Oregon

UNIFORM APPLICATION
FY 2007

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Oregon
DUNS Number: 623575339

Uniform Application for FY 2007 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Department of Human Services

Organizational Unit: Addictions and Mental Health Division

Mailing Address: 500 Summer Street NE E86

City: Salem Zip: 97301-1118

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Karen Wheeler

Agency Name: Addictions and Mental Health Division

Mailing Address: 500 Summer Street NE E86

City: Salem Zip Code: 97301-1118

Telephone: 503-945-6191 FAX: 503-378-8467

E-MAIL: karen.wheeler@state.or.us

III. STATE EXPENDITURE PERIOD

From: 7/1/2004 To: 6/30/2005

IV. DATE SUBMITTED

Date: 9/18/2006 ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Karen Wheeler Telephone: 503-945-6191

E-MAIL: karen.wheeler@state.or.us FAX: 503-378-8467

Form 1 Footnotes
Effective September 1, 2006, the agency name "Office of Mental Health and Addiction Services" (OMHAS) was changed to "Addictions and Mental Health Division" (AMH).

Form 2 (Table of Contents)

State:
Oregon

UNIFORM APPLICATION FOR FY 2007 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Oregon	
Name of Chief Executive Officer or Designee: Bruce Goldberg, MD	
Signature of CEO or Designee:	
Title: Director, Department of Human Services	**Date Signed:**
If signed by a designee, a copy of the designation must be attached	

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1)No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Director, Department of Human Services

APPLICANT ORGANIZATION	DATE SUBMITTED
State of Oregon, Dept. of Human Services, Addictions and Mental Health Division	

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____ , if known: _____	
Congressional District, *if known:* _____	**Congressional District**, *if known:* _____
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. Federal Action Number, if known:	**9. Award Amount,** if known: $
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Department of Human Services
APPLICANT ORGANIZATION State of Oregon, Dept. of Human Services, Addictions and Mental Health Division	DATE SUBMITTED

Oregon

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #1: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division (AMH) will expend block grant funds to maintain a continuum of substance abuse treatment services through its county/tribal financial assistance agreements and direct contracts with community-based substance abuse treatment providers.

During FY 2004, the Addictions and Mental Health Division utilized the Institute of Medicine's (IOM) Spectrum of Intervention to frame the elements of an effective AOD service system, based on the current body of research evidence. The Spectrum of Intervention model includes the following essential service elements: prevention, (universal, selected, and indicated); treatment (case identification and treatment); and maintenance of treatment effectiveness (compliance with long-term treatment and aftercare or continuing care).

Oregon's substance abuse treatment services are delivered through contractual arrangements among the state, counties, tribes, managed care entities, and a network of community-based providers. The state Medicaid agency, the Office of Medical Assistance Programs (OMAP) contracts with managed care plans (Fully Capitated Health Plans) to deliver a limited range of treatment services to Oregon Health Plan (Oregon's 1115 Waiver Medicaid program) clients. Services supported by Substance Abuse and Prevention Treatment (SAPT) block grant funds are targeted to low-income clients who do not quality for the health plan, as well as extended services for health plan clients who need extended support. Health plans and counties contract with community-based providers to deliver services at the local level. The state contracted with community mental health programs and tribes to deliver outpatient continuum of care services with block grant funds and state general funds. Per contract definition, Continuum of Care services consist of case management, clinical services, and continuing care or aftercare. This approach provides more flexibility for the counties, tribes, and treatment providers delivering services to tailor services to the unique needs of the populations they serve. Under the previous funding methodology (prior to 2001), providers were held to utilization standards based on the number of funded treatment slots. Under the Continuum of Care approach, providers must meet certain quality improvement outcomes: Engagement, Retention, Completion, and Reduced Use.

Oregon's publicly funded treatment system offers five levels of care including:

Level .05 (Early Intervention) Non-residential education and informational services designed to intervene with individuals at risk of developing substance use disorders. Services include individual counseling, educational sessions, group or family counseling.

Level I (Outpatient Treatment) Non-residential treatment services (usually less than 9 hours per week) provided to the individual in regularly scheduled face-to-face therapeutic sessions. Service may include individual, group and family counseling, pharmacotherapies, case management and long-term support for relapse prevention.

Level II (Intensive Outpatient) A structured, non-residential evaluation, treatment, and continued care service for those individuals who are abusing or are dependent on alcohol and other drugs and who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.

Level III (Residential Treatment) Structured programming that provides assessment, treatment, rehabilitation and twenty-four hour observation and monitoring for alcohol and other drug dependent clients. This level of service also provides 24-hour observation, monitoring and treatment for individuals who are suffering from alcohol or other drug intoxication or withdrawal.

Level IV (Medically Managed Inpatient Treatment) is not supported by the SAPT block grant, but is part of the continuum of treatment services in Oregon. This service is financed by the Office of Medical Assistance Programs through contracts with Fully Capitated Health Plans (FCHP). This is an organized service delivered in an acute care inpatient setting. Services are delivered by an interdisciplinary staff of addiction-credentialed physicians and other appropriate credentialed treatment professionals.

Goal #1 FY 2006 (Progress):

Throughout FY 2006, the Addictions and Mental Health Division (AMH) continued to support a continuum of substance abuse treatment services as described above through county and tribal financial assistance agreements. Regional residential services continue to be funded through a combination of direct contracts, county contracts, and local options. These agreements continue to support the outpatient continuum of care service model vs. the traditional slot funding methodology. The AMH continues to refine the quality improvement measures in an effort to improve statewide treatment outcomes associated with Engagement, Retention, Completion, and Reduced Use. In addition, the discussion of National Outcome Measures (NOMS) has influenced our work in refining the outcome improvement reports. AMH moved to performance-based contracting for all counties and tribes during FFY 2006.

The AMH is currently in the process of reviewing all administrative rules that govern the provision of addiction and mental health services in an effort to align the rules with principles of recovery, resiliency, evidence-based practices, cultural competency, as well as to provide administrative and operational efficiencies to the system. For this reason, AMH has not yet revised the detoxification rule and has slowed down the process of developing a rule for institution-based addiction treatment for offenders. AMH adopted a policy statement on Resilience and Recovery to promote the concepts through statewide policy, contract, and workforce development strategies and to support the provider system in implementing services that are aligned with the principles of resilience and recovery. The statement is available for review on the AMH web site at: http://www.oregon.gov/DHS/addiction/publications/recovery-resil-policy.pdf

Oregon's methamphetamine problem has been highly publicized in the media. During the 2005 legislative session, approximately ninety bills were drafted to address the methamphetamine issue through various proposed law enforcement, public health, child welfare, and prevention policies. The Governor commissioned a Methamphetamine Task Force in 2004 to come up with recommendations to address Oregon's methamphetamine problem. AMH is represented on the task force. Representatives from law enforcement, public health, child welfare, substance abuse prevention and treatment, and other interested stakeholders developed forty-one recommendations that were synthesized into two legislative bills which passed during the session. One of these bills included funding for the expansion of Oregon drug treatment courts. These funds, $2.5 million, were allocated to the Criminal Justice Commission for drug treatment court grants. In

addition to these funds, the Oregon State Police, Criminal Justice Services Division, added $3 million to the pool of funds to support treatment and recovery support services for methamphetamine addicted women and their dependent children. AMH participated on the workgroups charged with designing the request for proposals and the review panel to select projects for funding. The proposals were required to include treatment programs that were licensed /approved by AMH. Proposals were also required to demonstrate that the drug treatment court projects were integrated into the system of community addiction services and supports.

During 2006, AMH analyzed the adolescent treatment system in terms of challenges and barriers to continuity of care, particularly for adolescents with co-occurring mental and substance use disorders. AMH met with providers, managed care organizations, and other stakeholders to restructure adolescent residential treatment rates and draft revised contract language for these services. This applies to 71 publicly funded adolescent residential treatment beds. Adolescent residential providers are now required to ensure that all youth entering treatment are screened for the presence of mental health disorders and that youth receive mental health assessments and treatment while they are participating in residential services. Treatment may be delivered by the provider if they are qualified to provide these services, or coordinated with community-based mental health providers. New contract standards and rates went into effect on July 1, 2006. Daily bed rates were increased from $113 to $159 per day. The rate change was made possible by maximizing Medicaid participation and capturing state general fund savings to increase the daily rate paid for daily clinical services. Adolescent residential providers are now required to meet the following additional service standards:

1. Provide a co-occurring competent program capable of delivering adequate and appropriate services.

2. Address co-occurring disorders in program policies and procedures, client assessment, treatment and planning, program content and transition / discharge planning.

3. Address the interaction of the substance-related and mental health disorders in assessing each adolescent's readiness to change, relapse risk and recovery environment.

4. Provide pharmacological monitoring and psychological assessment and consultation, either on site or through coordinated consultation off site.

5. Involve the family or significant others of the client in the treatment process.

6. Document efforts to obtain clinically appropriate family or significant other involvement and participation in all phases of assessment, treatment planning, and treatment.

7. Use treatment methods appropriate for children with significant emotional disorders that are based on sound clinical theory and professional standards of care.

8. Document efforts to plan the transition from residential to community-based services and supports that are most likely to lead to successful clinical outcomes for each adolescent.

AMH worked with stakeholders including counties, tribes, providers, the Governor's Council on Alcohol and Drug Abuse Programs, and the Oregon Prevention, Education, and Recovery Association to develop an equitable funding allocation formula that applies to outpatient alcohol and drug treatment, non-Medicaid, State General Fund, funding during 2006. This process included an analysis of census / population data, prevalence data, methods for funding distribution by other states, per capita funding for each Oregon county and tribe from a variety of sources including state general funds, SAPT block grant, beer and wine tax revenues, Medicaid, and other local funding at the disposal of these intermediaries. A policy and plan for redistributing the funds was adopted by AMH and distributed to all stakeholders and is described in more detail under the FY 2007 Intended Use section.

Goal #1: FY 2007 (Intended Use):

The AMH intends to continue to use county and tribal financial assistance agreements to support a continuum of substance abuse treatment services statewide in 2006. SAPT block grant funds will continue to support outpatient and social detoxification services throughout the state. Treatment outcome improvement measures will continue to be refined as part of the outcome based contracting process and in response to any new measures or performance domains included in the National Outcome Measures (NOMS).

Oregon's allocation of State General Fund (GF) funding to counties and tribes is not equitable and is based on a number of historical actions including: 1. Competitive grants funding pilot projects in some counties, funds were later shifted to the county base alcohol and drug budget; 2. Redistributing outpatient "slots" from under-utilized counties to over-utilized counties; and, 3. Unequal population growth also contributes to inequities. State GF funding per capita ranges from around $2 in one Central Oregon intermediary to $17 for an Eastern Oregon intermediary.

At the beginning of the 2007 – 2009 biennium, Oregon will implement a new equitable funding formula for outpatient treatment services funded with SAPT and State GF. The following principles have been outlined for redistributing funds;

1. Base Funding for small counties: AMH will maintain a base State GF allocation for small counties. AMH will consider a two-tier base level of $50,000 for the smallest counties and $75,000 for small counties.

2. Prevalence and Population Factors: The weighting factors include prevalence at 30% and population at 70%. Data from the 1999 Oregon household survey and the Oregon Health Teen Survey (conducted annually) will be used to determine substance use and addiction prevalence. The most recent census data available as estimated by the Portland State University, Population Research Center (updated each July) will be used to estimate population in each county.

3. Timing and Implementation: New State GF or federal block grant funds that may be available in the DHS, AMH 2005-07 or 2007-09 budgets that are not identified for specific programs or services by the Legislature will be used in whole or in part to fill gaps in A&D funding equity. Regardless of funding levels, the new formula for A&D funding equity will begin to be

implemented through the 2007-09 funding allocation. Funding equity will be achieved through a phasing-in process. It may take several biennia to achieve funding equity depending on the resources that may be available as well as the number of counties that are brought up to the average per capita funding level in each biennium.

4. Shared accountability and outcomes: As defined in statute (ORS 430.359), Counties will continue to share responsibility for funding A&D services through local matching funds including local beer and wine tax revenues and other local funds available. The biennial implementation plans define shared accountability and outcomes.

During 2007, AMH will continue to work to make structural improvements for the substance abuse and mental health services system in order to provide more effective services to individuals with co-occurring mental and substance use disorders. Key issues will be analyzed such as systems, data management, workforce development, financing, and linkages and either contribute to the effectiveness or create barriers to providing services for this population.

Oregon

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #2: FY 2004 (Compliance):

During FY2004, the AMH allocated prevention funding to each of the thirty-six counties and nine federally-recognized Tribes in Oregon. In addition, three statewide projects were funded. The AMH also continued implementation of a Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effects (FAE) project during FY2004 with state public health officials and local partners. Under the umbrella of the Institute of Medicine framework, prevention services are targeted to universal, selected or indicated populations utilizing the Risk/Protective Factor Framework (Communities that Care Model) developed by Dr. David Hawkins and Dr. Richard Catalano. Listed below is a summary, by strategy, of Oregon's prevention activities for FY2004. This data is has been collected from prevention contractors using the Minimum Data Set (MDS) for Prevention web-based database. FY2004 was the fourth year that MDS reporting was a requirement of County Financial Assistance Awards for county and statewide prevention contractors.

Strategy	Number of Services	Percent of Services	Total Served	Males	Females
Alternative Activities	2,843	26.8%	103,218	50,892	52,326
Community-Based Services	1,892	17.8%	19,450	7,382	12,068
Drug-Free Workplace	26	<0.1%	2,080	1,090	990
Prevention Education	2,822	26.6%	20,453	9,634	10,819
Environmental Strategies	115	<0.1%	0	0	0
Information Dissemination	1,591	15.0%	164,075	81,074	83,001
Problem ID and Referral	1,340	12.6%	6,371	2,813	3,558
Totals	10,629		315,647	152,885	162,762

A brief summary, by CSAP strategy, of the types of services provided with SAPT Block Grant funds follows:

Alternative Activities:

- AMH provided funding for mentoring, after-school programs and a variety of leadership programs at the local level.

Community-Based Strategies:

- Each county completed their Phase II updates of the Coordinated and Comprehensive Plans under Senate Bill 555. Phase II included data collection, identification of service gaps, and cultural competency training.

Drug-Free Workplace:

- Through a statewide contractor, businesses across the state have requested and received assistance in developing comprehensive drug-free workplace policies, practices and training.

Prevention Education:

- An ongoing focus on parent education allowed implementation of a variety of parenting curricula, including Active Parenting 1234, Families in Action, Latino Parenting Education, Love & Logic, Making Parenting a Pleasure, NICASA Parent Project, Parents as Teachers, Parents Who Care, Positive Parenting, Strengthening Families, Strengthening Multi-Ethnic Families, The Incredible Years, and others.

Environmental Strategies:

- A number of communities have addressed school alcohol and drug policies, working on changing the norms that currently exist. Working with school officials, policies have been reviewed and revised to provide equal and consistent consequences for any student found to be using substances.
- Reward and reminder visits to check retailer compliance with state and local laws regarding alcohol and tobacco sales have also been utilized.

Information Dissemination:

- Block grant funds have provided a statewide alcohol and other drug Resource Center/RADAR site, statewide and local public awareness campaigns, internet listserv, and a statewide information and referral helpline.

Problem Identification and Referral:

- Activities include student assistance and employee assistance programs, peer counseling, youth courts, and a statewide youth helpline.

Goal #2: FY 2006 (Progress):

AMH contracts with Counties and Tribes to deliver countywide and community-based prevention services. In addition, AMH contracts with three direct contractors for specific prevention services that are not responsibilities for the counties/tribes. Examples include Oregon's tobacco retail compliance program (Synar), contracted through the Oregon State Police; a statewide 24-hour Helpline, contracted through the Oregon Partnership; and drug-free workplace prevention efforts, contracted through Workdrugfree.

Needs assessments for prioritizing services in each County or Tribe is conducted locally through the County Implementation Planning process. This process is a component of Oregon's Comprehensive and Coordinated Planning Process as required by Statute - Senate Bill (SB) 555.

Statewide strategies focused on reducing underage drinking, implementing community development and mobilization strategies, and improving parenting skills. A fourth focus area for 2006 was added to address Oregon's increasing alcohol and drug use rates for girls. Increasing public awareness about underage drinking, furnishing alcohol to minors, and methamphetamine abuse was emphasized through a variety of local and statewide efforts during 2006. Information on activities conducted under each of the six CSAP strategies are as follows:

Alternative Activities:
Each County and Tribe has developed a plan to offer programs and activities that are consistent with their local needs. Target populations vary and services are provided on an ongoing basis. These activities are designed to provide youth with positive ways to spend their time so they are better able to resist alcohol and drug use.

Community Based Strategies:
Oregon's goal is to maintain or increase the number of community teams and coalitions organized for the purpose of reducing alcohol and other drug use locally. These teams are multi-disciplinary and include citizens from the business and faith communities, parents, teachers, youth, law enforcement, school personnel and others. Local strategies are developed consistent with the County Implementation Plans and the SB 555 Coordinated and Comprehensive Plan. AMH Prevention Specialists assist communities in

developing community teams and coalitions. SAPT block grant funds are used for training, technical assistance, and team activities that fall under other strategies. During 2006, new coalitions continued to form across the state to deal with methamphetamine.

Prevention Education:
The primary focus continues to be on increasing funding for evidence-based practices. As a result of the passage of SB 267 in the 2003 Legislative Assembly, AMH must demonstrate that it spends incrementally more funds on practices proven to be effective. Another of the focus areas continues to be on parenting and family-management. Statewide prevention efforts also focus on mentoring and peer-leader/peer-helper programs and ongoing classroom presentations. The objective is to increase the skills of parents and peer helpers to set appropriate rules, guidelines and boundaries and to assist the youth they influence to develop skills that will aid in their resisting alcohol and drug use.

Environmental/Social Policy:
The emphasis in 2006 continues to be on reducing underage drinking with a focus on college campuses and rural areas. In partnership with the Oregon Liquor Control Commission, AMH works to educate communities about laws and norms and offer training on implementing more effective community policies and practices. Community team training focuses on how communities can engage key leaders to bring a stronger focus to the problem of drug and alcohol use. Through the Governor's Council on Alcohol and Drug Abuse Programs, AMH developed plans and recommendations that guide local implementation statewide.

Information Dissemination:
A statewide public awareness campaign targeted parents with the objective of increasing parents' awareness of the importance of talking with their children about alcohol, the dangers and costs of underage drinking, and the importance of not furnishing alcohol to minors throughout the month of April (Alcohol Awareness Month). In addition, more than 60 communities across the state held Town Hall forums to discuss the issues of underage drinking locally. Awareness materials were distributed statewide through the Oregon Partnership Resource Center and through local media. Radio public service announcements were developed and produced by youth in a number of communities and played on local radio stations.

Problem Identification and Referral:

All County and Tribal contracts require that problem identification and referral are components of the local prevention program. The Community Mental Health Programs (CMHP) function as the single point of contact for this purpose. The AMH agreement with each CMHP requires that anyone who presents with a problem must have access to an assessment and be referred to an appropriate service. Through SAPT block grant dollars, AMH supports a statewide helpline that provides referrals to local treatment and prevention services. This is a service that is available in every Oregon County.

Goal #2: FY 2007 (Intended Use):

High need populations identified through the local planning processes will continue to be targeted service recipients. Each quarter the county planning and implementation teams are required to report progress toward identified outcomes. Through consistent program evaluation, AMH ensures adequate progress toward identified outcomes and implementation adjustments as appropriate.

Underage drinking will be a major focus for statewide prevention efforts in FY 2007. AMH analyzed data from the 2005 Oregon Healthy Teens Survey and determined the underage drinking alcohol use rates had increased, particularly for girls. In 2007, AMH will implement gender specific prevention services targeting girls statewide with an emphasis on preventing underage drinking among this population.

Statewide strategies will focus on reducing underage drinking, implementing community development strategies, and improving parenting skills. In addition, gender-specific services will be encouraged in response to the increasing rates of underage drinking among girls. Increasing public awareness about the dynamics of alcohol and other drugs will be emphasized during 2007. Information on activities to be conducted under each of the six CSAP strategies during 2006 is as follows:

AMH projects the number of services and recipients will remain consistent with those identified in the previous fiscal years barring significant budget reductions.

Alternative Activities:
Each County and Tribe has developed a plan to offer programs and activities that are consistent with local needs. Target populations vary, so the types and numbers of services provided will be different in each area of the state. Services will be provided on an ongoing basis. These activities are designed to provide youth with positive ways to spend their time so that they are better able to resist the use of drugs.

Community Based Strategies:
Oregon's goal is to increase the number of community teams that are organized for the purpose of reducing drug use locally. These teams are multi-disciplinary and include citizens from the business and faith

communities, parents, teachers, youth, law enforcement, and others. Local strategies are developed consistent with the Implementation Plans and the SB 555 Coordinated and Comprehensive Plan. AMH Prevention Specialists will continue to assist communities in developing their teams. SAPT block grant funds will be used for training, technical assistance, and team activities that fall under other strategies. The Strategic Prevention Framework model will be used as a platform to move the local and regional teams forward with underage drinking prevention strategies.

Prevention Education:

The primary focus will be on parenting and family-management. Statewide prevention efforts will focus on mentoring and peer-leader/peer-helper programs and ongoing classroom presentation. The objective is to increase the skills of parents and peer helpers to set appropriate rules and boundaries and to assist youth they influence to develop skills that will aid in their resisting use of drugs and alcohol. Funds will continue to be distributed through County Financial Assistance Agreements. Annual reports have been received from most counties that support this level of programming and services provided according to contract specifications.

Environmental/Social Policy:

Oregon's focus in 2007 will continue to be on reducing underage drinking on college campuses and rural areas. In partnership with the Oregon Liquor Control Commission, AMH will continue work to educate communities about laws and norms and offer training on implementing effective community policies and practices. The community team training will focus on how communities can engage key leaders to bring a stronger focus to the problem of drug and alcohol use. Through the Governor's Council on Alcohol and Drug Abuse Programs, AMH will guide local implementation statewide. AMH will also partner with the Governor's Office, Governor's Task Force on Methamphetamine to support policies designed to change community norms and behaviors associated with methamphetamine abuse and manufacturing. This includes promoting Oregon's Meth Watch program, educating local merchants, landlords, and other community members about effective approaches to prevent methamphetamine products from being sold or used in the production of methamphetamine.

Information Dissemination:
Public awareness campaigns will continue to target parents with the focus of increasing awareness of the importance of talking with their children about alcohol and marijuana. Awareness materials will continue to be distributed statewide through the Oregon Partnership Resource Center and through local media. Materials will be developed by the State and distributed through local county prevention programs, or developed locally with funds awarded from the SAPT block grant. Emphasis in 2007 will be on underage drinking and methamphetamine. With assistance from Western Center for the Application of Prevention Technologies (CAPT), AMH will develop marketing materials and information related to the benefits of prevention to be distributed and made available to all prevention professionals, communities, and the general public.

Problem Identification and Referral:
All County and Tribal contracts require that problem identification and referral are components of the local prevention program. The Community Mental Health Programs function as the single point of contact for this purpose. Oregon Administrative Rules governing prevention services require that anyone who presents with a problem or referral must have access to an assessment and be referred to an appropriate service. Through SAPT block grant dollars, AMH supports a statewide helpline that provides referral to local treatment and prevention services. This is a service that is available in every County.

State:
Oregon

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☐ Yes ☒ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☒ Yes ☐ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☒ Yes
☒ No	☒ No	☐ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	☐ Yes	☐ No	☒ Unknown
Dissemination of materials?	☒ Yes	☐ No	☐ Unknown
Media campaigns?	☐ Yes	☐ No	☒ Unknown
Product pricing strategies?	☐ Yes	☐ No	☒ Unknown
Policy to limit access?	☐ Yes	☐ No	☒ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☐	☒	☐
Alcohol	☐	☐	☒	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .08

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 89

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Attachment A Footnotes
Oregon's present legal alcohol concentration tolerance level for:
Motor vehicle drivers under age 21 is .08 for DUII and .00 for MIP.

Oregon

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal # 3: FY 2004 (Compliance):

Objective 1: Ensure contractual requirements for providers to prioritize pregnant women and women with dependent children.

Pursuant to the Federal Regulations and Oregon Administrative Rule (OAR) 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, the Office of Mental Health and Addiction Service (AMH) requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. Through onsite reviews, the AMH ensures that the providers meet the priority requirement for pregnant women and women with dependent children. The AMH conducts these reviews every two years for residential providers and every three years for outpatient programs. Noncompliance with an administrative rule or contract requirements is reported and action plans are created to ensure compliance**.**

Objective 2: Ensure contractual requirements for providers to make referrals for prenatal care.

AMH requires that all chemical dependency treatment providers refer pregnant women for prenatal care within two weeks of admission to the program pursuant to the federal regulations through regulatory methods outlined in the Oregon Administrative Rules (OAR) 415-051-0040 and financial assistance agreements with each of the thirty-four community mental health programs (CMHP) that represent all thirty-six Counties. AMH also requires that providers refer pregnant women for a physical examination and appropriate lab testing within 30 days of admission to the program. AMH staff monitor all of the requirements described above through regulatory on-site review inspections. These reviews are conducted at a minimum every two years for residential and every three years for outpatient programs. Noncompliance with administrative rule or contract requirements is described in an onsite review report and a plan of correction is required.

Objective 3: Maintain requirements for agencies to provide referrals or collaboration agreements in place for childcare.

AMH requires treatment providers to have on-site child-care or refer children to qualified childcare centers while clients are in residential

treatment, pursuant to the federal regulations, OAR 415-051-0110 and CMHP agreements. Some treatment providers utilize family therapy (including child development specialist) to work with women and their children. AMH staff monitors all requirements for specialized services during site reviews. As mentioned, AMH conducts these reviews a minimum of every two years for residential and every three years for outpatient programs. Noncompliance with administrative rule or contract requirements is described in an administrative site review findings and corrective action is required. Documentation from onsite reviews assures that the women's residential programs are complying with this rule either by using in-house childcare or referring to qualified childcare providers in the community. During weekends and evenings some of the treatment providers employ parenting trainers to work the clients and their children.

Objective 4: Maintain OHP coverage for alcohol, drug, and mental health services as well as medical services for pregnant women and women with dependent children who are at or below poverty.

Oregon provides support to Federally Qualified Health Clinics (FQHC) and Rural Health Clinics (RHC) to ensure pregnant women and women with dependent children (who live in rural counties or medically underserved areas) in Oregon have access to health care providers**.**

Goal # 3: FY 2006 (Progress):

Objective 1: Ensure contractual requirements for chemical dependency treatment providers to prioritize pregnant women and women with children.

AMH requires that pregnant woman be given first priority to publicly funded substance abuse programs. Through regulatory onsite inspections, AMH staff monitors the compliance for admitting pregnant women to treatment within the guidelines specified in the SAPT block grant requirements. AMH conducts these reviews at minimum every two years for residential and every three years for outpatient programs. The Regional Alcohol and Drug Specialist (RADS) conduct the monitoring process by using "Substance Abuse Prevention and Treatment (SAPT) Block Grant Monitoring Checklist". Noncompliance with administrative rule standards or contract requirements is described in an onsite review report. The report identifies the corrective action needed and the timeline for implementing corrective action. Treatment providers report are in compliance with this requirement. Alcohol and Treatment providers call a Regional Alcohol and Drug Specialist if an emergency placement is required.

Objective 2: Ensure contractual requirements for providers to make referrals for prenatal care.

Contractual and administrative rule requirements specify that all approved and funded chemical dependency treatment providers refer pregnant women for prenatal care within two weeks of admission to the program pursuant to the federal regulations, OAR 415-051-0040 and community mental health program (CMHP) contractual agreements. AMH also requires that treatment programs refer pregnant women for physical examination and appropriate lab testing within 30 days of admission to the program. In Region One, pregnant women are referred to Oregon Health Science University (OHSU) Women's Health Clinic for prenatal care, delivery and post-partum care. The doctor's staff refers mother of newborn to pediatric specialist for continuing primary care and she continues to see her OB-GYN if she is under a doctor's care prior to admission. In Region Five, the AOD provider sets up an appointment for pregnant clients prior to treatment. The provider contacts the local hospital and makes an appointment for the client.

AMH staff monitors all of the requirements described above through regulatory onsite review inspections. AMH conducts these reviews at

minimum every two years for residential and every three years for outpatient programs. Noncompliance with administrative rule or contract requirements is described in an onsite review report**.** The provider must comply with the prescribed action or is at risk of losing their alcohol and drug license.

Objective 3: Maintain requirements for providers to make referrals, collaborate with community partners, or establish childcare within their own agencies.

The AMH requires AOD agencies to have either on-site child-care or refer children to qualified childcare centers while they are in residential treatment, pursuant to the federal regulations, OAR 415-051-0110 and CMHP contractual agreements. Chemical dependency treatment providers collaborate with in-house family therapists or early development specialists to work with women and dependent children. During weekends and evenings some of the providers employ parenting trainers to work with the clients and their children.

AMH staff monitors all of the requirements for specialized services described via on-site reviews. AMH conducts these reviews at minimum every two years for residential and every three years for outpatient programs. Noncompliance with administrative rule or contract requirements is described in an onsite review report**.** Women's residential programs are complying with this rule.

Objective 4: To maintain Oregon Health Plan coverage for alcohol, drug, and mental health services as well as medical services for women and their children who are at or below the poverty line.

AMH, Office of Medical Assistance Programs, managed care plans, community mental health programs and addiction treatment providers work together to improve coordination to increase the availability of integrated treatment for co-occurring disorder and to utilize existing funds for co-occurring disorder treatment. AMH provides technical assistance/ training, workforce development assistance, and general guidance in how to utilize the funds**.**

Goal # 3: FY 2007 (Intended Use):

Objective 1: Ensure contractual requirements for providers to prioritize pregnant women and women with children.

Pursuant to federal regulations and Oregon Administrative Rule (OAR) 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, the Office of Mental Health and Addiction Service (AMH) requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. Contracts and administrative rules for the 2007-09 biennium will continue the requirements for prioritization of pregnant women and women with dependent children. AMH continues to monitor the process through site reviews. The goal is to develop additional monitoring procedures to ensure that pregnant women and women with dependent children continue to receive preferential alcohol and other drug treatment including medical services, childcare, case management and interim services in case of wait-lists.

During 2007, AMH will administer a survey to identify how well publicly funded chemical dependency treatment providers prioritize pregnant women and women with dependent children for treatment. The survey will be distributed in December 2006. The objective is to identify providers by region that need technical assistance in managing their priority list.

Objective 2: Ensure contractual requirements for chemical dependency treatment providers to make referrals for prenatal care.

All substance abuse providers must refer pregnant women for prenatal care within two weeks of admission to the program pursuant to the federal regulations, OAR 415-051-0040 and community mental health programs (CMHP) contractual agreements. Providers must also refer pregnant women for a physical examination and appropriate lab testing within 30 days of admission to the program. Contracts and administrative rules for the 2007-2009 biennium will continue the requirements to ensure pregnant women receive prenatal care. AMH continues to monitor the process through site reviews. The survey referenced above will also be developed to determine the percent of pregnant women receiving prenatal care. The objective is to document that pregnant women are receiving prenatal care and identify any areas that require assistance in developing linkages with prenatal care or other technical assistance.

Objective 3: Maintain requirements for providers to have on-site childcare, make referrals, or have collaboration agreements in place for childcare.

AMH requires substance use agencies to have either on-site child-care or refer children to qualified childcare centers while they are in residential treatment, pursuant to the federal regulations, OAR 415-051-0110 and CMHP contractual agreements. AMH staff monitors all of the requirements for specialized services described via on-site reviews. AMH conducts these reviews at minimum of every two years for residential providers and every three years for outpatient programs. Noncompliance with administrative rule or contract requirements is described in each onsite review report. The survey described above will be developed to determine how many agencies provide in-house childcare verses referrals for childcare. The objective is to determine how many clients receive childcare while in treatment and how to help expand childcare services where needed either in-house or create additional referrals to the community.

Objective 4: To maintain Oregon Health Plan coverage for alcohol, drug, and mental health services as well as Medicaid services for women and their children who are at or below poverty.

For the 2007-2009 biennium the Governor is requesting enactment of the Healthy Kids Initiative. Parts of the Healthy Kids Initiative being developed in the Governor's Office expand health coverage to all children under the age of nineteen. The Department has proposed a budget package for the 2007 – 2009 budget to expand health coverage for an additional 10,000 people covered in OHP Standard, Oregon's expanded Medicaid program. The proposal will need to be included in the Governor's recommended budget, to be released by December 1, 2006, and approved by the 2007 Oregon Legislature if it is to be implemented.

Oregon

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2004. In a narrative of up to two pages, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependant Children

The following is a list of contracted residential and outpatient treatment providers who deliver services for pregnant women and/or women with dependent children. Capacity is reflected in the number of beds licensed, not necessarily funded.

Programs	Location	Sub-State Region	I-SATS	Level of Care	Capacity	Amount of Funds
Residential						
Letty Owings Center	Portland	1	OR901034	3	56	672,100
CODA New Directions	Portland	1	OR102674	3	24	489,800
Legacy- Project Network	Portland	1	OR100985	3	50	366,900
NARA	Portland	1	OR100462	3	33	352,800
Volunteers of America-Women's Program	Portland	1	OR101023	3	52	737,500
Lifeworks-Mountaindale	Hillsboro	2	OR103573	3	20	329,900
Willamette Family Treatment Services - Parenting/Non-Parenting	Eugene	3	OR104225	3	29	457,400
Cascadia-Bridgeway	Salem	3	OR101585	3	5	124,100
Milestone Family Recovery	Corvallis	3	OR100538	3	15	243,500
Eastern Oregon Alcoholism Foundation	Pendleton	4	OR750407	3	15	341,900
ADAPT	Roseburg	4	OR901562	3	18	144,400
On Track, Inc	Medford	4	OR101908	3	35	442,900
New Directions- Northwest	Baker City	5	OR104175	3	28	311,300
Outpatient						
{Outpatient programs have a Letter of Approval for women-specific programs, but no dedicated funding for women-specific services.}						
ASAP Treatment Services	Portland	1	OR750829	1 & 2		
Cascadia	Portland	1	OR100850	1 & 2		
Changepoint, Inc	Portland	1	OR901471	1 & 2		
Changepoint, Inc	Gresham	1	OR103144	1 & 2		
CODA- New Directions Family Treatment	Gresham	1	OR102674	1 & 2		
DePaul Adult Treatment Center	Portland	1	OR750688	1 & 2		
In Act, Inc	Portland	1	OR101551	1 & 2		
Legacy Emmanuel Hospital-Project Network	Portland	1	OR100985	1 & 2		

Stay Clean, Inc	Portland	1	OR102195	1 & 2		
Lifeworks	Portland	1	OR750514	1 & 2		
Cascadia	Hillsboro	2	OR000021	1 & 2		
Changepoint, Inc	Beaverton	2	OR104001	1 & 2		
Changepoint, Inc	Canby	2	OR104019	1 & 2		
Clackamas County Mental Health	Oregon City	2	OR101874	1 & 2		
Clackamas County Mental Health	Sandy	2	OR103615	1 & 2		
CODA Tigard Recovery Center	Tigard	2	OR900747	1 & 2		
Benton County Treatment Program	Corvallis	3	OR750126	1 & 2		
Bridgeway, Inc	Salem	3	OR901588	1 & 2		
Bridgeway, Inc	Stayton	3	OR100994	1 & 2		
Bridgeway, Inc	Woodburn	3	OR100165	1 & 2		
Columbia Community Mental Health	St. Helens	3	OR900796	1 & 2		
Discovery Counseling	Corvallis	3	OR102865	1 & 2		
Discovery Counseling	Lincoln	3	OR102047	1 & 2		
Discovery Counseling	Newport	3	OR102716	1 & 2		
Discovery Counseling	Waldport	3	OR104258	1 & 2		
Lincoln County Behavioral Health	Newport	3	OR900739	1 & 2		
Linn County Mental Health	Albany	3	OR900549	1 & 2		
Linn County Health and Human Addiction	Lebanon	3	OR103086	1 & 2		
Linn County Health and Human Addiction	Sweet Home	3	OR103094	1 & 2		
Milestone Family Recovery	Corvallis	3	OR100538	1 & 2		
Polk County Mental Health	Dallas	3	OR900267	1 & 2		
Tillamook Family Counseling Center	Tillamook	3	OR301391	1 & 2		
Lifeworks	Seaside	3	OR000381	1 & 2		
Lifeworks	Astoria	3	OR000381	1 & 2		
Willamette Family Treatment Services	Eugene	3	OR104225	1 & 2		
Yamhill County CD Program	McMinnville	3	OR100587	1 & 2		
ADAPT	Grants Pass	4	OR103425	1 & 2		
ADAPT	Roseburg	4	OR103524	1 & 2		
ADAPT	North Bend	4	OR000261	1 & 2		
BestCare Treatment Services, Inc	Bend	4	OR100648	1 & 2		

Choices Counseling Center	Grants Pass	4	OR101734	1 & 2		
Curry County Mental Health	Gold Beach	4	OR750761	1 & 2		
Genesis Recovery Center	Central Point	4	OR101536	1 & 2		
Klamath Alcohol and Drug Abuse, Inc	Klamath Falls	4	OR103037	1 & 2		
Klamath Community Treatment Center	Klamath Falls	4	OR103888	1 & 2		
On Track, Inc	Medford	4	OR101908	1 & 2		
Rogue Valley Addictions Recovery Center	Medford	4	OR750738	1 & 2		
BestCare Treatment Services, Inc	Madras	5	OR103540	1 & 2		
BestCare Treatment Services, Inc	Redmond	5	OR100874	1 & 2		
Center for Human Development	La Grande	5	OR301367	1 & 2		
Confederated Tribes of Umatilla	Umatilla Indian Reservation	5	OR750415	1 & 2		
Deschutes County Mental Health	Bend	5	OR900556	1 & 2		
Grant County Center for Human Development	John Day	5	OR750803	1 & 2		
Harney Behavioral Health	Burns	5	OR750092	1 & 2		
Lifeways Behavioral Health	Ontario	5	OR900507	1 & 2		
Lutheran Community Services	Lakeview	5	OR104035	1 & 2		
Lutheran Community Services	Prineville	5	OR750530	1 & 2		
Mid-Columbia Center for Living	Condon	5	OR100876	1 & 2		
Mid-Columbia Center for Living	Hood River	5	OR901687	1 & 2		
Mid-Columbia Center for Living	The Dalles	5	OR301201	1 & 2		
Morrow Wheeler Behavioral Health	Boardman	5	OR104191	1 & 2		
Morrow Wheeler Behavioral Health	Heppner	5	OR102450	1 & 2		
Safe Haven	Ontario	5	OR100501	1 & 2		
Umatilla County Mental Health	Pendleton	5	OR900192	1 & 2		
Wallowa Valley Mental Health	Enterprise	5	OR750167	1 & 2		

All women-specific programs provide gender specific services and are required to address issues for women such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems. Programs are required by Oregon administrative rules (OAR) to provide or coordinate services that meet the special access needs of this population, such as childcare, mental health services, and transportation.

Providers are required to use the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC 2R) in making level of care determinations. All residential programs provide transition services so that women and children can smoothly move from residential to community-based outpatient and continuing care services. This requirement is monitored by AMH through periodic onsite inspections and analysis of treatment outcomes improvement reports.

Each of the residential providers has designed programs so that mothers enrolled in treatment can bring their young children with them. Generally, cribs or infant beds are placed in the mother's room, although some programs offer suites where adjoining rooms can accommodate older children. Children's beds are not included in the capacity numbers provided in this section. All women's specific residential programs offer therapeutic childcare and parent training as part of the services.

Staff working in women's specific programs must have specialized training and must possess qualifications that include formal training and education in women's treatment needs and family counseling.

Funded residential programs for pregnant women and women with dependent children are generally regionally based with the highest concentration along the I-5 corridor from the Portland metropolitan area to Medford in Southern Oregon. Oregon's population is most highly concentrated in this area.

Two of the residential programs target specific minority populations. Project Network specializes in treating African American women and NARA (Native American Rehabilitation Association) specializes in services for Native American women. Two programs offer specialized services for young pregnant females: Willamette Family Treatment Services and DePaul Treatment Services.

Outpatient services specifically designed and approved for women are located in all 36 counties in Oregon, partly due to the influence of the Oregon Children's Plan. Outpatient providers work closely with residential providers to ensure continuity of care and with other providers who offer early childhood services and supports.

Providers are paid for residential services based on full utilization of the contracted number of bed days. Because Medicaid funds a large portion of funding for residential treatment, residential service utilization is monitored each quarter by matching Client Process Monitoring System (CPMS) data with Oregon Health Plan encounter data. Financial recoupment occurs in counties that are underutilized or providing less than the contracted amount of bed days. Residential programs are required to maintain their own waiting lists. Procedures for ensuring priority admission for pregnant women and IV drug users pursuant to SAPT block grant requirements are reviewed and monitored during the onsite review process.

Utilization for outpatient services is monitored based on CPMS data submitted and verified during onsite program reviews. Until March 2003, outpatient programs rarely had waiting lists, as a result of the inclusion of alcohol and drug treatment coverage in the Oregon Health Plan (OHP) in 1995. However in March 2003, this benefit was limited to only those categorically eligible for Medicaid. This reduction in coverage significantly limited outpatient treatment capacity in some areas. On August 1, 2004, chemical dependency treatment coverage was restored to a relatively small number of people. Fully Capitated Health Plans, which provide alcohol and drug treatment coverage for the categorically eligible in OHP are required by contract to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care.

Drug free housing remains a critical issue. Women all too often utilize higher levels of care such as residential primarily because their living environment is incompatible with sobriety. Those same women, when provided a safe, drug free environment, could be successful with outpatient or intensive outpatient treatment. Women who successfully complete residential treatment are faced with difficulties finding safe, affordable housing options. Oregon has been able to continue allocating resources to local communities to support high-risk families including drug free housing, rental assistance, and housing coordination. There are forty-one Oxford Houses for women with a capacity of 308 people in sixteen Counties.

Oregon

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2004 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2004 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B-Part 2

1. Identify the name, location, NFR ID number, type of care, capacity and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

See Attachment B for the list of residential and outpatient programs. These programs served the following in FY 2004, FY2005 and FY 2006.

The following table includes service utilization and demographic information related to treatment for women, women with children, and pregnant women.

Activity	**FY 2004**	**FY 2005**	*** FY 2006**
# of pregnant women admitted to treatment	1,091	1,134	1,251
# of pregnant women completed treatment	533	447	359
# of pregnant women abstinent at completion	180	329	158
# of women terminated from treatment	438	318	267
# of women admitted to treatment who has children	6,499	7,199	5,624
# of children staying with client in treatment	10,924	12,717	9,353

* Partial data, providers have not sent in all data for FY 2006 since we called 7/31/06.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22 (b) (1) in spending FY 2004 block grant funds?

Set asides from the block grant for these clients have been determined by calculating the percentage of total clients served who are pregnant women and/or women with dependent children. This percentage was applied to the total block grant expenditures for the year to derive block grant funds to be claimed for the set-aside.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every thee years. These reviews ensure that contractual requirements to give priority admission to pregnant women and women with dependent children are met. Further, the reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, and housing and financial problems. Programs are reviewed to evaluate compliance with administrative rule requirements to provide or coordinate services that meet special access needs such as childcare, mental health services, and transportation.

Providers are required to submit Client Process Monitoring System (CPMS) enrollment and termination data on all clients. CPMS is a database that tracks clients in publicly funded treatment programs in Oregon. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, arrest history) the CPMS system collects whether or not the client is pregnant at admission and the number of dependent children in the household. Termination data identifies if the pregnant client was abstinent from substance abuse in the last 30 days prior to delivery of her infant, and if the client was able to comply with the child welfare service agreement during treatment to sufficiently progress toward regaining custody of children.

4. What sources of data did the State use in estimating treatment capacity for the utilization by pregnant women and women with dependent children?

The CPMS system, described above, is Oregon's database for clients served in the public treatment system. The database indicates, among other things, the total number of clients served, the number of women served, whether or not the woman is pregnant at admission, and the number of dependent children in the household. The CPMS system also tracks source of income and insurance availability to determine those clients who are eligible for contracted services, making it possible to determine actual utilization of public funded treatment beds.

The AMH funds treatment capacity in each County and several Tribes. The Counties and Tribes either provide the services directly or sub-contract with local private, nonprofit organizations. Counties, Tribes and programs are provided quarterly quality improvement reports that highlight utilization patterns and report progress in meeting estimated treatment demand. The AMH provides ongoing training and technical assistance to providers on using the CPMS forms for proper data collection.

For women participating in residential treatment services, CPMS data is matched with Medicaid encounter data to determine bed-day utilization and calculate the daily rate paid to providers.

5. What did the State do with FY 2004 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children.

Objective: To work with child welfare to develop alternative funding mechanisms to ensure non-Medicaid eligible women with children in foster care have access to treatment.

The 1999 Oregon Legislative Assembly gave its first major infusion of funds in ten years. It appropriated $10 million dollars for services for high-risk youth and families. The special project funds addressed perceived needs of youth that were at high-risk due to their own abuse of alcohol and drugs or parents with allegations of child abuse or neglect resulting from alcohol or drugs use. Funds were allocated to Community Mental Health Programs who partnered with Department of Human Services, Children and Families (DHS-CAF). The goal was to develop a project to minimize the time a child is in an out- of-home placement to ensure the health and safety of the child. The model has been remarkably successful by bringing together

case managers, a full time screener at the Family Court, family court judges, County Defense Attorney's, CAF, and treatment agencies with clients and their children. The goal is to provide every opportunity for children to be safe and families to remain together. Outcomes reflect women are engaging in AOD treatment while maintaining custody of their children.

Objective: To connect with local partners in early childhood system of care, early childhood education, and prenatal care providers to ensure parents and their children have adequate resources and support.

General Funds were allocated to contribute behavioral health services in seven geographic areas for pilot sites for the Oregon Children's Plan (OCP) that:

- Support early identification of risks and problem behaviors in young children and their families
- Provide linkages to the behavioral health care and prevention systems of supports and services, and
- Provide necessary treatment based on a family-centered approach.

Pilot sites implement an array of services focusing on outcomes that map to the goals of the Early Childhood System.

The goals of the Early Childhood System (ORS 417.727) developed through the Oregon Children's Plan are summarized as follows:

- Prevent child abuse and neglect;
- Improve the health and development of young children;
- Promote bonding and attachment in the early years of a child's life;
- Support parents in providing the optimum environment for their young children;
- Link and integrate services and supports in the voluntary statewide early childhood system;
- Ensure that children are entering school ready to learn; and
- Ensure that children receive quality service delivery.

The Department of Human Services, a partner in the Oregon Children's Plan (OCP), received a legislative appropriation of two million dollars in 2003-2005 to resume mental health and drug and alcohol services through the Addictions and Mental Health Division (AMH). OCP funding is designed for children aged 0-8 and their families who have, or are at high risk of developing, a mental health or addiction condition and have no other resources to pay for needed services.

The unique projects selected through the Request for Proposals required the identification of specific quantitative outcomes. The following numbers are based on the assumption that the sites served unique clients each quarter.

- Children 189 minority 637 total
- Families 623 minority 1603 total
- Parents 334 minority 2168 total
- Consultations and meetings: 1337
- Training and consultation hours: 2818.5

Components that contributed to the success of projects included:

- Specific therapies for parents and young children
- Training and supervision for staff
- Evidence-based programs and curricula
- Initial community education and marketing
- Hiring or assigning staff with expertise in early childhood
- Collaboration across disciplines

Oregon

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. What did the State do to ensure compliance with 42 U.S.C. 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2004 SAPT Block Grant funds (See 45 C.F.R. 96.126(a))?

3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?

4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2004 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

5. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

6. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C: Programs for Intravenous Drug Users (IVDUs)

1. Oregon defines IVDUs in need of treatment services as persons who administer intravenously their primary or secondary drug of choice through a six dimensional alcohol and drug assessment consistent with the American Society of Addiction Medicine Patient Placement Criteria, second revision (ASAM, PPC 2-R) conducted by a certified addictions counselor and state licensed program.

2. AMH requires programs to report the primary and secondary drug of choice of each client admitted. The reports are made through a management information system, the Client Processing Monitoring System (CPMS). The office monitored data to ensure that providers meet the 35% requirement for drug prevention and treatment. Onsite reviews of providers conducted by Regional Alcohol and Drug Specialists on behalf of AMH ensure that accurate data are being submitted and that programs continue to prioritize IVDUs.

3. AMH contracts require that no funds be used for distribution of needles.

4. Contractual agreements with intermediaries and providers require that programs provide notice to AMH upon reaching 90% capacity. To assist in monitoring the 90% capacity a checklist which was developed with technical assistance from SAMHSA was implemented 2004.

5. The AMH contracts include a requirement that IVDUs be admitted within 14-120 days and that they be prioritized for admissions and interim services are provided during the time in between. Onsite reviews confirm compliance with these requirements.

6. AMH contracts require providers to conduct infectious disease risk assessments on all clients and to refer those engaging in high-risk behavior to their primary physician or local health clinic for further evaluation and testing. The local county health departments provide routine infectious disease risk assessments, testing, and counseling as needed for clients accessing STD, TB, Hep C, family planning and prenatal classes.

Oregon

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a) (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

- A description of the problems identified and corrective actions taken.

Attachment D: Program Compliance Monitoring (FY 2005)

Notification of Reaching Capacity

The Addictions and Mental Health (AMH) contracts require providers to serve priority populations first and to provide interim services or referrals when there is insufficient capacity. AMH conducts regular onsite reviews of all providers to monitor compliance with administrative rules and contract requirements, including capacity reporting requirements associated with SAPT.

AMH used technical assistance from SAMHSA to refine and improve the checklist that it uses on onsite reviews. Prior to the site review, agencies are mailed the " Substance Abuse Prevention and Treatment (SAPT) Block Grant Monitoring Checklist". This checklist is completed by the program prior to the review to educate the provider of the federal requirements and to identify whether the program is out of compliance with any of the related SAPT requirements. Any compliance issues related to the SAPT Block Grant requirements will be discussed with the provider at the time of the review. This change has improved the ability of AMH to detect and address noncompliance with contract requirements, including the capacity reporting requirements. AMH uses statewide meetings with Community Mental Health Program directors and with the Oregon Prevention Education, Recovery Association (OPERA), the alcohol and drug treatment providers' organization, to remind service delivery system participants of the importance of compliance with SAPT requirements.

Monitoring Strategies for Tuberculosis Services

The Addictions and Mental Health (AMH) administrative rules require all programs to have their clients complete an infectious disease risk assessment upon admission. The assessment includes tuberculosis, HIV/AIDS and other infectious diseases. For high-risk clients, providers must make referrals to county health departments for further testing and treatment. AMH monitors compliance with these requirements through onsite reviews conducted by AMH staff. A high level of compliance with this requirement has been established across the state and no specific concerns were noted for FY 2005.

Compliance Monitoring for Treatment Services for Pregnant Women

The Addictions and Mental Health (AMH) contracts require that pregnant women be given priority in admission to state-funded programs. The AMH administrative rules require that all providers refer pregnant women for prenatal care within two weeks of admission. The rules also require that providers refer pregnant women for a physical exam and appropriate lab testing within 30 days of admission to the program.

In addition to these standard requirements, providers applying for approval as specialized women's treatment programs must meet additional requirements for treatment planning, services, referrals and staff training. Through onsite reviews of providers, the AMH staff monitors all of the requirements described above. AMH conducts these reviews every two years for residential providers and every three years for outpatient programs. The reviews include an examination of a sample of client or patient records, interviews with program staff, and a review of the program's written policies and procedures. The process includes a review of the response forms completed anonymously by allied agencies. Noncompliance with administrative rule or contract requirements is described in an onsite review report. The report identifies the corrective action needed and the timelines for completing the corrective action. The AMH staff may verify accomplishment through subsequent onsite inspections. AMH will continue to monitor the system closely. We will continue working to ensure timely and effective treatment and referral for pregnant women.

Oregon

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #4: FY 2004 (Compliance):

Objective: AMH will increase the effectiveness of onsite monitoring of provider compliance with contract requirements for funded capacity reporting, interim services and outreach activities.

In 2004, AMH used technical assistance from SAMHSA to refine and improve the checklist that it uses on onsite reviews. Prior to the site review, agencies are mailed the "Substance Abuse Prevention and Treatment (SAPT) Block Grant Monitoring Checklist". This checklist is completed by the program prior to the review to educate the provider of the federal requirements and to identify whether the program is out of compliance with any of the related SAPT requirements. Any compliance issues related to the SAPT Block Grant requirements are discussed with the provider at the time of the review. This change improved the ability of AMH to detect and address noncompliance with contract requirements, including the capacity reporting requirements.

In 2003 the AMH completed a revision of its administrative rule standards for opioid treatment services. The revisions eliminated outdated requirements that acted as barriers to treatment and made Oregon rules consistent with federal regulations and standards for opioid treatment services. A greater proportion of opioid treatment clients have used drugs intravenously than clients represented among other treatment populations. This change has enabled opioid treatment providers to be more successful in tailoring services to meet the individual needs of clients.

Goal #4: FY 2006 (Progress):

The revised checklist for monitoring provider compliance with contract requirements for funded capacity reporting, interim services and outreach activities has been implemented. All OTP's in the state have completed accreditation. The majority of medical directors of OTP's in Oregon have completed a minimum of 8 hours of instruction on Buprenorphrine, Subutex and Suboxone, which is a DEA requirement in order to prescribe the new drugs for opioid dependence treatment.

Goal #4: FY 2007 (Intended Use):

In areas where capacity issues have become apparent, AMH will provide technical assistance to Community Mental Health Programs to improve treatment access and utilization monitoring. In an effort to improve monitoring at the state and sub-state levels, the Department proposed a policy option package to address deficiencies in the current data collection system.

AMH has also participated in on going meetings with providers receiving SAPT block grant funds to assist in reallocation of funds because of population increase or decrease. AMH will implement a new equity funding formula based on population and prevalence beginning July 1, 2007, to address inequities in the funding distribution of SAPT block grant, state general funds, and beer and wine tax revenues.

AMH will continue to partner with the state public health entity to provide relevant training and technical assistance for providers and local partners through 2007 in an effort to provide effective outreach services for IVDU's at risk of infectious diseases such as HIV / AIDS, Hepatitis C, and other preventable diseases.

Oregon

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #5: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division (AMH) will make available tuberculosis services to each individual receiving treatment for substance abuse by ensuring agreements are in place between local treatment providers and local public health departments through the regulatory review process.

During 2004, AMH required substance abuse treatment providers to conduct infectious disease risk assessments with all clients during 2004. This requirement is specified in the Oregon Administrative Rules governing alcohol and drug treatment programs. The Infectious Disease Risk Assessment and Procedures were most recently revised in 2001. All substance abuse treatment providers utilized this tool. AMH monitored compliance with the requirements through regulatory, onsite reviews. AMH staff members ensured that the requirements were effectively implemented and provided follow-up technical assistance using the revised risk assessment tool, procedures developed for implementing the tool, and treatment improvement publications available through SAMHSA. Alcohol and drug treatment programs rely on linkages with local public health agencies to provide infectious disease testing and follow-up health services.

Goal #5: FY 2006 (Progress):

Substance abuse treatment providers continue to utilize the infectious disease risk assessment tool for their clients. This requirement remains in the Oregon Administrative Rules (OARs) governing alcohol and drug treatment programs. All Oregon physicians and other health care providers are now required to report patients with verified or suspected cases of active tuberculosis to local health departments within one working day of identification. The OARs mandate inpatient and residential substance abuse treatment clients, as well as the provider's staff of the facility to test for tuberculosis (TB) yearly. Tests are done at the local health departments in each county, or at a physician's office.

Some programs have incorporated the testing services into the agreements with their Medical Director. The local health department evaluates all identified positive results, and determines a drug treatment regimen to combat the TB infection. Compliance with the requirements in treatment facilities is monitored by regulatory onsite reviews by the AMH staff. AMH continues to work with DHS, Public Health, Addiction Counselor Certification Board and other training resources to refine counselor training associated with the administration of the infectious disease risk assessment. Collaboration between AMH and the board continues on the requirements specified in the administrative rules, and legal and ethical issues concerning tuberculosis infection among the client population served by public funded programs.

Goal #5: FY 2007 (Intended Use):

AMH will continue to coordinate training activities associated with tuberculosis infection, and continue to require the use of the risk assessment tool by substance abuse treatment providers. AMH will continue collaboration with DHS, Public Health, the Addiction Counselor Certification Board, and other training resources to reach the largest potential group of addiction counselors throughout the state. AMH staff will continue to monitor compliance with the requirements under this section through regulatory onsite reviews and follow-up technical assistance with the substance abuse treatment programs. AMH will continue to monitor the health services tuberculosis program of any changes in reporting protocols, and actively participate in efforts to eliminate tuberculosis in Oregon.

Oregon

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #6: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division (AMH) will ensure treatment is provided for persons with substance abuse problems AMH will emphasize making early intervention services for HIV available statewide and will monitor service delivery through their regulatory review process.

According to the HIV/STD/TB Data Fact Sheets for 2004, trends in the data for Oregon indicates increasing injection drug use (IDU) and heterosexual exposure as risk factors for both HIV and AIDS cases. Of the 208 AIDS cases in Oregon in 2004, 22 (11%) were heterosexual injection drug users (IDUs), 20 (10%) were men who have sex with men (MSM) IDUs. Of the 288 HIV cases newly diagnosed in 2004, 36 (13%) were IDUs, 15 (5%) were MSM / IDU according to the same report. Multnomah County (Portland Metro Area) was identified as having the most AIDS cases (116, 56%) and HIV cases (147, 51%). According to HIV/AIDS in Oregon, Oregon Reported HIV/AIDS Cases living as of 12/31/2004, during 2002-2004, 11% reported IDU, 8% reported MSM / IDU, and among women 33% reported IDU risk. However, the numbers of recent HIV infections remain small, probably due to successful prevention strategies. AMH required substance abuse treatment providers to conduct HIV/infectious disease risk assessments with all clients during FY 2004. This requirement is specified in the Oregon Administrative Rules governing alcohol and drug treatment programs. Compliance with the requirements was monitored by regulatory onsite reviews. AMH staff members ensured that the requirement had been effectively implemented by providing follow-up technical assistance.

Goal #6: FY 2006 (Progress):

An AMH staff member continues to be represented at the quarterly HIV Prevention Statewide Planning Group Meeting. The Statewide Planning Group is a 40-member group, comprised of community representatives, local health department staff and HIV prevention activists who develop an annual HIV prevention comprehensive plan for the state of Oregon. Oregon Administrative Rules specify the requirements for HIV/infectious disease risk assessments, follow-up care and referrals. AMH monitors program compliance with the requirements through regulatory onsite reviews. Anonymous and confidential HIV testing is available through local county health departments at low or no cost. Substance abuse treatment providers continue working relationships with local county health departments and routinely refer clients who are at risk of HIV infection for further HIV testing and counseling services. AMH works closely with the Addiction Counselor Certification Board to: 1) Develop and refine counselor training associated with the administration of the HIV/infectious disease risk assessment tool; 2) Develop referral policies to local public health and follow-up services; and 3) Address legal and ethical issues concerning HIV/AIDS among the population served by publicly funded programs.

Goal #6: FY 2007 (Intended Use):

AMH will continue to coordinate training activities associated with HIV, and continue risk assessment and referral of clients to the local health department for follow up HIV testing and counseling services. AMH staff will work with the Addiction Counselor Certification Board of Oregon to refine the administration of the risk assessment tool and counselor training associated with referral and follow-up services.

AMH is planning to develop a product with the Public Health Division to assist addiction treatment providers in understanding the preventative, clinical and treatment elements related to the Hepatitis C Virus. Through these efforts there will be increased attention to infectious disease prevention and screening protocols among the substance abuse treatment providers.

AMH will continue to monitor compliance with the requirements under this section through regulatory onsite reviews and will provide follow-up technical assistance to substance abuse treatment programs. AMH staff will continue to participate in the quarterly HIV Prevention Statewide Planning Group meetings. Through these meetings, collaboration between statewide agencies will plan and evaluate HIV prevention services and establish HIV prevention priorities for the state.

Oregon

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV.

The Addictions and Mental Health Division (AMH) requires in its administrative rules and in its contracts that all providers conduct infectious disease risk assessments on all clients. Those screened to be at high risk for HIV, TB and other infectious diseases are referred for further testing to the county health department. An AMH regional coordinator reviews outpatient providers every three years and residential providers every two years for contract and rule compliance. Reviews of client records continue to confirm that most programs are in substantial compliance with screening requirements. In instances in which compliance is not complete, findings are identified and corrective actions, with timelines, are communicated to providers in the final onsite review report. Yearly follow-up onsite reviews are standard to monitor compliance with any corrective action plans.

State expenditures for TB in FFY 2004 were $256,805.

Tuberculosis Prevention and Treatment

The local county health departments are responsible for testing and treating persons who are TB infected. The single state authority for public health and communicable disease is the Department of Human Services, Health Services. The role of the Health Services TB Program is to prevent and control the spread of tuberculosis in Oregon by:

- Focusing on the identification and treatment of cases of active TB and TB infection in Oregon.
- Providing TB medication for TB clients through local health departments.
- Providing support for Directly Observed Therapy (DOT) programs at local health departments.
- Collecting and evaluating surveillance data to ascertain TB is treated appropriately.
- Providing expert consultation, education and outreach activities.

At the state level, the Department of Human Services, Health Services tracks the number of identified cases and estimates statewide treatment costs for TB services. For 2004, Oregon's TB case rates remained the same from the previous year at 3.0 per 100,000 (106 cases). The majority of Oregon's TB patients are treated using the internationally recognized strategy of Directly Observed Therapy (DOT). This ensures that people with TB receive quality medical care and restricts further

spread of the disease to others in the community. Oregon is now very near the national goal of TB elimination.

HIV Prevention and Treatment

The same contract and administrative rule requirements for screening and referral that are applied for TB are also applied for HIV. All clients in alcohol and other drug treatment undergo an infectious disease risk assessment. Referral to the county health department for testing and treatment are made when indicated. The risk assessment and procedures for administering the tool were revised in 2001. A Spanish translation of the tool is available to download from the internet. Clients who have used drugs intravenously within the last 30 days are required to undergo a physical examination, appropriate laboratory testing for infectious diseases and a serology test for HIV. AMH monitors compliance with these administrative rule requirements through onsite reviews that occur every three years for outpatient programs and every two years for residential programs. AMH increases the frequency of reviews if substantial non-compliance is found.

The role of the HIV Program of the Department of Human Services, Health Services, is defined as follows:

- Measure the impact of the epidemic in Oregon, forecast its future course and severity, and identify populations for targeted prevention activities.
- Facilitate HIV prevention activities through local health departments, community-based AIDS service organizations, the media, schools, Corrections, and public education (including local community planning and program implementation).
- Serve HIV-infected persons to coordinate their case management, enrollment in the AIDS Drug Assistance Program, emergency assistance, and referral for social supports.
- Develop public policy, monitor quality of program delivery, provide fiscal oversight of funds both within the program and with local health departments and community-based organizations, and provide technical assistance.

Oregon Health Services reports 273 newly diagnosed HIV cases in 2004. A first-ever positive Western Blot confirmatory test that occurred in 2004 indicates a newly diagnosed case.

Oregon

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2004 (Compliance): (participation OPTIONAL)

FY 2006 (Progress): (participation OPTIONAL)

FY 2007 (Intended Use): (participation OPTIONAL)

Goal #7: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division will expand the number of group homes for recovering substance abusers, with particular emphasis on expanding access for recovering women.

In FY 2004, Ecumenical Ministries of Oregon (EMO) continued to administer the Oregon Recovery Homes revolving loan fund under a contract with the Addiction and Mental Health Division. EMO conducted outreach, reviewed and approved loan applications, monitored loan payments and provided monthly reports on all activities relating to the loan fund. In late 2003, the Oregon Housing and Community Services Department agreed to provide funding for a second Outreach Coordinator who began work in January 2004. Attachment F summarizes these activities in detail.

Goal #7: FY 2006 (Progress):

Oregon continues to make substantial progress in this area. As of June 2006, there were 139 Oxford Houses in Oregon housing over 1,060 persons in recovery from alcoholism and drug addiction. Since July 2005, the state-funded Outreach Coordinators, who are both former Oxford House residents, directly assisted with opening 17 new Oxford Houses in eight counties located throughout Oregon. Recent expansion of these recovery homes into Benton, Clatsop, Columbia, and Lincoln counties is especially noteworthy. Publicity materials continue to be distributed and include a web site (www.oxfordhousesoforegon.com), poster and brochure.

On September 30, 2005 Ecumenical Ministries of Oregon (EMO) contract ended. On May 23, 2005 AMH advertised a Request for Proposals to obtain the services of contractor to continue to provide services that support the development, operation and expansion of Oregon Recovery Homes (ORH). This included administering the ORH Revolving Loan Fund and providing ORH Outreach Coordination services. On July 28, 2005, as a result of the competitive solicitation process, Central City Concern (CCC) was selected as the contracting agency in partnership with The Recovery Association Project (RAP).

This contract supports two full-time Oregon Recovery Homes Outreach Coordinator positions. The Outreach Coordinators assist with the establishment of new homes (especially expansion outside of the Portland and Salem metropolitan areas), provide assistance to stabilize existing homes that encounter difficulty, coordinate with service providers and individuals in recovery, publicize the availability of homes operated under the Oxford House charter, and report on progress. In early 2005, Washington County Community Corrections funded another Outreach Coordinator to work in the Washington County geographic area.

On October 12-16, 2005, 10 Oregon Oxford House members participated in the annual Oxford House World Convention 30th Anniversary held in Alexandria, Virginia. On December 9-11, 2005, the 8th Annual Oxford House Workshop was held which provided training for approximately 300 Oregon Oxford House members. On May 5-7, 2006, the Oxford House Leadership Summit provided training on leadership skills to State Association and Chapter members. The first Oxford Northwest Women's Conference is currently being planned.

Goal #7: FY 2007 (Intended Use):

Oregon will continue to support the revolving loan fund and outreach coordinators. The number of homes will continue to expand and will include new homes in additional Oregon counties. AMH housing staff continues to work with Central City Concern, Recovery Associates Program, and the Outreach Coordinators to identify additional resources to sustain and fund further outreach staff positions. Some noteworthy developments are as follows:

- There is currently a budget proposal to fund three additional Outreach Coordinators that will hopefully be included in the Governor's budget to be considered by the Legislature in 2007.

- Because of recent research completed by De Paul University, AMH is in the process of proposing that the Oxford House model be adopted as an "evidence-based practice" under ORS 182.515, an Oregon law that requires an increasing use of evidence-based practices by community service providers.

- In response to a recent court decision centering on the application of residential landlord-tenant laws to recovery homes, AMH submitted a legislative concept that will revise the exemptions so these recovery homes can continue to operate as substance-free environments supportive of recovery.

In addition to continuing support for the Oregon Recovery Homes revolving loan fund and Outreach Coordinators, AMH will continue to support "alcohol and drug free" housing through two other efforts:

- A total of $1 million has been made available in each of the past three biennia to assist the development of alcohol and drug free housing for individuals in recovery. This funding is allocated through a consolidated application process with Oregon Housing and Community Services. In the 1999-2001 biennium, $1 million assisted the development 64 units in 8 projects located in 6 Oregon counties and valued at over $11 million. In the 2001-2003 biennium, the second $1 million assisted the development of 88 units in 8 projects located in 6 Oregon counties and valued at over $16 million. In the 2003-05 biennium, another $1 million assisted the development of 102 units in 9 projects located in 7 Oregon

counties and valued at over $27 million. In the 2005-07 biennium, the fourth transfer of $1 million is assisting the development of 38 units in 6 projects located in 6 Oregon Counties valued at over $6 million.

- Extending an effort initiated in the 1999-2001 biennium, AMH contracts out over $1 million to seven Counties and one Tribe to provide rent subsidies and housing coordination services to families and individuals receiving substance abuse treatment who, without this supportive housing intervention, would likely be homeless and/or relapse. As of the quarter ending March 2006, a total of 1,493 recovering persons were assisted in achieving residential stability and continued sobriety through these services. Of the total served, 607 households were families re-uniting with children. Program evaluation data demonstrate that the rent subsidies and housing coordination services helped participants to achieve residential stability, employment and increased income.

Oregon

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25; 45 C.F.R. 96.129; and 45 C.F.R. 96.122(f)(1)(vii))

If the State has chosen in Fiscal Year 2004 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2004 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F: Group Home Entities and Programs

This attachment summarizes compliance for FFY 2004. A list of all entities that received loans from the revolving loan fund is provided at the end of the narrative responses.

Number and amount of loans made. A total of 17 new loans were made during FFY 2004. These loans totaled $67,000. An individual listing of loans is provided below.

Amount available in fund. The amount available at the beginning of FFY 2004 was $18,258.13. The balance in the account ranged from $5,415.11 to $34,154.92, and averaged $19,785.02.

Source of funds. The source of funds for the revolving loan fund is Federal Block Grant dollars. After the initial investment of $100,000 to establish the fund, an additional $40,000 was added in April 2000 and an additional $20,000 was added in November 2000.

Loan requirements, application procedures, loans made, repayments, problems encountered. Requirements for loans are as follows:

1. The house must be registered as a non-profit organization or affiliated with a non-profit, i.e. chartered by Oxford Houses Inc., and there must be a minimum of six recovering alcoholics and/or addicts.
2. The loan will not exceed $5,000.
3. The loan is to be repaid in 24 equal payments, due on or before the 20th day of each month. A fee of $25.00 is assessed for late payments.
4. Loan funds can be used for first and last month's rent, security deposits, utility deposits, and to purchase furniture.
5. The borrower must maintain the house as an alcohol and drug-free environment.
6. Residents must remain alcohol and drug free.
7. The residents will pay the cost of the housing.
8. The house will be operated as a self-managed democracy.

Applicants for loans provide a list of names of the prospective house members. Each person on the list must complete a loan application. Each person on the list is asked to supply an employer contact telephone number, if employed, and three other references. The loan agreement form is sent to all members and must be

signed and returned by each. In approving loans, the following guidelines are used: (a) A prospective Oxford House recovery home must have the support of its Chapter. (b) The members of the house must demonstrate that they will be capable of repaying the loan; usually this means two-thirds of the house will have reliable incomes. (c) There must be a signed lease agreement before a loan is granted. (d) It is strongly recommended that loan applicants do not use other house members or loan applicants as references.

The typical turnaround time for a loan application is two weeks. Staff work closely with applicants to help them through the application process.

As previously mentioned, 17 new loans were made during FFY 2004. Repayments totaling $25,049.66 were received during this same year. In response to late or missed payments in some homes, the late fee was increased and some loans were restructured or are in the process of being paid off by sponsoring chapters.

Managing entity, agreement and monitoring. Ecumenical Ministries of Oregon (EMO), a private, non-profit corporation, continued to administer the revolving loan fund. The management of the fund by EMO was through a direct contract with the Office of Mental Health and Addictions Services. The Office monitored the fund and loan operations through monthly reports submitted by EMO. The reports indicate the last payment from each house, the current balance for each loan, and any late fees. The report is accompanied by deposit slips, the monthly bank statement for the fund, and individual recovery home statements. The report identifies new loans, loans paid off, and repayments. There are copies of all checks received or sent to recovery homes for that month.

Changes from previous year. None

The following entities received loans from the revolving loan fund during FFY 2004.

Name of House	Loan Amount
Berntzen	$4,000
Tolman	$5,000
Sheldon	$4,000
Waterside	$2,000
Hillsdale	$5,000
McKenzie	$5,000

Steele	$5,000
Moon Rising	$5,000
Klamath	$2,000
Cross Street	$5,000
Davis Creek	$4,000
Sisters	$5,000
Bentley	$2,000
Shadywood Park	$2,500
Brookwood	$3,500
Century Park	$4,000
Maywood Park	$4,000
Total	**$67,000**

Oregon

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

- Is the State's FY 2007 Annual Synar Report included with the FY 2007 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2006

Note: The statutory due date is December 31, 2006.

Goal #8: State law that makes it unlawful to sell tobacco to minors (Annual Synar Report Format)

Oregon Revised Statute 431.840 is the state law that outlines regulation of tobacco sales.

REGULATION OF TOBACCO SALES

431.840 Free distribution to minors prohibited; restriction on sales; notice. (1) It shall be unlawful to do any of the following:

(a) To distribute free tobacco products to persons under 18 years of age as part of a marketing strategy to encourage the use of tobacco products.

(b) To fail as a retailer to post a notice substantially similar to that set forth in subsection (3) of this section in a location clearly visible to the seller and the purchaser that sale of tobacco products to persons under 18 years of age is prohibited.

(c) To sell cigarettes in any form other than a sealed package.

(2) As used in this section "tobacco products" means bidis, cigars, cheroots, stogies, periques, granulated, plug cut, crimp cut, ready rubbed and other smoking tobacco, snuff, snuff flour, cavendish, plug and twist tobacco, fine-cut and other chewing tobaccos, shorts, refuse scraps, clippings, cuttings and sweepings of tobacco and other kinds and forms of tobacco, prepared in such manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for chewing and smoking, and shall include cigarettes as defined in ORS 323.010 (1).

(3) The notice shall be substantially as follows:

NOTICE

The sale of tobacco in any form to persons under 18 years of age is prohibited by law. Any person who knowingly sells, or causes to be sold, tobacco to a person under 18 years of age commits the crime of endangering the welfare of a minor, pursuant to ORS 163.575.

[1989 c.764 §1; 2001 c.187 §1]

Note: 431.840 to 431.853 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 431 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

FY 2006 (Compliance Progress for Inspections Conducted in FY 2006):

The Addictions and Mental Health Division is currently compiling information to be included in our annual Synar Report. The final report for the FY2007 Application will be mailed to CSAP, SAMHSA by the end of September 2006.

Oregon

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #9: FY 2004 (Compliance):

Objectives:

- Oregon will ensure that providers give pregnant women preference in admission.
- Oregon will maintain requirements for providers to refer pregnant women to another provider when necessary to ensure immediate access to care.
- Oregon will ensure that contractors and providers continue to conduct outreach activities to inform pregnant women of the availability of treatment services.

Pursuant to the federal regulations and Oregon Administrative Rule (OAR) 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, the Office of Mental Health and Addiction Service (AMH) requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. Through the County Financial Assistance Agreements, Oregon maintained its contract requirements that providers prioritize pregnant women for access to care. Contracts for state funded treatment providers require that, in the case of delayed admission, the program must provide interim services. These services include education and referral to counseling about infectious diseases, referral to prenatal care, referral to medical care, referral to self-help support groups, education about the effects of alcohol and drug use on the fetus, and crisis intervention.

Fully Capitated Health Plans that manage the chemical dependency treatment benefit for the Oregon Health Plan are required by contract with the Department of Human Services to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care. AMH and the Office of Medical Assistance Programs jointly monitor compliance with these requirements through onsite reviews and contract audits.

Goal #9: FY 2006 (Progress):

Pursuant to the Federal Regulations and Oregon Administrative Rule (OAR) 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, the office of Mental Health and Addiction Service (AMH) requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. AMH continues to monitor contract compliance through onsite inspections, reviews and audits. With technical assistance from SAMHSA, AMH has revised its monitoring checklist and procedures to produce a more refined and effective monitoring process. Additional time and resources were assigned to those parts of the licensing onsite review process that focus on compliance with contract requirements for prioritization of pregnant women and delivery of interim services. For pregnant women who are involved in the child welfare system or the self-sufficiency (TANF) system components of the Department of Human Services, capacity for screening and linking these women to services has been enhanced throughout the state at the local Service Delivery Area (SDA).

Goal #9: FY 2007 (Intended Use):

AMH will continue to monitor contract requirements and compliance with administrative rules through onsite inspections of providers. Inspections consist of clinical record reviews, staff interviews, collateral information from clients and referral sources, and reviews of program documents. Using the revised checklist developed in 2004, AMH will continue to intensify the monitoring of requirements for prioritization of pregnant women and delivery of interim services. Fully Capitated Health Plans will also continue to monitor their providers for contract compliance. AMH will continue to partner with the Department's child welfare and self-sufficiency (TANF) areas in an effort to improve and enhance case coordination and linkages to provide more immediate access to treatment services for pregnant women. AMH will work with County Mental Health Programs (CMHP) to improve transportation options for pregnant women receiving treatment.

Oregon

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G: Capacity Management

The Addictions and Mental Health Division contracts with all thirty-six Counties and nine Tribal governments to provide alcohol and drug treatment and prevention services. Counties have the first right of refusal to directly provide services or subcontract them. Counties are required to develop comprehensive implementation plans each biennium outlining how they will deliver services along the continuum of care for all population groups, including intravenous drug users and pregnant women. The plans result in contracts that outline specific funding amounts for each service type. Residential services are funded and paid for in terms of bed days. Should a subcontractor within a county not meet utilization, counties may shift resources to other providers. Should the county fall short, resources may be shifted to other regions.

Counties are paid for residential services based on full utilization of the contracted number of bed days. Residential services are monitored each quarter by matching Client Process Monitoring System (CPMS) data with Oregon Health Plan encounter data. Financial recoupment occurs in counties that are underutilized or providing less than the contracted amount of bed days. Residential programs are required to maintain their own waiting lists. Procedures for ensuring priority admission for pregnant women and IV drug users are reviewed and monitored during the onsite review process.

Utilization for outpatient services is monitored based on CPMS data submitted and verified during onsite program reviews. Until March 2003, outpatient programs rarely had waiting lists, as a result of the inclusion of alcohol and drug treatment coverage in the Oregon Health Plan (OHP) in 1995. However in March 2003, this benefit was limited to only those categorically eligible for Medicaid. This reduction in coverage significantly limited outpatient treatment capacity in some areas. On August 1, 2004, chemical dependency treatment coverage was restored to a relatively small number of people. Fully Capitated Health Plans, which provide alcohol and drug treatment coverage for the categorically eligible in OHP are required by contract to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care.

AMH has historically issued quarterly quality improvement reports to the counties. The reports provided outcome information regarding total services delivered in each county and for each of the subcontracted providers. These reports are

currently being developed to capture and report more relevant outcome measures, including access and engagement. The data for these reports is provided by CPMS.

AMH has initiated a Behavioral Health Integration Project (B-HIP). System requirements for a new data collection and reporting system have been developed and an RFP process was conducted to identify potential public domain and "off the shelf" products that meet the system requirements. This system will eventually replace CPMS and potentially other legacy systems. One of the primary system requirements that have already been identified is waitlist/capacity management. This system is several years from implementation. A policy option package was developed that would finance the data improvement project by AMH and included in the recommended budget for the Department for inclusion in the Governor's recommended budget. The Governor and 2007 Oregon Legislature will determine whether or not this package is funded for implementation during the 2007 – 2009 biennium.

Oregon funds a statewide toll-free information and referral phone system to ensure access to information regarding the availability of treatment or prevention programs or specific services throughout the state. In addition, each county provides crisis services with 24-hour response and many chemical dependency providers have crisis services as a component of service delivery for the populations they serve.

Oregon

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #10: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division will continue to improve the process for referring individuals to the most appropriate treatment.

The Office adopted the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition Revised (ASAM PPC-2R) in 2002 for outpatient and residential programs. At that time the Office also implemented a training and technical assistance program to ensure adoption of ASAM PPC-2R at the program level

In 2003 the rules for Synthetic Opiate Treatment Programs (SOTP) were changed to include ASAM PPC-2R. Prior to the change, SOTP rules described two levels of treatment (stabilization and maintenance) and prescribed minimum treatment contacts regardless of individual needs. The changes were made in response to changes in federal rules and recommendations from various sources, including the 1997 NIH Consensus Statement on Effective Medical Treatment of Opiate Addiction. The change allowed providers significantly increased flexibility in treatment placement by removing administratively mandated treatment contacts and allowing individualized treatment.

Throughout 2004, the Office monitored program compliance in implementing and utilizing ASAM criteria through regulatory onsite inspections. The Office continued to provide technical assistance and consultation for providers as needed in an effort to enhance the utilization of ASAM criteria among outpatient (including synthetic opiate treatment programs) and residential providers in 2004.

Goal #10: FY 2006 (Progress):

ASAM PPC-2R remains a statewide standard to provide a clinical terminology and a system for placement consistent with national standards. ASAM PPC-2R is also a more effective tool for placing clients with co-occurring disorders in appropriate services.

The Office continues to monitor implementation and utilization of ASAM PPC-2R through regulatory onsite inspections and technical assistance activities statewide. Use of the criteria is enforced by entities managing the Oregon Health Plan chemical dependency benefit, the managed health plans known as Fully Capitated Health Plans (FCHP), in the quality assurance and utilization management functions carried out to ensure appropriate placement and utilization of services.

The Office is currently involved in an administrative rule revision process including rules governing the provision of mental health and addiction services. Two of the primary goals driving this rule revision process are specific to improving the process for referring individuals to the most appropriate treatment and include promoting service continuity and promoting recovery and resilience. In addition to this effort, the Office adopted a Resilience and Recovery Policy Statement during 2006. The policy statement reads: AMH promotes resilience and recovery for people of all ages who experience or are at risk for psychiatric and/or substance use disorders. The principles of resilience and recovery guide services supported by AMH. Recovery must be the common outcome of services. AMH develops and supports policies consistent with the principles of resilience and recovery. Policies governing service delivery systems will be age and gender appropriate, culturally competent, evidence-based and trauma informed and attend to other factors known to impact individuals' resilience and recovery. The statement is intended to guide AMH efforts to promote a more recovery oriented system of care and to recognize resilience as "a universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity." Further, "resilience reflects a person's strengths as protective factors and assets for positive development."

Referral to appropriate treatment modality is important, however, AMH is concerned with treatment access and retention in the appropriate levels of care to promote positive outcomes for individuals with substance use disorders. In 2006, AMH applied for a Strengthening Treatment Access and Retention (STAR) grant through the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment in an effort to further improve access and retention

outcomes in outpatient substance abuse treatment. From the grant abstract, "Key components of the project include technical assistance activities, a peer-to-peer learning network and a performance measurement system. The project will reflect principles of recovery, resilience, and cultural competency."

Client access to and retention in publicly funded outpatient treatment is affected by a number of factors. Some of these factors include inadequate funding, reduced workforce development, excessive and duplicative paperwork, inadequate data collection and analysis, and ineffective transitions between levels of care.

To address these barriers, the STAR project will meet three goals:

1. Improve outpatient treatment access and retention.
2. Streamline administrative process in the delivery of outpatient treatment services through provider and state level process improvements.
3. Develop and implement a peer-to-peer learning network for treatment providers and state staff.

Goal #10: FY 2007 (Intended Use):

The Addictions and Mental Health Division (AMH) will continue to offer training and technical assistance aimed at increasing provider competency in the use of ASAM PPC-2R. AMH will also continue to monitor implementation and compliance through onsite client record reviews. These reviews will also serve to identify technical assistance needs. As we progress through the process to revise administrative rules, maintaining focus on developing a system of care approach will be key so that the publicly funded chemical dependency resources are used in the most efficient and clinically appropriate manner.

Oregon

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #11:

The Addictions and Mental Health Division (AMH) workforce development plan and activities facilitate the implementation of our mission which is "… Promoting recovery (and resiliency) through culturally competent, integrated, evidence-based practices treatments of addictions, mental illnesses, and emotional disorders."

The AMH workforce development unit, in support of the office mission, offers technical assistance and training in four primary focus areas: essential, evidence-based practices (EBPs), integrated services and culturally competent/trauma informed programs. Definitions of the four areas follow:

- **Essential:** Those efforts, which facilitate compliance with federal, state and agency rules.
- **Evidence-Based Practices:** Those efforts, which support the identification, implementation and sustainability of EBPs.
- **Integrated Services:** Those efforts that support the delivery of integrated services to those with both a mental health diagnosis and substance abuse and efforts that integrate client support services.
- **Culturally Competent and Trauma Informed Programs**: Those efforts that facilitate the implementation of AMH policy's regarding program development in these areas.

FY 2004 (Compliance):

AMH provided the following services in meeting its charge and in compliance with the requirements and commitments made in the block grant application.

Essential

AMH provided technical assistance and trainings to facilitate provider compliance with federal, state and agency rules. Examples include:

- The delivery of an American Society of Addiction Medicine ASAM PPC-2R Training of Trainers (25 participants). The trained trainers delivered 11 courses to 188 participants in 2004 and continue to provide trainings (August 2006) and,
- The ongoing delivery of courses facilitating correct completion of AMH data collection forms for prevention, the Minimum Data Set (MDS) (225 participants) and treatment, Client Progress Monitoring System (CPMS) (40 participants).

Evidence-Based Practices (EBPs)
AMH is dedicated to increasing the delivery of EBPs to clients, families and communities. Events that were delivered include the following:

- Four day institute, "Evidence-Based Practices for the 21st Century" for over 400 professionals in partnership with the Northwest Institute of Addiction Studies (NWIAS).
- Matrix Model training co-sponsored by CSAT with 10 programs (30 staff) participating in two-day training and ongoing technical assistance for delivery of one cycle of the model with follow up "lessons learned" training.
- Three deliveries of "Best Practices in Treatment" for over 250 providers co-sponsored with the Northwest Frontier Addiction Technology Transfer Center (NFATTC).

Integrated Services
The following are examples of workforce development efforts to integrate and increase the delivery of trauma informed services:

- AMH, in collaboration with Child Welfare, trained 380 substance abuse and child welfare professionals on treatment of and case management of families affected by methamphetamine, alcohol and other drug use.
- In order to increase effectiveness of integrating substance abuse prevention and treatment throughout the state, AMH worked with the Governor's Council on Alcohol and Drug Abuse Programs to facilitate a stakeholder conference. Over 150 participants offered recommendations to the Council for inclusion in their plan to the Governor.
- Technical assistance on prevention practices was delivered to all Oregon Counties and Tribes by AMH prevention staff on all six CSAP strategies including community mobilization, and risk/ protective factors, as well as underage drinking.
- AMH co-sponsored, with the Oregon Department of Education, to provide the Annual Prevention of Violence Institute, where topics included pharmacology and cultural competency.
- In partnership with the Western Center for Applied Technology (CAPT), we delivered substance abuse prevention trainings for prevention professionals to enable their certification as Prevention Specialists.

Culturally Competent and Trauma Informed Programs

In order to increase substance abuse provider ability to implement and sustain culturally competent and trauma informed programs, AMH focused on the development of clinical supervisors. Three clinical supervision courses were delivered by NFATTC staff to over 60 supervisors.

To increase clinicians' skills in providing culturally appropriate and trauma informed services we supported a two day conference, "Back to Basics" for over 200 people in collaboration with the Oregon Association of Addiction Professionals, and a four day conference for over 400 participants with the NWIAS. AMH staff helped select both content and speakers for each of these events.

Goal #11: FY 2006 (Progress):

AMH workforce development delivery strategies are three-fold. The first is working with individual programs in an immersion model to identify, implement and sustain an evidence-based practice with on-site training and ongoing technical assistance. The second is working with providers to learn to use the Addiction Technology Transfer Center's (ATTC's) "change book process" and the Network for the Improvement of Addiction Treatment (NIATX) "model" to identify and improve services. The third is working with the institutions of higher education and programs to identify the competencies needed to work effectively in the profession today, as well as impact the curriculum of the pre-service and post-service preparation programs.

Oregon offers limited support to one-time training events that provide information necessary to operate programs. AMH also co-sponsors conferences to increase awareness and collaboration.

Essential

AMH supported or delivered the following courses in order to facilitate provider ability to meet federal, state or administrative rules:

Ten regional trainings on "HIPAA with an Alcohol and Drug Twist" to over 500 providers and partners, ASAM PPC-2R to over 500 providers, CPMS and MDS trainings to about 300 providers and the required ethics course for prevention specialists.

Evidence-Based Practices

AMH contracted, delivered or co-sponsored trainings, technical assistance, immersion projects to identify, implement and sustain the following EBPs: Motivational Interviewing and Motivational Enhancement Therapy; Cannabis Youth Treatment; Functional Family Therapy; Matrix Model; Supported Employment with clients with co-occurring disorders; and, Integrated Dual Diagnosis Treatment (IDDT). AMH supports a wide variety of programs identified by CSAP as best practices and, for the most part, this is provided on-site by AMH prevention staff.

Integrated Services

The current efforts to increase provider ability to provide integrated services include: technical assistance to the state hospital to develop a co-occurring treatment program; regional delivery of " Outreach and Case Management for the

Hard to House People with Co-occurring Mental Health and Substance Abuse Disorders" training to over 200 mental health, substance abuse providers; a six-week series of phone conferences reviewing the CSAT Treatment Improvement Protocol (TIP) # 42; service improvement projects that focused on increasing integrated services; and, the inclusion of cross-training and primary care integration competency development as a part of the Behavioral Healthcare Workforce Development project. In addition, AMH provided training on early childhood systems collaboration to over 300 providers and early childhood professionals to increase the effectiveness of those services and 25 providers were trained on providing Wrap Around services for young children.

Culturally Competent and Trauma Informed Programs

In 2005 AMH developed an agency-wide Cultural Competency Plan and in 2006 we developed an agency-wide Trauma Policy. Those plans and policies guide all of the services AMH supports. All of the workforce development efforts, including curriculum, technical assistance, contract language and evaluation, reflect those directives. In keeping with our strategies to develop the workforce, we are co-sponsoring the six-month Leadership Institute with NFATTC. This "immersion" type project will be more effective to enhance provider ability now and in the future to provide the services reflective of the policies. The participants were selected primarily to reflect ethnic diversity with a gender and recovery balance and significant rural representation. The Oregon-specific curriculum includes cultural competency as well as suggestions for project selection.

Efforts to facilitate provider ability to provide trauma-informed programs include the following: regional delivery by AMH staff to over 400 providers on the trauma policy and clinical implications, and six video conferences at 21 locations on the impact on and treatment of trauma on children 0-8 to over 200 providers and early childhood experts.

Efforts to facilitate provider ability to design culturally competent programs, include distribution of diverse materials from the Resource Center, participation at conferences and fairs which reach out to individual ethnic communities, and scholarships to support women and non-dominant culture people's participation in events increasing their effectiveness to serve the same population.

Goal #11: FY 2007 (Intended Use):

AMH workforce development unit will focus its efforts on increasing programs ability to promote resiliency and support recovery as directed by our policy, "…Recovery must be the common outcome of services…Policies governing service delivery systems will be age and gender appropriate culturally competent, evidence based and trauma informed and attend to the factors known to impact individuals' resilience and recovery."

AMH plans to develop and implement "Centers of Excellence." The specifics depend on funding, stakeholder input and potential partners. Three models are being considered: a university as the Center, a provider program as the Center, or a combination.

Essential

AMH will continue to provide trainings and on-site technical assistance with both our staff and contractors that facilitate programs ability to meet administrative requirements.

Evidence-Based Practices

AMH will continue to provide trainings, technical assistance, and immersion projects to identify, implement and sustain the following EBPs: Motivational Interviewing and Motivational Enhancement Therapy; Cannabis Youth Treatment; Functional Family Therapy; Matrix Model; Supported Employment with clients with co-occurring disorders; and, Integrated Dual Diagnosis Treatment (IDDT). We will survey the providers and determine which other practices they are interested in implementing and incorporate them into the plan. Some of these projects may be designed as Centers of Excellence. The prevention staff will continue to provide technical assistance on-site for implementing practices identified by CSAP and the National Registry of Evidence-based Practices and Programs (NREPP).

Integrated Services

The current efforts to increase provider ability to provide integrated services, include service improvement projects that focused on increasing integrated services and the inclusion of cross-training and primary care integration competency development as a part of the Behavioral Healthcare Workforce Development project. In addition, AMH provided training on early childhood systems collaboration regarding fetal alcohol prevention, intervention and

treatment effects to providers and early childhood professionals to increase the effectiveness of those services including targeted work with the nine Oregon tribes AMH is also working with Portland State University to develop a certificate program in dual diagnosis

Culturally Competent and Trauma Informed Programs

The 2005-07 AMH training plan reflects integration of training projects for the prevention and treatment of mental health, substance abuse, and problem gambling (See Appendix). More information regarding the specifics of the plan is available from Shawn Clark, AMH Workforce Development Manager, 503-945-9720, shawn.clark@state.or.us

Oregon

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #12: FY 2004 (Compliance):

Objective: The Addiction and Mental Health Services Division (AMH) will ensure collaboration between state and local partners and stakeholders in planning for and delivery of prevention and treatment services.

AMH required Counties and Tribes to submit biennial plans for treatment and prevention services that include written collaboration agreements with significant community partners, including corrections child welfare, employment, TANF, education and the local Commissions on Children and Families. Senate Bill 555 (passed in 1999) continues as a legislative mandate to collaborate planning and delivery of services for at-risk youth and their families.

Contracts with providers continue to require collaboration, with special emphasis on Fully Capitated Health Plans, providing member services for at-risk youth and their families. Administrative rules continue to require providers to document collaboration and referral in clinical and service records, which are monitored during the onsite review process.

Goal #12: FY 2006 (Progress):

State statutes continue to mandate collaboration among all state and local partners providing services to children 0-18 and their families. State and local partners include those agencies and organizations providing planning and services relating to ATOD alcohol and drug treatment, mental health/co-occurring disorder treatment, juvenile justice prevention, teen pregnancy prevention, school retention, positive youth development, early childhood development systems and others. An Executive Order signed in July 2002 reinforced the requirement for collaborations at the state and local levels described in state statutes. This Executive Order also required state agencies to work collaboratively to develop formal interagency agreements and required the development of a state plan for the planning and delivery of services for children 0-18 and their families.

AMH and partners in Oregon's child welfare agency, DHS Children, Adults and Families, have worked extensively to coordinate services. In 2006, AMH and child welfare agencies continued working to ensure close collaboration between alcohol and drug treatment providers and child welfare field staff. Child welfare continues to staff branch offices with alcohol and drug specialists who assist conducting screening services and providing linkage and referral for families who need access to treatment services.

AMH continues to coordinate services with the Department of Corrections, and local community corrections agencies. Oregon has been a leader in developing treatment drug courts, and this year the Oregon Governor's Methamphetamine Task Force, Addiction Treatment Subcommittee recommended a broad expansion of treatment drug courts statewide. This policy and program expansion initiative was included in the funding package to support the methamphetamine strategy by the 2005 Legislature.

AMH collaborated with the Oregon Youth Authority (OYA) in 2006 to implement substance abuse services, transition, and community support for youthful offenders with substance abuse problems who are ready to be released from correctional facilities. The OYA is piloting the implementation of the Global Assessment of Individual Needs (GAIN) assessment tool and the Cannabis Youth Treatment Series manuals in one of its programs in an effort to implement evidence-based practices. AMH, with OYA, submitted a technical assistance request to CSAT to support training

and implementation of components of the Cannabis Youth Treatment / Motivational Enhancement Therapy protocols. Training and technical assistance events are scheduled to begin this fall. In addition, AMH, OYA, the Association of Oregon Community Mental Health Programs, the Juvenile Rights Project, and other partners have recently been notified that the Oregon team was selected to participate in the upcoming policy academy on co-occurring disorders among youth in the juvenile justice system. This effort will further increase our opportunity to collaborate with OYA in developing system and programmatic improvements to better meet the needs of youth who are involved in the juvenile justice system.

AMH continues to work closely with the State Tobacco Program to ensure that planning and service delivery at the State and local levels strengthen the continuum of care for all Oregonians. Additionally, planning and services are closely coordinated between prevention and treatment, and with other state agencies such as Juvenile Justice and the Department of Education in the area of underage and high-risk youth alcohol use.

Goal #12: FY 2007 (Intended Use):

The Department of Human Services will continue consolidation and integration efforts. During 2007, AMH will move forward on the following collaboration efforts:

- AMH will continue to work on enhancing service system infrastructure and financing strategies to increase capacity to provide accessible, effective, comprehensive, integrated, and evidence-based treatment services for persons with co-occurring substance abuse and mental health disorders.
- AMH will continue to collaborate with the Governor's Task Force on Methamphetamine, the Criminal Justice Commission, and the Oregon Judicial Department to implement the legislatively mandated expansion of drug treatment courts.
- AMH will continue to work on increasing collaboration between treatment providers and child welfare field staff.

In 1999, Oregon legislatively included comprehensive planning for implementation of prevention services as a requirement. The coordinated and comprehensive state level planning process described in this legislation is now known as "Partners for Children and Families." This process included the Addictions and Mental Health Services Division (AMH), the Juvenile Justice Commission, and the Commission on Children and Families. However, Oregon's nine federally recognized Tribes and the Asian Pacific American Community Support and Service Association (APACSA) were not included. Therefore, AMH and the Juvenile Justice Commission will continue to meet with the Tribes and APACSA quarterly. Other agencies such as the Oregon Youth Authority, State Tobacco Prevention, Suicide Prevention, Indian Health Services, Oregon Department of Education and other guests attend these meetings for coordination and collaborative planning.

The overall strategies will continue to focus on reducing underage drinking, implementing community development strategies and improving parenting skills. AMH will also add a focus on methamphetamine prevention to correspond with the Governor's Methamphetamine Task Force efforts. Efforts to strengthen school-based prevention will also be strengthened by developing in-service training curricula with the DOE for teachers and staff and looking for opportunities to infuse developmentally appropriate,

evidence-based school prevention strategies into the programs and services offered throughout Oregon's K-12 educational system.

Since 1995, the AMH Prevention Unit has utilized data collected from the Counties. This data is published as County Profiles and is used in each County as part of their planning process. AMH uses the risk and protective factor framework and the information provided in the Oregon Healthy Teens Survey. With this data, the Office can estimate the number of youth, families, and communities who would benefit from the three levels of prevention services. These are universal, selected and indicated. Counties use this demographic information provided by AMH for targeting population groups by age, gender and ethnicity. AMH has requested specific technical assistance through CSAP in redesigning the County profiles to be in line with the National Outcomes Measures and to serve as a useful tool for state and local policy makers in carrying out the stages included in the Strategic Prevention Framework. The County Profile is an information and data resource that will assist Counties in 2006 by:

- Providing a snapshot of substance abuse, poverty, and other risky behaviors.
- Summarizing risk factors and protective factors for each domain: Community, School, Family, and Individual/Peer domain.
- Guiding Counties in their efforts to focus services on the highest need as indicated by this data.

Services will be offered at the local level through contracting, partnerships, and statewide use of AMH prevention staff and statewide contractors. Targeted technical assistance will be provided by AMH Prevention Specialists to assist Counties and Tribes to analyze the risk and protective factor data, identify effective strategies for their target populations, and implement evidence-based prevention strategies and programs.

Oregon

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #13: FY 2004 (Compliance):

The Addictions and Mental Health Services Division (AMH) provided alcohol and drug treatment and prevention services through Counties, Tribes and direct contractors. Allocation of resources and service delivery were guided by county and tribal level plan developed with technical assistance from the AMH. The AMH provided county level estimated needs for treatment and prevention services that augmented and enhanced local special need identification and prioritization of services. The AMH also worked with county planning committees on identifying high risk and/or underserved populations and trained prevention coordinators and providers.

The AMH awarded grants to Counties, Tribes, and direct contractors on a competitive basis. County and Tribe grant applications identified and prioritized special needs for women, women with children, and minority populations particularly African Americans and those with Hispanic and Southeast Asia background. Direct contractors and county contracted providers provided treatment services in a residential setting to women, women with children and African American adolescents. The AMH also provided housing services to children younger than 18 and whose parents are in residential treatment for alcohol and drug abuse. The AMH working with Counties and Tribes identified special need for culturally competent treatment and prevention services. Measures were taken including hiring additional bilingual and bicultural providers in areas of high need for such services.

The AMH provided standard and intensive outpatient services across the state to those identified to have high need for treatment, those coming out of residential services and those who are on the wait list for residential treatment.

The AMH performed preventive activities intended to strengthen protective factors and overcome temptations to abuse alcohol and drugs. There was special emphasis on school-based preventive activities including after school programs. Teaching parenting skills, basic life skills, and engaging unrepresented minorities in community activities dominated prevention efforts statewide.

Goal #13: FY 2006 (Progress):

The Addictions and Mental Health Services Division (AMH) has initiated the State Epidemiological Outcomes Workgroup (SEOW) to improve its assessment of needs and ability to identify specific preventive and treatment needs across the state. The SEOW comprises a range of stakeholders, providers, and state and county staff. AMH is working through the SEOW to address challenges faced by the current prevention and treatment system. One such challenge has been not being able to promptly identify and address targeted preventive and treatment service needs arising from rapidly expanding minority population particularly those with Hispanic and Southeast Asian background. AMH is also increasing its inventory and implementation of evidence-based practices. Such practices complement AMH's effort to meet the high demand for preventive and treatment services with limited resources.

As part of Oregon's needs assessment process for prevention and treatment services, AMH participates with the Oregon Commission on Children and Families and Partners for Children and Families in implementing Senate Bill (SB) 555. Each Oregon county completed a six-year coordinated comprehensive plan for children, youth and families in January 2002, as required in SB 555 (1999). This formal planning process was followed by a biennial plan update in June 2004 and again in January 2006. The update provided counties the opportunity to reassess the original plan and revise it to incorporate significant changes and communicate successes and challenges to state partners.

Counties reported on the critical gaps that exist in services and supports for children, youth and families. In the updated guidelines, Counties were asked to list the top 10 gaps across all service system areas. The question was intended as a way of assessing where resources are most noticeably falling short in allowing Counties to achieve the vision in their plans. The most frequently listed gap (21 Counties) was in mental health services for children and youth, which include the need for mental health services for their families.

The second most frequent gap (also 21 Counties) was in support services for high-risk families, which is in recognition of the significant impact that poverty and low wages have on families. The third and fourth most frequent gaps were youth substance abuse treatment (19 Counties) and living wage jobs (18 Counties).

Gaps were separately compiled within juvenile crime prevention, substance abuse or early childhood. The most frequently mentioned gap for juvenile crime prevention was the ability to involve families in services (12 Counties), for substance abuse the most frequent gap was in youth treatment (19 Counties) and for early childhood, the most frequent gap (12 Counties) was hard-to-find child care, which includes non-traditional hours, sick child, etc., followed by affordable child care (also 12 Counties).

Coordination of services is a major goal of the planning process. Counties were asked about progress in efforts to better coordinate and improve services. A total of 30 Counties reported that planning has resulted in improved coordination of services. Of the total, 26 Counties said that planning has resulted in changes in how services are provided in the community and 35 Counties said that while coordination has improved, services have not changed.

Barriers exist that inhibit implementation of plans. Counties were asked to pick the one most significant barrier other than financial. When the question was asked in that way, program capacity (i.e., waiting lists) was the most frequently identified barrier (10 Counties), follow by partners unable to participate (19 Counties).

The Addictions and Mental Health Services Division (AMH) continued working with stakeholders including at County/local, Tribal, and State level. AMH funded adult and youth residential and both Level I and II outpatient treatment services through County, Tribal and directly contracted providers. The AMH is providing alcohol and drug treatment enhancement or support services including housing for children whose mothers are in intensive outpatient treatment and are at risk of losing their children to the state child welfare program. Children whose parents are in residential treatment also receive housing services. The AMH provides non-clinical or housing services to youth and adult residential treatment clients.

The outpatient treatment program continued to serve those identified to have high treatment need for alcohol and drug abuse, those coming out of residential treatment, and those on the waiting list for residential treatment. This continuum of care includes individual or group therapy; detoxification for those who physical withdrawal; and methadone treatment services. Methamphetamine-specific treatment services are partly provided in collaboration with other agencies to address parenting, employment, and housing issues. The AMH works with other

agencies to assure the reintegration of treated clients with their communities.

Life skills including parenting skills development classes are provided across the communities in English as well as Spanish language when necessary. The AMH provides funding and technical assistance to schools for school-based preventive activities provided to students and their families. Certain counties including Jackson County in Southern Oregon have identified specific needs for high risk youth in general and for at risk middle school girls in particular. These at risk populations are the target of the life skills development activities youth, peer, and family education. Certain counties including Washington County have expanded their bi-cultural preventive and treatment activities to address identified needs for culturally competent services. The Native American Confederated Tribes are participating actively in AMH's preventive activities.

Goal #13: FY 2007 (Intended Use):

Lack of resources continues to be of major concern at local and state level in meeting the growing need for preventive and treatment services. Currently, AMH relies on a prevalence study conducted in 1999 and the Oregon Healthy Teens Survey data, compiled each year, to determine the need for prevention and treatment services. AMH intends to improve its ability to assess the needs for prevention and treatment services by using the information gathered through the State Epidemiological Outcomes Workgroup (SEOW) to develop substance abuse profiles for various substances including alcohol / underage drinking, methamphetamine, tobacco, and marijuana. Datasets are currently being analyzed by this group in an effort to move toward using this information to inform each profile and future prevention planning efforts.

AMH will continue providing both preventive and treatment services through the community of County and Tribal, county-contracted, and directly contracted providers. The AMH has estimated needs and demand for treatment services for 2007 (see Form 8)[1]. Grants are already awarded on a competitive basis for the 2007 - 2009 biennium based on identified needs. A wide range of local and state level stakeholders, preventive and treatment service providers, and County and State staff participated in identifying and prioritizing the critical needs in several dimensions including level of service, target population, and cultural competency. The AMH provided guidelines, the necessary data, and technical assistance.

The AMH will continue providing treatment services in a residential setting to pregnant women, women, women with children, and minorities. The AMH will continue identifying and treating clients among the general population with demonstrated need for treatment. Support services for dependent children and housing for those in residential treatment will continue in the 2007 fiscal year. Outpatient treatment (Level I & Level II), detoxification, methadone treatment will remain the core functions of the treatment program across the state. The growing methamphetamine abuse in urban and rural areas alike will be the focus of our prevention and treatment effort.

AMH will also use treatment improvement reports to inform sub-state entities about their status with regard to treatment access and retention measures as well as completion rates. This information will be used to influence counties, tribes, and other entities that assist AMH in managing the treatment system to work on improving these measures.

1 See “How your State Determined the Numbers for the Matrix” for the methodology.

Oregon

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #14: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division (AMH) will use its contracts to require that no contractor or subcontractor will use block grant or other AMH funds to provide individuals with hypodermic needles or syringes.

AMH continued to maintain the relevant contract requirement and did not find any noncompliance during this period.

Goal #14: FY 2006 (Progress):

The Addictions and Mental Health Services Division (AMH) continued compliance monitoring of funded providers through the onsite review process. AMH has not found any noncompliance during this period.

Goal#14: FY 2007 (Intended Use):

AMH will continue to monitor this requirement through the onsite review process.

Oregon

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #15: FY 2004 (Compliance):

Objective: The Addictions and Mental Health Division (AMH) will assess and improve the quality and appropriateness of block grant funded treatment services through independent peer review.

The Oregon Department of Human Services, Addictions and Mental Health Division (AMH), has designed and implemented an Independent Peer Review Process to be consistent with criteria and guidelines established in Public Law 102-321, Subsection 1943 (1) (A) and (B). During the FFY04 funding cycle, AMH identified eight programs for review. The eight funded programs are equivalent to five percent of the programs receiving SAPT Block Grant funding through the state system for distribution of treatment services dollars by AMH. A lead person was identified by AMH administration to invite programs to apply, or volunteer, to be reviewed. The programs selected represented American Society of Addiction Medicine Placement Criteria, Revised Edition-2 (ASAM PPC-2R) levels I, II and III. Additional criteria considered when identifying agencies to be reviewed included client population (AMH funding priorities) as well as representation from the varied geographic areas of Oregon.

AMH FY 04 Independent Peer Review: Selected Programs

Program Name/ Location	ASAM Levels of Care	Client Population/ Geographic Area
Rimrock Trails Adolescent Treatment Center Prineville, Oregon	Levels III.5, III.1, II.1 & I	Youth ages 12-18 Rural-Central
DePaul Adolescent and Family Treatment Center Portland, Oregon	Levels III.5, III.1, II.1 & I	Youth ages 12 – 18 Urban- Northwest
New Step – Catholic Community Services Salem, Oregon	Levels II.1 & I	Youth 12-18 Suburban - Midwest
Rosemont Treatment Center and School Portland, Oregon	Level II.5	Youth 11 –17 (Females) Urban - Northwest
Youth Contact	Level II.5, II.1 & I	Youth 12-18

Hillsboro, Oregon		Suburban – Northwest
Linn County Alcohol and Drug Treatment-Youth Albany, Oregon	Level II.1 & I	Youth 12-18 Rural - Midwest
Columbia Community Mental Health –Day Treatment St Helens, Oregon	Level III.5, II.5 & II.1 & I	Youth 12 – 18 Rural Northwest
Elkhorn Adolescent Treatment Program Baker, Oregon	Level III.5 & III.1	Youth 12 –13 Rural Northeast

GOAL #15: FY 2006 (Progress):

AMH has initiated the 2006 Independent Review Process. SAPT block grant funded programs have been selected and contracted peer reviewers / consultants are currently completing their assignments and reporting back the results from program reviews. A report summarizing the compilation of reviews and providing recommendations to AMH for future direction in technical assistance and program development will be drafted for management and the Governor's Council on Alcohol and Drug Abuse Programs upon final analysis of the data from program reviews.

AMH has provided technical assistance to those agencies identified in the Peer Review Process from previous years by implementing a "System Improvement Project" designed to promote system and process improvement at the provider level and improve clinical and business practices.

Goal # 15: FY 2007 (Intended Use):

AMH will continue to implement an independent peer consultation/review process in 2007 by reviewing at least five percent of the programs funded with SAPT block grant dollars. The chemical dependency treatment provider system has requested that AMH continue to include peer reviewers in the regulatory/licensing onsite review process as well. AMH will review the 2006 process and make improvements and enhancements to the process by modifying tools, forms procedures, and recruiting additional programs and peer reviewers as appropriate during 2006.

The Governor's Council on Alcohol and Drug Abuse will review the final summary report that integrates data from all of the Peer Consultation/ Reviews. This report will provide the basis for discussion about trends in the application of addiction technologies and areas where technical assistance and targeted training is needed.

Oregon

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2005 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H: Independent Peer Review

Oregon Department of Human Services
Addictions and Mental Health Services Division
Independent Peer Review Process
Final Report – Federal Fiscal Year 2004

The Oregon Department of Human Services, Addictions and Mental Health Services Division (AMH) has designed and implemented an *In-dependent Peer Consultation Process* consistent with criteria and guidelines established in Public Law 102-321, Subsection 1943 (1)(A) and (B). The following describes the components of the AMH FY04 *Independent Peer Consultant Process*.

Program Selection

AMH has followed the federal regulations specifically requiring at least 5% of the programs funded through the SAPT block grant, be reviewed. During 2004, Oregon funded approximately 150 programs provided by the SAPT block grant. Treatment services for youth were identified for review. Agencies often provided multiple treatment services; location and level of care separated the range of services. Eight programs were selected for review. AMH contacted programs directly to solicit participants in the 2004 Independent Peer Consultation Process to ensure representation of three ASAM levels of care, targeted AMH priority population, and Oregon's geographic areas.

Peer Review Documentation Form

An AMH independent peer consultation review form has continued to be refined. Through use of this form, peer consultants assess the adequacy of documentation specific to each policy and procedure area. Peer consultants summarize their findings and report specific findings in each of the four identified areas through a narrative summary.

Peer Review Data Collection

Peer consultants review a "representative" sample of a program's client records in order to determine the application of the policies and procedures upon which the conclusions are based. The general clinical areas listed in

the regulations were considered in the development of a site visit documentation tool. This tool reflects the two major components of a peer consultant's program site visit. The first components involve a review of the selected program's written policies and procedures covering clinical and administrative areas that significantly impact treatment service delivery. The second component consists of an audit of selected client records using the policies and procedures, Oregon Administrative Rules and SAPT block grant requirements. The review is scheduled to be completed within a day.

Program Policy and Procedure Review

The peer consultant gains an understanding for the client record audit and a sense of the program's theoretical approach to treatment by a brief review of a program's written policies and procedures. Both federal block grant and AMH program licensure requirements were considered in establishing content criteria upon which to base the review of written program policies and procedures. The following program administrative and clinical areas are included in the policy review: detoxification services (if provided); assessment and admission criteria; client waiting list management; provision of interim services to priority populations; medical screening and referral protocols; client orientation and education; medication administration and dispensing, infection disease risk assessment and referral procedures; gender specific services; treatment plan development; documentation of client progress; discharge criteria and summary; and development of continuing care plans.

Patient/Client Record Audit

The peer consultant's client record audit is divided into the following major content areas: admission and assessment; treatment planning; treatment service delivery; and discharge planning/continued care. Review criteria established in each of these four content areas were assessed for each reviewed client record. The nature of the review criteria was established to be consistent with standards contained within AMH program licensure regulations and SAPT block grant requirements.

Selection of Peer Consultants

Based on Federal requirements, AMH established the following minimum qualifications to select independent peer consultants: expertise in the field

of alcohol and drug abuse treatment with a minimum of five years experience; represent the various disciplines utilized by the programs under review; knowledge regarding the modality being reviewed and its underlying theoretical approach to addictions treatment, sensitivity to cultural and environmental issues influencing the quality of services provided.

Independent Peer Consultant Summary Conclusions and Recommendations

Eight site visits were conducted as scheduled, and written site visit reports were prepared by the peer consultants and submitted to AMH. The peer consultant summary and conclusions follow.

Through the use of the independent peer consultation process treatment services and quality are assessed assisting in the development of AMH quality improvement measures. While responding to the focus placed on the system of care, copies of submitted site visit reports were provided to AMH technical assistance staff for further review. In those areas requiring further technical assistance, the peer consultant offered immediate technical assistance in the area of expertise. Following the peer consultant's report, AMH staff contacted programs to identify technical assistance needs to develop an improvement plan of action. These conclusions are offered as indications of the current status of the publicly funded substance abuse treatment system in Oregon. This responds to the second identified objective, which identifies the peer consultant's assessment of competency and reflection of treatment needs and technical assistance.

1. Policy and procedure documentation was determined to be adequate and program specific. Most programs provide treatment with a degree of "evidence-based" practices. The initiation of ASAM placement criteria, motivational interviewing, stages of change, and cognitive behavioral therapy have improved clinical outcomes. Most treatment staff are trained in developmental stages and understand the barriers Axis One and Two diagnoses may have on treatment outcomes.
2. Areas needing strengthening include expanded collection of ASAM Dimension 2 and 3. Improved medication management improved involvement of significant others, discharge placement and the refinement of waitlist management systems is necessary to accommodate the increased demand for non-Medicaid treatment services.

Oregon

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007(Intended Use):

Goal #16: FY 2004 (Compliance):

Objective: Oregon will include a review of confidentiality compliance as a component of all alcohol and drug treatment provider license reviews.

The Oregon administrative rule standards require that providers of alcohol and drug treatment services comply with 42 CFR Part 2, the federal confidentiality regulations. As part of the site review process, AMH reviews a sample of clinical records to evaluate program compliance with the confidentiality regulation as well as other Oregon administrative rules. Licensing staff continues to provide ongoing training and technical assistance to assure providers understand and are in compliance with these regulations.

Goal #16: FY 2006 (Progress):

Oregon continues to maintain its requirements for compliance with federal and state confidentiality regulations and continues to monitor through onsite reviews. With the addition of the HIPAA Laws, the site review process found many providers who were confused around their responsibilities in complying with both HIPAA and 42 CFR Part 2. Throughout the year, the Office worked with providers and SAMHSA to help clarify the differences and similarities within each of the requirements. These efforts culminated through the sponsoring of the SAMHSA/CSAT Training "HIPAA with a Twist and Confidentiality, Privacy, and Ethics Training" presented by Robin Kandel and Brian Ballicki. Within the last year, all licensing staff within AMH and hundreds of providers in Oregon attended this training. Both the notebook and CD provided in the training have been utilized by staff to assist providers in their compliance.

Goal #16: FY 2007 (Intended Use):

Oregon will continue to maintain and enforce its administrative rule standards protecting patient records from inappropriate disclosure. Trainings and technical assistance will continue to be provided as needed based on provider requests and site review outcomes.

Oregon

Goal #17: Charitable Choice

GOAL #17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations).

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Goal #17: FY 2004 (Compliance):

Not Applicable.

Goal #17: FY 2006 (Progress):

AMH currently does not contract with any faith-based prevention or treatment providers. If AMH did contract with faith-based providers, there would be requirements explicitly detailed in the contract(s) to provide notice, referral, and alternative services as outlined in the federal regulations.

Goal #17: FY 2007 (Intended Use):

If AMH contracts with any faith-based providers in 2007, there will be requirements explicitly detailed in the contract(s) to provide notice, referral, and alternative services as outlined in the federal regulations.

State:
Oregon

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2006) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☐ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA’s Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

State:
Oregon

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Oregon

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Oregon

Description of Calculations

Description of Calculations

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations:

a) Base rate for services to pregnant women and women with dependent children

Oregon understands that money spent each year since 1994 must be equal to or greater than the 1994 amount. The 1994 cost for services to pregnant women and women with dependent children was determined by using the block grant expenditures for 1992 and increasing this amount by adding 5% of the grant award for 1993 and 5% of the grant award for 1994. The resulting number was Oregon's baseline MOE for women's services.

Since February of 1994, Oregon has transitioned many women to the Oregon Health Plan, whose contracted providers deliver, or make available, the full array of services as mandated in the CFR. The State's share of costs for these services is reported as part of the MOE.

Oregon counts women in five different program areas, compares the counts to total usage in each area, and develops percentages of women's services. Since 1999, Oregon has applied the percentage against the block grant expenditures as recorded in the State's accounting system (SFMS).

Oregon's MOE is reported on Table IV.

b) Base rate for TB services

Oregon uses data from the Public Health Office, Department of Human Services, which provides all services for TB.

To establish the baseline, the percentage of substance abusers was applied against total TB expenditure data for 1991 and 1992. The resulting amounts were averaged to give the MOE baseline. Since 1999, Oregon has used Health Division Data for total TB expenditures and percentages provided for substance abusers.

Oregon's MOE is reported on Table II.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Oregon

Dates of State Expenditure Period:
From 7/1/2004 to 6/30/2005

Activity	A. SAPT Block Grant FY 2004 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$12,609,549	$14,810,099	$3,031,804	$12,583,447	$	$
2. Primary Prevention	$3,282,961		$1,683,724	$281,786	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. Administration (excluding program/provider level)	$522,296		$	$	$	$
6. Column Total	$16,414,806	$14,810,099	$4,715,528	$12,865,233	$	$

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Form 4a

Primary Prevention Expenditures Checklist

State:
Oregon

	Block Grant FY 2004	Other Federal	State	Local	Other
Information Dissemination	**$328,296**	**$16,669**	**$2,818**	**$**	**$**
Education	**$656,592**	**$334,388**	**$56,357**	**$**	**$**
Alternatives	**$361,126**	**$66,844**	**$11,271**	**$**	**$**
Problem Identification & Referral	**$1,017,717**	**$847,755**	**$140,893**	**$**	**$**
Community-Based Process	**$459,615**	**$267,544**	**$45,086**	**$**	**$**
Environmental	**$459,615**	**$150,525**	**$25,361**	**$**	**$**
Other	**$**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$3,282,961**	**$1,683,725**	**$281,786**	**$**	**$**

Form 4b

Resource Development Expenditure Checklist

State:
Oregon

Did your State fund resource development activities from the FY 2004 block grant?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$153,354**	**$125,469**	**$**	**$278,823**
Quality Assurance	**$38,195**	**$**	**$**	**$38,195**
Training (post-employment)	**$130,062**	**$14,451**	**$**	**$144,513**
Education (pre-employment)	**$**	**$15,275**	**$**	**$15,275**
Program Development	**$**	**$30,555**	**$**	**$30,555**
Research and Evaluation	**$19,097**	**$**	**$**	**$19,097**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$340,708**	**$185,750**	**$**	**$526,458**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Oregon

					FISCAL YEAR 2004		
1. Entity Number	2. National Register (I-SATS) ID	3. Area Served	4. State Funds	5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
00-279	OR101024	Region 1	$51,356	$	$31,982	$192,589	$
01-001	OR104175	Region 5	$34,857	$67,392	$18,098	$41,592	$1
01-525	OR100648	Region 4	$65,083	$86,110	$14,300	$	$2
01-943	OR101034	Region 1	$3,959	$	$2,670	$16,079	$3
01-968	OR102534	Region 4	$9,403	$	$6,342	$38,188	$4
01-969	OR102526	Region 4	$9,403	$	$6,342	$38,188	$5
01-970	OR750415	Region 5	$9,403	$	$5,889	$35,460	$6
01-971	OR100926	Region 4	$9,403	$	$6,342	$38,188	$7
02-001	OR750126	Region 3	$333,922	$160,134	$38,617	$72,411	$8
03-001	OR101874	Region 2	$309,209	$421,150	$96,940	$162,599	$9
04-001	OR000381	Region 3	$32,869	$74,464	$19,895	$45,342	$10
05-001	OR900796	Region 3	$301,066	$211,407	$42,671	$45,546	$11

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State:
Oregon

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
06-001	OR000261	Region 4	$40,919		$75,285	$28,400	$95,733	$12
06-481	OR100462	Region 1	$60,515		$257,962	$42,838	$	$13
06-592	OR100579	Region 3	$6,559		$3,421	$7,619	$42,461	$14
06-634	OR101502	Region 3	$38,093		$36,572	$13,098	$42,301	$15
06-635	OR100900	Region 4	$116,492		$76,546	$19,763	$42,461	$16
06-636	OR900648	Region 5	$8,936		$9,909	$8,706	$42,517	$17
07-001	OR750530	Region 5	$24,555		$49,781	$16,729	$50,955	$18
08-001	OR750761	Region 4	$36,160		$78,137	$23,094	$60,927	$19
09-001	OR900556	Region 5	$64,058		$150,012	$36,467	$69,583	$20
12-001	OR750803	Region 5	$20,751		$41,040	$14,466	$46,071	$21
13-001	OR750092	Region 5	$20,581		$41,572	$14,069	$43,147	$22
15-001	OR900077	Region 4	$752,046		$639,191	$117,571	$68,797	$23

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State:
Oregon

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
16-001	OR103540	Region 5	$26,217		$52,519	$18,062	$56,248	$24
17-001	OR102609	Region 4	$679,055		$455,021	$86,654	$66,791	$25
18-001	OR103888	Region 4	$356,852		$436,757	$82,672	$61,077	$26
19-001	OR104035	Region 5	$19,886		$39,671	$13,753	$43,147	$27
20-001	OR301375	Region 3	$758,739		$990,176	$175,916	$69,152	$28
21-001	OR900739	Region 3	$84,401		$131,270	$34,416	$75,975	$29
22-001	OR900549	Region 3	$132,514		$171,770	$52,733	$145,775	$30
23-001	OR900507	Region 5	$339,021		$416,830	$75,278	$36,480	$31
24-001	OR100090	Region 3	$658,934		$739,983	$134,359	$69,096	$32
25-001	OR102450	Region 5	$37,920		$83,266	$23,796	$60,026	$33
26-001	OR102096	Region 1	$6,011,622		$3,118,940	$529,600	$70,193	$34
27-001	OR900267	Region 3	$30,236		$60,166	$20,960	$66,048	$35

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State:
Oregon

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
29-001	OR301391	Region 3	$24,943		$48,907	$21,362	$79,729	$36
30-001	OR900192	Region 5	$264,892		$327,227	$70,530	$97,489	$37
31-001	OR301367	Region 5	$13,637		$44,004	$24,567	$103,936	$38
32-001	OR750167	Region 5	$20,495		$40,432	$14,319	$45,796	$39
34-001	OR901331	Region 2	$1,162,845		$1,053,166	$194,269	$116,678	$40
36-001	OR100587	Region 3	$382,485		$205,505	$49,761	$94,144	$41
37-001	OR301201	Region 5	$118,660		$193,081	$54,141	$132,943	$42
39-021	OR101032	Region 5	$40,468		$96,212	$23,049	$42,582	$43
99-361	OR100538	Region 3	$193,528		$201,124	$33,399	$	$44
99-362	OR000361	Region 1	$137,742		$131,045	$21,762	$	$45
99-484	OR901562	Region 4	$669,186		$580,055	$105,242	$53,690	$46
99-511	OR101163	Region 5	$123,956		$129,101	$21,439	$	$47

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State:
Oregon

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
99-523	OR101025	Region 3	$13,789		$37,742	$6,268	$	$48
99-524	OR104175	Region 5	$246,979		$304,908	$50,634	$	$49
99-525	OR103524	Region 4	$-36,897		$54,888	$9,115	$	$50
99-526	OR101026	Region 1	$-6,858		$	$59,833	$360,304	$51
TOTAL	TOTAL	TOTAL	$14,864,845		$12,623,851	$2,640,797	$3,278,434	$1,326

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PROVIDER ADDRESS TABLE

State:
Oregon

NO PROVIDER ADDRESSES LISTED

Prevention Strategy Report

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Youth/adult leadership activities [22]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Pregnant Women/Teens [2]	Student Assistance Programs [32]	0
	Multi-agency coordination and collaboration/coalition [43]	0
Drop-Outs [3]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Mentors [15]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Driving while under the influence/driving while intoxicated education programs [33]	0
	Multi-agency coordination and collaboration/coalition [43]	0
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Physically Disabled [7]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Information lines/Hot lines [8]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Physically Disabled [7]	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Abuse Victims [8]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Youth/adult leadership activities [22]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Already Using Substances [9]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Homeless and/or Run away Youth [10]	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0

TREATMENT UTILIZATION MATRIX

State:
Oregon

Dates of State Expenditure Period:
From 7/1/2004 to 6/30/2005 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**4,818**	**3,775**	**$.00**	**$.00**	**$.00**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)			**$.00**	**$.00**	**$.00**
5. Long-term (over to 30 days)	**5,726**	**5,232**	**$9,768.00**	**$.00**	**$.00**
Ambulatory (Outpatient)					
6. Outpatient	**35,218**	**32,950**	**$273.00**	**$.00**	**$.00**
7. Intensive Outpatient	**8,581**	**8,030**	**$273.00**	**$.00**	**$.00**
8. Detoxification			**$.00**	**$.00**	**$.00**
Methadone	**1,768**	**1,637**	**$.00**	**$.00**	**$.00**

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Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Oregon

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AGE GROUP	A. TOTAL	B. White		C. Black		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	5,250	2,669	1,675	193	69	16	5	44	22	232	208			74	43	3,228	2,022	499	209
2. 18-24	10,738	6,306	3,159	232	97	58	17	140	25	288	233			127	56	7,151	3,587	1,465	249
3. 25-44	27,818	15,388	8,924	827	398	103	34	281	83	763	666			217	134	17,579	10,239	3,131	401
4. 45-64	12,134	7,513	3,265	445	203	24	6	85	20	283	176			80	34	8,430	3,704	512	99
5. 65 and over	575	426	104	17	2			7	2	10	5			1	1	461	114	20	2
6. Total	56,515	32,302	17,127	1,714	769	201	62	557	152	1,576	1,288			499	268	36,849	19,666	5,627	960
7. Pregnant Women	1,062		918		46		1		2		74				21		1,062		72

Did the State base the values reported on Form 7A and 7B from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 43,900

State:
Oregon

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2004) + B2(2005) / 2 (C)
SFY 2004 (1)	$11,360,557	
SFY 2005 (2)	$12,906,550	$12,133,554
SFY 2006 (3)	$12,821,730	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2004 ☒ **Yes** ☐ **No**

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☐ **Yes** ☒ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy): 9/30/2006

The MOE for State fiscal year(SFY) 2006 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount** **$0**

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

SSA (MOE Table I) Footnotes
Figures for 2004 and 2005 were incorrectly entered due to confusion on the time frame for the data (State fiscal year vs Federal fiscal year.

TB (MOE Table II)

State:
Oregon

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$372,841	10%	$37,284	
SFY 1992 (2)	$399,239	10%	$39,924	$38,604

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2006 (3)	$200,706	27%	$54,191

HIV (MOE Table III)

State:
Oregon

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1993 (1)	$2,063,612	
SFY1994 (2)	$2,237,148	$2,150,380

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2006 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

Womens (MOE TABLE IV)

State:
Oregon

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$1,872,018	
2004		$3,035,050
2005		$2,640,795
2006		$2,496,225

Enter the amount the State plans to expend in FY 2007 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $2,682,602

State:
Oregon

FY 2004 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2004 is reflected on Line 8 of the Notice of Block Grant Award

$16,414,806

Oregon

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29 requires the State to submit a Statewide assessment of need for both treatment and prevention.
- 42 U.S.C. 300x-51 requires the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. If there is a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, describe its composition and its role in needs assessment, planning, and evaluation processes.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2007 application for SAPT Block Grant funds.

Planning:

The Planning Process

Under the guidance of the Governor's Council on Alcohol and Drug Abuse Programs (GCADAP), the Addictions and Mental Health Services Division (AMH) initiates and facilitates state and local level planning for alcohol and drug prevention and treatment services. Planning commences with the AMH's County Profiles document developed by the AMH. The document provides county-specific needs for alcohol and drug prevention and treatment services and describes prevention and treatment strategies consistent with the Institute of Medicine (IOM) spectrum of services model.

The planning process involves meetings and discussions among state social service agencies (Children, Adults and Family Services, Oregon Youth Authority, Department of Corrections, Children's Commission, and Department of Education), county-level social service committees, local advisory councils, contractors, and advocates. These meetings discuss planning parameters and tools including the AMH's County Profiles. The meetings develop strategies; set priorities, and establish criteria for delivering alcohol and drug prevention and treatment services to those who need them the most. As a lead agency, the AMH facilitates the planning process, provides technical assistance, and develops reports to share with all participants and the GCADAP. Specific plans are then developed by local councils and submitted to AMH for review and approval. Working both with the local councils and the GCADAP, the AMH ensures that plans meet policy and financing requirements. Final plans are reviewed and approved by the GCADAP acting on behalf of the Governor.

The AMH uses different data sources in developing the county profile document. Prevention and treatment needs for the adult (18+) population are assessed from the 1999 household survey funded by CSAT under the State Treatment Needs Assessment Program (STNAP). Prevention and treatment service needs for the youth (12-17) are based on the Oregon healthy teens school survey data. This survey is designed based on the Hawkins and Catalano's risk/protective factors model. The Public Health Agency in collaboration with others including the AMH administers the Healthy Teens survey annually. The AMH also uses social indicator data from the Client Processing and Monitoring System (CPMS) and the statewide Law Enforcement Data Set (LEDS). Management makes decisions based on treatment needs prevalence information.

The AMH just established State Epidemiological Outcomes Workgroup (SEOW) consisting of representatives of stakeholders, service providers, state administrators, and private/public researchers. Its main goal is to help the AMH improve its overall planning and prevention service delivery system. The SEOW will also assist the AMH build capacity to report the prevention National Outcome Measures and conform to SAMHSA's Strategic Prevention Framework.

Sub-State Planning Regions

Oregon is divided into five sub-state planning regions. The first region consists of Multnomah County. Nineteen percent of Oregonians reside in this region, yet the region is the most populated one at 1,473 residents per square mile. In 2005, this region accounted for 41%, 39%, and 29% of reported AIDS, TB and HB cases respectively. About two-third of intravenous drug users also reside here.

The second region includes Clackamas and Washington Counties.[1] Twenty-three percent of Oregonians live here at 321 persons per square mile. Thirteen percent of AIDS cases and 20% of TB cases are reported in this region. The region also accounts for about 29% of hepatitis B cases and 13% of intravenous drug users.

The third region consists of ten Counties (Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill). This region has mixed frontier and rural characteristics. About 31% of Oregonians live in this region at a density of 81 residents per square mile. About a third of treatment recipients come from this region. In 2005, about one-fifth of AIDS case were reported in this region The region accounts for 30% of TB and 27% HB cases reported in 2005.

The fourth region includes six Counties (Coos, Curry, Douglas, Jackson, Josephine, and Klamath). The region has both rural and frontier characteristics. About fifteen percent of Oregonians reside in this region at a density of 27 persons per square mile. One in nine AIDS and 6% of both AIDS and TB cases were reported in this region. Tuberculosis prevalence is

[1] Clackamas and Washington counties along with Multnomah are collectively referred to as tri-counties. These are frontier and the most populated counties accounting for about 43% of the population, 69% of AIDS cases, 59% of TB cases, and 58% of hepatitis B cases reported in 2005.

low at only 6% of reported cases in 2005. The region accounts for about 14% of those in need of treatment, 11% of intravenous drug users, and 15% of those in treatment.

The fifth region consists of 17 Counties (Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Lake, Malheur, Morrow, Sherman, Umatila, Union, Wallowa, Wasco, and Wheeler). This is a rural region accounting only for 11.7% of the population at a density of 7 residents per square mile. Only 4% of AIDS cases and 5% each of TB and HB cases were reported in this region in 2005. The region also accounts for 7% of intravenous drug users, 10% of those in need of treatment, and 14% of those in treatment.

State and Local Level Advisory Councils

Oregon has both state and local level advisory councils. The Governor's Council on Alcohol and Drug Abuse Programs (GCADAP) is a state level 11-member body designed intentionally to represent geographic regions of the State; at risk populations such as women, minorities, youth and the elderly; categories of alcohol and drug related professions; and non-professional alcohol and drug social advocacy groups. Members are appointed by the Governor for a term of 4-years. To ensure public accountability, only individuals without conflict of interest are appointed and each member is eligible only for one re-appointment.

The major function of the GCADAP is to advise the Governor on the economic and social impact of alcohol and drug abuse; setting goals, priorities, and strategies for addressing alcohol and drug abuse issues effectively; developing and implementing alcohol and drug abuse prevention and treatment capacity; and monitoring alcohol and drug treatment and prevention programs.

Specifically, the Council oversees and coordinates the following activities.

- The assessment and description of alcohol and drug treatment and prevention needs,
- Development and implementation of statewide alcohol and drug prevention and treatment plans,
- The assimilation of priorities and recommendations contained in locally developed alcohol and drug related plans,
- Design and implementation of organizational capacity, and

- Setting criteria for the purchase and delivery of treatment and prevention services.

The Council receives all technical and financial support from the AMH.

Each County has a Local Alcohol and Drug Planning Council (LADPC). Membership to these councils reflects the geographic and social diversity of the local community. These councils play vital role in the effort to develop and implement comprehensive and realistic alcohol and drug prevention and treatment plans. The councils are responsible to assist the GCADAP, the AMH and other local planning committees to identify needs and set priorities for alcohol and drug prevention and treatment services.

Monitoring Process

The Addictions and Mental Health Services Division (AMH) develops quarterly performance measures at County and provider levels. These indicators are designed to measure access to services, retention, and treatment outcomes relative to levels of need for those services. Observations are shared quarterly with local committees and contractors. Contractors with less than satisfactory performance are put on notice to take corrective actions. The AMH provides technical assistance as necessary to contractors to ensure that those in need of treatment are adequately served.

The AMH estimates the number of adults and youth who need alcohol and other drug treatment annually. The 1999 Oregon Household Survey of Adults provides the percentage of adults (18 and older) who are abusing or are dependent on alcohol and other drugs. This factor is applied to the current year's population estimates of adults by county to calculate the number of individuals in need of treatment. The youth estimates are derived by determining what percentage of the students surveyed have used alcohol and/or other drugs 10 or more times in the previous 30-day period. This percentage is multiplied by the county's population of youth. Twenty percent of those in need of treatment are expected to actually participate in treatment.

The AMH produces using data from the CPMS, quarterly Treatment Outcome Improvement Report (TOIR) and shares with county Mental Health Program Directors. The TOIR summarizes each county's performance measures including access to treatment. The AMH measures access by the number of unduplicated individuals who received treatment

during the year. This number is compared for each county to the annual demand for treatment services. Other performance measures the AMH shares with Counties include Engagement, Completion, Retention, and Length of Stay.

The AMH uses this performance related information to make recommendations to Counties regarding County Biennial Implementation Plans. If a County does not appear to address access issues adequately, the AMH will reject or request amendments in County plans. Based on observations, the AMH may also require changes that redirect funding from a specific service to another or from one group of population to another or from one county to another county. The AMH monitors the data continuously and may make changes in funding levels or categories at any point in the biennium.

The AMH monitors prevention activities through three primary methods. First, each County/Tribe is required to provide the Office with a biennial prevention plan and track activities and services through the use of the Minimum Data Set (MDS) for Prevention system. This allows the Office to monitor activities and insure that populations identified in the County/Tribal needs assessment are being served. Second, the Office requires each County/Tribe to complete an annual report on the services that have been provided. This report is compared to the original implementation plan to ensure that services are being provided to the intended populations. Third, a site review is conducted with each County/Tribe every two years. The purpose of the site review is to ensure that services are provided consistent with the relevant laws and administrative rules and identify problem areas and training needs. The AMH then provides recommendations to address problem areas as well as training and technical assistance to enhance counties' capability to serve the needs of identified populations.

Public Comment

The Governor's Council on Alcohol and Drug Abuse Programs (GCADAP) and the Addictions and Mental Health Services Division (AMH) are required by the Oregon Legislature to ensure citizen participation at both state and local levels in the development and execution of alcohol and drug prevention and treatment plans (ORS 430.255(2)(e)). The GCADAP and the AMH use two constitutional tools to ensure public participation in planning for alcohol and drug abuse prevention and treatment services and developing annual block grant applications.

First, the GCADAP and the AMH are required (ORS 430.250(2)(a)) to reflect local priorities and recommendations in their statewide plan for alcohol and drug abuse prevention and treatment services. Local plans are developed with broad citizen involvement (see planning process) and technical assistance from the AMH.

Second, state social service agencies (Children, Adults and Family Services, Oregon Youth Authority, Department of Corrections, Children's Commission, and Department of Education) are required by the Oregon Legislature as condition of budget approval (ORS 430.250(3)) to work with the GCADAP and the AMH in preparation of statewide alcohol and drug abuse prevention and treatment services plan.

Senate Bill 555 enacted in 1999 cemented this cooperative approach to planning by requiring agencies to work through the GCADAP and the AMH with each other and local committees, councils, providers and advocates in developing a comprehensive statewide alcohol and drug abuse prevention and treatment services plan.

The AMH working with the Governor's Council on Alcohol and Drug Abuse Programs received inputs from several state and county level stakeholder meetings and public discussion forums. These expert and public opinions were used in developing both the State's biennial service plan and 2007 SAPT Block Grant application.

At state level, the AMH and the Governor's Council on Alcohol and Drug Abuse Programs conducted a series of open public hearings at diverse locations throughout the state. In addition, the AMH regularly arranged and facilitated meetings between individual Council members and representatives of local planning committees, including Local Alcohol and Drug Planning Councils. The AMH also coordinated the Council's monthly meeting to synthesize and develop planning ideas. The Council routinely received feedback and reports from alcohol and drug prevention and treatment providers, other state agencies, communities, and medical groups.

At the county level, Local Alcohol and Drug Planning Councils held several public hearings and facilitated public comments and crafted local service plans. The Councils conducted regular meetings, at which public participation was encouraged and insightful inputs were received. The

Councils also participated in a varying array of public functions, such as open planning forums and meetings with local civic and service organizations to further enrich the outcome of the planning process.

State:
Oregon

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2007 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

_ Population levels, Specify formula:

_ Incidence and prevalence levels

_ Problem levels as estimated by alcohol/drug-related crime statistics

_ Problem levels as estimated by alcohol/drug-related health statistics

_ Problem levels as estimated by social indicator data

_ Problem levels as estimated by expert opinion

1 Resource levels as determined by (specific method)
historical funding patterns

_ Size of gaps between resources (as measured by)

and needs (as estimated by)

_ Other (specify):

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Oregon	2004

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	**Total Population**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Number of DWI arrests**	**B. Number of drug-related arrests**	**C. Other:**	**A. Hepatitis B / 100,000**	**B. AIDS / 100,000**	**C. Tuberculosis / 100,000**
Region 1	**692,825**	**110,112**	**22,022**	**28,221**	**5,644**	**36,026**	**7,205**	**4,171**	**5,383**	**0**	**23.5**	**9.1**	**5.8**

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 2	**851,085**	**98,151**	**19,630**	**9,808**	**1,962**	**29,400**	**5,880**	**6,032**	**2,760**	**0**	**19**	**5.2**	**2.5**

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 3	**1,136,655**	**146,945**	**29,389**	**20,629**	**4,126**	**50,006**	**10,001**	**7,962**	**9,580**	**0**	**13**	**2.6**	**2.7**

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 4	**526,005**	**63,162**	**12,632**	**7,967**	**1,593**	**18,244**	**3,649**	**4,005**	**5,423**	**0**	**10.1**	**1.9**	**1.1**

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Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Oregon	2004

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 5	424,870	48,574	9,715	5,406	1,081	15,763	3,153	3,382	3,184	0	7.1	1.6	1.2

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	3,631,440	466,944	93,389	72,031	14,406	148,056	29,611	25,552	26,330	0	15.3	4.2	2.8

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Form 8 Footnotes
Data for #6, "Prevalence of Substance related criminal activities," is from calendar year 2004.

Data for #7, "Incidences of Communicable Diseases," is from calendar year 05.

Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Oregon	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	41,924	0	0	0	0	0	0	0	0	0	0	0	0	41,924	0	0	0	0	0
2. 18 - 24	80,765	41,697	25,173	756	130	174	30	1,664	282	941	742	1,867	1,145	4,504	1,660	43,885	25,941	7,718	3,222
3. 25 - 44	219,966	119,203	67,298	3,000	1,113	375	126	4,414	1,961	3,246	2,318	3,679	2,129	7,992	3,112	133,733	71,661	8,175	6,395
4. 45 - 64	100,751	64,047	26,310	948	492	177	35	2,757	501	1,528	485	1,300	517	1,254	400	67,103	27,369	4,908	1,372
5. 65 and over	23,536	8,880	12,654	271	172	23	5	595	184	132	266	100	128	57	69	9,585	13,013	474	466
6. Total	466,942	233,827	131,435	4,975	1,907	749	196	9,430	2,928	5,847	3,811	6,946	3,919	55,731	5,241	254,306	137,984	21,275	11,455

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Form 9 Footnotes
The number for the 17 and Under group, 41,924, was entered as males of unknown race/ethnicity. However, it should be interpreted as the total for all races and genders in this age group. We do not have a sufficient sample to estimate need for this age group by race and gender.

Form 11

State:
Oregon

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

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SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2007 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$12,052,609	$32,046,505	$3,746,464	$22,958,614	$0	$0
2. Primary Prevention	$3,214,029		$2,645,558	$1,267,176	$0	$0
3. Tuberculosis Services	$0	$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0	$0	$0	$0	$0	$0
5. Administration (excluding program/provider level)	$803,507		$0	$0	$0	$0
6. Column Total	$16,070,145	$32,046,505	$6,392,022	$24,225,790	$	$

Form 11a

Primary Prevention Planned Expenditures Checklist

State:
Oregon

	Block Grant FY 2007	Other Federal	State	Local	Other
Information Dissemination	**$321,403**	**$26,191**	**$12,672**	**$**	**$**
Education	**$642,806**	**$525,408**	**$253,435**	**$**	**$**
Alternatives	**$353,543**	**$105,029**	**$50,687**	**$**	**$**
Problem Identification & Referral	**$996,349**	**$1,332,038**	**$633,588**	**$**	**$**
Community-Based Process	**$449,964**	**$420,379**	**$202,748**	**$**	**$**
Environmental	**$449,964**	**$236,513**	**$114,046**	**$**	**$**
Other	**$**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$3,214,029**	**$2,645,558**	**$1,267,176**	**$**	**$**

Form 11b

Planned Expenditures on Resource Development Activities

State:
Oregon

Does your State plan to fund resource development activities with FY 2007 funds?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$157,955**	**$129,233**	**$**	**$287,188**
Quality Assurance	**$39,341**	**$**	**$**	**$39,341**
Training (post-employment)	**$133,964**	**$14,885**	**$**	**$148,848**
Education (pre-employment)	**$**	**$15,733**	**$**	**$15,733**
Program Development	**$**	**$31,472**	**$**	**$31,472**
Research and Evaluation	**$19,670**	**$**	**$**	**$19,670**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$350,930**	**$191,323**	**$**	**$542,252**

Form 12

State:
Oregon

TREATMENT CAPACITY MATRIX

This form contains data covering a 24 month projection for the period during which your principal agency of the State is permitted to spend the FY 2007 block grand award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**9,636**	**7,550**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)		
5. Long-term (over to 30 days)	**11,452**	**10,464**
Ambulatory (Outpatient)		
6. Outpatient	**70,436**	**65,900**
7. Intensive Outpatient	**17,162**	**16,060**
8. Detoxification		
Methadone	**3,536**	**3,274**

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State:
Oregon

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2007 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 17%
☐	Non-competitive grants	Percent of Expense: %
☐	Non-competitive contracts	Percent of Expense: %
☒	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: 83%
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☒	According to county or regional priorities	Percent of Expense: 100%

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget	Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot	Percent of Clients Served: % Percent of Expenditures: %

	Rate:	Type of slot:
	Rate:	Type of slot:
	Rate:	Type of slot:

☒	Price per unit of service	Percent of Clients Served: % Percent of Expenditures: 48%
	Unit: Youth residential bed/day	Rate: 160
	Unit: adult residential bed/day	Rate: 102
	Unit: dependent bed/day	Rate: 30

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

State:
Oregon

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) every three years

(Frequency for prevention:) every three years

☒ Activity Reports

(Frequency for treatment:) monthly

(Frequency for prevention:) quarterly

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) weekly

(Frequency for prevention:) not applicable

☒ Performance Contracts

☐ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) every three years

(Frequency for prevention:) every three years

☒ Licensure standards - personnel

(Frequency for treatment:) every two years

(Frequency for prevention:)

☐ Other (Specify):

Oregon

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How your State Determined the Estimates for Form 8 and Form 9

State and regional level estimated treatment needs are provided in Form 8. Form 9 shows the distribution of estimated treatment needs by age group, race and sex. Adult (18 or older) treatment needs are estimated using prevalence rates from CSAT funded household survey administered in 1999. Youth (12 – 17 years old) treatment needs are estimated using prevalence rates from the 2005 Oregon Healthy Teens school survey data. The number of substance related criminal activities are obtained from the 2004 annual report of criminal offenses and arrests. The Oregon State Policy publishes this report annually. Incidence rates of communicable diseases (AIDS, Hepatitis B, and TB) are obtained from the State's Communicable Diseases Reporting and Monitoring program data.

The household survey was administered over a period of ten months (March through December 1999) using computer assisted telephone interview (CATI) to minimize non-sampling bias. The sample was generated using a Random Digit Dialing (RDD) technology. At the end of the survey, 12,017 completed questionnaires were returned yielding a response rate of 56.6%.

The survey asked respondents about their general use of alcohol, marijuana, cocaine, methamphetamine, heroin, hallucinogen, and any substance. Survey questions were developed to generate responses that indicate substance abuse and dependence based on the Diagnostic and Statistics Manual (DSM-IV criteria of the American Psychiatric Association. Final prevalence rates were derived from statistically adjusted (weighted) survey data.

Adult (18 or older) treatment needs were estimated by applying regional prevalence rates for each age group, race and sex category to the corresponding 2005-estimated population. For example, for a population of group "X" defined by age group, race, and sex with a prevalence rate of 'p_x', treatment needs were obtained as '$p_x n_x$' where 'n_x' is the corresponding population size. Prevalence rates for the Asian race group were applied to the Native Hawaiian/Other Pacific Islander race because the latter were not represented in the sample. Similarly, average prevalence rates across race groups were used to estimate treatment needs by other and two or more race categories. When a particular group in any region is not represented in the Survey population, the statewide average prevalence rate for that particular group is used.

Youth (12 – 17 years old) treatment needs were estimated by applying prevalence rates from the 2005 Oregon Healthy Teens school survey to the 2005 youth population. Prevalence rates among the youth population are defined as the proportion of those using alcohol or drugs at a high frequency in the sample. Youth treatment needs were not assessed by age, race and sex categories due to low sample sizes.

Intravenous Drug Users

We estimated the number of intravenous drug users in need of treatment by applying the proportions of intravenous drug users in the treatment recipient population to those in need of treatment at the general population level. Intravenous drug use prevalence rates are the proportions of those who reported to the Client Processing and Monitoring System (CPMS) administering their drugs by injection to the total treatment population in SFY 2004/2005. One-fifth of those in need are expected to seek treatment.

Prevalence of Substance Related Criminal Activities

We estimated prevalence of alcohol and drug related criminal activities from the Oregon Law Enforcement Data System (LEDS), which is instituted and maintained by the Oregon State Police (OSP). The Oregon State Police analyze and disseminate criminal justice information as authorized by the Oregon Legislature (ORS 181.730). The Office develops standards and procedures (ORS 181.715) for reporting criminal justice data and all law enforcement agencies in the State are required to report criminal activities to LEDS (ORS 181.550). The database is also part of the national network of criminal justice information. The reported numbers in this application are taken from the 2004 (the most recent year available) report.

Incidences of Communicable Diseases

We reported incidence rates (# of persons per 100,000 residents) of communicable diseases (Hb, AIDS, & Tb) for CY 2005 as indicators of communicable disease prevalence. The Oregon Public Health Division is charged to develop and institute reportable disease (e.g., tuberculosis, hepatitis B and AIDS) reporting procedures and enforce the rules governing the reporting process (ORS 433.004). The Public Health Division requires all licensed health professionals to report upon encountering any reportable disease to County public health offices. Other agencies required by law to report any reportable disease to county public health offices include law enforcement officers (ORS 433.009, ORS 433.085), paramedics (ORS 433.085) and magistrates (ORS 433.130). County public health offices

subsequently report such data to the Public Health Division using standardized forms. The Public Health Division documents, maintains, analyzes and disseminates the information for intervention and prevention service planning. Compliance with reporting requirements is high and the Public Health Division ensures that the data are valid and reliable.

REFERENCES:

1. Feyerherm, William; Goff, Clinton; and Campbell, Caitlin. Oregon Household Treatment Need Survey, Portland Survey Research Laboratory, Portland State University, May 2001.
2. State of Oregon Report of Criminal Offenses and Arrests, 2003. May 2005.

State:
Oregon

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T1 - TREATMENT PERFORMANCE MEASURE
EMPLOYMENT STATUS (From Admission to Discharge)

Employment Status - Clients employed (full-time or part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients employed (full-time and part-time) [numerator]	23,074	25,606	
Total number of clients with non-missing values on employment status [denominator]	51,975	51,975	
Percent of clients employed (full-time and part-time)	44.39%	49.27%	4.87% / 10.97%

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THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T1.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T1.2
How is Admission/Discharge Basis defined? (Select one)

- ☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T1.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T1.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T1.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

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State Description of Employment Status Data Collection (Form T1)

GOAL

To improve the employment status of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being employed (including part-time) at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on employment that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S) Source(s): Client Processing Maintenance System (CPMS)

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DATA ISSUES Issues: none

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DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Oregon

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T2 - TREATMENT PERFORMANCE MEASURE
HOMELESSNESS: Living Status (From Admission to Discharge)

Homelessness - Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients homeless [numerator]	3,682	2,009	
Total number of clients with non-missing values on living arrangements [denominator]	51,975	51,975	
Percent of clients homeless	7.08%	3.87%	-3.22% / -45.44%

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THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T2.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T2.2
How is Admission/Discharge Basis defined? (Select one)

- ☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T2.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T2.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T2.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Homelessness (Living Status) Data Collection (Form T2)*

GOAL

To improve the living conditions of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being homeless at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on living status that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S) Source(s): Client Processing Maintenance System (CPMS)

DATA ISSUES Issues: none

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Oregon

Reporting Period:	
From	To

FORM T3 - TREATMENT PERFORMANCE MEASURE
CRIMINAL JUSTICE INVOLVEMENT (From Admission to Discharge)

Arrests - Clients arrested (any charge) (in prior 30 days) at admission vs. discharge - T3	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of Clients arrested [numerator]	0	0	
Total number of clients with non-missing values on arrests [denominator]	0	0	
Percent of clients arrested			/

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T3.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T3.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T3.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T3.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T3.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Number of Arrests Data Collection (Form T3)

GOAL

To reduce the criminal justice involvement of persons treated in the States substance abuse treatment system.

MEASURE

The change in persons arrested in the last 30 days at discharge for all clients receiving treatment.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☐ NO ☒

State collects discharge data.

YES ☐ NO ☒

State collects admission and discharge data on criminal justice involvement that can be reported as a Yes/No response.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S) Source(s):

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA ISSUES

Issues:

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

State:
Oregon

Reporting Period:	
From	To

FORM T4 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - ALCOHOL USE (From Admission to Discharge)

Alcohol Abstinence - Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from alcohol [numerator]	0	0	
Total number of clients with non-missing values on 'used any alcohol' variable [denominator]	0	0	
Percent of clients abstinent from alcohol			/

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T4.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T4.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T4.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T4.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T4.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Alcohol Use Data Collection (Form T4)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change of all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☐ NO ☒

State collects discharge data.

YES ☐ NO ☒

State collects admission and discharge data on alcohol use that can be reported using TEDS definitions.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S) Source(s):

DATA ISSUES

Issues:

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Oregon

Reporting Period:	
From	To

FORM T5 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - OTHER DRUG USE (From Admission to Discharge)

Drug Abstinence - Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from illegal drugs [numerator]	0	0	
Total number of clients with non-missing values on 'used any drug' variable [denominator]	0	0	
Percent of clients abstinent from drugs			/

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T5.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T5.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T5.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T5.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T5.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Other Drug Use Data Collection (Form T5)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☐ NO ☒

State collects discharge data.

YES ☐ NO ☒

State collects admission and discharge data on other drug use that can be reported using TEDS definitions.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S) Source(s):

DATA ISSUES

Issues:

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Oregon

Reporting Period:	
From	To

FORM T6 - PERFORMANCE MEASURE
CHANGE IN SOCIAL SUPPORT OF RECOVERY (From Admission to Discharge)

Social Support of Recovery - Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0	
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0	
Percent of clients participating in social support activities			/

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T6.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T6.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T6.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T6.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T6.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Social Support of Recovery Data Collection (Form T6)

GOAL

To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported participation in one or more social and or recovery support activity at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission and discharge data on social support of recovery that can be reported using definitions provided as follows:

Participation in social support of recovery activities are defined as attending self-help, attending religious/faith affiliated recovery or self help groups, attending meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S) Source(s):

DATA ISSUES

Issues:

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Oregon

FORM T7: RETENTION

Length of Stay (in Days) of Clients Completing Treatment

Length of Stay			
LEVEL OF CARE	**AVERAGE**	**MEDIAN**	**STANDARD DEVIATION**
DETOXIFICATION (24 HOUR CARE)			
1. Hospital Inpatient			
2. Free-standing Residential			
REHABILITATION / RESIDENTIAL			
3. Hospital Inpatient			
4. Short-term (up to 30 days)			
5. Long-term (over 30 days)			
AMBULATORY (OUTPATIENT)			
6. Outpatient			
7. Intensive Outpatient			
8. Detoxification			
9. Methadone			

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Oregon

Reporting Period:
From 7/1/2005 To 6/30/2006

Prevention Form P1
NUMBER OF PERSONS SERVED

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Persons served in Block Grant funded services include all persons served in prevention programs that receive all or part of their funding through the SAPT Block Grant.

AGE	TOTAL	SINGLE SERVICES	RECURRING SERVICES	RACE/ETHNICITY	TOTAL	SINGLE SERVICES	RECURRING SERVICES	GENDER	TOTAL	SINGLE SERVICES	RECURRING SERVICES
0-4	3067	2915	152	American Indian / Alaska Native	15797	15079	718	MALE	261145	248961	12184
5-11	32447	24254	8193	Asian	8543	8149	394	FEMALE	298419	285077	13342
12-14	49558	36622	12936	Black / African American	22003	21679	324				
15-17	29487	27292	2195	Native Hawaiian / Other Pacific Islander	959	890	69				
18-20	33255	33078	177	White	513051	488626	24425				
21-25	112570	112240	330	More than one Race	2663	2599	64				
26-44	136602	135426	1176	Unknown	0	0	0				
45-64	131697	131346	351	Total	563016	537022	25994				
65+	30881	30865	16	Not Hispanic Or Latino	500551	479503	21048				
				Hispanic Or Latino	58608	54233	4375				
Total	559564	534038	25526	Total	559159	533736	25423	Total	559564	534038	25526

Form P2

State:	Reporting Period:
Oregon	From To

PREVENTION FORM P2
NUMBER OF EVIDENCE-BASED PROGRAMS, PRACTICES, AND POLICIES

Programs include all prevention programs, practices, policies, and strategies that receive all or part of their funding through the SAPT Block Grant.

1.List NREPP programs or practices below.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

2.List programs or practices from lists recommended by other Federal agencies.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

3.List peer-reviewed journal-evidenced programs, practices, and policies (attach journal citation).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

4.List the names of other evidence-based programs, practices, and policies (attach source and type of evidence).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

5.List the names and sources of other non-evidence-based programs, practices, and policies (attach additional information on the program, practice, or policy).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

TOTALS

GRAND TOTAL all programs, practices and policies	**0**
Percent Evidence-Based (sections 1 - 4 above)	**%**
Percent Non-Evidence-Based (section 5 above)	**%**

Form P3

State:
Oregon

Reporting Period:	
From	To

PREVENTION FORM P3
PERCEPTION OF RISK/HARM OF, AND UNFAVORABLE ATTITUDES TOWARD SUBSTANCE USE BY THOSE UNDER AGE 21

For perception of risk/harm, report the number and percent of the State population who responded “slight risk”, “moderate risk” or “great risk” (add the three categories).

For unfavorable attitudes, report the number and percent of the State population who responded “somewhat disapprove” or “strongly disapprove” (add the two categories).

Indicator	Drug	No. of Respondents	Percent of Respondents
Perception of Risk/Harm of Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**
Unfavorable Attitudes Toward Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form P4

State:
Oregon

Reporting Period:
From To

PREVENTION FORM P4
USE OF SUBSTANCES DURING THE PAST 30 DAYS

Report the number and percent of the State population who responded having used at least one or more times in the past 30 days.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Drug		12-17 year olds	18-25 year olds	>26 year olds	Total
Alcohol	**N**				
	%				
Tobacco	**N**				
	%				
Marijuana	**N**				
	%				
Cocaine/Crack	**N**				
	%				
Stimulants	**N**				
	%				
Inhalants	**N**				
	%				
Heroin	**N**				
	%				

Oregon

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

State applicants should include a discussion of topics relevant to outcome reporting in general. This would include topics mentioned in instructions above as well as any additional information (e.g., data infrastructure needs) that the State deems important.

Oregon

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.

WD Block Grant Information
(7-06)

Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Behavioral Health Workforce Development Forum #1		On-site seminar and work sessions		To increase the educational institutions' ability to produce graduates prepared to deliver appropriate EBP services by establishing core curricula/ competencies for adult treatment.
Behavioral Health Workforce Development Forum: Adolescents #1	August 2006 100-200	On-site seminar and work sessions		To increase the educational institutions' ability to produce graduates prepared to deliver appropriate EBP services by establishing core curricula/competencies for adolescent and children's treatment.
College Infusion of current practices applied to public funded programs #1	Follow up project of Forum	TBA		To infuse EBP into college curriculum. To prepare students to treat clients with the most current practices.
SA Workforce Survey #1	Survey of 100% of providers	Survey		To survey SA treatment providers regarding work satisfaction, pay, benefits and training needs. This is a part of regional trend survey.
Public Psychiatry Conference #1	Fall '05/06 1 day/year 300	On-site Salem		Increase the knowledge of professionals regarding EBPs including algorithms and treatment of those with co-occurring disorders.

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WD Block Grant Information
(7-06)

Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Co-Occurring Part 1: Dual Diagnosis #1		TA with on-site training and on-going support		Implement one of the EBP's for those with psychiatric and substance abuse disorders for adults and one for children. These will then become sites for providing a model for implementation and will provide TA to others.
Co-Occurring Part 2: Cross-Training of MH and ATOD professionals #1	Development will determine Option #1 Support course delivery in "schools"	Development will determine Option #2. Create Cohort group to get CADC or "AMH certificate of competence"		To increase the number of professionals with essential competencies in both mental health and substance abuse screening, assessment, referral and multi-discipline case management. To increase the skills of professionals delivering services to children and families with both mental health and substance abuse disorders.

WD Block Grant Information
(7-06)

Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Cultural Considerations EBPs Part 1 Ethnicity and Poverty African American Wellness Village		Consultants AMH staff VC or Net Link		To implement the recommendations of the OCCP and DHS DDCC. To increase the effectiveness of service provided to the identified populations and increase client outcomes.To provide culturally and age appropriate MH & AD education resources materials to the African American families in the Portland/Metro area.
Cultural Considerations EBPs Part 2 Gender and Sexual Orientation/People with Disabilities	TA projects School courses	Consultants AMH staff VC or Net Link		To implement the recommendations of the OCCP and DHS DDCC. To increase the effectiveness of service provided to the identified populations and increase client outcomes.
Cultural Considerations EBP Part 4 Counselor Development Rural Focus	Development will determine.	Scott Miller's model and research regarding counselor characteristics		To provide entry level counselors with the skills necessary to meet OARS. To provide counselors with the skills necessary to implement EBPs. To help rural areas develop and retain counselors prepared to provide competent services to clients.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Recovery Support: Homeless/Oxford #1		Keynote Speakers panel; Breakouts On-site	K. Wheeler	Symposium Recovery Support: Homeless: Oxford To re-conceptualize the behavioral health system in terms of integration across all disciplines and the adoption of a service model that transcends the current acute medical model. To teach the guiding principles of Behavioral Health Recovery Management Project (BHRMP). To identify the best clinical guidelines that are evidence-based and/or consensus derived for BHRMP. To identify ways to integrate BHRMP principles for our community alcohol and drug providers and housing providers.
Recovery Support: Speakers Bureau TA & Consultation Promote consumer directed services that promote recovery) #2		On-site, VC, Audio NetLink	K. Reer M. Hlebechuk M. Moore K. Wheeler NAMI/RAP/ OFSN	This supports the AMH strategies to increase the focus on recovery and resiliency. To increase the involvement of people, families and communities in recovery. To support the leadership of those in recovery.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
EBP Research How to find, read, interpret and share research findings including prevention (MH & ATOD). Focus on culturally specific practices. #1		Web-based and ongoing. May use DHS LC Consultants AMH Staff VC or NetLink Options for distribution		To increase the number of entry level counselors able to read and analyze research and implement EBPs. To increase the skills of providers to find, analyze and implement EBPs. To increase the number of programs doing evaluation and fidelity assessment of their practices. To provide the prevention wokforce the information necessary to criticallly analyze prevention research and put the findings to work in evidence based practices. To increase the identification of and number of EBPs serving specific cultural populations. To increase the ability of culturally specific programs to evaluate practices and provide evidence for replication.
Primary Care/Mental Health Integration Model	3 regional: Southern, Eastern, and metro areas; 50 at each; dates TBD	On-site TA Consultant on Impact Model		This technical assistance initiative carries out the intent of SB 267 to implement evidence-based practice mental health services. Implementation of this EBP is a part of the plan to achieve AMH federal block grant goal 11A, increasing the percentage of older adults with severe mental illness who receive public mental health services. This TA initiative supports cultural competency in that the primary care/MH integration model is specifically designed to serve older adults.
Trauma Informed Services	Vary 6-8 regional deliveries	On-site NetLink Web-caste Web page		This is part of the Trauma Policy Implementation Plan. To inform providers about the DHS/AMH trauma policy with recommendations for implementation.
Systems Change TOT Current staff update New staff and providers with interest #2	5 days over 6 months TA on phone and on-line 15-20 participants	On-site, video conferencing, phone consultation		The goal of the project is to develop a small cadre of systems improvement technical assistants who will assist treatment agencies to assess their agency for readiness for change, help them identify, plan, implement and monitor fidelity.

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Systems Change A	9-month project for 7 agencies 10 TA 1 TA provider for teams 1 agency must be from rural Oregon, 1 from a culturally specific agency, 1 faith-based	3 on-site meetings Ongoing agency TA (person, e-mail and phone) or infusion model		Assist prevention/treatment agencies to assess their agency for readiness for change, help them identify, plan, implement, monitor fidelity, evaluate and sustain EBPs. EBPs selected must have a fidelity scale or way of measuring adherence to the practice/model. Suggestions for AMH to offer help on following practices; 12-Step facilitation, family psycho-education, CBT, DBT
Systems Change B	Repeat with learnings applied from first effort 1 agency must be from rural Oregon, 1 from culturally specific agency, 1 faith based			Assist prevention/treatment agencies to assess their agency for readiness for change, help them identify, plan, implement, monitor fidelity, evaluate and sustain EBPs. EBPs selected must have a fidelity scale or way of measuring adherence to the practice/model. Suggestions for AMH to offer help on following practices; 12-Step facilitation, family psycho-education, CBT, DBT

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ASAM - EBP Rule Compliance and Integrated screening/ assessment #1		On-site Agency specific		Providers will use the ASAM PPC-2R as directed by the OARs. Increase use of an EBP assessment tool and support implementation with fidelity.
Client Process Monitoring System (CPMS) Training #1	Forty 1-day trainings: 20 in 2005 20 in 2006	On-site AMH staff		To increase the accuracy and reliability of treatment data. The data will then be used to determine needed resources and distribution.
Motivational Interview (MI) Motivational Enhancement Therapy (MET) MATRIX 12-Step Facilitation Dialectical Behavior Therapy (DBT) TIP on Older Adults TIP 42 #2	Six month project with 4-6 agencies	TA model with AMH staff		To increase the implementation of EBPs approved by AMH to meet requirements of SB 267. To develop cadre of providers trained to provide technical assistance to programs planning to implement one of the EBPs.
Family/SO Involvement and Treatment #1	Six month project with 4-6 agencies	TA model with AMH staff		To increase family involvement in treatment and recovery to meet OARs and improve client outcomes. To increase providers ability to involve the families in treatment and recovery.
Drug Court HIPAA/CFR42 Series #1	15 days Regional	Tigard P 7/19-20 DC 7/21 Bend P9/28-29 LaGrande P 10/19-20 DC 10/21 Medford P 11/16-17 DC 11/18 Eugene P 1/25-26/06 Portland P 2/8-9/06		To teach providers and drug court administrators to keep the federal requirements for confidentiality and collaborate to serve clients effectively. To provide a forum for the discussion of ethics involved in the implementation of the privacy and confidentiality laws (42CFR and HIPAA).
Older Adults and Substance Abuse TA Project #2	Six-month project Two-day training TA on-site and off One-day followup	Programs would apply and location would depend on projects selected		To define EBPs for older adults with substance abuse disorders. To facilitate the implementation of best practices in helping older adults with substance abuse disorders. To develop resources for providing technical assistance for SA treatment programs working with older adults.
Opiod Summit EBP-Methadone and others. "Heroin - the epidemic that hasn't gone away" #3	1-2 days Direct 1-2 hours to MDs	Metro area		To reduce the stigma of Methadone treatment and establish its status as an EBP. To increase referrals, increase allied social service providers acceptance.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
National Prevention Network Conference #2		NPN hires a conference planner		To keep AMH commitment to co-sponsor the National conference. To provide EBP information to Oregon Prevention Specialists and Counties.
Series of Prevention Trainings: Evaluation, Program Monitoring, Ethics and Interviewing Adolescents #1	Four 1-day trainings Regional	Prevention Coordinators meetings		To provide the prevention specialists and prevention contractors with the latest information regarding evaluation, program monitoring, ethics and interviewing adolescents. To provide the mandatory number of hours necessary for certification and re-certification.
MDS Minimum Data Set #1	Four 1-day trainings Regional	On-site Staff to train		To provide the prevention workforce with the most updated information and training on the web-based prevention data collection system, required by AMH prevention contracts.
Prevention Violence Institute Support #1	3-5 days	Central Conference		To provide financial support to the only prevention-related summer institute for the prevention workforce allowing alcohol and other drug prevention to continue as a main topic of training.

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Crisis Intervention & Advanced Civil Commitment #2		On-site		To provide information to help professionals meet the requirements of the laws/OARS. To increase effectiveness of the Civil Commitment process to serve clients, families and communities.
Enhanced Care Services Quarterly #1	Sept 05/06 Two 1-day 70	On-site Salem		To update providers on the rule revisions. To provide information on EBPs. To increase networks and resource information among providers.
Evidence-Based Practices in the Adult Health System Supported Employment #1 Note: at least one of the sites in Eastern Oregon	TBA Application and selection process 1 project/year	TA with on-site training and ongoing support		To facilitate implementation and sustain an EBP supported employment. To support the implementation of supported employment in an eastern rural agency. To increase staff capacity to provide TA to implement EBPs.
Evidence-Based Practices in the Adult Health System Assertive Case-Management (ACT) #1	TBA Application and selection process 1 project/year	TA with on-site training and ongoing support		To facilitate implementation and sustain an EBP - ACT. To support the implementation of ACT in a rural agency. To increase staff capacity to provide TA to implement EBPs.
Extended Care Management Unit (ECMU) Forum #1	Three Forums: Winter 2005 Spring 2006 Fall 2006 8 hours each 50-75 participants	On-site Local experts		To provide information on the following: Recovery focused treatment Policy and Procedure EMU's Role Mental Health (MH) Education System collaboration Changes in MH treatment and recovey
New Provider TA quarterly for PSRB & ECMU #1	Quarterly: Fall 2005 Winter 2006 Spring 2006 Summer 2006	VC or audio conference		To provide information on the following: Crisis management Billing and documentation Care coordination Community integration Client rights
Pre-Commitment Investigator/ Examiner #1	Eight/year Two-day 25 Providers	On-site TA Counties J. Williams		To train providers in the law, rules, processes and procedures of Pre-Commitment Investigations.
Psychiatric Security Review Board (PSRB) Conference #1	Sept. 12-13, '06 300 participants	On-site 2-day TA, Basic Policy & Procedures, Portland		To provide PSRB coordinators current information on the rules, legislation, policies, expectations and processes. To deliver information on the potential application of EBPs within supervision guidelines to promote recovery. To learn from those who are living in the community. To maintain and strengthen partnerships with all stakeholders in the PSRB system.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
QI Conference: Improving Performance Improvement Projects #1	Fall 2005 OMPRO & MHO TA	On-site Regional		To increase MHO's knowledge and skill in the process of conducting a reliable and valid performance improvement project.
Quality Improvement Conferences (focus on EQR Results & Statewide Performance Improvement Projects (CSCI & 2nd topic to be determined) #1	Fall 2006 and June 2007 Two 1-day	On-site Regional		To present and review MHO External Quality Review Results/Identify areas in need of improvement and areas of strength. Continue to encourage MHO participation in Statewide Performance Improvement Projects.
Rule Training: Intensive Treatment Services Intensive Rules Children's #1	At least 2-4 regional	On-site, VC, NetLink may be used		These trainings will support the new Children System Change Initiative. The goal is to increase provider knowledge of the new rules and share implementation strategies.

Mental Health - Children & Adolescents

Child and Adolescent Service Intensity Instrument (CASII) and Early Child Service Intensity Instrument (ECSII) #1	Three regional trainings Spring 2006	On-site		These trainings will support the new Children System Change Initiative. To train staff on how to use the Child and Adolescent Service Intensity Instrument (CASII) and the Early Child Service Intensity Instrument (ECSII).
Intensive Treatment Services Mentoring Program (train family members to become paraprofessionals) #2	Regional Schedule TBD	On-site, follow-up with VC or audio conference		
Trauma-Informed Treatment Services: The BESST Model (BESST goal to reduce S&R) #1-2	Statewide	On-site		This training will support the Best Environment for Supporting Success in Treatment (BESST) initiative, which is a national effort to reduce seclusions and restraints. To provide technical assistance of trauma-informed treatment training based on the BESST initiative.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
EBP and Wraparound Services (TA to provide a comprehensive, coordinated, culturally competent, child-centered, family-driven continuum of care.) #1	Regional and local offerings	Various on-site TA		This training supports the Children System Change Initiative. To assist each region on implementing an effective wraparound system of care for children diagnosed with mental illness. The training will focus on facilitating child and family teams, developing service coordination and behavior support plans, providing home-based services.

Mental Health - Older Adults

Pre-Admission Screening Resident Reviews (PASRR) Level I #1	Two 1-day Regional 2005 & 2006 One East	On-site, using distance technology		This training is necessary to educate and provide technical assistance to PAS screeners and nursing facility staff about the federally mandated PASRR program.
PASRR Level II #1	Two half-day each year East/West regions	On-site, using technology		This training is necessary to educate PASRR II evaluators about the requirements of the federally mandated PASRR program. It also includes a clinical component to strengthen the geriatric skills of the public mental health workforce.
Dialectical Behavioral Therapy for Enhanced Care Services		TA Model		This technical assistance initiative advances AMH' work to move mental health provision to evidence-based services as required by SB 267. It also promotes cultural competence in employing and modifying an EBP for a new population: older adults and younger disabled adults with medical and psychiatric needs who live in specialty long-term care settings. This initiative also promotes recovery for a group of consumers that Enhanced Care Services has had difficulty serving. This model will be disseminated to CMHPs for use with other older adults and younger disabled adults in the non-enhanced SPD long term care system so will increase culturally competent, recovery-focused services for this special needs population.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Systems Improvement Grant (SIG) Trainings: Part 1 - Systems Development		On-site Portland South East Salem		This is a requirement of the SIG. This series will facilitate the development of local networks and systems to identify, intervene and support children 0-6 and their families in preventing or reducing effects of mental illness and/or substance abuse.
SIG Trainings: Part 2 - EBP/Research	Four 1-day Regional	On-site Wash. County Lake County Klamath Co. Lane County		This is a requirement of the SIG. This series will increase provider knowledge and skills in finding, reading, analyzing, selecting and then implementing EBPs.
SIG Trainings: Part 3 - Skill Building	Five 1-day Individual skills building topics	On-site Salem Coast Central Hood River NetLink		This is a requirement of the SIG. This series meets the specific goals of the SIG advisory committee in teaching providers and communities about the following areas with regards to early childhood prevention: Cultural Competency Effects of Trauma FAS and FASD Advocacy TBA

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Problem Gambling: Series of presentations Gambling Manager and GAT		On-site Central		To provide information and continuing education credits (CEUs) so that the problem gambling professionals can meet the OAR and certificate requirements. To increase shared knowledge of what is working in Oregon.
Problem Gambling: Information for allied service providers	One 2-day seminar (14 hours) 100 participants	On-site Regional		To provide identification and resource information to allied social service providers to increase screening and referral for people and families with gambling problems.
Problem Gambling: Information for County Prevention Coordinators	Two 6-hour trainings 20 participants Total: 40	On-site Metro		To increase prevention specialists knowledge of prevention efforts to reduce the incidence of problem gambling.
Problem Gambling: Pre-certification course for those interested in problem gambling field.	Series of two 6-day trainings 20 participants each Total: 40	On-site Metro		To provide the credits, knowledge and skills for professionals to become certified to treat people with problem gambling. To insure that the colleges prepare students to work effectively in AMH funded treatment programs.
Problem Gambling: Training for ATOD service providers	Two 1-day trainings at NWIAS	On-site Metro		To increase knowledge and skills of SA and MH providers regarding problem gambling. To increase identification of people with gambling problems and referral to problem gambling professionals.
Problem Gambling: Training for problem gambling professionals	Four 2-day seminars 100 participants each Total: 400	Regional		To increase problem gambling professionals' knowledge of EBPs and how to do research to assess outcomes. To increase the knowledge and skills of professionals to treat specific populations i.e. ethnic groups, youth, older adults, people with disabilties, etc.
Problem Gambling: Gambling Summit	Two 1-day events 200 people each Total: 400	On-site Regional		To increase awareness of the need for policy development and legislative action regarding the individual and societal consequences of problem gambling. To develop and outline an action plan for the implementation of those policy and legislative directives. To draft "papers" with recommendations and best practices.

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Title/Description	Date/Length # of Parts	Delivery Method	# Participants	Purpose or Value
Problem Gambling: Think Tank: Oregon's needs to address problem gambling	One-day event 40 people	On-site Regional		To develop the agenda and direction for the Problem Gambling Summit. To review the "papers" and follow through with action plans.
Problem Gambling: Learning Follow Through Program	Fifty TA sessions 5 participants Total: 250	Regional		To provide on going technical assistance to problem gambling professionals on specific concerns identified by local communities. Outcome data to be collected.

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SOAR Trg: Enhance Access to SSA Disabilities Programs for People Who are Homeless #1		On-site Regional Delivered by SOAR trainers		To meet PATH grant requirements. To enable more people disabled by MH and addiction disorders to have an income and medical benefits.
Oregon Coalition on Housing & Homelessness Conference #1	9/18-20/05 2.5 days	On-site Hood River		Sam Tsemberis will present on Housing First: SSI session and trauma session. Will address homelessness and present EBPs to staff of MH and ATOD and community agencies.
EBP Workshops/TA #1	Four to six 1-day sessions accompanying TA visits	County or Regional		Ideas include the following: * Collecting ideas for TA and seminars; have TA plan with the RC TA provider. * Experts on California AB 3024 * Medicaid maximization * Services for recovery in supportive housing (TN Bridges Model)
Resources for Supportive Housing: Manual and Training (Accessing services for people with co-occuring disorders) #2	Six to eight regional or SDA training sites 2005-2007 200 attendees	1-2 days statewide seminar and TA		To meet RCSG grant requirements. Will increase the availability of supportive housing and reduce homelessness and institutionalization. "Integrating Long Term supports with affordable housing"
Personal Care Assistant & Contract RN Training #1	July 2005	On-site Eugene & Portland		To meet requirements of Real Choice Systems Grant.
Oxford House World Conference and Oregon Oxford House Annual Conference #1	Two Annual Fall World conferences; two summer workshops; two leadership summits	County or Regional		To support people in recovery to attend conferences to improve their skills in advocacy and leadership. To build leadership and strengthen the volunteer network of over 130 recovery homes serving 975 people in recovery from alcohol and other drugs.