March 2007

EFFECTIVENESS REPORT

Governor's Council on Alcohol and Drug Abuse Programs

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Principles and Assumptions That Drive the Evolution of Oregon System of Substance Abuse Care

- Treatment for alcohol or other drug disease should be personalized to each person's cultural and social factors and based on the best scientific protocols and standard of care, including the use of appropriate medications, behavioral therapies, and ancillary services that significantly enhance the likelihood of success.

- As with all chronic medical conditions treatment should be available to all who need it.

- Adolescent programs need to be developmentally appropriate, immediately accessible and affordable.

- Children in parent and child programs should be provided with a full continuum of early childhood services. It should be recognized that these children are also clients and funding should follow them.

- Providers are essential contributors to processes of system improvement. They should be brought in at the question formulation not just on workgroups for solutions.

- Substance abuse prevention and treatment is a highly skilled professional field, utilizing evidenced based practices provided by a trained and certified staff. The staff should be compensated on parity with similar professions. This will substantially improve the workforce crisis.

- Data collection strategies should be standardized across the state with local options. The data should involve qualitative and quantitative measures for both prevention and treatment programs.

- Site reviews should be clinical reviews not file reviews and Oregon Administrative Rules (OARS) should be written to reflect this. State site reviewers should be seen as technical assistance staff for both prevention and treatment providers.

- Medical Marijuana criteria for use should be specified using evidence based practice and reflect the spirit of the legislation.

Background

State and local governments are facing unprecedented demands to meet critical service delivery needs with limited resources. Decision makers in government, as well as taxpayers, are more concerned than ever in insuring that precious tax dollars are being spent wisely. The public is demanding accountability and results. This underscores the timely and critical nature of this report on the effectiveness of Oregon's alcohol and drug abuse programs.

The Governor's Council on Alcohol and Drug Abuse Programs is directed by statute to review effectiveness of alcohol and drug abuse programs and make recommendations to the Governor, outlining the priorities for improvement of prevention and treatment programs engaged with or financed through state agencies. We hope this report will be a useful tool for decision-makers charged with allocating limited financial and human resources.

In the following pages, several key points will emerge. There is some positive news, but there are also several key indicators of critical challenges facing Oregon's prevention and treatment delivery system.

- A large body of scientific data indicates that addictions prevention and treatment services presently being offered are effective.
- That data is being used to refine practices in a manner expected to produce even better outcomes.
- Service providers need additional resources to implement the latest Evidence Based Practices (EBP).
- There are major gaps in publicly funded prevention and treatment programs that must be addressed.
- There is a workforce crisis in the addictions treatment field, which must be addressed.
- The trend toward integration of substance abuse and mental health prevention and treatment with primary care should continue.

Treatment Effectiveness

Effectiveness

Effectiveness of public funded treatment programs has historically been defined primarily by abstinence at the end of a treatment episode. It has been measured largely through client outcomes specified in minimum standards negotiated with treatment providers in 1982. The state data system (also designed from early 1980's) used to measure these indices is called the Client Process Monitoring System (CPMS).

Outcome Measures

The areas measured for adults and adolescents are summarized in the table below:

Adult Outcomes	Adolescent Outcomes
Abstinence	Abstinence
Treatment completion	Treatment completion
Improved living arrangement or conditions	Improved living situation or conditions
Improved employment	Improved employment
Enrolled in school or employment training	Enrolled in school or employment training
Decreased arrests	Decreased arrests
Use of self help groups	Use of self help groups
Improved parenting	
Increased monthly income	
	Academic improvement in school
	Improved school attendance
	Improved school behavior

In the 1990's, with the onset of managed care for Medicaid clients and with research demonstrating that longer stays in treatment produce better outcomes the following standards were added: engagement in treatment and retention in treatment (calculated measures). Additionally regaining custody of children is now measured. The implementation of the American Society

of Addiction Medicine (ASAM) placement criteria supported an outcome measurement for whether a client received the appropriate level of treatment.

With the movement toward full implementation of EBPs, these treatment outcome protocols can be broadened. Parts of the service delivery systems already collect strong outcome measures and further spread of this practice is expected to occur. The Governor's Council encourages the state to look at broad and universal outcome measures as well as program specific ones which will allow the analysis of how well the system is functioning as a whole. These outcomes should be captured across venues and departments where substance abuse treatment is being offered.

Monitoring of Outcomes Measures

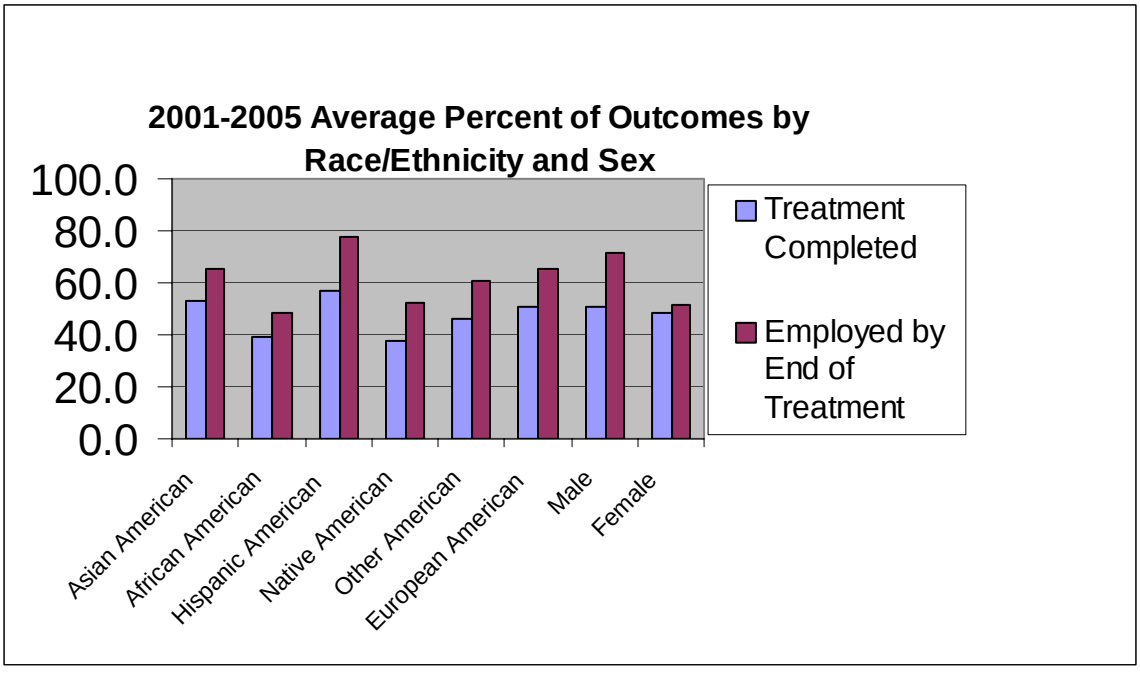
Treatment outcomes in addiction have historically been measured using a treatment episode to define outcome rather than lifetime management of a chronic condition usually requiring at least periodic treatment. As the implementation of EBP's becomes more widespread research will set practice guidelines closer to the health care standards for other chronic illnesses. Today's knowledge of addiction as a brain disease demands that new outcomes be used which view addiction as a condition requiring lifetime management rather than a single course of treatment.

Research has demonstrated that outcomes for substance abuse treatment are as good as outcomes for other medical conditions, which require a behavioral change. A. Thomas McLellan, Ph.D. et all, wrote in his article published in the October 2000 edition of the Journal of Addiction Medicine (JAM) on how substance dependence is a life long chronic disease (not acute with a one time treatment) that is best managed as other chronic diseases. The graph below illustrates the disease management process for chronic disease, including substance abuse. Notice similar rates needed for follow-up treatment within one year for long-term management.

Disease description:	Within 1 year symptoms requiring care	Continuously abstinent for 1 year, might need care
Type I Diabetes	30-50%	
Hypertension	50-70%	
Asthma	50-70%	
Substance Abuse		40-60% (an additional 15-30% have not resumed dependant use)

Oregon Outcome Results

AMH grants letters of approval for any organization that provides Alcohol and Drug Abuse Services in the state of Oregon. Private practitioners do not receive letters of approval. Outcome information is only collected from organizations that receive public funds. Over the years, Oregon's publicly funded alcohol and drug abuse treatment system has met or surpassed national outcome standards for treatment completion. Oregon's statewide treatment completion rate, which includes abstinence in 2005, was 51 percent measured at the end of a treatment episode and 72 percent reduction in use rate. The graph below illustrates the trend for treatment completion and employment at the end of treatment. Please note the relative highest rate of completion and employment for Hispanic American and lower rates of completion and employment for African Americans and Native Americans. The reported differences can be used to better target ongoing needs.



Current data collection does not follow clients after they leave treatment. However, if they return to treatment, meeting a lower level of care, these data are available and support once again the effectiveness of treatment.

Cost effectiveness studies have demonstrated over and over again that treatment works and saves money. It is just good public policy to invest in treatment and prevention activities.

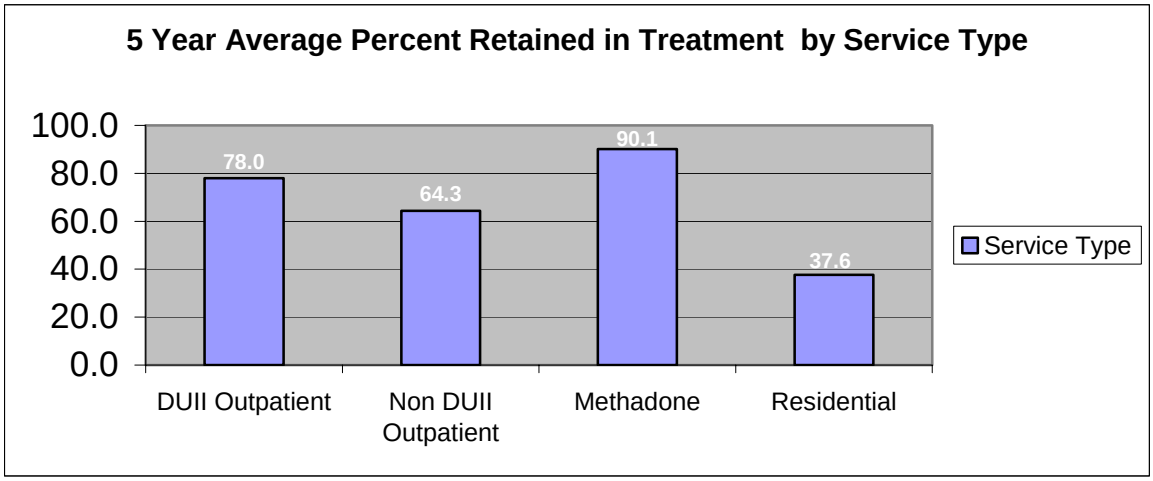
Demographics

The bulleted items highlight some characteristics of those served by the public funded system through the Addictions and Mental Health Division (AMH):

- 67%male and 33% are female
- Pregnant clients served has increased by 25% since 2001
- 61% of referrals to the treatment system are from the criminal justice system and 6% of the referrals are from the child welfare system. The remaining referrals are self, family or hospital referrals.

Level of Care

Another factor that affects treatment effectiveness is assuring that clients access the appropriate level of care. In 2005, the percentages of clients accessing the appropriate level of care ranged from a low of 79.7 percent for Methadone clients to a high of 94.2 percent for residential services. This underscores a gap in services for Methadone clients who need residential services. The graph below illustrates the type of addiction service received and percent of those retained in treatment (minimum of 90 days). For those receiving treatment most treatment services are quite effective to retain the client except for residential services. Numerous studies show the longer a client is in treatment, there is a higher degree of abstinence or reduced usage.



*Residential percentage has shown improvement over the last 5 years from an average of 29.4% in 2001 to 45.4% in 2005.

Length of stay (LOS)

Length of stay (LOS) in treatment has been shown to be the best predictor of long-term sobriety.

- Outpatient treatment LOS has decreased by 12 percent or (17 days), between 2001-2005 across all populations and age groups except for those 65 years and older, which has increased by 10% percent (14 days)
- Residential treatment LOS has increased by 19 % (17 days) for males, 25 % (19.4 days) for Hispanics and 32.9 % (25.9 days) for Native Americans in the last 5 years.
- Methadone maintenance LOS has decreased by 8.5 % (71days)
- Finally there has been a large reduction in child welfare referrals to methadone maintenance 87 % in the last five years.

The decrease in funding to outpatient and the reduction of the number of health plan enrollees during this same period made it hard for providers to offer intensive outpatient treatment. With a reduction in that level of care, length of stay would also be reduced. These same funding reductions caused several Methadone Maintenance programs to close and fewer women could access care which would reduce the number of in child welfare referrals.

Gaps in Service

Gaps in the levels of care have widened as funding reductions were implemented. Some reductions were accomplished by cutting allocations equally across outpatient and residential services. Other reductions resulted in complete closures of detoxification centers as the amount of funds were so small that overhead could not be met. When the Oregon Health Plan's (OHP) standard population was nearly eliminated from OHP in 2003, some outpatient drug free and methadone programs closed as they were reliant on OHP billing. Some of the remaining programs cannot afford to provide intensive outpatient services, which further diminish the continuum of care.

The gaps in care significantly impact effectiveness. In the last six years, significant reductions in treatment dollars have resulted in reduced access to

treatment at all levels. Reductions in access to treatment have brought extreme pressure on the continuum of care. This pressure is being further magnified as the public becomes aware of the impacts of methamphetamine use as it reaches epidemic proportions.

The crisis in treatment, which comes from reduced access to services, has resulted in clients progressing further in their addictions and becoming more difficult to treat as they wait for protracted periods to enter treatment. As a result, they often have to be treated in levels of care that are inadequate and/or are incarcerated. Such inadequate treatment or access to treatment can increase the risks of death through over-dose, suicide, medical complications from AIDS (HIV) and Hepatitis C (HCV) or homicide. Death rates have not been measured, yet staff and families face this tragic outcome regularly.

The gaps in service levels of care that impact the overall effectiveness of treatment services are:

1. Long term stabilization for severe methamphetamine addiction. The system of care does not have the specialized capacity to treat a person who is severely addicted to methamphetamine and becomes psychotic or so out of control that they are a danger to themselves and others. Jail, prison and the state hospital currently house this group. Other states like Washington and Iowa have designed a level of care for this population to keep them out of the more costly settings and to begin treatment as the person is stabilized.

2. Detoxification in rural areas is needed. Transporting addicted persons to urban areas for care is physically and medically dangerous, and the likelihood of a smooth transition back to the rural community is severely restricted by residential wait lists and insufficient intensive outpatient program access. This process dilutes the effectiveness of treatment at all levels.

3. Residential care for the hearing impaired is unavailable in the state of Oregon. A specialized service is available in Vancouver, Washington and could be utilized to provide this service.

4. Residential care for clients on methadone is rare and many clients need this level of care for stabilization and on going care.

Workforce Crisis

There is an acknowledged workforce crisis in the field of addictions treatment and prevention which negatively affects the quality and effectiveness of care as reported in the Institute of Medicine's Report: Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Increasing Workforce Capacity for Quality Improvement.

Workers remain grossly underpaid, at an average of ten dollars per hour. They carry large and very difficult caseloads and they are required to complete onerous amounts of paper work. These issues combined with the demoralization, which occurred through unprecedented funding cuts, have led to professionals leaving the field in alarming numbers. Programs find it difficult, if not impossible, to recruit credentialed staff. One third of certified addiction counselors are not renewing their certification according to the Addiction Counselor Certification Board (ACCBO at www.accbo.com).

Criminal Justice

All criminal justice programs define effectiveness as whether the offender's risk of re-offending is reduced. The Department of Corrections (DOC) also defines effectiveness through a cost benefit analysis.

The DOC and the Oregon Youth Authority (OYA) are using EBP's (Evidence Based Practices) in all programs and has implemented a standardized review process of all treatment programs serving offenders that is currently underway. The review uses the Correctional Program Assessment Inventory and Program Checklist. Any programs found to be unsatisfactory with the level of EBP will be re-reviewed to assess their progress. The DOC has contracted with the Washington State Institute for Public Policy to analyze clinical and cost effectiveness of the various programs delivered.

A preliminary report of corrections inmates released between 1996-2000 shows that Native Americans and Caucasians are more likely to have severe addiction. Hispanics are the least likely.

- Native Americans are more likely to have substance abuse issues at 85%
- Women have a high substance abuse rate 84%
- Asians are the least likely 56%

This data underscores the need for targeted programs for those in greatest need with the corrections programs.

Driving Under the Influence of an Intoxicant (DUII)

DUII programs are evaluated by three different governmental bodies, each with a different prospective and mandate to measure effectiveness.

1. The Traffic Safety Division of the Department of Transportation defines and measures effectiveness by the number of traffic fatalities

that are alcohol or drug related. They also measure effectiveness by a DUII enforcement index, which is the number of DUII offenses divided by the number of nighttime fatal and injury crashes. The percent that say drinking and driving are unacceptable social behavior is also used as a a prevention measurement. 2005 data shows a reduction in alcohol related deaths by 12% compared to 2004. Oregon's percentile of alcohol related fatalities is 34% percent, while the U.S. percentile is 39%. It is also interesting to note an additional 10% of the traffic fatalities within Oregon involved some other drug than alcohol. Although Oregon is lower then the U.S. average, it is far behind the best state, which has a rate of 12 percent.

2. The state police measure DUII effectiveness by the number of DUII arrests. The number of arrests is related to the number of patrol officers available to make the arrests and the training of the officers. Both the number of officers and the number of arrests have declined significantly since 2002, even though the number of driver's licenses has increased.

3. The Governor's DUII task force review current DUII policies and make recommendations to the Governor in the form of legislative concepts to decrease the number of DUII offenders by changing laws and policies. They report that 27% of DUII convictions each year are for repeat offenders. The task force has recommended several changes in the law to reduce the number of repeat offenders by adopting more stringent laws such as lowering the blood alcohol content (BAC) from .08 to .05 for repeat offenders or extending the hardship wait times. They also recommend expanding the definition of intoxicants to include different drugs.

A recent study, Pacific Institute for Research and Evaluation (P.I.R.E.) by the Behavioral Health Research Center, found that "more than half of DUII offenders also suffer from at least one mental illness in addition to a drug or alcohol use disorder." They also found that "60 percent of those with two or more DUII convictions reported experiencing major depression, bi-polar disorder, obsessive-compulsive disorder or past traumatic stress disorder over their lifetime." Programs that treat DUII offenders need to treat both substance abuse and mental health disorder to improve treatment to those clients who have a co-occurring mental illness.

Criminal justice system clients, both adult and youth who receive treatment services outside of the prison, are included in the CPMS data system, as are people arrested for DUII. Data on drug court clients are also in the system; however they are not separated from other criminal justice clients. As the AMH Division refines their data collection methodology following particular groups of clients will continue to inform us about what services yield the best outcomes for these specific groups.

Evidence-based Practices

The alcohol and drug addictions treatment and prevention fields continue to professionalize. There are now additional requirements for providers to use EBP's across 75% of services offered by the next biennium. The AMH Division has developed a list of acceptable evidence based practices:

(http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml).

Alcohol and drug abuse treatment providers have been surveyed and 56% report at least implementing one of the practices listed. The growing commitment toward using EBP's is separate and apart from the required legislation.

Supervision levels, staffing pattern requirements, caseload size etc. are dictated by the treatment design developed and utilized by each program. There are minimum required staffing patterns articulated in the OAR for residential programs and child care settings for safety purposes. The minimum staff credentials required for counselors, supervisors and directors are expressed in administrative rule. All programs are required to have medical directors to review medical histories, write standing orders and develop medical practice and procedures as required by administrative rule. Detoxification centers and residential treatment programs are required to have medical staff on call. Opiate replacement treatment centers are required to have medical staff to prescribe medications such as methadone or buprenorphine.

Oregon System Improvement Efforts

Oregon Administrative Rules

Treatment providers are required by administrative rules to have quality assurance plans and practices in place. These plans range from simple reviews of outcome reports by the program staff with planned improvements identified to extensive reviews required by National accrediting bodies like Joint Commission on Accreditation of Healthcare Organizations (JACHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), certification review by AMH Division, and others as required by statue.

AMH Division staff and community partners are reviewing mental health and substance abuse administrative rules. The goal is to make them consistent, align better with evidenced based practices, reduce paperwork, and be more outcomes driven. These changes will lead to site reviews conducted with a clinical focus rather than a paper work compliance exercise.

Consistent with a continuum of care and management, AMH Division has begun to define treatment much more broadly involving both clinical processes and support services to help families stabilize. Supportive services include such things as mentoring, peer support, housing and employment that aid outcomes relating to substance abuse.

Data System

The purpose of the Alcohol and Drug Enrollment Form is to collect specific client data under the treatment program's state-assigned provider number. The data are then available for aggregation within the CPMS (an aged and somewhat limited database developed in the early 1980's and is still in used today-Client Patient Monitoring System) to produce reports. By enrolling a client in CPMS, the provider has opened an individual account, which is used by AMH Division to document services delivered during the report period. CPMS produces monthly provider-specific reports (lists) of clients currently enrolled, which were mailed to the provider. This practice stopped

in 1996. Quarterly reports on client outcomes were reported to providers, which were discontinued last year.

The CPMS documents the clients were served and services delivered by community providers supported by state treatment funds, in compliance with the legislatively approved budget and statutory mandates. Additionally, it provides documentation that clients on OHP (Oregon Health Plan) were served and that services were delivered in compliance with the legislatively approved budget and statutory mandates. Lastly, CPMS provides data on performance that is used by state and local management to manage services and funding. Using a comprehensive data system (CPMS is currently quite limited in what it can do compared to the needs for process/performance tracking due to being the same system developed in the early 1980's) provides accountability for funds spent, how they were spent, and outcomes from the funds spent.

How state agencies and communities use the available data differs. A consistent set of data points collected through standardized methodologies needs to be implemented if we are to look comprehensively at Oregon's treatment system. The growing recognition that the impact of addictions issues across state agencies effect statewide outcomes can be defined as a "domino effect". The time is right to develop a data collection methodology that serves individual agencies, while providing a whole picture of the role substance abuse has in our system of care.

The process of devising the list of EBP's has provided a platform for the DHS, Department of Human Services, DOC (Department of Corrections) and OYA (Oregon Youth Authority) to begin a dialogue about what outcomes to target and the data needed to capture them. The AMH Division can then provide analyzed data to guide funding, priorities, quality improvement, and policy decisions in the addictions field. With EBP implementation and standardized data collection, prioritizing types of services delivered to the various populations will achieve specific department objectives and overall objectives for the State.

National Research Reports

Guidance for designing and implementing these new data systems can come from national bodies as well as local experts. Three of the national bodies are:

1. National Quality Forum-Evidence Based Practices for Substance Abuse Disorders, 2005.

2. Improving the Quality of Health Care for Mental and Substance-Use Conditions Quality Chasm Series for the IOM, National Academy of Sciences, 2006.

3. The Substance Abuse and Mental Health Services Administration (SAMHSA) Performance Management Strategy National Outcome Measures (NOMS), 2005.

The National Quality Forum and Oregon Evidence Based Practices (EBP)

The National Quality Forum lists the following practice guidelines for client assessment and treatment:

1 Screening
2. Initial Brief Intervention
3. Prescription for Services
4. Psychosocial Intervention
5. Pharmacotherapy
6. Patient Engagement and Retention
7. Recovery/Chronic Care Management

Each of these guidelines is described briefly in the forum's report. Data collection to monitor the utilization of each of the guidelines is required. The report also lists ineffective practices and attributes of evidence based treatment programs. These attributes could be codified in the state administrative rules to support EBP. Five factors for accelerating adoption

of evidence-based treatment are outlined. These factors are:

1. Financial
2. Legal/regulatory and oversight
3. Education/training
4. Healthcare infrastructure
5. Research as well as knowledge translation.

Each of the factors is delineated in the report and can give guidance to AMH, the DOC, and OYA in their continued efforts to implement EBP. Some providers have participated in community based research and/or federal grants that require extensive evaluation. However there is not a formal statewide structure to disseminate these findings across departments. Furthermore, there is no longer any statewide planning process to provide the necessary training to support EBP. Some private organizations like the ACCBO, the Northwest Summer Institute and various regional organizations offer periodic workshops. A federally funded project Northwest Frontier Addiction Technology Center (NFATTC), provides some web based and face to face trainings but is at risk of reduction depending on the federal budget. However, the loss of training resources from the State has resulted in even further cost burdens to providers. With each provider struggling to provide training to meet the requirements of any EBP they implement standardization is lost and therefore fidelity is questionable.

Improving the Quality of Health Care for Mental and Substance-Use Conditions

A report titled Improving the Quality of Health Care for Mental and Substance-Use Conditions (McGlynn et al., 2003), underscores the significance of the impact of addiction on the health care system. This impact includes publicly funded and insurance-based treatment on workplace, child welfare, prisons and jails. The report states,

> *"In a landmark study of the quality of a wide variety of health care received by U. S. citizens, people with alcohol dependence were found to receive care consistent with scientific knowledge only about 10.5 percent of the time."*

Another finding reported in the document states: "Together, Unipolar Major Depression and drug and alcohol use and dependence are the leading cause of death and disability among American women and the second highest among men behind heart disease, (Michaud et al., 2001). The report found that "Mental Health and Substance Abuse problems and illnesses also co-occur with a substantial number of general medical illnesses, such as heart disease and cancer, (Katon, 2003:Mertenset al., 2003), and adversely affect the results of treatment for these conditions."

This finding underscores the need for integration of mental illness and substance abuse treatment with primary care as well as increase research and evaluation of services provided. Because substance abuse is funded with primary care for Medicaid patients, this integration has occurred under some managed care contracts with improved services and outcomes resulting. However, for the patient who needs treatment for their co-occurring mental illness and substance abuse disorders integration with primary care is more complicated and less accessible.

Another approach to improve quality care is to use the six aims of quality care listed in the report:

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

Although the report stresses effectiveness, all of the other aims are essential and need to be reviewed within our service networks. Current data collection and resources for the data collection systems limit any systematic review of these other aims. Methodology for reviewing these important elements of quality of care should be included in any data collection protocols.

The report further underscores some distinctive features of addiction that must also be addressed. They are: "the greater stigma attached to M/SU (mental/substance use) diagnoses: more frequent coercion of patients into

treatment, especially for substance-use problems and conditions: a less developed infrastructure for measuring and improving the quality of care; the need for a greater number of linkages among multiple clinicians, organizations, and systems providing care to patients with M/SU health care."

SAMHSA's Performance Management Strategy (NOMS) 2005

SAMHSA has created National Outcomes Measures (NOMS), which must be in effect in all states by October of 2007. The system involves ten domains, which include five domains of client outcome measurements, two domains of treatment process measurements and three domains that examine the quality of services provided (client perception of care, cost effectiveness and use of EBP's). A web link with detailed additional information and measures can be found at:

(http://www.nationaloutcomemeasures.samhsa.gov/)

The current CPMS system does not measure any of the three "quality of services" domains due to limitations of the current database and data collection system that was developed in the early 1980's. AMH Division is undertaking a revision of both the mental health and substance abuse outcome measurements to facilitate the collection of these data. This is being referred to as the Behavioral Health Improvement Project (B-HIP) process. The inclusion of the quality services measurements should involve provider input.

Unfortunately, the SAMHSA NOMS does not address the need for integration with primary care or in the measuring of outcomes based on a chronic illness model. To keep the state from having to run two side-by-side systems, it is imperative that any new data system includes the domains covered by the Quality Health Care report.

Conclusions

Each state agency that provides alcohol and drug abuse prevention and treatment has different methods of both defining and measuring effectiveness depending on their mandate. Although each agency shows strong effective outcomes, improvements can be made in some specific treatment settings and with some specific populations. As substance abuse becomes more recognized as a chronic disease, new methods of measuring effectiveness both in client outcomes and systems of care will have to be employed. It is imperative that all affected agencies begin to plan and implement for these needed changes.

Prevention Effectiveness

Coming together is a beginning.
Keeping together is progress.
Working together is success.
- Henry Ford

History And Background: Prevention In Oregon

During the late 1970's the federal government allowed 10% of treatment funding to be allocated to prevention activities. Funds and programming were managed by the Mental Health Division's Alcohol and Drug Treatment Office. The Alcohol and Drug Information Service Library was established and operated by the Oregon Drug and Alcohol Information Center. By the early 1980's state staff were hired to manage training and education (including DUII), the library and prevention. The first Alcohol and Drug Prevention conference was held in 1984.

During the mid 1980's the Drug Omnibus Bill created funding for prevention and Oregon responded by increasing it's commitment to prevention. During this period a full-time statewide prevention coordinator was hired. Later there would be a prevention manager's position responsible for overseeing all prevention programming around the state. During this same period, the first statewide youth organization was formed: Oregon Student Safety on the Move (OSSOM) and the first statewide Red Ribbon Campaign was initiated.

Program management and comprehensive planning for prevention began in 1986. By now OADAP had been created as an entity separate from the Mental Health Division. Funding sources included revenue from the state department of education, the state's substance abuse office, juvenile justice and adolescent early intervention and teen pregnancy. During this period the Oregon Prevention Resource Center, the Western Center for Drug Free Schools and the Oregon Teen Leadership Institute was created. The Oregon Prevention Resource Center was responsible for the annual prevention

conference which by now had been moved to Sun River to accommodate attendance of more than 500. Rounding out the late 1980s, the Prevention 101 course had been developed and William Lofquist, prevention pioneer and author of Discovering the Meaning of Prevention, was promoted statewide.

In 1989 Doctors J. David Hawkins and Richard Catalano from the University of Washington approached Oregon with a proposal to explore taking their research on substance abuse risk and protective factors from science to practice. They had identified several factors that put youth at risk and kept them protected from becoming involved with substance use and abuse and they want to see how their research could be applied at the community level. This culminated in the first statewide prevention initiative offered in Oregon: Preparing for the Drug Free Years (PDFY). PDFY was a parent-training curriculum designed to educate parents about the Risk and Protective Factors and encourage them to implement a variety of protective strategies for the family.

Eventually, Doctors Hawkins and Catalano presented their research at the annual prevention conference. From this grew the second statewide prevention initiative: Oregon Together. Communities were given the opportunity to form coalitions and receive training and funding for prevention activities. Oregon Together was formed with 25 communities. By 1995 there were 70 Oregon Together coalitions. The annual prevention conference became the vehicle to train coalitions. Communities attended the prevention conference as a Together coalition. Each was assigned to work with a consultant/trainer to develop an action plan and integrate the science into practice during the conference. The action plans developed each year served as the basis for prevention activities and programming for the state. Schools were an integral partner in the Together initiative. Many school districts had prevention coordinators, student assistance and Natural Helpers programs; most used a K-12 curriculum called Here's Looking At You 2000, now an evidenced based curriculum and almost every school in the state participated in Red Ribbon Week.

As a result of the work conducted in Oregon with the Together coalition initiative the Center for Substance Abuse Prevention (CSAP) awarded a Six State Consortium Grant to focus on Risk and Protective Factors using the statewide model created in Oregon. At the end of the six-state-study, the Oregon Model became the basis of taking their science and applying it at the

local level. It was called Communities That Care (CTC). For years, the CTC model was required by several federal agencies in their grant application requirement. The Risk and Protective Factor Framework has become the basis for evidence-based prevention programming in Oregon and across the country.

In another precedent setting move, the OADAP initiated the states first Drugs in the Workplace program. Originally targeted to business in rural areas, Workdrug Free as it is now called, is still the state's only workplace initiative. In an attempt to bring prevention to higher education, the office also instituted an annual substance abuse prevention conference for universities and community colleges. Clearly, Oregon's prevention services have a rich and illustrious history.

What Is Prevention?

Typically, prevention has been defined as stopping something before it happens. This definition always posed a dilemma: How do you prove your effectiveness when you can't measure something didn't happen? How do you establish a strategy as an evidence-based practice if you can't measure its outcome?

The Merriam-Webster dictionary defines prevention as "producing a decided, decisive, or desired effect" or "capable of producing a result". The Cambridge dictionary talks about "the result of a particular influence". Encarta, which uses more of a discussion format, has perhaps the more broad-brush definition: "Prevention implies taking advance measures against something possible or probable. Anticipate may imply merely getting ahead of another by being a precursor or forerunner or it may imply checking another's intention by acting first. Forestall implies a getting ahead so as to stop or interrupt something in its course".

The pioneering research initiated by Hawkins and Catalano eventually led to research concerning program effectiveness. This set the tone for an operational definition: preventing the use of alcohol, tobacco or other drugs (ATOD) or, at the very least, delaying the on-set of use. While this definition helped address part of the dilemma as you can measure both the reduction in level of use as well as changes in the age of onset of use, it did not solve the bigger question. How do you prove your effectiveness when you can't measure something didn't happen?

More recently, the prevention field has agreed on the following definition: *Prevention is a proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and life styles.* Or, more simply put, prevention is about change and change can be measured.

The Research

Although Oregon has led the nation in its pioneering legislation to phase in evidence-based practices and institute standards for those practices, the prevention field in Oregon implemented evidenced based principles and practices starting with the groundbreaking Risk and Protective Factor Framework based on the work of Hawkins and Catalano, pioneered several years ago. Since then, the CSAP, the National Institutes on Alcoholism and Drug Abuse, and the Anne E. Casey and Robert Wood Johnson Foundations have invested in documenting what works in prevention.

The underlying principle for prevention programming effectiveness is: *Multiple Strategies Employed Across Multiple Sectors, Consistently Applied Over Time.* Given this principle it is easy to understand why, despite most communities attempts to conduct "scared straight" and one-time-only events, the research clearly shows those strategies are ineffective.

In addition, CSAP research has documented six strategies that when implemented together have proven merit:

1. Alternatives: activities which are alcohol, tobacco and other drug free; community events; after-school programs; and mentoring.

2. Environmental: media awareness and social marketing campaigns; public and workplace policy; drug-free workplace programs; and initiative aimed at changing community norms, standards and beliefs.

3. Information Dissemination: media campaigns designed to inform; information and educational materials; public speaking on topics designed to inform and educate.

4. Information & Referral: crisis and other type of help lines; employee and student assistance programs.

5. Education: parent education and parenting programs; peer education initiatives; youth groups; and youth interest area groups.

6. Community Processes: youth and adult leadership development; community mobilization initiatives; youth and adult volunteer training; reclaiming neighborhood and parks initiatives.

The National Institute of Drug Abuse recently published the second edition of "Preventing Drug Abuse Among Children and Adolescents: A Research-Based Guide for Parents, Educators and Community Leaders". The guide outlines a series of prevention principles that serve as the framework for prevention effectiveness.

1. Prevention programs should enhance protective factors and reverse or reduce risk factors.

2. Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g. tobacco or alcohol); the use of illegal drugs (e.g. marijuana or heroin); and the inappropriate use of legally obtained substances (e.g. inhalants), prescription medications, or over-the-counter drugs.

3. Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.

4. Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

Other principles covering prevention planning and program delivery are equally specific. Each offers guidance for effectiveness. Needless to say, there is too much information to replicate in this report. However, the Council will use this publication as the primary guide to defining effectiveness for Oregon's prevention work and for determining appropriate public policy for prevention effectiveness. In addition, both National Institutes have researched the effect of substances on developing brains and bodies. This work will also guide the Council in determining what is effective. Lastly, there is guidance to be found in studies conducted by two prominent national charitable foundations that have looked at the effectiveness of community coalitions.

Much of prevention in Oregon, as well as across the nation, takes place through community coalitions. According to the Community Anti-Drug Coalitions of America (CADCA), there are as many as 5000 coalitions. Given this mechanism and the fact that this approach is grassroots in nature, how do we assure prevention effectiveness when a community coalition is the primary vehicle for delivering prevention services? Research shows that successful coalitions have infra-structure in place (mission statement; strategic plan; organizational structure; diversified, mission driven funding); people in place (leadership; representative membership); effective operations (understand the community; purposeful decision-making; clear expectations; current technology; professional development; mission driven fund-raising); and a "results" orientation (clearly defined goals, objectives, outcomes; data driven decision-making; access to leaders).

In addition, the research shows that successful coalitions know where they are headed and why. They have a clearly identified purpose, membership configured to accomplish their mission and sufficient leadership. They meet the participation needs of members. Their organizational structure is designed to meet their needs and accomplish their mission. Their planning reflects their purpose and mission and their membership and strategies are sufficient to address the problem. Staff roles are appropriate and everyone is committed to results and willing to change to achieve the results they want. Community coalitions mobilize their communities and change norms. One only has to look at the civil rights movement or Mothers against Drunk Driving (MADD) or American Association for Retired Persons (AARP) to understand the power of community coalitions.

The Current Model

The Oregon prevention system consists of three frameworks, guidelines for model programming: the Institute of Medicine (IOM), Risk and Protective Factors and the CSAP Strategies.

The IOM Model defines three levels of prevention by target populations:

- Universal, which targets a whole population or community. Examples of Universal prevention include media campaigns, initiatives designed to change public opinion, public policy campaigns, ordinances or legislation and community wide events.
- Selective, which targets a specific population. Examples are children of alcoholics, DUII offenders, juvenile arrestees, children of addicted parents, parents or school dropouts.
- Indicated, which targets individuals identified as having problems but who have not been diagnosed. Examples are employees identified with performance problems and referred to an Employee Assistance Program, a student identified with performance problems and referred to a Student Assistance or Early Intervention Program, first time DUII offenders or young people at risk of dropping out of school.

These are the three levels of prevention promoted in Oregon through the AMH Division. The vehicle for this promotion can be found in the Biennial County Implementation Guidelines and OAR's.

The Risk and Protective Factor Framework model prescribes a community wide assessment process that leads to identifying the specific factors that may put young people at risk or keep them protected from becoming involved in ATOD use in the given community. The assessment looks at a wide variety of indicators: juvenile arrests, types and rates of ATOD use, school achievement, and parental involvement. Indicators which assess protection might include the number and range of activities for youth, mentors and coaches working with youth, church group involvement, family dinners together and after-school programs.

The Risk and Protective Factor Framework is promoted in Oregon through the AMH Division. The vehicle for this promotion can be found in the Biennial County Implementation Guidelines. Although a comprehensive community wide assessment is required through the Partners for Children and Families legislation, SB-555 it has not been required for some years; one of the unintended consequences of three biennia of reduced resources. The AMH Division requires participation in this process and any plan must identify it's collaborative relationship to this plan and the locally identified priorities.

The six CSAP strategies are as follows:

1. Information dissemination, designed to increase awareness and knowledge on a given topic.
2. Education, designed to teach and help individuals acquire skills.
3. Alternatives, designed to provide healthy and ATOD free activities.
4. Problem identification and referral, designed to offer early intervention services and short-circuit use.
5. Community-based processes, designed to initiate a grassroots or collaborative effort around an identified issue or action step or provide networking activities that might target a specific agency, organization or public policy body.
6. Environmental, designed to change attitudes and behaviors or community standards.

The CSAP strategies are required by the AMH Division through the biennial county implementation guidelines see page twenty-four for a full description).

Finally, the Oregon prevention system operates on a system of principles developed by a workgroup of stakeholders in 2003. These principles are used by AMH Division to make decisions about distribution of prevention funds, programming and planning from biennia to biennia although the reductions in prevention funding over the last three biennia have reduced this to a paperwork exercise; another unintended consequence. The principles developed are:

1. Evidence based practices: Whenever possible, programming will be based on scientific study with proven outcomes.

2. Accountability: Practice will respectful of and responsive to the public trust.

3. Data based planning and programming: Good date is a tool for accountability and will be used to drive decision-making.

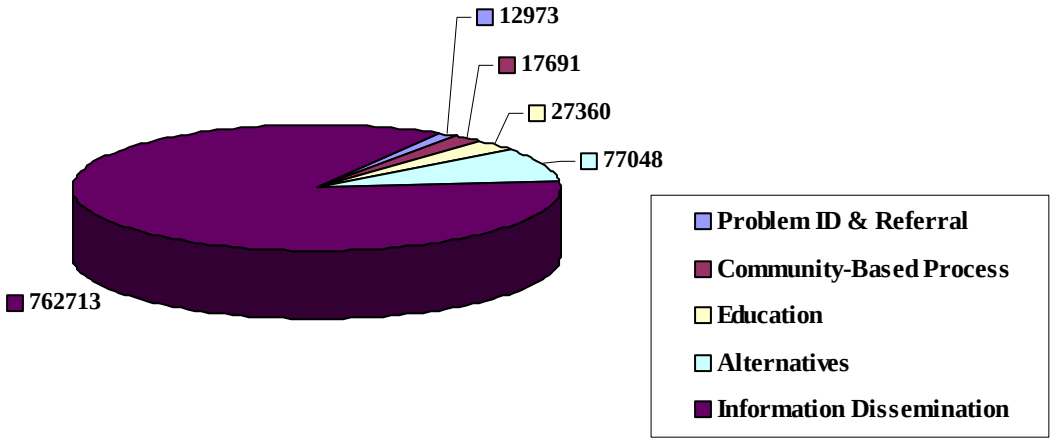
4. Collaboration: Partners and stakeholders working together embodies the basic assumption about prevention. By definition, prevention must involve community participants and professionals working together to achieve outcomes at all levels: state, county, city and community.

5. Capacity-building and support: The state will provide an accessible outlet for training, technical assistance and other resources available to all.

6. Equitable resource distribution: Funding and other resources will be distributed based upon an articulated framework consistently applied statewide.

Prevention programs funded through the county system and under the county implementation guidelines issued by the AMH Division are required to report prevention activities through what's known as the Minimum Data Set (MDS). Data is reported against activities conducted in the six CSAP strategies. The data for 2006 follows:

Total Numbers Served - 2005-06
by CSAP Strategy



While the MDS captures some useful and pertinent data, it isn't comprehensive nor does it get the system to the point of being able to make decisions driven by data and performance, a goal of both the Council and AMH Division. It is after all, named the "Minimum" Data Set. Fortunately, the AMH Division and the Governor's Council are well on their way to improving this situation. The State Epidemiological Workgroup, convened and staffed by AMH Division, is in the process of identifying outcomes that Oregon wants measured as well as readying the system to respond to the NOM's required by SAMHSA. The reporting requirements also include outcome documentation based on approved programs and evaluation identified through the implementation guidelines process.

As has been inferred above, prevention has experienced extreme losses in both financial and human resources over the last three biennia. The net result has been a dismantling of much of prevention's base. To illustrate the gravity of the reductions experienced and the affect it has had on prevention services, the Council offers the following list of losses:

- Statewide annual prevention conference.
- Significant capacity loss in statewide training and technical assistance.
- Severe reduction in statewide resource library capacity.
- Reduction in funding for County and Tribal Prevention Coordinators from full time (1 FTE) to as low as 10% (.10 FTE) .
- Significant reduction in statewide drug-free workplace initiatives.
- Statewide parent initiative(s).
- State level manager dedicated to prevention.
- Reduction in number of state level prevention specialists and support staff from 6 to 4.
- Dissolution of Together community coalitions to less than a dozen.
- Technical and networking support for Drug-Free Communities Coalitions.
- Dissolution of Risk and Protective Factor comprehensive community assessment process.
- Dissolution of Oregon Student Safety on the Move.
- Dissolution of statewide Higher Education Prevention Conference.

- Dissolution of Oregon Teen Leadership Institute.
- Discontinuation of monthly newsletter (Goldenrod) to the field and partners.
- Student Assistance Programs.
- K-12 Alcohol and Drug Curriculum Instruction.
- Statewide Red Ribbon March.
- Discontinuation of 6th grade from Oregon Healthy Teen Survey.
- Discontinuation of Oregon Household Survey.

Exacerbating the situation further has been public policy decisions that have fractured systemic program management, planning, service delivery and evaluation. In addition to the AMH Division, the Commission on Children and Families (CCF), the Department of Education (DOE), the Department of Transportation (ODOT) and the Tribes all have prevention responsibilities. This has led to the dilemma of determining how to manage and coordinate what is essentially a split prevention mandate. Adding to this dilemma, are other fractures in the system as various entities conduct prevention initiatives outside DHS: Synar campaigns; media campaigns; Weed and Seed, and Drug-Free Communities coalitions. The net effect is that prevention is happening in multiple sites with little or no overall coordination or accountability.

Conclusion: Why Should We Care?

There are two reasons we should care about prevention. Simply put, there's an excellent return on the public's investment: for every $1 spent on prevention $7-$39 is saved on allied costs (depending on which study is referenced). And, it prevents human suffering. Prevention might mean one less family torn apart by a member's addiction. It might mean keeping more young people healthy and successful in school. Prevention could mean business hiring as many employees as they need. It might mean fewer crimes are committed. And it might mean fewer children placed in foster care.

Perhaps the most important reason we should care is best illustrated in the quote from Joseph Califano, Jr., The National Center on Addiction and Substance Abuse:

> *"Substance abuse and addiction is the elephant in the living room of American society. Too many of our citizens deny or ignore its presence. Abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem our nation faces: crime, disease, AIDS, cirrhosis, child abuse and neglect, domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children, and poor schools and disrupted domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children, and poor schools and disrupted*
> *classrooms. Every sector of society spends hefty sums of money shoveling up the wreckage of substance abuse and addition. Nowhere is this more evident than in the public spending of states."*

Recommendations

The Governor's Council calls for the following initiatives to improve treatment services and reduce the use of alcohol and other drugs.

Treatment Initiatives

1. Improve the early identification and intervention of substance abuse in health care throughout the state of Oregon. This initiative must include the following steps:
    a. Repeal the UPPL law.
    b. Train physicians and other allied health care workers in identifying the symptoms of substance abuse and provide a brief intervention and referral as needed with treatment available immediately.
    c. Design and implement health care systems that provide on-going care management including recovery services.
    d. Design and implement an information system that measures qualitative and quantitative outcomes of care.
    e. Establish a statewide benchmark to track the progress of the initiative.

2. Improve the employment rate for African American, Native American and women who are in treatment by offering incentives to use EBP's. This will help increase their treatment completion rate in the community setting, and will also lower the high severity rate of these populations in prison.

3. Adopt an EBP for treating DUII clients who have co-occurring mental illness and provide both training for counselors and the necessary ancillary services needed by this population.

4. Plan and implement treatment services to fill the current gaps, and improve the rates of retention for residential.

5. Plan and implement a rate increase for adult services to help decrease the workforce crisis and increase the amount of intensive outpatient services.

6. Send out results of outcomes to providers immediately.

Prevention Initiatives

1. Support revenue and public policy measures that begin to rebuild the base for prevention.

2. Support structural changes that lead to recommendations in the Domino Effect: A Business Plan for Rebuilding Substance Abuse Prevention, Treatment and Recovery, including but not limited to: a workforce training initiative to elevate counselor expertise in evidence based practices; establishing public policy supporting Behavioral Health Workforce Counselors becoming a part of the Oregon Health Workforce Initiative. In addition, support measures that provide for Prevention Specialist Certification as well as Continuing Education Courses.

3. Support measures that expand SB 267: resources to measure outcomes and monitor attainment of National Outcome Measures, including but not limited to stable funding for the Oregon Household and Healthy Teens Surveys; adding 6th grade back into the Healthy Teens Survey and revising the Healthy Teens Survey per recommendations of the DHS Epidemiological Workgroup.

3a. Take steps to modify the Oregon Healthy Teens survey adding questions that will allow us to quantify the impact of prevention activities. Information regarding why someone never started using (or stopped using) alcohol, tobacco or other drugs as a result of a prevention initiative (or treatment approach) or because of some other intervening factor (health concerns, threatened job loss or school expulsion) would greatly facilitate assessing effectiveness.

4. Support measures that assure dissemination of science to practice and facilitate decision-making based on performance and data.

5. Support measures that unify prevention mandates into a single structure.

6. Support public policy and financial support of substance abuse curricula for professionals: physicians and other health care providers, including ORSAM members; social workers and other human service workers and counselors; policy makers and elected officials; law enforcement and criminal justice professionals; business owners and Chamber members.