

Ways & Means Subcommittee Human Services  
Questions from the February 15, 2005  
Office of Mental Health & Addictions Services Presentation

March 9, 2005

**1. Are you asking for additional funding to expand beds in community settings for individuals leaving the state hospital?**

**A:** Yes, the 2005-07 Governor's Recommended Budget includes funding to develop community-based services for adults who are either civilly or criminally committed to the Department. The Budget includes resources to develop 184 community-based placements for adults who are civilly committed and 94 for those who are criminally committed.

**2. Are there plans to increase bed capacity at the state hospital?**

**A:** The Governor's Recommended Budget includes funding for the second phase of a Master Plan for the state hospital, but **does not** include funding to increase the number of state hospital beds. The Department will respond to growth in caseload by creating more community-based services and discharging people who have made maximum benefit of state hospital treatment.

**3. What are the specific goals (numbers) related to capacity of state hospital beds vs. community beds?**

**A:** The system will begin 2005-07 biennium with 791 total community beds for adults who are civilly committed and have extended treatment needs and 245 total community beds for adults under the supervision of the Psychiatric Security Review Board. There are 193 state hospital beds budgeted for adults who have been civilly committed to the Department and 434 state hospital beds for adults who have been criminally committed to the Department or are being treated until fit to proceed.

**4. How many community placements have been created?**

**A:** As of March 1, 2005, 54 beds have been developed between July 1, 2004 and February 2005 for adults who are **civilly committed**. By June 30, 2005 an additional 111 beds will be developed.

As of March 1, 2005, 37 beds have been developed between July 1, 2004 and February 2005 for adults who have been **criminally committed**. By June 30, 2005 an additional 95 community placements will be developed.

**5. Senator Winters asked for statistics related to OSH employee worker compensation claims.**

**A:** Exhibit A shows the July 2003 through January 2005 Behavioral Management Injuries reported compared to the Behavioral Management Claims made.

**6. Requested addition of two outcome measures for substance abuse:**

**-What is the length of time people are in treatment?** See Exhibit B.

**-What happens to people after treatment?** In order to determine what happens to people after treatment, OMHAS is actively working with Oregon Youth Authority (OYA) and the Employment Department to exchange data. In both cases, the goal is to look at OMHAS clients' arrest and employment status before, during, and after treatment. The employment data will allow OMHAS to look at changes in employment and income levels for our clients. The OYA data will allow OMHAS to better understand the overlap with OYA and juvenile justice clients. OMHAS will be able to track arrest rates and juvenile justice referrals for OMHAS clients. This will be key to tracking system outcomes related to SB 267.

OMHAS also has access to Department of Corrections data, the Law Enforcement Data Set (LEDS), and DHS data sets, such as child welfare data, through the DHS Integrated Client Database (ICDb). OMHAS will begin using this resource to better understand OMHAS clients and their impact on other Offices within DHS.

All of these data sets allow OMHAS to develop system and provider level outcomes, such as rate of client employment following treatment and arrest rates pre- and post-treatment.

**-How do our measures compare with national averages and data?** At the national level the work on a set of comparable outcomes for alcohol and drug treatment is in the development stages. The data are not currently available.

**7. Percentage of mandated vs. voluntary alcohol & drug clients?**

**A:** Exhibit B expands on the information provided at the hearing.

**8. What are the rules associated with urinalysis testing in alcohol & drug treatment?**

**A:** Exhibit C describes the requirements.

**9. Senator Westlund asked about getting people into alcohol & drug treatment soon enough. What are the wait lists looking like? How long does it take for someone to access treatment once he or she requests it?**

**A:** See Exhibit D.

**10. Erinn Kelley-Siel forwarded a series of issues/questions to Weeks and Becker. One was Senator Winters wanting to know how DHS uses its contracts to ensure that county-based programs are “evidence-based” and results in good outcomes. She was particularly focused on alcohol & drug.**

**A:** See Exhibit E.

**11. Senator Winters asked about mental health issues in other states, especially related to state hospital census.**

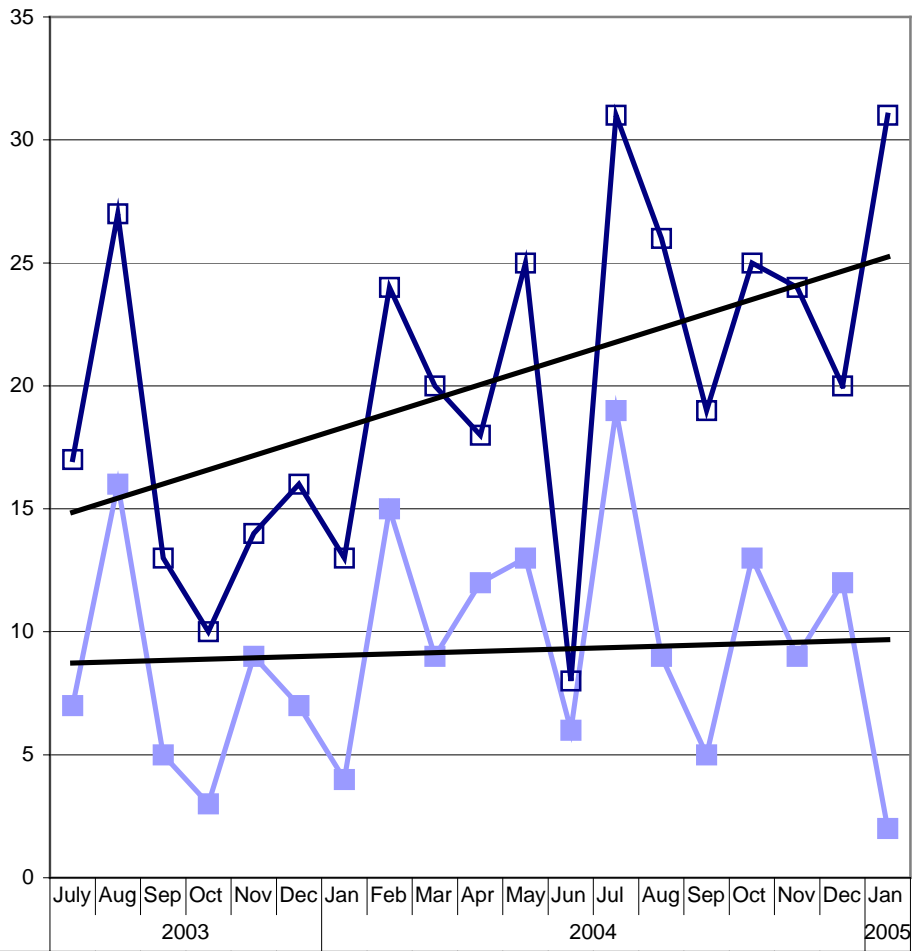
**A:** See Exhibit F.

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**EXHIBIT A**

Injury Trends  
July 2003 – January 2005

**OSH WORKER'S COMPENSATION DATA**



Behavior Management Injuries	17	27	13	10	14	16	13	24	20	18	25	8	31	26	19	25	24	20	31
Behavior Management Claims	7	16	5	3	9	7	4	15	9	12	13	6	19	9	5	13	9	12	2

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## EXHIBIT B

Average length of time in treatment  
and  
percentage of clients referred from justice system

**Time Period: FY03/04**

<b>Average Length of Stay</b>	
	Number of Days in Treatment
Detox	6
DUII	129
Methadone	618
Outpatient	123
Residential	80

Note: Includes only those clients who were discharged from treatment in FY03/04.

<b>Clients Referred from Justice System to Treatment</b>				
	# of Clients Justice System Referrals to Treatment	# of Clients Voluntary to Treatment	Total # of Clients Served	<b>% of Justice System Referral Clients</b>
Detox	63	2,600	2,663	<b>2%</b>
DUII	22,339	1,043	23,382	<b>96%</b>
Outpatient	13,165	12,631	25,796	<b>51%</b>
Residential	1,761	2,616	4,377	<b>40%</b>
Methadone	59	4,047	4,106	<b>1%</b>
	37,387	22,937	60,324	<b>62%</b>

Note: Total Referrals is an unduplicated count and is taken from updated FY03/04 files.

## **EXHIBIT C**

### Urinalysis testing

DUII treatment programs collect a minimum of two urinalysis samples for each client. The program must collect at least one sample during the first two weeks of treatment and one sample during the last two weeks of the program. The program may not discharge a client as having successfully completed unless the client has demonstrated continuous abstinence for a minimum of 90 days prior to discharge, documented by urinalysis tests and other evidence.

Opioid treatment programs (methadone treatment) must provide adequate testing for drugs of abuse, including at least eight random drug abuse test per year for each patient. More frequent testing must be done if clinically indicated.

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**EXHIBIT D**

Wait time to access substance abuse treatment

In order to determine the length of time individuals are waiting to access substance abuse treatment services, OMHAS conducted a survey of statewide treatment providers. OMHAS sent out e-mail surveys and posted an on-line survey. In addition, 18 programs in 10 counties statewide were contacted by telephone. The survey was conducted to determine approximate waitlists for outpatient and residential alcohol and drug treatment. Wait times varied by county and payment source, pregnant women and IV drug users are prioritized for admission.

<b>Type of program</b>	<b>Average</b>	<b>Range</b>
Adult Residential	4 months	2 – 6 months
Adult Outpatient	2 ½ weeks	1 day – 4 weeks
Youth Residential	3 months	1 ½ – 3 ½ months
Youth Outpatient	1 ½ weeks	1 – 2 weeks

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**EXHIBIT E**

County contracts and evidence-based practices

In order to increase the use of evidence-based practices, OMHAS has drafted language for the 2005-2007 county agreements that require counties to design their competitive selection processes for subcontractors to include the use of evidence-based practices as a selection criterion. Counties will also be required to report annually on the percentage of OMHAS funds being used to deliver evidence-based practices. Knowledge of the level of evidence-based practices in use in particular areas will assist in making future decisions on resource allocation.

OMHAS requires the contractors to report more than just the volume of service or the types of services provided. Contractors must also report measurable outcomes, including engagement in treatment, treatment retention, and successful completion. These outcomes are continuously monitored and are shared with providers as a quality improvement mechanism.

## **EXHIBIT F**

Summary of what other states are doing  
By: Robert E. Nikkel, Administrator, OMHAS

I reviewed the National Association of State Mental Health Program Directors' Research Institute, Inc. state profiles for 9 states from the latest year available (2002). I chose states that were either similar in size to Oregon (Connecticut, Oklahoma, Colorado, South Carolina) or with reputations for being innovative (Vermont, Ohio, Indiana) or closeby (Washington) or at the suggestion of Senator Winters (Kansas).

The preliminary findings are summarized as follows:

1. Almost all of the states are struggling with a shortage of psychiatric inpatient beds. No state said that they had enough.
2. All states are experiencing shortages of mental health professionals
3. All states report that they have gatekeeping mechanisms in place to assure authorization for admissions and transitions back to communities for patients ready to place.
4. All states are implementing Evidence-Based Practices, some more than others, especially Vermont, Ohio and Kansas. Oregon is rapidly catching up with the implementation of SB 267.
5. All states are using 24/7 crisis and alternatives to lessen reliance on hospitals for acute inpatient care.
6. All states are involved with various initiatives to better interface with the criminal justice system including such options as mental health courts, liaison with law enforcement, local jails and state corrections.
7. Kansas serves relatively few children and relatively more adults who do not have severe and persistent mental illness.

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Oregon stands out for several reasons:

1. We serve a relatively high proportion of clients per capita.
  
2. We have by far the highest rate of persons found Guilty Except for Insanity or whatever the equivalent adjudication is in others states. Even in comparison to Connecticut, which is the only other state that has a Psychiatric Security Review Board, we are far ahead. Connecticut's population size is very similar to Oregon's and they had only 7 new PSRB adjudications compared to Oregon's 79 (probably 2001 data). We have now set an all time record in 2004 with 126 new adjudications.
  
3. Not surprisingly then, we have by far the highest percentage of state hospital patients with criminal court commitments (67%) compared to the next highest states (Vermont at 49% and Ohio at 47%). Kansas has 43% but has a sexual offender population that Oregon is not responsible for. Connecticut has 34% (in spite of having a PSRB). South Carolina has only 21% and Indiana has 18%.
  
4. Oregon has a relatively high number of intermediate (we call them "Extended Care") beds for community alternatives to the state hospital. We are also unique in having a clinical gatekeeping team that assists programs and state hospitals in matching with client needs and in utilization management.

In reviewing other states through newspaper and personal communications, it is obvious that since 2002, the difficulties with increasing numbers of forensic patients has increased. Washington State is adding another 30-bed forensic unit. Utah built a new hospital but is realizing it will soon be filled with forensic patients. West Virginia had a 40% cut in Medicaid mental health services 4 years ago and has been seeing the results in state hospital overcrowding (whereas before they had empty state hospital beds), record setting civil commitment proceedings, record setting suicides, and local emergency departments clogged with mentally ill patients in crisis. Connecticut recently opened new forensic beds and they are already filled and overfull. Indiana reviewed its mental health system several years ago and looked at Oregon as one of the model states from which to learn. Ohio's state prisons have been overwhelmed with inmates who have mental illness;

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a policy decision was made to increase responsibility for mental health treatment provided within the state Department of Corrections. California is about to open a new 1,500 bed forensic psychiatric hospital in Coalinga in order to serve the large number of inmates with sex offender status.