OFFICE OF THE DIRECTOR

Tina Kotek, Governor

Oregon Health Authority

500 Summer St. NE E-20
Salem, OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.oregon.gov/oha

March 16, 2023

Senator WInsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

Dear Co-Chairs and Committee Members:

Please find below some additional information requested at the meeting of the Joint Ways and Means Human Services Sub-Committee meeting on March 13, 2023, where OHA's Behavioral Health team presented.

What does OHA mean by "improving civil commitment services?" Please be more specific (Rep. Diehl)

The administrative rules for civil commitment have not been subject to a system-wide review for over 30 years. In the last 9 months OHA has begun revisions that aim to increase patient safety, make treatment providers more accountable, and emphasize the goal of using the least-restrictive care option possible. One example of this is the removal of a rule that allowed Community Mental Health Providers (CHMPs) to discharge patients from civil commitment for a lack of placement. While in place, this rule enabled providers to avoid investing in more treatment options and could result in people who were a danger to themselves, or others being released into the community.

OHA is also working with our partners to give technical assistance on areas such as outpatient commitment, conditional release, and trial visits. This includes working with CMHPs in developing community-based commitment programs since there has not been this capacity for decades, as well as increasing engagement with the judicial system so that that judges understand the benefit of new outpatient options and how their courts can effectively utilize them.

The agency is also improving its use of data. We are building reports that keep us informed of admissions, denials, and waitlists for the Oregon State Hospital (OSH). This in turn is helping us to build out the PAITS (post-acute-intermediary treatment services) program which is designed to divert people from OSH and step down from highly restrictive placements.

OHA's work in this area is complex and wide ranging. The above information is a snapshot and we welcome the opportunity to meet with members of the committee to discuss the agency's work on civil commitment and related areas in more detail.

How does OHA measure success? Please give key performance measures for all your programs. (Rep. Diehl)

After decades of underinvestment, OHA's behavioral health portfolio has in recent years received significant investments from the legislature. These investments have enabled the agency to stand up new programs, revisit existing initiatives, and take a fresh look at performance measurement and management. This includes refining quantitative approaches to ensure that the agency is focusing on the metrics that are most useful for understanding where further investments, legislative interventions and policy changes may be needed, as well as increasing the use of qualitative methods that center the experiences of our partners, providers, and service users.

Attachment A outlines at a high level the key measures used to evaluate progress and success across the 13 behavioral health portfolio programs shared in the overview presentation. The information has been organized by Program Area for ease of interpretation.

A few things for consideration:

- Several programs in this portfolio were newly funded in the 21-23 biennium and the associated metrics reflect what is relevant and feasible data in the early implementation phase.
- Some of the metrics listed here have less comprehensive current data available due to the reporting pause that OHA has had in place throughout the pandemic in response to provider workforce challenges and urgency to maintain focus on direct care. There are several relevant strategic and operational conversations and plans in motion as it relates to meaningful data reporting, as well as streamlined and coordinated quality/process/performance improvement activities, measures and outcomes that align with OHA's strategic goal to eliminate health inequities by 2030. This includes the context of the design, development, and implementation of a comprehensive modernized data collection system and an integrated Behavioral Health Data Warehouse.
- OHA is committed to community engagement and elevating consumer experience. Accordingly, many program teams actively invite and gather qualitative input and consumer experience stories from community providers, organizations, and individuals.

Does OHA have evidence that low-barrier housing prevents drug abuse? Please provide. (Rep. Diehl)

While low-barrier housing cannot by itself prevent someone from developing a substance abuse disorder or from relapsing into one, it is a critical component of the whole-person, system-wide approach that OHA is adopting in the face of Oregon's substance abuse and behavioral health crisis.

This study published in the National Library of Medicine demonstrates that inability to pay rent and/or the threat of losing housing can lead to stress and trigger substance use or relapse.

This study published in The Lancet demonstrates that the lack of stable housing also creates barriers to accessing treatment and makes it less likely that those suffering from substance use disorders will follow treatment recommendations.

This systemic review published in the National Library of Medicine concluded that: ""since homelessness and unstable housing are factors that continue to be associated with public injection, infection, and reduced access to care, this further highlights the importance of offering low threshold services in close proximity to homeless populations and integrating housing supportive services for individuals who are homeless and have concomitant substance use disorders."

Further information is available on the website of the Substance Abuse and Mental Health Services Administration.

OHA states that people are 3-5 times more likely to come off drugs if a harm reduction approach is used. Please provide evidence. (Rep. Diehl)

Attachment B includes information about harm reduction from the following federal agencies and programs:

- Centers for Disease Control and Prevention
- Substance Abuse and Mental Health Services Administration
- United States Department of Health & Human Services
- Office of National Drug Control Policy

The Centers for Disease Control and Prevention's *Summary of the Information on the Safety and Effectiveness of Syringe Service Programs* states that:

- People who inject drugs who regularly use a Syringe Service Program are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used a Syringe Service Program.
- Syringe Service Program facilitate entry into treatment for substance use disorders by people who inject drugs.

Please give information on the long-term survival rates linked to harm reduction. (Sen. Gelser-Blouin)

Harm reduction services enable individuals to access counseling, overdose education and referral to treatment for substance use disorders and treatment for infectious diseases. While it is challenging to quantify long-term survival rates linked to harm reduction due to the multiple variables that impact length and quality of life, evidence indicates that:

- Harm-reduction organizations provide a key engagement opportunity between people who use drugs and health care systems.
- Regular interactions between harm reduction staff and people who use drugs builds trust, allows for an ongoing exchange of information and resources, and can encourage individuals to pursue further treatment options.

- Harm reduction staff can build trust over time with people who use drugs and are in a unique position to encourage them to request treatment, recovery services and health care.

Attachment B (also referenced above) includes information about harm reduction from several federal agencies and programs.

Please share statewide youth suicide statistics. (Rep. Diehl)
Here are the latest statewide youth suicide statistics.

Suicide numbers, rates and rankings by county or state vary by year. Tracking trends across time is the most effective way to study the data. Oregon youth suicide deaths and rates increased significantly between 2011 and 2018. Youth suicides among people younger than 25 years old decreased from 118 deaths in 2019 to 102 deaths in 2020. Of the 102 deaths in 2020, one was a child younger than 10 years old. Compared to 2019, the 2020 rate decreased by 13 percent to 13.3 per 100,000. In 2020, suicide deaths decreased nearly 14 percent among youth under age 25. Oregon's suicide rate was 18th in the nation in 2020.

Table 3. Oregon suicide deaths and rates among those age 10 to 24 compared to the national rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is lowest rate)
2014	97	12.9	12
2015	90	12.0	16
2016	98	13.0	15
2017	107	14.1	17
2018	129	17.0	11
2019	116*	15.3	11
2020	101†	13.3	18

* In addition to these deaths among youths in Oregon age 10–24, there were two suicide deaths among children younger than 10 in 2019.

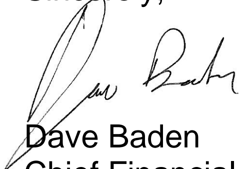
† In addition to these deaths among youth in Oregon age 10–24, there was one suicide death among children younger than 10 in 2020.

For the full Oregon Youth Suicide Intervention and Prevention Plan Annual Report from 2021 please see here:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874_2021.pdf?utm_medium=email&utm_source=govdelivery

The 2022 Annual report is due to be published within the next month once the CDC releases their national data and will include 2021 rates.

Please do not hesitate to reach out if you have any further questions or clarifications.

Sincerely,



Dave Baden
Chief Financial Officer

Oregon Health Authority

Attachment A: Key Metrics tracked by Behavioral Health program teams in response to Ways & Means Sub-Committee on Human Services: March 2023

Program Area	Metric
988 Call Center	Number of 988 Calls that were resolved and prevented death by suicide when suicide was in progress.
988 Call Center	Number of 988 calls that were resolved for individuals or families who were in behavioral health crisis
988 Call Center	Number of individuals and families who received Mobile Crisis Intervention Services after calling 988.
988 Call Center	Number of individuals and families who got connected to M110 line or BHRNs after calling 988
Adult Suicide Prevention & Intervention	Contract with a university to provide process and outcomes measures for the ASIPP
Adult Suicide Prevention & Intervention	Establish an adult suicide prevention advisory to OHA by July 1st of 2024 to guide the ASIPP initiatives
Aid & Assist Services	Number of individuals in community restoration who are classified as homeless by quarter
Aid & Assist Services	Number of individuals placed in community restoration by quarter
Aid & Assist Services	Current OSH goal is to come into compliance with the Mink order (Hospital admission within 7 days of written order) Per Dr. Pinals report this was to be a phased in approach
Behavioral Health Resource Networks	Service utilization: Number clients and number of client encounters reported a BHRN Partner in each of the 7 service areas by demographic group (race/ethnicity, age, gender identity)
Behavioral Health Resource Networks	Spending by service area and budget category
BH Rate Increase	FFS: Number of Culturally & Linguistically Specific Services (CLSS) provider applications approved by county, and number received
BH Rate Increase	CCO BH Directed Payment: Receipt of All CCO attestation of BHDP compliance by March 31, 2023
BH Workforce Development	Developmental: Number of students awarded loan re-payment grants
BH Workforce Development	Recruit/Retain: number of individuals with new Social Worker licenses funded by grants
BH Workforce Development	Recruit/Retain: number of Behavioral Health supervisors trained via Clinical Supervision grants
BH Workforce Development	Recruit/Retain: number individuals with certifications through MACBHO, entering Behavioral Health Workforce
Certified Community Behavioral Health Clinics (CCBHCs)	Access (I-Eval) - time between initial point of contact to formal evaluation/billable outpatient services. CCBHCs are required to meet a 10 day window
Certified Community Behavioral Health Clinics (CCBHCs)	Follow-up after ED/hospital for Mental Health (FUM, FUH-BH-A) - demonstrate CCBHCs' ability to provide a continuous episode of treatment through transitions of care
Certified Community Behavioral Health Clinics (CCBHCs)	Initiation/engagement of SUD treatment (IET-BH) - two part metric tracks both the start and continuous progress of an individual in substance use treatment
Certified Community Behavioral Health Clinics (CCBHCs)	Patient experience of care survey (PEC) - survey balances quantitive and qualitative feedback from perspective of diverse service users
Children's System of Care	https://www.oregon.gov/dhs/Pages/SOC-Dashboard.aspx

Oregon Health Authority

Attachment A: Key Metrics tracked by Behavioral Health program teams in response to Ways & Means Sub-Committee on Human Services: March 2023

Program Area	Metric
Civil Commitment Services	Number of Notice of Mental Illness (NMIs) filed and the number of NMIs that become civil commitments
Civil Commitment Services	Number of 14-day diversions statewide and how many result in discharge vs. civil commitment hearing
Civil Commitment Services	Number of community-based commitments: trial visits, conditional releases, outpatient commitment
Civil Commitment Services	Lengths of stay at acute psychiatric care facilities
Harm Reduction Clearinghouse	Reach: Number, type and location of entities participating in the HR Clearinghouse.
Harm Reduction Clearinghouse	Financial: Amount spent by entities on the HR Clearinghouse' allowable supply lists, including naloxone.
Harm Reduction Clearinghouse	Process: (a) Suppy orders by entity type (b) Entity naloxone distribution reports (c) Optional communtiy impact stories shared by entities in disteibution reports
Mobile Crisis Intervention Services	All ages: Number of individuals and families who received Mobile Crisis Intervention Services
Mobile Crisis Intervention Services	All ages: Services that the individuals was taken to connected to by the Mobile Crisis Intervention Teams.
Mobile Crisis Intervention Services	Number of individuals who required overdose reversal.
Mobile Crisis Intervention Services	Number of incidents that were resolved by Mobile Crisis Intervention team when suicide effort was active.
Treatment Capacity/SDOH	Total RFA Awards allocated (defn)
Treatment Capacity/SDOH	Total RFA Awards spent (defn)
Treatment Capacity/SDOH	Total residential beds associated with grantee projects, by type and by county
Treatment Capacity/SDOH	Total supportive housing units associated with grantee projects, by county
Youth Suicide Prevention & Intervention	Youth Suicide Fatality Number + Rates (ORVDRS)
Youth Suicide Prevention & Intervention	Visits to Emergency Departments for Suicide (ESSENCE report)
Youth Suicide Prevention & Intervention	Percentage of students self-report suicide thoughts of suicide (Student Health Survey)

Oregon Health Authority

Attachment B: Information and Citations about harm reduction from the federal agencies and programs (CDC, HHS, SAMHSA and ONDCP) in response to Ways & Means Sub-Committee on Human Services

Below is information from federal agencies and offices related to harm reduction, including the specific Syringe Service Program intervention model. I have included the reference citations.

The federal agencies and offices include the

1. Centers of Disease Control and Prevention (CDC)
2. US Health and Human Service (HHS) Overdose Prevention Strategy and Substance Abuse and Mental Health Administration (SAMHSA)
3. Office of National Drug Control Policy (ONDCP)

1. Centers for Disease Control and Prevention

Syringe Service Programs : SSPs save lives, help those experiencing a substance use disorder get the support needed to regain a healthy life, and reduce the impact of drug use on the community. We can prevent and treat infections and overdose deaths through SSPs. Together, we have an unprecedented opportunity to combat the nation's opioid crisis while continuing to strengthen infectious disease prevention and treatment for communities everywhere.

Summary of Information on the Safety and Effectiveness of Syringe Service Programs (SSPs)

Section: Linkage to Substance Use Treatment, Naloxone, and Other Healthcare Services

- Syringe services programs serve as a bridge to other health services including, HCV and HIV diagnosis and treatment and MOUD for substance use.[24]
- The majority of SSPs offer referrals to MAT,[25] and
- **People who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder** and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.[13,26,27]
- SSPs facilitate entry into treatment for substance use disorders by people who inject drugs.[26,28]
- People who use SSPs show high readiness to reduce or stop their drug use.[29]
- There is also evidence that people who inject drugs who work with a nurse at an SSP or other community-based venue are more likely to access primary care than those who don't,[36] also increasing access to MAT.[30]
- Many comprehensive community based SSPs offer a range of preventative services including vaccination, infectious disease testing, and linkage to healthcare services.
- Syringe services programs can reduce overdose deaths by teaching people who inject drugs how to prevent and respond to a drug overdose, providing them training on how to use naloxone, a medication used to reverse overdose, and providing naloxone to them.
- Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[31,32] SSPs have partnered with law enforcement, providing naloxone to local police departments to help them keep their communities safer.[33]

CDC Citations

[13] **Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER, "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors", Journal of Substance Abuse Treatment, 2000; 19:247–252.**

[24] HIV and Injection Drug Use: Syringe Services Programs for HIV Prevention. (2016). CDC Vital Signs.

[25] Des Jarlais D., Nugent A., Solberg A. Syringe service programs for persons who inject drugs in urban, suburban, and rural areas — United States, 2013 MMWR Morb Mortal Wkly Rep 2015;64: 1337-1341

[26]Strathdee, S.A., Celentano, D.D., Shah, N., Lyles, C., Stambolis, V.A., Macal, G., Nelson, K., Vlahov, D., "Needle-exchange attendance and health care utilization promote entry into detoxification", J Urban Health 1999; 76(4):448-60.

[27]Heimer, R. (1998). Can syringe exchange serve as a conduit to substance abuse treatment? Journal of Substance Abuse Treatment 15:183–191.

[28]Bluthenthal, R.N., Gogineni, A. Longshore, D., Stein, M. (2001). Factors associated with readiness to change drug use among needle-exchange users. Drug & Alcohol Dependence 62:225-230.

[29]Artenie, Andreea & Jutras-Aswad, D & Roy, É & Zang, G & Bamvita, J-M & Lévesque, Annie & Bruneau, J. (2015). Visits to primary care physicians among persons who inject drugs at high risk of hepatitis C virus infection: Room for improvement. Journal of Viral Hepatitis. 22. 10.1111/jvh.12393.

[30]Chou R, Korthuis PT, Weimer M, et al. Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Dec. (Technical Briefs, No. 28.)

[31]Seal, KH, Thawley R, Gee L, Bamberger J, Kral AH, Ciccarone D, Edlin BR (2005). "Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: A pilot intervention study", Journal of Urban Health: Bulletin of the New York Academy of Medicine, 2005; 82(2) 303–311.

[32]Leece PN, Hopkins S, Marshall C, Orkin A, Gassanov MA, Shahin RM, "Development and implementation of an opioid overdose prevention and response program in Toronto, Ontario", Canadian Journal of Public Health, 2013;104(3): e200-4.

[33]Childs, R. Law Enforcement and Naloxone Utilization in the United States [PDF – 1 MB, 24 pages].

[36]Klein SJ, Candelas AR, Cooper JG, Badillo WE, Tesoriero JM, Battles HB, Plavin HA, "Increasing safe syringe collection sites in New York State", Public Health Reports, 2008; 123(4):433-40.

2. US Health and Human Service (HHS) Overdose Prevention Strategy and Substance Abuse and Mental Health Administration (SAMHSA)

The US Health and Human Service (HHS) Overdose Prevention Strategies include

1. Primary Prevention
2. **Harm Reduction:** Current federal activities that promote harm reduction including advancing research and demonstrations on innovative harm reduction approaches, promote evidence-based harm reduction services, including those that are integrated with health care delivery and more…
3. Evidence Based Treatment
4. Recovery Support

From SAMHSA: Harm Reduction's Place in and Among Prevention, Treatment, and Recovery

Harm reduction is part of the continuum of care. Harm reduction approaches have proven to prevent death, injury, disease, overdose, and substance misuse. Harm reduction is effective in addressing the public health epidemic involving substance use as well as infectious disease and other harms associated with drug use. Specifically, harm reduction services can:

- Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders.
- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who might respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among people who use drugs, including those who inject drugs by equipping them with accurate information and facilitating referral to resources.
- Reduce overdose deaths, promote linkages to care, facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders
- Promote a philosophy of hope and healing by utilizing those with lived experience of recovery in the management of harm reduction services, and connecting those who have expressed interest to treatment, peer support workers and other recovery support services.

3. Office of National Drug Control Policy (ONDCP)

2021 Office of National Drug Control Policy Priorities

Priority 3: ***Enhancing evidence-based harm reduction efforts***

Access to quality health care, treatment, and recovery support services is essential for people with substance use disorders. However, for some people with chronic conditions, formal systems of care are often inaccessible. Their **first point of contact may be through organizations that offer low-barrier services, including harm reduction**. Such services meet people where they are.

These services include lifesaving and evidence-based interventions such as

- Providing the overdose antidote naloxone,
- Sterile syringes,
- Fentanyl test strips (FTS), and
- testing for the human immunodeficiency virus (HIV) and Hepatitis C virus.

Research has shown that syringe services programs (SSPs)

- Reduce HIV prevalence.[34,35,36]
- Have the potential to connect at-risk populations to needed care.[37]

Harm-reduction organizations provide a key engagement opportunity between people who use drugs (PWUD) and health care systems, often employing peer support workers.

Regular engagement between harm reduction staff and PWUD builds trust,[38] allowing for an ongoing exchange of information, resources, and contact. This relationship can encourage individuals to further pursue a range of treatment options including MOUD induction, psychosocial treatment, and long-term recovery. Harm reduction staff can build trust over time with patients and are in a unique position to encourage PWUD to request treatment, recovery services, and health care.

Oregon Health Authority

Attachment B: Information and Citations about harm reduction from the federal agencies and programs (CDC, HHS, SAMHSA and ONDCP) in response to Ways & Means Sub-Committee on Human Services

ONDCP Citations

[34]Hurley, S., Jolley, D., & Kaldor, J. (1997). Effectiveness of needle-exchange programmes for prevention of HIV infection. The Lancet (British Edition), 349(9068), 1797–1800. https://doi.org/10.1016/S0140-6736(96)11380-5

[35]World Health Organization. (2004) Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injection drug users. Geneva, Switzerland. (Author). http://www.who.int/hiv/pub/idu/e4a-needle/en/

[36]National Institutes of Health. (1997). Consensus Development Statement: Interventions to prevent HIV risk behaviors, February 11-13, 1997:7-8 Rockville, MD. https://consensus.nih.gov/1997/1997PreventHIVRisk104html.htm

[37]Amundsen EJ. Measuring effectiveness of needle and syringe exchange programmes for prevention of HIV among injecting drug users. Addiction. 2006;101:911–2. https://doi.org/10.1111/j.1360-0443.2006.01519.x

[38]Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: compassionate care of persons with addictions. Medsurg nursing: official journal of the Academy of Medical-Surgical Nurses, 22(6), 349– 358. ttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC4070513/