Local Alcohol and Drug Planning Committee Meeting

Wednesday, January 26, 2011

Members Present: Mike O'Malley, Jan Taylor, Eric Guyer, Larry Lyman, Jody Parrott, Theresa Morris. Ron Dunn, Pam Bergreen.

Guests: Rita Sullivan (OnTrack), Chris Mason (ARC), Reba Smith ARC), Keziah Hinchen (Phoenix Counseling), Kristen Hanson (CRC/Allied Health), Ed Burns ARC).

Staff: Michele Morales, Dr. Jim Shames, Becky Longie

I. Introductions

Mike O'Malley called the meeting to order and asked members and guests to introduce themselves. The November 2010 minutes were reviewed for approval. Larry Lyman moved that the minutes be approved; Eric Guyer seconded the motion; all in favor, the minutes were approved as written.

II. Treatment Updates

Suboxone Titration (CRC/Allied Health)

Kristen said as of today they have three patients enrolled in the new program (1 methadone, 2 Suboxone) and will have seven enrolled by next Wednesday. CRC plans to enroll 12-15 patients in the program. These patients hope to be off Suboxone within a year and will take part in a titration group that will be separate from other patients. These patients will be connecting with case managers from ARC/OnTrack, will have an individual counselor, and will also be able to participate in groups with their abstinence based provider.

Mike asked if CRC did blood screens for Suboxone. Kristin replied that they use urinalysis as patients come in daily for medication.

Legislation

Rita said legislation has been introduced to reduce paperwork for Addictions and Mental Health agencies. The legislation would change requirements to follow federal guidelines instead of State OAR's. She noted that the amount of time required to do paperwork (40-60%) takes away from time needed for direct service to clients.

Trauma Informed Care

Chris Mason and Reba Smith from ARC discussed trauma informed care. State AMH trauma policies differentiate between trauma informed (not specifically designed to treat symptoms or syndromes related to trauma, but are informed about, and sensitive to, trauma-related issues) care and trauma specific (designed to treat the actual consequences of trauma) care. Reba noted that ARC looked at what they were already doing and what they needed to do to provide trauma informed and trauma-specific services to their clients.

Reba provided a handout (see attachment for specifics) outlining the trauma care plan ARC has developed, which is summarized below:

Goal 1: Fully adopt an agency culture that is trauma informed.

Goal 2: Develop curriculum that will lead to full implementation of trauma-specific services by 2012.

Objective 1: Develop services to clients

Objective 2: Enhance staff ability to respond

Objective 3: Create a safe emotional and physical environment

Discussion/Questions:

· Keziah said with a smaller agency like hers (10 employees) it is simpler to train staff. She said PCS will be training all staff in both trauma informed and trauma specific services. Will be developing policies, working with the Seeking Safety program.

· Mike said at the VA if the people they're working with don't have PTSD from childhood or combat trauma, they have it from street trauma, which seems to meet the DSM criteria for PTSD. They are just now changing the curriculum so everyone gets trauma treatment (Seeking Safety). They were separating people out by diagnosis or self-selection, but based on feedback from clients they decided to provide the trauma treatment to everyone for a quarter and will study that to see if it's effective.

· Reba said OnTrack has made a cautious estimate that 80% of clients who come in for services have some sort of trauma background.

· Rita noted that state policies are changing and noted that simple things like changing when they ask clients certain questions can make a big difference in their responses. The assessment process can be brutal, with clients being asked pointed questions about sexual abuse, sexual partners, and other personal issues during their first visit. These policies are changing, and now providers can do a brief assessment to get them into treatment before getting into the more traumatic issues. When clients feel safe and comfortable with counselors/providers, which they seldom do at intake, they are more likely to answer questions about personal experiences and traumas and can work these issues through as part of the recovery process.

· Mike said the Seeking Safety program provides information and a good part of their treatment process with people is trying to get them to stay "in the present moment" and understand their behavior – and if they do understand it they may not behave the way they have in the past.

III. Prevention

<u>Budget Update and Funding</u>

Michele provided an updated 2010-2011 addictions budget, showing outcomes for each service element. She noted that there was some extra money in SE66 outpatient funding that the County contracted to the Suboxone Titration Project, which is reflected in the chart with some other small changes that were talked about recently. Michele said this chart shows outcomes; she has been talking with members individually and one thing they have asked for is more transparency around the budget and outcomes. Linking the budget with the outcomes gives an overall view and may allow us to develop more streamlined/standardized outcomes for these programs. She noted that providers must report on each separate outcome quarterly. Michele asked if anyone had more information about what we can expect for our budget for the next biennium. Mark said nobody knows at this time. When the Governor releases his

budget on Monday (January 31st) we'll be able to see the way things are going and then the Legislature will do their part, but we will certainly be facing budget cuts.

Michele said our total addictions budget is $3.3 million; $2.9 million comes directly from the state as service element funding, with the rest being a mixture of funding from eight different entities. We anticipate that the federal prevention funding, approximately $56,000 will stay the same. Gambling and Beer and Wine Tax funding are also anticipated to be stable.

Mark noted that some of the federal funding we receive depends on match, so if the state lowers general fund we also lose a portion of federal funding, so there is always a discussion about how to balance this issue. Michele said we are anticipating a flat budget for 2011-2012; all our service elements will be the same for next year until we have more information. Whatever happens with the state budget will be made public on Monday, January 31st and we will have a better idea about funding.

Discussion/Questions:

· Michele noted that for the first two quarters of this fiscal year outcomes for our A&D reports are almost all at or above state levels.

· Mike asked providers about A&D outcomes. Are the state requirements realistic? Rita said there's a committee who will be looking at outcomes and there is going to be a push to standardize outcomes more, have fewer outcomes, and make them more robust, which will give a better picture of what treatment providers do and a more accurate representation of client treatment and recovery numbers. Important elements include employment, preservation of families, retention in school, foundational – addressing domestic issues, etc. The broader we make the outcomes, the more reliant the treatment system will be.

· Mike – need simple standardized measures to demonstrate functional improvement over time, and could also include the more global issues of employment, housing, etc. Southern Oregon could be a leader in innovation if we could develop these and use them across the board.

· Rita – the OWITS data system the state is developing will allow all providers to have access to electronic records and extract data reports directly from them. Rita is on a committee looking at gap analysis for OWITS, and this is where we can imbed the data pieces we want to get out for the broad-based outcomes.

<u>Prevention</u>

Michele said Prevention makes up about 4% of the total service element funding that comes from the state, a little over $100,000 out of $2.9 million, but is clearly a very important part of the services we're providing in Jackson County. Michele noted that a new biennium is coming up and she would like the group to discuss what we've been doing in prevention and open up a discussion of what the group, and especially LADPC members, see as priorities for prevention and areas of greatest need. She said the state has been doing a thorough review of their strategic prevention framework and a couple of things they are about to suggest are increasing the target age for prevention, which currently ends at 21, to 25 and maybe change the lower age range to 15 instead of where it's been at age12. The state says this idea is based on a pretty thorough review of the evidence that there's a lot of binge drinking, among college students in particular, which accounts for a large percent of the primary and secondary problems the state is seeing. Presumably this population responds well to prevention efforts. The state also wants

prevention to be data-driven, but have not yet come out with what the priorities for prevention are from their perspective.

Michele said from her perspective she has done a lot of review of what's going on with Oregon teens using the National Wellness Survey and College Health Assessment and would like to share her thoughts and then hear what the group's priorities are. Michele sees, and keeps hearing from everyone, that we need to talk about prescription drugs and have a campaign to focus on reducing the non-medical use of prescription medication, and secondly, about marijuana. Jackson County has the second highest number of medical marijuana cards issued in the state although we have the sixth highest population Michele said these are her two suggestions for Jackson County prevention priorities, and asked people to share theirs.

Discussion/Prevention Priorities

· Jody said one thing we need to do is teach kids/adults how to "narc" on someone who is using; to teach that it's okay and how to do it – like "friends don't let friends drive drunk"

· Rita said for medical marijuana we need to change the underlying law. Can we prevent kids from getting cards, and can we follow the guidelines of the FDA, use of marijuana for the conditions it's proven to benefit, and for people with terminal illnesses that traditional medicine doesn't work for. We need to stress that this is not an "alternative" medicine. If MM remains legal, Rita would like to see doctors prescribe and follow their patients like they would with any other medication.

· Judge Crain said acceptance and cultural norms play a big part in marijuana use by kids in Jackson County and she often has parents in court who say they are applying for medical marijuana cards for their kids because of chronic pain.

· Dr. Shames said if a kid is prescribed marijuana for chronic pain, they should be followed by a pediatrician, and with adults, depending on the medical issue, maybe they should be followed by an orthopedist or neurologist and get it out of the hands of the folks that are advertising and advocating how easy it is to get a medical marijuana card.

· Rita noted but there is still the matter of education for physicians, as evidenced by the issue of opiates for pain management , but said she feels more positive about marijuana being prescribed by a doctor who follows the patient's progress and use as opposed to a clinic that hands it out and never sees the patient again.

· Keziah said she feels the prevention target age should be younger than 12, not older, based on the number of kids they see who started using at age 9 or 10.

· Mike said there is no requirement by the state for prevention education; he feels schools should be required to provide at least half an hour of drug education each week, and prevention messages need regular reinforcement.

· Theresa said there is a huge transition at 9th grade and she feels starting at age 15 is too late. Even kids going from 5th grade to middle school are facing a big transition.

· Ron said it depends on the target market we're looking at. 85% of our kids are probably not going to drink or use drugs, they're doing a great job. We probably have 7-8% that are unreachable and are going to drink or use and will not be prevented no matter what we do. So what we're really looking at is 6-7% of the youth, a large population who are going to swing between the other two groups – that's our target market, and how do we reach the kids in that

group? How do we find them and how do we approach them? Ron said in his experience schools don't have the time or energy to let people in to provide prevention education, even if the presentation is free and done by peers, it's very difficult to reach the most at-risk kids. Ron feels that the majority of these kids have parents who are already in the system, abuse alcohol and drugs, and provide a permissive norm at home. How to define who these kids are and how to target our resources to that number is the secret.

· Michele noted that prevention is traditionally broken down into three target areas: universal , selective, and targeted, and what Ron is talking about is targeted prevention.

· Eric said he thinks the targeted approach is what we should work for, otherwise the resources will be so diluted as to be ineffective. Look at kids with MIPs or kids referred by schools. He doesn't like the idea of the state limiting that by age, but he thinks we need to be very selective about who gets this intervention.

· Pam said we also need to give messages to kids and our community about what alternatives are available. Pam said many kids choose to stay clean and sober because of school music, art, and sports programs. Many of these programs are disappearing from schools because of budget cuts – what happens when kids lose those activities? It has to be more than education and "don't use"; it also needs to be what alternatives are available.

· Rita said one thing that gets ignored is cigarettes. Cigarettes are the biggest gateway for kids; kids who smoke are more likely to use anything else. Larry agreed and said the culture they hang with has a big influence on them. Ron said he once read research that said 100% of meth addicts smoked as teenagers.

Consensus about target age for prevention: LADPC members feel that starting prevention at age 15 is too late, and younger is better.

Prevention Plan

Michele referred to the draft Prevention Plan handout, which lists strategies, priorities, population, output, outcomes, outcome measurement tools, and who is responsible for each role. She noted that prevention is hard to research, but one prevention activity that has been proven ineffective is the single shot education session. That's something we don't want to waste our money on.

The Plan is based on the Center for Substance Abuse Prevention strategies, which include six strategies:

· Information dissemination

· Education

· Alternative activities

· Problem identification and referral

· Community-based process

· Environmental approaches

Michele said current illicit use is defined as use in the last 30 days, and is really high – Oregon has the highest rate of illegal drug use in the country, not including marijuana, for 11-17 year olds. Any progress we can make in bringing that down will be helpful. The last community survey of people's issues was done by the Commission on Children and Families in 2007;

they surveyed 680 people and the #1 recommended focus area for the community over the next 6 years were drug use among youth/teens. This was also the top issue people believed the community could impact and the 2nd highest issue they were likely to get involved with or support.

Michele said Dr. Shames is doing some amazing work with doctors, bringing together opiate providers to discuss responsible prescribing practices, which is a prevention activity. It's not what the state has in mind, because it doesn't involve direct service to youth, but large scale community discussions are key. She noted that state policy is sometimes difficult. State HHS issues medical marijuana cards, and county employees can't take any kind of political stand, so it's a complicated place to be. How do we promote an initiative change like Rita talked about when that may be seen as the county advocating against the state? For that reason, it's important for a community coalition to take the lead on these issues.

Judge Crain said, based on the earlier discussion about how to find the target population, that she sees the kids in her courtroom who are have A&D arrests on specific days each week. This court meets twice a week and there are usually 20 kids with their parents. She gives a simplified lecture about the effect of marijuana on brain development. She said some of the kids are actually interested and talk to her about it after the court session is over. This may be the target population we're looking for and we might create a video to be shown to these kids/families while they're in the courtroom. Mike said he's been to visit the court and there are usually other folks in there observing, so the information has the potential of getting out to a larger audience.

Michele asked the group what they thought about the two focus areas: marijuana and prescription drug use. Ron said he felt cigarette smoking was a big issue that we aren't addressing. Michele said tobacco prevention has its own funding and a totally different program setup. Jane Stevenson is the Tobacco Coordinator for the County and we might discuss some joint efforts.

The group agreed that LADPC endorses the two focus areas of marijuana and prescription drug use, and do not endorse the change to a higher target age.

IV. State Access to Recovery (ATR) Grant Update

Michele said there was a community meeting to launch the ATR grant and there were a lot of people in attendance. This grant encourages faith-based and other community agencies to provide recovery support to clients enrolled in the program. Michele said she was happy to announce that after discussion at the state level, when they talked about "free and active choice" the consumer would have, they were referring to choice of provider, not choice of service. Some providers and recovery support services have sent in their applications and Michele said if anyone present wants to apply and needs help with the process to let her know so they can get to the state as soon as possible. She said Jackson County is almost ready to begin and the state would like us to be the second county to roll out the program; Umatilla has already begun. The only thing Jackson County is missing is the Care Coordinator position; so far there have been no viable applicants for the position. This is the person who will be doing assessments and recommending services. Michele asked people to get the word out. The position is part-time, pays $15-20hour, and the applicant needs to be working towards or in possession of a CADC, and preferably connected to the recovery community.

Announcements

There will be a prescription drug forum at Public Health at 10:00 a.m. on January 12th in Building A (Public Health).

Next Meeting

The next LADPC meeting will take place on Wednesday, February 23, 2011, 4:00-5:30 p.m. in the Carpenter Room at the Medford Library.

Adjourn

The meeting was adjourned at 5:30 p.m.