THE ELEPHANT IN

VERMONT'S

LIVING ROOM:

The Impact of Substance Abuse on The State Budget*

December 2001

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Report of the Commission on Tobacco, Alcohol and Substance Abuse Addiction
To the Vermont General Assembly and the
Governor of the State of Vermont

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* The Commission would like to recognize the work of The National Center on Addiction and Substance Abuse at Columbia University; in particular, its report entitled Shoveling Up: The Impact of Substance Abuse on State Budgets (January 2001) which analyzes spending for FY 1998 and likens state spending on the burden of substance abuse to the elephant in the living room that nobody wants to acknowledge.

REPORT OF THE COMMISSION ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE ADDICTION

I. INTRODUCTION: REALLOCATING THE SUBSTANCE ABUSE DOLLAR

Substance abuse and addiction is a public health problem the people of Vermont cannot afford to ignore or underestimate. The longer we wait to provide comprehensive and effective treatment and prevention, the more we will have to pay. Indeed, the costs to society caused by substance abuse are overwhelming and inescapable. No citizen, no institution goes unburdened.

> Substance abuse and addiction is the elephant in the living room of American society. Too many of our citizens deny or ignore its presence. Abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem our nation faces: crime; cripplers and killers like cancer, heart disease, AIDS and cirrhosis; child abuse and neglect; domestic violence; teen pregnancy; chronic welfare; the rise in learning disabled and conduct disordered children; and poor schools and disrupted classrooms. Every sector of society spends hefty sums of money shoveling up the wreckage of substance abuse and addiction. Nowhere is this more evident than in the public spending of money.[1]

With this great problem, however, comes the opportunity, the necessity even, for great change, including unprecedented support for existing programs that seem to be working. What is needed at this time is no less than a shift in attitude, accompanied by a reallocation of funding.

Recent figures indicate that for every dollar spent on substance abuse in Vermont, approximately 97 cents goes to public programs affected by substance abuse, such as corrections, whereas only 3 cents goes to prevention and treatment.[2] Nearly 12 percent of our total state budget is spent on the collateral consequences of substance abuse, and only 3/10 of one percent on prevention and treatment.[3] These spending patterns are not only fiscally irresponsible, they do not do nearly enough to ameliorate the human suffering associated with the disease of substance abuse addiction. Moreover, the state does not have the capability of raising enough money to "shovel up" the entire wreckage of substance abuse.

Simply put, money spent on prevention and treatment now is money and suffering saved in the long run. This conclusion stems from a holistic view of substance abuse and addiction, one that recognizes its interdepartmental effects, as well as the need for coordinated provider services and an accessible and complete continuum of care. As policymakers, we are obligated to endorse more than just one ounce of prevention, and our efforts must be comprehensive, intense, and sustained.

II. THE COMMISSION

The Commission on Tobacco, Alcohol and Substance Abuse Addiction was established by Sec. 116 of Act No. 63 (H.485) of the Acts of the 2001 Biennial Session. (Appendix 1.)

The Commission was staffed by Maria Royle, Esq., Herb Olsen, Esq., Rachel Levin, Legislative Council, and Maria Belliveau, Joint Fiscal Office.

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[1] Shoveling Up: The Impact of Substance Abuse on State Budgets, at i (emphasis added).

[2] Id. at 73.

[3] Id.

III. THE COMMISSION'S CHARGE

The Commission was directed to:

A. Study the structure, organization, and funding of tobacco, alcohol and substance abuse programs, including existing agencies and instrumentalities of the state and nongovernmental organizations engaged in preventing and treating addictions. The purpose of the Commission was to make recommendations for the development of a coordinated, effective, and adequately funded system for preventing tobacco, alcohol and substance abuse addiction, and treating such addictions, when they occur, in a humane, caring and effective manner. More specifically, the Commission was charged with: making a recommendation as to whether tobacco trust fund monies should be spent to address alcohol and substance abuse addiction, as well as tobacco prevention, cessation and control activities; developing strategies and measurable actions directed at preventing and reducing the incidence of tobacco, alcohol and substance abuse; developing strategies and actions directed at interdicting the sale and distribution of illegal substances, including alcohol and tobacco, for underage users; and developing strategies and effective treatment techniques and programs which recognize the myriad factors and variables essential to effective treatment and rehabilitation.

B. Report its findings and recommendations to the governor and the general assembly on or before November 1, 2001. Rep. Walter E. Freed, Speaker of the House, extended the reporting requirements until January 15, 2002.

IV. MEETINGS AND WITNESSES

The Commission met seven times in 2001: September 21, October 4, October 18, November 1, November 15, November 29, and December 13.

The Commission heard testimony from a broad range of people representing the various sectors of society directly and indirectly having an interest in treating and preventing substance abuse. Witnesses consisted of consumers, including their friends and families, providers, both private and public, and other experts who work in the field. A detailed list of witnesses is contained in Appendix 2. In addition, the Commission established a web page (http://www.leg.state.vt.us/tobacco/default.htm) to receive further public input.

Major topics addressed by the Commission included:

- Funding of existing prevention and treatment programs
- Gaps in the continuum of substance abuse care
- Measuring the performance and needs of service providers
- Overview of the preferred provider system
- Opiate treatment
- Drug Intervention Docket
- Treatment programs offered by the Department of Corrections
- Community planning and prevention efforts and needs
- The burden on the state budget created by substance abuse

V. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Throughout its study, the Commission heard compelling testimony from persons in recovery, as well as from the many state and local professionals who deal with substance abuse on the frontlines. It is clear the entire community is filled with an impressive array of dedicated and courageous individuals. From their personal accounts, the Commission was able to recognize reoccurring themes and develop a broad overview of the substance abuse landscape, gaining a clearer understanding of how it is working and, more importantly, not working. In light of budgetary realities, the Commission felt it was important to address systemic weaknesses by focusing on efficiency, coordination, cost-saving, and achieving maximum return on dollars spent. From this perspective, the Commission identified problem issues and recommended solutions which may be summarized as follows:

A. Finding: Our substance abuse dollars are not being spent wisely.
Recommendations: Reallocate spending from cleaning up the wreckage caused by substance abuse to preventing and treating substance abuse and addiction, and target populations that are especially costly.

B. Finding: There is insufficient coordination and accountability within government.
Recommendation: Consider options that will allow state government to function in a manner such that there is a level of accountability and responsibility sufficient to ensure a comprehensive, effective system of alcohol and substance abuse programs.

C. Finding: The system for delivering services lacks quality measures for prevention programs and treatment services.
Recommendation: Use the preferred-provider system to ensure that programs are science-based and effective.

D. Finding: We need to promote human resource development.
Recommendation: Develop the means for assessing organizational performance and, in particular, methods to assure continuous improvement in the quality of services provided, and determine what influence the state has over providers and whether it is being used.

E. Finding: Prevention is best implemented through a comprehensive strategy, with an emphasis on community coalitions.
Recommendation: Promote the establishment of community coalitions.

F. Finding: There is no continuum of substance abuse care in Vermont.
Recommendations: Ensure there are adequate resources and facilities for: all stages of treatment, including early intervention and aftercare; all categories of consumers and, in particular, specialized services for juveniles, women, families, and senior citizens; and all types of treatment, including opiate addiction programs.

G. Finding: Some prevention and cessation programs evidence positive trends.
Recommendations: Recognize successful programs within the system, continue to support them, and apply their techniques to other substance abuse programs, as appropriate.

H. Finding: An unjustified stigma prevents many individuals from seeking the care they need.
Recommendations: Develop policy consistent with an understanding that substance abuse addiction is a disease, and balance the need to provide treatment for this disease with the need to hold individuals accountable for their actions.

I. Finding: We may need to raise revenue to support and further develop prevention and treatment efforts.
Recommendations: Through increased state coordination and quality assessment, work towards developing priorities for limited resources and, if necessary, develop revenue-raising

strategies, such as a cigarette or alcohol tax, to meet specific financial needs.

A. Our substance abuse dollars are not being spent wisely.

> The choice for governors and state legislators is this: either continue to tax their constituents for funds to shovel up the wreckage of alcohol, drug and nicotine abuse and addiction or recast their priorities to focus on preventing and treating such abuse and addiction.[4]

The cost impact of substance abuse and addiction is overwhelming. By not directly spending money on preventing tobacco, alcohol and illicit drug abuse and addiction and treating it early and effectively, we indirectly pay a much higher price through public programs left to deal with the fallout it causes. There are primarily seven budget categories burdened by the effects of substance abuse and addiction: justice (adult corrections, juvenile justice and judiciary), education (elementary and secondary), health, child and family assistance (child welfare and income assistance), developmental and mental health disabilities, public safety, and the state workforce.[5] In Vermont, recent (FY 1998) figures indicate that nearly 12 (11.9) percent of the total state budget was directed toward the substance-abuse burden on these budget categories, whereas only 3/10 of one percent of the global budget went toward substance abuse prevention and treatment.[6] Of the money being spent only on substance abuse, the numbers indicate that for every dollar spent, 97 cents was spent on the burden to public programs, and less than 3 cents was spent on prevention and treatment.[7] (See Appendix 4.)

It is estimated that for every dollar invested in treatment, there is a seven dollar return in reduced incarceration, hospitalization, sick time, accidents, and other costs to society.[8] In particular, treatment of medical problems caused by substance abuse and addiction places a huge burden on the health care system. "There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition."[9] Moreover, the disease is linked to many social problems. Over 30 people die each year on Vermont highways in alcohol-related crashes; hundreds of others are injured. Alcohol and illicit drug abuse often result in family violence and the mistreatment of children; 68 percent of domestic violence is substance-abuse related. In turn, many victims of abuse rely on illicit drugs as a means of self-medicating.

With respect to Vermont's tobacco-related costs alone, the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention estimates that, in 1999, smoking-related direct health care costs amounted to $182 million per year, and smoking-related indirect costs, such as loss of productivity, amounted to $172 million per year. In addition, smoking-related neonatal expenditures approximated $785,000 per year. Even more distressing is the fact that every year 1,000 Vermonters die as a result of smoking-related illnesses.

As reflected in the 2001 Youth Risk Behavior Survey, Vermont kids are faced with many substance abuse challenges: 43 percent of high school students drink alcohol; 22 percent have smoked cigarettes at least once in the last 30 days; 26 percent used marijuana during the past 30 days; and 3 percent have used heroin. The younger a child is when using begins, the more likely it is that that child will develop an addiction. Conversely, a person who does not begin using tobacco, alcohol, or illicit drugs by age 21 is likely never to do so.

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4 Id. at ii-iii.

5 Id. at 13.

6 Id. at 73.

7 Id.

8 Gerstein, D.R.; Johnson, R.A.; Harwood, H.J.; Fountain, D.; Suter, N.; Malloy, K. Evaluating recovery services: The California Drug and Alcohol Treatment Assessment (CALDATA). General Report and Executive Summary. Sacramento, CA: State of California, Health and Welfare Agency, 1994-95 p. (124575).

9 Substance Abuse: The Nation's Number One Health Problem, at 6, February 2001, The Schneider Institute for Health Policy, Brandeis University for The Robert Wood Johnson Foundation, Princeton, New Jersey.

Approximately 85 percent of our total (1,600) prison population has a serious substance abuse problem, and yet treatment is limited to only a few (80). As a result, for many, incarceration may interrupt an addiction, but it does nothing to cure it. It costs about $26,000 a year to imprison an individual, and an additional $3,100 per inmate for drug treatment. Because the evidence is clear that coerced treatment is as effective as voluntary treatment, the threat of incarceration can provide the needed incentive to move toward recovery, and persons convicted of crimes constitute a prime target population for treatment.[10]

RECOMMENDATIONS

1. Reallocate the substance abuse dollar: Our best investment is in prevention and early intervention.

Providing greater resources to effective prevention and early intervention programs allows us to realize almost immediate cost avoidance which will persist for a long time. In particular, we must continue to develop and support prevention and early intervention programs in our schools, such as Life Skills and Student Assistance Programs, because there we have the greatest likelihood of reaching many of our young people.

In reallocating the substance abuse dollar, the Commission feels strongly that the money presently being spent on tobacco prevention and cessation programs must be preserved and not directed toward other substance abuse programs. We do not want to jeopardize the positive outcomes evidenced by our tobacco control efforts by diluting their funding. Rather, we need to redirect the money currently being spent on the public-program burden of substance abuse towards prevention and early intervention programs.

2. Intervention should take place at every opportunity.

Most state employees who interact with the public should be aware of the signs of substance abuse. For some addicts, participation in a state-funded program such as public assistance might be the only opportunity to get treatment. Public employees should be trained and prepared to assess multiple needs, including the need for substance abuse services and, if appropriate, condition benefits on substance abuse treatment. The potential benefits are obvious. Without treatment, an addict's chances of getting and retaining a job are negligible, likely resulting in the need for continued public assistance. Likewise, when a child is taken into state custody, an opportunity arises for state employees to assess whether that child's family is in some way controlled or influenced by substance abuse and, if so, to assist those individuals with obtaining appropriate treatment. The same can be said for various other professional groups--physicians and other health care providers, members of the clergy, teachers, and law enforcement officers, for example--who should be prepared to recognize the symptoms of substance abuse and, if necessary, refer individuals to treatment.

3. We can maximize our return on investing in prevention and treatment if we target specific populations.

It is important to develop a list of priority populations that place an inordinate burden on the system and, therefore, present the greatest opportunity for cost savings. At the top of the list is the prison population.

> The next great opportunity to reduce crime is to provide treatment and training to drug and, alcohol abusing prisoners who will return to a life of criminal activity unless they leave prison substance free and, upon release, enter treatment and continuing aftercare.[11]

Strategies for treating persons within the custody of the department of corrections include providing additional therapeutic-community treatment programs and intensive substance abuse programs (ISAP), both inside and outside of prison; requiring treatment as a condition of probation; expanding the diversion and deferral

[10] Shoveling Up, at 5; The National Institute of Drug Abuse, National Institute of Health, Principles of Effective Treatment. ("Treatment does not need to be voluntary to be effective.").

[11] Shoveling Up, at ii.

programs for treatment purposes; supporting the establishment of a drug intervention docket, permitting judges and prosecutors to refer individuals to treatment, while maintaining leverage over treatment participation; and providing resources for separate adolescent facilities.

Other populations that should be targeted, in order of priority, include:[12]

- Youth in the juvenile justice system who are substance-involved.
- Reach-Up participants, and their children, whose substance abuse interferes with their ability to be self-supportive.
- Clients in the mental health system whose substance abuse problems increase the probability that they will cycle back into mental hospitals or emergency rooms.
- Parents of children in the foster care system whose abuse of alcohol or drugs interferes with their ability to care for their children at home.
- Alcohol- and drug-involved drivers.
- Substance-abusing pregnant women and their partners.
- Children of substance-abusing individuals in the criminal justice system, because those children have a greater likelihood of abusing substances and committing crimes themselves.

B. There is insufficient coordination and accountability within government.

The impact of substance abuse and addiction crosses all departmental lines. There is a distinct need for integrated efforts from various state departments, most specifically, the departments of corrections: education; health; social and rehabilitation services; prevention, assistance, transition, and health access; public safety; aging and disabilities; and developmental and mental health services. Many abusers engage in criminal conduct, are minors, have a history of family violence, develop chronic health conditions, and suffer from co-occurring disorders.

There are some instances in which departments are working together. For example, the Co-occurring Disorders Treatment Program, which offers intensive team-based outreach services, is jointly funded by the department of developmental and mental health, the department of corrections, and the office of alcohol and substance abuse. Such coordination, however, is the exception rather than the rule.

Presently, we have a fragmented and pluralistic treatment system with a collection of services offered by private practitioners, multiple state agencies, and nonprofit community-based organizations, funded by a variety of sources.

In some instances, this fragmentation also results in duplication of services, increased administrative costs, and unnecessary competition among providers for limited resources. Partially as a result of this very fragmentation, the Commission feels it was disadvantaged in its ability to quantify precisely that duplication, cost increase, and competition.

RECOMMENDATION

State government should function in a manner such that there is a level of accountability and responsibility sufficient to ensure a comprehensive, effective system of alcohol and substance abuse programs.

The Commission discussed several options for ensuring accountability and responsibility:

- Work within the existing organizational structure, recognizing that some members of the Commission, and especially the legislative members, are not satisfied that the status quo is a viable and effective option.

[12] Id. at 4-5.

- Expand upon existing state law, assigning to the office of alcohol and drug abuse accountability and responsibility for alcohol and substance abuse programs and funding.
- Create an agency of alcohol and substance abuse at the highest level of government.

Under existing Vermont law, the alcohol and drug abuse council has the authority to "make recommendations to the governor for developing a comprehensive and coordinated system for delivering effective programs, including any appropriate reassignment of responsibility for such programs [and] provide for coordination and communication among the regional alcohol and drug abuse councils, state agencies and departments, providers, consumer advocates and interested citizens." 33 V.S.A. §§ 703 and 705.

Under Vermont law, the office of alcohol and drug abuse is charged with planning, operating and evaluating a consistent and effective program of substance abuse programs, including prevention, intervention, and treatment services. See 33 V.S.A. § 706. The director also is responsible for licensing alcohol and drug counselors. Under the supervision of the commissioner of health, the director has authority to review and approve all alcohol and drug programs developed or administered by any state agency or department, except the department of education. Any federal or private funds received by the state for purposes of alcohol and drug treatment are supposed to be in the budget of, and administered by, the department of health. Id. The secretary of the agency of human services has authority and accountability for alcoholism services; and state, federal and private funds for alcoholism prevention and treatment programs, except corrections programs, are to be administered by a single governmental unit designated by the secretary. Id. at § 707.

If the General Assembly prefers to expand upon existing law, then the Commission recommends the elimination of the department-of-education and the department-of-corrections exceptions in the above-referenced provisions, and further recommends that the office of alcohol and drug abuse, or another unit designated by the secretary, exercise budgetary control over all state alcohol and drug programs. In doing so, the office would have the responsibility of making targeted and effective treatment investments with substance abuse dollars, facilitating interagency partnerships and coordination among community coalitions, and overseeing team-based research and integrated treatment.

If the General Assembly prefers to create a new agency of substance abuse, the unit should be at least at the departmental level, with the functions of the office of alcohol and drug abuse, the tobacco evaluation and review board, and other scattered functions transferred to the new department. The department would have overall jurisdiction to plan, coordinate, exercise, and evaluate substance abuse prevention, treatment and cessation programs throughout state government.

C. The system for delivering services lacks quality measures for prevention programs and treatment services.

There has been movement within the department of health to require that prevention, intervention, and treatment policies be based on scientific research and best practices. For example, all coalitions funded through the New Directions grant program were required to have a substantial portion of their programming devoted to either research-based model programs or activities that were consistent with research and prevention principles. In addition, tools for assessing the quality and value of tobacco prevention programs exist. Nevertheless, to date, many providers do not have sufficient data to form the basis of a meaningful evaluation of their programs' performance. Without such data, the state is constrained from making effective, targeted investments of limited resources.

RECOMMENDATION

Use the preferred-provider system to ensure that programs are science-based and effective.

The Commission recommends legislation specifying that the office of alcohol and drug abuse shall develop and require substance abuse programs to be science-based and consistent with best practices. In addition, the office should develop performance indicators with the twin goals of establishing greater uniformity, as well as an objective means of evaluating a program's success.

D. We need to promote human resource development.

The division of alcohol and drug abuse programs controls licensing of alcohol and drug counselors, as well as eligibility for preferred-provider status and Medicaid/VHAP reimbursement. Presently, there is a lack of certified counselors in Vermont.

RECOMMENDATION

Reinforce the preferred-provider system.

The Commission recommends legislation specifying that the office of alcohol and drug abuse shall employ national certification for the licensure of alcohol and drug abuse counselors, and also ensure that substance abuse subjects and questions are a part of licensing examinations and any other professional tests or evaluations. Further, the office shall provide intensive statewide training, continuing education classes, and program consultation with the objective of achieving the highest skill level of provider care. The system needs to function in a way that ensures that available resources are made available to those seeking treatment without endangering the existence of those services.

E. Prevention is best implemented through a comprehensive strategy, with an emphasis on community coalitions.

Community coalitions have the grassroots connections to allow them to understand the substance abuse issues specific to their particular community or region. When combined with research-based school curricula, and, in the case of tobacco, effective countermarketing strategies and enforcement of youth access laws, community coalitions are effective in influencing community values and norms. Young people are more likely to listen to their peers, families, neighbors, and teachers than to distant public officials. Without the concerted efforts of dedicated local providers, state policies would have little impact beyond the State House walls.

In Vermont, coalitions funded through the New Directions grant program have been particularly successful. For three years, 23 coalitions were funded through the department of health by a State Incentive Grant from the federal Substance Abuse and Mental Health Services Administration for the purpose of reducing alcohol and drug use among youth. All grantees were required to be part of a coalition or collaborative that represented stakeholders within the community, including prevention service providers and the general public. Strategies shown to be effective included increasing positive relationships between youth and adults, promoting youth leadership roles, and positively reinforcing good qualities and behaviors. Using tobacco funds, the department of health has continued to fund 13 New Directions coalitions.

RECOMMENDATION

The Commission recommends continued and, if possible, increased funding for the establishment and further development of community coalitions.

F. There is no continuum of substance abuse care in Vermont.

A comprehensive continuum of substance abuse care includes prevention, intervention, case management, outpatient, residential, and recovery services. (See Figure 1.) Our present system does not evidence that type of a continuum. The gaps are so great and numerous that what we really have are scattered pieces.

The greatest single contributing factor to success in treatment is length of time in the system at the appropriate intensity. If length of treatment is sufficient, treatment for substance abuse is effective 65 percent of the time. The average length of stay at some Vermont residential facilities is 2 weeks; the recovery process generally demands more. Many residential facilities have lengthy waiting lists. Aftercare and wraparound

services designed to help recovering addicts return and reintegrate into their communities are lacking, thereby increasing the chances of relapse. The state is spending money to send people to out-of-state residential treatment facilities only to return to Vermont where inadequate aftercare is provided, resulting, almost inevitably, in relapse. (Approximately $600,000 annually is spent at Conifer Park, a residential treatment facility in New York.) There are limited specialized services recognizing the unique treatment needs of adolescents, women, families, and senior citizens. Parents are frustrated they cannot get their children into secure treatment programs. To date, we are awaiting the opening of an opiate treatment center.

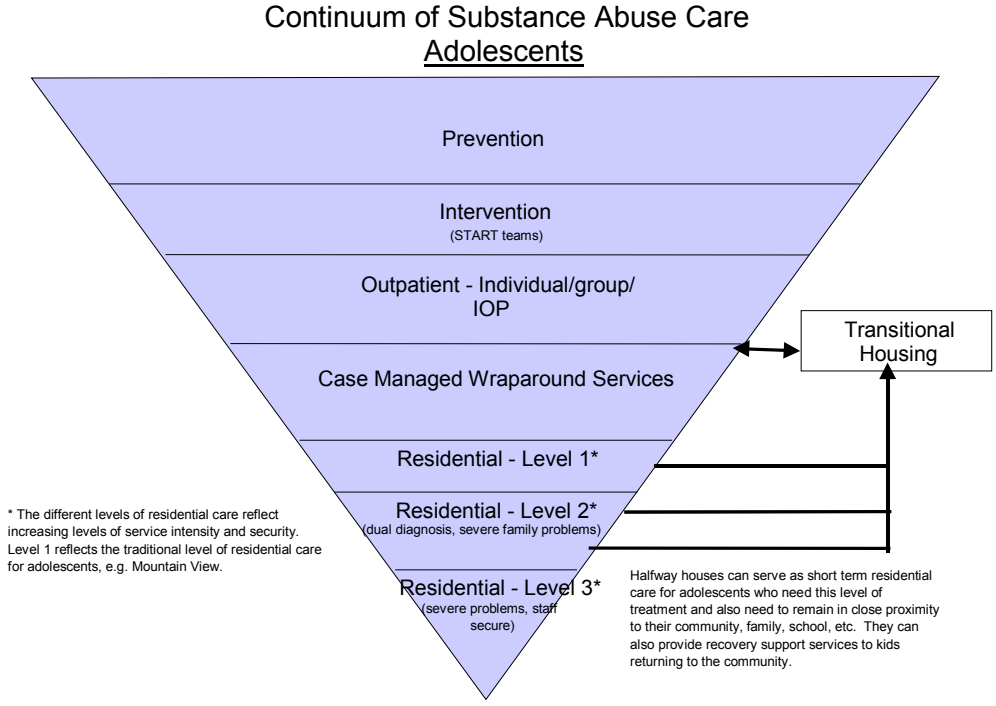
Some emergency rooms are not equipped to respond in a satisfactory and timely manner to users who are in desperate need of treatment. VHAP approval time (2 weeks) prevents immediate care. Many users and friends and relatives of users do not know where to turn when help is needed.

For addicts, the window for seeking help is often very small, and some addicts get only one opportunity. It is unacceptable for the system to miss an opportunity to help any person who voluntarily presents him or herself for substance abuse treatment. These individuals represent our greatest hope and our greatest opportunity to provide an essential public service.

Noteworthy are local programs, such as The Turning Point Club in White River Junction. The Turning Point Club is a recovery center that sponsors community outreach and educational programs for schools and local businesses. The Club is open daily from 8:00 a.m. until 10:00 p.m., averages 450 visits and hosts 17 twelve-step meetings weekly, including two teen meetings. In addition, the facility has a recreation room, meeting room, library, and childcare space. Programs such as these merit our encouragement and support. They are examples of how we can realize a significant return on a modest investment.

Our least costly residential modality is a halfway house that provides a community home for individuals in need of immediate treatment, and allow residents to receive clinical services and case management from local treatment providers. The cost is $25.00 a day per resident. The optimum capacity is no more than 16 residents at a time, and the optimum length of stay is 6 to 9 months.

Figure 1. Published by the Division of Alcohol and Drug Abuse, Department of Health



RECOMMENDATIONS

1. Ensure communities have the resources necessary for crisis-response work.

Having full-scale crisis intervention services must be one of our highest priorities, and the general public needs to be made aware of how to access such services.

2. Assist parents who seek appropriate substance abuse care for their children.

The Commission recognizes that a serious problem exists when minors are resistant to drug treatment and parents are helpless to do anything to put them in a secure substance abuse treatment facility. Though we have no specific recommendation at this time, we encourage the General Assembly to seek a solution, including consideration of an appropriate means of empowering parents to obtain involuntary treatment for their children.

3. Fund the development of greater residential-treatment capacity.

Invest in halfway houses and secure residential treatment facilities.

4. Expand the public inebriate law.

The Commission recommends that the General Assembly consider ways to broaden the public inebriate law, 33 V.S.A. § 708, to cover other drugs in addition to alcohol. In particular, provide law enforcement with the authority to place in protective custody someone who is incapacitated from using any illicit substance.

G. Some prevention and cessation programs evidence positive trends.

In addition to the apparent success achieved by twelve-step programs and support groups and the research-based prevention programs implemented by New Directions coalitions, a positive trend seems to be developing with the control of tobacco use, particularly among our young people. In FY 2000 the Legislature appropriated $6.4 million of the Master Settlement Agreement funds for a comprehensive tobacco control program and created the Vermont Tobacco Evaluation and Review Board. The program, implemented by the departments of health, education, and liquor control, was designed to be comprehensive (as recommended by the Centers for Disease Control and Prevention's Best Practices for Tobacco Control), effective (supportive of programs based on scientific research), and accountable (subject to an independent evaluation).

The board has worked with the department of health to establish community-based programs, countermarketing, smoking cessation services, statewide training programs, youth initiatives, and surveillance and evaluation. In addition, the board has worked with the department of education to implement school-based tobacco prevention programs, and with the department of liquor control to support enforcement of tobacco sales laws and training for retail clerks.

Cigarette smoking among students is decreasing. Those students answering "smoking during the past 30 days" increased from 1991 to 1995, and is now declining. As reported in the 2001 Vermont Youth Risk Behavior Survey, this is especially true across 8th and 10th grades. From 1995 to 2001, cigarette use decreased from 41 to 22 percent among 10th graders and 29 to 13 percent among 8th graders. Overall, 22 percent of students reported smoking at least once during the past 30 days, compared to 31 percent in 1999, 36 percent in 1997 and 38 percent in 1995.

RECOMMENDATIONS

1. Stay the course.

The Commission recommends the General Assembly continues to appropriate funds from the Master Settlement Agreement according to the formula passed by the General Assembly in 1999 under which

one-third of the funds were directed to tobacco prevention and cessation programs. Investments in prevention and treatment take time to mature. We need to give programs that seem to be moving in a positive direction more time in order to realize maximum success.

2. Use the Tobacco Evaluation and Review Board as a model for reviewing other programs.

Because of the apparent success of tobacco prevention and cessation programs overseen by the Tobacco Evaluation and Review Board, the Commission recommends that this model be applied to other fields. In addition, the Commission recommends that the board coordinate its efforts with the efforts of other substance abuse programs. Although some aspects of prevention and treatment are substance specific, we believe the services provided have much in common. The Commission heard testimony suggesting the correlation between various types of drug use: for example, the rate of smoking increases in social environments where alcohol is served, and tobacco is often the "gateway" through which persons enter before moving on to using and abusing other illicit drugs.

H. An unjustified stigma prevents many individuals from seeking the care they need.

> We in recovery have been part of the problem. We have both accepted and perpetuated the stigma that kept us from getting help, and that has killed millions of addiction disorder victims. By hiding our recovery we have sustained the most harmful myth about addiction disease – that it is hopeless. And without the example of recovering people it is easy for the public to continue thinking that victims of addiction disease are moral degenerates – that those who recover are the morally enlightened exceptions. We are the lucky ones, the ones who got well. And it is our responsibility to change the terms of the debate for the sake of those who still suffer.
>
> Harold Everett Hughes, United States Senator (1969-1975)[13]

Substance abuse is a chronic, relapsing health condition. When community attitudes and laws in any way prevent or discourage individuals from seeking help for substance abuse, we defeat ourselves.

RECOMMENDATIONS

1. Promote policies consistent with the understanding that addiction is a public health problem.

Reaffirm for all substance abuse the declaration made by the General Assembly in 1977 with regard to alcohol abuse, 33 V.S.A. § 701:

> It is the policy of the state of Vermont that alcoholism and alcohol abuse are correctly perceived as health and social problems rather than criminal transgressions against the welfare and morals of the public. The general assembly therefore declares that: (1) alcoholics and alcohol abusers shall no longer be subjected to criminal prosecution solely because of their consumption of alcoholic beverages or other behavior related to consumption which is not directly injurious to the welfare or property of the public; [and] (2) alcoholics and alcohol abusers shall be treated as sick persons and shall be provided adequate and appropriate medical and other humane rehabilitative services congruent with their needs.

[13] Harold Hughes' most frequently cited achievement was the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, (P.L. 91-616). That legislation established the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and, for the first time, made formula grants available to the states for the development of community-based programs.

2. Actively seek public participation from persons in recovery.

Recovering persons are our greatest resource for effectively shaping substance abuse prevention and treatment policy. Recovery members should be represented on all boards of programs that serve individuals with substance abuse problems.

3. Provide education for various professional groups.

Resistance and the unmet need for continuing education among professionals, such as, physicians and other health care providers, members of the clergy, teachers, and law enforcement officers, perpetuate the stigma of addiction by not dealing effectively with the problem. Such professionals should be prepared to recognize the symptoms of substance abuse and refer individuals to treatment, rather than to impose moral judgment or not respond at all.

I. We may need to raise revenue to support and further develop prevention and treatment efforts.

The Commission has attempted to indicate some of the priorities for state spending on substance abuse, even though we do not have some specific cost estimates. For example, we have noted target populations, such as inmates, who present sizable opportunities for cost savings if investments are made in treating their substance abuse problems. In addition, we have pointed out the lack of an effective continuum of substance abuse care in Vermont and made suggestions as to where our dollars might be well spent, such as on halfway houses and secure residential facilities. We realize, however, that the more precise we can be with respect to the specific cost savings generated by particular substance abuse prevention and treatment programs, the more compelling is the argument in favor of increased spending on existing programs or the development and implementation of new programs.

RECOMMENDATIONS

1. Reallocate first and then, if necessary, consider alternative revenue-raising strategies.

In terms of funding prevention and treatment programs, the Commission recommends first that the appropriations process be used to reallocate existing funds in a manner that prioritizes substance abuse prevention and treatment programs over shoveling up the wreckage caused by substance abuse. The Commission does not recommend, however, the reallocation of the one-third of the Master Settlement Agreement funds presently appropriated to the Tobacco Control Program. In the Commission's view, this allocation represents a sound investment. Rather, the General Assembly must use monies being spent on public programs burdened by substance abuse more efficiently by redirecting them toward prevention and treatment efforts.

Depending upon how the General Assembly decides to proceed, however, additional resources may be necessary. The reality is that at the front end of fighting substance abuse, increased spending may be a required investment. Moreover, in order for our efforts to be sustainable, we cannot have continued reliance on federal grants. Thus, as a possible funding stream, the Commission suggests the General Assembly consider such revenue-raising strategies as an alcohol or cigarette tax.

2. Require rules on data collection, evaluation criteria, and standardized forms.

It is critical for us to be able to show the nexus between substance abuse prevention and treatment programs and cost savings. There needs to be a compelling correlation between recommendations and projected outcomes. We recommend the development of any procedures or standardized criteria that will help us to achieve this end.

VI. CONCLUSION

By not spending adequate money on substance abuse prevention and treatment programs, we essentially are throwing money away. If not now, when will we be prepared to spend our resources more efficiently? Substance abuse and addiction is a serious public health problem that will only worsen over time if we do not respond to it swiftly and comprehensively. And we must work together. Each of us stands to gain to the extent we treat the problem effectively. Each of us will continue to lose if we do not.

APPENDIX 1

Act No. 63 (2001), An Act Making Appropriations for the Support of Government

Sec. 116. COMMISSION ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE ADDICTION

(a) he commission on tobacco, alcohol and substance abuse addiction is created for the purpose of studying and making recommendations for the development of a coordinated, effective and adequately funded system for preventing tobacco, alcohol and substance abuse addiction and treating such addictions, when they occur, in a humane, caring and effective manner.

(b) The commission shall consist of the following 16 members or their designees:

(1) the commissioner of health;

(2) the director of the office of alcohol and drug abuse programs;

(3) the director of tobacco control programs;

(4) the commissioner of social and rehabilitation services;

(5) the commissioner of public safety;

(6) a representative of local law enforcement selected by the Vermont Chiefs of Police Association;

(7) the chair of the Vermont tobacco evaluation and review board;

(8) the commissioner of corrections;

(9) the commissioner of education;

(10) a representative of a community-based prevention program appointed by the governor; and

(11) six legislative members, including three members from the House appointed by the Speaker of the House and three members of the Senate appointed by the Committee on Committees. Members appointed from each body shall not be all of the same political party. The chair of the commission shall be a legislator elected by the six legislative members.

(c) The commission shall have the assistance and cooperation of all agencies and instrumentalities of the state, which shall provide to the commission such information and analysis as the commission determines is necessary for the performance of its duties, subject to applicable laws of privilege and confidentiality. The commission may meet for no more than eight meetings or public hearings, and shall have such powers as are needed to carry out the purposes of this section.

(d) The legislative council and the joint fiscal office shall provide professional and administrative support for the committee. Legislative members shall be entitled to per diem

compensation and reimbursement of expenses in accordance with 2 V.S.A. § 406. Members who do not represent governmental agencies shall be entitled to per diem compensation and reimbursement of expenses in accordance with 32 V.S.A. § 1010.

(e) The commission shall report its findings and recommendations to the governor and the general assembly on or before November 1, 2001, whereupon it shall cease to exist. The report shall:

(1) identify existing agencies and instrumentalities of the state and nongovernmental organizations engaged in preventing and treating tobacco, alcohol and substance abuse addiction, together with the programs, the personnel, and the financial resources and funding sources of such entities;

(2) consider how to coordinate and make the most effective use of Vermont's resources allocated to addressing tobacco, alcohol and substance abuse addiction, including consideration of whether any organizational restructuring should take place;

(3) recommend whether tobacco trust fund monies should be spent to address alcohol and substance abuse addiction as well as tobacco prevention, cessation and control activities;

(4) make recommendations for the development of a coordinated, effective and adequately funded system for preventing and treating tobacco, alcohol and substance abuse addiction;

(5) include legislative and fiscal proposals to implement the commission findings and recommendations; and

(6) make such other findings and recommendations necessary to carry out the purposes of this section.

(f) In developing its recommendations, the commission shall include as specific goals: strategies and measurable actions directed at preventing and reducing the incidence of tobacco, alcohol and substance abuse; strategies and actions directed at interdicting the sale and distribution of illegal substances, including alcohol and tobacco, for underage users; and strategies and the development of effective treatment techniques and programs which recognize the myriad factors and variables essential to effective treatment and rehabilitation. In its deliberations, the commission shall recognize that prevention, enforcement and treatment services must meet the needs of the abusers, family and community, and that the structure and organization of tobacco, alcohol and substance abuse programs must reflect what is essential to meet these goals.

APPENDIX 2

SUMMARY OF FUNDS SPENT ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE TREATMENT AND PREVENTION

FY 2002 budgeted funds

DEPARTMENT OF STATE GOVERNMENT	Tobacco Funds	General Funds	Federal Funds	Other	Total	Comments
AHS CENTRAL OFFICE						
Projected Tobacco Spending						
Tobacco Review Board (Sec. 96)	125,000				125,000	
PATH						
Projected Tobacco Spending						
Smoking Cessation	117,548		199,292		316,840	
Projected Alcohol and Substance Abuse Spending						
Substance Abuse Treatment		1,121,991	1,902,243		3,024,234	
Families in Recovery		289,042			289,042	
HEALTH DEPARTMENT						
Projected Tobacco Spending						
Administration/Management			377,300	109,250	486,550	
Community Based Programs (Sec. 113)	1,100,000		216,000	25,000	1,341,000	
Countermarketing (Sec. 113)	1,000,000		141,500	165,000	1,306,500	
Tobacco Cessation (Sec. 113)	1,275,000		89,650		1,364,650	
Statewide Programs (Sec. 113)	200,000		62,050	40,000	302,050	
Surveillance and Evaluation (Sec. 113)	600,000		133,000	2,000	735,000	Statewide programs
School Programs			127,000	158,750	285,750	Funded with Legacy funds and foundation grants
Projected Alcohol and Substance Abuse Spending						
Treatment	500,000	2,711,138	5,374,129	660,500	9,245,767	
Prevention	575,000	859,073	1,939,903		3,373,976	
Youth Initiative	116,000		117,333		233,333	Outpatient substance abuse treatment to youth who are at risk and need intervention
New Directions Program	250,000				250,000	May be used to replace a portion of the "New Directions" grant that was used for similar purposes.
DEPT. OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES						
Projected Alcohol and Substance Abuse Spending						
Medicaid Exp. for substance abuse		213,775	362,439		576,214	Medicaid expenditures for people with substance abuse problems served in CMHCs
Adolescent Case Mgt/Spec. Rehab			253,828	149,714	403,542	
co-occurring Disorders Program		113,940	203,060	125,000	442,000	

SUMMARY OF FUNDS SPENT ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE TREATMENT AND PREVENTION

FY 2002 budgeted funds

DEPARTMENT OF STATE GOVERNMENT	Tobacco Funds	General Funds	Federal Funds	Other	Total	Comments
Youth Initiative (Sec. 280b(a)(1) and (2))	87,500	175,000	148,349		410,849	Funds 6 Youthful Corrections Service Specialist positions to provide intensive supervision and service to youth on probation. Also funds outpatient substance abuse treatment for up to 75 youthful offenders served by youthful corrections service specialists.
Substance Abuse treatment Pgm		345,362	288,000		633,362	
Substance Abuse Residential Treatment		487,344			487,344	
DEPT. OF SOCIAL AND REHABILITATION SERVICES						
Projected Alcohol and Substance Abuse Spending						
Youth Initiative- Facility for Girls (Sec.280b(b)(2))		225,000	255,000		480,000	Establish a 8 to 10 bed, staff secure residential substance abuse facility for girls in SRS custody.
Substance Abuse Boys Res. Home		376,000	424,000		800,000	
Drug Testing		10,800	97,200		108,000	
Substance Abuse Certificate Training		20,000			20,000	
Substance Abuse Counselor, Burlington		23,750	23,750		47,500	
DEPARTMENT OF EDUCATION						
Projected Tobacco Spending						
Tobacco Prevention (Sec. 162)	925,000				925,000	Utilizes $175,000 to support four positions and assoc. operating expenses in Dept. for administration and regional collaborative support and $750,000 grants to schools.
Projected Alcohol and Substance Abuse Spending						
Substance Abuse Prevention		10,000	1,704,346		1,714,346	Funds One position and assoc. operating expenses as well as $1.8 million in grants to local community organizations.
Alcohol & Highway Safety			175,000		175,000	
DEPARTMENT OF PUBLIC SAFETY						
Projected Alcohol and Substance Abuse Spending						
Byrne Formula Grant Program			1,308,000		1,308,000	Provides funding to staff and equip multi agency VT Drug Task Force
Local Law Enforcement Block Grant			50,000		50,000	Funds highway enforcement efforts focused on transportation of illegal drugs and Rutland County law enforcement agencies to combat influx of heroin and other illicit drugs.
Marijuana Eradication			50,000		50,000	Allows Dept to investigate marijuana cultivation crimes and eradication.
DEA Drug Task Force			9,461		9,461	Assists or investigates Federal Drug Crimes
DUI Enforcement Program				744,109	744,109	Special DUI Funds-Supports 16 dedicated troopers for DUI enforcement.

SUMMARY OF FUNDS SPENT ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE TREATMENT AND PREVENTION

FY 2002 budgeted funds

DEPARTMENT OF STATE GOVERNMENT	Tobacco Funds	General Funds	Federal Funds	Other	Total	Comments
Stop Teen Alcohol Risk Team (START)			45,000		45,000	Multi-agency response team dedicated to reduce teen alcohol consumption.
Ed- Drug Abuse Resistance Educator			7,300		7,300	DARE training and materials
Drug Task Force/Leahy			399,120		399,120	Funds five detective trooper positions to investigate heroin distribution.
Community Heroin Interdiction Project		230,000			230,000	One-Time funds support heroin interdiction efforts by local law enforcemen
Safe Highways Accident Reduction Program			250,000		250,000	Supports county-based SHARP teams.
VT Law Enforcement Challenge			34,000		34,000	Encourages police agencies to implement various highway safety initiatives
Alcohol Detection Equipment			15,000		15,000	Pays for hand-held breath testing equip and data master infrared testers.
DUI Resource Attorney			58,000		58,000	Attorney located in State's Attorney office to work to enforce DUI laws.
DUI Forfeiture and Impoundment Attorney			45,000		45,000	Attorney in State's Attorney office to impose vehicle sanctions in DUI cases.
Law Enforcement Liaison (LEL)			50,000		50,000	Position to encourage police agency participation in highway safety program.
Training Officer			38,365		38,365	Officer provides highway safety training across VT.
Community Traffic Safety Prg (CTSP)			83,350		83,350	Local highway safety training incl. discouraging drinking and driving.
Dept of Education Youth Programs			224,000		224,000	Youth oriented traffic safety education programs.
Stay in the Picture Public Ed Prog.			75,000		75,000	A victim of DUI talks to high school students about dangers of DUI.
Emergency Nurses CARE			12,000		12,000	Educates all Vermonters about effects of alcohol and other drugs.
VT Network of Employers for Traffic Safety			58,700		58,700	Partnership with VT employers to promote safe driving habits.
Public Information Officer			52,600		52,600	Position in charge of helping to publicize driver behavior issues.
Alcohol Programs Assessment			20,000		20,000	Panel of 5 experts will evaluate Vermont's alcohol safety program.
Traffic Court Judges Training			4,500		4,500	Training for VT Traffic Court Judges.
DUI Enforcement Program						
Local Enforcement Grant program				450,000	450,000	DUI Special Funds-Local law enforcement efforts to reduce DUI.
Coordinator of Alcohol Traffic Safety Pgm.				50,000	50,000	Position to monitor and coordinate all alcohol traffic safety activities.
TOTAL DEPT OF PUBLIC SAFETY ALCOHOL SPENDING		230,000	2,889,396	1,244,109	4,363,505	
DEPARTMENT OF LIQUOR CONTROL						
Projected Tobacco Spending						
Enforcement (Sec. 65)	309,000				309,000	
TAX DEPARTMENT						
Projected Tobacco Spending						
Enforcement/Compliance	58,000				58,000	Funds one compliance position to monitor Non-Participating Manufacturers
ATTORNEY GENERAL						
Projected Tobacco Spending						
Enforcement/Compliance	290,000				290,000	Includes funding for Non-Participating Manufacturers enforcement position

SUMMARY OF FUNDS SPENT ON TOBACCO, ALCOHOL AND SUBSTANCE ABUSE TREATMENT AND PREVENTION

FY 2002 budgeted funds

DEPARTMENT OF STATE GOVERNMENT	Tobacco Funds	General Funds	Federal Funds	Other	Total	Comments
JUDICIARY						
Projected Alcohol and Substance Abuse Spending						
Drug Intervention Docket (Sec. 280d)		82,000			82,000	One time approp. to develop a plan for drug court. NOTE: ALL BUT $27,333 HELD BY ADMIN FOR POSSIBLE BUDGET REDUCTION
Home Studies and Forensic Evaluations				30,000	30,000	These studies and evaluations are ordered as needed by Judges in Family Court
TOTAL STATE GOVERNMENT SPENDING	7,528,048	7,294,215	17,503,768	2,709,323	35,035,354	
PRIVATE SECTOR SPENDING ESTIMATE						
Projected Alcohol and Substance Abuse Spending						
Out-of-pocket				2,380,000		
Private Insurance				5,460,000		
Other Private				790,000		
Total Private Sector Spending Estimate				8,630,000	8,630,000	Based on ratio of spending in "Spending on Mental Health and Substance Abuse Treatment, 1987-1997, Health Affairs, 19/4
TOTAL SPENDING	**7,528,048**	**7,294,215**	**17,503,768**	**11,339,323**	**43,665,354**	
TOTAL SPENDING ON TOBACCO					**7,845,340**	
TOTAL SPENDING ON ALCOHOL AND SUBSTANCE ABUSE					**35,820,014**	

APPENDIX 3

Commission on Tobacco, Alcohol and Substance Abuse Addiction

Witness List

Allen Aiken, Program Director, Drug and Alcohol Program, Tri-County Substance Abuse Services; President, Treatment Providers Association

Angela Baker, Tobacco and Control Programs Manager, American Lung Association of Vermont

Mark Beresky

Christopher Berini

Lori Best

Bob Bick, Director of Adult Behavioral Health Services, Howard Center for Mental Health; VT Council of Developmental and Mental Health Services

Warren Bickel, Ph.D., Director, University of Vermont Research Treatment Clinic for Heroin Addicts; Interim Chair of Psychiatry Department

Laurie Bland, Delinquency Prevention Coordinator, Juvenile Justice Team Prime Family Resources

Jason Bongiorno, Smoking Prevention

John Brumsted, M.D., Chief Medical Officer, Fletcher Allen Health Care

Kitty Canfield, Student Assistance Professional, Rutland High School

Marie Cecchini, Executive Director, Narconon

Todd Centybear, Executive Director, Howard Center for Human Services

Christine Dawson, Coordinator, Rutland Area Prevention Coalition

Nicole Dewing, Vermont State Employees Association

Alice Diorio

Linda Eastman, Director, Central Vermont Substance Abuse Services; President, Vermont Substance Abuse Coalition

Jennifer FauntLeRoy, M.D., Medical Director Psychiatric Services, Rutland Regional Medical Center

Jim Fuller, Law Enforcement Representative

Karen Gannette and Avery Cleary, Rutland United Neighborhoods

Joe Garbelli, Director, Burlington Emergency Homeless Shelter

Angela Geiger, Director of Strategic Initiatives, American Cancer Society Quitline Program

Karen Gennette

Clay Gilbert, Director, Adult Substance Abuse Services, Rutland Mental Health Services

Diana Harrington, Friends of Recovery

Debby Haskins, Executive Director, Association of Student Assistance Professionals of Vermont

Mark Helijas, The Turning Point Club, White River Junction

Sue Holden, Smoking Cessation

Howard Hood, Coordinator of Adolescent Services, Central Vermont Substance Abuse Services

Tom Huebner, CEO, Rutland Regional Medical Center

Burt Klevens, Washington County Youth Bureau

Larry Kumpf

Fran Levine

Lisa Levesque

Diane Matthews, Smoking Cessation Coordinator, Northeastern Regional Hospital

Dennis McBee, New Directions Coalition, South Burlington

Eloise McGarry, Coordinator of Support Services, Rutland City Schools

Mark Monson, Rutland Mental Health Services

Jamie McGurn, local coalition on tobacco prevention and cessation, St. Albans

Sarah Monroe, Friends of Recovery

Tim Moran

Joellen Mulvaney, New Directions for Barre

Robert G. Newman, M.D., M.P.H., Professor of Epidemiology and Social Medicine and Professor of Psychiatry at the Albert Einstein College of Medicine in New York

Jason Nokes, Law Enforcement Representative

Rick Palmisano, President and CEO, Brattleboro Retreat

Darrilyn Peters, Administrator, Tobacco Evaluation and Review Board

John Pratt, State Coalition on Substance Abuse and Older Vermonters

Layla Ray

William Shakespeare, Director, Substance Abuse Services, Health Care Rehabilitative Services for Windsor and Windham Counties; Research Associate, Dartmouth Medical School, Department of Psychiatry

Rose Sheehan, Smoking Cessation

Joan Spaulding, R.N., Emergency Room Nurse, Rutland Regional Medical Center, Community Programs Specialist, Rutland County Sheriff's Department

Shelly Sweet

Wendy Wilton, Rutland First

Peg Young, R.N., Adult Tobacco Cessation Coordinator, Rutland Regional Medical Center

Gladys Zelman, Residential and Outpatient Services for Chemical Addiction, Maple Leaf Farm and Maple Leaf Counseling

Chris Zern

STATE GOVERNMENT

Department of Corrections
John Gorczyk, Commissioner
Thomas Powell, Director, Criminal Services
Richard Powell, Director, Addiction and Violence Services
Christopher Dinnan, Community Resource Coordinator
Scott Graham, Out-patient Programs
Mike Jones, Therapeutic Community Residential Programs
Dave Bellini, Service Team Leader, Chittenden County
Glenn Boyd, Community Correctional Officer, Burlington
Mel Chamberlain, Probation and Parole Officer, Burlington
Scott Decatur, Community Correctional Officer, Burlington
Laura Mumley, Probation and Parole Officer, Burlington
Tom Terenzini, Community Correctional Officer, Rutland
Carl Yalicky, Parole Officer, Burlington

Office of Court Administrator
Lee Suskin, Court Administrator
Sally Fox, Director, Family Court Operations

Vermont District Court
The Honorable Paul Hudson, Windsor District and Family Court
The Honorable Benjamin Joseph, Grand Isle District Court

Office of Defender General
Mathew Valerio, Defender General

Department of Developmental and Mental Health Services
Susan Besio, Commissioner

Department of Education
Doug Dows, Director, Safe and Healthy Schools
Matt Myers, Assistant Director, Safe and Healthy Schools

Department of Health
Jan Carney, M.D., Commissioner
Tom Perras, Director, Office of Alcohol and Drug Abuse Programs

Agency of Human Services

John Dick, Prevention, Assistance, Transition and Health Access

Department of Liquor Control
Michael Hogan, Commissioner
Melanie Boutin, Investigator

Department of Public Safety
James Walton, Commissioner
Francis X. Aumand, III, Director, Criminal Justice Services

Department of Social and Rehabilitative Services
William Young, Commissioner

Department of State's Attorneys
Jane Woodruff, Director

Joint Fiscal Office
Maria Belliveau, Associate Fiscal Officer
Steve Kappel, Fiscal Analyst

Legislative Council
Herb Olson, Legislative Counsel
Maria Royle, Legislative Counsel

APPENDIX 4

The Summary of State Spending on Substance Abuse (1998) published by the National Center on Addiction and Substance Abuse at Columbia University can be viewed at the following web address:

http://www.casacolumbia.org/usr_doc/state/Vermont.pdf

Commission on Tobacco, Alcohol and Substance Abuse Addiction

/s/
James P. Leddy, Co-chair

/s/
Thomas F. Koch, Co-chair

/s/
John H. Bloomer

/s/
Frank M. Mazur*

/s/
Nancy I. Chard

/s/
Michael C. Vinton

Jan Carney

/s/
Christine Dawson

Karen Garbarino

John Gorczyk

Raymond McNulty

/s/
Steve McQueen

Thomas Perras

/s/
Roger Secker-Walker

James Walton

William Young

* Representative Mazur's comments and reservations are in the attached letter, dated January 2, 2002.

REP. FRANK M. MAZUR
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www.frankmazur.com
Vice-Chair House Appropriations
January 2, 2002

Sen. James Leddy, Co-Chair
Rep. Tom Koch, Co-Chair
Commission on Tobacco, Alcohol and Substance Abuse Addiction

Re: Position on Report

I support the commission's report with the exception of the recommendation that the Master Settlement Agreement tobacco money given to Vermont should be preserved for tobacco related activities and not used for substance abuse prevention, cessation and rehabilitation initiatives.

Vermont has serious substance abuse in our schools and communities and inadequate resources for early prevention and treatment. Though the Commission recommends "reallocating existing funds in a manner that prioritizes substance abuse prevention and treatment," there may be a need for more revenue. It's vital that Vermont must have an effective prevention and intervention program. However, this state has limited financial resources to meet the needs identified by the Commission.

I believe tobacco money should be spent to address addiction whether it's tobacco, alcohol or substance abuse. Though tobacco has terrible health consequences, alcohol and substance abuse are far more devastating to Vermonters whose rehabilitation is vital because many are young and in crisis.

As the Commission recommendations are considered by the legislature and the reallocation of resources occurs, any short fall in funding substance addiction programs should be met with Master Settlement Agreement tobacco money and our funding level should be cost effective with measurable results.

Sincerely,

Rep. Frank Mazur

We are deeply committed to building on positive and successful interventions that will address the adverse public health impact that addictions cause and we strongly support the efforts of the Commission on Tobacco, Alcohol and Substance Abuse to more fully address these issues. We support all of the summary findings in the Report of the Commission with two notable exceptions.

We take very seriously our fiduciary responsibility to be good stewards of public funds. To characterize our spending on addictions as unwise needlessly casts a negative tone on our work, and does not accurately portray the diligent and successful efforts of many individuals and organizations to address this public health issue. To be clear, we have no disagreement with the intent behind "Summary Finding A". Surely we must do more to prevent addictions from occurring. The challenge will be to do so, while sustaining needed investments for treatment at the same time in light of limited resources.

"Summary Finding B" claims that no one is in charge of our efforts to combat addiction issues. We believe there is ample accountability for these efforts in Vermont, and that continued coordination among state agencies is the rule, not the exception. The report places high emphasis on structural remedies, such as creating a new state agency, to solve public health issues. Yet, there is no evidence that demonstrates the correlation between such changes and improvements in outcomes.

Again, there are many excellent ideas in the report from the Commission. We whole-heartedly agree that this is a top priority for Vermont and that we must work together if we are to address this important issue. In no way will this report diminish our very strong resolve to work with Legislators and others to address this major public health issue. We look forward to collaborative discussions on this topic.

/s/_____
Jan K. Carney, M.D., Commissioner
Department of Health

/s/_____
Karen Garbarino, Director
Tobacco Control Programs

/s/_____
Thomas Perras, Director
Alcohol and Drug Abuse Programs

/s/_____
William Young, Commissioner
Social and Rehabilitative Services

/s/_____
James Walton, Commissioner
Department of Public Safety

/s/_____
John Gorczyk, Commissioner
Department of Corrections

/s/_____
Ray McNulty, Commissioner
Department of Education