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Progress Report on the Implementation of
Evidence-Based Practices

Evidence-Based Practices in Mental Health and Addiction Services

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

The research related to mental health, substance abuse, and problem gambling services is extensive, although the amount of existing research for any particular type of service may vary considerably, depending on the type of service and the population being served. Implementation of EBPs addresses a matrix of services and evidence, with major efforts focused on those practices that have the widest applicability and the strongest research base. The continuing efforts will address a broad range of issues and will need to accommodate the needs of the service delivery system for training, technical assistance, and new workforce development efforts.

Initial Implementation Actions

The first step in implementing ORS 182.525 was to develop an operational definition of EBPs for mental health and addiction services. After a review of definitions found in the literature and developed by other states, AMH developed an initial draft for review by the field. Two large stakeholder meetings followed and included, among other topics, a discussion of the draft definition. Subsequent drafts were distributed widely to stakeholders, including consumers, providers, managed care entities, counties, tribes, and other state agencies affected by the legislation. After extensive consultation with these stakeholders, AMH adopted a definition for use in continuing the implementation. AMH has continued to review and revise the definition, making improvements and adjustments based on stakeholder comments and implementation experience.

Secondly, AMH established an internal steering committee to direct a system-wide approach to ensuring the widespread adoption of EBPs. The steering committee reviews policy issues and evaluates input from a broad-based stakeholder group. To further promote implementation of ORS 182.525, AMH also established an Evidence-Based Practices Unit. The manager of that unit leads AMH EBP implementation activities and chairs the stakeholder workgroup and the AMH internal steering committee. The Evidence-Based Practices Manager also coordinates the EBP activities of AMH with other state agencies subject to the requirements of ORS 182.525.

Third, AMH has established a policy and procedure for identifying, evaluating, approving and listing evidence-based practices and programs. Again, AMH developed the policies and procedures with the advice and assistance of the stakeholder workgroup. The procedures include a means for practices to be nominated by stakeholders and include review by researchers and other specialists outside AMH.

Current Status of Evidence-Based Practices in the Oregon Prevention and Treatment System

Oregon has made substantial progress in the adoption of EBPs and stands as one of the leaders in evidence-based practices in mental health and addiction services. Oregon's efforts have attracted the interest of researchers, providers and policymakers nationwide. In establishing a framework for the progressive,

systematic EBP adoption, Oregon presents a model for other states. Oregon's efforts are not the results of AMH action alone, but the results of collaboration between providers, consumers, researchers, state agencies, managed care organizations and other system stakeholders. The collaboration has resulted in an approach that has minimized unintended consequences and many of the pitfalls encountered by other states.

It should be noted that EBP implementation began before passage of SB 267. Many providers were "early adopters" who began the steps necessary for EBP implementation on their own initiative well before passage of the legislation. Providers were delivering a significant proportion of mental health and addiction services through evidence-based practices and programs, even before AMH began the formal process of implementing ORS 182.525. The task was, therefore, to support, strengthen and expand a process that was underway and to provide a formal framework for broader implementation and measurement of system-wide progress.

Measuring progress presents some methodological difficulties. AMH uses a variety of management information systems to measure contract and administrative rule compliance. These systems record and monitor demographics, compliance with minimum standards, and compliance with contract requirements for the volume of service or numbers served. These systems were not designed to measure provider or program quality, nor the implementation of EBPs; consequently, AMH established an initial baseline percentage of expenditures in EBPs by conducting structured surveys of providers and contractors.

In February 2005, AMH asked the Community Mental Health Programs (CMHPs), state hospitals, residential programs and tribes to provide estimates of the amount of funds spent on specified EBPs. Relying on these estimates, AMH compiled an estimate of the amount of funds in each service area spent on EBPs. This established a baseline for later measurement of progress. Based on the survey results, AMH estimates that the percentage of public funds being expended to support EBPs for alcohol and drug prevention and treatment is 56%. For mental health services, we estimate that 33% of state funding is used to support EBPs.

Cost Effectiveness

A large array of evidence-based practices may be applied to mental health and addiction services. The diagnostic and demographic diversity of the populations being served means clinical interventions will vary greatly, depending on the needs of the individual client. As the practices vary, so will the level of cost and/or cost effectiveness. However, because they provide improved outcomes, most EBPs will provide potential cost savings for treatment providers and for allied agencies.

A recent survey of the scientific literature (Belenko, Patapis, and French 2005) reached the following major conclusions about the cost effectiveness of alcohol and drug treatment:

- Nearly two decades of treatment research, represented by hundreds of studies, finds that substance abuse treatment, especially when it incorporates evidence-based practice, results in clinically significant reductions in alcohol and drug use and crime, and improvement in health and social function, for many clients.
- Economic studies across settings, populations, methods, and time periods consistently find positive net economic benefits of alcohol and other drug treatment that are relatively robust. The primary economic benefits occur from reduced crime (including incarceration and victimization costs) and post-treatment reduction in health care costs.

An example of Oregon-based research on cost effectiveness of alcohol and drug abuse treatment is a study of the Multnomah County drug court (Finegan 1998). This study showed savings of $10 for every dollar spent on drug court treatment. A subsequent study (Carey and Finegan 2004) concluded that the Multnomah County drug court achieved lower recidivism at a lower cost than standard court processing. Research from other states (Barnoski & Aos 2003, Logan et al. 2004, Loman 2004) replicates the conclusions of the Oregon research, validating the drug court model as an EBP and confirming the evidence of substantial savings from using this practice.

Studies on the most significant mental health EBPs provide a similar picture. For instance, the assertive community treatment model has been the subject of more than 25 randomized controlled trials. Results show that this type of program is effective in reducing hospitalization, costs no more than traditional care, and is more satisfactory to consumers and their families than standard care (Phillips et al.

2001). A study by the Washington State Policy Institute (Aos et al. 2001) on the costs and benefits of programs to reduce crime showed high cost/benefit ratios for adolescent programs using multi-systemic family therapy and functional family therapy. The same study showed high cost benefit ratios for adult offender programs using cognitive behavioral therapy.

While cost-effectiveness for many EBPs is impressive, both implementation costs and outcomes vary between practices, so the expected savings for each practice also vary. Accordingly, the research on cost effectiveness for each practice will be useful for providers to consider when selecting practices for implementation. To assist providers in selecting practices that are cost effective and financially feasible, AMH has begun including cost and cost effectiveness information in the Web site summary of each practice that is added to the AMH list. AMH will also provide links to the Substance Abuse and Mental Health Services (SAMHSA) National Registry of Evidence-Based Practices and Programs (NREPP), which provides similar information on each practice. With accurate information on costs and cost effectiveness, system stakeholders will be able to make informed decisions when selecting practices for adoption and implementation. This will ensure that the service delivery system maintains cost effectiveness as a principal goal in the EBP effort.

Although much more work remains to be done in evaluating the long-term economic benefits of mental health and addiction treatment, the current literature provides abundant evidence that each dollar spent on EBPs provides a positive return. However, in evaluating cost effectiveness and projected savings from implementing EBPs, policymakers should not assume that savings resulting from effective treatment would necessarily be manifested in reduced caseloads or even in expenditures in the same social service system that provides the cost effective service. Current treatment capacity and access to care is so limited that even effective evidence-based treatment may not keep pace with the demand for services or the expansion social service or criminal justice caseloads. A more realistic expectation is that evidence-based services will decrease the need for high-cost psychiatric emergency services and reduce criminal justice caseload growth. Lower recidivism will, in turn, enable providers to serve a higher proportion of the population in need.

Workforce Development

Effective adoption and implementation of EBPs will require a workforce with the knowledge and training relevant to specific EBPs, as well as leaders and administrators who understand the challenges of implementing and maintaining systemic change. Working with the field to address these challenges, AMH has developed a strong, research-based technical assistance effort that has replaced the older model of training individuals on specific topics. Published research on implementation processes for EBPs, as well as practical experience from Oregon stakeholders, suggests that providers will benefit most from consultants or mentor programs that deliver advice and technical assistance specific to particular EBPs. To this end, AMH makes teams of consultants on EBP adoption available to providers at little or no cost. These teams provide programs with ongoing advice on theoretical and organizational approaches. This goes beyond simple training in techniques and assists providers to manage the organizational and procedural changes necessary to adopt and maintain EBPs.

In addition to making consultation available to providers, AMH has updated its training plan and schedule. Remaining workforce development resources have been focused on delivering training designed to provide workers with knowledge and technical skills necessary to deliver evidence-based services. AMH has also been working with counselor accreditation bodies, universities and community colleges to ensure that college curricula related to mental health and addiction services focus more closely on evidence-based prevention and treatment theory and practice.

As a long-term strategy for workforce development and technical assistance, AMH is considering the "centers of excellence" concept. A center of excellence is a unique mix of partners, including universities, consumer groups, providers, and private research groups, that promotes a particular EBP by providing education, training, consultation, and fidelity and outcomes evaluation. Their primary audience is agency-based mental health and addiction practitioners and key constituents from other systems, such as education and criminal justice. The concept has been applied successfully in other states and would provide added impetus to Oregon's EBP implementation efforts. AMH has begun discussions with other states to determine the amount of additional resources needed to implement a center of excellence and to review processes for development and implementation. Because investments in centers of excellence provide a cost

effective means of strengthening EBP adoption, implementation and fidelity monitoring, AMH will seek to identify resources to support one or more of these centers.

Workforce development remains a significant challenge for the EBP effort. Turnover in professional staff is high and the higher education system is not adequately preparing students to implement evidence-based practices. Providers have difficulty finding resources to support the re-training and reorganization necessary for effective EBP adoption and implementation. AMH and its stakeholders will continue to work together to find solutions to these problems, but inadequate resources for workforce development may slow the progress of EBP implementation.

Fidelity Monitoring

The effectiveness of a particular EBP depends on how accurately the provider has followed or replicated the essential elements of the model defined in the research. Incomplete or ineffective adherence may result in outcomes not meeting expectations. Providers must therefore have a means of looking at or measuring their adherence to the model they are implementing. AMH has been assisting some providers by conducting fidelity monitoring using research-based fidelity scales. For example, AMH conducts fidelity reviews of Supported Employment providers.

Ensuring adequate fidelity monitoring presents challenges. AMH has limited resources to redirect to fidelity monitoring activities. Providers may conduct self-monitoring, but funding for administration is limited and must also be used to support clinical supervision and quality assurance activities. Administrative rule streamlining underway may free some AMH staff resources for fidelity monitoring, but system-wide monitoring would require resources well beyond what streamlining might provide. Recognizing that additional resources are needed, AMH continues to seek grant funding and other resources to enhance fidelity monitoring capacity.

Evidence-Based Practices and Cultural Competence

In pursuing a comprehensive and systematic effort to meet the requirements of EBP legislation, AMH has continued to consult with a diverse stakeholder group

about implementation strategies. In the course of these consultations, stakeholders raised concerns that the EBP efforts might not meet the needs of Oregon's culturally diverse population and that some groups might be left behind or disadvantaged by new definitions, practices, or funding patterns. Stakeholders expressed the view that a narrow, rigid focus on scientific validity that ignores cultural norms, values and traditions would provide negative results for particular groups or populations. The increased focus on science might not provide the desired outcomes if other variables such as cultural competence and counselor ability were ignored.

In response to questions and comments from stakeholders, AMH re-examined the context of the EBP effort. With stakeholder input, AMH revised the definition of EBPs to reflect the understanding that beneficial outcomes from EBPs require programs that are culturally competent and that respect and understand the values and beliefs of the persons receiving the services. Scientific technique alone is not enough. The revised definition recognizes cultural competence as an essential value in the ongoing effort.

In working with providers and programs that serve diverse populations, AMH will avoid the pitfall of compelling providers to abandon traditional, culturally-validated practices in favor of practices that may not have been adequately tested with the particular population being served. AMH will instead work closely with entities such as the One Sky Center at OHSU or White Bison in Colorado to ensure that adoption, implementation or maintenance of evidence-based practices results in services that are culturally competent and that meet the needs of the people being served.

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

Administrative Rule and Contract Changes

Because the number of EBPs applicable to behavioral health treatment services is very large, it is not feasible to write a rule that defines each and every practice. We can, however, identify elements and principles that provide the necessary core of

effective EBP implementation for a broad array of practices. These core elements can be defined by rule and implementation can be measured through onsite reviews by AMH staff. Accordingly, AMH is amending existing rules to incorporate these key elements. In particular, AMH will focus on developing clearer and more detailed requirements for provider quality assurance/quality improvement processes and more clearly defined requirements for clinical supervision.

It may be useful in some instances to develop a rule incorporating the essential elements of a particular EBP model for providers serving a specific population. For example, in cooperation with the Department of Corrections, AMH is developing an administrative rule setting standards for corrections alcohol and other drug treatment programs. The rule will incorporate EBPs specific to providers serving corrections clients.

Finally, AMH is working with stakeholders and advisory groups to define contract changes that provide incentives for the adoption of EBPs. Competitive solicitations have already begun to feature requirements to demonstrate the use of EBPs as part of the selection criteria. AMH has requested that counties address how they will implement EBPs in their 2007-2009 Biennial Implementation Plans. For the 2007-2009 contracts, AMH is examining the need and feasibility of adding a performance requirement for contractors to demonstrate the use of EBPs. AMH is also studying changes in fee structures that would increase reimbursement rates for EBPs, while reducing payments for services that have not clearly demonstrated improved outcomes.

Conclusion

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

References

Aos, S., Phipps, P., Barnoski, R., Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime.* Document No. 01-05-1201. Olympia, WA: Washington State Institute for Public Policy.

Barnoski, R. and Aos, S. (2003). *Washington State's drug courts for adult defendants: Outcome evaluation and cost benefit analysis.* Document No. 03-03-1201. Olympia, WA: Washington State Institute for Public Policy.

Belenko, S., Patapis, N., & French, M.T. (2005). *Economic benefits of drug treatment: a critical review of the evidence.* Treatment Research Institute at the University of Pennsylvania.

Carey, S.M. & Finegan, M. (2004). A detailed cost analysis in a mature drug court setting. *Journal of Contemporary Criminal Justice,* 20, 315-338.

Finegan, M. (1998). *An outcome program evaluation of the Multnomah County S.T.O.P. Drug Diversion Program.* Northwest Professional Consortium, Portland, OR.

Logan, T.K., Hoyt, W.H., McCollister, K.E., French, M.T., Leukefeld, C., & Minton, L. (2004). Economic evaluation of drug court: Methodology, results, and policy implications. *Evaluation and Program Planning,* 27, 381-386.

Loman, L.A. (2004). *A cost-benefit analysis of the St. Louis City adult felony drug court.* St. Louis, MO: Institute for Applied Research.

Phillips, S.D., Burns, B.J., & Edgar, E.R. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services, 52, 771-779.*