd in the U.S. for illegal drug use in adults 26 and older, ranks 7th in the U.S. for illegal drug use among Oregonians 12 and older, and ranks 4th in the U.S. for alcohol & drug dependence among 18-25 year olds. (SAMHSA, National Survey on Drug Use and Health 2004)
- 1 out of 10 Oregonians has used methamphetamine, 1 out of 99 has used methamphetamine in the past year, and 1 out of every 200 Oregonians has used methamphetamine in the last 30 days. (SAMHSA, National Survey on Drug Use and Health 2002-2004)

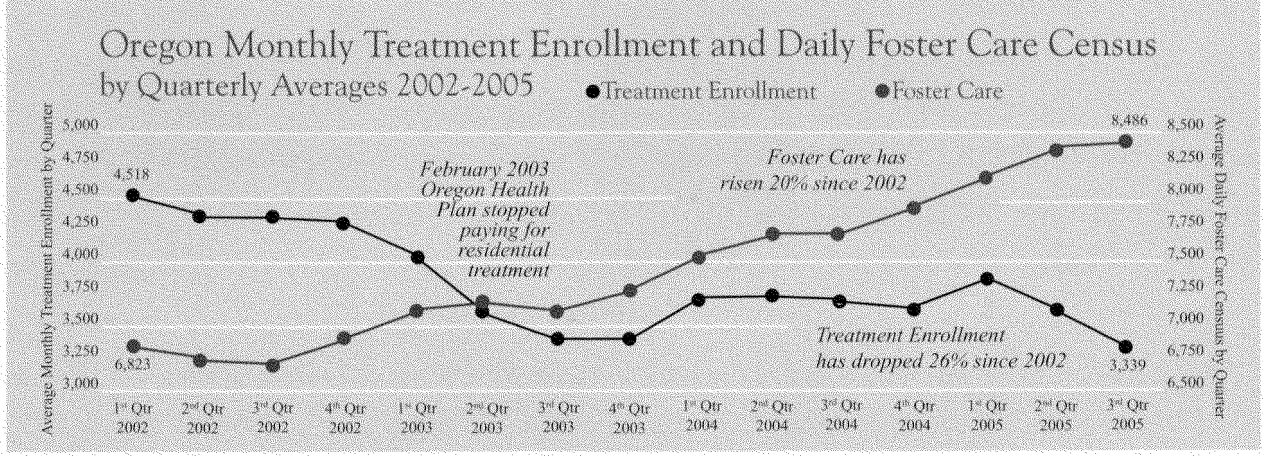
A Dangerous Trend Among Oregon Girls

In Oregon, teenage girls binge on alcohol and abuse meth at higher rates than teenage boys, a dangerous trend leading to increasing rates of probation & incarceration for Oregon's young women with waning prevention or treatment services. According to the Oregon Department of Corrections, children of incarcerated women are five times more likely to be incarcerated in the future than their peers. In 2005, 5.3% of teens entering Oregon treatment were pregnant, a 51% increase since 2001. (OMHAS, 2006)

Which do you think costs more, Treatment or Foster Care?

Answer: Foster Care

Oregon now ranks 45th in the U.S. for funded Treatment access per capita. In 2002, Child Welfare spent $7,000 per month on urine drugs screens. Now, Child Welfare is spending $80,000 per month on urine drug screens because Treatment is no longer there to provide the service.



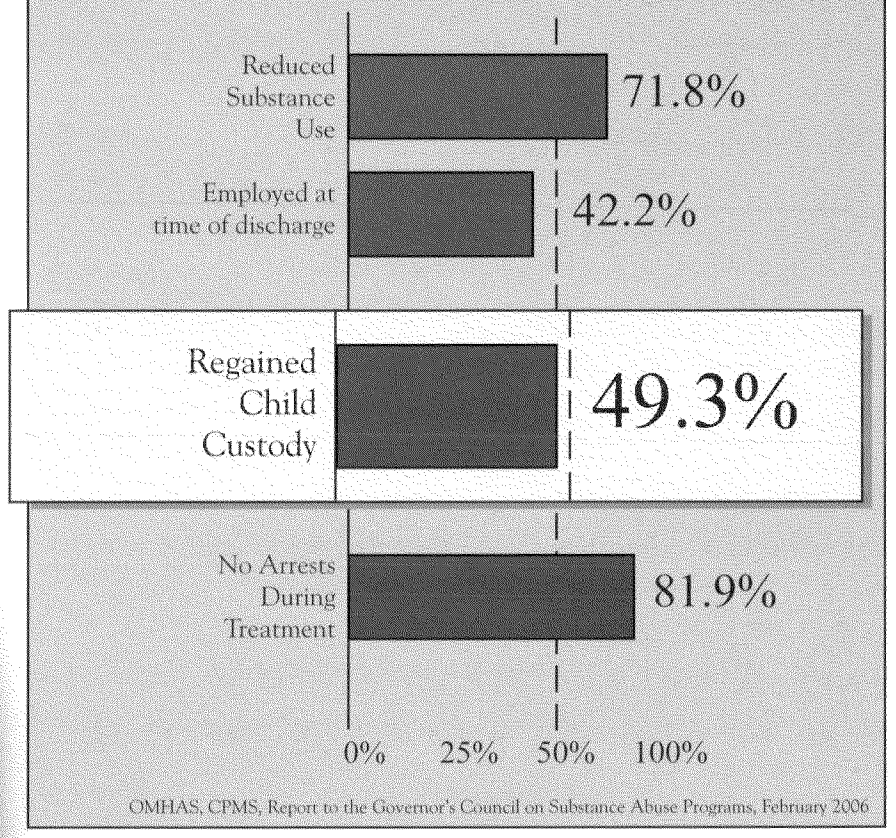
2006 Oregon Research Brief
on Addiction Treatment Effectiveness

Addiction & Child Welfare

Oregon Outcomes
for Substance Abuse Treatment at discharge

2004 2005

DHS Child Welfare estimates that about 60% of child foster care placements are due to substance abuse (DHS, 2006)



OMHAS, CPMS, Report to the Governor's Council on Substance Abuse Programs, February 2006

49.3% of moms being reunited with their children saves taxpayers the expense of foster care and further child welfare services

Reuniting women in recovery with their children saves Oregonians foster care dollars, and stops the cycle of addiction, abuse and crime. Children of incarcerated women are five times more likely to be incarcerated in the future than their peers. Helping moms into recovery not only helps reunite them with their children, it also reduces the likelihood of state involvement and taxpayer expense with future pregnancies.

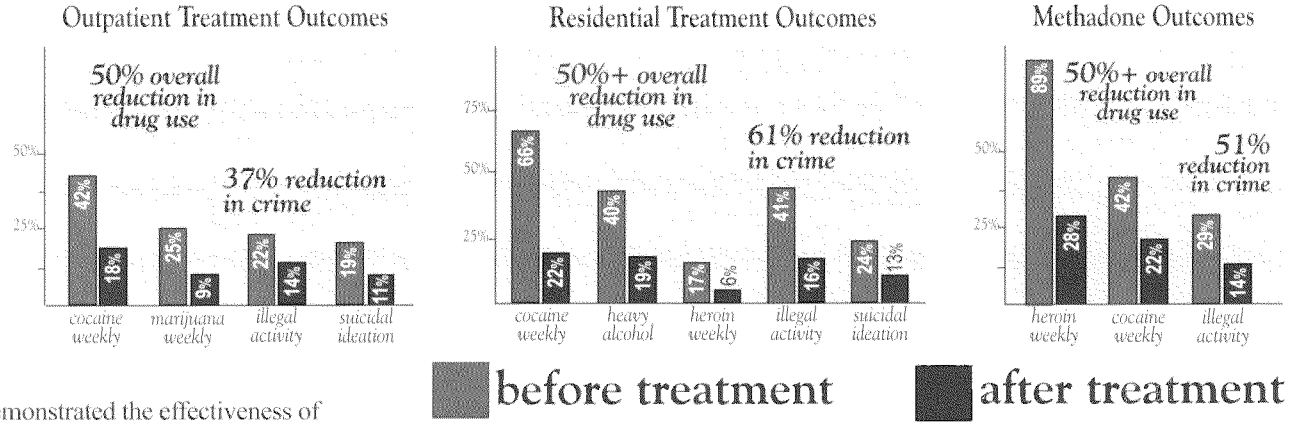
This Research Brief was made possible through the generous donations of:
AADACO The Association of Addiction Professionals, ACCBO, ADAPT, Care Oregon, Milestones DUII & Women's Program and YES House, NFATTC, Oregon Office of Mental Health and Addiction Services, OPERA, Pastor James Martin, Eric Martin.
For additional copies call (503)231-8164
CareOregon

2006 Oregon Research Brief on Addiction Treatment Effectiveness

Does Treatment Work?

DATOS 2003 Report: *Addiction Treatment clients at one-year through five-year follow-up*

DATOS (Drug Abuse Treatment Outcome Study) is the largest Addiction Treatment outcome study ever performed. This study of more than 10,000 Addiction Treatment clients demonstrated the effectiveness of treatment and found that results were generally stable at five-year follow-up.



Hubbard, R. L., (2003), Overview of 5-Year Follow-up in the Drug Abuse Treatment Outcome Study (DATOS), Addictions Treatment When Knowing the Facts Can Help, Institute for Research, Education and Training in Addictions.

Aren't there better things to spend Tax Dollars on than Addicts & Alcoholics?

Unfortunately, substance abuse costs society money through police, courts, emergency rooms, auto accidents, unwanted teen pregnancies, foster care, jails, prisons, health disorders and medical care, work place accidents, workers' compensation, lost productivity, increased sick time, public assistance, and many other expenses.

The White House Office of National Drug Policy indicates that substance abuse costs Americans more than $200 billion per year.

Treatment actually saves money. Researchers have compared the cost of substance abusers who receive treatment to those who do not receive treatment. Substance abusers who receive treatment use far less of society's resources.

A recent Cost-Benefit Compendium Study completed by the Treatment Research Institute at the University of Pennsylvania, 2005, showed that hundreds of cost-benefit studies have revealed that *for every $1 invested in treatment, anywhere from $1.33 to $39 dollars is saved, primarily by reducing crime and the cost of incarceration. In Oregon, research shows that for every $1 invested in treatment $5.60 is saved.*

The Physician Leadership on National Drug Policy Panel has evaluated more than 600 scientific studies on Addiction Treatment effectiveness. They have concluded that treatment is far more cost effective than incarceration or emergency medical care.

Physician Leadership on National Drug Policy, 2000, Position Paper on National Drug Policy, Brown University, Center for Alcohol Studies, 2-3.

Do Oregon Treatment Programs use Evidence Based Practices?

Oregon Addiction Treatment is very effective. Numerous studies have demonstrated this. Moreover, Oregon Addiction Treatment programs are required to utilize "Evidence-Based Practices (EBP's)."

EBP's are therapeutic approaches that have been proven to work in multi-site randomized studies. Using EBP's is a guarantee to taxpayers that their tax dollars are not being wasted on unproven or ineffective treatments.

A study completed by the Oregon Office of Mental Health and Addiction Services in 2006 showed that all of Oregon's Publicly-funded Treatment programs use EBP's. Moreover 56% of funding supported EBP's.

A recent Cost-Benefit Compendium Study completed by the Treatment Research Institute at the University of Pennsylvania, 2005, *showed that those programs that utilize Evidence-Based Practices demonstrate the most significant Cost-Benefit Ratios.*

Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, February 2005, Treatment Research Institute at the University of Pennsylvania, Belenko, S., Ph.D.

2006 Oregon Research Brief on Addiction Treatment Effectiveness

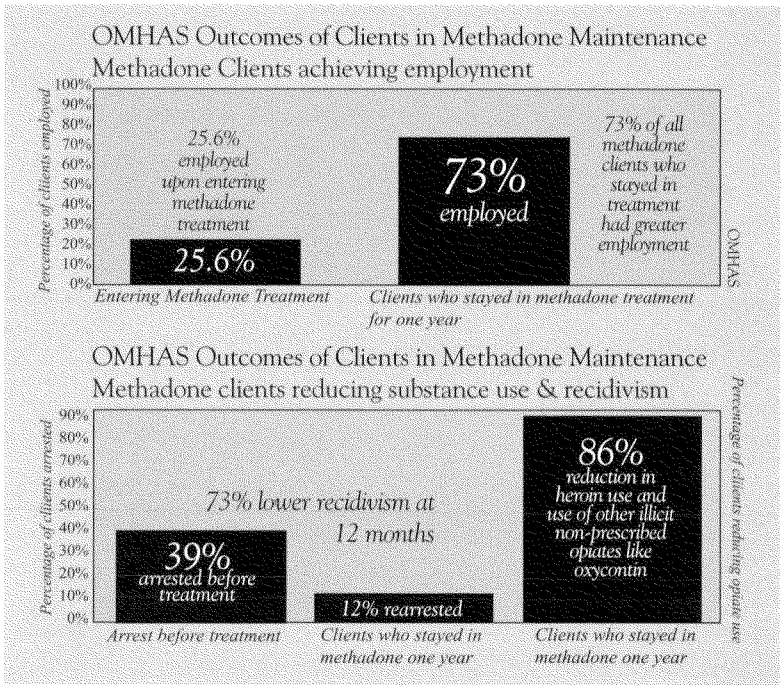
Medication Assisted Treatment

Oregon Methadone Treatment works!

A 2005 Methadone Treatment outcome study was completed by the Oregon Office of Mental Health and Addiction Services.[1] This study demonstrated that methadone treatment clients who stay in treatment have dramatic improvements. Additionally, even methadone treatment clients who don't stay in treatment, and receive only partial treatment, showed improvements.

New research from NIDA shows that for every dollar invested in methadone treatment, $38 is saved in associated costs.[2] Oregon is also a "NIDA Research Node" (national research location for the National Institute on Drug Abuse) for the use of Buprenorphine, a new scientific breakthrough in the treatment of opiate addiction. Preliminary research suggests that Buprenorphine therapy may exceed the already excellent results of methadone in: reducing the spread of infectious disease, increasing employment, reducing criminal recidivism, reducing incarceration, reducing reliance on public assistance, and reducing emergency room visits.

1. Kahn, B., Outcomes of Clients in Methadone Maintenance Who Have Received Services for One Year, OMHAS, May, 2005.
2. Zarkin, G., PhD, Health Economics, November 2005.



Treatment Completion-Compliance

Why should we fund treatment when only 51% actually complete treatment?

A study of 326,000 addiction treatment admissions nationwide showed that the average rate of addiction treatment completion was 51% (TEDS, 2003).[1] This rate of treatment completion is comparable with many other health disorders. In fact, alcoholics & drug addicts have higher rates of treatment compliance than those with hypertension, diabetes and asthma.[2] Research also tells us that the major factors for not completing addiction treatment are similar to the factors of noncompliance to treatment regimens for hypertension, diabetes, and asthma. Those factors are: socioeconomic status (low income), low family support, psychiatric co-morbidity (higher rates of mental illness) and, sadly, ethnicity. The aforementioned study shows that about 55% of whites completed treatment, while only 42% of African Americans and Hispanics completed treatment.

Treatment Compliance or "Adherence"

Addiction Treatment:	
compliance (completion)	51%
Hypertension:	
compliance to medications	less than 60%
compliance with diet/exercise	less than 30%
"retreated" within 12 months	50-60%
Diabetes:	
compliance to medication	less than 50%
compliance with diet/exercise	less than 30%
"retreated" within 12 months	30-50%
Asthma:	
compliance to medications	less than 30%
"retreated" within 12 months	60-80%

Oregon treatment completion rates are higher than the national average. Research from OMHAS for CY 2003 indicates that 59.5% of all Oregon treatment clients completed treatment. Research also indicates there is a cost-benefit to partial completion of treatment. Many partial completers also have reduced substance abuse, increased employment, have lower recidivism, decreased use of healthcare services and reduced use of public assistance.

1. TEDS: Treatment Evaluation Data Sets, Treatment Completion, 2003
2. McClellan, PhD, Treatment Research Institute, and the National Center on Health

2006 Oregon Research Brief on Addiction Treatment Effectiveness

Criminal Justice

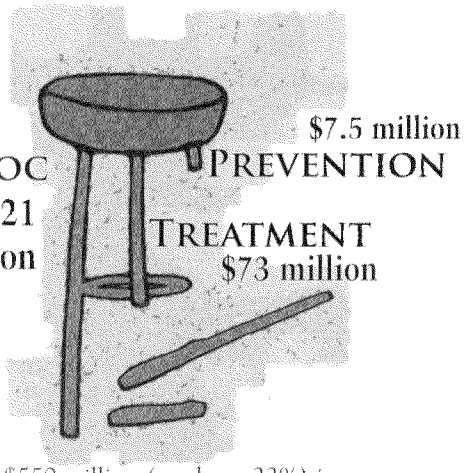
Isn't it cheaper to send people to Jail rather than to Treatment?...

A 2003 Multnomah County study of 1,167 substance abusing offenders demonstrated that it was actually less expensive to send people to drug court than "business as usual." Up front, the drug court treatment approach actually saved taxpayers $1,441.52 compared to business as usual. The study also showed at 30 month follow-up that drug court treatment participants cost taxpayers $5071.57 less than those offenders who went through the system -business as usual- due to reduced rearrests, less probation time, less jail time, and fewer victimizations.

Taxpayers saved $5,071.57 per drug court treatment participant

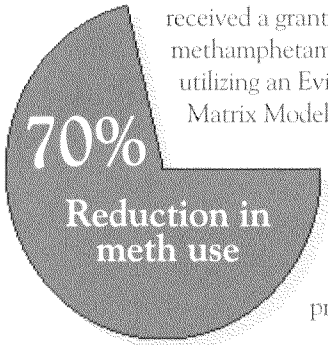
NPC Research, A Cost-Benefit Evaluation of the Mutlnomah County Drug Court, July 2003

Is Oregon's three-legged stool lopsided?



In the Annual State budget, $550 million goes to the Oregon Department of Corrections. This covers the cost of prisons and parole. It is conservatively estimated that $121 million of their $550 million (or about 22%) is spent on "nonviolent substance-abusing offenders."

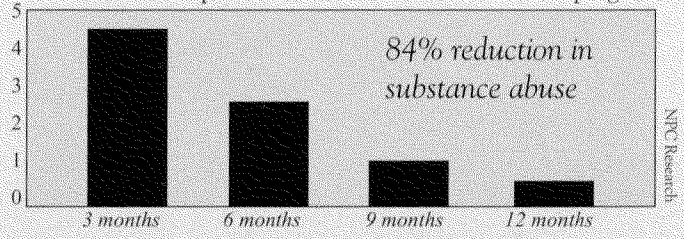
Oregon Meth-Treatment works!



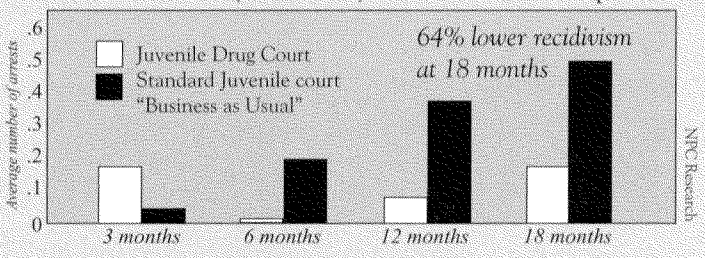
ChangePoint Inc. in Multnomah County Oregon received a grant to provide no-cost treatment to methamphetamine addicts in Multnomah County utilizing an Evidence-Based Practice known as The Matrix Model. In 2005, at 6-month follow-up, 70% of those who engaged in treatment were clean from methamphetamine. This includes those who completed the program and those who did not complete the program.

Treatment works in the Oregon Criminal Justice System

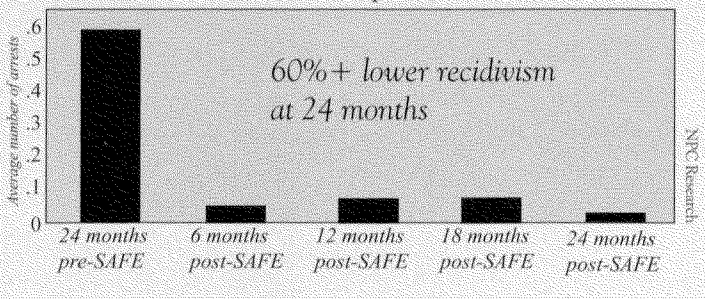
2004 Clackamas County Juvenile Drug Court Evaluation
Mean number of positive UA's over 12 months in the program



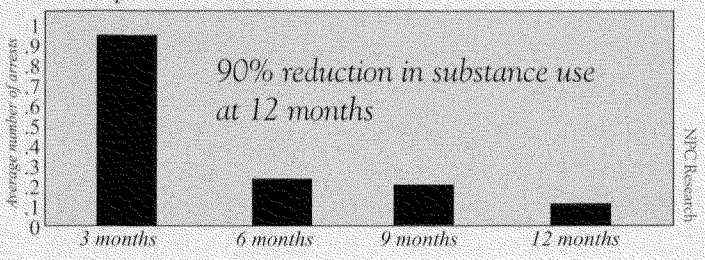
2004 Clackamas County Juvenile Drug Court Evaluation
Mean recidivism (re-referrals) over 18 months compared to BAU



2004 Malheur County Women's SAFE Court Recidivism:
before SAFE Court, 24 months pre SAFE Court, and 24 months post



2004 Marion County Drug Court:
Mean positive UA's over 12 months



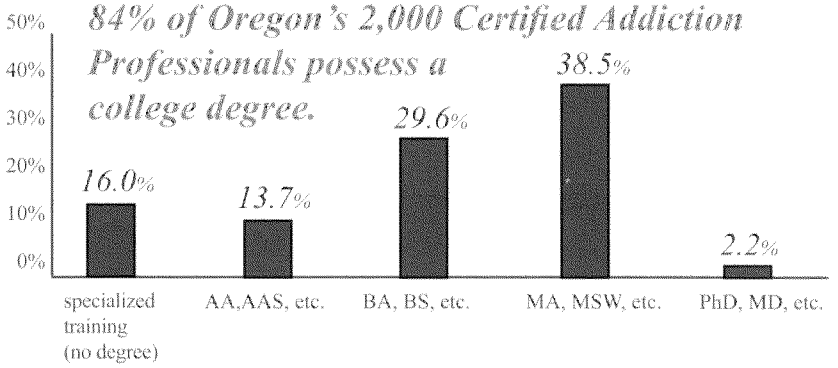
2006 Oregon Research Brief on Addiction Treatment Effectiveness

Oregon Credentialing

Oregon Addiction Counselors are trained and tested in Evidence-Based Practices for Fiscal Accountability to the Taxpayers, Client Outcomes, Public Safety, and Ethical Compliance. All of Oregon's State Approved Addiction Treatment agencies are required to employ certified and/or licensed professionals. Oregon CADC's undergo legally-professionally-scientifically defensible autonomous examinations produced by the National Association of Alcoholism & Drug Abuse Counselors, the National Board of Certified Counselors, and the Professional Testing Corporation of New York. These examinations are routinely tested for validity and reliability (Kuder-Richardson formula 21), to insure that certified counselors are knowledgeable and capable of practicing at the appropriate academic proficiency level.

Who comprises Oregon CADC's?

Composition Analysis 2004:



CADC I

Associate Proficiency Level

EDUCATIONAL REQUIREMENTS
A minimum of 150 core alcohol-drugs-addiction-counseling education hours, including the following topical areas (or 15 college credits):
- Basic Counseling Skills
- Group Counseling Skills
- Alcohol & Drugs of Abuse Pharmacology
- Infectious Disease: Risk Assessment & Risk Reduction
- Counseling Ethics

SUPERVISED CLINICAL EXPERIENCE
1,000 Hours of Supervised Clinical Experience in the Addiction Counselor Competencies *(TAP 21, CSAT)*.
All experience hours occur under a supervisor that meets the Oregon Administrative Rule (sec. 415) for Clinical Supervision in State Approved Addictions Treatment.

EXAMINATION
The Addiction Counselor Certification Board of Oregon utilizes the professional NCAC Level One National Certification Examination produced by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC)

ON-GOING ETHICAL COMPLIANCE & CONTINUING EDUCATION
All CADC's pledge adherence to the ACCBO Code of Ethics and are subject to investigation and sanctions resulting from Ethics complaints.
All CADC's must obtain continuing education in order to renew their certification biannually.

This Research Brief was made possible through the generous donations of:
AADACO The Association of Addiction Professionals, ACCBO, ADAPT, Care Oregon, Milestones DUII & Women's Program and YES House, NFATTC, Oregon Office of Mental Health and Addiction Services, OPERA, Pastor James Martin, Eric Martin.
For additional copies call (503)231-8164
CareOregon

CADC II

Baccalaureate Proficiency Level

EDUCATIONAL REQUIREMENTS
A Bachelors Degree or equivalency (a minimum of an Associates degree and a combination of academic courses with specialized training commensurate with baccalaureate degree credit/hour requirements).

A minimum of 300 core alcohol-drugs-addiction-counseling education hours, including the following topical areas (or 30 college credits):
- Basic Counseling Skills
- Group Counseling Skills
- Alcohol & Drugs of Abuse Pharmacology
- Infectious Disease: Risk Assessment & Risk Reduction
- Counseling Ethics
- Counseling Diverse Populations
- ASAM, Assessment, or Case Management, etc.
- Dual Diagnosis or Coexisting Disorders

SUPERVISED CLINICAL EXPERIENCE
4,000 Hours of Supervised Clinical Experience in the Addiction Counselor Competencies *(TAP 21, CSAT)*.
All experience hours occur under a supervisor that meets the Oregon Administrative Rule (sec. 415) for Clinical Supervision in State Approved Addictions Treatment.

EXAMINATIONS
The Addiction Counselor Certification Board of Oregon utilizes the professional NCAC Level Two National Certification Examination produced by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). Candidates must also successfully pass the NAADAC Oral Case Presentation Examination.

ON-GOING ETHICAL COMPLIANCE & CONTINUING EDUCATION
All CADC's pledge adherence to the ACCBO Code of Ethics and are subject to investigation and sanctions resulting from Ethics complaints.
All CADC's must obtain continuing education in order to renew their certification biannually.

CADC III

Graduate Proficiency Level

EDUCATIONAL REQUIREMENTS
A Masters degree (M.A., MSW, M.S., etc.) in the human arts.

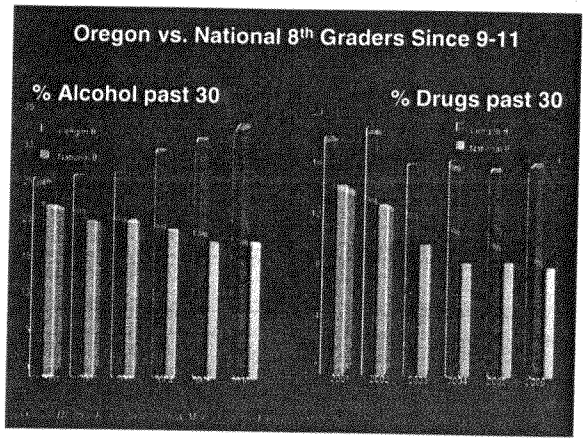
A minimum of 300 core alcohol-drugs-addiction-counseling education hours, including the following topical areas (or 30 college credits):
- Basic Counseling Skills
- Group Counseling Skills
- Alcohol & Drugs of Abuse Pharmacology
- Infectious Disease: Risk Assessment & Risk Reduction
- Counseling Ethics
- Counseling Diverse Populations
- ASAM, Assessment, or Case Management, etc.
- Dual Diagnosis or Coexisting Disorders
- Addiction Treatment Best Practices, or Evidence-based Addiction Treatment Approaches, etc.

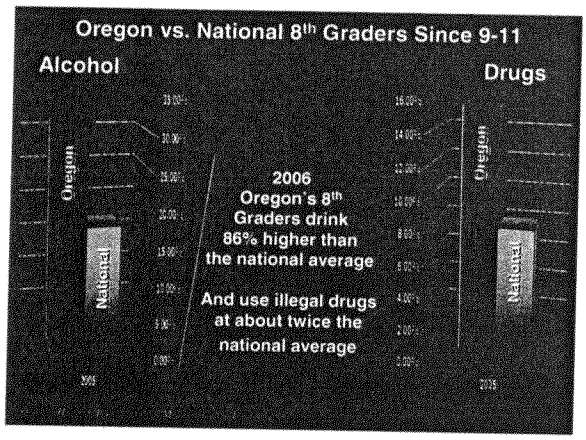
SUPERVISED CLINICAL EXPERIENCE
6,000 Hours of Supervised Clinical Experience in the Addiction Counselor Competencies *(TAP 21, CSAT)*.
All experience hours occur under a supervisor that meets the Oregon Administrative Rule (sec. 415) for Clinical Supervision in State Approved Addictions Treatment.

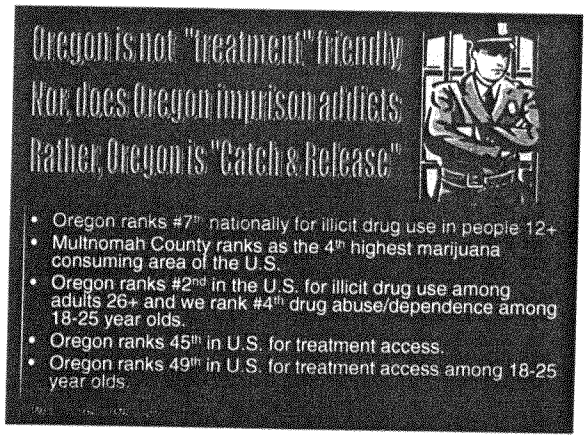
EXAMINATIONS
The Addiction Counselor Certification Board of Oregon utilizes the professional MAC National Certification Examination coproduced by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the National Board of Certified Counselors (NBCC). Candidates must also successfully pass the NAADAC Oral Case Presentation Examination.

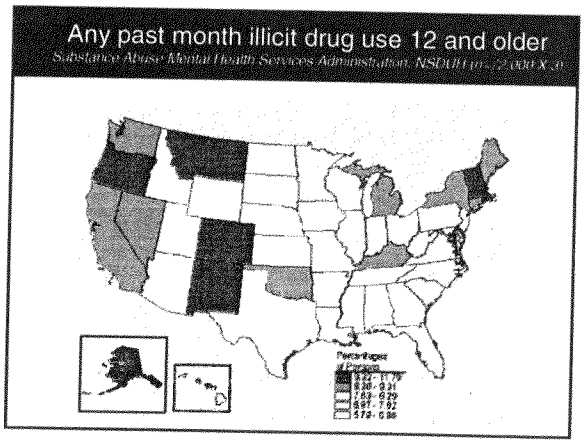
ON-GOING ETHICAL COMPLIANCE & CONTINUING EDUCATION
All CADC's pledge adherence to the ACCBO Code of Ethics and are subject to investigation and sanctions resulting from Ethics complaints.
All CADC's must obtain continuing education in order to renew their certification biannually.

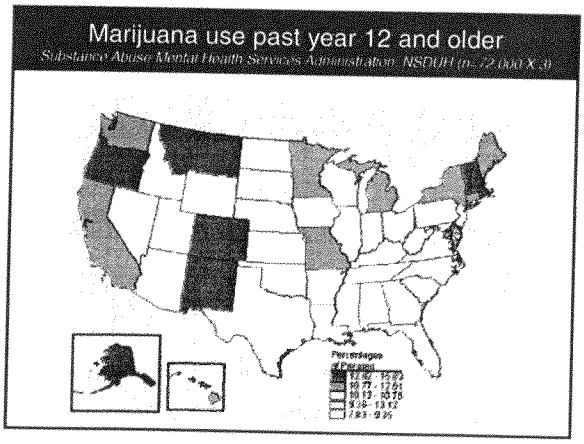

Nationwide youth alcohol and drug use has gone down, except in a handful of states like Oregon
abc NEWS EXCLUSIVE
abc 7


Oregon vs. National 8th Graders Since 9-11
% Alcohol past 30
% Drugs past 30


Oregon vs. National 8th Graders Since 9-11
Alcohol
Drugs
Oregon
National
2006
Oregon's 8th Graders drink 86% higher than the national average
And use illegal drugs at about twice the national average

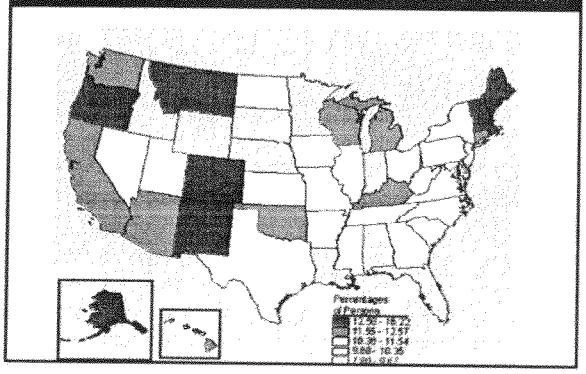

Oregon is not "treatment" friendly, Nor does Oregon imprison addicts
Rather, Oregon is "Catch & Release"
• Oregon ranks #7th nationally for illicit drug use in people 12+
• Multnomah County ranks as the 4th highest marijuana consuming area of the U.S.
• Oregon ranks #2nd in the U.S. for illicit drug use among adults 26+ and we rank #4th drug abuse/dependence among 18-25 year olds.
• Oregon ranks 45th in U.S. for treatment access.
• Oregon ranks 49th in U.S. for treatment access among 18-25 year olds.


Any past month illicit drug use 12 and older
Substance Abuse Mental Health Services Administration, NSDUH (n=~2,000 X 3)


Marijuana use past year 12 and older
Substance Abuse Mental Health Services Administration, NSDUH (n=~2,000 X 3)

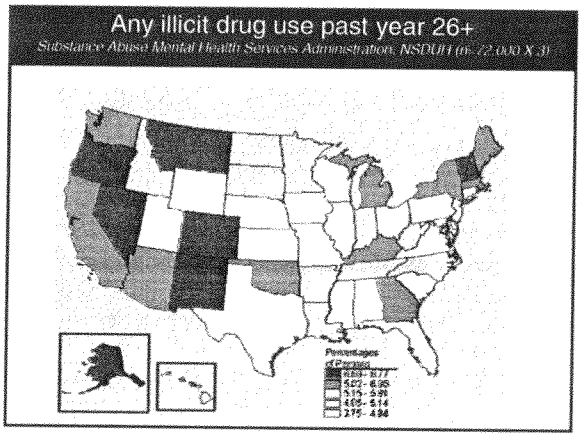
Any illicit drug use past year 12-17

Substance Abuse Mental Health Services Administration, NSDUH (n=72,000 X 3)



Any illicit drug use past year 26+

Substance Abuse Mental Health Services Administration, NSDUH (n=72,000 X 3)



U.S. top weed smokin' Areas (9-12.5% of population reports using marijuana in the past 30 days)

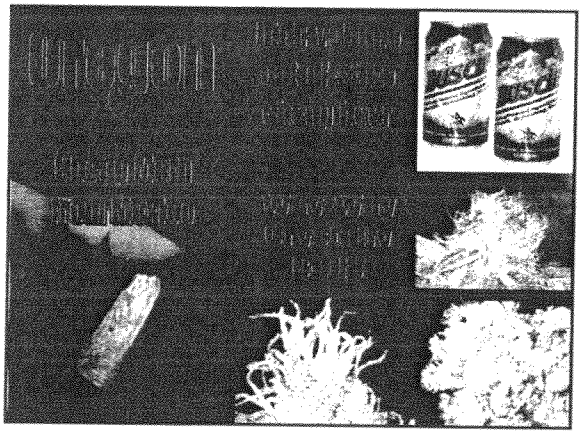
- #1 Boston, Massachusetts
- #2 Boulder, Colorado
- #3 Southeast Massachusetts
- #4 Multnomah County Oregon
- #5 Northern California

4 Multnomah

Top weed smokin' States (6.5-9.5% of population reports using marijuana in the past 30 days)

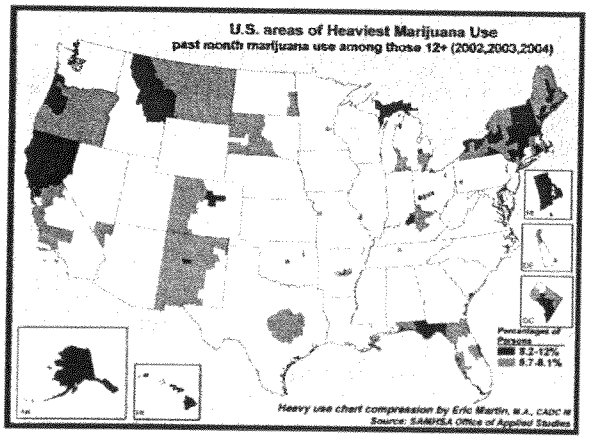
- #1 Massachusetts
- #2 Colorado
- #3 Vermont
- #4 Hawaii
- #5 Alaska
- #6 Rhode Island
- #7 Oregon
- #8 Maine
- #9 Delaware
- #10 New Hampshire

7 Oregon



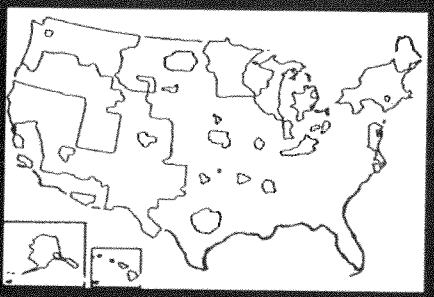
U.S. areas of Heaviest Marijuana Use

past month marijuana use among those 12+ (2002,2003,2004)



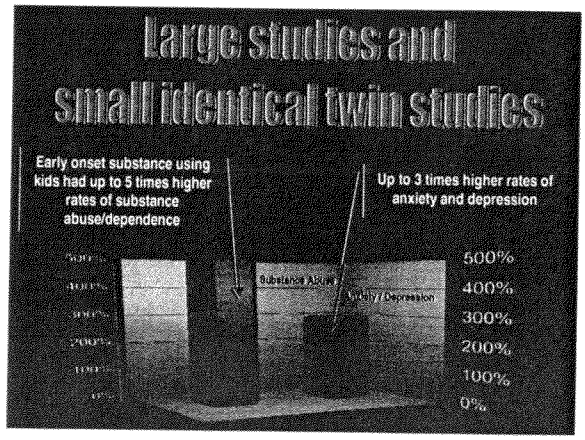
Areas of U.S. Early Onset Substance Abuse

SAMHSA Office of Applied Studies
1999-2004 data (n=72,000 x 5)



Why is this "early onset substance abuse" such a big deal?

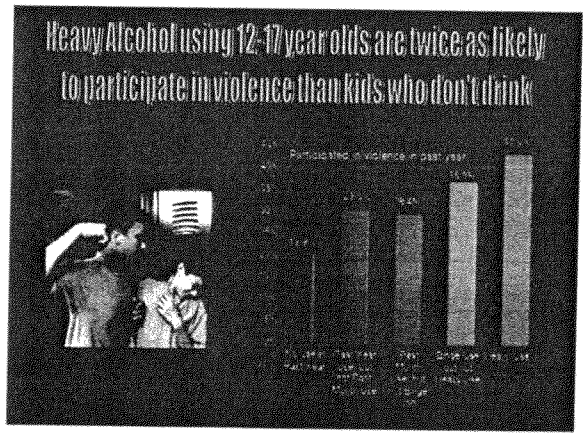
Large studies and small identical twin studies



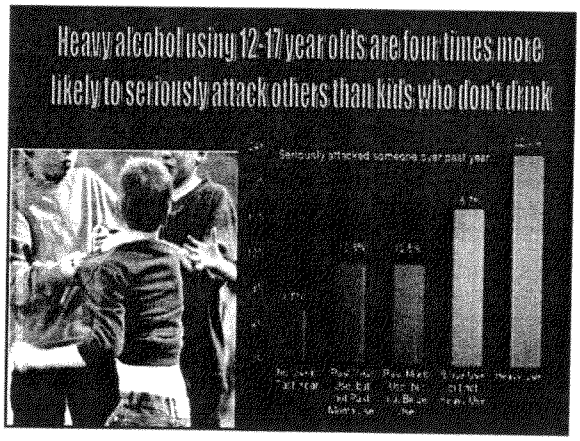
95% of U.S. Adult Alcoholics & Alcohol Abusers...

....started drinking before the age of 21

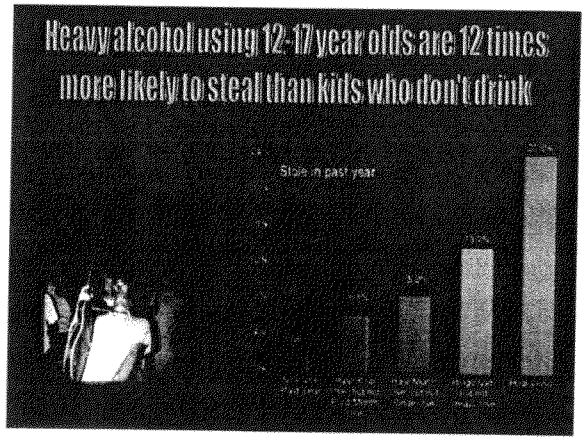
Heavy Alcohol using 12-17 year olds are twice as likely to participate in violence than kids who don't drink



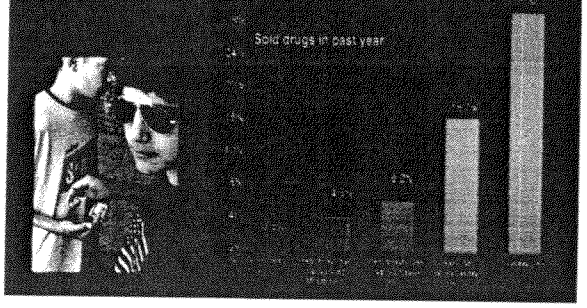
Heavy alcohol using 12-17 year olds are four times more likely to seriously attack others than kids who don't drink



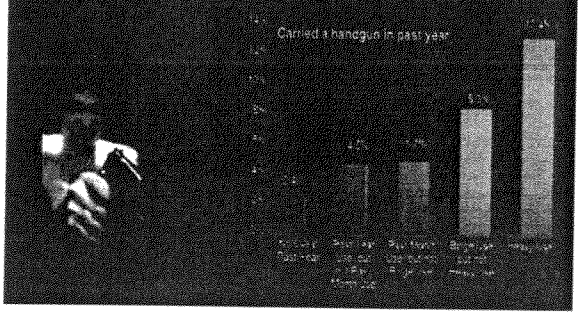
Heavy alcohol using 12-17 year olds are 12 times more likely to steal than kids who don't drink



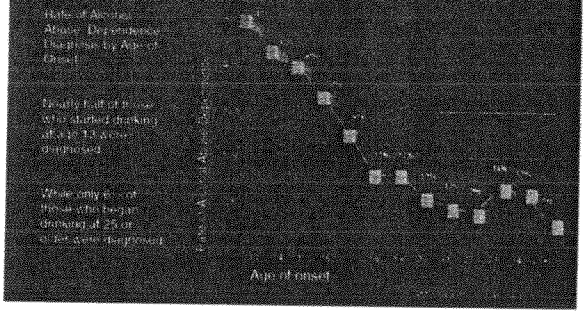
Heavy alcohol using 12-17 year olds are 34 times more likely to sell drugs than kids who don't drink



Heavy alcohol using 12-17 year olds are 5 times more likely to carry a handgun than kids who don't drink



Risk of Alcohol Abuse/Dependence (DSM-IV) drops each year drinking is postponed



Now is the time to invest in Treatment and Prevention.

Treatment saves money right away!

- In 2003 when Treatment suffered drastic cuts taking Oregon down to 45th in the U.S., inversely Foster care placements rose dramatically.
- In 2004-2005, of those mom's who were able to get treatment, about 50% were reunited clean & sober with their children.
- In 2005-2006, 65% were reunited with their children.

Multnomah County Drug Court

- In 2003, MCDC saved money right away … not ten years down the road.
- Taxpayers saved $5,071.57 when 1,167 substance abusing offenders were tracked over a 30 month period, comparing drug court to "business as usual"

Oregon Treatment Rocks!

- Even though Oregon doesn't have as much treatment as other states, what little we have is "**stunning**":
  - Changepoint, 70% meth-free at 6 month follow-up
  - TEDS, nationwide approx. 50% complete.
  - Oregon, approx. 60% complete

California Drug Courts Cost Analysis Study Phase II

NPC RESEARCH

ADMINISTRATIVE OFFICE OF THE COURTS

The California Drug Court Cost Evaluation Team

Shannon M Carey, Ph.D. – NPC Research
Michael W Finigan, Ph.D. – NPC Research
David Crumpton, M.P.P. – NPC Research
Mark Waller, B.S. – NPC Research
Francine Byrne, M.S. – AOC California

This Study Was Designed to Answer Two Key Policy Questions:

- Are drug courts cost-effective (cost-beneficial)?
- What drug court practices appear most promising and cost-beneficial?

Project Phases

Phase I: Building the Cost Analysis Methodology

Phase II: Validating & Revising the Methodology

Phase III: Developing a Cost Analysis Tool for Drug Courts to Use Statewide

Phase II: Validating and Revising the Methodology

Six additional court sites

- Monterey
- Los Angeles (El Monte)
- Orange County (Santa Ana and Laguna Niguel)
- San Joaquin
- Stanislaus

Phase II: Validating and Revising the Methodology

(continued)

Additional Data Elements

- Social services utilization
  - Aid Received
  - Child welfare

Research Strategies

- **Costs and Benefits (opportunity resources)**
- **Cost to taxpayer approach (Public Funds)**
- **Transactional Cost Analysis**

Methods

- Site selection
- Sample/Cohort Selection
- TICA methods

TICA*

Transactional and Institutional Cost Analysis

- Organizational/Institutional Analysis
- Transaction Cost Analysis
- Enhanced Cost-Benefit

*Dave Crumpton

TICA Methods

Step 1: Determine the flow/process
Step 2: Identify the transactions
Step 3: Identify the agencies involved
Step 4: Determine the resources used
Step 5: Identify costs associated
Step 6: Calculate cost results

TICA Methods

Step 1: Determine the flow/process

DC program and "business-as-usual"

- Interviews
- Observation
- Document review

TICA Methods

Step 2: Identify the transactions

Examine the process description from Step 1

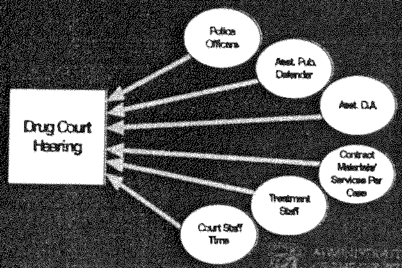
Examples of transactions:

- Drug court hearings
- Treatment sessions
- Drug Tests
- Re-arrests
- Jail Time

TICA Methods

Step 3: Identify the agencies involved

Interviews and Observations



TICA Methods

Step 4: Determine the resources used

Interviews, Observations, Admin Data, Files

Do this for each transaction – example court hearings

- Time spent in court
- Time spent preparing
- How many court hearings for each participant

TICA Methods

Step 5: Identify costs associated

Interviews and Budget Reviews

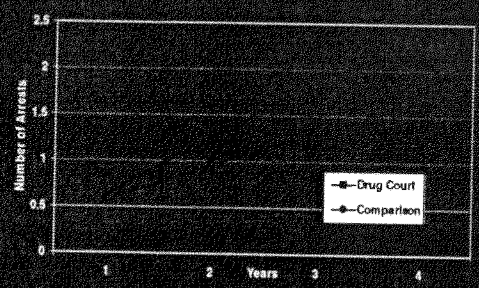
- Direct Costs
- Support Costs (% of direct costs)
- Institutional Overhead Costs (% direct costs)

TICA Methods

Step 6: Calculate cost results

- Investment Cost
- Outcome Costs
- Difference (Savings – or not)

Results

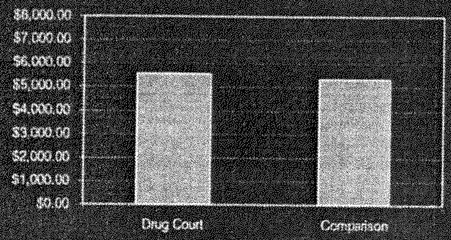


Results

Phase II Sites	South Metro 2	Central Coast	South Coast 2	South Coast 1	Central Valley	South Central Valley
Investment DC	$5,540.57	$8,121.03	$16,560.34	$16,287.55	$12,214.59	$5,457.75
Comparison	$5,345.75	$5,356.47	$13,056.55	$15,051.55	$12,787.41	$4,333.54
Net Investment	$194.82	$2,764.56	$3,603.79	$1,236.00	(- $572.82)	$1,124.21
Outcome Costs DC	$16,963.70	$30,724.91	$8,915.50	$18,285.44	$35,553.97	$26,573.00
Comparison (4 Years)	$23,921.96	$21,443.36	$18,586.81	$21,649.98	$50,707.06	$41,500.04
Net Cost in	$6,958.26	(- $9,281.55)	$9,671.31	$3,364.54	$15,153.09	$15,927.04

Results

Investment costs per participant



Results

Cost-Benefit Ratio

	Phase II					
	South Metro 2	Central Coast	South Coast 2	South Coast 1	Central Valley	South Central Valley
Net Investment	$194	$2,764	$3,603	$1,236	(-$572)	$1,124
Net Outcome (Savings)	$6,958	(-$9,281)	$9,671	$3,384	$15,153	$15,927
Cost-Benefit Ratio	1 : 35.7	NA	1 : 2.7	1 : 2.7	Saving only	1 : 14.2

Results

Investment by agency (Part 1)

Agency		Phase II Sites					
		South Metro 2	Central Coast	South Coast 2	South Coast 1	Central Valley	South Central Valley
Superior Court	Net Investment	-$996	-$413	-$47	-$323	-$351	-$601
	Outcome Savings	$34	$615	$227	$146	$324	$161
District Attorney	Net Investment	-$93	-$418	-$252	$357	-$411	-$523
	Outcome Savings	$8	$293	$58	$37	$14	$106
Public Defender	Net Investment	-$336	-$410	-$76	-$203	-$448	-$329
	Outcome Savings	$14	$351	$103	$468	$162	$81
Probation	Net Investment	-$634	$152	$1,256	$1,909	-$217	$931
	Outcome Savings	$19	$229	$712	$559	$103	$212

Investment by agency (Cont.)

Agency		Phase II Sites					
Treatment Agencies	Net Investment	$1,939	$3,174	$1,692	$607	$812	$2,332
	Outcome Savings	-$142	-$348	-$336	$249	$31	$59
Law Enforcement	Net Investment	$226	$672	$1,031	-$1,112	$42	-$686
	Outcome Savings	$2,003	-$1,964	$952	$631	$1,672	$3,622
Corrections	Net Investment	$0	$0	$0	$0	$0	$0
	Outcome Savings	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NET SAVINGS Per Participant	Total DC costs minus comp. costs	$6,696	-$12,052	$6,064	$1,884	$15,763	$13,602

Results

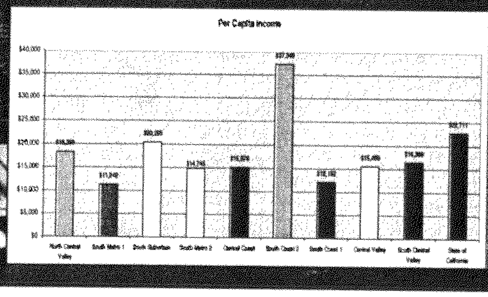
Four Perspectives

- Program Context
- Program Organization
- Program Policies
- Program Participant Characteristics

Results

Cost and Drug Court Context

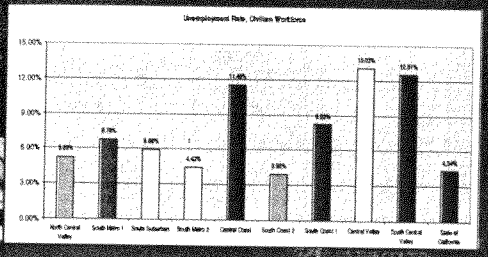
Average Income of DC Service Area



Results

Cost and Drug Court Context

Unemployment Rate in DC Service Areas



Results

Cost and Drug Court Organization

Team FTE and Attendance at Meetings

DA Attendance	If needed	No	Yes	Yes
PD Attendance	If needed	Yes	Yes	Yes
Law Enforcement Attendance	No	Yes	No	No
Probation Attendance	Yes	Yes	Yes	Yes

Results

Cost and Drug Court Policies

- Frequency of drug tests, treatment sessions, court hearings
- Judge assignment and rotation

Results

Cost and Drug Court Participant Characteristics

- Drug of Choice

Overall Savings

Combined savings per year for nine sites*

- **$9,647,703**

***Including loss in Central Coast**

Conclusions

(Phase II)

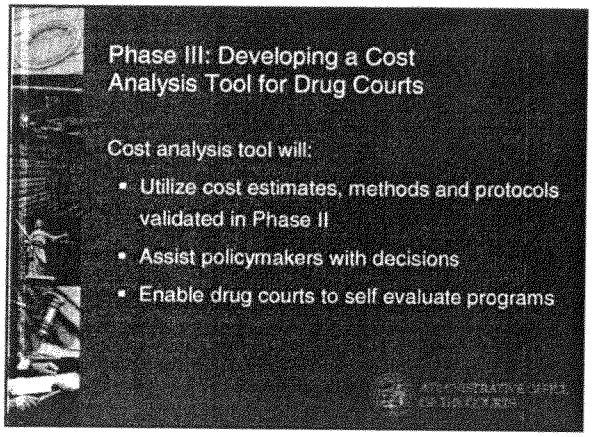
NPC RESEARCH

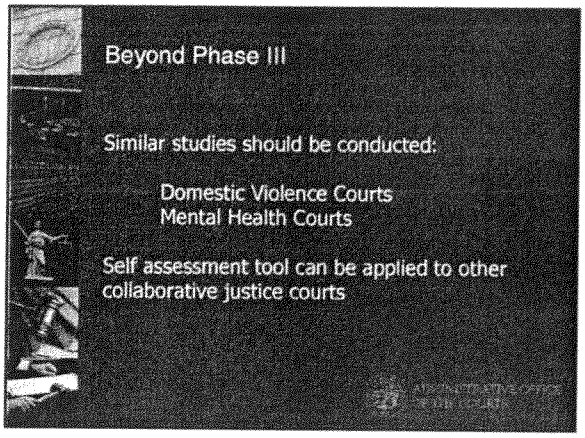
TICA Approach

Important to understand organizations and how they contribute resources

Important to look at program results from at least 4 perspectives in order to understand results

1. Context
2. Organization
3. Program Policies
4. Participant Characteristics


Phase III: Developing a Cost Analysis Tool for Drug Courts
Cost analysis tool will:
• Utilize cost estimates, methods and protocols validated in Phase II
• Assist policymakers with decisions
• Enable drug courts to self evaluate programs


Beyond Phase III
Similar studies should be conducted:
Domestic Violence Courts
Mental Health Courts
Self assessment tool can be applied to other collaborative justice courts

Effective Prevention of Youth Problems

Carol W. Metzler, Ph.D.
Oregon Research Institute
Center on Early Adolescence
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Center on Early Adolescence

Overview

- The Problems
- The Cost
- The Development of Problem Behaviors
- A Wealth of Evidence-Based Preventive Interventions
- Cost-Benefit of Prevention

Center on Early Adolescence

Youth Substance Use in Multnomah County, 2005

- Tobacco, 30 days (decreased since 2001):
  - 8th graders: 9%
  - 11th graders: 16% (f > m)
- Alcohol, 30 days (increased since 2001):
  - 8th graders: 24% (f > m)
  - 11th graders: 49%
- Binge drinking, 30 days (increased since 2001):
  - 8th graders: 10% (f > m)
  - 11th graders: 31%

Center on Early Adolescence

Youth Substance Use in Multnomah County, 2005

- Marijuana, 30 days (8th decreased, 11th increased):
  - 8th graders: 10% (m > f)
  - 11th graders: 27% (m > f)
- Methamphetamine, lifetime (up & down since 2001):
  - 8th graders: 1.5%
  - 11th graders: 4% (f > m)
- Other drugs, 30 days (8th decreased, 11th increased):
  - 8th graders: 2%

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Youth Substance Use Tends to Co-Occur With Other Problems

- Antisocial and delinquent behavior
- Risky sexual behavior
- Depression
- Suicidality

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Students in 7th-12th Grade Reporting One or More Health Risk Behaviors

Behavior	% Reporting the Behavior	% Reporting at Least One Other Problem Behavior
Regular tobacco use	11	85
Regular alcohol use	11	92
Regular binge drinking	7	97
Marijuana use	14	88
Other illicit drugs	5	95
Fighting	33	56
Weapon carrying	6	89
Suicide attempt	13	100
Unprotected sex	12	76

Center on Early Adolescence

Risk Factors

- Many problems of children and youth arise from similar social circumstances
  - Ineffective parenting, especially if child has difficult temperament
  - Chaotic home environment
  - Conflictual relationship between parent and child; weak parent-child bond
  - Poor quality early educational environment

Risk Factors (cont.)

- Family circumstances that make poor parenting more likely
  - Poverty
  - Single parenthood or multiple marital transitions
  - Higher levels of stress and chaos
  - Parental depression
  - Parental substance use
  - Marital conflict
  - Social isolation, little social support

- Children with these problems by age 6…
  - Behavior problems (aggression, defiance, non-compliance
  - Difficulty managing strong emotions
  - Poor academic skills (e.g. poor concentration, difficulty following directions
- … tend to experience these problems throughout elementary school:
  - Academic difficulties
  - Poor bonding to school
  - Peer rejection

Center on Early Adolescence

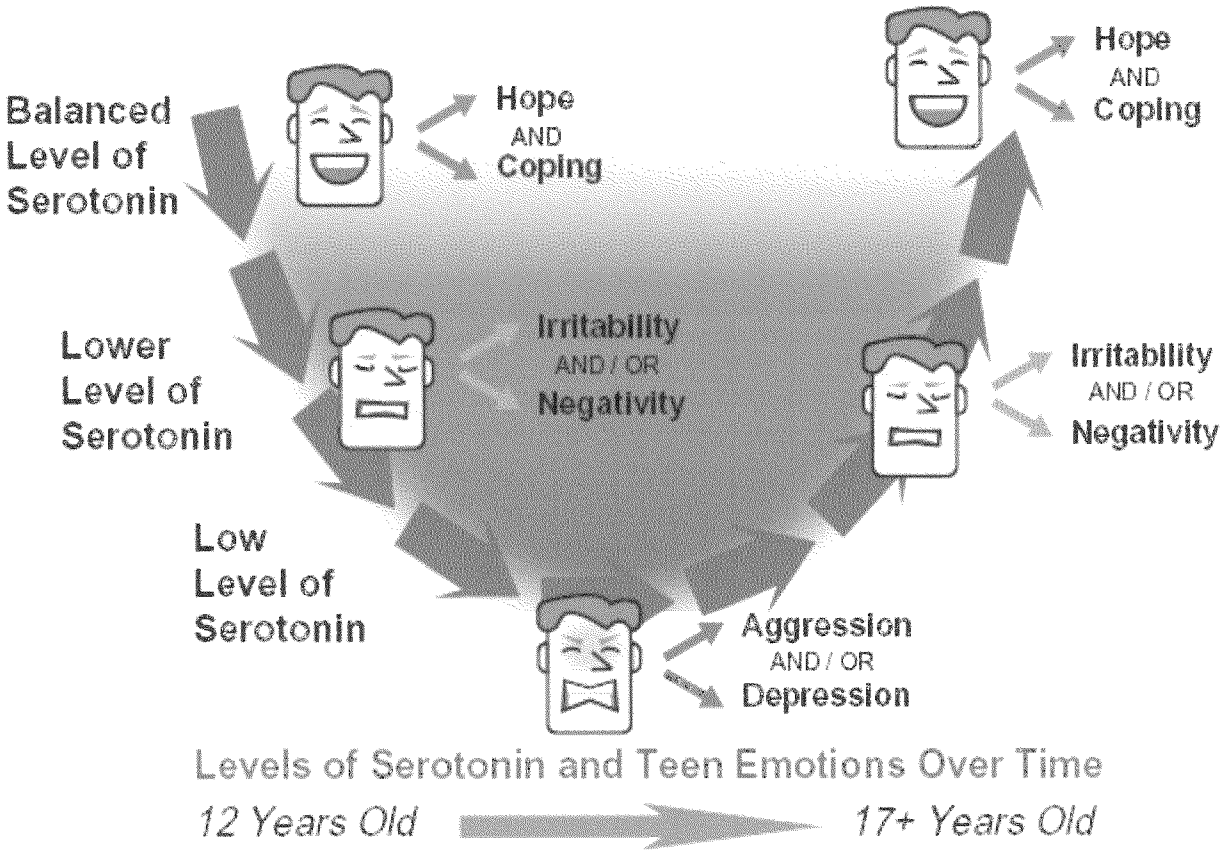
- By early adolescence, failure with peers and in school can lead to:
  - Drift toward other troubled peers, creating a deviant peer group
  - Experimentation with a variety of problem behaviors (substance use, delinquency, risky sex)
- The earlier these problems begin, the more chronic and serious they become throughout adolescence

New Reasons for Creating Nurturing Environments for Early Adolescents

- Effects of the transition to middle school
  - Reduction in academic performance
  - Lowered self-esteem
  - Increased rate of depression
  - Formation of deviant peer groups
  - Initiation of substance use and delinquency
- The growing, changing teen brain

Center on Early Adolescence

Adolescent Changing Personalities



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The Cycle

- Early behavior problems
- Substance use and other problem behaviors as a youth and young adult
- Parenthood
- Neglectful/abusive/ineffective parenting
- Foster care placement
- Children at great risk for early behavior problems
- Substance use and other problem behaviors as youth and young adult
- If unbroken, the cycle continues, collecting more and more victims as it spirals across generations

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Human Costs of Youth Problem Behavior

- Lost productivity
- Poor health
- Victimization of self and others
- Premature parenthood
- Lost potential

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The Annual Costs of Problem Behaviors

Behavior	Cost
Antisocial behavior	$166 billion
Binge drinking	$42 billion
Cocaine/heroin use	$22 billion
High-risk sex	$48 billion
Smoking	$419 million
High school dropout	$141 billion
Suicide acts	$16 billion
Total	**$435.4 billion**

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Costs to Oregon

- About $5 billion per year
- About $4.1 billion (80%) is attributable to multiproblem youth

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Protective Factors

- Positive, warm family relationships
- Effective parenting, with clear rules of conduct, consistent non-harsh discipline, monitoring, involvement in child's life
- Successful academic performance
- Positive bonds with prosocial institutions, such as family, school, religious organizations
- Positive relationships with positive adult role models

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Implications for Intervention

- Start early
- Universal interventions may be most effective during times of natural transitions and vulnerability: birth, toddlerhood, preschool, school entry, middle school
- More intensive interventions should be targeted at at-risk and high-risk children, youth, and families throughout the age span
- Interventions should work to mitigate known risk factors and strengthen protective factors

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The Value of Evidence-Based Prevention

- Improving child and youth health and wellbeing
- Reducing current problems
- Preventing future problems
- Strengthening families
- Saving future costs

Center on Early Adolescence

Nurse-Family Partnership

(Olds et al., 1998)

- Home-visiting program for poor single mothers throughout pregnancy and first two years of life.
- Effects 15 years later
  - Reduced substance use
  - Reduced delinquency
  - Reduced risky sexual behavior
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $2.88 per dollar invested
  - Total savings of $17,180 per family

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Strengthening Families 10-14 program

- Group-based parenting program for parents of early adolescents. (Spoth et al., 2001)
- Effects up to 6 years later
  - Reduced tobacco, alcohol, & drug use
  - Reduced delinquency
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $7.82 per dollar invested
  - Total savings of $5,805 per youth

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Adolescent Transitions Program

(Dishion et al., 2002)

- Provides parenting support to families of adolescents via a family resource center in middle schools
- Effects
  - Reduced substance use
  - Fewer arrests
  - Better school attendance & academic performance
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $5.02 per dollar invested
  - Total savings of $1,938 per youth

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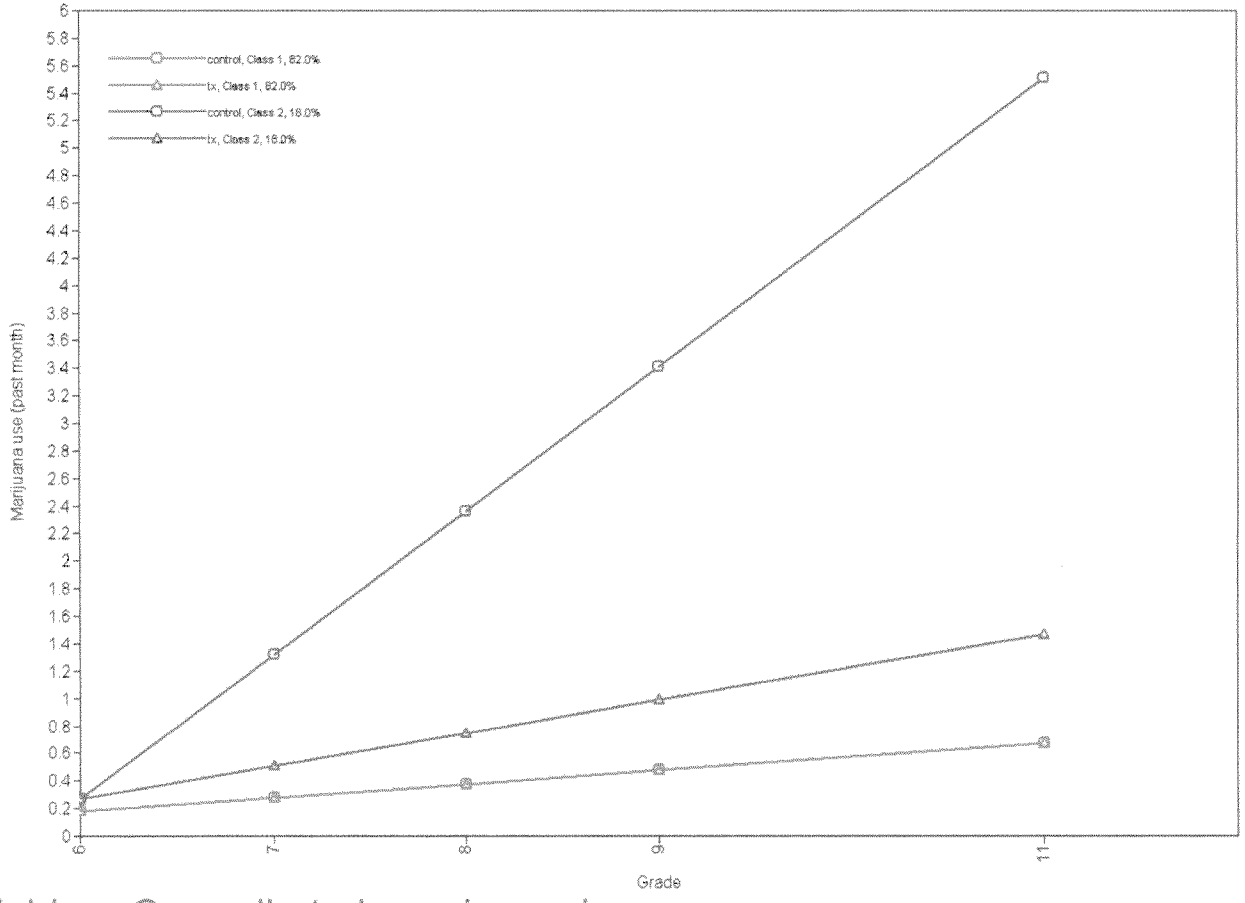
ATP: Changes in Adolescent Report of Marijuana Use, Age 16-17



Dishion, Connell et al., under review

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Multidimensional Treatment Foster Care

- Intensive, highly structured foster-family-based alternative to incarceration for adjudicated youth (Chamberlain & Reid, 1998)
- Effects
  - Fewer arrests
  - Reduced delinquency
  - Reduced crime
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $10.88 per dollar invested
  - Total savings of $24,290 per youth

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Multisystemic Therapy

(Henggeler et al., 1996)

- Intensive intervention for highly troubled youth that targets multiple domains (family, peers, school)
- Effects up to 8 years later
  - Reduced substance use
  - Reduced delinquency
  - Reduced arrest and institutionalization rate
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $2.64 per dollar invested
  - Total savings of $9,316 per youth

Functional Family Therapy

(Gordon, 1995)

- Intensive family therapy program for substance abusing youth
- Effects
  - Reduced substance use
  - Reduced delinquency
  - Fewer arrests
- Cost-effectiveness (Aos et al., 2004)
  - Savings of $7.69 per dollar invested
  - Total savings of $14,315 per youth

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Evidence-Based School Substance Abuse Curricula

- Life Skills Training
  - Effects: reduced rates of substance use
  - Cost-effectiveness (Aos et al., 2004)
    - Savings of $25.61 per dollar invested
    - Total savings of $717 per youth
- Towards No Tobacco
  - Effects: reduced rates of substance use
  - Cost-effectiveness (Aos et al., 2004)
    - Savings of $55.84 per dollar invested
    - Total savings of $274 per youth

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Community Interventions

- Tobacco Interventions
  - Project SixTeen
- Alcohol Interventions
  - Project Northland
  - Communities Mobilizing for Change on Alcohol
  - The Saving Lives Project
  - The Community Trials Project
- Any Substance Use
  - Midwest Prevention Project

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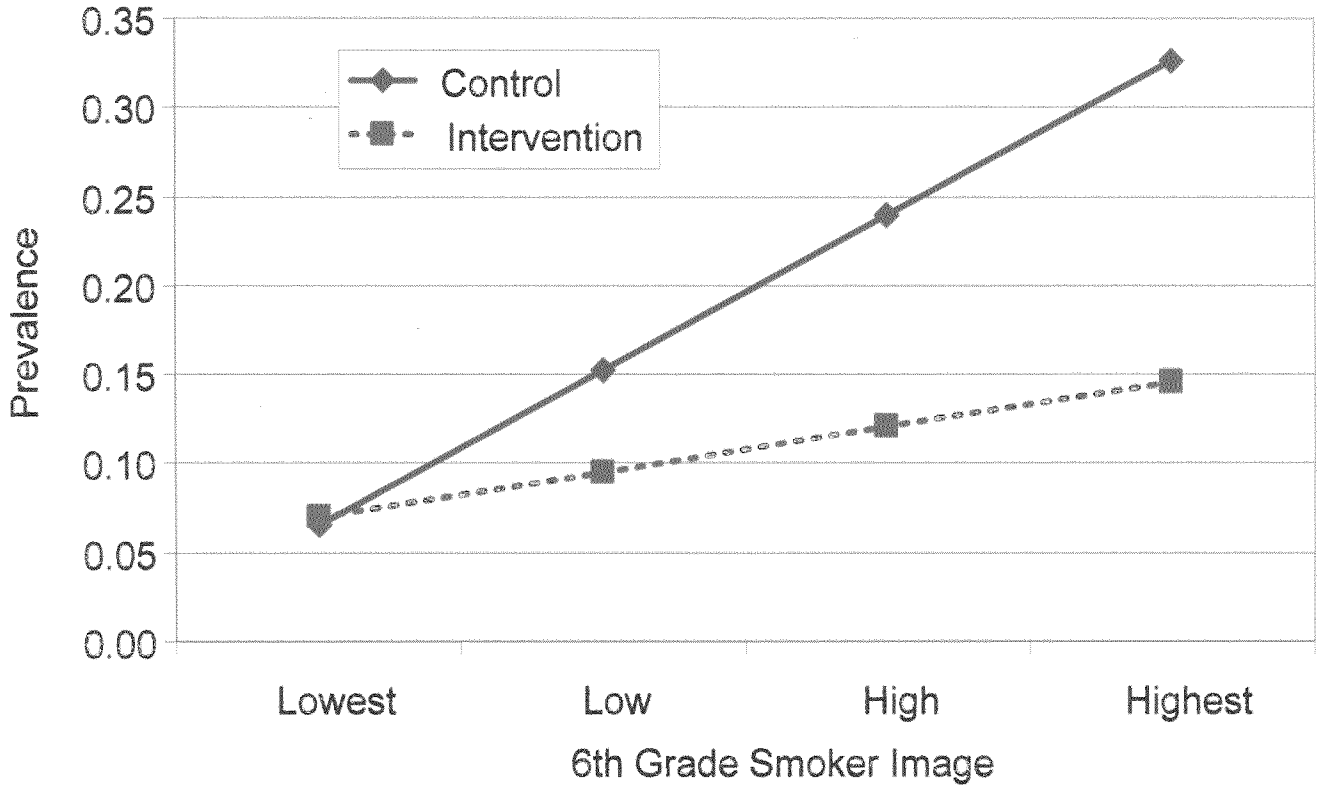
Parents and Children Together: Effects on Smoking Prevalence



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The Importance of Fidelity of Implementation

- High-quality implementation is essential to ensure that effects achieved in research will be achieved in the "real world"
- High-quality implementation and program maintenance require:
  - Training
  - Technical assistance
  - Administrator support
  - Adequate resources

Center on Early Adolescence

Oregon Can Foster the Successful Development of Young People, **IF**:

- We require that evidence-based treatment and prevention programs be used whenever they are available.
- We devote adequate resources for high-quality implementation and maintenance.
- We increase collaboration between the behavioral sciences and policy makers and practitioners.
- We make successful youth development a fundamental value.

Center on Early Adolescence

A Fundamental Value for Multnomah County?

- Young people arrive at adulthood with the skills, interests, assets, and health habits needed to live healthy, happy, and productive lives in caring relationships with other people.

Center on Early Adolescence

Improving Alcohol and Drug Treatment

Dennis McCarty, PhD
Oregon Health & Science University
April 17, 2007
Portland, Oregon

Overview

- Why Improve?
  - Changing expectations, environment, organizations
  - Opportunities for growth and new markets
- How to Improve?
  - Leadership and staff, customer involvement, rapid cycles
- Do Improvements Work?
  - Network for the Improvement of Addiction Treatment (NIATx)

Why?
Dissatisfied with Status Quo

- Comparable outcomes for chronic disease
  - Type 1 diabetes (60% adherence)
  - Hypertension and asthma (40% adherence)
    (McLellan, et al., 2000, JAMA, Vol 284, 1689 – 1695)
- Favorable outcomes can be improved
  - 40% to 60% continuous abstinence at 12 mo.
  - 15% to 30% have not resumed dependent use
- Inefficiencies in repeated treatments

Why? Availability of Empirically Effective Therapies

1. Brief intervention
2. Motivational enhancement
3. GABA agonist (acamprosate)
4. Opioid antagonist (oral naltrexone, nalmefene)
5. Social skills
6. Community reinforcement
7. Behavior contracting
8. Behavioral marital therapy

Miller & Wilbourne. *Addiction*. 2002;97:265.

Why?
Changing Policy Environment

- Demands for More Accountability
  - Crossing the Quality Chasm
  - Care must be safe, effective, patient-centered, timely, effective and equitable
- SAMHSA Reauthorization
  - Performance Partnership Grants
  - National Outcome Monitoring System
- State Initiatives
  - Oregon: SB267
  - California: Substance Abuse and Crime Prevention Act

Why?
Opportunities

- New alliances and linkages
  - Primary care and mental health services
  - Criminal justice and child welfare systems
- Participate in research
  - Clinical Trials Network (CODA, ChangePt, Kaiser, NARA)
    - Buprenorphine, Concerta
    - Motivational Effectiveness and Motivational Interviewing
    - STAGE12 (12-step facilitation)
  - Network for the Improvement of Addiction Treatment
- Implement evidence-based practices

Simon and Garfunkel on Change

- The monkeys stand for honesty
- Giraffes are insincere
- And the elephants are kindly but they're dumb
- Orangutans are skeptical of changes in their cages
- And the zookeeper is very fond of rum

(At the Zoo)

How?

- Change is not self-executing
- Implementation requires purposeful activity and attention to
  - Organizational and staff selection
  - Staff training
  - Supervision, coaching and feedback
  - Administrative support and system interventions

(Fixsen et al, 2005, *Implementation Research: A Synthesis of the Literature)*
http://nirn.fmhi.usf.edu/resources/publications/Monograph

Key Principles for Change

(Network for the Improvement of Addiction Treatment www.niatx.net)

- Understand and involve the customer
- Fix big problems (help the CEO sleep)
  - Make the business case
- Pick a powerful change leader
- Pressure and ideas from outside the field
- Use rapid cycle testing

- NIATX 200 coming soon to Oregon

Use Rapid Cycle Testing: Plan, Do, Study, Act – PDSA

- **Plan** the change
  - What needs to be improved? Why is it important?
  - Collect baseline data
- **Do** the plan – take action
  - Test the idea with one patient, for one week, etc.
- **Study** the results
  - Did the change work?
- **Act** on the results
  - Are modifications required?

Rapid Cycles …

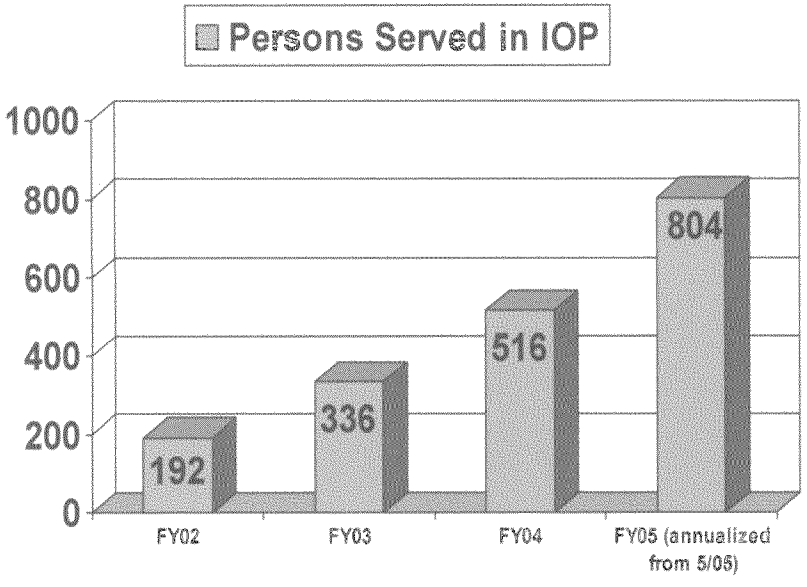
- "…reduce staff resistance to change because they engage staff at a low level – the change is temporary and begins small."

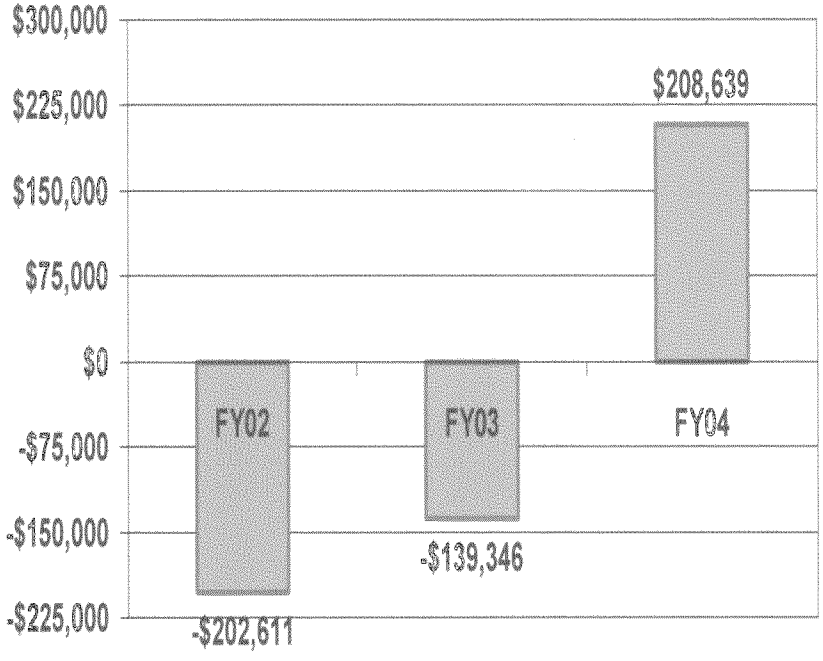
  Arthur Schut, CEO, MECCA, Iowa City, IA, June 27, 2006

Acadia Hospital: Open Access to IOP

- Problem
  - IOP was underutilized and few patients (19%) completed
- Solution
  - Clients offered assessments @ 7:30 the next morning
  - Clients start treatment @ 9:00 after the assessment
- Reduced days from 1st contact to treatment: 4.1 to 1.3
- More clients stayed in treatment: 19% to 67%

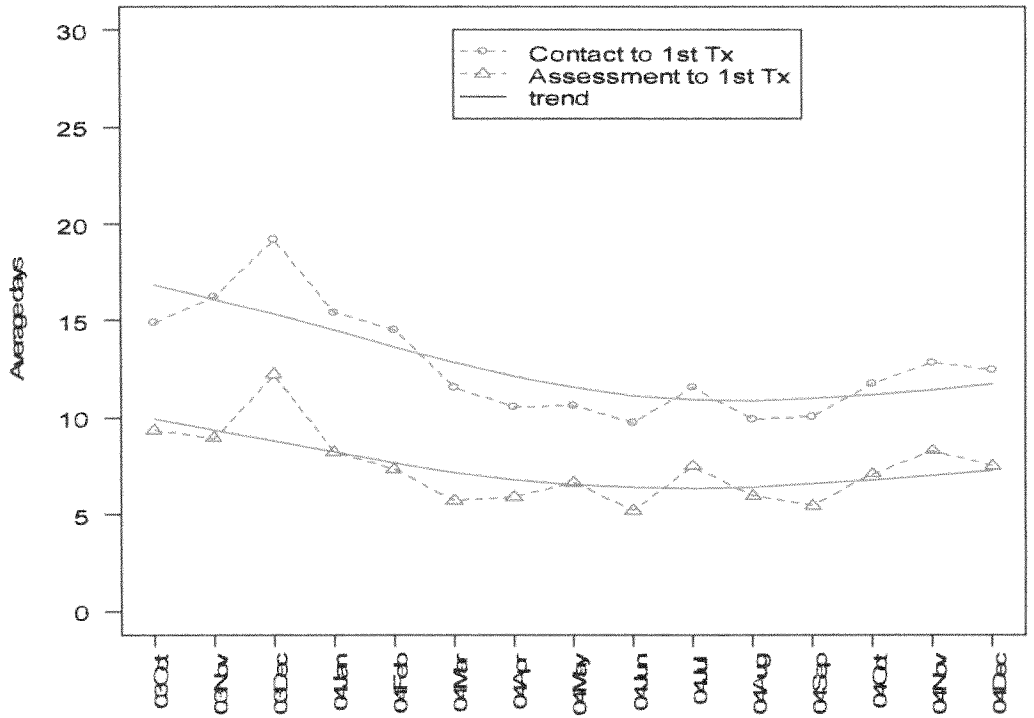
Acadia Hospital
Admissions and Revenues Increased





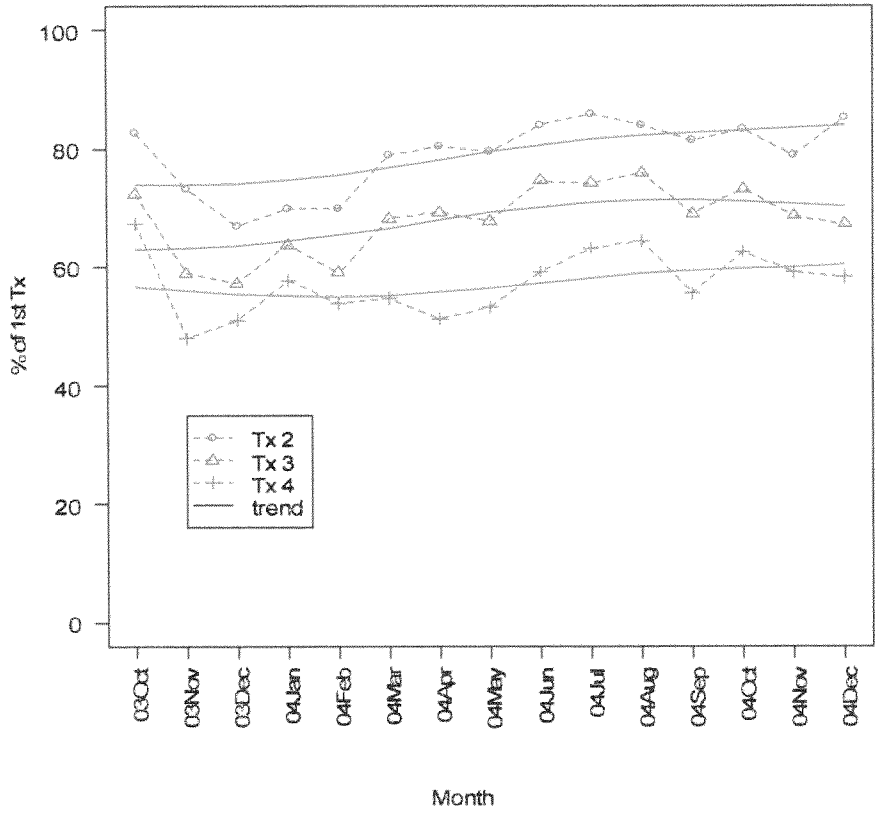
Outpatient Substance Abuse Services Net Profit or Loss

NIATX National Results
Days to Treatment Declined 39%



Retention in Care Increased

(Session 1 to 2 = 18%; Session 1 to 3 = 17%; 1 to 4 = 11% ns)



Keep Focused on the Goal

- Persistent improvements in the quality and effectiveness of care
- NIATx 200 coming soon
  - Opportunity for 50 Oregon outpatient programs to participate and learn process improvement

Many of My Friends Never Made It

Acknowledgements

- Preparation of this presentation was supported through awards from
  - Robert Wood Johnson Foundation: 46876 & 50165
  - The Center for Substance Abuse Treatment: SAMHSA SC-05-110
  - The National Institute on Drug Abuse: R01 DA018282; R01 DA020802
- The Network for the Improvement of Addiction Treatment provided data included in the presentation.

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MULTNOMAH COUNTY ALCOHOL AND DRUG TREATMENT SYSTEM: FY2007 PRESENTED TO THE BOARD IN RESPONSE TO THE FY2007 BUDGET NOTE

DAVE BISERS
MATT NICE
BUDGET OFFICE EVALUATION

HIGHLIGHTS

WHAT DO WE BUDGET ON ALCOHOL AND DRUG TREATMENT IN THE COUNTY?

- Multnomah County budgeted[1] $28.6 million for A&D in FY2007.[2]
- 62% of the budget is managed by Department of County Human Services (DCHS) and 38% by the Department of Community Justice (DCJ).[3]
- Direct adult treatment services accounted for 74% of total A&D system funds, direct youth services accounted for the 13% of funds, and administration costs took the remaining 13%.
- Direct adult services funds can be broadly categorized into residential (63%), outpatient (19%), or prevention/ treatment access and supports (19%).
- Proportionally, total adult treatment capacity is 80% outpatient and 20% residential.
- Average Length of Stay for standard residential is 100 days and 101 days for standard outpatient treatment.
- The distribution of people treated over race, ethnicity, and age has remained stable except for a small but steady increase in the proportion of Hispanics. Also notable is that 41% of those engaged for standard residential services are non-White.

WHAT'S CHANGED IN THE ADULT SYSTEM SINCE FY2004?

- Direct services funding has decreased 15.5% (from $24.9 million in FY2004 to $21.1 million in FY2007)[4].
- Adult capacity has decreased 23% for residential services and 25% for outpatient services.
- The decreases are most notable in DCJ high risk services; with the elimination of Clean Court (outpatient and residential), RiverRock secure treatment, and reduction in STOP drug diversion capacity.

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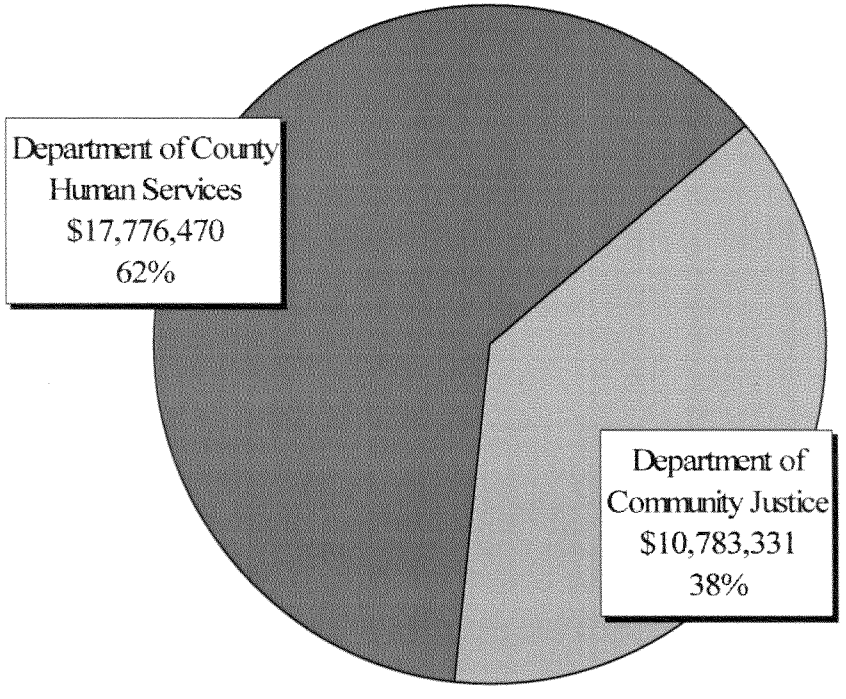
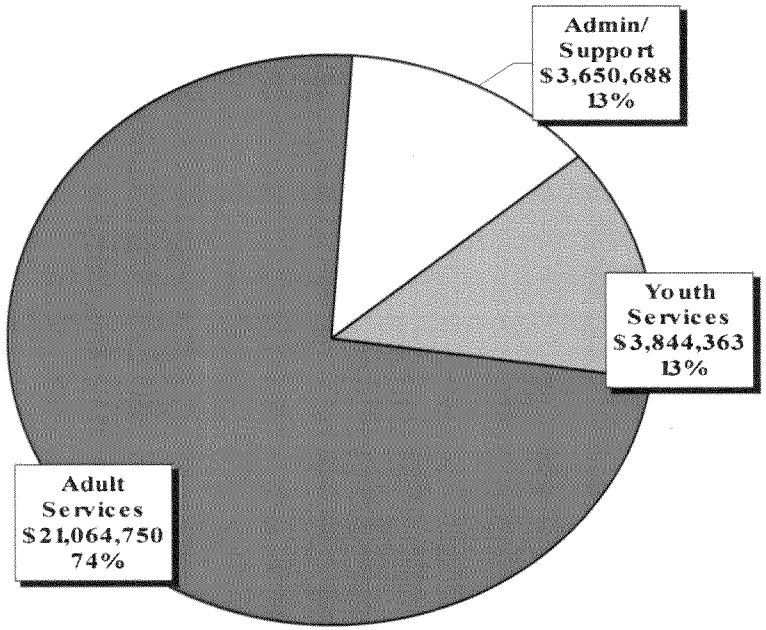
[1] There may be small amounts of additional funds used for A&D services at other departments, not included in this analysis; it does not capture the PPO's associated with the DCJ high-risk drug unit.
[2] Previously a program's administration and support costs were not fully accounted for. The switch to *Priority-Based Budgeting* accounts for these costs but results in comparisons to previous years being distorted.
[3] In FY07 the Office of School and Community Partnerships was folded into the DCHS, which previously accounted for 1% of A&D dollars.
[4] Amount excludes A&D-free housing reported in previous years (FY2004).

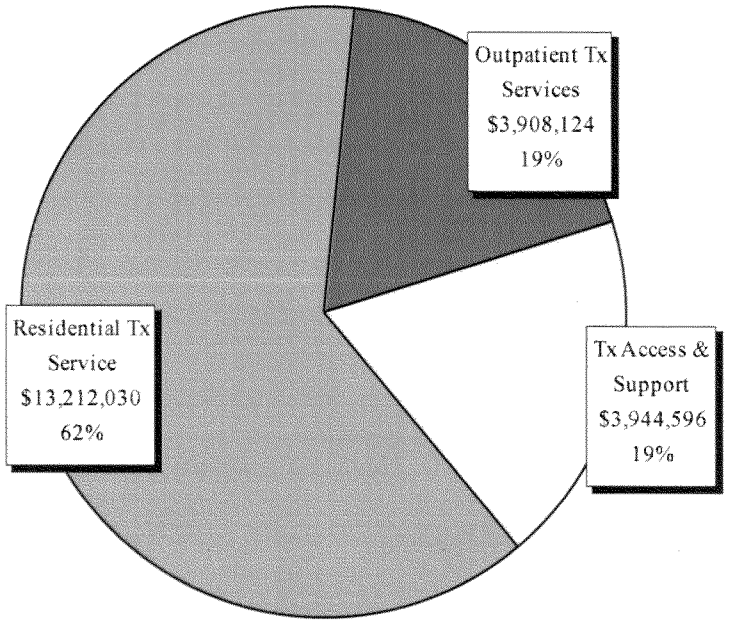
FY07 Total A&D Treatment Expenditure ($28.6m)
Which Departments Manage It



TOTAL: Where Is It Spent:
FY07 ($28.6m)

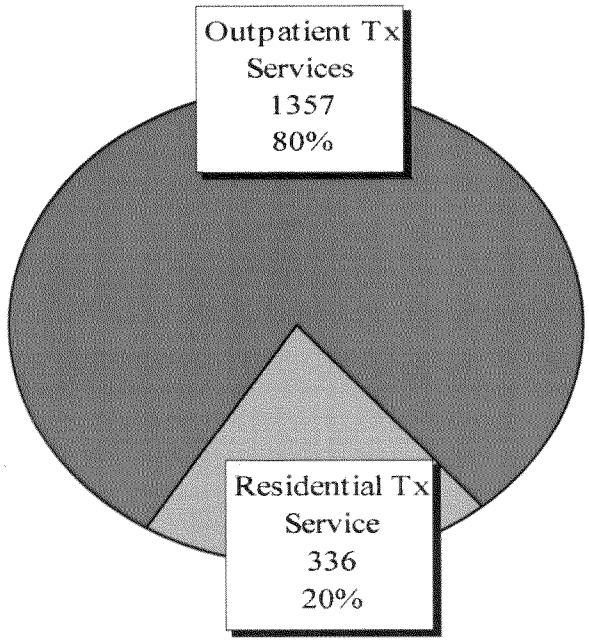


Where Does Adult Money Go: FY07 ($21.1m)
Excludes Admin & Support



Direct Adult Only Funds (Excludes Admin & Support)	FY03-04	FY06-07	%Δ FY04-07
Residential Tx Service	$15,995,892	$13,212,030	**-17%**
Outpatient Tx Services	$4,916,763	$3,908,124	**-21%**
Tx Access & Support	$4,030,462	$3,944,596	**-2%**
Total	$24,943,118	$21,064,750	**-16%**

How Much Adult Capacity Exists: FY07



ADULT ONLY Capacity	FY03-04	FY06-07	%Δ FY04-07
Residential Tx Service	435	336	-23%
Outpatient Tx Services	1800	1357	-25%