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March 13, 2012

TO: The Honorable Senator Alan Bates, Co-Chair
The Honorable Representative Nancy Nathanson, Co-Chair
Joint Ways and Means Human Services Subcommittee

FROM: Linda Hammond, Interim Director
Addictions and Mental Health Division

SUBJECT: Response to Questions from Addictions and Mental Health Division Presentation to Subcommittee, February 25-27, 2013 & March 5, 2013.

Thank you for the opportunity to provide information about the Addictions and Mental Health division (AMH) to your committee. The following are responses to questions/requests from committee members during the presentation.

Questions from February 25, 2013

1. Provide information regarding interface with primary care providers, now and in the future.-Senator Steiner-Hayward

Physical Health and Behavioral Health Integration
Currently integration of physical and behavioral healthcare occurs in pockets around Oregon. Examples of integrated services include:

- Benton County operates integrated health centers that are accredited as Tier 3 Patient Center Primary Care Homes
- In Roseburg, the Harvard Medical Park primary care clinic has a behavioral health professional embedded in the clinic.
- Central City Concern provides integrated health services in Portland.

In the future the goal is for these exceptions become the rule. In January CCOs submitted draft Transformation Plans that addressed 8 focus areas. The first area is the integration of physical health and behavioral health. Innovator Agents will work

with CCOs to facilitate the implementation of the Transformation Plans. The Governors Balanced Budget includes $15 million to incentivize integration the integration of physical and behavioral healthcare.

2. Is there research around the long-term effects of methadone use and suboxone?- Senator Winters

Long-term Methadone and Buprenorphine Use: AMH conducted a literature review to respond to the first part of this question. Methadone has few adverse biological effects. The research on this topic suggests no dangerous or troubling psychological effects from long-term administration of methadone. The most common and enduring complaints after 6 months to 3 years of continuous methadone treatment are sweating, constipation, abnormalities in libido and sexual functioning, sleep abnormalities (insomnia and nightmares), and altered appetite (mild anorexia, weight gain).*(See attachment A for back-up documentation)*

The long-term effects of buprenorphine have not been studied extensively due to the short time on the market. However, experts suggest that they may be similar to those of other opioids. Upon cessation, some long-term effects of buprenorphine may persist and include depression, fatigue, and insomnia. As this medication continues to be used to treat opiate addiction, and more studies are conducted, more will be revealed about the effectiveness as well as long-term effects of this medication.

Oregon Lengths of Stay: The average length of stay for patients in methadone maintenance therapy in Oregon is 3.59 years. Data was analyzed for the calendar year 2011 and includes patients who successfully completed treatment (N=118) and patients whose cases were closed as other than successfully compete (N=1,513). In the latter group, reasons for case closure vary and include patients who moved out of the area, transferred to another clinic, were closed due to non-compliance with clinic agreements, or who left services against clinic advice.

3. How much money actually reaches the client after administrative costs -- provide data after looking at services delivery numbers and funds. -Senator Winters

The Association of Community Mental Health Directors surveyed the counties and report that the average administration cost associated with state funding for the counties is approximately 5%. AMH provides some Local Administration Funding which is 4.5% ($10.7 million) of the Total Funds ($430.6 million) for the community mental health. This is based on the 11/13 LAB.

4. The committee would like to hear more about how we coordinate and collaborate with other agencies. -Senator Steiner-Hayward

The Statewide Children's Wraparound Initiative (SCWI) is a joint project of OHA, Addictions and Mental Health Division (AMH) and DHS Child Welfare. Key managers from the two agencies direct this project. *(See attachment B-SCWI July Progress Review Summary)*

As OHA was developed as separate from DHS some organizational structures were put in place to facilitate coordination and collaboration. The Joint Policy Steering Committee addresses policy issues that cut across the organizations and the Joint Operations Steering Committee focus on shared operations. These committees provide the opportunity address concerns before they become problems and to identify opportunities for collaboration.

5. How much does OHA spend on ITRS and how much does DHS spend? What about Housing and Community Services? -Senator Winters

The 2007 Legislature invested $10.4 million in addiction treatment and recovery services for parents involved in the child welfare system or at risk of involvement. The initiative became known as the Intensive Treatment and Recovery Services (ITRS) initiative because the aim is to provide a range of clinical and recovery support services for parents specifically focused on helping people achieve recovery while improving parenting skills. AMH administers these services in close partnership with DHS Child Welfare. Neither DHS or Housing and Community Services fund ITRS.

6. Please provide the profile of problem gamblers and the connection to domestic violence, foster care, etc.-Representative Nathanson

It is difficult to provide a stereotypical profile of a problem gambling client. Anecdotally we know that even spouses and significant others are often unaware of gambling problems until creditors start calling or it is discovered that credit cards are maxed out and sometimes retirement savings are wiped out. What we do know is that there is most likely a common denominator related to trauma, especially early childhood trauma.

Males and females are equally represented in both the Oregon gambling population and the Oregon treatment population with approximately 51.4% females and 48.6% males. The average age of those accessing treatment was 47.6 years with males typically being younger (45.9 years) than females (49.1 years). Client ages usually range from 18 years to the mid-eighties with about 9.5% being 65 years or older. Over 1,300 individuals enrolled in treatment this past fiscal year. The average problem gambling client is a high school graduate; 36.8% were in full-time employment with an average household income of $32,000. The average gambling debt was $26,739. Unfortunately we do not have empirical evidence relating to child welfare involvement.
(See attachment A for back-up documentation)

7. Provide a comparison between Oregon and other states with similar lotteries. - Senator Steiner-Hayward

The Oregon Council on Problem Gambling commissioned three population based prevalence studies. The first, in 1997, reported a problem gambling rate of 1.9% and a pathological gambling rate 1.4%. A replication of that study in 2001 found the problem gambling rate of 1.4% and a pathological rate of 0.9%. The third study, also a replication study, found a problem gambling rate of 1.7% and a pathological rate of 1.0%. The combined rates were 3.3%, 2.3%, and 2.7%. An early meta-analysis in 1997 of 50 previous U.S. and Canadian studies estimated the average rate at 3.9%.

A most recent study (2012) found an average rate of 2.2% across U.S. states. That study found Mississippi, Louisiana, Nevada, Minnesota, and New Jersey with a higher than average rates and lower than average rates in Florida, Indiana, New Mexico, Wisconsin, Kentucky, Delaware, North and South Dakota, and Iowa. Oregon was considered in the intermediate rates. It should be noted that rate is an adjusted rate, not calculated by the same process as the Oregon studies. In that report Oregon “scored” 2.2% also.

An interesting comparison of state funding for problem gambling services was completed in 2010 by the Association of Problem Gambling Service Administrators. That study found the Oregon had the highest per-capita investment in problem gambling services of any state at $1.61 with Maryland as the lowest with $0.01. The average investment was $0.33 per-capita.

Due to the difficulty stemming from methodological difference among prevalence studies, and the unavailability of data, a timely and meaningful comparison of the identified states by prevalence rate was not possible. Nor was a complete comparison of Lottery activities readily comparable. Nonetheless, there were figures available on the per-capita sales for all states with lotteries and that information is provided in the accompanying table for comparison.

Per-Capita Treatment/Prevention Investment and Per-Capital Lottery Sales		
State	**Per-Capita Treatment/Prevention Investment 2010**	**Per-Capita Lottery Sales 2011**
Oregon	$1.61	$82.00
Iowa	$1.35	$90.00
Delaware	$1.18	$139.00
Indiana	$0.80	$123.00
Nebraska	$0.75	$73.00
Connecticut	$0.58	$288.00
Louisiana	$0.55	$85.00
Nevada	$0.50	na
North Dakota	$0.50	$35.00

The menu of state funded treatment and prevention services includes awareness, prevention, helpline, treatment, research, training, certification, evaluation, and in some cases other activities.

Oregon's Problem Gambling Services are guided by a public health paradigm and approach that take into consideration biological, behavioral, economic, and cultural and policy determinants influencing gambling and health. It incorporates prevention, harm reduction and multiple levels of treatment by placing emphasis on quality of life issues for gamblers, their families, and communities. By appreciating the multiple dimensions of gambling, Oregon's Problem Gambling Services have been developed to incorporate strategies that minimize gambling's negative impacts while recognizing the reality of gambling's availability, cultural acceptance, and economic appeal.

The most frequent access point to treatment is a call made to the state's Problem Gambling Help-Line (877-MY LIMIT). The Help-Line is staffed 24 hours a day by

professional counselors with problem gambling expertise. Callers are informed that problem gambling treatment services in Oregon are no cost to them or their families and are confidential. When appropriate, counselors conduct brief assessments and motivational interviews with callers. The counselor then makes referrals based on screening information, clinical judgment, and available resources. To facilitate a successful referral, Help-Line counselors can use three-way calling to place the caller in contact with the referral agency and offer follow-up calls to provide further support. In 2009 a web-based, real-time chat capability was introduced and is maintained by the helpline staff.

Typically the treatment system follows a stepped-care approach beginning with a home-based, telephonically supported minimal intervention program that is available for individuals who live too far away from brick-and-mortar facilities to make commuting sensible. Originally designed as an intervention for those with less severity, the effort has proven to be utilized by many with severity similar to those entering traditional outpatient programs. Traditional outpatient programs comprise the bulk of the treatment effort, supported by limited availability of short term, residential respite programs (typically three to no more than five days' stay), and finally with a residential program with a typical one-month length of stay.

To facilitate timely and convenient care from the traditional outpatient programs, field tests were successfully undertaken to determine the efficacy of technology-based counseling sessions (telephonic and web-based [e.g., Skype]) that have become institutionalized. Also, efforts continue to be made to provide culturally specific treatment with Asian, Latino, Native American, and Black/African American programs or program components.

8. Provide service numbers for problem gambling-Senator Winters.

The six-month sample was 168 successful completers and the enrollment survey was completed by 1,081 individuals. Clients can only be followed with a signed informed consent for which approximately 60% of clients volunteer. Out target is 70% of 25% of those eligible.

9. What is the program completion rate and drop-out rate for problem gambling? - Senator Steiner-Hayward

Gambler Completion Status by Gender
(In Percent)
(n= 1,242)

Status	All	Males	Females
Adjusted Successful Completion Rate*	45.7	42.7	48.5
Stopped Attending ASA*	42.2	44.8	39.7
Successful Completion*	35.7	33.6	37.7
Evaluation Only	5.7	3.0	2.5
Moved from Catchment Area	4.1	0.3	0.3
Refused Service	3.3	3.5	4.7
Further Treatment Not Appropriate	2.7	3.0	3.6
Conflicting Hours	2.2	0.5	0.2
Physical/Mental Illness	1.0	1.0	0.5
Incarcerated	0.7	0.3	0.3
Non-Compliance With Rules*	0.3	6.8	4.7
No Transportation	0.3	0.2	0.2
Deceased	0.3	0.3	1.7
Program Closure - Non-Cap	0.2	2.1	2.2
Unknown	1.3	0.6	1.7

*Used for Adjustment

The adjusted successful completion rate is calculate by including those who graduated, those who stopped attending, and those who were asked to leave the program due to non-compliance with rules. A successful completion is defined by policy when the client has completed at least 75% of the treatment plan, has been problem free for the past 30 days, and has a continuing wellness plan.

It should be noted that this is a volunteer (non-mandated) treatment population. A special study conducted earlier with those individuals who "dropped" from treatment found that majority reported that they felt they had received enough care. Also of interest is the finding by Substance Abuse and Mental Health Services Administration that the average treatment completion rate for substance abuse treatment was only 47% and this included mandated clients.

10. Provide problem gambling data showing ethnic breakdown. -Representative Gallegos

There is evidence that members of minority populations have increased prevalence of problem gambling.

Race & Ethnic Composition (percent)

	Problem Gambling Treatment Population
White	85.5
Hispanic	4.4
Asian	3.4
Black	3.3
Native American	1.5

11. Problem gambling – read a study from 1976 –age.-Senator Winters

Breakdown by Age:

The average age of enrolling clients was 47.6 years. The median age was quite similar at 47.3 years. The median age for males was 45.4 years and that for females was 49.2 years. The accompanying table provides the number of clients by age group. It should be noted that clients below the age of 25 have been quite limited as expected.

Age by Group (In Years

Years	n
18 - 24	17
25 - 34	227
35 - 44	334
45 - 54	383
55 - 64	252
65 +	107

12. Why isn't EASA in more than 17 counties? What is the penetration? Over the next few weeks develop a business plan for EASA statewide with full penetration over the next two biennia. Provide longitudinal data, when did program start, how does it reduce hospital utilization, etc.-Senator Bates & -Senator Winters.

Status of Current System
Schizophrenia and other psychotic disorders affect three in 100 individuals. Until very recently, psychosis was considered a life sentence to disability, crisis and poverty. Mid-Valley Behavioral Care Network (MVBCN) and its partners began reversing this reality when they created the Early Assessment and Support Team (EAST) in 2001. In 2007, the Oregon legislature funded the beginning of a statewide expansion of EAST, and the Early Assessment and Support Alliance (EASA) was born. Since that time, hundreds of young people and families have had a fundamentally different treatment experience than what existed prior to EASA.

Current Funding for EASA, including funding to sites and support for training and technical assistance is $4.3 million per biennium.

MVBCN TA Center
The current technical assistance (TA) center provides training, TA and fidelity review as well as data collection. AMH general funding to the current TA Center is $42,000 annually. The TA center operations have been subsidized by MVBCN by approximately $300,000 per year since the inception of EASA.

Service Sites
Coverage and Access
- 15 sites provide services to 19 counties.
- Existing sites are in Clackamas*, Clatsop, Columbia, Deschutes, Douglas*,Hood River, Wasco & Sherman, Lane, Linn, Marion, Multnomah, Polk, Sherman & Wasco (combined) Tillamook, Union, Washington, and Yamhill. *These sites are not currently provided AMH EASA funds.
- 11 of the sites are in rural counties and all sites combined cover 81% of the eligible Oregon population
- Of the over 2000 teens and young adults referred since 2008, 884 were enrolled into ongoing services. Referred individuals may be screened out because their symptoms are inconsistent with a schizophreniform or bipolar spectrum psychotic disorder, because their IQ is under 70, or because the family declines services.
- Outreach and community education is a key component to access and utilization; access remains challenging

Site Funding Sources and Payer Mix

Sites utilize private and public pay insurances to pay for services for those young adults that have insurance. AMH funding is intended to pay for services that are not covered by insurance of any kind.
35% of young adults over 18 are uninsured as of December 2012, compared to 7% of those ages 18 and under. 34% of both groups have private insurance.

What We Have Learned

- Community Education and Referral along with are key to access
- There are significant gaps between what insurance pays and the true costs of the program
- EASA is a conduit to other service and community supports (employment, housing, connections) for young adults with mental health challenges. These are instrumental in the success of the young person.

Moving Forward-13-15 Implementation Strategy

The follow are the anticipated uses for the additional $1.8 million biennial EASA funds:

PSU/RRI Center for Excellence

Funding under proposed 13-15 budget: $125, 000 in general funds per year

- Funding will support the move from TA from the MVBCN to the PSU Regional Research Institute as a center for Excellence. This move is critical for EASA and Mental Health System Development for Young Adults
- Current levels of training, TA, and fidelity review will be maintained
- New funds will focus on state-wide infrastructure development and sustainability, including technical assistance to new and developing sites, state-wide evaluations, monitoring, strategic utilization of funds, and sustainability
- The Center for Excellence will continue to seek diversified sources in order to sustain its operations

Service Sites

Funding anticipated to go toward EASA site development in the 13-15 Budget: $825,000 per year

- These funds will be available as part of the flexible funding going to counties to support their prioritized services

- These funds can be used for start-up costs including public education (needed to get young adults into the program early on), training and materials, community integration including linkages between EASA and CCO's, and predominantly clinical services
- The additional funding will be used to bring the Eastern Oregon region on line within the year through GOBHI and AMH is initiate planning with the provider community in Jackson, Josephine, Klamath, Cooks and Curry.

Funding Strategies for Implementation and Sustainability
In order to move EASA into state-wide coverage under the proposed funding recommendations, several key strategies will take place:

- Making inroads into private pay parity and the private insurance market.
- Increase the number of EASA clients covered by insurance, both public and private.
- Increase the types of EASA services and activities covered or subsidized by Vocational Rehabilitation (VR) and other partner sources.

13. How much does the state pay for Intoxicated Driver Program Funds (IDPF) devices? -Representative Nathanson &Senator Bates.

So far, during the 2011-13 biennium, AMH has administered IDPF to assist 271 persons monthly with Ignition Interlock Device (IID) installation and monthly monitoring. The installation fee is $53 and the monthly device check/monitoring fee is $53 for an annual cost of $689 per person assuming the device is installed and maintained for a period of 12 months. AMH contracts with an entity to carry out the IID installation and monthly device monitoring for indigent DUII offenders. During the 2009-11 biennium, the contracted amount for this activity was $115,000. For the 2011-13 biennium, AMH has increased the contract limit to $500,000 due to legislative changes made during the 2011 session requiring more people (Diversion population) to install the devices. An estimated compliance rate for individuals requiring the IID installation is 25 - 30% according to the ODOT Traffic Safety Commission.

Questions from February 26, 2013

1. DHS programs related to Wraparound (slide 18), are these programs overlapping? Requested a meeting with Erin Kelley-Siel to make sure we are working together. Duplication and gaps – the legislature provides funds to multiple departments for the same objective - look at the silos and the different agencies. SB 450 may get us closer? -Senator Bates, Senator Steiner-Hayward, Representative Nathanson & Senator Winters.

The Statewide Children's Wraparound Initiative (SCWI) is a joint project of OHA Addictions and Mental Health Division (AMH) and DHS Child Welfare. Key managers from the two agencies direct this project. *(See attachment B-SCWI July Progress Review Summary)*

As OHA was developed as separate from DHS some organizational structures were put in place to facilitate coordination and collaboration. The Joint Policy Steering Committee addresses policy issues that cut across the organizations and the Joint Operations Steering Committee focus on shared operations. These committees provide the opportunity address concerns before they become problems and to identify opportunities for collaboration.

2. Provide schematics that tie together the information on what DHS and OHA is doing related to wraparound and like programs. -Representative Gallegos

From the start of the Statewide Children's Wraparound Initiative (SCWI) AMH and DHS Child Welfare worked with stakeholder input to identify metrics that would be used to monitor progress of project. AMH developed a technical solution to gather many of the data elements. The project issues regular progress review reports that focus on the outcome data. *(See attachment B-SCWI July Progress Review Summary)*

3. Provide more about plans for integration of physical and behavioral health as a whole.-Senator Steiner-Hayward.

See response to 2/25/13 question #1

4. Provide ROI data on investment in A&D prevention. -Senator Steiner-Hayward

A number of studies have been conducted that look at the cost-benefit of providing substance abuse prevention programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported in 2008:

- The average effective school-based program costs $220 per pupil. It would save an estimated $18 per $1 invested.
- Among 10 effective school-based life skills programs, the average return on investment exceeded $15 to 1.

Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

5. Provide break down of county funding to see whole picture including the breakdown between alcohol and drug funding. *(See attachment C)* -Senator Winters.

6. Provide information on partnership with college health centers related to A&D and any work we do with OLCC. -Representative Nathanson

Through the Strategic Prevention Framework State Incentive Grant (SPF-SIG), a number of collaborative efforts between community prevention providers and Oregon Colleges/Universities are taking place to reduce high-risk and binge drinking. Specific projects include: Social marketing messages around high-risk drinking, sleep hygiene, mental health and stress issues, and gambling and addiction issues; Working with City Councils and University Presidents to address community livability issues around alcohol use; Educating incoming freshmen about high-risk and binge drinking; Developing strong partnerships with school housing coordinators; Establishing prevention coalitions with a focus of building relationships with local university and college partners; Passing social host ordinances; Working with local grocery stores to remove alcohol displays that promote high-risk drinking games; Assessing the feasibility of extending student codes of conduct to off-campus issues and creating a restorative justice program for adult MIP offenders; and, Hiring student "peer educators" to assist in efforts to reduce underage and binge drinking on campus.

The prevention work related to high-risk and binge drinking noted above is currently being implemented in conjunction with a number of college and university groups, including: Oregon State University (Student Health Services, Office of Student Conduct, and the campus law enforcement agency – Oregon State Police),

Clackamas Community College, Central Oregon Community College, Southern Oregon University, University of Oregon, Eastern Oregon University, Oregon Health & Sciences University, and Pacific University.
(See attachment A for back-up documentation)

7. Provide information on community residential facilities and 16-bed facility - who, where and cost, plus number of forensic patients and gero patients. -Senator Bates & Senator Winters.

Addictions and Mental Health Division
Updated 3/6/13

State Hospital Annual Cost of Care

Blue Mountain Recovery Center (Pendleton)	$229,482
Civil Commitment (Portland and Salem)	$349,928
Geropsychiatric (Salem)	$260,436
Forensic (Salem)	$247,632

Data Source: DHS, Institutional Cost of Care Rates, 2011-2012

Estimated Average Cost of Care in Adult Community Residential Facilities
Total Funds

Facility Type	Annual Average	Annual Range
Secure Residential Treatment Facility	$172,320	$273,180 to $139,044
Residential Treatment Facility	$67,800	$131,844 to $28,356
Residential Treatment Home	$101,640	$385,224 to $53,275
Adult Foster Home	$26,760	$119,472 to $10,992

Data Source: 2011 RBASE and MMIS

Adult Mental Health Residential Facilities and Capacity
Addictions and Mental Health Division
March 7, 2013

Data Source: AMH Consolidated Database
AHF: Adult Foster Home RTF: Residential Treatment Facility
RTH: Residential Treatment Home SRTF: Secure Residential Treatment Facility

County	Total Facilities	Facility Beds	AFH		RTF		RTH		SRTF	
			Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
Benton	5	29	2	8	1	13	2	8	0	0
Clackamas	21	156	6	29	5	46	8	33	2	48
Columbia	3	30	1	5	2	25	0	0	0	0
Coos	7	36	5	25	1	6	1	5	0	0
Curry	2	13	0	0	1	8	1	5	0	0
Deschutes	6	41	2	10	0	0	3	15	1	16
Douglas	6	23	6	23	0	0	0	0	0	0
Grant	1	11	0	0	0	0	0	0	1	11
Harney	2	15	1	5	1	10	0	0	0	0
Jackson	21	109	20	93	0	0	0	0	1	16
Josephine	10	89	4	20	1	10	1	5	4	54
Klamath	7	45	6	29	0	0	0	0	1	16
Lane	31	189	22	103	4	43	2	10	3	33
Lincoln	2	9	0	0	0	0	2	9	0	0
Linn	6	29	1	5	1	7	4	17	0	0
Malheur	6	29	6	29	0	0	0	0	0	0
Marion	27	285	17	81	5	60	3	15	2	129
Morrow	2	22	0	0	1	12	0	0	1	10
Multnomah	50	397	10	46	18	195	14	65	8	91
Polk	7	40	5	22	1	13	1	5	0	0
Tillamook	1	5	1	5	0	0	0	0	0	0
Umatilla	6	51	3	14	0	0	1	5	2	32
Wallowa	4	48	0	0	3	43	1	5	0	0
Wasco	1	12	0	0	1	12	0	0	0	0
Washington	21	104	12	55	3	22	6	27	0	0
Yamhill	3	26	2	10	1	16	0	0	0	0
Totals	258	1843	132	617	50	541	50	229	26	456

8. Provide clarification on "prevalence chart" and who it reflects.- Senator Steiner-Hayward

Each of the columns in the referenced table is defined below:

In need of services

The estimated need for service for mental health service is based on general estimates provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) and are based on epidemiological studies commissioned by SAMHSA. OHA is required to use the estimates to help with planning documents submitted as a SAMHSA Block Grant requirement.

The studies used a series of diagnostic questions to help differentiate the severity of needs. Demographic information was also collected to understand its impact or correlation with mental illness. These can be useful for refining estimates in smaller geographic areas. For adults, a state level general estimate of 5.4 percent was chosen. For children, there was such a strong correlation with poverty rates that states use poverty rates to pick within a range of eight to 13 percent for the prevalence rate. Based on the most recent poverty information, Oregon uses 12 percent, which is at the high end of its associated prevalence range.

The estimates for adult and children are focused on individuals with severe needs. If the rates were for more general mental health concerns the rates would be higher.

The estimate for the need of addiction services in Oregon comes from the National Survey on Drug Use and Health (NSDUH). The NSDUH is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). This survey is the primary source of information on prevalence of alcohol, tobacco and illegal drug use in the general U.S. civilian non-institutionalized population. It is a computer-assisted survey conducted at the person's residence. As a result the reader should be aware that some populations at greater risk for substance use or mental health disorders are not included in the survey sample (i.e. the homeless, incarcerated person and military personnel).

Survey data for two years are combined to yield prevalence estimates for substance use disorders in Oregon. A series of questions are asked to determine whether the person meets the DSM-IV criteria for substance abuse or dependence. Questions related to dependence ask about health and emotional problems associated with

substance use such as unsuccessful attempts to cut down on use, tolerance, withdrawal and spending a lot of time engaging in activities related to substance use. Questions on abuse ask about problems at work, home and school; problems with family or friends; physical danger; and trouble with the law.

People served in the public system
The counts of people served in the public system represent people served with state general fund, beer and wine tax, federal block grant, and Medicaid dollars made available through various contracts between OHA and providers, counties, and Coordinated Care Organizations.

Percent of need met through public system
This percent is simply the number of people served in the public system divided by the number in need of services. It only demonstrates the need being met by the public system administered by OHA. It does not account for services that may have been supported by private means, such as insurance or self-pay.

In addition, "need met" in this case is defined as access to services. Whether or not an individual's full service needs are met is not addressed by this table.

Questions from February 27, 2013

1. Provide more information about Opiod dependence and abuse – what is a physician to do with patient. Clarity around meaning of slide. -Senator Bates

Treating opiate addiction requires a patient-centered approach which may include withdrawal management, psychosocial interventions, and pharmacotherapy. Pharmacological interventions help alleviate the effects of opioids on the brain and reduce drug craving. Medications also help manage withdrawal symptoms. Over 40 years of addiction research demonstrates that both behavioral and pharmacological interventions are most effective for those with opioid addiction.

Medications used to treat opiate addiction include methadone, burprenorphine and naltrexone.

- Methadone, a synthetic opioid blocks the effects of heroin and other opioids; in therapeutic doses methadone eliminates withdrawal symptoms and relieves drug

cravings. Methadone has been used for over 40 years to successful treat heroin addiction. Opioid treatment providers licensed by the state provide behavioral and pharmacological interventions using methadone or buprenorphine for their patients.

- In October 2002, the Food and Drug Administration (FDA) approved the use of buprenorphine to treat opiate addiction. For some individuals buprenorphine, prescribed by waivered physicians (http://buprenorphine.samhsa.gov/) in an office setting in conjunction with outpatient addiction treatment is another option to treat an opioid addiction.

- In 2011 the FDA approved injectable naltrexone (Vivitrol) to treat opioid addiction. This intervention involves a once a month intra-muscular injection in a physician's office also in conjunction with outpatient addiction treatment.

Physicians who would like to learn more about prescribing burprenorphine for patients may explore the following web-link http://buprenorphine.samhsa.gov/). The link contains information about physician waiver qualifications, training and support.

2. Is the residential treatment system move to CCOs delayed? We need to be careful that we don't lose capacity, lose providers, etc. -Representative Freeman.

In 2011, House Bill 3650 directed the Oregon Health Authority (OHA) to change the health care system with the focus on Medicaid funded services. Senate Bill 1580 also directed OHA to change the health care system through transformation efforts and implementation of CCOs, referencing the need to "continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013." In addition to the residential chemical dependency treatment services, the Waiver Amendment approved by CMS stated Adult Residential Services would be integrated into CCO's, July 1, 2013. AMH is working to be in compliance with SB 1580 as related to the transition for alcohol and drug residential treatment to CCOs. While there is not a legislative directive pertaining to the mental health residential system in this area, AMH is phasing in the mental health residential treatment services beginning July 1, 2013 with one of the service components in an effort to be consistent with the CMS approved waiver. The rest will be phased in as of January 2014.

3. Provide data regarding Lottery revenue versus funds for A&D treatment. - Representative Freeman

The alcohol and drug treatment system is funded with a combination of Substance Abuse Prevention and Treatment Block Grant, Beer and Wine Tax revenues, State General Funds, federal Medicaid Match, and other funds. The problem gambling treatment system is funded solely through lottery revenues. The alcohol and drug treatment revenue sources combined make up a budget of nearly $100 million per biennium and are comprised of federal funds, State General Funds and Other Funds (primarily beer and wine tax revenues and court fines and assessments revenues). The problem gambling treatment services budget relies solely on the dedicated lottery revenue and equals roughly $8 million per biennium.

While the approach to treatment has similarities when it comes to problem gambling and addiction, prevalence rates and the treatment demand for these services are very different. About 300,000 Oregonians need some kind of intervention for a substance use disorder, while roughly 80,000 problem gamblers need assistance. There are multiple levers that contribute to more people seeking addiction treatment, mostly related to court mandates, criminal/juvenile justice involvement and child welfare involvement. The addiction services system is also a more established system with dedicated federal structures and funding dating back to the early 1970s. While the investment may appear small be comparison to other behavioral health systems, Oregon is one of the few states with dedicated investments in problem gambling treatment services.

4. Provide additional OSH staff turnover data. -Senator Steiner-Hayward

OSH Staff Turnover
In 2012, 261 staff left employment

- 42 retirements
- 219 separations (resignations & dismissals)

In 2012, 230 staff were hired, including full-time, limited duration, and temporary (relief pool) staff.

5. Provide additional information on the success/failure of the move to two tiers of GEI – SB 420 and HB 3100 from 2011 session. -Senator Bates & Senator Winters.

There is a new report being finalized this week which it will be forward to Linda Ames when it is complete.

6. Provide comparison of length of stay (LOS) total and post- ready -to-place (RTP). How long are people there, what does it cost us each day, does community placement allow better match? -Senator Bates

In 2012, .370 patients (Aid and Assist) had an average length of stay (LOS) of 72 days. This is an increase of one day compared to 2011, but a decrease of 7.5 days compared to 2010. The average LOS for 2012 is 13 days less than it was in 2008.

In 2012, the average length of stay for Guilty Except for Insanity (GEI) patients was 1016.5 days, an increase of 34.5 days compared to 2011.

In 2012, the average length of stay for civilly-committed patients was 148 days, a decrease of 13 days compared to 2011. The 2012 average length of stay for civilly-committed patients has decreased by 49 days compared to 2008.

Regarding forensic patients who have been assessed by their treatment team, the Oregon State Hospital Risk Review Panel, and by PSRB or SHRP (as appropriate), as being "Ready to Place":

Of the 35 Tier 1(Measure 11) patients who were discharged in 2012:

- 3 were discharged within 90 days of being designated as "Ready to Place"
- 9 were discharged within 180 days of being designated as "Ready to Place"
- 5 were discharged within 240 days of being designated as "Ready to Place"
- 9 were discharged within 360 days of being designated as "Ready to Place"
- 9 were discharged/conditionally released more than a year after being designated as "Ready to Place"

These patients, at times, exercise their right to refuse a placement that is offered to them. Thus, the length of time a patient remains on the "Ready to Place" list is not, in all cases, related to the absence of an available bed in the community.

Of the 34 Tier 2 (non-Measure 11) patients who were discharged in 2012:

- 2 were discharged within 90 days of being designated as "Ready to Place"
- 9 were discharged within 180 days of being designated as "Ready to Place"
- 6 were discharged within 240 days of being designated as "Ready to Place"
- 2 were discharged within 360 days of being designated as "Ready to Place"
- 5 were discharged/conditionally released more than a year after being designated as "Ready to Place"

These patients also, at times, exercise their right to refuse a placement that is offered to them. Thus, the length of time a patient remains on the "Ready to Place" list is not, in all cases, related to the absence of an available bed in the community.

Regarding the cost of care at Oregon State Hospital, the cost for a forensic patient is $678.44 per day.

7. How many of the OSH float pool positions are vacant?-Representative Tomei.

Of the 35 float pool RN positions, ten are currently vacant.

Of the 75 float pool Mental Health Technician positions, twelve are currently vacant.

It must be noted that the float pool vacancy rate fluctuates regularly, as staff in the float pool regularly fill in full-time vacant positions, as full-time staff retire or resign.

8. How much do furlough days cost/save OSH in our 24-hour facility? - Representative Tomei.

It would not be possible to specifically tie required overtime to a furlough day taken. However, an analysis of leave and overtime does show a correlation between the number of hours of leave – including sick leave, vacation, furloughs, etc – and the number of hours of overtime. Early in the 2011-13 biennium, 2 hours of overtime were seen for every 3 hours of leave. This ratio was very consistent until March 2012. At that time, the ratio changed to less than 1 hour of overtime for 2 hours of leave. This reduction was the result of creating an appropriate level of float pool positions and changes in scheduling that have reduced the use of overtime.

Using the above data, one could make the assumption that furlough time results in a similar amount of overtime. Using an average salary for the hospital of $3,952, one could project that every employee furlough day results in overtime costs of $136.80. At the current number of full-time staff, this would result in a cost of $242,546 for each mandatory furlough day.

9. Provide OSH OT expenses for past few years. -Representative Tomei.

The raw data shows:
$9,018,406 for 2009-2010
$10,612,466 for 2010-2011
$10,113,754 for 2011-2012
$5,799,781 for the first 8 months of 2012-2013

For the 2009-11 biennium, overtime costs were $19.6 million (not including associated OPE costs). This equates to an average monthly cost of $817,953. With negotiated salary increases, that average would be $842,261 in today's dollars.

At the beginning of the 2011-13 biennium, overtime costs were up, due to training costs associated with moving to the new hospital systems. The current average – last six months – is $730,525, or an 11% decrease from last biennium.

One thing that makes this comparison difficult is that the hospital has increased the number of units. The hospital currently has 28 units open, compared to 22 in 2009-11. In addition, the staffing changed in order as a result of treatment mall operations.

10.Provide community bed capacity details. -Representative Tomei.

Adult Mental Health Residential Facilities and Capacity
Addictions and Mental Health Division
March 7, 2013

Data Source: AMH Consolidated Database

AHF: Adult Foster Home RTF: Residential Treatment Facility
RTH: Residential Treatment Home SRTF: Secure Residential Treatment Facility

			AFH		RTF		RTH		SRTF	
County	Total Facilities	Facility Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
Benton	5	29	2	8	1	13	2	8	0	0
Clackamas	21	156	6	29	5	46	8	33	2	48
Columbia	3	30	1	5	2	25	0	0	0	0
Coos	7	36	5	25	1	6	1	5	0	0
Curry	2	13	0	0	1	8	1	5	0	0
Deschutes	6	41	2	10	0	0	3	15	1	16
Douglas	6	23	6	23	0	0	0	0	0	0
Grant	1	11	0	0	0	0	0	0	1	11
Harney	2	15	1	5	1	10	0	0	0	0
Jackson	21	109	20	93	0	0	0	0	1	16
Josephine	10	89	4	20	1	10	1	5	4	54
Klamath	7	45	6	29	0	0	0	0	1	16
Lane	31	189	22	103	4	43	2	10	3	33
Lincoln	2	9	0	0	0	0	2	9	0	0
Linn	6	29	1	5	1	7	4	17	0	0
Malheur	6	29	6	29	0	0	0	0	0	0
Marion	27	285	17	81	5	60	3	15	2	129
Morrow	2	22	0	0	1	12	0	0	1	10
Multnomah	50	397	10	46	18	195	14	65	8	91
Polk	7	40	5	22	1	13	1	5	0	0
Tillamook	1	5	1	5	0	0	0	0	0	0
Umatilla	6	51	3	14	0	0	1	5	2	32
Wallowa	4	48	0	0	3	43	1	5	0	0
Wasco	1	12	0	0	1	12	0	0	0	0
Washington	21	104	12	55	3	22	6	27	0	0
Yamhill	3	26	2	10	1	16	0	0	0	0
Totals	258	1843	132	617	50	541	50	229	26	456

Questions from March 5, 2013

OSH

1. How much are we spending on interpreters? -Senator Bates

In the first year of this biennium, the average expenditures for interpreters was $124,680 per month. An analysis showed that the hospital was using interpreters with skills for legal matters for all interpreters. This was changed to only use those with legal skills when dealing with legal matters. As a result, the current monthly average for interpreters is now $65,294, a 48% decrease in costs.

2. What is best practices for psychiatrist: patient ratio? Provide info on psychiatrist support team and if you need more psychiatrists on staff. -Senator Bates

The Western Psychiatric Hospital Association recently conducted a survey of member organizations on this issue, and the data is summarized on the attached table (See attachment D).

Analysis reveals that Oregon State Hospital's ratio of one psychiatrist to 15.2 patients is lower than ten of the thirteen States (range is 12.5 to 116.0) reporting.

It must be noted that two full-time psychiatrists at Oregon State Hospital do not carry a "caseload", since they are assigned to Forensic Evaluation Services, where they complete assessments of forensic patients (e.g., ability to aid and assist in their defense, or eligibility for the insanity defense).

Further, three psychiatrists are "supervising psychiatrists", and thus are responsible to provide direct supervision to assigned staff (i.e., to recommend clinical privileges, to lead case consultations, etc.). These three psychiatrists carry a smaller "caseload" than non-supervisory physicians.

Taking this into account, Oregon State Hospital has 35 full-time equivalent psychiatrists with full caseloads, a ratio of 1 to 17.1, which compares favorably to six other States in the Western region (i.e., five States have a lower ratio, eight States have a higher ratio).

3. Show comparison of OT between us and peer institutions. -Senator Steiner-Hayward

Pending information from Western Psychiatric State Hospital Association (WPSHA).

4. Compare regular positions, relief pool which is better re OT? Wants a better picture…"phase 2 type of thing" – inc. staff training. Analyze float workers, regular staff (PERS, etc.), limited duration. Provide the best staffing scenario to address OT. -Senator Bates, Representative Freeman, & Senator Steiner-Hayward

This analysis compares the cost of a regular staff person, a temp position, and the equivalent of 100 of full time employee (FTE) hours of overtime using an average salary of $3,952. The primary driver for the differences in costs are Other Payroll Expenses (OPE) which include fixed costs (Employee Relations Board, Workers' Compensation Division, and Flexible Benefits) and variable costs (Social Security and Public Employee Retirement System (PERS). Temporary employees do not receive PERS, so that variable amount is not included in the cost of temps.

Overtime cost comparisons

For the regular staff person using the average monthly salary of $3,952 the OPE would be $2,358. This would be a monthly total cost of $6,310. The cost for 100 FTE hours equals $631,015.

For the temporary employee using the average monthly salary of $3,952 the OPE would be $306. This would be a monthly total cost of $6,310. The cost for 100 FTE hours equals $425,842.

For the overtime comparison this calculation assumes that overtime is paid at 1 ½ times the base hourly rate of the average employee salary listed above. Only the variable amount of OPE is applied to overtime, because the fixed OPE is

only applied to the base salary. Using these assumptions, the total monthly cost of overtime is $7,551. The cost for 100 FTE hours equals $755,109.

The least expensive cost option for the state is to hire temporary employees. The hospital has addressed the issue of training costs and float pool turn over by using the temp pool as part of the fulltime permanent hiring strategy, moving temporary employees from the float pool to full-time permanent status as vacancies become available.

5. Compare forensic patients at OSH with other states. -Senator Bates

Pending information from Western Psychiatric State Hospital Association (WPSHA).

6. What crimes are the 370 folks responsible for – Tier 1 and 2 from SB 420. -Senator Bates

Tier One crimes are also known as Measure 11 crimes, the list of which are as follows:

(a) Aggravated murder as defined in ORS 163.095;
(b) Attempt or conspiracy to commit aggravated murder as defined in ORS 163.095;
(c) Murder as defined in ORS 163.115;
(d) Attempt or conspiracy to commit murder as defined in ORS 163.115;
(e) Manslaughter in the first degree as defined in ORS 163.118;
(f) Manslaughter in the second degree as defined in ORS 163.125;
(g) Assault in the first degree as defined in ORS 163.185;
(h) Assault in the second degree as defined in ORS 163.175;
(i) Kidnapping in the first degree as defined in ORS 163.235;
(j) Kidnapping in the second degree as defined in ORS 163.225;
(k) Rape in the first degree as defined ORS 163.375;
(l) Rape in the second degree as defined in ORS 163.365;
(m) Sodomy in the first degree as defined in ORS 163.405;
(n) Sodomy in the second degree as defined in ORS 163.395;
(o) Unlawful sexual penetration in the first degree as defined ORS 163.411;
(p) Unlawful sexual penetration in the second degree as defined ORS 163.408;
(q) Sexual abuse in the first degree as defined in ORS 163.427;

(r) Robbery in the first degree as defined in ORS 164.415;
(s) Robbery in the second degree as defined in ORS 164.405;
(t) Arson in the first degree as defined in ORS 164.325;
(u) Using a child in a display of sexually explicit conduct as defined in ORS 163.670;
(v) Compelling prostitution as defined in ORS 167.017; or
(w) Aggravated vehicular homicide as defined in ORS 163.149.

Tier two offenders are individuals whose offenses are not listed above.

7. Lean methodology – wants to see results, not just monetary.
OSH Improvements Using Lean Methodology -Representative Gallegos

- Improved Communication between Nursing Shifts – Standardized process to communicate vital information only.

- Staff Training – Provided eight training modules to hundreds of staff to ensure that staff understand lean methodology. This required a great deal of coordination among/between departments.

- Involuntary Medication Process – Standardized process to track the status of each case so as to ensure timeliness.

- Approval of Visitor Application Process – Reduced from 43 days to 48 hours.

- Direct Care Staff Schedules – Established computerized schedule system, to be followed up with a computer-based time-and-attendance system.

- Medical Records Transport – Reduced cycle time for transporting paper records across campus.

- PSRB/SHRP Assessment Completion – Increased timeliness of assessment completion and delivery to PSRB and SHRP so as to avoid delay/rescheduling of hearings.

- Risk Review – Standardized process reviewing and approving requests for patient on-grounds and off-grounds privileges. Reduced timeframe of review/approval.

- Progress Note Completion – Developed standard process enabling faster review and action for data users and auditors/surveyors.

- Dietary Consultations – Reduced "process steps" by 47%, created completion timeframes of five days or less.

- Interpreter Services – Developed plan that ensures appropriate level of services in timelier fashion, at lower cost.

- .370 Patients – Length of stay reduced by average of seven days, reduced errors in information sent to courts, increased transparency.

8. What federal funds can we obtain for which populations, units? -Senator Bates & Representative Tomei.

The sources of federal funds for the hospital are Medicaid and Medicare (parts A, B, and D). In addition, the hospital receives disproportionate share revenue – a form of Medicaid – for serving a large number of patients that have no resources.

Medicaid revenues are only available on units that are CMS certified and only for patients under 22 years of age or 65 and over. The hospital is an institution for mental disease (IMD) and is excluded from other Medicaid revenues as a result of an IMD exclusion in the federal law.

Medicare Part A revenues are only available for patients that have that coverage as a result of their age or disability and are on a CMS certified unit. This is full coverage, but for a limited number of days.

Medicare Part B revenues are fee-for-service for professional services provided by physicians and licensed clinical psychologists and available for any patient that has coverage as a result of their age or disability.

Medicare Part D revenues are for pharmacy (drug) costs and are only available for those with Medicare Part A or Part B coverage.

OSHRP

9. Is Avatar linked to Epic – status of Oregon and other states. -Senator Bates & Senator Steiner-Hayward

A. Is Avatar linked to Epic?
Avatar is currently not linked to EPIC. Federal rules governing Certified Electronic Health Records (EHR), specify that Meaningful Use - Stage Two will require DIRECT communication between all EHRs (by end of 2014). EPIC will need to communicate with Avatar, and vice versa to meet Stage Two Meaningful Use. So, for an EHR like EPIC or Avatar to stay competitive and stay in the market, they will be working hard to use standard communication protocols to talk to each other by the end of 2014. This is a big focus for Netsmart the vendor for Avatar, and many of the private and non-profit customers are starting to use health care exchanges.

B. Are there other status that have successfully made this connection?
We currently do not have any data on other states implementing a direct link between Avatar and Epic but have put the question on our various discussion sites to get additional information which we will provide as we receive it.

ATTACHMENT A

Response to Questions from Addictions and Mental Health Division Presentation to Subcommittee, February 25-27, 2013
Backup documentation supporting responses

2/25/13

Question #2: Methadone and Buprenorphine research on long-term use and length of stay information.

Long-term impact of methadone maintenance therapy -
"A combination of the methadone treatment and a comprehensive program of rehabilitation was associated with marked improvement in patient problems such as jobs, returning to school, and family reconciliation. No adverse effect other than constipation was found" (Dole & Nyswander, 2008, p. 646).

"Our results support the feasibility and efficacy of transferring stable opioid-dependent patients receiving methadone maintenance to primary care physicians' offices for continuing treatment and suggest guidelines for identifying patients and clinical monitoring" (Fiellin et al., 2001).

"Methadone medical maintenance is complex to arrange but feasible outside a research setting, and can result in good clinical outcomes" (Merrill et al., 2004, p. 344). Eighty-seven percent of patients were satisfied with methadone treatment. Physicians were satisfied in 50% of methadone maintenance individuals and somewhat satisfied with the other 43% of individual outcomes.

"Medical Maintenance has been developed and evaluated over the past 6 years. It has shown itself to be a successful method for treating a selected group of socially rehabilitated methadone patients in the private medical practices of physicians affiliated with medical centers and health maintenance organizations" (Novick & Joseph, 1991, p. 233).

"Compared with enriched detoxification services, methadone maintenance is more effective than enriched detoxification services with a cost effectiveness ratio within the range of many accepted medical interventions and may provide a survival advantage. Results provide additional support for the use of sustained methadone therapy as opposed to detoxification for treating opioid addiction (Masson et al., 2004, p. 718).

ATTACHMENT A

Response to Questions from Addictions and Mental Health Division Presentation to Subcommittee, February 25-27, 2013
Backup documentation supporting responses

Safety-
Methadone has few adverse biological effects. There appear to be no dangerous or troubling psychological effects from long-term administration (Verdejo, Toribio, Orozco, et al., 2005).

Methadone sometimes causes minor side effects, such as sweating, constipation, temporary skin rashes, weight gain, water retention, and changes in sleep and appetite (Lowinson et al., 1992).

Methadone prescribed in high doses for a long period of time has no toxic effects and only minimal side effects for adult patients maintained in treatment for up to 14 years and for adolescent patients treated for up to 5 years (Kreek, 1978).

Although early studies demonstrated no persisting abnormalities directly attributable to methadone in the functioning of five organ systems (pulmonary, cardiovascular, renal, ophthalmologic, and liver) (Krantz, Lewkowiez, Hays, et al., 2002).

Patients maintained on methadone have no impairment in driving and have no more frequent motor vehicle accidents than people not receiving methadone maintenance treatment (Schindler, et al., 2004).

The most common and enduring complaints after 6 months to 3 years of continuous methadone treatment are sweating, constipation, abnormalities in libido and sexual functioning, sleep abnormalities (insomnia and nightmares), and altered appetite (mild anorexia, weight gain) (Kreek, 1979).

A study of 92 methadone-maintained patients found that the rate of global sexual dysfunction in methadone-treated men was similar to the general population but that orgasm dysfunction may respond to methadone dose reduction.

Although euphoria and drowsiness, with occasional nausea and vomiting, can occur before tolerance develops, these side effects are most noticeable when doses are increased too rapidly. Conversely, if a heroin habit has been particularly heavy,

initial methadone doses may be too low to prevent the onset of early withdrawal symptoms (Kreek, 1979).

Life-threatening interactions of methadone with other drugs have not been identified. Drugs found to affect the metabolism of methadone include phenytoin (Dilantin) and rifampin. Opioid antagonists such as pentazocine (Talwin) and buprenorphine can cause withdrawal symptoms in methadone patients and should not be prescribed (Kreek, 1978).

Buprenorophine v Methadone-
"Buprenorphine did not differ from methadone in its ability to suppress heroin use, but retained approximately 10% fewer patients. This poorer retention was due possibly to too-slow induction onto buprenorphine. For the majority of patients, buprenorphine can be administered on alternate days" (Mattick et al., 2003, p.441). Randomized double-blind trial with 405 opioid-dependent patients. "

Cost Effectiveness-
In an analysis of methadone detoxification patients (N=102), authors observed that for every dollar spent on treatment, $4.87 of health care costs were offset. (Hartz, D.T., P. Meek, et al., 1999, pgs. 270-218).

"Combining pharmacotherapy with psychosocial support strategies that are tailored to meet the individuals' needs is a demanding and costly task. But this combined treatment constitutes the most thorough approach to facilitate the long-term behavior change that is necessary to treat opioid addiction effectively. (Lobmaier et al., 2010, p. 543).

"Providing methadone maintenance therapy along with ART for HIV-positive DUs is a cost-effective intervention in Vietnam. Integrating MMT and ART services could facilitate the use of directly observed therapy that supports treatment adherence and brings about clinically important improvements in health outcomes. This approach is also incrementally cost-effective in this large injection-driven HIV epidemic" (Tran et al., 2012, p. 260).

"The data showed clear economic benefits to treating drug misusers in England" (Godfrey, Stewart, & Gossop, 2004, p. 691).

(References for all of the above sources can be provided as requested.)

Length of Stay

The average length of stay for patients in methadone maintenance therapy in Oregon is 3.59 years. Data was analyzed for the calendar year 2011 and includes patients who successfully completed treatment (N=118) and patients whose cases were closed as other than successfully compete (N=1,513). In the latter group, reasons for case closure vary and include patients who moved out of the area, transferred to another clinic, were closed due to non-compliance with clinic agreements, or who left services against clinic advice.

Question #6 from Representative Nathanson – profile of problem gambling client:

The average number of years of formal education was 13.2 years with no difference between male and female clients. Over the years, marital status of clients has remained relatively stable with 31.5% married, 28.7% divorced, and 23.8% never married.

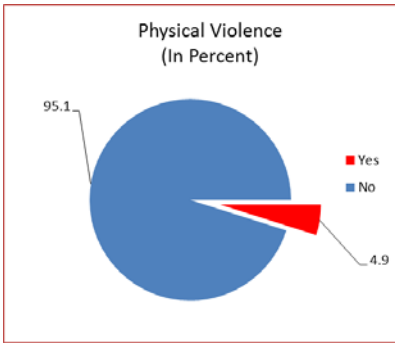
Employment status has changed during the economic recession. Last year 36.8% were employed full-time, 15.6% part-time or irregular, and 17.8% unemployed and looking for employment. Approximately 29.2% were disabled, retired, or otherwise not looking for employment. The average annual household income was $32,140 while the median was $25,200. The average gambling related debt was $26,739. For those reporting a debt, the ratio of debt to income was approximately 1:1.5.

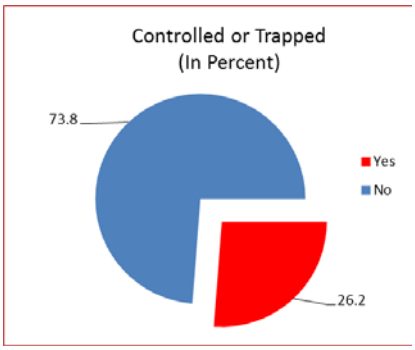
Slightly over 33% reported owning their own home, 41% market rental, 7.4% rental assistance, and 2.9% were homeless at enrollment.

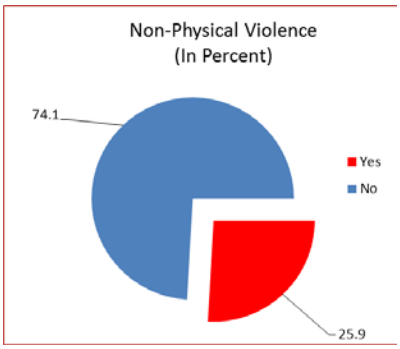
Nearly two-thirds of the clients reported jeopardizing a significant relationship (47.3%) or job (15.8%) due to their gambling. Slightly over 11% reported

gambling related bankruptcy and 10.3% reported legal problems while 33.6% reported committing illegal acts in order to get money to gamble.

Approximately 27.4% of the clients reported having suicidal thoughts "sometimes" (17.7%), "often" (7.3%) or "always" (2.4%) during the past six months. Nearly 51.5% reported "never" having such thoughts and 21.1% reported "rarely." During the clinical screening 2.6% reported making threats of suicide, 1.4% reported having a plan, and 1.6% reported actually taking action to complete the suicide.







Nearly five percent reported experiencing physical violence in a relationship in the six months prior to enrolling. Both non-physical violence and feeling controlled or trapped by a significant other was reported by slightly over one-quarter of the enrolling individuals. Interestingly, there was no significant difference in the distribution of responses for both these question by males or females.

Approximately 21% reported experiencing alcohol related problems and 12.8% reported problems with illegal drug abuse. Over 58% reported using tobacco products frequently while 42% reported no use. Nearly 30% reported prior treatment for substance abuse/addictions and 33% reported prior mental health treatment.

2/26/13

6. Representative Nathanson asked for information about our partnership efforts with college/university health centers or other college/university health partners to address alcohol use on campus and in the community. She also asked for

information about our partnership with OLCC around minor access to alcohol and enforcing underage drinking laws.

Partnership efforts with college/university health partners to address alcohol use on campus and in the community.

Benton County:

- Working collaboratively with OSU Student Health Services, Office of Student Conduct, and Oregon State Police (Law Enforcement for OSU) to provide technical assistance. Strategies include conducting more in-depth needs assessment activities with resident halls and designing, market testing, implementing, and evaluating social marketing messages around high-risk drinking.
- Providing technical assistance on high-risk drinking prevention to the Collaboration Corvallis Project, which was enacted by Corvallis Mayor Julie Manning and OSU President Ed Ray, to address livability concerns in the community related to OSU and the growing student population.
- Working together with University of Oregon to create normative policies and practices that extend across both campuses to address high risk drinking.

Clackamas County:

- Increase partnership with Clackamas Community College to educate students about binge drinking and increasing readiness for collaboration on bigger projects to address high risk drinking among college students.

Deschutes County:

- Shared Future Coalition is developing a strong relationship with the Housing Coordinator at Central Oregon Community College.

Jackson County:

- Working with Southern Oregon University to partner on a "Healthy Campus" campaign using positive social marketing to address gambling and other addictions, sleep hygiene, mental health and stress.

Lane County:

- Established the Eugene Prevention Coalition to focus on reducing high-risk drinking among 18-25 year olds with a focus of building relationships with local university and college partners, including the newly hired University of Oregon Substance Abuse Prevention Coordinator.
- Community passed a Social Host Ordinance.
- Due to a high number of college students in the community, the increasing amount of negative consequences and livability issues from alcohol-fueled parties at private residences has gained energy and attention. As a result the Eugene Prevention Coalition successfully carried out a media campaign that highlighted local grocery stores that took down alcohol displays that promoted drinking games.
- Currently assessing the feasibility within the campus and community about extending the Student Conduct Code off-campus as well as creating a restorative justice program for adult, MIP offenders.
- Working together with Oregon State University to create normative policies and practices that extend across both campuses to address high risk drinking.

Union County:

- Eastern Oregon University and their student health center through OHSU have partnered with the local Coalition to craft a social norms campaign on campus to address high risk drinking. This involves working with administrators, health center program staff, resident halls and student involvement.
- Working with health center to promote the American College Health Association/ National College Health Assessment (ACHA/NCHA) survey, in hopes to increase student participation in this surveillance tool to increase accuracy to prevention programming.

Washington County:

- Develop awareness at Pacific University regarding underage and binge drinking both among the student population and faculty. Hired a student on campus as a "peer educator" to assist in these efforts with students attending Pacific.
- Forest Grove Police Department and Pacific University are working together and developing a system of communication and jointly engaging in the development of a drug and alcohol free coalition.

Partnership with OLCC around minor access to alcohol and enforcing underage drinking laws

Benton County:

- The Partnership Coalition, we also work collaboratively with our local OLCC agent to provide retailer trainings to help increase retailers knowledge and skills in effectively checking ID.

Clackamas County:

- OLCC is planning a Minor Decoy Operation for spring. Current focus on implementation of Social Host Ordinances in local jurisdictions where law enforcement has deemed it would be a useful tool and the OLCC will be instrumental in these processes.

Deschutes County:

- OLCC, since becoming fully staffed, has increased involvement in local coalitions throughout the County. OLCC staff is an integral part of the Shared Future Coalition.

Union County:

- Success in partnering with regional OLCC office to complete projects around minor access and enforcing underage drinking laws. In addition data collection has increased and improved through increased partnership with the local coalition.

Washington County:

- 6 Police Departments (Beaverton, Tigard, Tualatin, Sherwood, Forest Grove and the Sheriff's Office) are engaged in compliance checks, partnering with OLCC, with the goal to cover all of Washington County establishments.
- Law Enforcement agencies have jointly developed an MIP patrol operation that they will pilot this spring, if successful repeat in the summer and following fiscal year.
- Joint systems (law enforcement, juvenile justice, treatment, county, and education) are working together to collaboratively address social hosting issues in Washington County. This law is not enforced, cities are considering the benefits of adopting ordinances, but also to simply increase messaging to parents and young adults of the potential consequences related to party hosting.

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ATTACHMENT A

Response to Questions from Addictions and Mental Health Division Presentation to Subcommittee, February 25-27, 2013
Backup documentation supporting responses

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ATTACHMENT A

Response to Questions from Addictions and Mental Health Division Presentation to Subcommittee, February 25-27, 2013
Backup documentation supporting responses

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Oregon Health Authority (OHA) /
Department of Human Services (DHS)
Statewide Children's Wraparound Initiative
Progress Review Summary
July 2012 Update

This summary follows progress on children participating in the Wraparound Demonstration Projects from beginning to end of their participation in Wraparound. Because data at each testing point (Entry, 1st Review, and Exit) were collected from the same group of children, we are able to measure comparable change.

The data from the Children's Progress Review System (CPRS) were refreshed from an earlier report. All of the cases include Progress Review data at Entry, at the child's first quarterly Progress Review, and at Exit from Wraparound.

Executive Summary

In 2009, the Oregon legislature passed legislation authorizing the creation of the Statewide Children's Wraparound Initiative. In July 2010, three demonstration sites were selected encompassing eight counties with a diversity of characteristics. The demonstration sites are Washington County Wraparound, Mid-Valley WRAP, inclusive of Marion, Linn, Polk, Tillamook and Yamhill counties, and Rogue Valley Wraparound Collaborative inclusive of Jackson and Josephine counties.

Wraparound is a care management process that has evolved over the past 15 years through efforts to help families with children with the most challenging behaviors to function more effectively in the community. It is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes. Wraparound is a comprehensive process that is rooted in a specific set of values, elements, and principles.

The population focus for the project are youth who have been served in the child welfare system, with mental health needs, who have had four or more placements or whose needs were significant upon entry into the child welfare system. DHS/OHA contracted with Portland State University to provide workforce development, training and technical assistance to support implementation of the SCWI. To date, over 21 months of data have been compiled regarding the children and families served in the project.

The Statewide Children's Wraparound Initiative began in July 2010, with concurrent hiring and training while existing staff also provided care coordination and Wraparound facilitation during the initial months of the project.

The data show that SCWI participation has had a significant impact in moving children back into living arrangements with their parents or other relatives. In many cases, children are able to exit the custody of DHS. This was a significant focus of the project's goals at the outset.

The data also portray a pattern of stabilization in children's lives, with decreased need for psychotropic medications, increased ability to refrain from harm to self and others, increased capacity to produce schoolwork commensurate with their ability levels, and a lower likelihood of running away or delinquent behavior. Families are noticing that their children are improving over time in the project, and are feeling a better sense of support, especially for problematic behaviors.

Use of the Children's Progress Review System for electronic reporting of these data has facilitated feedback to the child and family teams and assisted with managing the project as a real-time data source to track improvement during participation in the project. Continued work to refine the data elements and reporting tools is ongoing.

Methods

This report summarizes results for a total of 136 children who participated in the Wraparound project since its inception in 2010.

Data for the current analysis were obtained from the online Children's Progress Review System (CPRS). Electronic progress review records are created for each child at entry into Wraparound, every 90 days during participation and upon exit from the Wraparound project. Demonstration project staff members enter information gathered from the child and family team using an online data entry format which automatically updates a central database. For this report, data were extracted directly from CPRS system tables for all clients whose records include an initial progress review, at least one subsequent progress review, and an Exit review.

Study population

Nearly two thirds (61.8%) of the 136 youth who have left Wraparound service and supports were 12 years of age or older at the time of their initial progress review; 30.9 percent were between six and 11 years of age and 7.4 percent were less than six years old.

One fourth (35 children, 25.7%) entered Wraparound during the first three months of the demonstration project. Another 83 children (62.3%) entered between

the third and ninth month (October 2010-March 2011), and the remaining 18 clients (13.2%) entered between April 2011 and February 2012 (nine to 19 months after the demonstration project inception).

The amount of time in treatment is defined here as the number of days or months between Entry and Exit review dates. Overall, these clients spent an average of 10 months in Wraparound. More than half (52.2%) spent 6-12 months in the program; 17.6 percent exited after less than 6 months, while 30.1 percent remained in Wraparound for a year or more.

Youth who entered Wraparound during the first quarter of the project, July-September, 2010, spent an average of 13.4 months in the program. In comparison, those who entered between the third and ninth month stayed an average of 9.6 months. The average length of stay was 6.1 months for children who entered Wraparound after March 31, 2011.

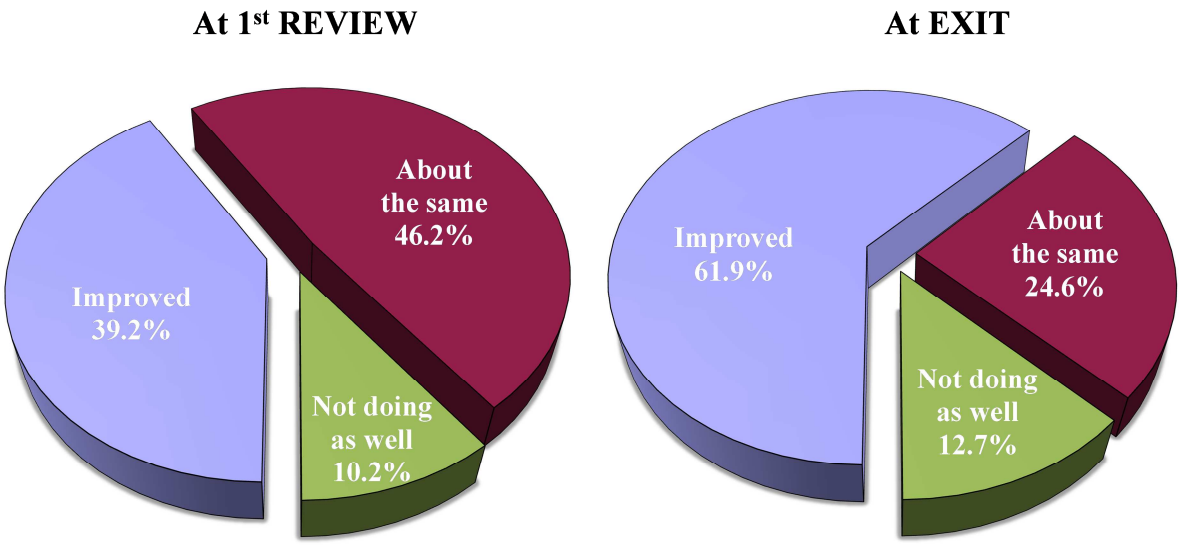
Representation of the three Wraparound demonstration sites reflects the relative numbers served in each project. Mid-Valley Wrap clients comprise about half of the sampled cases (47.8%), 39.7 percent are Rogue Valley clients, and the remaining 12.5 percent are served by Washington County's program.

Progress during Participation in Wraparound

This measure reflects the parent/caregiver rating of the child's improvement during participation in the Wraparound project. Exit ratings reflect progress since prior quarterly review, not since entry. Please note that this prior review may not be reflected in these data since children participate in the program for varying lengths of time. A child may have had several progress reviews between the first 90 day review and exit.

Figure 1 shows that nearly 23 percent more have improved since their previous quarterly review.

Figure 1: Summary Estimate of Child's Progress Since Last Review



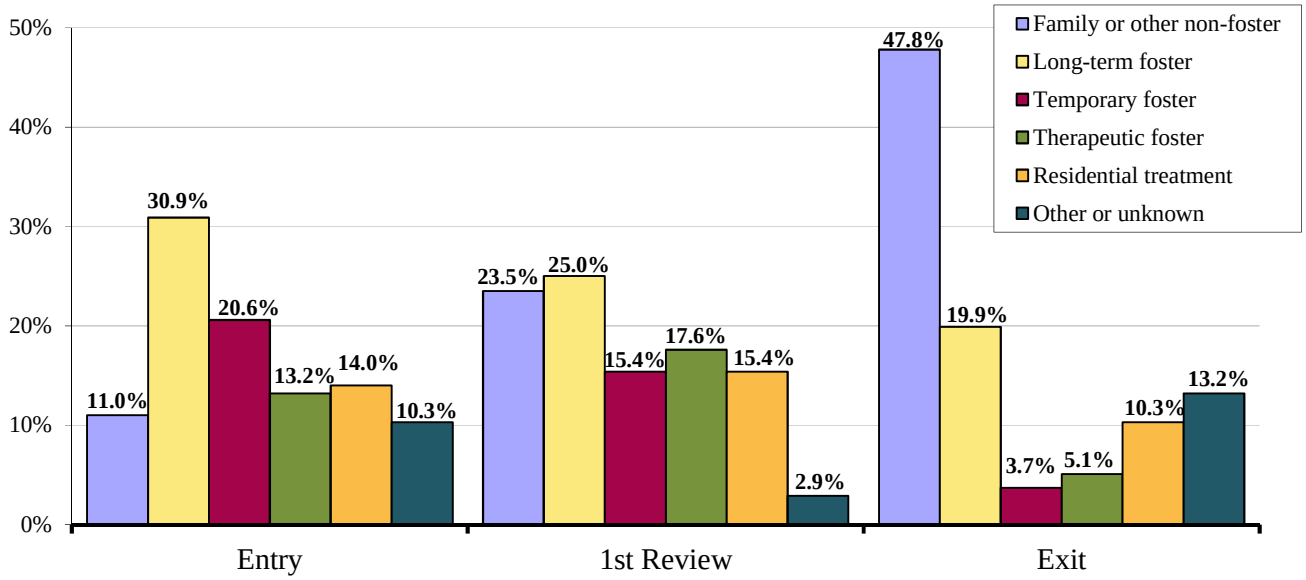
Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Residence

For the cohort of children served in Wraparound, all of whom are in the custody of Child Welfare, the importance of remaining with their families, or returning to their families or extended families is paramount. These children have already had disruptions of their living situation that have been significant. They are in need of family and living arrangement stability.

In the first 90 days in the project, the percentage of children who are able to progress to living with their immediate families or relatives in non-foster care settings more than doubles, from 11.0 to 23.5 percent. By the time of exit from the project the youth in Wraparound project sites rely less on therapeutic foster care or residential treatment and the percentage living with their own families has doubled again to 47.8 percent.

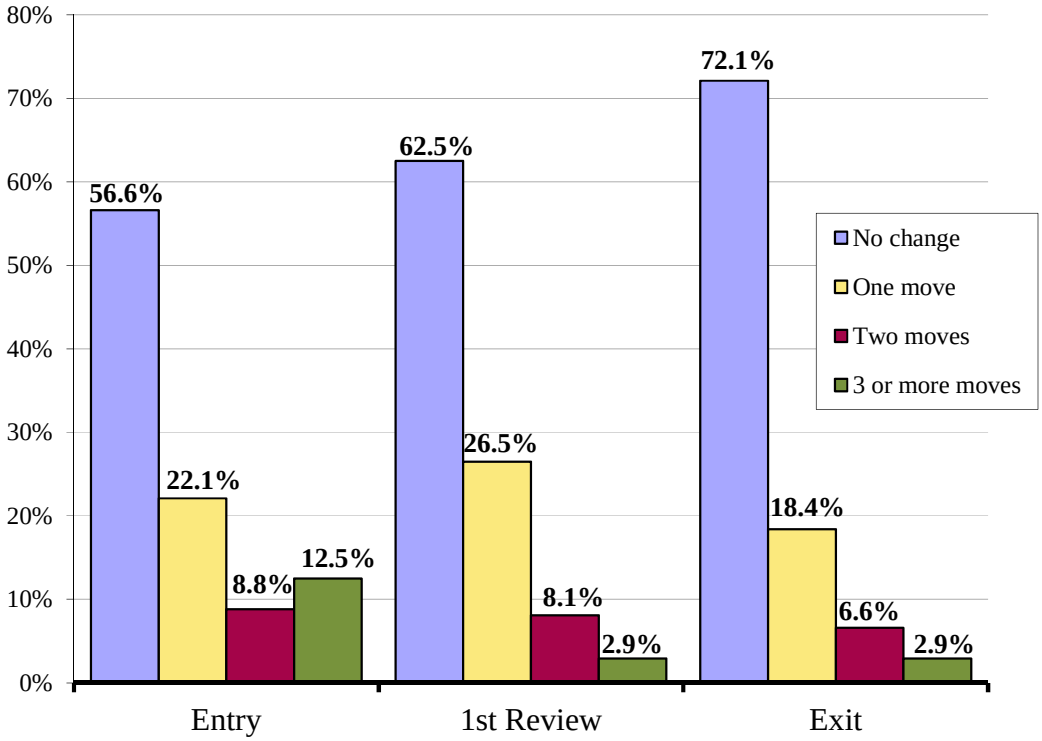
Figure 2: Current Residence



Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Figure 2b below shows that as treatment progresses living situations stabilize. The proportion of youth who did not change residence during the previous 90 days rises from 57 percent at entry to 72 percent when they leave Wraparound. At the same time, the number of children who moved three or more times drops from 12.5 percent at the first review to less than three percent at exit.

Figure 2b: Residence Changes in Prior 90 Days



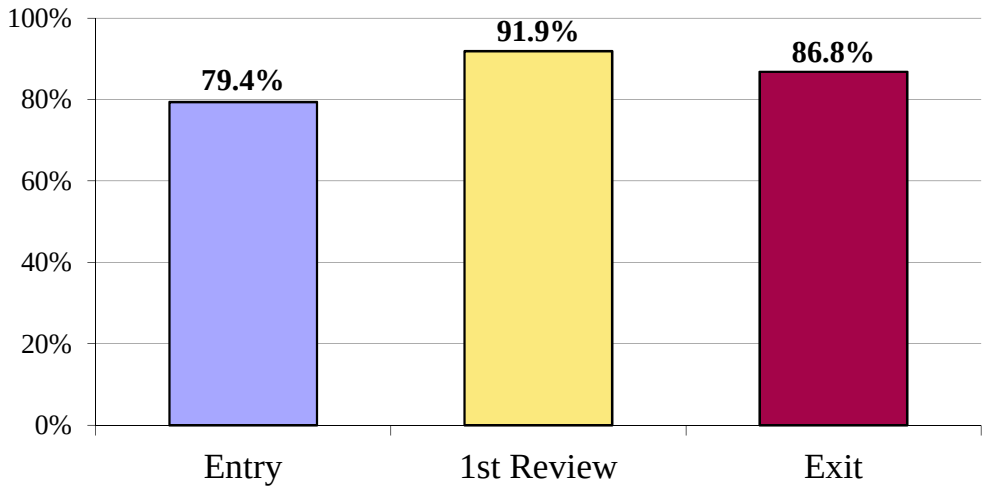
Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Health Care

More children have a primary care provider of record upon exit from the project than upon entry. More than half of the children without a primary care provider at entry obtain one in their first 90 days in the project.

This finding lends support to the potential benefit of Wraparound as a process which improves integration of mental and physical health care. Further information about the quality of coordination across disciplines is needed to support this claim.

Figure 3a: Children Who Currently Have a Primary Health Care Provider



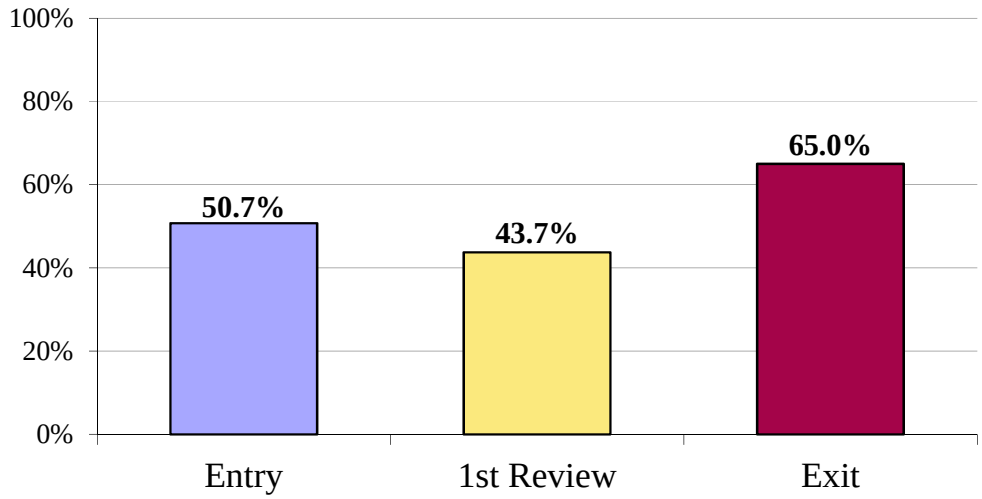
Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Medications

Children who enter this program by definition are high utilizers of psychotropic medications. At the time of entry, half of the children received treatment with psychotropic medications. At exit 35 percent of the children remained on psychotropic medications.

Wraparound appears to reduce the need for psychotropic prescribing, because the child's mental health conditions improve substantially as evident on functional measures. Decreased reliance on psychotropic medications within the first ninety days can reflect the increased availability of a primary care provider and can also reflect implementation of changes in a child's treatment plan.

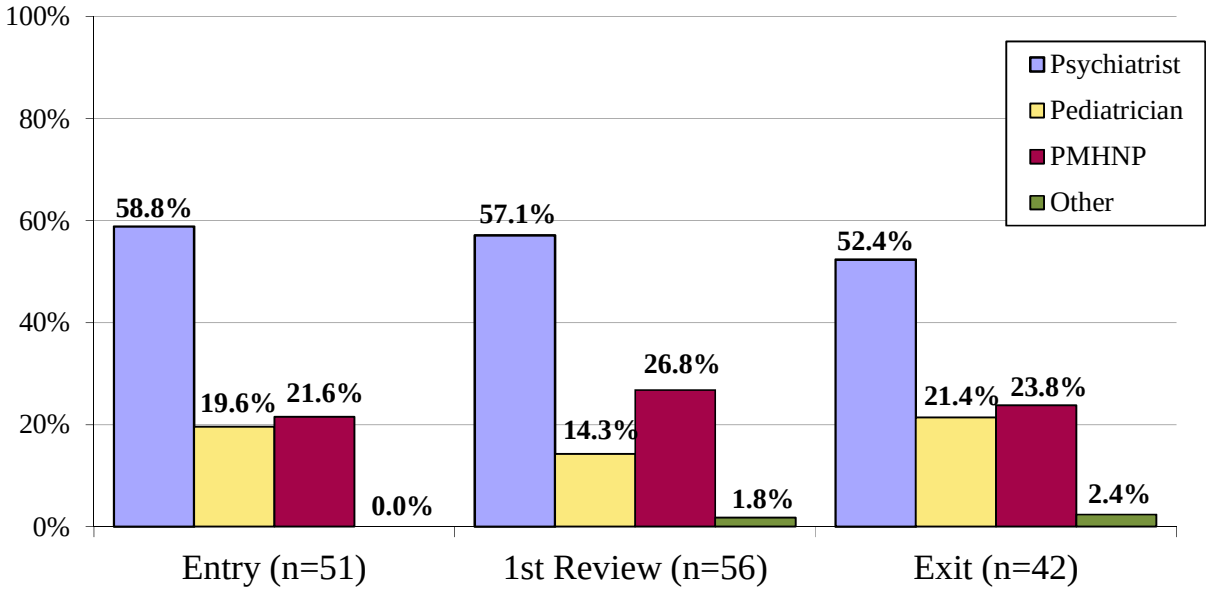
Figure 3b: Children Who Are NOT Currently Prescribed Psychotropic Medications



Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

The type of prescribing provider also changes over time, moving away from psychiatrists to primary care providers. As supports are in place and functioning improves, children's medical treatments may become less complex allowing for the transition to primary care.

Figure 3c: Type of Provider for Children Currently Prescribed Psychotropic Medications



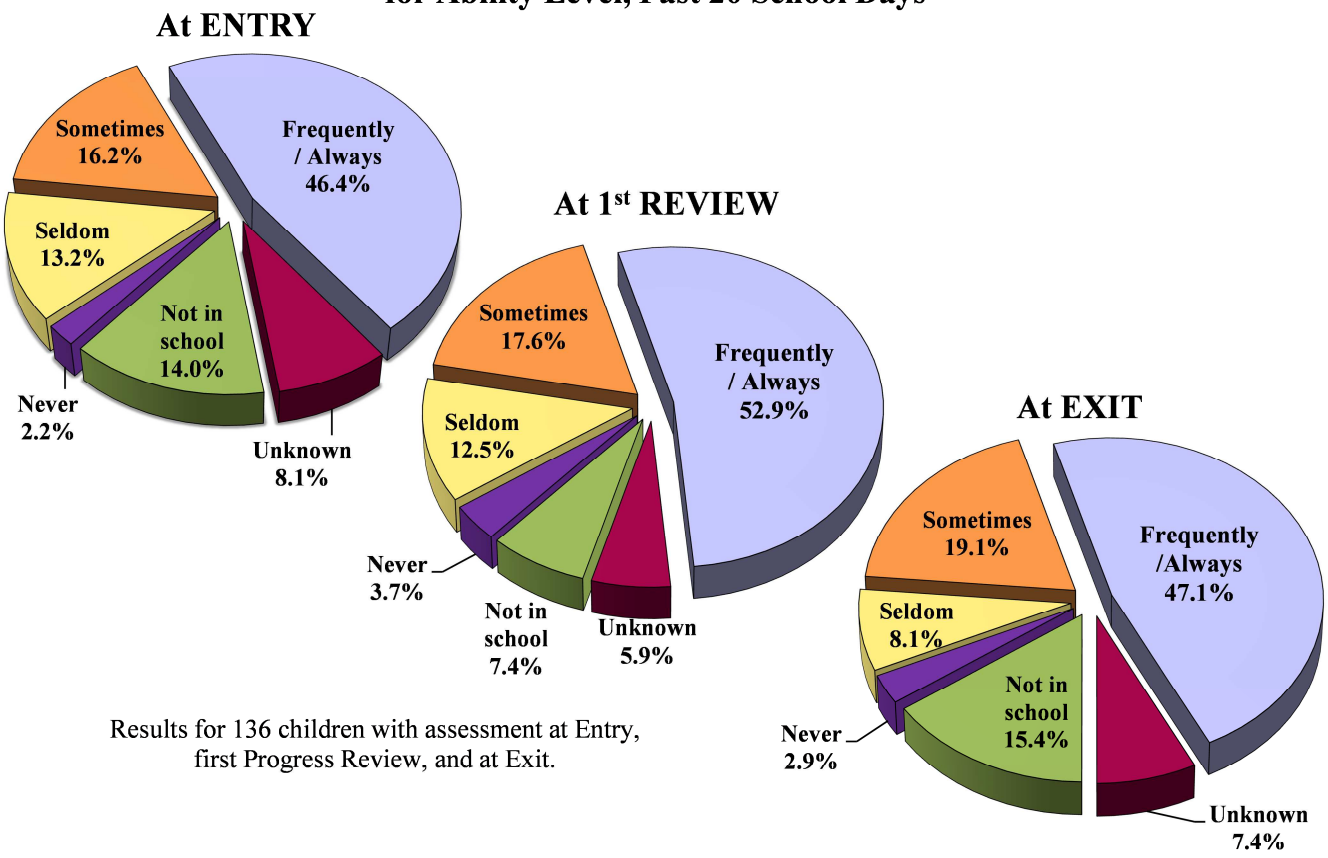
Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

School

Parents and caregivers observed modest gains in the quality of their children's schoolwork during the first months of treatment. Notable is the drop in the percentage of children not attending school, from 14 percent at the beginning of treatment to half that amount at the first Progress Review. The majority of children in the group are older and may choose not to attend school, may be working, may be experiencing limitations caused by their personal challenges preventing school attendance, or are not yet enrolled in a new school if they have moved.

While gains are made during the first months, at exit the proportion of children who frequently or always produce acceptable schoolwork is lower (47% compared to 53%) and the percentage of children who are not in school is higher than at the first review (15% compared to 7%). But, fewer of these children are rated by their caregivers as never or seldom producing acceptable quality schoolwork at exit (11%), compared to either entry (15%) or first review (16%).

Figure 4: Children Producing Schoolwork of Acceptable Quality for Ability Level, Past 20 School Days

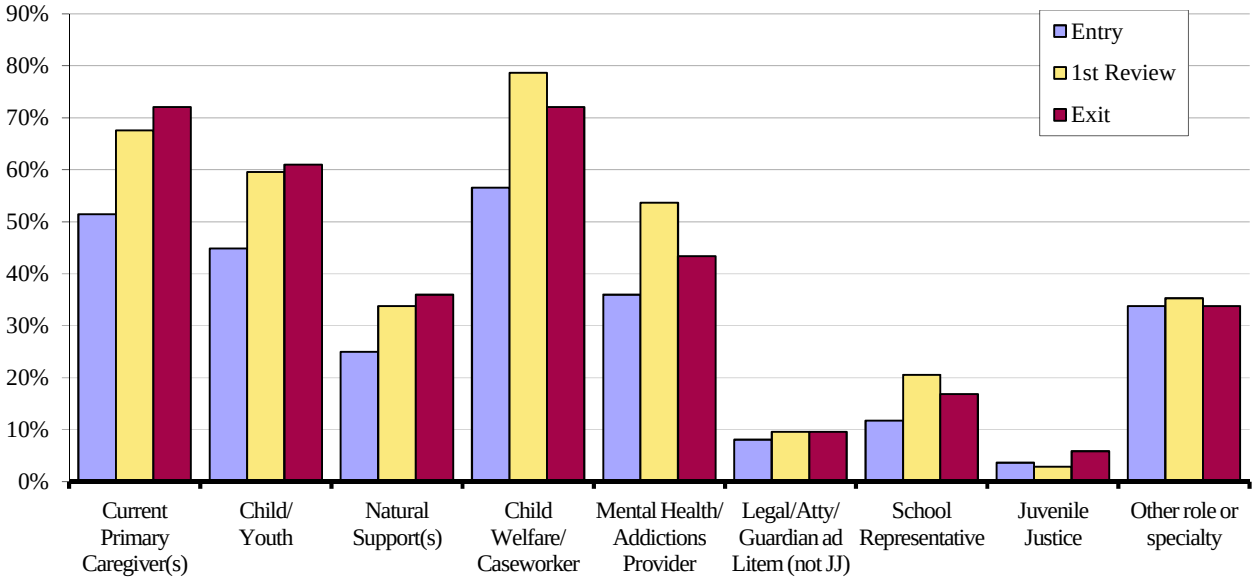


Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Participation in Child and Family Teams

Ideally, all people who are significant in a child's life participate in the Child and Family Team, in addition to the child and family themselves. In building a system of care, inclusion of juvenile justice, education and other child-serving system representation for a given child, depending on which agencies are working with the child and family, is crucial. Other important participants include any natural supports such as extended family, and other important people in the child's life such as a mentor or other community figure. The chart below illustrates participation in the most recent child and family team meetings.

Figure 5: Participants at Child's Most Recent Child & Family Team Meeting (percent of all children)



Results for 136 children with assessment at Entry, first Progress Review, and at Exit.

Attendance by children and their parents or caregivers is not 100 percent. This group reports that at entry, 62 percent of the youth had a recent CFT meeting which was attended by their parents/caregivers and/or by themselves. At the first review and exit review, the proportion rose to 81 and 80 percent, respectively.

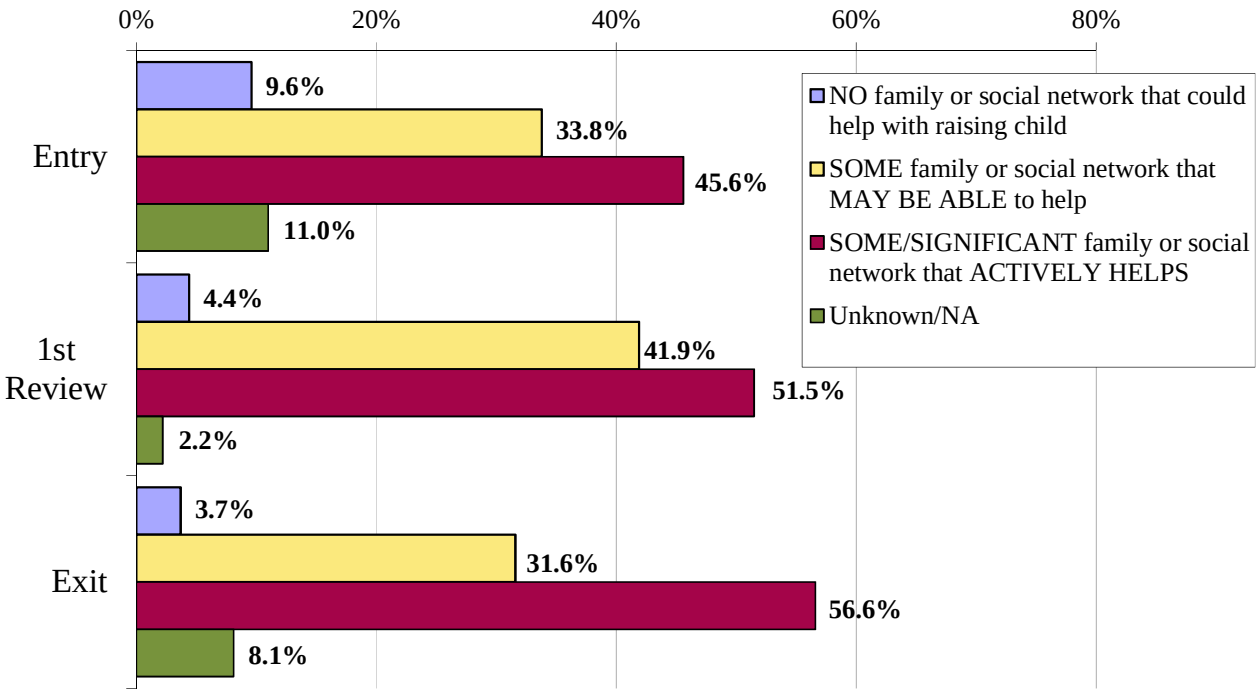
It is notable that child welfare/caseworker representation at child and family team meetings is 79% at the 1st review and 72% at exit, indicating good collaboration between child welfare, care coordinators, and families at the project sites.

Perceived Support Available to Caregivers

Youth whose lives have destabilized are often difficult to support. Difficult patterns between caregivers and youth may emerge, and may make the situation more challenging. It is extremely important that caregivers feel supported in caring for and parenting youth; this is especially true if the children or youth are exhibiting more extreme "problematic" behaviors. Such behaviors test the caregivers' ability to maintain a safe environment for the youth.

These charts illustrate that caregivers participating in Wraparound feel more supported over time. The percentage of caregivers who respond that they have active help from family or social networks is 57 percent at exit, compared to 46 percent at entry (Figure 6a).

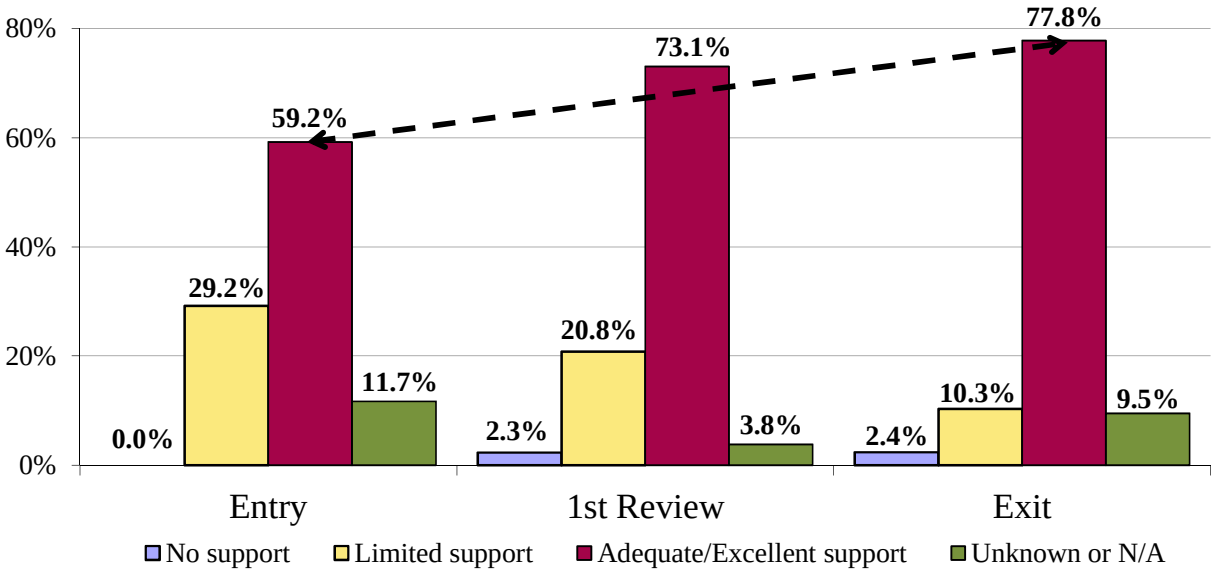
Figure 6a: Caregiver Family/Social Network Support Past 30 Days



Results for parents/caregivers of 136 children with assessment at Entry, first Progress Review, and at Exit

Caregivers' support for addressing problem behaviors of their children also increases with each stage of Wraparound, particularly between entry and the first Progress Review (Figure 6b).

Figure 6b: Caregiver Support to Address Problematic Behaviors

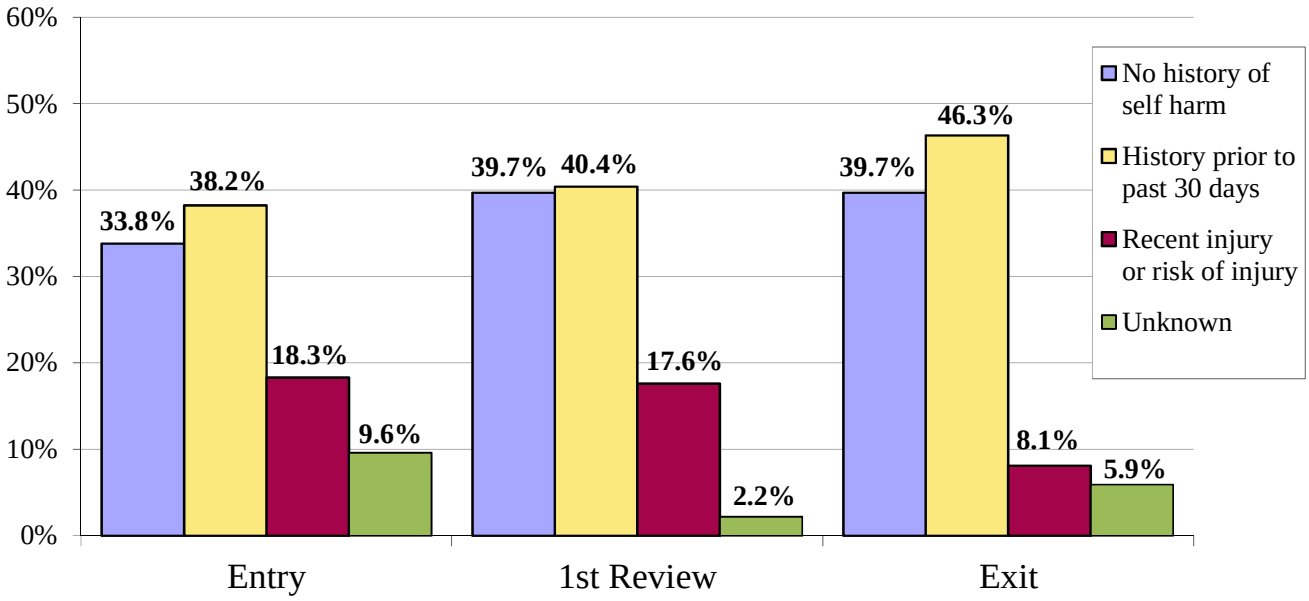


Results for parents/caregivers of 136 children with assessment at Entry, first Progress Review, and at Exit

Risk of Harm to Self and Others

Young people who are struggling in their lives may turn to self-destructive behavior in efforts to cope with painful and difficult feelings and thoughts. More adaptive coping options may not be in the youth's repertoire. With Wraparound services and supports, risk of harm to self and others decreases over time (Figures 7a and 7b).

Figure 7a: Child's Risk of Self-Harm
Past 30 Days

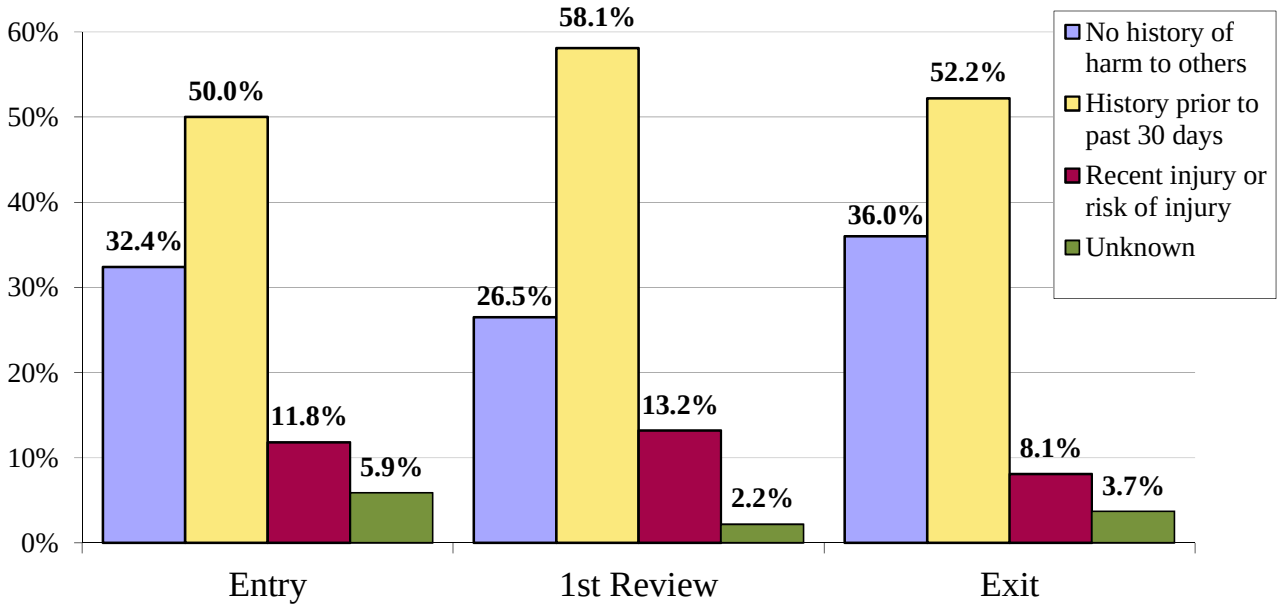


Results for parents/caregivers of 136 children with assessment at Entry, first Progress Review, and at Exit

For specific definitions of the categories noted in the Figure 7a key, please refer to the footnote below.[1]

[1] No history of self-harm: No history of behavior that would place the child at risk for physical harm to self, or that has resulted in physical harm to self
History prior to past 30 days: History of behavior (but NOT in the past 30 days) that has placed the child at risk for physical harm to self, or that has resulted in physical harm to self
Recent injury or risk of injury: (2 items combined) 1)Within the past 30 days, child has engaged in behavior that has placed the child at risk for physical harm to self, or that has resulted in physical harm to self AND 2) Child has engaged in behavior within the past 30 days that has placed child at immediate risk of death

Figure 7b: Child's Risk of Harm to Others
Past 30 Days



Results for 136 children with assessment at Entry, first Progress Review, and at Exit

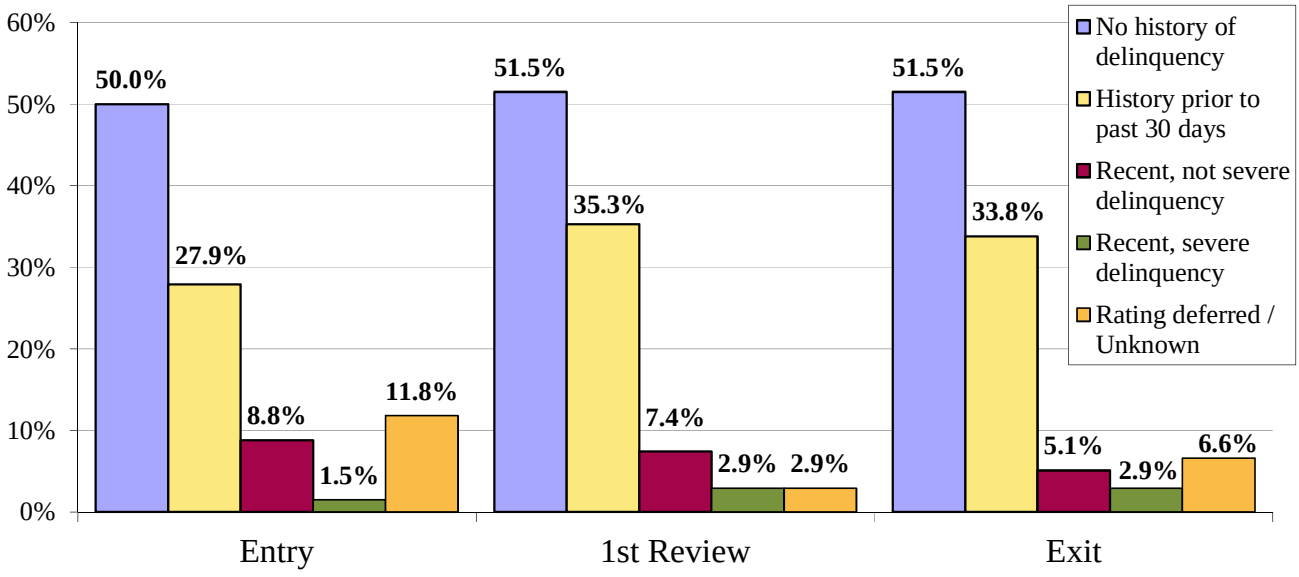
For specific definitions of the categories noted in the Figure 7b key, please refer to the footnote below[2].

[2] No history of harm to others: No history of behaviors that pose danger to others
History prior to past 30 days: History (but not in past 30 days) of homicidal ideation, physically harmful aggression, or fire setting that has put self or others in danger of harm
Recent injury or risk of injury: (2 items combined) 1) Homicidal ideation, physically harmful aggression, or deliberate fire setting in past 30 days (but not in past 24 hours) AND 2) In past 24 hours, homicidal ideation with plan, physically harmful aggression, deliberate fire setting, or command hallucinations involving harm of others

Delinquency

Another way young people may respond to severe emotional distress is by poor decision-making that can result in encounters with legal authorities. A pattern of delinquent behavior can develop that leads to incarceration. Successful services and supports can become more difficult to maintain when youth are incarcerated. Wraparound services and supports are useful in interrupting this progression. For definitions of the key in Figure 8, please refer to the footnote[3].

Figure 8: Child's History of or Risk for Delinquency Past 30 Days



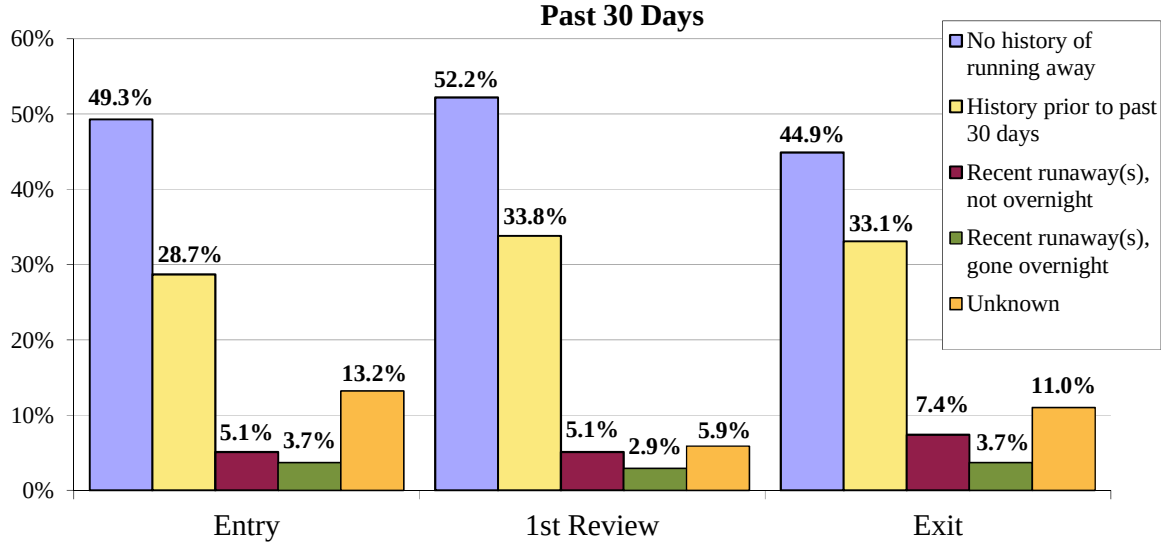
Results for 136 children with assessment at Entry, first Progress Review, and at Exit

[3] No history: No history of delinquency
History prior to past 30 days: History of delinquency, but not in the past 30 days
Recent, not severe delinquency: Recent acts of delinquency (in the past 30 days)
Recent, severe delinquency: In the past 30 days, severe acts of delinquency that place others at risk of significant loss or injury and place child at risk of adult sanctions

Running Away

Young people may run away because they find their current situation intolerable or stressful. Ability to weigh choices and make better ones may be impaired or there may seem to be no better choices. Using running away as a coping tool prevents young people from getting the services and supports they need. In the Wraparound project to date, running away decreases slightly over time. Running away may no longer be a needed coping tool, or housing improvements may make it unnecessary from the youth's perspective. For definitions of the key in Figure 9 please refer to the footnote[4].

Figure 9: Child's History of or Risk for Running Away Past 30 Days



Results for 136 children with assessment at Entry, first Progress Review, and at Exit

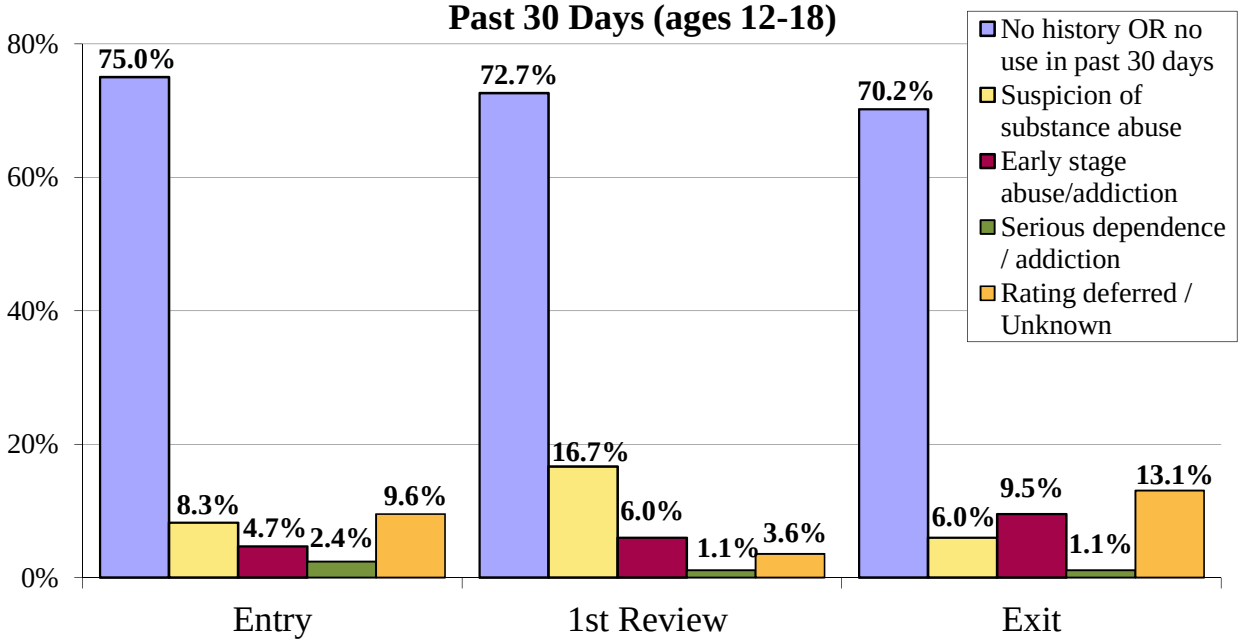
Children's running away behavior differs between age groups. Among children under 12 years of age at entry, no recent runaway episodes were reported at entry, first review, or exit. For children ages 12-14, the percentage with recent runaway behaviors increased from 9.1 percent at entry to 15.1 percent at first review, and 18.2 percent at exit. All except one of this group had daytime-only absences. However, overnight absences account for roughly half of the recent runaway episodes reported among older teens (ages 15-17 years at entry). In this age group 17.6 percent had recently run away at entry and at exit; the rate was 11.8 percent at first review.

[4] No history of running away: No history of running away
History prior to past 30 days: No instances of running away in the past 30 days
Recent runaway(s), not overnight: (2 items combined) 1) Ran away once or twice in the past 30 days (with no instance of child being gone overnight) AND 2) Ran away several times in the past 30 days (with no instance of child being gone overnight)
Recent runaway(s), gone overnight: Ran away at least once in the past 30 days (with at least one instance of child being gone overnight)

Substance Use/Abuse

Based on national data we might expect to see a larger number of young people with substance use or addictions (co-occurring disorders) in addition to mental health concerns. It is being reported that a large percentage of young people served in the project either have no history of use in the past 30 days, or may not yet be ready to disclose their history and enter into addictions treatment. Suspicion of abuse does increase slightly over the time spent in the project, which would support this hypothesis. At the present time, no inquiry is being made about past use, and the tool is undergoing revision to include this.

Figure 10: Evidence of Substance Abuse Past 30 Days (ages 12-18)



Results for 84 children ages 12-18 at Entry, with assessment at Entry, first Progress Review, and at Exit

Summary

The Statewide Children's Wraparound Initiative began in July 2010, with concurrent hiring and training while existing staff also provided care coordination and Wraparound facilitation during the initial months of the project.

The data show that SCWI participation has had a significant impact in moving children back into living arrangements with their parents or other relatives. In many cases, children are able to exit the custody of DHS. This was a significant focus of the project's goals at the outset.

The data also portray a pattern of stabilization in children's lives, with decreased need for psychotropic medications, increased ability to refrain from harm to self and others, increased capacity to produce schoolwork commensurate with their ability levels, and a lower likelihood of running away or delinquent behavior. Families are noticing that their children are improving over time in the project, and are feeling a better sense of support, especially for problematic behaviors.

Use of the Children's Progress Review System for electronic reporting of these data has facilitated feedback to the child and family teams and assisted with managing the project as a source of real-time data to track improvement during participation in the project. Continued work to refine the data elements and reporting tools is ongoing.

County General Fund and Direct Federal Contribution to Community Mental Health System
2011-12 and 2012-13

County	FY	MENTAL HEALTH		ALCOHOL & DRUG	
		General Funds	Direct Federal	General Funds	Direct Federal
Baker	2012-13	$ 7,598	$ -	$ 15,000	$ -
	2011-12	$ 9,668	$ -	$ 15,000	$ -
Benton	2012-13	$ 546,344	$ -	$ 382,648	$ -
	2011-12	$ 312,781	$ -	$ 414,538	$ -
Clackamas	2012-13	$ 739,159	$ 126,860	$ -	$ 323,992
	2011-12	$ 702,034	$ 126,860	$ -	$ 323,992
Clatsop	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Columbia	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
COOS	2012-13	$ -	$ 63,840	$ -	$ -
	2011-12	$ -	$ 57,904	$ -	$ -
Crook	2012-13	$ 40,000	$ -	$ -	$ -
	2011-12	$ 40,000	$ -	$ -	$ -
Curry	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Deschutes	2012-13	$ 1,158,079	$ 316,099	$ 2,462,674	$ -
	2011-12	$ 1,225,115	$ 24,298	$ 1,172,912	$ -
Douglas	2012-13	$ 27,399	$ 41,200	$ -	$ -
	2011-12	$ 78,829	$ 105,313	$ -	$ -
Gilliam	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Grant	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Harney	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Hood River	2012-13	$ 22,500	$ -	$ -	$ -
	2011-12	$ 21,625	$ -	$ -	$ -
Jackson	2012-13	$ -	$ -	$ 162,828	$ 180,000
	2011-12	$ -	$ -	$ 162,204	$ 84,000
Jefferson	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Josephine	2012-13	$ -	$ 41,507	$ -	$ -
	2011-12	$ -	$ 24,611	$ -	$ -
Klamath	2012-13	$ 2,029,123	$ 22,579	$ 355,740	$ 554,275
	2011-12	$ 1,411,413	$ 63,161	$ 304,884	$ 642,995
Lake	2012-13	$ -	$ -	$ -	$ 140,650
	2011-12	$ -	$ -	$ -	$ 179,854
Lane	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ 326,525	$ -
Lincoln	2012-13	$ 153,750	$ -		$ -
	2011-12	$ 70,878	$ 138,115	$ 78,145	$ -
Linn	2012-13	$ 14,274	$ -	$ 417,041	$ 37,500
	2011-12	$ 44,168	$ 147,279	$ 417,300	$ 96,036

Source: Association of Oregon Counties Shared Services Survey, Fall 2012

County General Fund and Direct Federal Contribution to Community Mental Health System
2011-12 and 2012-13

County	FY	MENTAL HEALTH		ALCOHOL & DRUG	
		General Funds	Direct Federal	General Funds	Direct Federal
Malheur	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Marion	2012-13	$ 8,129,526	$ -	$ 1,313,308	$ -
	2011-12	$ 6,765,370	$ -	$ 1,466,456	$ -
Morrow	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Multnomah	2012-13	$ 10,865,859	$ 503,072	$ 5,564,146	$ 160,000
	2011-12	$ 10,719,973	$ 507,613	$ 5,205,519	$ 541,750
Polk	2012-13	$ -	$ 833,000	$ -	$ -
	2011-12	$ -	$ 1,148,705	$ -	$ -
Sherman	2012-13	$ -	$ -	$ 4,000	$ -
	2011-12	$ -	$ -	$ 4,000	$ -
Tillamook	2012-13	$ 59,000	$ -	$ -	$ -
	2011-12	$ 59,000	$ -	$ -	$ -
Union	2012-13	$ -	$ -	$ 58,945	$ -
	2011-12	$ -	$ -	$ 58,945	$ -
Umatilla	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Wallowa	2012-13	$ -	$ -	$ -	$ -
	2011-12	$ -	$ -	$ -	$ -
Wasco	2012-13	$ -	$ -	$ 20,000	$ -
	2011-12	$ -	$ -	$ 20,000	$ -
Washington	2012-13	$ 1,436,287	$ -	$ -	$ 243,528
	2011-12	$ 1,436,287	$ -	$ -	$ 124,000
Wheeler	2012-13	$ -	$ -	$ 1,300	$ -
	2011-12	$ -	$ -	$ 1,200	$ 6,000
Yamhill	2012-13	$ 335,053	$ 103,911	$ 298,242	$ 197,602
	2011-12	$ 294,824	$ 100,000	$ 398,552	$ 299,039
TOTAL		**$ 48,738,650**	**$ 4,495,927**	**$ 21,102,052**	**$ 3,811,221**

Source: Association of Oregon Counties Shared Services Survey, Fall 2012

ATTACHMENT D

Addictions and Mental Health Division
Presentation to Joint Ways and Means Human Services Subcommittee
Question #2 from March 5, 2013

Staff-to-Patient Ratios Comparison
State Hospital Members of the Western Psychiatric Hospital Association

State	Psychiatry
Alaska	12.5
Arizona	20.0
California	35.0
Colorado (Pueblo)	13.5
Hawaii	15.7
Idaho	17.0
Montana	24.0
New Mexico	116.0
North Dakota	29.0
South Dakota	15.0
Nevada	20.0
Utah	25.0
Washington	25.0
Wyoming	Not Available
Oregon	15.2