Maine Office of Substance Abuse

OSA

Report to the Joint Standing Committees of
Health & Human Services and Legal & Veterans Affairs

Funding
the Efficient and Effective Delivery of
Substance Abuse Prevention and Treatment Programs

LD 1838/RESOLVE Chapter 142

Executive Summary

January 1, 2007

INTRODUCTION

This report is submitted in response to LD 1838/RESOLVE Chapter 142, directing the Office of Substance Abuse to study the potential use of liquor license fees and liquor taxes to fund efficient delivery of substance abuse treatment and prevention programs. In detail, this resolve calls for a study of:

- Potential sources of funding for the efficient and effective delivery of substance abuse prevention programs, including, but not limited to
  - Increasing liquor licensing fees based on sales volume,
  - Increasing the taxes levied on liquor,
  - Public-private partnerships, and
  - Using money from the revenue-sharing agreement between the State and the private distributor who wholesales spirits listed for sale by the State Liquor and Lottery Commission.
- The current funding for substance abuse prevention and treatment programs offered in the State.
- The adequacy of substance abuse prevention and treatment programs offered in the State.
- The best practices for the delivery of substance abuse prevention and treatment programs.
- Industry-funded programs.

A literature review of publications from government, industry, and the substance abuse field was performed to determine the best practices in substance abuse prevention and treatment, as well as to uncover current needs specific to Maine. Additionally, reviews of other state's alcohol policies concerning taxation, licensing fees, and other policies that generate funds dedicated to prevention and treatment was performed using similar sources. Data concerning alcohol production, consumption, and current tax revenue were collected from both governmental and alcohol-industry reports. Methodology governing specific analyses and calculations can be found in the Appendices of the full report.

This summary provides an overview of each chapter of the full report, in addition to several tables and graphs designed to quickly convey important concepts and data. For more in-depth information, please refer to *Funding the Efficient and Effective Delivery of Substance Abuse Prevention and Treatment Programs LD 1838/RESOLVE Chapter 142: Full Report* available at the Maine Office of Substance Abuse or online (see back cover).

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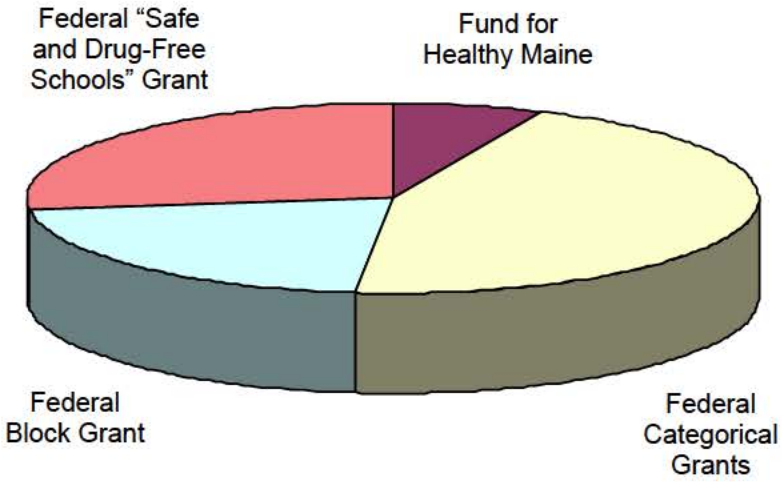
Current Funding for Prevention

Table 1 SFY 2006 Allocations		
Funding Source	**Funding**	**% of Total**
State General Funds	**$0**	0.0%
Fund for Healthy Maine	**$387,842**	6.5%
Federal Categorical Grants		
One ME Contracts (ending Sept 06) *$938,237*		
Other Prevention Contracts *$1,745,212*		
Total	**$2,683,449**	45.2%
Federal Block Grants	**$1,258,304**	21.2%
Non-OSA Funds	**$0**	0.0%
Fed. Safe and Drug-Free Schools Grant	**$1,601,556**	27.0%
Total	**$5,931,151**	100.0%



Current Funding for Treatment

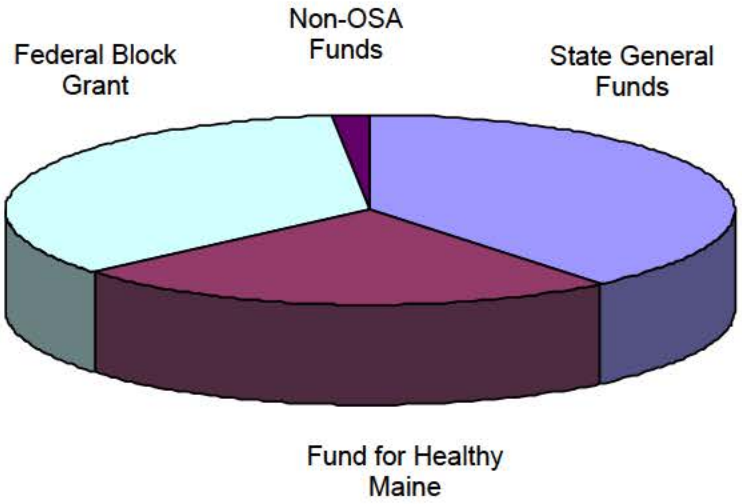


Table 2
SFY 2006 Allocations

Funding Source	Funding	% of Total
State General Funds	**$5,131,728**	39.1%
Fund for Healthy Maine	**$3,221,341**	24.5%
Federal Categorical Grants	**$0**	0.0%
Federal Block Grant (SAPTBG)	**$4,555,352**	34.7%
Non-OSA Funds		
Department of Corrections Grant	**$232,850**	1.8%
Total	**$13,141,271**	100.0%

In addition to money channeled directly to prevention and treatment providers, $4,083,273 in SFY 2006 was also directed towards other service contracts that support the substance abuse infrastructure. These contracts fund projects such as the Juvenile Drug Court, the Maine Youth Drug and Alcohol Use Survey (MYDAUS), the Parent Media Campaign, grant writing, program evaluations, and interactive databases for both prevention and treatment providers, among others.

Medicaid also contributes substantially to treatment, spending $24,506,395 in SFY 2004 (the most recent reliable data). The majority of this money (40.8 percent) covers hospital services related to substance abuse.

Best Practices in Prevention

An evidence-based practice is "a program or policy supported by a rigorous outcome evaluation clearly demonstrating effectiveness."

One of the most widely-used sources for evidence-based practices is SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), formerly the National Registry of Effective Programs. NREPP is currently being revised and expanded, and the new system has not been entirely unveiled as of the publishing date of this report. NREPP formerly performed evaluations on prevention programs in order to create a database of "model programs." This NREPP database has been utilized by OSA, and many of OSA's grantees have either adopted these programs in their entirety or based their efforts largely upon them. While it seems that many of their criteria will remain similar, the new NREPP will not seek to designate specific programs as models, "but rather will provide useful information on evidenced-based interventions to a wide range of decision-makers at the local, state, and national levels." The intention is to allow more room for innovation and focus more attention on specific behavioral outcomes of certain interventions. This change mirrors the evolution of prevention as a field, in that it is moving away from a restrictive and less evidence-based model-program approach.

Table 3
NREPP Criteria for Best Practices

- Degree to which outcome measures were selected based on theory or a logic model
- Reliability of outcome measures
- Validity of outcome measures
- Nature and quality of the comparison group/condition
- Standardized data collection efforts
- Degree of data collector bias
- Appropriateness of chosen data analyses selected and used
- Research design method used to assess the intervention

Additional Criteria

- Incorporation of multiple strategies in multiple domains
- Inclusion of environmental strategies
- Participation in a continuum of services that encompass prevention, intervention, treatment, and recovery
- Involvement in all sectors of the community
- Addressing the needs of all people across the life span
- Using the risk and protective factor model
- Inclusiveness in working with diverse cultures and identities

Best Practices in Prevention

Table 4 Types of Evidence-Based Practices	
Environmental / Public Health Strategies	
Policy	Increasing the price of alcohol Raising the minimum legal drinking age Regulating sales Strengthening Minimum Legal Drinking Age (MLDA) laws Mandating seller/server training Improving zoning ordinances regarding alcohol outlet location
Enforcement	Enforcing underage drinking laws Enforcing BAC/drunk driving laws Compliance checks Sobriety checkpoints
Changing Community Norms	Providing alternatives to substance use Peer-programs (set a non-use example) Media Campaigns
Changing Physical Environment	Decreasing outlet density Lighting dark places where use or sale may occur Reducing alcohol advertising Instituting "safe ride" programs or providing cheap taxi rides.
Universal / Selective Strategies	
Education	When used in tandem with other strategies (otherwise effectiveness has not been demonstrated)
Skill-Building	Life-skills training Parenting programs
Indicated Strategies	
Early Intervention	
Substance Abuse Treatment	

Environmental approaches—those that seek to change the physical and social environment in order to increase protective factors and decrease risk factors—are the most supported by research in terms of effectiveness. Other, more traditional practices—universal (targeting the whole population), selective (targeting high-risk individuals), and indicated (targeting individuals showing signs of substance abuse) are also backed by research, but to a lesser extent. It is important, however, to not discount the importance of maintaining such strategies, so that individuals not reached by environmental methods are not left out in the cold. Such individuals may include school drop-outs and rebellious youth, high-risk individuals that require more targeted prevention efforts.

Price-Related Prevention Strategies

Since a focal point of this study relates to raising revenue for substance abuse services, special attention is warranted to price-related prevention strategies. Numerous studies have shown that increasing the price of alcohol—typically done by raising the alcohol tax—is associated with a decrease in alcohol consumption and abuse.

This makes sense given the basic economic concept that the more expensive a product is, the less likely it is that consumers will purchase it. While there has been some debate about whether or not there are other factors involved with alcohol prices and consumption (e.g. demographic shifts, social norms, and addiction), there has been a substantial amount of research that illustrates that alcohol consumption does in fact decrease when prices go up, particularly among price-sensitive groups such as youth.

Logically, if alcohol consumption decreases, the negative effects of excessive alcohol consumption should decrease as well. This turns out to be true, as the research shows that in areas where alcohol prices went up, its negative effects on health and well-being also dropped.

Price Increases, Decreased Alcohol Consumption, and a Healthier Community

- The Swedish government cites increased alcohol excise taxes as the key factor in reducing per capita consumption of alcohol by 21 percent between 1976 and 1983.
- Cook and Tauchen have estimated that a doubling of the federal alcohol excise tax would reduce the mortality rate by 20 percent, preventing 6000 deaths annually nationwide.
- Hollingsworth, et al. predict that a $1.00 increase per six-pack of beer would decrease the prevalence of 20-year olds engaged in frequent and/or heavy drinking by 24.4% for males and 13.1% for females. They continue to estimate 1,490 deaths would be prevented as a result of this reduction, the total years of life lost cut by 31,130. The higher the tax hike, the greater the benefits.
- Increased price affects not only light and moderate drinkers, who account for about half of all alcohol-related problems, but heavy drinkers as well. One study estimated an 8 percent decrease in monthly binge-drinking episodes in response to a 10 percent increase in price. Additionally, Duke University researchers have found a link between increased state liquor taxes and decreases in problems related to heavy drinking such as liver cirrhosis and alcohol-related crash deaths.
- The National Bureau of Economic Research has concluded that raising the price of alcohol slightly (e.g. 10 cents per six-pack of beer) could reduce underage drinking as much as would raising the minimum legal drinking age one year.
- Increases in price have also been linked to decreases in transmission of STDs, as well as higher graduation rates at both the high school and college level.
- A 10 percent increase in the price of alcohol could reduce drunk driving fatalities overall by 5 to 10 percent, youth drunk driving fatalities by 7 to 17 percent.

Economists call this inverse relationship between price and consumption the product's *price elasticity*. This equation allows us to predict how much consumption of a product will decrease due to a specific price increase.

$$\textit{Price Elasticity} = \frac{\%\text{ change in quantity}}{\%\text{ change in price}}$$

This study uses Leung and Phelp's conservative, and widely-accepted, price elasticity rates of:

Beer	-0.3
Wine	-1.0
Spirits	-1.5

This means that for every 1 percent increase in price, beer consumption will decline 0.3 percent, wine consumption will decline 1 percent, and spirits consumption will decline 1.5%.

The most common ways that a price increases is implemented as a prevention strategy are through state control of alcoholic sales price or increasing alcohol taxation.

Maine could implement such an evidence-based practice for spirits by increasing the prices set by the Bureau of Alcohol Beverages and Lottery Operations, however this would not affect other types of alcohol as they are not under state control. The most consistent way to implement this strategy, therefore, would be to raise the premium tax on alcohol as this tax is levied on all types of alcohol beverages. Studies have shown that prices are usually marked up by the distributor and the retailers anywhere from 7.5 to 30 percent above the value of the tax, therefore an increased tax would not have to be outlandish in order to have an impact on consumption.

Table 5
Estimated Impact of Five Possible Alcohol Tax Increases on Maine Alcohol Consumption

Premium Tax Increase	Product	Current Tax (per gallon)	New Tax (per gallon)	Consumption Decrease (gallons)	Consumption Decrease as a Percentage
Penny Per Drink	Beer	.35	.46	-101,204	**-0.34%**
	Low-alcohol Spirits	1.24	1.35	-3,255	**-0.34%**
	Table Wine	.60	.86	-33,252	**-0.97%**
	Spark. Wine	1.24	1.50	-2,323	**-0.97%**
	Totals			**-140,033**	**-0.41%**
Adjust for Inflation	Beer	.35	.62	-248,409	**-0.83%**
	Low-alcohol Spirits	1.24	1.84	-17,756	**-1.85%**
	Table Wine	.60	1.66	-135,565	**-3.95%**
	Spark. Wine	1.24	1.40	-1,429	**-0.6%**
	Totals			**-403,160**	**-1.17%**
Nickel per Drink	Beer	.35	.88	-487,618	**-1.64%**
	Low-alcohol Spirits	1.24	1.77	-15,684	**-1.64%**
	Table Wine	.60	1.88	-163,702	**-4.77%**
	Spark. Wine	1.24	2.52	-11,435	**-4.77%**
	Totals			**-678,438**	**-1.97%**
Dime per Drink	Beer	.35	1.42	-984,436	**-3.31%**
	Low-alcohol Spirits	1.24	2.31	-31,665	**-3.31%**
	Table Wine	.60	3.16	-327,403	**-9.54%**
	Spark. Wine	1.24	3.80	-22,869	**-9.54%**
	Totals			**-1,366,373**	**-3.97%**

Best Practices in Treatment

Like substance abuse prevention, treatment effectiveness is, in the end, measured in terms of outcomes. Outcomes such as reduced alcohol and other drug (AOD) use, decreased criminality, increased employment, attainment of adequate and socially supportive living arrangements, improved physical health, and improved mental and social health are commonly used to gauge the effectiveness of a treatment.

Unlike substance abuse prevention, however, in which best practices are proven to work across populations, substance abuse treatment is a more individual-based practice. Effectiveness depends on a number of factors specific to the individual client including severity of the substance abuse problem, degree of motivation, presence of social support, and existence of co-occurring illnesses or other physical/social issues. Because of this, no single treatment modality can be said to be superior or effective for everyone.

NIDA's Guiding Principles

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available. "Because 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."
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use. Including other medical, psychological, social, vocational, and legal problems.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that at least 3 months in treatment is usually needed before significant improvement occurs.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. This includes increasing motivation, building skills, and changing the client's attitude towards alcohol and/or other drugs.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Helpful medications include Methadone, levo-alpha-acetylmethadol (LAAM), Naltrexone, nicotine replacement products, Bupropion, Buprenorphine, and many others.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. "Patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder."
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Even though treatment is much more individualized than prevention, there are still several evidence-based practices that have demonstrated effectiveness among a large portion of the treatment population. Following are eight popular examples of such practices.

- **Cognitive-Behavior Therapy (CBT):** Helps the client recognize their problem and understand what is necessary to overcome the problem. Skills training falls into this category, as does stress management, assertiveness training, and relapse prevention.
- **Motivational Enhancement Therapy (MET):** Also known as Motivational Interviewing (MI). Client-centered approach to overcome resistance to treatment, by motivating clients to want to change behavior. Generally short-term and done in preparation for other forms of treatment. MET/MI has also been identified as the treatment modality with the lowest overall cost.
- **Community Reinforcement Approach (CRA):** Involves the community in the client's treatment. Creates a social support network by engaging the client in vocational counseling, social clubs, support groups, recreational activities, etc.
- **Contingency Management:** Also known as behavioral contracting, it involves a system of rewards and punishments to aid in recovery. It might involve a point system for both good and bad behavior which are redeemable for prizes such as material objects, outings, access to activities, methadone take-home privileges, etc.
- **Behavioral Marital, Family, and Relationship Therapy:** Works on improving the client's relationships with others by improving his or her communication, parenting, money management, problem solving skills, etc.
- **Conditioning-Based Approaches:** Also known as cue exposure. Involves exposing the client to situations in which he or she would normally use drugs or alcohol – called relapse triggers – while sober. Repeated exposure teaches the client how to stay sober in those situations in the future.
- **Medication Adjuncts:** Also known as pharmacotherapy or medication-assisted therapy, this involves the use of prescription medications such as Methadone, Naltrexone, Disulfriam, and Buprenorphene. Treatment can be expensive using this method, but it is extremely effective especially when used in tandem with counseling and a desire to stop using. Appropriate for cases in which the client experiences extreme craving for the substance.
- **AA Twelve-Step Facilitation Therapy:** Although its effectiveness is questionable when used alone, AA and other support groups are very effective when used in combination with other forms of treatment, and when used as a post-treatment continuation of care. Less effective with clients with co-occurring disorders.

Alcohol Industry Funded Programs

The alcohol industry has a long history of involvement with substance abuse prevention—mainly alcohol abuse prevention—including both funding of external programs and implementation of industry-created programs. The three most popular beer companies—Anheuser-Busch, Coors, and Miller—as well as the Distilled Spirits Council of the United States (DISCUS), all assert participation in alcohol-abuse prevention work, mainly in the form of responsibility advertising. Some examples are listed below. No companies were found that fund treatment. The wine industry does not publish any contributions towards substance abuse.

- Anheuser-Busch notes that since 1982 they have invested almost $500 million in a wide variety of alcohol abuse prevention work. Their strategy is primarily information dissemination with a responsibility message, although they also host speakers in giving presentations at schools and community events.

- DISCUS collaborates with the Century Council, an industry-based coalition. Projects include a program working to install police officers in alcohol retail locations to deter underage purchasers and adults buying for youth (Cops in Shops), live appearances of a speaker injured as a youth in a drunk driving accident, and an interactive computer program that calculates one's blood alcohol content based on information the user plugs in.

- Coors Brewing Company creates responsible advertising, and states that they have advocated for tougher drunk driving and underage drinking legislation. They assert that they work with 22 "prevention partners," such as the American Council on Alcoholism.

- Miller Brewing Company distributes pamphlets, booklets, and guides for retailers and parents. They also distribute "We I.D." stickers to retailers, emblazoned with the Miller logo. They have played a role in the "Friends don't let Friends Drive Drunk" campaign and server training initiatives.

- Maine Beverage incorporates a "Responsible Drinking" campaign into their budget, integrate that message into their marketing and advertising initiatives. The company budgets $150,000 each year to fund this campaign.

Criticisms of Alcohol Industry Funded Programs

How effective are they?

Industry-Created Programs

- **Reverse Effect:** Studies have shown that some alcohol warnings can actually have the reverse effect on adolescents who often perceive benefits in risk-taking activities.

- **Lost in the Crowd?** A recent study by the Center on Alcohol Marketing and Youth discovered that youth are 96 times more likely to see industry ads promoting alcohol consumption than they are to see industry ads discouraging underage drinking.

- **Lost in the Ad?** By using eye-tracking technology another study revealed that only about one-third of adolescent participants actually viewed the cautionary responsibility component of an alcohol print ad when it was shown to them. This study (and several others) also showed that even when adolescents do remember the presence of a responsibility or cautionary message, they generally could not recall the general concept of the message

- **Not Enough:** Some criticize the industry's reliance on information dissemination and education as research in the prevention field has not shown such a strategy to be effective when used alone.

- **Absent or Questionable Evaluations:** Generally, alcohol companies do not perform —or at least do not release—reports evaluating the effectiveness of their programs. Anheuser-Busch did in fact release such a report regarding their designated driver campaign, but it was more of a Marketing survey that asked respondents irrelevant questions such as what celebrity they would choose to be their designated driver. Other evaluations are less light-hearted, but still do not evaluate the impact of their programs on actual drinking behavior.

Industry Funding of External Programs

- **Potential for Bias:** Studies conducted by the Center for Science in the Public Interest and the American Medical Association indicate that even independent community-based programs are susceptible to pro-industry bias once they receive industry funding.

Vested Interests?

The National Center on Addiction and Substance Abuse (CASA) estimates that underage drinkers and pathological drinkers (alcoholics) provide the industry with between **$48.3 billion and $69.2 billion** annually. This profit accounts for at least **37.2%**—and even as much as **half** (48.8 percent)—of all alcohol sold.

While it is easy to criticize and question the alcohol industry's contribution to substance abuse prevention, it is important to not completely discount the potential for public-private partnerships. Such partnerships with the alcohol industry can be fruitful.

Needs of Maine's Prevention System

Although Maine's prevention system has done much to help reduce substance abuse rates, there is still a need for expanding the existing system and filling in the gaps where the current system does not reach. In order to provide a comprehensive prevention effort in the state of Maine, the financial need of the system is estimated at **$9,600,000** annually

In addition to the needs outlined in Tables 6 and 7, the most prominent concern consistently voiced by local stakeholders is the need for increased funding. Both federal and state-level budget cuts in recent years have reduced resources for prevention and treatment programs. For example, cuts in federal funding for the Safe and Drug Free-Schools Program last year caused a reduction in the number of grants OSA could offer by half. Issues of funding have stifled the potential effectiveness of many programs, as underfunded organizations often cannot maintain the skilled staff required to collect the needed data or to execute every aspect of a program.

Table 6
Needs for Improving Prevention Infrastructure

Increase collaboration between departments and organizations
Improve training for both leadership and staff of programs serving youth, young adults, and other high-risk populations
Improve collection, analysis, and use of data

Table 7
Needs for Improving Prevention Practices

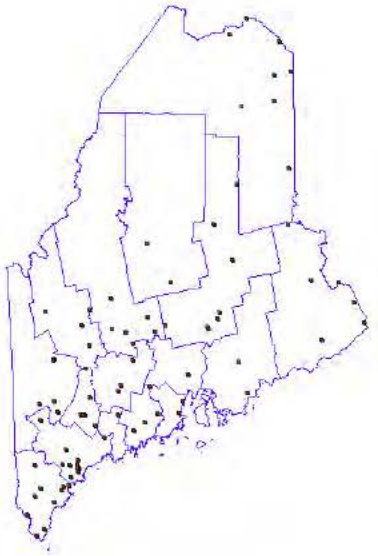
Implement earlier identification and intervention for alcohol-abusing youth
Increase practices that approach substance abuse in coordination with other social problems
Increase environmental strategies including enforcement
Increase cultural competence and targeting of subpopulations
Increase communication with the public
Make youth issues more visible
Improve geographic coverage

Monetary support for the continuation of current programs is also a priority. Since most prevention efforts are grant funded, the constant threat of losing funding is very real. The instability caused by this threat indicates a crucial need to install a permanent, statewide prevention infrastructure that is sustainable and consistent.

Needs of Maine's Treatment System

The needs of Maine's treatment system mostly involve meeting demand for treatment services. In order to meet this demand, the financial need of the substance abuse treatment system is estimated at **$4,086,000.**

- In 2005 Maine was able to serve 17% of those in need of substance abuse treatment. According to the 2003 and 2004 National Survey of Drug Abuse and Health, there are a total of 34,000 individuals classified as needing—but not receiving—treatment for illicit drug use, and 81,000 individuals classified as needing—but not receiving—treatment for alcohol in Maine.
- As of early 2006, there were 413 people on waiting lists for treatment across the state. This, if anything, is likely to be an understatement, as many agencies do not report their waiting list data to OSA.
- Additionally, there are several treatment facilities operating at past their capacity for non-residential services, averaging 26 clients over capacity. The most overwhelmed facility reports serving 61 clients beyond the number for which they are equipped.
- The average wait time to enter treatment is 9.25 days. Some treatment modalities, however, have much longer wait times. For example, clients without co-occurring mental illnesses wait an average of 58.33 days to gain admission into a short-term residential treatment. Some clients can wait up to a year to enter treatment. Such wait times are not only frustrating to those who need treatment, but can be dangerous in cases of severe substance abuse.

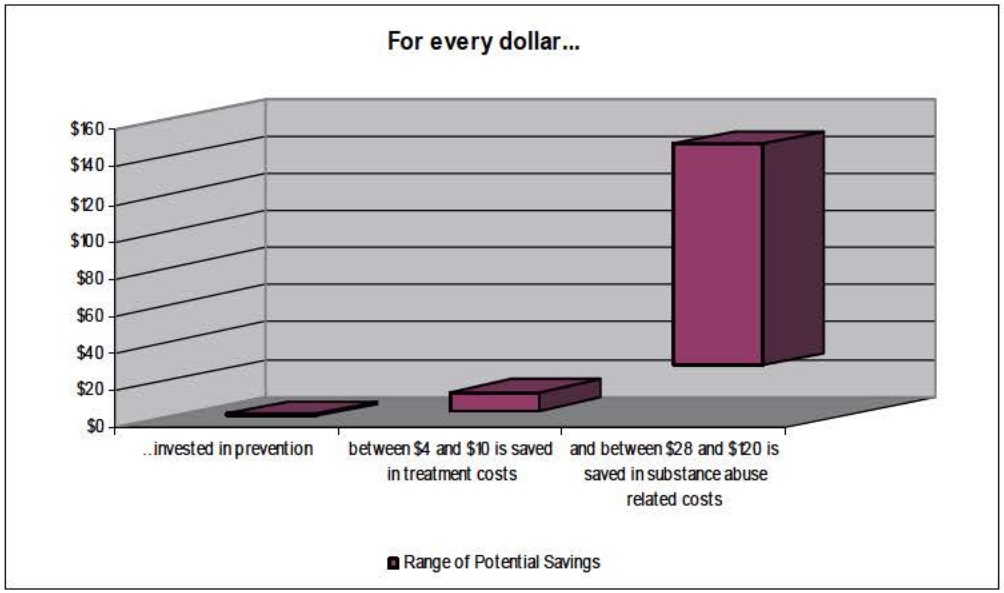


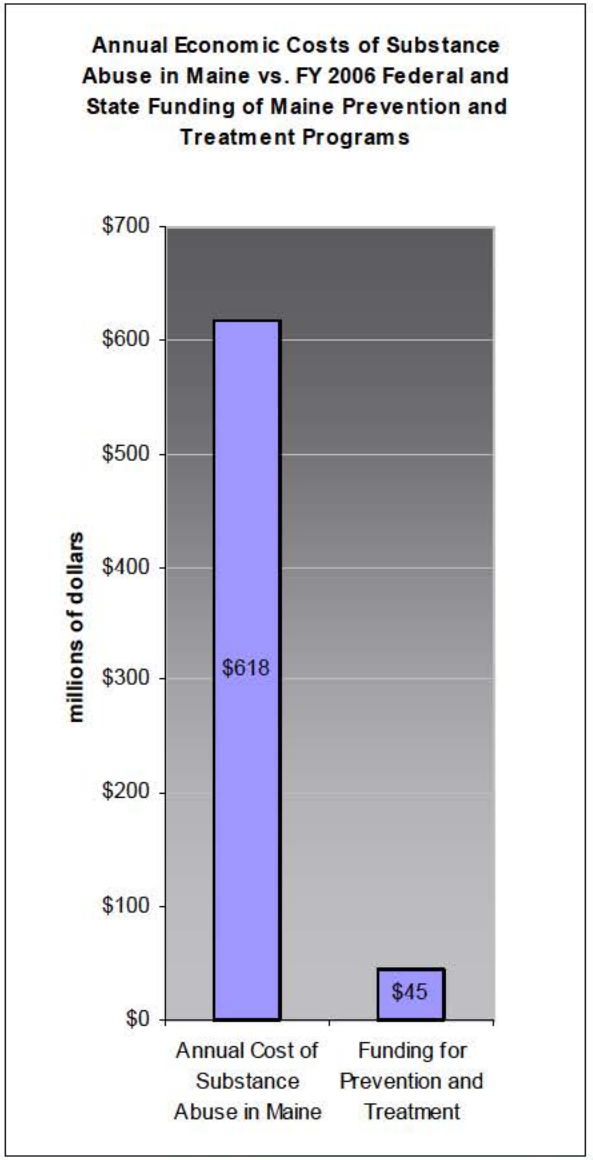
Substance abuse treatment is also in need of better geographic coverage. Note the sparseness of facilities (represented by the dots) in the Northern part of the state.

Potential Sources of Additional Funding

The total economic cost of alcohol and drug abuse in Maine for the year 2000 is estimated at **$618 million annually, $485 a year for every resident in Maine**. Alcohol abuse is responsible for approximately 70 percent of those costs. These estimates includes things like substance abuse related crime, fire, and medical costs.

Investing in substance abuse prevention and treatment has been shown to be extremely cost-effective. In fact, the Washington State Institute for Public Policy recently released a study that found that in 99 percent of cases, investing in evidence-based substance abuse practices generates benefits for the State. The chance that such an investment would actually cause a State to lose money was less than 1 percent.





INCREASING LIQUOR LICENSE FEES

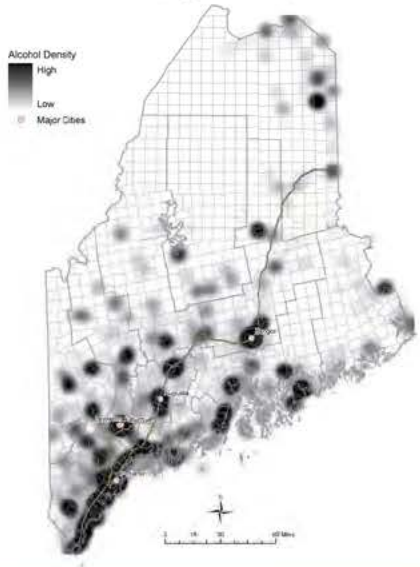
Although the resolve requested the impact of a liquor license fee increase based on sales volume, this information was not available for individual stores. Volume-based models Maine could examine are provided by Honolulu, HI and Washoe County, NV. The statutes are designed slightly differently, but both impose higher license fees on outlets selling over a predetermined volume of alcohol. Honolulu sets a maximum fee, whereas Washoe County's fee scale is not capped. For more detail regarding these models, and their potential problems, please see the full report.

Other types of license fee increases could be implemented. The first table to the right represents the potential revenue raised from a flat fee increase imposed on all types of licenses. The second table illustrates the potential revenue raised by implementing a percentage increase on current license fees, which is then rounded up to the nearest tens place. This rounding helps simplify the fee scale while further increasing revenue.

If Fees Are Increased by…	Revenue will increase by…	And Total Revenue will be…
$10.00	$87,420	$3,191,410
$25.00	$218,550	$3,322,540
$50.00	$437,100	$3,541,090
$75.00	$655,650	$3,759,640
$100.00	$874,200	$3,978,190

If Fees Are Increased by…	Revenue will increase by…	And Total Revenue will be…
1% and rounded up to tens place	$92,922	$3,196,912
5% and rounded up to tens place	$190,730	$3,294,720
10% and rounded up to tens place	$331,620	$3,435,610
20% and rounded up to tens place	$634,320	$3,738,310
25% and rounded up to tens place	$803,670	$3,907,660

Map LA0-2. Licensed Alcohol Outlet Hot Spots
(August 4, 2006, v.1)



Since research indicates that areas with higher densities of alcohol outlets experience higher rates of alcohol-related crime, the State could consider increasing license fees for outlets located in towns with higher outlet densities. If fees in these "hotspots" were raised by imposing, for example, an additional $20 fee on outlets located in towns with more than 1 outlet per square mile, the State could raise $34,480 in new revenue. This could be increased by imposing a higher fee or creating a graduated structure that increases the fees as density goes up.

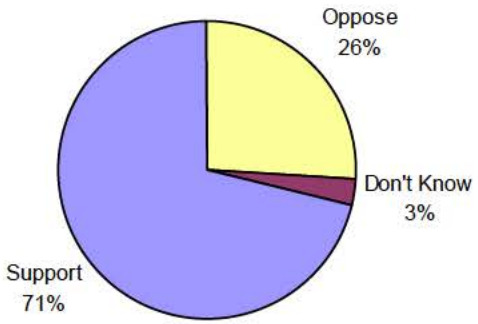
The number of outlets per 1000 people could also be considered. Either approach has the potential to both increase revenue and discourage outlets from locating too close to one another.

Increasing Alcohol Taxes

Currently, alcohol taxes comprise a few cents of every drink, and the majority of Mainers support a increase in those taxes if the revenue is dedicated to substance abuse prevention, enforcement, and treatment programs. Since alcohol taxes are based on gallonage and not retail prices, they have been significantly eroded by inflation in the past two decades, particularly beer taxes. For example, for beer taxes to be worth as much as they were in 1987 they would need to be raised to 62 cents per gallon.

Maine Support for a Dedicated Alcohol Tax Increase

"Would you support an increase in the alcohol tax that would be used to fund substance abuse prevention, enforcement and/or treatment programs?



Source: June 2006 Critical Insights on Maine Tracking Survey, Portland, ME

Table 8
Current Alcohol Taxes per Gallon and per Drink

Product	Tax per Gallon	Tax per Drink
Beer & Hard Cider	$0.35	3.28 cents
Low-alcohol Spirits	$1.24	11.63 cents
Table Wine	$0.60	2.34 cents
Sparkling & Fortified Wine	$1.24	4.84 cents
Distilled Spirits	$1.25	0.98 cents

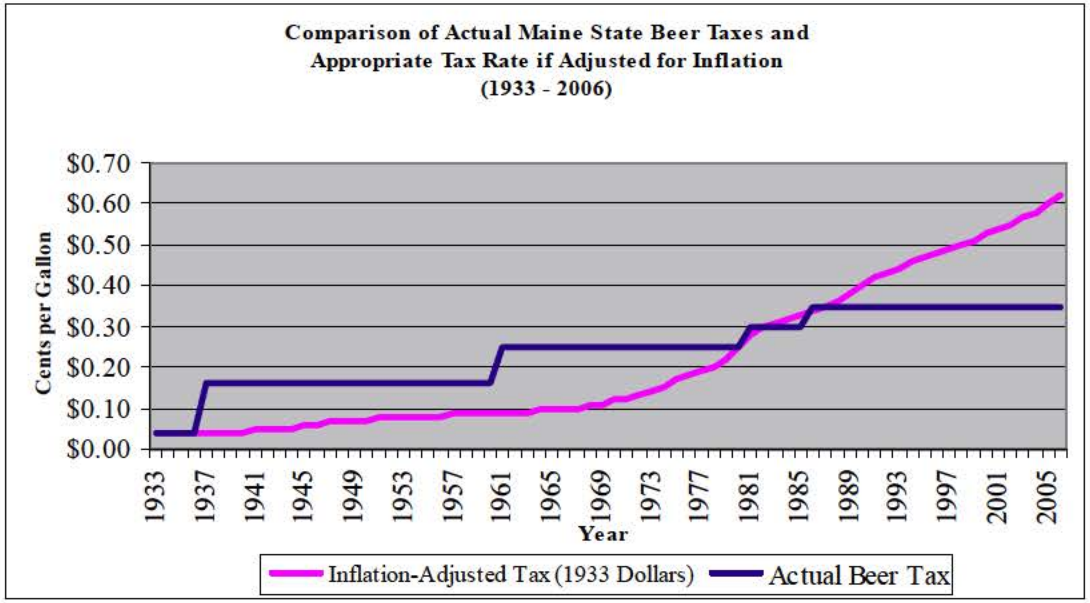


Table 9
Estimated Revenue Generated From Five Possible Alcohol Tax Increases

Premium Tax Increase	Product	Current Tax Rate (per gallon)	New Tax Rate (per gallon)	Projected Revenue Increase	Projected Total Revenue
Penny per Drink	Beer	.35	.46	$3,229,083	$13,653,819
	Low-Alcohol Spirits	1.24	1.35	$100,984	$1,288,887
	Table Wine	.60	.86	$871,601	$2,924,169
	Spark. Wine	1.24	1.50	$58,868	$356,258
	Totals			**$4,260,536**	**$18,223,133**
Adjust for Inflation	Beer	.35	.62	$7,886,970	$18,311,706
	Low-Alcohol Spirits	1.24	1.84	$542,121	$1,730,025
	Table Wine	.60	1.66	$3,421,919	$5,474,486
	Spark. Wine	1.24	1.40	$36,368	$333,758
	Totals			**$11,887,378**	**$25,849,975**
Nickel per Drink	Beer	.35	.88	$15,355,569	$25,780,304
	Low-alcohol Spirits	1.24	1.77	$479,971	$1,667,875
	Table Wine	.60	1.88	$4,094,557	$6,147,125
	Spark. Wine	1.24	2.52	$278,161	$575,551
	Totals			**$20,208,258**	**$34,170,855**
Dime per Drink	Beer	.35	1.42	$30,469,819	$40,894,555
	Low-alcohol spirits	1.24	2.31	$951,901	$2,139,804
	Table Wine	.60	3.16	$7,762,537	$9,815,105
	Spark. Wine	1.24	3.80	$527,053	$824,443
	Totals			**$39,711,310**	**$53,673,907**

Tables 9 and 10 illustrate the estimated increase in revenue generated from four possible alcohol premium tax increases. Liquor is separated from the rest as the formula used in Table 9 does not apply to alcohols controlled by the state (the price of liquor is controlled by the Bureau of Alcoholic Beverages). The estimates in Table 9 take a potential decrease in consumption into consideration (see page 9), while those in Table 10 do not. This is because little research has been done analyzing how control states will adjust alcohol prices in reaction to a tax increase. Consequently, projected revenue increases in Table 10 may, in reality, be slightly less due to a possible decrease in consumption.

Table 10
Estimated Revenue Generated from Five Possible Liquor Premium Tax Increases

Premium Tax Increase	New Tax Rate (per gallon)	Projected Revenue ncrease	Projected Total Revenue
Penny Per Drink	$2.53	**$1,732,487**	**$3,424,368**
Adjust for Inflation	$1.38	**$175,956**	**$1,867,837**
Nickel per Drink	$7.65	**$8,662,432**	**$10,354,313**
Dime per Drink	$14.05	**$17,324,864**	**$19,016,745**

Public-Private Partnerships and the Revenue-Sharing Agreement

Public-Private Partnerships

More often than not, traditional prevention providers and private industries such as the alcohol industry are disconnected, operating independently of one another. A way to overcome many of the criticisms of industry-funded programming would be to increase the involvement of experienced prevention and treatment practitioners in developing the programming. Many accuse industry prevention efforts of being ineffective, yet if the actual programming was designed by those experienced within the field, this would no longer be a problem.

Such reasoning suggests that money currently spent by industry on their own programs would be better spent by funding non-affiliated, experienced prevention and treatment groups. Funds directed in this way would be much more cost-effective, as money would more likely be allocated towards evidence-based "best practices" while also supporting the infrastructure of Maine's prevention system.

Revenue-Sharing Agreement

Beginning in SFY 2004, the State of Maine initiated a contract with Maine Beverage. This contract leased Maine Beverage the rights to distribute distilled spirits in the State of Maine for ten years, subject to price regulation by the Bureau of Alcoholic Beverages and Lottery Operations. These rights were sold in exchange for $125 million dollars combined with a profit-sharing agreement. Through this agreement, Maine Beverage is guaranteed a gross profit margin of 36.8% (the "Gross Profit Guaranty"), calculated on a calendar year. That is, if, after subtracting the cost of goods sold (which includes the cost of merchandise and the premium tax levied), Maine Beverages' profits are less than 36.8% of total sales, the State would have to pay them the difference. However, If Maine Beverage's profits exceeded 36.8% of total sales in a calendar year, 50 percent of the profit overage is deposited into the General Fund.

While money could potentially be used from this agreement, the reliability of this funding source should be considered. It is theoretically possible that some years the State could receive no money from Maine Beverage, in fact possibly have to pay them. Additionally, as this agreement is in effect for a term of only ten years—set to end on June 30, 2014— any funding drawn from it represents a relatively short-term solution in comparison to the other options discussed.

Dedicating Alcohol-Related Fines

Currently, all fines for civil, criminal, and administrative violations of Maine's liquor laws are deposited into the General Fund. Instead, this money could be channeled into grants or funds dedicated to substance abuse prevention, enforcement, and/or treatment programs.

This would not be an unusual procedure. Recently enacted by PL 2005, c. 223, money from tobacco administrative fines is to be split between DHHS (to help to defray the costs of administering tobacco licenses) and the Attorney General's Office (to support enforcement and responsible retailing programs). Additionally, fines from some traffic infractions are dedicated to the Highway Fund to help maintain Maine's transportation system.

In SFY 2006, the State of Maine ordered the collection of $4,450,935 in alcohol-related fines under Titles 12, 28-A, and 29-A, and as of August 11, 2006 had collected $3,672,098 (82.5 percent).

Conclusion

There are certain generally agreed-upon principles that characterize a best practice in both the prevention and treatment fields. The Substance Abuse and Mental Health Services Administration (SAMHSA) has summarized many of them well in their evidence-based practices criteria, currently under revision. While treatment is more individualized, certain principles and types of practices are still correlated with more effective results. OSA and the majority of prevention and treatment agencies are familiar with these principles.

The beer and spirits industry has a long history of involvement with substance abuse prevention, both funding external programs and creating their own. Industry-created programs more often than not focus on drinking and driving initiatives, usually incorporating brief responsibility messages into their existing advertising. Some companies go a step further, initiating more action-oriented programs such as hosting speakers and distributing information to retailers. However, there has been much criticism regarding the effectiveness of industry-funded programs, given their economic interest in underage and pathological drinkers.

Although currently Maine's prevention and treatment systems have generated some impressive results, both systems do not currently meet the needs of all Maine citizens. Both systems need a greater presence in the Northern part of the state, and more work needs to be done to improve service to cultural subpopulations. Current treatment services are only able to meet the needs of 17 percent of those in need of treatment, and although such a percentage is impossible to determine in prevention, one can see the need for expansion by looking at our high youth substance abuse rates. To provide a comprehensive prevention effort in the state of Maine would cost $9,600,000 annually. To meet the treatment demand (defined as treating all people that would seek treatment, not all people that need treatment) of Maine's population would require $ 4,086,000 in additional annual funding. The total financial need of substance abuse prevention and treatment in Maine is therefore estimated at $13,686,000 in annual funding

There are a number of different avenues the legislature could consider to raise additional funding for prevention and treatment, including changing the liquor license fee structure, raising alcohol taxes, creating partnerships with the alcohol industry, using money from the revenue-sharing agreement, and dedicating a portion of alcohol-related fines. These suggestions, as stated, could generate anywhere from $33,128 to $57 million more revenue annually, perhaps more if more than one revenue source is implemented. This money could be dedicated to prevention and treatment through the creation of a substance abuse fund or grant, or by channeling it through the Office of Substance Abuse.

We urge legislators to review the full report in addition to this summary, as much valuable information had to be omitted in the interest of space. This report, *Funding the Efficient and Effective Delivery of Substance Abuse Prevention and Treatment Programs LD 1838/RESOLVE Chapter 142: Full Report*, can be obtained from the Maine Office of Substance Abuse or online (see back cover).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAINE OFFICE OF SUBSTANCE ABUSE

#11 SHS, AMHI Complex, 3rd Fl, Marquardt Bldg., Augusta, ME 04333-0011 • Web: www maineosa.org • Email: osa.ircosa@maine.gov
1-800-499-0027 or (207) 287-8900
TTY: 1-800-606-0215