

# State of Oregon Alcohol and Drug Policy Commission Long-Term Strategic Prevention and Treatment Plan

## Role of the ADPC in Establishing Statewide Drug Policy

The Alcohol and Drug Policy Commission (ADPC) is an independent state government agency that was created by the Oregon Legislature to improve the effectiveness and efficiency of state and local alcohol and drug\* abuse prevention and treatment services.

The Legislature gave the ADPC a **mandate to create this long-term statewide strategic plan** for prevention and treatment programming, and in that context, to establish priorities and policies for alcohol and drug abuse prevention and treatment services for the State of Oregon. Some of the cross-department areas that the Legislature directed this Commission to address are:

- The capacity, type and utilization of prevention and treatment programs;
- Methods to assess the effectiveness and performance of those programs;
- The best use of existing prevention and treatment programs;
- Budget policy priorities for Oregon's Department of Corrections, Department of Human Services, Oregon Health Authority, Department of Education, Oregon Criminal Justice Commission, Oregon State Police, Oregon Youth Authority, and any other state agency approved by the ADPC to be involved in alcohol and drug abuse prevention and treatment services;
- Standards for licensing of prevention and treatment programs;
- Minimum standards for contracting, providing, and coordinating alcohol and drug abuse prevention and treatment services that use federal, private, or state funds administered by the state;
- The most effective and efficient use of participating state agency resources to support prevention and treatment programs.<sup>1</sup>

## Objectives

There are ten public policy objectives embedded in this strategic plan:

- (1) Reduce or eliminate the exposure of children (people under 18) to drugs.
- (2) Reduce the use of drugs by people of all ages.
- (3) Reduce health risks and other harm to people who use drugs.
- (4) Reduce harm caused by people who use drugs.
- (5) Reduce the violence that often accompanies distribution and use of drugs.
- (6) Reduce the number of people in jails and prisons because of drug use.
- (7) Improve timely access to effective treatment services by people who use drugs.
- (8) Reduce or eliminate demographic and geographic disparities in enforcement and treatment.
- (9) Increase the value of drug use prevention programs supported by taxpayer funds.

(10) Improve the value of drug treatment programs supported by taxpayer funds.

\* Sometimes, Oregon legislation or other government documents use the phrase “alcohol and drug.” In this document, the term “drugs” is synonymous with “substances,” meaning it is inclusive of all forms of tobacco, alcohol, cannabis (“marijuana”), diverted or misused pharmaceuticals, other misused substances such as inhalants, and illicit/illegal/“federally-scheduled drugs” or “controlled substances.”

## Policy Principles

All state funds used for substance abuse prevention and treatment should be directed toward reducing the morbidity, mortality, inequity, and costs to the community associated with substance abuse.

All state funds used for substance abuse prevention and treatment should be used for evidence-based, promising, and research-based prevention and treatment programs.

No more than 5% of funds allocated to the state under the SAMHSA mental health block grant, which provides federal funds for certain programs funded, offered, or coordinated by the Oregon Health Authority, may be used for administrative expenses.<sup>2</sup> This is reasonable expectation: no more than 5% of all state funds allocated to counties, CCOs, or other providers for substance abuse prevention and treatment should be used for administrative costs or other costs of planning, organizing, coordinating, or monitoring prevention or treatment programs.

The outcomes and effectiveness of all substance abuse prevention and treatment programs funded by the state should be continuously evaluated using a predictive analysis system like that presently in use within the Oregon Department of Corrections and the Oregon Youth Authority.

State departments and agencies tend to operate as silos. Those structural divisions are replicated locally across the state. People who work on aspects of Oregon’s substance use problems in prevention, harm-reduction, treatment (“public” or “private” or now, “integrated care”), public health surveillance, law enforcement or courts, often operate with little coordination of effort. Oregonians benefit more when work is coordinated across sectors and silos.

## References

<sup>1</sup> ORS 430.242 and ORS 430.242. Available online at <http://www.oregon.gov/adpc/docs/ADPC - Rev 2015 ORS 430.241 and 430.242.pdf>

<sup>2</sup> U.S. Code, Title 42, Sec. 300x-5 (b)

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## Quality of State-Funded Treatment and Prevention Activities

### Policy Rationale

#### Evidence-Based Practice (EBP)

*Independent published research has shown that an activity that is accurately labelled an EBP, when conducted “with fidelity” (following exactly the structure and processes specified in the program design) is significantly-more-likely-than-chance to produce well-defined positive outcomes, and is unlikely to produce detrimental results.*

This term was coined in the discipline of medical care, beginning in the early 1990s, where it originally meant diagnostic and treatment decision-making that integrates three domains: 1. Currently-available peer-reviewed research demonstrating the efficacy and safety of a particular course of treatment; 2. Knowledge and experience of the treatment provider; 3. Patient choice, belief, and values.

When discussing government-funded substance use disorder (SUD) prevention and treatment, we usually refer only to the first domain. We use the term “evidence-based practice” as shorthand or a synonym for activities that are empirically-supported (by valid experimental design) interventions. These are prevention or treatment activities that have been proven by:

1. randomized control trial, or
2. interrupted time series experiments, or
3. regression discontinuity <sup>1,2</sup>

...to reliably produce positive outcomes for a specified population, and are designed to be replicated in communities, schools, or treatment settings.

There are two principal rivals of evidence-based (or empirically-supported) practices: tradition (what we’ve always done) and conventional wisdom (what we believe is possible).

***In making Policy Recommendations and Directives, the ADPC is strongly biased in favor of evidence-based practices. Where there is research supporting an EBP designation, the ADPC will likely endorse the EBP-program over others.***

#### Promising Practice (PP)

*This activity seems consistent with published research suggesting that it is likely to produce well-defined positive outcomes without detrimental results, but its program design or effectiveness hasn’t been fully evaluated.*

Most simply, a promising practice is a method or approach that seems to be on its way to becoming an evidence-based practice. Compared to an EBP, a promising practice may impact an outcome in a way that indicates, but doesn’t prove, its effectiveness. Or the supporting research may lack a randomized control group or may have been conducted on a small subject group.

### **Research-Based Practice (RBP)**

*This activity is based on published research suggesting that it is likely to produce positive outcomes, but it has not been independently evaluated to assure that its particular design or implementation reliably produces positive outcomes without detrimental results.*

A research-based practice is the first step toward generating positive outcomes that may one day prove the effectiveness of the method or approach. This is where experiments begins: the prevention or treatment professional asks questions: what is the problem we want to change? What do we know (what have scientists published) about it? And based on this knowledge, what seems reasonable to try?

### **Funding Preferences**

Governments, foundations, and individual philanthropists often express a preference for funding evidence-based practices. Some governments, for example, require that funding be spent exclusively, or mostly, on EBPs. To help funders identify EBPs, PPs, and RBPs, several reputable organizations (including Oregon Health Authority, Washington Department of Social and Health Services, and SAMHSA) publish lists of evidence-based and promising practices.

### **What Is a “Best Practice”?**

A “best practice” is simply an activity that a treatment or prevention professional has found works well for her or him, or it’s a “community standard” for how things are typically done. One example is the “best practice” of paying bills when they are due. Sometimes “best practices” are institutionalized in accreditation standards or procedure manuals. “All forms must be signed and dated legibly in ink,” for example.

### **Who Determines Whether a Treatment or Prevention Activity is an EBP?**

Typically that determination is made by a panel of scientists who are well-versed in statistics and research methods, who able to apply advanced analytical methods to examine peer-reviewed, published, research about the practice to assess its effectiveness, reliability, cost-benefits, etc.

Several organization publish lists of programs that they have determined meet their standards for EBPs, PPs, or RBPs. Some of those are listed below:

1. [AMH-Approved Practices and Process](#)<sup>5</sup>  
The Oregon Health Authority, Addictions and Mental Health Services (OHA-AMH), publishes a “Complete List of AMH-Approved Practices.” OHA-AMH lists programs and practices that it has determined are EBPs. This list was last updated in October, 2012. In the past, OHA has told providers who wished to receive OHA funding to select and offer programs from this list.
2. [SAMHSA-National Registry of Evidence-Based Programs and Practices \(NREPP\)](#)<sup>6</sup>  
SAMHSA maintains a website displaying its National Registry of Evidence-Based Programs and Practices (NREPP). These include prevention EBPs as well as treatment EBPs. Most are designed to address mental health or substance use topics, though some of these EBPs are said to produce positive outcomes in other areas.

SAMHSA Cost-Benefit Estimate<sup>7</sup>

SAMHSA published its “Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis” in 2009. It analyzed the costs of substance abuse, and the cost savings yield of effective prevention programming. It lists the substance abuse prevention programs that SAMHSA considers most cost-beneficial.

3. Washington State Institute for Public Policy – WSIPP<sup>8</sup>

WSIPP is a non-partisan policy research organization funded and operated for the benefit of Washington State. The Washington State legislature has directed WSIPP to identify “evidence-based” policies in many areas, including substance abuse treatment and prevention.

WSIPP Benefit-Cost Rating<sup>9</sup>

WSIPP has published its “Inventory of Evidence-Based, Research-Based, and Promising Practices” since 2004, most recently updating it in October 2013. It analyzes the costs of substance abuse, and the cost savings yield of effective prevention programming.

4. Athena List of Evidence-Based Practices<sup>10</sup>

The State of Washington Department of Social and Health Services maintains a list of practices endorsed by that state agency. It is Washington’s equivalent of Oregon’s “List of AMH-Approved Practices.” It is displayed on a website called “The Athena Forum.”

5. PPN - Promising Practice Network on Children, Families, and Communities<sup>11</sup>

The Promising Practice Network is operated by the RAND Corporation. RAND is a “think tank,” a nonprofit research organization providing objective research and analysis on issues of policy in child health, juvenile justice, education, child care, labor, prenatal health, substance abuse, firearms violence, and early childhood interventions. Based on RAND’s meta-analysis, the PPN rates programs as “Proven,” “Promising,” or when identified below as “NOT RATED, pending,” as “undergoing further investigation and analysis.”

6. Coalition for Evidence-Based Policy – Social Programs that Work<sup>12</sup>

The Coalition is a nonprofit, nonpartisan organization, whose mission is to increase government effectiveness through the use of rigorous evidence about “what works.” Its main concern is **that government programs intended to address important social problems often fall short because they fund interventions that are not effective.** The Coalition rates effective prevention programs as “Top Tier” or “Near-Top Tier.”

7. Matrix of Children’s Evidence-Based Interventions – Center for Mental Health Quality and Accountability<sup>13</sup>

The National Association of State Mental Health Program Directors Research Institute operates the Center for Mental Health Quality and Accountability, an independent research organization. It conducted a large scale meta-analysis and published its matrix of evidence based interventions for children in 2006. It listed programs that it determined were evidence-based.

While supporting the concept of maintaining an authoritative, approved list of programs, research scientists and professional treatment providers who serve Oregon as Commissioners on the ADPC have misgivings about each of the lists above. They assert that some of the programs listed were supported by inadequate research, or are designed too poorly to be replicated, or other concerns. None of the lists is current; for these to be effective tools they must be continuously re-evaluated in light of new research and new programs.

### Policy Recommendations and Directives

1. The Alcohol and Drug Policy Commission should be funded and staffed sufficiently to be able to continuously monitor (a.) the emergence of new promising treatment and prevention programs, and (b.) newly-published research that may establish the evidence basis of a treatment programs, and to (c.) continuously publish its findings, to establish a basis for requiring that all state funds spent, managed, or coordinated by any state agency on substance abuse treatment and prevention must be spent on evidence-based, promising, or research-based practices.
2. The Oregon Health Authority, the Department of Human Services, the Department of Education should evaluate all substance abuse treatment and prevention programs that their department provides, specifically to determine if those programs are producing significant desired outcomes in the target population. Each department should reports its findings to the ADPC, publish those findings, and use the evaluation results to determine whether funding of those programs will continue.
3. The Department of Corrections has developed predictive analysis tools that it has developed, to assess the effectiveness of various community-based treatment programs and providers, and to guide DOC referrals to treatment services for corrections clients. The Oregon Youth Authority has begun using this same tools to evaluate its contracted providers. Similar evaluation methods should be developed and used by the Oregon Health Authority, the Department of Human Services, the Department of Education and any other state department funding, offering, or coordinating treatment or prevention services.

### References

<sup>1</sup> BR Flay, A Biglan, RF Boruch, et al., "Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination." *Prevention Science* (September 2005) 6(3):151-75.

<sup>2</sup> DC Gottfredson, TD Cook, FE Gardner, et al., "Standards of evidence for efficacy, effectiveness, and scale-up research in prevention science: Next generation." *Prevention Science* (October 2015) 16(7):893-926.

## Access to Treatment for Nicotine Addiction

### Policy Rationale

Smoking causes cancer, heart disease, stroke, and chronic obstructive pulmonary disease<sup>1</sup>. Addictive use of cigarettes, chewing tobacco, cigars, pipes, electronic nicotine delivery systems is more costly to Oregonians than use of any other substance, illicit or licit<sup>2</sup>:

• High school students in Oregon who smoke:	<b>16,200</b> (8.3% of high school students)
• Male high school students in Oregon who chew tobacco:	<b>9.1%</b> of boys (relatively rare behavior among girls)
• Oregon kids (people under 18) who become new daily smokers each year:	<b>2,600</b>
• Packs of cigarettes bought or smoked by Oregon kids each year:	<b>3,300,000</b> (3.3 million)
• Adults in Oregon who smoke:	<b>529,000</b> (17.0% of all adults; about four or five adult people of every 25)
• Oregonian kids (people presently under 18) who will die prematurely from smoking:	<b>68,000</b>
• Healthcare costs in Oregon directly caused by smoking, every year:	<b>\$1,540,000,000</b> (\$1.54 billion)
• Medicaid (Oregon Health Plan) costs directly caused by smoking, every year:	<b>\$347,600,000</b> (\$347.6 million)
<i>Campaign for Tobacco-Free Kids, last updated April 15, 2016</i>	

General medical providers who are funded or otherwise influenced by OHA, e.g., healthcare personnel in CCOs, FQHCs and Look-Alikes, public health and WIC clinics, Primary Care Medical Homes, integrated care sites, Certified Community Behavioral Health Clinics, should be trained and supported to address nicotine addiction during healthcare encounters with their patients. Healthcare providers should be expected to systematically identify and intervene with all nicotine users at every healthcare visit.<sup>3</sup>

When medical providers learn that their patient is planning pregnancy or is pregnant, the medical provider should screen for tobacco use and firmly recommend immediate tobacco cessation treatment for all household members.

Clinical guidelines published by the Agency for Health Care Policy and Research (AHCPR) recommend:

- Every person who smokes should be offered smoking cessation treatment at every visit.
- Healthcare providers should ask and record the nicotine-use status of every patient.
- Cessation “treatments” even as brief as three minutes per office visit are proven effective

- More intense treatment is more effective in producing long-term abstinence from nicotine use
- Nicotine replacement therapy (NRT), provider-delivered social support, and skills training are particularly effective component of smoking cessation treatment.

### **Medication-Assisted Treatment (MAT)**

Medicaid funding for pharmacological treatment of nicotine-addicted people should be generous and readily available. A similar level of funding for treatment should be provided for non-Medicaid/uninsured individuals. Pharmacological treatment should be prescribed for individuals who wish to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents.

Healthcare providers should be directly encouraged by OHA to prescribe nicotine replacement therapies (NRTs: patch, gum, lozenge, inhaler, nasal spray) and as indicated, other pharmacological aids, such as bupropion (Zyban, Wellbutrin), or varenicline (Chantix).

Other medications, aversive treatment, 12-step programs, hypnosis, inpatient therapy, and acupuncture have not been proven to be effective interventions for nicotine addiction. These should not be offered by providers who are funded by the state.<sup>3</sup>

### **Psychosocial Treatments**

Psychosocial treatments are also effective for the treatment of nicotine dependence. At minimum, these should always include social support in the form of clinician-provided encouragement and assistance, and skills training/problem solving techniques to achieve and maintain abstinence.<sup>3</sup> Better, would be nicotine cessation programming that includes cognitive behavioral therapy (CBT), other structured behavioral therapies, brief interventions, and Motivational Enhancement Therapy (MET) or motivational interviewing (Miller and Rollnick)<sup>3</sup>.

### **Policy Recommendations and Directives**

1. The OHA Public Health Department presently operates a Tobacco Quit Line and offers limited distribution of two weeks of free NRT--nicotine patches or gum. Because the free NRT offer combined with Quit Line availability (in 2004) was proven to be cost effective<sup>4</sup>, the state should continue to fund this service indefinitely as a public health priority.
2. These services for nicotine cessation should be funded for all Medicaid (Oregon Health Plan) recipients, fee-for-service, and uninsured people: nicotine replacement therapies—whether patch, gum, lozenge, inhaler, nasal spray; bupropion (Zyban, Wellbutrin), varenicline (Chantix); in-office provider-delivered social support and skills training; CBT or other structured behavioral therapies, brief interventions, Motivational Enhancement Therapy (MET) or motivational interviewing.
3. Though medications are effective for nicotine cessation even when no psychosocial treatment is provided, CCOs and other providers currently building systems of “integrated care” should

provide psychosocial treatment (CBT or other structured behavioral therapies, brief interventions, Motivational Enhancement Therapy (MET) or motivational interviewing) along with NRT or medication-assisted nicotine withdrawal methods.

4. The Oregon Health Authority should monitor insurance companies that operate in Oregon to ascertain the coverage provided for nicotine cessation treatment; the OHA should use its influence with those insurers to promote and expand coverage for proven nicotine cessation interventions such as those cited above<sup>5</sup>.
5. Oregon's colleges and universities should ensure that similar levels of nicotine cessation treatment are prioritized and widely available through their student health services and counseling centers. Colleges and universities should offer and support quit-smoking/quit-chewing psychosocial support groups for students.
6. Oregon's public schools should that host school health clinics should ensure that similar levels of nicotine cessation treatment are prioritized and available within their programs. Clinics that have agreed with districts not to prescribe to students should work assertively with district administrators to obtain their authorization to prescribe and dispense NRT products to nicotine-addicted students at the school health clinics. High schools should offer and support quit-smoking/quit-chewing psychosocial support groups for students.
7. Oregon's Legislature should significantly increase taxes on nicotine delivery products (e.g., cigarettes, vaporizing devices and supplies) to recoup a greater portion of healthcare costs and to influence consumer purchasing behavior.
8. Increase the frequency and regional spread of retail testing programs.

## References

<sup>1</sup> Thun, M.J., Myers, D.G., Day-Lally, C., Namboodin, M.M., Calle, E.E., Flanders, W.D., Adams, S.L., Heath, C.W., Jr. (1997). Age and the exposure-response relationships between cigarette smoking and premature death. *Cancer Prevention Study II, Changes in Cigarette-Related Disease Risks and Their Implications for Prevention and Control. Smoking and Tobacco Control Monograph No 8*. Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute.

<sup>2</sup> Campaign for Tobacco-Free Kids. (2016). *The Toll of Tobacco in Oregon*. Multiple primary sources, online at [https://www.tobaccofreekids.org/facts\\_issues/toll\\_us/sources/](https://www.tobaccofreekids.org/facts_issues/toll_us/sources/) Accessed June 14, 2016.

<sup>3</sup> Fiore, M.C. (1996). *Clinical Practice Guideline Number 18*. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research (AHCPR), Centers for Disease Control and Prevention.

<sup>4</sup> Fellows, J.L., Bush, T., McAfee, T., Dickerson, J. Cost effectiveness of the Oregon quitline “free patch initiative.”(2007). *Tobacco Control*. 2007 Dec; 16(Suppl 1): i47–i52. Portland, Oregon. Center for Health Research, Kaiser Permanente Northwest.

<sup>5</sup> King, B., Pechacek, T., Mariolis, P. (2014) *Best Practices for Comprehensive Tobacco Control Programs, 2014*. Atlanta, GA. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 40-43.

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## Alcohol Abuse and Addiction

### Policy Rationale

### Policy Recommendations and Directives

Monitor effects of changes in alcohol control system – pricing, taxation, outlet density  
Monitor statewide alcohol use and abuse proxy measures: gallons per outlet, school discipline incidents, juvenile court referrals for MIP, DUI arrests, alcohol-related ER visits  
Increase taxes on alcohol products to reduce use and to reduce availability to underage users  
Reduce deaths due to alcohol (and alcohol+polydrug) overdose  
Reduce use of alcohol by drivers  
Improve impaired driving enforcement and court oversight  
Reduce gestational exposure to alcohol; establish and maintain high rates of prenatal screening and education; enable immediate treatment access for alcohol-addicted mothers  
OLCC to maintain and expand warning label and warning sign programs  
Monitor and publish incidence of FAS, low birth weight, neonatal infectious disease, or other complications related to prenatal alcohol exposure  
Reduce adolescent use of alcohol; improve funding and availability of treatment for adolescents  
Reduce binge drinking; support binge-drinking prevention in colleges and universities.  
Improve identification and intervention with alcohol abusers in healthcare system  
Improve access to treatment

### References

## Management of Opioid Addiction

### Policy Rationale

#### Healthcare System Issues

##### Prescription Drug Monitoring Program

- Engage opioid prescribers to expand participation
- Engage pharmacy management to expand participation
- Proactively use PDMP data for enforcement

##### Provider Education

- Provide training for physicians and mid-levels (and dentists), in pain treatment
- Educate medical and dental providers to prevent, identify, and treat addictions
- OHSU establish a Pain Management Residency or specialty within Internal Medicine Residency
- OHSU establish an Addiction Medicine residency or specialty within Internal Medicine Residency

##### Non-Opioid Pain Management Programs

- Increase availability and access to physical therapy, CBT, other pain management methods

##### Access to Treatment for Chronic Pain Patients with Opioid Addiction

- Require referral to treatment rather than abrupt cut-off
- Engage and educate medical and dental providers to develop effective treatment referral protocols

##### Surplus Prescription Disposal

- Maintain and expand surplus drug drop-off programs

#### Community-Level Prevention

##### Public Messaging

- Provide clear and consistent guidance for consumers on safe storage and disposal of prescription drugs

##### Develop Community Standards of Care

- Convene stakeholders to replicate work of Oregon Pain Guidance Group (Jackson and Josephine Counties) in other communities

#### Maintain and Expand Harm-Reduction Programming

##### Good Samaritan Laws

##### Needle Disposal and Exchange Programs

- Coordinate/consolidate purchasing to reduce unit cost
- Partner with community groups to sustain programs by identifying stable funding sources

##### Naloxone Distribution/Co-Prescription

- Work with insurers and third-party payers to ensure coverage of naloxone products
- Change Legislation to remove training barriers to access; enable OTC access
- Coordinate/consolidate purchasing to reduce per-dose cost

Partner with community groups to sustain programs by identifying stable funding sources  
Engage medical community to develop co-prescribing protocols; enable third-party reimbursement for co-prescription  
Train caregivers and family members to manage accidental overdose

**Supervised Injection Sites**

Study and consider developing pilot programs

**Hepatitis A and B Vaccinations for Injection-Drug Users**

Expand availability

**Hepatitis C Treatment for Infected Injection-Drug Users**

Expand availability

**PrEP (HIV prophylaxis) for Injection-Drug Users**

Expand availability

**HIV Treatment for Infected Injection-Drug Users**

Expand availability

**Infectious Disease Training for First Responders**

Safer interactions with people who have addictions

**Access to Evidence-Based Treatment**

**Evaluate treatment program effectiveness**

Conduct program evaluation and referral-matching (DOC/OYA model) and conduct QI as needed  
Reduce use of ineffective programming

**Availability of Medication-Assisted Treatment**

Expand availability/capacity/access to MAT

**Statewide Treatment Access System**

One-Stop/No Wrong Door systems  
Open Access/Same Day Care systems  
Break down public-private silos

**Real-Time Capacity and Availability Data**

Monitor and maintain access to data

**Treatment Navigators to Facilitate Access to Treatment**

Provide knowledgeable advocacy and placement assistance

**Timeliness of Access to Treatment**

Monitor treatment drop-off at first and second scheduled contact, and avert

**Increase Treatment Completion**

Over the 21-month period from October 2011 through June 2013\*, 45,072 Oregonians were “engaged” in treatment funded by the Oregon Health Authority for a substance use disorder<sup>1</sup>. This represents about 87% of the people referred to treatment. (Reported range was ~70% to 100%.) Engagement means that the individual attended an initial appointment within 14 days of enrollment and was then retained in treatment for at least seven days.

OHA reported subsets of the total “engaged.” Over the seven quarters reported, the proportion of those individuals who were “retained,” “complete,” and who reported “no use” were consistent at about 70%, 57% and 70% respectively:

- Approximately 70% of the individuals “engaged” were also “retained,” meaning that the individuals continued treatment for at least 90 days.
- About 57% of the individuals “engaged” were recorded as “completed.” “Completed” means the individual’s treatment ended with treatment goals achieved.
- About 70% of the individuals “engaged” reported “no substance use” at the end of treatment. This included some individuals who were not “retained,” and some individuals who ended treatment without “completing” treatment.

Oregon Statewide	During Q4 of 2011	During Q1 of 2012	During Q2 of 2012	During Q3 of 2012	During Q4 of 2012	During Q1 of 2013	During Q2 of 2013
Engaged in SUD Treatment	6,344	6,871	7,685	6,586	6,550	5,986	5,050
Retained in SUD Treatment	4,386	5,056	5,308	4,560	4,328	3,968	3,503
Completed SUD Treatment	3,684	4,046	4,364	3,740	3,589	3,213	3,045
No Use	4,426	4,970	5,422	4,660	4,563	4,001	3,708

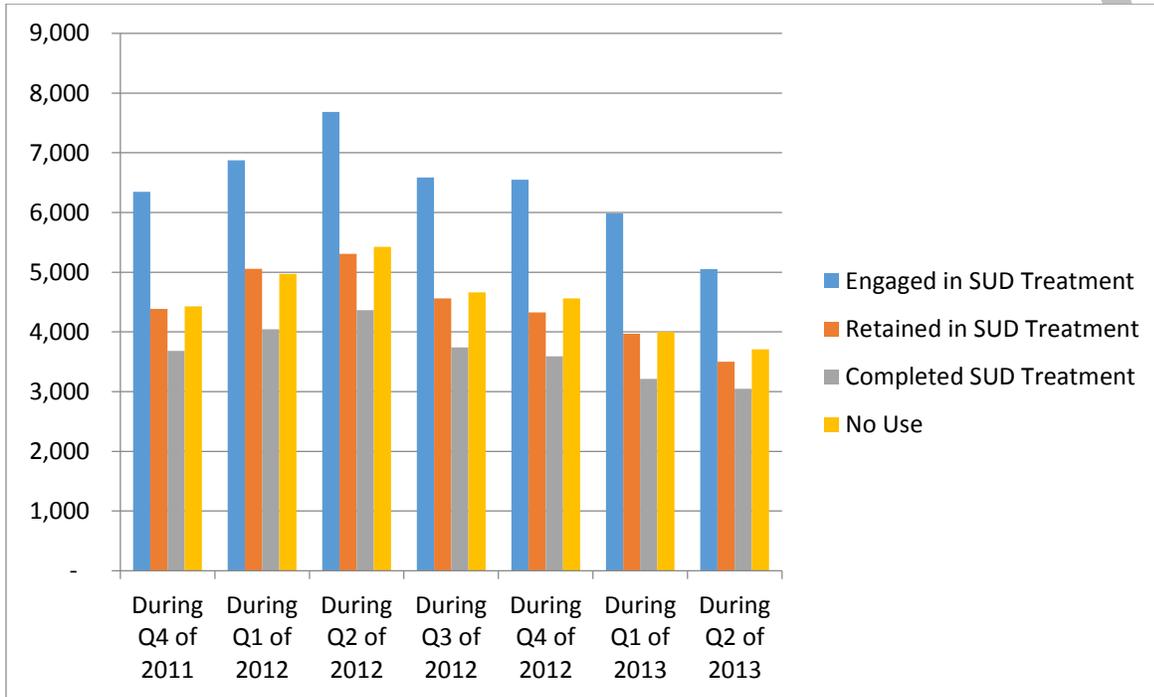
By all four measures, the statewide-aggregated numbers of individuals in state-supported treatment dropped in the first quarter of 2013 and continued to drop during the second quarter. A few counties had increases; in a few counties, the measures dropped to zero during the first and second quarters of 2013. The chart below shows the totals of each of the four measures for 2012, then compares year-over-year the first quarter and second quarter of each year.

The actual totals for the first two quarter of 2013 are extrapolated to make a rough projection of the 2013 totals, assuming no further declines:

Oregon Statewide	Total During All of 2012	Q1 2013 Compared to Q1 2012	Q2 2013 Compared to Q2 2012	Total During Q1 and Q2 of 2013	Q1 and Q2 Extrapolated to full year	Extrapolated (Q1+Q2) x 2 Total 2013 Compared to Total 2012
Engaged in SUD Treatment	27,692	- 885	- 2,635	11,036	22,072	- 5,620
Retained in SUD Treatment	19,252	- 1,088	- 1,805	7,471	14,942	- 4,310
Completed SUD Treatment	15,739	- 833	- 1,319	6,258	12,516	- 3,223

No Use	19,615	- 969	- 1,714	7,709	15,418	- 4,197
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During the first two quarters of 2013, by each of the four reported measures, there were fewer individuals in treatment than in any of the previous five quarters:



\* Current data is not available: these quarterly reports have not been published since the second quarter of 2013.

<sup>1</sup> Oregon Health Authority. Quarterly Addictions Treatment Outcomes Report, Outpatient Services, 2011-Q4 through 2012-Q4; Quarterly Addictions Treatment Outcomes Report, Outpatient Services, 2012-Q1 through 2013-Q1; Quarterly Addictions Treatment Outcomes Report, Outpatient Services, 2012-Q2 through 2013-Q2. Online at [https://www.oregon.gov/oha/amh/datareports/Addiction Treatment Outcomes Report, Outpatient 2011 Q4.pdf](https://www.oregon.gov/oha/amh/datareports/AddictionTreatmentOutcomesReport,Outpatient2011Q4.pdf); [https://www.oregon.gov/oha/amh/datareports/Addiction Treatment Outcomes Report, Outpatient 2012 Q1.pdf](https://www.oregon.gov/oha/amh/datareports/AddictionTreatmentOutcomesReport,Outpatient2012Q1.pdf); [https://www.oregon.gov/oha/amh/datareports/Addiction Treatment Outcomes Report, Outpatient 2012 Q2.pdf](https://www.oregon.gov/oha/amh/datareports/AddictionTreatmentOutcomesReport,Outpatient2012Q2.pdf) Accessed October 14, 2013

Actively re-engage

**Duration of Treatment**

Monitor treatment duration; support and fund most effective duration

**Relapse Re-Engagement**

Monitor relapse; enable barrier-free immediate re-engagement in treatment

**Criminal Justice System**

**Law Enforcement Assisted Diversion programming**

(See Seattle's LEAD)

**Treatment Courts**

Maintain, expand, and spread model

**County Jails**

Enable Medicaid funding for pre-adjudication SUD treatment in county jails

**Community Corrections**

Improve coordination, access to reimbursement and access to treatment for post-prison and probation clients

**Re-Entry Treatment Programming**

Seamless, reduce recidivism

**Data Linkages**

**Prescription Drug Monitoring Program Data Sharing**

Improve timeliness and data quality

**Cost-Effectiveness Data Sharing among State Court Administrator, Criminal Justice Commission, ADPC**

**Real-Time Data Sharing among Public Health, Medical Examiner, Hospitals, Law Enforcement**

Drug seizures

Opioid drug-, poly-drug-, alcohol-related ER visits

Opioid drug-, poly-drug-, alcohol-related deaths

Contaminated or mis-formulated drugs; incidence of adverse reactions

Trends in illicit drug use

**Program Effectiveness Data Sharing among DOC, OYA, OHA, DHS**

The Oregon Department of Corrections and the Oregon Youth Authority have invested in creating an innovative method of systematic treatment program evaluation and treatment referral. Their system offers a valuable model that should be replicated by OHA, the CCOs, and DHS for the programs that they fund and coordinate. Here is a brief, simplified description of that system.

**1. Program Evaluation Model**

The Research Unit within the Oregon Department of Corrections (DOC) has developed a system that estimates program effectiveness. This newly-designed automated model provides real-time

data to enable assessments of a program's effectiveness. This component is frequently updated and is coupled with service matching methodology, described below.

This evaluation model continuously quantifies any reduction in recidivism (a primary measure of “success” in corrections programming) that is attributable to programming. How it works: treatment program participants are matched with their statistical “identical twin.” The matching variables used to identify the identical twin are the same variables generally used to predict the outcome (i.e., combinations of the seven component variables of the Automated Criminal Risk Score, which is used to identify an individual's risk of recidivating). “Twin-ness” is determined by matching the combination of ACRS variables.

Recidivism rates of the corrections clientele who receive substance use disorder treatment services are compared with their “twins” who receive treatment from different programs or no treatment. A lower recidivism rate indicates that for clients with that combination of risk variables, a particular program may be more effective than another program.

## **2. Service Matching Tool**

The Service Matching Tool uses the data from the Program Evaluation Model to identify and quantify, in advance, the treatment program most likely to produce a successful outcome for an individual client. The Service Matching Tool was built for the Oregon Youth Authority (OYA). The DOC is studying the methodology to adapt it for the adult population and DOC programs.

The tool relies on equations developed for each program provider. Each provider equation considers all previous clients; some of these clients had a good outcome (did not recidivate) and others recidivated. The demographic and criminal history profile of the successful participants usually differs from the profile of those who recidivated. This information enables the continuous evolution of the individual provider equations.

The equation for any provider allows researchers to estimate the likelihood of success for each new client. By analyzing thousands of “identical twin” pairs, the calculations can determine which program is best suited for each individual. The tool looks at successful client profiles from all providers and compares those profiles to the new client.

Service Matching can identify poor treatment outcomes attributable to not having capacity in the most desirable program at the time of initial program engagement. (Professional discretion is also built into the automation.) The Service Matching Tool enables DOC to evaluate the effectiveness of its own programs and contracted treatment programs for effectiveness. It also can help to identify populations that are poorly served by existing programs, and program service gaps or capacity issues.

## **Policy Recommendations and Directives**

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## References

The Department of Corrections and the Criminal Justice Commission [ORS 423.150 (3)]

...

(b) The Oregon Criminal Justice Commission shall periodically conduct independent evaluations of the programs funded by this section for their effectiveness in reducing criminal behavior in a cost-effective manner and shall report the findings to the Alcohol and Drug Policy Commission.

Drug Courts [ORS 3.450]

...

(6) A court, the State Court Administrator, the Alcohol and Drug Policy Commission or the Oregon Criminal Justice Commission:

(a) May use records described in subsection (3) of this section and other drug court program information to track and develop statistics about the effectiveness, costs and other areas of public interest concerning drug court programs.

(b) May release statistics developed under paragraph (a) of this subsection and analyses based on the statistics to the public.

## Prevention

### Policy Rationale

The Oregon Department of Education, local school districts, the Oregon Health Authority, and Oregon’s colleges and universities are the principal public investors in prevention programs in Oregon. During the 2013-2015 Biennium, for example, the OHA spent \$12 million a year<sup>1</sup> to fund counties and tribes for substance use disorder (SUD) prevention programming. The Oregon Health Authority has also invested heavily in the past several years in a “Strategic Prevention Framework” intended to foster more community participation, and local sustainability, in prevention programming. Despite these prevention efforts, the most recent “Behavioral Health Barometer” published by SAMHSA<sup>2</sup> showed these results:

Measure	Oregon Rate Compared to National Average	Significant Change Since 2010
Illicit drug use among Oregon adolescents aged 12-17	Higher	No
Cigarette use among Oregon adolescents aged 12-17	Similar	No
Binge drinking among Oregon citizens aged 12-20	Higher	No
Non-medical use of pain relievers among Oregon adolescents aged 12-17	Similar	Decreased
Alcohol dependence or abuse among Oregonians aged 12 and over	Similar	No
Illicit drug dependence or abuse among Oregonians aged 12 and over	Similar	No
Heavy alcohol use among Oregonians aged 21 and over	Similar	No

Source: Behavioral Health Barometer, Oregon, 2015. SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014

When OHA funds were documented as having been spent on SUD prevention activities, most of those activities were school-based, targeted toward children,<sup>3</sup> and classified as Universal interventions.<sup>4</sup> Selected or Indicated interventions are not documented as occurring with the frequency that might be expected.

SAMHSA provides a Substance Abuse Block Grant allotment to state, including Oregon, for treatment and prevention services. Grantees are required to devote 20% of that total grant for prevention programming. In past years, OHA and other parts of the state substance abuse treatment and prevention system have come to regard this minimum standard as a benchmark goal. Given the unchanging prevalence of health-damaging drug use in Oregon, all state agencies, including OHA, should consider allocating a larger share of funding for evidence-based prevention work.

### Participation in Evidence-Based Prevention Activities

OHA’s documentation shows about 6% of the people reported to have participated in OHA-funded SUD prevention activities were exposed to activities listed as AMH-approved Evidence-Based Practices<sup>5</sup>: 10,935 people. If all of these 10,935 had been school-age children, approximately 1.7% of Oregon’s

school-age children<sup>6</sup> were participants in evidence-based SUD prevention programming during the most recent fiscal year, 2014-2015.

We know that school districts and even individual schools have implemented evidence-based prevention methods using their own (non-OHA) budgeted funds. Some CCOs have similarly initiated evidence-based prevention programming. Neither of these programming efforts is well-documented or evaluated other than the SAMHSA study cited above.

#### **Accountability for OHA-Funded Prevention Programs**

Presently, the system used by OHA and the counties to account for prevention spending is likely not accurate. Some of the available data may reflect inaccuracies inherent in the current methods of collecting and reporting data from the counties. The Oregon Health Authority has recently initiated some promising changes in how it administers prevention funds. OHA recently moved its drug prevention program to its Public Health Division, and has announced plans to implement an improved method of accounting for CCO and county SUD prevention activities, the Oregon Prevention Data System (OPDS), beginning in July 2016.

#### **Tribal Prevention Programming**

Improve access to evidence-based prevention programming in tribal communities

#### **Clinical Preventive Interventions**

Reduce gestational exposure to alcohol and other drugs

Improve timeliness of medical and behavioral healthcare evaluations for children entering foster care

Training for medical providers to identify and intervene with adolescent substance abuse

#### **Policy Recommendations and Directives**

1. Effective substance abuse prevention must be a higher priority for all state departments.
2. All state departments should commit to developing policies that reduce children's exposure to adverse childhood experiences (ACEs) and foster resilience.
3. See **Policy Recommendations and Directives #1** and **#2** elsewhere in this Plan, under "**Quality of State-Funded Treatment and Prevention Activities.**" As described there, the Oregon Alcohol and Drug Policy Commission should create a new process to continuously update and evaluate prevention activities, beginning with the current "the AMH-approved list" to reflect current prevention science, including classifying the listed interventions as Universal, Selected, or Indicated.<sup>4</sup>
4. Interventions should be classified as evidence-based only if they have been evaluated via a valid experimental design. In most cases, the experimental design will be a randomized control trial, although other valid experimental designs include interrupted time series experiments and regression discontinuity designs.<sup>7,8</sup>

5. By July 2017, the ADPC should establish standards for the percentage of state-administered funding to be spent on, and/or the number of participants to be included in, each category of intervention.
6. All state-administered funds allocated for prevention programming funds must be spent on activities listed by the ADPC.
7. OHA should incorporate full accountability for all county and CCO spending of OHA-administered prevention funds in the new data collection system--Oregon Prevention Data System--that is planned to be implemented in July of 2016.
8. Access to evidence-based prevention programming should be measured, monitored, and expanded. Whether the prevention activities are CCO-based, school-based, family-based, or community-based, Oregon needs a greater quantity and much improved effectiveness.
9. Oregon Department of Education should survey school districts to compile and inventory of prevention activities being conducted in local schools and outcome evaluations, if any. Survey results should be reported periodically to OHA's Public Health Division and to ADPC.
10. All periodic activity reports, outcome evaluations, and other SUD prevention data submitted by the CCOs, counties, and state agencies should be rapidly published for public oversight.
11. State agencies that fund prevention programs should monitor the reach and impact of each preventive intervention. Funders should also conduct effective program evaluation to determine whether the hoped-for reductions in alcohol and other drug use and all of the other intended behavioral, academic, and health-related outcomes are improving as results of prevention programming.
12. Future rules by the State Board of Education related to district school boards' comprehensive alcohol and drug abuse policy and implementation plan should be developed in consultation with the ADPC and OHA. These include rules related to prevention curriculum and public information programs, as well as district intervention plans for students who appear to have drug or alcohol problems.<sup>9</sup>
13. The ADPC should support school districts' strategies to gain access to federal funds for drug abuse prevention programs.<sup>9</sup>

## References

<sup>1</sup> Hammond, Linda. "Governor's Balanced Budget 2013-2015, Presented to the Human Services Legislative Sub-Committee on Ways and Means." State of Oregon, Oregon Health Authority, Addictions and Mental Health Division. February 25, 2013. Online at [https://www.oregon.gov/oha/2013\\_2015BudgetMaterials/Addictions and Mental Health, Feb. 25, 2013-2015.pdf](https://www.oregon.gov/oha/2013_2015BudgetMaterials/Addictions%20and%20Mental%20Health/Feb.%2025,%202013-2015.pdf) Accessed April 9, 2014.

<sup>2</sup> SAMHSA. (2015). [http://www.samhsa.gov/data/sites/default/files/2015\\_Oregon\\_BHBarometer.pdf](http://www.samhsa.gov/data/sites/default/files/2015_Oregon_BHBarometer.pdf) Accessed May 20, 2016

<sup>3</sup> Oregon Health Authority. March, 2016. Prevention Services 2014-15.

<sup>4</sup> Community Prevention Institute/California Department of Alcohol and Drug Programs: 2006. The IOM Model: A Tool for Prevention Planning and Implementation. In "Prevention Tactics, Edition 8:13." Springer, Fred and Phillips, Joel.

<sup>5</sup> Oregon Health Authority, Addictions and Mental Health Division. AMH Approved Evidence-Based Practices. Online at <https://www.oregon.gov/oha/amh/Pages/ebp-practices.aspx> Accessed March 22, 2016.

<sup>6</sup> Oregon Department of Administrative Services, Office of Economic Analysis. Oregon Economic and Revenue Forecast, March 2016. Page 58.

<sup>7</sup> BR Flay, A Biglan, RF Boruch, et al., "Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination." *Prevention Science* (September 2005) 6(3):151-75.

<sup>8</sup> DC Gottfredson, TD Cook, FE Gardner, et al., "Standards of evidence for efficacy, effectiveness, and scale-up research in prevention science: Next generation." *Prevention Science* (October 2015) 16(7):893-926.

<sup>9</sup> ORS 336.222 District policy and plan: In accordance with rules adopted by the State Board of Education in consultation with the Oregon Health Authority and the Alcohol and Drug Policy Commission, each district school board shall adopt a comprehensive alcohol and drug abuse policy and implementation plan, including but not limited to:

- (1) Alcohol and drug abuse prevention curriculum and public information programs addressing students, parents, teachers, administrators and school board members;
- (2) The nature and extent of the districts expectation of intervention with students who appear to have drug or alcohol abuse problems;
- (3) The extent of the districts alcohol and other drug prevention and intervention programs; and
- (4) The districts strategy to gain access to federal funds available for drug abuse prevention programs. [1989 c.1076 §1; 2009 c.595 §208; 2011 c.673 §6]

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## Oregon Health and Science University

### Policy Rationale

### Policy Recommendations and Directives

### References

ORS 353.120 Adoption of alcohol and drug abuse policy

The Oregon Health and Science University, in consultation with the Alcohol and Drug Policy Commission, shall adopt a comprehensive alcohol and drug abuse policy and implementation plan. [1995 c.162 ORS 27; 2011 c.673 ORS 10]

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## Oregon Public Colleges and Universities

### Policy Rationale

### Policy Recommendations and Directives

### References

ORS 351.105 Rules for minimum content of alcohol and drug abuse policy

In order to carry out the duties described in ORS 352.008 (Alcohol and drug abuse policy and implementation plan), the State Board of Higher Education, in consultation with the Oregon Health Authority and the Alcohol and Drug Policy Commission, shall adopt by rule, as a minimum, descriptions of the content of what shall be included in the policy and plan described in ORS 352.008 (Alcohol and drug abuse policy and implementation plan). [1989 c.1076 ORS 5; 2009 c.595 ORS 222; 2011 c.673 ORS 8]

ORS 352.008 Alcohol and drug abuse policy and implementation plan

In consultation with the Oregon Health Authority and the Alcohol and Drug Policy Commission, each public university listed in ORS 352.002 (Oregon University System) shall adopt a comprehensive alcohol and drug abuse policy and implementation plan. [1989 c.1076 ORS 3; 2009 c.595 ORS 223; 2011 c.637 ORS 239; 2011 c.673 ORS 9]

## Cannabis

### Policy Rationale

### Policy Recommendations and Directives

Monitor effects of the medical cannabis and adult-use cannabis control system – pricing, taxation, outlet density, enforcement activity involving gangs and crime organizations  
Monitor abuse and minor-use proxies: cannabis-related school discipline, cannabis-related DUII arrests and crashes, referrals to juvenile court for MIP-cannabis  
Implement statewide retail testing programs for minor purchasing  
Improve and expand pesticide testing  
Maintain and monitor concentration standards for edible cannabis products  
Improve access to banking services for cannabis industry  
Control product diversion through effective supply chain monitoring

### References

## Cannabis Use Prevention Policy for K-12 Schools

### Policy Rationale

Oregon House Bill 3400, enacted during the Legislature's 2015 Session, directed the Oregon Health Authority, State Board of Education and the Alcohol and Drug Policy Commission to collaborate on developing marijuana abuse prevention curricula and public information programs for students, parents, teachers, administrators and school board members, as part of the local districts' comprehensive alcohol and drug abuse policy and implementation plan.

### Policy Recommendations and Directives

In late 2015 and early 2016, staff members of the Oregon Department of Education and the Oregon Health Authority Public Health Division met several times with an ADPC Commissioner with expertise in prevention, and with the Executive Director of the Commission.

Together, they produced the informational document shown below.

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#### **Youth Marijuana Use Prevention: Information for educators, school administrators and other youth-serving professionals**

The good news is that most Oregon students do not use marijuana. Still, we should be concerned about the young people who do. In 2015, about one in five Oregon 11<sup>th</sup> graders and nearly one in ten 8<sup>th</sup> graders reported using marijuana in the past month.<sup>1</sup>

#### **Marijuana Legalization**

On July 1, 2015 marijuana use and possession by those over the age of 21 became legal. Retail sale of marijuana, currently limited to dried marijuana flowers and leaves and immature marijuana plants, has been allowed in Oregon since October 1, 2015.

The Oregon Liquor Control Commission (OLCC) began accepting applications on January 4, 2016 for marijuana producers, processors, wholesalers and retailers in anticipation of full retail sales of marijuana and marijuana products by fall of 2016. To learn more about what is legal in Oregon related to marijuana visit: <http://whatslegaloregon.com/>

#### **Marijuana and Youth Brain Development**

Because brain development is not complete until people are in their mid-twenties, marijuana should not be used to get high while this process is still happening. Marijuana may cause difficulty in learning, memory issues and lower math and reading scores. In short, the more

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<sup>1</sup> Oregon Healthy Teens Survey, 2015.

often youth get high, the harder it may be for them to learn. Some people who use marijuana, especially adolescents who use marijuana frequently, may become dependent on it.

### Preventing Student Marijuana Use

- **Keep channels of communication open**

Listen carefully to students and stay positive. Keep the conversation open so they can come to you with questions. Respectful dialogue with trusted adults can help young people develop critical thinking and independent decision-making skills.

Tailor your conversations to the age and developmental stage of your students.

Marijuana can get in the way of students' goals. Ask about their dreams and help them connect with what they need to achieve their goals. Be honest, and explain how avoiding marijuana use can help them reach their goals.

- **Remind students of the facts about adolescent marijuana use:**

- Breaking school or after school activity rules: Youth could lose the ability to participate in extracurricular activities, be suspended, expelled or face prosecution.
- Breaking Oregon laws: Youth may be cited for Minor in Possession, which can lead to probation, fines, public service labor, and loss of a driver's license.
- Breaking federal laws: Since marijuana is still illegal at the federal level, youth with marijuana charges may have difficulty getting financial aid to help pay for college.

- **Have clear and effective policies which are equitably enforced**

Ensure your district's policies that prohibit alcohol and other drugs on campus are clearly visible to all students. Policies should include the following components:

- Ban possession of all marijuana products, including marijuana-related clothing, and any marijuana use.
- Define smoking in your policy to include inhalant delivery systems (vaping products and e-cigarettes).

Remind students of their responsibility to uphold these policies and enforce the policies equitably.

- **Promote alternatives to suspension and expulsion**

Be clear about consequences for violations. Promote alternatives to suspension that improve educational outcomes, like restorative justice approaches. More information about restorative justice can be found at <http://www.dignityinschools.org>

- **Connect students to help when needed**

At the beginning of each school year, remind students, parents and staff about the schools substance use policy and consequences. Let everyone know how to get help for problems with alcohol or other drug use. The Lines for Life Helpline provides confidential crisis intervention and referral 24/7 at (800) 923-HELP (800-923-4357).

- **Use evidence-based health education curricula and tools**

- Adapt existing evidence-based curricula to reflect that marijuana is legal for those over 21. Many students will likely see trusted adults using marijuana. The following messages resonate with youth. Please use them!
  - When you get high, you may have difficulty learning, memory issues and lower math and reading scores. The more frequently you get high, the harder it may be to learn.
  - Brain development is not complete until your twenties. For the best chance to reach your full potential, you should not use marijuana to get high while you are young.
- Use evidence-based marijuana prevention materials, or adopt additional curricula that contain marijuana prevention information and activities. Examples of curriculum that meet this standard are below.
  - Life Skills Training – Middle School
  - Good Behavior Game (GBG)
  - Guiding Good Choices
  - Incredible Years
  - Lions Quest Skills for Adolescence
  - Project Northland
  - Project Star
  - Mentoring for students (Across Ages, Big Brothers/Big Sisters, Career Beginnings Sponsor-a-Scholar)
  - Strengthening Families Program: For Parents and Youth 10-14.
- **Support students to help one another**

Mentor students in organizing clubs to promote healthy and fun activities for students, and peer-led health promotion messages. Find ways to let students know that most of them are making healthy choices (use [Oregon Healthy Teens Survey](#) or [Student Wellness Survey](#) data for your school or county to show the percentage of students who are not using alcohol or other drugs). Messages should reinforce that making healthy choices now will help them succeed in school and achieve their dreams.
- **School climate supports achievement and healthy development**

Be aware of how marijuana is discussed among staff and administrators. A positive school climate supports healthy and open dialogue between youth and adults on a range of issues, including the risks of substance use. Attention to school climate initiatives supports student achievement and healthy development. More information about school climate can be found here: <https://safesupportivelearning.ed.gov/scirp/about>

For more information and ideas, visit:

- [Healthoregon.org/marijuana](http://Healthoregon.org/marijuana)
- [www.AboveTheInfluence.com](http://www.AboveTheInfluence.com)
- [www.TooSmartToStart.samhsa.gov](http://www.TooSmartToStart.samhsa.gov)

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## References

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2015 Session HB 3400 Cannabis Education Program

SECTION 117. (1) As part of the comprehensive alcohol and drug abuse policy and implementation plan described in ORS 336.222, the Oregon Health Authority, State Board of Education and Alcohol and Drug Policy Commission shall collaborate on developing marijuana abuse prevention curricula and public information programs for students, parents, teachers, administrators and school board members.

(2) In the manner provided by ORS 192.245, the authority [OHA] shall report on the implementation of this section to the Legislative Assembly on or before February 1 of each odd-numbered year.

SECTION 118. Notwithstanding section 117 (2) of this 2015 Act, the Oregon Health Authority shall first report on the implementation of section 117 of this 2015 Act and may make recommendations for legislation, including recommendations related to the use of moneys collected as a tax from businesses involved in marijuana operations, to the Legislative Assembly on or before February 1, 2016.

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## Capacity, type and utilization of prevention programs

### Policy Rationale

### Policy Recommendations and Directives

### References

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## Capacity, type and utilization of treatment programs

### **Policy Rationale**

### **Policy Recommendations and Directives**

### **References**

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Methods to assess the effectiveness and performance of programs

### **Policy Rationale**

### **Policy Recommendations and Directives**

### **References**

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The best use of existing prevention and treatment programs

### **Policy Rationale**

### **Policy Recommendations and Directives**

### **References**

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## Budget Policy Priorities

### Policy Rationale

Oregon's Department of Corrections  
Department of Human Services  
Oregon Health Authority  
Department of Education  
Oregon Criminal Justice Commission  
Oregon State Police  
Oregon Youth Authority  
Any other state agency approved by the ADPC to be involved in alcohol and drug abuse prevention and treatment services;

### Policy Recommendations and Directives

### References

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## Standards for Licensing of Prevention Programs

### Policy Rationale

### Policy Recommendations and Directives

### References

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## Standards for Licensing of Treatment Programs

### Policy Rationale

### Policy Recommendations and Directives

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## References

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### Minimum Standards for Prevention and Treatment Services

#### Policy Rationale

for contracting, providing, and coordinating alcohol and drug abuse prevention and treatment services that use federal, private, or state funds administered by the state

#### Policy Recommendations and Directives

## References

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### Most effective and efficient use of funds and personnel

#### Policy Rationale

Of participating state agency resources to support prevention and treatment programs:

Oregon's Department of Corrections  
Department of Human Services  
Oregon Health Authority  
Department of Education  
Oregon Criminal Justice Commission  
Oregon State Police  
Oregon Youth Authority  
Any other state agency approved by the ADPC to be involved in alcohol and drug abuse prevention and treatment services;

#### Policy Recommendations and Directives

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Restore judicial sentencing discretion  
Re-align drugs and penalties in statutes  
Reduce racial and ethnic disparities in drug enforcement  
Evaluate variations in available programs across the state; focus expansion in underserved areas  
Address racial, ethnic, income, geographic, other disparities

## References

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