



September 29, 2008
Department of Human Services
Addictions and Mental Health Division
Presentation to the Joint Interim Judiciary Committee
**Progress Report on the Implementation of
Evidence-Based Practices**

The Department of Human Services, Addictions and Mental Health Division (AMH), is required by Oregon Revised Statute 182.525 (ORS 182.525) to report to the Legislature, over three biennia, an increasing proportion of funds that support evidence-based practices (EBPs). By the 2009-11 biennium, 75 percent of AMH funds for those populations at risk of emergency psychiatric services or criminal or juvenile justice involvement are to support EBPs. The services subject to the statutory requirement are the treatment and prevention services funded by AMH and do not include expenditures for non-clinical services, such as room and board in residential or hospital settings. AMH and its providers believe the requirements of ORS 182.525 apply to all of its clinical and prevention services because of the risks for the populations served with public funds. AMH and its contractors developed its plans and implementation processes accordingly.

For the 2007-09 biennium, 54 percent of AMH treatment funds are expected to be spent on EBPs. This meets the required 50 percent goal. It also leaves AMH with a large challenge to meet the 75 percent goal associated with the 2009-11 biennium.

Outcomes

The Department of Human Services, Addictions and Mental Health Division's role under ORS 182.525 is to decrease the use of emergency psychiatric services through the implementation of EBP. Since the 2002-03 fiscal year, AMH has reduced the number of people hospitalized for psychiatric reasons by five percent. This may not seem significant but it translates to roughly 300 people not hospitalized per year. The average admission usually results in nine days of hospitalization. At a conservative estimate of \$800 dollars a day, the five percent decrease represents a savings of \$2.2 million dollars per year.

AMH can also demonstrate a decrease of 18 percent in the number of people who were civilly committed per year from 2003 through 2007. A person who is civilly committed has been judged to be a danger to themselves or others or is unable to take care of themselves as a result of a psychiatric disorder. People who are civilly committed often spend long periods of time in structured residential services and/or the state hospitals at significant costs --\$413.5 million in the current biennium. One of AMH's goals is to promote recovery in the least restrictive level of care and EBPs have greatly contributed to the realization of this goal.

Involvement with criminal justice for both adults and adolescents receiving mental health and addiction services is another important issue for AMH services to address. Among caregivers of adolescents receiving mental health services, roughly 25 percent indicated that coordination with county juvenile justice and/or Oregon Youth Authority (OYA) was important to services. Jails and prisons are not good settings for providing mental health services.

Based on a caregiver report for youths receiving mental health services, AMH noted a major reduction in the number arrested within the year after services began (2.9 percent) compared to the year prior to services (5.8 percent).

Based on self-report, adults receiving mental health services indicated a decrease in the number arrested within the year after services began (1.3 percent) compared to the year prior to services (12.6 percent). This is consistent with many other reports on the effect of services to adults.

Adults also spent less time in jail in the year following initiation of mental health treatment. A representative sample of clients indicated that they spent an average of 5.54 days in jail during the year prior to treatment beginning, but only an average of 0.37 days in jail during the year following treatment starting. This is not meant to imply that the number of people with mental illness in county jails and/or state prisons has been decreasing, just that service made an impact on this sample of survey respondents.

Important outcomes related to criminal justice clients are also seen within drug and alcohol treatment services. Since the beginning of ORS 182.525, adult clients with criminal justice referrals completing outpatient addictions treatment were 7.9 times less likely to be arrested during treatment compared to those not completing treatment in the same time period. Youth clients with criminal justice referrals who completed addictions outpatient treatment were 3.1 times less likely to be arrested during treatment compared to those not completing treatment in the same time

period. Completion rates for these clients generally range in the 60 to 70 percent range and are greatly facilitated by evidence-based practices.

Implementation of the work required by ORS 182.525.

After extensive consultation with stakeholders, AMH adopted an operational definition of evidence-based practice for use in implementing ORS 182.525. AMH also established a policy and procedure for identifying, evaluating, approving and listing evidence-based practices and programs. There are six criteria used to evaluate a practice as evidence-based:

- Transparency in development;
- Research published in peer review journals;
- Standardized implementation;
- Replication in various locations and research findings;
- Fidelity scales associated with practice; and
- Meaningful outcomes associated with the practice.

These criteria are consistent with components discussed in the research literature and are as, if not more, stringent than criteria often used by national bodies that review practices for their evidence base.

Providers and stakeholders continue to review and revise AMH's EBP definition. An internal steering committee reviews policy issues and evaluates input from a broad-based stakeholder group which meets quarterly. As a result of this process, 167 addiction, mental health and prevention practices have met AMH EBP criteria. Of seventeen practices submitted in 2007-08, eight met the criteria.

According to work published in the Journal of Behavioral Health Services & Research (2008) by Traci Rieckmann at Oregon Health & Sciences University, in 2007 Oregon remained the only state in the nation with fully operational legislative mandate to implement evidence-based practices for alcohol, drug, and mental health treatment and prevention services.

EBP reporting methodology

For the 2007-09 biennium, 54 percent of AMH treatment funds were expended on EBPs. This meets the required 50 percent goal and equates to roughly \$238.6 million spent on EBPs by the providers responding to the survey.

AMH's current administrative databases do not capture information directly regarding all EBPs because the systems became operational in the early 1980s. The data was collected through an extensive survey process directed at the providers of

treatment services. AMH had already established an inventory of providers implementing EBPs. AMH surveyed these providers asking them to describe their current status in regards to EBP implementation, including the costs of EBPs. This methodology does not yield a 100 percent response rate, which means the percent of expenditures on EBP is an estimate.

AMH would greatly prefer to produce this information from available administrative data sets, rather than the survey process. The data systems created in the early 1980s were not constructed to collect this type of information, nor can the systems be changed to collect the information. While the data systems provide information to track numbers of individuals enrolled in services, the length of time in service, basic demographics, and allow staff to measure many outcomes, they cannot be revised to support changes in treatment delivery. DHS currently has a policy option package that if funded would address data issues, including tracking EBP.

Determining the status of EBP implementation

AMH uses a variety of methods to measure contract and administrative rule compliance. Since measuring the implementation of EBPs requires specific attention, AMH established a baseline percentage of expenditures in EBPs by conducting structured surveys of providers.

- In February 2005, AMH asked the Community Mental Health Programs (CMHPs), and other providers to estimate the amount of funds spent on specified EBPs. Based on the results, AMH determined that the percentage of public funds expended on EBP for substance use prevention and treatment was 56 percent. For mental health services, the baseline was 33 percent of **state** funding used to support EBPs.
- In 2007, AMH asked providers for an inventory of the EBP approved practices they were using. AMH posted the results by county on its EBP website, <http://www.oregon.gov/DHS/mentalhealth/ebp/inventory-map/main.shtml>.
- In May 2008, AMH surveyed the CMHPs, providers, treatment programs with direct contracts, County Prevention Programs, and the Oregon State Hospital. The result indicated that 54 percent of treatment funds are spent on EBPs.

AMH is in the process of revising many of its rules associated with treatment. The rules will incorporate important infrastructure associated with the implementation of EBPs and will become a part of AMH's approval and licensing process. Recent contracts have also focused on EBPs. Funding approved by the 2007 Legislature earmarked specific EBPs, such as supported employment and early identification of psychosis services. AMH established a "Center of Excellence" for supported employment to act as a resource for high fidelity implementation of supported employment. This is a model AMH intends to follow for other EBPs, following examples from other states.

Focus on fidelity

In 2007, AMH began focusing on fidelity of practice. Fidelity is important as the effectiveness of a particular EBP depends on how accurately the provider has followed or replicated the essential elements of the model defined in the research. Incomplete or ineffective adherence may result in outcomes not meeting expectations. AMH is focusing on fidelity for those practices that have been widely implemented according to provider surveys.

The immediate goal of the project was to collect data and develop protocols for the AMH fidelity review process, to prepare AMH staff and "peer" providers to conduct fidelity reviews, and increase provider knowledge about the implementation of the EBP practice reviewed. The long-term goal is to develop a learning community comprised of "peer reviewers" and providers.

AMH began the fidelity process by selecting mental health, substance abuse treatment and prevention practices. Over the last two years, AMH has trained 52 external providers, consumers, and AMH staff on the components of conducting a fidelity review. Those trained have conducted fidelity reviews on 20 programs. In 2008, AMH added the component of including consumers to our review teams and will continue to focus efforts on this in the future. A report summarizing the process, results of the reviews and recommendations to AMH regarding future training, technical assistance and next steps was distributed to AMH management, the EBP Steering Committee and Stakeholder Group. The report is posted on the AMH EBP web page.

The current survey that supplied data for AMH's EBP funding estimates for 2007-09 asked for information regarding programs' efforts to monitor fidelity.

- Most of the programs use structured clinical supervision and/or quality assurance activities to monitor adherence to practice criteria.

- Roughly half of the providers use actual fidelity reviews or individual clinician proficiency reviews.
- A small percentage use tools such as the Corrections Program Checklist to review standards.

The providers also indicated the status of implementation of a given practice based on their review process. Roughly 70 percent felt that they were in the middle or late stages of implementation. The remaining programs were in the early stages of practice implementation.

Evidence-Based Practices and cultural competence

AMH will continue to work with providers and researchers to identify and disseminate information about EBPs that are particularly appropriate or promising for programs and providers serving diverse populations. AMH continues to seek opportunities to apply technical assistance resources to expand and improve the delivery of EBPs to diverse populations.

In 2007, the Oregon tribes held their “First Gathering of Tribal Researchers and Evaluators” to discuss concerns that AMH’s overall EBP framework places Native American programs at a disadvantage. These concerns stem from the knowledge that research related to practices delivered by Native American program remains small and these programs may feel pressure to replace practices that have strong cultural validation with practices on the AMH list. Representatives of the Tribes drafted a position paper of their concerns and presented it to AMH administration.

Since scientific evidence for imposing practices on Native American providers is lacking, AMH concluded that a different framework was needed for working with the Native American stakeholders. Native American stakeholders have taken a primary role in designing and developing a framework for evaluating and disseminating effective practices for the Native American culture and values.

In 2008, Oregon Tribes held their “2nd Gathering of Tribal Researchers and Evaluators”. At this meeting criteria were developed for evaluating Native American practices. The criteria ensure that a practice is being provided by trained persons and follows the history and general guidelines of the practice in order to provide positive outcomes. Approval is granted by a panel of Native American elders in the field of addictions and mental health. This criterion is being piloted. Results and recommendations will be provided to AMH early in 2009.

In the spring 2008, Oregon held its first African American Summit on Best Practices and Peer Delivered Services. The day included presentations on future funding for recovery mentors and the state's commitment to African American treatment, evidence-based practices, gambling, and implementation of the Network for the Improvement of Addiction Treatment practices. Over 200 community members and providers attended.

In the summer 2008, AMH collaborated with NFATTC and the Latino Addiction Professionals group for the 2nd annual Latino Institute. This training was specific for Spanish language providers and covered Latino issues in the treatment and mental health field. Approximately 85 Spanish-speaking providers attended this presentation.

Workforce development

Over the past two years, AMH has sponsored or co-sponsored approximately 158 days (1,264 hours) of training on evidence-based practices. AMH has provided training to over **3,000** of our providers on specific EBPs, strategies for successful implementation and adherence to the model.

The Change Leader Institute

The Change Leader Institute is a training and technical assistance project co-sponsored by AMH and the Northwest Frontier Addiction Technology Transfer Center (NFATTC). The goal of the projects is to maximize the skills of leaders who are implementing change in their agencies. Participants study a variety of change models and explore effective leadership skills in the implementation of change initiatives.

Twenty people participated in the project, which involved five training sessions scheduled in 2007 and 2008. This included diverse cultural representation, individuals in recovery and leaders in a variety of service systems.

The change leaders completed a variety of individual change projects including implementation of evidence-based practices and other service improvements. To assist participants with their change projects and development of their change leadership skills, the project coordinators provided on-site individual consultation in addition to formal training. AMH will conduct a follow-up survey to assess the outcomes of the project at the beginning of 2009.

Center for Excellence

Oregon Supported Employment Center for Excellence is proud to be part of a national movement to provide evidenced-based services such as supported employment. Currently, Oregon has 14 evidence-based supported employment sites across the state. Some of the Center's activities included conducting baseline fidelity reviews for new supported employment sites, developing fidelity action plans with sites, and conducting on site trainings. Additionally, the Center has coordinated a statewide supported employment training in conjunction with Portland State University.

All supported employment sites have shown progress in implementing the model; the numbers of people served and the number of jobs obtained have increased significantly. The following data provides a summary of the last quarter:

- 646 people received supported employment services.
- 39% (254) worked in competitive employment vs. roughly 20% in the general mental health treatment population.
- 197 new enrollees started supported employment.
- There are 38 part and full time employment specialists across the state.

Conclusion

The changes brought about by ORS 182.525 have provided a strong impetus to Oregon's efforts to move toward a treatment and prevention system based on evidence. Using this foundation, we expect the field to become progressively more reflective of what research indicates will produce the best outcomes for consumers, families and communities. The ultimate result will be improved services and a lasting positive impact on the lives of thousands of Oregonians.

While AMH had worked on the implementation of EBPs prior to ORS 182.525, the efforts during the past five years have impacted important parts of the system including decreasing the number of people admitted for acute psychiatric care in hospitals and a decrease in the number of people civilly committed. Most importantly EBPs have helped by promoting a system of mental health and addiction services and supports that foster quality of life, self-determination and recovery through community-based planning and education.

The 2009-11 goal is 75% of treatment funds will support evidence-based practices. To achieve this goal AMH will look to a number of possibilities:

- Financial incentives and mechanisms;

- Improving Medicaid reimbursement rates for select practices;
- Use of regulations and accreditation;
- Writing integrated rule for addictions and mental health services;
- Education and training; and
- Infrastructure development.

In addition, AMH will thoroughly examine the current strengths and weaknesses in the approach to implementing EBPs in the publicly funded addictions and mental health system. The current definition for EBPs was developed five years ago. It needs to be re-examined. In addition, other processes AMH established regarding EBP need to be compared to national trends and accomplishments in other states. This self examination will ensure that AMH is implementing EBPs as effectively as possible and demonstrating best practices as an administrator of public funds. It also fits squarely with the transformation initiative the Department of Human Services is currently engaged in to become a leaner, more efficient, and effective organization.