



Alcohol and Drug Policy Commission

October 19, 2010

10:00-11:30 AM

DHS Metro Training Center
1425 NE Irving, Bldg 200, Suite 250
Portland, OR 97232

Conference Line: 1-877-455-8688 Code: 915042

Follow-up and Action Summary

Members

X	Ann Lininger	X	Gary Cobb	X	Lane Borg	T	Richard Harris
	Anthony Biglan		George Brown		Laurie Monnes Anderson	X	Sarah Goforth
X	Bruce Goldberg		Heather Crow-Martinez		Lee Lederer	X	Steve Pharo
X	Cameron Smith	X	Jack Costello		Madeline Olson		Susan Castillo
X	Carolyn Tomei		Janet Holcomb	X	Mary Ellen Glynn	X	Timothy Hartnett
	Dennis Dotson	X	John King	X	Max Williams		Timothy Thompson
X	Dennis McCarty	X	John Kroger	T	Mickey Lansing		
	Erin Hubert	X	Judith Cushing	T	Randy Schoen		

Guests

Paul Bellatty (DOC), Shannon Carey (NPC Research), Shannon Sivell (DOJ), Devarshi Bajpai (OCJC), Keith Falkenberg (Multnomah Co.), Samantha Johnson (NA), Miriam Widman (Lund Report), Rusty Cochran (NA), Jonathan Eames (OPERA)

Agenda Item

Lead(s)

Welcome

Chair Kroger

Approval of Minutes

Chari Kroger

The approval of the September minutes was deferred to the November meeting.

A&D Policy Commission Tour

Chair Kroger

Handout: Alcohol and Drug Policy Commission – Fall 2010 Potential Tour Dates

Action: Please take a moment to let us know which of the events you are planning to attend. We would like to ensure that at least a few commission members are able to make each event. Doodle Survey: <http://www.doodle.com/uueh5thz23pvh3bw>

DRAFT

Legislative Concept	Chair Kroger
<p>The draft of the legislative concept is now available. It will be circulated shortly. Please review the concept and confirm that this concept is what we voted on as a body earlier in the year.</p> <p>Action: Please take the time to review the legislative concept draft and confirm it is what this body voted on earlier this year. If you have any questions or issues please flag them and get them to Mary Ellen Glynn ASAP.</p>	
Prevention Proposal	Chair Kroger
<p><i>Chair Kroger:</i> The prevention subcommittee has been working to list out 10 to 12 pilot projects as part of a recommendation that will be discussed at the November meeting of the commission. The plan is to take a vote on the recommendation to move it forward to the next legislative body. The group is current working on finalizing fiscal impact statements for the proposed pilot projects.</p>	
Prescription Drug Summit	Chair Kroger, Cushing
<p><i>Chair Kroger:</i> On November 22, at the Federal Courthouse, there will be a Prescription Drug Summit sponsored by the US Attorney and the Office of National Drug Control Policy.</p> <p><i>Judy Cushing:</i> The goals of the summit are to bring together the stakeholders who have a piece of the pie in the challenges around prescription drug abuse. That means bringing together health care, PhRMA, law enforcement, prevention community, justice, Oregon Medical Association and behavioral health to have a robust dialogue about the issues. However, before that experts from around the country will present on issues from pain management to the most abused substances to what is happening to the systems in Oregon (DHS and Justice) and then move toward the more robust conversation around solutions in the afternoon. This is the first, maybe second, session of its kind. The session is being convened by the top leaders of the state to call upon the entities that have a stake in the issues to look at solutions. This will require them to set aside some of their own wants to look at the good of the whole for Oregon’s citizens.</p> <p>If members want to participate, Chair Kroger encourages your participation. This is a great opportunity to have the frank conversation between various communities (health, law enforcement, pharmaceutical companies) about where we are on this issue as a country.</p> <p>Decision: The commission has been asked to be a sponsor of the event. Chair Kroger requested objections to this request, hearing none the request was approved.</p>	



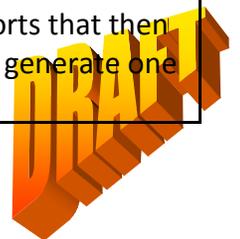
Chair Kroger: One of the things the commission has been trying to accomplish around accountability is to collect some basic data sets about outcomes that treatment programs have. While recidivism reduction is not the only outcome that matters, but it is an important one.

Paul Bellatty, Department of Corrections Research Unit: Some of the things DOC has done around program evaluation, as it pertains to drug and alcohol programs.

If you look at the traditional analysis you look at those who have gone through treatment and those who have not. You make statistical adjustments to account for the differences in the two groups. Usually the control group is very diverse and the adjustments can sometimes be large. Over the past 5 to 10 years they have developed techniques that allow you to match individuals so you can look at a person who has gone through treatment and you find their data “twin”. This is accomplished by looking at the data you have and associate demographic (criminogenic factor) with the outcome (recidivism). You can narrow it down to about eight key variables that can be associated with the outcome to look at the individuals. You find a “twin” with the same key variable to compare someone who has and has not been through treatment. The work done on these techniques over the last five to ten years. DOC uses propensity scoring, which is supposed to be the best alternative to a randomized design. From there you can take 100 people who have gone through the program and look at the control group and look at recidivism rate vs. the treatment group is to find the effect sizes. Other advantages of going through these efforts. One is to return the information to the treatment providers and look at individuals who have recidivated in both groups. This will indicate that we are not effective with that group. We can then look at those individuals that they are and are not effective with. This will allow the providers to focus more strongly on those groups that they are most effective with.

One example at DOC is the boot camp. When the data was analyzed it showed that that boot camp was ineffective. One of the first questions that supports of the boot camp had was what is the recidivism rate for those who did and did not complete the program? By matching those up it would show whether the program was effective or a great filter. Yes there was a lower recidivism rate among those who completed the program. However it was more about who completed the program. The demographics and criminogenic factors of those who completed the program indicate that those participants were lower risk. So it’s a great filter verses a program that is effective.

The one thing that DOC has that most do not is a data warehouse. It allows DOC to automate this process. This system allows DOC to match up participants that enter the program to be matched up with a “twin” early on. The information can be provided back to the providers early on to access recidivism as soon as they leave. The treatment providers can look at the effectiveness of treatment programs over the last year, five years; females vs. males; etc. The warehouse allows us the ability for members of the treatment community to send us identifiable information (name, SID number, etc.) to match up and send information back to them so they can access their own effectiveness. It will also allow us the opportunity to get an overall effect size of the overall population. In addition, DOC has been working with other groups that can contribute to program evaluation like groups that do fidelity estimates, cost benefits, treatment providers, and outcome evaluators. One of the down sides is that not all of these groups contribute to the report so the director receives six or seven reports that then have to be reviewed, digested and weighed. We are moving toward a model that would generate one report.



Chair Kroger: Can you tell us about the results that you are seeing, given the data collection, between the treatment population and non-treatment population and recidivism? We used this methodology early on to review a program in eastern Oregon to see if it was effective. There were about 175 beds and 200 individuals had already been through the program. We followed them for a number of years and the data suggested that the recidivism rates were substantially lower for this group. However, over time there was turnover in staff and a number of issues so those estimates do change considerably depending on who is there, who is providing treatment and stability.

Every couple of years we evaluate the programs and provide the programs feedback. Sometimes dosages are insufficient, they are not serving the right populations, etc.

Max Williams: It is important to draw the distinction in the statistical information about the effect size of the programs and the fidelity work. We have a group using the Corrections Program Check-list (CPC) to evaluate internal DOC programs and external programs funded by community corrections funding in the counties. This an on the ground assessment of the program to see if it is meeting an identified set of evidence based standards based on how the program is being administered, the curriculum, the right number of clinical staff at the right level to provide the treatment, and a variety of other issues. That is the key – having an evidence based program and good initial statistical results but if the fidelity issues is not constantly being assessed, monitored and improved you end up with a program that is not producing what you thought it would. We use both methods to constantly monitor that DOC is getting what we think we are buying.

Paul Bellatty: Things can change quickly so that is why there is that feedback mechanism so people can look at the numbers to ensure what was effective remains effective.

Chair Kroger: Is there a report that shows what the recidivism reduction associated with the programs is over time?

Paul Bellatty: We will send a report through Mary Ellen. (Attached to notes.)

Chair Kroger: Is there a number you can throw out that is current or on a last report?

Paul Bellatty: When we look at the initial 200 in the AIP program, if they completed the program they were released early, so we only had people who completed the program. The attrition rate was about 50 percent. The estimate is twice what it should be because it does not include those that did not complete it. The estimate is 29 percent so the effect size is about 15 percent (reduction in recidivism) for the first 209 [Powder River]. This initial study was completed in 2006/2007.

Chair Kroger: Has that rate maintained over time or changed because of staffing and other issues?

Paul Bellatty: The methodology is on our web page and I'll leave the report with Mary Ellen. It looks back at it 6 months later and reflects that there is no treatment effect because of the change. It is difficult to keep personnel there. People tend to move to DOC or other state positions over there because the contract provider is unable to retain staff.

DRAFT

Max Williams: It is a contract issue with the provider. We continue to work with them, but it does demonstrate that you cannot just have one good outcome and assume everything is fine. There are leadership and management changes that have direct impact on the program delivery. Like most programs, we have had peaks and valleys in effectiveness. In other programs and facilities across the board we can generally assume the same level of effect size to the extent that the program is being delivered with the right level of fidelity. That is alcohol and drug treatment, there are other things that we do with this same population, like cognitive restructuring, that help leverage the effect of alcohol and drug treatment to be more successful. That information is available on our research web site.

<http://www.oregon.gov/DOC/RESRCH/index.shtml>

Representative Tomei: Paul, help me to understand, you gave us some figures that about half of these folks finished the program. What was the 29 percent number?

Paul Bellatty: There was a 29 percent reduction in recidivism attributable to the program. When we normally do an evaluation we include those that do and do not complete the program. For this first 209 who graduated from the program, we did not have anyone to compare them to because those who did not complete the program had not been released and given the opportunity to recidivate.

Representative Tomei: Help me to understand that number. Out of the 100 that finished the program, 29 percent never recidivated, right?

Paul Bellatty: Based on the effect size, or the percent reduction attributable to the treatment program. So say that normally half would recidivate (50) and you get a 50 percent reduction in recidivism it would go down to 25 because it cuts it in half. So if you have a 29 percent reduction in recidivism that means if you had 100 who would normally recidivate, than you would have only 71 based on the program. That is only those that would recidivate, not everyone that went through the program. This was over a 3-year period.

Max Williams: Recidivism in Oregon is measured by a conviction of a new felony within three years of release. It does not mean that they have not committed a crime. It is an imperfect measure, and we must be careful about how much we rely on recidivism as measure for demonstrating all success in all things. I think a lot of all we are also trying to do in the development of appropriate measures is to measure how many people who get alcohol and drug treatment are employed at 6 months, 12 months, 18 months or how many have stable housing within 6 months, 12 months, 18 months after release. There are other factors that can play a part in why someone recidivates independent of the effectiveness of the alcohol and drug treatment program. When someone gets out, if they don't have a place to work, live, or no on going treatment is available to them in the community the likelihood is that they will not be very successful which may have nothing to do with the effect of the program but rather the effect of the transition resources that aren't available to them when they are released. Understanding the interrelationship of those nuances is important as we as we evaluate these issues and important that we don't place all of our money on the single measure of recidivism as a basis for whether or not a program is going to be successful or not.

Generally recidivism in Oregon sits at about 30 percent. For this category of offenders that we are focusing on with alcohol and drug issues they are typically higher recidivists. They have a high alcohol and drug need and in our program because they have a high criminal risk score (score rating their



likelihood to reoffend upon release). We are trying to target people who have a risk to recidivate and a high alcohol and drug treatment need. The rigger of the program is that if you cannot make it work we will not let you through the program and you will fail. They will spend all of their time in prison and not benefit from any reduction.

Shannon Carey: I just finished a statewide cost study for adult drug courts in Oregon. Recidivism was any rearrest for any crime. There is a comparison group of people who were eligible for drug court who did not attend matched county by county to people who did attend drug court. 60 percent of the control group over a three-year period was rearrested at least once. Compared to 48 percent of the people who went to drug court, whether they graduated or not. The number was 30 percent for drug court graduates.

Looking at the number of rearrests, on average the comparison group was rearrested twice. On average participants were rearrested once over the two-year period and 0.6 times for program graduates.

The top four drug courts for reduction in recidivism over three years:

- 1 Marion County – 67 percent reduction
- 2 Jackson County – 62 percent reduction
- 3 Washington County – 61 percent reduction
- 4 Clackamas County – 61 percent reduction

Max Williams: Different county drug courts cater to different participants that they allow to qualify to participate. How did this study take into account that certain counties allow drug court for what might be lower risk offenders than another county that took on a more challenging group of offenders.

Shannon Carey: We did match county by county based on prior criminal history. They are matched on that and other demographics. Some of the reason you might see a reduction in rearrests is because a county that is taking a high risk offender into the program will see a bigger reduction because their offender will not get rearrested multiple times verses a low risk offender that might not have been rearrested anyway. So there is a bigger effect size.

Bruce Goldberg: Why are some better than others?

Chair Kroger: Is there something that the top four programs share in terms of their approach that a lesser performing programs does not?

DRAFT

Shannon Carey: Part of the study in Oregon, and 101 courts across the nation, that is looking at best practices in drug courts. What are the best drug courts doing?

- 1 They have everyone on the team and attends court sessions. (Attorneys, judge, treatment providers)
- 2 UA's two to three times per week.
- 3 Drug court sessions every two weeks – once a week for high risk populations.

Bruce Goldberg: So it's the protocol, not the individuals? Do the top four have all of those protocols?

Shannon Carey: I am still analyzing the data for Oregon, but nationally they are. I would be surprised if they are different.

Question: The population size of these drug courts, does it vary greatly?

Yes between 15 participants to 400 or 500 participants.

Question: In Multnomah County, Marion Counties, the statistics are drawn from what size of the group?

It's a midrange. 60 to 70 participants. The main program for Multnomah County is down to around 200.

Question: Does that skew the statics?

We take that into account in the stats. We have found a best practice nationally that the smaller the number of participants the better the outcomes. We don't have enough research to know why that is. Although it is hard for a judge to get to know so many participants in the larger programs. It is not that the larger courts do not have good results; they just are not as good as the smaller programs.

Of the 101 drug courts in the national study, there are both pre-plea and post-conviction, it made not difference they had the same results. On average the drug courts in Oregon saved about \$7,000 per participant due to reduced recidivism costs. Not just arrests but what they served in prison, jail, time on probation and other factors that go with rearrest. Washington County had the highest rate at \$10,155 saved per person over a three year period. A public report will be available with the next 30 days.

Chair Kroger: We requested a report from AMH to compare recidivism rates, like what we asked DOC to compare. Unfortunately the data is preliminary, but the report does not capture what we need to know. What are the recidivism effects of treatment? We will try again to get data that is responsive to that question. This highlights our need for a more comprehensive and coherent data collection system at the statewide level.

DRAFT

Handout: WITS/MTM Overview

Mary Ellen Glynn: We looked at both WITS and MTM.

Sarah Goforth: Multnomah county had declined to use MTM service.

We were looking to see what was duplicative, was there cross over, do we both, do we need neither. The question is what do we need to do? We had a great presentation from WITS. WITS is currently being used by Alaska, Nevada, Iowa, and Maryland to name a few. One of the things that WITS has is a component that would allow us to implement a voucher system. AMH has been awarded a four year grant, about \$3.5 million per year, to implement a voucher system for access to recovery services. This would be traditional and non-traditional services. AMH has to have a voucher system in place in the next four months to take advantage of the funding, and it will be in the WITS system. There are some states that only use the voucher system of WITS. WITS is a well known open system that has been in use by various organizations for quite some time with some success. MTM is being used by some counties and states across the nation.

The differences between the two systems include:

WITS is seen as an electronic health record. Most major providers have some type of electronic health record. AMH would offer this system to smaller providers for free to help track outcomes. WITS also has very good potential for interoperability with the criminal justice system, employment and other databases that ultimately would want to connect with. 20 providers over the next year or so. WITS can do read record keeping, billing, the voucher program. Maryland and San Diego County use an e-court system interface with WITS.

MTM has a one-year contract to do data mapping, with standardization and data warehousing done in subsequent years. Some counties have signed up for only portions of this work. Multnomah and Lane counties will not participate as they already have other systems already in place. The counties that are doing the data mapping (looking at what is being measured and where the gaps are). It can also help the clinicians get more efficient.

The most important thing is not what system are you on, but can the systems talk to each other and do they collect the same data. We need to figure out how to have uniform data collection between providers, counties and the state and to have that data talk to other statewide systems.

DRAFT

Jack Costello: Just a few comments, the MTM system is mainly a mental health oriented system. WITS was developed for chemical dependency programs. There is one state that uses it for outpatient mental health right now, but it is not a mental health application. CPMS that everyone fills out right now, but does not provide very good data right now. We are stuck right now without the capital funding that would put a system that would cover a system that would capture both mental health and chemical dependency treatment. About half of the funding that goes into addictions treatment is through Medicaid and we hope to move more of this into Medicaid in 2014. I believe in any discussion DMAP and OHP needs to be part of the development of the data set that is being determined. Half of the data is currently available through claims submission under OHP membership. However, they are not a player in this discussion to this point but need to be involved in both the MTM and WITS discussions. One of the things that other states have available through the WITS system is a repository for data to be put into, a data warehouse, so that the information can be pulled down and analyzed by the state or university. This could be pulled out of the WITS or MTM system. We need to be creating a set of data that could be fed up into the system so a set of reports could be pulled down for the feds, state or programs.

Chair Kroger: Follow-up questions, everyone seems to agree that having a unified data set so providers don't have to collect a lot of data that will not be used or collect one piece of information for this group and another thing for another group. What is the process for getting everyone to the table that would have could work to get agreement for that data set? Does this commission need a working a group that gets with their constituencies to try to do that work?

Jack Costello: Bruce can probably speak to this, but I believe Health Care Reform is working towards this.

Bruce Goldberg: Part of it, a part of it is the work that is being done of interoperability of health records in general across the state. No one is mandating single systems, but rather what is being developed is standards of interoperability. So that any system, whether it be a hospital, clinic, mental health, substance abuse, etc. can all exchange information in a common data field. Likewise, those of us in research and policy can get apples to apples comparisons. What I'm not sure about, from this conversation, is that much of the larger health care interoperability discussion I don't know how much the substance abuse portion is a part of that conversation and planning?

Jack Costello: I believe that both the mental health and substance abuse are excluded at this point.

DRAFT

Dennis McCarty: They have not been included in the federal authority to develop the systems and more importantly the national standards are not yet developed. That means that people are building systems in anticipation of standards that will likely change before they release their products. It is a bit of chaos at a federal level, but it is important for Oregon to be thinking proactively to include mental health and substance abuse as they develop their own electronic health records.

I believe that Chair Kroger is putting another issue on the table, which is what is the ability to link with the criminal justice system, court system, and social services system? These are additional systems that are not currently included under electronic health record systems.

Ann Lininger: I was at a meeting a couple of weeks ago where MTM and WITS representatives came together to talk about where they both were. It was clear that counties have some costs that make it clear that they must move forward with MTM. However, at that meeting there seemed a clear willingness by county and state folks to look at prospectively align them in areas where the systems are not yet finished. If this commission has the spending authority over alcohol and drug treatment spending in Oregon, then it has the ultimate action forcing mechanism. Which is, that you would like to contract with entities that have systems that have been created in a way that they can talk to each other and provide the relevant information. It is the right time, because they are still building. You have the right action forcing mechanism, as a condition of getting the funding they need to be sure that their systems can do what is needed.

Chair Kroger: What would be the process, starting now, to try to get people on the same page about the data that this system should collect?

Ann Lininger: In this meeting people expressed a desire to have an ongoing joint team to ensure that we didn't have two parallel or diverging tracks. I don't know who those names are, but it seemed clear that both camps wanted to continually be in the room to design the systems productively.

Chair Kroger: Can we put together a list of folks that you would need to have in a room on the county, provider and state level to try to hone in on what that standard data set looks like?

Dennis McCarty: The list of variables are pretty well developed already, it is more about the operationalization of those variables.

DRAFT

Bruce Goldberg: I think the commission is a good vehicle to do that. But I would say we should broaden the conversation to not be driven by two systems (WITS and MTM), but rather by an overall look at what we want from the state. Bring in some people from the Health Information Technology Oversight group that is looking at the overall electronic architecture. This is not about what the data elements are, but the technical aspects about how they captured and whether they can talk to each other. The issue is how you can technically collect the data so they are interoperable.

Ann: I think there are two issues. If only one of the systems is only focusing on one part of it then we need to have concurrence from the policy level about what the pieces of information are. Then we need the architects to figure out the design of it.

Chair Kroger: We don't have consensus yet about what the basic data set is or the operability. At some level, I think it will be very hard to tell everyone to work out what the operability is. I think the state is going to play an important role in saying what the parameters of operability are.

My basic point is that you can't mandate that everyone develops systems that talk to one another. You have to say for the health plan, here is our primary system and you will need to have a system that will communicate with it.

Dennis McCarty: I believe these discussions have been going on in the overall health side but I don't believe that alcohol and drug and mental health have not been involved. We are just looking for a seat at that table. **Action:** Dennis and ___ will work to put together a list of participants to further this discussion about how to add linkages for substance abuse and mental health to projects already in progress.

Chair Kroger: I assume you are not designing a health records architecture that would easily communicate with law enforcement. There would be no reason why you would, except in this area. That alone might require a different software platform for this area. We will need a capability of having the systems be interoperable with law enforcement databases.

We will be asking someone from Maryland to come to the November meeting. They have implemented WITS with some operability with the criminal justice data. We will ask them to present on what they have done, how they did it, and what the costs associated with it was.

Mary Ellen Glynn: Eventually MTM has a repository but the counties are not there yet. Maryland did this legislatively. The repository of the data is with the University of Maryland.

DRAFT

Bruce Goldberg: I think it is a great idea that we have the folks from Maryland come and speak to us about this. My experience with this is that there are a lot of technical aspects to all of this that it would be really good to have some people who understand this from the operational and technical level on the law enforcement side; the alcohol and drug and mental health sides; and the larger health interoperability side so we can try to understand how we can reach some of these objectives. The commission would be a great place to get some of those folks together. We have to be careful about making pronouncements with out some of the work from the people who are doing this every day.

Chair Kroger: Let me see if I can get some to operate as our Chief IT Officer to help give us some of that technical guidance over the next six months.

Prevention Subcommittee Policy Recommendations	Cushing
---	----------------

Judy Cushing: I would suggest because so many people could not be on the phone, because they are such a large issue and cost us so much I believe it is best that we do just a quick overview today and get into a more detailed conversation at the next meeting.

Three main areas that the prevention subcommittee has looked at:

Availability of alcohol (outlet density or outlet saturation)

Handout: Memo – Policy Recommendations on Alcohol for consideration by the full Commission

One of the things the commission asked the subcommittee to do at the last meeting was to provide evidence around what works and what does not. On the memo there is specific research related to these issues including neighborhood and community safety; traffic crashes and fatalities; consumption by young adults; and what happens in neighborhoods with high outlet density. There is very little neighborhoods can do but there is a lot of information about what happens in areas of high outlet saturation.

The bottom line is that policy recommendations from the national academy of science and others recommend the reduction in outlet density in communities that are experiencing high rates of crime and violence. It is different in every community. Sometimes rural communities will have a very high outlet density purely based on population is not necessarily the way to go. We feel this is an area that the commission should take a closer look at and that will require some time.

Chair Kroger: I concur that the research is definitive that outlet density is associated with problem occurrence. I would also argue that this will be a major problem with marijuana dispensaries, although this is not in the research yet. I believe the commission needs to be proactive and look at the density of outlet for drugs broadly, not just alcohol.

DRAFT

Judy Cushing: In states that already have marijuana dispensaries it is being reported that there are problems associated with dispensaries that are linked to alcohol outlets. I believe that Representative Tomei and other members of our legislative body may putting forth some recommendations around outlet density. Does the commission want to take action to say that they concur with actions?

Chair Kroger: The plan to reduce this to specific recommendations to vote on to support. We will bring this to the November meeting.

Oregon Liquor Control Commission

The size of the commission:

One of the recommendations is to increase the commission to a seven member body, from five. And that the membership not be confined by congressional district. The population of the state is not evenly distributed by congressional district. There would be some economic impact, but that should be minimal as commission members make \$30 per day. Another consideration may be to recommend an increase to a more reasonable stipend. That commission spends a considerable amount of time. There should also be representatives from moderation, public health, and public safety. There is a designated industry represented that sits on the commission already so having other sectors represented on the commission would make sense. **Action:** Recommendations will be brought back to the November meeting.

Retaining control and regulation:

Judy Cushing: There is a ballot measure in Washington state that would deregulate the sale of alcohol driven by big box stores. The evidence around health and safety around those types of sales are clear. There has been a lot of money invested to campaign on both sides. The members of the subcommittee believe there is prudence in maintaining our controlled state status in Oregon.

Revenue recommendation around licensing:

Judy Cushing: We asked Administrator Pharo and the OLCC to provide an analysis of on premise licensing fees. We were blown away to find that Oregon falls 43rd state in application and renewal fees. We charge \$100 and California charges \$12,000.

Handout: Analysis of US 2009 On-Premise Licensing Fees Compared to Oregon

Steve Pharo: Oregon has not changed its licensing fee schedule in years. The handout looks at on-premise licensing (where alcohol is consumed at the site of purchase). Currently Oregon charges \$400 for both initial application and annual renewal. California charges \$12,000 per year.

DRAFT

Off-premise fees are not much difference. Oregon charges \$100 per year for this licensing and California charges \$12,000 per year.

Those licenses are non-limited. There use to be a cap on the number of licenses that can be issued, but that was lifted. Licenses are inexpensive. Since they are unlimited and cheap, the value of a license can be diminished. If a licensee loses a license they are out \$100 for not following the rules. There is some logic that says if the investment is higher more effort will be put into following the rules to not suffer a great loss. Some may say this offers more opportunity to open new business, but this is something that the state will need to weigh.

Limit the number of licensees or change the number of licenses. There are ways to do it. If you increase the license fees, the higher you charge for a license you do begin to push people out of the market. When they are cheap there is no reason for a business not to get a license. When the cost is increased they will need to weigh the cost of the license against the potential return. The fees are set by statute. There is a cap on state liquor stores.

The Oregon Liquor Control Commission has a legislative concept that would allow a local district to affect the cap of the number of premises in their community.

Public Comment	Chair Kroger
None.	
Next Meeting: Tuesday, November 16, 2010	
Contact Information: Mary Ellen Glynn 971-673-1674 or mary.e.glynn@state.or.us . Evonne Alderete 503-932-9663 or evonne.j.alderete@state.or.us	ADPolicy.Commission@state.or.us

DRAFT

**Alcohol and Drug Policy Commission
Fall 2010
Potential Tour Dates and Scheduled Meeting Dates**

October 19, Tuesday	Full Commission Meeting, 10 – 11:30am
November 5, Friday	Portland area
November 10, Wednesday	Albany/Corvallis
November 16, Tuesday	Full Commission Meeting, 10 – 11:30am TBD
November 18, Thursday	Eugene
November 19, Friday	Medford
December 2, Thursday	Bend
December 9, Thursday	Newport
January 12-13 or 26-28	Eastern Oregon



Research Issue Brief -2007

OREGON DEPARTMENT OF CORRECTIONS

Executive Summary: Preliminary Results of DOC Alternative Incarceration Programs

Overview

The Oregon Department of Corrections (DOC) Alternative Incarceration Program (AIP) is a series of intensive services intended to eliminate criminal tendencies. The newest AIP is also intended to treat alcohol and drug addiction.

AIP provides 14-16 hours of intensive programming each day. Programming occurs seven days each week for six months. The institutional program is followed by a 90-day "non-prison/transitional leave," which involves intensive supervision while in the community. Violators of transitional conditions are returned to prison to complete their sentences. Inmates completing the six-month institutional programming and the 90-day non-prison/transitional leave are placed on post-prison supervision and are eligible for prison sentence reductions averaging between 12-13 months.

The first AIP – called Summit – began with a boot-camp model for men and women at Shutter Creek Correctional Institution in North Bend in 1994. In 2003, the Oregon Legislature approved an expansion of AIP focused on inmates with moderate-to-severe substance abuse problems. These treatment beds serve a higher proportion of inmates incarcerated for drug offenses, driving offenses, theft, and burglary.

In January 2004, two new AIPs began to serve higher-risk offenders willing to accept intensive substance-abuse treatment. New Directions AIP for men is located at Powder River Correctional Facility in Baker City. The program will successfully graduate approximately 200 inmates to post-prison supervision annually. Turning Point AIP is located at Coffee Creek Correctional Facility in Wilsonville. The program will successfully graduate approximately 55 inmates to post-prison supervision annually.

Does AIP Work?

DOC has 11 years experience with Summit. However DOC's experience with New Directions has not been long enough to adequately measure its effects on recidivism. Because of this lack of data, direct comparisons of effectiveness between Summit and New Directions are not yet possible.

DOC Research and Evaluation did look at preliminary data on program effectiveness. Using a propensity scoring analysis, groups of offenders from both programs who had been released for at least six months were statistically matched. Control and treatment groups matched based on time since release and the following demographic factors: number of prior incarcerations, any prior theft convictions, revocations from supervision, age, crime type, earned time, sentence length, ethnicity, substance abuse risk, and severity of crime.

Comparisons were completed with the following preliminary results:

- Inmates completing the Summit program at Shutter Creek showed a small improvement in recidivism over the comparison group; however the change was not sufficient to attain the level of statistical significance.
- Inmates completing the New Directions program at Powder River showed a statistically significant improvement in recidivism rates over the comparison group.

Early data shows that the New Directions AIP at Powder River has a significant effect on reducing recidivism, particularly in the early post-prison supervision period. However, it must be stressed that this data is preliminary.

Additional AIP research on comparison of attitudes

A recent doctoral dissertation by Alexander M. Millkey, MS, Psy.D., titled: *Comparison of Attitudes Related to Substance Abuse in Male Inmates Following Treatment in Boot Camps and Therapeutic Communities*, reports that participants in both treatment conditions were found to have statistically significant change in attitudes related to criminal thinking and substance abuse.

His study shows that participants who completed the therapeutic community at New Directions AIP had significantly better attitudes regarding substance use than those who completed the boot-camp model (Summit). However, the effect sizes associated with these differences were small.

Summary

Estimate of AIPs' fiscal impact

Inmates successfully completing any AIP and transitional leave average 385-day reductions in sentence. The resulting reduced number of DOC beds saved \$4.8 million in the 2003-05 biennium. AIP is expected to save DOC \$6.1 million in the 2005-07 biennium.

Ongoing study

Preliminary results show that PRCF's New Directions program is effective in reducing early recidivism. Over the next 24 months, refined research on both the Summit AIP and the New Directions AIP will study larger samples and control groups. This will provide more-definitive results, with data to quantify and compare the effects of all DOC Alternative Incarceration Programs.

Study results also will better associate changes in offender attitudes with subsequent reductions in recidivism, and will help identify the most appropriate inmates for specific Alternative Incarceration Programs. Such ongoing improvements in AIPs can improve effectiveness, reduce the number of future victims of crime, and save taxpayer dollars. ■

**The mission of the
Oregon Department of Corrections
is to promote public safety by
holding offenders accountable for their
actions and reducing the risk of future
criminal behavior.**



**Max Williams, Director
(503) 945-0920**

**Mitch Morrow, Deputy Director
(503) 945-0921**

**Paul Bellatty, Ph.D.
Research & Evaluation Administrator
(503) 947-1010**

**Ginger Martin
Assistant Director for Transitional Services
(503) 945-9062**

**Colette S. Peters
Assistant Director for Public Services &
Inspector General
(503) 945-9092**

**Oregon Department of Corrections
2575 Center Street NE
Salem, Oregon 97301-4667**

www.oregon.gov/doc

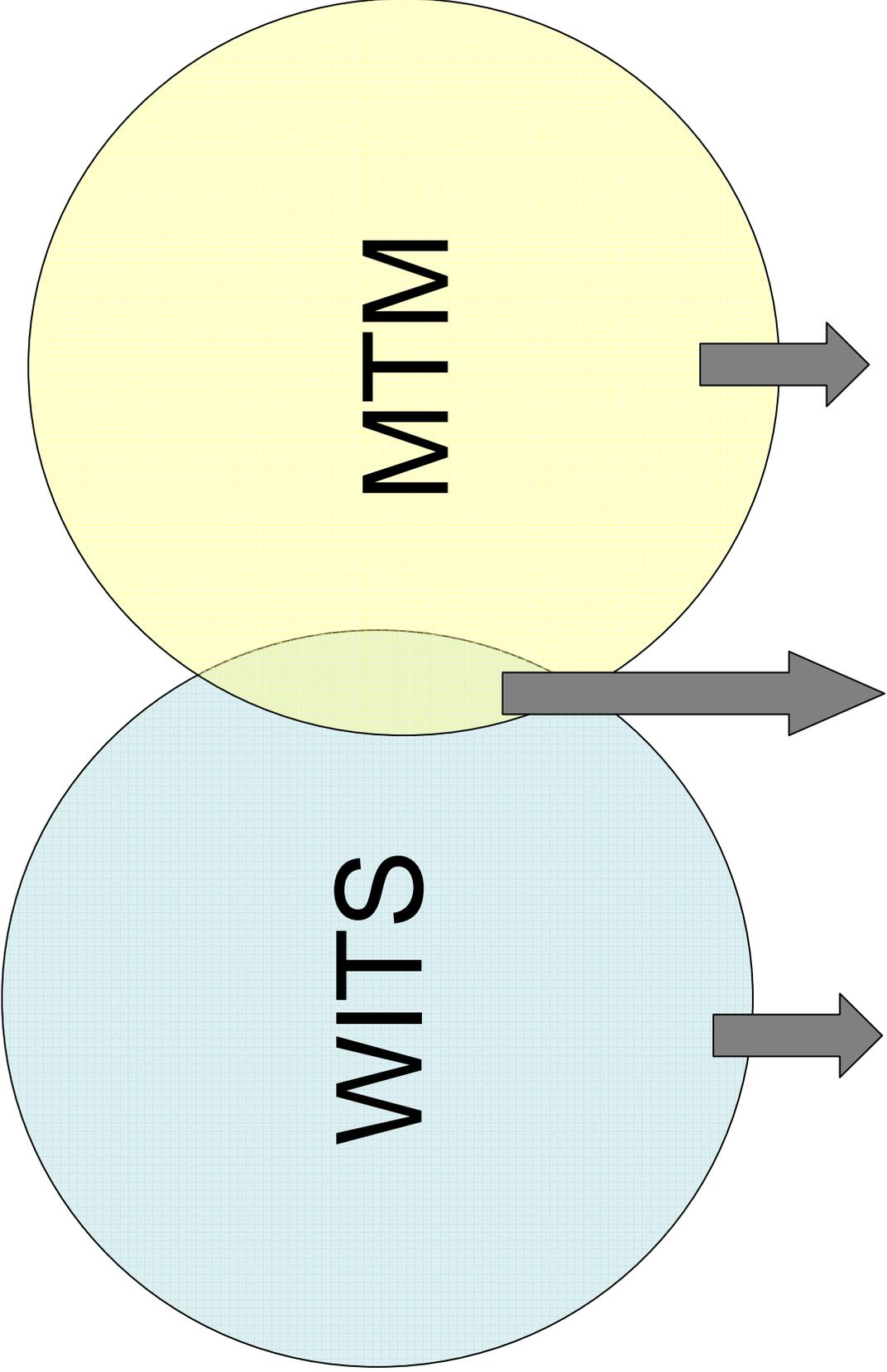
R1-DOC/PA:2/5/07

WITS/MTM Overview

Mary Ellen Glynn

October 19, 2010

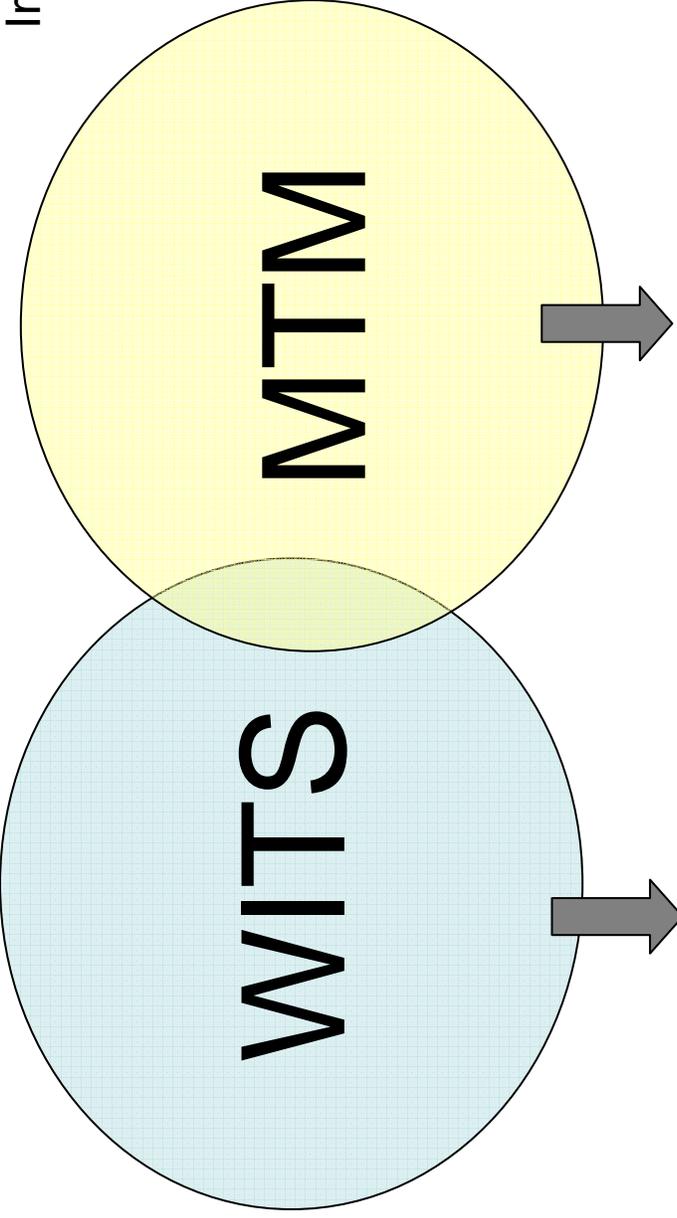
A&D Policy Commission



WITS

MTM

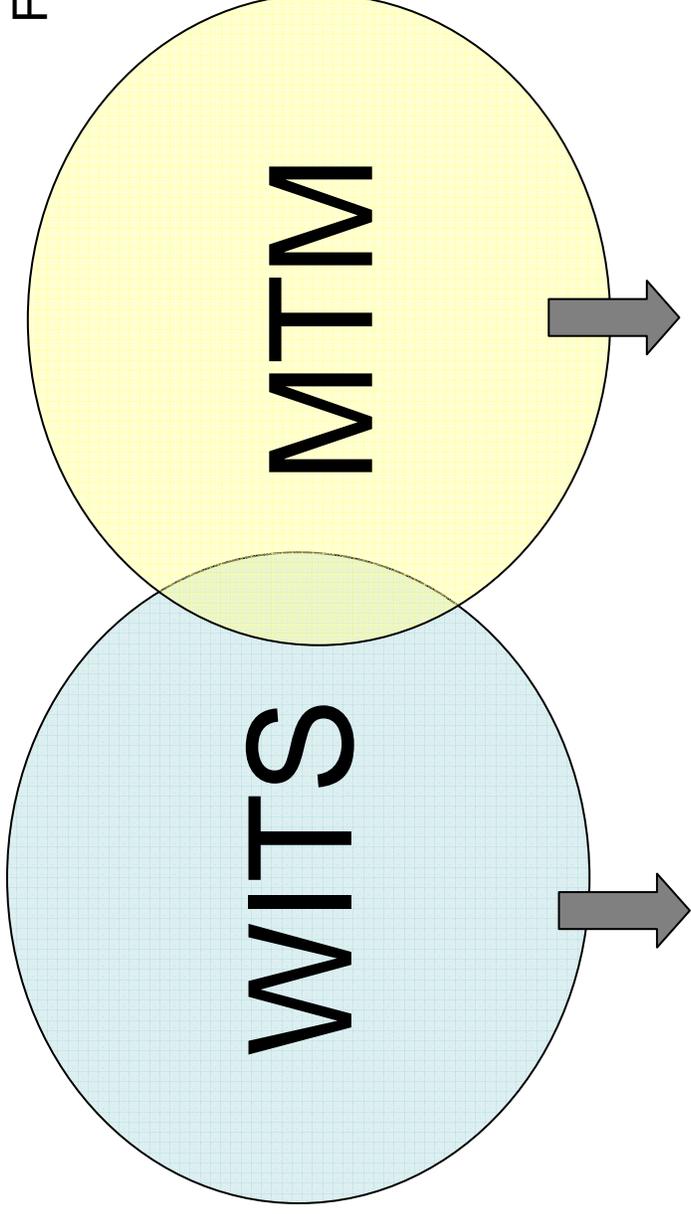
Implementation



Alaska, Iowa, Maryland, Nevada
Just ATR states:
Arizona, Hawaii, Illinois, Indiana,
Tennessee, Wyoming, Washington DC
Counties (several)

Ohio,
New York,
Massachusetts
Counties
(several)

Form of license



Focuses on multiple business

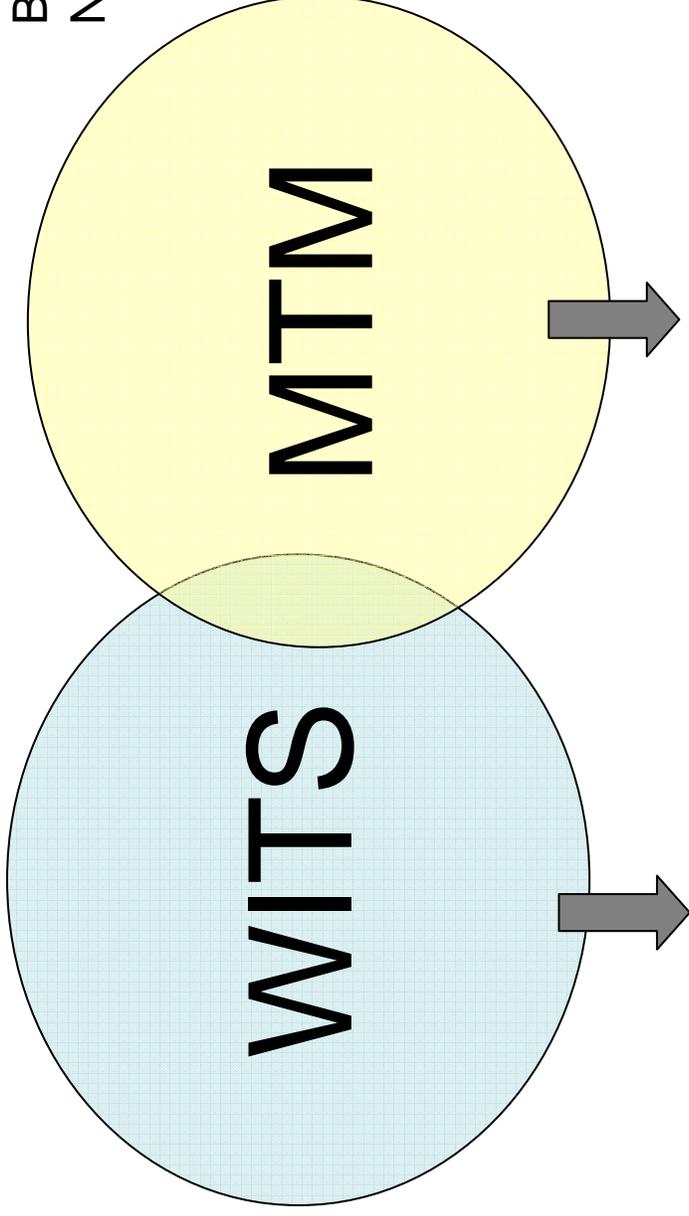
needs including:

- i) providing an ability to track outcomes,
- ii) providing an electronic health records system,
- iii) potential interoperability with criminal justice systems, providing a voucher system

Predominantly focused on single business need.

Allows users that need to make decisions across multiple providers make decisions across those multiple providers.*

Business
Needs



(States)
Alaska, Iowa, Maryland, Nevada
(States – just ATR)
Arizona, Hawaii, Illinois, Indiana,
Tennessee, Wyoming, Washington DC
**(Counties-all implemented more than
ATR)** Salt Lake County UT, San Diego,
Ca; Mendocino, Ca, Marin, Ca, Sonoma,
Ca

Ohio,
New York,
Massachusetts

WITS (*Eight Modules*)

- 1) Mental Health
- 2) Core Clinical records
- 3) Medical Billing
- 4) Voucher (or ATR)
- 5) Payor
- 6) Outcomes - WITS can be configured to capture state required data TEDS/NOMMS/GPRA which can then be electronically submitted to SAMHSA.
- 7) Contract Management
- 8) Drug Courts - The eCourt module is for organizations that require a streamlined system for managing clients that are in a Court driven substance abuse program (capability of interfacing with drug testing laboratory systems.)

Other:

- To work with legacy systems (such as LEDS), Oregon would need to create API or repository interfaces. It might be a business work around is possible for some data if Oregon moved to creating a state identifier
- DHS is initially contracting for i) Core Clinical Records, ii) Contract Management, and iii) Voucher

TO: Members of the Alcohol and Drug Policy Commission

FROM: Prevention Subcommittee

RE: Policy Recommendations on Alcohol for consideration by the full commission

DATE: October 19, 2010

- Alcohol Outlet Density and Impact
- Evidence:
 - “Wetter” neighborhoods have higher levels of drinking, accidents and violence. Scribner, Richard: *Alcoholism: Clinical & Experimental Research*, February 2000.
 - There is a 15-16% difference in individuals' drinking attitudes and 11% difference in individuals' alcohol consumption attributable to density of alcohol outlets in their neighborhoods (ibid)
 - The number of alcohol outlets is related to violent assaults. A study done in 1995 in Los Angeles showed that each additional alcohol outlet was associated with 3.4 additional assaults per year. Scribner, R., Mackinnon, D. & Dwyer, J.: “The risk of assaultive violence and alcohol availability in Los Angeles County.” *American Journal of Public Health* (85) 3: 335-340. 1995.
 - Alcohol outlet density in Newark, N.J. was the single most important environmental factor explaining why violent crime rates are higher in certain areas of the city than in others. Alcohol outlet density was much more important in determining crime rates than other factors, including employment rate and median household income. LaBouvie, E. & Ontkush, M.: “Violent crime and alcohol availability: relationships in an urban community.” *Journal of Public Health Policy* 19(3):303-318. 1998.
 - According to a study done in Los Angeles, there is a greater number of alcohol-related injury crashes in cities with higher outlet densities. A 1% increase in outlet density means a .54% increase in alcohol-related crashes. Thus, a city of 50,000 residents with 100 alcohol outlets would experience an additional 2.7 crashes for each new outlet opened. Scribner, R., Mackinnon, D. & Dwyer, J.: “Alcohol outlet density and motor vehicle crashes in Los Angeles County cities.” *Journal of Studies on Alcohol* (44): 447-453, July 1994.

- OLCC has a leg concept that would allow cities and counties some ability to determine the number of liquor licenses in their respective jurisdictions.
 - **Evidence:** Positive relationship between outlet density and violent crime after controlling for neighborhood socio-structural characteristics in study's two regions. Results showed a direct relationship between the density of alcohol outlet and violent crime in both regions of Texas. Zhu, L., Gorman, D.M. & Horel S. (2004) Alcohol outlet density and violence. *Alcohol and Alcoholism*, 39(4), 369-375

- Additional tools for OLCC
 - There are legislators who would like to give the OLCC graduated enforcement powers prior to the drastic step of revoking a liquor license.
 - HB 3201 (2009) would have made it easier for neighborhood associations to quell problem locations
 - **Evidence:**
 - Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis. Gruenewald, P.J., Freisthler, B., Remer, I., LaScala, E.A. * Treno, A.J. (2006). *Addiction*, 101(5), 666-677.
 - Studies have found that the complaints about alcohol outlets most often reported to city planners had to do with noise, traffic or loitering. Freedom from unwanted interruptions in one's house or place of business are fundamental legal rights. A basic tenet of law is the right to the "quiet enjoyment" of one's own property. *Preventing Problems Related to Alcohol Availability: Environmental Approaches*. U.S. DHHS Pub No. (SMA) 99-3298.
 - Limits on outlet density and locations: Effects on traffic safety. Gruenewald, P.J. (2007). Paper presented at the traffic Safety and Alcohol Regulation Symposium, Irvine, CA.

 - Expand Oregon Liquor Control Commission to 7 Commissioners (presently there are 5)
 - Current make-up is via congressional district.
 - Allow local law enforcement to shut down a problem location in an emergency situation until OLCC can act.

- Toughen penalties for adults who allow minors to drink in their homes.
 - CA law passed 8/31/10 increases penalties when a minor is injured after the provision of alcohol in a home.

- Ban Alcoholic Energy Drinks (AED's) in Oregon
 - **Evidence:** The combination of alcoholic beverages and caffeinated energy drinks and particularly alcoholic beverages containing caffeine and other

typical energy drink ingredients has become a serious concern because the alcohol impairment is masked by the caffeine or excess caffeine consumption and keep intoxicated drinkers awake potentially increasing the risk of injury and drunk driving. Reissig, C.J. Strain, E.C. & Griffiths, R.R. (2009). Caffeinated energy drinks – a growing problem. *Drug and Alcohol Dependence*, 99(1-3), 1-10.

- Caffeinated cocktails; energy drink consumption, high-risk drinking, and alcohol related consequences among college students. O'Brien, M.C. McCoy, T.P., Rhodes, S.D. & Wagoner A. (2008). *Academic Emergency Medicine*, 15(5), 453-460.
- Alcohol, Energy Drinks, and Youth: A Dangerous Mix. Marin Institute, Simon, M., & Mosher, J. (2007).

- Encourage statewide school and athletics policies regarding drug and alcohol use.
- Include more DMV driver license test questions involving alcohol and drug information for all applicants.

Analysis of US 2009 On-Premises Licensing Fees Compared to Oregon

Data Source

National Alcohol Beverage Control Association 2009 Survey Book
State and Local Alcohol Regulation Websites

Assumptions

Initial licensing fee includes both application and first year fees.

Licensing fees in many states have variable rates based on population, establishment size and establishment type. The average state licensing fee in this analysis is based on the rate for bars and restaurants in larger cities that serve distilled spirits, wine and beer.

States that allow local control of liquor licensing and fees are excluded from this analysis.

Fee amounts for this analysis are those amounts charged by government to grant application for a new license. Many states such as Florida and California have active private brokerage systems that buy and sell licenses associated with individual establishments. Only fee revenues going to government are included in this analysis.

Results

Current Oregon On-Premises Application Fee - \$400

Oregon's application fee rank in the 44 states included in this analysis – 7th lowest

Average Initial On-Premises US Licensing Fee - \$1,746

Median Initial On-Premises US Licensing Fee - \$1,150

Current Oregon On-Premises Annual Renewal Fee - \$400

Oregon's renewal fee rank among 44 states in this analysis – 8th lowest

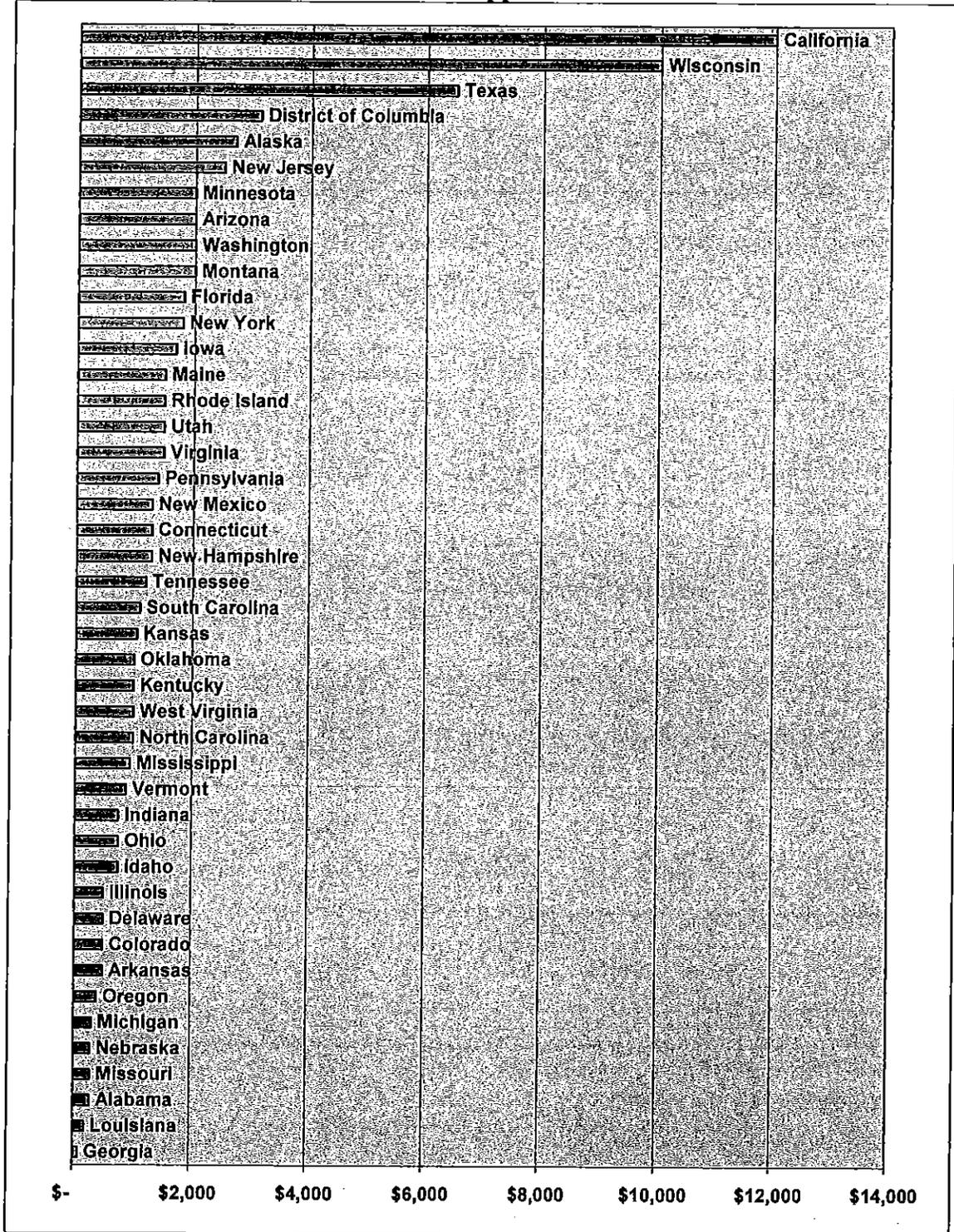
Average Annual Renewal US License Fee - \$1,080

Median Annual Renewal US License Fee - \$963

Table 1. On-Premises Application and Annual Renewal Fees for 44 States

State	On-Premises Application Fee (bars/restaurants)	On-Premises Annual Renewal Fee (bars/restaurants)
Georgia	\$ 100	\$ 100
Louisiana	\$ 200	\$ 200
Alabama	\$ 300	\$ 300
Missouri	\$ 300	\$ 300
Nebraska	\$ 300	\$ 300
Michigan	\$ 320	\$ 250
Oregon	\$ 400	\$ 400
Arkansas	\$ 500	\$ 500
Colorado	\$ 500	\$ 500
Delaware	\$ 500	\$ 500
Illinois	\$ 500	\$ 500
Idaho	\$ 750	\$ 800
Ohio	\$ 750	\$ 750
Indiana	\$ 750	\$ 750
Vermont	\$ 880	\$ 880
Mississippi	\$ 950	\$ 925
North Carolina	\$ 1,000	\$ 750
West Virginia	\$ 1,000	\$ 1,000
Kentucky	\$ 1,000	\$ 1,000
Oklahoma	\$ 1,005	\$ 905
Kansas	\$ 1,050	\$ 1,010
South Carolina	\$ 1,100	\$ 1,100
Tennessee	\$ 1,200	\$ 1,200
New Hampshire	\$ 1,300	\$ 1,200
Connecticut	\$ 1,300	\$ 1,200
New Mexico	\$ 1,300	\$ 1,300
Pennsylvania	\$ 1,400	\$ 350
Virginia	\$ 1,495	\$ 1,430
Utah	\$ 1,500	\$ 1,250
Rhode Island	\$ 1,500	\$ 1,500
Maine	\$ 1,510	\$ 1,510
Iowa	\$ 1,690	\$ 1,690
New York	\$ 1,800	\$ 1,700
Florida	\$ 1,820	\$ 1,820
Montana	\$ 2,000	\$ 400
Washington	\$ 2,000	\$ 2,000
Arizona	\$ 2,000	\$ 2,000
Minnesota	\$ 2,000	\$ 2,000
New Jersey	\$ 2,500	\$ 2,500
Alaska	\$ 2,700	\$ 2,700
District of Columbia	\$ 3,120	\$ 3,120
Texas	\$ 6,512	\$ 2,012
Wisconsin	\$ 10,000	\$ 500
California	\$ 12,000	\$ 758

Figure 1. Ranking of State On-Premises Application Fees



States with Local Control of Liquor Licensing

There are seven states with significant local control over liquor licensing where local communities grant the licenses and set the fees. Table 3 presents a sample community from each state.

Table 3 Sample Community Liquor License Fees with Local Control

State/City	On-Premises Application Fee (Bars/Restaurants)	Off-Premises Application Fee (Grocery stores/Convenience Stores)	On-Premises Annual Renewal Fee (Bars/Restaurants)	Off-Premises Annual Renewal Fee (Grocery stores/Convenience Stores)
Hawaii (Honolulu)	\$ 1,200	\$ 1,200	\$ 25,000	\$ 15,000
Maryland (Montgomery county)	\$ 2,500	\$ 750	\$ 2,550	\$ 800
Massachusetts (Brookline)	\$ 200	\$ 200	\$ 2,850	\$ 2,000
Nevada (Las Vegas)	\$ 700	\$ 765	\$ 2,000	\$ 1,200
North Dakota (Fargo)	\$ 115,000	\$ 90,000	\$ 1,900	\$ 1,600
South Dakota (Rapid City)	\$ 295,000	\$ 100,000	\$ 1,500	\$ 1,500
Wyoming (Cheyenne)	\$ 10,500	\$ 1,500	\$ 1,500	\$ 1,500

Other Notes

Hawaii (Honolulu) - Annual On-Premises Fee is calculated based on a base fee plus percent of gross sales not to exceed \$25,000.

Maryland (Montgomery county) – Local control - county grants approvals and sets fees.

Massachusetts (Brookline) - Local control where cities can also add on extra fees.

Nevada (Las Vegas) - Local Control - county grants approvals and sets fees

North Dakota (Fargo) - Local control where city grants approvals and sets fees at estimated market value.

South Dakota (Rapid City) - Local control where city grants approvals and sets fees at estimated market value.

Wyoming (Cheyenne) – State and city control where city can set fees within a statutory range determined by the state.