



Oregon

Theodore R. Kulongoski, Governor

Department of Human Services

Addictions and Mental Health Division

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September 22, 2010

The Honorable Floyd Prozanski, Chair
Interim Senate Judiciary Committee
900 Court Street N.E., S-417
Portland, OR 97238

The Honorable Jeff Barker, Chair
Interim House Judiciary Committee
900 Court Street N.E., H-491
Salem, OR 97301

Dear Senator Prozanski and Representative Barker:

Enclosed is the Addictions and Mental Health Division (AMH) biennial report to the Legislative Assembly detailing progress on the adoption and implementation of evidence-based practices for mental health and addiction treatment and prevention services. The report is required by ORS 182.525(2) and details AMH actions and progress in implementing the requirements of ORS 182.525.

If you have questions about the report or would like additional information regarding any issues discussed in the report, please contact me at 503-569-3183.

Sincerely,

Richard L. Harris
Assistant Director

LC/jzh

If you need this letter in alternate format, please call 503-945-5763 (Voice) or 800-375-2863 (TTY)

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Department of Human Services/Oregon Health Authority
Addictions and Mental Health Division (AMH)
September 2010, Interim Judiciary Committee
Report on Evidence-Based Practices, ORS 182.525

Background

The Oregon Health Authority, Addictions and Mental Health Division (AMH) is required by Oregon Revised Statute 182.525 (ORS 182.525) to report to the Legislature, over three biennia, an increasing proportion of funds that support evidence-based practices (EBPs). The first biennium the law was in effect was 2005-07 and 25 percent of funds were required to be spent on EBPs. In 2007-09 the requirement increased to 50 percent. By the 2009-11 biennium, 75 percent of AMH funds for those populations at risk of emergency psychiatric services or criminal or juvenile justice involvement are required to support EBPs. The services and populations subject to the requirements of ORS 182.525 are: 1) the AMH funded treatments focused on clients with substance abuse disorders referred by the criminal justice system; 2) clients who have been court committed for treatment due to mental illness; and 3) children and adolescents with severe emotional disorders receiving intensive, integrated community services.

Summary

AMH worked with the Department of Corrections (DOC), community-based programs treating offenders, the Criminal Justice Commission, and the Oregon Youth Authority (OYA), to refine and focus the approach for determining services and client groups subject to the requirements of ORS 182.525.

AMH provided service data to community programs on the clients served who are subject to the requirements of ORS 182.525. The programs estimated total treatment costs for those clients and then estimated the proportion costs that funded of the approved evidence-based practices on a list provided by the state. The survey results were used by AMH to estimate the statewide percentage of the cost of services for evidence-based practices.

For the 09-11 biennium, 75 percent of treatment funds covered by ORS 182.525 are expected to be spent on EBPs. This meets the statutory requirement.

Revised Process

After participating in data gathering for the November 2008 ECONorthwest report Costs and Participation for Selected Evidence-Based Programs in the Criminal Justice System, AMH staff reviewed the final report and realized that the process that had been used for designating populations to be covered by ORS 182.525 was not sustainable. AMH worked with the EBP Steering Committee and the other covered agencies to revise the approach to collecting the data in order to better align with the intended goals of ORS 182.525, reduce the propensity of a person to commit a crime, reduce recidivism and reduce the use of emergency mental health services. The new process is more consistent with that used by the other state agencies covered by the statute.

AMH uses funding mechanisms similar to those used by the DOC for allocating resources supporting community-based addictions and mental health services. AMH revised its approach to capture budget information supporting EBP for this report to be more consistent with the approach used by DOC in terms of identifying programs that meet the definition of evidence-based for correctional populations.

A widely accepted body of scientific evidence has been developed about what works in the treatment of medium and high risk offender populations. This research has been translated into a set of program attributes, the Correctional Program Checklist (CPC), by which service providers can be measured. Costs attributed to meeting the clinical and programmatic elements defined in the CPC, including implementing and sustaining evidence-based programs, are reported by the providers as a component of their cost for serving the populations at higher risk for criminal behavior.

Risk analysis is performed at the provider level for each client receiving mental health services. Similarly, a core set of evidence-based programs have been researched and proven to reduce risk and mitigate symptom severity to reduce use of emergency mental health services among the population at greater risk.

Treatment for the following client populations were included in the estimated costs of EBP:

- Alcohol and Drug Treatment Services: Clients referred by criminal justice system, including Driving Under the Influence of Intoxicants (DUII) clients;
- Adult Mental Health Services: Clients who are a danger to themselves or others and at risk of long-term hospitalization due to a severe and persistent mental disorder; and
- Children’s Mental Health Services: Children and adolescents with severe emotional disorders who are at risk for emergency hospitalization.

Elements of the Revised Process:

1. AMH provided programs with the number of clients served in the previously listed categories during calendar year 2009.
2. Programs were asked to estimate the total treatment costs associated with those clients.
3. Programs were asked to estimate the percentage of the cost spent on approved EBPs with those clients. AMH provided a list of the approved practices consistent with the intent of ORS 182.525 and asked respondents to identify those used within their programs.
4. AMH used the responses to estimate the percentage cost of services for these clients that were evidence-based and to complete this report.

The survey did *not* include: prevention services; crisis services; pre-commitment services; personal care services; state hospital services; acute care hospital services; or services delivered to individuals outside the population described.

Results: Community Addictions and Mental Health System

Total invested in community programs delivered consistent with EPBs:

A total of \$119,710,707 will be spent on the client populations defined for this survey. These dollars will support services to 21,400 people receiving alcohol and drug treatment; 15,362 adult mental health clients; and 1,861 adolescent mental health clients.

Based on the results of the most recent survey, 75 percent (\$89,968,219) of the funds used to treat the populations that are the focus of ORS 182.525 (SB 267) will be spent on EBPs.

Progress to Date

For addiction services delivered to medium/high risk offenders, AMH identified the Correctional Program Checklist (CPC) as the appropriate tool to determine if programs are evidence-based in the way that they are being designed and delivered. Working in partnership and collaboration with the Criminal Justice Commission, DOC and OYA, AMH provided direction to the addiction provider system through administrative rule development, specialized and targeted technical assistance, training and program review. One such collaboration, with OYA in the spring of 2009, funded by the Robert Wood Johnson Foundation, on introducing evidence-based treatment methods aimed at reducing delinquent and criminal activity among youth and prepared programs to understand and meet standards set in the CPC.

AMH amended administrative rules for institution-based addiction services working with DOC in 2009 and revised rules for community-based services in 2010 to be consistent with the principles of effective intervention. The division is now providing technical assistance to providers based on the new rules. Programs delivering community-based services may request, or be directed to request via contract, designation as a specialty program for individuals in the criminal justice system.

AMH continues to engage minority-specific service providers in focused dialogue, process improvement strategies and culturally-specific program implementation meeting the revised definition for culturally validated EBPs. This effort is important for minority-specific providers. It is also important to the knowledge base on adapting research-based practice for culturally-specific groups and to validating cultural practices that have proven to be effective in generating recovery-related outcomes and reducing crime. This work is most active among Oregon's nine federally recognized Native American tribes. Given the overrepresentation of minorities in the justice system, AMH anticipates continued efforts focused on assisting the minority-specific providers to adopt and implement

culturally-adapted practices as well as assisting these providers to build evaluative and research capacity.

Future Strategies and Recommendations

Outcome Monitoring and Data Systems: AMH is committed to using treatment practices proven to produce positive outcomes in the populations at high risk for recidivism, criminal behavior, and use of emergency mental health services. That said, tracking outcomes over time and quantifying the return on investment for behavioral health services, including cost avoidance due to reduced crime and reduced use of emergency mental health services, is a worthy future goal from a policy and funding perspective.

Currently, AMH must rely on survey information validated by provider audits or reviews to determine the validity of information supplied by service providers and payers. Since the provider agencies funded by AMH are generally the same providers funded by DOC and OYA, a modern data system that captures service type, frequency and intensity, payer source, and outcomes would be of great benefit to state decision-makers, payers, and to the providers delivering these services. AMH is in the process of testing a new data system that will have optimal functionality for capturing and reporting this information but implementing the system will take time, resources, and cooperation across a large statewide network of behavioral health providers and partners.

Program Fidelity Monitoring: Budget reductions at the state and local level have had a serious impact on the capacity for programs to adopt, implement and sustain use of evidence-based programs. Staff turnover, retraining and insufficient payment rates are all challenges that will continue to pose obstacles for the provider system in the coming biennium.

With dozens of evidence-based practices and well over 500 alcohol and drug and mental health programs throughout Oregon it is unlikely that AMH will have adequate staff resources to conduct fidelity reviews or CPC reviews on all publicly funded programs. In light of the revised approach used by AMH to capture dollar amounts associated with delivering EBP and recommendations, AMH will continue to strengthen coordination and leverage partnership opportunities for

program review as well as identified technical assistance and system development with the other agencies subject to the requirements in ORS 183.525..

Policy: The environment has changed dramatically since the Legislature passed SB 267 codified as ORS 182.525. The political and economic climate will continue to evolve as our understanding of effective treatment improves with scientific advancements and additional research studies. Now more than ever the public wants to know that services have value and want proof of the return on investment. ORS 182.525 – SB 267 provided an important impetus for the addictions and mental health system to review research findings, adopt practices that produce better outcomes, and evaluate the impact of delivering EBP on business and clinical practices. This is a good outcome for state policy, however now is the time to move beyond adopting and implementing the practices to focusing on the outcomes achieved, calculating the return on investment and communicating this message to the public.