Oregon Health Authority & Oversight and Accountability Council

Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain

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M110 Review Highlights

Oregon Health Authority and Oversight and Accountability Council Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain

This legislatively required review focused primarily on treatment and recovery services provided under Ballot Measure 110 (M110) by grantees in new Behavioral Health Resource Networks (BHRNs). The measure passed in 2020, decriminalizing possession of small amounts of drugs as of February 2021 and providing more than $100 million annually for drug and alcohol services under grants administered by the Oregon Health Authority (OHA).

Why this review is important

- The OAC awarded more than $260 million to BHRN providers through December 2023, and expects to award another $150 million through June 2025.
- M110 services can help narrow large gaps in Oregon's substance use services.
- As of 2021, Oregon continued to rank high nationally in rates of substance use disorders and low in access to treatment.
- Fentanyl use has exploded since 2019, before M110 took effect, increasing the urgency to expand effective treatment services.
- The number of fentanyl pills seized in Oregon and Idaho's high-intensity drug trafficking areas rose from 690 in 2018 to 3,020,802 in 2022.

What We Found

1. M110's Oversight and Accountability Council (OAC) approved BHRN grants for services required by statute, helping expand community-based services (pg 10). Despite challenges, providers are delivering accessible services to highly vulnerable people. (pg 14)
2. The OAC prioritized cultural competence among grantees. This focus is likely to improve service access statewide and help address inequities in substance use treatment and outcomes. (pg 23)
3. BHRN providers have increased spending and clients served over time, but the first year of reporting showed limited spending and services amid difficulty hiring staff and other challenges, raising risks that some of Oregon's 42 networks may not provide all required services. (pg. 13)
4. It is not clear how many providers of culturally specific services were funded to help serve populations most affected by the war on drugs, an important measure. (pg 23) The grant process also needs improvement to better attract community-based applicants. (pg 27)
5. OHA publishes details on BHRN spending and clients served, but additional reporting on staffing, services, and capital expenditures would help the program better demonstrate impact. (pg 17)
6. OHA is developing a new system for collecting more detailed behavioral health service data, but it remains uncertain if the agency will have adequate data to demonstrate M110's effectiveness. (pg 20)

Recommendations for OHA and OAC

We made six recommendations to the OHA and the OAC to improve the program. In its response, OHA agreed with all of our recommendations. The OAC also provided a response following a discussion at a public meeting after the report was issued. Both responses can be found at the end of the report.

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Introduction

Voter approval of Ballot Measure 110 (M110) led to a first-in-the-nation law coupling decriminalization of drug possession with new services to expand drug treatment availability. Controversial from the start, M110 attracted more scrutiny when funding of services was delayed and decriminalization took effect amid an explosion in fentanyl use. Critics are planning to seek reforms in 2024 by legislation or ballot measure.

This legislatively required review focused on Behavioral Health Resource Network (BHRN) grants issued under M110. Our review addressed specific legislative questions about M110 finances and the services for people with substance use disorders funded through the grants.[1]

The scope was largely limited to the legislative questions, as modified in the 2023 legislative session:

- Whether grants and funding were disbursed based on measure priorities.
- Whether grants and funding went to culturally specific and linguistically responsive organizations.[2]
- Barriers that exist for Black, Indigenous, and people of color grant applicants.
- Applicants that were denied and why.
- Whether governmental entities supplanted or substituted M110 funding for local funding.
- The organizations and agencies who received grants and what amount they received.
- What proportion of grants received by grantees was devoted to administrative costs.
- The total number of entities that applied for funding.
- What money remained after grants and funding were disbursed.

This review was limited in nature and does not address the performance of M110 grantees or the decriminalization of possession of small amounts of drugs, perhaps the most controversial aspect of the measure; these topics will be addressed in a separate, legislatively required audit due by December 31, 2025. This review is the second legislatively required report on M110 issued by our office. An initial audit was released in January 2023.[3]

[1] ORS 430.392, Secretary of State to audit use of funds from Drug Treatment and Recovery Services Fund.
[2] In the legislation, this review requirement specified "culturally responsive and linguistically specific" services. We interpreted it consistent with the rest of the statute, which required BHRNs to provide "culturally specific and linguistically responsive" services.
[3] Report 2023-03, Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has Yet to Be Determined.

M110 decriminalized drug possession and provided millions of dollars for services to help people with substance use disorders

Oregon voters approved M110 in November 2020, combining decriminalization of drug possession with more than $100 million in annual grant funding from cannabis tax revenue to expand access to recovery services and treatment for people with substance use disorders.

M110 gave local communities decision-making authority in the spending of grant funds through the creation of the Oversight and Accountability Council (OAC). The OAC includes members from the substance use disorder recovery community and diverse communities disproportionately impacted by the war on drugs. The council serves as the decision-making body for M110 grants and works closely with the Oregon Health Authority (OHA) to accomplish its goals.

> **Substance use disorders** occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.
>
> - Substance Abuse and Mental Health Services Administration

Beginning in 2021, OHA distributed about $37 million In initial "Access to Care" grants designed to expand services quickly before the Behavioral Health Resource Networks (BHRNs) were established. [4] After delays, the council approved $264 million in BHRN grants to 233 applicants to spend from July 2022 through December 2023.[5] These grantees are organized into 42 networks — at least one in each county — to expand free addiction recovery and support services across all 36 Oregon counties. Another $11.4 million went to 11 Tribal grantees outside the network system. Each network is charged with treating substance use disorders within a continuum of care, including client screening, assessment, peer services, low-barrier substance use treatment, harm reduction services, housing, and supported employment services. The networks are a collection of individual grantees, all service providers, that together offer the services required under M110 for each network. A network is not required to have one provider in charge, but network providers are expected to work together to serve clients. Many of the grantees are well-established and draw funding from multiple sources.

[4] The acronym BHRN is pronounced like "burn."
[5] The OAC subsequently terminated three of the grants, leaving 230 grantees and $261 million in active grants.

Key Service Definitions

Screening & Assessment: Evaluate behavioral health needs, including a substance use disorder screening, and create a treatment plan if needed.

Peer Services: Community-based services from a certified peer who has experienced addiction and recovery.

Low-barrier substance use treatment: Services that improve access through steps such as putting harm reduction first, minimizing wait-times, tailoring treatment, and providing free services.

Harm Reduction Services: Focus on reducing harmful effects of substance use. Examples include access to Naloxone/Narcan to reverse overdoses, fentanyl test strips, needle exchanges, and sobering or detox centers.

Housing: Low-barrier, subsidized shelter ranging from temporary emergency housing to transitional housing to permanent housing, with variations in-between.

A large portion of cannabis taxes are routed into a Drug Treatment and Recovery Fund established under M110 to help fund these services. Projections of revenue to the fund from cannabis sales and related cannabis taxes have fallen, but revenue remained high enough that the OAC is expected to approve an estimated additional $150 million in grant extensions for existing grantees through June 2025.[6] The 2023-25 biennium's M110 budget also includes $39 million in estimated state savings from reduced arrest and prosecution of people possessing small amounts of drugs, an ongoing revenue source also built into M110 statutes.[7]

Previously, cannabis taxes were allocated between the state school fund, state agencies, cities, and counties. About two-thirds of cannabis tax revenue is now allocated to M110 instead of those entities, leaving them with the remaining third. For the 2021-23 biennium, taxes totaled roughly $316 million.

The measure also decriminalized possession of small amounts of controlled substances. It replaced criminal charges, typically misdemeanors, with a newly formed Class E violation, a citation carrying a $100 fine, and 24/7 hotline assistance system for people receiving citations to receive a substance use assessment in exchange for a waiver of the fine.

A key goal of the measure was for Oregon to "shift its focus to addressing drugs through a humane, cost-effective health approach" as opposed to a law enforcement approach. Advocates of M110 hope it will succeed where previous recovery and treatment efforts have failed, especially when it comes to supporting Black and Indigenous communities and people of color disproportionately affected by the war on drugs. Black Americans, for example, represented only 12% of individuals with substance use disorders in 2019 while representing 26% of individuals arrested for drug abuse violations.

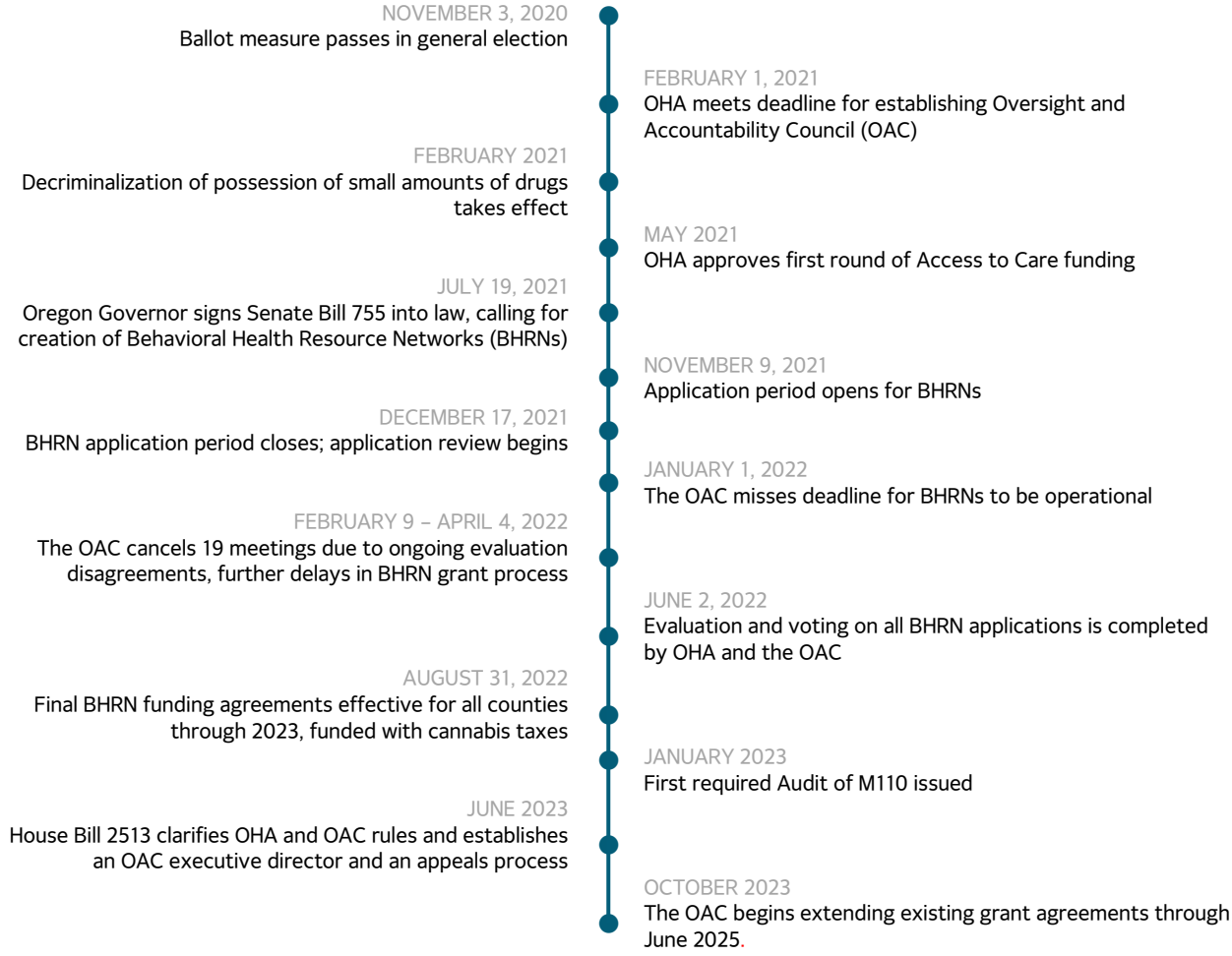
Data from the Oregon Judicial Department and Portland State University researchers indicate possession arrests have fallen as intended since decriminalization took effect in February 2021, but police are issuing relatively few citations, and the hotline has received few calls. The three-month moving average of possession arrests was roughly 1,200 before the pandemic's onset in early 2020,

[6] Cannabis revenue destined for the drug treatment fund is projected to fall from $210 million in 2021-23 to $194 million this biennium amid falling cannabis prices, but rise to $230 million for the 2025-27 biennium if the market stabilizes as expected.
[7] The savings come primarily from reduced caseloads for probation and post-prison supervision.

dropped to about 700 during late 2020, then fell further once decriminalization took effect, averaging less than 200 in the first half of 2022. Class E Citations have averaged about 200 a month since February 2021, but have risen since June 2023. Citation-related hotline calls averaged only 10 a month through June 2023.

Earlier in 2023, as efforts to revoke the decriminalization aspect of M110 grew, the Governor signed House Bill 2645, which raised possession of fentanyl to a misdemeanor.

Figure 1: M110 timeline highlights milestones and implementation delays



Previous audit highlighted a delayed rollout of BHRN funding and limited data collection

Our January 2023 real-time audit of M110 found a number of risks, including a delayed rollout of BHRN funding and a risk that the data being collected for the program will not be enough to credibly measure results.

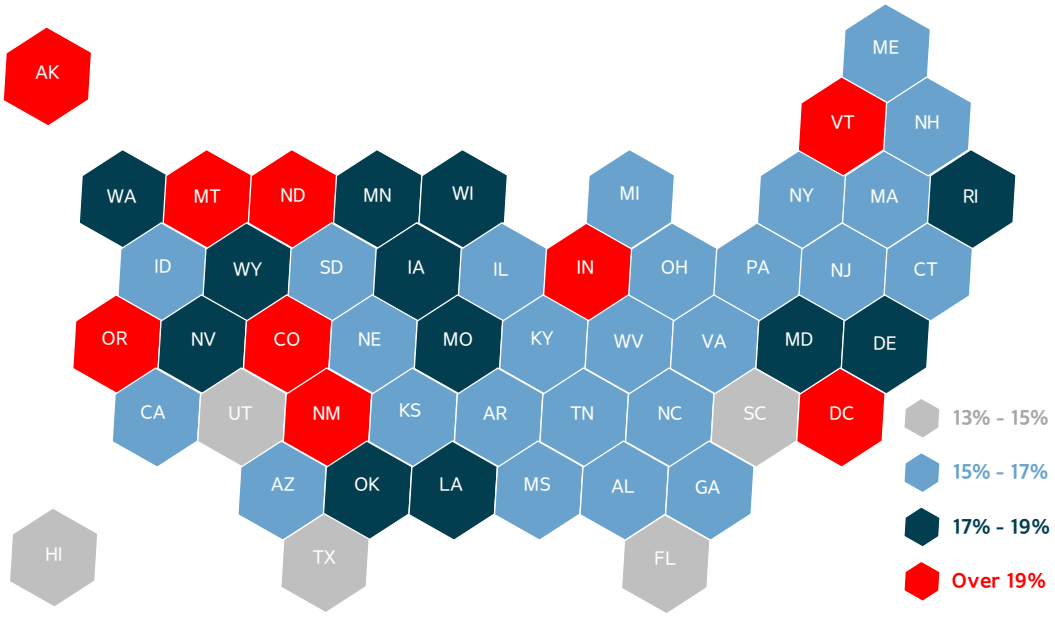
House Bill 2513, passed in the 2023 legislative session, addressed several issues identified in the audit. It established an executive director for the OAC, an appeals process for denied grant applicants, and gave OHA clearer authority to run the technical aspects of grant applications, administration, and monitoring. As of December 2023, the executive director position has not yet been filled. OHA officials said two candidates turned down job offers due to the political volatility of M110.

As discussed in detail later in this report, OHA has made progress toward improved data collection and outcome reporting, but substantial risks remain in this area.

Oregon has high rates of substance use disorders and substantial shortfalls in treatment

Oregon has historically faced a more severe substance use disorder crisis than most of the country. In the 2021 National Survey on Drug Use and Health, Oregon had the 6th highest substance use disorder rate in the nation, at 19.4% of residents 12 or older, or an estimated 700,000 people. Alcohol use disorder had the highest estimated incidence, followed by disorders involving illicit drugs.

Figure 2: In 2021, Oregon had the 6th highest rate of substance use disorder among states



Source: Substance Abuse and Mental Health Services Administration, age 12 and older

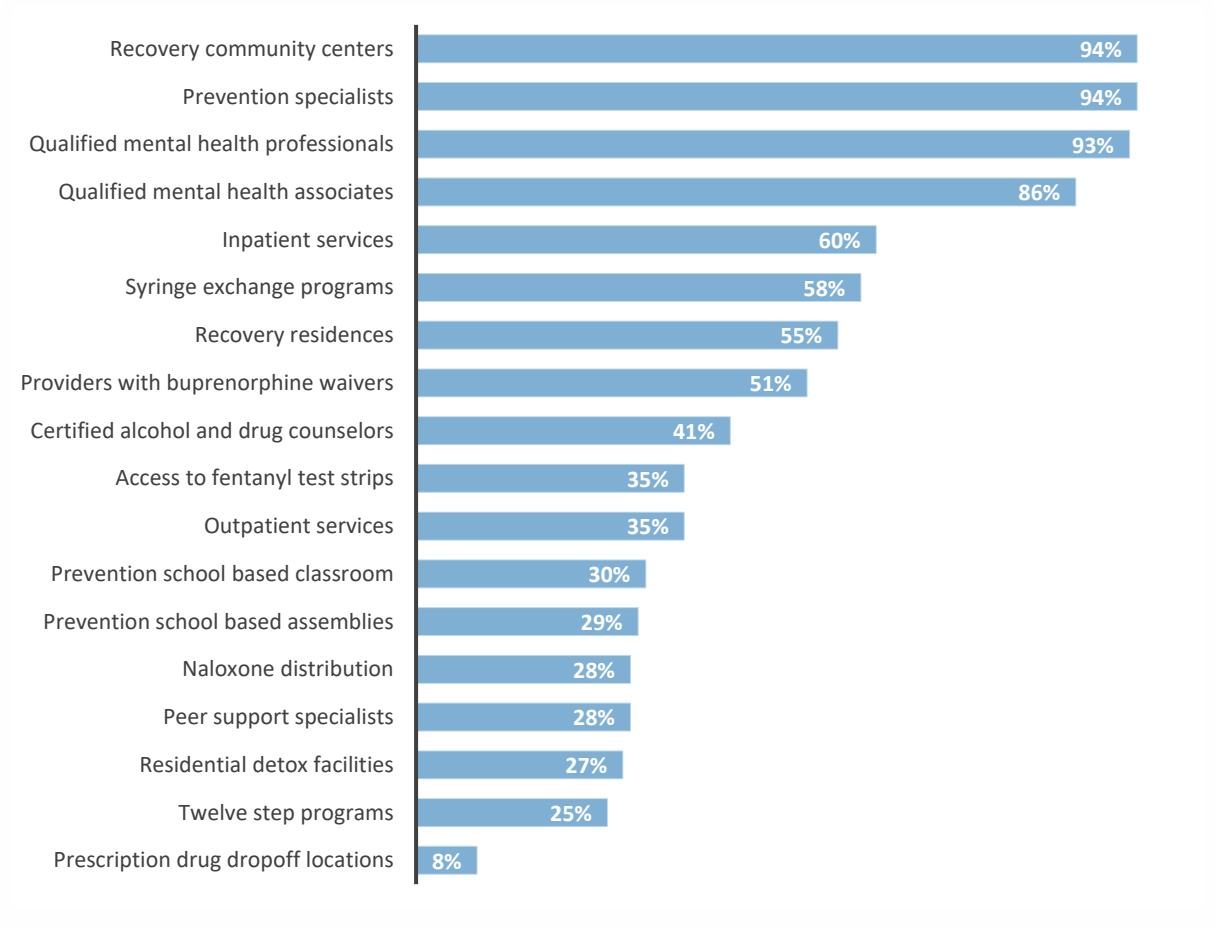
High substance use has coincided with relatively low access to care, with Oregon ranking 7th highest for people who need and are not receiving treatment for substance use disorders.[8]

Service shortfalls range across the treatment and recovery continuum. A January 2023 study by researchers at Oregon Health and Science University and Portland State University included a survey of treatment and recovery service providers.[9] The survey, which predated implementation of M110's BHRN funding, found more than half of substance use disorder service providers said they lacked capacity to meet current demand for services and have inadequate funding and staffing levels to support their organizational mission.

[8]The Substance Abuse and Mental Health Services Administration survey is conducted annually. Due to a change in methodology, figures are not comparable to prior years.
[9] Oregon Substance Use Disorder Services Inventory and Gap Analysis, updated January 2023.

Providers also reported substantial gaps in serving the populations M110 is trying to address. Only a third of surveyed providers said they provided services tailored for clients from specific racial or ethnic groups. The researchers also estimated service capacity across the state and found gaps for select types of prevention, harm reduction, treatment, and recovery services, with an overall statewide gap of 49% of recommended staff and services.

Figure 3: Researchers found substantial gaps in Oregon substance use services and staff prior to M110 implementation
(Gaps are ordered from the largest gap to the smallest)



Source: OHSU and Portland State University study

In addition, the study identified a racial and ethnic disparity in the substance use treatment workforce compared to the population. The disparity is particularly large among the Latino community, which comprises 13.2% of the statewide population but makes up only 6.3% of the non-prescribing substance use treatment workforce and 0.4% of prescribers in Oregon.

Increases in fentanyl use, overdoses, and Oregon's homeless population have added urgency to expand drug treatment

Rapid growth in fentanyl use, in overdose deaths, and in homeless populations has increased the need for treatment services promised under M110.

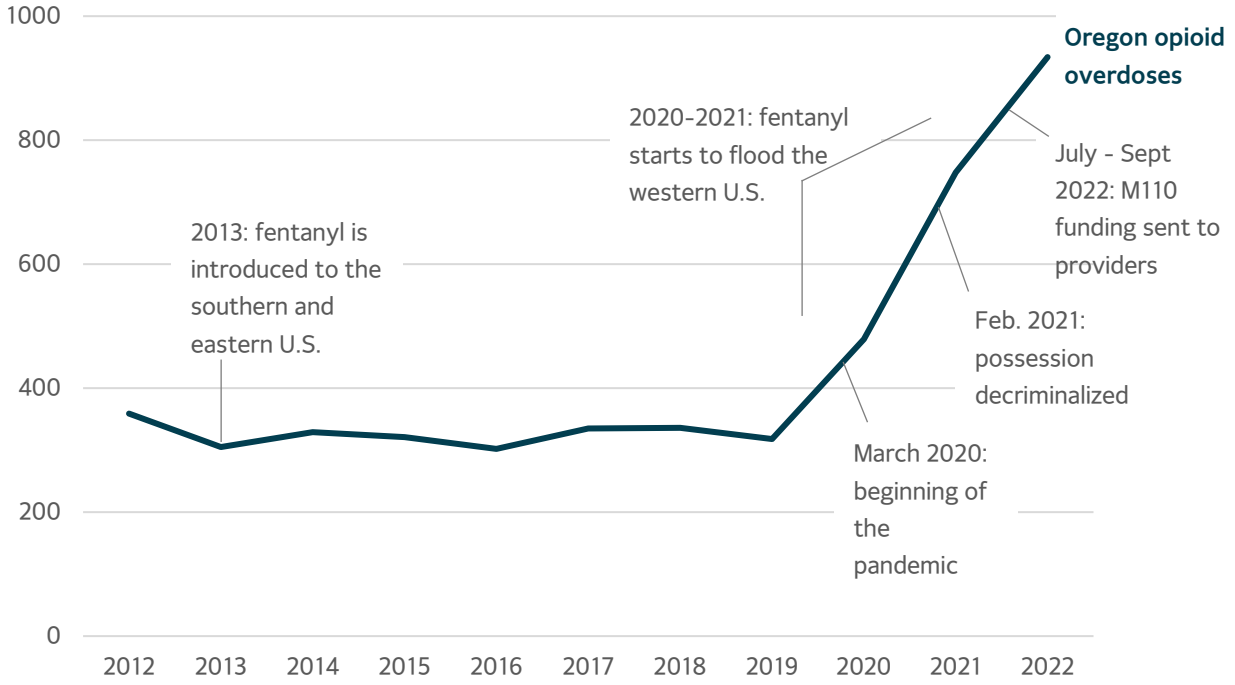
The supply and use of the opioid fentanyl, potent and highly addictive, has exploded nationally and in Oregon. In Oregon and Idaho's high-intensity drug trafficking areas, the count of fentanyl pills seized increased from 690 in 2018 to 3,020,802 in 2022. Agents also seized 50 times more fentanyl in powder form in 2022 compared to 2018, an increase that adds millions of potentially fatal doses to the pill totals.[10]

Fentanyl is now considered the primary drug threat in Oregon, though methamphetamine and cocaine are also involved in many overdose deaths. Fatal overdoses from opioid use in the state, which averaged 322 deaths per year in the five years prior to the pandemic, jumped nearly threefold to 955 deaths in 2022.[11] Fentanyl, inexpensive and readily available, is used at higher rates in communities with higher poverty and economic hardship, in particular Native American and non-Hispanic Black communities.

A potentially lethal fentanyl dose for an average adult compared to a penny.

Source: Stand Up, Mississippi

Figure 4: Fatal opioid overdoses in Oregon have soared, though the spike began before M110 decriminalized drug possession



Sources: U.S. Drug Enforcement Administration and data from SUDORS and Oregon Center for Health Statistics.

The COVID-19 pandemic also contributed to increased drug and alcohol use and posed challenges for providers and their clients, increasing client isolation and reducing in-person services amid shutdowns. According to the National Institute on Drug Abuse, limited data indicate increases in drug and alcohol

[10] The Oregon-Idaho High Intensity Drug Trafficking Area is established by the White House Office of National Drug Control Policy and consists of 12 counties in Oregon and 4 in Idaho. Fentanyl seizure data is obtained from the 2024 Oregon-Idaho HIDTA Threat Assessment

[11] Mortality data for 2022 from the State Unintentional Drug Overdose Reporting System is preliminary and subject to change. As of December 2023, reported figures for 2023 are only available through March.

use after the national emergency was declared in March 2020, especially for people with clinical anxiety and depression and those experiencing COVID-19-related stress.

Growth in Oregon's overall drug overdose rates is rapid compared to the nation as a whole. Reporting by the Centers for Disease Control and Prevention found reported overdose deaths from May 2022 to May 2023 rose at least 17.2% in Oregon versus a decline of 0.8% nationwide.[12]

The growth in fentanyl use and overdoses has led to scrutiny of decriminalization's role in these trends, a matter of continuing debate. Oregon data indicates fentanyl use and overdoses began surging two years before decriminalization took effect, and it may be too soon to say to what extent decriminalization has affected these last few years. To date, two studies have arrived at different conclusions about the impact of decriminalization on overdoses, one finding decriminalization increased overdoses [13] and another finding no effect.[14] These studies related to overdose deaths in 2021, before funding to BHRNs was distributed. We will analyze decriminalization's impact in more depth in our 2025 audit, factoring in the 2023 Legislature's recriminalization of fentanyl possession.

In recent years, homelessness has also increased along with rising housing prices, in Oregon and elsewhere on the West Coast. Research indicates substance use disorders can contribute to homelessness, and that being homeless can cause and exacerbate substance use disorders. A lack of social support and the weight of trauma, physical, and mental health issues can all initiate or increase substance use among homeless people. A 2019 point in time study in Multnomah County found more than 45% of unsheltered people had a substance use disorder.[15] A study in Boston from 2003 to 2018 found drug overdose counted for 25% of the deaths of all unhoused people, with opioids involved in over 90% of those deaths.[16]

M110 is part of a series of substantial investments intended to improve Oregon's behavioral health system

M110 is part of a larger effort in Oregon to improve services in behavioral health, which covers both mental health and substance use. In the 2021-23 biennium, the Legislature approved $1.35 billion for investments into the behavioral health system to address pay, housing, staffing, and access to care, including M110. For 2023-25 the Legislature approved $15 million for expanded residential treatment centers for people with substance use disorders and funding for an opioid harm reduction clearinghouse, which distributes life-saving supplies such as naloxone to over 180 agencies throughout the state. The budget also includes nearly $1 billion for a federal Medicaid waiver that includes expanded coverage of residential treatment centers with more than 16 beds, housing, and employment support for Medicaid and OHP members with substance use disorders.

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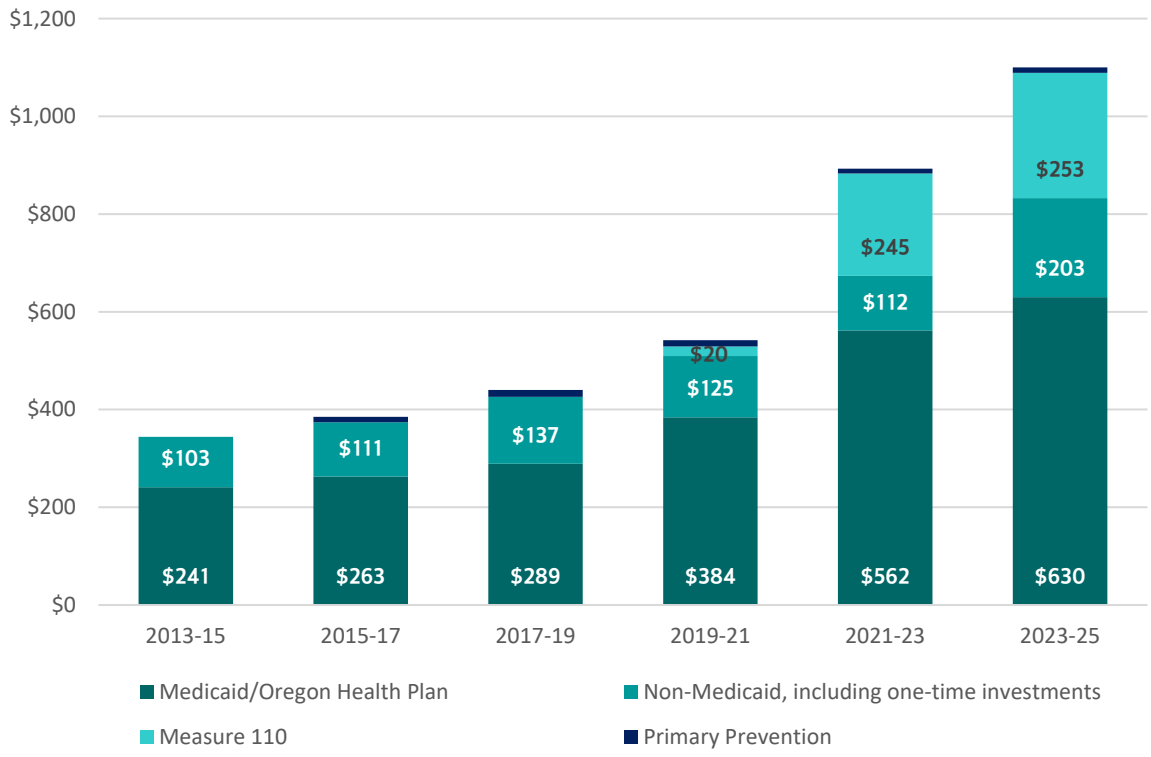
[12] CDC's National Vital Statistics System Provisional Drug Overdose site reports both reported data and predicted deaths. Predicted overdose rates are estimated to be higher in Oregon and nationally.
[13] Spencer, Noah. Does drug decriminalization increase unintentional drug overdose deaths? Early evidence from Measure 110. *Journal of Health Economics*. Published online July 2023.
[14] Joshi S, Rivera BD, Cerdá M, et al. One-Year Association of Drug Possession Law Change With Fatal Drug Overdose in Oregon and Washington. *JAMA Psychiatry.* Published online September 27, 2023.
[15] The 2019 Point-in-Time Count of Homelessness in Portland/Gresham/Multnomah County defines "unsheltered" as sleeping outdoors, in public spaces, vehicles and places not meant for human habitation. The report includes two other categories, 'Emergency Shelter' and 'Transitional Housing.'
[16] Fine DR, Dickins KA, Adams LD, et al. Drug Overdose Mortality Among People Experiencing Homelessness, 2003 to 2018. *JAMA Netw Open*. 2022;5(1):e2142676. Published January 2022.

Medicaid coverage, provided under the Oregon Health Plan with both federal and state dollars, accounts for the majority of state-controlled spending on substance use disorder services. M110 funding is also substantial. In the 2023-25 biennium, OHA estimates M110 will account for nearly a quarter of total spending on substance use disorder services and about half of non-Medicaid spending. Figure 5 also illustrates that spending on prevention of substance use disorders is relatively low, an issue being discussed by legislators.

Figure 5: M110 is a substantial addition to the state's funding of substance use disorder services (funding in millions)



Source: Auditor constructed based on data provided by OHA

Many of the challenges facing M110 are challenges facing behavioral healthcare as a whole, such as hiring shortages, data collection difficulties, and the rapid growth in opioid use. For example, our 2020 audit of mental health treatment services within OHA's Behavioral Health Division[17] found a fragmented system that lacked complete or consistent data, preventing agency staff from having a full picture of mental health services provided. The audit also identified workforce shortages stemming from low wages and the inherent difficulty of jobs treating mental illness and substance use.

OHA is working on two separate studies involving substance use services, one on residential bed capacity in behavioral health and a second to pin down costs for substance use services and unmet needs. These studies should help the state set clearer priorities for individual funding sources such as M110 and for the full behavioral health system.

[17] Report 2020-32: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis.

Responses to Statutory Review Questions

This report section details responses to review questions specified in M110 statutes. Responses include a summary followed by detailed explanations.

Are grants and other funding being disbursed based on the priorities specified in ORS 430.389?

Answer:

The OAC approved and funded BHRN grants for services required by statute, helping to improve service access and expand the system beyond traditional treatment providers. However, providers have reported limited spending thus far, raising the risk that networks in some counties will not provide all required services. We also found limited tracking of provider services and continuing uncertainty about whether OHA will be able to demonstrate the effectiveness and impact of M110. Finally, we found the OAC did not prioritize expanding traditional residential treatment, but funded detoxification facilities and low-barrier housing and awarded substantial funds to providers whose services include residential treatment that should help them improve their services.

Funded BHRN grants focused on required services and community-based supports

The OAC approved BHRN grants and OHA disbursed funds designed to provide the services required by statute. The council focused on free, community-based services such as harm reduction services, peer support, and housing to help increase access to more easily accessible services, particularly for racial and ethnic populations most affected by the war on drugs.

ORS 430.389, part of the implementing statues for M110, required the state to fund six services in each community network, which often contain multiple BHRN providers. As noted earlier, the required services include client screening, assessment, and planning, low-barrier substance use treatment, peer services, housing, and harm reduction services, such as providing Naloxone to counteract opioid overdoses. The council also added funding for employment services, which was not required by statute. The OAC added it to help clients get jobs and increase their stability, an important aid to recovery.

In general, the council approved and funded all required services for each network, and OHA signed grant agreements with service providers that specified which services they would offer through December 2023. (Although the provider networks had to provide all required services, each provider within a network did not have to provide all the required services.) Of the 233 BHRN providers approved in the initial grant period, 168 agreed to provide community-based peer and mentoring services, the highest total among the required service categories. Fifty-two providers, the lowest total, signed up to provide supported employment services.

Figure 6: Spending and the number of providers offering services varied among service categories funded

Service Category	Grantees Signed Up to Provide	Reported Spending — April to June 2023*	Reported Clients Served — April to June 2023*	Cost per client
Peer Support and Mentoring	168	$10.95 million	14,447	$759
Comprehensive Behavioral Needs Assessment	110	$1.31 million	3,676	$356
Low-Barrier Substance Use Treatment	109	$4.51 million	8,284	$545
Screening	109	$1.94 million	5,274	$368
Housing Services	87	$7.42 million	2,840	$2,613
Harm Reduction	84	$3.14 million	18,097	$174
Supported Employment	52	$1.57 million	989	$1,589

Source: Auditor prepared using OHA data

* Notes: This table focuses on one quarter of provider reports on expenditures and clients — the latest available — as clients cannot be added between quarters without duplication. Clients are also duplicated across services and cannot be added to an unduplicated total. In addition, OHA continues to review quarterly provider reports, making the figures subject to change.

The costs per client are likely higher at this relatively early stage because of administrative setup costs. Construction costs in a quarter, including building and renovation costs in the housing services category, also increase quarterly costs per client, though the new projects will benefit clients in future quarters as well. As discussed later in this section, the reliability of provider-reported expenditure and client data is questionable, making it even more difficult to evaluate the reasonableness of program costs. However, despite challenges with cost metrics, this financial data needs to be tracked and improved to help assess program effectiveness.

We examined three other areas pertinent to the statutory service requirements:

Low-barrier substance use treatment: Administrative regulations for the program define most of the required services with some precision, but the definition of low-barrier substance use treatment is unclear on what these services entail. The original ballot measure and implementing statutes did not define the term at all, other than that such services are free to clients and easily accessible.

To better understand this category, we reviewed reporting by grantees who listed providing low-barrier treatment services. Costs reported in provider narrative descriptions included construction, design, and maintenance expenses for treatment facilities, drop-in centers, and clinics. Costs also included expenses for services such as individual and group therapy, family support, urinary analysis screenings, and Medication Assisted Treatment. Personnel reported in this category most often included Certified Alcohol and Drug Counselors, case managers, and supervisors. Providers also allocated administrative support costs and included costs to provide services to uninsured or under-insured clients. The grantee reporting does not provide account-level detail, reducing its reliability, and we found some potential for overlap with other cost categories such as peer services. In general, however, the reported services appear reasonable to include in the low-barrier treatment category.

Medication Assisted Treatment (MAT) uses FDA approved drugs to help treat substance use disorders, including opioid and alcohol use disorders.

Funding of full BHRN services provision: Under the implementing statutes, while individual grantees do not have to provide all services, the state must ensure that each BHRN network collectively provides all six required services. Documents indicated the OAC funded the complete set of services for Oregon's 42 BHRNs, with two exceptions in rural counties with limited applicants: Harney County, where the county used reserves and in-kind contributions to fill service gaps; and Polk County, where the county said it would work with providers outside the network to fill gaps. These exceptions appear to be consistent with the statutory requirement that BHRNs provide access to all required services.

Provision of community-based services: The statutes also prioritize expanding a full spectrum of free community-based services across all service areas. In general, documents, interviews, and council subcommittee meetings show the council emphasized low-barrier, inclusive housing and inclusive housing for clients still using substances. It also focused on funding personnel who interact directly with clients and can often spend more time with them than medical staff, such as peer support specialists, peer mentors, and harm reduction workers. Data from the Mental Health & Addiction Certification Board of Oregon (MHACBO) indicates certification of new peers has risen steadily in Oregon since 2021, one sign that M110 and other programs are boosting community-based services. Overall, board staff said, the number of active peers doubled from the beginning of 2022 to late in 2023, from roughly 1,400 to 2,800.

Figure 7: M110 has helped drive the increase in newly registered Peer Support Specialists in Oregon

Source: Auditor compiled based on information provided by MHACBO

Evidence for the effectiveness of community-based services

The community-based approach leans heavily on recovery community centers, community outreach, and peer support for clients.

Recovery community centers help clients build social connections and employ staff such as peers, recovery mentors or coaches, and case managers who help clients connect to clinical treatment, housing, education, and employment. A 2016 report from the U.S. Surgeon General, "Facing Addiction in America," concluded participants in both substance use treatment and recovery supports, such as those offered by the centers, have better long-term outcomes than people who participate in just one. But it said the centers had yet to be studied rigorously.

Since the report was issued, a survey of center clients in the northeastern United States and a subsequent longitudinal study added more evidence. Both studies noted increases in psychological well-being and quality of life, while the longitudinal study also noted improvements in abstinence and substance use. The longitudinal study's description of center clients also suggests the centers may be particularly helpful for populations M110 aims to serve: racially diverse and beginning recovery with few resources, low quality of life, and limited education and income.

Researchers have also evaluated the impact of peer workers. The federal Substance Abuse and Mental Health Services Administration describes research on peers as "still growing." But says mounting evidence indicates people receiving peer coaching show reduced substance abuse, improvement on recovery outcomes, or both. They may stay in treatment longer, for example, increase their housing stability, decrease their criminal justice involvement, and improve their access to social supports.

Reported BHRN grantee spending has been limited, increasing the risk that networks in some counties will not provide all required services

Provider reports show meaningful services provided to vulnerable populations, and increases in reported spending, service provision and client counts quarter to quarter from July 2022 through June 2023, the first year of the grant term. However, limited reported spending in that first year relative to the total grant amount for the 18-month grant term raises concerns that providers may not fully execute their grants and networks in some counties could fall short of statutory obligations to provide all required services. Initial delays in grant funding contributed to low early spending. Providers also reported difficulty hiring and low wages, mirroring challenges throughout the broader behavioral healthcare system. Other challenges include community opposition in some cases and reduced referrals from drug courts to treatment services.

Provider-reported spending on services from July 1, 2022, to June 30, 2023 — two-thirds of the way through the initial BHRN grant period — totaled $95 million, or just over one-third of the $261 million in active grants through December 2023.

Two-thirds through the initial grant period, reported spending was just over a third of the total grant awards.

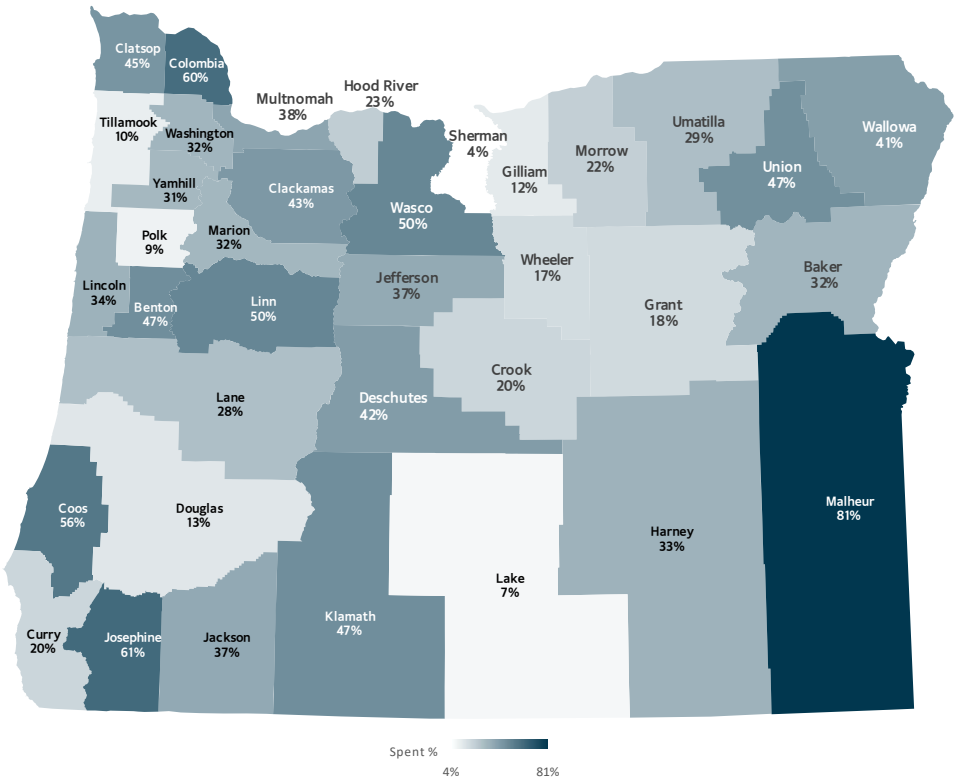
From April to June 2023, the fourth quarter of the grant term and the latest quarter available, provider networks in 12 of Oregon's 36 counties reported serving no clients in at least one of the six statutorily required service categories. Networks for five counties, all rural, reported serving 15 clients or less

across all six required service categories. Gilliam County's two BHRN providers reported no clients served, noting hiring challenges and low patient awareness of services.

Overall, reported spending, service provision, and client counts grew from quarter to quarter, an encouraging trend. Reported peer support clients served in the fourth quarter rose 27% over the third quarter, for example, staff spending increased 22%, and overall spending grew by 12%. However, if providers sustained that growth rate through December 2023, they would still fall about 36% below the original grant total by the end of December.

We analyzed overall county spending through the fourth quarter and found comparable low spending results in rural counties, frontier counties, and the remaining urban and mixed counties.[18] The OAC allocated total grant funding by county. Amounts awarded by county ranged from a $750,000 minimum in five rural counties to $58.1 million in Multnomah County, by far the highest total. Lane, Marion, and Washington counties all received $20 million or more.[19]

Figure 8: Low spending percentages in the BHRN grants first year pose risks that complete M110 services will not be available in all county networks



Source: Auditor constructed based on data from OHA. This data is subject to change as OHA reviews provider reports.

Despite the relatively low spending, provider reports documented delivery of ground-level services to highly vulnerable populations.

[18] Frontier Counties: Any county with six or fewer people per square mile. Ten of 36 counties in Oregon qualify as frontier.
[19] The OAC's county allocation formula included four variables: the county's share of Medicaid recipients, and its houseless population, overdose deaths, and possession-related arrests and prison intakes. Multnomah County received 22% of the total allocation. If the allocation had been done solely by county population in 2022, the county would have received $49.6 million, or 19% of the allocation, about $8.5 million less.

Additional peers and mentors helped connect clients with basic needs, the reports said, such as food, clothing, and transportation, providing bus passes and gasoline cards to attend recovery meetings. The peers helped clients get to doctor's appointments and connected them to housing and to other treatment services, such as detox centers and clinics. They worked with drop-in clients, met with clients in recovery one-on-one to discuss treatment plans and recovery options, and reached out to people in distant rural areas, at courthouses and jails, and in hospitals and homeless camps.

Providers also reported significant harm reduction assistance. Outreach teams distributed Narcan, fentanyl test strips, safety supplies, and motel vouchers. They operated syringe exchanges, conducted brief intervention counseling, and made referrals to housing, treatment, and medical appointments. Workers provided harm reduction training to service providers and communities. Nurses tested people for HIV and Hepatitis C and provided triage and wound care.

Spending for housing included rental assistance, costs for staff who work in supportive housing, and housing construction and expansion. It also funded free rooms and emergency motel stays. Several BHRN providers have completed substantial capital projects with the help of M110 funds, including opening or expanding supportive housing and detoxification centers.

Some causes for lower spending and services may persist

Some contributors to low early spending, such as front-end delays in funding and construction delays, should resolve with time. Others, including hiring difficulties and referral limitations, could persist.

Spending started off slowly in part because of delayed grant issuance by OHA and the OAC, with grant funding not completed until August 2022, two months into the grant period. Some providers had not fully spent down their initial M110 Access to Care grants, allowing them to use those funds before spending the BHRN grant funding. In general, expanding services or starting new services takes time to scale up and awareness of new programs takes time to build. In M110's case in particular, some providers said uncertainty about funding also delayed hiring. Property purchases and construction projects have also faced delays.

As part of the 18-month grant extensions from January 2024 through June 2025, providers estimated their operating spending through December 2023, the end of the first grant period, and their spending on capital projects included in the original grant through June 2025, the end of the extension period. If the providers' estimates prove accurate, they will have spent about 80% of their original grant amount by June 2025.

However, as noted in Figure 9, providers and OHA program staff also cited additional problems that could limit spending and services further into the future. Among them:

Figure 9: BHRN providers cited potentially more persistent causes of low spending and services

Difficulty Hiring	Hiring struggles and low wages are a persistent problem across behavioral health services.
Funding Stability	Providers are concerned about hiring staff with M110 funds that could disappear or be reduced if M110 is repealed or modified.
Housing Costs	High housing costs make it harder to attract staff and provide housing for clients.
Social Stigma	Community opposition to M110 or providing services to people with substance issues can stall services.
Limited Reimbursements	By statute, BHRN funds cover costs only after providers tap Medicaid and other funding sources, which can limit providers' ability to use the funds.
Client Pipeline	Class E violations have also prompted few calls to the M110 hotline, which was supposed to serve as a significant source of new clients.
Reduced Referrals	Referrals from drug courts to treatment services declined during the pandemic and fell further after decriminalization. [20]

A 2022 study by the Center for Health Systems Effectiveness at OHSU reinforced the impact of low wages in behavioral health.[21] It also emphasized high burnout and workforce turnover given large caseloads, high administrative burdens, and increased severity of client problems. Workers have been leaving for jobs in primary care, in schools, and in hospitals for better work environments and compensation, the report said. Medicaid rates are also low relative to Medicare or commercial insurance, the report said, contributing to shortages of providers.

Labor availability for treatment and recovery services also likely differs between rural and urban areas. A 2023 analysis of Oregon's mental health staffing found rural areas had a far more limited labor supply, with one-third the staff per 1,000 residents compared to urban areas.

The Legislature has taken steps to increase behavioral health wages and boost Medicaid reimbursement rates for behavioral health services. At the OAC level, the council prioritized grantees including living wages for employees in their budgets when awarding grants. OHA grant managers have also been working with providers struggling to provide services. As part of the 18-month grant extensions through June 2025, grant managers worked with providers to examine their past spending and better define their needs.

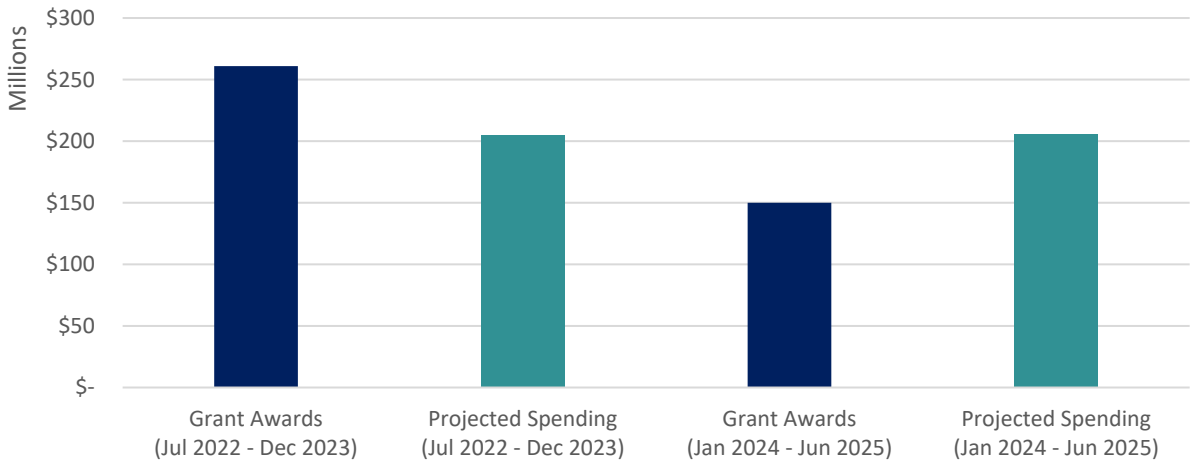
The 18-month extension period, with a lower level of funding after declines in projected cannabis tax revenues, should help level spending over the combined 36-month grant term, from July 2022 through June 2025.

Total funding in the initial 18-month grant period, through December 2023, was $261 million, while the 18-month extensions through June 2025 are expected to provide an additional $150 million. To offset the decline, unspent funds from the initial grant period will be carried over by grantees to help fund operations in the extension period. All told, grantees are projecting spending $206 million for

[20] A 2023 Oregon Judicial Department analysis noted that referrals to and participation in specialty courts fell during the COVID pandemic, then fell a further 11% after decriminalization of possession cases. The department does not have comparative data prior to 2020, making the extent of the total decline unclear. Department officials said an emphasis on shifting the courts to high-risk/high-need defendants and largely away from possession-only cases, independent of M110, means these cases would likely not have rebounded to pre-pandemic levels regardless of decriminalization.
[21] Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature, February 2022.

operations and capital projects from the first term, which would leave a $55 million carryover if those preliminary numbers hold. That carryover plus the $150 million in extension money provides $205 million for operations in the extension period, which does not include new capital projects. If providers can meet their spending projections for the first term and their extension budgets, the M110 program will be on a more stable track.

Figure 10: About $55 million in unspent funds from the initial grant period will be carried over into the next grant period, which should help level spending across the first 36 months of M110 implementation



Source: Auditor prepared based on information from OHA
Notes: Projected spending related to the first grant term, from July 2022 through December 2023, includes spending through June 2025 for capital projects included in the original grants. Projected spending figures are estimates and subject to change. OHA staff are still examining reported spending associated with five grants, which could change these figures.

Moving forward, the OAC and OHA can take a more strategic approach to funding BHRN grants. The approval process for the BHRN grants did not include an analysis of the potential demand for services by county. The OAC and OHA can work with communities and providers to identify the most critical service gaps by county and barriers to increasing services. To the extent that M110 services can address the gaps, the council can target M110 funding to help close them.

OHA is conducting a study of substance use disorder service spending and needs that should help define the service gaps. The study, requested by the Legislature, will analyze public spending and investments for substance use services in Oregon, including cost estimates for unmet needs. It will also include recommendations for how the state can use new or existing funding sources to address those needs.

More detailed tracking of grantee services and staffing would better document program impact and statutory compliance

OHA collects and publishes data from quarterly reports on provider spending and clients served, providing important information and transparency about how the BHRN system is working. However, the depth of provider reporting varies widely, making it more difficult to verify and quantify grantee progress on expanding critical services. OHA can use its reporting system to supply more specifics on staffing and service expansion and to report capital projects in detail. The agency should track and report services to youth and virtual services, both emphasized in statute. Improved oversight of reported spending and client data would also increase the data's reliability.

The council must balance reporting requirements with the impact on grantees, often short on time and staff. However, M110 is a particularly high-profile program. Working with grantees to provide more detail about their efforts would help improve public reporting and further demonstrate program impact and statutory compliance.

More detail on the extent M110 has expanded staff and services would help demonstrate the program's impact

M110 and its implementing statutes pledged to expand access to drug treatment and make health assessment, treatment, and recovery services available to all who need those services.

OHA has taken important steps that can help document expansion and impact of staffing and services. The agency publicly reports the quarterly results of provider-reported client counts and expenditures online, documenting expansion in areas such as peer support and harm reduction. Its public reporting also summarizes provider narrative responses in quarterly reports. For the third quarter of provider reporting, for example, the agency asked providers to detail how they used M110 funding to expand service capacity and client access. Staff identified 127 providers, or 55% of providers reporting, whose responses indicated increased service hours, locations, or staffing.

However, responses that the agency identified as indicating expansion ranged widely in detail, with some providers providing rich descriptions of increased services and the positions, number, and impact of new staff, while others provided few specifics. Some providers that serve multiple counties also provided one response in all counties served, not supplying details by county. Few providers detailed staffing levels before and after M110.

The narrative responses to questions posed by OHA are a powerful tool to document program impact and provide clarity on how providers are increasing access to care. OHA can improve its public reporting by working with providers to supply more specifics on staffing and service expansion details in quarterly reporting, and by asking providers to note when M110 funds have maintained existing service levels rather than expanded them. The agency can also use its existing real property tracker, combined with provider reporting, to more comprehensively report capital projects funded and completed, providing details on housing beds and treatment capacity added, for example.

This closer tracking would help improve public reporting and help providers by more clearly demonstrating the benefits of the measure.

OHA and providers can better track youth services and virtual services

Youth services were not tracked or evaluated as part of the application approval process, though most substance use disorders begin before age 25. Statutes required the OAC to consider the needs of residents of all ages when awarding grants. An OHA count indicates 36 of the 230 active BHRN grantees offer services to youth or parents, but 20 of Oregon's 36 counties do not have providers focused on youth or parents in their networks. In quarterly reports from April to June 2023, only 16% percent of clients with known ages were under 26.

Mobile or virtual outreach services are also specified in statute, but not specifically tracked in the application approval process or reported. Our review found a specific online provider was approved in eight counties, mainly rural counties. As noted later in this report, the OAC also rejected that same

applicant in 28 counties, including five of Oregon's 10 relatively remote frontier counties. The federal Substance Abuse and Mental Health Services Administration concluded in a 2021 report that virtual services have increased engagement in opioid use disorder treatment, can reduce stigma in accessing services, and can be particularly valuable for reaching rural populations in areas with workforce shortages.

Reporting reliability and provider oversight has been limited

Providers are required to report quarterly to OHA on expenses, accomplishments and challenges, and clients served, including details by client demographic categories. OHA staff provide guidance on quarterly reporting of spending and clients, and review individual grantee reports for reasonableness. Staff follow up as needed, and require grantees to resubmit reports when staff spot anomalies. OHA also issues formal requests for information to providers with substantial expenditure reporting issues. In three cases, outside complaints led to the OAC terminating grants to BHRN providers amid concerns over inappropriate expenditures or lack of service provision.

Beyond review of quarterly reports and tracking of provider spending on property and vehicles, OHA oversight of provider spending has been limited, though it may improve with plans to hire additional M110 program staff.

In the application process, reviews of applications did not evaluate provider capacity to manage and account for funds— a particular risk for start-up organizations and small nonprofit providers receiving large amounts of funding. Providers budgeted in financial categories but not for services, making it difficult to evaluate the reliability of the service expenditure reporting. The M110 program also had five grant managers covering more than 230 grants, limiting their ability to support grantees, verify spending reports, or provide more robust monitoring, such as spot checks of invoices, payroll registers, and other operations spending documentation.

OHA staff also noted that, by OAC design, the BHRN program uses grant agreements instead of contracts. Contracts would have had more rigorous requirements, though grants still require the OAC and OHA to ensure funds are spent for the intended purpose. OHA is also distributing grant money in advance, another characteristic of grants, instead of paying after services are provided. This approach gets money out more quickly to providers and reduces administrative burdens on providers and OHA, but also adds risk to the state. As of the end of October 2023, OHA had paid M110 providers $214 million on $261 million of active grants.

OHA should have more capacity to work with grantees in the future. The agency is planning to hire two additional M110 grant managers and assign grant managers regionally to work with providers and provide technical assistance. Staff will also have more ability to evaluate client numbers and service reporting given their budget work with providers for the grant extensions, and as providers begin to report individual clients instead of aggregate numbers, increasing data reliability. Other steps to assess provider capabilities during the application process, such as requesting nonprofit 990 reports and information about the status of providers' accounting systems, would help OHA identify providers who need to upgrade accounting and data reporting through their grant budgets.

Some M110 metrics specified in statute may not be available, limiting measurement of M110's effectiveness

The enabling legislation for M110 requires a second audit examining the effectiveness of the M110 program by December 31, 2025. The legislation includes a substantial list of metrics that legislators want to be evaluated, including client treatment outcomes, program details, and trends since just after M110 passed, such as increases in client access to treatment and housing.

Challenges with collecting data extend well beyond M110 to Oregon's entire behavioral health system.

As first noted in our January 2023 audit, the data collected to date falls well short of the information needed to assess many of these metrics. A new data system, ROADS, coupled with a behavioral health data warehouse, should improve OHA's ability to assess M110 effectiveness., However, it does not appear the agency will be able to address all the legislatively specified metrics, and the system may not collect enough data in time to meet the 2025 deadline for the metrics it can assess.

Challenges with collecting trend and outcome data, including the difficulty of establishing baselines to allow measurement of trends, extend well beyond M110 to Oregon's entire behavioral health system. OHA hopes to go live with ROADS in April 2024, and start drawing reliable data from it in early 2025. If implemented as planned, the system will collect client-level data and increase analysis of outcomes.

We discussed the new system with OHA staff and evaluated their template for data collection in the new system. For program details requested by the Legislature, OHA appears to be largely on track if ROADS is successfully implemented. The data collection template and input from OHA staff indicate OHA should be able to track details such as clients receiving services and client race and ethnicity. OHA is also planning to include data on sexual orientation and gender identity in ROADS provider reporting, though an advisory committee is still working on details and the agency is still determining the extent of collection and reporting required by the Legislature.

OHA's ability to respond to the Legislature's requests for trend data, such as changes in individuals accessing treatment since 2020, before M110 passed, appears uncertain in most cases. OHA has some confidence in its ability to track trends in individuals accessing treatment and time to access housing. However, it is not clear whether the agency will be able to track other legislatively specified trends, including changes in treatment providers, culturally specific providers, access to harm reduction, and access to housing. Pinning down specific health outcomes for clients receiving services, another legislative request, also appears uncertain. OHA is confident it can track client discharges from services and whether they re-enter treatment. Beyond that, specific health outcomes after completion may have to come from independent research studies.

Figure 11: Some metrics to assess program implementation may not be available in new data system

On-Track

- Clients receiving services
- Duration of client participation
- Number denied and why
- Data on client race/ethnicity and disability
- Whether clients re-enter treatment

Possible

- Time to access services and reasons for delay
- Increase in individuals accessing services

Unclear

- Client health outcomes

Increases in:

- Treatment providers
- Culturally specific providers
- Access to harm reduction services and housing
- Client access to housing

Even if ROADS is implemented on schedule by 2025, it is not clear that enough data will be available to assess the metrics in M110's statutes during the next legislatively required audit of M110. That audit is due at the end of 2025, more than two years after the first BHRN grants were approved and five years after voters approved the ballot measure.

The OAC did not prioritize adding residential treatment beds but funded detox facilities, housing, and enhanced services for residential treatment providers

Funding of residential treatment is not required by statute, but concerns about M110 funding of traditional residential treatment have been prominent given the shortage of treatment beds for substance use in Oregon.

The OAC did not prioritize expanding licensed residential treatment beds. However, it did help fund at least five projects to add detoxification or withdrawal management beds, including two that also expanded residential treatment capacity. All told, those five projects took up about a third of the $62 million in capital spending approved for BHRN grantees. Among other capital projects, the council also prioritized low-barrier housing. That housing ranges from emergency, temporary housing to peer-supported recovery housing, also in short supply, for people in outpatient treatment.

The council also approved substantial BHRN funds for organizations that provide residential treatment services in Oregon — at least a fifth of the BHRN grant funding total — in ways that should help them improve their work.

Twenty of the 32 OHA-licensed operators of drug and alcohol residential treatment facilities or detoxification centers in Oregon as of May 2023 applied for the first round of BHRN funding. The OAC awarded a total of $57.4 million to 18 of those applicants, or 21% of the total grant funding awarded.

At least a fifth of BHRN funds went to applicants whose existing services also included residential treatment.

For these applicants, the OAC's main focus was on funding low-barrier housing and on adding community-based staff who can expand access and client connections to services, including Certified

Alcohol and Drug Counselors, peers and mentors, and youth, housing, and admission specialists. The BHRN grants also funded expanded outreach and access through connection centers. Research indicates that the best steps to prevent client relapse after treatment include providing stable housing and employment, helping build positive support networks, and providing services to meet basic needs. These services are part of the M110 program's approach, and are generally not covered by Medicaid.

Residential treatment is not required for recovery from substance use issues. However, it may be particularly important for those with more severe disorders, and the shortage of residential treatment beds remains a large hole in Oregon's substance use treatment system. A 2022 year-end report from OHA's Ombuds Program raised concerns about a lack of timely access to substance use disorder residential treatment and a lack of capacity at withdrawal or detox centers. The report recommended expanding capacity for residential treatment of substance use and mental health issues. In the 2023 legislative session, backers of a bill for expanded residential treatment estimated it would take 311 beds and $93 million to close the gap. The bill did not pass.

OAC members and OHA officials cited several reasons for not prioritizing expanded residential treatment, as noted in Figure 12:

Figure 12: Key arguments against prioritizing residential treatment funding under M110

Medicaid eligibility	Residential treatment services are more readily billable to Medicaid than the non-clinical, easily accessed services and housing the council prioritized.
High costs	Expanding residential treatment is expensive and could easily take a large portion of M110 funding.
High barriers	M110 statutes emphasize "low-barrier treatment," which prioritizes rapid, no-barrier access. Wait lists for residential treatment and the need for clients to leave families and jobs create higher barriers.
Alternative funding sources	Other funding sources for expansion are available, including other state funds and investments from Coordinated Care Organizations, which cover Medicaid services under the Oregon Health Plan.
Better treatment options	More accessible alternatives such as outpatient treatment, in some cases combined with low-barrier housing, can be as or more effective than residential treatment at a lower cost.

Peer-focused BHRN providers, who see a lack of available treatment for their clients, are among those raising alarms about the shortfalls in residential care and detox facilities. BHRN money could help cover residential treatment construction costs, which Medicaid does not cover. As some BHRN-funded capital projects demonstrate, BHRN funds can be used to fill in funding gaps instead of covering total project costs.

The initial M110 funding process did not include an in-depth assessment of services available by county and where residential treatment and other services were most needed. OHA is conducting a study, requested by the Governor, of adult bed capacity in Oregon's behavioral health treatment facilities, including capacity for substance use and detox treatment. The study, due by mid-2024, and a related five-year plan should help the OAC prioritize funding sources for the facilities and more deliberately allocate funding to reduce service gaps.

Are grants and funding going to organizations that are culturally specific and linguistically responsive?

Answer:

Our review indicates the OAC prioritized the cultural and linguistic capabilities of providers during the grant application and approval process, a focus likely to improve provider cultural competence statewide and help address inequities in substance use treatment and outcomes. However, it is not clear how many providers of culturally specific services were funded to help serve populations most affected by the war on drugs, an important measure given the ability of these services to improve outcomes. The OAC and OHA did not track culturally specific service capabilities in this area by county or network during the application process and OHA's list after the fact appears incomplete, making it unclear how well M110 is addressing shortfalls in this area.

M110's enabling statutes require the OAC to focus on funding services for historically underserved communities. In the BHRN application process, the OAC's priority populations included Black, Native American, Latino, Pacific Islander, Asian, and LGBTQ+ people, along with veterans and people with disabilities, without housing, or formerly or currently incarcerated. The application also emphasized focusing on populations most impacted by the criminalization of drug possession and disproportionate rates of drug-related incarceration. Black communities and Indigenous, or Native American, communities have been most clearly impacted in these areas.

Culturally and linguistically specific providers offer services designed for a specific population by a provider who shares the culture, language, or identity with the person seeking services.

Providers are **culturally and l**inguistically responsive when they work to connect clients to services in their culture or language of choice.

To help serve these populations, M110's statutes require that all network services be culturally specific and linguistically responsive, connecting clients to written materials in other languages, for example, and to interpreters if necessary. Culturally and linguistically specific providers do this by having staff who share a cultural connection, language, or identity with a specific population. Providers who are not culturally and linguistically specific must provide and coordinate these services.

BHRN application requirements, application review requirements, and OAC subcommittee deliberations all demonstrate that provider cultural competence was a high priority for the OAC. By OHA's count, 47 applicants that provide culturally specific services by race or ethnicity received funds. More broadly, providers have also reported progress in cultural competence in quarterly reporting, such as boosting training, hiring more diverse staff, and collaborating with more diverse providers to help clients. Providers are also required to develop policies and procedures on cultural and linguistic practices. The OAC's focus appears likely to increase awareness and improve the overall cultural competence of service providers in Oregon, an important step toward providing effective low-barrier services for all communities. In addition to the network funding, the OAC also designated $11.4 million in M110 grants to 11 tribal partners across the state.

By OHA's count, based on provider applications, the council's funding of BHRN providers with the ability to provide culturally specific services by race and ethnicity had significant gaps. The count indicates 25 of Oregon's 36 counties do not have a provider offering culturally specific services, and these providers are clustered largely in the Portland metro area. For LGBTQ+ clients, OHA's count indicates only eight of Oregon's 36 counties have providers of culturally specific services in their networks. OHA did not track services specific to other priority populations, such as veterans and people with disabilities.

The list of providers offering culturally specific services by race and ethnicity appears to be incomplete, however. We reviewed application materials in seven counties with no culturally specific service providers by race and ethnicity listed, including Marion and Deschutes counties and five rural counties with high Latino populations. We found at least one provider in Marion, Deschutes, and in three of the five rural counties that appeared to clearly provide culturally specific services, most often for Latino specific services.

Three issues during the grant process affected OHA's ability to track providers offering culturally specific services:

- The Oregon Department of Justice advised the OAC not to take the racial or ethnic diversity of applicant's staff into account when making their award decisions, though they could consider the applicant's provision of services to culturally specific populations.
- During the grant review process, OHA did not track whether each network included providers of culturally specific services — the agency's count came after the fact.
- The application also did not require details that would allow reviewers to better assess a provider's ability to provide culturally specific services, such as client diversity, details on languages spoken by staff, and details on how they provide culturally specific services to priority populations. In our own review, it was often unclear whether providers were providing culturally specific services or not.

Providers are reporting some demographic data on clients quarterly, including data on race and ethnicity, age, and gender identity. This information can help identify providers offering culturally specific services and gaps in those services. OHA can also use its narrative questions in quarterly reporting to ask all providers to describe how they are providing or coordinating these services for their clients. Better tracking of these services is important. M110 legislation emphasizes provision of culturally specific services several times, and these services can improve outcomes.

Culturally appropriate services can improve outcomes, but Oregon faces shortfalls in this area

The service funding from M110 gives the OAC and OHA a strong opportunity to reduce substantial gaps in cultural and linguistic services. Research indicates expanding these services improves access and outcomes for populations that may not be well-served by the traditional treatment system.

> To meaningfully address inequities in health care access, "one of the most modifiable factors is the lack of culturally and linguistically appropriate services."
>
> - Federal Standards for Culturally and Linguistically Appropriate Services

The federal department of Health and Human Services sets standards for culturally and linguistically appropriate services, or CLAS standards. Inequities in healthcare access and outcomes tie directly to discrimination and social injustice, according to the standards, but "one of the most modifiable factors is the lack of culturally and linguistically appropriate services."

Guidance from the Substance Abuse and Mental Health Administration calls cultural competence an "essential" skill to decrease disparities in behavioral health. The agency's guidance says culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Specific therapies, such as cognitive behavioral therapy, can also be modified to account for cultural factors.

Two surveys that predated the implementation of BHRN grants found shortfalls in culturally responsive care in Oregon. A 2022 survey of substance use treatment providers by Oregon Health and Science University and Portland State University, also noted in the Introduction, found only 36% of the surveyed organizations reported providing culturally specific services specific for a racial or ethnic group and less than 20% offered specific services to veterans, people with mental or physical disabilities, or LGBTQ+ populations.[22] The study also identified gaps in language interpretation and translation services, and a workforce that does not represent the demographics of the state.

Separately, researchers with the Coalition of Communities of Color surveyed Black, Indigenous, and residents of color across Oregon in 2021, with surveys in English and Spanish, issuing their report in 2021.[23] In the English survey, the most-cited barrier to accessing behavioral healthcare was that services were not culturally and linguistically responsive, the study found, leading to less utilization and trust in the healthcare system. In the Spanish survey, the top barrier was not having health insurance or not having services covered by health insurance.

Asked to describe why they might experience a provider as untrustworthy, the English-language survey takers said the top reasons were a lack of empathy, past harmful care practices, and being stereotyped by providers.

> Providers "don't listen and have preconceived biases," one respondent to the Coalition of Communities of Color survey wrote, "and it's known that they treat Black people poorly, so I have that feeling going in."

In addition to M110 efforts, OHA has at least 10 broader behavioral health initiatives to increase culturally and linguistically specific providers. For example, one program offers enhanced Medicaid rates for culturally and linguistically specific services. Another sets specialty rates for residential providers who offer culturally specific services and services tailored for LGBTQ+ clients, veterans, and pregnant or parenting clients.

OHA is also running an $80 million Behavioral Health Workforce Initiative to increase recruitment and retention of diverse staff as well as staff in rural areas. The effort, initiated by the Legislature, also seeks to increase culturally responsive providers for diverse communities.

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[22] The Oregon Substance Use Disorder Services Inventory and Gap Analysis also found that among Oregon Health Plan members, rates of substance use disorder diagnoses suggested that less than half of those with a disorder have been diagnosed or treated.
[23] The report, "Investing in Culturally and Linguistically Responsive Behavioral Health Care in Oregon," also recommended investing in a multilingual and multicultural workforce.

Culturally specific services can help clients succeed

To better understand what culturally specific services entail, we spoke with BHRN providers who see culturally specific services as critical to their work.

Ashle Tucker is a peer support specialist at the Miracles Club in northeast Portland, which primarily serves Black and African American communities. She draws on her own experience in recovery to form a connection with incoming clients. When she went into treatment, the staff were predominantly Caucasian, she said, until she met an African American counselor who helped her stay sober. "I was like, thank God," Tucker said. "It's just something about having people with your background and history that makes you more open to sharing your experiences."

Jose Luis Garcia is the founder and executive director of Juntos, a BHRN grantee in Northeast Portland. Born in Mexico, with 22 years of experience in providing behavioral health services in Oregon, he has long witnessed the shortage of services available to the state's Latinx population. Without culturally specific services, he says, Latinos are dismissed from treatment for not speaking English, or because they do not qualify for state assistance with food, clothing, and medications. M110 funding is helping Juntos work with providers to help connect clients to services, basic needs, rental assistance, and bridge other gaps. "We've never had this level of funding and resources available to care for the Latino community before."

Jerrod Murray is the executive director at Painted Horse Recovery in Portland, which serves mainly Native American clients. He struggled with recovery until he found the Native American Rehabilitation Association of the Northwest, where "being exposed to the cultural piece sent me on my journey." At Painted Horse, peer support services are combined with longstanding Native healing traditions: drumming, beading, singing, crafting, dancing, sweat lodges and ceremonies. For Murray, treatment is anything that supports the spirit and keeps a client moving. M110 funding gives his organization "a chance to help our people from the ground up."

Katie Keck is the outpatient director at Rimrock Trails, a youth-focused treatment center in Crook and Deschutes counties. The best approach to teens is to be "consistent, non-judgmental, and create community," she says. M110 funds have helped them add LGBTQ+ and bilingual staff to the team, creating queer support groups and providing Spanish-language services throughout treatment. Peers connect with youth at schools, detention centers, and homeless camps. The peers, along with Xboxes and sober activities, make treatment more approachable. "With youth we have to be much more proactive," Keck says, "It's important to not make them feel like they have to come sit in an office."

What barriers exist for grant and funding applicants who are Black, Indigenous or people of color?

Answer:

The grant process prioritized community-based applicants and gave decision-making authority to community members, positive steps toward reducing barriers. Barriers in the process include a complex application and limited technical assistance for applicants.

Similar to the focus on culturally specific populations, the OAC hoped to attract applicants with deep experience working with diverse clients, including applicants led or staffed by people of color.

Organizations led by Black, Native American, and Latino people were included among the approved grantees, and we spoke with providers led by people of color who said the M110 grants have been crucial to expanding their operations. However, the OAC and OHA do not track staffing composition, and it is not clear how many providers fit that definition. Our review focused on identifying leading practices for making grants accessible to smaller community-based organizations, including organizations led by people of color, then assessing how well the OAC and OHA's process has met those criteria to date.

The grant process included some key elements designed to reduce barriers for applicants led by people of color and community-based applicants, including prioritizing culturally responsive organizations. The composition of the OAC, required by statute, gave decision-making authority to community members. The OAC established multi-provider networks that can better fit in small organizations, and provided funding for community space and overhead that could add stability for smaller providers.

Several important barriers remain, however. The application process was complex, with limited technical assistance, creating barriers for smaller groups that may have few staff and little grant writing expertise. The difficult and rushed first round of funding also strained relationships between the OAC and OHA, and between the state and grantees, reducing their ability to cooperate in making program improvements.

Methodology

To identify leading practices, we collected criteria from statutes and administrative regulations and interviews with subject matter experts, grant recipients, OAC members, OHA staff, and other stakeholders. We drew on guidance for other grants in Oregon that have focused on effective grantmaking for BIPOC, community, or grassroots groups. We also analyzed best practices for effective grantmaking outlined by the U.S. Government Accountability Office and by organizations focused on participatory grantmaking, a process that substantially increases the role of affected community members in the grant process. The seven criteria identified through this analysis are listed in Figure 13, along with their status in grantmaking for M110 BHRN grants.

As noted in Figure 13, legislative action in 2023 may help OHA and the OAC improve the process for smaller applicants and all applicants, through a new OAC executive director position and clearer authority for OHA to administer the process. OHA is also adding some M110 program staff. The next round of grants will not take effect until July 2025, allowing more time to make improvements.

Figure 13: The OAC and OHA made progress reducing barriers for applicants who are Black, Indigenous or people of color, but systemic improvements are still needed

Leading Practice	What OHA/OAC did	Criteria met?
Community: Give decision-making powers to community members most impacted by the problem.	Statutes required that the OAC include community representatives. The council approved grants and help set requests for applications, application forms, scoring rubrics, and review requirements.	☑ **Yes**
Equity: Prioritize applicants with demonstrated ability to serve priority populations.	The grant request, application, and scoring rubric prioritized culturally responsive organizations, as did OAC subcommittees. But applicants were not required to provide details, and neither the OAC nor OHA tracked provision of cultural and linguistic capabilities by network.	☑ **Partially**
Capacity: Ensure that the agency and oversight board have adequate staff to administer the grant process and fulfill program requirements.	OHA and the OAC lacked staff to cover a large workload in a short time. In 2023, the Legislature added an executive director position for the OAC and clarified OHA responsibilities. OHA is adding staff, but it is not clear yet if it will be enough to administer the next grant process effectively.	☑ **Partially**
Stability: Provide operational and administrative funding to grantees and longer-term funding to ensure stability over time.	Establishing multi-provider networks helped smaller providers fit in. The OAC added funding for community space and overhead and extended grants through 2025. However, few applicants requested money for overhead and reviewers did not assess applicants' capacity to do the work.	☑ **Partially**
Simplicity: Ensure application requests, grant applications, and required forms are easy to access and complete.	All parties noted the complexity of the forms and process. The Legislature gave OHA clearer authority to simplify the process going forward, particularly important for grassroots applicants.	☑ **Not Yet**
Support: Prioritize relationship building with applicants and grantees to build trust, provide ongoing technical support, and be flexible on budget allocations and results reporting.	Low staffing limited OHA's ability to provide technical assistance in the application process. OHA and the OAC have been flexible with grantee deadlines, and OHA is providing technical assistance with financial and results reporting. Yet supporting 230 grantees is challenging. Added OHA staff and more OAC focus on improving relationships with grantees can help in this area.	☑ **Partially**
Cooperation: Collaborate to improve the program and determine measurement of results.	The difficult first round of funding strained the working relationship between the OAC and OHA, and between the state and grantees. OHA staff and OAC members have worked to improve relationships. The OAC also needs to support OHA and encourage collaboration with providers as the agency tries to measure the effectiveness of the BHRN grants.	☑ **Partially**

What applicants were denied and why were they denied?

Answer:

The OAC denied a quarter of applicants. The most common reason was reviewer uncertainty about applicant plans and whether they met M110 goals. Other reasons included concerns about high costs and applicant focus on mental health treatment or clinical positions. The OAC and OHA can improve the application and the review process, increasing transparency and consistency.

The OAC denied applications for multiple reasons, including concerns about applicant plans not matching M110 values

OAC members and OHA staff had the challenging task of reviewing 328 BHRN grant applications, including applications in highly competitive counties. The OAC denied 87 applications, or roughly a quarter of the total.

One applicant, Boulder Care, a virtual telehealth provider that applied in all of Oregon's 36 counties, was denied 28 times. Outside Boulder Care, the OAC denied applications in only 17 of Oregon's 36 counties. The council denied 46 of 129 applications in Multnomah, Benton, Clackamas, and Washington counties, more populous counties that likely have a higher supply of potential providers. In Multnomah, Benton, and Washington counties, providers also requested far more funding in total than the OAC's total allocation for the county, which can increase competition among grantees for limited funds.

Figure 14: Four counties accounted for more than half of all denials

County	Total Applicants	Applicants Denied	Total Provider Funding Request (millions)	OAC Funding Allocated to County (millions)
Multnomah	61	21	$95.3	$58.8
Washington	32	12	$59.2	$20.5
Benton	13	7	$7.8	$3.5
Clackamas	23	6	$14.4	$14.5

Methodology

To identify specific reasons for OAC denials, we reviewed 10 denied Boulder Care applications and 40 of the 59 denials beyond Boulder Care. Our review included applications, proposed applicant budgets, reviews of applications by OAC members and OHA staff, and OAC subcommittee meetings, where initial denial decisions took place. Most of the denials involved multiple factors.

For Boulder Care, grant reviewer documents and OAC meeting recordings indicate denials stemmed from Boulder Care using the same application for each county. Reviewers and council members were concerned about a lack of demonstrated knowledge of specific BHRN regions, which they saw as particularly important for outreach to connect with people in need of services. The council did approve eight of Boulder Care's applications, most often in rural counties with fewer applicants and long travel distances that can be a burden for clients. However, the applications were rejected in five of Oregon's

ten frontier counties, and it was not clear from applications in those counties how telehealth services would be provided.

Outside Boulder Care, there were multiple, overlapping reasons for denials. The most common are listed in Figure 15.

Figure 15: Applicants were denied most often for the following reasons

Unclear applications	Reviewers were often uncertain about what applicants intended to do with requested funding.
High administrative salaries	Salaries in the six-figure range for directors and administrative staff raised red flags for reviewers.
Not reflective of M110 values	Providers that focused on providing for underserved and culturally specific communities, hiring peers, and paying living wages to all staff were more likely to succeed.
Not offering low-barrier treatment	Providers were denied who required sobriety for housing or supportive employment, conducted random house calls, or followed other practices not in line with low-barrier treatment and harm reduction.

Other reasons for denials included:

- Issues with application materials, such as narratives that did not match provider budgets;
- Including mental health staff in applications, rather than specific substance use treatment staff;[24] and
- Focusing on clinical staff such as doctors, therapists, and nurses, though clinical staff were approved in some applications.

The OAC denied some significant applicants and individual projects

The denials, both full and partial, had a large impact in several counties. For example:

Multnomah County's $4.8 million application to provide treatment, peer support, housing, and harm reduction was denied, despite split recommendations by the two reviewers of the application. An OHA staff member identified Multnomah's application as a "thorough, equity-centered proposal" by a "well-positioned" entity with a feasible and appropriate budget. The other reviewer, an OAC member, flagged the application for excessive funding and the use of professional personnel for positions peer support would be able to fill at lower cost. The OAC subcommittee denied the application with no discussion.

Equinox Clinic in Lincoln County requested $4.7 million to provide low-barrier treatment services, peer support, and harm reduction services. These reviewers were also split in their recommendation. One recommended a yes vote, but noted that more peers should be hired. The other reviewer recommended a no vote, citing a lack of clarity in the application and the use of M110 funds to pay employees, such as medical staff, whose services are billable to insurers. Before denying the application subcommittee members discussed the proposal, including the reviewer's concerns and additional subcommittee member concerns.

[24] This position has drawn criticism from some stakeholders given how frequently people with substance use disorders also have mental health issues.

In Washington County, where providers requested nearly three times the OAC's allocated funding for the county, the county itself had $12 million cut of its $17 million proposal for a treatment center. The county objected after the decision was made, noting the county itself bore almost the entire reduction of funds among approved providers in the county. Subsequently, the county did obtain enough funding from other sources to meet projected capital costs for the center.

The OAC and OHA can improve the application and approval process before the next round of grants

This review and the audit released in January 2023 both found the OAC and OHA can improve the application process to improve decision-making in three areas: application quality, transparency, and consistency.

The lack of public discussion and at times sparse and inconsistent application reviews stemmed in part from the volume of applications, vague or confusing applications, and the pressure to review applications quickly given delays in M110 funding.

Application quality: In our review of application documents, we were often uncertain about what improvements the provider intended to make, whether they were funding new staff or existing staff, and what funded staff would be doing. The review sheets from the OAC and OHA application reviewers indicated reviewers were often uncertain about the applicant's intent and capabilities as well. The OAC can improve application quality by requiring more clarity and by making it clear before applicants apply how much grant money is allocated to their counties. We saw cases of applicants asking for far more than the dollars available, making their applications less realistic and effective.

Transparency: The OAC subcommittees that denied applicants often did not discuss reasons for their decisions. Transparency in decision making is crucial for program credibility. It is also particularly important for the OAC given its community-focused structure. The council includes many members who work in the substance use treatment field, increasing the risk of "familiarity bias" in decision making based on prior knowledge of applicants instead of the quality of the application itself. Familiarity bias is a common risk in community-based decision making, and must be balanced against the value of having community members in leading roles. OHA has helped develop tailored Ethics Commission training for OAC members that should help OAC members be more aware of these risks.

Consistency: Each application had two reviewers, and we saw inconsistency in the depth of their reviews and in what each reviewer considered most important. We found most reviewers gave clear, insightful recommendations on whether an applicant should be funded, but some simply wrote "yes" or "no" without additional information for the OAC subcommittee considering the application. We also found reviewers citing reasons for denials not cited by other reviewers reviewing similar applications.

The lack of public discussion and at times sparse and inconsistent application reviews stemmed in part from the volume of applications, vague or confusing applications, and the pressure to review applications quickly given delays in M110 funding. OHA temporarily assigned over 100 staff from other divisions to help the OAC complete grant reviews in the spring of 2022. OAC members were also involved in the application reviews and had multiple meetings cancelled for lack of a quorum, increasing the time pressure when they could meet.

Are government entities supplanting local funding with M110 grant funding?

Answer: The risk of counties, the primary government entity funded through BHRN grants, using M110 funds to replace existing local funding appears low. However, our review did find that counties and other grantees may be using M110 funds to maintain existing services and staff rather than expanding or improving services as intended under the measure. In quarterly reports, OHA does not require grantees to specify whether staff or services are new.

OHA is not tracking whether grantees are "supplanting" local funding with M110 funding — that is, using M110 funds to replace existing spending instead of expanding or improving services. However, the BHRN local government grantees we interviewed report having controls in place to prevent supplanting, and the risk of supplanting of local funds used to provide treatment services appears low.

Thirteen county government agencies and one health district in Oregon's 36 counties were awarded M110 grants, receiving $26.6 million of the $261 million available, or 10% of the grants.

Under federal definitions, an entity has supplanted funds when it uses incoming money to replace existing funding. The goal is for the new grant funds to instead "supplement" existing services, by expanding or improving them.

> **Supplanting:** The grant recipient uses the money to replace existing funding, generating no expansion or improvement of services.
> *- Source: SAMHSA*

Methodology

To assess supplanting risks, we reviewed the six counties that received more than $1 million in grants, accounting for 86% of funding provided to local governments. Counties were already involved in treatment services and the M110 grants went to their health or other pertinent departments. We examined budgets, grant agreements, expenditure reports, interviewed OHA staff, and corresponded with or interviewed county financial managers.

All counties reviewed had signed agreements clarifying they would not supplant funding and certified within submitted quarterly reports that supplanting had not occurred. From interviews with OHA, we determined this was the extent of controls at the state level for M110 providers. OHA officials said this limited oversight of supplanting is also true of providers in the Medicaid program.

However, county managers we contacted said they do have controls in place to prevent supplanting. The controls include staff training, matching expenditures to their related programs, separate accounting for BHRN funds, and management review of quarterly expenditure reports prior to submittal to the state. Municipal auditors audit the counties annually and county management is accustomed to complying with restrictions on supplanting federal grant funds.

Review reinforces the need to improve tracking of service expansion

Our review did not identify any findings of supplanting of local funding at the local government level, the specific statutory requirement for our review. We did find that find that two counties —

Washington and Lincoln counties — used M110 funds to replace expiring state and federal grants, which are non-local funds. M110 program staff said OHA leaders do not consider this to be supplanting.

However, the results indicate that counties and other grantees may use M110 funds to maintain existing services and staff rather than expanding or improving services as intended under M110. Organizations treating substance use disorders commonly rely on multiple sources of funding, including grants, that can end abruptly.

Moving forward, OHA can increase program transparency by having grantees specify whether M110 funds have expanded staffing and services provided by their organizations or maintained them.

How much is total funding and administrative spending for the M110 program, BHRN grantees, and contractors involved with the program?

Answer:

The requested details are included below. Perhaps the most important ongoing detail for OHA to monitor is administrative costs reported by BHRN providers, which vary widely. Provider reports show an average of 7% in administrative costs through the first year of the grant period, but the range is large, ranging from zero to more than 20%. Ensuring more consistent accounting for these numbers will help OHA grant managers and providers assess the reasonableness of administrative costs, and gauge whether providers have adequate administrative spending to support their services.

The statutory requirements for this review include requests for specific M110 funding and spending details, included below. As part of this work, we also examined OHA's administrative costs for the M110 program.

M110 Program Details

OHA administers the Drug Treatment and Recovery Services Fund, which receives the M110 share of cannabis taxes and provides the largest source of funding for the M110 program. Opioid Settlement funds also contribute to the program.

From the program's inception through June 2023, OHA reports collecting $284 million in M110 revenues, including $275 million in cannabis tax revenues. The agency expended $265 million of M110 revenues in that period, leaving an estimated carryover balance of $19 million at the end of the 2021-23 biennium.

Figure 16: M110 expenditures through June 2023

Disbursements to Tribes	$9.7 million
Access to Care Grants	$36.8 million
Disbursements to BHRN grantees	$209.3 million
OHA Administration – covered by Drug Treatment Fund	$9.2 million
OHA Administration – covered by General Funds	$6.1 million

Source: OHA September 2023 M110 Revenue and Expenditure Report

OHA administrative costs through June 2023 totaled $15.3 million, or 5.4% of M110 revenues. They paid for OHA staff to manage the M110 program, contractors used for the program, data reporting, and funding for the OAC.

In the 2021-23 biennium OHA used $6.1 million of General Fund dollars outside M110 revenues to cover the portion of administrative costs beyond a 4% statutory cap on administrative spending from drug treatment fund revenues. In the 2023 legislative session, the Legislature added more responsibilities for OHA and eliminated this cap.

BHRN Provider details

From the inception of the BHRN program through October 31, 2023, providers received $214 million from OHA to execute their grants –- including disbursements through the 2021-23 biennium noted above and further disbursements through October 2023. (See Appendix A for detail of amount allocated and received by provider.)

From July 2022 through June 2023, BHRN providers reported spending $95.2 million on staff, supplies, capital improvements, and other costs. Of that, they reported spending $6.4 million on administration, or about 7% of the total. At the federal level, the de minimis indirect cost rate to cover overhead and administration — allowed without negotiation — is 10% for grantees.

However, based on an analysis of third quarter reporting, provider-reported administrative costs varied substantially among providers. Almost half the providers reported no administrative costs. For the 118 providers that did, administrative costs averaged 11% of their total spending, with 12 providers reporting administrative costs above 20%. Accounting for the costs also varied. Some providers booked specific costs such as administrative staff and insurance expenses. Others used an indirect cost rate. More consistent accounting would help OHA grant managers and providers assess the reasonableness of administrative costs, and gauge whether administrative spending is adequate to support provider services.

Contractor details

We examined documents for two large contracts paid for, at least in part, through the M110 program: Lines for Life, which operated the M110 24/7 hotline,[25] and Deloitte Consulting.

From the inception of the M110 program through June 2023, OHA reported spending $1.7 million on the Lines for Life contract, at a cost of roughly $7,000 for each call related to citations created by M110. OHA reported spending $5.8 million on Deloitte contract work related to M110. Deloitte contracted to help OHA with behavioral health project management and information technology improvements, including assistance to the M110 program. The contract also called for Deloitte to set up contract management tools, standardize financial reporting for M110 grantees, and help grantees with reporting to OHA.

Lines for Life projected 20% administrative costs in its original budget submitted to OHA. OHA does not track contractor spending details and does not have documents breaking down administrative costs for the Deloitte contract.

[25] According to OHA, Lines for Life's contract shifted to a new contactor, Health Resources in Action, in August 2023. The new contract totals $2.8 million and runs through January 2025. In a statement announcing the new contract, OHA said the hotline has been "vastly underutilized" and said the new contractor will improve it.

Recommendations

This review details areas where the OAC and OHA can collaborate to make improvements, in addition to continuing work on steps such as working with providers to increase services. Below are key recommendations for the two entities, which will need to work together to address them and involve the Legislature if statutory changes are needed.

To improve the demonstration of M110 program effectiveness, impact, and outcomes:

1. Develop a strategic plan with specific M110 outcome metrics and timelines and present it in the 2024 legislative session. Consider working with outside researchers for outcome evaluation if needed; (pg 20)
2. Work with providers to better track and report:
    a. Specifics on staffing, service expansion, and capital projects; (pg 18)
    b. Youth services and virtual services; and (pg 18)
    c. The availability of culturally and linguistically specific services. (pg 23)
3. Work with providers to improve the consistency and reliability of service expenditures and client data. (pg 19)

To improve the application and review process moving forward:

4. Work with communities and providers to identify the most critical service gaps by county and barriers to increasing services; (pg 15)
5. Make the application clear and direct (pg 27) and improve review process transparency and consistency; (pg 31)
6. Require providers to clearly detail what they plan to do with M110 funds (pg 31) and their experience, capability, and plans for providing services to clients from linguistically diverse or culturally specific backgrounds. (pg 23)

Project Approach

Objective & Scope

This review is required by ORS 430.392, one of the statutes governing M110. Our objective was to answer the legislative questions detailed in the statute while meeting the December 31, 2023, legislative deadline.

Our scope was largely limited to the legislative questions, as modified in the 2023 legislative session:

- Whether grants and funding were disbursed based on measure priorities.
- Whether grants and funding went to culturally specific and linguistically responsive organizations.[26]
- Barriers that exist for Black, Indigenous, and people of color grant applicants.
- Applicants that were denied and why.
- Whether governmental entities supplanted or substituted M110 funding for local funding.
- The organizations and agencies who received grants and what amount they received.
- What proportion of grants received by grantees was devoted to administrative costs.
- The total number of entities that applied for funding.
- What money remained after grants and funding were disbursed.

Addressing these requirements also led to additional work in two risk areas: relatively low grantee spending in the first year of the BHRN grant period and the availability of data to assess M110's effectiveness.

Methodology

The individual sections of this report include details for specific methodologies we followed. In general, we:

- Interviewed or corresponded with M110 providers, OAC members, OHA management and staff, staff at other state agencies involved in the program, and advocacy groups.
- Examined pertinent documents and recordings, including financial and budget documents, statutes and regulations governing the program, recordings of OAC meetings and records presented at the meetings, and documents involving M110 providers, such as applications, budgets, application reviews, grant agreements, and quarterly reports.

[26] In the legislation, this review requirement specified "culturally responsive and linguistically specific" services. We interpreted it consistent with the rest of the statute, which required BHRNs to provide "culturally specific and linguistically responsive" services.

- Researched issues related to M110, such as best practices for funding and supporting people of color or grassroots grantees, the growth of fentanyl use, the connections between homelessness and substance use, and the effectiveness of specific services for substance use disorders.

For this limited review, we did not conduct a formal evaluation of the reliability of information system controls. However, we noted concerns in the report about the reliability of the spending and client data. At this point, providers report the data in aggregate, making it more difficult to verify. OHA also continues to review quarterly provider reports on spending and clients, making the figures subject to change. This is particularly true of submissions from the initial grant term's fourth quarter, covering April through June 2023, which arrived closer to the issuance of this report. The reliability of the data, particularly client counts and demographic information, should increase when OHA begins collecting information on individual clients from M110 providers.

The legislation requiring this report set it as a more limited review and specified two full audits of M110 in addition to this report, one that the Audits Division issued in January 2023 and a second due by December 31, 2025. Accordingly, we conducted the review work to match the limited legislative requirements and to meet the legislative deadline. This more limited review does not adhere to the full set of government auditing standards, including formal internal control review of auditees. However, the report has undergone the same rigorous quality assurance process as does each audit from the Oregon Audits Division, with auditors not involved in the project checking evidence for each assertion in the report. We also consulted with the OAC and OHA leadership prior to initiating the project and obtained feedback on a preliminary draft of the report from council members and the agency.

We would like to thank OAC members and OHA management and staff for their cooperation.

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About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

Appendix A: BHRN Grant Recipients by County

This list of BHRN providers shows the total amount of their initial grant and the amount OHA reported disbursing, or sending to them, as of October 31, 2023. For more up-to-date figures, go to OHA's M110 Dashboard. The OAC terminated the grants for three providers, noted with blue shading below.

BHRN Provider	Grant Amount	Amount Disbursed
Baker		
New Directions NW	$860,829	$688,663
Benton		
Benton County Health Department	$313,445	$250,756
CHANCE	$1,058,507	$846,806
Corvallis Housing First	$262,924	$219,103
Family Recovery, Inc.	$912,642	$730,114
Family Tree Relief Nursery	$717,510	$597,925
Pathfinder Clubhouse	$260,458	$208,366
Clackamas		
Bridges to Change	$2,493,470	$2,077,891
Cascadia Behavioral Healthcare, Inc.	$306,608	$255,507
Harmony Academy Recovery	$1,246,601	$997,280
LifeStance	$327,050	$272,542
MetroPlus Association	$42,710	$34,168
Morrison Child and Family Services	$192,097	$160,081
New Avenues for Youth	$786,131	$628,905
Northwest Family Services	$1,198,802	$959,042
Outside In	$356,789	$297,325
Parrott Creek Child & Family Services	$843,594	$674,875
Phoenix Rising	$96,691	$77,353
Recovery Works NW	$2,181,240	$1,744,992
The 4th Dimension Recovery Center	$1,742,400	$1,452,000
The Mental Health Association of Oregon	$719,897	$575,918
Transcending Hope	$1,079,703	$863,762
Volunteers of America Oregon	$376,414	$301,132
Youth ERA	$481,979	$401,649
Clatsop		
Clatsop Behavioral Healthcare	$1,093,678	$874,943
Clatsop Community Action	$1,581,378	$1,265,103
Clatsop County Public Health	$267,603	$223,003
Helping Hands Re-Entry and Outreach	$1,801,780	$1,441,424
Iron Tribe Network	$1,037,496	$829,997
Morrison Child and Family Services	$188,696	$157,246
Providence Seaside Hosp. Foundation	$221,313	$177,050
Columbia		
Boulder Care Provider Group, P.A.	$97,256	$77,805
Columbia Community Mental Health	$1,304,252	$1,086,877
Iron Tribe Network	$1,151,036	$920,829

Medicine Wheel Recovery	$874,955	$699,964
Youth ERA	$181,787	$145,430
Coos		
Adapt	$1,385,000	$1,108,000
Bay Area First Step Inc.	$2,540,435	$2,032,348
Coos Health & Wellness	$295,080	$236,064
HIV Alliance	$272,586	$218,069
Youth ERA	$177,004	$141,603
Crook		
BestCare Treatment Services, Inc.	$1,501,319	$1,201,055
Rimrock Trails Treatment Services	$352,855	$282,284
Curry		
Adapt	$1,312,468	$1,049,975
Brookings Community Resource Response	$250,000	$200,000
Deschutes		
BestCare Treatment Services, Inc.	$5,493,640	$4,394,912
Boulder Care Provider Group, P.A.	$409,800	$327,840
Deschutes County Health Services	$2,890,046	$2,408,372
Healing Reins Therapeutic Riding Center	$367,135	$293,708
Ideal Option	$1,170,164	$936,131
Rimrock Trails Treatment Services	$1,190,080	$952,064
Douglas		
Adapt	$7,747,527	$6,198,022
Boulder Care Provider Group, P.A.	$210,251	$175,209
HIV Alliance	$575,371	$460,297
Gilliam		
Boulder Care Provider Group, P.A.	$40,000	$32,000
Community Counseling Solutions	$710,000	$568,000
Grant		
Boulder Care Provider Group, P.A.	$40,000	$32,000
Community Counseling Solutions	$710,000	$710,000
Harney		
Symmetry Care, Inc.	$857,712	$686,169
Hood River		
Hood River County Health Dept.	$81,435	$65,148
Mid-Columbia Center for Living	$950,914	$792,428
One Community Health	$121,637	$97,310
Providence Hood River	$147,181	$117,745
Jackson		
Addiction Recovery Center	$1,109,347	$976,225
ColumbiaCare Services	$390,319	$343,481
Community Works	$119,617	$99,681
Compass House	$76,480	$63,733
HIV Alliance	$104,358	$91,835
Jackson County Health & Human Services	$610,527	$508,773

La Clinica	$1,502,327	$1,322,048
Max's Mission	$719,798	$633,422
Oasis Center of Rogue Valley	$1,425,981	$1,254,863
OnTrack, Inc.	$1,541,627	$1,356,632
Options for Homeless Residents of Ashland	$563,413	$495,803
Options for Southern Oregon, Inc.	$303,873	$267,408
Reclaiming Lives	$352,211	$309,946
Rogue Community Health	$5,010,125	$4,175,104
Stabbin' Wagon	$582,396	$512,508
The Family Nurturing Center	$1,367,463	$1,203,367
The Pathfinder Network	$1,349,947	$1,187,953
Youth ERA	$349,553	$307,607
Jefferson		
BestCare Treatment Services, Inc.	$2,007,563	$1,606,050
Josephine		
Adapt	$4,083,750	$3,267,000
Grace Roots	$1,146,250	$917,000
Grants Pass Sobering Center	$229,454	$183,563
HIV Alliance	$323,280	$258,624
Max's Mission	$505,160	$404,128
OnTrack, Inc.	$2,288,350	$1,807,766
Options for Southern Oregon, Inc.	$1,463,795	$1,171,036
The Family Nurturing Center	$713,619	$594,683
Klamath		
Klamath Basin Behavioral Health (dba of Klamath CFT)	$425,630	$374,554
Lutheran Community Services	$771,433	$642,861
Max's Mission	$564,628	$451,702
Red is the Road to Wellness	$1,552,833	$1,086,983
The Stronghold	$816,371	$653,097
Transformations	$1,491,159	$1,192,927
Lake		
Lake Health District	$1,233,987	$987,189
Lane		
Addiction Counseling and Education Services (Emergence)	$1,486,715	$1,238,929
Center for Family Development	$1,001,989	$801,591
Centro Latino Americano	$4,565,567	$3,652,454
Community Outreach Through Radical Empowerment (CORE)	$1,086,254	$869,003
Daisy C.H.A.I.N.	$1,102,215	$881,772
HIV Alliance	$1,302,583	$1,042,066
Housing Our Veterans	$978,735	$782,988
Ideal Option	$312,970	$250,376
Laurel Hill Center	$938,075	$781,729
Looking Glass Community Services	$5,190,485	$4,152,388

OSLC Developments, Inc.	$2,402,469	$1,921,975
Restored Connections Peer Center	$1,082,051	$865,341
Shelter Care	$308,618	$257,182
South Lane Mental Health Services, Inc.	$509,166	$407,333
TransPonder	$670,626	$536,501
Veteran's Legacy	$940,575	$783,813
White Bird Clinic	$4,693,019	$3,754,415
Youth ERA	$356,044	$284,835
Lincoln		
CHANCE	$310,320	$248,256
Coastal Phoenix Rising (NW Coastal Housing)	$479,977	$383,982
Community Services Consortium	$390,494	$312,395
Confederated Tribes of the Siletz	$78,452	$65,377
Faith, Hope and Charity, Inc. (FHC)	$208,955	$167,164
Lincoln County Health & Human Services Program	$1,196,010	$598,005
Phoenix Wellness Center LLC	$1,536,047	$1,228,838
Samaritan Treatment & Recovery	$455,148	$364,118
Linn		
Addiction Counseling and Education Services (Emergence)	$175,388	$146,157
Albany Comprehensive Treatment (CRC Health OR)	$110,720	$88,576
CHANCE	$3,645,179	$2,916,143
Community Services Consortium	$890,000	$712,000
Faith, Hope and Charity, Inc. (FHC)	$504,210	$403,369
Family Tree Relief Nursery	$843,323	$702,769
Samaritan Health Services	$1,081,703	$865,362
Malheur		
Eastern Oregon Center for Independent Living	$516,535	$412,429
Lifeways	$698,210	$581,842
Origins Faith Community Outreach Initiative (OFCOI)	$616,152	$513,460
Marion		
Bridgeway	$11,096,437	$8,877,150
HIV Alliance	$388,105	$323,421
Ideal Option	$924,441	$739,553
Iron Tribe Network	$768,824	$615,059
Marion County	$6,419,022	$5,349,185
The Pathfinder Network	$493,935	$395,148
Morrow		
Community Counseling Solutions	$924,517	$739,614
Multnomah		
Alano Club of Portland	$1,175,009	$940,007
Bridges to Change	$8,483,790	$6,787,032
Bright Transitions	$896,018	$716,815
Cascadia Behavioral Healthcare, Inc.	$797,355	$637,884

Central City Concern Puentes	$633,100	$527,583
CODA, Inc.	$545,025	$454,188
Fresh-Out Community Based Re-Entry Program	$494,408	$395,526
Going Home II	$4,954,114	$3,963,291
Iron Tribe Network	$395,361	$316,289
Juntos LLC	$564,794	$451,835
Just Men In Recovery	$2,230,025	$1,784,020
Lutheran Community Services	$1,447,214	$1,157,771
MetroPlus Association	$418,628	$334,902
Morrison Child and Family Services	$287,521	$239,601
New Avenues for Youth	$1,059,239	$847,391
Northwest Family Services	$512,761	$451,230
Northwest Instituto Latino De Adicciones	$1,204,981	$963,985
OHSU, Addiction and Complex Pain	$15,028	$12,023
OHSU, Partnership Project	$56,875	$45,500
Oregon Change Clinic	$3,218,373	$2,574,698
Outside In	$2,110,456	$1,758,713
Painted Horse Recovery	$886,222	$721,851
Phoenix Rising	$168,928	$135,142
Portland Street Medicine	$563,473	$450,778
Prism Health	$359,176	$299,313
Project Patchwork	$1,127,145	$901,716
Project Quest (Quest Center for Integrative Health)	$2,807,764	$2,246,211
Providence Portland Medical Foundation	$4,306,032	$3,444,826
Raphael House of Portland	$109,856	$87,885
SE Works Inc	$1,056,070	$880,058
Sovalti LLC	$152,867	$122,293
The 4th Dimension Recovery Center	$2,639,337	$2,199,448
The Everly Project	$381,255	$305,004
The Insight Alliance	$1,008,031	$806,424
The Marie Equi Institute	$756,047	$604,838
The Mental Health & Addiction Assoc. of Oregon	$4,015,519	$3,212,415
The Miracles Club	$3,201,077	$2,667,564
The Pathfinder Network	$1,660,187	$1,328,150
Volunteers of America Oregon	$947,614	$758,091
WomenFirst Transition & Referral Center	$952,979	$762,383
Yasiin's Luv LLC	$388,336	$310,669
Polk		
Polk County	$3,078,773	$2,463,018
Youth ERA	$185,949	$148,759
Sherman		
Boulder Care, Inc.	$40,000	$32,000
Mid-Columbia Center for Living	$710,000	$568,000
Tillamook		

Adventist Health Tillamook	$332,640	$266,112
CARE	$858,214	$715,179
Rinehart Clinic and Pharmacy	$203,074	$169,229
Tillamook County Community Health	$436,944	$364,120
Tillamook Family Counseling	$207,271	$172,726
Tillamook Serenity Club	$192,982	$154,385
Umatilla		
Community Counseling Solutions	$388,000	$310,400
Eastern Oregon Alcoholism Foundation	$3,958,110	$3,166,488
Eastern Oregon Center for Independent Living	$977,781	$782,225
Union		
Center for Human Development	$1,257,129	$1,005,703
Eastern Oregon Center for Independent Living	$567,433	$453,946
Wallowa		
Boulder Care, Inc.	$40,000	$32,000
Wallowa Valley Center for Wellness	$710,000	$568,000
Wasco		
Bridges to Change	$589,466	$432,275
Eastern Oregon Center for Independent Living	$400,085	$320,068
Give them WINGS	$115,800	$96,500
Mid-Columbia Center for Living	$647,086	$539,238
North Central Public Health District	$105,271	$84,217
One Community Health	$11,770	$9,808
Youth Empowerment Shelter	$101,427	$84,523
Washington		
Bridges to Change	$1,522,480	$1,217,984
CODA, Inc.	$545,025	$454,188
Forest Grove Foundation	$2,606,426	$2,085,141
HIV Alliance	$404,829	$337,358
Ideal Option	$47,500	$38,000
LifeWorks NW	$1,712,378	$1,844,661
Lutheran Community Services	$814,072	$678,393
MetroPlus Association	$42,710	$34,168
Morrison Child and Family Services	$280,098	$233,415
NW Instituto Latino	$734,594	$612,162
Phoenix Rising Transitions	$69,466	$55,573
Sequoia Mental Health	$701,134	$584,278
The 4th Dimension Recovery Center	$444,560	$370,466
The Mental Health Association of Oregon	$624,496	$520,414
The Miracles Club	$395,701	$329,751
The Recovery Gym (Alano Club)	$639,243	$511,395
Virginia Garcia Memorial Health	$1,187,803	$989,836
Washington County Behavioral Health Division	$5,328,561	$4,262,848
Washington County Public Health	$1,927,410	$1,541,928

Wheeler		
Boulder Care, Inc.	$40,000	$32,000
Community Counseling Solutions	$710,000	$568,000
Yamhill		
Encompass Yamhill Valley	$253,245	$202,596
Providence Newberg Medical Center	$273,213	$227,678
Provoking Hope	$1,925,413	$1,540,330
Recovery Works NW	$1,093,552	$874,842
Virginia Garcia Clinic	$409,478	$341,232
Yamhill Community Action Partnership	$977,681	$814,734
Yamhill County HHS	$2,096,198	$1,746,832

HEALTH SYSTEMS DIVISION
Office of Behavioral Health Services
Tina Kotek, Governor

Oregon Health Authority

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December 19, 2023

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 180
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled *Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain*.

The Oregon Health Authority (OHA) appreciates the role of the Secretary of State Audits Division in providing oversight of Oregon's State funded programs on behalf of taxpayers and the people we serve. The scope of this audit was: whether grants and funding were disbursed based on measure priorities; whether grants and funding went to culturally specific and linguistically responsive organizations; barriers that exist for Black, Indigenous, and people of color grant applicants; applicants that were denied and why; whether governmental entities supplanted or substituted M110 funding for local funding; the organizations and agencies who received grants and what amount they received; what proportion of grants received by grantees was devoted to administrative costs; the total number of entities that applied for funding; and, what money remained after grants and funding were disbursed.

OHA appreciates the identified need for improved data from Behavioral Health Resource Network (BHRN) partners. Using lessons identified sending COVID-19 funds to Community Based Organizations, OHA made an intentional commitment to BHRN partners to keep administrative burdens low using a phased approach to program data collection and a simple template for financial reporting. As OHA implements these recommendations, the agency will continue to strive to minimize administrative burdens on BHRN partners to the greatest extent possible while continuing to ensure program integrity and impact.

Below is our detailed response to each recommendation in the audit:

RECOMMENDATION 1 Develop a strategic plan with specific M110 outcome metrics and timelines and present it in the 2024 legislative session. Consider working with outside researchers for outcome evaluation if needed.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	02/01/2024	Jackie Fabrick

Narrative for Recommendation 1: OHA agrees to create and present a draft strategic plan specific to outcome metrics to the legislature in the 2024 session with a finalized version by August 1, 2024. OHA sees this plan as an opportunity to use the experience and knowledge gained over the first 18 months of this grant with our 230 BHRN Partners, and their capacity for data collection. It is OHA's goal to set strategic parameters around data collection, managing expectations around the type of data that is appropriate to collect, modifying our systems to collect data needed for outcomes metrics, and the role administrative burden plays in the provision of service. Due to the timeline of the 2024 legislative session, OHA cannot contract with an outside research expert prior to session, but OHA will consider that recommendation for future work.

RECOMMENDATION 2 Work with providers to better track and report: a. Specifics on staffing, service expansion, and capital projects; b. Youth services and virtual services; and c. The availability of culturally and linguistically specific services.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	July 1, 2025	Kristen Donheffner

Narrative for Recommendation 2: OHA agrees and acknowledges that reporting on the expansion of staffing and services are important measures to track. OHA continues to balance collecting high-quality data and the administrative burden on BHRN Partners to report on their program activities. The Measure 110 team will ask BHRN Partners for a count of the number of newly hired positions beginning in the Quarter 5 expenditure reports (for services provided between July 1, 2023 – September 30, 2023). The Measure 110 team has also worked to ensure that all BHRN Partner budgets are uniform and that all funded positions are listed including their corresponding salary and FTE for the grant extension period, beginning January 1, 2024. The program will add a question about how Measure 110 funding aided in the expansion of services to the Quarter 7 expenditure report, corresponding with the grant extension period (January 1,

2024 – June 30, 2025). BHRN Partners will be asked to provide a retrospective answer to both questions of hiring and service expansion for all quarters in the final report for this grant.
Current and future data collection efforts include client age, which allows OHA to report on services provided to youths. Additionally, Quarter 5 reporting included an opportunity for Partners to identify if they provide outreach services to K-12 schools and/or minors. Future report forms, starting in the Quarter 7 grant extension period, will include an option for Partners to select if they provide services in-person, virtually, or both, and if they provide culturally and linguistically responsive/specific services.

However, OHA would like to note that in evaluating and selecting applicants for BHRN funding, the Measure 110 Oversight and Accountability Council (OAC) could not consider race, gender, or other protected identity of the applicants, because to do so is unlawful under the Equal Protection Clause of the 14th Amendment to the U.S. Constitution. Rather, the OAC could appropriately consider what types of services were proposed in the applications, such as whether applicants proposed to provide services to historically underserved populations in alignment with Measure 110's purpose.

RECOMMENDATION 3
Work with providers to improve the consistency and reliability of service expenditures and client data.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	June 30, 2025	Kristen Donheffner

Narrative for Recommendation 3: OHA agrees that technical assistance and partnership are the keys to successful grant administration. The Measure 110 team will continue to provide 1:1 guidance and technical assistance throughout the end of this funded grant cycle, June 30, 2025, to BHRN partners when appropriate to facilitate the collection of high-quality expenditure and programmatic data. These efforts also include developing a roadmap for improving our data collection systems to better support this and other recommendations. With the addition of new Measure 110 grant administration staff, the capacity for technical assistance to our 230 BHRN grantees will increase over time. The Measure 110 team seeks to continually improve reporting templates and internal processes in response to partner feedback and SOS recommendations.

RECOMMENDATION 4
To improve the application and review process moving forward: Work with communities and providers to identify the most critical service gaps by county and barriers to increasing services.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	July 1, 2025	Jessica Carroll

Narrative for Recommendation 4: OHA agrees that identifying critical service gaps and barriers increasing services is important to improve the state's behavioral health and substance use treatment system. OHA is conducting a residential and facility study, due June 2024, and a SUD financial analysis, due April 2024, that will help the agency better identify service gaps and barriers to care. Additionally, under HB 2513 (2023), local alcohol and drug policy committees have been directed to coordinate with BHRNs to identify needs and establish priorities for alcohol and drug prevention and treatment services and report their findings to OHA. Together, these analyses will be presented to the Measure 110 Oversight and Accountability Council to inform their decision-making process in the future. OHA will also incorporate the results of these analyses and any identified gaps into the 2025 Measure 110 BHRN Request for Grant Application (RFGA) process to better inform the community of cri tical opportunities. By statue, the Oversight and Accountability Council **is** the sole body that can award Measure 110 funding.

RECOMMENDATION 5 To improve the application and review process moving forward: Make the application clear and direct and improve review process transparency and consistency.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	December 31, 2024	Jessica Carroll

Narrative for Recommendation 5: OHA agrees that a clear and direct grant application is essential. Acting on Recommendation 3 from the SOS Real Time Audit (January 2023) and the agency's newfound authority from HB 2513 (2023), OHA will work to ensure that the next iteration of the BHRN grant applications includes standard grant requirements including a statement of work, uniform budget documents, and enforced word counts. The M110 program will also work to create clear documentation that Measure 110 Oversight and Accountability Council can complete to accompany funding decisions and discussion in their public meetings. Taken together, these steps will ensure the application and review process is transparent, consistent, and clear to the public.

RECOMMENDATION 6 To improve the application and review process moving forward: Require providers to clearly detail what they plan to do with M110 funds and their experience, capability,

and plans for providing services to clients from linguistically diverse or culturally specific backgrounds.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	July 1, 2025	Jessica Carroll

Narrative for Recommendation 6: OHA agrees that the new grant application should include a detailed statement of work outlining how providers will provide Measure 110 services with specificity regarding how they will render services to clients who are culturally and linguistically diverse and how they will utilize funds to ensure the services are provided. Using the new authority under HB 2513 (2023), OHA will require all future BHRN applicants include a detailed statement of work as part of their application, including detailed information on how applicants plan to provide culturally and linguistically specific/responsive services. In addition, there will be detailed and standardized budget documents in the new grant application process that will ensure all applicant budgets are clear and directly speak to the statement of work provided.

For any questions, please contact:
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Sincerely,

Ebony Clarke, Behavioral Health Director
Health Systems Division
Oregon Health Authority

cc: Dave Baden, Interim OHA Director
Kristine Kautz, OHA Deputy Director
Janelle Evans, Interim OHA Chief Financial Officer
Vivian Levy, Interim OHA Medicaid Director
Sam Byers, OHA Adult Behavioral Health Director
Shawna McDermott, Interim OHA Health Systems Division Director

MEASURE 110

Oversight and Accountability Council

O'Nesha Cochran, OAC Tri-Chair
www.oregon.gov/oha/HSD/AMH/Pages/OAC.aspx

February 8, 2024

The OAC would like to thank the Oregon's Secretary of State Auditor's Office for its trauma-informed diligent overview of the Drug Addiction Treatment and Recovery Act (Measure 110). Although there can be differing perspectives of this work, we can agree that all parties involved value the overarching dedication to create and maintain a valuable behavioral health care system that addresses equitable addiction, assessment, and various treatment options for those struggling with substance use disorders. For that we all can agree and for that reason, we thank you for your time, effort, and expertise in evaluating the outcome of this measure.

The audit found that the amount of youth, residential treatment and culturally specific providers who serve populations most affected by the war on drugs was unclear. It is our intention to ensure that we improve the BHRN dashboard in these areas of reporting so those services can be highlighted and easily accessible. The OAC funded dozens of youth service providers, organizations who offer Inpatient Rehab and/or sober living houses and culturally specific providers. A substantial percentage of these organizations serve more than one county providing these services as far as their resources can reach.

All the providers are listed on the BHRN dashboard which can be found here: BHRN DASHBOARD. We see now it would be more accessible if there was a blurb for each organization that would highlight their services and targeted populations. However, here is a list of providers who provide culturally specific services, youth services and/or inpatient or recovery housing. We encourage anyone to check out their websites as there you will find out about the life saving work, they are doing for M110 dollars.

Culturally Specific Recovery Programs Serving those most impacted by the war on drugs are:
Burns Paiute Tribe, Coquille Indian Tribe, Coquille Indian Tribe, Ct Coos, Lower Umpqua, Siuslaw, Grand Ronde, Klamath Tribes, NARA, Siletz, NPAIHB, Siletz, Umatilla, Warm Springs, the Miracles Club, Juntos, Women's First Transition and Recovery Center, La Clinica, Painted Horse Recovery, Centro Latina Americano, Central City Concern Puentes, Fresh Out Community Based Reentry Program, Going Home II, Just Men in Recovery, Northwest Instituto Latino, Latino De Adicciones, Oregon Change Clinic, SoValTi, Yasiins LUV, The Stronghold, Northwest Family Services, Transcending Hope, Medicine Wheel Recovery, HIV Alliance, Centro Latino Americano, Virginia

Garcia Memorial Health, MetroPlus Association, Phoenix Wellness Center, Transformations, and Medicine Wheel Recovery.

We categorize those most impacted by the war on drugs as individuals, who were poverty stricken due to the early onset of the crack cocaine epidemic, well into the era of the fentanyl crisis and identify as having a substance use disorder. This unfortunate title is held primarily by Blacks or African Americans, Latinx Communities, Indigenous tribal, transgender, queer, urban, underserved rural communities and poor Whites.

A culturally competent health care system can help improve health outcomes, offer effective care, and can contribute to the elimination of racial and ethnic health disparities. Although we funded dozens of culturally specific organizations to support this work, we understand that there should have been more. However, we also recognize that white constituents heavily populate Oregon. Unless a clear ratio is completed to contrast the number of actual citizens residing here by race with the ratio of culturally specific providers we funded, it will not give a clear picture of whether we funded enough or whether we funded all that were eligible.

According to the latest consensus found here: https://worldpopulationreview.com/states/oregon population.
Those demographic statistics are:
White: 80.69%
Two or more races: 7.74%
Asian: 4.44%
Other race: 3.77%
Black or African American: 1.85%
Native American: 1.1%
Native Hawaiian or Pacific Islander: 0.41%

If we take these demographics into consideration, we think the amount of culturally specific providers funded is noteworthy.

We also funded several organizations who offer inpatient rehabilitation, housing, counseling, therapy, and outpatient peer recovery counseling to our youth. Those BHRN providers are, CORE, New Avenues for youth, 4th Dimension Recovery, Youth Era, Morrison Child and Family Services, Northwest Family Services, Youth Empowerment Shelter, Family Nurturing Center, Parrott Creek Child and Family Services, Clatsop Behavioral Healthcare, Transformations, Columbia Community Mental Health, Adapt, Rimrock Trails Treatment Services, Deschutes County Health Services, Symmetry Care Inc, Mid-Columbia Center for Living, Community works, Options for Southern Oregon, Lake health District, Center for Family Development, Centro Latino Americano, Looking Glass Community Services, South Lane Mental Health Services, White Bird Clinic, Phoenix wellness Services, Lifeways, Center for Human Development, Yamhill Community Action Partnerships, Yamhill County

HHS, Family Tree Relief Nursery, Family Recovery Inc, Harmony Academy Recovery, Outside In, Community Works, OnTrack, Inc., The Pathfinder Network, Grace Roots, Center for Family Development, and OSLC Developments, Inc.

The audit highlights the lack of residential treatment in Oregon. BM110 specifically calls for funding programs/activities not otherwise covered by insurance (Medicaid). Medicaid funds residential treatment. However, the OAC did fund costs for some residential/detox programs that would not be otherwise reimbursable through Medicaid. OAC also funded recovery housing, which is often used in conjunction with outpatient treatment as a quasi-replacement for residential treatment beds. Moreover, most residential treatment closures in Oregon have not occurred primarily due to a lack of funding, but rather a lack of qualified staff, and in the case of youth residential, sufficient referrals (especially during COVID).

We also think it is important to share about the success of transitional, stabilization, and/or recovery housing and how it can be utilized as an alternative to *traditional* inpatient treatment. Many consumers may find it difficult to thrive within inpatient treatment, as it *can* be a sterile, isolated, experience that does not take into consideration the social and behavioral health identities that come with many years of substance use, prison and houselessness. Although these life experiences are not ideal or comfortable, they do create a person with many characteristics that have honed them into the person they are today. Historically treatment centers have been unable to develop a culturally sensitive curriculum or atmosphere to receive many of the subcultures that are developed from a lifelong history of substance use.

For this reason, transitional recovery housing was created and works well for this population. The standard rules for a traditional recovery home in Oregon, is that it is peer led. The house manager is in recovery themselves and is the first primary example of what living a new life without drug use can be like. Everyone else in the house is in various stages of abstinence and abstinence is required for the participants to remain living in the recovery home.

Tenants of these homes have some autonomy of a private living space and are required to engage in outpatient recovery support, find employment and follow a curfew. It is found that with this structure to support participants to acquire short term attainable goals while living in the home with other people who are striving to remain abstinent *can* be successful. Surrounded by natural supports every day can have life sustaining impacts on the way they view daily challenges *while* learning to say no to the temptations of substance use. We define Natural Supports as: personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships; friendships reflecting the diversity of the recovery journey and the community.

The OAC funded many of these organizations who offer sober housing in more than one county and all of them have had success stories.

SAMHSA recently released "Best Practices for Recovery Housing.' LAPPA and the White House Office of Drug Control Policy has recently released their Model Legislation for Recovery Housing, including a fact sheet supporting recovery housing as an evidence-based practice, Recovery Residences Fact Sheet (legislativeanalysis.org).

Examples of recovery housing in Oregon are:

Level I (peer-run) – democratically run. Offers drug screening, house meetings, and attendance at self-help meetings (12-step programs) are encouraged. There are no paid positions on staff, it is an all voluntary, peer-run organization.

Level II (monitored) – house manager or senior resident acts as administrator. Offers peer-run groups, drug screening, house meetings, and involvement in self-help and/or treatment services. Includes at least one compensated staff position.

Level III (supervised) – administered by an organization which provides oversight for service providers and may be licensed by the state. Provides life development skills, clinical services, and service hours are provided in-house. Includes a facility manager and certified staff or case managers.

Level IV (service provider) – organizational hierarchy that provides clinical and administrative supervision. Must be licensed. Clinical services and programs are provided in-house. Offers life skills development. Staff are credentialed.

SUD services awarded via BM110 funding were all required to employ research-based evidence-based practices. The practices derived from SAMHSA, the Substance Abuse and Mental Health Services Administration, such as Contingency Management and Motivational Interviewing. Nonetheless, the SUD field in general is consistently asked to "prove" that their services are effective at a granular level. General health services and mental health services are rarely required to provide "proof" that their billable services are effective to the extent that research-based SUD programs are asked to continually justify their existence.

Those who suffer with substance use disorder come with many social determinants of health. Social determinants of health are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. This population may have experienced a tremendous amount of prison time, various trauma, or chronic homelessness. It is also likely this population may have suffered abandonment and the condition they share is proven to be a family disease. Individuals may struggle coming from an isolated, sterile treatment environment only to be released too the stressors of sustaining a pro-social life.

Recovery housing offers access to the same support as in inpatient treatment, while teaching these individuals to build the stamina to know how to navigate life on life's terms *while* being surrounded by others like them who have achieved and are role-modeling in real time a life of recovery. Recovery houses that are peer led offer a curriculum that is peer driven and can be just as stabilizing as traditional treatment institutions.

The BHRN offers both options. Here is a list of the providers we funded who offer inpatient rehab *and/or* the recovery housing model: Transformations, New directions N.W., Family Recovery Inc., Bridges to Change, Cascadia Behavioral Healthcare, Northwest Family Services, Parrott Creek Child and Family Services, Recovery works Northwest, the Miracles Club, Transcending Hope, Volunteers of America Oregon, Clatsop Behavioral Healthcare, Iron Tribe, Columbia Community Mental Health, Medicine Wheel Recovery, Adapt, Bay Area First Step, HIV Alliance, Best Care Treatment Services Inc, Rimrock Trails Treatment Services, Community Counseling Solutions, Addictions Recovery Center, Columbia Care Services, Grace Roots, OnTrack Inc., Options for Southern Oregon, the Family Nurturing Center, Klamath Basin Behavioral Health DBT of Klamath CFT, Daisy C.H.A.I.N, Housing our Veterans, Looking Glass Community Services, Veterans Legacy, Samaritan Treatment and Recovery, Community Services Consortium, Samaritan Health, Lifeways, Bridgeway, The insight alliance, Polk County, Mid-Columbia Center for Living, Rinehart Clinic and Pharmacy, Eastern Oregon Alcoholism Foundation, Wallowa Valley Center for wellness, Lifeworks Northwest, CODA, Sequoia Mental Health, Providence Newberg Medical Center, Virginia Garcia Clinic and the Yamhill County HHS.

The audit stated a concern that BHRN providers had to increase spending over time and the first year lacked fully spending of the allotted program budgets. Which raises risks that some of Oregon's 42 networks may not provide all the required services. Our interpretation of the audit was that they focused less on the OAC and Contracts process for awarding funds and timelines, and more on the BHRN providers themselves spending the funds once they received them. There is a process to allocate funding to over **233** organizations. Planning, Solicitation, formulation (creating an application), award negotiations, presentations, voting for the public and finally execution of the actual funding process. Although the timeline moved to a later date than we initially were striving for, it was not due to lack of due diligence.

The audit discussed community-based organizations. At least a third of our applicants were CBO's who had never done work of this magnitude before and many of them we funded. The OAC provided free Tech support for these organizations at request. We saw the value in supporting Community Based Organizations. They may have never had the financial support to function on this level. But we never doubted their ability, passion, expertise, or cultural agility to do this work. Contracts and Procurement is efficient despite the time it takes to complete the funding process, we value their steadfast approach to see these contracts through to existence. We understand that some of these nuances as it pertains to delays could not be avoided. It comes along with the territory of creating an entire behavioral health network system in *every* county in Oregon. After the funds were allocated, it took

the BHRN provider's time to hire staff required to do the work. However, despite the delays and growing pains, we were successful and have in operation forty-two **complete** BHRNs that offer all required service areas.

The OAC funded evidence-based services provided to treat substance use disorder and increase access to life saving harm reductions. According to SAMHSA, evidence-based services include Cognitive-behavioral therapy (CBT), Motivational Interviewing, Acceptance- and mindfulness-based interventions, Contingency management, Twelve-step facilitation therapy, and assessment/referral to Medication Assisted Treatment. All these services are offered with Peer-to-Peer recovery counseling, inpatient treatment, and outpatient treatment. Each is offered in every BHRN. If someone is receiving peer recovery services, they are receiving evidence-based practices. According to the study below: "Most studies reported statistically significant findings indicating that participants receiving the peer intervention showed improvements in substance use, a range of recovery outcomes, or both."
Ellen L. Bassuk, Justine Hanson, R. Neil Greene, Molly Richard, Alexandre Laudet, Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review, Journal of Substance Abuse Treatment, Volume 63, 2016, Pages 1-9, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2016.01.003.

And here is another study about Adult Addiction Peers we think is valuable to explore. It states: "The studies demonstrated increased treatment retention, improved relationships with treatment providers and social support, increased satisfaction, and reduced relapse rates."
Tracy K, Wallace SP. Benefits of peer support groups in the treatment of addiction. Subst Abuse Rehabil. 2016 Sep 29;7:143-154. doi: 10.2147/SAR.S81535. PMID: 27729825; PMCID: PMC5047716.

To become a trained Addiction Peer Specialist, you must complete an OHA certified training course that trains all those certified with these skills. Every Peer mentor service counted includes these evidence-based services as well. And that does not include the inpatient treatment interventions available within the BHRN, which are also receiving this care on a more intense level. Contemporary studies show the effectiveness of peer mentor services and correlate their value with success. Government websites will list twelve step recovery groups as being effective in treating SUD. And all twelve step recovery meetings function from the perspective that one addict helping another addict get clean is without parallel. Furthermore, although there is limited scientific study to back up peer mentor services, we only need to look at history and progress to know it works.

In 1935 a stockbroker named Bill was struggling to stop using alcohol and he met a doctor named Bob. Bill described his addiction as: "My whole life seemed to be centered around doing what I wanted to do, without regard for the rights, wishes, or privileges of anyone else; a state of mind which became more and more predominant as the years passed."

Bill found recovery first and showed Bob how to also find sobriety. Once they both became free from substance, they began to mentor other addicts who were also suffering. It was a remarkably uncomplicated process; *I know what you have been through, and I can help you to change your life.*

That was 89 years ago, since then this same model is used and recognized in over *180 different NATIONS*. This non-complex method of mentorship has been supporting millions of people worldwide to maintain and practice abstinence, via sponsorship (or **mentorship** which are extremely similar concepts.)

Worldwide government funded, addiction treatment, websites will give credit to twelve step recovery meetings, which are peer led and peer run, they will acknowledge that they indeed work and at times, they will make it a requirement for treatment programs to require participants to attend these groups. They see the benefits*, implement the structure of the peer led movement yet,* **professional peer mentors** are still fighting for the *evidence-based label* which can be quite frustrating.

In closing we would like to acknowledge and thank the state auditors' team and all who invested in creating this council and made it possible for us to address this tragic epidemic that is affecting our community. Serving this population is an honor. Everything we do is out of our dedication to see individuals learn new skills and live a sustainable, harm reducing, healthier life. We understand the magnitude of the assignment and we are also aware that our behavioral health system has flaws that interfere with our ability to offer the best optimal care. The OAC's mission is to implement evidence-based practices for those who have been most impacted by the war on drugs. We are invested in the process and outcome now and in the future and are always open to new ways we can improve behavioral health care systems to better serve our community.

OREGON SOS

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