

**Zeroing In On Recovery and  
Resilience in Oklahoma (ZORRO)  
Final Workgroup Recommendations  
October 1, 2013**

The Oklahoma Department of Mental Health and Substance Abuse Service thanks each and every participant of last spring's ZORRO Summit and the workgroups who so diligently developed recommendations for improvement of the public behavioral health system in Oklahoma. The final group recommendation list was received last week! Leadership and management staff at the ODMHSAS have been working diligently to see how many of the recommendations involved policy and/or rate change requests, since the deadline for both is imminent.

The groups were asked to focus on recommendations with the potential to increase access to services, maximize resources, and ensure best quality of services.

This document is a summary of all the workgroup recommendations. Some of the workgroups prepared documents outlining their process and giving additional information. These documents will be posted on the ODMHSAS website along with this summary, by October 15, 2013.

**Inpatient**

- (1) Group therapy – change the requirement for process therapy to state just “group therapy “and not designate whether expressive or process. Add that the group therapy must be done by someone licensed or certified to provide the model.
- (2) Include the psychosocial evaluation in the first session requirement
- (3) Allow a higher level of service to be substituted for lower level services in 15 minute increments
- (4) Physician requirement to contact family members is best practice; however, need to set a standard on how many times the physician is required to try to contact if family is not available. Concern is that there will be recoupment if the physician cannot reach parents.
- (5) Allow physician's visit with the child to be a time when family contact is done by phone.

## Transition to Adulthood

### Goal 1: Improve Partnerships

Specific Recommendations	Time Frame
1. Appoint a transition-age specialist to participate in ODMHSAS's Community Based Services Adult Leadership Team, to help develop policies and practices for moving clients from children's services to adult services.	0-3 months
2. Create a funded state level advisory group made up of youth and providers. This group would tackle issues related to transition-age youth including, but not limited to: <ul style="list-style-type: none"> <li>• Developing a transition toolkit.</li> <li>• Creating MOUs to formalize partner commitments.</li> <li>• Aligning agency missions for transition-aged youth.</li> <li>• Developing coordinated training among all child-serving agencies.</li> <li>• Developing training standards for all transition-age service providers.</li> <li>• Developing a comprehensive joint plan for all youth aging out of the systems that cross over agency boundaries.</li> <li>• Developing matching paperwork requirements for Medicaid consumers.</li> <li>• Creating a way for transition-age youth to acquire or have access to their records electronically.</li> </ul>	3-9 months

### Goal 2: Develop Workforce

Specific Recommendations	Time Frame
1. Provide coordinated training among all child-serving agencies for providers who work with transition-age youth. This might include: <ul style="list-style-type: none"> <li>• Developing a coordinated training calendar for all agencies.</li> <li>• Developing a "Transition 101" course for all agencies' employees.</li> <li>• Developing a new employee training module concerning transition-age youth.</li> <li>• Marketing training opportunities to agencies and appropriate college students.</li> <li>• Developing training standards, skill sets, competencies, etc. so that all trainings are giving the same important information.</li> </ul>	> 9 months
2. Add required training modules to case management certification (and other agency certifications) for those who will serve transition-age youth.	> 9 months
3. Add trainings related to transition-age youth to ODMHSAS's Chapter 17 training requirements.	> 9 months

### Goal 3: Improve Access to Services and Supports

Specific Recommendations	Time Frame
1. Modify ODMHSAS’s contractual time restraints for Service Coordination work with transition-age youth because 4-6 weeks is not enough time to deal with their complex needs sufficiently.	0-3 months
2. Add language to ODMHSAS contracts that specifically addresses transition-age services. That is, all services to transition-age youth should be culturally competent and developmentally appropriate, and that these young people should have access to both children’s and adult services according to their needs.	9-12 months
3. Expand Medicaid to cover services to transition-age youth.	> 9 months
4. Create a “Peer-Support” billing code to improve transition-age young people’s access to peer guidance.	> 9 months
5. Expand the contractual funding for SOC transition-age sites so they can hire adequate staff. The cost for this should be shared between ODMHSAS’s Children and Adult Services.	> 9 months
6. Create transition plans for every transition-age youth seeking services through CMHCs regardless of whether or not the youth is in wraparound	> 9 months

### Older Oklahomans

**Description** - Addressed in *Long-Term Goals, Themes and Strategies* are specialized services to specific groups; provide competent services to under-served populations; increase availability of culturally competent services; and develop a continuum of services providing access to the least restrictive appropriate service option. It is recommended that ODMHSAS recognize the current disparity in services and target older adults as a specific under-served population and create a culturally competent system of services in the least restrictive environment.

**Need** – Significant numbers of older adults suffer with mental health and addiction issues while very few access treatment. Culturally appropriate services are very limited; the workforce is not trained in geriatric care; and the system does not support a suitable service delivery network that meets the needs of older adults. To engage older adults in the mental health system, services need to be developed that are wraparound services, addressing older adult wellness and each of its components.

**Anticipated Outcome** – An improved and expanded mental health and substance use disorder system that includes older Oklahomans. The development of a *Systems of Care for Older Adults* that is comparable to the highly successful *Systems of Care* program.

**Integration into current system** – The development of wraparound services for older adults, or a Systems of Care for older adults, would require an increase and expansion of community supports and resources; recruitment of geriatric trained mental health professionals, or cross-training of current staff; and the development of a reimbursement rate system to support the specialized services. Oklahoma has the expertise and experience to construct and successfully implement and sustain an older adult program.

### **Medicare Optimization Plan**

**Description** – Medicare Optimization is a plan developed by the Oklahoma Mental Health and Aging Coalition, with technical assistance from the Geriatric Mental Health Alliance of New York, to optimize funding for older adult mental health services from Medicare.

**Need** – Providers may not fully understand Medicare rules and neither bill nor receive optimal funding. Training in the effective delivery, billing and coding for available mental health benefits under Medicare can increase access, availability, quantity and sustainability of mental health services.

**Anticipated Outcome** – Expert training that enables providers to increase their capacity to serve older adults with mental health conditions with financially sustainable models of mental health delivery. Additionally, providers no longer accepting Medicare and/or providers who do not currently accept Medicare may re-assess their decision, with the anticipated outcome of increasing the number of providers and the quantity of services available to older adults.

**Integration into current system** – This is an optimal time for this plan due to full parity being attained in 2014. A specific Medicare training event focusing on Medicare mental health and substance abuse services can be developed or it can be included in provider trainings offered on a regular schedule.

### **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)**

**Description** - Healthy IDEAS is an evidence based program designed to detect and reduce depressive symptoms in community dwelling older adults at high risk. The program is integrated into existing case management services.

**Need** – 1 in 5 older adults experience mental disorders with anxiety and depression being the most common. Older adults are among the fastest growing segment of Oklahoma's population. Oklahoma seniors' health status is among the lowest in the nation with senior health ranking 49th and the state ranking 43rd. (America's Health Rankings 2012) The connection between unhealthy bodies and unhealthy brains is well established.

**Anticipated Outcome** – The case manager screens for depression and, if indicated, for suicide; provides education about depression, treatment and recovery; provides linkage to resources or referrals; engages consumer in behavior activation, with the anticipated outcome of the reduction of depressive symptoms; and re-assesses symptom management.

**Integration into current system** – Healthy IDEAS has been implemented on a small scale in Oklahoma to Advantage Case Management Agencies. Oklahoma has two Certified Regional Trainers available to expand the program to additional case management agencies.

### **Older Adult Peer Support Specialty**

**Description** – Following certification, current peer support specialists could choose an additional area of specialty to become an older adult specialist.

**Need** – Older adults do not access and are unfamiliar with the mental health and substance abuse networks. An older adult peer support program could provide an introduction to the system, assist in navigation and would be less threatening to this population.

**Anticipated Outcome** – The engagement of older adults in treatment and recovery. The implementation of this program would address the serious workforce issues – that of a shortage of professionals as well as the lack of professionals trained in geriatric issues.

**Integration into current system** – Oklahoma has a certification process in place for Peer Support Specialists. Specialists would complete the certification process and have the option for additional training to become certified with an older adult specialty. An Older Adult Peer Support Specialty curriculum has been developed by Dr. Cynthia Zubritsky at the University of Pennsylvania which could be utilized, or Oklahoma could develop their own curriculum.

### **SBIRT** (Screening, Brief Intervention and Referral to Treatment)

**Description** – An evidenced based program used to address alcohol and medication misuse and abuse through screening and preventative motivational brief interventions. SBIRT can effectively reduce at-risk drinking and address issues of prescription medications and illicit drugs.

**Need** – Aging bodies are more vulnerable to alcohol and older adults may be prescribed as many as 10+ medications to manage numerous chronic diseases. Information about weight, aging organs, decreased muscle mass, medications and over the counter medications are critical to the decision-making process of older adults regarding alcohol consumption. Additionally, the amount of alcohol that can be safely handled in an aging body is critical education for older adults and family members, as well as facility staff.

The culture of individuals who are now older adults supported regular alcohol consumption, but does not recognize necessary adjustments in the amounts consumed due to an aging body.

**Anticipated Outcome** – Older adults are perfectly capable of making good decisions about their health and well-being, but they need the appropriate information from a variety of sources in various settings.

**Integration into current system** – While a physician’s office is the most ideal setting, SBIRT can and should be promoted in senior centers, nutrition sites, health fairs, aging events, conferences, assisted living and retirement communities.

## **Programs of Assertive Community Treatment (PACT)**

### **Goal 1: Improve Access to Services and Maximize Supports**

#### Specific Recommendations

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1. Expanding the admission criteria to include other SMI diagnoses. Requiring at least 80% of the consumers to have a psychotic disorder. Priority will continue to be given to individuals with a psychotic disorder (schizophrenia, schizoaffective & bipolar) and individuals without a psychotic disorder shall be evaluated and admitted based on need.
2. Each team shall be required to use the same referral form and adhere to a uniform screening and admission process. This would include requiring:
  - The referral source to send information on all the admissions to their facility,
  - Changing the hospitalization criteria from 4 hospitalizations in the last 24 months or lengths of stays totaling over 30 days in the past 12 months to 4 hospitalizations or lengths of stay totaling over 30 days in the past 24 months which can include:
    - not attending scheduled appointments and/or not taking their medications
    - frequent ER visits or the police taking them to the crisis center but they do not meet admission criteria
    - being in jail/prison and receiving mental health care
3. Expand Medicaid to compensate for visits that are under 8 minutes (when consumer doesn’t want staff to say, well checks, medication deliveries/prompts). Perhaps a PACT service event code. If this is not possible, perhaps this is something that ODMHSAS could fund.
4. Initial screenings are very time consuming and due to safety reasons, may require 2 staff. For non- Medicaid consumers, could contractual funding be expanded to compensate for this service. In addition, expand Medicaid to allow for billing before they are admitted. In addition to being compensated for the screening, allow for case management units for the team to research, request records and communicate with the referral source. If this is not possible, perhaps this is something that ODMHSAS could fund this service for Medicaid consumers as well.

5. Expand ODMHSAS contractual funding to include the following:

- 6 visits= \$950
- 4 visits= \$725
- 3 visits= \$362.50
- 2 visits= \$241.61
- 1 visit= \$120.50 (for consumers who are stepping down)

State teams would like to be compensated in the same manner as the private teams.

6. Expand ODMHSAS contractual funding to include a compensation method for teams that admit over 92 consumers. Currently, if a large team billed over 92 consumers, their total contract amount would not compensate them.

7. Change Chapter 55 staffing requirements:

- Change the rules to reflect that the team maintain a 1:10 ratio and not be as specific about the number/title of positions.
  - Currently, a large team (up to 100) requires 10-13 direct service staff and the average census is 85. A small team (up to 50) requires 8-10 direct service staff and the average census is 36.
  - Exclude Team Leader and Assistant Team Leader from the staff count for caseload. This would allow more time for screenings and clinical supervision.
  - Instead of 2 additional licensed staff, allow for more CM's. They cost less and 1 licensed staff would be able to handle the therapy needs. Licensed staffs on PACT teams are usually providing IR and CM.

## **Systems of Care (SOC)**

### **Four recommendations:**

- 1) The ability to do intakes, assessments, and treatment plan development via telehealth. This would address issues around accessing services, it would improve outcome for Oklahomans in rural and frontier areas, and it would account for some of the workforce issues (i.e. lack of Master's level clinicians who are willing to do community based services, etc.).
- 2) Ask the state to hire a child psychiatrist and Master's level providers and let the agencies buy time in it. Look at Dr. Nathan Davis, who is finishing up his residency.
- 3) Increased access to crisis stabilization resources:
  - a. Look at the possibility of creating some 23 hour crisis stabilization placements (similar to what the adult systems do with the Urgent Recovery Centers) to help prevent youth from going to higher levels of care. These could be located in residential settings (look at the possibility of modifying their contracts to encourage this).

- b. Look at the possibility of funding “Emergency Mental Health Responders”, similar to EMSA. Hire Bachelor’s and Master’s level people who can respond to emergency mental health crises in the community and who have the ability to access telehealth services in a van for assessments.
- 4) Increased use of psychologists and psychological evaluations for youth who are very high need. This would give the families of these children the necessary tools to have a better understanding of their child’s behavior/situation, which might decrease the burden on other systems (such as inpatient providers) and could assist in future diversion. This would be similar to the need for a MRI for those kids who have medical issues that would warrant such a test.
- a. Ability of Psychologists to bill for evaluations while the youth is inpatient.
  - b. Inpatient facilities, per contract and when necessary, will coordinate evaluations to be done with a psychologist.

### **Evidence-Based Practices**

1. Recommend that Oklahoma develop a trauma informed organizational change training model for the CMHC system that is cost effective.
2. Recommend that for evidence based group therapy that requires two staff to facilitate that the group size be increased to twelve (12) for adults and eight (8) for children.
3. Recommend that the rate for evidence based group peer support services currently at \$1.45/15 minutes be increased to \$4.50/15 minutes, the same as the wellness group rate currently set at \$4.50/15 minutes.

### **Rural Workgroup**

#### **1) Recommended Rule/Policy Changes:**

- A. Being able to utilize telehealth for diagnosing/therapy:
  - Jeff followed up with Jackie Shipp and telehealth can be used for therapy and for assessments.
- B. Allow inpatient providers to utilize telehealth for family therapy sessions.
- C. Increased rate for rural providers to help offset the cost of travel and providing services to the rural areas.
  - There is public transportation in the urban areas, but this is not the case in rural areas. Transportation can be a huge, costly barrier in order for families to access services. Also, look at an increased rate for rural providers to help offset the cost of services.

- D. Consider changing the current Medicaid standards to allow for billing of outpatient services while a youth is inpatient; this is actually when the family needs the most help.

## **2) Greater and more flexible use of paraprofessionals:**

- Jeff pointed out that based on the current rate, FSP's can't even support their own salary based on what the reimbursement is. Jeff did some math, and came to the conclusion that FSP's would need a little over 5 hours/day to break even on what that position costs; this doesn't include all of the services that the FSP does that's not billable to Medicaid (ie travel, being at a meeting with the CC, etc). This is all dependent on how much they make (Jeff based this off of \$28,000/year salary). This poses a challenge for that position. See Jeff's attachment for additional details.

Look at using Family Support Providers (FSP's) beyond just the scope of Wraparound as more of a community provider.

- A. Look at designing new paraprofessional positions based on the FSP and RSS positions as models, i.e., PA (physician's assistants, dental assistants, etc.). These positions would need to be directly supervised by someone who's a LBHP.
- B. Consider opening up the current paraprofessional codes (i.e., FSP, RSS, BHA, etc.) to allow for Medicaid entities (i.e., CMHC's, youth service organizations, etc.) to hire for these types of positions.
- C. Open up the RSS code to allow for providing services to children (currently it can only be utilized for 18 and up).

## **3) Trainings and workforce development/recruitment:**

- A. Focus on outreach to high school students and college students regarding their interest in the psychology field.
- B. Improve outreach to hospitals and private providers to offer them trainings and monitoring of evidence based practices.
- C. Revise current standards for ODMHSAS to influence the licensing board to consider supervision for licensure be done via video conference on a case by case basis.
- D. Partner with/offer outreach to local community taskforces as a way to offer community trainings.

## **Infant and Early Childhood**

- 1) **Develop a workforce with specialization in Infant and Early Childhood Mental Health (IECMH) founded on the *Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (Endorsement) competencies* (<http://www.okaimh.org/>).**

- Adopt nationally recognized standards (Endorsement) in the definition of provider qualifications
  - Incentivize providers to pursue Endorsement by tying qualifications to reimbursement
  - Establish, through collaborations to braid funding, the training and reflective supervision/consultation structure to support Endorsement
- 2) **Redefine and align the ODMHSAS and Medicaid billing systems to support IECMH best practices including promotion, prevention, early intervention and treatment required within an early childhood system of care.**
- Adopt Colorado's *Ten Standards for Best Practices in Early Childhood Mental Health: Creating Continuity in Early Childhood Mental Health Services Between Medicaid and Other Funding Sources* in Oklahoma for all services for children under age six  
<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline%3B+filename%3D%22Early+Childhood+Best+Practices+2012.pdf%22&blobheadvalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251795239109&ssbinary=true>
  - Require the most current version of the *Diagnostic Classification of Mental and Developmental Disorders of Infancy and Early Childhood* as the primary diagnostic tool for families with infants and young children, including updates to the existing crosswalk and ongoing provider training and support in using the tool  
<http://www.zerotothree.org/child-development/early-childhood-mental-health/dc-0-3-revisions.html>
  - Continue ongoing efforts to integrate knowledge of IECMH best practices within the billing and authorization processes
- 3) **Utilize IECMH best practice standards, billing and provider qualifications to support the OKDHS Pinnacle Plan to address the needs of the largest cohort of children in out-of-home placement in Oklahoma.**
- Establish a funding/billing structure for current “non-billable” supports and services identified as best practices for families with infants and young children in the child welfare system (e.g. case management, court time, frequent and meaningful visitation to support early relationships, etc.)
  - Infuse best practice IECMH standards within the broader child welfare system to include courts, legal, child welfare, mental health, foster care, CASA, early care and education, pediatrics, SoonerStart, schools, etc.

- Develop a sustainable funding structure for certified Child Parent Psychotherapy (CPP) learning communities to support evidence based practice in addressing early childhood trauma  
[http://www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/Child Parent Psychotherapy CPP fact sheet 3-20-07.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/Child_Parent_Psychotherapy_CPP_fact_sheet_3-20-07.pdf)

## **Recovery Oriented System of Care (ROSC)**

### **Tier One Priorities**

It was asked that these recommendations be implemented and/or addressed immediately:

#### **1. CAPACITY**

- A) Creating a Statewide Housing Association
  - a. Providing more housing at all levels.
    - i. Oxford House.
  - b. Creating an oversight group to address housing alternatives.
- B) Streamline access to services
  - a. Reduce wait lists.
  - b. Ensure “no wrong door” philosophy exists.
- C) Increase the billable service array for all service levels
- D) Create and/or increase family services
  - a. Create services specific to family members.
  - b. Increase family therapy options.

#### **2. CAPABILITY**

- A) Develop a trauma informed field
  - a. Create a trauma informed continuum of care.
  - b. Identify best practice models and provide ongoing training.
- B) Create/enhance programs for long term and ongoing support for consumer success
  - a. Enhance peer advocacy options.
  - b. Create family peer recovery support alternatives.
- C) Develop wrap around services
  - a. Provide full service array.
  - b. Address all identified issues for each consumer.

### **3. COMPETENCY**

- A) Create an Integrated Resource Center
  - a. A community based system of services that is
    - i. family-centered,
    - ii. comprehensive,
    - iii. coordinated,
    - iv. efficient
    - v. culturally competent and
    - vi. family and consumer run
- B) Appropriate and accurate use of ASAM PPC 2R
- C) Empower consumers through enhancing self-efficacy

### **TIER TWO PRIORITIES**

These are recommended to be addressed immediately if at all possible. If not, this set of recommendations should be introduced as time and resource give each recommendation a good chance of successful implementation.

#### **1. CAPACITY**

- A) Continue to increase housing with children options.
- B) Continue to increase housing options.
- C) Education.
- D) Employment Support.

#### **2. CAPABILITY**

- A) More structured housing (see above)

#### **3. COMPETENCY**

- A) Coordinating service delivery by utilizing existing community resource.
- B) Develop Agency/provider coalitions.
- C) Reduce stigma.

### **Front Door**

#### **I. Front Door Identified Priorities**

- 1. Streamlined process for access to outpatient and inpatient services
- 2. A standardized screening tool and biopsychosocial and a concise biopsychosocial assessment meeting the requirements for ODMHSAS and OHCA *(these priorities were merged together)*

3. Recommendation to eliminate the “timed” portion of billing codes for the biopsychosocial
4. Recommendation to OHCA to create a billing code and rate for screening

## **II. Recommendations based on Identified Priorities**

Recommendation One: A streamlined process for access to outpatient and inpatient services

- a. It is the recommendation of the workgroup that there is a consistent process across the state regarding requirements. This way consumer have the same access to services across state and are able to contact a mental health professional who could triage and engage clients as quickly as possible.

Recommendation Two: A standardized screening tool and bio-psychosocial assessment meeting the requirements for ODMHSAS and OHCA.

- a. This would better assist consumers who change providers. The benefits of standardizing tool include the portability of assessment, consumer becomes familiar with structure of questions if they are repeatedly seek services or change providers- more standardized like other types of doctor visits, assessments from past being accessible and same tool continuing to be utilized also make it easier to identify what factors have improved or declined over time and increases the ability to detect potential red flags or symptoms that are not presenting or being reported by consumer
- b. Caveats - Looking at how standardized screening is impacted by health information exchange and privacy laws. Recognition that with EHR creating or recreating data fields can become very costly therefore if ODMHSAS or HCA could provide financial assistance to assist with expense of agencies having to recreate forms on their EHR.
  - ZORRO Front Door proposes that a separate documentation workgroup be created to follow up on assessments and tools. Group proposes looking at a few revisions to suicide questions, trauma questions, and rephrasing guardian and child/ adolescent related questions to make it clear as to who question is referring to. This workgroup should include representatives from state operated, community, private entities. Several members of this workgroup where willing to be a part of this group or appoint someone from their agency to serve on this group.

Recommendation Three: Eliminate the Current Time portion of Assessment and make it standard with other billing codes - using units

- b. Recommendation to eliminate the low and moderate “timed” portion of billing codes for the biopsychosocial assessment and replace with ability to bill in 15 minute increments (minimum 4 unit and max 12 units). Further recommendation is that the billing allows for assessment to be broken into multiple visits when the level of functioning, age of consumer, or other factors are presenting that would make multiple visits best care for consumer in question.

Recommendation Four: Create a billing code and rate for screening

- c. A good screening tool is valuable part of the assessment process and begins the process of identifying needs and matching services. It is therefore the workgroup recommendation that the ODMHSAS advocates to OHCA to adopt the practice of having a billing code for screening.

### **Jail Diversion and Reentry Programs and Services Workgroup**

Recommendations:

1. The ODMHSAS has recently been awarded a federal grant to provide more Crisis Intervention Training (CIT) to law enforcement. An analysis was conducted to compare those counties which have both the highest prison reception numbers as well as rates per capita to areas which CIT training has previously been provided. **It is a recommendation of the workgroup that the following law enforcement entities be specifically targeted for these new training opportunities:**
  - Atoka County
  - Comanche County
  - Cotton County
  - Creek County
  - Custer County
  - Greer County
  - Harmon County
  - Kay County
  - Lawton, City
  - Muskogee County
  - Okmulgee County
  - Pottawatomie County
  - Pushmataha County
  - Tribal Law Enforcement Entities
  - Tulsa Public Schools
2. Many pre-plea diversion/bond options have been developed over the last several years. These options provide offenders with the opportunity to participate in supervision or treatment in order to receive a release from jails pending their criminal case processing. Violations in the terms of these agreements often times have a significant negative impact in the final outcome of the criminal case. Participation in these agreements is typically those whom could not afford to bond out of jail or afford a private-pay criminal attorney. **It is a recommendation of the workgroup that legislation be written to identify that participation in pre-plea diversion/bond options impact only the ability for offenders to remain out of custody pending their criminal case processing and that violations of pre-plea agreements not negatively impact the final outcome of the criminal case.**

3. Post-plea diversion programs are operational in most of the state's jurisdictions including programs such as Community Sentencing, DA Supervision, Drug Court, Mental Health Court, etc. The workgroup identified the importance of ensuring that these diversion programs are targeting the appropriate offender population based on evidence-based risk and need principles. **It is a recommendation of this workgroup that a document be developed jointly by all agencies operating a diversion program, including but not limited to the ODMHSAS, DOC, and DAC, which identifies the target population of each of the subsequent diversion programs offered in the majority of the state's jurisdictions. In doing so the most efficient and effective use of diversion programs can be ensured**
4. Post-plea diversion programs operate within existing authorizing statutes which have been in place for many years with varying levels of modification. There is a growing body of research which identifies specific evidence-based practices within diversion programs. **It is a recommendation of the workgroup that a review be conducted on the authorizing statutes and operational practices of the diversion programs offered in the majority of the state's jurisdictions in order to ensure that the research-identified evidence-based practices are include.**
5. The workgroup identified a need for development of additional support networks for offenders released after county jail or prison sentences. The timeframe in which an offender is most likely to recidivate without intervention is within ninety (90) days post release. **The workgroup recommends the implementation of a sentence structure which releases offenders with at least ninety (90) days of post-release jurisdiction. Further, the workgroup recommends that all released offenders received a risk and needs assessment prior to release, which will identify risk to reoffend, substance use treatment need, mental health treatment need, case management needs, etc. The development of a holistic, wrap-around approach to work with released offenders of all risk and need levels should occur. This wrap-around approach should include, but not be limited to the development of re-entry officers (in lieu of probation officers), case managers, vocational-rehabilitation, and treatment (as indicated).**