

Analysis of Oregon's Drug and Alcohol Treatment and Prevention System

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Revised



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CHAPTER ONE: INTRODUCTION

In March 2008, the Office of the Governor, through the auspices of the Oregon Department of Human Services (DHS) and the Oregon Department of Corrections (DOC), contracted with Human Services Research Institute (HSRI) to conduct a brief and intensive assessment of the current status of Oregon's alcohol and drug (A&D) treatment and prevention system. The scope of the study is limited to five state agencies: DHS and DOC are the most prominent players, bearing responsibility for the broadest segments of the adult population in need of A&D services; the Oregon Youth Authority (OYA) and the Oregon Commission on Children and Families (OCCF) carry primary responsibility for serving children and youth; and the Oregon Criminal Justice Commission (CJC) has lead responsibility for drug courts. HSRI began by exploring the nature of the service delivery systems of each agency-- the programs and population mandates, organizational structure, funding sources, regulations and legislative mandates. This provided a foundation for the core study issues: understanding the level of need for prevention and treatment services, the variety and volume of services each agency provides, the flow of A&D prevention and treatment funds into and out of each agency, and the capacity of each agency to monitor and evaluate performance.

Four separate but closely related studies comprise this project:

(1) The Gaps Analysis compares the need for A&D services – using statewide estimated prevalence figures for Oregon's population, supplemented by specific service need calculations where available – with the amount of service provided by each state agency. The difference between the number of people needing services and the number who receive services represents the “gap” or the extent of unmet need. This analysis provides a baseline for any discussion about needed increases in A&D prevention and treatment services.

(2) The Investments Analysis examines changes in expenditure patterns over time. Using data compiled by state agency staff, HSRI analyzed both the inflows and outflows of funds for each state agency. Presenting investment figures for each of the past four biennia (2001 to the present), we illuminate aggregate fluctuations in A&D spending which could be related to shifts in population need and/or services provided over time. For the 2005-2007 Biennium, we offer a more detailed analysis of funding flows and breakdowns among major spending categories for each state agency. This analysis reveals the relative financial importance of different services and funding streams in Oregon's overall A&D system.

(3) The Performance Analysis documents the policies and procedures in place in the state agencies to assure that contractual agreements are met and that agencies are accountable for what they spend and for how service initiatives impact clients. This assessment of the core agencies' performance and quality management capacity sheds important light on the ability of the A&D system as a whole to be more efficient and effective.

(4) The Case Study Analysis profiles A&D treatment and prevention systems in four Oregon localities (three counties and one tribe). The purpose of the case study analysis is to highlight variation in service provision, funding sources and levels, contracting and allocation, and performance measurement across the selected counties.

This study encompasses many but by no means every service activity that impacts alcohol and drug abuse behavior. The five state agencies targeted for this analysis together provide

virtually all the state funds that support local service delivery. These resources are usually tied to particular types of services and sometimes to specific program interventions. For this study, HSRI has focused on:

- ✓ AMH-funded treatment and prevention services classified under Service Elements (SE) 60-71:
 - SE60, Special Projects, are services delivered on a demonstration or emergency basis for a specific period of time; these projects focus on high-risk youth and families, doing outreach and non-traditional treatment.
 - SE 61 and 71, Youth and Adult A&D Residential Services, include services that support, stabilize, and rehabilitate individuals so they are able to return to their community.
 - SE66, Continuum of Care services, include case management, clinical care, continuing care, outpatient, intensive outpatient, and non-medical detoxification.
 - SE 70, Prevention Services, include a variety of integrated strategies to prevent substance abuse and associated effects; for example, the Strengthening Families Program, a new evidence-based prevention program for middle schools.
- ✓ Oregon Health Plan (OHP) chemical dependency services: OHP-eligible individuals are served through 12 contracted Health Plans around the state or through fee-for-service arrangements in some rural areas. Covered A&D services include assessment, medically appropriate treatment (outpatient), inpatient detox, and alternatives to inpatient detox (e.g., medically-monitored non-hospital detox, to assure more continuity of community treatment). OHP does not cover residential A&D treatment.
- ✓ Children and Families (CAF) supportive services: CAF's Addiction Recovery Teams (ART) and Intensive Treatment & Recovery Services (ITRS) are available through the 16 regional CAF offices.
 - The local ART serves child welfare families with addiction needs through a variety of services including screenings, referrals, general support services, and random urinalysis testing. Each ART consists of a certified A&D counselor who screens and does some counseling and an outreach worker (similar to a recovery coach) who helps people get to treatment. When a family is identified as having an A&D need, the caseworker will call ART who subsequently completes a screening and makes an appropriate referral. ART refers to various local providers for both residential and outpatient treatment
 - ITRS is a new A&D service program for CAF parents who are not eligible for OHP. ITRS includes 3 components -- (a) intensive outpatient treatment, (b) residential beds for parents and residential beds for dependent children, aged 1-5, and (c) housing for parents actively in treatment or who participated in treatment previously and need housing to avoid relapse.
- ✓ DOC treatment services: DOC provides residential A&D treatment for incarcerated adults plus some outpatient services for people on parole, probation or in county jails. Residential A&D treatment is provided in separate housing units; in-prison treatment programs are all provided by a few contractors who often have permanent staff on-site in the prison; and A&D treatment is provided in the community through contractors.

- ✓ OYA services for youth: OYA provides residential treatment for youth in close custody or in community residential facilities. Once the youth is back in the community, Parole and Probation divisions refer to private providers for A&D services.
- ✓ CJC-funded Drug Courts: Drug Courts integrate A&D treatment services with the judicial case processing system, and serve adult, juvenile, and family dependency cases. These courts have specialized dockets and work with non-violent substance abusing offenders to help them successfully obtain and complete treatment, and hopefully prevent future criminal behavior. To create a non-adversarial approach, Drug Court Teams include the local judge, court administrator, District Attorney, Public Defender, sheriff, community corrections, and treatment providers.
- ✓ OCCF-funded prevention programs: Various preventive activities are selected by the local commissions. Typically, local CCFs work collaboratively with local partners who serve children, youth or families, to identify needs, mobilize the community, and complete a Comprehensive Community Plan each biennium. They may also offer separate prevention activities directly related to youth development.

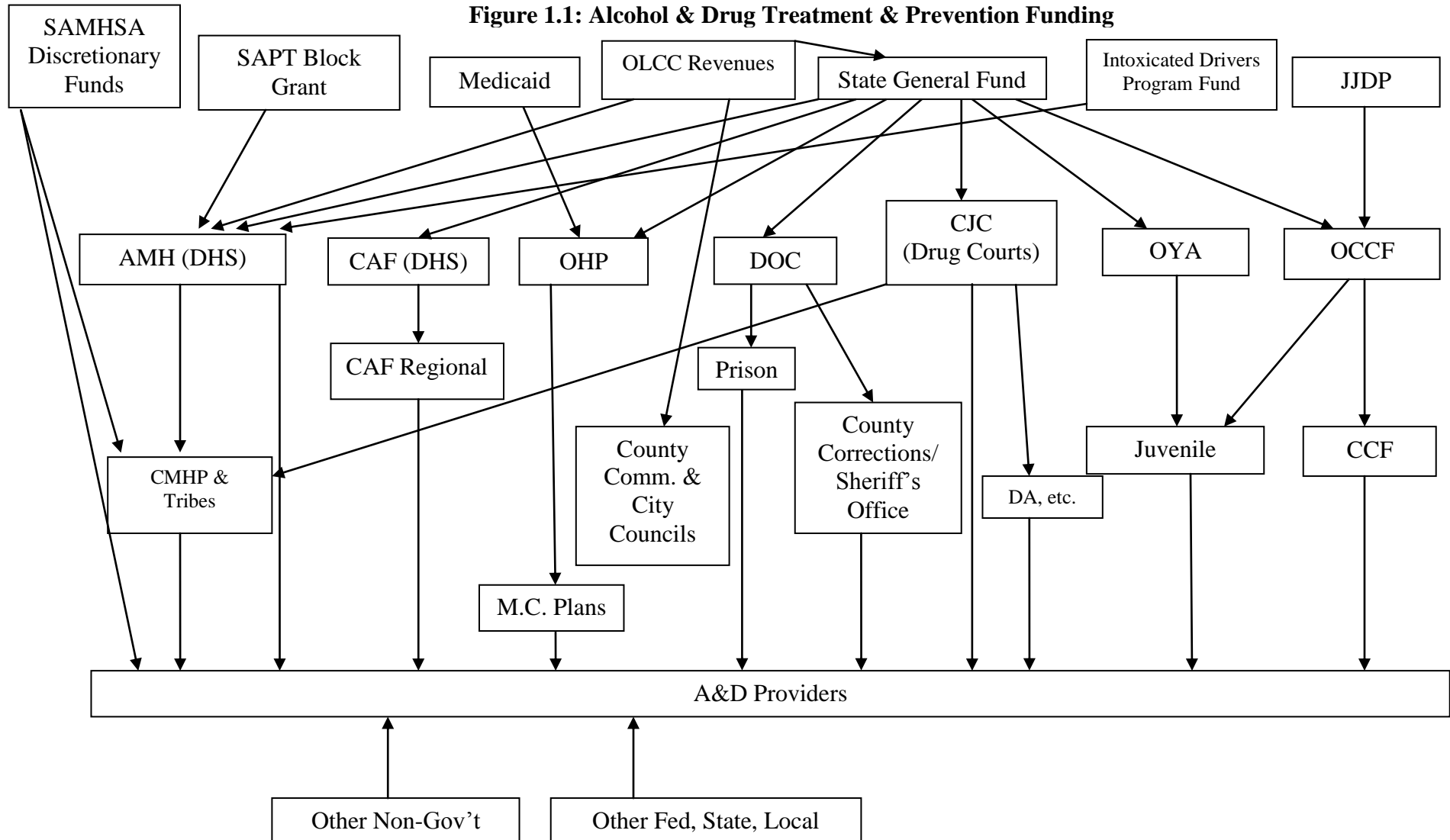
Outside the purview of this study are many other state agency programs aimed at preventing alcohol or drug abuse. The most obvious omission is school-based programs to teach children and youth about the risks of alcohol and drug use and to nurture alternative behaviors. Local communities also pursue a wide array of prevention initiatives that can be understood to influence alcohol and drug use – for example, Healthy Start and Head Start strive to intervene in families early enough to alleviate some of the conditions which later give rise to addictive behaviors. In addition, certain populations are not systematically included in the study, e.g. people who are homeless, seniors and people with disabilities; and certain addiction behaviors, e.g. smoking and gambling, are outside the scope of work. Further, it was beyond the resources of the project to examine population subgroups – breakdowns by gender, race/ethnicity, or geographic location (urban/rural). In short, the findings of this study do not constitute the full force of the state's efforts to address substance abuse, but they do highlight the most direct and concentrated approaches of the five main state agencies to address A&D addiction statewide.

Alcohol and drug abuse is a pressing problem facing Oregon. The Governor's Council on Alcohol and Drug Abuse Programs (GCADAP) documents the interconnections between alcohol and drug use and a wide range of community problems (GCADAP, 2006 & 2008), arguing that declines in state spending for alcohol and drug services have led to a "domino effect" in increased strains on public health, law enforcement, public safety, and child protection systems, as well as schools and workplaces. Other strong voices in Oregon, focusing on crime rates, disagree that the solution to escalating community problems lies in increasing A&D services; they argue that tougher law enforcement and sentencing will do more to promote community safety and public health by removing criminals from the community and deterring further criminal activity. In the face of these conflicting theories, the Governor's Office is seeking to establish a baseline on current A&D service efforts, as a necessary foundation for subsequent reform of what is widely acknowledged to be a complex collection of A&D-related activities and funding streams.

Figure 1.1 displays HSRI's understanding of the current A&D service "system", and identifies the major public entities being examined. To fully understand the impact of funding shifts over time, it is essential to be cognizant of the web of connections among funding streams,

state agencies, and local service providers. Our primary focus is the five state agencies, but we also look as closely as possible at the county-level jurisdictions and the private provider community.

The next five chapters of this report document and synthesize the findings from intensive interviews with state and local agency staff, supplemented by review of relevant written materials. Chapter Two presents findings from the Gaps Analysis, linking prevalence of alcohol and drug abuse problems to current levels of service. Chapter Three describes the results of the Investments Analysis, offering both a broad look at overall A&D spending and detailed spending figures and patterns for each of the five core state agencies. Chapter Four reports on agencies' capacity to manage performance, examining procedures for sending funds down to the local level and maintaining accountability for both that spending as well as overall agency operations. Chapter Five profiles several county A&D systems, providing glimpses of the impact of state agency decisions on local service delivery practice. In Chapter Six, we reflect on the range of findings and offer some recommendations related to policy, program and system infrastructure.



CHAPTER TWO: GAPS ANALYSIS

Crucial to understanding the current status of Oregon's A&D system is an examination of the extent to which service needs are met. In the Gaps Analysis, HSRI examined the prevalence of A&D needs among various subgroups of the state population, and compared this needs profile to information on numbers of people served.

This chapter has six major sections. The first addresses the substance abuse treatment gap for the overall Oregon population. The next three sections provide a more detailed look at the treatment gap for specific portions of the state population served by the CAF office in DHS, DOC, and OYA. Each of these sections contains an explanation of the data sources and methodology used to calculate the gap, presentation of findings, and discussion of caveats associated with the estimated gap and recommended steps for further work. HSRI computed all prevalence and treatment estimates using a combination of publicly available data sets and information provided by agency staff. Wherever possible, the project team incorporated the most recent data available, presenting more than one year for comparison purposes. However, data system lags and reporting delays (particularly for national data sets) make it difficult to provide accurate results into the current biennium. The fifth section presents brief findings on prevention services, and the final section of the report offers conclusions and discusses next steps.

2.1 GENERAL POPULATION ESTIMATES

In developing the estimates of treatment gaps for the general Oregon population, HSRI worked closely with staff in the division of Addictions and Mental Health (AMH) in DHS. Because most Oregonians in need of publicly-funded treatment services are served through AMH, the estimate of the general population need is compared to total AMH service delivery.

Data Sources and Methods

In order to arrive at a general population substance abuse treatment gap for the state of Oregon, HSRI used three main sources of information: population figures from Portland State University (PSU), prevalence or "need" figures from the National Survey on Drug Use and Health (NSDUH), and treatment counts from the Client Process Monitoring System (CPMS). These datasets are described below, and are the basis for Figures 2.1 through 2.4.

Population estimates: The PSU Population Research Center estimated the population of Oregon on July 1, 2007, to be 3,745,555 (Oregon Population Report, 2007). This population is defined as the population in 2000 plus natural increase and net migration. Of this total population, 3,173,450 individuals are ages 12 and older, the population examined for substance abuse need. State, county, and city officials submit annual information to PSU, in turn reviewing the University's methods and estimates. The PSU totals encompass all residents, including group quarter facilities such as college dormitories, jails, and prisons. PSU does provide population estimates for several age groups. However, these age ranges do not match the age ranges from the NSDUH (see next paragraph). Therefore, HSRI chose to compute age group totals for PSU data that match the NSDUH groupings. Table 2.1 displays these estimates.

Prevalence estimates: The NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is the primary source of information about illicit drug,

alcohol, and tobacco use in the United States population. Each year, approximately 70,000 individuals are interviewed at their place of residence. Individuals in non-institutionalized group quarter residences, such as college dormitories, are included in the sample. Incarcerated and homeless individuals are not included (SAMHSA, 2006). Although their numbers are relatively small, high rates of substance abuse within these populations make their absence worth noting. SAMHSA publishes extensive state reports on the results of the NSDUH. For this gaps analysis, the study team used 2005-2006 rates of alcohol or illicit drug dependence or abuse for Oregon. These rates (Table 2.2) are as follows: 8.22% for all ages 12 or older; 8.76% for ages 12-17; 20.13% for ages 18-25; 6.19% for ages 26 and older. The 2005-2006 rates are the latest results available from the NSDUH.

Treatment estimates: The CPMS is the primary data collection portal for publicly funded drug and alcohol treatment providers. CPMS has been in use since the 1980's and is constantly updated, although there is a three to six-month lag for most data. CPMS provides estimates of treatment numbers for clients who receive some public funds for treatment (who do not rely entirely on self-pay and/or private insurance). In addition, all DUII and methadone clients are included, regardless of their payment method. CPMS treatment numbers are Calendar Year 2007 counts for unique individuals who received any treatment, but who may or may not have completed an entire treatment episode. Table 2.1 shows treatment counts by age group.

Table 2.1			
Data used to calculate treatment gaps for Oregonians			
	Population	NSDUH "Need"	CPMS Treatment Counts
All Ages	3,173,450*	260,858 (8.22%)	64,532
Ages 12-17	305,540	26,765 (8.76%)	4,603
Ages 18-25	416,009	84,450 (20.13%)	14,759
Ages 26 and older	2,451,901	151,773 (6.19%)	45,170

* All ages includes children 12 and older.

Analytic Methods: To arrive at the treatment gaps, the NSDUH percentage rates were applied to the population figures. This resulted in the numbers for "need". The CPMS treatment figures were then subtracted from the overall need for each age group. The results are presented as numbers of individuals as well as percentages. Each figure is illustrated with three configurations (Figures 2.1-2.4): the gap for all income levels, the gap for individuals below 200% of poverty, and the gap for individuals below 400% of poverty. Poverty statistics are included in order to more accurately represent the need for publicly-funded treatment, as the NSDUH figures likely include some individuals who will self-pay for their treatment or will pay with private insurance. In 2006, the below 200% of poverty level for Oregonians was 32.3% (U.S. Census Bureau, 2006). This figure was applied to all age groups, as figures for different ages were not available. Figures for the below 400% of poverty level are available by age group and are as follows: 61.7% for all ages (applied to the all ages group, the 18-25 age group, and the 26+ group); 69.7% for ages 5-17 (applied to the 12-17 age group) (U.S. Census Bureau, 2006).

Evidence from SAMHSA and other sources indicate that individuals with incomes up to 400% of the poverty level require at least some of their treatment to be funded with public dollars.

Results

The following figures illustrate the gap between the need for substance abuse treatment (prevalence) and the treatment rates. As shown, the gap for adults over age 26 is substantially lower than the gaps for youth and young adults. For adults at less than 400% of the poverty level, the treatment gap is 52%, compared to 75% for youth ages 12-17 in the same income bracket.

Figure 2.1
Treatment Gap for All Ages
Need is 8.22% (260,858)

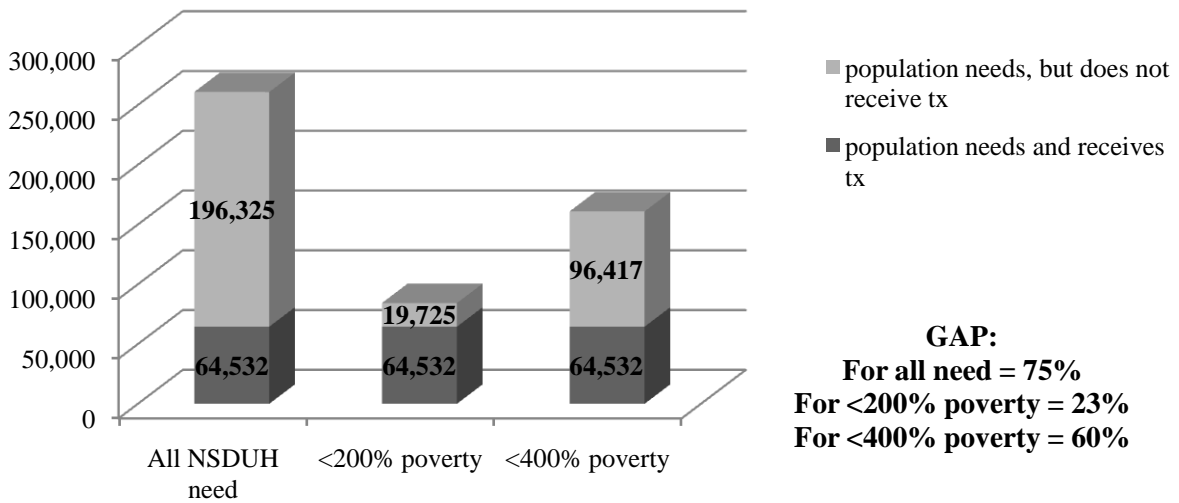


Figure 2.2
Treatment Gap for Youth ages 12-17
Need is 8.76% (26,765)

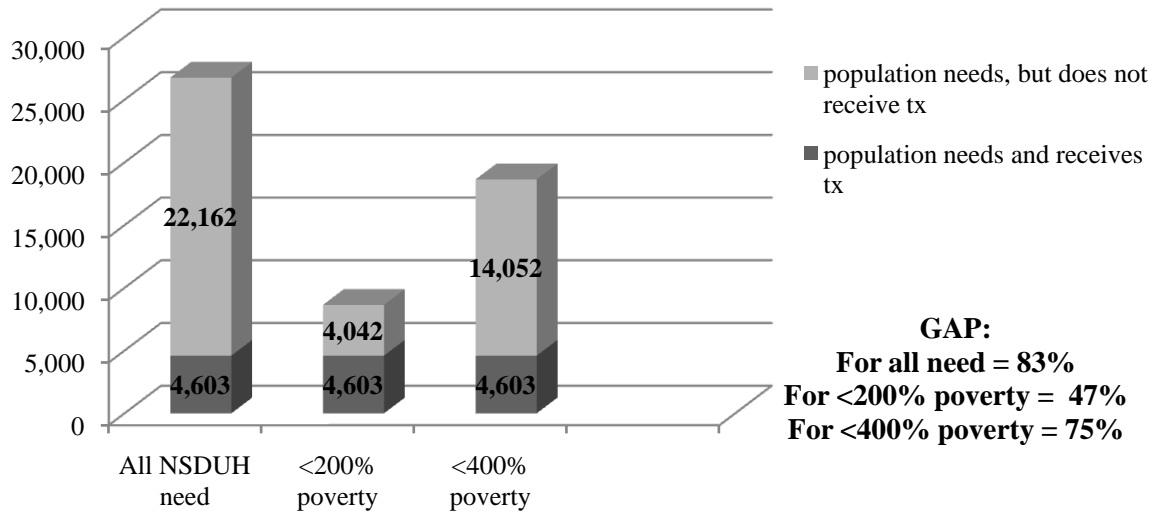


Figure 2.3
Treatment Gap for Young Adults Ages 18-25
Need is 20.13% (84,450)

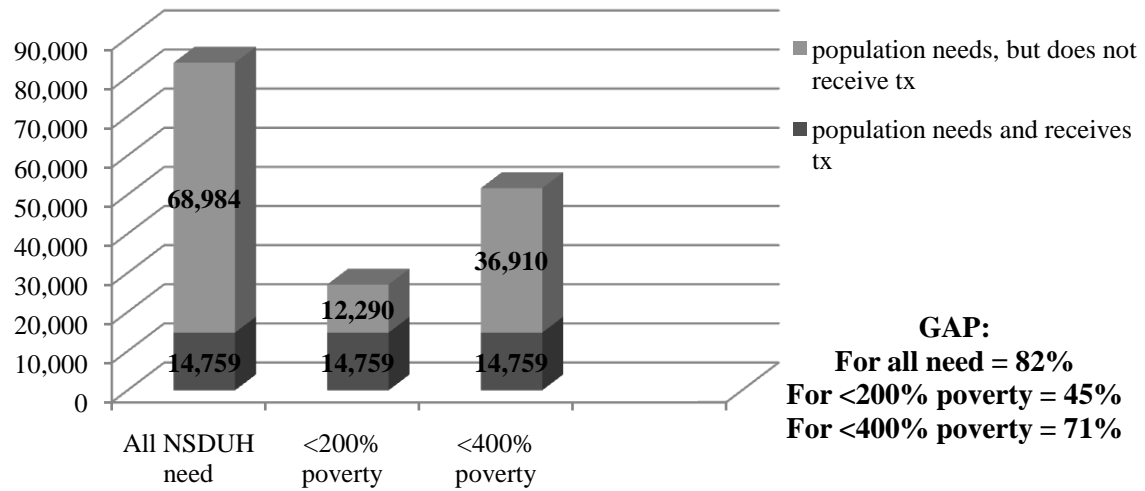
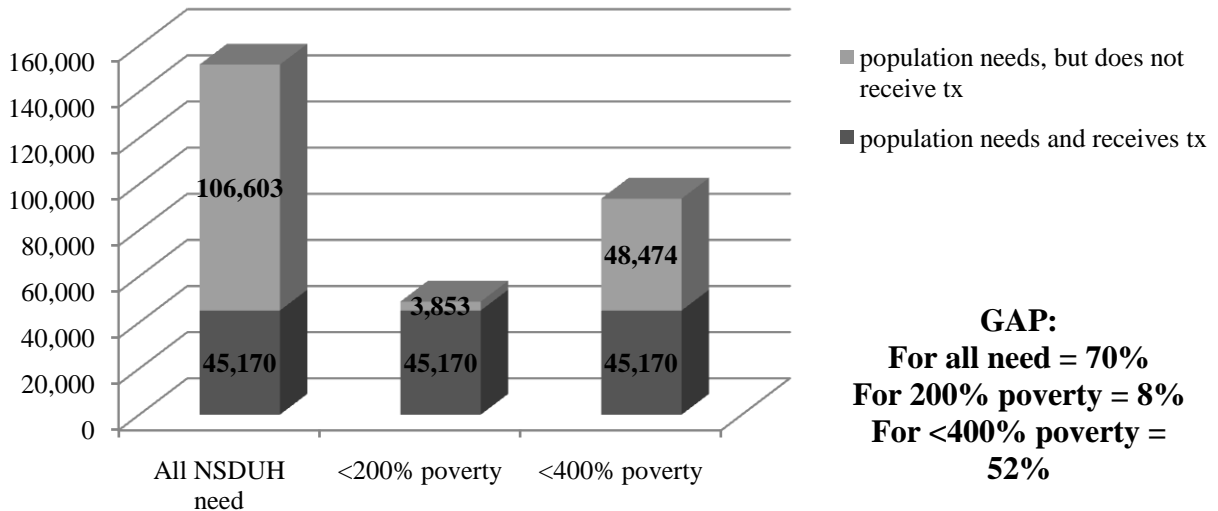


Figure 2.4
Treatment Gap for Adults Ages 26+
Need is 6.19% (151,773)



Discussion

As illustrated by the above figures and summarized in Table 2.2, the largest treatment gap occurs for the 18-25 age group. For this group, the gap between need and treatment is 83% for all income levels, 48% for less than 200% of poverty, and 76% for less than 400% of poverty. This age group also has the highest prevalence rates (20.13%). The gap for youth ages 12-17 is only slightly lower. Adults ages 26 and over have the lowest gap, although the gap percentage for less than 400% of poverty is still over half of the “need” population, at 52%.

	All	<200% poverty	<400% poverty
Ages 12-17	83%	47%	75%
Ages 18-25	82%	45%	71%
Ages 26 +	70%	8%	52%
All ages	75%	23%	60%

In examining the factors which contribute to these gaps in A&D services, it appears that, in general, treatment gaps generally occur for two reasons: inadequate service availability or incomplete identification of people in need. *Availability* refers to volume of services that can be produced – this depends on funding levels, number of providers, capacity of providers, availability and turnover of qualified staff, location of clients in relation to services, and other variables. *Identification* refers to the number of substance abusers who are referred for treatment, either through self-referrals or through an organization (such as a public agency or a health plan).

Youth are less likely to self-refer for treatment, and often don't receive treatment until they come into contact with a referral source. Both youth and adults, unfortunately, are more likely to be identified as needing treatment if they make contact with the justice system or with child welfare. Entrance into one of these systems usually triggers an assessment process, resulting in an awareness of a client's treatment needs (although the treatment itself may or may not be provided).

The OHP plays a critical role in identifying treatment needs. Since 2001, the decline in spending by the OHP has been a significant contributor to gaps in treatment for substance abuse. During the budget cuts of 2001-2003, mental health and addiction benefits for non-categorical eligibles were initially eliminated. When these benefits were restored, the number of individuals retaining eligibility in this category was reduced substantially. Enrollment of new people was closed. This had the effect of both reducing the number of clients screened and identified for treatment as well as reducing the number of clients receiving treatment. Clients in need of treatment had few options—among them were the corrections system and the limited amount of public funding available through AMH. Providers were also affected. Although many of them were able to increase their treatment options for clients who were still eligible, such as children, adolescents referred through CAF, and people with disabilities, they were generally not able to sustain their level of operations. Enrollment in the OHP was only recently re-opened by DHS with the development of a registration and random selection system. This process assures that enrollment of new people can be kept within the Legislatively Approved Budget. These shifts in OHP eligible individuals are likely reflected in the AMH treatment groups shown above.

Other Sources of Prevalence Data

While the NSDUH provides reliable estimates of A&D treatment needs in Oregon, it is valuable to also consider other sources of prevalence data. Among the most useful are the Oregon Healthy Teens Survey (OHTS), the Monitoring the Future Survey, and the Youth Risk Behavior Survey. Multiple indicators of substance abuse prevalence, including these surveys, are included in the upcoming report by the State Epidemiological Outcomes Workgroup (SEOW, 2008). These data illuminate some interesting facts, for example, 31% of 8th graders report consuming at least one alcoholic drink in the last 30 days. This is compared to 16% of 8th graders across the United States. Statistics compiled by the SEOW are also referred to in other reports covering various aspects of substance abuse prevention and treatment in Oregon, such as *The Domino Effect* and *Oregon Speaks*.

An additional source for prevalence measures is the National Outcome Measures (NOMs) State Summaries. These state summaries examine NOMs from the eight prevention domains, reporting on within-state trends and on state deviations from national means. Currently, the NOMs reports are produced by HSRI, under contract to the Center for Substance Abuse Prevention. The NSDUH is the primary source of data for the NOMs reports. Table 2.3 presents figures for Oregon's percent deviation from the national mean for alcohol, marijuana, and illicit drug use. These figures are for 2005/2006, the latest time period for which data is available.

Measure	Age Cohort	% deviation from national mean
% using alcohol in past 30 days	Ages 12-17	+14
	Ages 18+	+5
% using marijuana in past 30 days	Ages 12-17	+33
	Ages 18+	+43
% using illicit drugs other than marijuana	Ages 12-17	+2
	Ages 18+	-3

2.2 CHILDREN AND FAMILIES

CAF is a division of the DHS, protecting children from abuse and neglect. Substance abuse is highly prevalent among families engaged with the child welfare system; most families have a parent or a child needing intervention. For many parents, participation in treatment is part of their case plan and successful treatment is considered a precursor to termination of CAF's involvement with a family. CAF families are served in one of two ways: while their children remain in the home, and while their children are placed in foster care (family-based, group, or residential). Although CAF does not typically pay for treatment directly, the division administers over 40 contracts which support families receiving treatment. These supports consist of transportation, housing, and other logistical or recovery services to assist families with children in foster care or who are at risk of having children placed in care. Payment for treatment most often occurs through AMH, OHP, or private funding.

Data Sources and Methods

An analysis of treatment gaps for CAF families consists of two approaches: a gaps analysis for parents with children in foster care, and a gaps analysis for parents served while their children remain at home. Data for the former analysis is available and is reported on yearly by the CAF child welfare research unit (CAF, 2000-2008). Data for the latter analysis was compiled for this report.

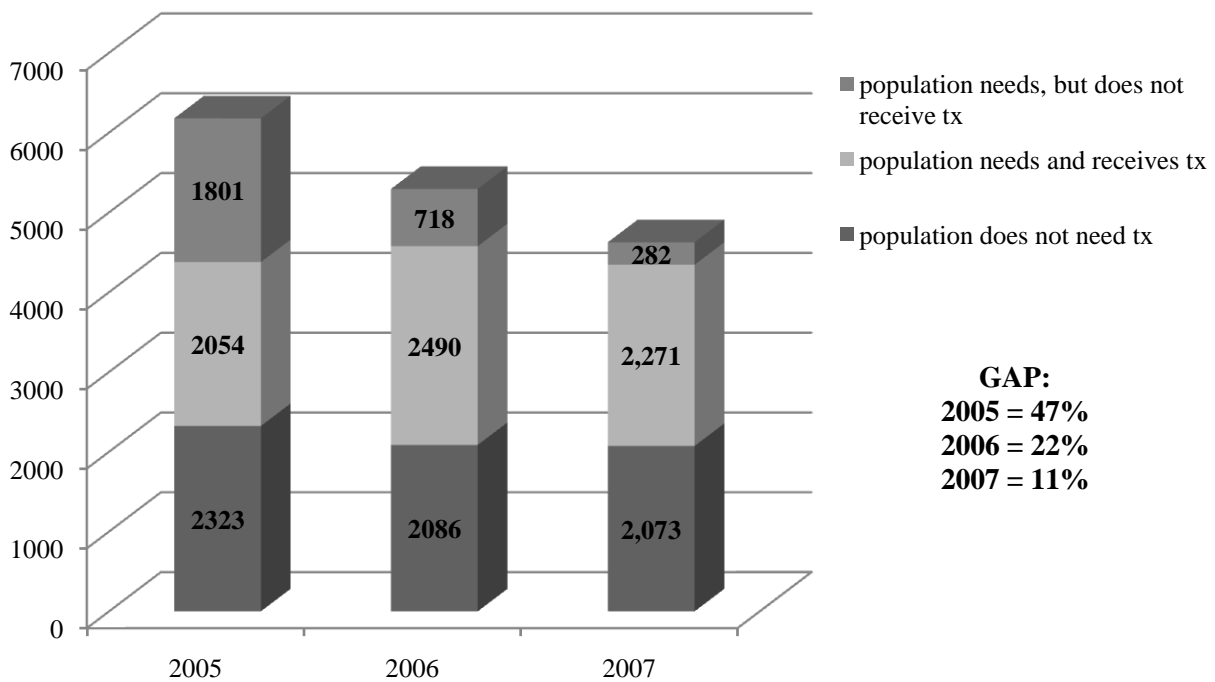
Results

Results for parents of youth in foster care: Figure 2.5 illustrates three calendar years of data on treatment gaps for parents with children in foster care. Data in this figure is at the child level: the full height of the bar represents the number of children entering foster care; the middle and top sections of each bar indicate the number of children entering foster care where the reason for removal was *parent drug abuse*; the top part of each bar shows the number of children with *one or more parents receiving treatment within 90 days of the child's move to foster care*. The left-hand bar shows that 2005 was a high point for the percentage of children entering foster care with parental drug abuse as a reason for removal – 3,855 children out of 6,178, or 62%; this has since decreased to 55% (2007). However, this percentage is still considerably higher than the

43% reported in 2000. Interestingly, the years 2000 and 2007 saw roughly equal numbers of children entering foster care overall; 4,675 and 4,626 respectively.

The gap numbers shown in Figure 2.5 indicate that over time, parents of foster care children are more often receiving treatment for their substance abuse need. Although the actual number treated has declined each year, those treated still represent a growing proportion of those with a treatment need.

Figure 2.5
Treatment Gaps for Parents of Children in Foster Care



Results for families served in-home: In 2007, 3,753 children were served as “in-home” cases. Of these, 1,233 (33%) had drug or alcohol use as a family stressor. Of these children, 34% had a parent who received treatment for a substance abuse issue. Although this percentage is considerably lower than the 89% of foster care youth whose parent(s) received treatment for their need, the identification measures are different. “Family stressor” may or may not indicate a direct need for treatment, while “reason for removal is parent drug abuse” implies that treatment is necessary for the child to return home. Therefore, although the foster care gap of 11% is much smaller than the in-home gap of 66%, it is potentially more concerning and is the focus of our discussion regarding CAF treatment gaps.

Discussion

The treatment gap for families with children in foster care has clearly diminished over the three years presented in Figure 2.5. However, treatment capacity has changed very little; the gap reduction is primarily a function of the changing demographics of the foster care population. Fewer children are entering foster care resulting in fewer families presenting with substance

abuse issues. Although the illustrated gap is small compared to overall population gaps discussed above, each CAF family that does not receive treatment may represent a child who stays longer in care than necessary or who returns to care at a later date.

2.3 DEPARTMENT OF CORRECTIONS

The Department of Corrections offers a variety of services to incarcerated individuals, including substance abuse treatment. Overall, 75% of incarcerated offenders are considered to be in need of this service. Treatment is prioritized for clients who are considered to have a high or medium risk of reoffending and who have a serious substance abuse issue (37% of the overall population), although some treatment is available to non-prioritized offenders.

Currently, 406 treatment beds are available for men and 54 beds for women in Oregon. Approximately 23% of these beds were added in 2007. Treatment is generally provided in housing units which are separate from the general population and are located at only a few facilities around the state. Treatment is prioritized for clients in the last six months of their prison stay. All treatment offered is evidence (research) based.¹

Data Sources and Methods

Data for the DOC state facility gaps analysis was obtained from the DOC data system for the years 2006 and 2007. Both analyses use an exit cohort of inmates released between January 1 and December 31 of each calendar year. In 2006, the exit cohort totaled 4,534. In 2007, the exit cohort totaled 4,551. The numbers of inmates in need of treatment for each year were obtained by applying the 75% prevalence figure to the total to create an *overall need* and by applying the 37% figure to the total to create the *prioritized group*. The DOC treatment numbers were then subtracted from the two “need” groups to highlight the treatment gap. The treatment numbers shown include offenders who received any treatment, not just those who completed treatment.

¹ More information on treatment protocols for incarcerated clients can be found in Chapter 4, Performance Management.

Results

The following figures illustrate the treatment gaps for all offenders (Figure 2.6) and just for the prioritized group (Figure 2.7). Although the total numbers of clients exiting corrections is roughly equal across the two years, the gap has increased by 15%. This pattern also holds for the prioritized group: total numbers of prioritized clients are nearly identical in the two years but the gap has increased by 15%.

Figure 2.6
DOC Treatment Gaps for all Offenders

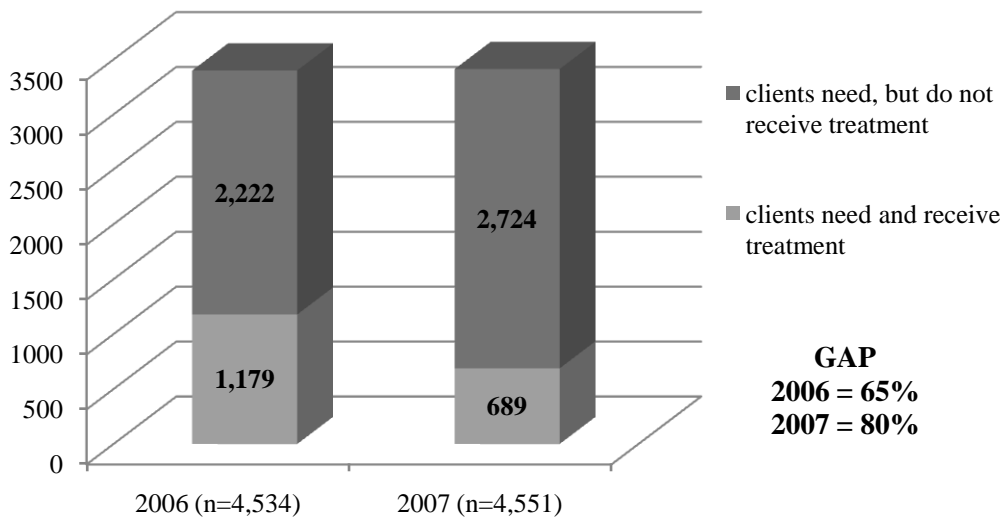
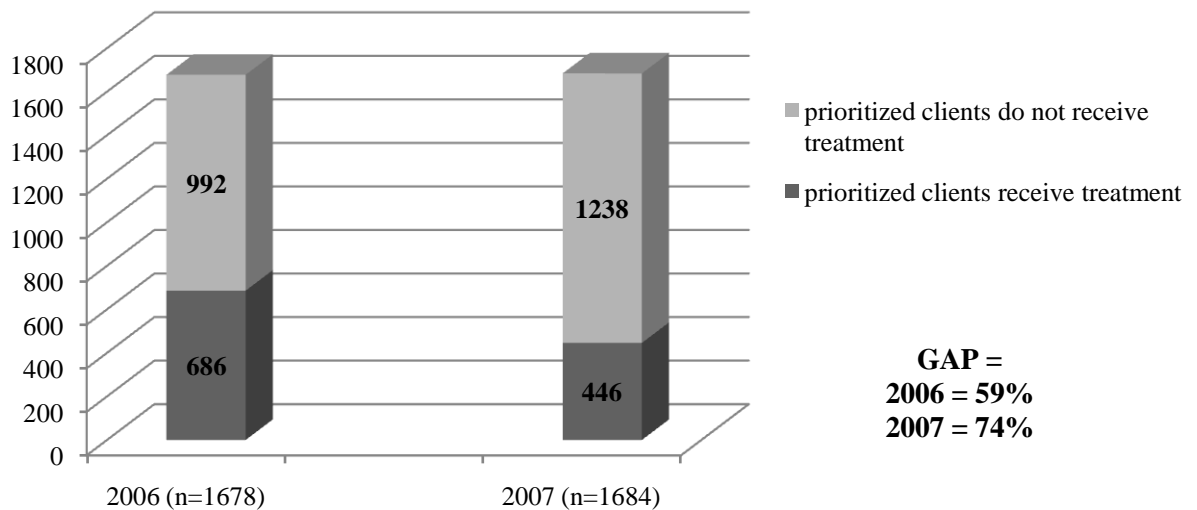


Figure 2.7
DOC Treatment Gaps for Prioritized Offenders



Discussion

As illustrated by Figures 2.6 and 2.7, the gap between the number of incarcerated offenders who are in need of substance abuse treatment and the number who received treatment in 2007 was 80% for all offenders, and 74% for prioritized offenders. These figures represent an increase since 2006, despite the addition of 105 treatment beds in the latter half of 2007. DOC staff report that more clients are completing treatment, resulting in fewer slots becoming available for waiting offenders.

Current funding and capacity levels only allow a fraction of Oregon inmates to receive evidence-based, segregated treatment for their substance abuse issues. Although offenders are required to have a transition plan that includes an appointment with a community provider, data on follow-up care for previously incarcerated clients released under supervision is not available for all counties. Most counties do not have specific programs for prison inmates exiting into their county, let alone for offenders exiting jail or those who are sentenced to probation. Both treated and untreated offenders generally exit into the same community treatment settings that serve non-offending clients.

2.4 OREGON YOUTH AUTHORITY

Treatment for substance abuse issues for youth in custody of OYA is provided by OYA staff using evidence-based practices assigned by client risk level and gender. Currently, 73% of all OYA youth in facility and community settings have histories of drug and/or alcohol usage. Of that group, 29% are diagnosed as “abusive” and 31% as “dependent” (OYA, 2008). Youth are assessed at entry into the system with a risk-needs assessment (RNA). The RNA identifies youth who have a need for a comprehensive drug and alcohol (AOD) evaluation and who are likely to need treatment. Youth who use drugs and/or alcohol, but are not identified as abusive or dependent, are targeted by OYA facility prevention and education programs operated by the Department of Education.² Although referred youth are not necessarily considered to be “ordered into treatment”, their participation is generally required while they reside in an OYA facility, as well as through parole and probation agreements.

Data Sources and Methods

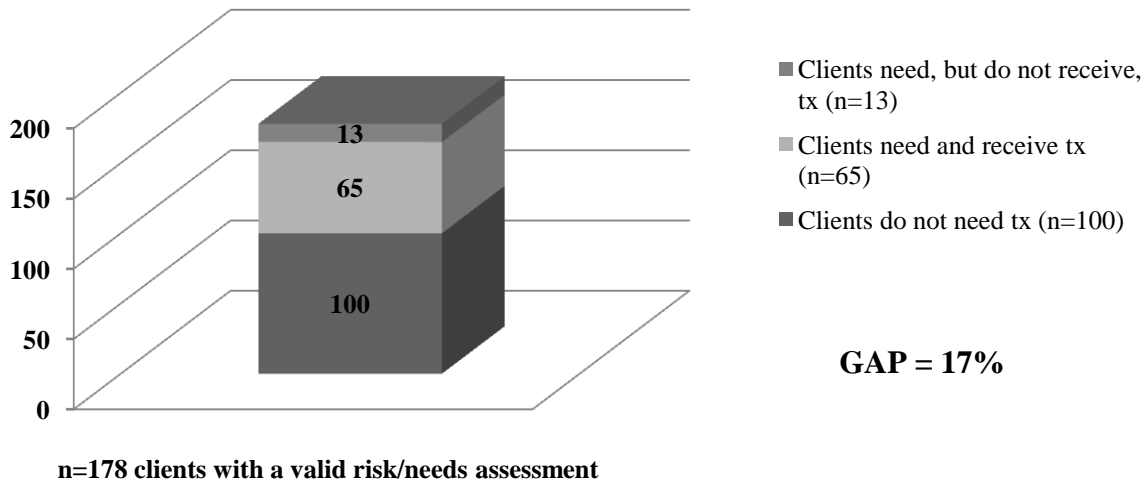
All data obtained for the OYA gaps analysis was provided by OYA and obtained from the Juvenile Justice Information System (JJIS). OYA research staff selected a six-month facility exit cohort consisting of 178 youth who exited between July 1 and December 31, 2007. Quantitative information extracted from JJIS for this sample was supplemented by electronic case notes pulled by OYA staff. For example, in some instances, case notes recorded that a youth participated in treatment prior to release, yet the service was not entered into JJIS. A few of these youth may have had treatment that was not entered into either JJIS or into case notes; evidence of treatment for these youth would have to come from paper files (not obtained for this analysis).

² The Department of Education was not an agency selected for this analysis.

Results

Figure 2.8 illustrates the treatment gap for OYA clients.

**Figure 2.8
Treatment Gap for Oregon Youth Authority Clients**



Of this sample, 78 youth, or 44%, scored high enough on the RNA to be referred for a full AOD evaluation and, most likely, treatment. JJIS data and electronic case notes show that 65 of these clients received treatment and 13 did not. Given these figures, the OYA treatment gap is 17% for this sample. Generally, youth committed to OYA receive treatment if they need it. The most common reasons for a youth not to receive treatment are:

- Some youth are not in close custody long enough for treatment to commence; shortly after intake these youth exit to a community setting where treatment may occur.
- Some youth are “capped out” if a higher-risk youth from their county needs to be committed.
- Some youth refuse to participate in treatment.

Discussion

The above information is presented for youth within OYA facilities. For these youth, most of whom enter with a substance abuse issue, treatment is consistently available. Data is less readily available on treatment gaps for youth committed to community settings. These youth are served by individual providers, some of whom may be under contract to OYA to serve non-Medicaid eligible youth.

2.5 PREVENTION GAPS

Calculating the gap for prevention services is more complicated than for treatment services. The complications arise from both parts of the calculation: it is difficult to identify who *needs* preventive services (Is it just those who have never abused alcohol or used/abused drugs?), and it

is very hard to specify who *receives* a prevention activity, especially when it takes the form of a public service announcement, a school assembly, or the like. The discussion below offers a fairly broad look at prevention gaps, synthesizing what little quantitative data is available while keeping in mind the imprecision of the counts.

HSRI relied on two primary data sources on the need for prevention: the NSDUH and the OHTS. As noted above, the NSDUH estimates that 9% of youth aged 12-17 need A&D treatment – this constitutes nearly 27,000 Oregon youth. Since this age cohort is a school-aged population, one can assume that most school students are exposed to illegal drugs³ to some degree. A conservative approach would view the entire age cohort (305,540 youth) as needing preventive services. OHTS data adds further support to this argument: 2007 summary statistics indicate that 31% of 8th graders reported using alcohol in the past month and 13% reported at least one occasion of binge drinking in the past month. In addition, the 2008 AMH strategic plan reported that youth participating in focus groups “have an overwhelming sense of urgency about the need for their peers to access effective prevention and treatment services” (AMH, 2008, page 5), pointing in particular to the need for prevention services to start at an earlier age.

To understand the service provision side of the gaps calculation, HSRI focused on two state agencies that support substance abuse prevention services in Oregon: OCCF, which funds prevention through the federal Juvenile Justice and Delinquency Prevention (JJDP) grant program, and AMH, which funds prevention through the federal Substance Abuse Prevention and Treatment (SAPT) block grant as well as other funding sources. Both agencies distribute funding to counties, where it is allocated for prevention purposes. Measuring the number of clients served through these activities is a challenging task. AMH measures prevention services through the Minimum Data Set (MDS), a prevention database into which counties enter information about their prevention services, subdividing services into IOM (Institute of Medicine) categories. These categories separate prevention activities into three types--*universal, selected, or indicated*. Universal prevention activities, such as a media campaign, aim to serve an overall population. Selected interventions serve a subset of individuals who are considered to be at higher risk, and indicated prevention efforts serve a population showing early signs of substance abuse. Unfortunately, aggregating data from MDS for comparison purposes across counties is generally unreliable for the following reasons:

- IOM prevention categories are not consistently defined across counties, i.e., one county may label an activity as “selected” while another may label the same activity as “targeted”.
- There is a large lag time for data entry—counties may be serving thousands of clients through activities that have not yet been entered into the data system.
- Numbers served vary widely, resulting in most counts appearing as statistical outliers, and many interventions simply list “0” under the total number served. Total numbers served can vary widely over time -- for example, a large media campaign occurring during one year can inflate the numbers served for that year by hundreds of thousands of people.
- Numbers reported are not unduplicated – the data entered is aggregate numbers served through each activity, not individual client-level information.

³ “Illegal drugs” here includes alcohol, since possession is illegal for Oregon youth under age 18.

- Many counties are not entering information consistently; although sanctions are possible, no county has had funding withheld due to non-compliance with data entry.
- It is difficult to use the available data to determine the location of services, i.e., “school-based” or “community-based”.

OCCF measures prevention through two linked databases: the comprehensive plans database and the local resources database. In addition, OCCF uses the JCP database for JCP-funded programs. The fields in these databases list community issues, such as alcohol and drug abuse, number of clients served, and amounts invested. At the time of this analysis, the OCCF database was not complete. OCCF staff selected preventive activities that they defined to be drug- and/or alcohol-related. In 2005-2007, 13 counties reported to OCCF that they carried out one or more activities related to substance use prevention.

Many individual prevention programs, such as **Safe and Drug Free Schools** and **Strengthening Families** have ongoing, independent, evaluations available which address the ways in which the intervention is meeting the needs of the community or communities.

A gaps analysis for prevention should analyze all available sources of prevention counts from Oregon Counties (AMH and OCCF) in order to gather information on areas most in need of preventive efforts. Many counties keep tallies of prevention efforts outside of MDS. If it is desired to categorize prevention efforts into IOM categories, standard definitions and counting practices by category should be applied since prevention counts are not, generally, unduplicated individuals. In addition, a standard definition of substance abuse prevention should be utilized, as many programs impact substance use even when not specifically targeted to do so. These standardized and consistent counts may assist in identifying prevention gaps across the state.

2.6 GENERAL DISCUSSION AND NEXT STEPS

Treatment gaps in Oregon appear to be significant for the population as a whole, particularly for young adults, and for DOC clients. Gaps appear to be less severe for CAF families with children in care, possibly because foster children come disproportionately from families who have low incomes and thus are eligible for Medicaid. The gap is also smaller for youth residing in OYA facilities.

It is important to reiterate that the gaps summarized in Table 2.2 above reflect much more than the shortfall in AMH service delivery. AMH-funded A&D services are the safety net for all Oregonians. For example, when eligibility for OHP is narrowed, families and individuals may continue to go to the same A&D provider who was serving them under OHP – but now the provider will have to find other funding sources for the needed treatment. Similarly, when adults or youth exit correctional facilities, they turn to local A&D providers for treatment; when funding is insufficient, those clients are counted as part of the general population with “unmet needs” – not part of the correctional system’s gap. On the other hand, access to A&D treatment for the general population may *prevent* some individuals from ending up in the correctional system. In some ways, therefore, AMH deals with a diverse and constantly changing population in need of A&D services – not only changing in size but also varied in the type of intervention needed and where the clients are located. Assuring an adequate A&D treatment capacity to respond to unexpected fluctuations in need requires a level of effort statewide that is challenging to sustain, both financially and structurally.

Services Provided

The fluidity in the populations needing A&D treatment sets the stage for difficulties in accurately tracking the amount of service provided. Table 2.4 brings together all the service delivery information presented earlier in this report. DHS divisions not surprisingly have been the ones to serve most of the population in need; even though AMH shows a 75% gap between clients needing services and those receiving it, its level of effort dwarfs all other agencies’.

Table 2.4 Number of People Receiving A&D Treatment, 2007		
	# Adults served	# Youth served
AMH (from CPMS)	59,959	4,603
CAF – parents of foster children	2,271	N/A
OHP – quarterly average	6,097	1,160
CJC – Drug Courts	1,883	248
DOC – 1-year exit cohort	689	N/A
OYA – 6-month exit cohort	N/A	65

Table 2.4 requires additional explanation. The first point is that the numbers cannot simply be aggregated to a total number receiving A&D services in the calendar year. Each agency provided unduplicated numbers for its own clientele, but it is resource-intensive to unduplicate across agencies. For example, it is very likely that some of the people served by DOC were also served during the same year by AMH, OHP and/or CAF. The CPMS provides the most comprehensive source of service recipient counts, since local A&D service providers enter client-level information on all those served using public dollars; but to create a cross-agency unduplicated tally would require matching client lists across various agencies’ databases. On the other hand, some of the counts in Table 2.4 may in fact be *undercounts*. For example, the CAF figure is the count of children whose parents have a substance abuse issue that is serious enough to have been the reason for the child’s removal from the home. One or both parents may have a treatment need; the CAF counts simply indicate that at least one parent received some amount of treatment. The actual number of CAF adults receiving A&D treatment may be larger than the figure in Table 2.4.

The second point to emphasize is that “receiving treatment” does not have a consistent meaning across agencies. A person may have attended one treatment session, or perhaps only received an assessment; at the other extreme, the individual may have completed a full treatment regimen.⁴ And, if an individual participated in several different cycles of treatment, he/she is counted only once. This has direct ramifications for the size of the service gap: as DOC has reported, when bed space is limited, keeping clients in treatment until “completion” effectively reduces the agency’s capacity to serve greater numbers of people.

⁴ CPMS treatment completion rates for fiscal year 2007 are considered to be around 61%, however, many caveats apply to this figure. For example, of the total number of clients in the system at that time, one-third have a completion code of “unknown” or are not closed out of the system.

The third point to note regarding Table 2.4 is that some of the figures are cumulative for the entire calendar year and others are not. For example, the OYA figure only reflects clients served during the second half of 2007.

All of these issues combine to make it very difficult to judge the extent to which a particular agency's target population is underserved. It is also difficult to consistently estimate gaps when tracking methods vary by agency and community. For example, some counties track clients who are referred to community treatment by DOC and some do not.

Next Steps

To develop a comprehensive understanding of treatment gaps in Oregon, further work needs to be done in terms of both supply and demand. HSRI's work points to five specific areas for further study: *First*, data needs to be gathered on the following populations:

- Homeless individuals;
- Community corrections clients, including those who are released from a state facility, those exiting from jail, and those committed to probation; and
- OYA youth served in the community.

Second, gaps in infrastructure also exist. Gaps in staffing and capacity within the provider network make it difficult for clients, particularly in some areas of Oregon, to obtain treatment on demand. There are also gaps in transitional and recovery housing. These kinds of gaps should be explored in greater detail.

Third, a prevention gaps analysis should be conducted using the methodology described above. As mentioned, it will be important to standardize categories of prevention so that need figures can be appropriately matched to numbers served through each type of prevention activity. Such an approach could also lay the foundation for more systematic examination of impact.

Fourth, more process work should be done to examine the waiting list issue. Because Oregon does not have a universal waitlist, it is difficult to determine if waiting periods are a significant contributor to treatment gaps. In the county case studies, HSRI begins to address the dimensions of the population awaiting service, as part of learning how all aspects of the Oregon A&D system interface at the local service delivery level.

Finally, long-term attention should be given to developing an approach to estimating an *overall system gap* for Oregon's A&D population. As noted throughout the discussion above, it is not currently possible to compute an unduplicated count of people served across the five main state agencies without integrating data systems or matching client lists. These tasks have been approached at various levels, primarily within DHS, but have not been comprehensive. For example, CAF clients who are captured in CPMS are matched for the foster care gaps analysis discussed above, but DOC or OYA clients have not been matched. Some database integration is currently being developed within DHS, but is not yet complete. A systematic approach to client matching would assist in developing an unduplicated, inclusive, baseline gap for Oregon. This gap could then be re-evaluated subsequent to changes in investments.

CHAPTER THREE: PUBLIC INVESTMENT

The Investments Analysis is a crucial counterpart to the Gaps Analysis -- examining changes in expenditure patterns over time. Using data compiled by state agency staff, HSRI analyzes both the inflows and outflows of funds for each state agency. By presenting investment figures for each of the past four biennia (2001 to the present), we describe aggregate fluctuations in A&D spending which may be related to shifts in population need and/or services provided over time, or may simply reflect a shift in available resources. For the 2005-2007 Biennium, we offer more detailed analysis of funding flows and breakdowns among major spending categories for each state agency. This analysis reveals the relative financial importance of different agencies and funding streams in the overall Oregon A&D system.

This chapter begins by describing HSRI's approach to the analysis and gives a broad look at overall A&D spending. The next five sections provide a more detailed look at spending patterns for each of the five core state agencies. We then briefly examine the role of the Oregon Liquor Control Commission because of its integral role in funding A&D services. The next section includes some initial insights into how resources are received and allocated at the local level, presenting findings from HSRI's surveys of the Community Mental Health Programs (CMHP) and private A&D service providers. We then provide a brief description of efforts to explore expenditure patterns in other states with similar characteristics to Oregon. The final section of this chapter offers conclusions and suggests some avenues for further study.

3.1 APPROACH AND OVERALL INVESTMENTS

Working closely with fiscal and program staff in each of the five state agencies, HSRI has developed a rough portrait of Oregon public sector investments on addiction services over the past eight years. We chose to study four biennia -- 2001-2003 through the current 2007-2009 period -- in order to capture the major recent ebbs and flows in the state budget. Actual expenditures were obtained wherever possible. When actual expenditures were not available, legislatively adopted budgets (LABs) were used. As in the Gaps Analysis, we separately examine treatment and prevention funding, where possible. It is important to note that not all five of the state agencies provide both types of services -- only DHS and OYA offer both A&D prevention and treatment, while DOC and CJC provide only treatment and OCCF provides only prevention.

To make this analysis more meaningful, we report not only the actual dollars budgeted or spent each year ("nominal dollars") but also adjust those figures for inflation ("inflation-adjusted dollars"), using the 2001-2003 Biennium as the baseline and adjusting in accordance with the Consumer Price Index⁵. Table 3.1 shows the inflation factor for each of the four biennia and how that translates into current purchasing power. For example, \$1 million of spending in 2007-2009 is equivalent to having only \$828,400 in 2001-2003 terms. In all subsequent tables showing investments over time, both nominal and inflation-adjusted figures are provided.

⁵ Using the consumer price index (CPI) is a standard means to account for the impact of inflation when comparing spending over multiple time periods. By determining the level of the CPI at the time an expenditure is made, one can readily calculate the value of that expenditure in terms of what a dollar will buy today. A higher CPI compared with an earlier period indicates that it takes more dollars now to buy something than during the earlier period.

Table 3.1 Calculating Inflation Adjustments		
Biennium	Inflation factor Adjustment	Inflation adjusted value of \$1 million spent in Biennium
2001-2003	100.00%	\$1,000,000
2003-2005	95.15%	\$951,500
2005-2007	88.11%	\$881,100
2007-2009	82.84%	\$828,400

Table 3.2 presents total drug and alcohol expenditures over the four selected biennia. The listed totals include budget amounts from the following agencies:

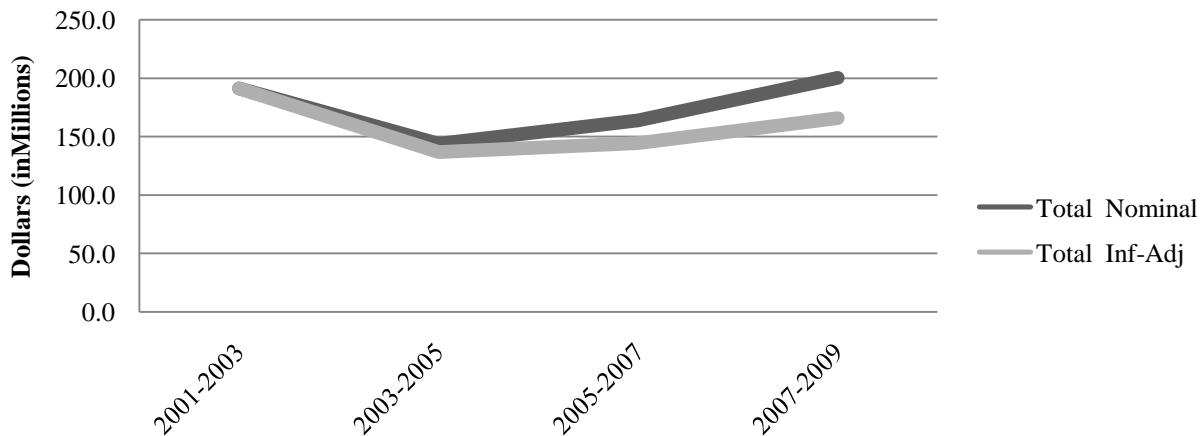
- Prevention: DHS (including Addictions and Mental Health, Children and Families, and the Temporary Assistance to Needy Families program), OYA and OCCF⁶
- Treatment: DHS (including AMH, CAF, and the Oregon Health Plan), CJC, DOC, and OYA

Table 3.2 Overall Drug and Alcohol Expenditures by Biennium (\$ Millions)							
Biennium	Total			Prevention		Treatment	
	Nominal	Inf-Adj	Rate of Change	Nominal	Inf-Adj	Nominal	Inf-Adj
01-03	\$191.3	\$191.3	--	\$19.9	\$19.9	\$171.4	\$171.4
03-05	\$143.8	\$136.8	-28.5%	\$17.7	\$16.8	\$126.1	\$120.0
05-07	\$163.8	\$144.3	5.5%	\$21.4	\$18.8	\$142.4	\$125.5
07-09	\$200.3	\$165.9	15.0%	\$28.5	\$23.6	\$171.8	\$142.3

⁶ OCCF spending on prevention was only available for the last two biennia.

Figure 3.1 shows the trend in total expenditures over time, illustrating the significant dip in 2003-2005 and the lack of recovery up to the current biennium. In inflation-adjusted dollars, the total amount of 2007-09 projected spending on A&D prevention and treatment is \$165.9 million, compared with actual expenditures in 2001-03 of \$191.3 million. Figure 3.1 makes clear that, across the five major Oregon state agencies providing A&D services, the system has not yet recovered from the severe losses in the 2003-2005 Biennium; in inflation-adjusted terms, in 2007-2009 Oregon expects to spend 13% less than it did in 2001-2003.

Figure 3.1
Drug and Alcohol Expenditure Trends by Biennium



The following sections disaggregate these total figures into profiles of spending by each of the five state agencies. Focus is placed on the 2005-2007 Biennium, and, to the extent possible, we provide a more detailed look at components of the total spending, such as direct service spending versus administrative costs and contracting versus agency-provided services. The 2005-2007 Biennium was selected because it is the most recent period for which there are actual expenditure figures -- the current biennium is still underway so its data represents budgeted amounts (LAB) rather than actual spending.

3.2 DEPARTMENT OF HUMAN SERVICES INVESTMENTS

Within DHS, the divisions responsible for providing A&D prevention and treatment services include AMH, CAF and the Division of Medical Assistance Programs/Oregon Health Plan (DMAP/OHP). In the analysis below, we discuss each of these arenas in turn, and supplement the picture with a brief look at the Temporary Assistance for Needy Families (TANF) program. However, it is important to note that many other offices in DHS may provide some prevention, treatment and/or recovery services that are essential complements to the core A&D activities, and, indeed, often serve as the “glue” that enables service recipients to initiate treatment and maintain their involvement as long as necessary. For example, we have identified that some investments in A&D services are made under the auspices of the Oregon Vocational Rehabilitation Services (OVRs), which is housed in the Seniors and People with Disabilities Division (SPD) of DHS. This and other similar activities are outside the scope of the current analysis.

To fully understand the measurements used in the following analysis, it is important to know the role played by each of the key DHS offices and divisions.

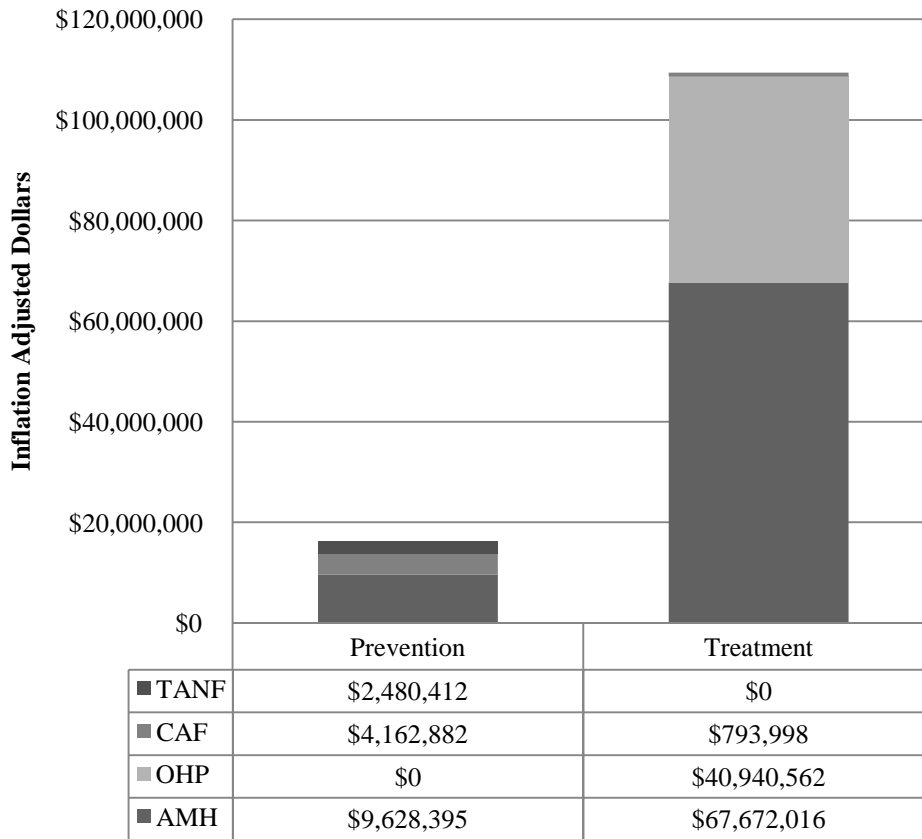
- **AMH** is the most significant division both in its focus on issues relating to A&D and in the size of its investment in both treatment and prevention services. It provides the majority of funding to CMHPs for services for individuals not eligible for OHP funding.
- **DMAP/OHP** provides significant investment in A&D treatment services for eligible populations with a majority of expenditures/services (approximately 70%) delivered through managed care plans and the balance using fee-for-service arrangements.
- **CAF** provides specific A&D investments in its Child Protection (Safety and Permanence for Children) area. Screening and assessment services are provided to ensure prompt, effective identification of parents' A&D problems affecting safety of children; and supportive services such as transportation are offered to facilitate parental use of services needed to address these problems.
- **TANF** (located in the Self-Sufficiency Program area in CAF) offers non-treatment services such as screening for indicators of addiction, information and referral, case management triage and staff training related to A&D issues.

Overall DHS Spending

Table 3.3 presents A&D expenditures by biennium for the above-listed sub-agencies within DHS; Figure 3.2 provides additional detail for 2005-07, separating prevention and treatment dollars and adjusting for inflation. It offers a graphic view of the relative size of these investments by DHS division.

Biennium	AMH <i>Tx & Prev.</i>	CAF <i>Tx. & Prev.</i>	TANF <i>Prev.</i>	OHP <i>Treatment</i>	Total	Total inflation- adjusted
01-03	\$109.6 M	\$5.6 M	\$1.9 M	\$51.9 M	\$169.0 M	\$169.0 M
03-05	\$81.2 M	\$5.6 M	\$2.6 M	\$40.3 M	\$129.7 M	\$123.4 M
05-07	\$88.9 M	\$5.6 M	\$2.4 M	\$46.5 M	\$143.4 M	\$126.3 M
07-09	\$114.8 M	\$5.8 M	\$2.7 M	\$41.0 M	\$164.3 M	\$136.1 M

Figure 3.2
A&D Treatment and Prevention Investments by DHS
2005 - 2007 by Division



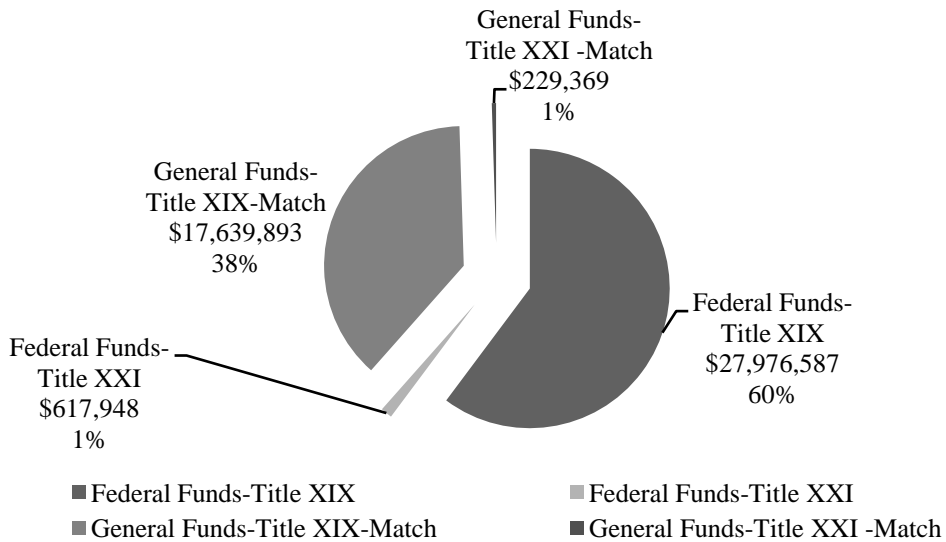
DHS total spending, even without adjusting for inflation, is still lower in the current biennium than it was in 2001-03. Table 3.3 makes clear that this is due largely to reduced funding for A&D treatment within the Oregon Health Plan. As discussed in the Gaps Analysis (Chapter Two), cuts in OHP have had a dual effect: they reduced the number of citizens identified as needing treatment (the Health Plans ceased screening OHP Standard participants for A&D issues, since A&D services were no longer a covered service); and they reduced reimbursements for clients attempting to access and complete treatment.

Two additional patterns in DHS spending are worth noting. First, CAF spending is virtually level over the four biennia, declining only due to inflation. This suggests that policy makers acknowledge that the CAF A&D initiatives are an ongoing and necessary expenditure. Despite declining numbers of children placed in out-of-home care (see Gaps Analysis - Chapter Two), these A&D resources are a core support for families who become involved with the Oregon child welfare system. Second, A&D prevention spending for the TANF population has remained fairly steady. It dipped somewhat in one biennium but has grown recently, with 2007-09 estimates exceeding the 2001-2003 baseline level. This increase may have come in response to the increasing frequency of A&D needs among TANF applicants; those joining the rolls tend to be those with the most need for A&D screening, case management, and support services.

One further point should be made with respect to OHP. As Figure 3.3 illustrates, OHP funds come primarily from the federal Medicaid Program (Title XIX) and the required state match. The

proportions shown in the pie chart therefore remain fairly steady regardless of changes in the total size of the pie over time. The sharp decline in OHP revenues in 2003-2005 resulted from the loss in available state general fund dollars, causing an automatic loss in federal Medicaid dollars.

Figure 3.3
Oregon Health Plan: Funding Sources
for Chemical Dependency Treatment, 2005-2007
 Total Expenditures = \$46,463,796



AMH Investments Over Time

Because AMH investments constitute well over half of DHS funding, this section offers greater detail on spending patterns. We discuss changes in A&D investments over time, examining differing allocations for prevention and treatment as well as fluctuations in amounts coming from various funding sources. We also explore more deeply the way dollars are distributed from the state to the local level.

Expanding on the total AMH figures provided in Table 3.3 (above), Table 3.4 and Figure 3.4 offer further data on A&D funding patterns for AMH. In inflation-adjusted terms, current AMH spending remains below 2001-03 levels. Table 3.4 breaks AMH funding into prevention and treatment, as well as showing the impact of inflation on budget allocations. As shown, neither nominal nor inflation-adjusted spending on treatment has yet returned to the levels experienced in the 2001-03 Biennium, but spending on prevention has increased somewhat. The growth in prevention activity is responsible for the nominal AMH increase.

Table 3.4
AMH Spending on A&D Prevention and Treatment by Biennium

Biennium	Treatment	Prevention	Total A&D Funding	Total in Inflation-Adjusted Dollars	Rate of Change
01-03 Actual	\$96.2 M	\$13.3 M	\$109.6 M	\$109.6 M	--
03-05 Actual	\$71.1 M	\$10.1 M	\$81.2 M	\$77.3 M	-29.5%
05-07 Actual	\$75.2 M	\$13.8 M	\$88.9 M	\$78.4 M	+1.4%
07-09 LAB	\$95.6 M	\$19.2 M	\$114.8 M	\$95.1 M	+21.3%

Figure 3.4
AMH Spending Trends on Drug and Alcohol Prevention and Treatment by Biennium

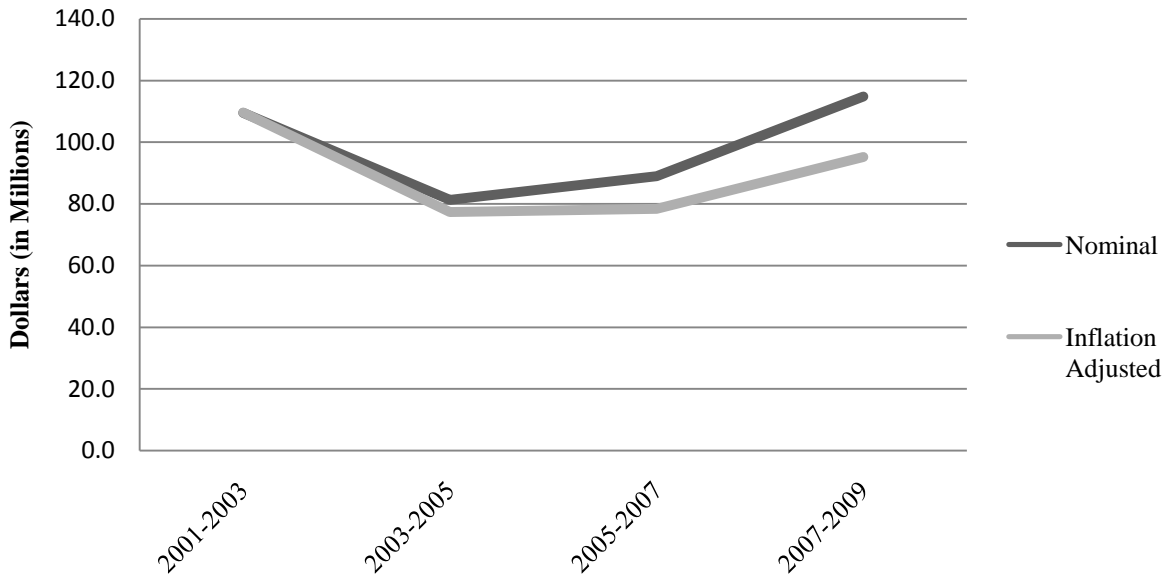


Figure 3.4 raises the question of what caused the decline in funding – was it a particular funding source? Figure 3.5 displays the trend line for the three major AMH funding sources over the four biennia – federal funds, state general fund, and “other” funds. Table 3.5 shows the dollar amounts for the 2005-07 Biennium, for each funding stream and also separating prevention and treatment funding. Overall, the federal fund contribution has stayed relatively flat over the four biennia, while the state general fund contribution has fluctuated sharply and “other” funds have steadily decreased. We discuss below the latter two patterns.

Figure 3.5
AMH Funding Sources for A&D Services
 (Nominal dollars)

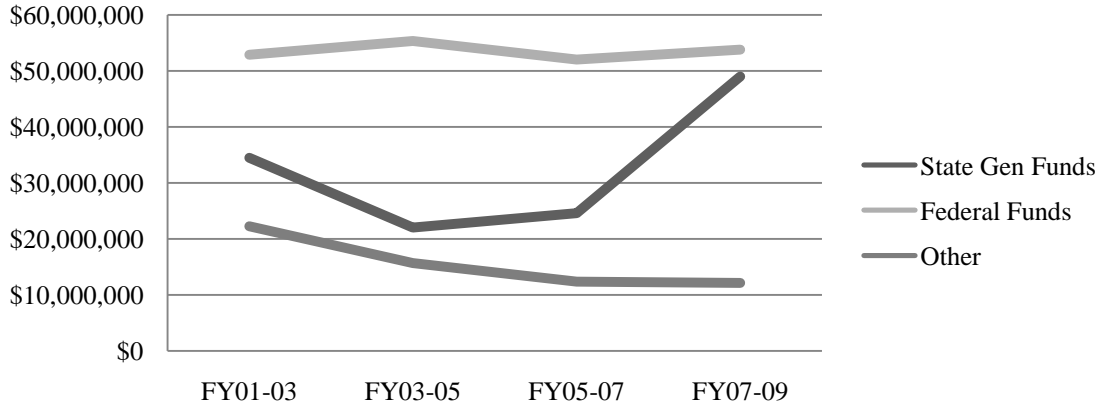


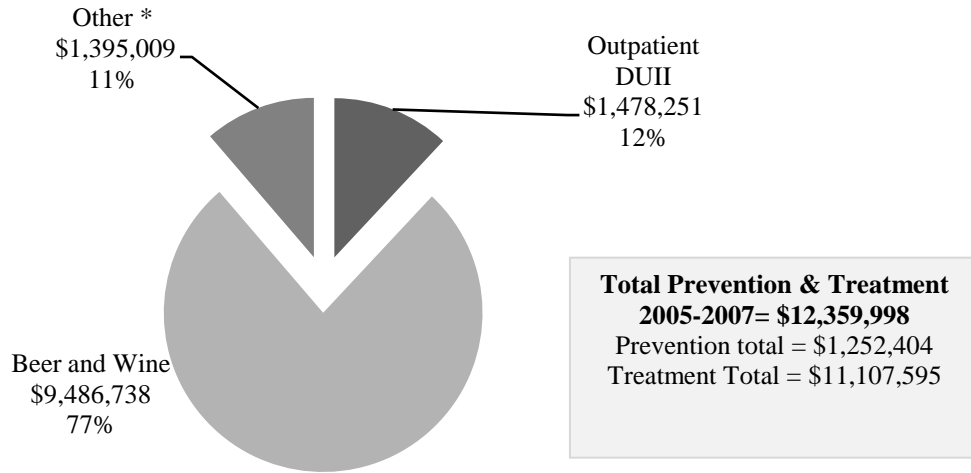
Table 3.5
AMH 2005-2007A&D Investments by Funding Source (in \$millions)

Funding Source	Treatment	Prevention	Total	% of Total
Federal Funds	\$40.0 M	\$12.0 M	\$52.0 M	58.4%
State General Fund	\$24.1 M	\$0.5 M	\$24.6 M	27.7%
Other funds	\$11.1 M	\$1.3 M	\$12.4 M	13.9%
Total	\$75.2 M	\$13.8M	\$88.9M	100%
% of total	84.5%	15.5%	100%	

Table 3.5 helps to clarify the implications of the dramatic changes in state general fund revenues coming to AMH. By displaying spending amounts for the 2005-07 Biennium, the table illustrates the differing effects on prevention versus treatment. Most of the impact of the state general fund losses was felt in the treatment arena because, as the table shows, nearly 85% of total A&D dollars go to treatment. Prevention, by contrast, receives nearly all its funds from federal sources which have been relatively unchanged.

Figure 3.5 above also highlights the steady decline in “other” funds, a pattern that continues into the current biennium. The steep increase in state general fund revenues since 2003-05 served to somewhat compensate for the decline in “other” funds. But what caused the continuing losses in other funds? Figure 3.6 offers some insight, indicating that the Beer and Wine tax represents the largest portion of the “other funds” category. However, as discussed in more detail in Section 3.7 below, the Privilege tax (which generates beer and wine revenues) has been unchanged since 1977, and, in recent biennia, the dollars coming to AMH have been fairly constant. The decline in “other” funds between 2003–05 and 2005–07 occurred in intra-agency transfers, going from \$7.1 M to \$ 0.2 M. A good portion of the earlier money was Medicaid matching funds from local jurisdictions, especially Multnomah County.

Figure 3.6
Components of “Other” AMH Funds 2005-2007



* Other income includes Synectics Grants (1%), Intra-Agency Transfers (2%), Contract Settlement Reimbursements (2%) and Miscellaneous (7%)

AMH Allocations 2005-2007

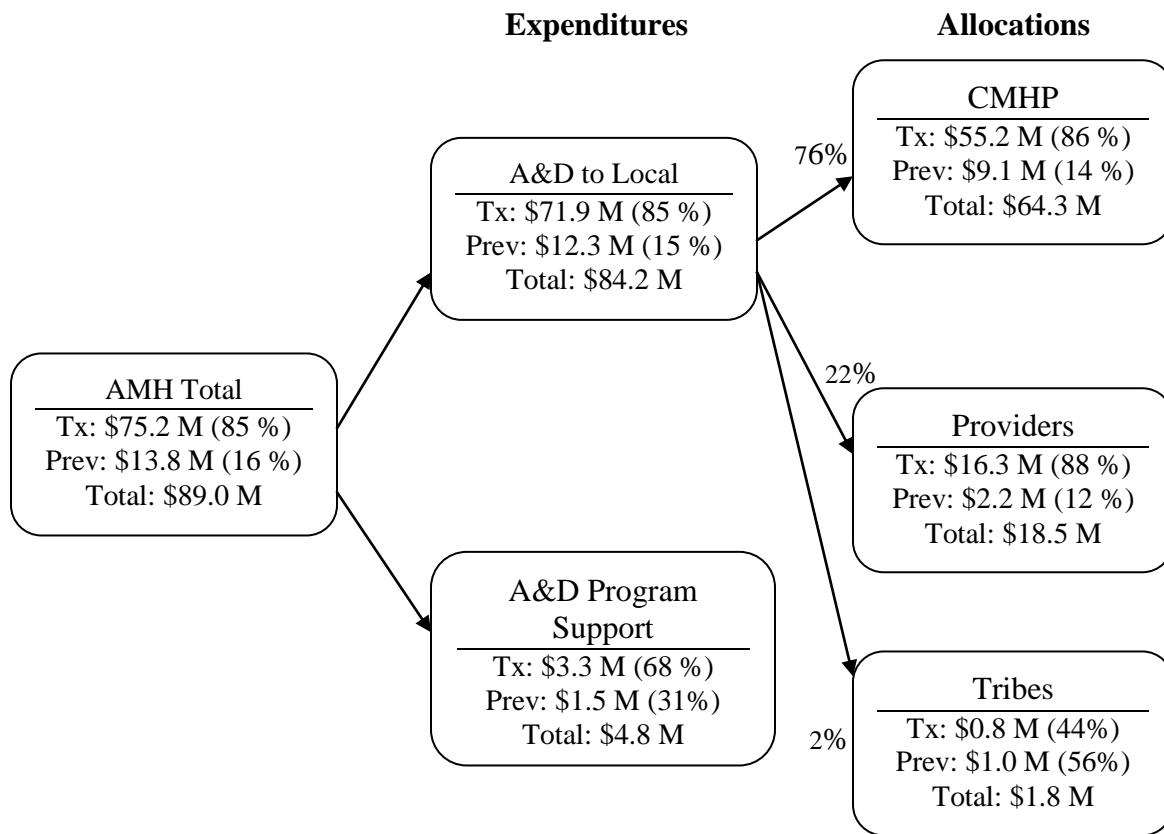
The full impact of AMH spending losses plays out at the local level. Figure 3.7 indicates how AMH’s 2005-07 funding was allocated. Over \$84 million of its \$89 million A&D budget went directly to local service delivery; only \$4.8M or 5.4% was set aside for AMH program support⁷.

As the right-hand boxes in Figure 3.7 show, the local dollars were distributed primarily to the CMHPs, the official county-level authority for a wide array of DHS functions – 76% of the \$84.7 million actually expended locally in the biennium. Smaller shares went directly to tribal governments⁸ and to individual A&D service providers. Further exploration of local spending patterns is presented in Section 3.8 below.

⁷ Additional program support funds come from outside the AMH budget, as part of overall DHS administration.

⁸ Tribal payments do not include one tribal government that is a CMHP. That allocation is included in the CMHP figure.

Figure 3.7
Flow of AMH A&D Investments for 2005-2007⁹



Discussion

Across the DHS four service areas addressed in this report, A&D expenditures have undergone substantial change over the past eight years. In the 2001-03 Biennium, nearly \$170M were available for addressing the A&D treatment and prevention needs of Oregonians; in the current funding period, inflation-adjusted expenditures are 19% below that earlier level. At the same time, the Gaps Analysis (Chapter Two) indicates significant unmet A&D need in the Oregon population overall and in particular DHS service areas. Two rounds of cutbacks to OHP clearly have had a major continuing impact, and AMH has not recovered from its 2003-05 losses. AMH-funded treatment services have suffered much more than prevention, largely due to declining state general fund revenues. These budget reductions pass directly to the local level, with CMHPs receiving the bulk of AMH's expenditures. Section 3.8, below, describes expenditure at the local investments in more detail.

⁹ A slight discrepancy of \$.5 M exists in the flow to locals; this represents a difference between the amount allocated to local entities and actual expenses incurred in the biennium.

3.3 CRIMINAL JUSTICE COMMISSION DRUG COURT INVESTMENTS

In 1989, a national movement began to develop a cost-effective alternative to incarceration for non-violent offenders with drug abuse issues. According to the National Association of Drug Court Professionals, the premise of drug courts is as follows (NADCP, 2008):

Drug courts represent the combined efforts of justice and treatment professionals to actively intervene and break the cycle of substance abuse, addiction, crime, delinquency, and child maltreatment. These special dockets are given the responsibility to handle cases involving addicted citizens under the adult, juvenile, family, and tribal justice systems.

In this blending of justice, treatment, and social service systems, the drug court participant undergoes an intensive regimen of substance abuse treatment, case management, drug testing, supervision and monitoring, and immediate sanctions and incentives while reporting to regularly scheduled status hearings before a judge with expertise in the drug court model. In addition, drug courts increase the probability of participants' success by providing ancillary services such as mental health treatment, trauma and family therapy, and job skills training.

Following this premise, one of the first drug courts in the country was established in Multnomah County in 1991. Since then, over 30 additional drug courts have been developed in Oregon, through collaborative planning processes with stakeholders from criminal justice, treatment providers, law enforcement, child welfare, education, and other community organizations. To fund these drug court initiatives, proponents have acquired financial resources from a variety of sources, including foundation and grant programs (i.e. the Byrne Memorial Grant Program, administered by the Oregon State Police) and local community contributions. However, until recently, no funding from the state general fund supported Oregon drug court initiatives.

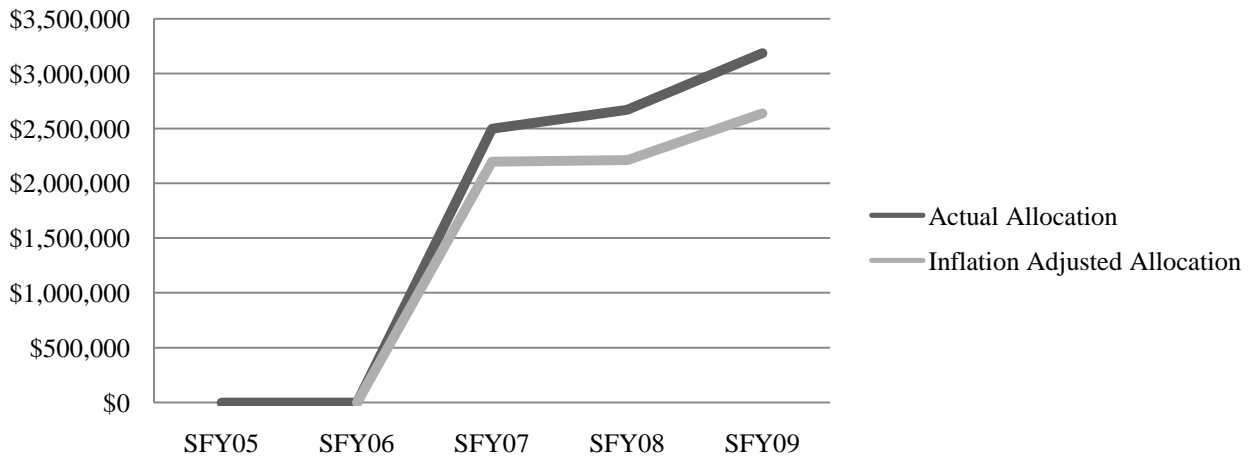
The funding picture changed in 2005 when the legislature passed House Bill 2485 which gave the Criminal Justice Commission (CJC) responsibility of overseeing the state-funded Drug Court Grant Program. This legislation made possible the expansion of existing drug courts and development of new drug courts around the state. The 2005 allocation provided \$2.5 million for SFY07 to support 17 drug court programs around the state, with allocations ranging from \$53,000 to \$283,000. In 2007, the legislature expanded the CJC Drug Court Grant Program allocation to \$6 million for the 2007-09 Biennium; this funding continued to support the 17 original grantees, as well as provided funding to five additional drug court programs across the state. Table 3.6 presents allocations for the CJC Drug Court Grant Program since 2005 when the CJC funding first became available; this table shows the amount distributed to local drug court programs, as well as CJC administrative costs for each biennium. Allocations differ from budgeted amounts because not all funds were distributed in the year they were received.

Table 3.6 CJC Drug Court Grant Program Allocation by Biennium				
Nominal Dollars		LAB for Drug Court General Funds	Allocation to Local DC Programs	CJC Administrative Funds for DC
2005-2007 Actual	05-06	\$0	\$0	\$112,705
	06-07	\$2,500,000	\$2,494,550	
2007-2009 LAB	07-08	\$3,000,000*	\$2,668,534	\$140,089
	08-09	\$3,000,000	\$3,183,881	

* An additional \$155,000 was allocated in FY 07-09 to adjust for inflation.

Figure 3.8 shows inflation-adjusted allocations to the CJC-funded drug court programs over time, since inception in 2005.

Figure 3.8
CJC Drug Court Allocations

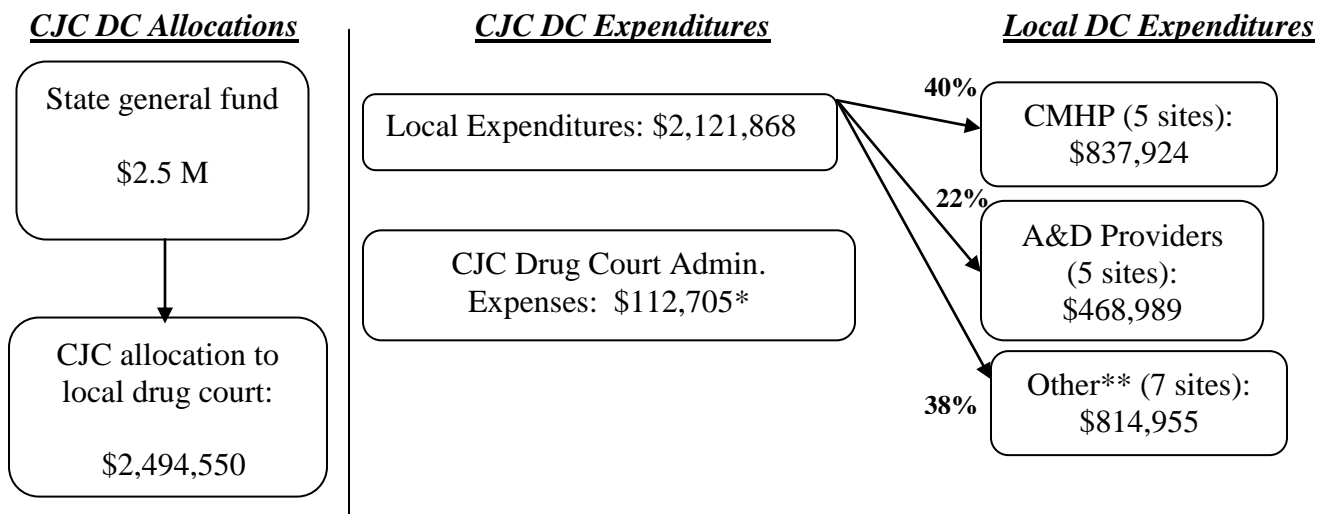


It is important to note that, while the CJC Drug Court Grant Program provides a significant amount of funding to 22 of the 37 existing drug courts in Oregon, most drug courts in the state receive financial resources from a wide variety of sources. In addition to CJC Drug Court Grant funding, the Oregon State Police distributed over \$3 million under the Edward Byrne Memorial Grant Program for the 2005-2007 Biennium to drug courts around the state. Yet, according to CJC staff, CJC and Byrne funding together account for only about one-third of all funds supporting Oregon drug courts. Each Oregon drug court has developed its own resource pool to support drug court activities. In addition to CJC and Byrne funds, drug courts also receive funding from AMH, local county budgets, OHP, Asset Forfeiture, OLCC Beer and Wine Tax, and client fees. Unfortunately, while it would be useful to understand the complete set of funding streams that support Oregon drug courts, there is currently no comprehensive source for this information.

CJC Drug Court Expenditures for 2005-2007

For each biennial allocation received from the legislature, CJC posts an RFP to determine how to distribute funds around the state. Local community stakeholders engage in a collaborative process to develop a proposal, and CJC awards contracts based on submitted proposals. Funding is then distributed to the local lead agency, most often the local CMHP or A&D treatment provider. Figure 3.9 illustrates the flow of funds from the state general fund to the local drug court programs for SFY07.

Figure 3.9
Flow of CJC Drug Court Expenditures (SFY07)



* This figure includes admin costs for both FY06 and FY07. FY06 was an implementation year (i.e. hiring staff, RFP process), but funds were not distributed to local drug court programs during this first year.

** Other includes: County, DA, Community Justice, Community Corrections, Juvenile Dept, and Sheriff offices.

Figure 3.9 requires a few notes of explanation: First, SFY06 was a planning year when no funds were distributed to local programs; for this reason, Figure 3.9 only includes allocations and expenditures for one fiscal year. Second, the CJC allocations to local drug court programs (\$2,494,550) exceeded the actual expenditures of these programs for SFY07 (\$2,121,868) and the difference was returned to the state general fund. Finally, the distribution of CJC funding among different types of local organizations differs noticeably from the AMH distribution pattern discussed above: CJC gives CMHPs only 40% of its Drug Court funds, whereas CMHPs receive 76% of AMH A&D funds (Figure 3.7).

Local Use of CJC Funds

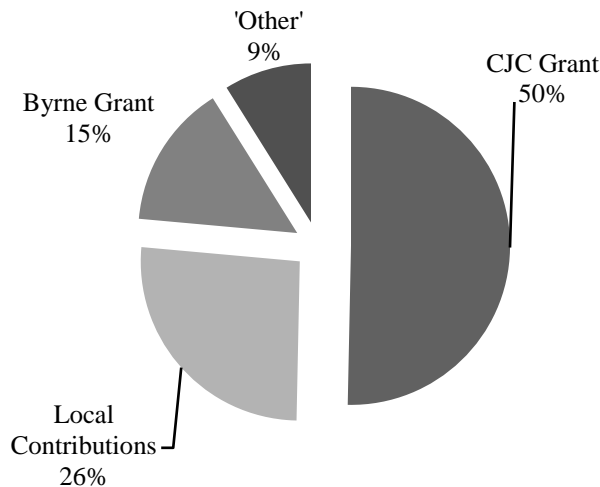
In an effort to understand the use of CJC drug court funding at the local level, HSRI explored the extent to which documentation is available on how drug courts spend the resources they received from CJC in 2005-07 Biennium. Although local drug courts report this data in their quarterly Requests for Reimbursement, the information is currently only available in hard copy and has never been aggregated. HSRI did work with CJC to compile the expenditure reports, but in the process learned that the reports did not always accurately reflect how drug courts are spending the CJC resources. While some program's report appeared accurate (expenditures were slightly less than or equal to CJC allocations) other programs showed significant discrepancies, sometimes due to programmatic changes, but in other cases, simply because forms were not

completed consistently. At this point, HSRI is unable to provide analysis of CJC expenditure data at the local level.

In lieu of actual expenditures data on CJC-funded drug courts, HSRI examined the successful Drug Court Implementation/Enhancement Grant proposals. In these 17 proposals¹⁰, grantees submitted a budget and budget justification. This information provides some sense of other funding sources that support the CJC-funded drug courts and how the drug courts anticipated that the resources would be used. It is important to remember that the figures below are based on the submitted proposals rather than actual revenue and expenditure figures.

Figure 3.10 displays the distribution of drug court investments for the 17 CJC-funded drug courts as a whole, indicating the expected level of reliance on CJC funding. The 'other' category includes revenue from sources such as OHP, client fees, local Commissions on Children and Families and other local matches. It is important to note that there was significant variation among drug court programs within each of these categories; for example, three drug courts expected to be 100% supported by CJC funds while another program expected CJC funding to account for only 20% of its entire drug court budget.

Figure 3.10
Source of Drug Court Revenue for CJC Funded Courts

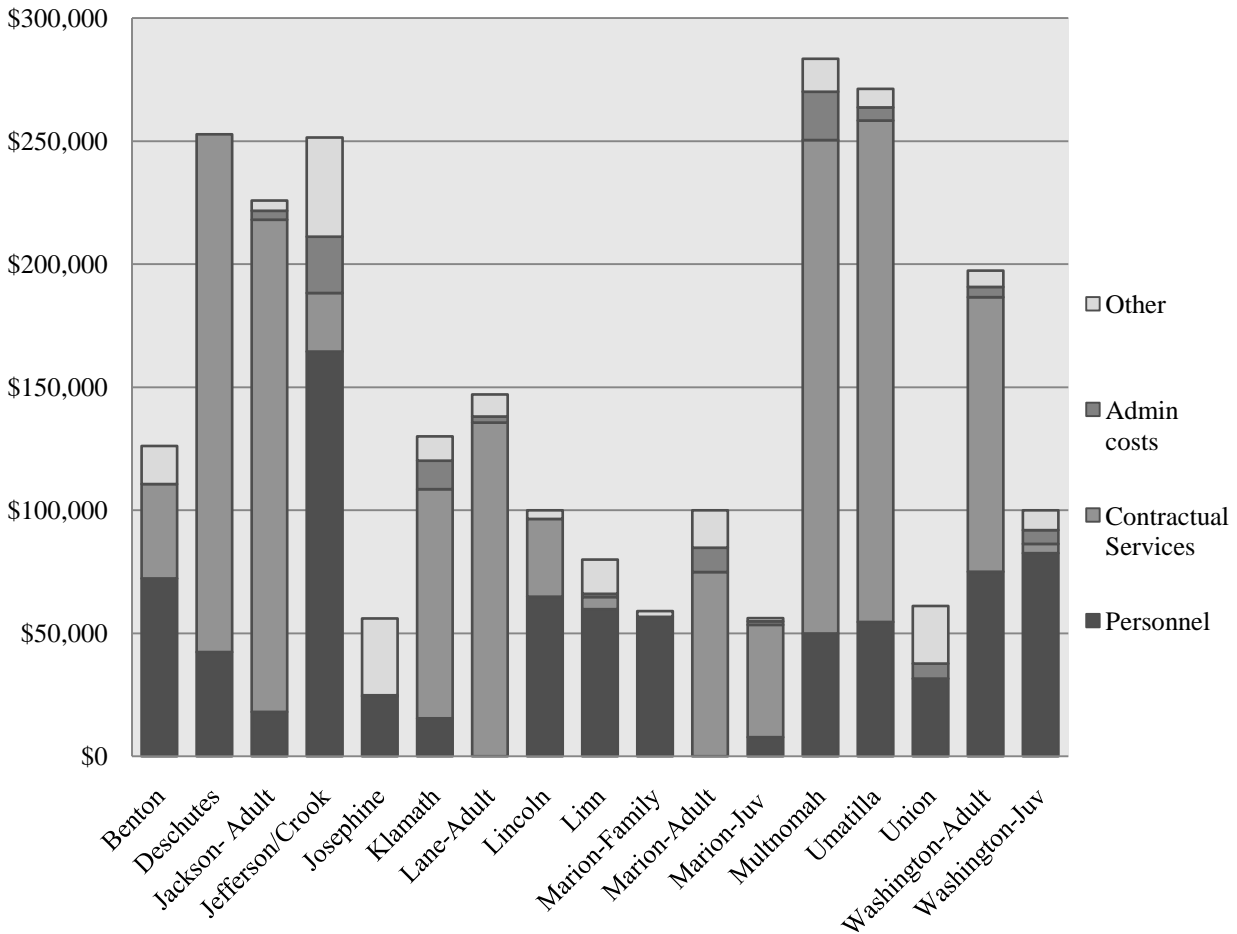


From the CJC proposals, HSRI also examined the proposed level of spending by several key categories. As Figure 3.11 indicates, significant variation exists in the total budget requested from CJC, as well as in how each program proposed to spend its CJC resources. The proportion allocated to personnel ranged from 0% to 96%, proportion on contracted services ranged from 0% to 92%, and percent allocated for administration costs ranged from 0% to 10%. Some of this variation is explained in the way each Grant recipient categorized expected expenses. For example, CMHPs that contract with a local treatment provider would include a large proportion of personnel expenses within the contractual services category, whereas a treatment provider would list these as personnel expenses. Another example is administrative costs: while some programs may have budgeted for administrative costs, other drug courts were able to obtain these

¹⁰ Seventeen drug courts were funded in FY06. The additional five drug courts were funded in the subsequent year.

services as in-kind contributions from local agencies, which are not accounted for in these figures.

Figure 3.11
Proposed Drug Court Budget, by Budget Category



Discussion

Understanding how CJC Drug Court resources are being used to pay for A&D services in 17 drug courts in Oregon has been relatively straightforward at the state level; it is clear how investments were allocated from state general fund down to local program level to support drug court initiatives. What is much more difficult to document, and beyond the scope of this project, is the larger picture of overall drug court expenditures and how these are utilized at the local level. CJC funds constitute only a portion of total drug court spending; without knowing the full investment picture, it is more difficult to accurately judge the need for future changes in drug court funding.

3.4 DEPARTMENT OF CORRECTIONS INVESTMENTS

The Department of Corrections (DOC) offers a variety of services to incarcerated individuals, including substance abuse treatment. Overall, 75% of incarcerated offenders are considered to be in need of this service. Treatment is prioritized for clients who are considered to have a high or medium risk of reoffending and who have a serious substance abuse issue (37% of the overall population), although some treatment is available to non-prioritized offenders. Currently, 406 treatment beds are available for men and 54 beds for women. Approximately 23% of these beds were added in 2007. Treatment units are housing units which are separate from the general population and are located at only a few facilities around the state. Clients are generally offered treatment during the last six months of their stay, at which point they may be moved to one of these facilities. All treatment offered is evidence-based.

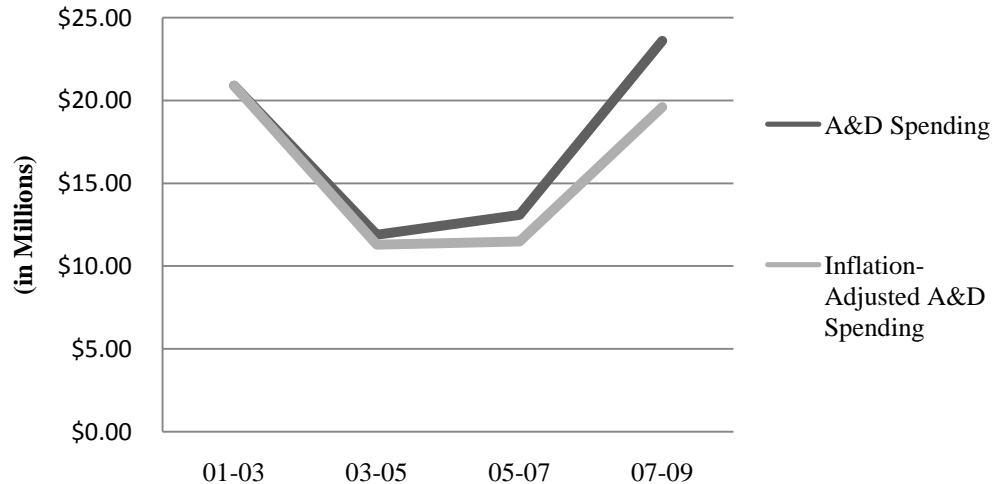
DOC Spending Over Time

Since the 2001-2003 Biennium, the overall DOC budget and the amount allocated to A&D treatment has fluctuated greatly (Table 3.7). In 2001-03, \$20.9 million was spent on A&D services (1.7% of the overall DOC budget). By 2003-05, DOC spending was down dramatically, reflecting substantial budget cutbacks across state agencies; A&D felt the cuts particularly severely, losing nearly 46% in inflation-adjusted dollars. A&D rebounded somewhat in the 2005-07 Biennium, and jumped considerably for 2007-09. A&D allocations are currently at \$23.6 million (1.76% of the overall DOC budget). Although this is an increase in nominal dollars over 2001-03, the inflation-adjusted amount has not caught up to 2001-03 levels. Figure 3.12 shows the trend line across the four biennia.

Biennium	Total	A&D	Total Inflation-Adjusted	A&D Inflation-Adjusted	A&D as % of Total	% Change in Inflation-adjusted A&D
01-03	\$1,229.5 M	\$20.9 M	\$1,229.5 M	\$20.9 M	1.70%	-
03-05	\$1,078.3 M	\$11.9 M	\$1,026.0 M	\$11.3 M	1.10%	-45.9%
05-07	\$1,090.9 M	\$13.1 M	\$961.2 M	\$11.5 M	1.20%	+1.8%
07-09	\$1,342.9 M	\$23.6 M	\$1,112.4 M	\$19.6 M	1.76%	+70.4%

It is important to note the contrast in Table 3.7 between shifts in overall DOC spending over time and simultaneous changes in A&D allocations. Using the inflation-adjusted figures, we see that total spending declined in 2003-05 and again in 2005-07, then rebounded somewhat in 2007-09. The pattern for DOC A&D spending is quite different: it declined in 2003-05 but began to rebound in the next period and then dramatically grew in 2007-09. This suggests a growing commitment to A&D treatment by DOC. It is important to note that in-prison substance abuse and mental health services were restructured between 2003-2005 and 2005-2007. Prior to 2003-2005, the two types of services were combined. Therefore, there are some mental health and co-occurring service dollars included in the totals under the A&D costs. These cannot be disaggregated. However, if it was possible to remove these costs, it would only serve to further highlight the increase in funds allocated to A&D in subsequent biennia.

Figure 3.12
Department of Corrections Spending on A&D Over 4
Biennia



DOC spending is subdivided into two categories: prison-based treatment and grant-in-aid (GIA) to county community corrections agencies for felony offenders. These two A&D service arenas have faced very different funding situations over the past eight years. As Figure 3.14 shows, spending for prison-based treatment has increased over the four biennia from \$6.6 M (.64% of total prison spending) in 2001-03 to \$12.1 M (1.08%) in 2007-09. By contrast, as shown in Figure 3.15, community corrections treatment spending has decreased from \$14.3 M (7.72%) of total GIA allocations in 2001-03 to \$11.5 M (5.11%) in 2007-09.¹¹

Spending fluctuations gain greater meaning when they can be linked to numbers of clients served, thus not only clarifying the person-level impact of cuts or increases but also allowing calculation of average per-person treatment costs. For the 2005-07 Biennium, DOC estimates that its \$6.5 M of in-prison treatment funding reached 1,132 inmates, at an average per-treated-offender cost of \$5,754.00.¹² Cost per day for a residential treatment bed is \$33.68 (treatment costs only); cost for the Spanish-language day treatment program is \$15.80 per day.

To put into context the differing patterns of in-prison and community A&D spending, it is important to recognize the relative roles of the two arenas overall. As Table 3.7 (above) shows, DOC's 2005-07 budget was over \$1 billion; only 1.2% of this went to A&D treatment. Of that \$13.1M going to A&D, Figure 3.13 indicates that roughly equal shares went to in-prison treatment and to community-based treatment: prison-based A&D treatment spending was somewhat higher -- \$6.5M compared to \$6.3M for the community.

¹¹ Department of Corrections County by County Budget Summaries for 4 biennia (2001-2009).

¹² 2005-2007 in-prison treatment allocation/total clients served for 2006 and 2007. If all clients completed 180 days of treatment, the total cost would be \$6,062 per client. Listed in-prison treatment budget does not include administrative costs.

Figure 3.13
Department of Corrections A&D Funding Streams
SFY 2005 – 2007 A&D Amounts

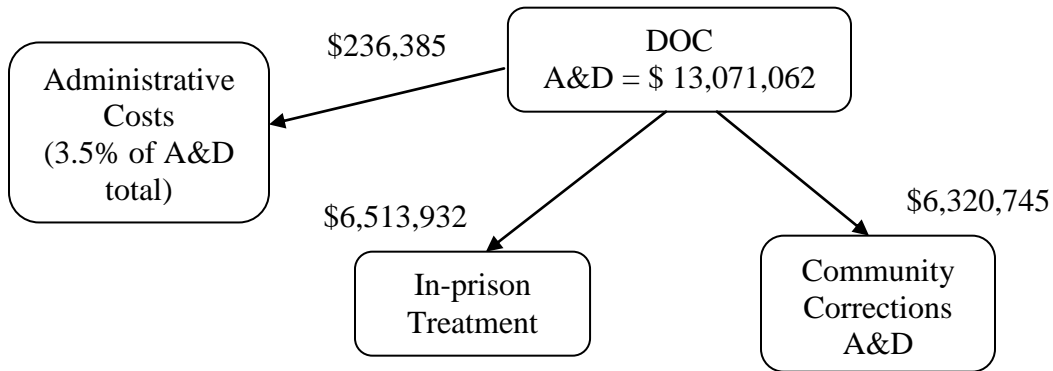


Figure 3.14
Department of Corrections Spending on Prison-based A&D Treatment

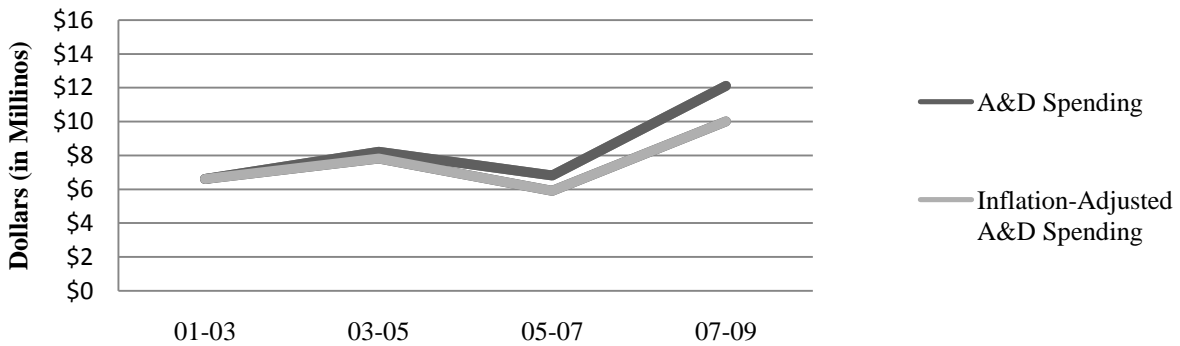
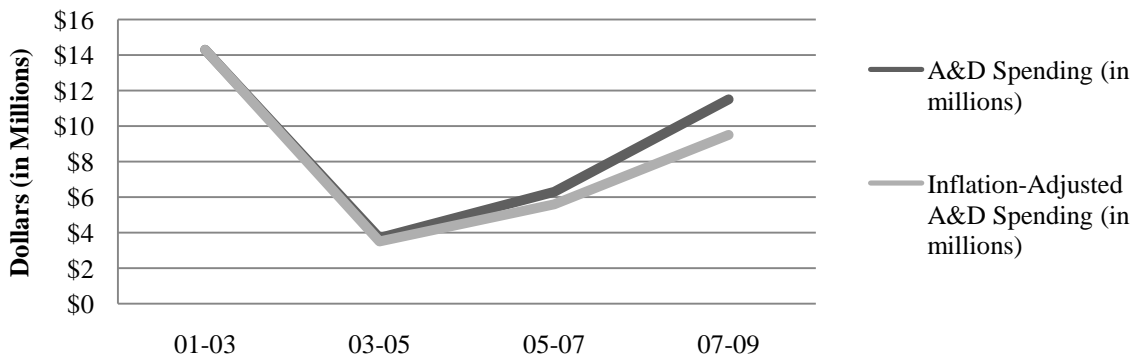


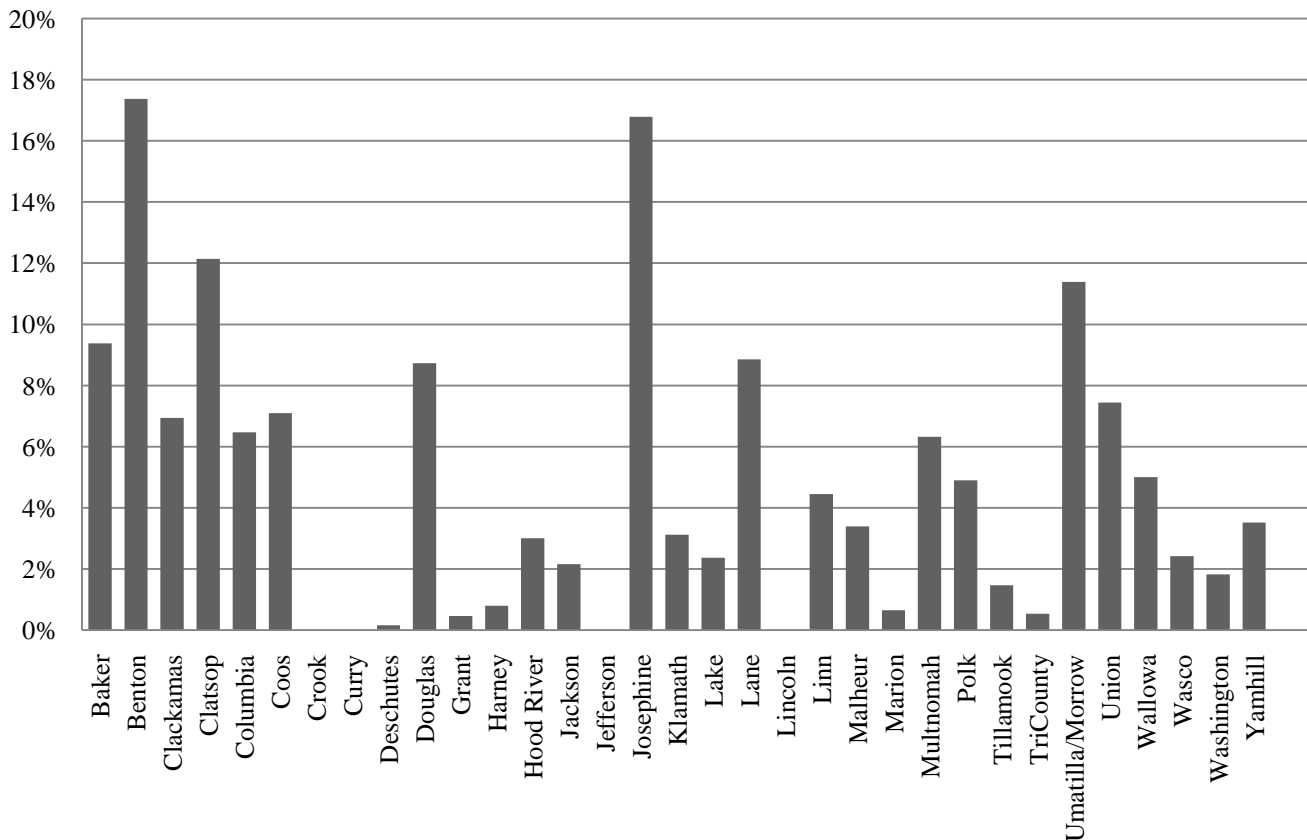
Figure 3.15
Department of Corrections Spending on Community-Based A&D Treatment



In-prison and community A&D spending have not always been at similar levels, as shown by the differing patterns in Figures 3.14 and 3.15. Community corrections experienced a sharp drop in 2003-05 while in-prison treatment dollars increased slightly; the reverse occurred in the 2005-07 Biennium, with a slight expenditure decline for prison-based treatment and an increase in community-based treatment. Only in the most recent biennium did both service arenas change in the same direction. These contrasts are not surprising because funding decisions are made differently for the two arenas. The state agency budgets specific amounts for in-prison A&D services, but DOC Grant-in-Aid allocations to the local level do not stipulate the proportion to be spent for A&D treatment -- each county corrections agency decides how to distribute its funds. This process varies somewhat by county and involves county commissioners and the Local Public Safety Coordinating Councils (LPSCC). Each county submits a biennial plan to DOC detailing the allocation categories and the amounts in each category.

Using these plans, HSRI computed the amount spent on A&D services in each county, as a percentage of each county’s total grant-in-aid spent on A&D (Figure 3.16). The percentages vary considerably, an important fact that is hidden in the aggregate numbers used for Figure 3.15. Some counties allocate none of their DOC funds to treatment, while others allocate relatively large percentages. This does not mean that some counties are not providing any treatment to community offenders—the community corrections agency may be providing these clients with A&D treatment which is funded by sources other than DOC.

Figure 3.16
Percentages of DOC Grant-in-Aid to Counties Spent on Substance Abuse Services (2005-2007 Biennium)



Discussion

Drug and alcohol treatment within the corrections system suffered a setback in 2003-05, as it did in other public agencies. Within state prisons, DOC has made a concerted effort to rebuild and recommit to spending on A&D. This spending has taken the form of opening new treatment beds, issuing new contracts, and committing to evidence-based practice and program review protocols (these efforts are discussed further in Chapter Four). Within community corrections, the amount of DOC funding allocated to A&D has not returned to the 2001-03 levels. However, DOC grant-in-aid provides only a portion of county funding used for A&D treatment. In looking at patterns within communities, more variables come into play. Offenders treated while on probation or post-prison supervision may have their treatment funded by one or more other sources. Finally, county budgets are susceptible to local funding fluctuations. Although exiting offenders are required to have a transition plan that includes an appointment for A&D treatment (if needed), the degree of follow-up both in terms of treatment and data collection varies considerably among counties.

3.5 OREGON YOUTH AUTHORITY INVESTMENTS

The Oregon Youth Authority (OYA) serves youth up to age 18 in residential and community programs. For those with A&D needs, treatment for OYA clients housed in OYA facilities is provided by licensed staff and is evidence-based. OYA youth who are committed to community custody are treated in the community, which may mean outpatient services or residential treatment -- OYA has two shared-funding contracts with Morrison Rosemont and Morrison Breakthrough to provide residential treatment services. In addition to serving youth in OYA custody, OYA passes through to counties its Juvenile Crime Prevention funds for prevention efforts.

OYA Spending Over Time

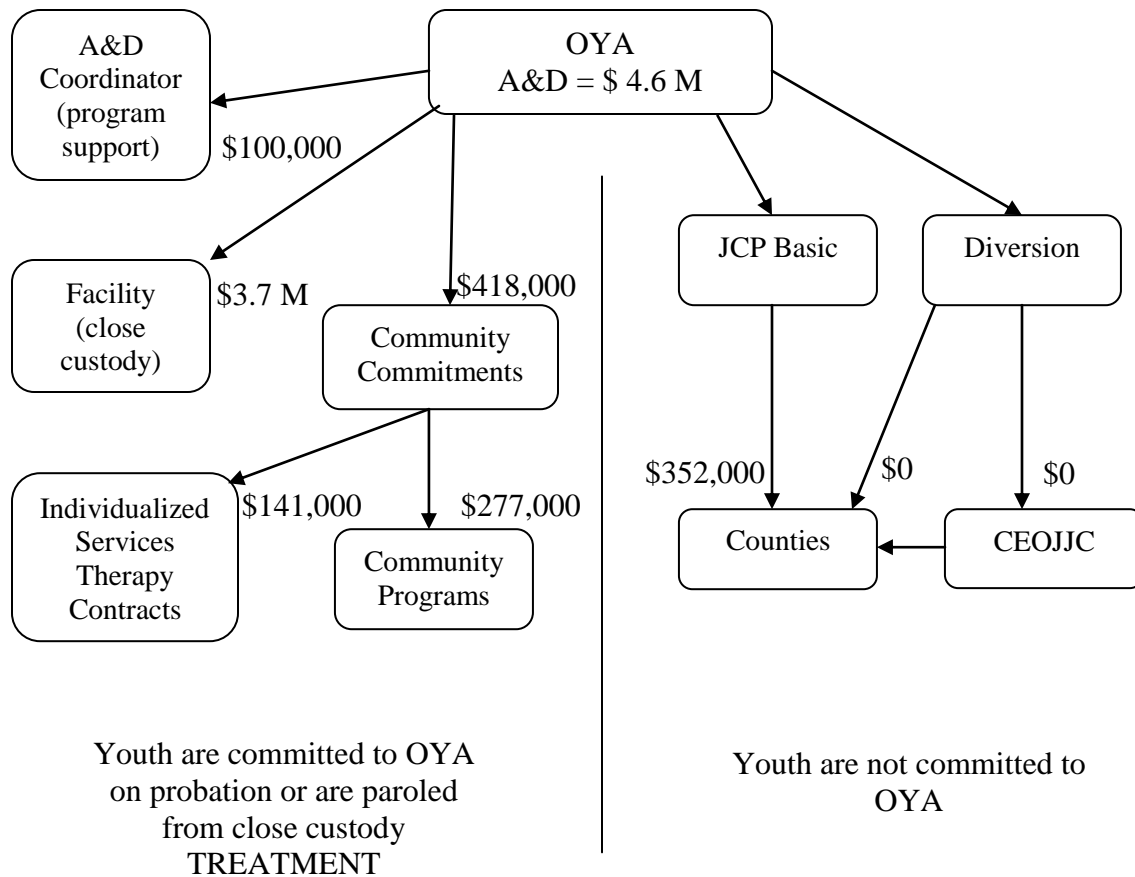
Like the other state agencies discussed earlier in this report, OYA has experienced substantial declines in funding during the past eight years. Table 3.8 shows total OYA expenditures and the amount spent on A&D services for each of the last four biennia. OYA not only faced sharp cuts in 2003-05, falling to \$227M in inflation-adjusted dollars, but subsequent years have not brought spending back up to 2001-03 levels. By contrast, funding for OYA A&D has fared well. OYA spending on treatment has increased in each biennium, in both constant and inflation-adjusted

Table 3.8						
Oregon Youth Authority Spending on A&D over 4 Biennia						
Biennium	Total	A&D	Total Inflation-Adjusted	A&D Inflation-Adjusted	Rate of Change	Percentage of Total on A&D
01-03	\$270.1 M	\$1.5 M	\$270.1 M	\$1.5 M	--	.55%
03-05	\$238.5 M	\$2.1 M	\$226.9 M	\$2.0 M	33.3%	.89%
05-07	\$245.9 M	\$4.6 M	\$216.6 M	\$4.0 M	100.0%	1.87%
07-09	\$305.6 M	\$5.8 M	\$253.2 M	\$4.8 M	20.0%	1.91%

terms. 2007-09 expenditures are \$4.8 million in inflation-adjusted dollars, more than three times the 2001-03 level. While the share of total OYA spending allocated to A&D services is small, it has increased noticeably, from approximately a half percent in 2001-03 to nearly two percent for the current biennium. This suggests a growing commitment to A&D services relative to other programs needed for youth in OYA custody. In addition, the percentage of A&D funding coming from the state general fund has increased from 91% in 2001-2003 to 98% for the current biennium. OYA reports that no federal funds were directly attributed to A&D. The remaining percentage of funding is listed as “other”.

OYA uses its A&D funds to provide services in detention facilities and community programs. Figure 3.17 shows the pathways that funds follow and the amount allocated for each of the main OYA A&D activities.

Figure 3.17
Oregon Youth Authority A&D Funding Streams
Biennium 2005 – 2007 A&D Amounts



For OYA committed youth, in 2005-07, detention facility treatment received the bulk of the A&D funds, \$3.7 M out of \$4.6M total. Less than half a million dollars went to the community for treatment services: \$141,000 was allocated to Individualized Services Therapy Contracts (ISTC) for youth not covered by Medicaid or private insurance; the remaining \$277,000 went to

two residential programs to help pay for skill-building services. In addition, OYA distributed prevention funds to the community through the Juvenile Crime Prevention (JCP) Basic and Diversion programs. These funds are allocated to counties for general prevention activities, and counties decide individually how to use them.¹³ In 2005-2007, only five counties reported using their JCP funds for A&D prevention for a total of \$352,000. OYA also allocated \$100,000 in 2005-2007 for an A&D facility program coordinator, the first biennium that this position was listed. Certainly, there are other administrative costs involved with providing treatment which are hard to disaggregate from other staff-provided program costs. Per client spending on OYA in-facility treatment will be calculated for the final draft of this report.

The steady growth in A&D spending has differently affected OYA's detention and community spheres. As Table 3.9 shows, A&D treatment in OYA facilities has grown over the past four biennia, from \$1.2M in 2001-03 to \$3.2M in 2007-09 (adjusting for inflation). Unlike other agencies discussed in this report, OYA did not lose A&D funding in 2003-05; both facility and community A&D efforts increased. But particularly notable is the sharp increase in facility treatment spending, up 136% in the 2005-07 Biennium. Growth in community-based A&D activities has been more modest. On the treatment side; spending has fluctuated but has grown overall since 03-05. On the prevention side, there appears to be a sharp increase in the most recent biennium; however, that shift arose from one decision by one county -- Multnomah County Corrections decided to use slightly over \$1 million of its JCP diversion funding to replace other funds supporting the Multnomah County Residential Alcohol and Drug program operated by the Morrison Center. In previous biennia, no diversion funds were reported as having been allocated to A&D.

Table 3.9
OYA Funding in Facilities and Communities

Biennium	Facility (Treatment)	Facility Infl-Adj	Biennial Rate of change	Prevention: JCP Basic & Diversion to Counties	Community Treatment for OYA Youth*
01-03	\$1,180,000	\$1,180,000	--	N/A	\$299,000
03-05	\$1,441,000	\$1,371,112	+16.7%	\$243,000	\$439,000
05-07	\$3,718,000	\$3,275,930	+135.7%	\$352,000	\$418,000
07-09	\$3,847,000	\$3,186,855	-3.1%	\$1,388,000	\$476,000

*includes Individualized Services Therapy Contracts and some residential treatment (shared funding with DHS)

Discussion

The Oregon Youth Authority has managed, despite an overall inflation-adjusted reduction in budget, to increase spending for A&D treatment and prevention. A&D efforts have grown for both the detention population and those in community custody. Although most of the A&D funds

¹³ Sixteen counties are members of the Central Eastern Oregon Juvenile Justice Consortium (CEOJJC) which receives a block of OYA distributed JCP funds, makes decisions about spending, and makes allocations to member counties.

serve youth in OYA facilities, it is nonetheless significant that OYA has continued to expand its community initiatives. OYA A&D efforts in the community, however, are subject to large fluctuations based on the decisions of individual counties regarding the distribution of their JCP Basic and Diversion funding.

3.6 OREGON COMMISSION ON CHILDREN AND FAMILIES INVESTMENTS

The Oregon Commission on Children and Families (OCCF) is responsible for distributing funds to counties for prevention activities, addressing a wide array of issues affecting children, youth and families. Decisions on how funds are spent are made by each local Commission on Children and Families (CCF) through a comprehensive coordinated planning process. Several funding streams pass through OCCF. These include both state general funds and federal funding sources. Each funding stream has different targeted populations and prevention goals. The most common funding sources for A&D prevention activities are Youth Investment, Family Preservation, Basic Capacity, and Juvenile Crime Prevention. As part of the comprehensive planning process, counties are required to select “focus” issues. Substance abuse focus issues include: teen alcohol use, teen drug use, teen tobacco use, adult substance abuse, and substance use during pregnancy.

Table 3.10 illustrates two biennia of spending on A&D prevention by OCCF¹⁴. As shown below, the percentage of county spending on A&D prevention activities is a tiny part of local CCF efforts. However, it has more than doubled to \$248,135 over these two biennia. It is important to note that these figures represent planned or contracted spending and not actual spending. In addition, because prevention is so broadly defined, a given CCF activity may have more than one goal. Programs targeted to, for example, the reduction of juvenile delinquency or the improvement of overall health, may also have the effect of preventing youth substance abuse. Thus, these figures are softer than other figures in this report.

Biennium	Total LAB	Total Allocations to Counties	County A&D	Total LAB Inflation-Adjusted	County Allocations (Infl-Adj)	County A&D (Infl-Adj)	A&D as % of Total County Spending
05-07	\$72.9 M	\$48.2 M	\$105,589	\$64.2 M	\$42.4 M	\$93,034	0.22%
07-09	\$88.1 M	\$64.0 M	\$299,535	\$73.0 M	\$53.0 M	\$248,135	0.47%

Substance abuse prevention spending by funding stream for the two biennia is illustrated in Table 3.11. A&D investments were identified by OCCF staff. As illustrated, only a small portion of any funding stream is allocated to substance abuse prevention. For example, for the 2007-

¹⁴ Due to database development, only two biennia of county allocations were available for OCCF.

2009 Biennium, just over 3% of the Children, Youth, and Families funding stream is allocated for A&D. This is the largest percentage allocation to A&D of any funding stream.

Some examples of substance abuse prevention activities listed by counties include the following:

- Conduct video viewing and discussion sessions addressing alcohol, tobacco and other drug prevention. This program is designed for acting-out youth, as identified by teachers and/or school counselors.
- The Drug Free Communities Coalition, which works to change community norms related to teen alcohol & drug use. This is accomplished through community meetings, a youth initiative network, a resource website, and a drug education program.
- Substance abuse treatment services for 45 high-risk non-offender youth ages 13-17 with risk factors in at least two of five domains. Services include substance abuse assessments and referral, participation in treatment, individual and group counseling.
- Three multi disciplinary teams from three school districts allocate funds to meet the needs of students and families by providing access to mental health and drug and alcohol and other support services.
- Peer-led alcohol and drug prevention programs.
- Provide a universal, non-stigmatizing approach to reduce risks of alcohol and drug use via Life Skills training to all youth ages 11 to 13 transitioning from an elementary school environment to a middle school environment.

Table 3.11
OCCF County Funding Streams Allocated to Substance Abuse Prevention

Biennium	Funding Stream	Total Allocation	Total A&D	% funds allocated to A&D	# of Counties allocating to A&D
2005-2007	Great Start	\$2,439,061	\$0	0.00%	0
2007-2009		\$2,514,671	\$4,822	0.19%	1
2005-2007	Basic Capacity (GF)	\$9,443,267	\$0	0.00%	0
2007-2009		\$12,736,008	\$5,100	0.04%	1
2005-2007	Children, Youth, and Families	\$2,521,844	\$9,974	0.40%	4
2007-2009		\$2,600,021	\$79,290	3.05%	4
2005-2007	JCP	Not allocated by OCCF			
2007-2009		\$7,401,643	\$110,480	1.49%	
2005-2007	Youth Investment	\$6,017,141	\$94,699	1.57%	5
2007-2009		\$5,484,803	\$84,906	1.55%	6
2005-2007	Youth Investment BC	\$689,915	\$0	0.00%	0
2007-2009		\$689,918	\$12,228	1.77%	1
2005-2007	Family Preservation	\$2,100,854	\$916	0.04%	1
2007-2009		\$1,776,714	\$0	0.00%	0
2005-2007	Family Preservation BC	\$152,852	\$0	0.00%	0
2007-2009		\$152,852	\$2,709	1.77%	1

Discussion

While OCCF plays a major role in supporting prevention activities in all Oregon counties, it appears to have a very small profile in terms of A&D activities. Current estimates suggest that less than one-half of one percent of local CCF funds go to A&D prevention. However, the role of local CCFs could be significant in planning: as the primary partner in the development of comprehensive coordinated county plans to address the needs of children, youth and families, CCF can bring attention to key A&D issues and encourage interagency initiatives. Further development of local CCF reporting and OCCF databases and analyses will be helpful in developing an understanding in the future of how changes in A&D funding impact Oregon communities.

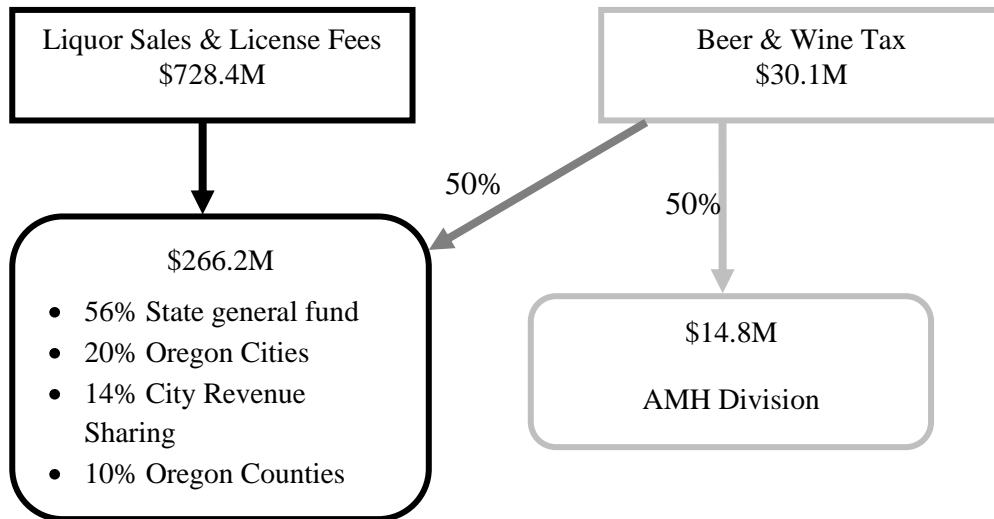
3.7 OREGON LIQUOR CONTROL COMMISSION INVESTMENTS

The Oregon Liquor Control Commission (OLCC) was created in 1933 to ensure that only qualified people and businesses are licensed to sell and serve alcoholic beverages, as well as to control underage drinking and alcohol problems in Oregon. The OLCC has three major revenue streams: liquor sales, licensing revenues, and privilege tax revenues. The privilege tax, also known as the Beer and Wine tax, is an assessment on the right to manufacture or import beer and

wine in Oregon. This tax was established in 1975 as dedicated funding for alcohol and drug services in the state, and is distributed to AMH, to the state general fund, and to Oregon cities and counties. Privilege tax revenues, along with all other OLCC revenues, are distributed among the various jurisdictions as shown in Figure 3.18. Table 3.12 gives a detailed accounting of allocations distributed to each jurisdiction over the last four biennia.

Figure 3.18

OLCC 2005-2007 Biennial Revenues*



**Not included in this chart are two types of expenses: a portion of liquor sales and license fees is used for OLCC operating expenses, and \$.02 per gallon of all B&W Tax goes to the OR Wine Board.*

Biennium	Total Revenue	Total Allocation*	General Fund Allocation	City Revenue Sharing & Incorp. Cities Allocation	County Allocation	AMH Allocation
01-03	\$555.1 M	\$215.6 M	\$114.9 M	\$67.9 M	\$20.0 M	\$12.8 M
03-05	\$633.3 M	\$242.7 M	\$128.4 M	\$77.7 M	\$22.9 M	\$13.6 M
05-07	\$758.5 M	\$281.0 M	\$149.1 M	\$90.5 M	\$26.6 M	\$14.8 M
07-08**	\$422.2 M	\$155.5 M	\$82.7 M	\$50.2 M	\$14.8 M	\$7.9 M

**Distribution to the OR Wine Board not included.*

***No information for SFY09 revenues, and only estimates of SFY09 allocation.*

One column in Table 3.12 merits further explanation. The AMH allocation shown here is larger than that reported in Figure 3.6 above. The discrepancy is due to a practice instituted in 1995, whereby 40% of the OLCC AMH allocation is immediately transferred to counties and thus does not appear in AMH spending figures.

HSRI spoke with staff at OLCC, the Association of Oregon Counties, the League of Oregon Cities, and several County Commissioners in order to get an understanding of what local governments are spending on addiction services funded by OLCC revenues. From these conversations, two major points emerged:

1. By statute, the recipient entities are not required to spend their OLCC revenues on any specific items, with the exception of the 50% portion of the Privilege tax funds which is earmarked for A&D services. Although liquor revenues have increased 5-6% every year, there has not been any change in the privilege tax rate since 1977 (\$2.60/barrel for beer; \$0.67 for wines under 14% alcohol, and \$0.77 for wines over 14% alcohol) resulting in minimal increases in dedicated funds for A&D services over the last 30 years.
2. OLCC provides a variable monthly distribution to local governments that goes directly to their general fund. It is at the discretion of each county to decide how to disseminate those funds. In some counties, a portion of these revenues are allocated to the local Community Mental Health Provider or individual providers in the county. However, given the lack of requirements attached to OLCC funding, the nature of the monthly distribution, and the fact that counties are pulling from a variety of sources to fund A&D services in their counties, it is extremely difficult, if not impossible in some cases, to know where local governments are spending OLCC revenues and how effectively that funding works to provide A&D services.

3.8 LOCAL A&D SERVICE SYSTEMS

Vital to understanding the impact of state spending on population needs is examination of the local A&D services situation. As the graphic at the beginning of this report illustrates, the core state agencies allocate A&D funds to a variety of local entities. Most often the monies go to a county-level agency, such as the Community Mental Health Program (CMHP), the community corrections agency, or the Juvenile Corrections Department. Some A&D funds go directly from a state agency to private A&D service providers; those same service providers also contract with the various county-level agencies. Chapter Five of this report profiles four particular counties, describing in some detail the way state funds and directives impact local service delivery systems. While that information gives a close-up look at certain counties, the discussion here reflects some modest efforts by HSRI to capture across-the-board local spending patterns.

The biggest player in the local A&D arena is the CMHP. Each CMHP receives an allocation from AMH specifically for A&D services; the amount is based on population size and is defined by service elements that specify where the funds are to be spent. The most commonly used A&D service elements include continuum of care services (outpatient services), prevention services, and special projects.¹⁵ Each CMHP acts as the local authority in the county and either directly provides services, subcontracts to local providers, or utilizes a combination of both. CMHPs operate in a variety of organizational structures, most often located within the county's Department of Health and Human Services; in some locales, the CHMP function is contracted out to the single non-profit A&D provider agency in that community.

¹⁵ One other commonly used AMH service element is gambling prevention and treatment; in the current analysis, HSRI did not include these dollars because they technically fall outside the scope of A&D expenditures.

To begin to explore the patterns in spending on A&D services at the local level, HSRI designed a one-page survey of CMHPs to gather the following detailed information on A&D investments during the 2005-2007 Biennium:

- Total spending on A&D prevention and treatment
- Amount of A&D funds received from federal sources and from the county general fund
- Amount of A&D funds spent on contracted services and on direct service provision
- Amount of A&D funds spent on administration

With assistance from the Association of CMHPs (AOCMHP), HSRI distributed the survey to all 36 counties and one Confederated Tribe (two CMHPs consist of more than one county, for a total of 33 CMHPs in the state). The CMHPs were given one month to return the survey, during which time they received reminders from AOCMHP staff. Twenty-two surveys were returned to HSRI, a 67% response rate.¹⁶ The data in each survey was examined for completeness and consistency, and was compared to other data obtained by HSRI (i.e., AMH county allocation totals). To clarify discrepancies, HSRI conducted follow-up phone calls with each county that returned a survey. Particular attention was given to reconciling spending totals with contractual/direct service/administration breakdowns. In addition, counties were asked for their total agency budget for the time period. Together, the survey and the follow-up calls produced enough data from 19 counties for HSRI to be able to confidently report on their A&D expenditures. We highlight below some of the main findings. It is important to bear in mind that these aggregate tables mask considerable variation among counties, both in their spending patterns and in how they responded to the survey. Subsequent detailed examination of a few selected counties may lead to a more complete understanding of the funding dynamics at the local level.

Total CMHP Spending on A&D

The 19 surveyed CMHPs reported spending a total of \$87.2 M in 2005-07 on A&D services, with a range from \$236,962 to \$32.6M. AMH provided the vast majority of this funding, \$52.8M or 61% of the total. Other sources of funding listed by CMHPs included federal grants and dollars from the county general fund. While these two additional funding streams were the most common supplements to AMH investments, they were by no means universal: only eight CMHPs reported receiving federal grant funds, and only nine get County General Fund revenues. Another eight CMHPs reported receiving no federal or county general fund dollars, but did receive funding from other sources, including fees for service, insurance, the Beer and Wine tax, and funding from contracts with the Department of Corrections, Juvenile Departments, and the Criminal Justice Commission. In six counties, AMH dollars contributed 35 percent or less of their total A&D funding.

Looking at A&D spending as a proportion of the overall CMHP agency budget, we again find considerable variation. Only 12 of the 19 CMHPs provided a total agency budget amount. Those 12 reported spending only a small percentage of their entire budget on A&D services. On average, these 12 CMHPs spent seven percent of their total revenues on A&D, although one agency reported spending 28 percent. This variability is directly related to the breadth of

¹⁶ In two counties, surveys were returned by the local direct service provider instead of the CMHP.

responsibility held by a particular CMHP. Some CMHP budgets include mental health, developmental disabilities, public health, veteran, and emergency services. The proportion that goes to A&D is partly fixed by the funding source and partly a flexible response to the availability of alternative funding sources for local A&D activities.

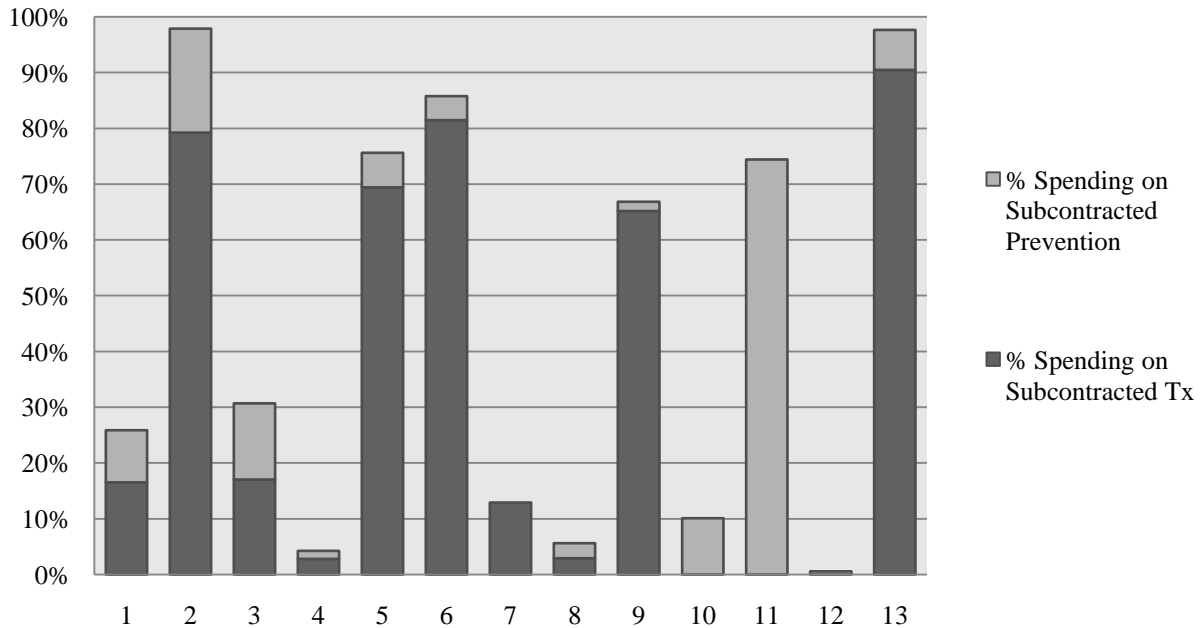
CMHP Use of A&D Funding

Each CMHP was asked to break down its spending between treatment and prevention, and also between contracting and direct service functions. On the first point, CMHP data roughly mirror AMH figures presented in Table 3.5 above – where we see that 84% of AMH A&D investments goes to treatment; for the 19 surveyed CMHPs, on average 83% of A&D spending goes to treatment services. The range across the surveyed CMHPs is 26% to 98%. This variation again speaks to the diversity of funding sources tapped by CMHPs and the differing levels of commitment to treatment relative to prevention in particular communities.

In terms of the mechanism chosen for providing A&D services, the surveyed CMHPs generally hold a middle ground, providing some services directly and also making use of contract providers. At the two extremes, only three CMHPs contract out 100% of their A&D services, and another three CMHPs directly provide 100% of their A&D services. The remaining 13 CMHPs spend an average of 54% providing direct service, and an average of 46% on subcontracting to local A&D providers.

Even among the 13 CMHPs that do both direct service and contracting, the extent of reliance on contracting for A&D services varies greatly. This variation is perhaps most evident when distinguishing contracts for prevention from those for treatment activities. Figure 3.19 displays the proportions of total contracting investments that are for prevention compared to treatment. The total height of the bar represents the portion of the agency's A&D funds being contracted out. Since treatment receives the bulk of funding, it is no surprise to see much greater contracting for treatment than for prevention. What is surprising, however, is the varied patterns among the CMHPs: for example, in two CMHPs, the entire contracting budget is spent on prevention (signified by a full light gray bar). By contrast, several of the 13 agencies clearly spend most of their contract funds for treatment services.

Figure 3.19
CMHP Spending on Subcontracted A&D Services (n=13)



CMHP Administrative Costs

Administration costs are difficult to calculate and compare. Most of the CMHPs provide other services in addition to A&D, making it challenging for agency staff to separate A&D administrative costs from the total agency administrative budget. Some CMHPs regularly track administration costs for A&D, while others separated out these expenses only at the request of HSRI. In addition, surveyed agencies included a wide variety of costs under the administrative category. Most commonly included items were: operating expenses (occupancy, supplies, phone, and copy machine), MIS staff and equipment, personnel (supervision, management, and office support), and Human Resources and accounting (fiscal, legal, and personnel benefits). The proportion of each of these categories that was allocated to A&D services also differed across counties. Although HSRI sought clarification from the CMHPs regarding their administrative cost calculations, some aspects still remain unclear and inconsistent. These limitations notwithstanding, two points are worthy of mention:

- The amount spent on administration ranged from \$24,057 to \$3.8 M; these dollar figures represent an average of 13 percent of total agency costs, with a range of between two and 33 percent. Virtually none of these dollars comes from the AMH allocation.
- As Table 3.13 suggests, the extent to which the CMHP relies on contracting appears to impact administrative costs. Not surprisingly, those CMHPs that contract out all their A&D funds have the lowest average administrative cost burden; and those that do not use A&D contracts at all had the highest average percentage for administrative costs.

Table 3.13 CMHP Average Spending on Administration	
Extent of CMHP Reliance on Contracting	Average % Spent on Administration
100% Direct Service (n=3)	20%
Both Contract & Direct Service (n=13)	13%
100% Contract (n=3)	8%

Provider Survey

To supplement the local investment information gathered through the CMHP survey, HSRI distributed a short survey to private A&D providers regarding expenditures for A&D services. This information is crucial to a thorough understanding of the impact of shifts in spending at the state level. While most state agency funds flow down to county-level agencies (see Figure 1.1 at the beginning of this document), some key grants and contracts go directly from a state agency to a private service provider, bypassing the county government structure. Without knowing the magnitude and nature of these activities, any profile of local A&D investment is incomplete. With the assistance of the Oregon Prevention Education & Recovery Association (OPERA), HSRI distributed surveys to the entire OPERA membership, which includes 40 providers that serve 80% of the people receiving publicly funded A&D treatment services in Oregon.¹⁷ OPERA sent several emails to its members encouraging them to respond. HSRI received four surveys (a 10% response rate), two of which were from the same county. With this small rate of return, HSRI is not able to report any aggregate findings. However, because two of the surveys were from Multnomah County, this information will be integrated into the case study analysis.

Discussion

Thus far in this study, HSRI has briefly examined CMHP spending patterns, focusing in particular on dollars used for prevention versus treatment, and for direct service versus contracting. Inconsistencies both within and between CMHPs in the figures they provided to HSRI make it very difficult to summarize and interpret the spending patterns. To gain further insight into the local level A&D arena, HSRI has conducted four case studies; this information is presented in Chapter Five. While the situation in a few counties cannot be generalized to all Oregon counties, it can highlight practices that foster a more systematic and comprehensive response to A&D needs.

3.9 COMPARISON TO OTHER STATES' A&D SERVICE SYSTEMS

To provide a larger context for understanding Oregon's investments in A&D services, HSRI briefly explored expenditure patterns in a few states which share some relevant characteristics with Oregon: they are similar in total population, relative size of the population in need of A&D services, and/or urban/rural balance. In addition, one state is known to HSRI as having an

¹⁷ Personal communication with OPERA, 4/28/08

unusually well managed substance abuse system, and another is commonly regarded as sharing Oregon's program and policy culture. The following tables present figures for Oregon and the seven comparison states, highlighting some interesting spending patterns.

Table 3.14 illustrates the A&D treatment need among all eight states. The percentage of the population in need of services in each state is similar to Oregon, helping to create a baseline of comparison states.

Table 3.14 State Comparisons A&D Treatment Need*		
State	Alcohol or Illicit Drug Dependence or Abuse (%)	Alcohol or Illicit Drug Dependence or Abuse (n)
Colorado	10.99%	409,000
Iowa	10.49%	258,000
Kentucky	8.43%	287,000
Louisiana	9.97%	362,000
New Mexico	11.68%	180,000
Oklahoma	9.28%	265,000
Oregon	9.82%	293,000
Washington	10.10%	515,000

*SAMHSA, 2003 & 2004

For the primary state agency responsible for A&D services, Tables 3.15 shows each state's expenditures for all A&D services and just for treatment, and viewing treatment spending in relation to the population in need. Oregon's total A&D spending resembles that in comparison states. However, both the percent spent on A&D treatment and treatment spending per capita for those in need are above average.

Table 3.15 Single State Agency Treatment Expenditures FY 2003*				
State	TOTAL A&D Spending	Treatment Spending	Percent Spending on Treatment	Total Treatment Spending Per Capita: Need
Colorado	\$ 35.3 M	\$ 29.0 M	82%	\$ 70.81
Iowa	\$ 45.7 M	\$ 37.2 M	81%	\$ 144.04
Kentucky	\$ 36.5 M	\$ 26.2 M	72%	\$ 91.18
Louisiana	\$ 56.4 M	\$ 49.9 M	89%	\$ 138.00
New Mexico	\$ 35.1 M	\$ 22.2 M	63%	\$ 123.35
Oklahoma	\$ 43.9 M	\$ 35.6 M	81%	\$ 134.44
Oregon	\$ 46.4 M	\$ 40.4 M	87%	\$ 137.88
Washington	\$ 117.2 M	\$ 102.2 M	87%	\$ 198.40

*ONDCP, 2006

Table 3.16 looks at states' A&D expenditures by select funding sources. Oregon has access to considerably fewer state dollars than all but one of the comparison states, and its SAPT Block Grant funding is lower than most of the other states shown here.

Table 3.16 Single State Agency Expenditures by Select Funding Source FY 2003*		
State	SAPT Block Grant	State Dollars
Colorado	\$ 23.4 M	\$ 11.0 M
Iowa	\$ 12.9 M	\$ 15.5 M
Kentucky	\$ 20.7 M	\$ 14.0 M
Louisiana	\$ 26.0 M	\$ 22.6 M
New Mexico	\$ 8.6 M	\$ 22.2 M
Oklahoma	\$ 17.8 M	\$ 22.6 M
Oregon	\$ 16.1 M	\$ 11.4 M
Washington	\$ 35.1 M	\$ 48.2 M

*ONDCP, 2006

These tables present only a very brief indication of how Oregon compares to similar states with respect to its A&D expenditures. To do justice to the question, “How does Oregon look compared to other state A&D systems?” would require considerably more time and resources than were available in the current project. These initial comparative tables show that Oregon is not an outlier, suggesting that perhaps the struggles facing Oregon’s A&D system are widely shared, and that learning more about other states’ approaches could benefit Oregon policymakers.

3.10 CONCLUSIONS AND RECOMMENDATIONS

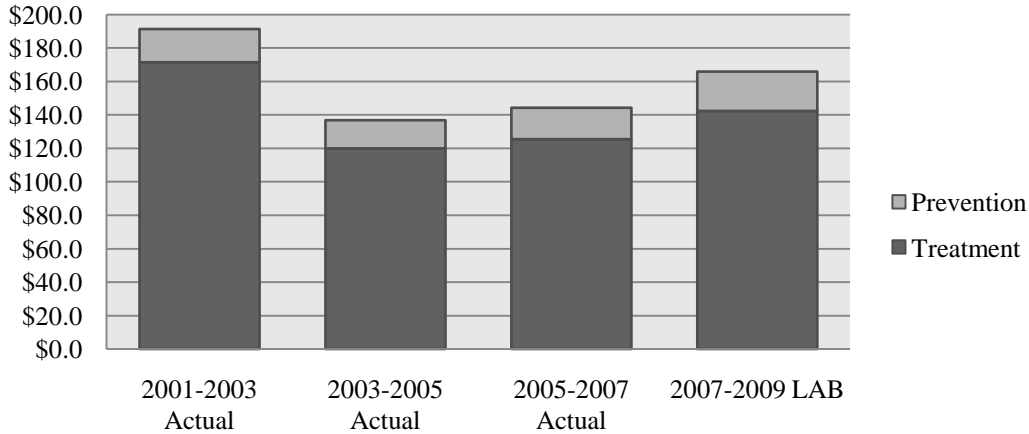
The foregoing discussion of A&D investments made by the five core state agencies has brought together a substantial amount of expenditure data, addressing both treatment and prevention activities over the past eight years. Despite inconsistencies in how figures are computed by agency and over time, this analysis has brought to light several critical aspects of the funding landscape. While no one of these patterns is surprising, together they provide a valuable synthesis of the current service environment and a foundation for policy and budget decisions. The following section discusses the four themes: the relative importance of treatment versus prevention, the complementary roles of the five state agencies, the role of the state general fund, and the impact of state funding on local service delivery capacity.

Treatment or Prevention?

A comprehensive approach to reducing substance abuse requires both prevention and treatment. Among the five agencies analyzed for this report, four are engaged in treatment interventions and three fund prevention activities. But the magnitude of the treatment investment far exceeds that for prevention. As Figure 3.20 shows, prevention is a very small component of overall A&D spending, although its role has increased over the four biennia from 10% of the total in 2001-03, to 14% in 2007-09. However, this relative expansion in prevention represents not only growing revenues allocated to prevention – it also is influenced by greater losses on the treatment side,

ending with less funds overall for A&D services. In short, when A&D resources decline, treatment absorbs a disproportionate share of the loss.

Figure 3.20
Proportion of A&D Investment in Treatment vs. Prevention



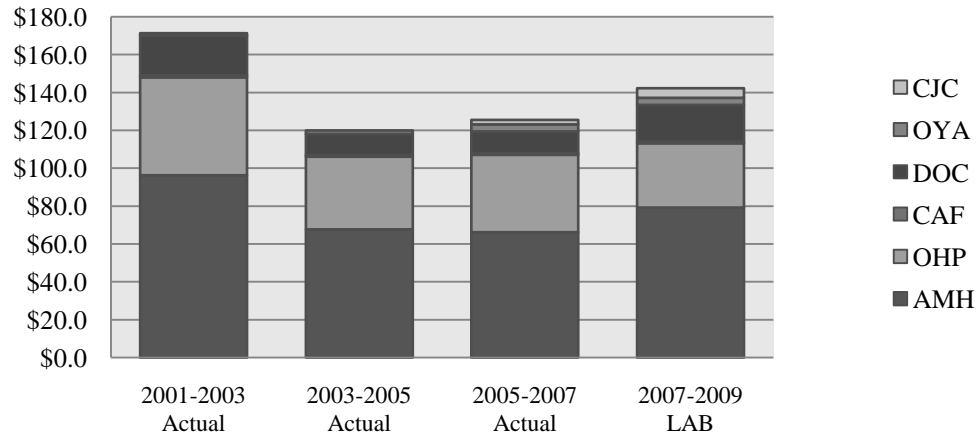
Who provides treatment services?

Because treatment spending dwarfs prevention activities, it is crucial to understand the relative role each of the major state agencies play in providing treatment services. Table 3.17 and Figure 3.21 display spending on substance abuse treatment over the four biennia for the four state agencies, separating out three divisions of DHS. Inflation-adjusted dollars were selected to show that spending on treatment, while increasing since the 2003-05 Biennium, has not fully recovered from the 2003-2005 cuts: treatment spending in 2007-09 stands at \$142.3M compared to \$171.4M in 2001-03. Figure 3.21 illustrates the primacy of DHS in the treatment arena: AMH controls just over 50% of the treatment dollars, and OHP contributes another 24% of available dollars; CAF funding represents less that 0.5%. Because of the sharp cuts experienced in 2003-05, the DHS divisions represent a smaller share of the total treatment funding – down from 87% in 2001-2003 to 80% for the current biennium.

Table 3.17
Agency Breakdown of Available Treatment Dollars, Inflation-Adjusted \$ in Millions

	Total Tx	AMH	OHP	CAF	DOC	OYA	CJC	Total biennial rate of change
2001-2003 Actual	\$171.4	\$96.2	\$51.9	\$0.9	\$20.9	\$1.5		
2003-2005 Actual	\$120.0	\$67.7	\$38.4	\$0.9	\$11.3	\$1.8		-30.0%
2005-2007 Actual	\$125.5	\$66.2	\$40.9	\$0.8	\$11.5	\$3.7	\$2.3	4.6%
2007-2009 LAB	\$142.3	\$79.2	\$34.0	\$0.8	\$19.6	\$3.7	\$5.1	13.4%

Figure 3.21
Inflation Adjusted Investments in A&D Treatment across Target Agencies



After DHS, DOC is the next largest recipient of treatment spending. Across the biennia, DOC has received between nine and 14% of the available treatment dollars, with the highest percentage occurring in the current biennium. If, as expected, the prison population increases, the DOC percentage is likely to increase further.

The remaining two state agencies providing treatment services are OYA and CJC. With only 3% of the treatment funding, OYA is a small player compared to DHS and DOC. However, its current role is an increase from less than 1% of total funding in 2001-2003. During this time, OYA has also increased the percentage of its total agency budget that is allocated to A&D, demonstrating a growing commitment to provide substance abuse treatment to OYA committed youth. Similarly, CJC treatment funding represents only a slightly larger piece of the graph than OYA, at 3.5%. The apparent increase in CJC treatment funds from 2005-07 to 2007-09 is an anomaly: the CJC Drug Court Program began in July 2006, the second year of the biennium.

Each of these agencies has a different client base. CAF, DOC, OYA, and CJC serve clients who have generally entered the treatment system involuntarily. AMH and OHP treatment dollars fund some of these clients (examples include many youth, some community corrections clients, and parents with children in foster care) but may also provide funding for clients who seek publicly funded treatment independent from contact with another agency. Many clients require dollars from more than one funding source in order to fully fund their treatment. Consideration of the paths that different groups of clients take to access the treatment system is essential to understanding the implications of changing A&D funding distributions.

How is treatment funded?

To fully understand the vulnerability of treatment to fluctuations in available state general fund monies, Table 3.18 and Figure 3.22 illustrate the relative importance of state funding sources for A&D treatment across the four target agencies for the 2005-07 Biennium. As the table shows, AMH relies on state general funds for 32% of its treatment dollars, with the remaining percentages coming from federal funds, the state beer and wine tax, and other small contributions. OHP treatment monies come from federal entitlements plus the required state match, making it particularly reliant on state general funds – the 38% proportion will remain

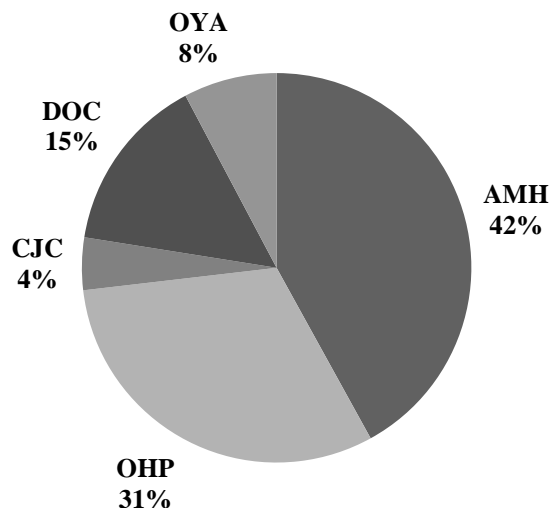
constant regardless of the SGF contribution because loss of state general funds translates directly into loss of federal funds.

Table 3.18					
Sources of Funding for A&D Treatment, 2005-07 (\$ Millions)					
	Federal Funds	State General Funds	Other Funds	Total	% Reliance on SGF
AMH	\$40.0	\$24.1	\$11.1	\$75.2	32%
OHP	\$28.6	\$17.9	.0	\$46.5	38%
CJC	.0	\$2.5	.0	\$2.5	100%
DOC	\$0.4	\$8.5	\$4.2	\$13.1	65%
OYA	.0	\$4.5	\$0.1	\$4.6	97%

The other three state agencies rely much more heavily on state general fund dollars for A&D services than do AMH and OHP. CJC funding comes entirely from the state general fund. Sixty-five percent of DOC A&D treatment dollars come from the state general fund, with the remaining amount coming largely from inmate welfare funds; federal funds make a small (3%) contribution. Similarly, OYA A&D funds are largely drawn from state general funds, comprising 97% of its total treatment funding.

Figure 3.22 shows how state general funds for A&D treatment are distributed among the core state agencies. Again, AMH and OHP capture the majority of these funds – 42% for AMH and 31% for OHP. DOC, CJC and OYA get relatively few state dollars. When considering decreases in state general funds for A&D, policy makers need to bear in mind that AMH and OHP are most immediately affected by overall changes in the availability of state monies.

Figure 3.22
State General Funds for A&D 2005-2007
 Total \$ from SGF = \$57.4 M



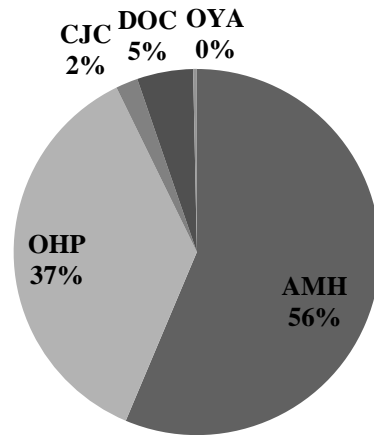
Treatment Funds to Locals

In Oregon, the vast majority of actual decisions regarding treatment priorities take place at the local level. Local CMHP's, tribal entities, community corrections and juvenile departments, and drug courts work with local providers and other stakeholders to determine how best to allocate available resources to serve their communities. Table 3.19 and Figure 3.23 show the A&D dollars distributed by each of the core state agencies to local communities in 2005-2007. These agency-specific amounts are often combined together and/or merged with other funding sources such as county general funds, to meet overall treatment needs. These other funding sources are highly localized. For example, some counties may have levies or timber tax dollars. On reservations, the Indian Health Service may be a majority contributor to A&D funding. As mentioned above, multiple funding sources may be combined to serve any particular client.

Table 3.19 Proportion of Treatment Funds Sent to Local Communities by Core State Agencies, 2005-2007			
	Total A&D \$	\$ to Locals	% of total to Locals
AMH	\$75.2	\$71.9	96%
OHP	\$46.5	\$46.5	100%
CJC	\$2.5	\$2.5	100%
DOC	\$13.1	\$6.3	48%
OYA	\$4.2	\$0.4	10%

Among the five state agencies, AMH is clearly the largest distributor of treatment funds to local communities. In 2005-2007, 96% of AMH treatment dollars were allocated to local CMHPs, tribes, and providers for the contracting and/or provision of direct treatment services. As mentioned, the client base for local AMH allocated funding is comprehensive and includes clients flowing among other agencies. The second largest player is OHP, spending all of its \$46.5M of A&D resources for local treatment interventions. Together, the DHS divisions account for over 90% of state agency funds flowing to local communities (Figure 3.23).

Figure 3.23
Proportion of A&D Treatment Funds Sent to Locals by Agency, 2005-2007
Total \$ to Locals = \$127.6 Mill.



The other three agencies play relatively small roles. Like OHP, CJC devotes all of its A&D resources to local activities, through the local Drug Courts. But because it is a relatively small initiative, CJC's relative contribution to local A&D effort is only 3%. OYA plays a similarly small role: it has a small number of contracts to serve OYA committed youth in the community. This constitutes less than 1% of state agency funds going to the local level. OYA spending on community contracts represents only 10% of its total A&D spending. Most OYA community-treated youth are funded through other sources—primarily Medicaid/OHP. The role of DOC is small but significant, contributing 8% of total A&D spending across the agencies. Of the \$190 million in grant-in-aid to local corrections departments, \$6.3 million was allocated to A&D by local decision-makers. Figure 3.23 makes clear how vulnerable the local A&D treatment efforts are to fluctuations in AMH and OHP investments. Although counties receive funds from many other sources, the dollars represented in the pie chart are a substantial part of total A&D resources at the local level.

Prevention

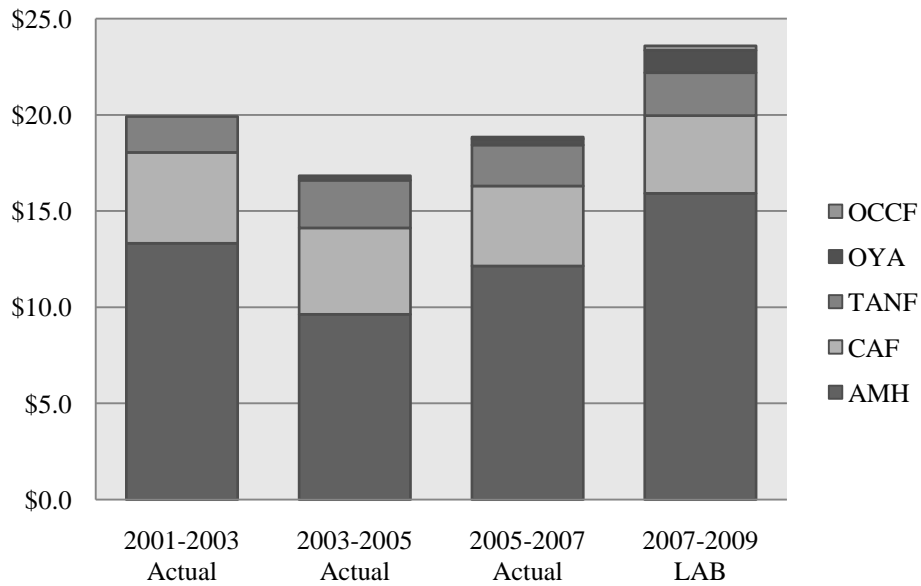
Although treatment is clearly the major focus of state agency A&D activity, and is far easier to measure level of effort, it is important not to overlook prevention funding. Most notable is that aggregate prevention investment has completely recovered from the 2003-05 cuts and has grown to \$23.6M (Table 3.20 and Figure 3.24). Virtually all of the growth occurred in AMH, largely due to increased prevention monies in the SAPT block grant. Only a small percentage of prevention funding comes from the state general fund. CAF, OCCF and TANF prevention dollars remained relatively unchanged over the eight-year period, and the amounts are small compared to AMH. These dollars are also more difficult to track—OCCF allocations are only available for the last two biennia and both OYA and OCCF substance abuse prevention spending reports are highly variable. For example, for the current biennium, Multnomah County allocated over one million dollars of their OYA-distributed Diversion funding to one prevention program. For the previous biennium, no diversion dollars at all were reported as allocated to A&D

prevention. In addition, data systems in place to track prevention funding are not as complete or comprehensive as those in place to track treatment.

Table 3.20
Agency Breakdown of Available Prevention Dollars
Inflation-Adjusted, in Millions

	Total Prev	AMH	CAF	OYA	OCCF	TANF	Total biennial rate of change
2001-2003 Actual	\$19.9	\$13.3	\$4.7	\$0.0		\$1.9	
2003-2005 Actual	\$16.8	\$9.6	\$4.5	\$0.2		\$2.5	-15.4%
2005-2007 Actual	\$18.8	\$12.1	\$4.2	\$0.3	\$0.1	\$2.1	11.9%
2007-2009 LAB	\$23.6	\$15.9	\$4.0	\$1.2	\$0.2	\$2.2	25.2%

Figure 3.24
Inflation Adjusted Investments in A&D Prevention
across Target agencies



Next Steps

These spending patterns, across agencies and over time, point to the substantial role played by DHS – in particular, AMH and OHP – in the overall financial health of the A&D system. The picture is fairly complete, sufficient to inform policy discussions in the immediate future. However, this analysis could be made more comprehensive by further exploration in several areas:

First, in view of the substantial effort made by state agency staff to provide HSRI with useful information on A&D investments over the past four biennia, each state agency should develop some routine expenditure tracking procedures and reporting templates; the data presented in this report could serve as the baseline for examining future spending patterns. And such a systematic approach could also go to the next level: together the state agencies should convene a group of managers to explore ways to regularly compile and share data on A&D allocations across localities and among different target populations.

Second, given the difficulties encountered in this study in seeking to document administrative costs, at both state and local levels, it may be important to field a special effort to explore how administrative costs are calculated, to develop a reasonable standardized approach that could be piloted in a few areas, and to eventually design a systematic reporting process having some factors common to both the state agencies and the local level.

Third, more attention should be given to understanding the scope of prevention investments. Because prevention services are more difficult to categorize – clearly identifying a preventive activity as related to potential A&D use and abuse – it is difficult to know whether sufficient resources are being applied to prevention; and, because it is difficult to identify the people who have been “touched” by a prevention activity -- participated in a community event or aware of a public service announcement – it is impossible to directly assess whether prevention initiatives are having the desired impact.

Fourth, given the prominent role played by OHP in funding A&D treatment services, it would be helpful to understand more about the variations across the 12 Health Plans in Oregon in terms of how they distribute and manage limited funds across many providers and client groups.

Fifth, it would be valuable to learn more about other state A&D service systems, to give some perspective on Oregon's current structure and funding levels. Examination of other state budget and planning documents, complemented by interviews with a few key policy staff, could provide valuable insight into how other states deal with challenges similar to those faced by Oregon – for example, how they determine funding priorities, how they track spending for various populations in need of A&D services, how service initiatives are coordinated across state agencies and among levels of government. Indeed, such an exploration of states similar to Oregon could yield useful information not only on investments but also related to service gaps and performance management.

CHAPTER FOUR: PERFORMANCE MANAGEMENT

As the Investment Analysis reveals, the five key state agencies targeted in this study were allocated over \$200 million dollars for the 07-09 Biennium to provide A&D services across the state of Oregon. In providing oversight of these resources, the agencies are responsible for assuring that the providers who serve A&D clients are doing so in an accountable, measurable, and effective manner. This section provides an overview of how these agencies provide oversight and encourage effective practice at the local level. In particular, this chapter explores how the five agencies:

- determine spending patterns/priorities,
- monitor A&D expenditures,
- gather information/data on A&D services,
- track performance and hold providers accountable, and
- encourage and foster better outcomes.

HSRI conducted a series of telephone interviews with staff from each of the five agencies, exploring these questions. This chapter provides an initial examination of performance management processes and issues related to A&D services. It should be noted, however, that each topic could be explored in significantly more detail if time and resources allowed.

4.1 CONTRACTING

State agencies use a variety of contracting methods with local service providers, both in terms of structure and execution, which impacts the amount of control and oversight the state agency exerts over service delivery at the local level. Agencies develop priorities for allocating their service dollars and processes to identify qualified A&D providers; these activities enhance the state agencies' capacity to understand community needs and select the most appropriate and qualified service providers.

In terms of A&D services, the five agencies can be categorized into two groups: those with a broad mandate to provide services to a very diverse target population, and those with a more specific mandate to provide services that address the needs of a particular subgroup of A&D clients through targeted treatment and prevention efforts. The distinction between these two groups informs the way resources are prioritized and contractors are selected.

AMH and OCCF are clearly agencies with a broad mandate: these agencies support a diverse group of individuals by providing a wide variety of services, including residential, outpatient, detoxification, and prevention programs. AMH is responsible for serving those in the general population who have A&D treatment needs, as well as all clients who first seek and/or receive treatment from another part of the A&D system. OCCF plays essentially the same role in the prevention arena. Though resources are limited, these agencies' mandates are all-inclusive, resulting in a need for careful prioritization of service area funding. To address this dilemma, both agencies have a comprehensive planning process at the state and local levels. In 2007-2008, AMH developed statewide priorities through a strategic planning process that included input

from focus groups held across the state, involving more than 150 Oregonians with a wide variety of perspectives. At the local level, CMHPs conduct a biennial collaborative planning process involving stakeholders to set local service priorities; this planning process requires input from a wide-spectrum of stakeholders, including consumers, advocates, family members, and community coalitions. OCCF has a similar process: at the local level, each local CCF leads a local comprehensive planning process around the needs of children, youth and families; this process identifies and addresses local needs and helps determine how the local CCF should prioritize its county allocations. In response to the priority areas of each of the local commissions, and in consultation with state level stakeholders, OCCF develops several broad statewide priority areas.

A collaborative approach to establishing statewide priorities is important for both AMH and OCCF since they both distribute most of their funding to local communities through a formula allocation. It is important to have consistent approaches and guidelines across the state, as each local entity receives allocations from the state with broad guidelines on how the resources must be used, and the local entity has considerable discretion regarding which local providers they wish to fund. Formula allocations provide each community with the ability to individualize services to best fit the local priorities, as well as to leverage funds from additional resources.

In contrast to AMH and OCCF, the other state agencies with A&D responsibility have more limited mandates, serve limited segments of the A&D population, and thus provide a more limited array of A&D services. They do not have a formalized process to determine funding priorities; rather, they target particular types of providers to contract with, looking at the provider's capacity (e.g. volume of people it can serve, ability to provide EBP) or simply following guidelines set out in legislation or as part of a federal grant. These agencies then use RFP or RFA processes to identify providers who can provide the targeted services. AMH and OCCF also use the RFP processes, but for specialized efforts: when there is a new or targeted service initiative with a separate funding stream (e.g. JCP); when funding is at levels insufficient to allow allocations to all counties; or when a service contract spans multiple counties and would benefit from a competitive bidding process.

Once a contract has been executed, a state agency then has the responsibility to distribute resources and monitor how A&D funds are being spent over time and the appropriateness of the allocated amount. State agencies use several monitoring methods:

- (1) AMH and OCCF issue a *fixed allocation* payment at the beginning of the funding cycle or at regular intervals throughout the year, allowing local entities to have a predictable cash flow over the course of a funding cycle. This requires some type of reconciliation process at the end and/or ways to adjust the allocation in response to changes in the scope of services or population to be served.
- (2) CJC uses a *Request for Reimbursement* process with a capped contract amount, allowing it to monitor ongoing expenditures for each drug court contract, but providing the drug court with a total budget for the two-year funding cycle.
- (3) For some of the contracts, a state agency may simply reimburse on a *fee-for-service* basis, with no guarantee of the amount of services or number of clients to be served by the contractor. This requires establishing a specific rate for a unit of service – an amount of time, a bed, etc.

4.2 DATA SYSTEMS, OUTPUTS AND OUTCOMES

Since the five state agencies contract with and provide financial resources to local communities, they require that local entities collect data on whom they are serving and how they are supporting the population in need of A&D services. The capacity and degree to which state agencies are able to collect data from local CMHPs and private providers determines how well the state is able to hold these providers accountable. Each state agency has a data system to collect a wide variety of information most relevant to its mandate or mission; each data system contains information on the A&D services being provided within their service system and/or the individuals being served.

<u>State Data Systems</u>	
<u>Clients Of:</u>	<u>Data System</u>
AMH/OHP/CAF	CPMS/ MMIS
DOC	CIS
OYA	JJIS
CJC	OTCMS
OCCF	OCCF web application

The following data systems are in use by the agencies covered in this report. AMH uses the Client Process Monitoring System (CPMS) which collects data for publicly-funded clients receiving treatment. OHP uses the Medicaid Management Information System (MMIS) to collect data for clients whose treatment is funded through OHP. DOC uses the Corrections Information System (CIS), which collects corrections-specific outcome data for offenders. CJC uses the Oregon Treatment Court Management System. OYA uses the Juvenile Justice Information System, which collects data on justice-involved youth. OCCF uses a combination of databases; a local resources database, a comprehensive plans database, and the JCP database.

It is important to note that most of these systems compile information on a subset of the population receiving A&D services; CPMS is the most inclusive data system, collecting data on all individuals receiving publicly funded A&D services. This section describes what data in each data system enables the state agencies to monitor service delivery and client movement, ultimately providing the building blocks for performance measures and research on effectiveness.

At the very basic level, in order to understand the scope of a service delivery system, it is vital to collect data on basic program *outputs*, that is, who is participating in A&D services and what activities are being provided. In examining how consistently output data is gathered across the five agencies, it appears that all the agencies collect information on the number of clients served, although there is variation in the level of detail collected: some agencies simply collect the number of individuals or families served, while others compile more detailed information on number of clients entering, participating, or completing a program. In regards to other outputs, significant variation exists in the amount of information available on service utilization: some systems simply don't collect information on A&D services provided, others are able to report whether a service was provided, and, at the opposite extreme, the OHP data system is able to report on specific utilization patterns (e.g., the number of units provided in ¼-hour increments), as this data system is the Medicaid billing system. It appears that, while these five agencies collect varying amounts and types of data on A&D service provision, they all have the capacity to examine basic outputs that are produced from A&D investments.

While it is clearly necessary to have an understanding of the outputs received given the investment in A&D services, it is also important for state agencies to be able to gather data on the outcomes which are achieved as a result of the provision of A&D services, that is, the successes gained in the short and long-term. Therefore, we explored whether state agencies have

the capacity to collect data which could be used to determine if substance abuse services are affecting outcomes for clients. In this area, there is variation among the five agencies because of the varying mandates and populations served. For example, the desired outcomes for an incarcerated individual (e.g. decrease re-entry to the criminal system) are very different from the desired outcome for a parent involved in the child welfare system (e.g. increase reunification of the removed child with the birth parent).

While all five of these agencies have a wide range of outcomes they are trying to impact, there are several shared outcomes most likely to be influenced by the provision of A&D services. Table 4.1 provides a list of the National Outcome Measures (NOMs) which have been developed by SAMHSA for the A&D field; these are considered to be ‘meaningful’ and ‘real-life’ outcome measures for people with substance abuse disorders. As the table indicates, most of the state agencies collect some outcomes related to these NOMs. It is also noteworthy, although not surprising, that CPMS captures all of the NOMs for the SAPT Block Grant¹⁸, except ‘Increased Access to Service’: while CPMS collects information on services provided, it is unable to capture whether the gap in service provision has decreased because there is not a finite population served by AMH providers.

<u>NOMS Outcomes</u>¹⁹ <i>(italicized items from Scope of Work)</i>	Data System Used by²⁰:				
	AMH (CPMS)	DOC (CIS)	OYA (JJIS)	CJC (OTCMS)	OHP (MMIS)
Abstinence from Drug/Alcohol Use	✓	²¹	✓	✓	
Increased/Retained Employment or Return to/Stay in School <i>(not expelled or suspended)</i>	✓	✓	✓		
Decreased Criminal Justice Involvement: <i>decrease in arrest or conviction after treatment (recidivism)</i>	✓	✓	✓	✓	
Increased Stability in Housing	✓		N/A		
<i>Reunification with child</i>	✓		N/A		
Increased Access to Services		✓	✓	✓	✓
Increased Retention in Treatment – Substance Abuse (Completion)	✓	✓	✓	✓	

It is important to note that this table simply indicates that there is a *capacity* to collect data on these nationally recognized A&D outcomes, indicating that exploration of the outcomes achieved by A&D clients is possible. However, it appears that CPMS is used more to report on specific aspects of performance, rather than to conduct research. Further, more wide-spread concerns and

¹⁸ As compiled in the Treatment Episode Data Set.

¹⁹ Four additional NOMs currently are under development: social connectedness, perception of care, cost effectiveness, and use of evidence-based practice.

²⁰ OCCF is not included in this chart, as it provides prevention services, thus would monitor different outcomes.

²¹ DOC has UA data but not on all service participants, so the outcome measure is difficult to use.

challenges exist in regard to the accuracy and availability of outcome data across the five agencies. Several themes arose in discussions with staff:

- Linking multiple data sources: Interviewees expressed the desire to match data files at the client level so they can begin to calculate an unduplicated count of people served, see which clients are served by multiple service systems, and explore related outcomes. For example, AMH is interested in securing law enforcement data which would provide more detail regarding overall service need and specific individual needs. However, the capacity to link these data systems is not yet available, due to lack of resources and also concerns about sharing client-level data across agencies.
- Inconsistency in data: While AMH and other agencies have made serious efforts to ensure reliability and accuracy of data, there remain concerns across most agencies that data entry is inconsistent at the local level, with providers using different definitions for data items and fields and having varying ability to keep up with data entry.
- Inability to provide quick outcome reporting to local providers: State officials realize the need to compile data in a timely manner and report this information back to staff at the local level. At this point, county-specific reports on A&D services are only available from a few agencies and there is often a significant data lag. Agencies are working to develop this capacity; for example, AMH has designed a web portal for providers and counties to access CPMS, offering some standard reports that they can run on their own data and compare to their county as a whole; more report templates are planned, although there remain concerns about the three to six month time lag in CPMS data.
- Local perspective: In the process of conducting the case studies, local providers spoke of their frustrations with the current set of data systems into which they must enter data. These providers are required to enter data into multiple systems, depending on what funds are paying for the A&D services. For example, providers may be entering data into CPMS, MMIS, CIS, and OTCMS. In addition, many local providers have developed their own data collection systems, with varying degrees of sophistication, giving them the ability to collect comprehensive data about their unique program to guide their management decisions. Local providers would clearly benefit from working together with state agencies to develop a standard set of measures which are useful to local providers, and thus reduce the burden of the current data collection systems.

These challenges are not surprising, given the lack of available staff and financial resources to build better data collection capacity.

4.3 ACCOUNTABILITY

As stewards of the state A&D investments, the five state agencies have a responsibility to implement processes that enable the state to monitor performance and establish accountability standards. These processes should not only monitor for compliance of an individual agency, but they should also provide the state agency with the capacity to make data-driven decisions, ensuring the overall quality of A&D services provided in Oregon.

A key method to ensure accountability is to develop *performance measures* that may be applied equally to all providers. Each performance measure requires data elements with specific

definitions which should provide a quick portrait of the quantity and quality of service delivery as well as identify opportunities for program improvement. Most of the state agencies targeted in this study have formalized performance measures, although as shown in Table 4.2, the measures vary significantly in scope, from broad agency efforts (e.g. % of total best practices) to targeted measures (e.g. decreasing 8th grade risk for A&D use). For OCCF and AMH, these performance measures relate to particular statewide Oregon Benchmarks, to which they are held accountable.

Table 4.2: Performance Measures²²		
AMH		
<ul style="list-style-type: none"> • Abstinence at A&D treatment • Employment after treatment • Reunification after treatment • 8th grader risk for A&D use 	<ul style="list-style-type: none"> • Improved school performance after A&D treatment • Engagement in treatment • Retained in treatment 	<ul style="list-style-type: none"> • Level of care • Completed treatment • Reduced use
DOC		
<ul style="list-style-type: none"> • Use of EBP • Hrs. of therapeutic services • Hours of structured activities 	<ul style="list-style-type: none"> • Successful completion of programs • Transition case staffing 	<ul style="list-style-type: none"> • Reduce recidivism • Monthly reports
CJC		
<ul style="list-style-type: none"> • Reduced Crime • Sobriety/Reduced Dependency 	<ul style="list-style-type: none"> • Drug-free parents • Accountability (graduation rates, retention rates, court attendance compliance, and AOD attendance compliance) 	
OHP		
<ul style="list-style-type: none"> • Enrollment 	<ul style="list-style-type: none"> • Service utilization rate 	<ul style="list-style-type: none"> • Type of chemical dependency service
OCCF		
<ul style="list-style-type: none"> • Locally Invested Funds • Leveraged Funds • Healthy Start Participation 	<ul style="list-style-type: none"> • % children served by Juvenile Crime Prevention • % children with Court Appointed Special Advocates 	<ul style="list-style-type: none"> • Relief Nursery Participation • Customer (local CCF) Satisfaction • Best Practices

While most agencies have developed performance measures, there is significantly less activity in terms of formalizing these expectations for the local providers. DOC and CJC have built the performance measures into contracts, so providers are made aware of the state agencies' expectations. Another method used to clearly define the expectations of a provider is to set targets or benchmarks for the provider to try to achieve; these provide a standard for acceptable performance, allowing comparison and evaluation within or among providers. While state agencies develop specific targets or benchmarks in their own planning efforts, at this point, DOC is the only agency which has included these expectations in contracts with local providers. For example, DOC contracts state that "at least 70% of the clients shall successfully complete the Program as evidenced by the number and rate of successful termination codes on the CPMS".

²² OYA and CAF are not included in this table; they do not have performance measures related to A&D outcomes.

The final level of formalizing performance measures would be to not only have targets within each contract, but also to tie funding to performance by providing financial risks and incentives for meeting these targets. No agencies are currently at this point, and this is not necessarily the ultimate goal. However, performance based contracting, when used carefully and in appropriate contexts, can help state agencies push forward with performance management to achieve better outcomes (Kimmich, 1996). Indeed, CJC is currently exploring the merits of linking performance to payment, through a study of the impact of financial incentives on the ability of drug courts to achieve specific performance benchmarks or targets and thus more effectively influence outcomes.

A less formalized process to ensure accountability is to establish regular reporting requirements. Such processes are vital in helping state agencies understand what is occurring at the local level, helping local providers to understand what their data looks like at an agency and even state-wide level, and helping state agencies report to the entities that oversee their activities, ensuring that a regular process is in place to provide accountability for the statewide A&D system. Most state agencies have regular reporting processes: DOC, CJC, OCCF, CAF and special projects out of AMH require that local providers regularly aggregate their own data on performance measures, expenditures, efforts around EBP, and overall progress reports. These reports are submitted on a regular basis, usually monthly or quarterly. Within DHS, information also flows in the opposite direction, from the state agency to the local community; AMH produces a quarterly Treatment Improvement Report (TIR) which presents CPMS data on five performance measures, while OHP produces quarterly utilization reports which are very similar to TIR in terms of reporting on service provision and individuals served (see Table 4.2).

It is surprising that there are few mandates for the state agencies to produce reports on a regular basis which provide an aggregate summary of the services provided under their watch. While most agencies provide a legislative presentation or report every few years and create specialized reports upon request, there is little regular reporting, and thus few opportunities that require the state agencies to pull together their findings in a comprehensive way. This formal reporting at the state level seems to occur only when an initiative is funded through a grant effort with specific reporting guidelines, as with the comprehensive SAPT Block Grant report.

Finally, in terms of accountability and monitoring for contract compliance, only two agencies appear to have a formalized process to conduct program reviews to provide feedback to the state agencies about what is happening in the local A&D programs. AMH and DOC have a formalized process to conduct program reviews which include the use of established review tools and result in a formal report. AMH conducts formal site reviews on all residential and outpatient providers every two to three years and DOC reviews providers when performance issues arise. Overall, it appears that state agencies struggle with providing regular reviews, due to limited resources.

4.4 EFFECTIVENESS

Above, we have described how A&D investments are distributed to the local level, how contracts are structured, what data collection efforts are in place, and how state agencies have begun to develop processes to ensure that contractors are providing services that meet the expectations of the state agencies. However, in addition to these efforts, there has been a clear movement in Oregon to develop processes to ensure that treatment, prevention and recovery

services result in positive outcomes for clients of the A&D system. This section includes a description of how agencies have been promoting the use of Evidence Based Practice and conducting comprehensive research to further the implementation of A&D strategies which are most effective, both in terms of client outcomes and cost.

Evidence Based Practice (EBP)

In 2003, the state legislature passed Senate Bill 267, which requires that the five state agencies targeted in this study develop processes to encourage providers to utilize EBP – service models which have research-proven efficacy. By 2009-2011, these agencies must be spending at least 75% of their public dollars on evidence-based services. By implementing EBPs, the state can increase the likelihood that the A&D services being provided will lead to better outcomes for recipients, without having to conduct rigorous evaluation studies to document the success of each program. State agencies have implemented a variety of strategies to meet the mandate of this legislation.

Of the mandated EBP agencies, AMH has made the most extensive effort to foster the use of such proven practices. The AMH website features an EBP-dedicated section listing approved practices and describing how to implement these EBPs. This webpage also offers information about measuring fidelity to an EBP model, including tools to assess fidelity and technical assistance resources. AMH plays the role of clearinghouse and coordination center, helping counties and individual providers to connect to each other and to nationally available research and expertise. In accordance with SB267, AMH tracks the use of EBP by all of its providers. Every few years, AMH surveys providers regarding their use of EBP, exploring implementation, fidelity activities, numbers served, costs and outcomes for participants.

In the strictest sense, AMH does very little direct monitoring of fidelity – assessing the extent to which specific components of the proven model practice are used; this is primarily due to resource limitations and the myriad of EBPs in use throughout the state. Rather, in its surveys of providers, AMH asks *what the provider has done* to assure that each EBP being used adheres to standard practice. Responses to the 2008 survey indicate that “most of the programs use structured clinical supervision and/or quality assurance activities to monitor adherence to practice criteria ... (and) roughly half of the providers use actual fidelity reviews or individual clinician proficiency reviews” (DHS/AMH, 2008). AMH compiles the results of its EBP surveys in periodic reports to the legislature; these reports are available on the DHS website. In addition, in 2007 AMH conducted a Fidelity Pilot Project, developing a monitoring process and training peer reviewers to look at some of the most common EBP models. The current focus of this monitoring effort is to foster greater use of EBPs and to support providers in improving fidelity over time.

Although there is little third-party or independent monitoring of practice fidelity or reporting of fidelity levels achieved, AMH is beginning to pay greater attention to monitoring providers' capacity to implement and sustain EBPs – in essence, assessing whether the provider has the needed infrastructure and basic operational processes in place. This approach will likely become part of the site review process, formally incorporated into administrative rule (akin to DOC's approach described below).

All treatment programs at DOC facilities are evidence-based. DOC uses the Correctional Programs Checklist (CPC), a tool developed to monitor adherence to a set of content and capacity standards which are considered key to all correctional A&D interventions. The CPC

tool consists of five domains²³ and 77 indicators. The CPC review process includes interviews with program staff and participants, as well as reviews of case files and other program materials, serving as an evaluation tool for in-prison EBP treatment programs. A high score on the CPC indicates high fidelity. As mentioned, the CPC benchmarks a given program against principles of correctional programs that have proven to be effective. Fidelity results are used to provide feedback to individual programs and to meet the requirement of SB267. The reviews result in a report to the contractor which discusses strengths, areas for improvement, and recommendations, along with overall percentage scores.

The other state agencies monitor the use of EBP through a variety of efforts.

- OYA uses the CPC to monitor compliance with EBP models in its facility-based programs.
- At OCCF, the Juvenile Crime Prevention Advisory Committee (JCPAC), established in 1999 as part of the Juvenile Crime Prevention Program, has responsibility for assuring that JCP programs conform to the SB267 mandate. JCPAC has a subcommittee dedicated to monitoring the degree to which JCP programs are implementing the proven practice model.
- CJC administers the Drug Court program, based on a nationally recognized EBP. Monitoring adherence to the EBP model is the responsibility of CJC; in each quarterly report submitted by local drug courts to CJC, programs describe their compliance with the model's key components and strategies, including findings from chart reviews and attendance at trainings that reinforce the model. CJC also meets annually with drug courts, observing staffings and drug court hearings, meeting with staff members, asking program-specific questions, and providing technical assistance. Adherence to EBP is not formally measured, but CJC gains a sense of which programs are closer to the intended drug court model and can anecdotally suggest relationships between fidelity and outcomes. CJC has recently contracted with an outside evaluator to conduct a study of the effectiveness of Drug Courts, including developing a fidelity tool to look at compliance with the EBP model.

From our review, it appears that evidence-based practices are a focus of all state agencies under the scope of this project. However, monitoring practices are varied; most do not require formal review of the adherence to EBP, but rely instead on self-reporting by the provider and qualitative reviews by the state agencies. For example, OCCF has a key benchmark which measures the “percentage of total best practices met by the Commission” – this simply calculates how many programs have implemented EBP, without particular attention to the degree of fidelity to a particular EBP model. On the other hand, DOC asks each program to “demonstrate utilization of principles of effective correctional interventions by scoring no less than satisfactory on Correctional Program Checklist”.

At this point, it appears that most efforts to monitor EBP involve agencies assessing the organizational capacity to implement EBP- trainings provided, staffing levels, and oversight of program practices by supervisors, building organizational principles and capacity to focus on EBP. However, without an ability to clearly evaluate the degree to which a clearly defined EBP

²³ The five CPC domains include: program leadership and development, staff characteristics, quality assurance, offender assessment, and treatment characteristics.

model is being implemented, it is difficult to say that the services provided in local communities include the key components of EBP, which are necessary in order for the programs to achieve the expected outcomes found in the EBP model program. This requires becoming more rigorous in monitoring programs by establishing clear guidelines and standards for what is considered acceptable review of EBP.

Measuring Effectiveness

While using evidence-based practices is one way to ensure that Oregon investments in A&D service lead to positive outcomes for recipients, service providers may nonetheless be using some programs that have not been thoroughly evaluated and proven effective. These could be interventions which the community supports and believes are successful. While performance measures give a rough sense of whether a program is working for a particular set of people, rigorous research studies are often needed to clarify how and for whom the program leads to successful outcomes.

In terms of capacity to test the impact and cost effectiveness of their funded programs, the five targeted state agencies are at varying levels. AMH has a Program Analysis and Evaluation unit which responds to various requests for analysis of CPMS data and linking CPMS data to other data sources; these efforts are sometimes completed by the internal research unit and are other times contracted out. Current external evaluations include an examination of DUII arrest/conviction and treatment, as well as the NIAtx2000 effort to improve the use of performance data among outpatient A&D services.

DOC has an in-house research unit with designated staff. While research has not focused on the effectiveness of DOC's A&D treatment programs, the unit is currently working to develop that capacity by screening all inmates, creating the possibility of establishing a control group, one ingredient of a rigorous experimental design. At the local level, a few Community Corrections agencies have undertaken studies of programs in their communities, but these are often in counties with larger populations and therefore larger staff and research resources.

Other agencies rely on outside consultants to complete formal research. OYA is currently funding a study examining the cost-effectiveness of their A&D program. CJC has contracted for several research projects related to Drug Courts: (a) a recidivism study of the Adult Drug courts, looking at cost savings and fidelity to the drug court model; (b) an evaluation of the Byrne-funded drug courts, examining effectiveness and focusing on the child welfare population and potential societal cost savings; and (c) a special study of the impact of financial incentives on the ability of drug courts to achieve performance measures. In addition, CJC indicates that some drug courts have built in evaluation components to local programs.

In general, the five agencies have some capacity to conduct rigorous evaluation efforts, but they do not have the resources to develop a regular, formal strategic process to determine research and evaluation priorities. More research appears to be conducted on targeted programs that are funded through grants, such as JCP, or by agencies with a smaller scope of responsibility and a mandate to examine efficiencies and effectiveness, such as CJC.

4.5 SUMMARY

With five state agencies providing a spectrum of A&D treatment and prevention services, it is important to understand how performance of A&D services at the state and local level is

enhanced. A few key points summarize what activities should take place to ensure accountability:

- Setting priorities is the first step in being able to clarify what the agency wants to achieve and to determine what state-level efforts have accomplished.
- Monitoring spending and gathering basic 'outputs' data on people and services serves as the foundation for describing how state investments are being used.
- Establishing performance measures and tracking performance over time enables state agencies to be accountable to higher authorities (the Governor's office, the legislature, and Oregon citizens).
- Examining outcomes is possible through clear measurement and deeper studies of impact, as well as attention to selection of proven practices by providers (e.g. EBP).

Overall, it appears that each of the five state agencies have adopted some basic mechanisms to promote efficiency and effectiveness of A&D services in Oregon, although there is significant variation among agencies in many of the topics explored in this chapter. To enrich understanding of current successful practices and to foster improved performance management, several steps should be taken:

First, more work should be done to understand variations in contracting arrangements, fiscal accountability processes, and efforts to incorporate performance measures in contracts. While this chapter provides some insights into performance management efforts, the topic is enormous in scope and HSRI has been able to only scratch the surface. With the wide variety of data systems that collect information on the performance of A&D providers, there is clearly a need to understand more thoroughly how these data systems overlap and how data could be shared among state agencies. Given the vast amount of data that is collected, it would be useful to explore ways to avoid duplication of data collection efforts at the local level, develop useful practices for sharing data to allow local entities to make data-driven management decisions, and provide methods for the state agencies to compile an overall understanding of how the state is faring in terms of the delivery of A&D services.

Second, more attention should be given to effectively supporting the use of evidence-based practices. While EBP is clearly at the forefront of the state A&D agencies' efforts, considerable variation exists in the extent to which agencies are systematically monitoring the implementation of EBPs. To truly understand the degree to which EBPs are being implemented as intended, there is a need for a comprehensive examination of agency efforts to provide oversight, technical assistance and monitoring of EBP. Particular attention should be given to distinguishing between monitoring the organizational capacity of an agency to implement EBP (i.e. staffing, access to training) versus actually measuring fidelity to a specific EBP model. By gaining a better understanding of the status of efforts around EBP in Oregon A&D services, the state will be able to continue to move forward in ensuring that A&D services are provided in an effective and efficient manner.

Finally, more information should be gathered about local management practices. While this project has explored how state agencies ensure accountability of the investments in A&D services, less attention has been paid to the parallel system of performance management at the local level, conducted by CMHPs and local providers. This local system was briefly explored in the case studies, but significantly more could be learned about the local perspective on

performance measurement. The local community network includes contracting arrangements between CMHPs and local providers with various contracting structures, requirements, and performance measures. Further, local providers have a unique perspective on the impact of trying to meet the mandates from different entities; some contractors provide A&D services for several state agencies and/or for multiple counties.

CHAPTER FIVE: LOCAL LEVEL CASE STUDIES

Building on the state agency analyses presented in this report, HSRI completed case studies of substance abuse treatment and prevention systems in three Oregon counties and one tribe. The four selected localities were: Multnomah, Lane, Umatilla, and Warm Springs. Multnomah was included at the request of the Governor's office and is a unique study for many reasons, not the least of which is its size and prominence in the state; Lane County is affected by timber tax revenues and also contains a large urban area; Umatilla provides an Eastern Oregon perspective, appears prominently in lists of counties affected by methamphetamine use, and contracts very little of its funds. Warm Springs is unique as a Tribe and also spends a larger proportion of its budget on prevention services than some other localities.

The case study approach included telephone interviews with representatives of local agencies, both public and private, that form the foundation of the local A&D service delivery system; and review of pertinent written materials such as biennial implementation plans, budgets, and/or performance reports. One goal of the case study process was to develop a comprehensive understanding of local provider organizations – looking at the state “system” from the direct service perspective. HSRI examined ways in which state-level processes, policies, and investments are carried through at the local level. While some treatment is provided within the state agency system (in prisons, for example), both the prevention dollar and the treatment dollar are predominantly spent at the local level. For example,

- Addictions and Mental Health dollars flow directly to county government (CMHPs) and tribes who either provide services directly or contract to local providers for services.
- Department of Corrections funding to county corrections offices is often combined with county general funds and other sources to provide treatment for released felony clients.
- JCP funds flowing through OYA and OCCF are used by their local counterparts (juvenile departments and local CCFs) to serve youth through prevention, diversion, and treatment. Some OYA dollars are used directly by local providers to serve OYA community youth who lack Medicaid or private insurance.
- CJC funding for Drug Courts is spent almost entirely by local providers for treatment needs.
- Regional CAF Addiction and Recovery Team funds are spent directly on recovery facilitation for local families.

The sections below present substantive portraits of the four selected counties. The main purpose of the case studies was to highlight variations at the local level; each case study provides a description of unique structural and procedural features. In the process of conducting these case studies, several important cross-county themes emerged; these are briefly summarized following the fourth case study.

It is important to note several limitations to the case study information presented below. Each of these county entities has a complex and dynamic structure. Within the short time frame

available, HSRI developed only a basic understanding of how each of the local A&D systems operates and how agencies interact. In addition, the local agencies examined are not inclusive of all the publicly-funded substance abuse and prevention efforts in each county. For example, the Oregon Health Plan pays for a significant portion of adult treatment, and the public school system engages in multiple prevention and diversion efforts. Outside of the public funding stream, non-profit and faith-based organizations may provide low to no-cost treatment using private donations. Gathering information on A&D services provided by Juvenile Justice agencies is more difficult than for some other local agencies. Most justice-involved youth are eligible for Medicaid or they have private insurance. While juvenile justice agencies provide some funding for residential treatment or small pieces of treatment (i.e. assessments), it is challenging to extract A&D expenditures from overall program budgets. Finally, while there were many topics we would like to have pursued further, we are deeply aware of the financial pressures currently facing local decision-makers as they address both immediate and long-term budget cuts, and we restricted our follow-up questions accordingly. We are very grateful for the cooperation and time given to us by many staff members within each agency.

5.1 MULTNOMAH COUNTY

Multnomah County, with an estimated population of 717,880, is the most populous county in the state of Oregon. As a large urban county, Multnomah County has some unique challenges when it comes to meeting the substance abuse prevention and treatment needs of its population. However, its population size also allows for a wider range of resources, including staff expertise, than may be found in smaller, less urban counties. The following sections provide an overview of prevention and treatment service provision, framed by an examination of local counterparts to the state agencies discussed in earlier chapters of this report. These include: the Department of County Human Services (DCHS), the Department of Community Justice (DCJ), Juvenile Justice, Children and Families (CAF), the local Commission on Children and Families (CCFC) and a selection of local providers. Interviews were conducted with representatives of most of these agencies.

County A&D Service Systems for Prevention and Treatment

Prevention

Substance abuse prevention efforts in Multnomah County are primarily provided through DCHS. A prevention coordinator position is funded by AMH and housed within DCHS. The tasks of the Multnomah County prevention coordinator are as follows: develop the prevention plan, procure and contract for services, provide technical assistance to contracted programs, apply for grants, enter some data into the Minimum Data Set for prevention activities, and compile an annual report which is sent to AMH. Priorities for prevention activities are determined by looking at both state and community goals. Often, the goal of prevention planning is to simply sustain existing activities and coalitions in the face of unstable funding.

Collaboration is essential to prevention efforts in Multnomah County, both in planning and in service provision. Planning is done with either direct or indirect input from other agencies, community groups, and task forces such as Community Action to Reduce Substance Abuse (CARSA) (Oregon Partnership, 2008). Service provision is collaborative as well. For example, DCHS contracts to the Housing Authority of Portland (HAP) who, in turn, subcontracts

elsewhere. The procurement process is coordinated by both agencies. Despite these efforts, a University of Oregon study found that communication among prevention providers could be further enhanced (Community Planning Workshop, 2006).

Additional prevention efforts in Multnomah County are undertaken by the local Commission on Children, Families, and Community (CCFC). At this time, however, the Commission's only specific A&D prevention effort is actually under contract with DCHS—Safe and Drug Free Schools. DCHS passes the funding to CCFC and the Commission then contracts to Portland State University for the EDG:E program. In general, CCFC focuses on “front-end” prevention, encompassing everything from early childhood programs to programs that promote school success and community involvement. CCFC plays an integral role in the county-wide collaborative planning process. Recently, as an alternative to duplicating planning processes undertaken by other entities, CCFC completed a meta-analysis of all community assessments and reports that had been done in the last three years (approximately 36). Although substance abuse did not emerge as one of the top two issues, it can be tied into other prevention efforts. For example, school completion efforts can involve substance abuse programming.

Listed below are current substance abuse prevention efforts underway through DCHS and CCFC. In SFY 2008, prevention programs contracted through DCHS served over 9,000 participants.²⁴

- HAP = Contracts to Lifeworks NW to provide after-school clubs and core services to youth and their families.
- Latino Youth Network = Provides project coordination and outreach to engage youth in a youth soccer team.
- Asian Family Center = Operates the Teens Uniting for a New Era program, developing youth leadership by involving youth in planning and implementing projects and community events.
- Safe and Drug Free Schools = Contracts to CCFC and then to PSU to conduct a service learning and mentoring program.
- Strengthening Families = Contracts to Lifeworks NW to conduct an evidence-based family training program.
- Strategies to Address Underage Drinking = Convenes partners to redesign the Minor in Possession system, exploring increased consequences for youth in possession of alcohol.

Treatment

Department of County Human Services: DCHS functions as the Multnomah County CMHP and is the recipient of the substance abuse service element funding from AMH. They serve, through their contracts, the broadest demographic of Multnomah County clients in need of publicly-funded treatment. They do not do any direct service provision. DCHS manages funding, contracts, and data for a range of providers offering residential, outpatient, and detoxification services.

²⁴ This figure excludes Safe and Drug Free Schools (over 300 participants), WorkDrugFree, and EUDL.

Department of Community Justice: Adult clients involved with the criminal justice system, whether they are probation clients, county jail clients, or clients transitioning from incarceration (clients under post-prison supervision) are served by DCJ. To best serve clients, DCJ works closely with DHS, CAF, the Health Department, and justice-related entities such as parole/probation and the police department. DCJ supervises over 9,000 offenders at any one time. Of this group, the vast majority are felony clients. At a minimum, 80% of medium to high risk locally supervised offenders have A&D needs.

DCJ-funded services include residential treatment, outpatient treatment, and STOP (drug) court. They work with a variety of providers, many of whom have expertise in addressing criminogenic risk factors as well as substance abuse issues. In general, DCJ believes that community corrections clients are best served by providers specifically skilled to work with this population. Most clients are assessed at the intake center, where a triage form is filled out by the parole officer. Generally, treatment intervention is focused on those clients who are at a higher risk to reoffend. This approach is both philosophical and practical. Community Justice clients who miss treatment appointments are subject to sanctions imposed at the discretion of their parole officers.

Clients transitioning from DOC are also assessed at the intake center—generally their parole officers and treatment providers do not rely on DOC transition plan information. Through the African American Program, some eligible offenders are able to receive outreach services while still incarcerated, as well as more comprehensive transition options. At this time, provider outreach services are not available to the general inmate population. Availability of these services could strengthen transition from incarceration to community supervision, potentially decreasing the amount of time it takes for an offender to become engaged in treatment.

Juvenile Justice: The primary A&D role of the Multnomah County juvenile justice system is to identify youth who are in need of treatment, rather than to provide the treatment itself. Screening and some assessments for youth are carried out as part of a youth's intake into the system. With the exception of the Residential Alcohol and Drug (RAD) program, juvenile justice does not pay for treatment. Youth are referred to providers who then work with the family to determine payment. Juvenile Justice often places the treatment connection and payment responsibility on youth and families. This is a philosophical approach as well as a practical one.

All youth are screened for substance abuse issues at entry into the system using the JCP screening. From entry, a youth usually enters one of three tracks, a) a formal accountability agreement track (adjudication), b) a sole sanction track, or c) a warning letter track. Only youth entering through the adjudication process receive a formal referral from their counselor, although this process is inconsistent. Even with a referral, many youth are not entering treatment. In order to better track these youth, Juvenile Justice has added an electronic referral process which is linked to a treatment intake and monitored by internal staff. Over a one-year period, 147 youth were referred to treatment and 126 were admitted. These figures are likely under-reported due to inconsistency in the reporting process and the lack of available data from one in-house program which provides both assessments and treatment.

Children & Families: The regional CAF office serves child welfare families with addiction needs through the FIT team. The FIT program is an umbrella for Multnomah County Addiction and Recovery (ART) teams and is an A&D triage system, providing substance abuse screening and logistical services. The FIT program works with several residential and outpatient providers,

each of whom has at least one case manager working with child welfare families. Participating providers have contracts with DCJ and/or DCHS. The FIT program brings together all of the above organizations to collaboratively meet the needs of families. The FIT program has recently been enhanced through a five-year grant from the U.S. Children's Bureau.

Private Providers: In Multnomah County, dozens of providers receive public funding to provide prevention and treatment services. Five providers completed interviews with HSRI. These providers are described below. Notes about provider processes and comments from provider representatives are included at the end of each section in this chapter.

- *DePaul Treatment Centers provides residential and outpatient services for youth in Multnomah and surrounding counties. DePaul is one of the few options for youth residential treatment. It has contracts with DCJ and DCHS.*
- *Central City Concern (CCC) provides a continuum of substance abuse treatment services -- detoxification services, inpatient treatment, outpatient treatment, housing, and recovery services. CCC works with the FIT program for child welfare families and has a post-incarceration counselor/mentoring program. Funding sources include state funding through DCHS, city funding (for Hooper Detox), grant funding, and private insurance (including OHP).*
- *Men's Volunteers of America program consists of 52 residential beds for probation and parole clients, funded entirely by DCJ. The program offers a continuum of residential and outpatient services.*
- *Janus Youth Programs provides services to street-affected youth.*
- *CODA provides residential and outpatient services to clients in Multnomah and surrounding counties; it offers both a regular and a medically-assisted outpatient program. CODA has contracts with both DCJ and DCHS.*

Investments

The following tables show A&D funding sources for Prevention, DCJ, Juvenile Justice, DCHS, and CAF.

Prevention

Table 5.1 shows Multnomah County substance abuse prevention programs and their respective funding sources for SFY 09. AMH provides the largest amount, with additional dollars coming from the county general fund. At this time, no substance abuse prevention dollars are flowing from OCCF (at the state level) to the local CCFC.

Program/Position → Dollars flow to subcontractor	AMH Base Funding	AMH Competitive Funding	Beer & Wine Tax	Total State Funding	County General Fund	Total
HAP → Lifeworks NW	\$173,899	-	-	\$173,899	-	\$173,899
IRCO → Asian Family Center	\$10,180	-	-	\$10,180	-	\$10,180
Latino Network	\$10,180	-	-	\$10,180	-	\$10,180
Admin (Prevention Coordinator)	\$85,741	-	-	\$85,741	\$37,283	\$123,024
Strengthening Families → Lifeworks NW	-	\$79,722	\$4,608	\$84,330	-	\$84,330
Safe and Drug Free Schools → CCFC → PSU	-	\$100,000	-	\$100,000	-	\$100,000
Oregon Partnership	-	-	\$10,000	\$10,000	-	\$10,000
CarryOver to FY2008-09	\$20,000	-	-	\$20,000	-	\$20,000
Total	\$300,000	\$179,722	\$14,608	\$494,330	\$37,283	\$531,613
				93 % of total	7 % of total	

Treatment

Department of County Human Services: Table 5.2 shows funding sources for DCHS. State funds comprise 69% of the total. Most salaries are covered by the county general fund.

	State Funds	Beer and Wine Tax	Grants	State Funds Total	County General Fund	Total
Sobering		\$383,124		\$383,124	\$527,559	\$910,683
Detox	\$1,391,089			\$1,391,089	\$755,234	\$2,146,323
Residential	\$5,707,634			\$5,707,634	\$848,261	\$6,555,895
Outpatient	\$4,118,990	\$131,035	\$1,009,032	\$4,250,025	\$2,265,474	\$7,524,531
Total	\$11,217,713	\$514,159	\$1,009,032	\$11,731,872	\$4,396,528	\$17,137,432
			6% of total	68% of total	26% of total	

Department of Community Justice: Table 5.3 shows the current DCJ budget for A&D services. The largest piece of funding (93%) comes from the Multnomah County general fund. The county general fund is also the only source of funding for residential treatment. DOC funds contribute very little to the overall picture (<1%) and state funds contribute only 6%. DCJ serves as the pass-through for CJC funds, with a very small amount removed for administrative costs. However, the CJC STOP grant for drug courts is due to be terminated in 2009, casting into question the future of the Multnomah County Drug Court.

	State MH Grant	State CJC Grant	State DOC AIP funds	Other Funds**	Total State Funds	County General Fund	Total
A&D Outpatient	\$216,968	-	\$58,114	\$88,455	\$275,082	\$202,268	\$565,805
A&D Residential	-	-	-	-	-	\$6,958,077	\$6,958,077
STOP Drug Court	-	\$264,006	-	\$7,500	\$264,006	\$840,120	\$1,111,626
Total	\$216,968	\$264,006	\$58,114	\$95,955	\$539,088	\$8,000,465	\$8,635,508
				1% of total	6% of total	93% of total	

**rounded to the nearest dollar **other funds include drug diversion fees and forfeiture revenue*

Juvenile Justice: The Residential Alcohol and Drug program (RAD) is the only service which is exclusively considered to be A&D and is funded by a combination of OYA diversion funds (57%) and county general funds (43%).

Children and Families: Table 5.4 illustrates the recovery-oriented funding sources available for child welfare families with substance abuse needs in Multnomah County. Treatment is generally provided by local providers under contract to DCHS or another agency. The resources listed below provide treatment facilitation and recovery to adult clients. It is important to note that state funding to CAF for certified alcohol and drug counselors, outreach workers, and housing does not pass through the counties for further allocation.

Table 5.4
Funding Sources for Child Welfare Clients A&D Needs
One-year period*

	State Funding to CAF	State Funding to DCHS	Federal Funding (CB** Grant)	Federal Funding (IV-E)	Total State	Total Federal	Total
CADC's	\$247,440	-	-	-	\$247,440	-	\$247,440
Outreach Workers	\$483,492	-	-	-	\$483,492	-	\$483,492
Parent Mentors	-	-	-	\$132,000	-	\$132,000	\$132,000
ITRS (through SE 66)	-	\$723,000	-	-	\$723,000	-	\$723,000
CB FIT	-	-	\$1,000,000	-	-	\$1,000,000	\$1,000,000
Other FIT	-	\$285,000	-	-	\$285,000	-	\$285,000
Housing	\$97,980	-	-	-	\$97,980	-	\$97,980
COPS Grant	-	\$50,000	-	-	\$50,000	-	\$50,000
Total	\$828,912	\$1,058,000	\$1,000,000	\$132,000	\$1,886,912	\$1,132,000	\$3,018,912
					63% of total	37% of total	

*some dollars are SFY and some are calendar year

**Children's Bureau Five-Year Grant (1st year listed in table)

Although these tables represent most of the available public funds, some smaller sources may not be included. As shown, the largest amount of funding comes from state sources—approximately 61%²⁵. This ranges from 93% for prevention to 6% for the Department of Community Justice. The second largest source of funding is the county general fund. For DCJ, this represents 93% of their overall budget for substance abuse treatment. CAF receives no direct funding from the county general fund. Other sources (~9%) include federal grants and city funding.

Providers: The providers interviewed for this case study obtain their funding from a variety of sources. The largest overall source is state funding, under contract with DCHS or DCJ. State funding either fully funds the cost of treatment or supplements a client's self-pay sliding scale charge. For adult residential beds, state funding is usually the entire source. For outpatient treatment, the Oregon Health Plan covers from 14% to 65% of clients' costs, depending on the provider and/or the type of program. Youth are most likely to be covered by Medicaid. In general, providers expressed frustration at losing federal matching funds when the state cut OHP funding.

²⁵ Beer & Wine tax funds are included in "Total State Funding".

Contracting

Prevention

The County Department of Human Services (DCHS) is the primary county contractor for prevention services. Within prevention, there is a continuum of levels of procurement. Most contracts are standard county contracts, under which the program or project budget is negotiated with the provider. Other types of contracts exist, such as the contracts with HAP (an inter-governmental agreement) and CCFC (a service-level agreement). The contracting process under DCHS is very structured, beginning with RFPs or RFPQs.

Both fiscal and service reporting are required under the prevention contracts. Providers are also required to measure outcomes and to report results to DCHS in annual reports. Service outcomes are considered a contract deliverable; providers who do not meet deliverables are subject to withholding of their monthly payments. In practice, however, the prevention coordinator will work with providers to meet their submission requirements and to adjust their service and outcome goals.

Treatment

Department of County Human Services: As mentioned, DCHS currently contracts out approximately 98% of the money it receives from AMH through the addictions service elements. Decisions about who to contract with are made largely by reviewing the availability of existing providers. These providers shift infrequently; DCHS is committed to working with existing providers because it is difficult to site new ones, and because all allocations must be contracted out at the beginning of the year. This is particularly true for residential programs. Outpatient slots are a bit more fluid and may float somewhat in response to shifts in priorities. For example, two groups are currently receiving increased focus: clients transitioning out of prison and/or jail, and homeless individuals. Some providers have expertise in these areas that other providers do not.

Reimbursement rates are determined based on historical rates, stability of providers, cost of living, comparative rates paid in other states (particularly Washington) and by other entities (such as OHP), experience of DCHS staff in determining rates, and the balance between quantity of slots and total compensation.

DCHS is currently collaborating on the RFPQ process with DCJ although they do not have joint contracts. Contracting issues are handled by the county contracting office. Recently, DCHS asked a representative from their staff to attend staff meetings and visit providers. This has helped speed up the contracting process. Currently, there are no fee-for-service contracts.

Contractors are required to enter data into CPMS and to submit monthly excel sheets to DCHS with information on utilization.

Department of Community Justice: All services provided through DCJ are contracted to local providers. These services include 131 residential beds, outpatient services, and STOP court funding for 275 clients per year. Contracting priorities are determined by looking at past data, demographics, and provider availability. The contracted provider mix has generally remained the same over the past several years due to adequate or above-average performance by existing contractors as well as to the difficulty of establishing or “siting” new providers within the community.

Contractors must provide substantial data to DCJ, showing numbers of clients served and amounts of treatment provided as well as financial information; the utilization information allows DCJ to measure the benchmarks in their contracts. If contractors do not meet activity and data submission requirements they are subject to having their monthly disbursements withheld. Providers must also enter data into the state CPMS data system.

Data Collection & Outcomes Measurement

Prevention

DCHS and its contract providers enter attendee and demographic data into the state prevention data system, the Minimum Data Set (MDS). Most programs enter their own data, although the prevention coordinator will enter data for smaller programs. The coordinator is proficient in running local reports on service provision by providers, and does so several times a month and for the required annual report which goes to AMH. AMH does not currently provide regular feedback to the county on either the data entered into MDS or on the county-submitted annual reports.

Contracted programs are responsible for measuring their own outcomes and reporting them to DCHS prevention through an annual report process. Some programs have other interim reporting requirements which are tied to their funding. An example is the Safe and Drug Free Schools program which measures outputs and outcomes specific to the EDG:E program. This program enters data into MDS and also participates in outcome measurement through Portland State University, a subcontractor.²⁶ Outcomes vary among programs, and programs are allowed to provide explanations for results. There are no specific sanctions for not achieving outcome goals; the prevention coordinator will work with a program to modify their plan.

Treatment

Department of County Human Services: DCHS now has a full-time analyst who is responsible for analyzing data delivered by contracted providers. This process is still in the early stages, just beginning to generate reports (e.g., looking at retention rates by provider). Although DCHS has not, in the past, used CPMS data (partially due to the six-month time lag), staff are beginning to work with CPMS raw data to look at completion rates for different groups of clients and to make sure that DCHS funds are not paying for any OHP clients. Because CPMS data is unduplicated, it is the only way to see if a client has returned to the system after being served by a different agency. Generally, DCHS does not receive feedback from AMH on outputs, outcomes, or services.

Department of Community Justice: DCJ is very data-driven. It maintains an internal data system which tracks both outputs and outcomes and also has internal research and evaluation staff. Provider data is transmitted to DCJ staff who enter it into an ACCESS database. Days in treatment, treatment completion rates, and recidivism are all tracked, aggregated, and compiled into trend reports. These reports are used to manage the provider relationship, assist with budgeting, and communicate with county executives. In addition, the research department has the ability to integrate DCJ, DOC, and CPMS data in order to get a complete picture of offender

²⁶ Although the Commission for Children, Families and Community (CCFC) in Multnomah County contracts for the Safe and Drug Free Schools program, no program dollars flow through OCCF. Therefore, data for this program is not currently being entered into the OCCF database. CCFC staff report that they have not received a request from OCCF to report data and that quarterly reports are not being done at this time.

participation in treatment. Different groups of community justice clients (jail clients, DOC clients, probation clients) can also be tracked.

Juvenile Justice: Juvenile Justice asks its providers to complete electronic referral, intake, exit, and reporting forms. A staff person keeps track of the forms and communicates with providers regarding how many youth they are serving and what reports are still needed. Even with this level of quality control, reporting is inconsistent. Providers serving justice-involved youth are largely contracting with other agencies such as DCJ or DCHS, and the juvenile justice reporting forms are not a requirement of these contracts. The statistics for youth referrals and admissions obtained from juvenile justice likely underreport the true number. The RAD program keeps additional data on clients for the purposes of research and evaluation. Outcomes measured for RAD juvenile justice clients include treatment completion, enrollment in school, and recidivism.

Providers: Interviewed providers keep their own internal information systems which track outputs and outcomes. In general, although they enter data into CPMS, they do not use state data for managing their organizations, measuring outcomes, securing funding, or writing reports. Providers who contract with different agencies and/or counties simultaneously have performance measurement requirements that are often confusing and burdensome. For example, one county requires that “clients maintain stable housing while in treatment” and another county requires that “clients obtain stable housing by treatment completion”. These providers spend a great deal of time producing required reports. Until recently, some providers relied on hand tallied counts of program participants.

Evidence-based Practice

Multnomah County prevention and treatment programs tend to be evidence-based practices, and share common challenges in embracing the state mandate in a meaningful way. The terms “evidence-based” and “research-based” are used frequently in the County planning process, suggesting a strong awareness of and intention to use proven interventions. County agencies are generally in favor of using EBP to promote program consistency and constructive change. In prevention, some, but not all, of the substance abuse prevention programs meet the requirements for evidence-based practice. Barriers to their increased use of evidence-based practice include the lack of fidelity and other measurement tools for existing or proposed programs, as well as funding for the evaluation work necessary to make the EBP determination. On the treatment side, DCJ, DCHS, and CAF work with providers who use evidence-based practice for most or all of their programming. However, interviewed providers believe evidence-based practice legislation to be an unfunded mandate. Evaluative reviews and fidelity checklists are expensive to implement. Treatment agencies operate under tight budgets and largely siloed funding with few to no resources available for establishing and monitoring EBP. County agencies and providers alike view the relationship between the client and the counselor as one of the most important factors in recovery. The quality of this relationship is difficult to measure quantitatively or with fidelity tools. Other barriers to total adoption of EBP include the lack of opportunities to implement new approaches and the lack of research on culturally-specific programming. All responding providers use EBP to some degree.

System Gaps and Waitlists

Prevention

Multnomah County prevention staff report that the largest gap in prevention services is the lack of a cohesive, unified prevention system. Currently, the system is fragmented—an opinion echoed in the 2007 prevention gaps analysis report referenced earlier in this chapter. Identified service gaps are many and varied, covering areas with little to no programming to areas where programming amounts are simply inadequate to address the need. Examples include: early prevention, culturally-specific prevention, parent and family management training, and after-school activities. There is also a need for a comprehensive resource database.

Treatment Waitlists

At any given time in Multnomah County, up to 500 people are waiting to get into residential treatment programs. Sixty-six percent of these potential clients are offenders. Youth clients waiting to get into the RAD program can wait for up to a month. Child welfare reports up to 26 clients every month need residential treatment but are not able to get a slot. Outpatient services are more easily accessed, with waits of only five to seven days. The wait for detoxification services can be several days, although certain groups of clients are prioritized and may be seen immediately. Most programs have pre-treatment groups available as an option to engage motivated clients who are on the waitlist.

Treatment Gaps

The most prominent gap mentioned by Multnomah County community agencies is housing. Clients coming out of residential treatment, in particular, need access to recovery-oriented housing. Employment is also an issue. While some clients are generally employable, or need only some assistance in maintaining employment, a large percentage are not employable without structured employment programs or supportive employers who are willing to work with recovering clients. Community corrections clients often have the added burden of a felony record, further reducing their employment options. This group of clients could also benefit from additional reach-in by treatment providers into jails and prisons, improving the likelihood that they will successfully transition into community treatment. Several interviewed county agency staff members expressed a desire for a shift in the system-wide focus from expensive residential treatment to a model which emphasizes intensive outpatient combined with readily available supported housing.

Providers: With one exception, all interviewed providers reported housing as the largest system gap. There are housing needs for all groups of clients: clients with families, street-affected youth, and community corrections clients with limited employment options are a few of the mentioned subgroups. Employment was also mentioned frequently by providers, a barrier that is likely to become more serious in the current economy. Providers mentioned a need for improved access to other types of health care for their clients, such as mental and physical health services. Two providers mentioned gaps in supports during the step-down process from residential or intensive outpatient.

Conclusion

As a system, the Multnomah County substance abuse treatment network of publicly-funded agencies and contracted providers has both strengths and challenges. The following strengths became apparent during the case study process:

- Continuum of available services including residential, outpatient, detoxification, and some housing;
- Established and experienced providers who are creative in leveraging resources such as grant funding;
- Community partners such as universities who provide evaluation and process-improvement assistance and non-profits who provide additional supports to recovering clients;
- DCJ's reputation within the provider network as an efficient, supportive, and data-driven organization; and
- The FIT program for adult child welfare clients with substance abuse issues.

Many of these strengths arise from Multnomah County's size and urban demographic which allows for a breadth of service provision and staff expertise in grant writing and data processes. Multnomah County also has, however, a breadth of client needs not seen as intensively in other Oregon counties. Many clients in Multnomah present across systems—clients who are frequently held in the county jail system, who have mental health needs, and who are homeless. Despite the appearance of a relative wealth of resources, Multnomah County remains as vulnerable as other Oregon counties to impending budget reductions in substance abuse treatment.

5.2 LANE COUNTY

Lane County, with an approximate population of 343,000 and covering 4,610 square miles, stretches from the Pacific Ocean to the Cascade Mountain Range. Although 90 percent of Lane County is forest land, Eugene and Springfield comprise the second largest urban area in Oregon. The size and terrain of the county, along with the dependence on natural resources such as timber, create a particular challenge to providing both effective and efficient A&D services across the county. Transportation is often difficult and time consuming, and many services are only located in the Eugene-Springfield area. In addition, continuing decreases in the timber revenues on which many of the rural areas rely have severe implications for Lane County-funded services and programs.

The following sections provide an overview of prevention and treatment services, framed by an examination of local counterparts to the state agencies discussed in earlier chapters of this report. These include: Lane County Health & Human Services, the Corrections Division, the Department of Youth Services, the regional Children and Families office (CAF), Lane County Department of Children and Families (DCF), and the local Commission on Children and Families, which is housed within and works closely with DCF, and a selection of local providers. Interviews were conducted with representatives of most of these agencies.

County Systems

Prevention

Substance abuse prevention efforts in Lane County are primarily provided through Lane County Health and Human Services (H&HS). A full-time Prevention Coordinator is housed within H&HS and is mainly funded by AMH, along with a small federal grant for the Lane County Coalition to Prevent Substance Abuse. A commitment to community mobilization and working with local prevention coalitions are essential components of Lane County's prevention efforts. The Prevention Coordinator supports these community-based coalitions, along with creating and assisting in the implementation of specific prevention strategies identified in the Biennial Implementation Plan. The planning process gathers input from community partners and uses local data to determine prevention focus areas and strategies.

The Prevention Coordinator leads the H&HS Prevention Program, which includes substance abuse, problem gambling, and suicide prevention. The Prevention Program supports each direct service provider with technical assistance, training, and coordination. In SFY08, well over 4,000 people were served through prevention efforts²⁷.

Lane County Commission on Children and Families (CCF) does not fund any A&D prevention efforts, although they work collaboratively with the Prevention Coordinator to develop the Local Comprehensive Community Plan to ensure that A&D issues are included. In 2007, DCF led a yearlong planning process, conducting numerous countywide community meetings and a telephone survey, to produce the six-year "Partners for Children and Families Plan". Although 18% of community members chose substance abuse treatment and prevention as a focus area, it was not ultimately selected as one of the top three priority areas. Nonetheless, information gathered during this planning process has helped to inform addictions prevention efforts in Lane County.

Treatment

Health & Human Services: Lane County H&HS is a broad-based organization, overseeing health, mental health, social services, and offender programs. As the CMHP, it is the "hub" for substance abuse services in the county. Most A&D services are subcontracted, with the exception of the Methadone Program and DUII evaluations. H&HS contracts with six local providers for adult and youth outpatient and residential treatment, along with sobering and detoxification services. Most services are centralized in Eugene and Springfield, with some available in rural areas.

Historically, H&HS received A&D funding from AMH, DOC, and county general funds, and used these monies to support treatment services, through its Treatment and Supervision department. In SFY07, 4,661 individuals were engaged in treatment with subcontracted providers. Of these clients, 89% were outpatient, 8% were residential, and 3% received methadone services. Recent changes have altered the structure of A&D services in Lane County. Beginning July 1, 2008, the Treatment and Supervision department was moved to the Lane County Public Safety Department, and all DOC funding and services contracted with this

²⁷ This figure includes some estimation for information dissemination efforts, including Public Service Announcements.

funding source are now managed by Public Safety. All other A&D funding streams still flow to H&HS; treatment services are located in the Behavioral Health division.

Lane County H&HS is also the fiscal agent for all Drug Court funding and administers all service subcontracts. Lane County Adult Drug Court, created in 1994, was the second of its kind in Oregon and the 22nd drug court in the nation. All treatment services are contracted to one local provider, who works collaboratively with the Drug Court Coordinator, the District Attorney and the Drug Court judge. Although there has been some under-utilization of Drug Courts in the past, services were recently opened to parole and probation clients, and they are now filled to capacity. In SFY08, Drug Courts served 181 new clients and had 339 active clients at the year's end; another 73 clients successfully completed the program in that year, and no graduates were charged with any type of crime within one year after graduation.

Community Corrections: Many individuals with A&D treatment needs are required to participate in treatment programs or education offered by local providers either during their period of community incarceration or once released. One provider supplies the bulk of treatment services for community corrections clients. Services include intensive outpatient treatment and drug court. Another provider offers detoxification services to offenders. Although shifts in DOC funds used for A&D services occurred in the middle of the 07-09 Biennium, all A&D treatment services for offenders will continue for the remainder of the current fiscal year (08-09).

Department of Youth Services: The Lane County Department of Youth Services (DYS) provides juvenile justice services for Lane County. All Youth Services are located on the 37-acre John Serbu Youth Campus. The four buildings located on site include the Juvenile Justice Center, which houses DYS intake, probation, parole, and detention center; the Juvenile Court; an Assessment Center for juveniles awaiting treatment placements or evaluations; and two residential programs. One of these residential programs, Pathways, is specific for drug and alcohol treatment. Adjudicated boys receiving treatment are Lane County residents, but the beds for girls are funded by OYA and serve adolescent women from across the state.

Screening and referrals for justice-involved youth in Lane County are based on the level of charge. For youth with an MIP or who are in possession of less than one ounce of marijuana, no JCP screening is completed. A letter is sent to the parents containing a referral to a local provider for an assessment. This process is tracked; currently there is an 80% to 90% compliance rate with recommendations put forth in the letters. Youth with a second time misdemeanor, a felony, or any other charge considered a crime receive the JCP screening. If substance abuse issues are indicated, a referral to treatment will be made. Options include local providers or the juvenile drug court (RAP).

Additional options include Pathways for boys (eight beds), mentioned above, the Phoenix program, and a new day treatment program beginning in January. The Phoenix program is a secure residential program which is not targeted specifically to A&D issues, although these services can be added on an individual basis. The program beginning in January is an intensive day treatment program for high risk youth with substance abuse issues. Activities will include after-school groups, tutoring, and mentoring support. The Pathways program serves between 28 to 35 youth per year. DYS hopes to serve an additional 80 youth with the new day treatment program.

Children & Families: The Addiction Recovery Team (ART) located in the regional CAF office has two caseworkers and three full-time certified alcohol and drug counselors (CADC)

who quickly connect with families with substance abuse needs. The ART team also has 2.5 outreach workers who work with the Relief Nursery to alleviate barriers to treatment. If there is an A&D allegation in a family's referral, the caseworker will be contacted by a team member or the caseworker will initiate the contact. Pre-screens can be done at court or in the field. Clients are responsible for making their own assessment appointments, although a CADC may accompany them for support when making the call. CAF does not pay for assessments. Pre-treatment groups are available for clients who are waitlisted or delaying treatment for other reasons. One provider in Lane County holds the contract for the ITRS funding, but there are seven other outpatient providers available to clients. Only one inpatient provider is available, and there is usually a waitlist. Another Lane County CAF service is the Substance Exposed Newborn Teams (SENT) who provide detoxification for newborns, on-site supervised visitation services, and immediate referral to residential treatment.

Providers: Several private providers supply most of the A&D services in Lane County. HSRI spoke with three treatment providers, which are described below.

- *Willamette Family Treatment* provides a full continuum of services for youth and adults with A&D treatment needs. Programs are mostly gender-specific and include residential and outpatient treatment, a Detoxification and Sobering Center, adolescent programs, A&D free housing, and DUII classes. These programs receive referrals from a variety of sources, including child welfare, public safety, hospitals, and self-referrals. The agency holds contracts with H&HS, the Corrections Division, CAF, and the Federal Bureau of Prisons. They are also part of the SENT team for substance-exposed newborns.
- *Emergence* serves the community through four main programs: two intensive A&D outpatient programs, one specifically for community corrections clients; a lower intensity outpatient program; and Drug Court. Emergence is the sole provider for Drug Courts in Lane County and is the primary provider for corrections clients.
- *Looking Glass* is a multi-service agency providing youth in Lane County with a variety of services including mental health counseling, runaway and homeless services, and residential treatment programs. It has two main A&D programs: the Addictions & Recovery Program (ARP), which serves youth 11-21 years old with outpatient treatment, including complete substance abuse assessments and individualized treatment plans for youth and their families; and the Pathways program, mentioned above.

Investments

Prevention

All A&D prevention spending in Lane County flows through the H&HS Prevention Program. Table 5.5 presents prevention spending for SFY08. AMH funds almost half of prevention spending (44%), with additional dollars from a small federal grant for community-based coalitions, and support from H&HS.²⁸ Over 80% of spending is for direct provision of services, with a small amount taken out for administrative costs.

²⁸ The percentage from AMH dollars may be slightly under-represented because some AMH funding was carried forward from the previous fiscal year and is included in 'Other Funding'.

**Table 5.5
Lane County Prevention Spending
SFY08**

	Federal	AMH	Other*	Total Federal	Total State	Total
Lane County Coalition to Prevent SA	\$90,271			\$90,271		\$90,271
Lane ESD – Safe & Drug Free Schools		\$97,000			\$97,000	\$97,000
Parenting Support/Education – Strengthening Families		\$8,448**			\$8,448	\$8,448
Prevention Coordinator		\$166,890	\$261,256		\$166,890	\$428,146
Total	\$90,271	\$272,338	\$261,256	\$90,271	\$272,338	\$623,865
			42% of Total	14% of Total	44% of Total	

*Other includes carry-forward funds, which may include AMH dollars, and support from H&HS.

**Reflects funds spent in SFY08. Unspent funds were rolled over to SFY09 and are currently contracted out.

Treatment

Health & Human Services: For Lane County H&HS, the main funding streams for A&D treatment include AMH, county general funds, and Beer & Wine Tax revenues. Table 5.6 presents H&HS spending for SFY08. In SFY08, state funding was the primary source for A&D treatment (78%).²⁹ Most services, with the exception of the Methadone Clinic and DUII evaluations, were subcontracted to local providers; about 88% of the total spent was subcontracted to six different community agencies. An additional \$43,400 was spent on administration for these contracted services, which is not included in the total in Table 5.6.

²⁹ H&HS receives AMH funding for SE 66 for Continuum of Care services, which primarily funds outpatient treatment, as well as SE 60, 61, 62, & 67, which fund special projects, residential treatment, and services for dependent children.

Table 5.6
Lane County Health & Human Services A&D Treatment Spending
SFY08

	AMH	DOC	County General Funds	Beer & Wine Tax	Other*	Total State	Total County & Other	Total
Residential & Outpatient Treatment	\$2,790,872	\$401,284	\$83,912	\$113,360		\$3,192,156	\$197,272	\$3,389,428
Sobering			\$40,844	\$167,943			\$208,787	\$208,787
Detox	\$199,553	\$73,000	\$117,738			\$272,553	\$117,738	\$390,291
Methadone Clinic**	\$67,872		\$80,012	\$75,594	\$298,502	\$67,872	\$454,108	\$521,980
TOTAL	\$3,058,297	\$474,284	\$322,506	\$356,897	\$298,502	\$3,532,581	\$977,905	\$4,510,486
						78% of total	22% of total	

*Other includes OHP, private insurance reimbursements, private pay, and a small amount of carry-over from SFY07.

**Additional funding streams flow to the Methadone Program that are not included here.

+ As of July 1, 2008, H&HS no longer receives DOC funding.

As the fiscal agent for Adult Drug Court, H&HS receives all drug court funding, including monies from CJC, AMH, DOC, and local funds from the Serbu Endowment³⁰. H&HS subsequently subcontracts with one provider to offer services in the community. Table 5.7 displays the funding for drug courts in SFY08. Primary funding is from the state (73%).

Table 5.7
Drug Court Funding
SFY08

	AMH	DOC	CJC	Serbu Foundation	Other*	Total State	Total Serbu & Other	Total
Drug Court	\$32,829	\$90,000	\$138,844	\$64,263	\$31,721	\$261,673	\$95,984	\$357,657
						73% of Total	27% of Total	

*Other includes Court Fees (no longer charged), Lane County Mental Health, and prior year cash carry forward.

Community Corrections: In SFY08 Community Corrections did not have any funding for A&D services since, as noted above, DOC funds at the time flowed to H&HS.

Department of Youth Services: The Serbu Endowment helps support facilities and some operations for the Lane County Department of Youth Services. The facilities, however, are underutilized due to a lack of other funding sources for programs.

In general, substance abuse services for justice-involved youth are funded through a variety of sources³¹. The diversion MIP program uses county general funds for the case manager, although families must negotiate payment for treatment with the provider. Some providers accept

³⁰ The Serbu Endowment is managed by the Oregon Community Foundation and is a unique funding stream to Lane County. It is used to fund substance abuse program operations.

³¹ HSRI was unable to obtain funding proportions for Youth Services in time for this report.

a sliding-scale fee. Pathways and the Phoenix program also utilize county general fund dollars, supplemented by Behavioral Rehabilitation System (BRS) funds and the Serbu Endowment. The juvenile drug court is also funded by county general fund resources and the Serbu Endowment.

Child Welfare: Funding sources for child welfare clients include CAF, AMH, and a small federal grant. CAF and AMH dollars contribute 95% of all funding. About half (54%) of funding flows to one local provider for service provision, including SENT and ITRS. Transitional housing is provided by a local community organization, and the remainder funds the ART team in Lane County. These numbers are shown in Table 5.8.

	CAF	AMH	Federal Grants	Total State	Total Federal	Total
Outreach Workers	\$136,560			\$136,560		\$136,560
CADCs	\$128,040			\$128,040		\$128,040
SENT			\$40,000		\$40,000	\$40,000
Transitional Housing	\$97,980			\$97,980		\$97,980
ITRS*		\$400,825		\$400,825		\$400,825
Total	\$362,580	\$400,825	\$40,000	\$763,405	\$40,000	\$803,405
				95% of Total	5% of Total	

**ITRS funding is for treatment, including residential and outpatient, and does not include start-up dollars.*

Providers: Six providers in Lane County have direct contracts with H&HS for publicly funded A&D services. Of the three respondents that HSRI contacted, all receive funding from H&HS, two have a contract with the Corrections Division, one receives funding from OYA and DYS to serve youth in the juvenile justice system, and another receives dollars from CAF to serve child welfare clients.

Despite these resources, the three providers obtain a much larger percentage of their funding from OHP, private insurance, or sliding scale fees than they do from state dollars. For outpatient treatment, they obtain 64-90% of their funding from these client-specific sources. State funding ranged from 5-21 percent.³² By contrast, residential treatment funding came predominantly from state sources (65% for men and 93% for women). The remainder, however, is supplemented by private funding, such as self-pay and private insurance reimbursements, because residential is not an OHP-covered service. Neither the outpatient nor the residential figures include private funding from foundations and grants, which often also contribute to agency income. One provider reported receiving dollars from twenty-three different funding streams in order to provide A&D treatment services.

³² Figures are estimates based on available data. ITRS dollars are not included.

Contracting

Prevention

Most contracts are with school districts and local providers for specific programming. The Prevention Coordinator gathers local data to determine programs that will best meet the community need, and then conducts a competitive RFP process to select the provider. Providers are selected based on the ability of their program offering(s) to meet the identified need and their cost effectiveness. Contracts are individualized for each program, rather than standardized. Contracted programs are required to enter data into the state prevention data system, the MDS. They also send annual reports to the Prevention Coordinator; these reports require outcome data specific to the program or service being provided. To improve the consistency and quality of outcome data generated by providers, the Prevention Coordinator recently offered trainings to providers on how to effectively report outcome data. If a provider does not complete an annual report, the remainder of the funding is withheld and the provider may not receive the contract in the future.

Treatment

Health & Human Services: As mentioned, Lane County H&HS contracts out roughly 88% of all funding for A&D treatment services to six local providers who offer outpatient and residential treatment. Selection of providers is based on a competitive RFP process occurring every three years. Contracts are built for one year, and then renewed for two subsequent years. All contracts include performance measures defined by the Treatment Performance Indicators set by AMH. These include: percent of clients engaged in treatment, percent of clients retained in treatment, percent of clients completing treatment, and use reduction. Each provider is expected to report regularly on these measures and to maintain performance "at or above the state mean". Providers who fall short on performance targets do not necessarily face sanctions by H&HS.

Community Corrections: Information on contracted A&D treatment services for offenders for FY 08-09 was not available to HSRI as this system is in transition. In SFY08, all services were contracted through H&HS to one local provider for drug courts and intensive outpatient treatment, and another provider for detoxification services.

Department of Youth Services: Contracting by Juvenile Justice is done through an RFP process. Current contracts include the Pathways (boys) program for residential beds, the treatment portion of the Phoenix program, and the new day treatment program which will begin in January. All contracted programs are based on EBPs and specific outcome measures are established individually with each program, such as percentage successfully completing treatment and reduction in re-offenses. Although contracted providers are expected to meet these performance measurements, they are more often used to guide, improve, and evaluate practice. If a provider does not meet an outcome, DYS will work with the provider to improve their program or occasionally set more realistic outcomes.

Providers: One provider that who spoke with HSRI contracts out a small amount for a specific parenting program and one residential treatment bed for females; however, most directly provide all treatment services. Providers interviewed discussed the need to report and use dollars differently based on the contract, which can become burdensome. Others spoke of the ease of contracts with H&HS. This is exemplified in the following comment. "We only have to report the waitlist each month because this shows that we are serving all the people that we have slots

for, and then we receive a check for services rendered". Overall, providers voice that it costs much more to provide services than they get paid through contracts with the county agencies. They all supplement state dollars with money earned in the private sector.

Data Collection and Outcome Measurement

Prevention

The Prevention Program enters data into the state MDS. To supplement this, they also compile specific program data and outcomes from annual reports submitted by each service provider. Overall, respondents report that prevention is difficult to measure because it is often not directly tied to a program where it is easy to count participants; therefore, the population reached can only be estimated. In addition, there are not enough resources in the county to fully measure effectiveness of the prevention efforts or even to follow up programmatically with next steps and additional strategies identified in the outcome data.

Treatment

Health & Human Services: Lane County Health & Human Services collects data through the state mandated data system, CPMS. H&HS collects data directly for the methadone clinic, while subcontracted providers each enter data on their own clients into CPMS. Rather than having a separate in-house data system, H&HS uses CPMS to collect data on all clients, not only those that are publicly-funded. An additional source of information is the waitlist that each provider is required to report to H&HS. H&HS uses these two sources to report to AMH on service provision and system capacity. In return, H&HS receives and uses the state-produced TIRs.

Lane County Drug Court enters data into the state-mandated OTCMS. The local treatment provider enters and reports this data to the Drug Court and H&HS. The provider also gathers other information through client surveys administered during treatment, and enters this into an independent database.

Community Corrections: When Treatment and Supervision was under the jurisdiction of H&HS, data was collected regarding sanctions and type of service provided to offenders. This was compiled and submitted with the Community Corrections Plan to DOC. In addition, all offenders served with A&D treatment are entered into CPMS and are included in the state-produced TIRs. Performance measurements set by DOC are included in all subcontracts and Community Correction plans, but no data regarding these measures was collected by H&HS.

Department of Youth Services: Lane County DYS has engaged in research and evaluation of its programs for the past 20 years. The agency collects and analyzes data regarding decision points (i.e. diversion, community-based probation, or out-of-home placement) and program outcomes. Data collected includes referrals, treatment attendance, completion rates, exposure to treatment, recidivism rates, and cost-effectiveness/cost-avoidance. All county-level data is entered into the state-mandated database, JJIS. DYS reports being very satisfied with JJIS and the ease with which they can collect and analyze data using this system. An internal data system for collecting specific program performance information is also used, which has the capacity to be merged with JJIS data. DYS completes quarterly reports for all required state funding sources, as well as produces annual reports which include a large amount of information on juvenile offenders and criminal behavior in Lane County.

Children & Families: At the state level, CAF recently began tracking ART referrals to treatment. In addition, Lane County tracks all child welfare cases with an A&D need through a local data system. Entry into this data system began in January of 2008, reaching full operation in July. Information collected includes: case opening, court appearances, pre-treatment and treatment attendance, treatment step-downs, dates of out-of-home placements, and case closing. Providers serving child welfare clients enter data into CPMS.

Providers: In addition to entering data into CPMS, each provider maintains an internal data system. The type and sophistication of each internal system varies across agencies. One provider has a separate research department funded by the National Institute of Drug Abuse (NIDA) and collects program evaluation data. Another provider collects a substantial amount of utilization data, in addition to information gathered from client satisfaction surveys, and enters all data into an internal Management Information System. A third provider has specific performance measurements and targeted outcomes for each program, and gathers information through questionnaires administered after each treatment session.

Evidence-based Practices

Most agencies interviewed spoke about the implementation of evidence-based practices in all of their A&D services. The Prevention Program asks for EBPs to be implemented in all programs with which they contract, but also utilizes prevention principles of planning and implementation if the program is not using an EBP. Although the state mandates that 75% of their budget be used for EBPs, where possible county agencies try to offer some flexibility in order to accommodate local choice and adaptation. Some providers go beyond just the use of EBPs; one provider uses a research team to determine and evaluate EBPs used, while another ensures that all staff are certified and trained in each EBP, and subsequently monitors fidelity.

System Gaps & Waitlists

H&HS does keep a central waitlist which compiles lists of waiting clients submitted by each agency; however, this often misrepresents the actual need in the community. With no central intake, the waitlist includes duplicated clients. At the same time, it fails to capture the number of individuals who have presented themselves for services and opted out due to long wait times, or because they have been told that no services are available for them.³³ Given these caveats, Table 5.9 illustrates the average monthly number of individuals waiting for publicly funded slots in SFY08.

³³ Those in the priority list are put on the waitlist and into services ahead of others who are not in one of the State defined priority groups. These groups are intravenous drug using pregnant women, pregnant women, intravenous drug users, DHS referrals, and drug court clients.

Type of Service	Average Number of Individuals Waiting	Number of Publicly Funded Slots
Youth Outpatient	11	31
Adult Outpatient	208	371
Minority Adult Outpatient	5	18
Adult Men Residential	22	11
Adult Women Residential	44	35
TOTAL	58*	466

**This is an average. However, with a range of 5 to 208, outliers affect the accuracy of this number.*

The following gaps noted by Lane County interviewees offer a sense of the challenges and barriers to serving clients with A&D needs.

- Overall financial resources are inadequate to meet the need for A&D treatment and prevention services. Cuts in the Oregon Health Plan and reductions in the availability of timber tax revenue have impacted both treatment and prevention efforts.
- Availability of residential treatment for youth is limited. The few available residential beds are targeted to youth involved with the juvenile justice system.
- Referrals, assessments, and treatment follow-through for youth is inconsistent across the county. No community standard exists for connecting youth with treatment or applying sanctions for non-participation. Services for youth with MIPs and other minor violations have been cut.
- Clients who are not members of a prioritized treatment group, such as pregnant women or IV drug users, often face long wait times for treatment.
- There is not enough drug free, recovery, and transitional housing in Lane County.
- Women with children seeking treatment face additional barriers such as affordable and reliable childcare and a lack of family residential treatment which will accept children over five years of age.
- Those who get a DUII and are living on a low income often do not get served in Lane County because they are not able to pay the fines that are required. There are no resources to serve these indigent clients.
- Sanctions enforcement for community corrections clients not participating in treatment has been reduced due to a lack of system capacity.

Conclusion

Lane County's substance abuse treatment and prevention system has both strengths and challenges. The network of publicly-funded agencies and contracted providers appears to run smoothly as a system throughout the county. There is an overall commitment to meeting the A&D treatment needs, evident in the relatively generous amount of funding coming from county general funds. In addition, the Serbu Endowment, a funding stream unique to Lane County,

assists in serving youth with A&D needs. Lane County's impressive use of EBPs, which includes training, evaluation, and monitoring of fidelity, shows a strong dedication not only to meeting the mandate, but also to serving clients most effectively. Adding to the system strengths is a strong collaboration between agencies in prevention planning and prevention program implementation.

Lane County's main challenge is a lack of funding to meet the A&D treatment need, especially for the offender and youth populations. Loss of federal revenue from the Timber Tax has resulted in cuts to both the Public Safety and Juvenile Justice departments. This tax was only partially restored and the solution is not permanent. In addition, Lane County has a large population of people waiting for treatment, many of whom respondents believe may never get services. This is seen as a direct result of state-mandated prioritized groups moving ahead in the waitlist, posing a considerable treatment access challenge for non-prioritized clients such as men who are not part of the corrections or child welfare systems.

5.3 UMATILLA COUNTY

Umatilla County, located in the Northeastern region of Oregon, is a largely rural county. It is the 13th largest of Oregon's 36 counties, covering 3,231 square miles with an estimated population of 73,000. The county has twelve cities; most of the alcohol and drug services are provided in the three major population centers: Pendleton, Hermiston and Milton-Freewater. This case study provides an overview of prevention and treatment services, framed by an examination of local counterparts to the state agencies discussed in earlier chapters of this report. HSRI conducted telephone interviews with representatives of all the major public agency players: Umatilla County Health & Human Services/County Addictions Program³⁴, the Eastern Oregon Alcoholism Foundation (EOAF), Umatilla County Community Corrections (UCCC), the Juvenile Services Division, the regional Children and Families office, and the local Commission on Children and Families. Umatilla County is a member of the Central and Eastern Oregon Juvenile Justice Consortium (CEOJJC) which pools OYA diversion funds from 17 counties and allocates them where needed. Umatilla does not have a typical CMHP structure, as do most other counties. In Umatilla County, the County Addictions Program (a provider) receives A&D outpatient and prevention funding from AMH, while the Eastern Oregon Alcoholism Foundation (a provider) receives AMH funding for residential and housing services.

County Systems

Prevention

Responsibility for substance abuse prevention in Umatilla County rests with two agencies – the County Addictions Program and the Commission on Children and Families (CCF). Within the County Addictions Program, the Prevention Program³⁵ leads county prevention efforts in planning as well as direct provision of prevention activities. Activities undertaken in the last year include a Strengthening Families program, a Summer Reading program, school-based programs,

³⁴ Although the County Addictions Program is not combined with the Community Mental Health Program in Umatilla, they do receive the AMH funding for A&D outpatient and prevention services. However, they are a stand-alone program and are considered a local provider in this report. Lifeways, Inc., the CMHP in Umatilla, receives no A&D funding from AMH, and therefore was not interviewed by HSRI.

³⁵ For the past two biennia, the Prevention Program in Umatilla County has been housed within the Juvenile Services Division. In October 2007, the Prevention Program became part of the County Addictions Program.

and teen parenting classes. The Prevention Coordinator also works with the community to identify needs and create a prevention plan.

Complementing the efforts of the Prevention Program is the local CCF. Housed within the Umatilla County Health & Human Services agency, CCF works collaboratively with local partners to identify needs, mobilize the community, and complete a Comprehensive Community Plan for each biennium. For specific A&D funded services, CCF contracts with local organizations, schools, and individual providers to offer services and programs. Examples of funded programs include CareTeams and Girl's Circles. Collaborative efforts include support for the County Prevention Program and an Adolescent Program for youth referred from the Juvenile Services Division. Services for the latter program are provided by both the County Addictions Program and another local provider.

Treatment

Health & Human Services: Umatilla County has two main providers of alcohol and drug services: the Umatilla County Addictions Program, which is part of H&HS, and Eastern Oregon Alcoholism Foundation (EOAF). The County Addictions Program provides a continuum of services, including screening, referral, assessment, outpatient, intensive outpatient, and DUII treatment. On January 1, 2009, the County Addictions Program will be serving all Community Corrections and drug court clients, in addition to clients referred from child welfare, self-sufficiency, the Juvenile Services Division, and self-referrals. The program's client base consists of adults, adolescents, and families experiencing problems with alcohol, drugs, gambling, and/or anger management. With a separate office in each of the three major cities, the program is able to serve a large geographic area.

EOAF provides a variety of A&D services, including: residential programs, transitional and drug free housing, a detoxification center, a DUII and MIP program, and outpatient treatment for the residential program graduates. They also house counselors who are members of the ART. Most clients served at EOAF are living on low or no income and lack health insurance.

In addition to the County Addictions Program and EOAF, four AMH licensed private providers are available to meet A&D treatment needs. All providers operate collaboratively through the Local Alcohol and Drug Planning Committee (LADPC).

Juvenile Justice: The Juvenile Services Division in Umatilla County operates a 24-bed Secure Detention Center for adjudicated youth, serving the 17-county Eastern Region. Staff at the detention facility run a 90-day treatment program, the Youth Care Center, for youth at risk of being placed in close custody. Although this program provides more than just A&D treatment, the lead staff member is a Certified Alcohol and Drug Counselor. If youth need any A&D service other than this in-facility program, they are referred to a local provider for assessment and treatment.

Community Corrections: Umatilla County Community Corrections (UCCC) serves offenders from both Umatilla and Morrow counties who are involved with the criminal justice system.. UCCC recently shifted the structure of community corrections A&D treatment contracting away from EOAF, creating the Umatilla County Community Corrections Treatment Services Program (UCCCTSP), which will be implemented beginning January 1, 2009. This program is managed by, and housed in, Community Corrections, and the County Addictions Program offers all clinical staff supervision and training. The creation of this program increases the department's

focus on alcohol and drug treatment. With the change in structure, the UCCC is hoping to realize cost savings along with increased authority to ensure effective and comprehensive treatment services for the offender population.

All non jail-based A&D services take place at the Community Corrections Program Center. The Program Center houses all community corrections staff, has classrooms, and provides a variety of corrections services, including a secure alternative to jail facility and A&D treatment. A&D treatment eligibility is based on client risk to reoffend. Offenders who are at medium or high risk to reoffend and who have a high need for A&D treatment are placed in one of three UCCC funded programs. All treatment is outpatient; options range from pre-treatment activities to nearly a year of participation in the core AOD program. UCCC also provides aftercare for those who complete treatment, which consists of one-on-one contact once a month with their past provider. At any given time, UCCC has about 950 clients in supervision and serves about 150 of those offenders with A&D treatment. Offenders at low or limited risk are referred to a direct service provider in the community, although UCCC holds no direct contracts with providers for serving these clients.

For offenders who are in the county jail, UCCC funds a program for men: the 900 Program. This is considered pre-treatment, using a cognitive and educational approach. Offenders are housed separately in the jail and after successfully completing 30 days in the program are moved to the Program Center for additional A&D treatment during the rest of their sentence.³⁶

In addition, UCCC is responsible for the Drug Courts in Umatilla County. Umatilla County Drug Court is a collaborative effort among the judge, treatment provider, H&HS, and the Sheriff's office. Individuals typically complete the program in 14 to 18 months. During SFY08, 86 people were provided drug court services, with about 35 engaged at any one time.

Children & Families: The ART serves child welfare families with addiction needs through a variety of services including screenings, referrals, general support services, and random urinalysis testing. ART refers to various local providers for both residential and outpatient treatment. Given the long wait times for residential treatment, sometimes up to three months, ART often refers clients to providers in surrounding communities, occasionally as far away as Multnomah County. From October 2007 to October 2008, ART completed 90 screenings, of which an estimated 80% resulted in an identified treatment need.

In addition to ART, Umatilla child welfare clients have access to Parent Mentors, transitional housing, and ITRS. These programs are administered by various local providers in the community.

Investments

Prevention

Both the local CCF and the County Addictions Program receive funding for A&D prevention services. CCF funding includes Youth Investment dollars from OCCF, as well as JCP basic and prevention dollars. Most of this funding is then subcontracted to local providers for service delivery. The Prevention Program in the County Addictions Program receives funding from AMH Service Element 70, Strengthening Families, and a small amount of JCP Prevention from a contract with CCF. In SFY08, the Prevention Program received \$111,757, all of which came

³⁶ There is also a program for women – the 500 Program – which is funded solely by a local provider.

from the state general fund. Prevention spending represents 11% of the County Addictions Program’s total A&D budget.

Treatment

Health & Human Services: The two main local providers - the County Addictions Program and EOAF – hold direct contracts with AMH for different services; the County Addictions Program receives funds to provide Service Element 66, continuum of care treatment services, while EOAF is funded for Service Elements 61 and 67 for residential services and housing. Both providers also receive treatment funding from a variety of other sources, as shown in Table 5.10. After AMH, the County Addictions Program relies most heavily on insurance (including both OHP and private plans) and client payments (36% of total funds); for EOAF, the second-largest funding source is a contract with community corrections.

	County Addictions Program	EOAF
Funding Source	% of Total	% of Total
AMH	44%	36%
Insurance/Private Pay	36%	6%
Corrections Contract	10%	23%
Beer & Wine	6%	-
AFS* Contract	4%	-
Federal Grants	-	3%
County General Fund	-	1%
CAF Contracts	-	10%
Other**	-	21%
TOTAL	100%	100%

**Adult and Family Services. **Other includes grant awards, interest payments, and miscellaneous revenue.*

Juvenile Justice: The Juvenile Services Division receives no funding specifically for A&D services. CCF receives all JCP funds, some of which is used for assessments. OYA diversion funds and individualized services dollars go directly to CEOJJC to serve the 17-county region³⁷. CEOJJC contracts with local providers in each county for service provision.³⁸ These funds are used for purchasing treatment for youth without insurance, as well as for beds at the Youth Care Center. In SFY08, no Umatilla youth were served at the multi-county Youth Care Center. Only a small fraction (<0.5%) of OYA diversion and individualized services dollars were used to fund A&D treatment for Umatilla County youth.

³⁷ Deschutes does not pool their diversion dollars, but does pool their beds.

³⁸ Although staff at CEOJJC reported using the OYA Individualized Services funding stream, OYA did not report any funding used in Umatilla County in SFY08.

Community Corrections: UCCC receives A&D treatment funds from DOC, CJC and the Office of Justice Programs (OJP); the latter two sources support local drug court activities. Additional A&D treatment expenses are covered by a variety of other minor revenue sources, accounting for 8% of total A&D expenditures (see Table 5.11). All treatment is provided at no cost to the client. While the drug court grants from CJC and OJP constituted half of UCCC's state treatment dollars, spending for drug courts in SFY08 exceeded the income from these two sources. Additional expenses for this program came from community corrections funds, including local fees and DOC grant-in-aid. Drug Courts actually accounted for 54% of UCCC addiction spending in SFY08.

	CJC	OJP	DOC	Other**	Total State	Total
A&D Tx Srvcs*	\$277,553	\$79,687	\$351,452	\$63,238	\$708,692	\$771,930
				8% of total	92% of total	

*Includes all general A&D services, such as pre-treatment cognitive-behavioral programs, drug courts, and treatment services.

**Includes supervision and court assessment fees from other programs, and some interest on investments.

Children and Families: The CAF regional office funds a variety of services to assist child welfare families with A&D treatment needs, including the ART, parent mentors, and transitional housing; the Parent Mentors program is the only one that is federally funded. Additional funding specific for child welfare clients comes from AMH for ITRS, which includes both residential and outpatient treatment. The two main local providers receive this funding stream. Table 5.12 presents total funding amounts for Umatilla County child welfare families in SFY08; state funding is 92% of the total.

	CAF	EOAF	County Addictions Program	Total State	Total Federal	Total
Outreach Worker	\$27,216			\$27,216		
CADC's	\$46,392			\$46,392		
Parent Mentors		\$30,000			\$30,000	
Transitional Housing		\$122,472		\$122,472		
ITRS		\$56,154	\$91,128	\$147,282		
TOTAL	\$73,608	\$208,626	\$91,128	\$343,362	\$30,000	\$373,362
				92% of total	8% of total	

Contracting

Prevention

While the Prevention Program provides all of its prevention services directly, CCF contracts out all prevention services to local providers and schools, using a biennial competitive RFP process. CCF has two contracts with the County Addictions Program; one contract provides support to the prevention coordinator, while the other funds a joint program between the County Addictions Program and TM Counseling for adolescents involved in the Juvenile Justice system. CCF also contracts with a variety of community providers for specific programs such as Girl's Circles, CareTeams, and after school programs. For the use of JCP dollars, CCF pulled together a "JCP Team" of local providers serving youth. This Team developed a plan for how to use the money and then made recommendations to CCF. CCF then distributes the funds through the competitive RFP process.

With each contract, CCF initially provides one quarter of the annual funding; subsequent payments are based on actual spending as reported by each provider on a quarterly basis. CCF will reimburse the agency up to the original budget amount. For all contracts, CCF requires reporting based on specific outcomes detailed in the proposals.

Treatment

Health & Human Services: The County Addictions Program subcontracts with EOAF specifically for detoxification services. It does not require any reporting, performance measurements, or targeted outcomes, but simply serves as a financial pass-through for this program. All other treatment services are directly provided.

Juvenile Justice: Individual providers in Umatilla have direct contracts with CEOJJC. For the individualized services funding there is no formal RFP process. Instead, the county approaches CEOJJC with specific providers that they would like to use and CEOJJC works with the provider directly to set up a contract. Although there is a set amount of money in each contract, this is not guaranteed. CEOJJC reimburses providers based on approval of individual treatment plans for each client. In Umatilla County, CEOJJC has contracts with three local providers.

CEOJJC also contracts with Umatilla County for 15 beds in their Youth Care Center, which serves all counties that are part of the Consortium. This does require a formal RFP process. In this case, CEOJJC does not approve treatment in advance for each client, but rather pays for the cost of the bed after the youth is referred and accepted into the program. CEOJJC requires a minimum level of reporting from all contractors, and is not currently monitoring any performance measures or benchmarks.

Community Corrections: The Community Corrections A&D treatment program is in the midst of change. Starting January 1, 2009, it will be starting the new treatment program mentioned above, the Umatilla County Community Corrections Treatment Services Program (UCCTSP). This involves a significant change in the current contracting structure. Previously, UCCC contracted with EOAF for provision of treatment and drug court services, and held several small contracts with other local providers outside of Pendleton. With the new structure, UCCC will manage the A&D program itself, contracting solely with the County Addictions Program for clinical oversight. All services and treatment staff will be housed at the Community Corrections Program Center.

UCCC conducted an RFP process to select the new provider, the County Addictions Program, for both the A&D treatment services and drug court services. They are required to follow SB267 requirements and participate in periodic Correctional Program Checklist assessments by DOC.

Data Collection and Outcome Measurement

Prevention

CCF keeps its own data on all of the programs that it funds, gathered from the quarterly reports submitted by each agency. CCF is able to pull reports from its internal database and get a variety of information regarding A&D prevention services. Because CCF receives funding from a variety of state sources they enter data into three additional databases: Data Manager for JCP funds, JJIS for JCP Basic funds, and the Local Resources Database for OCCF funds. Although CCF staff members are aware that they can pull reports from the various databases, those interviewed were unaware of the procedures for doing so.

Treatment

Health & Human Services: Both the Umatilla County Addictions Program and EOAF enter data into CPMS, but also have their own internal data collection systems. They collect information on numbers served, client demographics, client satisfaction, length of treatment, and caseload size. EOAF is beginning to formalize follow-up evaluations at 6 months, 1 year, 2 years, and 5 years post-treatment completion. Providers report to AMH regularly, but all mentioned receiving minimal, if any, statistical feedback.

Juvenile Justice: The Juvenile Services Division in Umatilla County does not collect A&D treatment data on justice-involved youth. CEOJJC does collect data from the providers that they contract with in order to report back to OYA. Collected data includes basic outputs such as: types of spending, counties in which the funds were spent, numbers of youth entering the correctional facility, recidivism rates, and demographic information on the youth who are receiving services.³⁹ In July 2008, they began to enter data into the JJIS database. CEOJJC is hopeful that this system will assist in identifying a cohort of youth that receive A&D services, improving their ability to measure outcomes.

Community Corrections: UCCC enters data into the CIS. From this system, UCCC staff members are able to gather information and complete Quarterly Treatment Reports. Information gathered and reported includes the following for each program: number referred for treatment, number entering treatment, number of closures (successful and unsuccessful), and numbers served per month.

UCCC uses the Corrections database frequently to report to the state and to measure performance and continuous quality improvement. UCCC staff members particularly appreciate the web-based interface; they use it for immediate reporting and for comparing their outcomes to statewide results.

With the upcoming shift in program structure, UCCC will begin to measure additional outcomes, which include offender retention, incidence of relapse and recidivism, individual client progress towards goals, and program fidelity. It plans to measure these outcomes with a

³⁹ At this point, the number receiving CEOJJC-funded A&D services is too small to get any significant outcome data.

variety of tools, including case file audits, client satisfaction surveys, pre- and post-tests, the Client Evaluation of Self and Treatment (CEST) assessment, the Criminal Thinking Scales (CTS) assessment, and exit interviews. Corrections staff will have time dedicated to this work, and a data collection system has been created to gather and process this information.

In addition, UCCC collects data on drug courts. The primary data reporting systems used are the OTCMS and the CIS. Information related to drug courts is pulled from the latter and inserted into OTCMS to provide the Drug Court Team with adequate and accurate weekly reports. This information is used to complete quarterly reports for CJC.

System Gaps

The following gaps noted by Umatilla County interviewees offer a sense of the challenges and barriers to serving clients with A&D needs.

- A continual waitlist for residential treatment: Beds are limited because of funding, and many are reserved for women with children or those on OHP. At times, up to 50 women are on the waitlist, and men often wait up to 3 months to access residential treatment.
- Lack of availability of services for clients with co-occurring disorders: Umatilla County has one agency that serves people with addictions needs and a separate agency for mental health services. Little collaboration reportedly exists between these agencies, leading to a lack of services for clients who have both types of needs.
- Minimal services for adolescents: there is a lack of consistency in referrals and treatment services for youth involved in the juvenile justice system, no adolescent DUII specific services, and little residential treatment for youth.
- Competition for referrals among various treatment providers in the community: Numerous providers and private practitioners in Umatilla County serve individuals with A&D treatment needs, and they are all competing for the same clients. In some instances, this has led to the underutilization of a few providers.

Conclusion

Umatilla County has experienced a number of changes to its A&D treatment system over the past few years. In 2005, the CMHP structure dissolved and service element funding was allocated in three parts: A&D funding went to the two agencies discussed above, the County Addictions Program and EOAF; and Mental Health funding was distributed to Lifeways, another provider. In 2007, the Prevention Program moved from the Juvenile Services Division and became part of the County Addictions Program. In 2009, a further change will occur: A&D services for community corrections clients will be managed in-house by the department who will then contract to the County Addictions Program for actual services. As is evident by these changes, Umatilla County is still building its publicly-funded treatment system. The coming year will begin to reveal the success of these changes.

Despite all the changes in its A&D system, Umatilla has shown strength in increasing collaboration among service providers and other community members, such as community corrections, the local CCF, and school systems.

5.4 CONFEDERATED TRIBES OF WARM SPRINGS

The Warm Springs reservation, with approximately 4,000 tribal members, is located in a largely rural area of Central Oregon. As a tribal entity and not an Oregon county, Warm Springs operates somewhat differently than the other entities selected for the case study analyses. Warm Springs does receive state funding from AMH but does not receive substance abuse treatment funding from DOC. All outpatient treatment is provided through the Warm Springs Community Counseling Center, which also functions as the CMHP. Residential treatment is contracted out. For this analysis, HSRI interviewed a representative from the Community Counseling Center (CCC). Warm Springs does not have a 2009-2011 implementation plan filed with AMH and their 2007-2009 implementation plan does not contain an allocation sheet, so these resources have not been available to review as they have been in the other case study localities.

County Systems and Investments

Prevention

Warm Springs takes substance abuse prevention very seriously. The prevention coordinator, a dedicated staff position, carries responsibility for completing the prevention plan and managing the prevention budget. For SFY08, Warm Springs received \$50,000 from AMH. The Tribe also receives some funding from the Indian Health Service (HIS), although the amount is not known. Prevention efforts focus on culturally relevant activities and include:

- Indian Night Out
- Back to the Boards (reduces SIDS and alcohol abuse by new mothers)
- Skate Park
- Soaring Butterflies (Indian culture for youth)
- Drug and alcohol free family cultural camps and classes
- Community pride park cleanup
- Visits by sportswear producers who promote alcohol and drug free living
- Community Gardens
- Meth Task Force
- Neighborhood Watch focusing on drugs, alcohol, and gang activity

Staff at the CCC decide what prevention activities to offer, in coordination with other groups such as the community center. Warm Springs tries to target both youth and adults in their prevention efforts, working to plan events and activities which will attract the largest attendance.

Treatment

As mentioned, all outpatient treatment for youth and adults is provided at the CCC. Staff members from the CCC also go to the Jefferson County jail three times a week to work with prisoners on substance abuse and behavioral health issues. Clients who exit from the state correctional system usually have an appointment set up with the CCC as part of their transition. Tribal parole officers help community corrections clients stay connected with treatment, and treatment may be a condition of parole. Although Warm Springs works closely with Jefferson County parole and probation, tribal members who break county supervision are usually managed

on the reservation with tribal resources. Warm Springs youth have very high rates of substance abuse; staff reported that this figure is as high as 90% of all tribal adolescents. The IHS provides \$90,000 per year for treatment, salaries, mileage, and residential care for youth. Child welfare families with addiction recovery needs are also served through the CCC. Over a one year period, the CCC serves approximately 350 clients⁴⁰.

By necessity, residential treatment is provided off the reservation. Warm Springs staff try to select culturally appropriate residential providers, although the supply is limited⁴¹. The counseling center refers about 15 clients per year for residential treatment. Occasionally a client is referred outside the reservation for outpatient treatment. However, since these are usually clients who have insurance through the Oregon Health Plan, Warm Springs tries to serve them at the counseling center.

The following table (Table 5.13) presents an approximate budget for Warm Springs prevention and treatment services. As shown, the largest portion of CCC revenues (39%) come from the Indian Health Service. This is a funding source that Oregon counties do not have. The Oregon Health Plan (35%) is also a large source of revenue for reservation clients. Warm Springs staff report that they are proficient at establishing OHP eligibility for clients. The listed JCP funds are used for treatment, although their source is the Oregon Commission for Children and Families. The Counseling Center does not receive any funding from the Department of Corrections or any direct allocation of Beer & Wine tax monies. The counseling center does not derive any revenue from self-pay or insurance other than IHS and OHP.

Funding Source	Amount	% of Total
AMH Prevention	\$50,000	6%
AMH Treatment	\$132,022	16%
Oregon Health Plan*	\$289,340	35%
Indian Health Service	\$324,735	40%
JCP Prevention	\$26,719	3%
Total	\$822,816	100%

**includes spending on other counseling services outside of A&D*

Contracting and Data Collection

Warm Springs contracts for residential substance abuse treatment since it is not available on the reservation. Providers receive an annual fixed amount, although the CCC usually ends up owing them extra at the end of the year. This results in what is technically a fee-for-service arrangement. Rates are determined by “what the providers want” and providers are selected based on past success with tribal clients. There is no other contracting for A&D treatment.

Warm Springs has limited data management capacity. To track prevention activities, tribal staff hand tally counts of numbers served and send them to AMH. They do not enter data into MDS. For treatment services, the counseling center enters data into CPMS but does not extract it in any form. They are currently in the process of creating an internal data system which will

⁴⁰ This count is not unduplicated.

⁴¹ Interviewed staff did not know how many providers they currently contract with.

collect information on the number of clients served, client demographics, treatment completion rates, and payment sources. At this time they cannot provide unduplicated counts or counts by referral source. They do not keep any data on UAs.

Warm Springs reports that they use evidence-based practices, “based on the [AMH] website”.

Gaps and Waitlist

Because substance abuse is a significant issue on the reservation, Warm Springs would like to see more prevention take place in the schools, both on and off the reservation (in Madras where many youth attend school); and respondents would like to see prevention efforts for even younger children.

For treatment, the biggest gap reported in Warm Springs is a lack of qualified staff to serve clients at the Community Counseling Center. It is difficult to find counselors who want to either live on or commute to the reservation, although funding is available for additional positions. Currently, the CCC has 18 staff members. Occasionally there may be a wait of up to two weeks for an outpatient therapist, but in general there is no wait for treatment commencement.

Conclusion

Warm Springs has a strong focus on substance abuse prevention for both youth and adults. The Tribe's prevention planning efforts and activities involve community members from various entities on and off the reservation. Prevention funding from AMH has increased slightly and is supplemented by other sources. An adequate amount of outpatient treatment is available on the reservation and is fully funded through AMH, OHP, and the Indian Health Service. In contrast to some other county agencies interviewed for this report, the Warm Springs Community Counseling Center is generally able to obtain OHP eligibility for clients. Perhaps due to its relatively small population, Warm Springs has not focused on data collection or outcome measurement. The data transmittal and feedback between Warm Springs and AMH (for both prevention and treatment) is minimal. However, improved internal data collection efforts, currently in progress, will allow Warm Springs to measure program outputs.

5.5 SUMMARY OF LOCAL LEVEL CASE STUDIES

The four localities examined for the case study analysis highlight the variety of system approaches and funding sources used for substance abuse treatment in Oregon. Although counties generally contain the same types of agencies such as a CMHP, a community corrections agency, and CAF staff, each county integrates its services and supports differently. Rather than following a prescribed allocation, contracting, and measurement approach, counties have designed their own systems over time. One of the counties examined here, Multnomah, has largely maintained the same interagency structure and provider network for the past several years. Two other counties, Lane and Umatilla, are in the process of transitioning funding and services for community corrections clients, significantly shifting the landscape for offenders being supervised in the community. Warm Springs has the least complex service delivery structure, operating largely through one agency for A&D services.

The mix of funding sources on which each of the four localities relies, and the relative importance of each source, are not consistent across counties, illustrating the varied ability of

counties to leverage resources other than state funding. For example, in Multnomah County, the Department of Community Justice counts state funding as only six percent of its overall budget; the vast majority of DCJ-contracted A&D treatment for offenders in Multnomah County is covered by the county general fund. By contrast, in Umatilla, state funding comprises 92% of the total available funding for community corrections clients. In terms of prevention, funding in all four localities comes almost entirely from state resources, both for CMHP-sponsored prevention efforts and those overseen by OCCF.

Not only do funding patterns vary across jurisdictions, but they also vary across agencies within a given county. Agencies that function as CMHPs—such as DCHS in Multnomah and H&HS in Lane—generally obtain their funding from a mix of state, county, and federal funds. Agencies which function as both CMHPs and providers—such as the County Addictions Program in Umatilla and the Community Counseling Center in Warm Springs—have the additional complication of OHP, other insurance, and self-pay as resources.

Grant funding is a resource which varies widely across counties. Multnomah has a Children's Bureau grant for \$5 million which largely funds their FIT (ART) team, yet Lane and Umatilla rely almost entirely on state funding for their ARTs.

The most difficult area to obtain budget figures seems to be juvenile justice. A&D funding sources for juvenile justice clients are hard to extract from overall juvenile justice agency budgets. Most youth clients are served by individual providers, because many have Medicaid or private, family-based insurance. Portions of juvenile justice budgets may go to fund residential treatment beds (not eligible for OHP reimbursement) or assessments for particular groups of clients, but A&D particulars are not immediately transparent.

All studied counties actively manage resources on a daily basis, responding to the ebb and flow of funding streams, the capacity and practices of local providers, and the needs of potential clients. In Multnomah, a shift in allocation of \$1 million for a residential treatment (RAD) program changed the mix of funding sources considerably, but did not affect overall funding for the provider; other funds were used to compensate. This is an example of the difficulties in tracking funding allocations over time at the county level. In addition, some counties have unique funding sources which are not available to any other locality. For example, the Serbu Foundation funds A&D services only in Lane County; and Warm Springs has the Indian Health Service, which provides up to 39% of their funding for outpatient A&D treatment.

Contracted providers, as mentioned, are not always aware of the original source of all their funds. Often, state, federal, and county resources are co-mingled within allocations to providers and are simply viewed as contracted funds. Providers may, however, receive funding directly from a city funding source (such as Hooper Detox in Portland), from independently acquired foundation grants, and, of course, from insurance and self-pay. The size of a county often factors into these equations; larger counties such as Multnomah are more likely to have staff with the time and expertise to write grant proposals. Warm Springs has staff members who are proficient at obtaining OHP eligibility for tribal members. Despite the variety of approaches to maximizing and maintaining funding, local agencies responding to this analysis still largely believe that state regulation and mandates can, at times, hamper innovation in system structure, funding distribution, and provider practices.

Having a variety of funding sources as well as differing grantor agencies presents challenges for providers beyond the issue of funding instability. One example is data collection and data

management requirements which reportedly vary somewhat across counties and across agencies within counties, depending on funding sources. All providers enter data into CPMS, yet no responding providers, and few county agencies, attempt to access the data or to interact with AMH to discuss their results. Instead, providers keep their own, internal data systems—partly to manage the data collection requirements of different contractors. At the time of the interviews, most agencies and providers were either getting a new system off the ground, or significantly tweaking an existing system. For example, the Lane County CAF ART team implemented a new system in early 2008 to track outputs and outcomes for the clients they serve. Warm Springs is adding a new data collection system for all clients served at the CCC.

The close examination of A&D prevention and treatment systems within these four localities offers insight into the impact of changes in investments at the state level, an impact which is most dramatically felt by county agencies, providers, and ultimately by clients. Because of the variation among systems at the local level, this impact also varies. Some counties may be more diversified in their funding sources and treatment resources, and therefore better able to continue to serve clients—or certain groups of clients—in a time of investment reductions. Other counties may be required to shut down part or all of their publicly-funded treatment offerings. Conversely, some counties may be in a better position to maximize funding increases, quickly adding staff and clients. Considering both the diversity and the small number of counties studied, it is difficult to aggregate findings across localities. However, there are some things that remain in common, for example, state funding streams and performance measurement requirements. Using those commonalities as a framework, analyses of additional counties could add to an even deeper understanding of the network of substance abuse services available at the local level.

Although Oregon localities have specific challenges when it comes to meeting A&D treatment and prevention needs, many of these gaps and barriers are fairly consistent across the case study sites. To address some of the shared challenges, HSRI offers the following recommendations:

- Reduce the data collection and reporting burden on providers who have multiple contracts, by aligning definitions of required data collection elements.
- Continue to investigate barriers within the *assessment to referral to treatment* path for justice-involved youth.
- Provide consistent technical assistance to providers around evidence-based practice.
- Improve the feedback loop from state agencies to their county-level counterparts, and subsequently to providers. For example, provide additional technical assistance around obtaining reports from state data systems and integrating the results into decision-making by agency and provider management.
- Expand availability of subsidized and recovery housing, both as a supplement to residential treatment and as a component of outpatient treatment options.
- In order to strengthen existing prevention resources, continue to encourage coordination of prevention efforts across agencies—including agencies not studied for this report such as the Department of Education.

These recommendations are made in light of the current fiscal situation where the Oregon publicly-funded A&D prevention and treatment network is facing severe budget cuts. Many of these recommendations can be accomplished with minimal resources and within the current organizational structure. None of them requires that an undue burden be placed on participating counties. In fact, implementing these recommendations will reduce some administrative challenges for county agencies and their corresponding providers as well as improve system efficacy.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

In the course of conducting the Gaps, Investment and Performance Analyses, HSRI has collected a significant amount of information on the current status of Oregon's A&D treatment and prevention system. Because A&D services are provided by a variety of state agencies, it is often difficult for policy-makers to develop a comprehensive understanding of the entire system and to judge where best to focus program improvement efforts. This concluding chapter provides an overview of the trends that have been identified in each of the three sub-studies, followed by suggested next steps to make this profile more complete. The final section offers some specific policy recommendations to help state officials focus collaborative efforts and improve the effectiveness of investments in the state's A&D system.

6.1 CROSS-AGENCY FINDINGS: GAPS ANALYSIS

Estimates from the National Survey on Drug Use and Health (NSDUH) of the need for A&D services among Oregonians age 12 and older show that Oregon has a long way to go to meet all the A&D treatment needs of its population. Only one-fourth of those estimated to need A&D services received any support in 2007. Looking only at those likely to need public funds to obtain services (those with income up to 400% of poverty), the gap remains substantial at 60%. In addition, among prisoners preparing to re-enter the community in 2007, 74% of those prioritized for treatment failed to receive it.

Of particular note is the group of individuals aged 18 to 25 years old. This group has the highest prevalence rate of any age segment (20% compared to 6-8% for older and younger age groups). The number of individuals in this group who needed publicly-funded A&D treatment but did not receive any in 2007 approached 37,000 people. Many of these young adults may also have come into contact with the criminal justice system and perhaps also the child protection system, making them an especially important group to reach with needed services.

While individuals needing A&D treatment are often involved in a variety of state agencies that provide A&D services, most Oregonians in need of publicly-funded treatment services are served through AMH and/or other parts of DHS during all or at least some part of the time they are receiving A&D services. In essence, DHS serves as the safety net for the A&D system. If, for example, an incarcerated adult with a substance abuse problem re-enters the community, he becomes part of the larger population seeking services from the community provider network which depends heavily on AMH and OHP dollars. Similarly, a mother on TANF, who has regained custody of her child after an episode of neglect associated with drug abuse, seeks continuing drug treatment from those same community providers. Many of the gaps identified in this study occur as individuals move from one state agency system where A&D services are mandated (e.g. DOC, CAF) to another (e.g. AMH-funded providers), as they are reintegrated into their own community A&D service systems as voluntary clients. And, as individuals make these transitions, what often appears as client non-compliance in obtaining A&D services in the community may reflect the difficulties people with addiction, who are also disproportionately low income and minority, have in negotiating public social service systems. Adding to the complexity of the service delivery system is the unpredictability of the health insurance system: the cuts weathered by the Oregon Health Plan during the 2003-2005 Biennium directly reduced both identification of clients with A&D needs *and* the scope of A&D treatment coverage. Thus,

many people remain untreated in the community, contributing to the gap between need and receipt of A&D services.

Gaps in the prevention realm of A&D services are more difficult to estimate, but the need for A&D efforts targeting youth is clear. Several data sources offer estimates of youth who have used illegal substances and would be the most appropriate target for prevention activities. Further, most youth in this state are exposed to other drug-using youth to some degree and could benefit from A&D prevention programs. However, the ability to examine the number of individuals affected by these prevention efforts is limited: prevention programs have multiple goals, with A&D use sometimes a distal target, and few programs track who participated, which is appropriate given the structure of the programs.

Next Steps in Understanding Gaps

In order to get a complete picture of treatment and prevention gaps in Oregon, further work needs to be done. Information is needed concerning the following issues: (1) the gap in services for populations excluded from this report (homeless individuals, community corrections clients, and OYA youth), (2) a detailed infrastructure assessment examining issues such as provider staffing and capacity, (3) a detailed prevention gaps analysis, (4) exploration of the universal waitlist for A&D services, and (5) ways to obtain an unduplicated count of A&D clients served.

6.2 CROSS-AGENCY FINDINGS: INVESTMENTS ANALYSIS

One of the primary goals of this project was to catalogue Oregon's investment in alcohol treatment and prevention services, to help policy makers understand the ramifications of shifting state funds among state agencies who currently provide A&D services. The Investment Analysis revealed some important facts:

- Overall funds for A& D services were deeply cut in the 2003-05 Biennium, and inflation-adjusted A&D investments have not yet rebounded to the levels reached in the 2001-03 Biennium.
- Prevention has consistently received a small share of A&D funds (10-14% of total A&D budget). And, while the proportion of A&D funding spent on prevention has grown recently, actual dollar growth was relatively small – the proportionate increase was largely due to cuts in treatment dollars.
- The vast majority of all A&D funds (80%-87%) comes from divisions within DHS (i.e. AMH, OHP, CAF), while DOC has received 9-14% of total A&D funds over the past four biennia. CJC and OYA received very small proportions of total A&D funding.
- Overall, 41% of A&D monies come from the state general fund. Of the core A&D agencies, AMH relies the least on state general fund distributions, deriving 32% of its A&D funds from that source. However, because AMH and OHP receive such a large proportion of the total A&D funding, together they receive nearly $\frac{3}{4}$ of the state general funds that go to A&D services – and thus they are the agencies most immediately affected by overall changes in the availability of state monies.
- The vast majority of state funds for A&D treatment flow through to local communities. AMH is the largest contributor of A&D funds to the local level; in 2005-2007, 56% of

state funds flowing to local A&D services were provided by AMH, and another 37% came through OHP. Clearly, decreases in either of these two state-level sources would have severe consequences for local service delivery systems.

These spending patterns, across agencies and over time, point to the substantial role played by DHS – in particular, AMH and OHP – in the overall financial health of the A&D system. The picture is fairly complete, sufficient to inform policy discussions in the immediate future. However, this analysis could be made more comprehensive by further exploration in several areas: (1) examining the development of routine processes to track expenditure data, (2) studying the magnitude of administrative costs across the state agencies and local counterparts, (3) understanding better how resources are spent in the prevention arena, (4) further exploring the OHP system and expenditures, and (5) further analyzing other state A&D systems and how resources are spent and tracked.

6.3 CROSS-AGENCY FINDINGS: PERFORMANCE ANALYSIS

The Performance Analysis provides an overview of how the key state agencies that provide A&D services contract with local providers and ensure accountability in the A&D service delivery system. Overall, the five agencies targeted in this project use a variety of approaches to ensure accountability, making varying degrees of effort. Several themes emerged from the analysis:

- Each state agency has an information system which tracks clients receiving A&D services, allowing for the collection of outputs and outcomes data. However, there are clearly issues of data comparability and reliability, and state agencies struggle with how to provide data to local providers for their own use in management decisions.
- As has been encouraged across the state, all agencies in this study have developed performance measures to describe expectations for providers; however, few agencies have formalized these performance measures to hold providers accountable to these expectations.
- In terms of effectiveness, all agencies are expanding the use of evidence-based practice, and they are able to assess the capacity of local providers to implement EBP and meet the legislative mandate. However, most agencies monitor EBPs rather informally. In order to assure that the potential impact of EBP is achieved, it is necessary to have a more rigorous and consistent review process. Further, a few agencies have been able to conduct rigorous evaluation projects on the effectiveness of their A&D programs; these efforts can significantly contribute to the field's understanding of the impact of A&D programs.

Overall, in terms of monitoring performance, it appears that state agencies providing A&D services are directing how their money is spent in the field and monitoring what has been achieved. Further, most of the agencies describe how they are working to become more thorough and systematic in managing performance. However, significant progress can still be made to develop systems to document expectations, hold providers accountable, and measure effectiveness.

In conducting this Performance Analysis, HSRI has barely scratched the surface of the many issues we explored. Several additional activities could help contribute to a better understanding

of these topics: (1) a more detailed review of performance management efforts across state agencies, (2) a thorough assessment of current EBP practices at the state and local levels, and (3) a closer look at how counties and providers have implemented performance management practices at the local level.

6.4 LOCAL LEVEL CASE STUDIES

The case studies developed in the course of this project provide valuable insight into how A&D services are delivered at the local level. This understanding is vital to assessing how changes in investments at the state might impact local service delivery. Across the four county systems which were examined, significant variation is evident in how A&D services are delivered, the degree of reliance on state funds, how contracts are developed, and how performance is monitored. The case studies also show how local communities struggle to meet the requirements of state systems (i.e. data requirements, monitoring EBP). Due to the limited scope of this project, the case studies provided only a brief picture of the four local service delivery systems. A more detailed examination of local A&D service delivery systems across the state would help state policy makers anticipate the impact of any redistribution proposals.

6.5 POLICY RECOMMENDATIONS

HSRI's assessment of the current status of Oregon's A&D system has yielded a fairly detailed profile of state-level activity, and has brought to light many strengths and challenges in existing management and service delivery practices. The A&D system has many active players, some of which work closely together and others which operate more independently; it relies on a complex web of funding streams, with varying eligibility requirements and accountability mandates; and individuals needing treatment are often hard-pressed to find their way to services and ongoing supports. Not surprisingly, the results of considerable state investments are mixed: some population groups are better served now than they were in the past, but others are not, and some programs have led to improved client outcomes while many others have not yet adequately measured their results.

While much more analysis could be done to enrich this initial profile of the A&D system, the findings presented in this report point to several key policy recommendations:

- *Target the 18-25 year-old population in need of publicly-funded A&D services.* As the group with the highest prevalence of A&D problems and with a large gap between need and service receipt, investment in this group could do much to reduce future involvement in the criminal justice system, the child protection system, and/or more intensive service needs in the community.
- *Prioritize re-entry services.* The community A&D provider network serves people who have been incarcerated, those with criminal involvement at a lower level (jail, probation), and those who have never been in contact with the justice system. By assuring that those leaving correctional institutions get appropriate treatment and support services in their home communities, the state can increase their likelihood of success— both in terms of staying free of drugs and not reoffending.

- *Expand A&D funding through the Oregon Health Plan:* Putting state general funds into OHP is a vital way to leverage federal dollars: each state dollar generates an additional \$1.66. [It is important to note that OHP Standard can be increased up to 200% of poverty and still receive full Federal Financial Participation.] Because local communities rely so heavily on OHP dollars, increasing this funding source directly supports local A&D infrastructure, helping to maintain the basic service delivery capacity. More importantly, OHP monies go directly to individuals, giving them the ability to “pay” for the services they need. The people potentially affected by an expansion of OHP eligibility may seek treatment anywhere in the system – through AMH, DOC, CAF, OYA, or CJC programs.
- *Capture additional revenues:* The Oregon Liquor Control Commission has a mandate to not only control the sale of alcoholic beverages but also to address underage drinking and alcohol abuse in the state. Beer & Wine tax revenues are distributed to AMH, to the state general fund and to cities and counties, but only the AMH portion – 50% – is earmarked for A&D services. Tapping into the non-earmarked portion could be beneficial – either by increasing the share of B&W tax revenues that go to AMH, or by earmarking some of the other B&W monies for A&D services. In addition, two other broad options should be considered: (1) increase the B&W tax rate, which has not been changed since 1977; and (2) channel some of the other OLCC revenues (from liquor sales and licenses) to A&D treatment programs; in SFY08, the AMH allocation (from B&W tax) constituted only 5% of total OLCC allocations.
- *Improve linkages among state data systems:* While each state agency has a data system to collect information on clients receiving A&D services, these systems are not linked and have different definitions of outcomes. Listings of clients served are not routinely unduplicated, making it impossible to compute total people served across the five state agencies or, consequently, a total service gap. In addition, the various data systems use differing definitions of outcomes, making it difficult to create an accurate aggregate picture of service impact. Further, these inconsistencies at the state level translate into a heavy (and sometimes confusing) data entry burden at the provider level. To improve this situation, it is vital to have routine matching of client lists and/or multi-database linkages, plus some shared output and outcome measures; this would make it possible to generate some overall system metrics (total people served, proportion with positive outcomes, etc.) Not only would such changes enhance state-level policy-making and program management but it would also decrease the data burden at the local level, as well as providing providers and counties a systemic perspective on their own activities.
- *Coordinate efforts to support Evidence-Based Practice:* Designed to increase the likelihood that A&D treatment has positive effects on clients, Oregon's EBP mandate clearly fosters greater use of proven interventions. However, the state agencies differ substantially in the manner and extent of support they offer to local providers in selecting, implementing, and assessing both fidelity and impact of EBPs. To fulfill the legislative mandate in a sustainable way would require substantially more resources than can be made available in the short term. One feasible alternative would be to gradually phase into a “full” EBP approach. This might entail (1) coordinating the existing agency-specific efforts to make EBP-dedicated resources stretch further; (2) establishing some core shared activities, such as technical assistance offerings, fidelity monitoring processes, and joint evaluation initiatives to identify new EBPs that fit Oregon population

subgroups; and (3) selecting a few EBPs each year for intensive promotion, support, and monitoring, as a way to test both the interagency collaborative approach and the technical support structure.

Much of the current A&D system works smoothly and provides accountability. In 2007, funds from at least seven distinct sources flowed through state agencies to counties and providers, generating services to some 65,000 Oregonians. Local and state programs collected information and reported on their activities to the legislature, to other funders, and to the public. Use of evidence-based practices expanded greatly. Nonetheless, state policy-makers realize that the system can and should operate more efficiently and effectively. This study has been the first of likely many similar steps to bring more rationality and equity to a complex array of funding sources, agencies, and population groups in need. In the face of budget shortfalls at all levels of government, mirrored in increasing stresses felt by individuals and families, Oregon's leaders recognize that they must act firmly, and soon, to begin to address the many issues highlighted by this status report.

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