Alcohol, Tobacco and
Other Drug Control Policy Task Force's

COMPREHENSIVE BLUEPRINT FOR THE FUTURE

A

~ LIVING DOCUMENT ~

Prepared for

Governor Judy Martz
and
Attorney General Mike McGrath

September 2002

LETTER OF TRANSMITTAL

September 1, 2002

Dear Governor Martz and Attorney General McGrath:

The Alcohol, Tobacco and Other Drug Control Policy Task Force respectfully submit our final report as requested in your joint resolution. This "Living Document" includes a current situation assessment, desired outcomes and strategy recommendations. As charged by you we have collaboratively developed this Comprehensive Blueprint for the Future to address the troubling drug issues facing Montana.

The Comprehensive Blueprint is available through a link at http://doj.state.mt.us and at the web site http://www.discoveringmontana.com/gov2/css/drugcontrol/default.asp.

We thank you for the opportunity to serve our state and we applaud your bi-partisan approach and leadership on this issue that affects all Montanans. We have been increasingly alarmed at the extent and breadth of the harm these issues have on our neighbors and citizens and are concerned about a future that does not shift our current course. Therefore, on behalf of all Montanans we respectfully suggest that implementing the recommendations in this report will improve the health and safety of Montanans and reduce the high costs that alcohol, tobacco and other drug abuse has on our society.

Respectfully submitted,

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ACKNOWLEDGEMENTS

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The input this Task Force received from the public and experts in the field helped to shape the following report. We greatly appreciate, commend and thank those who took the time to share their information and offer constructive input. We also thank those who supported the effort with providing data, research or other support activities. At the risk of inadvertently omitting important contributors, for which we apologize in advance, we acknowledge and thank the following people for their contributions.

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EXECUTIVE SUMMARY

Governor Judy Martz and Attorney General Mike McGrath jointly formed the Alcohol, Tobacco and Other Drug Control Policy Task Force (Task Force) to address the drug and substance abuse issues facing Montana. The goal of the Task Force was to collaboratively develop statewide drug control strategy recommendations. AQuest ~ Collaborative Solutions, of Corvallis, Montana, was contracted to facilitate the process and prepare the final written document.

The Task Force's effort was funded primarily through a $62,505 U.S. Department of Justice grant called the Edward Byrne Memorial Block Grant. Task Force members brought a broad range of expertise to the task. The members met around the state seven times between February 2002 and August 2002 and worked independently or in smaller groups between meetings to develop the following report. Public input was solicited and incorporated throughout the process.

The Task Force assessed the current situation related to tobacco, alcohol and other drug control issues in Montana by looking at the broad areas of prevention, treatment and judicial. The Task Force then created Desired Outcomes for Montana. Based on this information, research and valuable public input, the Task Force developed strategy recommendations to help Montana reach those Desired Outcomes.

Simply said, we are not effectively preventing Montana's youth from engaging in harmful and illegal activities. Montana's youth have the 2nd highest rate of illicit drug use, 6th highest rate of tobacco use, and 4th highest rate of alcohol use of all 50 states. Montana's youth are using marijuana and sedatives at rates above the national average. The costs of not preventing substance abuse are high in terms of both human lives and monetarily. Montanans spent approximately $256 million in 1998 on programs related to the negative effects of substance abuse. Less than 1% of that was invested in prevention and treatment.

The Task Force identified and explored seven areas that function as barriers or challenges to providing effective tobacco, alcohol and other drug prevention measures in Montana. The barriers include:

- Lack of leadership's support.
- Our culture and the mixed messages we send.
- Lack of comprehensive education and information availability and motivational tools.
- Fragmented services.
- Insufficient and unstable funding.
- Lack of commitment to science-based prevention programs and uniformity.

- Insufficient workforce development.

The Task Force reviewed national studies which document the effectiveness of substance abuse treatment programs in both helping patients and reducing societal costs. In fact, a study of California alcohol and drug treatment services found that every dollar invested in treatment generates a savings of $7.14 in future costs for taxpayers.

To understand the complexities and importance of the treatment system it is important to understand the science and nature of addiction. Drug addiction is a "brain disease". Every drug user starts out as an occasional voluntary user. But as time passes and drug use continues, a person goes from being a voluntary to a compulsive drug user because, over time, use of addictive drugs changes the structure and function of the brain.

For prevention and treatment to be effective the unique needs of different populations must be addressed. When treatment is done well, recognizing the varied needs of individuals, the likelihood of success increases significantly. The Task Force looked at issues and the current situation related to treatment for seven special populations: adults, Native Americans, youth, corrections populations, pregnant women and women with children, methamphetamine addicts, and patients with co-occurring addiction and mental disorders. The Task Force identified and explored six areas that function as barriers or challenges to providing effective tobacco, alcohol and other drug treatment measures in Montana. The barriers include:

- Lack of access to treatment.
- Attitudes and stigma.
- Funding and treatment costs.
- Lack of education and engagement.
- Lack of specific care levels.
- Workforce challenges.

Montana's total prison incarceration rate jumped 198% between 1983 and 1998. A 1997 study showed that 89% of all inmates in the Montana State Prison and Montana Women's Prison had a lifetime substance abuse disorder and records in Yellowstone County, as an example, show dramatic increases in drug offenses between 2000 and 2001. Without effective treatment addicted criminal offenders will likely return to the system over and over again. Supporting this premise are probation and parole officers' reports of an increase in revocations especially among alcohol and methamphetamine substance abusers. Over 50% of offenders entering the prison system are parole and probation revocations.

Methamphetamine is putting increased demands on public funds and resources. Violent crimes increased by 37 percent in Montana between 1999 and 2000 with aggravated assaults showing the largest increase. Law enforcement officers attribute the increase, in

large part, to violence committed under the influence of meth. The number of meth labs is increasing significantly throughout Montana, impacting local law enforcement, property values and communities.

Montana has only 18 of the 39 key laws that are important deterrents to driving under the influence of drugs or alcohol, according to Mother's against Drunk Driving. In 1999, 47 percent of all Montana youth auto fatalities (15 -20 year olds) were alcohol related. This is higher than the national rate of 31 percent. The National Highway Traffic Safety Administration estimates that alcohol-related crashes in Montana cost the public $600 million in 1998 and the average alcohol-related fatality cost $3.3 million.

The Task Force explored the current situation related to impaired driving laws, minors in possession issues, alternative sentencing, and inconsistent implementation of existing laws, drug courts and workforce issues.

Jurisdictional challenges exist with coordinating a statewide drug control policy with the seven Indian reservations in Montana. A number of factors are involved to determine which government has jurisdiction of crimes committed on reservations. Development and implementation of a drug control policy must be mindful of tribal, state and federal laws.

The Task Force concluded that instead of "getting tough on crime" related to alcohol, tobacco and other drug issues in Montana, we need to "be effective on crime" which means Montana also needs to be effective in prevention and effective in treatment. Based on their assessment of the current situation the Task Force has recommended a comprehensive blueprint of policy and strategy changes that they agree are necessary to reduce the significant social and financial impacts of substance abuse that currently plague Montana.

A Strategy Recommendation Table appears in Appendix B of this document. This six page table can be used as an Executive Summary of the Desired Outcomes and Strategy Recommendations from the Alcohol, Tobacco and Other Drug Control Task Force. Thirteen Desired Outcomes were identified with a corresponding sixty seven specific recommendations the Task Force agrees are necessary to help Montana reach those Desired Outcomes.

Foremost among the recommendations is the call for a high level Drug Czar position with the responsibility, authority and resources to integrate the currently divergent alcohol, tobacco and other drug control (ATOD) programs. The Task Force feels this position is critical for very practical reasons. The person in this position will be the champion and driving force for moving Montana toward its desired outcomes in a comprehensive and effective manner. This position is viewed as essential to managing effective and integrated prevention, treatment, public health and judicial programs in Montana. Research has shown that investment in effective prevention and treatment programs now

will save substantially in societal costs later. Other "Czars" have been created in Montana, but perhaps none with such potential for savings for the taxpayers as this position.

The entire process to develop this "Blueprint for the Future" was one of consensus building and prioritization. What remains in this document is agreed by the diverse interests on the Task Force to be a priority. It is a comprehensive package because a comprehensive approach is needed to move us from where we are to where we want to be. A comprehensive approach is necessary for us to be effective in preventing our youth from engaging in harmful and illegal substance abuse; effective in treating Montanans who have the chronic illness of addiction; and effective in reducing alcohol and drug related crime.

This "Blueprint for the Future" is an essential starting point; it can not be the end. This "Living Document" should change and evolve as more information is gained and as Montana's needs evolve. It is a solid plan, nevertheless, with which to start to build our new future. The Task Force believes we must start to implement this plan now in order to effectively reduce ATOD related deaths, injuries, crimes and societal costs in Montana.

1.0 TASK FORCE FORMATION

Under the leadership of Governor Judy Martz and Attorney General Mike McGrath a 20 member Alcohol, Tobacco and Other Drug Control Policy Task Force first convened on February 4, 2002. The goal of the Task Force, as directed by a joint resolution, is the…

> *"Development of a statewide drug control strategy to address the drug and substance abuse and drug trafficking problems of Montana. This drug control strategy should serve as a comprehensive plan for the coordination of all drug control efforts – including enforcement, education, prevention, treatment and rehabilitation."*

Task Force was charged to examine and provide, at a minimum, the following by September 1, 2002.

- Definition and analysis of the drug problem in Montana.
- Assessment of current drug control efforts in the state, including review of the adequacy of State law related to drug control.
- Identification of gaps and duplication of services.
- Identification of federal, state and local funding sources and recommendations for streamlining and maximizing these resources.
- Recommendations for developing and coordinating applications for federal funds at the state and local level.
- Recommendations on program priorities and expenditure levels within State government agencies; discussion of how program accountability should be addressed by administering agencies.
- Recommendations on any necessary legislation to address drug and substance abuse and drug trafficking in Montana.

AQuest ~ Collaborative Solutions, of Corvallis, Montana, was contracted to facilitate the collaborative Task Force Process and produce the final document.

1.1 TASK FORCE MEMBERS, MEETINGS & FUNDING

The Governor and Attorney General appointed Task Force Members that represent and respect the diversity of interests and issues surrounding substance abuse in Montana. Members brought vast expertise from the areas of: law enforcement, treatment, prevention, Native American interests, state departments, youth court, the Montana State House and Senate, businesses and victim advocates (Appendix A – Task Force Member List). Task Force Members also brought perspectives from rural and urban communities from throughout our great state (Figure 1-1).

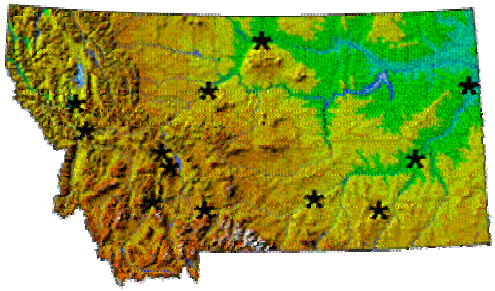


Figure 1-1. Drug Control Policy Task Force Members Represent Rural and Urban Communities from around Montana

Under the leadership of Chairman Senator Duane Grimes, Task Force Members collaboratively developed recommendations that address the drug and substance abuse issues troubling our state while meeting the unique interests of each member and the constituencies they represent. By bringing such a diverse group of people and interests to the table to share their views, concerns and interests the Governor and Attorney General provided the environment necessary to produce sound and lasting recommendations.

Task Force activities were funded primarily through a U.S Department of Justice grant called the Edward Byrne Memorial Block Grant. The $62,505 grant was administered by the Montana Board of Crime Control. The Department of Public Health and Human Services (DPHHS), Addictive and Mental Disorders Division (AMDD) also funded the effort by covering Task Force Member's travel costs ($15,000) using Center for Substance Abuse Treatment federal block grant funds for infrastructure development.

Each of the seven Task Force Meetings was held in 2002 in different parts of the state.

February 4	Helena
March 4	Billings
March 25	Kalispell
April 18	Great Falls
May 23	Miles City
July 18 & 19	Bozeman
August 14 & 15	Helena

Three Work Groups (Prevention, Treatment and Judicial) were organized to draft material between Task Force meetings. The purpose of these interdisciplinary teams was to develop creative solutions among otherwise typically segregated disciplines. Work Group drafts were discussed, debated, modified as needed and ultimately decided upon by the full Task Force.

The Task Force recognized that recommendations that met the interests of all Members would be much more powerful and enduring. Therefore they agreed to strive for 100 percent consensus on the strategy recommendations. They decided that if 100 percent agreement could not be reached on a recommendation then they would declare a majority at 17 of 20 members. Because all Task Force Members did not attend each meeting and since only 18 members were active (See Appendix A) this was later modified to 85 percent of those Task Force Members present at a meeting. If the minority appeared to be of one category (e.g., prevention workers, Tribal members, etc.) or one "interest", then the group continued to work to try to honor those interests. The facilitator had the responsibility to declare a topic discussion final. Recommendations that had less than 85 percent of members agreeing to it are presented here under Section 8.0 – Written Summary, Items Not Agreed To.

Proposals or ideas that were brought up by Task Force Members or Work Groups but that were not fully discussed by the Task Force Members (for lack of time) are presented in Section 9.0 – Items Not Fully Discussed. The Task Force accomplished a great deal in the seven meetings but they were unable to discuss, during a full Task Force Meeting, all items.

2.0 STRATEGY FRAMEWORK

The Task Force used a simple framework to develop recommended strategies (Figure 2-1). Basically, over a seven month period they collaboratively described:

Where we are (Current Situation),

Where we want to be (Desired Outcomes), and

How we are going to get there (Strategy Recommendations)

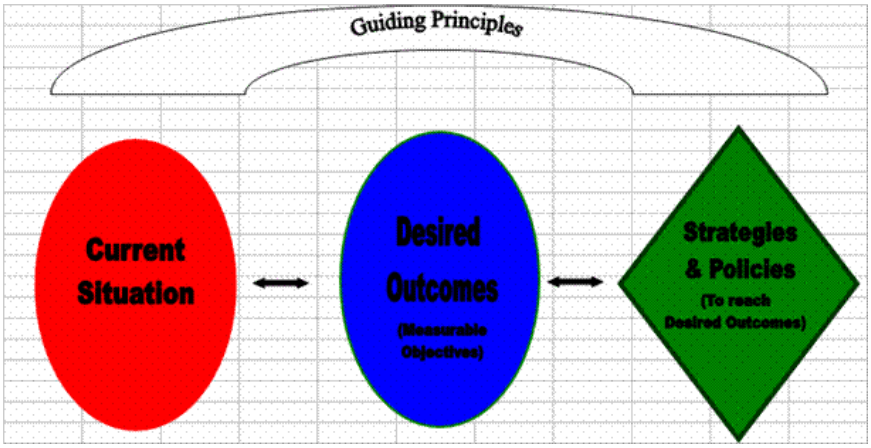


Figure 2-1. Strategy Development Framework

The Desired Outcomes are the vision for what the Task Force wants for Montana. The Strategy Recommendations were collaboratively developed to help reach the Desired Outcomes.

2.1 GUIDING PRINCIPLES

To steer their efforts the Task Force established the following Guiding Principles at the beginning or their process:

- We believe that the safety and welfare of all Montanans' is paramount.
- We believe that all individuals should be treated with respect and equality.
- We promote a holistic, balanced, coordinated approach that includes education, prevention, treatment, and enforcement and we recognize the importance of establishing priorities in each of those areas.
- We believe that financial ability or status should not be barriers to access to a continuum of services.
- While encouraging new and creative strategies, we believe that decisions, policy making, and programs should be outcome based and supported by data and ongoing evaluation.
- We solicit input and work to accommodate the views of fellow Montanans with regard to Task Force recommendations.
- We recognize the importance of a statewide public education campaign to promote and implement policy, strategies and tools adopted from the recommendations of the Task Force.

The Task Force also decided their recommendations must reflect developmental lifespan issues. Tobacco, alcohol and other drug addicts do not just happen at the age of 24 or 42. There are specific developmental sequences that predict elevated risk for substance abuse and different age groups must be approached differently to be effective. They looked at youth, adult and family issues in their analysis and recommendations. They also looked at policy, legislative and jurisdictional (tribal, federal, state, local and agency) issues.

Through this process they borrowed from and relied heavily on existing data related to tobacco, alcohol and other drug control issues specific to Montana and nationally. Planning efforts by agencies, organizations and other Task Forces were incorporated into the assessment and recommendations.

A number of significant strategic planning efforts, specific to one discipline area or another, have recently been completed in Montana. These plans have extensive data and many have specific goals, recommendations and benchmarks. With the diversity of representation on the Task Force, one or more members were familiar with each one of these plans (some were authored by Task Force Members) and they brought these findings and perspectives to the table.

Recent planning efforts include:

- Adult Household Survey and State Treatment Needs Assessment Study. Department of Public Health. (1997).
- Prevention Needs Assessment. Department of Public Health and Human Services – Addictive and Mental Disorders Division. (1998 & 2000).
- Montana's Tobacco Use Prevention: A 5-Year Plan (March 2000)
- Montana Comprehensive State Plan for the Provision of Chemical Dependency Services to Adult Correctional Offenders (March 2000)
- 2000-2002 Montana Board of Crime Control Anti-Drug Strategy
- Interagency Coordinating Council's Comprehensive Program, Goals and Benchmarks (2000)
- Native American Substance Abuse Treatment Needs Study. Montana Reservations (July 2001)
- Montana Youth Risk Behavior Surveys (September and October 2001)
- The State of Montana Impaired Driving Assessment, Prevention, Deterrence, Treatment & Rehabilitation, Driver Licensing, Program Management (October 2001)

This planning effort was not intended to produce any "new" data nor was it an exhaustive research and literature review effort. Wyoming completed a multi-year, multi-hundred thousand dollar comprehensive study and planning effort in November 2001. They invited the Montana Task Force to borrow information and ideas from their "Blueprint" [1]. Wyoming shares some similarities to Montana in having high national rankings for substance abuse and a relatively small population spread over a large geographic area. As appropriate the Task Force took advantage of Wyoming's work and investment.

2.2 PUBLIC INPUT

The public, and experts in this area, provided ideas and input throughout the seven month process in several ways. Public comments were taken at each of the seven meetings which were held throughout the state. News releases were sent to area media outlets prior to each meeting announcing meeting time and location. The Task Force held a

"Working Summit" at their meeting on April 18th. The Working Summit was specifically designed for the public and professionals to provide Task Force Members with their ideas and information. Task Force Members also sought information through personal dialogue with peers, other professionals and with members of their communities. Written comments were also encouraged and received.

A web site (www.discoveringmontana.com:gov2/css/drugcontrol/default.asp) provided information to the public about the Task Force and the process. In April 2002 a "Working Document" was posted on the web site and feedback requested and received. The "Working Document" contained a Preliminary Current Situation Assessment and process information. A second draft of the "Working Document", containing Preliminary Strategy Recommendations was posted on July 15 for review and comment.

3.0 PREVENTION ~ CURRENT SITUATION

"Prevention pertains to activities designed to prevent the use of alcohol, tobacco and drugs by providing programs and increasing opportunities for positive and law-abiding behavior, which includes various levels and types of approaches"

Governor's Interagency Substance Abuse Task Force
Continuum of Substance Abuse Services

3.1 THE NUMBERS ~ A CALL FOR ACTION

Simply said, we are not effectively preventing Montana's youth from engaging in harmful and illegal activities.

Montana's youth have the**:**

Second highest rate of illicit drug use

Sixth highest rate of tobacco use, and

Fourth highest rate of alcohol use of all 50 States![2]

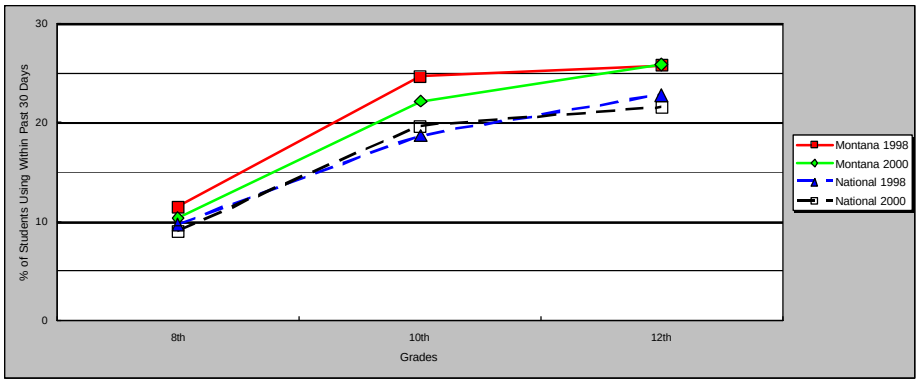
Why the alarm? Montana's young people are our most precious resource. Today's "kids" are tomorrow's parents, tomorrow's workforce, and our neighbors. Early use of tobacco, alcohol and illicit drugs has a strong link to substance addiction. Many young people begin to experiment with alcohol, tobacco and illicit drugs at early ages. Although not all who try alcohol, tobacco or other drugs continue to use them, heavier, longer-term and more frequent consumption, associated with addictive use patterns, is likely to result in problems with health, family members, school, work or the law[3].

Because alcohol, tobacco and marijuana are often tried before other illicit drugs they are often referred to as "gateway drugs"[4]. A report prepared by Brandeis University notes that Tobacco use among adolescents is a particularly powerful predictor of other drug use, especially among females. Alcohol is a strong predictor of progression into other

drug use for males. Fortunately, however, many youth who use cigarettes, alcohol or marijuana never try other illicit drugs.

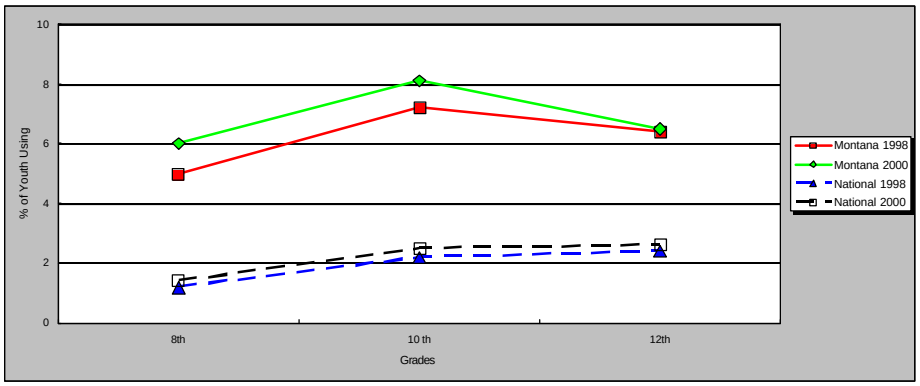
Montana Youths are using marijuana and sedatives at rates significantly above the national average (Figures 3-1 and 3-2) [5]. In 1998 the Office of National Drug Control Policy recognized Montana as one of eight states with the most serious and active threat from methamphetamine.[6]

Figure 3-1. Montana Student Marijuana Use Compared to National Rates of Use (1998 Compared to 2000 by Grade)



According to the 2001 Montana Youth Risk Behavior Surveys[7] one out of every five deaths in Montana can be attributed to tobacco use, as each year over 1,400 Montanans die prematurely from tobacco-related illnesses. Eighty percent of people who use tobacco start smoking or using smokeless tobacco before age 18, thus making nicotine addiction a disease that begins in childhood[8]. One study comparing 7th grade smokers, experimenters and non-smokers at both 7th and 12th grades found that when compared with non-smokers, early smokers were at least 3 times more likely to use marijuana and harder drugs, sell drugs, have multiple drug problems, drop out of school, and experience early pregnancy and parenthood[9]. In Montana in 2000, 17 percent of 8th graders reported smoking within the past 30 days along with 29 percent of 10th graders and 37 percent of 12th graders.

Figure 3-2. Montana Student Sedative Use Compared to National Rates of Use
(1998 Compared to 2000 by Grade)



Excessive alcohol consumption by youth contributes to truancy and drop out rates, academic failure, legal offenses, motor vehicle and other accidents, and suicides. In 1998 and 2000 Montana youths reported using alcohol within the past 30 days at higher rates than the national average (Figure 3-3)[10]. Binge drinking, or drinking five or more drinks in a row within the past two weeks, was reported by 30 percent of our youths[11]. That is 26,269 of Montana's youths between the ages of 12 and 17.

Traffic accidents involving drinking have been and continue to be a major problem in Montana. Youth in Montana are much more likely to drive when they have been drinking than the national average and are more likely to be in a vehicle driven by someone who had been drinking alcohol (Tables 3-1 and 3-2)[12]. Fifteen percent of all Montana's Driving Under the Influence (DUI) offenses are by those under the age of 21[13]. Alcohol related crashes tend to result in more severe injuries than do crashes with no alcohol involvement[14]. During the early 1980's, fatalities related to alcohol accounted for as much as 62 percent of all fatalities. In 1999, alcohol related fatalities were at 36.8 percent. Also in 1999, 31 percent of all youth auto fatalities (15 – 20 years olds) were alcohol related nation wide compared to a rate of 47 percent in Montana.

Methamphetamine (Meth), also called crank, is affecting Montana's youths in dramatic ways. Parents of meth addicts sent letters and talked with Task Force Members at many of the meetings held around the state. The stories of their child's battle with the extremely addictive drug were devastating and many without happy endings. Teenagers who were doing well in school and had active social lives until a meth addiction pulled them into a deadly spiral. Thirteen percent of Montana high school students reported that they have used meth in a 2001 survey[15].

There is no protection for children in homes where meth is produced or used. Meth labs are highly toxic and meth addicts have been tied to violent domestic crimes throughout Montana[16].

Figure 3-3. Montana Student Alcohol Use Compared to National Rate of Use
(1998 Compared to 2000 by Grade)

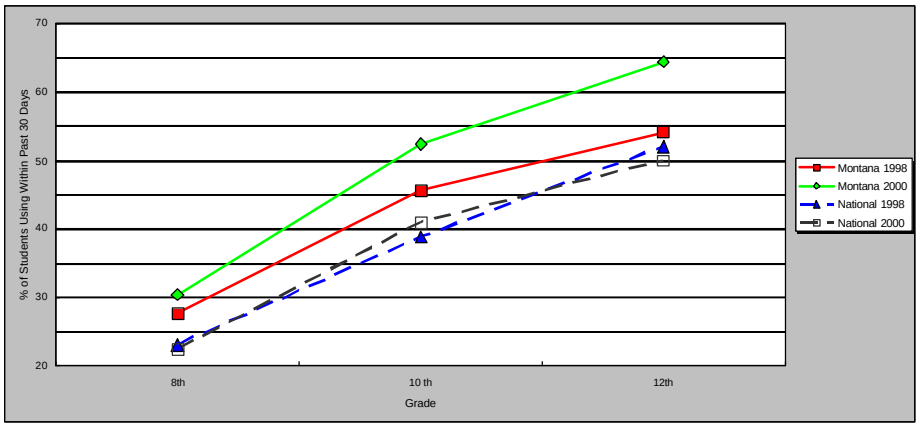


Table 3-1. Percentage of High School Students Who During the Past 30 Days Drove a Vehicle 1 or More Times When They Had Been Drinking Alcohol

Year	Montana	National
1993	24	14
1995	27	15
1997	27	17
1999	23	13

Table 3-2. Percentage of High School Students Who During the Past 30 Days Rode 1 or More Times in a Vehicle Driven by Someone Who Had Been Drinking Alcohol

Year	Montana	National
1993	46	35
1995	48	39
1997	47	37
1999	43	33

3.2 WHAT ARE THE "COSTS" IF WE DON'T PREVENT SUBSTANCE ABUSE?

Several studies have looked at what the costs of substance abuse are. You could view these costs as the consequences of NOT preventing (and treating) substance abuse.

The greatest cost of drug abuse is paid in human lives, either lost directly to overdose, or through drug abuse-related diseases such as tuberculosis, sexually transmitted diseases, hepatitis, and acquired immunodeficiency syndrome[17]. Across the nation alcohol alone kills 6.5 times the number of youths as all other drugs combined[18]. Alcohol was involved in approximately 40 percent (16,653) of the total number of traffic fatalities and responsible for in excess of three hundred thousand injuries in 2000[19]. Fortunately, fatalities due to alcohol related crashes have decreased by 10 percent in Montana since 1994 (from 96 in 1994 to 86 in 2000)[20]. The total number of alcohol related crashes, however remains high (2,245 in 1994 and 2,211 in 2000).

Traffic accidents caused by alcohol and drug-impaired drivers; street crime committed by addicts to support their addiction; and resources expended to apprehend, sentence, treat, and incarcerate drug abusers are the burdens borne by taxpayers year after year. The 1999 National Drug Control Strategy estimates that illegal drugs cost our society $110 billion each year[21]. Another study stated that in 1998 state governments alone spent $620 billion to "shovel up" the wreckage of substance abuse and addiction[22]. Federal Drug Control Spending alone has raised 12 fold between 1981 and 1999 ($1.5 Billion to $17.9 Billion)[23]. Though the estimates vary[24] the costs of substance abuse to the US economy and to the State of Montana is substantial.

The National Highway Traffic Safety Administration concluded that the societal costs of alcohol-related crashes in Montana averaged $1.20 per drink consumed[25]. This includes crash costs, auto insurance payments, and quality of life losses. People other than the drinking driver paid $0.60 per drink.

We Montanans spent 15 percent, (approximately $256 million) of our state budget, in 1998, on programs related to the negative effects of substance abuse (Table 3-3)[26]. That total equated to roughly $291 dollars for every man, women, and child in the state. Of all the money spent on substance abuse less than 1 percent ($7 million) of the state budget was invested in prevention and treatment as reported in 1998. That same year Montana's tobacco and alcohol tax revenue totaled $33 million or $37.87 per capita.

States collected $4.0 billion in alcohol and $7.4 billion in tobacco taxes in 1998 for a total of $11.4 billion[27]. For each dollar in alcohol and tobacco taxes that hit state coffers, states spent:

- $7.13 on the problem of alcoholism and drug addiction
- $6.83 to cope with the burden

- $0.26 for prevention and treatment
- $0.04 to collect taxes and run licensing boards.

The cost to tax payers of keeping drug related offenders in prison in Montana ranges from over $22,000 per year at Montana State Prison to $83,289 per year at Riverside Youth Correctional Facility[28]. The cost for probation is approximately $1,500 per year.

Table 3-3. Summary of Montana State Spending on Substance Abuse (1998)[29]

	State Spending by Category ($000)	Amount ($000)	Percent	As Percent of State Budget	Per Capita (879,000)
AFFECTED PROGRAMS	**$1,318,054**	**$247,504**		**14.9**	**$282**
Justice	90,789	70,208		4.2	80
Adult Corrections	68,943	55,343	80		
Juvenile Justice	18,437	12,031	65		
Judiciary	3,409	2,835	83		
Education (Elementary/Secondary)	467,456	44,824	10	2.7	51
Health	83,339	20,664	25	1.2	24
Child/Family Assistance	47,354	22,186		1.3	25
Child Welfare	26,295	18,147	69		
Income Assistance	21,059	4,039	19		
Mental Health/Developmentally Disabled	202,040	68,657		4.1	78
Mental Health	125,549	62,569	50		
Developmentally Disabled	76,491	6,088	8		
Public Safety	31,947	19,833	62	1.2	22
State Workforce	395,130	1,132	0	0.1	1
REGULATION/COMPLIANCE:	1,100	1,100	100	0.1	1
Licensing and Control	366	366			
Collection of Taxes	734	734			
PREVENTION, TREATMENT AND RESEARCH	**7,214**	**7,214**	**100**	**0.4**	**8**
Prevention	2	2			
Treatment	7,212	7,212			
Research	0	0			
TOTAL		**$255,818**		**15.4**	**291**

The real story, however, is that no study, statistic, or survey accurately reflects the suffering and heartbreak that occurs when a loved one sinks into addiction[30]or is injured or killed by the use of tobacco, alcohol or other drug (use by themselves—or by someone else). The biggest cost of not preventing and treating drug abuse is human pain and suffering.

3.3 CURRENT PROGRAMS

3.3.1 Interagency Coordinating Council for State Prevention Programs

In 1993 the Legislature created the Interagency Coordinating Council for State Prevention Programs (ICC). The ICC's mission is "To create and sustain a coordinated and comprehensive system of prevention services in the state of Montana."

The ICC has seven statutory duties.

- Develop, through interagency planning efforts, a **comprehensive and coordinated prevention program delivery system** that will strengthen the healthy development, well-being, and safety of children, families, individuals, and communities.

- Develop appropriate interagency prevention programs and services that **address the problems of at-risk children and families** and that can be provided in a flexible manner to meet the needs of those children and families.

- Study various financing options for prevention programs and services.

- Ensure that a balanced and comprehensive range of prevention services is available to **children and families with specific or multi-agency needs**.

- Assist in **development of cooperative partnerships among state agencies and community-based public and private providers** of prevention programs.

- Prepare and present to the Montana Legislature a **unified budget for state prevention programs**.

- **Develop, maintain, and implement benchmarks** for state prevention programs.

The number of participants in the ICC is substantial. Ten state agency directors, the Montana Children's Trust Fund Chair, the Lt. Governor and two community citizens appointed by the Governor have successfully identified five youth risk behavior prevention-related goals (Table 3-4) and associated benchmarks. Though Goal 2 is the only one that deals directly with reducing substance abuse in youth, all of the goals are closely linked with substance abuse. A reduction in substance abuse is likely to reduce other risk behaviors and increase opportunity to reach the other four goals.

Benchmarks were created based on very clear criteria:

- It should indicate success or failure of meeting a statewide goal.
- It should not measure only a specific program that is based on serving a target population and represents one funding stream. (Programs will have their own respective evaluation component.)
- It should **utilize a data source that is reliable and provides trend information**.
- It should be related to a **national standard**, such as Healthy People 2010, US DHHS.

Table 3-4. Interagency Coordinating Council's Five Prevention-Related Goals

	Goal 1 - Reduce child abuse and neglect by promoting child safety and healthy family functioning.
	*Goal 2 - Reduce youth use of tobacco, alcohol and other drugs by promoting alternate activities and healthy lifestyles.*
	Goal 3 - Reduce youth violence and crime by promoting the safety of all citizens.
	Goal 4 - Reduce school dropout by increasing the percentage of high school students who successfully transition from school to work, postsecondary education, training and/or military.
	Goal 5 - Reduce teen pregnancy and sexually transmitted diseases by promoting the concept that sexual activity, pregnancy and child rearing are serious responsibilities.

Goal 2 which states "Reduce youth use of tobacco, alcohol and other drugs by promoting alternate activities and healthy lifestyles" has two benchmarks.

- By 2005 decrease the number of high school students who report using alcohol, tobacco or other drugs in the past 30 days by 10% (Figure 3-4).

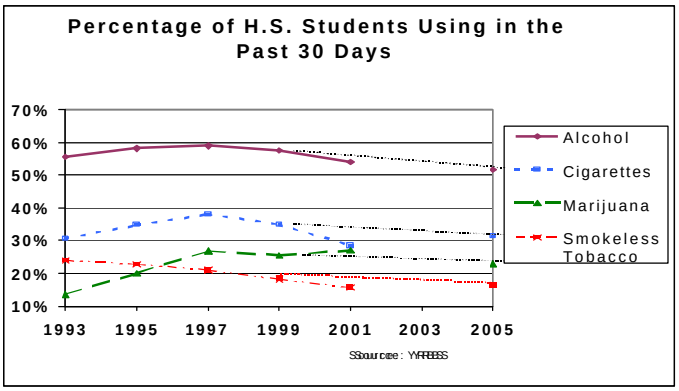


Figure 3-4. Percentage H.S Student Using Tobacco, Alcohol and Marijuana in Past 30 Days and Projected Target

- Decrease the percentage of students who use alcohol, cigarettes and other drugs before the age of 13 by 10% (Figure 3-5).

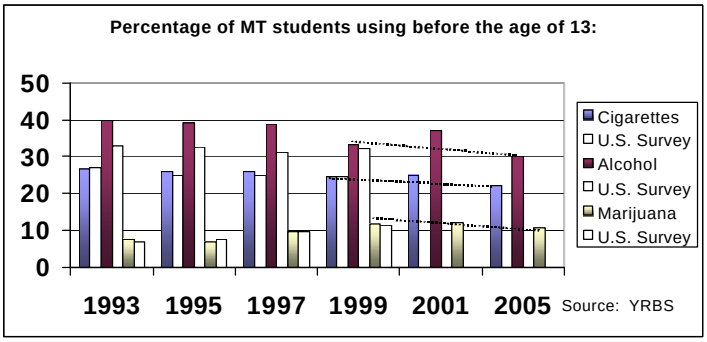


Figure 3-5. Average Age of First Use by Year for Tobacco, Alcohol and Marijuana and Projected Target

The ICC has also developed the following "Guiding Principles" for effective prevention.

Strategy

RESPECT COMMUNITY PERSPECTIVE

- Keep in mind the prevention approach is community-driven and rooted in the community's vision for prevention.
- Recognize cultural considerations – community-based values, traditions and customs -- in guiding prevention efforts.

COORDINATE APPROACH

- Create a strategy that considers a full range of prevention programs and provides opportunities to collaborate.

TARGET EFFORTS

- Design prevention strategies to develop assets or enhance protective factors and reverse or reduce known risk factors
- Focus on domain(s) or areas: School, Community, Family, Individual/ Peer

DESIGN RESEARCH-BASED PROGRAMS

- Base prevention programs on demonstrated effectiveness (success), the promise of effectiveness and established best practices and research.

Accountability

ASSESS NEED

- Use objective data to identify trends, demographics and related problems.

SET GOALS AND MEASURABLE OBJECTIVES

- Base objectives on community needs assessment
- Establish long-term goals, short-term objectives and benchmarks to measure the extent to which prevention efforts are effective.

EVALUATE

- Evaluate progress toward goals and objectives.
- Provide a basis to modify and strengthen the plan defined by the community.

3.4 BARRIERS TO EFFECTIVE PREVENTION

The Task Force identified seven areas that function as "Barriers" or challenges to providing effective tobacco, alcohol and other drug prevention measures in Montana. Several issues fall within and contribute to each of these barriers and we discuss some of those issues below.

Seven barriers to effectively preventing substance abuse include:

Lack of Leadership's Support	
Our Culture and the Mixed Messages We Send	**Lack of Comprehensive Education & Information Availability and Motivational Tools**
Fragmented Services	**Insufficient and Unstable Funding**
Lack of Commitment to Science-Based Prevention Programs and Uniformity	**Insufficient Workforce Development**

3.4.1 Lack of Leadership's Support

Montana does not have a high profile "champion" of alcohol, tobacco and other drug abuse prevention. The message of prevention's strong benefits and value has not reached or filtrated into the thoughts and actions of Montana's leadership. To date political and key leaders have not focused funding and resources on prevention efforts, rather, the emphasis has been on "after-the-fact" programs, such as the justice system, prisons, medical care and youth homes. Prevention strategies that have proven successful in many other states have, to date, not been actively supported by Montana's leadership.

3.4.2 Our Culture and the Mixed Messages We Send

In the first Task Force meeting four potential barriers to addressing substance abuse issues in Montana were written on flip charts in four corners of the room. A large majority of Task Force Members (though certainly not all) identified "Montana's

Culture" as the biggest barrier.

Montana has cultures-within-cultures but in a gross generalization Montanan's tend to be independent and resourceful people. We tend not to like other people telling us what we can and can't do; should and shouldn't do. We tend to let others do as they want and not to interfere or butt in.

Tobacco and alcohol are often significantly intertwined in our social lives and our communal events. While many people can occasionally use alcohol, tobacco and illicit drugs and not become addicted the younger children are when they first use mood altering substances the more susceptible they become to addiction.[31]

Though we may tell our children, "you're not old enough to smoke", "don't drink" or "if you drink, don't drink and drive", etc. the messages are often mixed with confusing contradictions and poor modeling. Many of us, including high state officials, teachers, professionals and parents don't "walk-the-talk". Public figures and community and family "role models" are not always assuming personal responsibility for promoting healthy decisions or lifestyles.

The media's portrayal of tobacco, alcohol and drug use as sexy and vital is also troubling. These messages often target young people. Social scientists have long considered the mass media to be a powerful influence on individual beliefs, values and behaviors. Recent research suggests that repeated exposure to positive media portrayals or product advertising fosters positive feelings toward the use of alcohol, tobacco and illicit drugs[32]

We have experienced cases of general acceptance, if not encouragement, for young kids to use alcohol and tobacco as part of their rights-to-passage. Coupled with this is a lack of understanding and knowledge of addictive pathways and risks. Task Force Members also sense a general denial by fellow Montanans that there even is a substance abuse problem in Montana. There is a mis-belief that the real problems with alcohol, tobacco and other drugs are in other states. As pointed out earlier, that is not what the statistics are showing. According to recent studies Montana youths are at or near the top in the nation in many categories of substance abuse[33].

Two major risk factors for youth problem behaviors are a student's perception of drug availability and the favorable attitudes or acceptance of the problem behavior[34]. The more available drugs are in a community, the higher the risk that young people will abuse drugs in that community. Perceived availability of drugs is also associated with risk. For example, in schools where students just *think* drugs are more available, a higher rate of drug use occurs. During the elementary school years, children usually express anti-drug, anti-crime, pro-social attitudes. They have difficulty imagining why people use drugs, commit crimes, and drop out of school. In middle school, as others they know participate in such activities, their attitudes often shift toward grater acceptance of these behaviors. This places them at higher risk. Montana's culture contributes to these risk factors.

The age when young people first start using alcohol, tobacco and illicit drugs is a powerful predictor of later alcohol and drug problems, especially if use begins before age 15[35]. Youth who drink before age 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 21[36]. If we can keep children from smoking cigarettes, using illicit drugs and abusing alcohol until they are 21, specialists say, they are much less likely to ever do so.[37]!

3.4.3 Lack of Comprehensive Education & Information Availability

The lack of education and information availability is a barrier that spans the broad continuum of contact levels: individuals, families, schools, communities, professionals and policy and law makers (Figure 3-6).

Figure 3-6. Education and Information Needs to Span the Full Contact Continuum

Because of this there is a general lack of awareness and appreciation of prevention needs. There is little knowledge of what the social and economic costs of substance abuse are and little understanding of the value of prevention and what prevention opportunities there are for Montanans. This lack of knowledge and understanding occurs throughout all levels of the contact continuum.

- How parents and peers can help prevent substance abuse is NOT common knowledge in Montana.
- How to get help or information for your loved one, your student or employee is NOT common knowledge in Montana.
- How to recognize signs of substance abuse in your child, family member or your neighbor is NOT common knowledge in Montana.
- What Risk Factors are and how to minimize them is NOT common knowledge in Montana.

- What Protective Factors are and how to maximize them is NOT common knowledge in Montana.

We currently lack an effective mechanism to get appropriate and timely information to parents and law makers alike. Part of the challenge is the difficulty in "motivating" parents and caregivers and others to attend programs that are offered or to use the material that is available. We lack effective motivational tools to engage those who need to be involved and informed in order for effective prevention to occur. Montana currently does not have strong prevention "champions" to effectively carry the message around the state and in our capitol.

Parents of methamphetamine addicts commented during Task Force Meetings that the information was not available to them when they needed it most[38]. Many had very similar stories of not being able to get help for their children until they, in their addictive state, finally broke the law! They said even agency and school personal did not have the knowledge or the resources to help them when prevention was needed the most.

The literature tells us that this situation is not unique; it is typically the case that powerful interventions do not happen until the child breaches the juvenile justice system[39].

3.4.4 Fragmented Services

Our state is rugged and rural with 902,195 individuals[40] living in 56 counties (Figure 3-7). There are seven population centers, the largest (Yellowstone County) with a population of 130,000. Three fourths of the state has towns with fewer than 1,000 people.

There are seven Indian reservations in Montana. They include Flathead; Rocky Boy; Fort Peck, Crow, Northern Cheyenne, Blackfeet, and Fort Belknap.

The environment that keeps us in Montana or draws us here poses challenges to providing unified and effective prevention services.

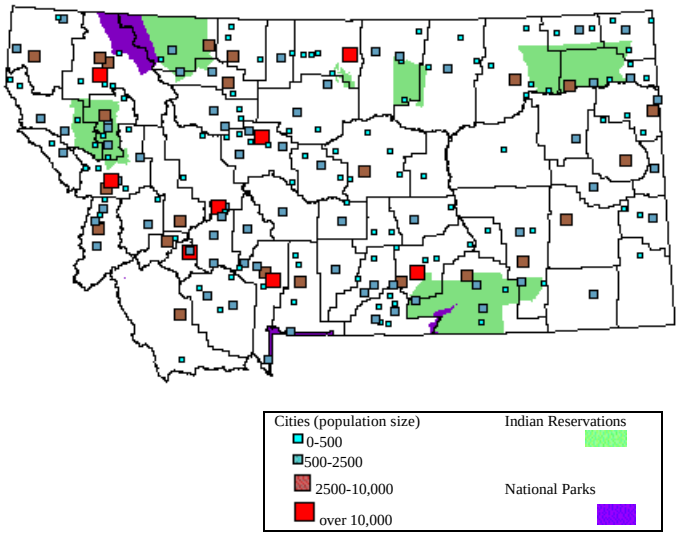


Figure 3-7. Montana Counties, Tribal Reservations and Population Centers

3.4.5 Insufficient and Unstable Funding

During an intensive three year study it was found that in 1998 for every dollar Montana spent of state funds on substance abuse less than 1 cent went toward prevention[41]. That year, of the $256 million we spent on substance abuse $2 million was spent on prevention.

The Interagency Coordinating Council coordinates a unified budget, which is a compilation of multi-agency prevention programs all of which assist Montana in achieving the five prevention goals identified by the Interagency Coordinating Council (Table 3-5). The unified budget, mandated in 1993, is not a functional budget; all budget items reflected in the unified budget are also listed within their specific agency budgets.[42]. In 2000 the Interagency Coordinating Council's unified prevention budget was $21.1 million; of that approximately $8 million were state funds. Because this reflects a unified prevention budget, and not just substance abuse budget, it can not be directly compared to the $2 million spent in 1998. The unified prevention budget is $28.9 million in 2002 with a projected budget of $29.0 in 2003[43]. These funds provide support to 29 prevention programs throughout the state (Table 3-5).

Despite the unified budget there are still "silos" of prevention management and funding for tobacco, alcohol and other drugs. This means that certain funds can be used only for alcohol or only for tobacco making it difficult to collaborate and run integrated prevention campaigns and programs.

The federal funds, which make up a large majority of our prevention spending, are "soft" grant dollars. These funds can change in availability from year to year. Montana must compete for these dollars and match the federal dollars with other funding. Grants may last three to five years and then those funds are gone. This makes prevention funding very unstable.

Some tobacco settlement funds are used for prevention, but this too is subject to change each year. It is estimated Montana will receive between $26 and $32 million dollars each year in settlement funds. Forty percent goes to a Trust Fund and 60 percent goes to the state's General Fund. Each year 10 percent of the interest generated from the Trust Fund is reinvested in the Trust Fund. The remaining 90 percent of the interest is invested in tobacco prevention or health care. In the 2002 – 2003 budget biennium these interest dollars were earmarked to cover health care provider rate increases.

The 60 percent of settlement funds that go to the state's General Fund are not tracked.

Having consolidated prevention funds can be a powerful way to integrate and leverage the prevention effort. Wyoming just passed legislation (3/2002) to "…direct the consolidation of certain prevention funds into one coherent fund for the purposes of an integrated, leveraged prevention effort—designed to promote the use of cost-effective, scientifically validated principles and procedures." The specialists who helped Wyoming build their plan felt that pooled prevention funds could be used to leverage Medicaid dollars[44].

The "Value" of the Prevention Dollar and Accountability

Policy and law makers have told us that they are not getting the information they need to understand the "value" of allocating money to prevention. They may be getting papers and reports but the sheer bulk of material that they see on a day-to-day basis has drowned out the prevention message -- if there has been one.

The tie or accountability between a dollar spent on prevention and it's effectiveness in reducing problem behaviors has not been adequately tracked or documented in Montana. Some on the Task Force have wondered if there are significant differences between the effectiveness of private programs compared to government programs. Though prevention, by definition is proactive, concerns have also been noted that historically, prevention spending has been more reactive than proactive.

These situations are not unique to Montana. Demand for better results and documentation of the impact of drug treatment and prevention programs are coming from a variety of areas including the federal government in their National Drug Control Strategy[45]. National studies have demonstrated that **the most significant opportunity to reduce the burden of substance abuse on public programs is through carefully**

designed and targeted prevention programs[46]. The Federal Substance Abuse and Mental Health Services Administration conducted a National Cross-Site Evaluation of High-Risk Youth Programs[47]. The six major findings, which highlight the cost effectiveness of prevention programs and practices, were:

- Substance Abuse Prevention Programs Reduce Rates of Substance Use
- Youth Already Using Cigarettes, Alcohol, and Marijuana Significantly Reduced Their Use of Substances After Joining a Prevention Program
- Gender Plays an Important Role in Risk, Protection, and Substance Use
- Family, Peers, School, and Community Can Protect Against Substance Abuse
- Science-Based Program Components Produce Consistent and Lasting Reductions in Substance Use
- Communities With More Opportunities for Participation in Prevention Positively Impact Substance Use by Youth

The Interagency Coordinating Council's work with measurable benchmarks that use a reliable data source to track trend information is an example of a good accountability system. Since investments in prevention and treatment take time to mature, they will not immediately reduce spending on neither substance abuse nor show instantaneous reduction in substance abuse. However, over the long run effectively spent prevention dollars do payoff.

Table 3-5. Interagency Coordinating Council's Unified Budget

Goal	Program	FY 2000 Budget ($Million - rounded)	Proposed FY 02 + FY 03 Budget ($Million - rounded)
Goal 1: Reduce child abuse and neglect by promoting child safety and healthy family functioning.	Big Brothers and Sisters * Domestic Violence * Head Start Collaboration * Maternal Child Health – Title V Home Visiting * Partnership to Strengthen Families – Home Visiting Program * Children's Trust Fund	$4.0	$9.6

Goal	Program	FY 2000 Budget ($Million - rounded)	Proposed FY 02 + FY 03 Budget ($Million - rounded)
Goal 2: Reduce youth use of tobacco, alcohol and other drugs by promoting alternate activities and healthy lifestyles.	Community Incentive Program * Substance Abuse Prevention and Treatment Block Grant * Tobacco Use Prevention Program * Fetal Alcohol Syndrome Consortium * Safe and Drug Free School	$8.7	$23.2
Goal 3: Reduce youth violence and crime by promoting the safety of all citizens.	Cognitive Restructuring * Rape Prevention * Montana Behavior Initiative *Title V Juvenile Delinquency Prevention * Suicide Prevention	$0.3	$2.6
Goal 4: Reduce school dropout by increasing the percentage of high school students who successfully transition from school to work, postsecondary education, training and/or military.	Gear UP * Workforce Investment Act; * Independent Living Project * Even Start * Montana Youth Challenge * Jobs for MT Graduates	$6.9	$20.1
Goal 5: Reduce teen pregnancy and sexually transmitted diseases by promoting the concept that sexual activity, pregnancy and child rearing are serious responsibilities.	Maternal Child Health Title V – Abstinence Education * Maternal Child Health Title V – Home Visiting * Title X – Family Planning	$1.2	$2.4
TOTAL		**$21.1**	**$57.9**

3.4.6 Lack of Science-Based Programs and Reporting Uniformity

Science-Based Prevention is the concept of using strategies, prevention actions, and products that have been evaluated and have been shown to have an effect on actual substance use, protective factors, norms related to use, or specific risk factors that have been linked to substance use. In Montana there is currently a lack of commitment to science-based programs. Prevention actions are based on science if they meet the following conditions:

- The interventions have been demonstrated to positively affect tobacco, alcohol, and other drug use, as well as the problems, risk factors and protective factors related to use.

- Research results have been published by a peer-reviewed journal or have undergone equivalent scientific review[48].

With scarce resources the state does not want to fund programs that are untested, based on questionable assumptions or that have delivered with little consistency or quality control. On the other hand, "one size does not fit all"; a variety of programs are needed to meet the diverse needs of all contact levels (individuals, families, schools, communities, professionals, policy and law makers)[49]. Several Reviews have identified research findings demonstrating what programs work and why[50]. Through an evaluation contract with the University of Montana the state will conduct an evaluation of all the science based prevention programs they fund between 2002 and 2003. This will be done through the Bureau of Economics in the Addictive and Mental Health Disorders Division of the Department of Public Health and Human Service (AMHDD/DPHHS). The evaluation will look at the program's fidelity to replicating the important elements of the science based programs and also assess the outcomes of those programs.

A 1996 study suggested that mental disorders precede substance abuse more than 80 percent of the time, generally by five to ten years[51]. This indicates the existence of a significant window of opportunity for substance abuse prevention and the need to target substance abuse prevention activities to children with serious emotional disturbance and other, less severe mental health problems[52].

We have also found that the reporting and assessment documentation varies between prevention programs. There is no uniformity in the information about individuals or whole programs and therefore it is difficult to compare data, compile data and track individuals.

3.4.7 Insufficient Workforce Development

Currently, workforce development and training are not sufficient to maintain the dedicated and committed prevention staff we have in Montana.

4.0 TREATMENT ~ CURRENT SITUATION

"Treatment pertains to activities for people who have received clinical alcohol, tobacco or drug assessments indicating they are in need of a range of individualized services designed to halt the progression of the disorder"

Governor's Interagency Substance Abuse Task Force
Continuum of Substance Abuse Services

In treatment the overall challenge is to assist chemically dependent individuals to overcome their dependency so that they can lead healthy and productive lives. This ultimately reduces the negative social consequences of drug abuse.[53]

Two national studies funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and referenced in the National Treatment Plan Initiative – Changing the Conversation, support the effectiveness of substance abuse treatment programs[54]. The studies showed that with treatment:

- Primary drug use was decreased by 48 percent.
- Reported alcohol/drug-related medical visits declined by 53 percent.
- Criminal activity decreased by as much as 80 percent.
- Illicit drug use for young adults (ages 18-20) declined by 47 percent.
- Client financial self-sufficiency improved (i.e., employment increased by 19 percent, welfare recipients declined by 11 percent, and the proportion of clients who reported being homeless at some point during the previous year dropped by 43 percent).

To understand the complexities of the treatment system this section first reviews the science and nature of addiction, then looks at the current situation with populations requiring treatment in Montana and finally assesses what some of the existing barriers are to providing effective treatment.

4.1 THE SCIENCE AND NATURE OF ADDICTION

REPRINT: Addiction: 'Oops,' a brain disease with clear biological underpinnings

By Doug Toft

This article was originally published in the Winter 2001 issue of the Hazelden Voice newsletter. Permission to reprint is granted by Hazelden Foundation, an internationally known nonprofit organization that provides a range of information and treatment services on addiction and recovery[55]. Graphics have been added, as cited, by the Task Force. The Wyoming Blueprint also reprinted this article.

No one raises a glass of alcohol, snorts a line of cocaine, or lights up a nicotine-laden cigarette with a toast: "Here's to addiction." When first using these drugs, people simply choose to do something that makes them feel good. But with continued use, these people can find themselves addicted: They depend on the drug not simply to feel good but to feel *normal*. Using drugs is no longer a choice but a compulsion. These people don't plan to become addicts; it just happens.

In a recent article, Alan Leshner, PhD, director of the National Institute on Drug Abuse, calls this the "oops phenomenon." It happens when occasional use of a drug turns into weekly use, then daily use, and then eventually into a surprising, distressing realization: "I'm addicted."

"Every drug user starts out as an occasional user, and that initial use is a voluntary and controllable decision," Leshner writes. "But as time passes and drug use continues, a person goes from being a voluntary to a compulsive drug user. This change occurs because over time, use of addictive drugs changes the brain—at times in big dramatic toxic ways, at others in more subtle ways, but always in destructive ways that can result in compulsive and even uncontrollable drug use."[56]

The fact is, drug addiction is a *brain disease*, Leshner says. "While every type of drug of abuse has its own individual trigger for affecting or transforming the brain, many of the results of the transformation are strikingly similar regardless of the addictive drug used. The brain changes range from fundamental and long-lasting changes in the biochemical makeup of the brain, to mood changes, to changes in memory processes and motor skills."

The changes Leshner refers to include specific alterations in the structure and function of the brain. Thanks to recent advances in research, we have a much more complete picture of those changes. With these discoveries have come new insights into the role of heredity—findings that may actually identify people at risk for addiction and prompt them to learn behaviors that prevent the disease.

Drugs change brain structure

Begin with structural changes in the human brain. Long-term drinking literally shrinks this vital organ. Autopsies consistently show that chronic alcoholics have lighter and smaller brains than other people of the same age and gender. Researchers have also observed this shrinking effect in living alcoholics through non-invasive medical tests that give a picture of the brain in action. These tests include magnetic resonance imaging (MRI), positron emission tomography (PET) scans, and computed tomography (CT) scans.[57]

The same techniques reveal how addiction harms or even kills brain cells. For example, research indicates that methamphetamine ("speed") damages cells that produce dopamine, a chemical in the brain that helps to create feelings of euphoria. Methamphetamine use can even trigger a process called aptosis, where cells in the brain self-destruct.

In long-term alcoholics, such changes can be devastating. Studies indicate that 50 to 75 percent of these drinkers show some kind of cognitive impairment, even after they detoxify and abstain from alcohol. According to the National Institute on Alcohol Abuse and Alcoholism, alcoholic dementia is the second-leading cause of adult dementia in the United States, exceeded only by Alzheimer's disease.[58]

Drugs change brain function

The effects of addiction on the brain don't stop with brain size. Research over the last decade reveals that addictive drugs also alter the function of the brain—the very way that cells work.

Human beings are "wired" with nerve cells (neurons) that extend from the brain and spinal cord throughout the body. Neurons with the same function group themselves into strands up to four feet long. However, the strands are not continuous. Between neurons is a small space called a *synapse*.

Researchers used to think that neurons passed signals to each other by sending electrical impulses across synapses—something like the way that electricity jumps the gaps in a car's spark plugs. Today we know that what crosses the synapse are not "sparks" but chemicals. Those chemicals are called *neurotransmitters*. The constant exchange of neurotransmitters makes it possible for the brain to send messages through vast chains of neurons and direct our thoughts, feelings, and behavior.

Addictive drugs wreak havoc with this normal exchange of neurotransmitters in countless ways. For example, drugs can:

- Flood the brain with excess neurotransmitters.
- Stop the brain from making neurotransmitters.
- Bind to receptors in place of neurotransmitters.
- Block neurotransmitters from entering or leaving neurons.
- Empty neurotransmitters from parts of the cells where they're normally stored, causing the neurotransmitters to be destroyed.
- Increase the number of receptors for certain neurotransmitters.
- Make some receptors more sensitive to certain neurotransmitters.
- Make other receptors less sensitive to neurotransmitters (leading to tolerance).
- Interfere with the reuptake system by preventing neurotransmitters from returning to the sending neuron.

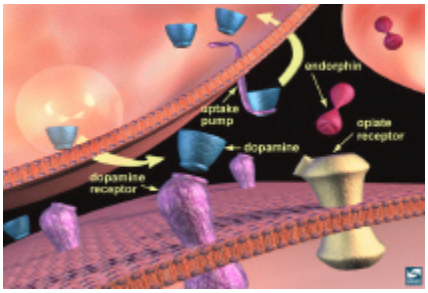


Figure 4-1. Synapse Diagram
As an electrical impulse arrives at the terminal, it triggers vesicles containing a neurotransmitter, such as dopamine (in blue), to move toward the terminal membrane. The vesicles fuse with the terminal membrane to release their contents (in this case, dopamine)[59].

A case in point—dopamine

Dopamine, mentioned above, is one of the primary neurotransmitters involved in addiction. All the major drugs of abuse—alcohol, nicotine, opiates, and cocaine—increase dopamine levels. That's a "good news-bad news" scenario. The "good" news, at least temporarily, is that the excess dopamine creates powerful feelings of pleasure. The bad news is that the excess levels take a long-term toll on brain chemistry and promote addiction.

To understand this, remember the biological concept of *homeostasis*, a word that literally means "same state." The brain seeks to maintain a constant level of cell activity. That stable level is critical to regulating our behavior. When supplies of dopamine remain constant, we can experience the ordinary pleasures of life — such as eating and having sex — without the compulsion to seek those pleasures in self-destructive ways.

When consistently subjected to artificially high levels of dopamine from use of a drug, however, the brain "downshifts" its internal supply of this neurotransmitter. The brain comes to depend on the presence of a drug in order to maintain homeostasis and function normally.

And that's the problem. If the extra dopamine supplied by drugs is missing, the alcoholic or drug addict feels much less pleasure. In fact, these people can experience symptoms such as depression, fatigue and withdrawal. To the addict, it seems that the only relief from these symptoms is to use more and more drugs. It all adds up to craving—addicts' constant drive to obtain their chemicals of choice.

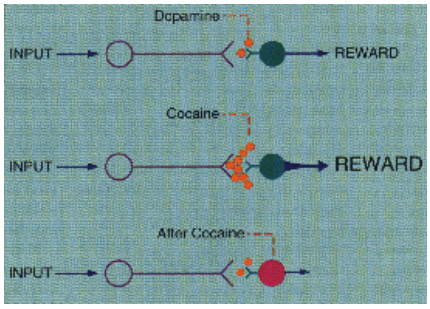


Figure 4-2. Process of Addiction
(ex. Cocaine) (top) dopamine triggers reward signal; (middle) cocaine blocks reuptake, causing excess dopamine at contact point; (bottom) adapted cell does not transmit reward signal in response to normal dopamine level[60].

Drugs hijack the brain's reward circuit

In addiction, craving becomes so powerful that it rules the addict's life. This power results in part from changes to a specific path of neurons throughout the brain—the "pleasure system" or "reward circuit." The reward circuit has been studied extensively in rodents. This is significant, since biochemical processes in these animals are strikingly similar to those of human beings.[61]

In a classic experimental design, researchers attach electrodes to points in the brains of living rodents—locations that correspond to the reward circuit. When rodents press a special lever in their cages, a small electrical current travels via the electrodes directly to the animals' reward circuit. Typically, some of the rodents press the lever compulsively—thousands of times, until they finally collapse in exhaustion.

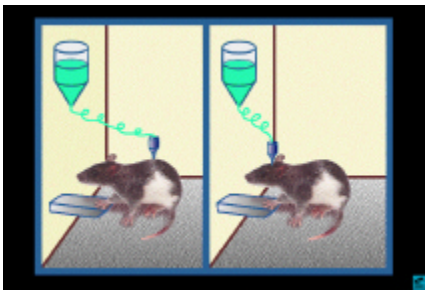


Figure 4-3. Reward Circuit Experiments
Rat on the left would NOT repeatedly press the lever to because the proper areas of the brain (nucleus accumbens, VTA, etc) would NOT be stimulated. Stimulation of the nucleus accumbens in the brain of the rat on the right WOULD cause activation of the Reward Pathway, and thus the behavior would be repeated.

These findings give a clue to the power of the reward circuit in human beings, which extends from the mid-brain to another section called the nucleus accumbens. This is where drugs of abuse create their effect by masquerading as natural chemicals. Steven Hyman, MD, director of the National Institute of Mental Health,

described the action of drugs on this part of the brain in an interview with Bill Moyers (aired on public television as part of Moyers' series on addiction titled *Moyers on Addiction: Close to Home*):
"*The nucleus accumbens seems to have a particular role in telling us what might be pleasing, what might be good for us . . .. Cocaine and amphetamine put more dopamine in key synapses over a longer period of time in this brain reward pathway than normal. And because they are so rewarding, because they tap right into a circuit that we have in our brains, whose job it is to say something like, "Yes, that was good. Let's do it again and let's remember exactly how we did it," people will take these drugs again and again and again."*[62]

For the person who uses chemicals to repeatedly stimulate the reward circuit, the prospect of abstaining from those chemicals can seem as hopeless and absurd as the idea of abstaining from food. An overpowering drive to drink or use other drugs compromises the user's will, changing what was once a voluntary behavior into an involuntary one.

Heredity influences response to drugs

Not all people who use drugs will experience the changes in brain structure and function described above. Some people can use drugs occasionally and remain occasional users. Other people, however, start using drugs casually and seem to progress inevitably to addiction. Researchers don't understand why this is so, but they know that heredity plays a role.

Each of us carries about 100,000 genes located in our cells on structures called chromosomes. And each gene directs the body to produce a specific protein (a process that's influenced by the action of neurotransmitters). The production of these proteins creates a chemical blueprint that shapes every aspect of a human being, from height and weight to personality and behavior.

Unfortunately, the genetic blueprint is not fail safe; chance mutations in genes can produce hereditary diseases. A few of these—such as cystic fibrosis and Huntington's disease—result from a change in a single gene. Researchers have had some success in pinpointing the exact location of those genes and designing specific treatments in response.

In contrast, alcoholism and other forms of addiction result from changes in *many* genes. What's more, the genes that are involved can vary from person to person. These facts make the effort to locate the genes that influence addiction (gene markers) a task of overwhelming complexity.

Still, we have abundant evidence that the predisposition to alcoholism is inherited. Identical twins born to alcoholic parents are more likely to become alcoholic than fraternal twins born to alcoholic parents. (Identical twins share identical genes; fraternal twins do not.) And, adopted children of alcoholic parents show higher rates of alcoholism than adopted children of non-alcoholic parents. This is true even when children of alcoholics are raised by non-alcoholic foster parents.

In a recent review article, Thomas McLellan, PhD, professor in the Department of Psychiatry at the University of Pennsylvania in Philadelphia, and his colleagues provide this summary of the relevant research: "Though there is need for more studies of heritability by drug and by gender, the evidence accumulated over the past several years suggests significant genetic contribution to the risk of addiction in approximately the same range as for chronic illnesses such as asthma and hypertension."[63]

Brain waves may predict risk for addiction

A promising development in this area comes from studies by Henri Begleiter, MD, PhD, professor of psychiatry and neuroscience at the State University of New York in Brooklyn, New

York. While not able to identify precise gene markers for addiction, Begleiter has discovered another possible marker in the brain waves of people from alcoholic families.

Brain waves are recorded by a common medical device called an electroencephalograph and printed out as an electroencephalogram (EEG). When subjected to a significant sensory stimulus, such as a loud sound, most people respond with a common pattern: Between 300 and 500 milliseconds after the stimulus, their EEG shows a characteristic peak in brain waves. This part of the EEG is called the P3 amplitude. (The term *amplitude* refers to the height of the waves on the EEG.)

In numerous studies that have been replicated by other researchers, Begleiter and colleagues discovered that the P3 amplitude tends to be lower in alcoholics—even those who have been abstinent for up to 10 years. In effect, people with this wave pattern often do not distinguish significant stimuli (those that are unique and unpredictable) from insignificant stimuli (those that are repeated and predictable). These people tend to process each sensory stimulus as new, a characteristic called *hyperexcitability*. This characteristic plays a key role in conduct disorders and other forms of impulsive behavior.[64]

The lowered P3 amplitude has another implication: It has been discovered in non-alcoholic relatives of alcoholics, including their children. This fact suggests that the unusual brain wave pattern is inherited, and that it may help predict people who are at risk to develop addiction. Begleiter suggests that people at risk for alcoholism inherit a general state of hyper-excitability, and that drinking alcohol relieves this state. Yet the relief is only temporary and depends on drinking increasing amounts of alcohol over time.[65]

Research has treatment applications

Begleiter believes that his findings have clear applications in treating and preventing addiction. "There are several approaches that may be implemented," he says. One is "using behavioral and pharmacological means to reduce this hyper-excitability in young adolescents at risk to develop substance dependence. The other approach deals with prevention initiatives involving intense education starting at a very early age."

Each of these strategies holds promise. For one, knowing the effects of addictive drugs on the brain holds the hope of developing medications to reduce craving. This has already been done with methadone for heroin addicts, naltrexone for alcoholics, and buproprion for nicotine addicts.

In addition, research can shape the way we educate people about addiction. "Research gives us information to use with patients and families in treatment to understand what has happened to them, why the addiction has occurred, and how it is not a matter of lack of will power," says Patricia Owen, PhD, director of the Butler Center for Research at Hazelden. Also, people who know that they've inherited a risk for addiction can learn to abstain from alcohol and other drugs early on.

Equally important is placing people in treatment programs that reinforce changes in addictive behavior. To say that addiction involves biological factors does *not* mean that addicts are victims of biology. Indeed, the addict's initial behavior—casual drug use—sets biological factors in motion. And, we can expect addicts to enter and comply with a treatment program.

Besides, it's not only drugs that change the brain; stable changes in behavior can also alter brain function. For example, recovering alcoholics know that it's wise to avoid the people, places, and things that they used to associate with drinking. This new behavior weakens the link

between drinking and pleasure that's been encoded in their brains.

Biology and behavior, then, must share the billing when it comes to explaining addiction and promoting recovery. According to the National Institute on Drug Abuse, the most effective treatment programs blend an array of strategies—medication, therapy, social services, rehabilitation, and self-help groups.[66]

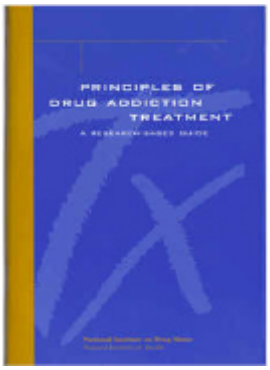


Figure 4-4. Drug addiction treatment is as effective as are treatments for most other similarly chronic medical conditions.[67]

Leshner believes that these programs succeed because they treat the whole person. "Their treatment strategies place just as much emphasis on the unique social and behavioral aspects of drug addiction treatment and recovery as on the biological aspects. By doing so, they better enable those who have abused drugs to surmount the unexpected consequences of drug use and once again lead fruitful lives."

SEE ENDNOTES FOR REPRINT REFERENCE

4.2 VARIOUS "POPULATIONS" NEEDING TREATMENT

For prevention and treatment to be effective, we must address the unique needs of different populations. When treatment is done well and recognizes the varied needs of individuals, the likelihood of success increases significantly[68].

4.2.1 Adults

Nationally, it is estimated that more than 75 percent of those who need treatment do not get it[69]. According to the 1997 Adult Household Telephone Survey the estimated number of Montana adults in need of treatment in 2001 is 53,107. The adults receiving treatment services in 2001 was 6,402 (12 percent of need)[70]. This means that **approximately 88 percent of Montana's adults who are in need of substance abuse treatment are not able to receive it** or don't seek treatment**.**

All of the Montana specific data and statistics in this section come from the 2001 Chemical Dependency Client Characteristics & Services Provider Profiles produced by the Chemical Dependency Bureau of the Addictive and Mental Disorders Division.[71]

The Department of Public Health and Human Services (DPHHS), Addictive and Mental Disorders Division (AMDD), Chemical Dependency Bureau (CDB) has the statutory authority (MCA 53-24-208) to establish standards and approve treatment facilities. There are 29 public and private programs that are approved by the department. The 29 programs provide a full range of services within the continuum of care.

Each state approved program receives a yearly site review conducted by the Departments Quality Assurance Division to assure program compliance with standards set forth in administrative rule (chapter 27 Chemical Dependency Programs, subchapter 1.)

The Department requires state approved programs to use uniform Patient Placement Criteria (PPC) authored by the American Society of Addiction Medicine (ASAM). ASAM establishes a uniform consistent application of criteria for assigning appropriate levels of individualized care.

The Department requires state approved programs to report on the Alcohol and Drug Information System (ADIS). The ADIS has over 20 years of data on the system. The System tracks client admission, transfer, discharge, and follow-up data using a unique client identifier. The system also collects demographics, alcohol and drug history data, level of care data, length of stay data, DUI / ACT data, and critical population data. The ADIS is the Department main data base for substance abuse prevention and treatment reporting, planning, management and evaluation of program effectiveness.

The state operates a publicly funded treatment program for adults called the Montana Chemical Dependency Treatment Center which is a 76 bed residential (inpatient) facility

that treats over 800 Montana residents with addictions every year. Seventy of the beds are used for treatment and six beds are reserved for detoxification of patients admitted to the treatment program. Patients are admitted to the program through referrals from Licensed Addiction Counselors. The Chemical Dependency Treatment Center serves critical populations such as: low income, indigent, pregnant women, women with dependent children, IV drug users, Native Americans, and co-occurring disorders.

Together these programs include both outpatient and inpatient services and currently many of these programs, especially in urban areas, have waiting lists of individuals needing treatment. A variety of services are provided by these treatment programs. The services include:

- Detoxification, physical examinations, diagnostic assessment.
- Individualized treatment based upon a comprehensive biopsychosocial assessment.
- Individual, family and group counseling.
- Crisis intervention.
- Chemical dependency education.
- ACT (DUI) Program.
- Transitional living facility.
- Referral and discharge services.
- Relapse prevention and continued care services.
- Follow-up program after discharge.

In 2001, there were 6,902 total admissions to state approved treatment programs. Eighty two percent of those in the programs were 20 or older. In the last five years 50 percent of those admitted to Montana's treatment programs were readmissions; people who had already attended at least one other treatment program within five years.

The majority of those treated, 51 percent are between 21 and 40 years old. Seven percent of the treated population is over 51 years old.

A summary of admission data follows. It is important to note that individuals may be included in more than one category.

- 71% began using alcohol and/or drugs before age 17.
- 58% of these admissions had no health insurance.
- 66% had household incomes under $10,000.
- 34% of the admissions are involved in the criminal justice system. (i.e., probation/parole).
- 34% have been convicted of a DUI offense.
- 22% received some form of public assistance.
- 11% are women with dependent children.

- 19% are IV drug users.
- 19% are Native Americans.
- 70% are males, 30% females.

Drugs of choice as indicated at intake are:

- Alcohol – 34%.
- Alcohol plus other drugs – 26%.
- Marijuana (hashish) –19%.
- Methamphetamine – 12%.

4.2.2 Native Americans

There are Indian treatment programs on all seven reservations as well as urban programs that provide specialized services for Native Americans in Helena, Butte, Great Falls, Missoula and Billings. Montana has state approved treatment programs in three of these locations, the Indian Health Board in Billings, Blackfeet Chemical Dependency Services in Browning, and the Missoula Indian Center.

In July 2001 the Montana Department of Public Health and Human Services completed a Native American Substance Abuse Treatment Needs Study for Montana Reservations. The Study was funded by the Center for Substance Abuse Treatment and was intended to establish baseline data to assist the tribes in planning and to enable them to access grants and contracts for addressing their substance abuse treatment needs[72]. The following information is from that study.

The study found that the prevalence of alcohol use in the last year and last month for Native Americans living on Montana's Reservations is lower than for the general population of adults in Montana and the U.S. (Figure 4-5). The percentage of Native Americans who have ever used alcohol is also lower than for Montana's general population but higher than the national percentage (Table 4-1).

Figure 4-5. Alcohol "Use" for Montana Reservations is Lower than State and National Estimates[73]

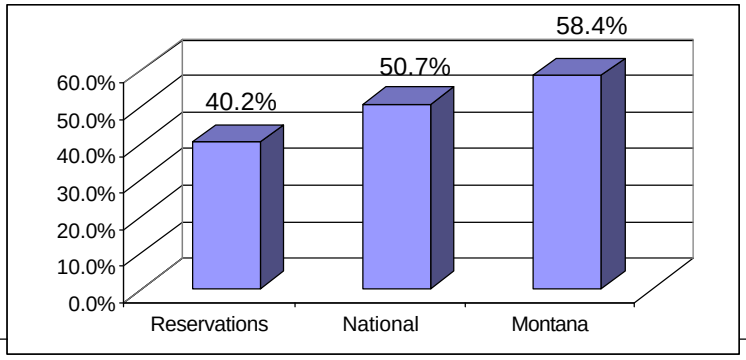


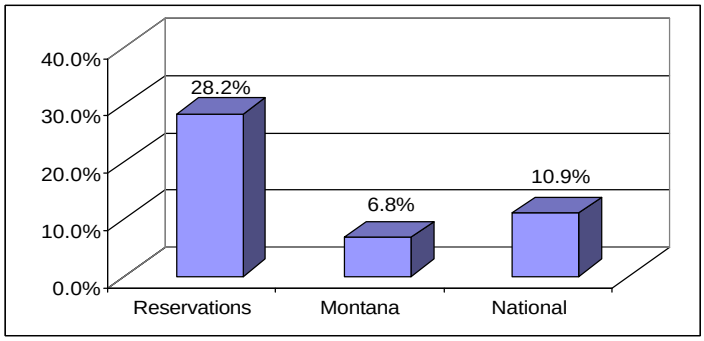
Table 4-1. Lifetime, Last Year, and Last Month Alcohol Use[74]

	Lifetime	Last Year	Last Month
Montana Reservations	91.9	60.0	40.2
Montana, general population	97.7	78.2	58.4
National	85.8	65.8	50.7

The prevalence of alcohol dependence, however, is more than three times higher for Native American adults living on Montana reservations (12.8 percent) than other adults (3.7 percent). Native American women who have been pregnant within the last year are more likely to need treatment for alcohol related disorders than other pregnant women in the state (23 vs. 5 percent). About one out of every four pregnant women on Montana reservations needs treatment for alcohol abuse or an alcohol dependency. Native American women ages 18-55 are less likely to use alcohol than other women in Montana.

The prevalence of drug use on reservations is higher than state or national estimates (Figure 4-6). Drug dependence is over four times higher for Montana Reservation's adult population (5.9 percent) than for the US population (1.4 percent).

Figure 4-6. Drug Use on Montana Reservations is Substantially Higher than State and National Estimates.



Substance abuse is not a matter of race; it's a matter of poverty[75]. People living in poverty are much more likely to need treatment services than individuals with incomes above the federal poverty guidelines (80 percent of those below the poverty line need treatment, 20 percent of those above the line need treatment). On Montana Reservations 37 percent of the households are living with annual incomes under $10,000, compared to 7 percent of households nationwide.

Nearly 1 out of every 2 young men living on reservations in Montana aged 18 to 24 are in need of treatment for alcohol or drug addiction. Approximately 28.4 percent of Montana American Indian adults living on reservations are in need of treatment. This is equivalent to over one out of every four adults (about 5,400 people). Approximately 13 percent of those needing treatment are receiving it. Therefore, **87 percent of those needing treatment are not receiving it**.

4.2.3 Youth

All of Montana's 29 approved treatment providers are contracted by the Department of Health and Human Services to provide specific adolescent treatment services for youths under 17 years of age with abuse or dependency problems. Of the 6,902 total admissions to treatment programs in 2001 approximately 1200 (18 percent) were under the age of 20. Of the estimated 14,693 youths who need treatment in Montana, 661 (4.5 percent) actually sought treatment[76]. This is an alarming statistic. **Approximately 95 percent of Montana's youths who need substance abuse treatment are not receiving it.**

As stated in the Section 3.0 of this Living Document, Montana's youths rank:

- 2nd in the nation for illicit use of drugs.
- 4th for use of alcohol.
- 6th for use of tobacco[77].

The Montana Board of Crime Control reported the following for 2000[78]:

- 1222 referrals for alcohol offenses (offenses may include use of false identification, Minor in Possession, and other liquor violations)
    - 39% of these were female.
    - 60% of these were male.

      Note: total may be greater than combination of gender counts because of reporting methods

- 753 referrals for drug offenses.
- 702 referrals for drug paraphernalia offenses.
- 17 referrals for DUI.

Sixty percent of youths appearing before youth court are first-time offenders[79].

Table 4-2 compares the past 30 day use of alcohol, marijuana and stimulants for Montana's 12th graders with national averages for the same grade. It shows a higher rate of use for alcohol and marijuana and a lower use rate than the national average for stimulants or methamphetamine.

The types of drug use reported in the Prevention Needs Assessment Surveys for 2000 and 2002 are compared in Table 4-3.

Table 4-2. Comparison of Past 30 Day Use for Montana's 12th Graders Compared to National 12th Grade Average (2002 data)[80]

12th graders who:	Montana	National
Have used alcohol within the past 30 days	59%	50%
Have used marijuana within past 30 days	27%	22%
Have used stimulants within past 30 days	3%	6%

Table 4-3. Comparison of Drug Prevalence Reported by Montana's 8, 10, 12 Graders for 2000 and 2002 Based on Prevention Needs Assessment[81]

	2000 % of Students	Number of Youth 12-17 yrs	2002 % of Students	Number of Youth 12 - 17 yrs
Alcohol	47.5%	40,911	44.5%	39,281
Cigarettes	27.1%	23,341	19.4%	17,125
Marijuana	18.8%	16,192	20.2%	17,831
Smokeless Tobacco	10.2%	8,785	8.7%	7,680
Sedatives	6.9%	5,943	6.2%	5,473
LSD (Hallucinogens)	2.9%	2,498	2.1%	1,854
Stimulants (Meth, etc.)	2.8%	2,412	2.4%	2,119
Inhalants	3.7%	3,187	3.3%	2,913
Cocaine	1.8%	1,550	1.8%	1,589
Heroin	0.7%	603	1.0%	883
Binge Drinking	30.5%	26,269	29.2%	25,775
Ritalin	NA	0	2.0%	1,765
Ecstasy (MDMA)	NA	0	6.0%	5,296
Steroids	NA	0	1.0%	883
Total Youth		**86,128**		**88,271**

Binge drinking means consuming 5 or more drinks in a row within past two weeks.

There is a high prevalence of youth with co-occurring chemical dependency and mental illness in residential treatment centers indicating a need for chemical dependency treatment in conjunction with mental health treatment. A Co-occurring Task Force has been formed and is discussed in Section 4.2.7.

A lack of appropriate "step-down" services has been identified in state residential treatment programs for youth.

4.2.4 Corrections Populations

In the Judicial Section of this report we further discuss the connections between drug use and crime. Incarcerating offenders without treating underlying substance-abuse problems simply defers the time when they are released back into our communities to start harming themselves and the larger society[82]. The largest percentage of people in Montana's treatment programs are referred through the corrections system.

A 1997 study found that **89 percent of inmates** in Montana State Prison and Montana Women's Prison **have a lifetime substance abuse disorder[83]**. Fifty eight percent of the men inmates and 64 percent of women inmates have a current need for treatment.

In 1999 8 percent of male on-site offenders at Montana State Prison were involved in chemical dependency treatment groups. At the same time roughly 38 percent of the on-site inmate population were either waiting to be screened for chemical dependency or waiting for a slot to become available in a treatment group. Twenty seven percent of the women on-site offenders at Montana Women's Prison were receiving treatment in 1998 while 86 percent of the women there met the criteria for substance dependency or abuse.

Several trends are noted in the seven years of Alcohol and Drug Information System reports about the Montana State Prison Chemical Dependency Program (MSP-CDP):

- Program admissions have risen from less than 100 in FY95 to over 300 in FY99, 00 & 01.
- Program completion percentage has risen from 70% in FY95 to 90% in FY99, 00 & 01.
- 55% of individuals completing MSP-CDP remain in prison at the time of six month follow up.
- 51% of individuals completing MSP-CDP remain in prison at the time of one year follow up.
- MSP-CDP was fully staffed only four months of the seven year reporting period.

The preceding information substantiates program activity has increased markedly, however, limited treatment slots means that many people in the correctional system who have a need are not receiving treatment. Program staff have dramatically increased the number of people served and maintained a high level of positive outcome despite lacking the human and logistical resources to fully implement the program as designed.[84]

In 2000 the Criminal Justice Advisory Group completed a comprehensive plan to address the growing issue of correctional offenders who need chemical dependency treatment[85]. They reviewed the issues thoroughly and recommended change and improvement to move toward a continuum of care for chemically dependent criminal offenders. Seven steps were outlined in the plan including:

- Standardized assessment – Chemical dependency counselors should be trained to deliver a standardized assessment with all offenders.
- Create a department level position and sufficient support to oversee all correctional chemical dependency programming and implementation of the plan.
- Develop a standardized continuum of sanctions and treatment.
- Implement a case management plan proposed by the committee.
- Design and implement a Management Information System.
- Plan and implement programs for special populations.
- Evaluate the implementation of this plan.

This plan has not been implemented to date.

4.2.5 Pregnant Women & Women with Children

Montana has three publicly funded programs designed for the specific needs of substance abusing women who are pregnant or who have dependent children. These programs include: Carol Graham Home in Missoula, Michael House in Billings, and, Gateway Group Home in Great Falls. These facilities provide care for the family unit (mother & child{ren}) instead of disrupting the family and placing the children in foster care. The family group homes serve both in-county and out-of-county residents. A large number of the women admitted to Montana's facilities with children are meth addicts.

In addition to these three programs, each of the 29 state approved programs is required to identify pregnant women and women with children as priority populations, meaning that they have priority over others to receive treatment.

In 1999 it was estimated that 311 pregnant women needed treatment in Montana. That same year 37 women or 12 percent actually received treatment[86].

Because pregnant women and women with children have priority status for receiving treatment at any of the state approved programs, it is not likely that this gap is due to a lack of available programs. Rather, the gap may be due to a lack of identification and referrals and a lack of comprehensive treatment services for women that includes transportation, childcare and gender specific approaches. Some drug dependent women do not seek treatment and do not even seek appropriate prenatal care for fear of losing their children.

Currently sanctions exist that make felony drug offenders ineligible for public benefits such as Temporary Assistance to Needy Families (TANF) and Medicaid funds. Some believe that by denying women drug offenders these TANF benefits the state is inadvertently reducing the women's treatment options and forcing them to return to a drug using lifestyle.

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) are patterns of birth defects and neurological damage caused by prenatal alcohol exposure. FAS and FAE are recognized as the leading cause of mental retardation and neurological dysfunction in the nation, yet it is 100 percent preventable[87]. Montana spends about $18.8 million per year caring for persons with FAS. The cost of lifetime care for a single case of FAS exceeds $1.4 million dollars. It is projected that over 5 years Montana will spend $93.8 million[88].

Minnesota, Montana, North Dakota and South Dakota have formed the Four-State Consortium on FAS in an effort to identify, treat, and prevent Fetal Alcohol Syndrome. In this four state region a child is born every seven hours with FAS or FAE[89].

4.2.6 Methamphetamine Addicts

Methamphetamine is a highly addictive drug that can be manufactured by using products commercially available anywhere in the United States[90]. The use of the drug is growing in Montana and the successful treatment of meth addicts is challenging but can be done. As one parent of a former meth addict stated, … "In this journey, we learned two important lessons. The first is that this problem can happen to anyone. The second is that treatment, when done well, works[91]."

For 2001, the Montana Department of Health and Human Services' special report on alcohol and drugs reported that out of 8,365 admissions in state-approved programs for alcohol and drugs, 1,530 of those admissions, or 18 percent, were for methamphetamine[92]. A further break-down of the admissions include:

- 2920 were female admission, of which 620 were meth
- 512 were Native American females, of which 126 were meth
- 5,455 were male admissions, of which 910 were meth
- 844 were Native American male admissions, of which 137 were meth

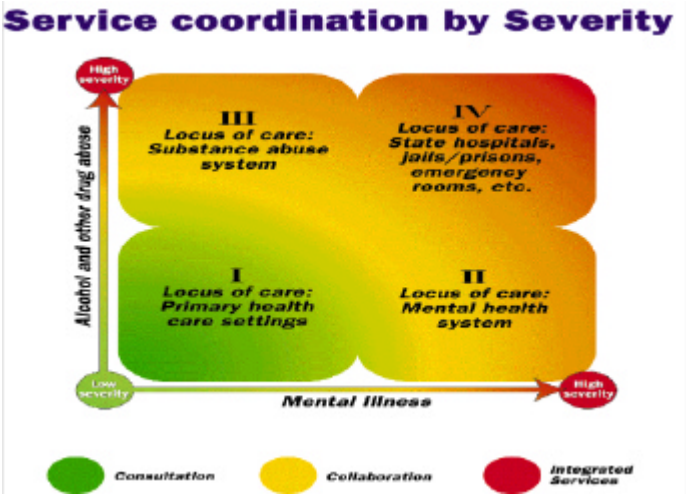
The Center for Substance Abuse and Treatment has funded a Methamphetamine Treatment Project. There were seven sites, one in Hawaii, five in California, and the one in Billings, Montana. The project assessed the characteristics of the clients when they started treatment. The project found that **Billing's meth users had the highest rate of intravenous drug use** of all seven sites with a rate of 56 percent. The next highest rate of any of the sites was 30 percent[93]! Intravenous drug use is significant due to the medical complications of Hepatitis B and C, HIV infections and other risk factors.

4.2.7 Co-occurring Chemical Dependency and Mental Illness

The Co-occurring Task Force was established in November, 2000, by Dan Anderson, Administrator of the Addictive & Mental Disorders Division of the Department of Public Health & Human Services, and is comprised of a broad cross section of representation,

including: mental health and substance abuse, private and public, in-patient and out-patient providers; consumers; advocacy representatives; public assistance; and staff of the Chemical Dependency Bureau.

Figure 4-7. The Conceptual Framework for Co-occurring Disorders Service Coordination[94].



The primary goal of the task force is to meet the challenge of developing an integrated continuum of care that expects both mental health and chemical dependency professionals to develop formal relationships of consultation, collaboration and integration. Within the context of this task force, co-occurring disorders were limited to those disorders which included both a chemical dependency and a mental disorder, regardless of which may be considered primary. Coupled with this parameter, professionals are asked to be aware, in their diagnosis and treatment, that co-occurring disorders are an expectation not an exception.

During the course of the task force, it has taken action on the following:

- Developed and issued an RFP and awarded funding for two co-occurring pilot projects; one in Great Falls and one in Butte.
- Conducted a statewide stakeholder conference in Billings in the fall of 2000 focusing on treatment, medications and other states applications of co-occurring principles.

- Developed a "cross-walk" of terminology commonly used in the mental health and chemical dependency professions.
- Assisted the establishment of a cooperative agreement between Montana State Hospital and Montana Chemical Dependency Center for the effective transfer and treatment of co-occurring patients.
- Conducting a review/analysis of common screening/assessment instruments.
- Requested providers submit written evidence to AMDD of their ability to be at least a "co-occurring capable program" according to criteria established by the American Society of Addiction Medicine.
- Cooperatively sponsored training to providers and clinical supervisors on the application of ASAM Patient Placement Criteria 2R

The Co-Occurring Task Force is currently active and is pursuing additional training conferences for clinical staff focusing on skill building and the practical application of unique treatment for co-occurring patients as well as possible creative funding designs to reimburse providers for co-occurring treatment.

4.3 BARRIERS TO EFFECTIVE TREATMENT

The Drug Control Policy Task Force (Task Force) identified six areas that function as "Barriers" or challenges to providing effective tobacco, alcohol and other drug treatment measures in Montana. Several issues fall within and contribute to each of these barriers and we discuss some of those issues below.

Six barriers to effectively treating substance abuse in Montana include:

Lack of Access to Treatment	**Attitudes and Stigma**
Funding and Treatment Costs	**Lack of Education and Engagement**

Lack of Specific Care Levels	Workforce Challenges

4.3.1 Lack of Access to Treatment

The numbers show a significant gap between those in need of publicly funded treatment and those who receive it (Table 4-4). These figures do not reflect treatment in private facilities or programs.

Table 4-4. Gap in Need for Treatment and Actual Treatment for Different Populations

Treatment Population	Need	Actually Treated	GAP % of Need Not Treated
Adults[95]	59,148	4,058	**88%**
Youth[96]	14,693	661	**95%**
Native Americans[97]	5,400	702	**87%**
Pregnant Women	311	37	**88%**

Treatment needs to be readily available. Since individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.[98]
We view the reasons for these treatment "gaps" as multi-dimensional. Some key factors include: availability of services in rural areas; waiting lists for services in more populated areas; lack of capacity in both programs and facilities—particularly for youth and families; and a lack of licensed addiction counselors. Table 4-4 reflects the public system's current capacity to respond to treatment needs.

The gap between the need for treatment for pregnant women and those that are actually receiving treatment may be due, in large part, to the reluctance of pregnant women and women with children to seek treatment for fear of losing their children[99].

One study, working with Native American's on reservations, looked specifically at why individuals who needed treatment were not receiving it. What they found was that among the 114 individuals on Montana Reservations with a need for treatment but who were not receiving treatment the most common barriers to receiving treatment were:

- 49.5% Treatment programs were full
- 45.3% Lack of transportation
- 42.7% Type of treatment available not what they wanted
- 42.7% Changed mind while placed on a waiting list
- 37% Treatment facilities were too far away
- 35.4% Too much red tape
- 31.2% No insurance

- 29.8% of the women Facilities were not sensitive to the needs of women.

Transportation to treatment programs and facilities can be a significant barrier to many people in Montana who need drug abuse or dependency treatment. Because of our extremely large land mass coupled with our small population size we have unique challenges in designing and delivering accessible treatment services.

An additional obstruction to involvement in treatment programs is affordable and accessible childcare. Montanans in their early adulthood (up through age 35) are a considerable component of the population needing treatment for substance abuse and dependency. This is also the prevalent age range for women of childbearing age and parenting males. Childcare is an infrequent element of treatment design, although a substantial deterrent to reliable participation in treatment programs.

4.3.2 Attitudes and Stigma

Societal attitudes and stigmas can be a barrier to treatment[100]. They can deter individuals or family members from seeking treatment to avoid the stigma or it can be an attitude of denial (there really isn't a problem). Attitudes and stigmas can also affect the way we treat or dismiss one another. Society tends to group together all individuals with substance abuse problems[101]. Many of us think "why don't they just cut it out and get their act together". This attitude may be brought on by the prevalent myths that surround drug addiction. Perpetuation of these myths is a barrier to treatment.

An article that addresses myths about drug abuse, was printed in the Wyoming Blueprint, and is reprinted here, at the end of this section, with permission from the National Institute on Drug Abuse.

The first intensive exploration of the stigmas and attitudes that affect people with alcohol and drug problems was initiated in the National Treatment Plan Initiative called "Changing the Conversation" which was published in 2000"[102]. The Plan addresses stigma as a powerful, shame-based mark of disgrace and reproach that impedes treatment and recovery. Prejudicial attitudes and beliefs generate and perpetuate the stigma; therefore, people suffering from alcohol and/or drug problems and those in recovery are often ostracized, discriminated against, and deprived of basic human rights. Their families, treatment providers, and even researchers may face comparable stigmas and attitudes. Ironically, stigmatized individuals often endorse the attitudes and practices that stigmatize them. They may internalize this thinking and behavior, which consequently becomes part of their identity and sense of self-worth.

Public support and public policy are influenced by addiction stigma. Addiction stigma delays acknowledging the disease and inhibits prevention, care, treatment, and research. It diminishes the life opportunities of the stigmatized[103].

"Exploring Myths about Drug Abuse"
by Alan I. Leshner, Ph.D., *Director, National Institute on Drug Abuse, National Institutes of Health*
Permission to reprint granted by the National Institute on Drug Abuse[104]

Myth: Drug addiction is voluntary behavior.

A person starts out as an occasional drug user, and that is a voluntary decision. But as times passes, something happens, and that person goes from being a voluntary drug user to being a compulsive drug user. Why? Because over time, continued use of addictive drugs changes your brain -- at times in dramatic, toxic ways, at others in more subtle ways, but virtually always in ways that result in compulsive and even uncontrollable drug use.

Myth: More than anything else, drug addiction is a character flaw.

Drug addiction is a brain disease. Every type of drug of abuse has its own individual mechanism for changing how the brain functions. But regardless of which drug a person is addicted to, many of the effects it has on the brain are similar: they range from changes in the molecules and cells that make up the brain, to mood changes, to changes in memory processes and in such motor skills as walking and talking. And these changes have a huge influence on all aspects of a person's behavior. The drug becomes the single most powerful motivator in a drug abuser's existence. He or she will do almost anything for the drug. This comes about because drug use has changed the individual's brain and its functioning in critical ways.

Myth: You have to want drug treatment for it to be effective.

Virtually no one wants drug treatment. Two of the primary reasons people seek drug treatment are because the court ordered them to do so, or because loved ones urged them to seek treatment. Many scientific studies have shown convincingly that those who enter drug treatment programs in which they face "high pressure" to confront and attempt to surmount their addiction do comparatively better in treatment, regardless of the reason they sought treatment in the first place.

Myth: Treatment for drug addiction should be a one-shot deal.

Like many other illnesses, drug addiction typically is a chronic disorder. To be sure, some people can quit drug use "cold turkey," or they can quit after receiving treatment just one time at a rehabilitation facility. But most of those who abuse drugs require longer-term treatment and, in many instances, repeated treatments.

Myth: We should strive to find a "magic bullet" to treat all forms of drug abuse.

There is no "one size fits all" form of drug treatment, much less a magic bullet that suddenly will cure addiction. Different people have different drug abuse-related problems. And they respond very differently to similar forms of treatment, even when they're abusing the same drug. As a result, drug addicts need an array of treatments and services tailored to address their unique needs.

4.3.3 Funding & Treatment Costs

The National Treatment Plan Initiative, Changing the Conversation, identifies inadequate funding for substance abuse treatment as a major barrier to providing effective treatment[105]. Investment in treatment, however, has proven to be very cost effective in some states. Oregon has estimated their return on every dollar spent on treatment services to be a $5.62 savings in state costs, primarily in the areas of corrections, health

and welfare.[106] A study of California alcohol and drug treatment services found that for every dollar invested in treatment, taxpayers save $7.14 in future societal costs.[107]

The financial costs of effective addiction treatment, which is a chronic, relapsing disease, can be significant and may pose a barrier to some potential patients. Some who have sought out-of-state (out-of-country) treatment for methamphetamine addiction reported costs of $40,000 for a 14 month program. Out-of-state residential services average 483 days per patient while in-state-residential treatment programs average 266 days[108]. Out-of-state facilities are necessary either when no openings are available at state programs or when special facilities or level of care are needed to meet the patient's unique needs which are not offered in Montana. In Montana, residential chemical dependency treatment for youth can exceed $35,000 a year. Estimates for the cost of treating those who are imprisoned jumps to from $25,900 - $83,289 per year[109]. Youth incarceration costs are higher than adult costs.

Associated with this barrier is the fact that health plans and third party payers typically provide less extensive coverage for substance abuse treatment than for other general medical services. Other chronic health conditions are currently afforded this medical coverage but substance abuse treatment is not, posing a barrier to treatment[110]. Montana's "Mandated Benefit Law" (MCA 33-22-703) provides minimum coverage for chemical dependency inpatient and outpatient treatment. It is not on parity with other disease coverage and is not sufficient to cover all treatment costs. For example, a patient with Children's Health Insurance Program (CHIP) coverage is eligible for a co-benefit of mental health and/or substance abuse treatment under the following limitations:

- $6,000 in a 12 month period for inpatient and outpatient services
- $12,000 per enrollee per lifetime for inpatient services
- Once the $12,000 lifetime maximum is met, $2,000 per benefit year is available.

The Department of Public Health and Human Services (DPHHS), Addictive and Mental Disorders Division (AMDD), Chemical Dependency Bureau (CDB) has the statutory authority (MCA 53-24-108) to allocated alcohol tax revenue generated by 16-1-404, 16-1-406, and 16-1-411, and earmarked to be used in state approved public and private programs whose function is the treatment, rehabilitation, and prevention of chemical dependency. DPHHS/AMDD may use these funds as matching funds for the Montana Medicaid program and to provide treatment for persons with co-occurring substance abuse and mental illness.

DPHHS/AMDD also has the statutory authority (MCA 53-24-206) to apply for and administer grants, allotments, or allocations of funds or other assistance for chemical dependency or related social problems. Each year the DPHHS/AMDD applies for, receives and administers the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant from the Center for Substance abuse Treatment for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. SAPT block

grant funds are allocated to 19 state approved programs through fee for service prevention, child and family, and adult contracts. The financial eligibility for services covered by SAPT funds is 200% of poverty. **This grant is the primary source of funds for the prevention and treatment of substance abuse in Montana.**

Table 4-5 reviews funding for fiscal year 2002 administered by the Department of Public Health and Human Services, Addictive and Mental Disorders Division; projected Medicaid Expenditures during the state's fiscal year (SFY) 2002; and Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds allocated in SFY2002.

Table 4-5. Funds Administered by the Department of Public Health and Human Services, Addictive and Mental Disorders Division – Fiscal Year 2002

Alcohol Earmarked Tax Legislative Appropriation:	
$1,000,000	County distribution according to MCA 52-24-206 to 17 state approved programs (these funds assure that services are provided by the 17 state approved programs in all 56 Montana counties).
$2,828,744	Montana Chemical Dependency Center and central office operations. The Montana Chemical Dependency Center is a 76 bed (6 detoxification beds and 70 treatment beds) adult residential program administered by the Department. The program treats over 800 clients a year.
$530,075	Services for persons with co-occurring substance abuse and mental illness.
Projected Medicaid Expenditures: (matched using Montana Chemical Dependency Center alcohol earmarked tax)	
$920,563	Provider enrollment is limited to state approved programs under contract with the Department. Fee for services reimbursement is available for outpatient services for youth, adults and their families. Residential services are limited to only youth.
Federal Substance Abuse Prevention and Treatment Block Grant:	
$312,18	Administration (maximum of 5%)
$1,248,750	Prevention (minimum of 20%)
$4,682,812	Treatment (funds have categorical requirements)

4.3.4 Lack of Education & Engagement

The lack of public and professional education and the resulting lack of engagement of those who need treatment is a barrier to effectively treating Montana's substance abusers. The education needs span a broad continuum of contact levels: individuals, families, schools, communities, professionals and policy and law makers (Figure 3-6).

There is a general lack of awareness and appreciation for treatment needs. There is little knowledge of what the social and economic costs of substance abuse are. There is a lack of knowledge by parents, teachers and social workers about the early signs of substance abuse, and what they should do if they suspect substance abuse. There is a need to

educate parents so they react appropriately if others alert them their child may have a substance abuse problem. This lack of knowledge and understanding occurs throughout all levels of the contact continuum.[111]

We currently lack an effective mechanism to get appropriate and timely information to parents and law makers alike. Part of the challenge is the difficulty in "motivating" parents and caregivers and others to attend programs that are offered or to use the material that is available. There is a lack of effective motivational tools to engage those who need to be involved and informed in order for effective treatment to occur.

4.3.5 Lack of Specific Care Levels ~ "Best Practices"

The American Society of Addictive Medicine (ASAM) has developed patient placement criteria (PPC-2R) that identify the "level of care" needed to most effectively treat a drug abuser or drug dependent patient based on their specific needs and motivational stage (Table 4-6) . Several studies have demonstrated that the success and cost effectiveness of treatment can be predicted by how well the treatment matched the specific needs of the patient[112]. Patients who receive a lower level of care than recommended by the PPC-2R have poorer outcomes than those who are correctly matched to treatment according to the criteria[113].

Table 4-6. ASAM PPC-2R Levels of Care

ASAM PPC-2R Level of Detoxification Service	Level
Ambul. Detox without Extended On-Site Monitor	I-D
Ambul. Detox with Extended On-Site Monitoring	II-D
Clinically-Managed Residential Detoxification	III.2-D
Medically-Monitored CD Inpatient Detoxification	III.7-D
Medically-Managed Intensive Inpatient Detox.	IV-D
ASAM PPC-2R Level of Care for Other Treatment & Recovery Services	**Level**
Early Intervention / Prevention	0.5
Outpatient Services / Individual	I
Intensive Outpatient Treatment (IOP)	II.1
Partial Hospitalization (Partial)	II.5
Apartments / Clinically-Managed Low-Int. Res. Services	III.1
Clinically-Managed Med-Intensive Residential Services	III.3
Clinically-Managed High-Intensive Residential Services	III.5
Medically-Monitored Intensive Inpatient Treatment	III.7
Medially-Managed Intensive Inpatient Services	IV
Opioid Maintenance Therapy	OMT

Historically in Montana there have been two levels of treatment care, inpatient and outpatient, without a lot in between. The state has been trying to expand care levels as opportunities arise. As an example, the three women's treatment facilities where children can live with their mothers while their mothers are in treatment are providing a new care level for Montana. In general, though, Montana lacks a full array of treatment levels, particularly in the vast rural areas of the state.

Discussions are occurring within the Chemical Dependency Bureau to divide Montana into three regions, based on population, for treatment services. The concept is to provide for a broader range of care levels within each region.

4.3.6 Workforce Challenges

The National Treatment Plan Initiative considers good substance abuse treatment to be a function of the following workforce characteristics[114]:

- Quantity – supply and demand, staff distribution, client-staff ratio;
- Quality – education, training, credentialing, experience (type and length);
- Social characteristics – cultural congruence, cultural competency;
- Practice – competence consistent with continuum of care, client experience, and client needs in environmental context.

The current situation with Montana's treatment workforce related to these four characteristics has not been fully assessed. There is a Governor appointed Blue Ribbon Task Force on Health Care Workforce Shortage that is looking at work force issues for Montana health care professionals.

In early 2002 there were 467 Licensed Addiction Counselors listed as "active" in the state of Montana. Of these "active" licenses it is not known how many Licensed Addiction Counselors were actually practicing. It is estimated that approximately 130 Licensed Addiction Counselors work in state approved programs.

A national shortage of qualified treatment professionals was noted in several publications[115]. In 2000 and 2001 there were a large number of Licensed Addiction Counselor vacancies in Montana (approximately 36). Agency managers have indicated it is difficult to recruit and retain qualified staff due to low wages and benefits, working conditions and stiff competition with other states. Recruiting in rural areas poses the biggest problem. Fortunately, fewer vacancies are reported in 2002 (approximately 6).

In 2001 the Department of Health and Human Services required that all state contracted treatment programs pay their Licensed Addiction Counselors a minimum of $27,462 per year (state pay grade 14) by the end of 2002.

The existing work force is challenged with increasing case loads. As treatment professionals attempt to "do more with less" their effectiveness is compromised and the outcomes are diminished.

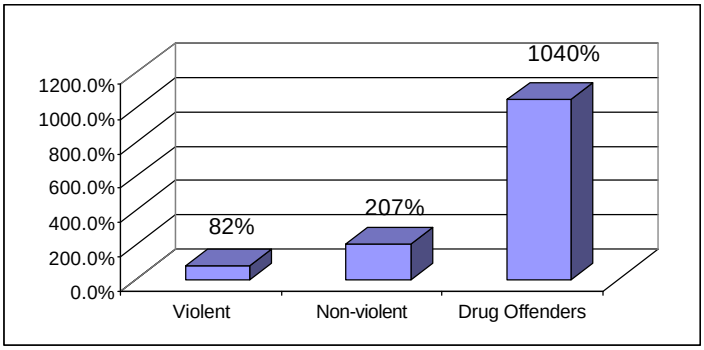
5.0 JUDICIAL ~ CURRENT SITUATION

5.1 A STRESSED CORRECTIONAL SYSTEM ~ THE DRUG/CRIME LINK

This document is laden with statistics and we are going to give you some more. But first shake the number "numbness" from your brain so you can appreciate the significance of these next findings. According to U.S. Department of Justice statistics, from 1980 – 1997 the number of **people entering prison for drug offenses increased 1040%**, that's 11 fold (Figure 5-1)[116]. Montana's total prison incarceration rate jumped from 104,000 in 1983 to 310,000 in 1998[117], this is a 198 percentage increase. This would be like going from accommodating three people living in your home to having to accommodate 9! --- How would you do that? ---

The local impacts are significant. No community in Montana can escape the problems of alcohol, drugs and related crime. Yellowstone County, the most populated county in our state, showed dramatic increases in drug offenses between 2000 and 2001 (Table 5-1). These statistics, though specific for Yellowstone County, are indicative of the current situation throughout Montana.

Figure 5-1. From 1980 – 1997 the Number of People Entering Prison Nationally for Violent, Non-violent and Drug Offenses[118].



A study conducted in Montana in 1997 further substantiates the connection between chemical dependency and criminal behavior[119]. The study showed that **89 percent of all inmates** in the Montana State Prison and Montana Women's Prison **had a "lifetime substance abuse disorder"** and 58 percent of the men and 64 percent of the women have a current need for treatment. Treatment needs for pregnant women and women with dependent children can offer special challenges.

Table 5-1. Increases in Drug Related Offenses in Yellowstone County Between 2000 and 2001[120]

Offense	2000	2001	% Change
Misdemeanor and felony drug cases	433	560	+ 29%
Alcohol related cases filed	285	339	+ 19%
Felony Driving Under the Influence cases (meaning three previous DUI's)	68	92	+ 35%
Probation violations	22	63	+ 186%
Probation violations based on felony criminal possession of dangerous drugs	11	38	+245%
Probation violations based on DUI	9	16	+78%

Many crimes are committed under the influence of drugs or may be motivated by a need to obtain money for drugs[121]. Across the United States at least half of adults arrested for major crimes, including homicide, theft and assault, tested positive for drugs at the time of their arrest[122]. Nationally, 36 percent of convicted offenders arrested had been drinking at the time of arrest. 31 percent of convicted offenders were using drugs at the time of their offense[123].

Nationally, the occurrence of violent crimes is declining but in Montana violent crimes increased by 37 percent between 1999 and 2000 with aggravated assaults showing the largest increase[124]. While the Board of Crime Control reported that many factors may be responsible for this increase including new record keeping and reporting mechanisms, it is widely accepted by law enforcement officers that the increase is due in large part to violence committed by an increasing number of offenders under the influence of methamphetamine.

The expansion of America's prisons has been largely driven by the incarceration of nonviolent offenders[125]. Montana is continuing to expand its facilities to address these needs[126] and in 2000 it was reported there was no longer a "backup" of male inmates in county jails[127]. In Montana **drug offenses were reported to law enforcement at a rate of one every two hours 36 minutes** according to a 1996 Annual Report of the Montana Board of Crime Control[128].

Montana's Comprehensive State Plan for the Provision of Chemical Dependency services to Adult Correctional Offenders states that only punishing those who commit alcohol or

drug related crimes will not stop the pattern of criminal behavior; but, punishment, appropriately linked with treatment alternatives will[129]. The support for this view is overwhelming in contemporary reports and studies[130]. The challenge is providing those treatment services.

> *"State and local corrections officials, as well as public and private human service providers throughout the state, should be commended for the level and quality of services provided to correctional populations both in secure facilities and community settings. It is safe to assume that the demand for treatment services will continue to outpace supply for these services. As a result, it is necessary to develop a coordinated system of comprehensive planning and effective collaboration that ensures correctional populations will receive the best possible treatment at equitable costs to the taxpayers.[131]"*

Without effective treatment addicted criminal offenders will likely return to the system over and over again. If you are wondering why please review the Section on the Science and Nature of Addiction. There is currently not an effective means to move individuals into correctional facilities – provide them with effective and individualized treatment – and return them to society without compromising the safety and health of our communities. Probation and parole officers confirm this fact with their reports of an increase in revocations especially among alcohol and methamphetamine substance abusers, over 50 percent of offenders entering the prison system are parole and probation revocations[132]. Over 95 percent of offenders who violate probation and parole supervision are using alcohol, marijuana, and or methamphetamines.

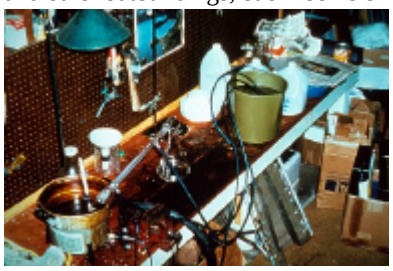
In 1999 the Parole and Probation Board developed chemical dependency and employment programs but due to a 5 percent budget cut all but one of these programs was eliminated. Currently sanctions exist that make felony drug offenders ineligible for public benefits such as Temporary Assistance to Needy Families (TANF) and Medicaid funds. Some believe that by denying women drug offenders these benefits we are inadvertently reducing their treatment options and forcing them to return to a drug using lifestyle.

5.1.1 The Impacts of Meth

Across the nation, while burdens to the correction systems are increasing, primarily due to non-violent offenders, state coffers are suffering[133]. Montana is no exception to the reduction in available "public funds" and county revenues are also down. In spite of reduced budgets methamphetamine is putting increased demands on public funds and resources.

Between October 2001 and April 2002, 63 methamphetamine labs were discovered by local law enforcement officials throughout the state of Montana[134]. Cleaning up these lab sites cost the Federal Drug Enforcement Agency $670,000. The increase in the number of meth labs has been phenomenal. As an example, in Great Falls the Police Department dealt with two meth labs in 1999 and two in 2000. In 2001 they investigated and/or cleaned 38 sites.

Meth labs are a large drain on local and state resources and are a major environmental problem. Clandestine labs are found in rural, city and suburban residences; barns, garages and other outbuildings; back rooms of businesses; apartments; hotel and motel rooms; storage facilities; vacant buildings; and vehicles. Small portable labs are commonly referred to as "Mom and Pop" or "Beavis and Butthead" labs.[135]



Each pound of methamphetamine produced leaves behind five or six pounds of toxic waste. Methamphetamine cooks often pour leftover chemicals and byproduct sludge down drains in nearby plumbing, storm drains, or directly onto the ground.

Chlorinated solvents and other toxic byproducts used to make methamphetamine pose long-term hazards because they can persist in soil and groundwater for years. Clean-up costs are exorbitant because solvent contaminated soil usually must be incinerated. Cleanups of labs are extremely resource-intensive and beyond the financial capabilities of most jurisdictions. The average cost of a cleanup is about $5,000 but some cost up to $100,000 or more.[136] Some law enforcement officers have said that nothing has impacted local law enforcement in Montana more than meth.

In July, 2002 representatives from the Montana Departments of Environmental Quality (DEQ), Justice (DOJ), Labor & Industry (DLI), Public Health & Human Services (DPHHS), the federal Agency for Toxic Substances and Disease Registry (ATSDR), and Region VIII EPA Helena Office met to discuss issues surrounding clandestine drug labs in Montana to identify options to help protect human health and the environment. They decided by consensus to work together to develop meth lab clean-up guidance that can be used without government oversight. The guidance will consist of a pamphlet containing general information gathered from other states with incorporation of information relative to Montanans. It will also include the creation of a website with pertinent information to help landowners identify solutions for cleaning up both indoor and outdoor

environmental impacts. The group also determined that if the Montana Legislature determines that environmental impacts associated with clandestine drug labs needs to be addressed in a more comprehensive manner, it will be incumbent upon them to provide the financial and human resources to do so.

The environmental contamination at meth lab sites also impacts realtors and insurance companies who are very concerned about the toxicity of Meth labs and the cost of cleaning up the sites. There currently is no system to "certify" a former meth lab as "cleaned-up" enough to restore its property value.

Although revenues from properties seized each year from drug related offenses in Montana go directly into the state special revenue funds and are credited to the Department of Justice to help offset enforcement costs, the total amount is only approximately $125,000. A relatively small amount compared to overall drug impacts to the correctional system.

Through the leadership of Senator Max Baucus in March 2002 six Montana counties were included in the Rocky Mountain High Intensity Drug Trafficking Area (HIDTA) a long awaited federal designation that helps state law enforcement officials fight the growing methamphetamine problem in the state with federal funds. These counties were recognized for having among the highest number of meth lab seizures in the nation in 2001.

In 2002 $500,000 will be available to be shared by those six counties, allowing some state funds to be shifted to rural communities across the state. Starting in 2003 Montana will receive $1 million annually in HIDTA funds, again to be used by the six counties.

The Agency for Toxic Substances and Disease Registry recently (mid 2002) established a satellite office in Montana to assist with the problems associated with clandestine drug labs. They are considering offering training courses to federal, state, county, local and tribal agencies who may encounter chemicals associated with drug labs, as well as providing assistance to victims. While their primary concern at this time is with agency activities at Libby, it is hoped that further assistance may be garnered from this office by the rest of the State.

5.1.2 Workforce Challenges

While the population in most areas of Montana is growing, and the drug related work load is increasing there has been no parallel increase in the law enforcement work force statewide. To the contrary, in the past few years, several federal drug investigation efforts have been scaled back[137]. Some counties have a large work force shortage. Many upper-level drug traffickers, who in the past have resided in metropolitan areas, are moving to rural areas and smaller communities, which could include Indian reservations,

where law enforcement's presence is substantially reduced (In many jurisdictions officers must protect several hundred square miles.)[138].

To complicate the situation not all individuals in the judicial system, from judges and attorneys to probation and police officers have been provided with sufficient training in chemical dependency and other important areas to address drug specific issues. There currently is no training in areas of:

- Addiction and understanding the disease model and relapse.
- Types of treatment and sanctions that together are the most effective tools for helping alcohol abusers, meth addicts and other specific addictions.
- Pro-social change.
- Criminal behavior patterns.
- Promoting responsibility and accountability of offenders, and integration of family members into sentencing regimes.

5.2 MONTANA'S LAWS

5.2.1 Impaired Driving Laws

According to Mother's Against Drunk Driving, Montana has only 18 of 39 key laws that are important deterrents to driving under the influence of drugs or alcohol. This organization states that by most measures Montana currently ranks at the bottom in terms of drinking and driving, alcohol related fatalities, prevention legislation, and DUI penalties[139].

Montana stands to lose $115 million in federal funding in 2004-2012 if the state does not pass a law that lowers the legal blood alcohol content limit from the current standard of .10 to .08[140]. Montana is one of 18 states that have not adopted the lower blood alcohol content level. Montana is one of only 12 states that do not require automatic blood alcohol level testing[141].

According to the National Highway Transportation Safety Administration, alcohol-related crashes in Montana cost the public $600 million in 1998, including more than $200 million in monetary costs and almost $400 million in quality of life losses. NHTSA estimates that the average alcohol-related fatality cost $3.3 million and the estimated cost per injured survivor of an alcohol-related crash averaged $81,000[142].

In October 2001 The National Highway Traffic Safety Administration Technical Assistance Team completed a State of Montana Impaired Driving Assessment by interviewing some 29 Montana program experts and staff. The report presents 42

different recommendations on Program Management, Prevention, Deterrence (including laws), Driver's Licensing and Treatment and Rehabilitation.

On April 4, 2002 Governor Judy Martz announced her intention to propose legislation in the 2003 Legislative Session to change the legal Blood Alcohol Content limit from .10 to .08. This was one of the Impaired Driving Assessment recommendations.

The Governor's proposals also include the following:

- Increased penalties for repeat Driving Under the Influence offender.
- Address the need for increased treatment requirements for offenders.
- Examine Montana's open container laws as they relate to open containers in vehicles.

The Governor stated…

> *"Today, I am asking the newly formed Alcohol, Tobacco and Other Drug Task Force to specifically work on comprehensive changes to our state's DUI and open container laws. The work and research of this important task force will aid our administration in developing a plan to address drunk driving by proposing legislation that will toughen Blood Alcohol Content limits, increasing the penalties for repeat DUI offenders, and addressing treatment for offenders, and open containers in vehicles."*

The Department of Transportation's Traffic Safety Bureau's report, Traffic Safety-Problem Identification FY2002, states that "DUI arrest data is not readily available in Montana…in lieu of arrest data, we now present conviction data, which is gathered by the Department of Justice." In the latest Department of Justice data, for 2000, there were 5,787 convictions for DUI in Montana.[143]

In 2001 there were 5,707 admissions to "court school"– Assessment, Course, Treatment Program (ACT)[144]. Of those admitted to the program:

- 14% were under the age of 20
- 11% were over the age of 50
- 25% were readmitted within five years
- 79% male
- 21% female
- 84% had no prior alcohol & drug treatment
- 80% successful completions of court school
- 41% were recommended for treatment

Some Task Force Members have expressed the need to assess the financial impact to local law enforcement and court systems of implementing new laws.

5.2.2 Minors In Possession (MIP)

In 1998, according to data from the Office of the Court Administrator, Montana courts heard 7,744 Driving Under the Influence (DUI) cases compared to 10,422 Minor in Possession (MIP) cases. This relative distribution of MIPs to DUIs seems to be fairly consistent over time. There is a clear body of law that provides for regulation of the sanctions applied by courts in DUI cases. This body of law specifies qualifications for those individuals who provided the alcohol information course required by MCA 61-8-732.

The law that governs MIP's is less clear and provides fewer individual protections. This law, MCA 45-5-624, provides for a community based substance abuse course. It is clear that minors found in possession of alcoholic beverages are referred to the court system and they are to be required to take an educational course, when available. The law identifies this as a community based substance abuse course. Beyond that, very little about the community-based substance abuse information course (CBSAIC) is defined. Who sets the standards for the course? Who determines if it is an appropriate and effective sanction? Who determines if it is consistent with other courses across the state?

The absence of legislative guidance on these issues means that community-based substance abuse information courses offered both within communities and across the state vary widely. There is a standard course of training required for anyone who provides the DUI sessions identified as the Assessment, Course and Treatment Program (ACT). There is currently no such training required for anyone offering the education course required for a minor receiving an MIP.

Reports from the field indicate that tracking of multiple MIP's is somewhat haphazard. For whatever reason, counties, cities and towns do not share information on MIP's making it possible for a minor to receive multiple MIP's without receiving the appropriate sanctions. Since an adolescent can become chemically dependent in a shorter period of time than an adult, this becomes a serious health issue.

5.2.3 Alternative Sentencing

Montana provides the opportunity for a judge to impose "alternative sentences". One opportunity under this law is to provide offenders with drug treatment instead of jail or prison time (M.C.A. 45-9-202). Unfortunately, however, sentencing to a residential drug treatment facility is permissible but not always possible due to lack of treatment facility availability and funding. Consequently, judges rarely use this important authority. When

this law was established no provisions were made to provide program facilities or a system for offender placement.

Another alternative sentencing opportunity that exists today but is seldom used it the imposition of a mandatory dangerous drug information course. This alternative can be used when a person is convicted of possession of drug paraphernalia and can be a powerful educational tool.

5.2.4 Inconsistent Implementation of the Law

Drug control laws are implemented inconsistently across the state of Montana. The inconsistencies run through the whole correctional system from whether or not an individual is arrested by a law enforcement officer to the judicial response if they are arrested to the probation officers response to parole issues.

Law enforcement personnel in Montana have been faced with new legislation to enforce, such as the tobacco possession law, without funds being allocated to cover the increased costs. To an already burdened correctional system these "unfunded mandates" pose problems. The work load goes up with the passage of new laws but the personnel numbers to enforce and process them have stayed the same. Without available resources officers can not address all violations so there is inconsistency in enforcing the law from one situation and location to the next.

Judicial responses to drug violations are viewed by some as inconsistent as well. It was noted by one attorney, as an example, that even though there is a mandatory jail sentence for adults who deliver drug paraphernalia to minors, judges rarely impose jail time for conviction of this offense. The reason cited; overcrowding of jails and the costs.

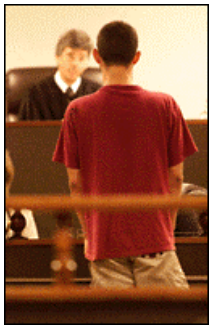
In some DUI cases County Attorneys are using the Criminal Endangerment Statute in place of DUI 4th offense. The ability to use this statute skews the tracking of DUI 4th offense and changes the subsequent penalty. There are inequities among counties in the application of the 4th DUI offense law and sentencing.

Some are concerned that this inconsistency in implementing Montana laws creates a perception in young people and parents alike that they will have little or no consequences to unlawful behavior related to alcohol, tobacco and other drugs.

5.2.5 Drug Courts

A drug court is a special court program given the responsibility to handle cases involving drug-addicted offenders through a supervision and treatment program. Drug court programs bring the full weight of all interveners (judge, prosecutor, defense counsel, substance abuse treatment specialists, probation officer, law enforcement and correctional personnel, educational and vocational experts, community leaders and others) to bear,

forcing the offender to deal with his or her substance abuse problem.[145] Family drug courts work to reduce the incidence of permanent termination of parental rights for parents with substance abuse problems and promote the possibility of reunification in abuse and neglect cases[146].



It was explained by Rita Weeks, Fort Peck Tribal Courts administrator in 1999 as follows: "The drug court is sort of an alternative way of doing traditional court business. The focus is on rehabilitation vs. incarceration. We know incarceration isn't helping them. ... It's based on accountability. The focus is on the entire family. Parents have to go to court every week with their child. They have tasks they have to complete." [147]

The design and structure of drug court programs are developed at the local level, to reflect the unique strengths, circumstances and capacities of each community. The National Association of Drug Court Professionals provides the following national statistics.

697 Drug Courts in Operation

- 483 Adult Drug Courts
- 167 Juvenile Drug Courts
- 37 Family Drug Courts
- 10 Combination Drug Courts

220,000 Adults, 9000 Juveniles Enrolled in Drug Courts to Date

- 73,000 Adult, 1,500 Juvenile Graduates
- 70%+ Retention Rate
- 75% Previously Incarcerated
- 1000+ Drug Free Babies Born
- 3,500+ Parents who Regained Custody of Children
- 4,500+ Re-engaged in Child Support Payments
- 73% Retained or Obtained Employment

The Columbia University's National Center on Addiction and Substance Abuse (CASA) conducted a critical review of 37 drug court evaluations in 2001. They concluded that drug courts have achieved considerable local support and have provided intensive, long-term treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems. They also concluded that drug use and criminal activity are reduced while participants were in drug court programs and recidivism for the drug court participants is reduced.

Several studies revealed that average per-client drug court costs are lower than standard processing, primarily due to reduced incarceration review. Nationally, incarceration of

drug-using offenders costs between $20,000 and $50,000 per person per year. The capital costs of building a prison cell can be as much as $80,000. In contrast, a comprehensive drug court system typically costs less than $2,500 annually for each offender.[148]
The Montana State judicial system currently has three drug court programs; Family Drug Court for Yellowstone County in Billings; Family Drug Court for Gallatin County in Bozeman; and a Juvenile Drug Court in Missoula. Several Tribal Court Systems are also using or exploring the use of drug courts, including The Assiniboine Sioux Tribe on the Fort Peck Reservation, the Crow Agency and Rocky Boy. According to some, a major challenge to establishing drug courts in Montana is to first establish adequate access to drug treatment.[149]

Bozeman's Drug Court has had 16 participants graduate from their program to date and the results have been very successful. None of the 16 graduates have relapsed or returned to prison to date.[150]

5.3 TRIBAL SOVEREIGNTY AND JURISDICTION

Jurisdictional challenges exist with coordinating a statewide drug control policy with the seven Indian reservations in Montana and their sovereign governments. There are several basic principals of state-tribal relations that exist and should be considered in the development of a comprehensive drug control strategy. These principles follow:

- Tribal governments are not subordinate to state governments and are not bound by state laws.
- There is always a federal dimension to consider in formal state-tribal interactions. The federal government holds "trust responsibilities" to the tribes.
- Government-to government relations are the norm, not the exception. Protocol in these relations is very important.
- Indian nations are generally wary of state government.
- Many Montana tribes have a drug-alcohol task force.

There is not an Indian reservation in the United States in which the federal, state and tribal governments can simultaneously exercise their full criminal jurisdiction. A determination must be made on whether federal, state or tribal government has jurisdiction to prosecute and punish crimes committed on tribal reservations. A number of factors must be considered to determine which government has jurisdiction. These factors include: location of the crime; the type of law violated; and, whether the victim or perpetrator was an Indian or non-Indian.

Due to this "jurisdictional maze" the Task Force noted that they needed to be mindful of tribal, state and federal laws as they developed and ultimately implemented a drug control policy.

6.0 DESIRED OUTCOMES AND STRATEGY RECOMMENDATIONS

All details of the following recommendations have not been discussed. The Task Force recommends these strategies in concept. This is particularly true for proposed legislation where full language has not been drafted and full knowledge of how the proposed legislation would interact with laws currently on the books is not known.

6.1 OVERARCHING STRATEGIES

Some of the recommendations that the Task Force identified address many "Desired Outcomes" and so they are presented here as Overarching Strategies. These recommendations affect and enable many or all of the Desired Outcomes.

6.1.1 Hold State and Individual Tribal Government to Gov. Discussions

Recommendation: Hold government to government discussions between the state and all the individual tribal governments in Montana regarding Task Force recommendations.

Explanation: The intent of this recommendation is to formalize a consultation process for all tribes in Montana related to alcohol, tobacco and other drug control issues.

The Task Force identified the following desired outcome.

Desired Outcome:
Montana has very effective inter-jurisdictional cooperation between the tribal governments and state government.

In order to reach this desired outcome there needs to be parallel processes – working toward agreements and resolutions with each tribal government on recommendations and proposed legislation at the same time that the state is also pursuing state-wide approval.

The state should coordinate their efforts through the Governor's Coordination of Indian Affairs Office.

6.1.2 Hold State and Federal Government to Government Discussions

Recommendation: Hold government to government discussions between the state and the federal government regarding Task Force recommendations and the coordination of efforts on lands held in trust by the federal government for the Tribes in Montana.

Explanation: The federal government does not speak for the Tribes in Montana, nor do the Tribes speak for the federal government.

6.1.3 Establish a "Drug Czar" Position

Recommendation: The consensus of the Task Force was that this is their **MOST IMPORTANT RECOMMENDATION**. It is viewed as critical to improving alcohol, tobacco and other drug control problems in Montana and it is **PIVOTAL TO THE SUCCESSFUL IMPLEMENTATION OF ALL THE OTHER RECOMMENDATIONS**. The recommendation has two parts.

> (1) Encourage a joint Governor/Attorney General initiative (including authorizing legislation and attached funding) to establish the permanent position of a "drug czar" within Montana with the responsibility and authority to provide leadership and direction for state prevention, treatment and correctional programs. This position would also have responsibility to analyze the impact of alcohol and drugs, inform citizens and lead cross-department planning for the most effective use of state dollars over time.
>
> (2) Establish a permanent advisory board, with broad representation, to advise the Drug Czar.

Explanation: The intention of this recommendation is to have a full time, dedicated, point person who has the authority and responsibility to oversee, integrate and implement all alcohol, tobacco and other drug control (ATOD) programs. This position is the champion for moving Montana toward its desired outcomes. This position is viewed as essential to successfully implementing effective ATOD programs in Montana.

Historically, Montana has focused efforts and resources primarily in one area, law enforcement. There is no doubt, we need a strong law enforcement piece, however, that alone is not enough; it's NOT working. Instead of being tough on crime we need to be effective on crime, and we can do that through effective and integrated prevention, treatment and judicial programs coordinated through a Drug Czar's leadership.

The system(s) and framework we currently have are not being effective enough. We need strong leadership and authority in prevention and treatment and the strong coordination provided by a Drug Czar position. With a broad, integrated perspective the Drug Czar would advise the Governor, Attorney General and interim legislative committees on ATOD issues and how to most effectively use our resources. A lesson learned from other states, through the Western Governor's Conferences, is that if a position, such as this, is not elevated to the governor's level and given supportive funding it is not successful. The Task Force has concluded that in states where drug control strategies have been effective, it has largely been due to a comprehensive approach by

various coordinated agencies and private concerns and groups. Several states have a drug czar position that is appointed by the Governor. These positions have been credited with helping successfully reduce alcohol, tobacco and other drug control issues in their states.

The Drug Czar's office would be the centralized clearing house for data and information related to ATOD issues. Currently it has been difficult to know where to turn for information. Where this position should reside was not determined by the Task Force but several options were discussed including: The Board of Crime Control, the Attorney General's office and the Governor's office.

One Task Force Member has had discussions with private funding foundations concerning financial support of various ATOD projects. The foundations said they want to see support from the governor and legislative level before they would provide funding. A position of this level would demonstrate that support.

The Drug Czar position, working with the Coordinator of Indian Affairs (CIA) would be very important for Tribal collaboration. There is concern that without this position collaboration with Tribes on ATOD programs may not happen.

Montana's Drug Czar would be a logical person to serve as the Chair of the Board of Prevention described in the recommendation in Section 6.5 D.

This recommendation includes establishing a permanent body, with of broad view of ATOD issues, to serve as advisers to the Drug Czar. The advisory body should have tribal, state, local, private and citizen representation as well as representation from prevention, treatment, law enforcement, public health, victim advocates, businesses, the media and the courts. This body would be similar to the Task Force that put this document together.

6.1.4 Explore Funding and Resource Options to Support ATOD Programs

Recommendation: The following ideas should be explored as potential mechanisms to provide needed funding and resources to the alcohol, tobacco and other drug control programs.

Explanation: State agencies and private community based programs can not absorb additional duties or substantially improve alcohol, tobacco and other drug related services without additional funding and resources. Investing in substance abuse prevention and treatment actually costs LESS than paying for the related social problems that result when addictions are ignored. In fact, a study of California alcohol and drug treatment services found that for every dollar invested in treatment, taxpayers save $7.14 in future societal costs.[151]

The Task Force briefly discussed the following potential funding and resource mechanisms. The following ideas were generated in a brainstorming session and the Task Force agreed that they merit further exploration and analysis. The ideas are broken down into three categories, though some ideas may cross between the categories. The three categories are: New revenue opportunities; Re-allocating existing funds or resources or cost saving measures, and; Getting the message out.

ALL FUNDS and RESOURCES WOULD BE USED TO BENEFIT ATOD PREVENTION, EDUCATION and TREATMENT PROGRAMS.

1. New Revenue or Resource Opportunities:

a) Increase driver's license fees, both the initial fee and the annual charge. Also increase the reinstatement fee for DUI offenders.

   License reinstatement fees (61-2-107) could go to fund county drinking and driving prevention programs. Specifically, potential language includes; (1) Notwithstanding the provisions of any other law of the state, a driver's license that has been suspended or revoked under 61-5-205 or 61-8-402 must remain suspended or revoked until the driver has paid to the department a fee of $100 in addition to any other fines, forfeitures, and penalties assessed as a result of conviction for a violation of the traffic laws of the state. (2) The department shall deposit the fees collected under subsection (1) in the general fund. One-half of the fees must be appropriated and used for funding county drinking and driving prevention programs as provided in 61-2-108.

   Possible change: (2) In any suspension or revocation under 61-5-205 where alcohol is a factor in the suspension, or under 61-8-402, the fee shall be $150 for a first offense, $200 for a second offense, $300 for a third or subsequent offense as defined by Title 61, Ch. 8. (3) All fees generated under subsection 2 above shall be appropriated and used for funding county drinking and driving prevention programs as provided in 61-2-108.

b) Establish an ATOD Endowment Fund. The interest would be used for ATOD programs (ex. grants to community projects). The endowment fund would be part of a formalized state strategic resource development plan for ATOD. A planned state-wide giving campaign would be the primary fund development mechanism. The fund raising campaign would be designed NOT to directly compete with local community fund raising efforts. When the state has surplus dollars some percentage would be put in the endowment fund and used to request additional private or federal matching dollars. Some ATOD related fees could also be allocated to the endowment fund.

c) Increase the annual tobacco licensing fee from $5 to $100. Use the increased fee amount to provide incentives for establishments to NOT sell ATOD products to underage consumers (one example could be training for sales people). Currently the fee goes to the general fund.

d) Increase taxes on tobacco products. (Example: raise the tax on all products such as cigarettes, cigars, smokeless, by a certain percentage.). Coordination and partnerships with the Tribes will be very critical for this. When fees are collected on reservations the fees should be used for tribal ATOD programs. It was noted that 90 percent of the clients in Montana's treatment system also are tobacco users.

e) Any crime committed "under the influence" will have an additional fine (perhaps a range of $100 – to some larger amt.). The money would be used for ATOD programs. The issue of where the money would be dispersed would need to be addressed.

f) Increase insurance benefits and separate mental health and chemical dependency coverage. This would ease the burden on public funding.

g) Propose legislation enabling counties to pass Permissive County Levies for local ATOD programs. This is also known as Local Options. State permission is needed for counties to have the option to use the levees. It is up to each county to choose to use the levies or not to use them. The use is optional or voluntary. Concern was raised that this may not be a state-wide strategy. There would be pockets of use and the poorer counties would not use it. Discussion also included potentially using a pilot program to test it.

h) Require "On Premise Servers License". The license fees would go to training of servers in order to decrease sales to underage consumers.

i) Increase fines significantly for establishments that sell ATOD products to underage customers. The issue of forging ID cards (driver's licenses, college ID's) should be explored as well. Out-of-state ID's have posed problems in the past.

j) Increase Minors in Possession fines (see the recommendation in Section 6.2.4 B) and designate the increased revenue to local adolescent ATOD services.

k) Initiate a bottle and can deposit program. Fifty percent of deposit revenues would go to prevention and fifty percent would go to the industry.

l) Initiate a fee on any local advertising that promotes drinking. (i.e. two for one drinks; women drink for free).

2. Re-allocating Existing Funds or Cost Saving Mechanisms:

a) Allocate the money currently spent by the state to serve adult felons (i.e. Department of Correction's funds) directly to each of the counties. The counties would then have discretion how to best utilize those funds.

b) Use the fees collected for driver's license reinstatements for ATOD programs. Currently the money goes to the general fund.

c) Use cultural interventions when appropriate. They can be both less costly and more effective.

d) Continue to use alcohol tax dollars as matching dollars to receive additional Medicaid funds for chemical dependency services (both counties and state wide).

e) Use ½ of 1st offense DUI fine ($1000 proposed in the recommendation in Section 6.7.1) for local DUI enforcement, prevention and treatment. This is estimated to be $3 million per year.

f) Fully use the senior volunteers for ATOD programs. Senior programs include: Senior Corp Program, the Retired and Senior Volunteer Program (RSVP), Foster Grandparent Program (FGP) and Senior Companion Program (SCP). Central offices are located in Baker, Billings, Bozeman, Butte, Glendive, Great Falls, Havre, Helena, Kalispell, Miles City, Missoula, Roundup, Wolf Point and Polson. As an example: In Polson, a Foster Grandparent volunteers at Youth Court by conducting court ordered anti-smoking classes for teens. She worked with 12 youth that had been arrested and were at risk of re-offending. To date, there are approximately 600 volunteers working with 3,092 youth, who are at risk. There are 628 senior volunteers serving as mentors to 6,944 children in Montana. Volunteers also work as citizen patrol members, support services in health care programs, do public speaking, conduct workshops and serve on councils.

g) Release state prisoners (non violent substance abusers) from incarceration 1 yr. earlier if they: are assessed and shown to be ready and motivated to be in treatment; make the commitment to attend an appropriate local community treatment program which they pay for. The dollars that would have been used to incarcerate would be shifted (or percentage of the money) to treatment.

h) Provide for state funded assessments to determine treatment readiness after offenders have been convicted but prior to sentencing. This would help determine alternative sentencing options such as self pay residential treatment and work release options, and help to reduce revocations and prison numbers. This could include 2nd offense DUI offenders who need treatment, 3rd offense DUI and 4th offense felons but is not limited to just DUI offenses. It is estimated that in 2

years an actual savings would be realized in incarceration costs. A portion of these funds should be used to support community treatment programs.

i) Use drug forfeiture money for ATOD programs. Also, change the DUI vehicle forfeiture program to place the financial burden of the lien on the offender.

j) Change the distribution of beer, liquor and wine taxes. The present distribution is as follows: Beer Taxes: 23% Department of Health and Human Services (DPHHS) & 76% General Fund; Wine Taxes: 31% DPHHS & 69 % General Fund; Liquor Taxes: 65% DPHHS & 34 % General Fund. Proposal would be to increase the percentage going to DPHHS to either 50% or 40% with the remainder going to the General Fund

k) Implement an early release program at the county level such as a modern day "Community Restitution/Work" program. Offenders would do local ATOD related or cost savings restitution.

l) Establish a policy that no child can be removed from their family if the parent has no previous ATOD treatment and agrees to attend treatment, and are assessed to be ready and motivated for treatment. Also, a portion of the cost savings could be shifted from the foster care programs into family treatment programs. With these options the safety of the child should always remain the paramount concern.

m) Develop self supporting cottage industries that are used for long-term rehabilitation of addicted offenders. Examples: contract janitorial services; equipment assembly.

n) Identify areas of overlap and secure agreement to share resources at both state and local levels. An example of this is tobacco and alcohol prevention dollars. Efficiencies could be made in designing prevention efforts that cover both alcohol and tobacco.

o) Formalize resource and funding partnerships with federal & tribal agencies.

p) Shift state funds from other programs into ATOD. Examples: Shift some Highway Traffic Safety funds to DUI prevention (perhaps the enhanced 1st offense program described in the recommendation in Section 6.7.1). The federal funds have specific spending requirements that may well encompass this type of use. Another example is shifting funds from the Economic Development budget.

q) Earmark littering fines for ATOD programs and more actively enforce littering laws. Establish a citizen reporting mechanism to enhance enforcement. There are a couple of links between litter and ATOD. Aluminum Anonymous has documented anecdotal connections between roadside alcohol litter and underage

drinking.[152] Secondly, Task Force members noted a connection between hepatitis infections and garbage.

3. Getting the Message Out:

a) Establish collaborative partnerships between the state and large businesses that operate in Montana (ex. phone, credit card companies, and banks) to engage in "Cause related marketing".

b) Create partnerships with local advertisers to run Pubic Service Announcement's for each advertisement they air that promotes drinking. As an example, if they advertise 2 for 1 drink night or ladies drink free night they also run an ATOD related PSA.

6.2 REDUCE UNDERAGE CONSUMPTION AND CONCOMITANT PROBLEMS

Desired Outcome:
Underage alcohol, tobacco and other drug consumption and concomitant problems are reduced.

6.2.1 Develop uniform "curriculum" for the MIP program

Recommendation: Develop uniform standards or a "curriculum" for the Minors In Possession (MIP) program using the standards already established for DUI as an example.

Explanation: The uniform standards will have a set curriculum for every child in the state, including what office the MIP goes through, who the minor is referred to for the rest of the process and what intervention options there are. Minors arrested for MIP may or may not have a "certifiable" disorder requiring "treatment". Therefore MIP is both a prevention and intervention program.

6.2.2 Use training to change accepting culture of ATOD use

Recommendation: Add a component to existing mandatory training for "allied service providers" to address and change the accepting culture of drug use in Montana.

Explanation: Judges, Prosecuting Attorneys, Law Enforcement (City/County/State) and Juvenile Probation and Parole Officers (County/ State) currently have mandatory training requirements. This training includes training by the Attorney General's office, to explain any new standards (changes brought about by new legislation). Another type of training that is needed and that should be added to existing mandatory curriculums, is training to

address and change the accepting "culture" of alcohol, tobacco and other drug abuse in Montana. The intent of this training would be focused on changing the current culture that accepts and downplays alcohol, tobacco and other drug use by minors.

6.2.3 Provide state-wide "clearing house" for MIP information

Recommendation: Provide state-wide resource clearing house for information related to MIP offenses.

Explanation: The MIP resource clearing house would serve as a one-stop-shop for judges, prosecuting attorneys, law enforcement and juvenile probation and parole officers and other allied service providers to gain information related to MIP's.

6.2.4 Strengthen MIP law

A. Recommendation: Clarify current statute on MIP describing what constitutes possession. (i.e. Is it necessary to see consumption to have possession; what is the "zone of control?"). Also, clarify language to make it very clear that an offense is a "Minor in Possession" offense for those **under** 18 years of age.

Explanation: The law is interpreted differently by different officers regarding possession. The intension of this strategy is to make the MIP laws stronger by clarifying this area of confusion. Additionally, there has been confusion regarding "Minor in Possession" (for those under 18 years of age, i.e. 17 or younger) and "Under Aged Possession" (for those 18 and older but under 21 years old.)

B. Recommendation: Modify MIP law to increase parent/guardian involvement, increase fines and community service and require treatment for 1st, 2nd and 3rd offense.

Explanation: The intention of this recommendation is to increase offender accountability and offender treatment completion and effectiveness.

For 1st MIP convictions:

- The standard "curriculum" (See Section 6.2.1) should include mandatory parental/guardian involvement in programming. There is precedence for this type of guardian involvement requirement. The Youth Court Act Law says that a parent must accompany the juvenile.

- Sanctions should be imposed if parent/guardian doesn't show up or if the minor does not fully participate in or complete his or her curriculum. An example of a sanction is to use the privilege to drive and a "graduated driver license" to motivate youth and guardians to participate.

- If the minor or their guardian does not fully participate in the MIP curriculum then their existing driver's license could be suspended for three months (90 days) or sanctions could be imposed to delay by one year when the minor can receive a full driver's license. {Note: one Tribal Reservation does not require driver's licenses, so this would not be an effective sanction there.}.

  While the Task Force did not find extensive research on the topic of license suspension for MIP's they did find that 31 states suspend a youth's driver license from 30 days to one year for the first offense. The "average" appears to be 90 days of suspension for first time convictions for possession or attempts to purchase.[153]

- MIP educational class, paid for by the offender, that is interactive and flexible and that has measurable outcomes (example, pre and post testing and/or pre and post client satisfaction). It should be noted that parents are already included in the MIP ed. classes and this should continue.

- Mandatory 20 hours Community Service. This should be meaningful service that connects the offender with the community.

- Mandatory minimum fine of $100 and maximum fine of $150. In setting the minimum and maximum fine the Task Force considered the following: wanting to make fines reasonably consistent (now offenders can be fined anywhere within a larger range); wanting to balance sending a strong message and not making the fines so high for the first offense that it discourages people from reporting incidents.

2nd MIP

- Mandatory assessment & appropriate counseling/treatment (this means that all involved "allied service providers" need to follow the counseling/treatment recommendations – starting with the judicial side through the treatment side.)

- Mandatory 40 hours community service and $100 minimum fine and $200 maximum fine.

- Use the privilege to drive and "graduated driver license" to motivate youth and family/parents to complete programming & treatment curriculum by suspending the offenders driver's license for 6 months.

3rd MIP

- Mandatory 80 hours community service and mandatory $300 fine. (This is the current fine).

- Use the privilege to drive and "graduated driver license" to motivate youth and family/parents to complete programming & treatment curriculum by suspending the offenders driver's license for 12 months.

6.2.5 Develop uniform MIP data base

Recommendation: Develop a state-wide uniform reporting, data collection and tracking system for all MIP's. (Management Information System)

Explanation: The state needs a reliable and centralized statewide tracking system so that Minors In Possession (MIP) trends can be measured. This system would track convicted offenders and those referred to the State Correctional System. The AMDD/DPPHS would be the responsible agency to establish standards, program management, data collections, quality assurance in enforcement, and rewrite the manual for MIP's.

Through this strategy the state would need to assure that the courts share their information with the tracking system. AMDD/DPPHS should look at the possibility of using the existing Child and Adult Protective Services Program (CAPS) system with screens just for MIP cases.

The data in the tracking system needs to be accessible to all agencies that have proper authority and it needs to be very clear who has access and use of the data. This recommendation refers to judicial data, not treatment data.

To implement the work related to this recommendation one full time employee would need to be added to AMDD/DPPHS. This position would also review all of the existing MIP and Assessment, Course and Treatment Program (ACT) data.

6.2.6 Propose keg registration legislation

Recommendation: Propose a law requiring keg registration.

Explanation: Keg Registration is used to identify and penalize adults and youth who purchase beer kegs and allow underage youth to consume alcohol from them. This legislation would require kegs to be marked with unique, and preferably, non-removable identification.

Keg registration was first implemented at the local level; however, purchasers could drive to a nearby town where registration of beer kegs was not required (Hammond, 1991).

6.2.7 Propose Graduated Driver's License Legislation (GDL)

Recommendation: Any Graduated Driver's License Legislation bill should include strong and immediate penalties or sanctions for any violation of Minors in Possession laws.

Explanation: In 2001 a Graduated Driver's License bill (HB No. 403) was vetoed by the Governor. The act would have revised the driver's license laws in four ways. It would: 1) require minors to hold an instruction permit, a traffic education learner license, or a traffic education permit for six months prior to the issuance of a license; 2) restrict a driver's license issued to a minor for the first year after issuance; and 3) remove the time limit in which a person must pass the driver's examination after first applying for a license; 4) and provide a delayed effective date and an applicability date. The bill was vetoed due to concerns about how the bill would affect young drivers in rural areas (farm/ranch areas). A similar bill is being drafted to reintroduce during the next legislative session.

The intent of this recommendation is to provide an early intervention strategy and an incentive not to engage in illegal substance abuse. The desire for most teens to drive is very strong. The potential to lose or postpone that right can be a strong motivating factor. There is an indirect but significant link between illegal substance abuse by teens and driving. Teens generally do not engage in illegal substance abuse at home – they drive or are driven. Section 3.1 of this document shows several statistics about youth drinking and driving including that in 1999 47 percent of all youth auto fatalities (15 – 20 year olds) were alcohol related, compared to a nation wide rate of 31 percent. In the Montana Youth Risk Behavior Survey, 22 percent of high school respondents reported that, within the 30 days prior to the survey they had driven a car after drinking alcohol. And of those students one in seven (15 percent) reported drinking and driving six or more times in the 30 days prior to the survey[154]. A non-profit advocacy group, Aluminum Anonymous, describes teenage in-vehicle drinking and related drug use as an integral part of the social dynamic of underage risk-taking[155].

For this recommendation to be effective a state-wide data base of MIP offenses will need to be developed and managed. The recommendation in Section 6.2.5 calls for the development of a uniform MIP tracking system.

Legislation should be written so that it does not penalize legitimate use of vehicles (such as work, school, etc.) by teens. This, and other concerns identified by the Governor's office should be addressed in the bill. It should also be noted that this legislation would not apply to some tribal jurisdictions that don't require driver's licenses.

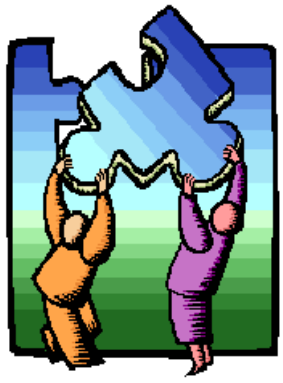
6.3 INVESTMENT IN PREVENTION

Desired Outcome:
State and local leadership support investment in scientifically defensible prevention practices because they understand and are convinced of prevention's value.

A. Recommendation: Support and fund the Interagency Coordinating Council (ICC).

Explanation: The ICC has established clear benchmarks and mechanisms to monitor results that are scientifically based and consistent with the national Healthy People 2010 initiative. The ICC does a good job of coordinating with the Native American Advisory Council and prevention efforts in the DPHHS.

B. Recommendation: Support and fund the Prevention Resource Center (PRC).



Explanation: The PRC, which is the working arm of the ICC, serves as a centralized resource and referral clearing house for prevention information. They monitor the benchmarks established by the ICC. The PRC provides a "Hot News" email update and quarterly newsletter which should be continued as an important educational tool. The newsletter is a good tool for reaching legislators. It also serves as a good archive and is often used as a reference for grant writing and educators. Two additional programs managed by the PRC include the State Prevention Resource Directory and VISTA programs. These programs should also be supported and sustained. The VISTA program provides vital assistance to community level prevention planning and delivery. Currently the Prevention Resource Center is under funded.

C. Recommendation: Change the name of the ICC.

Explanation: The name ICC is confusing. The name should be changed to something more easily recognizable as associated with prevention efforts. The ICC has recently discussed a name change and is preparing draft legislation to change its name to Montana Prevention Council

D. Recommendation: The ICC should produce a "State of the Kids" executive summary annually based on existing data sources.

Explanation: Current data on youth in Montana is spread out over several resources and publications including the: Youth Risk Behavior Survey, Prevention Needs Assessment,

Kids Count, Reservation Profiles and Indian Health Services Information. The State of the Kids executive summary should compile this information, incorporating risk and protection factors and the ICC benchmarks. The report should be developed in collaboration with the Montana Kids Count annual report prepared by the University of Montana. The summary should be used to educate leaders regarding impact of prevention efforts.

E. Recommendation: The ICC should facilitate discussions to define the line between prevention and intervention programs in Montana. Also, awareness should be raised as to what the definition of prevention is and what constitutes scientifically defensible programs.

F. Recommendation: Support and raise Montanans' awareness of the National longitudinal studies that describe the cost effectiveness of prevention and those that look at the effectiveness of prevention by monitoring behaviors.

Explanation: These national studies are very important and are currently used extensively by professionals. Using the national Prevention Needs Assessment, local profiles can be developed.

G. Recommendation: Establish strong partnerships with Universities to do long-term (10-20 yr.) cost effectiveness studies of Montana's prevention efforts.

Explanation: These long-term studies can be extremely costly but are important for demonstrating actual local effectiveness. A down side of this type of study is that each dollar spent on the study takes a dollar away from treatment or prevention efforts. By building capacity within universities to conduct such studies through partnerships it is hoped the studies may be completed much more cost effectively. The studies should be linked to the Kid's Count Annual Report. ICC and PRC would be responsible parties for these long-term cost effectiveness studies. In the interim, Montana should reference the national studies that clearly demonstrate the cost effectiveness of prevention efforts.

H. Recommendation: Provide *adequate funds*, from the general fund or otherwise, to fund prevention programs based on recommendations developed by Center for Disease Control (for tobacco prevention), and other federal agencies.

I. Recommendation: Support youth programs and activities that provide good role models and mentors to youth. In addition, the state should explore new means to encourage men to mentor young people.

Explanation: Programs that provide for positive male role models are particularly important as are programs that encourage youth to give something back to the community. Examples of such programs include, but are not limited to, Big Brothers and Sisters, Fishing with the Young, Boys & Girls Clubs, RSVP shooting and fishing

programs, community programs that reward positive activities (i.e. reading programs). Note: this is not an endorsement of these programs by the Task Force.

Additionally, the state should explore innovative means of getting adult male role models active with young men. They should look at ways to foster this important prevention tool. Some ideas brainstormed by the Task Force include: Ask metro and regents to give discounts for men and youths who attend together; free access to state parks if accompanied by a youth; fishing and hunting license "breaks" for engaging Montana's youth in hunting and fishing activities. The state should have discussions with agencies such as Fish, Wildlife and Parks and the Bureau of Land Management to brainstorm incentives for mentors.

J. Recommendation: Encourage communities to create partnerships with schools and other organizations to help keep schools and other facilities open after school hours as community centers.

Explanation: These are state funded (tax funded) facilities that often lock their doors in the early afternoon. Partnerships could be formed with entities to help offset the additional costs of keeping the doors open, and the lights on longer each day. These costs can be high in the larger schools.

K. Recommendation: Broaden participation in the existing statewide Prevention Specialist training program available at both state and local levels to facilitate accomplishment of all outcomes.

6.4 RESPONSIVE TREATMENT DELIVERY SYSTEM

Desired Outcome:
Montana has a treatment delivery system that is responsive to treatment demands, geographical issues and specific target populations. Target populations include reservation/urban Native Americans, correctional populations, women and youth. This includes a system that is specific to drug types, addresses dual diagnosis, is accessible, affordable and that considers family needs.

Recommendation: Conduct a comprehensive evaluation of the continuum of state-supported treatment services to monitor performance and outcomes related to core benchmarks.

Explanation: Core benchmarks for treatment have already been established. It is important to evaluate how the treatment services are doing related to these benchmarks.

6.4.1 Corrections Pop. – Improve Coordination; Treatment Options

A. Recommendation: Coordinate with Department of Corrections (DOC) on existing standards and "levels of care".

Explanation: The existing standards, which are adopted from the American Society of Addictive Medicine, are sequential; age-appropriate, beginning with juvenile through adult populations; and, should be mandatory statewide for any addiction program utilizing state funds. The intent of this recommendation is to have a uniform addiction treatment program whether it is provided through the correctional system or through a community system. It would apply to all 29 state approved treatment providers and follow-up care. Within these standards innovative and cultural treatment programs are still appropriate and encouraged. The power of the American Society of Addictive Medicine standards is that they design and plan a treatment program around the INDIVIDUAL.

This recommendation would be helpful toward providing accessible and timely assessments, treatment & programming and on-going support groups for those drug abusing offenders within the Criminal Justice System.

B. Recommendation: For 1st and 2nd offense, non-violent, felony substance abuse convictions (excluding 4th time DUI offenders) offer alternative programming that includes "monitored" treatment.

Explanation: The intention of this recommendation is voluntary coercion to enter and complete treatment. It is not intended to be treatment in lieu of restitution.

1st offense

- During the period of probation, offenders will be offered an alternative programming that includes "monitored" treatment as determined appropriate in the community. Upon successful completion of all of the court ordered conditions of probation (restitution etc), including "monitored" treatment, the offender can petition the court for early discharge from supervision.
- The offender will be required to pay $30.00 per month toward the cost of treatment.

2nd offense (excluding 4th time DUI offenders or Revoked DEF or SUSP sentence):

- If incarcerated, the offender will be offered chemical dependency treatment, and upon successful completion of the treatment program while incarcerated, may earn an early release of up to six months from incarceration.
- The offender will not be released until they are enrolled in an approved community treatment program and under Community Corrections supervision.
- The offender will be required to pay $30.00 per month toward the cost of treatment.

The DOC is proposing legislation this session that provides for DOC commits to get early discharge or time off of the sentence upon completion of treatment.

Ideally, over time additional savings for Corrections realized as a result of lessening incarceration time could be rolled into Corrections treatment programs; additional general revenue would then be provided to community based treatment providers. However, the logistics of this financial reallocation would be very complicated, perhaps prohibitively so. The DOC has fixed costs within the prison systems and so there really is not any savings if someone is released 6 months early. There is a savings to the DOC only if the offender is in a Pre Release Center or facility that the DOC pays a cost per day. However, tracking these offenders in the system would create a need for several more full time employees. It would be difficult to track the offenders and the money. Money from one agency can not be transferred to another agency at this time.

C. Recommendation: Develop a statewide, uniform and consistent DUI process strategy for clinical assessment, treatment, and education of DUI offenders.

Explanation: It is important that there is consistency in assessment, treatment and education related to DUI offenses in Montana. The approach needs to be consistent with current research and relevant to currently accepted and effective education strategies.

6.4.2 Women – Allow Felony Drug Offenders Access to Public Benefits

Recommendation: Encourage state legislation to remove sanctions related to public benefits for certain felony drug offenders.

Explanation: Sanctions were imposed during the "get tough on drugs" era that removed the ability of felony drug offenders to access to Temporary Assistance to Needy Families (TANF) and Medicaid funds. By denying women drug offenders these TANF and Medicaid the state may inadvertently be reducing the women's treatment options and forcing them to return to a drug using lifestyle.

There is concern, however, that repeat offenders are taking money away from others. There is a desire to not allow "chronic offenders" to abuse the system. TANF research has defined "chronic offenders". This recommendation is to allow those felony drug offenders who are not chronic offenders and who are in active treatment to be eligible for public assistance.

It should be noted that even if a mother loses her public assistance her children are still covered through TANF and Medicaid.

6.4.3 Youth – Family Based Treatment Intervention

Recommendation: Encourage DPHHS to apply innovative approaches to rate structure to allow development of family based treatment intervention for families and children.

Explanation: There is a need in Montana for support and funding of family based treatment intervention.

6.4.4 Native American Populations – Encourage Cultural Treatments

Recommendation: Cultural treatments, such as sweat house in prisons, should be allowed and encouraged.

Explanation: Because of the disproportionately high representation of Native Americans in the correctional system it is important to assure that cultural treatment is well intertwined. Coordination needs to occur with the Disproportionate Minority Confinement (DMC).

Ideally, over time any savings realized as a result of corrections treatment choices identified in Section "6.4.1 B" directly attributed to early release of Native American populations should be designated for licensed Native American community based treatment programs. The logistics of this financial reallocation, however, would be very complicated, perhaps prohibitively so as explained in that section. For this reason money from one agency can not be transferred to another agency at this time.

6.4.5 Methamphetamine Addicts – and other chronic addictions

Recommendation: Adequately fund two new meth or other chronic addiction community treatment extended care facilities. The facilities would include a psychosocial rehabilitation component to successfully integrate the patients back into being productive and contributing members of the community.

Explanation: These facilities would be affordable and culturally and age appropriate treatment centers. One facility would be for adult patients and one would be for juvenile patients.

This is a very high cost recommendation but an essential one. As described in Sections 4.2 and 4.3.1 a tremendous percentage of those who need chemical dependency treatment are not getting it (95% of youths, 88% of adults, 88% of pregnant women and 87% of Native Americans who need treatment are not getting it). This is due in large part to a lack of programs and facilities in Montana. These extended care chronic addiction treatment facilities would help ease the existing large gap.

Two studies, that are already planned, should be coordinated and used to help plan and design these facilities. The two studies already planned are the Household Needs

Assessment study and a study to assess the methamphetamine situation in Montana (a contracted study with Montana State University).

6.5 COMPREHENSIVE PLAN FOR ATOD PREVENTION

Desired Outcome:
Montana has a comprehensive statewide plan for alcohol, tobacco, and other drug abuse prevention education. The plan should include education for youth, parents, caregivers, allied service providers, the media, and the general public. Implementation of the plan would result in informed attitudes and beliefs, and appropriate cultural norms toward the use and abuse of alcohol, tobacco, and other drugs.

A. Recommendation: The Legislature should review, support and fund elements of the Interagency Coordinating Council and prevention resources that "work".

Explanation: See recommendations in Section 6.3.1.

B. Recommendation: The Governor should grant authority to the Interagency Coordinating Council (ICC) to facilitate goal accomplishment and to develop a comprehensive prevention plan. Uniform prevention planning strategies should be developed in each prevention member agency and programs designed to meet unified prevention goals.

Explanation: Currently the ICC is advisory and it has no authority to mandate participation by prevention entities. The ICC does not have strong motivational tools to encourage the accomplishments of the prevention goals important to Montana. This planning effort builds on the goals and planning already initiated through the Interagency Coordinating Council and is intended to assure that all agencies working in prevention are working in a coordinated method to reach state wide goals and objectives.

C. Recommendation: All prevention agencies should adopt and adhere to the prevention guiding principles developed by the ICC and adhere to them. All funding grants and incentives should hold these guiding principles as a base.

Explanation: Currently there is not consistent implementation of the guiding principles. The guiding principles are presented in Section 3.1.3.

D. Recommendation: Establish a Board of Prevention that includes and incorporates prevention departments and programs from throughout the state, including tobacco, alcohol and other drugs.

Explanation: The intention of this recommendation is to give a valid and strong structure to state prevention efforts. It is intended to strengthen the Interagency Coordinating Council and the Prevention Resource Center efforts and to provide a representative board.

The Board of Prevention would model the Board of Crime Control. The role of the Board will be to dole out grant money and set state wide prevention goals and objectives. The ICC has initiated a lot of work in this area which would be built upon. This would "elevate" prevention. The Board would serve as a working Board for the ICC.

State funds would be required to effectively implement this recommendation so prevention is not overly dependent on grants or ephemeral dollars. Some believe this is the most important piece of all the prevention recommendations.

6.6 INFORMED PROFESSIONALS & CITIZENRY

Desired Outcome:
Montana has an informed citizenry, and skilled professionals regarding the process of addiction, the impact of drugs and treatment strategies.

Position Statement: The Task Force does not have specific recommendations to meet this desired outcome however, they feel it is important to emphasize how critical it is to retain, recruit, and sustain a skilled and sufficient pool of chemical dependency professionals to address the needs presented in the state. It is important for all service providers and allied service providers to know how to identify and refer chemical abuse and dependency. It is important to have training and public policy initiatives that enhance the links between assessment, prevention, enforcement and treatment providers. This is particularly true for treatment programs that are available to meth addicts.

Currently there are groups of people who are not receiving addiction education but should be. They include professionals (teachers, youth court officers, public health nurses, probation and parole officers) and members of the community (family, neighbors, employers).

Every state agency should provide opportunities to provide professional development and training to all personnel and other allied professionals regarding the process of addiction and promising and "best practices" to prevent, intervene and treat addiction.

6.7 STRONG FRAMEWORK FOR COMBATING DUI

Desired Outcome: Montana has a strong and cohesive legal framework for combating DUI problems.

A. Recommendation: Support .08 Blood Alcohol Content per se legislation that meets federal requirements.

Explanation: The Transportation Equity Act for the 21st Century (TEA – 21) should be referenced for specific federal requirements (http://www.fhwa.dot.gov/tea21/). In general, Section 163 of TEA – 21 states that to be eligible for qualification, a state's law must meet basic elements. To qualify for TEA funds the law must apply to all drivers. It must establish that driving with a blood alcohol content of .08 or higher is an illegal per se offense. It must apply to the criminal code and, in states with administrative license revocation (ALR) laws, to the ALR law as well. It must be deemed to be equivalent to the state's standard "driving while intoxicated" offense.

If this is passed in the next legislative session the state will receive an additional $700,000. It was noted by several Task Force Members that this law should not be passed just to secure federal dollars; rather it should be passed to improve the safety of Montanans.

B. Recommendation: Propose Administrative License Revocation Legislation.

Explanation: Administrative License Revocation (ALR) is the suspension or revocation of a DUI offender's license at the time of arrest when an individual refuses to take or fails a BAC test. The police officer seizes the offender's license and issues a temporary license. Because it offers an immediate consequence, ALR has proven to be one of the most effective ways to combat drunk driving. Forty states have enacted ALR legislation.

Research has shown that driver licensing sanctions have a significant impact on the problem of impaired driving. Licensing sanctions imposed under state administrative licensing revocation systems (not criminal) have resulted in reductions in alcohol-related fatalities of between 6 and 9 percent. Illinois, New Mexico, Maine, North Carolina, Colorado and Utah have seen significant reductions in alcohol-related fatal crashes following the implementation of administrative license revocation procedures, according to a NHTSA study. Alcohol related fatalities have dropped by 6 percent in states that have passed ALR legislation.[156]

Montana currently has a "partial" ALR law for BAC refusal only. It gives judges discretion, however, whether a license is suspended or revoked or not. Passage of the ALR will have some impact on the work load of the Motor Vehicle Division State Licensing Bureaus.

C. Recommendation: Propose Vehicular Homicide and Aggravated DUI legislation.

Explanation: A key purpose to this legislation is in its name. The term "negligent" is very offensive to victims of these tragedies according to victim rights groups and the County Attorney's Association. The essence of the new legislation is to make it clear that if you get behind a wheel in an impaired state (i.e. drunk or under the influence of drugs) it is NOT simply a negligent act.

Montana is one of only four states without a Vehicular Homicide law.

D. Recommendation: Modify the Driving Under the Influence law by increasing mandatory fines for first offenses.

Explanation: The intention of this recommendation is to create another strong deterrent to add to a complete and comprehensive package of DUI deterrents to ultimately reverse the trend of increasing DUIs. There is no one silver bullet; a strong and comprehensive package is needed. Other states, such as Washington, have very stiff 1st offense penalties.

1st DUI offense:

- Mandatory $1000 fine.

  This could generate $2 million for cities & counties. The $1000 fine amount is proposed because that is the national projected cost per DUI incident. This level of fine raises the offense to a high misdemeanor (not a felony). The current fine of $350 has been in effect for a long time.

  There is some concern that there is little consequence to not paying fines. The difficulty is in collecting the fines. The City of Billings has approximately 4000 outstanding warrants. In addition to the existing tools judges have to collect fines (i.e. setting up a contract for payment over time or an extended due date) the Task Force recommends another tool. If fines are not paid or a payment contract is broken then the judge would have the option to take the offender's driver's license away permanently (consideration should be given to ability to access work etc.). Currently an offender can loose their license for 6 months on the 1st DUI. This would extend beyond that. The potential of loosing their license is a strong deterrence to many, especially for younger individuals.

  Studies have shown that the majority of 1st time DUI offenders have driven under the influence numerous times before they were ever stopped by a police officer. With the overall intention of changing our culture and getting those who have been drinking away from behind the wheel, taking away their privilege to drive if they don't pay their fine is appropriate.

- Other sanctions to include community service when available.

- Individualized (i.e. age and culturally appropriate) assessments and subsequent appropriate programming & treatment.

E. Recommendation: Propose Open Container law that is in compliance with Section 154 of 23 U.S.C. (Note this is for motor vehicles on public roadways). If it does not pass the Task Force recommends that incentives for counties and cities to pass local open container legislation be explored. The incentives could be funneling Highway Traffic Funds to jurisdictions that pass the legislation.

Explanation: According to the National Highway and Traffic Safety Administration, Section 154 of 23 U.S.C. requires that a state's open container law must[157]:

- Prohibit both possession of any open alcoholic beverage container and consumption of any alcoholic beverage;

- Cover the passenger area of any motor vehicle, including unlocked glove compartments and any other areas of the vehicle that are readily accessible to the driver or passengers while in their seating positions;

- Apply to all open alcoholic beverage containers and all alcoholic beverages, including beer, wine, and spirits that contain one-half of one percent or more of alcohol by volume (including 3.2% beer);

- Apply to all vehicle occupants except for passengers of vehicles designed, maintained, and used primarily for the transportation of persons for compensation (such as buses, taxi cabs, and limousines) and motor homes;

- Apply to vehicles on a public highway or the right-of-way (i.e., on the shoulder) of a public highway; and

- Require primary enforcement of the law, rather than requiring probable cause that another violation had been committed before allowing enforcement of the open container law.

All states must certify that these laws comply with the above elements, that the law is in effect, and that they are enforcing the law.

The Open Container law addresses, and works to change the current attitude and accepted norm that drinking while driving is O.K. This is a very challenging issue in Montana because there is a strong attitude of "this is my right." Though some drinking and driving is legal (otherwise the legal BAC level would be .000) this law sets a new norm. Most

major cities in Montana already have an open container law. It is estimated that over 50 percent of Montana's population are already living in areas with open container laws.

States without this law, including Montana, have had a portion of their Federal-aid highway construction funds redirected into other state safety activities each year, beginning in Fiscal Year 2001. In Montana it is estimated that $5.5 million are redirected each year. The redirected monies go to the state's Section 402 highway safety program to be used for alcohol-impaired driving countermeasures or for enforcement of anti-drunk driving laws. Alternatively, the state may elect to use the monies for the state's hazard elimination program under Section 152[158]. If a state wide law is not passed, opportunities to use these transferred funds as incentives to cities and counties should be explored. The money could perhaps be used to enhance 1st offense DUI programs in those jurisdictions (Recommendation in Section 6.7 D).

F. Recommendation: Propose Repeat Intoxicated Drivers (DUI) Law

Explanation: According to the National Highway Traffic Safety Administration, Section 164 of 23 U.S.C requires that states must[159]:

- Require a minimum one-year driver's license suspension for repeat intoxicated drivers.
- Require that all motor vehicles of repeat intoxicated drivers be impounded or immobilized for some period of time during the license suspension period, or require the installation of an ignition interlock system on all motor vehicles of such drivers for some period of time after the end of the suspension.
- Require mandatory assessment of repeat intoxicated driver's degree of alcohol abuse and referral to treatment as appropriate.
- Establish a mandatory minimum sentence for repeat intoxicated drivers:
    - Of not less than 5 days of imprisonment or 30 days of community service for the second offense; and
    - Of not less than 10 days of imprisonment or 60 days of community service for the third or subsequent offense.
    - Under the program, a repeat intoxicated driver is defined as a driver convicted of driving while intoxicated or driving under the influence of alcohol more than once in any five-year period. Thus states must maintain records on driving convictions for DUI for at least five years.

Montana's current laws only meet one of these requirements. Montana does require chemical dependency treatment programs for 2nd or subsequent DUI currently (61-8-732).

States without this law, including Montana, have had a portion of their Federal-aid highway construction funds redirected into other state safety activities each year, beginning in Fiscal Year 2001. In Montana it is estimated that in FY 2003 $5.5 million will be redirected. It should be noted, as mentioned earlier, that it was the strong view of some Task Force Members that Montana should not pass legislation just because it would loose federal dollars if it did not. The legislation should be passed because it is good for the citizens of Montana.

G. Recommendation: Propose legislation that increases the consequences in the law for people who refuse to provide a breath sample.

Explanation: The intent of this recommendation is two-fold; to create penalties that are stiff enough that people will not want to refuse to provide a breath sample; and to eliminate a means around getting a DUI if they refuse. Blood Alcohol Content's have become almost irrefutable in court. The other mechanisms to determine whether or not someone is under the influence are very subjective.

Some options that could be considered for increased consequences include: license revocation for one year increasing to three years for prior refusal; amending current statute to remove the suspension appeal option. According to the Montana County Attorney's Association (MCAA) Montana refusal rates are higher than the national average.

H. Recommendation: Propose legislation requiring mandatory Blood Alcohol Content/Drug testing for crashes involving fatalities or serious injuries.

I. Recommendation: Re-establish local DUI task forces with funding.

Explanation: See Section "6.1.3; 1. a)" of this document for funding opportunity details. DUI task forces do not need to cost the state general fund anything. They have been and could continue to be a win/win self supporting program and effective community based prevention tool[160].

J. Recommendation: Develop a centralized DUI tracking system.

Explanation: An important component of a strong framework for combating DUI is a centralized DUI tracking system. To effectively implement many of the recommendations in this section an effective tracking system that is accessible to all who need the information is required. Such a system was considered by the Dept. of

Transportation last year as a possible expenditure of construction funds transferred to the Governor's Highway Safety Plan.

6.8 YOUTH UNDERSTAND MEDIA PLOYS

Desired Outcome:
Montana youth understand the manipulative techniques used by the media, product marketers, and drug traffickers. They understand the difference between medicinal prescription drug use and drug abuse.

A. Recommendation: The Governor and or the Attorney General should take "media literacy" on as an initiative.

Explanation: Media literacy programs are essential to effective prevention. It is important that Montana's youth understand how they are targeted and manipulated by marketers and others. Media literacy training programs are being done in Montana and they are being done well. Wider and broader exposure is needed. This initiative could be part of an existing initiative such as Healthy Family – Healthy Community.

B. Recommendation: Encourage media literacy education of licensed broadcasting agencies and agencies that provide prevention services to youth.

6.9 POSITIVE PREVENTION ROLE MODELS

Desired Outcome:
State and local leaders are role models of a positive prevention lifestyle.

Position Statement: The Task Force believes that if Montana implements the recommendations proposed in this Blueprint for the Future we will have better role models for our youth. The Task Force recognizes all Montanans as leaders. We are leaders in our families, in our schools and in our communities. We all need to take responsibility and accountability for our actions and improve the messages we send to our youth.

6.10 PREVENTION FUNDING BASED ON OUTCOMES

Desired Outcome:
Prevention funding allocations are based on established outcomes and there are incentives for melding or "braiding" of prevention funds at the local level.

Recommendation: State prevention grants utilize prevention guiding principles and standardized prevention definition in Request for Proposals (principles and definition already exist).

Explanation: The intent of this recommendation is to put our limited resources where they will be most effective by investing in programs with elements that are known to be effective in preventing alcohol, tobacco and other drug abuse.

6.11 MEDIA MESSAGES IMPROVED

Desired Outcome:
Media messages that target minors and that portray the misuse or abuse of alcohol, tobacco, and illicit drugs are limited.

A. Recommendation: Encourage media advocacy training for state and local prevention professionals.

Explanation: Media advocacy needs to be a part of prevention messages developed by the state and local prevention professionals. The Prevention Board (see recommendation in Section 6.5 D could educate prevention partners in media advocacy issues.

B. Recommendation: Encourage that media advocacy be incorporated into prevention Request for Proposals (RFP's).

6.12 REDUCE REVOCATIONS

Desired Outcomes:
Montana has reduced revocations for probation and parole offenders for alcohol and other drug use.

A. Recommendation: Encourage immediate sanctioning and alternative sentencing (including treatment) when substance abusing offenders violate their condition of parole or probation, in lieu of prison.

Explanation: As described in Sections 4.1 and 4.3.2, some level of relapse for people with chemical dependency is expected. This does not mean that the offender can't or

won't improve. Relapse is expected. Therefore, when relapse occurs (i.e. violation of parole or probation) it does not necessarily mean that treatment didn't work. The individual should receive consequences for their actions and continue treatment. Long term prison sentences (without treatment) are not effective. Short term community jail time in conjunction with treatment is more effective.

The possibility of having to go to the community jail if parole or probation is violated is and incentive for the offenders to continue with their treatment programs.

B. Recommendation: Use graduated system of sanctioning offenders for the use of alcohol and drugs while in the Criminal Justice System providing both immediate and meaningful sanctions in lieu of revocation, recognizing that revocation may be the end result.

Explanation:

- Up to and including 30 days in jail at own expense.
- Use of Pre Release Center jail sanction beds.
- Chemical Dependency Program or facility in lieu of jail.
- Transitional Living Program beds at Pre Release Center.

C. Recommendation: Support existing contracts and develop localized, effective and accessible resources for chemical dependency treatment.

- Use college and university resources to provide expertise and student internship and training programs.
- Encourage non-profit, private support (including faith based organizations), for programs to help offenders just released from prisons and jails. These programs help the offenders to be self sufficient and contribute back to the community. This effort is most challenging in the vast rural areas of Montana.

D. Recommendation: Support the Sanctioning Center "pilot project" which is currently being planned and developed in a regional prison in Montana.

Explanation: A sanctioning center is a short-term (30 days or less) facility. The county jails and prisons are full therefore a sanctioning center is being tested to see if it can be used to hold offenders accountable for their actions and get them back into treatment when appropriate. Transportation issues to get offenders to sanctioning centers will be challenging.

6.13 COMPREHENSIVE METHAMPHETAMINE PLAN

Desired Outcome:
Montana has a comprehensive plan to deter manufacturing and sale of methamphetamine; cleanup of sites and contamination; and increase education.

The comprehensive plan should include: increased enforcement designed to deter the manufacture, sale and use of methamphetamine (meth); increased training and education for citizens and professionals impacted by meth; cleanup of meth-related sites and contamination; and improved prevention, enforcement and treatment that is coordinated in an effort to mitigate the impacts of meth in Montana.

A. Recommendation: The Montana Departments of Justice, Environmental Quality and Health and Human Services should cooperate to develop and promote standards, protocols and procedures that are appropriate to the cleanup of the immediate areas or surrounding environments, both public and private, where chemicals, equipment and wastes from clandestine laboratory operations have been placed or come to rest.

Explanation: The Health and Human Services Department has been directed by the Governor to set cleanup standards. This department should get federal clarification of who has the responsibility and authority to certify that a site is "clean" and what the standards and risks are. The federal government is currently encouraging letters be sent to owners of properties where meth labs have been found informing them that there could a problem; but the problem and risks are not well defined, nor is the remedy clear.

There are liability issues to consider in determining who is ultimately responsible in declaring a property "clean".

Cleanup protocol should include clear guidelines on the responsibilities of governmental jurisdictions (tribal, state and federal) and on individual responsibilities. It should include communication/notification requirements and specifics on what type of cleanup is required in different instances.

B. Recommendation: The Montana Department of Justice should assemble and establish a bank of public information resources relative to the prevention, treatment and enforcement of methamphetamine offenses, including guidelines for the public and private cleanup of sites and contamination, treatment options and their effectiveness and how to identify if someone you know is abusing drugs or alcohol.

Explanation: There needs to be a state agency that the public, education personnel and other professionals can go to for information relative to the clean-up of sites, contamination issues, treatment options and their effectiveness and how to identify if someone you know is abusing drugs or alcohol.

C. Recommendation: Seek out federal funds that can be utilized: (1) to reduce methamphetamine abuse and the violence associated with meth-related offenses; (2) to increase public awareness and reporting; (3) and to increase the amount of law enforcement manpower and specialized equipment available for the purpose of disrupting production and prosecuting the individuals and organized groups who use, manufacture or distribute meth in Montana.

Explanation: Two tools that would be helpful in increasing public awareness and reporting are a 1-800 speedy notification/information number and a very effective and interactive web site.

D. Recommendation: There needs to be a clear medical protocol for treatment of youth and allied professionals at meth sites.

Explanation: The state needs to ensure that procedures and protocols are developed to coordinate and improve the efforts of criminal justice personnel, child protective services, medical staff and other professionals allied for the purpose of identifying and protecting children who are endangered by the production and use of methamphetamine.

E. Recommendation: The Attorney General's office should explore whether the issue of precursor materials being transported into the U.S. from Canada is a significant issue or not.

Explanation: Anecdotal information indicates that precursors and required chemicals for production of meth are readily available in Canada and that some are producing the product there and transporting it into Montana or transporting the raw materials into Montana[161]. The scope of the issue should be explored before significant international discussions occur.

F. Recommendation: For adults, ingestion should constitute possession.

G. Recommendation: Propose legislation to improve interdiction capabilities by: (1) increasing highway patrol staff, (2) giving highway patrol officers interdiction authority. (3) increasing the number of interdiction check points, and (4) assigning a hwy patrol officer to each Drug Task Force around the state.

Explanation: Highway patrol officers are currently viewed only as traffic cops. That, view and role needs to change, however, to effectively address drug trafficking in Montana. Currently highway patrol officers are limited in being able to conduct criminal investigations. Training is a very important component of effective interdictions.

It will be important to carefully coordinate interdiction efforts with local jurisdictions. Having a highway patrol officer on each Drug Task Force could be encouraged by making that a condition of receiving federal grant dollars managed by the state.

H. Recommendation: It should be determined that a child's physical or mental health is endangered if illegal substance manufacturing is present.

Explanation: An additional felony charge would be available to use in cases of meth labs where children are present.

I. Recommendation: The State of Montana should develop and support new resources for assessing the full scope and impact of meth (and other emerging drugs) in Montana and analyzing available information in a manner that streamlines and improves statewide counter-drug efforts.

Explanation: There needs to be a commitment to get up-to-date information through intelligence collection methods.

J. Recommendation: Enforcement of meth manufacturing and sale should be coupled with assessments and treatment opportunities.

Explanation: Many people who manufacture and sell meth are doing so to support their own addiction.

K. Recommendation: The Attorney General's office should review whether the over the counter sale of Pseudo-Ephedrine products should be restricted and recommend legislation accordingly.

Explanation: Pseudo-Ephedrine is an ingredient of meth and is readily available in stores.

7.0 WRITTEN SUMMARY ~ ITEMS NOT AGREED TO

Throughout the seven month Drug Control Task Force process the Members strove to reach 100 percent agreement on all of their strategy recommendations. They knew that recommendations that met the interests of all Task Force Members would be much more powerful and enduring. They decided that if 100 percent agreement could not be reached on a recommendation then they would declare a majority at 17 of 20 members (later amended to 85 percent of the Task Force Members present). If the minority appeared to be of one category (e.g., prevention workers, Tribal members, etc.) or one "interest", then the group continued to work to try to honor those interests.

The items in this section are proposals brought forward by individuals or Work Groups but that had less than 85 percent of the Task Force Members agreeing to recommend it to the Governor and Attorney General. They are presented in this section as "written summary" though some of the items were only briefly discussed. No attempt is made to make the following "summary" exhaustive; rather it is a brief presentation of some of the information provided about the proposed strategy. Items in this section are NOT Task Force recommendations.

7.1 INCREASE BEER TAX – NOT RECOMMENDED

Proposed Recommendation – NOT AGREED TO: Increase the beer tax from $4.30 to $8.60 per barrel (from 1.3 to 2.6 cents per 12oz). Increase the wine and low cider (ex. hard lemonade) tax (amount not specified).

Discussion and Analysis: The intention of an increased beer tax would be fourfold. First, the increase in taxes would provide additional state revenues to implement specific prevention and treatment programs in Montana as well as provide additional general fund revenue. Secondly, the increased cost of beer is projected to reduce underage drinking and concomitant problems. Thirdly, an increase in beer tax would bring Montana's tax closer to the national average and historic tax levels. And finally, the beer tax would put some of the burden of the social costs of alcohol use on the users.

Major concerns with this proposal include: That the tax would impose an inappropriate negative economic impact to local family owned alcohol businesses; that beer is already heavily taxed; and, that it is inappropriate to tax non-dependent legal drinkers for social problems they are not responsible for.

Many Task Force members shared the concern that state agencies and private community based programs, can not absorb additional duties or substantially improve alcohol, tobacco and other drug related services without additional funding. If a tax increase was

passed the additional tax revenue could provide a source of funding to implement the appropriate recommendations in this document. The Department of Health and Human Services estimates that an increase in the beer tax to $8.60 per barrel would generate approximately $4.1 million in additional state funds annually. This estimate is likely a high end estimate, however, because it assumes a 4 percent annual consumption increase which does not accurately reflect recent trends. In fact, total beer and wine tax revenues in Montana in 2001 were down 6.6 percent compared to 1999. And, in 2001 beer and wine tax revenues were down 20 percent compared to 2000[162].

Industry representatives on the Task Force expressed deep concern over trying to cover these social costs by impacting small businesses throughout Montana. Beer taxes are paid at the wholesale level. At present there are 27 beer and wine wholesaler businesses in the state of Montana; that number is steadily declining. These businesses are run by families and are usually passed from generation to generation[163].

Many research studies have clearly established that increases in alcohol taxes and/or increases in the retail price of alcoholic beverages are associated with decreases in alcohol consumption[164]. Alcohol-related traffic crashes, violent crime and liver cirrhosis, among other social and health problems also significantly decline with increased taxes. Several studies have shown that youth are especially sensitive to changes in price, which means that when prices rise, there are greater reductions in consumption and alcohol-related problems among youth than among the general adult population[165]

The Montana Tavern association agrees that an increase in cost would cause the customer base to decline. But their concern is that the decline would be in the responsible working class who are currently struggling economically to keep above water. A tax increase would be punishing them further[166].

Average state-level beer taxes have eroded dramatically over the past three decades. In 2001 Montana's beer tax was lowered for small producers (less than 20,000 barrels of beer/year.) Under the new legislation producers of: 0 – 5,000 barrels pay $1.30/barrel; 5,001 – 10,000 barrels pay $2.30/barrel; and, 10,001 – 20,000 barrels pay $3.30/barrel. Producers of over 20,000 barrels per year pay $4.30/barrel. Prior to 2001 the last beer tax change occurred in 1985 or 1987[167]. A temporary, one year, Sur Tax of 7% on beer tax liability was enacted in 1992. After adjusting for inflation, the average state beer tax in 2000, nation wide was approximately one-third of the beer tax in 1968. Montana's current cost of $4.30 per barrel would be over $12 if it was adjusted for inflation since 1968.

According to the Federation of Tax Administrators in January 2002 the national average for state beer tax was about 2.27 cents per 12 oz.[168] (or $7.50 per barrel). Montana's state beer tax, at $4.30 per barrel, is currently well below the national average. Many of our neighbors, (Oregon, Colorado, Idaho, North Dakota, South Dakota and Wyoming) also have beer taxes below the national average. Wyoming's tax is the lowest in the nation, at

$0.62 per barrel and Hawaii's is the highest at $28.52. Washington's beer tax is above the national average at $8.09 per barrel[169]. If Montana raised the state beer tax to 2.6 cents per can ($8.60 per barrel) it would bring our beer tax to $1.10 over the national average. The increased tax would still be below the tax rate of several other western states such as Utah, Oklahoma, New Mexico, and Alaska.

The federal beer excise tax was just raised in 1991 to $18, the first increase since 1951. Montana has one of the lowest beer taxes in the nation (34 states have higher and 15 states have lower beer taxes) but one of the highest taxes for "spirits". The beer industry is concerned about the increased taxes. There have been serious proposals to reduce the federal beer tax and a state increase would not be supported by all Task Force members.

The Task Force discussed and debated whether using the beer tax as a user's fee was appropriate. Some Task Force members said that a user's tax is not appropriate and they can not support a tax increase because it would be asking non-alcoholics or non-dependent consumers to fund something they aren't a part of. Concern was raised within the Task Force that this was a blame tax while the vast majority of consumers are responsible in their use and cost society nothing. They feel it is unfair to punish the many for the conduct of a few.

Others argue that for most consumers who drink minimally, a tax increase will hardly be noticed. Consumers will pay in proportion to how much they drink, and the bulk of the tax hikes will be paid by the relatively small percentage of drinkers who consume most alcohol. These same drinkers, are responsible for the highest concentration of alcohol-related problems and societal costs they contend.[170] They feel it is appropriate and important to tax the consumption to help cover the societal costs of that consumption. They suggested that taxes generally are for the greater good, like taxes that go toward education, whether you have a child or not. They point out that alcohol is a discretionary item, not a necessity. Statistics were presented that some feel support the ethics of using a beer tax as a user's fee to offset societal costs. Some of the data includes[171]:

- Beer consumed by the highest 10 percentile of drinkers by volume represents 42 percent of the reported alcohol consumption in the United States.
- Beer accounts for over 81 percent of all the alcohol that is reported drunk in hazardous amounts in the United States.

Though the Task Force did not come to consensus on this proposal some members expressed excitement that this discussion took place. They said it was the first time in many years that this level of conversation had occurred.

7.2 ADDITIONAL FUNDING AND RESOURCE OPTIONS – NOT RECOMMENDED

Proposed Recommendations – NOT AGREED TO: The following ideas of potential alcohol, tobacco and other drug control program funding and resource mechanisms were briefly discussed by the Task Force but are NOT Task Force recommendations. These ideas were generated in a brainstorming session. There was not consensus to recommend these items nor was their consensus to delete them. Members wanted it shown that each of these options were at least considered.

a) Hire "Fine Collection Czar". Use collection agencies to collect unpaid fines.

b) Consider Class 3 gaming for Indian Tribes. Though the Task Force is NOT recommending this option they respect the rights of the tribes to make this decision.

c) Charge a $1.00 per month sur-charge on cell phones in Montana. Drug dealers use cell phones.

d) DUI offenders must pay for their own treatment and all restitution regardless of their income or ability to pay.

e) Tap the coal tax trust fund. A percentage of the coal tax trust fund would go into the ATOD endowment fund.

f) Use a gambling tax percentage to go to local prevention services.

g) Tax tattoo and piercing parlors.

h) Eliminate 4th DUI as a felony.

i) Use colleges and universities to assist with on-going prevention and treatment research (interns).

j) Initiate methanol gas tax.

k) Initiate a sales tax.

l) Establish a fee for establishments that serve alcohol and that allow those less than 18 years of age to be in establishment.

8.0 ITEMS NOT FULLY DISCUSSED BY TASK FORCE

During the seven month Alcohol, Tobacco and Other Drug Control Task Force process there were items brought up by individuals or Work Groups that did not get discussed by the full Task Force. At each meeting these were put into a "Parking Lot" if they were not addressed during the meeting. The Task Force was charged with meeting as a group seven times over the seven month period and, though they accomplished a great deal they were not able to discuss all "parking lot" items. The Task Force was also asked in an evaluation at the end of the process if there were any issues not addressed. This section captures those ideas and proposals that were not discussed by the Task Force.

- Add special sanctions to DUI offenses that endanger children.
- More detail related to methamphetamine and its control.
- Funding sources.
- Other drugs (besides meth).
- Victim's Rights.
- Binge Drinking Issues. Different ages receive different penalties. Need tools to let people know what the issues with binge drinking are.
- Don't allow minors into establishments that serve alcohol.
- Use a percentage of Tobacco Settlement dollars for ATOD programs.
- Looking at where fines from alcohol, tobacco and other drug offenses currently go.
- Tobacco. Task Force intended to focus an equal amount on tobacco, since that was the charge; however the severe nature of the alcohol and drug problems overshadowed discussions on tobacco.
- School ATOD programs. A Montana State Impaired Driving Assessment reported that only 5% of Montana Schools had all eight elements of a comprehensive ATOD program. No citation was given and the source of this information could not be found before the Task Force ended their work.

9.0 CONCLUSION

The Task Force concludes that instead of "getting tough on crime" related to alcohol, tobacco and other drug issues in Montana, we need to "be effective on crime" which means Montana also needs to be effective in prevention and effective in treatment. Based on their assessment of the current situation the Task Force has recommended a comprehensive blueprint of policy and strategy changes that they agree are necessary to reduce the significant social and financial impacts of substance abuse that currently plague Montana.

Foremost among the recommendations is the call for a high level Drug Czar position with the responsibility, authority and resources to integrate the currently divergent alcohol, tobacco and other drug control (ATOD) programs. The person in this position will be the champion for moving Montana toward its desired outcomes. This position is viewed as essential to managing effective and integrated prevention, treatment, public health and judicial programs in Montana. Research has shown that investment in effective prevention and treatment programs now saves substantially in societal costs later. Other "Czars" have been created in Montana, but perhaps none that have nearly as much potential for societal and economic savings for the taxpayers as this position.

The entire process to develop this "Blueprint for the Future" was one of consensus building and prioritization. What remains in this document is agreed by the diverse interests on the Task Force to be a priority. It is a comprehensive package because a comprehensive approach is needed to move us from where we are to where we want to be. A comprehensive approach is necessary for us to be effective in preventing our youth from engaging in harmful and illegal substance abuse; effective in treating Montanans who have the chronic illness of addiction; and effective in reducing alcohol and drug related crime.

While the Task Force was legitimately concerned about funding issues and budget ramifications and though they devoted time to developing funding options, they decided that their most important charge was to determine and recommend strategies necessary to effectively combat alcohol, tobacco and other drug related problems in Montana first. They concluded that the strength and merit of effective strategy recommendations would earn appropriate allocations of limited state resources.

This "Blueprint for the Future" is an essential starting point; it can not be the end. This "Living Document" should change and evolve as more information is gained and as Montana's needs evolve. It is a solid plan, nevertheless, with which to start to build our new future. The Task Force believes we must start to implement this plan now in order to effectively reduce ATOD related deaths, injuries, crimes and societal costs in Montana.

GLOSSARY OF TERMS, AGENCIES AND PROGRAMS

(AS USED IN THIS DOCUMENT)

ACT – Assessment, Court, Treatment Program

Addictive & Mental Health Disorders Division (AMHDD) – One of ten divisions of the Montana Department of Health and Human Services. The mission of this Division is to implement and improve appropriate statewide systems of prevention, treatment, care and rehabilitation for Montanans with addictive and mental disorders.

Addiction – Uncontrollable craving, seeking, and use of a substance such as a drug or alcohol. Dependence is such a point that stopping is very difficult and causes severe physical and mental reactions.

Allied Service Providers – A term Task Force members used to describe all the individuals who directly or indirectly may influence an addiction patient's treatment. (i.e. judge, prosecutor, defense counsel, substance abuse treatment specialists, probation officer, law enforcement and correctional personnel, educational and vocational experts, community leaders and others.)

AMHDD – Addictive & Mental Health Disorders Division

Assessment – Assessment is the process used to determine the nature and extent of a candidate's substance use and its impact on the individual's quality of life. Assessment results guide judgment of the suitability for placement in a specific alcohol, tobacco or drug treatment modality or setting.

Assessment, Course, and Treatment Program (ACT) – Also known as Driving Under the Influence Court Schools. This program provides offenders of DUI laws an approved course to educate and deter drinking and driving. After a four day course the offenders receive an assessment of their chemical dependency and if a dependency is diagnosed they are recommended to appropriate treatment. Most often people are ordered through the courts to attend the ACT program.

Assets – Resources that help youth grow-up strong, capable and caring, including positive relationships, opportunities, competencies, values, and self-perceptions.

Asset Building – Any action or activity carried out by an individual, family, organization, or community that contributes to the development of assets among children.

ATOD – Alcohol, tobacco and other drugs

BAC – Blood Alcohol Content or the amount of alcohol in a person's blood.

Benchmark – A specified reference point, when a given state of affairs is measured. The benchmark is used to determine progress toward or attainment of an ultimate goal or outcome the desired state of affairs.

CAPS – Child and Adult Protective Services Program

CASA -- Columbia University's National Center on Addiction and Substance Abuse

CBSAIC -- Community-Based Substance Abuse Information Course

CDC -- Chemical Dependency Bureau (CDB)

CDC -- Centers for Disease Control and Prevention

Centers for Disease Control and Prevention -- The Centers for Disease Control and Prevention is the lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Center for Science in the Public Interest (CSPI) – This is a nonprofit education and advocacy organization that focuses on improving the safety and nutritional quality of food supply and on reducing the carnage caused by alcoholic beverages. CSPI seeks to promote health through educating the public about nutrition and alcohol; it represents citizens' interests before legislative, regulatory, and judicial bodies; and it works to ensure advances in science are used for the public good.

Chemical Dependency Bureau (CDB) – This is a Bureau within the Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division.

Child and Adult Protective Services Program (CHAPS) -- A computerized case tracking system, which tracks the payments for children, and adult protective needs such as foster care payments. The system also tacks juvenile criminal activity by providing a case management component for Juvenile Probation offices. A joint effort between the Montana Board of Crime Control and the Montana Department of Health and Human Services transferred all JPIS functions and historical data into the CAPS case management system. The Probation offices enter all juvenile offense information into the CAPS program and maintain electronic case files on juvenile criminal activity. The referral/offense data collected in CAPS is provided to the Board of Crime Control on a semi-annual basis.

CIA – Coordinator of Indian Affairs – for the State of Montana

Community – A defined geographical area, such as a neighborhood, town or county.

Continuing Care – Continuing Care pertains to post-treatment services designed to meet the ongoing needs of the recovering individual. This was formally referred to as Aftercare.

Co-occurring Capable Criteria: Based on the American Society of Addiction Medicine the criteria include:

- Co-occurring Capable (COC) providers routinely accept individuals who have co-occurring mental and substance-related disorders.
- COC providers can meet such patients' needs to ensure that that the individual's psychiatric disorders and detoxification are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders and/or detoxification needs do not interfere with participation in treatment.
- COC providers address co-occurring diagnosis in their policies and procedures, assessment, treatment planning, program content and discharge planning.
- COC providers have practices in place for coordination and collaboration with both Chemical Dependency and Mental Health disciplines.
- COC can provide psychopharmacologic monitoring and psychological assessment and consultation on site or by well-coordinated consultation off site.

Co-occurring Chemical Dependency – Individuals who have both mental health and chemical dependency problems

Dependency – Addiction to alcohol or other drugs.

DEQ – Montana Department of Environmental Quality

Developmental Assets – Key building blocks critical for successful growth and development.

DMC – Disproportionate Minority Confinement

DOC – Montana Department of Corrections

DOLI – Montana Department of Labor and Industries

Domain – A targeted area or environment often referred to as school, community, family and individual/peer.

DPHHS – Montana Department of Public Health and Human Services

Drug Court – A drug court is a special court given the responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program. Drug court programs bring the full weight of all interveners (judge, prosecutor, defense counsel, substance abuse treatment specialists, probation officer, law enforcement and correctional personnel, educational and vocational experts, community leaders and others) to bear, forcing the offender to deal with his or her substance abuse problem.

DUI – Driving Under the Influence

Dual Diagnosis – Diagnosis of an individual who exhibits both mental health and dependency problems.

Education – Education pertains to activities designed to provide pertinent information on aspects of alcohol, tobacco or drug use and abuse.

FAE – Fetal Alcohol Effect

FAS – Fetal Alcohol Syndrome

HIDTA – High Intensity Drug Trafficking Area

High Intensity Drug Trafficking Area (HIDTA) – The HIDTA program was authorized by the Anti-Drug Abuse Act of 1988 and is administered by the Office of National Drug Control Policy. Since the original designation of five HIDTAs in 1990, the program has expanded to 31 areas of the country. The Drug Enforcement Administration plays a very active role in the program. The HIDTAs mission is to reduce drug trafficking in the most critical areas of the country, thereby reducing its impact in other areas. This is accomplished by institutionalizing teamwork among local, state, and federal efforts; synchronizing investments in strategy-based systems; and focusing on outcomes.

Hepatitis – Refers to "inflammation of the liver", which can be caused by many things such as viruses, bacterial infections, trauma, adverse drug reactions, or alcoholism. Hepatitis B is spread primarily through blood, unprotected sex, shared needles, and from an infected mother to her newborn during the delivery process. Hepatitis C is spread through infected blood, primarily in those who use illicit street drugs and those who received blood transfusions prior to 1992.

Interagency Coordinating Council for State Prevention Programs (ICC) – Created by the 1993 Legislature, this council is comprised of ten Montana state agency directors, as well as two persons

appointed by the Governor, both of whom have experience related to the private or nonprofit provision of prevention programs and services.

Interdiction – Highway drug interdiction is a strategy to intercept the flow of illegal drugs and related currency during transport along public highways. Interdiction includes procedures as routine as observing the interiors of vehicles stopped for traffic violations and as deliberate as developing psychological profiles of suspects, behaviors, and vehicles. Federal law provides for the seizure and civil forfeiture of any assets, including vehicles connected to illegal drug trafficking.

Intervention – Intervention pertains to activities designed to intercede in and address behavior that leads to or may result from alcohol, tobacco and drug use or abuse.

Kids Count – KIDS COUNT uses the best available data to measure the well-being of children & families. KIDS COUNT projects in 50 states, D.C., & the U.S. Virgin Islands report on the status of children at the state & local level. It assesses conditions necessary for a healthy community (i.e. economics and demographics). In MT the KIDS COUNT program is run through a contract with the U of M.

Living Document – The Alcohol, Tobacco, and Other Drug Control Policy Task Force considers this "Blueprint for the Future" to be a living document. One that will change and improve over time with knew knowledge and new needs.

MADD – Mothers Against Drunk Driving

MBCC – Montana Board of Crime Control

MCAA – Montana County Attorney's Association

Media Advocacy – A term used by prevention professional that means using the media effectively. That means getting the message out that you actually intended to send out. Without media advocacy knowledge it is possible to send out good intentioned messages that actually have bad results. Media Advocacy is the art of using "effective" messages.

Methamphetamine (Meth) – Methamphetamine is a powerful central nervous system stimulant. The drug is made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients. These factors combine to make methamphetamine a drug with high potential for widespread abuse. It is a white, odorless, bitter-tasting crystalline powder that easily dissolves in water or alcohol.

Methamphetamine is derived from amphetamine, which was used originally in nasal decongestants and bronchial inhalers. It causes increased activity, decreased appetite, and a general sense of false well-being. The effects of methamphetamine can last six to eight hours, which includes the initial "rush," and afterwards, a state of high agitation that in some individuals can lead to violent behavior.

Methamphetamine is referred to as meth, speed, crank, chalk, go-fast, zip, and cristy. Pure methamphetamine hydrochloride, the smokable form of the drug, is called "L.A." or - because of its clear, chunky crystals which resemble frozen water - ice, crystal, crank, 64 glass, or quartz. Use of methamphetamine became widespread in Hawaii by 1988. Distribution of ice spread to the U.S. mainland by 1990.

MIP – Minors in Possession

Montana Board of Crime Control (MBCC) – The Board of Crime Control is the state's designated planning and program development agency for the criminal justice system. The Board is attached to the Department of Justice for administrative purposes only. The Board provides funding to local, regional, and

statewide projects with the central goal of making Montana a safer state. The Crime Control Division administers federal anti-drug and anti-crime grants, certifies peace officers, and provides funding for programs that assist victims of crime. It also collects and analyzes crime data from Montana law enforcement agencies and publishes the annual Crime in Montana report.

Montana Department of Corrections – Corrections holds about 9000 juveniles and adults accountable for their actions against victims through a combination of secure facilities and community corrections. These include: Montana State Prison, Montana Women's Prison, Pine Hills Youth Correctional Facility for juvenile males, Riverside Youth Correctional Facility for juvenile females, Treasure State Correctional Training Center(Boot Camp), Three Regional Prisons, a private prison, 23 Probation and Parole offices, six intensive supervision programs, and two youth Transition Centers. The Department does contract oversight for five prerelease centers and the Alternatives Youth Adventures(Aspen) program.

Montana Department of Labor and Industries (DOLI) – The purpose of the Department of Labor and Industry is to promote the well-being of Montana's workers, employers, and citizens, and to uphold their rights and responsibilities.

Montana Department of Public Health and Human Services (DPHHS)– State department dedicated to improving and protecting the health, well-being and self-reliance of all Montanans. This department houses ten different Divisions, including the Addictive and Mental Disorders Division.

Montana Office of Public Instruction – The Office of Public Instruction's mission is to improve teaching and learning for all through education, communication, advocacy and accountability for those they serve.

Mothers Against Drunk Driving (MADD) – A 501(c)(3) non-profit grass roots organization with more than 600 chapters nationwide. MADD is not a crusade against alcohol consumption. Their focus is to look for effective solutions to the drunk driving and underage drinking problems, while supporting those who have already experienced the pain of these senseless crimes.

MSP-CDP – Montana State Prison Chemical Dependency Program

National Highway Traffic Safety Administration – Under the U.S. Department of Transportation the NHTSA is responsible for reducing deaths, injuries and economic losses resulting from motor vehicle crashes.

NHTSA – National Highway Traffic Safety Administration

Nonviolent Offender – A nonviolent offender is a person whose offense does not involve the threat of or actual harm to a victim.

OPI – Montana Office of Public Instruction

Per se – According to Webster's Encyclopedic Unabridged Dictionary, per se means by, of, for, or in itself; intrinsically. With respect to its inherent nature; "this statement is interesting per se" [syn: intrinsically, as such, in and of itself]

PNA – Prevention Needs Assessment

PRC – Prevention Resource Center or Pre Release Center

Prevention – Prevention pertains to activities designed to prevent the use of alcohol, tobacco and drugs by providing programs and increasing opportunities for positive and law-abiding behavior, which includes various levels and types of approaches.

Prevention Needs Assessment – Montana Prevention Needs Assessment Project (student survey) for substance abuse. Starting in October 1998 this voluntary survey has been administered every other year in grades 8, 10 and 12 to measure the need for substance abuse prevention services among youth. The information is also useful for prevention services in the areas of delinquency, teen pregnancy, school drop-out, and violence. Two schools in Montana have chosen not to use this tool. Montana survey results can be compared from year to year and to nation-wide surveys such as the Monitoring the Future Survey.

Prevention Resource Center (PRC)– The Prevention Resource Center assists Montana communities with comprehensive prevention efforts by: Supporting the Interagency Coordinating Council (ICC); Directing a statewide VISTA Project; and Providing Resources. In 2002 the Prevention Resource Center has two staff members.

Protective Factor – The combination of environmental assets, behaviors and attitudes protecting individuals from initially expressing problem behavior.

Publicly Funded Treatment – Publicly funded treatment programs are available to individuals who are eligible for Medicaid and those whose income does not exceed 200% of the poverty level.

Relapse – The return (or recurrence) of symptoms of a disease after a period of improvement.

Revocation – Revoking rights given under probation or parole because the offender violated the conditions of their probation or parole.

Risk Behavior – Problem activities. (ex., alcohol, tobacco or other drug (ATOD) use)

Risk Factor – The combination of behaviors and attitudes that can help predict the future occurrence of problem behavior.

Safe and Drug Free School (SDFS) – Safe and Drug Free Schools and Communities Act is Title IV of the Elementary and Secondary Education Act. This federal legislation appropriates funds to each state's education agency and chief executive to distribute to schools and community based programs to support drug and violence prevention programs.

SAMHSA – Substance Abuse and Mental Health Services Administration

SAPT - Substance Abuse Prevention and Treatment (SAPT) Block Grant

Science-Based Prevention -- Strategies, prevention actions, and products that have been evaluated and have been shown to have an effect on actual substance use, norms related to use, or specific risk factors that have been linked to substance use. Prevention actions are based on science if they meet the following conditions:

- The interventions have been demonstrated to positively affect tobacco, alcohol, and other drug use, as well as the problems, risk factors and protective factors related to use.

- Research results have been published by a peer-reviewed journal or have undergone equivalent scientific review

Substance Abuse – A maladaptive pattern of substance use leading to clinically significant impairment of distress as manifested by the following and occurring within a 12 month period:

a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences of poor work performance related to substance use;

substance-related absences, suspensions, or expulsions from school; neglect of children or household), and

b. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use); or
c. Recurrent substance-related legal problems (e.g. arrests for substance related disorderly conduct, minor in possession, arrests for crime while under the influence of substance); and
d. The adolescents' symptoms have never met the criteria for substance dependence as set forth in the DSM –IV.

Substance Abuse and Mental Health Services Administration (SAMHSA) – An agency of the U.S. Department of Health and Human Services. SAMHSA is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Substance Abuse Prevention and Treatment (SAPT) Block Grant -- This federal grant which is managed by the Center for Substance Abuse Treatment is applied for each year by Montana's Department of Health and Human Services, Addictive and Mental Disorders Division. It is the primary source of funds for the prevention and treatment of substance abuse in Montana.

Temporary Assistance to Needy Families (TANF) – Provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs.

Treatment – Treatment pertains to activities for people who have received clinical alcohol, tobacco or drug assessments indicating they are in need of a range of individualized services designed to halt the progression of the disorder.

Use – (Alcohol) Individuals who drink "socially" but do not experience problems from their alcohol use.

Violent Offender – A violent offender is a person whose current offense involves a threat of or actual harm to a victim. These offenses generally include homicide, sexual assault, robbery or assault.

Well-being – Healthy attitude, beliefs, and behavior.

Youth Risk Behavior Study (YRBS) **–** The Montana YRBS assists educators and health professionals in determining the prevalence of health-risk behaviors as self-reported by youths. In 1988, the Centers for Disease Control and Prevention initiated this process to identify the leading causes of mortality, morbidity and social problems among youth nation wide - these were identified and categorized into six risk areas: 1) behaviors that result in unintentional and intentional injuries; 2) tobacco use; 3) alcohol and drug abuse; 4) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; 5) physical inactivity; and 6) dietary behaviors. The Montana Office of Public Instruction has been involved with this survey project since 1991. The survey is voluntary and is conducted every other year in the odd years (ex. 1991, 1993) in the 6^{th} through 12^{th} grades. This alternates with the Prevention Needs Assessments which occur in even years.

YRBS – Youth Risk Behavior Study

ENDNOTES

[1] Personal conversation on March 19, 2002 between Sandy Mack, AQuest ~ Collaborative Solutions and **Roger McDaniel**, HB 83 Consultant, Substance Abuse Division Wyoming Department of Health. Co-author of Reclaiming Wyoming: A Comprehensive Blueprint for Prevention, Early Intervention, and Treatment of Substance Abuse. A Study Prepared in Response to Wyoming House Bill 83. Also, personal conversation on March 11, 2002 with **Thomas Pagel**, Director Division of Criminal Investigation Cheyenne, WY.

[2] Unpublished and preliminary data provided by **Douglas Wright** of the Office of Applied Studies, Substance Abuse and Mental Health Service Administration, at the "Winter 2001 Needs Assessment Convergence, Hyatt Regency on Capital Hill, Washington, D.C., January 11, 2001. **IN:** Addictive and Mental Disorders Division's Chemical Dependency Bureau. (Date unknown). **A Coloring Book on Montana Youths' Substance Use**. Page 1

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[154] Montana Office of Public Instruction, Division of Health Enhancement HIV/STD Education Program (September 2001). **2001 Montana Youth Risk Behavior Survey High School.** Page 9.

[155] Letter from Dennis W. Brezina, Director of Aluminum Anonymous, Inc. to Task Force Consultant and Facilitator Sandy Mack, AQuest ~ Collaborative Solutions. Dated June 4, 2002.

[156] National Highway Traffic Safety Administration http://www.nhtsa.dot.gov/people/outreach/stateleg/repaeatintoxdrivers.htm

[157] National Highway Traffic Safety Administration. http://www.nhtsa.dot.gov/people/outreach/stateleg/opencontainers.htm accessed on 7/25/02.

[158] National Highway Traffic Safety Administration. http://www.nhtsa.dot.gov/people/outreach/stateleg/opencontainers.htm accessed on 7/25/02.

[159] National Highway Traffic Safety Administration. http://www.nhtsa.dot.gov/people/outreach/stateleg/repaeatintoxdrivers.htm

[160] Letter from Jean Caplette, Coordinator from Gallatin County DUI Task Force, to Governor's Task Force on Drugs and Alcohol. Dated July 15, 2002.

[161] Letter from Ron Clem, parent, to Senator Duane Grimes. Received 4/7/02.

[162] Letter from Karen Olson Beenken, Task Force Member, to Duane Grimes. Emailed on June 18, 2002.

[163] Letter from Karen Olson Beenken, Task Force Member, to Duane Grimes. Emailed on June 18 2002.

[164] Toomey, T.L., Wagenaar, A.C. **Policy options for prevention: the case of alcohol**. Journal of Public Health Policy, 20(2):192-213, 1999.;
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From SAMSA web site: http://www.health.org/govpubs/PHD822/aar.htm accessed 6/12/02. Four studies were econometric analyses: Grossman et al. (1987) and Coate and Grossman (1985) developed estimates of the responsiveness of alcohol use by youth aged 16 to 21 years to variations in the price of alcohol;
AND
Levy and Sheflin (1983) examined the importance of cross-price effects and provided estimates of price elasticity based on demand; Wette et al. (1993) examined the relationship between price and the consumption of beer, wine, and spirits to assess changes in alcohol consumption in New Zealand as a function of increases in the price of alcoholic beverages;
AND
Ornstein and Hanssens (1985) estimated the impact of a variety of control measures on the demand for distilled spirits and beer.

Two studies examined the effects of alcohol taxes on alcohol-related problems: Cook and Moore (1993) analyzed the effect of beer excise taxes on rates of homicide, rape, assault, and robbery in the 48 contiguous United States;
AND
Saffer and Grossman (1987) examined the relationships of beer taxes and the minimum legal drinking age to traffic fatalities among youth aged 15 to 24 in the 48 contiguous United States from 1975 through 1981.
AND
Manning, Blumberg, and Moulton in 1995 found that a 10% increase in alcohol taxes would result in: Very Light Drinkers consumption would not change; Light drinkers would consume 5.5% less; Moderate drinkers would decrease 11.9%; Heavy drinkers consumption would actually increase 1.2%
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Chaloupka, Grossman, & Saffer (in press) shows that decreases in consumption of alcohol due to prices increases is especially pronounced in youth with lesser affects amongst adult beer drinkers.

[166] Letter from Steve Morris, Task Force Member, to Duane Grimes. Emailed on June 13, 2002.

[167] Memo from Dave Ohler, Montana Department of Revenue to Judy Paynter, Department of Revenue and Bill Muhs, Task Force Member. August 8, 2002. AND follow-up email asking for clarification indicates that the last beer tax increase was in 1985. However, a memo from "vjz" to Kristi Blazer, both of the law firm Luxan & Murfitt, July 15, 2002; indicates with supporting documentation (Montana Session Laws 1987 copies) the last change was made in 1987.

[168] Federation of Tax Administrators (www.taxadmin.org/fta/rate/beer.pdf) State Tax Rates on Beer (January 1, 2002) accessed on 7/11/02.

Note that a tax rate of 2.51cents per 12 oz. for 2000 appeared in: Alcohol Epidemiology Program, University of Minnesota, School of Public Health
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[169] Federation of Tax Administrators (www.taxadmin.org/fta/rate/beer.pdf) IN: Letter from Karen Olson Beenken, Task Force Member, to Duane Grimes. Emailed on June 5, 2002.

[170] Centers for Science in the Public Interest. May 1996. **State Alcohol Taxes & Health: A Citizen's Action Guide.** Page 3. IN: Letter from Bill Muhs, Task Force Member, to Duane Grimes. Emailed on July 5, 2002.

[171] Rogers, J.D., & Greenfield, T.K. (1999). **Beer drinking accounts for most hazardous alcohol consumption reported in the United States.** Journal of Studies on Alcohol, 60(6). IN: Booze News, Fact Sheet: Beer Consumption & Taxes at web site: www.cspinet.org/booze/beertax.htm accessed 5/25/02.