
Oregon Department of Human Services

Addictions and Mental Health Division

Joint Ways and Means Committee Presentation

2007 Legislative Session

DHS Core Values

Integrity • Stewardship • Responsibility • Respect • Professionalism

Addictions and Mental Health Division

Mission

The mission of the Addictions and Mental Health Division (AMH) is to prevent and reduce the negative effects of alcohol, other drugs, gambling addiction and mental health disorders; and promote recovery through culturally competent, integrated, evidence-based practice treatments of addictions, pathological gambling, mental illness and emotional disorders.

Goals

The goals of AMH are to:

- Reduce the number of children coming into and remaining in the child welfare system due to parental substance abuse by providing effective treatment to the parents.
- Reduce the number of youths and adults who are incarcerated in the criminal or juvenile justice system by treating their substance abuse or mental health problems.
- Increase the number of adolescents in middle school, high school and college who refrain from using alcohol and other drugs.
- Stabilize the acute psychiatric hospital treatment system.
- Manage state hospital resources within the budget.
- Increase the recovery options available to patients in state hospitals and in the community treatment system.
- Assist in the development of a statewide wraparound project for children and adolescents with emotional, behavioral and substance abuse problems.
- Simplify the regulatory structure of the mental health and substance abuse treatment system while maintaining quality services, and client and public safety.
- Ensure compliance with the ORS 182.525 requirement that at least 50 percent of expenditures for mental health and substance abuse treatment in 2007-2009 will be for evidence-based practices.
- Reduce the average length of stay in Adult Treatment Services at the Oregon State Hospital Portland campus by 10 percent.
- Increase use of gambling treatment services during 2007-2009 by 25 percent over the 2005-2007 rates.

History

Oregon's mental health system has been in existence for 160 years. A portion of the Oregon State Hospital facility built in 1883 remains in use today. Prior to the mid-twentieth century, virtually all people with mental illness received treatment in institutional settings. In 1971 the state created the community mental health system and included both mental health and addictions treatment as part of that system. Services are financed and regulated by the Department of Human Services (DHS) and delivered through Community Mental Health Programs (CMHPs) or their subcontractors.

Mental health and addictions policy, prevention and treatment services have been combined, separated and recombined – most recently in 2001 – and now include problem gambling policy, prevention and treatment.

The emphasis on community-based treatment for these disorders grew in the 1980s based on recommendations by a series of commissions, task forces appointed by the Governor and DHS, and Executive Orders. In the mental health treatment area, more people are treated in the community than in institutions, and approximately 75 percent of public funding goes to community-based services.

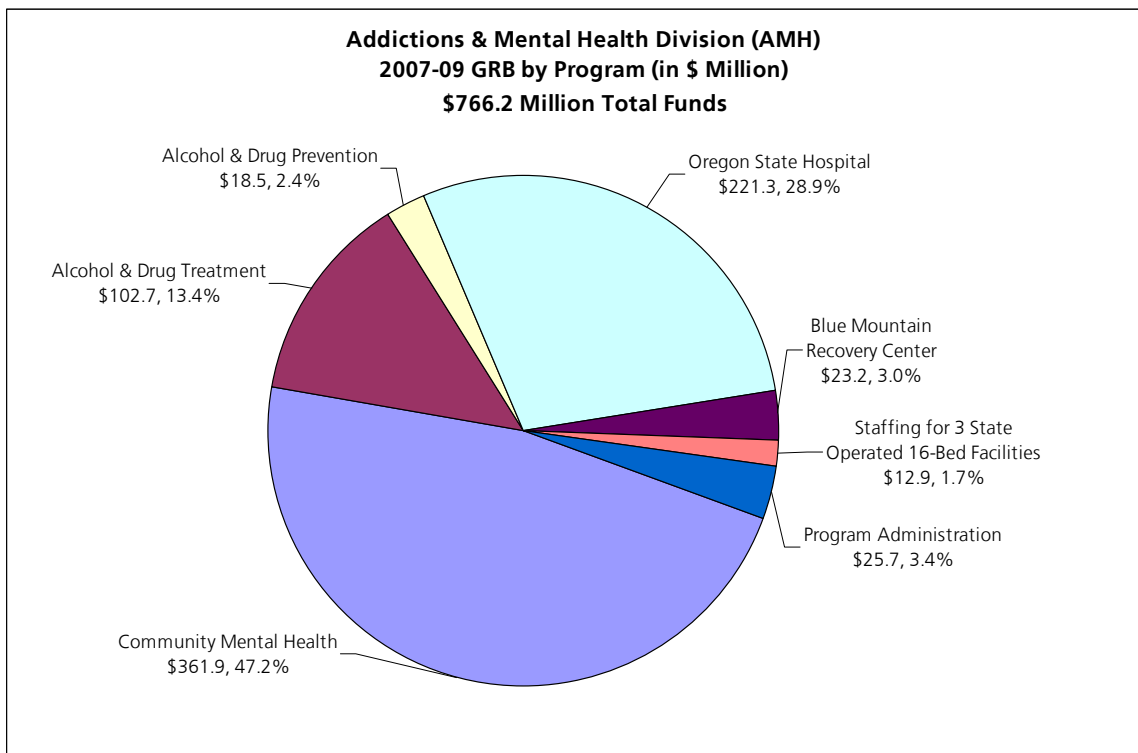
Major trends include the focus on recovery-oriented services, consumer-driven services, and services for children based on strengths and input from their families, and delivered in the most normal setting nearest their homes. Since the 2003 passage of Evidence-Based Practices (EBPs) legislation, prevention and treatment services that have proved effective are provided for people with substance abuse disorders, problem gambling behaviors and mental health disorders. These services are directed at people who have a propensity to commit crimes, experience emergency mental health services, or are juveniles with a propensity to commit crimes. AMH, the community mental health system and the providers have made major changes to refocus prevention and treatment methodologies to those that have proved effective. In 2005-2007 the system exceeded the requirement that at least 25 percent of state and federal funds were spent on EBPs. During 2005-2007, 56 percent of addictions treatment services and 33 percent of mental health services were evidence-based. In 2007-2009, that amount will be at least 50 percent, and by 2009-2011, the amount will be 75 percent.

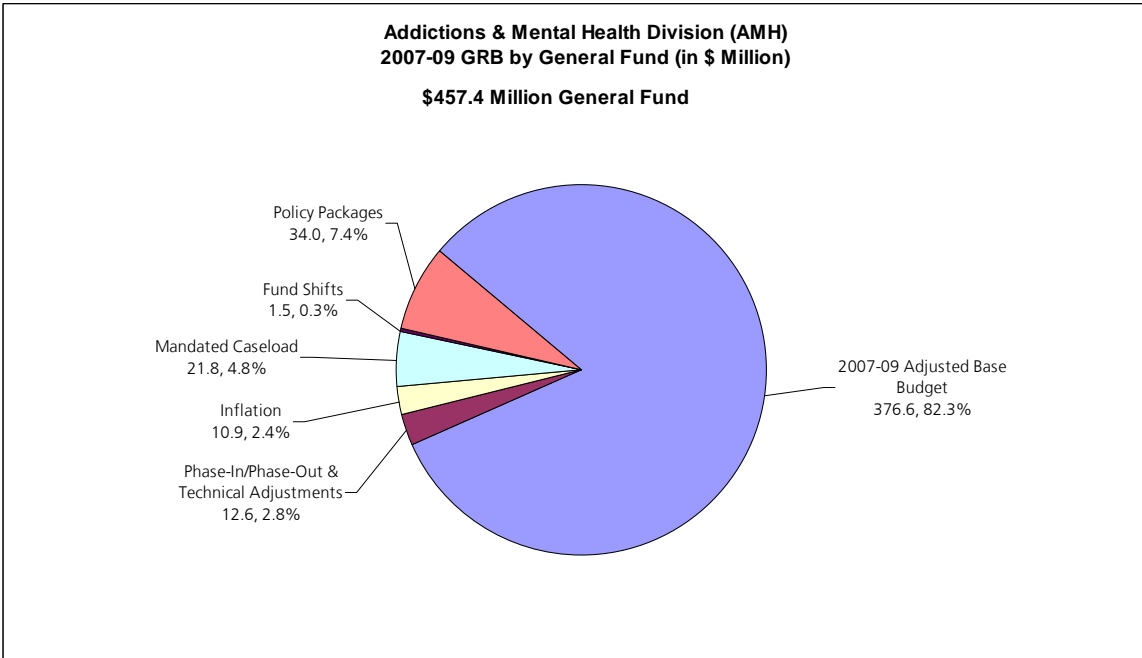
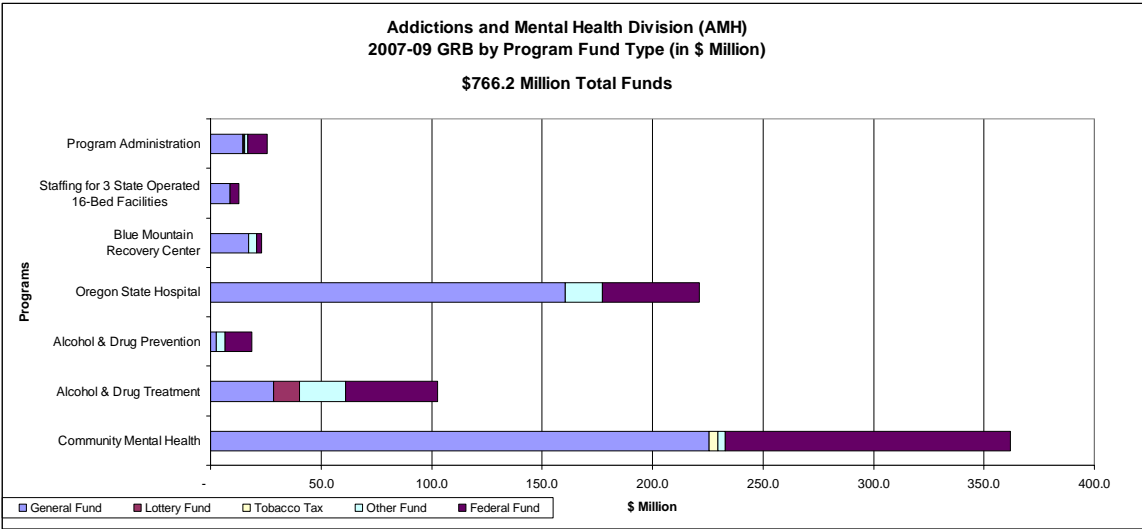
As a result of Governor Kulongoski's 2004 Mental Health Task Force, the state has entered into a process to replace the aging and unsafe buildings of Oregon State Hospital (OSH) and strengthen the community-based mental health system to support future population growth and the treatment of people requiring long-term psychiatric care nearer their homes. The Governor and legislative leadership agreed upon the recommended option by an independent consultant to locate a 620-bed facility in the

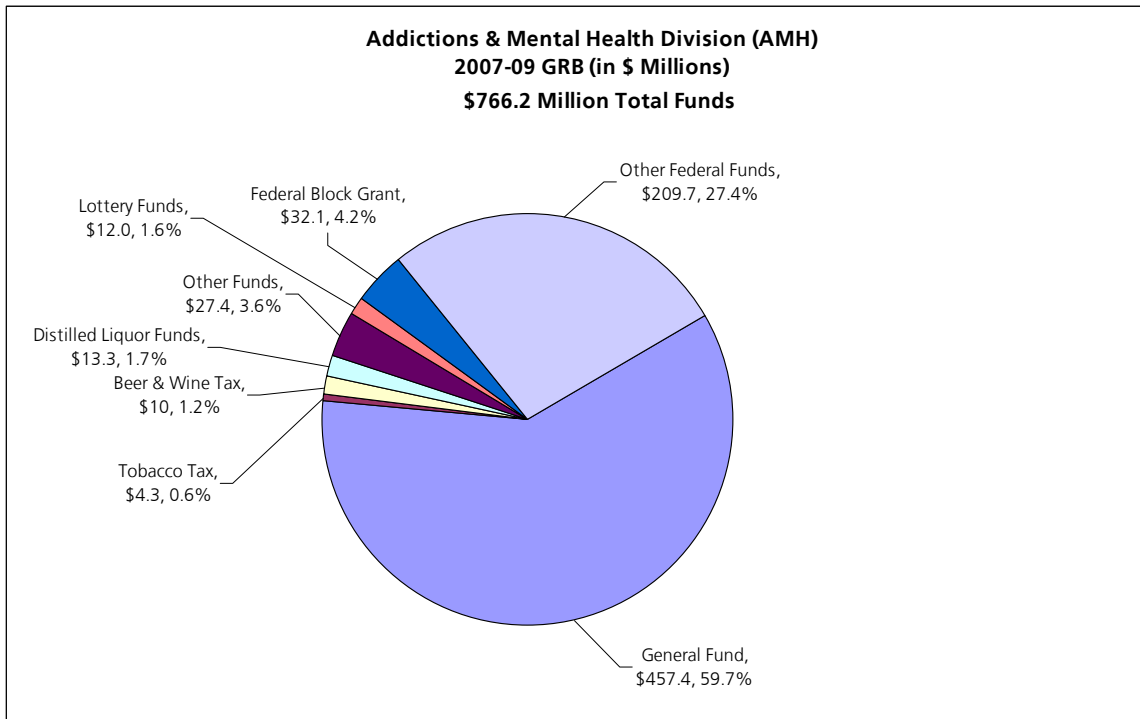
north Willamette Valley, a 360-bed facility west of the Cascades and south of Linn County, and at least two 16-bed secure residential treatment facilities east of the Cascades, all predicated on sufficient investment in community-based treatment to accommodate reduced lengths of stay in the state hospital and increased population growth.

These changes will occur in a state environment that provides parity in the coverage of alcohol and drug and mental health treatment services by Oregon-based group insurance carriers effective January 1, 2007. The services may be managed based on medical necessity using similar methods as for physical health care.

Budget summary







Services

AMH restores functioning, promotes health and protects public safety by serving adults, children and adolescents, and their families who have substance abuse disorders, mental and emotional disorders, and problem gambling disorders. In 2005-2006, 128,252 adults and 44,527 children and adolescents were served. AMH:

- Provides state hospital level care to adults with mental illness who cannot be safely or successfully treated in a lesser level of care.
- Contracts with county mental health programs, federally recognized Indian tribes, mental health organizations (MHOs), and private nonprofit agencies to provide community-based services to Oregonians who have mental illness, emotional and substance abuse disorders, and who are addicted to gambling.
- Contracts with these same entities to provide prevention services. The services available include:
 - ◆ Prevention,
 - ◆ Outpatient,
 - ◆ Day treatment,
 - ◆ Residential treatment,
 - ◆ Acute psychiatric treatment in local hospital specialty units,
 - ◆ Medications,

- ◆ Case management,
- ◆ Housing,
- ◆ Peer supports,
- ◆ Employment and education supports, and
- ◆ Long-term active psychiatric treatment in two state hospitals on three campuses.

Services are available to people who are eligible for Medicaid and those who are indigent.

Programs

AMH either provides or contracts for services that will restore people with addiction disorders, including gambling, and people with mental disorders to a level of functioning that allows them to:

- Become employed,
- Live safely in the community,
- Avoid repeated cycles of arrest and incarceration,
- Become good parents, and
- Reduce the use of acute psychiatric hospitals for crisis stabilization.

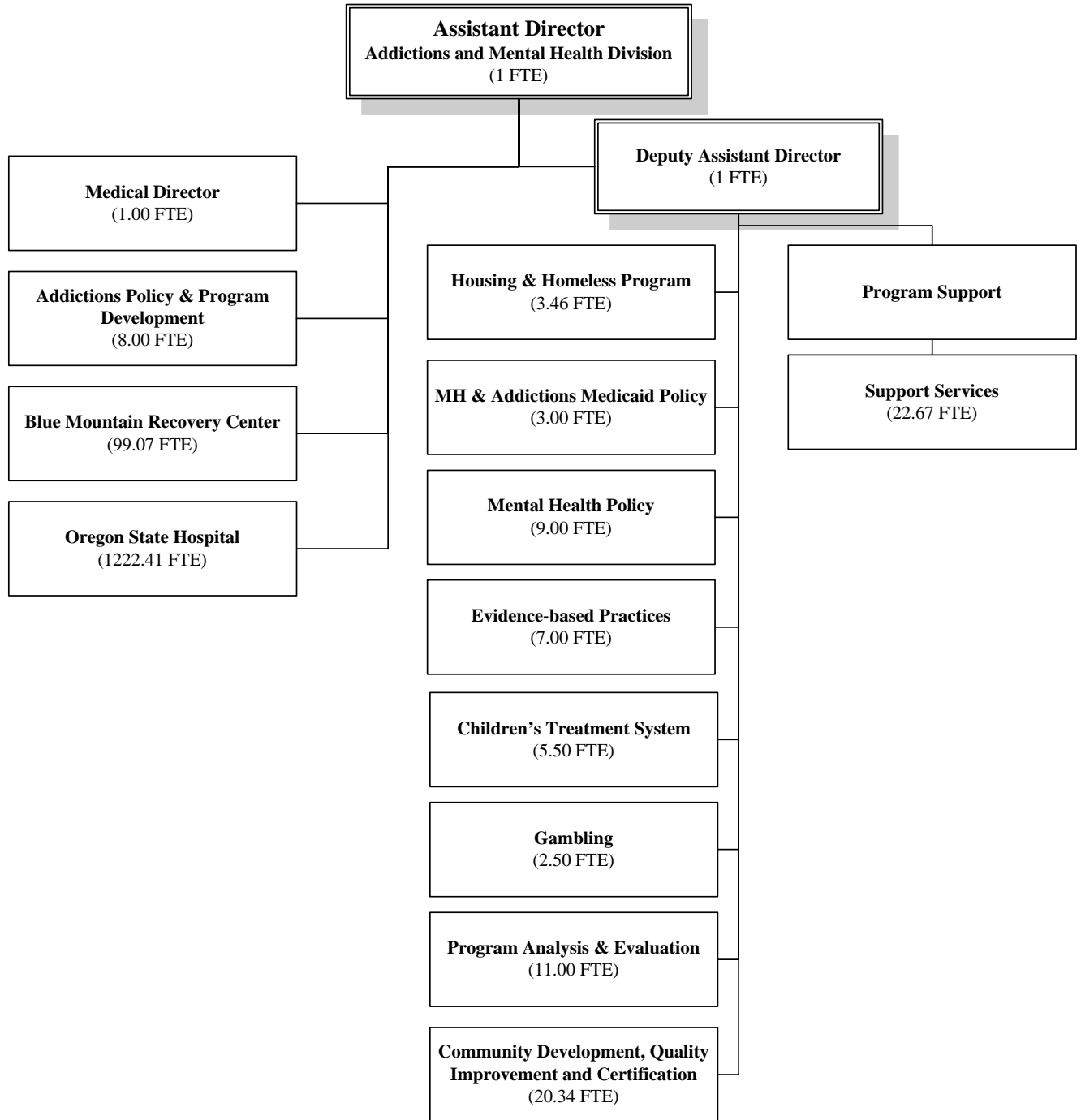
Services are aimed at promoting health for youths by assisting them in avoiding the use of alcohol and other drugs, and for adults by assisting them to enter into recovery and adopt safe and healthy lifestyles. In addition, services assist people in developing social skills and meaningful use of their time so they can form appropriate social relationships. When people are in recovery and in control of their lives, the public's safety is protected.

AMH has four primary program areas:

- Alcohol and drug prevention,
- Alcohol and drug treatment,
- Community mental health programs, and
- State Hospitals Services
 - ◆ Oregon State Hospital (OSH) and
 - ◆ Blue Mountain Recovery Center (BMRC).

Organizational structure

Addictions and Mental Health Division



As of March 1, 2007
1,416.95 Total Full-time Equivalent (FTE)

Alcohol and Drug Prevention (ADP)

Alcohol and drug prevention services are designed to promote healthy choices by Oregonians when presented with the opportunity to use drugs or to drink inappropriately. These are critical services for young people who are frequently presented the opportunity to drink in spite of their age. Underage drinking is dangerous and is frequently linked with binge drinking. This results in increased risk for traffic accidents, risky sexual behavior, violence and suicide. It is important that adults of all ages, especially older adults, understand the effects on their bodies from the use of alcohol and other drugs. With appropriate information people can make healthy, responsible choices.

Services provided

Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. AMH administers prevention services aimed at people who have not yet been diagnosed with alcohol or drug problems. These services will reduce the rate of underage drinking and the development of substance abuse disorder and the associated social problems (e.g., drunk driving, violence and child abuse).

Where service recipients are located

Prevention services are available in every Oregon county. CMHPs, federally recognized Indian tribes, and statewide contractors provide evidence-based services to prevent the problematic use of addictive substances and activities including alcohol, drugs and gambling. These services support and are integrated with the priorities set forth in each county's Comprehensive Plan as developed by the local Commission on Children and Families.

Who receives services

Services to prevent problem gambling and the use of addictive substances are available to all Oregonians with a focus on youths. The primary audiences for prevention services are:

- The entire population through public education and awareness campaigns,
- Sub-groups of people who are at above average risk of involvement with alcohol and other drugs through selected prevention services such as family management programs for families with youth who have poor academic performance, and

- Individuals who show minimal but detectable signs of involvement with alcohol and other drugs, but do not meet diagnostic criteria for abuse or dependence through indicated prevention services such as substance abuse educational programs for youth who receive a Minor in Possession (MIP) violation.

More than 800,000 Oregonians were provided access to broad-based prevention information during 2005-2006. In addition, 36,777 people received selected prevention services; another 10,899 received indicated prevention services; and 4,706 made use of the Problem Gambling Helpline.

How services are delivered

Services are delivered by CMHPs, federally recognized Indian tribes and statewide nonprofit organizations. The evidence-based interventions are selected to meet the needs of local communities, and may be delivered to groups of individuals at risk of substance abuse or may be delivered to the population as a whole to educate them about the risks of youth substance abuse.

Why these services are significant to Oregonians

Effective prevention services reduce the incidence of underage drinking and lessen the risk of alcohol- and drug-related traffic accidents and resulting deaths. These services reduce the risk of youth violence, youth suicide and risky sexual behavior. Youth who are not involved in underage drinking or other drug use perform better in school, are more likely to graduate, and avoid contact with the juvenile justice system.

Performance Measures (ADP)

KPM #19 – 8th Grader risk for alcohol and drug use

Purpose

AMH tracks many different measures that help assess and plan needed prevention services. Eighth grader risk for alcohol and drug use serves as a central indicator. Many of the prevention efforts target children and adolescents, making this indicator critical in tracking performance and directing resources. The data are collected through an annual survey called the Oregon Healthy Teens Survey. The survey is conducted with a representative sample of 8th and 11th graders.

Target

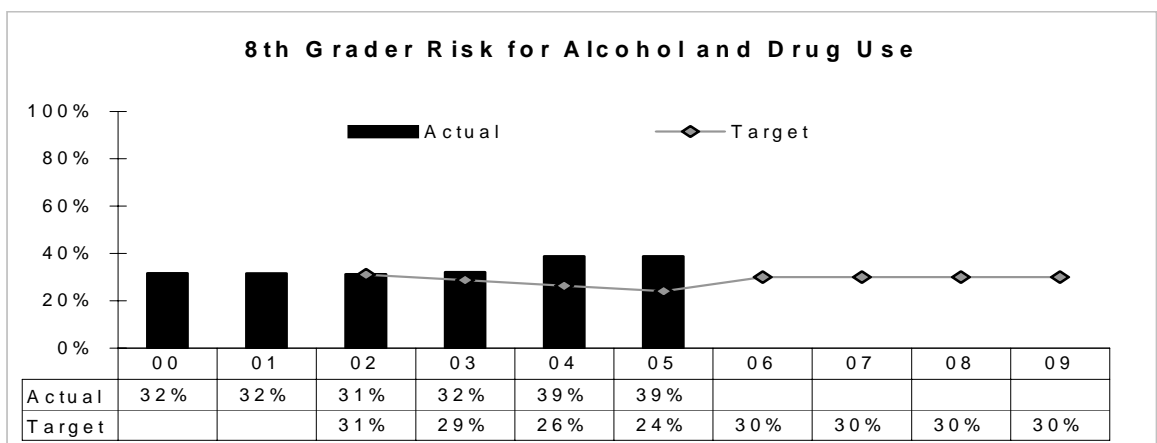
The current target for this measure is 30 percent.

Results

After remaining steady in the low 30 percent range for several years, this measure has risen 22 percent during the past two years. Currently 39 percent of Oregon 8th graders are at risk for alcohol and drug use. While state funding for substance abuse prevention has not been reduced, the population in Oregon has grown and other prevention programs have been cut including the Commissions on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youths involved in healthy and positive activities. During this same period, marketing and advertising efforts promoting alcohol and tobacco have increased, particularly advertising for distilled spirits and hard liquor.

How Oregon compares to other states

Oregon combines the risks associated with alcohol use and drug use, while most other states assess them separately. If alcohol use within the past 30 days is compared between Washington and Oregon 8th graders, Oregon does not compare favorably –18 percent versus 32 percent. Washington has maintained funding for its prevention efforts, and it shows.



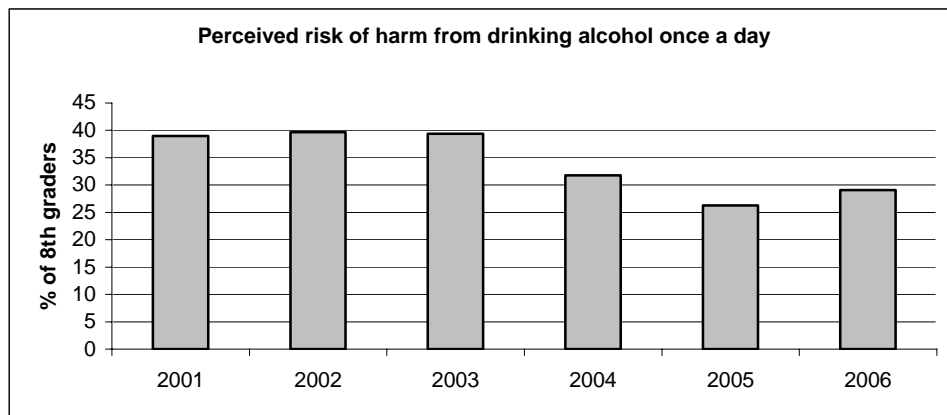
Other Performance Measures

Prevention services outcomes within the National Outcome Measures (NOMs) range from prevalence data to consequence data. Prevalence data tells the extent of a problem, such as the percentage of youths who drink. Consequence data provides information about the results of the problem, such as the number of drunk driving fatalities per 1,000 population. In both cases the information helps AMH direct its prevention efforts.

As described in the section on Key Performance Measures, for the past two years 8th graders who are at risk for alcohol and/or drug use has hovered at approximately 39 percent.

During 2006, 39 percent of 8th graders reported using alcohol or an illicit drug within 30 days of being asked.

Data shows that the percentage of 8th graders who perceive alcohol as dangerous has decreased over the years. Alcohol use is the drug responsible for the recent increase in 8th grade drug use risk. In contrast, the 30-day use of marijuana has declined by 22 percent during the past four years.



The consequences of drug and alcohol abuse are many. One highly visible result is traffic fatalities where at least one person involved in the crash was drinking.

During 2003, the most recent year for which data are available, 4.9 deaths for every 100,000 people were tied to drinking and driving. This was an almost 25 percent decrease from the late 1990s to 2003. Additional data from the Oregon State Police show a 15 percent decrease in the number of DUII offenses from 1999 to 2006 (76 versus 65 per 10,000 people).

Taken together, this information suggests that prevention efforts, at least for youths and adults old enough to drive, have had a positive effect.

Quality and Efficiency Improvements (ADP)

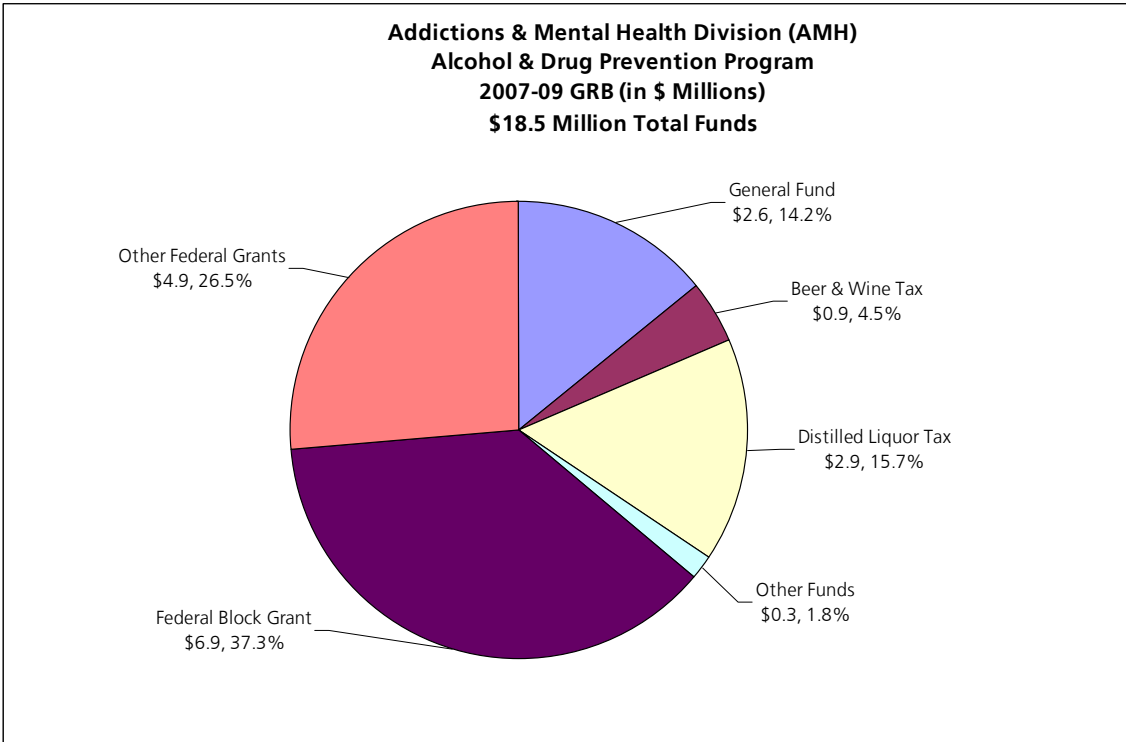
Restoring funding for prevention

The Governor's Recommended Budget includes a \$3 million policy package for targeted substance abuse prevention services. This restoration of prevention services will be implemented using research-based strategies. Two strategies will be implemented including community substance abuse prevention coalitions and a science-based, family-focused prevention program known as the Strengthening Families Program (SFP).

These services will have a positive impact on Oregon families and communities by providing tools to prevent the onset of youth substance abuse. Communities will understand the nature and degree of substance abuse and learn how they can mobilize to implement effective local strategies to address the problem. Families will learn and practice effective problem-solving and communication skills that have been scientifically proven to reduce the onset of substance abuse among parents and children.

These effective strategies coupled with existing prevention services will allow Oregon to get ahead of the growing substance abuse problem. Youths will delay the use of alcohol and other drugs. This will decrease the number of youths who develop substance abuse problems. Stronger families will experience reduced rates of substance abuse among all members, which will reduce the rate of children taken into foster care due to parental substance abuse.

2007-2009 Budget Summary (ADP)



Major Federal Fund (FF) Revenues:

- The Federal Block Grant consists of the Substance Abuse Prevention & Treatment (SAPT) Grant.
- The Other Federal Grants consist of:
 - ◆ Temporary Assistance for Needy Families (TANF);
 - ◆ Early Childhood Prevention Enhancement;
 - ◆ Safe & Drug Free Schools;
 - ◆ Enforcing Underage Drinking UAD; and
 - ◆ Enforcing Underage Drinking Rural UAD.

Key budget drivers and issues

Underage drinking

Oregon youth are continuing to drink at rates above the national average, with 8th grade girls drinking at higher rates than boys. These youths will continue to use and abuse alcohol and other drugs, which will increase the demand for treatment services. There will be added social costs including increased teen pregnancy, motor vehicle

accidents and death, school failure, entry into the juvenile justice system, and continued high rates for adolescent suicide. It is critical to restore funding for effective, evidence-based prevention and early intervention services to reverse the trend in underage drinking and improve the associated social indicators.

Governor’s Recommended Budget

Reductions

No reductions were proposed to this program in the Governor’s Recommended Budget.

Policy Option Packages

107 Youth Substance Abuse Prevention

<p><u>107 Youth Substance Abuse Prevention:</u> Staff are working on an evidence-based prevention strategy focused on reducing likelihood that youth will try methamphetamine or other harmful substances including alcohol. Funded with OLCC revenues.</p>	GF	OF	FF	TF
AMH		\$ 3.0		\$ 3.0
(\$ in millions)				

These resources will be contracted to the counties and the federally recognized Indian tribes to ensure county prevention staff work with local communities to implement effective evidence-based services. In addition, these resources will support 23 additional community prevention coalitions. As a result of these services there will be a reduction in the percent of 8th graders at high risk for alcohol and drug use. The evidence-based services to strengthen families will result in:

- Decreased family conflict and stress,
- Decreased child depression and aggression,
- Decreased substance use among parents and children,
- Improvements in family environments and parenting skills, and
- Increased prosocial behaviors in children.

Alcohol and Drug Treatment (ADT)

Alcohol and drug treatment services assist people in recovering from addictive behaviors. People in recovery function better in society and work, do a better job parenting their children, and stop committing crimes. Their physical health improves, which reduces medical care costs and use of emergency departments.

Services provided

Services consist of outpatient, intensive outpatient, residential and detoxification services. Outpatient services include specialized programs that use synthetic medications such as methadone as an alternative to chronic heroin addiction. Education and treatment is available for people who are convicted of driving under the influence of intoxicants (DUII). Treatment to reduce the effects of problem gambling is funded through a statutory one percent set-aside of state Lottery revenue.

Where service recipients are located

CMHPs and county-designated nonprofit organizations provide treatment for alcohol and drug abuse problems and problem gambling in all 36 counties and in statewide and regional residential treatment programs.

Who receives services

Children and adults of all ages who have a diagnosed substance abuse disorder may be eligible for services. Any person eligible for the Oregon Health Plan (OHP) or the State Children's Health Insurance Program (SCHIP) has access to the OHP substance abuse benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services under the federal Substance Abuse Prevention and Treatment Block Grant. There are specialized services designed to meet the needs of women, parents with children, minorities, and adolescents. During 2005-2006, 56,432 adults and 7,060 adolescents received substance abuse services, and 2,056 people received problem gambling services.

How services are delivered

Services are delivered by CMHPs, nonprofit programs and statewide contractors in outpatient programs, school-based health centers and residential treatment programs throughout the state.

Why these services are significant to Oregonians

As a result of these services, fewer children are admitted to foster care due to parental substance abuse. State and local jurisdictions have reduced costs to the criminal justice system for adults and juveniles. Local hospitals experience reduced use of emergency departments. There are fewer bankruptcies related to problem gambling and more people are working.

Performance Measures (ADT)

KPM #18 – Completion of alcohol and drug treatment

Purpose

After getting a client into alcohol and drug treatment service, the next goal is for the client to complete treatment. Clients who complete treatment have achieved at least two-thirds of their treatment plan goals and have been abstinent from drug and/or alcohol use for 30 days prior to treatment ending. Research has found evidence that treatment completion rates and other process measures are strongly related to long-term positive outcomes after treatment, such as abstinence and not being involved in criminal activities. Given this relationship and the availability of data, treatment completion is a good, practical indicator for the long-term success of services.

Target

AMH's target is to push overall completion rates to 75 percent and beyond during the next few years.

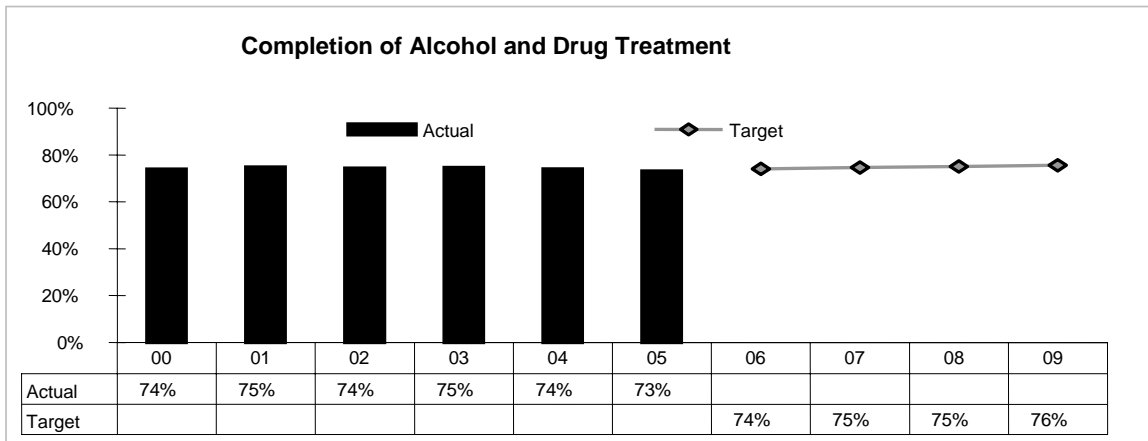
Results

For purposes of the key performance measure, completion rate is aggregated across all alcohol and drug services and has been in the low to middle 70 percent range for the past several years. It is currently 73 percent. It is expected to increase during the next few years as more providers implement evidence-based practices.

How Oregon compares to other states

One reason the completion rate has not changed substantially during the past several years is that it is already very high, making further improvement difficult. Nationally, the completion rate for alcohol and drug treatment services is 51 percent. This is based on

data submitted by states to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.



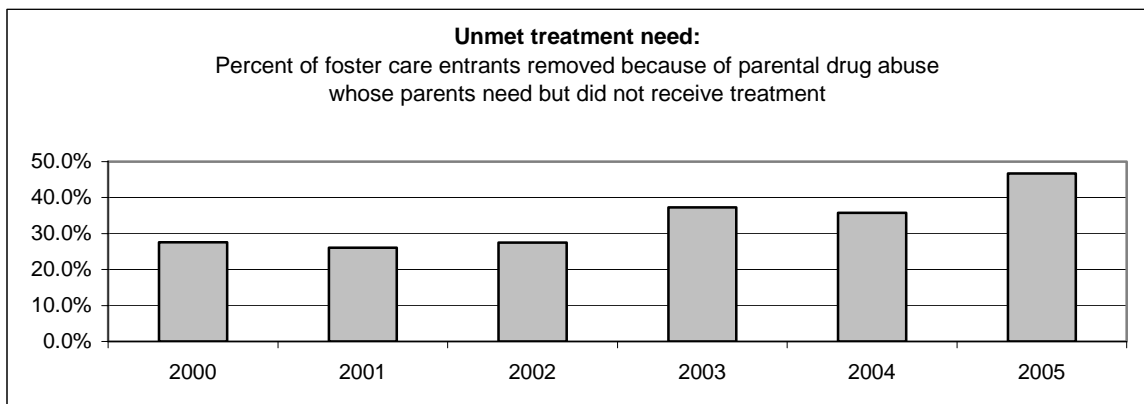
Other Performance Measures (ADT)

Alcohol and drug treatment services

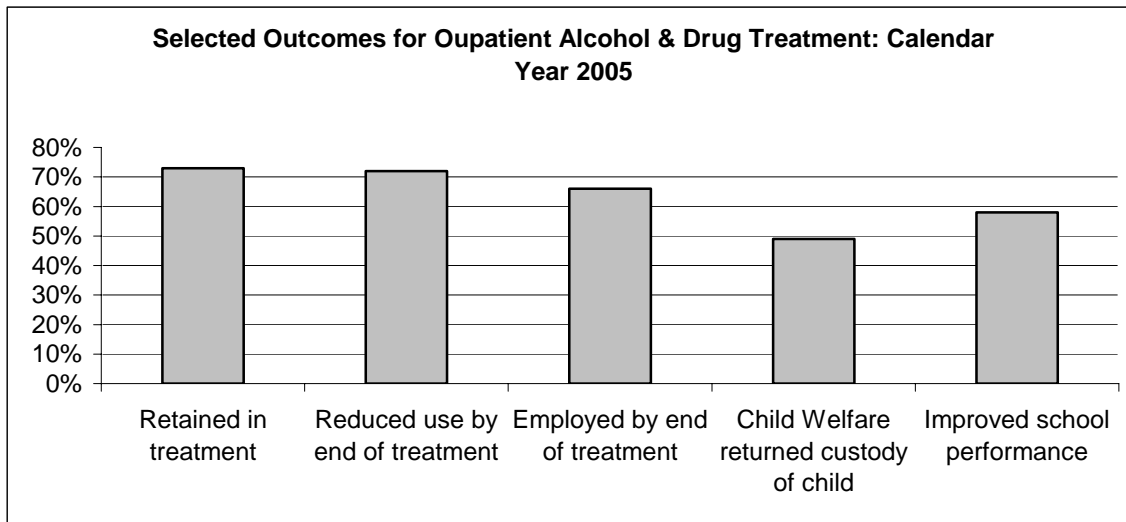
Approximately 11.2 percent (or 99,252) of adolescents and children have substance abuse issues, while 15.2 percent (or 410,173) of adults do. It is estimated that approximately 20 percent of these individuals need public services.

AMH serves 35.6 percent of the adolescents and children and 68.9 percent of the adults in need of public alcohol and drug treatment services.

Recently there has been a special focus on the children who are taken into custody by child welfare and their parents. Data show that the need for alcohol and drug treatment among those parents is growing. The Governor’s Recommended Budget contains funds to address this problem.



The following chart illustrates several key outcomes from the NOMs framework that AMH wants to emphasize for outpatient alcohol and drug treatment services.

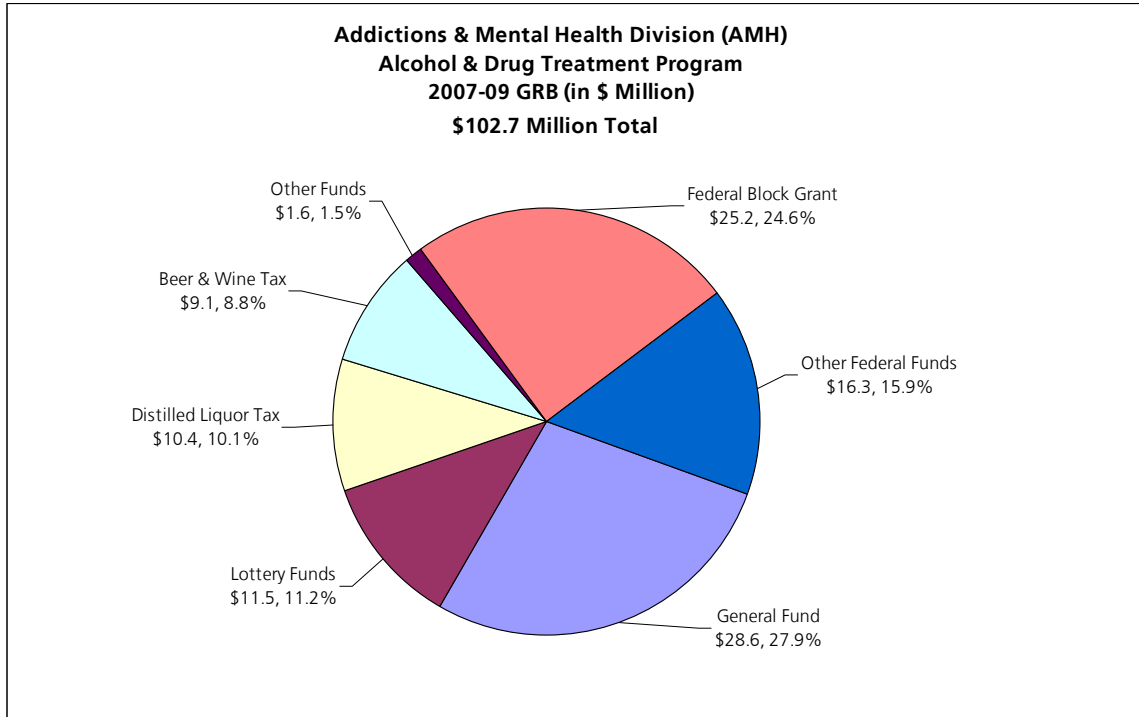


Problem gambling

While the NOMs are not inclusive of problem gambling services, AMH collects data that fit closely within the framework described by NOMs – both prevention and treatment information. For example:

- ◆ An estimated 47,019 adult Oregonians are problem gamblers and an additional 27,658 are pathological gamblers.
- ◆ FY 2006 data indicate 43 percent of problem gamblers successfully completed treatment services. Six months after gamblers left treatment, more than 81 percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.

2007-2009 Budget Summary (ADT)



Major Federal Fund (FF) Revenues:

- The Federal Block Grant consists of the Substance Abuse Prevention & Treatment (SAPT) Grant.
- The Other Federal Funds consist of:
 - ◆ Medicaid Title XIX;
 - ◆ Temporary Assistance for Needy Families (TANF) Grant; and
 - ◆ Safe & Drug Free Schools Grant.

Key budget drivers and issues

Methamphetamine epidemic

The impact of methamphetamine abuse has been devastating to many Oregon communities and families. Professionals from local law enforcement, child welfare and medical communities consistently report they need more tools, including prevention and treatment, to address methamphetamine abuse. The current system is able to meet just 15 percent of the treatment demand.

Methamphetamine consistently is reported as a primary or secondary drug of choice among new treatment admissions. In 2005, approximately one-third of individuals admitted to addictions treatment reported methamphetamine as their primary or secondary substance of choice. According to reports compiled by SAMHSA, Oregon had the nation's highest rate of admissions for methamphetamine treatment per 100,000 people in both 1993 and 2003. In 2003 Oregon admitted 251 people per 100,000 for treatment, with methamphetamine as the primary drug of choice, 4.5 times the national rate of 56 per 100,000. Since FY 1997, there has been a 71 percent increase in youth treatment admissions where methamphetamine was identified as the primary drug of choice and a 46 percent increase in adult methamphetamine primary treatment admissions. Some acute psychiatric units report that 50 percent of their psychiatric admissions are meth-related.

The number of Oregon children entering foster care because of parental drug abuse has increased 33 percent since 2000, while the parents of these children are much less likely to access treatment. The proportion of parents of foster care children who do access treatment and have an addiction to methamphetamine (70 percent) is much greater than the general adult treatment population (30 percent).

Oregon's treatment system is less equipped to address methamphetamine addiction than it was just four years ago due to decreased treatment capacity. General Fund reductions during the 2001-2003 biennium made cuts to outpatient treatment services that have not been restored. There currently are 442 adult residential beds statewide. Residential beds were reduced by 115 in February of 2003. Sixty-nine beds were restored in October 2003, bringing the net loss to this system to 46 beds. The biggest loss, and the single most significant impact to the system, was the reduction to the OHP Standard population from 110,000 to 24,000 eligible people.

Population increase and unmet need

As Oregon's population grows, there will be an increase in the number of people with addiction disorders. However, the funding for basic community treatment services needed to treat these disorders has not increased in relation to the need for services. National research that looks at the need for services indicates 15.2 percent of the adult population requires alcohol and drug treatment services. In Oregon that is 410,173 people. That research also shows 11.2 percent of youths require treatment. In Oregon that is 99,252 youths. It is estimated that approximately 20 percent of individuals with a substance abuse problem need public services. Public funds provided services for 56,532 adults (68.9 percent of the need) and for 7,060 youth (35.6 percent of the need). Some of these people will have insurance and, with the approval of equal access to treatment for these disorders, more will obtain treatment paid by their insurance company. However, many people with addiction disorders do not seek treatment until

they have lost their jobs, insurance and families; and when they seek or are mandated to treatment, they must rely on publicly funded services.

Governor’s Recommended Budget

Reductions

No reductions were proposed to this program in the Governor’s Recommended Budget.

Policy Option Packages

101-7 Improved Addictions Treatment Access

<p>101-7 Improved Addictions Treatment Access: Part of a continuum of services to children and families aimed at keeping kids safe at home with their families. This package will assure that at least 2,664 people have access to evidence-based A&D treatment and that at least 90 adults and their children have access to residential treatment and that additional recovery homes are established in underserved areas of the state and existing homes are stabilized by contracting for three additional Outreach Coordinators. Governor's budget funds this package with OLCC revenues.</p>				
	GF	OF	FF	TF
AMH	\$	10.4	\$	0.8
			\$	11.2
(\$ in millions)				

Services will be provided to families with alcohol and drug problems who are receiving Temporary Assistance to Needy Families (TANF) supports or who are in danger of having their children removed by child welfare due to parental substance abuse. These families will receive intensive treatment and supports.

As a result of these services, fewer families receiving TANF supports will enter the child welfare system. Currently more than 25 percent of families entering child welfare are on TANF. With these services, this rate will drop to 15 percent.

As a result of these services, 60 percent of the parents involved in the child welfare system who successfully complete addiction treatment will regain custody of their children. Currently, 50 percent regain custody.

As a result of these services, those children who enter child welfare due to parental substance abuse will experience shorter stays.

TANF families who receive alcohol and drug treatment will be better able to find and retain jobs.

This initiative provides funds to contract for three additional outreach coordinators to assist in the development of Oxford Houses. At least 14 new recovery homes will be developed and available for TANF families.

103-39 Equitable Alcohol and Drug Treatment

103-39 Equitable Alcohol & Drug Treatment: This package will improve the distribution of A&D treatment funds by adding treatment resources for indigent clients to the counties that receive less than the statewide average per capita funding. That amount is currently \$2.70. This will improve access to A&D outpatient treatment in those counties that have been under funded historically, particularly those counties in central Oregon and suburban areas that have experienced significant population growth in the last 10 years.

	GF	OF	FF	TF
AMH	\$ 4.0	\$ -	\$ -	\$ 4.0

(\$ in millions)

This package provides funds to improve the per-capita funding for 13 counties and five federally recognized Indian tribes that are below the statewide average. This will improve access to treatment for people in these communities. As a result, more people will be employed, fewer families will lose their children to state custody due to parental substance abuse, and there will be a decrease in jail time for these populations.

111 Funding for Drug Courts

111 Funding for Drug Courts: Expanding Drug Courts (Criminal Justice Commission [CJC] budget) This action would backfill one-time federal grants supporting Oregon's existing drug courts and increase the number of drug courts. This is a pass-through of \$3.6 million of the proposed new OLCC revenues to CJC for use in funding drug courts.

	GF	OF	FF	TF
AMH	\$ -	\$ -	\$ -	\$ -

(\$ in millions)

This initiative adds drug court services that will result in more people accessing substance abuse treatment and will increase the percentage of engaged clients who complete drug abuse treatment. These clients will be employed at greater rates than people with untreated substance abuse problems.

Community Mental Health Programs (CMHPs)

Services provided

Mental health services reduce public safety problems and negative consequences; improve functioning for Oregonians with severe mental disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for further treatment and whether other supportive services will be provided.

Services and supports include help establishing personal relationships, help obtaining employment or schooling; independent living skills training such as cooking, shopping and money management; residential or adult foster care; and supervision of people who live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, clinics and doctor offices, schools, drop-in centers, and homes. OHP covers mental health services for eligible persons with conditions funded under the Health Services Commission Prioritized List for all Medicaid and SCHIP.

Where service recipients are located

Crisis services provided by qualified mental health professionals are available in all communities 24 hours a day, 7 days a week. Mental health services are available in all 36 counties. These services include civil commitment procedures, acute inpatient treatment, residential treatment, adult foster care, outpatient therapy, supports needed for successful community living, medications, case management, assistance with finding and maintaining housing and work, and social support.

Who receives services

CMHPs provide mental health services for adults and children who have serious emotional and mental disorders and are a danger to themselves or others, are unable to meet their needs, or are in danger of being removed from their homes due to emotional disorders. In FY 2005-2006, publicly funded programs served 71,820 adults and 37,467 children and adolescents.

How services are delivered

Mental health services for adults and children are funded in the community through:

- Financial assistance agreements with county governments,
- Contracts with OHP mental health organizations (MHOs), and
- A limited number of direct contracts with providers of regional, statewide or specialized services.

Services are delivered in every county through the 32 CMHPs. Services are provided by a combination of county employees or subcontracted private nonprofit agencies.

Professionally trained staff including physicians, nurses, social workers and trained peers provide:

- Crisis evaluation, stabilization and civil commitment functions;
- Medication, counseling and other outpatient and residential treatment to help people recover from mental illness;
- Case management, housing, and supported employment and education assistance to help people continue to live successfully in community settings; and
- A range of peer-delivered services and supports.

Why these services are significant to Oregonians

As a result of publicly funded mental health services, more children remain in their homes, in school and out of trouble. Adults with major mental illnesses who receive treatment are working more and functioning better, less likely to be hospitalized, and less likely to be jailed.

Performance Measures (CMHPs)

KPM #28 – Mental health client level of functioning

Purpose

Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children use a similar tool called the Children's Global Assessment Scale (CGAS). These tools are used to gather information during the initial assessment and throughout treatment. AMH is able to

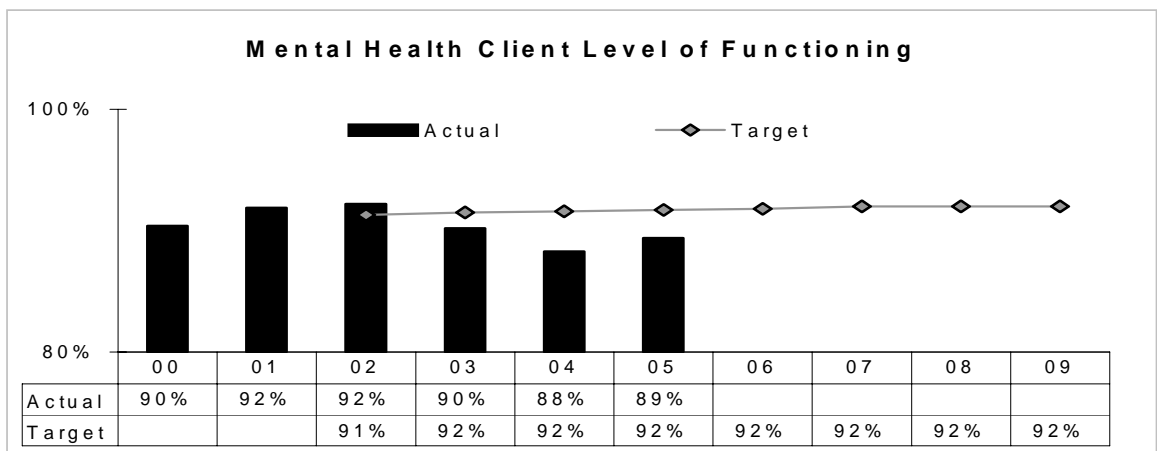
determine clients' improvement over time by looking at changes to the GAF and CGAS scores. The goal is to demonstrate maintenance of functioning or improved functioning.

Target

The current target for this measure is 92 percent.

Results

In recent years, the percentage of clients who maintain or improve functioning has dropped a few percentage points, although it remains very high at 89 percent for the most recent reporting period. There is a concern that this tool, while in broad use, is not very sensitive to changes. AMH is exploring other ways to assess clients' general improvement as a result of treatment.



How Oregon compares to other states

Despite the broad use of the GAF and CGAS by clinicians in all states, there is not a great deal of data summarized at the state level. As an alternative, many states, including Oregon, administer a statewide survey to adults and caregivers of children receiving mental health services. The survey allows states to create a score for clients' perception of improvement for outcomes such as housing, school and employment. The most recent survey in Oregon found that:

- 57 percent of adults were satisfied with outcomes, and
- 56 percent of caregivers of children were satisfied with outcomes.

These figures are consistent with results from past surveys in Oregon. The most recent data available from other states are from 2004. Data from a few similar states are presented below:

- In Washington, 34.9 percent of adults and 54.7 percent of caregivers of children were satisfied with outcomes.
- In Utah, 50.9 percent of adults and 79.6 percent of caregivers of children were satisfied with outcomes.
- In Colorado, 62.6 percent of adults and 80.4 percent of caregivers of children were satisfied with outcomes.

A great deal of caution should be used in looking at comparative data from other states because of the variance in available services as well as the methodology for administering the survey.

Other Performance Measures (CMHPs)

Approximately 12 percent (107,916) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 6 percent (161,736) are estimated to have a severe mental illness.

AMH serves 35 percent of the children and adolescents and 44 percent of the adults with a severe emotional disorder or severe mental illness, respectively.

Several key outcomes from the NOMs framework that AMH wants to emphasize for community mental health services are:

- Employment is an important outcome for most people. A recent survey found that slightly more than 30 percent of the people receiving mental health services were looking for or needed assistance in finding employment when they sought mental health services. Of those, 62 percent received active help from service providers, and 44 percent of those receiving help got a new job.
- AMH's most recent data found that 22 percent of the adults receiving community mental health services are employed when discharged.

Education outcomes are of great importance to children and adolescents receiving mental health services. Fully 82 percent of the caregivers of these children have indicated that coordination with educators is a key for services. An important element is attendance.

Based on caregiver reports for youths receiving services, AMH found a 228 percent reduction in the number of suspensions/expulsions from school when comparing the year after services began (8.7 percent of the children) to the year prior to services starting (20 percent of the children).

Involvement with criminal justice for both adults and adolescents is another important issue for AMH services to address. Among caregivers of adolescents, 25 percent indicated that coordination with county juvenile justice and/or Oregon Youth Authority (OYA) was important to services. Jails and prisons are not good settings for providing mental health services.

Based on a caregiver report for youths receiving services, AMH noted a major reduction in the number arrested within the year after services began (2.7 percent) compared to the year prior to services (8.2 percent).

Based on a self-report, adults indicated a decrease in the number arrested within the year after services began (3.6 percent) compared to the year prior to services (11.9 percent). This is consistent with many other reports on the effect of services to adults.

Housing is another important outcome. Almost 43 percent of people receiving services said they needed help with housing at the onset of services. Of those, 75 percent received help and 80 percent of those receiving help found new housing. In addition, 57.4 percent of all Oregon adults receiving services said their housing situation had improved over the course of services. However, homelessness remains a major issue. An estimated 2,972 people with mental illness were “currently homeless” in 2005.

Quality and Efficiency Improvements (CMHPs)

Community-based services

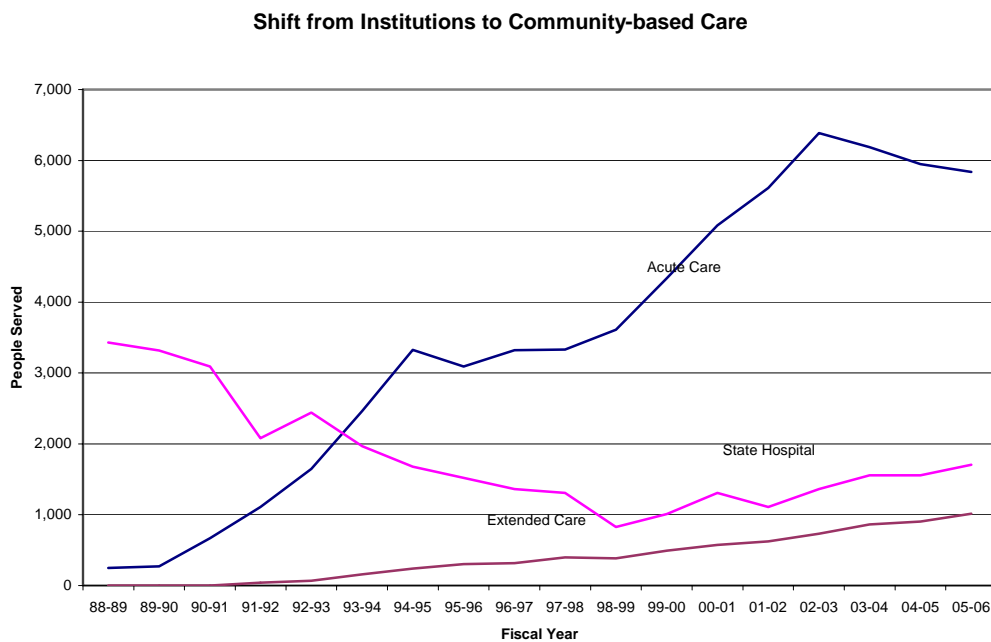
For the past 15 years Oregon has systematically moved from an institution-based system to a community-based system. This allows people who need publicly funded mental health services to be served in their communities. Hospitalization for acute mental illness is provided in psychiatric units of local hospitals. Increasing amounts of the long-term treatment and stabilization for adults with major mental illnesses is provided in community-based settings. This allows people the opportunity to stay connected with family, to learn the skills needed to be more independent, to be engaged in their community and, when possible, to work. Community-based services have proven to be more effective in assisting people to recover from mental illness and to live independent lives.

The cost to the system is less for community services than it is for institutional services. In addition, the services needed in community settings often can be supported with federal Medicaid funds that are not available for institutional services.

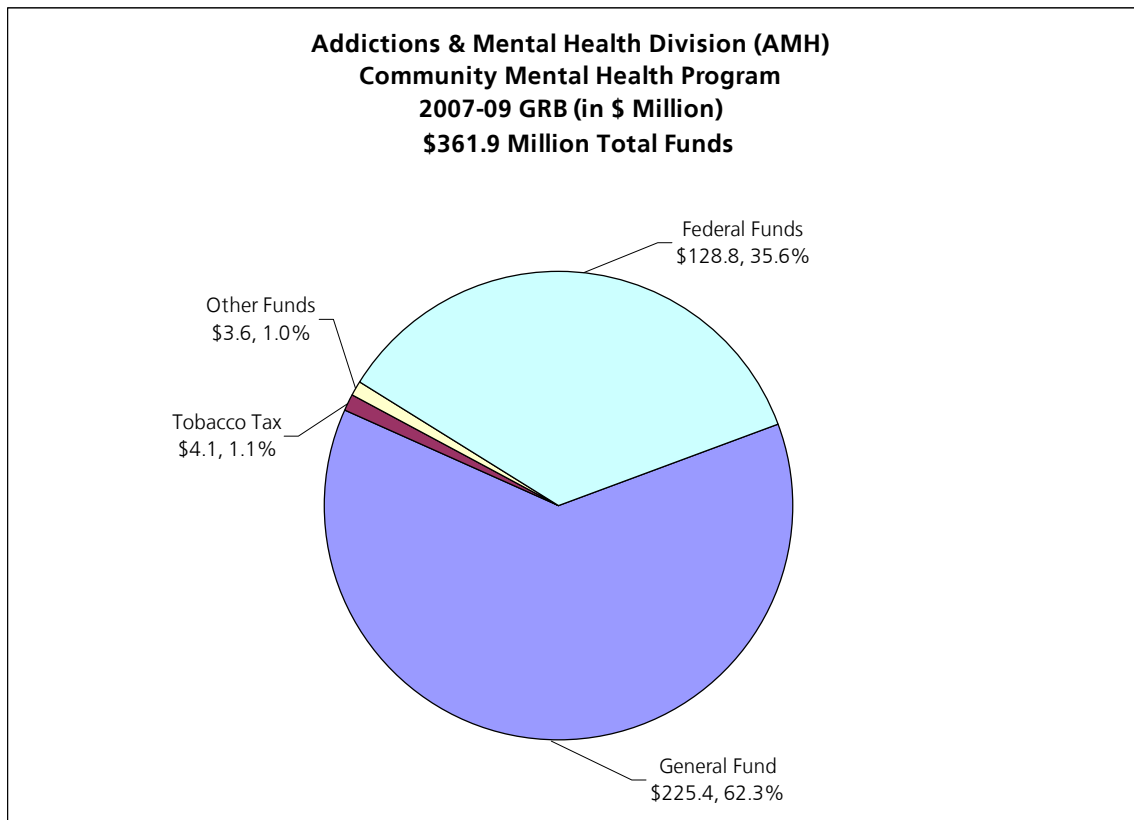
During FY 2005-2006, 1,477 people were served in the state hospitals. All of the other 71,820 adults served in the system were served in the community.

As of March 2005 Oregon no longer serves children or adolescents in a state psychiatric hospital. All Oregon youths including those who need intensive, medically directed treatment in a secure setting, are treated in community programs. The length of stay is shorter and children are more quickly returned to their home community and receive the treatment and supports they and their families require for successful community living.

The following chart displays the admission trends in the system since 1988-1989 and shows the growth in community-based acute and extended care. The numbers reflect unduplicated individuals – an individual is counted once per year even if admitted more than one time.



2007-2009 Budget Summary (CMHPs)



Major Federal Fund (FF) Revenues consist of:

- Medicaid Title XIX;
- Community Mental Health Services (CMHS) Block Grant;
- Project to Assist/Transition from Homeless (PATH) Grant; and
- Real Choice System Change Grant.

Key budget drivers and issues

As Oregon's population grows, there will be an increase in the numbers of people with mental health disorders. National research that looks at the need for mental health services indicates that 161,736 Oregonians (6 percent of the adult population), require treatment for a mental disorder. For children and adolescents, national estimates indicate that 12 percent of the population, (107,916 youths) require treatment for mental and emotional disorders. Public funds provided services for 71,820 adults (meeting 44 percent of the need) and services for 37,467 children and adolescents (meeting 35 percent of the need). Some of these individuals will be able to receive

insurance-covered services. However, adults with major disabling mental illnesses frequently must rely on the publicly funded system.

The lack of investment in early identification and treatment for these disorders increases social costs and pushes more people into the intensive and mandated treatment in the public system. In many cases, people with substance abuse and mental disorders end up in the criminal justice system due to lack of treatment. They are more expensive to supervise in jail, stay longer for similar crimes and are more vulnerable to exploitation than other inmates.

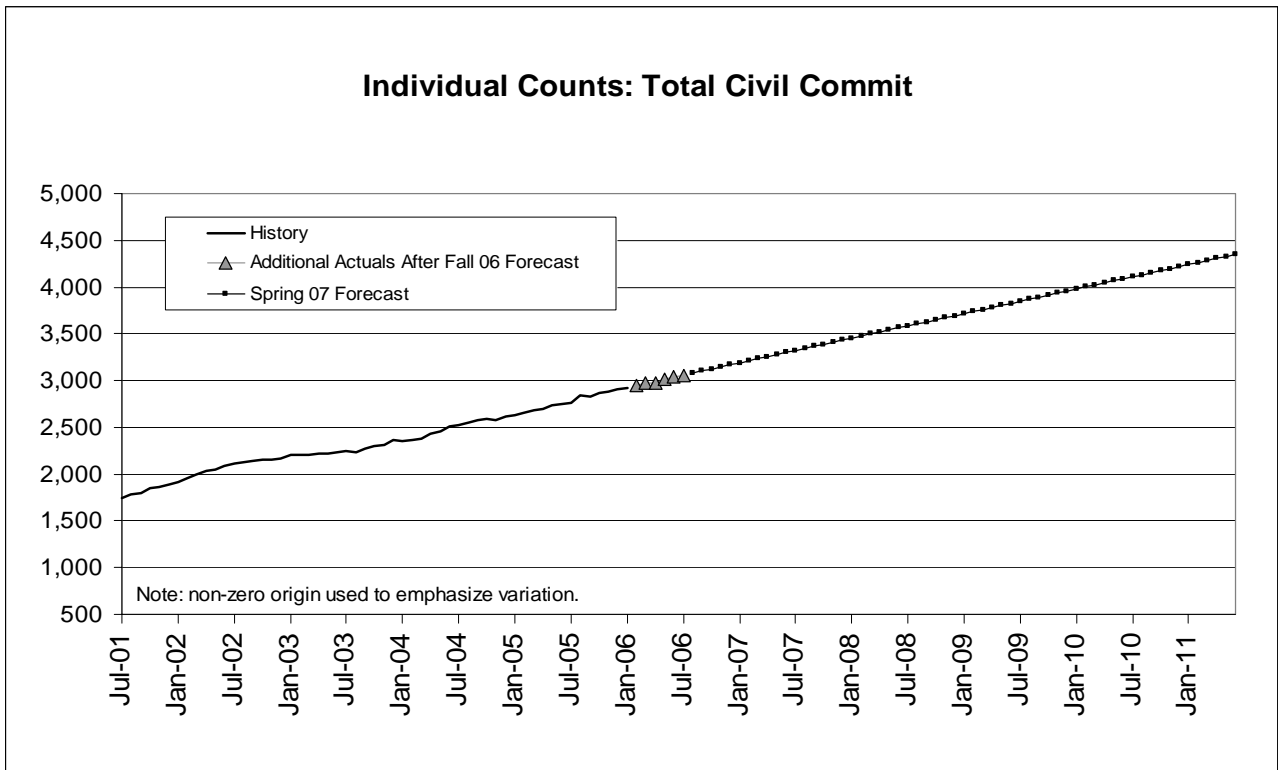
Mandated treatment

There have been two groups of people in the mental health system who are mandated by the courts to receive treatment for their mental illness – those who have been civilly committed and those who are criminally committed.

Beginning July 1, 2007, AMH will be required to provide on-demand treatment and support services to youths who are under the jurisdiction of the Juvenile PSRB. These youths, who have committed crimes and have been found responsible except for serious mental condition, present substantial danger to others.

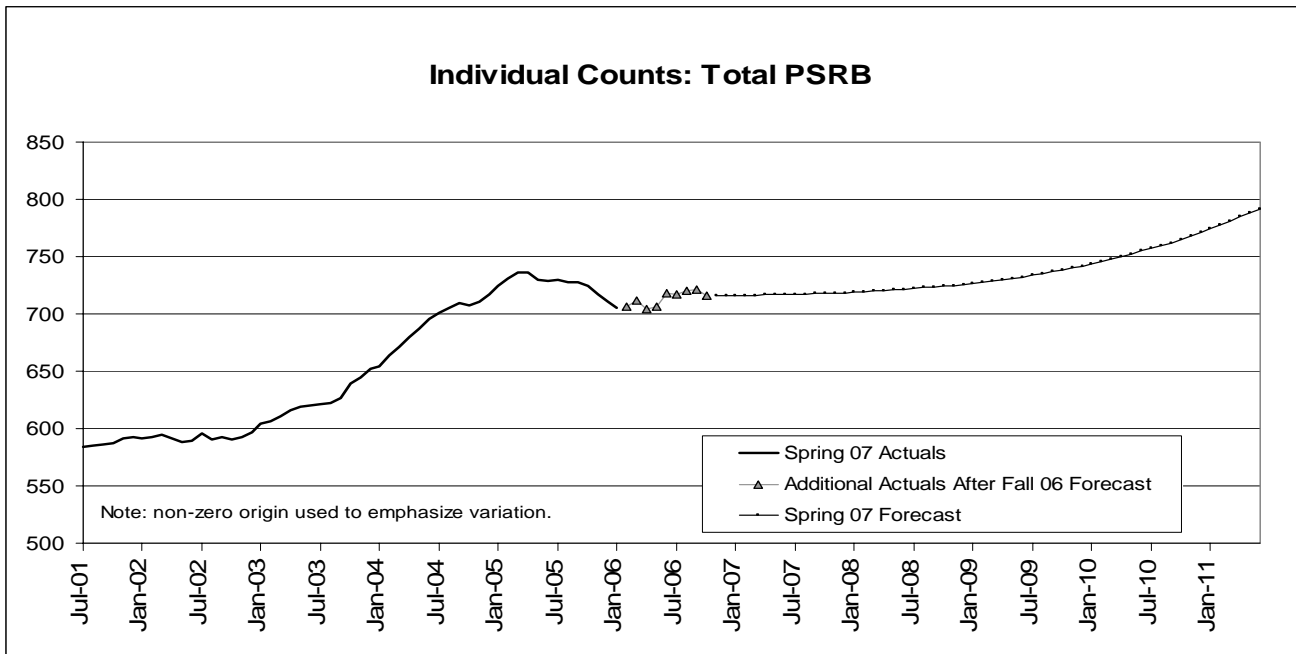
The civil commitment caseload includes people who are found through a civil court process to be dangerous to themselves or others, or to be unable to care for themselves as a result of mental illness. Through this process the individuals are mandated by court to treatment (ORS 426.070). People on this caseload are served in a variety of settings that include the state hospitals and community outpatient settings.

Currently there are approximately 1,160 people in state hospitals or other 24-hour community settings including enhanced care, adult residential and foster care. Based on the forecast, an increase of 150 people is expected in the next biennium. The following graph displays the trend in civil commitment caseloads since 2000.



The criminal commitment caseload is based on two separate categories of criminal commitments. The first group, known as "Aid and Assist," are people mandated to OSH for assessment and treatment until they are fit for trial (ORS 161.370). The second group is people who have been found "guilty except for insanity" of a crime by a court (ORS 161.315). These individuals are placed under the jurisdiction of the PSRB. AMH is required by Oregon law to provide treatment and supervision for these individuals either in the community or in a state hospital (ORS 161.319 and ORS 161.327).

The PSRB caseload has been increasing steadily for many years, although there has been a modest slowing during the past year. The following graph displays the trend in criminal commitments since 2001.



Governor’s Recommended Budget Reductions

No reductions were proposed to this program in the Governor’s Recommended Budget.

Policy Option Packages

104-43 The State Hospital Master Plan for expanded community services and administration

104- 43 The State Hospital Master Plan for expanded community services and administration: For the system to function with the recommended hospital capacity, it is essential to develop the additional community-based client services called for in the replacement plan for the State Hospital. In addition, investment in the administration of the OSH Master Plan implementation is needed. This package also provides the resources to will allow the counties to designate staff for program development for state hospital patients who are ready for discharge and thus increase the pace of community-based development.

	GF	OF	FF	TF
AMH Program & Admin	\$ 9.9			\$ 9.9

(\$ in millions)

As a result of increased funding for community crisis services, acute psychiatric treatment services, supported employment/education services and treatment, and case management services for people diverted or released from local jails, the following outcomes will be measured:

- Decreased days in jail,
- Decreased days homeless,

- Decreased hospital costs,
- Increased days of competitive employment, and
- Increased days without alcohol and drug use.

104-44 Harmon Settlement (Federal Lawsuit)

104- 44 Harmon Settlement - (Fed Lawsuit): Provides funding for 17 additional OSH staff and to develop approximately 81 community placements over and beyond 2007-09 caseload growth development.				
	GF	OF	FF	TF
AMH Program & Admin	\$ 11.3		\$ 4.2	\$ 15.6
	(\$ in millions)			

The community mental health portion of this package, \$12.9 million total funds supports intensive community placements for 33 state hospital patients whose illnesses require specialized treatment and supports for safe, successful community living.

This package provides resources to open 48 state-operated secure residential treatment beds in three 16-bed facilities. This will allow the safe discharge of 48 OSH patients who require added treatment in a secure environment to be ready for less restrictive community settings.

104-45 Early Assessment and Support Teams

104- 45 Early Assessment & Support Teams: Early treatment of psychosis with evidence-based practices provides the best opportunity for ensuring long-term recovery for 540 persons (ages 16-24) during 07-09. Expanding specialized treatment of this kind will reduce hospitalizations, homelessness, and involvement with the criminal justice system. The Governor's Recommended Budget funds this package with Tobacco Tax.				
	GF	OF	FF	TF
AMH Program & Admin		\$ 4.3		\$ 4.3
	(\$ in millions)			

This package will serve 540 young adults who are experiencing the early symptoms of psychosis. As a result of receiving community services that are evidence-based, these young people will:

- Be employed,
- Have a lifetime increase in earnings,
- Have reduced use of alcohol and drugs, and
- Experience increased independent living.

There will be fewer young Oregonians on disability. The families will experience:

- Decreased family burdens,
- Increased satisfaction with services, and
- Improved quality of life.

State Hospital Services

Mental health services for adults who need long-term psychiatric hospitalization are provided in both extended community care services and state hospitals with campuses in Salem, Portland and Pendleton. These services are essential to restore patients to a level of functioning that allows successful community living. These services in a secure setting promote public safety by treating people who are dangerous to themselves or others, and those who have committed crimes and are adjudicated guilty and insane. To support the functions of the state hospitals, Oregon has developed more than 1,200 extended care placements provided by counties and a variety of non-profit and for-profit providers.

Oregon State Hospital (OSH)

Services provided

With campuses in Salem and Portland, OSH provides inpatient and residential services with a budgeted capacity of 681 beds and a licensed capacity of 768 beds. OSH is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Geropsychiatric treatment services are certified to receive Medicaid Title XIX funding by the Centers for Medicare and Medicaid Services (CMS). The hospital is organized into two treatment programs, serving the entire state.

Recovery Services Program, serving adults with major mental illness who have been committed to the state for care treatment.

- **Adult Treatment Services:** These services are provided in two adult general psychiatric units on the Salem campus (65 beds) and at a 68-bed leased facility in Portland. This program provides hospital-level psychiatric services for 133 adult patients with major psychiatric illnesses who are between the ages of 18 and 65 years. Patients treated in this program are unable to function in a less structured environment and have been civilly committed and assigned to hospital-level care. This program provides intermediate and long-term state hospital treatment for patients transferred from community acute care hospitals.
- **Geropsychiatric/Medical Services:** These services are provided in 114 beds in three units of specialized active inpatient treatment for elderly persons with mental illness and a specialty unit for neurologically impaired patients of all ages. Five beds providing acute nursing care for patients suffering from medical conditions are included on one of the acute geropsychiatric wards. Inpatient services are available to older adults who have major psychiatric disorders and adults over age 18 who have brain injuries. These adults require nursing care and are unable to function in a

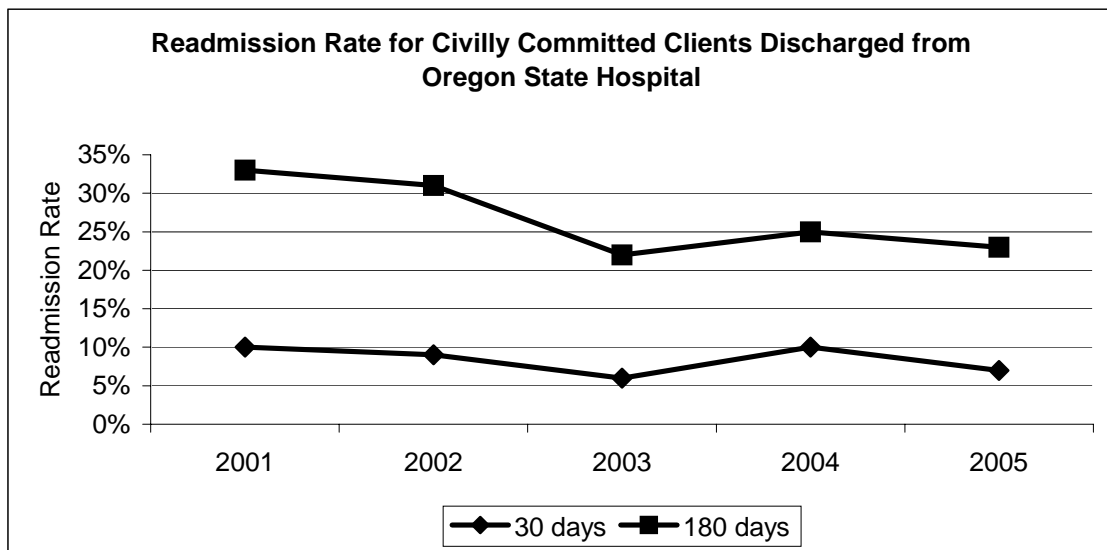
less restrictive nursing home environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical/surgical hospital.

Forensic Services Program, providing hospital and residential treatment services to patients committed by the courts for evaluation or treatment to be able to aid and assist or to the jurisdiction of the Psychiatric Security Review Board (PSRB).

- **Forensic Hospital Services:** These services consist of 334 hospital-level beds on six wards. A full array of clinical programs is offered in maximum and medium security levels. This inpatient care is available to patients who are adjudicated guilty except for insanity and who are committed to the jurisdiction of the PSRB. In addition, this program provides services for some civilly committed patients who are either too dangerous or too difficult to manage in the less restrictive and secure environment of a general adult hospital program. This program also provides evaluation and treatment services for patients determined by the courts to be unable to assist in their own defense (ORS 161.365 and 161.370). The January 2006 Legislative Emergency Board provided funding for 30 additional staff to provide focused evidence-based services for patients with substance abuse disorders co-occurring with mental illnesses. Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors. A treatment mall has been developed to provide active treatment to prepare patients for successful transition to community-based care.
- **Forensic Residential Services:** These services provide treatment for 100 patients on three residential wards. These wards provide treatment to PSRB patients who have shown substantial improvement in their conditions and who require a less restrictive environment in preparation for their release. These new services were developed as part of the settlement of a federal lawsuit; *Harmon v. Fickle*.

Performance Measures (OSH)

Readmission rates at 30 and 180 days are key performance measures for the state hospitals. This information gives insight into the quality of discharge planning and the coordination of services with the community. The following table shows that the readmission rate at 30 days has remained stable during the past five years, while the 180-day readmission rate has dropped 30 percent – a good sign that coordination has improved.



Quality and Efficiency Improvements (OSH)

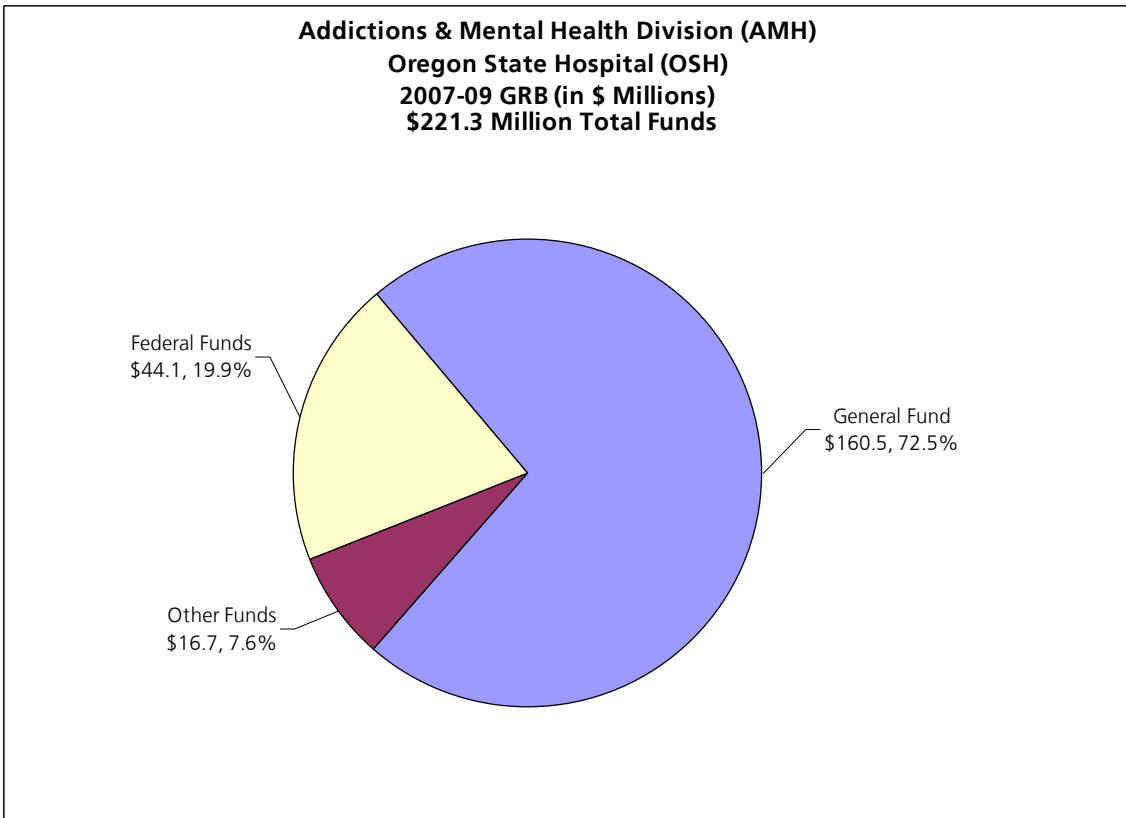
State Hospital Response to United States Department of Justice (U.S. DOJ) Civil Rights of Institutionalized Persons Act (CRIPA) Investigation

Prior to and following a November 13-17, 2006, review by a team of psychiatrists, psychologists, nurses and facility experts accompanied by U.S. DOJ attorneys, OSH has developed a draft plan for continuous improvement of patient treatment and is making changes to the treatment process for patients at the hospital.

The treatment mall was expanded in October 2006 to provide specialized treatment to allow patients to be prepared for discharge to the community more quickly than previously occurred. There are services for those who have co-occurring substance abuse disorders and for those who have histories of sex offenses. There are services to prepare people for successful community living and to provide supported employment and supported education for those patients who are able to work and those who want to improve their educational levels.

AMH entered into an agreement with Oregon Health and Science University (OHSU) to provide a chief psychiatrist and up to six additional psychiatrists to strengthen the psychiatric services at OSH. At the same time, recruitment for regular staff physicians is being enhanced with expert consultations from the DHS recruitment manager and Dr. Joseph Bloom. This dual effort will improve treatment and working conditions at OSH.

2007-2009 Budget Summary (OSH)



Key budget drivers and issues

Lawsuits

During 2005-2007 the *Harmon v. Fickle* lawsuit filed in federal court alleged civil rights violations of OSH forensic patients due to crowding and insufficient staff to effectively treat the patients. The state settled with the Oregon Advocacy Center (OAC) June 7, 2006. As part of the settlement, the state agreed to make every possible effort to improve the staff-to-patient ratio, to strengthen the active treatment program in the hospital and to discharge an additional 71 patients. The January 2006 Legislative Emergency Board provided funding for 30 additional staff in the state hospital and 71 additional community placements.

While the state was able to settle this lawsuit, there is continued risk due to the aging and poorly designed OSH physical structures in which treatment must be accomplished. It is critical that the state continue its efforts to develop appropriate community-based resources and discharge people from the state hospital. The location and design of a new state hospital will be discussed during the 2007 Legislative Session as part of the deliberations on the Governor's Recommended Budget. These decisions also will be critical to the management of the state's risk of future lawsuits.

Governor's Recommended Budget Reductions

No reductions were proposed to this program in the Governor's Recommended Budget.

Policy option packages

104-44 Harmon Settlement (Federal Lawsuit)

104- 44 Harmon Settlement - (Fed Lawsuit): Provides funding for 17 additional OSH staff and to develop approximately 81 community placements over and beyond 2007-09 caseload growth development.				
	GF	OF	FF	TF
AMH Program & Admin	\$ 11.3		\$ 4.2	\$ 15.6
(\$ in millions)				

This package adds 17 additional registered nurses to OSH at a total cost of \$2.5 million total funds. This will improve the staff-to-patient ratio in accordance with the settlement of the *Harmon v. Fickle* lawsuit. There will be an improved quality of patient care.

104-46 State Hospital Facility and Data Systems Replacement

104- 46 State Hospital facility & data systems replacement: The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues with the complex on the Salem campus of the Oregon State Hospital. The Phase I Master Plan notes that the existing facilities on this campus have physical limitations that cannot be remediated to provide safe and secure treatment environments. In addition to the facilities replacement needs, the current State hospital has antiquated technology, which no longer meets the business needs of the hospitals. This request will allow for the issuance of a State bond to begin the replacement process. The Governor's Budget funds this package through Certificate of Participation funding.				
	GF	OF	FF	TF
AMH		\$ 0.6		\$ 0.6
(\$ in millions)				

The administrative portion of this request, \$0.3 million of the total, will be located at OSH. The positions will provide the hospital oversight of work done by DAS, contracted engineering firms, architectural firms, and other consultants necessary to complete the siting and design process for the first replacement state hospital facility.

106-61 OSH and SPD MMA Implementation – ongoing workload

106- 61 OSH & SPD MMA Implementation - on-going workload: This package assures that OSH and the community programs will be able to comply with the requirements of the MMA Part D and on-going staffing for new Federal program requirements that require SPD field staff workload increases of over 40,000 cases monthly.					
		GF	OF	FF	TF
AMH	\$	0.4			\$ 0.4
(\$ in millions)					

This package makes two limited duration pharmacy technician positions permanent. These positions assist with the work necessary to successfully bill Medicare for medications for patients eligible for the Medicare Part D Drug Benefits. One position is added to work with patients upon admission and in preparation for discharge to help them select a plan that covers their required medications. With these supports, OSH will be able to continue enrolling patients in the best plans for their needs and then billing the plans for medication costs.

Blue Mountain Recovery Center (BMRC)

Services provided

Located in Pendleton, the Blue Mountain Recovery Center (BMRC), also known as the Eastern Oregon Psychiatric Center (EOPC), provides diagnosis, evaluation and treatment for adult patients. Acute psychiatric care and long-term treatment for men and women are provided on a 30-bed ward. There is an intensive treatment services 30-bed ward for men only.

BMRC provides acute psychiatric admissions for 16 Eastern Oregon counties plus diagnosis, evaluation and treatment for general psychiatric patients who are dangerous to themselves or others, unable to care for themselves, and cannot be effectively treated in community hospitals or managed in community outpatient programs. In addition to the provision of pharmacological, behavioral and cognitive therapies, the rehabilitative program provides medication management, nutrition planning, personal finance and other life management skills necessary for integration into the community. Since BMRC has no capacity to provide in-house non-psychiatric medical or skilled nursing care, these services are obtained at the local community hospital in Pendleton.

BMRC serves as a source of training and consultation for psychiatric and medication services for CMHPs in its service area. Close coordination is maintained between BMRC and Eastern Oregon CMHPs and service providers.

Where service recipients are located

Adults from throughout Oregon are served at the three state hospital campuses.

Who receives services

Services are provided to adults who are a danger to themselves or others, are unable to care for their basic needs, and who are civilly committed to the department for treatment of a major psychiatric illness. Adults who are adjudicated guilty except for insanity and who are committed to the jurisdiction of the PSRB are treated at OSH in Salem. Adults who require evaluation and treatment services when the courts have determined they are unable to aid and assist in their own defense are treated at OSH in Salem.

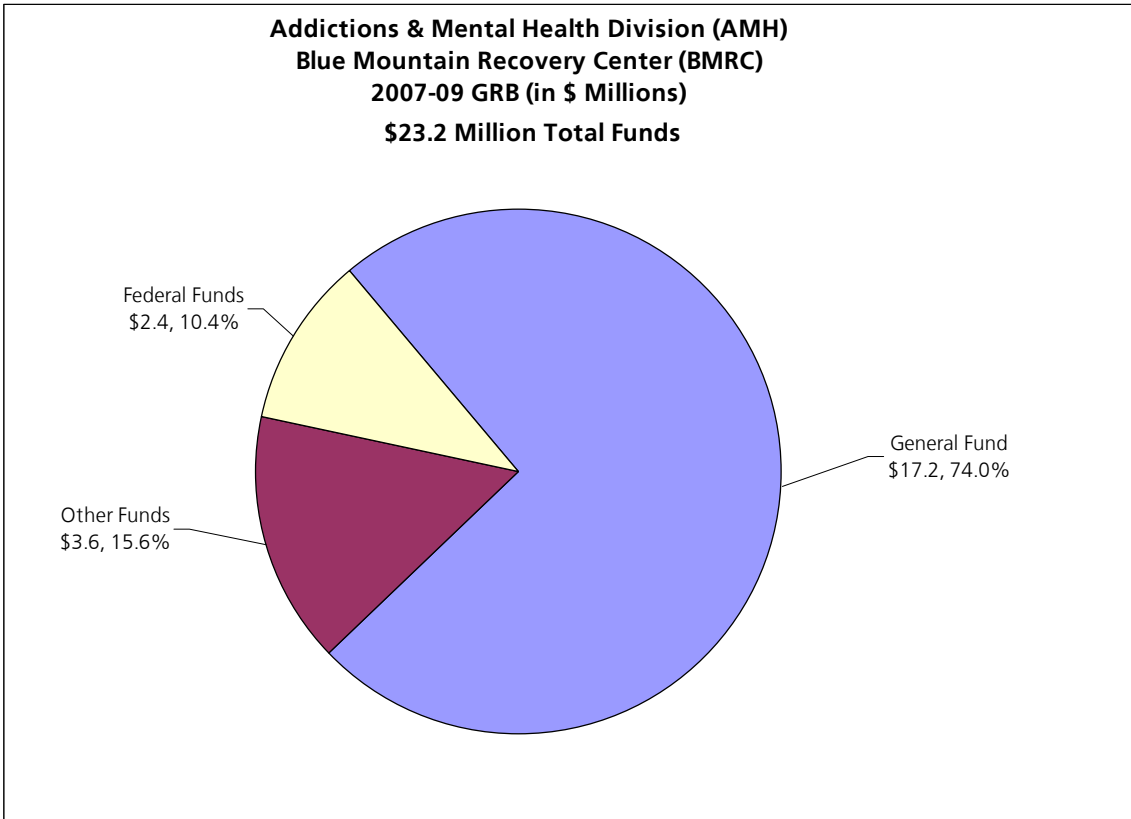
How services are delivered

Intensive, secure environments are the sites for physician-directed treatment teams who work with patients to determine appropriate medications. In addition, patients receive individualized services to ameliorate the disability and loss of functioning caused by the mental illness. Individual and group therapies are available, as well as specialized services for patients who have both mental illness and substance abuse disorders. Specific research-based services have been developed for people who have been adjudicated for sex offenses or who have a history of sexual acting out. Transition services recently have been developed to prepare patients for successful discharge into community-based services. Services to track work skills and the opportunity to work are available for patients whose level of functioning has improved sufficiently to allow them to participate.

Why these services are significant to Oregonians

One of the primary functions of the state hospitals is to ensure that individuals who require treatment are kept safe until they are able to manage their symptoms and behaviors. Another primary function is to ensure public safety through the secure intensive treatment of persons who have been court-ordered to the hospital for treatment after having been found guilty of a crime except for insanity. These secure intensive services also are available to persons who are being evaluated and treated so that they are able to assist in their defense. This ensures public safety as well as the safety of the individual patient.

2007-2009 Budget Summary (BMRC)



Program Administration and Support (PA&S)

AMH, in collaboration with external partners and stakeholders, creates the vision for mental health and substance abuse prevention and treatment systems of care, and sets policy to bring the vision into practice. The AMH Assistant Director supervises the state hospitals and works with the leadership of the state hospitals to integrate their services into the statewide system of care for people with mental illness.

AMH Program Administration and Support staff are responsible for:

- Developing state plans for substance abuse prevention and treatment services and mental health services;
- Implementing state addiction, gambling and mental health programs and laws;
- Directing services for persons with substance abuse disorders, and those with problem and pathological gambling;
- Directing services for persons with mental illness;
- Directing services for persons with co-occurring mental illness and substance abuse disorders; and
- Maintaining custody of persons committed by courts to the state for care and treatment of mental illness.

Program Administration and Support staff share responsibility with the counties for developing and managing community programs as part of the overall state mental health and addiction system. If a county is unable to operate a program area, AMH is responsible for contracting for services directly with providers.

The Assistant Director of AMH represents Oregon on matters of federal and national policy for mental health and substance abuse prevention and treatment.

Program Administration and Support staff ensure the efficient and effective functioning of the program office and the necessary supports to the program and policy staff. AMH Central Administration works closely with the department budget staff and contract administration staff to ensure sound financial management of the addiction and mental health services community and state hospital program budgets, and the appropriate implementation of community treatment programs through contractual relationships.

Program Administration and Support staff provide support and assistance to the Governor's Council on Alcohol and Drug Abuse to achieve its statutory responsibilities. This support includes staffing monthly meetings, arranging public testimony throughout the state, and developing the Council's biennial report to the Governor.

Program Administration and Support staff provide direction and coordination of the public addiction and mental health services system in the areas of:

- Addictions Policy and Program Development,
- Housing and Homelessness Services,
- Mental Health Policy,
- Extended Care Management,
- Quality Assurance and Certification,
- Mental Health Community Development,
- Program Analysis and Evaluation,
- Evidence-Based Practices,
- Support Services,
- Problem Gambling,
- Forensic Mental Health Policy,
- Children's System Development,
- Mental Health and Addictions Medicaid Policy,
- Prevention and Treatment,
- Oregon State Hospital, and
- Blue Mountain Recovery Center.

Program Administration and Support is composed of three sections – Alcohol and Drug Prevention, Alcohol and Drug Treatment, and Community Mental Health.

These sections set policy for the alcohol and drug abuse prevention and treatment system, the mental health treatment system, and the problem gambling prevention and treatment system. This is accomplished through:

- Program development;
- Administrative rules development;

- Biennial planning;
- Coordinating policy and contracts for all Medicaid-covered services including the Oregon Health Plan;
- Strengthening coordination between the state hospitals and the community mental health programs to ensure appropriate admission to and timely discharge from the hospitals;
- Conducting site reviews;
- Conducting licensing and certification inspections;
- Providing timely system data, analysis of data and reports to leadership;
- Development of contracts for community-based services;
- Providing training and technical assistance;
- Policy direction,
- Administrative oversight;
- Quality improvement;
- Conducting research on effective programs and measuring outcomes;
- Providing technical assistance to community programs;
- Policy development, contracting and policy direction in rate setting for the OHP services available to people with substance abuse disorders or mental health conditions;
- Implementing evidence-based practices as required by ORS 182.525;
- Managing the development of community housing for persons with mental illness;
- Collaborating with state and local partners to reduce and end homelessness; and
- Staffing advisory bodies and participating in workgroups.

Alcohol and Drug Prevention

This section of AMH is responsible for policy direction, program development, technical assistance and oversight of the community-based and statewide alcohol and drug prevention programs. These programs work closely with local partners including the Commission on Children and Families in all 36 Oregon counties. The nine federally recognized Indian tribes also provide prevention services to their members. Staff focus on developing evidence-based statewide strategies to maximize the effectiveness of

prevention programs in order to delay the use of alcohol, prevent the use of other drugs and minimize the disabling effects of addictions. This section also is responsible for the programs that prevent problem gambling in Oregon.

Alcohol and Drug Treatment

This section of AMH is responsible for policy direction, program development, technical assistance and oversight of the community-based alcohol and drug treatment system providing services in all 36 Oregon counties and through the federally recognized Indian tribes. This section also is responsible for policy direction, program development, technical assistance and oversight of the service delivery system for the treatment of problem gambling.

Community Mental Health

This section of AMH provides oversight, policy direction, program development and technical assistance to the community mental health system, and ensures linkages with the state hospitals. These staff are responsible for the development of new community-based resources to treat adults who have achieved maximum benefit from state hospital treatment and are ready to be discharged into the community. The Children's Treatment System provides oversight, development, training and technical assistance to the community-based system in order to maximize the effective treatment of children in their home communities. The Mental Health and Substance Abuse Medicaid Policy staff ensure appropriate policy considerations in rate setting for managed care, contract for managed mental health services, and monitor federal Medicaid and Medicare policy affecting services to people with mental health and substance abuse problems.

Program Administration and Support also is responsible for the program aspects of budget development, compliance monitoring, training and technical assistance for the 32 CMHPs and more than 100 providers offering prevention and treatment services to children, adolescents, adults and older Oregonians to prevent or ameliorate the disabling effects of substance abuse, problem gambling, and mental and emotional disorders.

Statewide program coordination

A key function of Program Administration and Support is the coordination it provides within DHS and with other state agencies to ensure quality services for Oregonians with substance abuse disorders, mental illness and/or problem gambling. Key activities are.

Linkages between services, programs and agencies

Mental health and addiction services are only effective when delivered in concert with other support services that include child welfare, housing, income assistance, health care, vocational and educational programs, and social services. AMH develops the

linkages necessary to provide opportunities for persons with mental illness and those with addiction disorders to recover and create independent and meaningful lives. Areas of linkage include:

Oregon Health Plan

OHP contractors for mental health services are required to establish linkages with all needed support services. Linkages also are required with CMHPs, which provide mental health and addiction services not covered by the capitation payment. Enrollment in an OHP MHO provides a single access point for all necessary social support services available to persons eligible for Medicaid who receive mental health services. AMH and the Division of Medical Assistance Programs (DMAP) are working with the fully capitated health plans (FCHPs) and MHOs to integrate physical health care and behavioral health care services for the population covered by OHP. This will increase identification of persons in need of services because of substance abuse and improve access to timely treatment for all disorders.

Housing

AMH provides technical assistance to local agencies for the development of housing resources, financing packages, and applications for federal and state housing funds. AMH provides leadership and direction for housing initiatives to provide alcohol- and drug-free housing, housing coordination services, rent subsidies for people in recovery, and the development of peer-supported recovery homes for people with substance abuse disorders. AMH also provides leadership, direction and funding for the development of housing and residential treatment facilities for people with severe and persistent mental illness. AMH manages the Mental Health Housing Trust Fund created by the 1999 Legislature from the proceeds of the sale of Dammasch State Hospital in accordance with ORS 426.502.

Children in state custody

Children in the care, custody and supervision of the DHS child welfare program comprise more than half of children receiving mental health treatment services. AMH works with the Children, Adults and Families Division (CAF) to co-finance and co-manage many out-of-home treatment services provided to these children.

Children in the juvenile justice system

The Oregon Youth Authority (OYA) and local juvenile authorities share responsibility for youth offender accountability and services. AMH works closely with OYA and local juvenile departments throughout the state to improve access to mental health and substance abuse services for children and adolescents involved in the juvenile justice system. AMH will develop treatment services and monitoring systems for youth who are committed through the newly created Juvenile PSRB. The law takes effect July 1, 2007.

Prevention

AMH collaborates with the Commission on Children and Families to guide the development of comprehensive county plans including strategies to decrease the negative effects of alcohol and other drug abuse. AMH staff work with county mental health prevention experts, local coalitions, and the state and local commissions on children and families to strengthen those community factors that help youths avoid using alcohol and other drugs at an early age.

Seniors and People with Disabilities Division

AMH collaborates with Seniors and People with Disabilities Division (SPD) to improve access and quality of mental health services to SPD clients. The two offices provide integrated mental health treatment and other services for seniors and younger people with disabilities in nine specialty programs. Outreach and consultation services are provided statewide to individuals, families, guardians, conservators, public or private health care facility staff, and social agency staff upon request.

Stakeholder participation in policy-making and oversight

AMH works extensively with key stakeholders to ensure safe, efficient and effective prevention and treatment services.

AMH works with four primary stakeholder councils – the Governor’s Council on Alcohol and Drug Abuse, the Problem Gambling Services Advisory Committee, the Mental Health Planning and Management Advisory Council, and the Consumer/Survivor Council.

The Governor’s Council on Alcohol and Drug Abuse, created in 1985, is charged with implementing legislative policy with the following functions:

- Develop a statewide alcohol and drug abuse plan that recommends goals, specific priorities and programs for review by the Governor and Legislature.
- Monitor the programs and financial efforts of the state that prevent, intervene in, and treat alcohol and other drug problems for compliance with the approved statewide alcohol and drug abuse plan.
- Assess the economic and social impact of alcohol and drug abuse on the State of Oregon and report the findings and recommendations to the Governor by January 1 of each even-numbered year.
- Review and recommend to the Governor the goals, financing, priorities and a state plan for prevention, intervention and treatment of alcohol and drug abuse problems that encompasses all appropriate state agencies by January 1 of each even-numbered year.

- Review alcohol and drug abuse programs and recommend to the Governor the effectiveness and priorities for improvements of all such prevention and treatment programs for alcohol and drug problems engaged in or financed through state agencies by January 1 of each even-numbered year.
- Review the current and proposed efforts of state agencies to deal with problems caused by alcohol and other drug misuse and addiction.
- Identify gaps in needed services, duplication of services, and opportunities for multi-agency cooperation in less costly or more effective services.
- Assist with the review of the comprehensive county plans created through local collaborations coordinated by Partners for Children and Families.

As provided in ORS 409.430, the Problem Gambling Services Advisory Committee meets every other month. Participation is open to the public. The advisory committee makes recommendations to DHS concerning performance standards and evaluation methodology, fiscal reporting and accountability, delivery of services, and a distribution plan for use of available funds.

The Mental Health Planning and Management Advisory Council is responsible for overseeing mental health programs. The Council's by-laws describe five primary functions:

- Advise AMH about mental health policies and programs for children, adolescents and adults.
- Facilitate effective, cooperative working relationships among the components of the mental health system.
- Make recommendations regarding the identification, development and use of resources.
- Identify problems and develop recommendations for resolution.
- Serve as the federally mandated Planning Council for the purpose of monitoring, reviewing and evaluating the federally mandated state annual plan for mental health services funded through the federal Center for Mental Health Services Block Grant.

The AMH Assistant Director meets every other month with the Consumer/Survivor Council. The purpose of this council is to:

- Inform the state mental health authority on mental health policy and service delivery from the perspective of people who receive or have received mental health services (consumer/survivors).
- Provide a forum for consumer/survivors to communicate special and unmet needs and concerns to the state mental health authority.
- Provide a forum for the state mental health authority to inform consumer/survivor leadership of efforts being made to provide a better system of mental health delivery.

AMH also provides services and coordination through various local and regional councils. AMH works closely with NAMI Oregon and Oregon Family Support Network (OFSN) to ensure locally based quality treatment services.

Quality of services

Program Administration and Support ensures the quality of services through the following activities:

Training

- AMH sponsors and coordinates a variety of educational workshops, conferences and training programs. Trainings are focused on continuous improvement in the knowledge, skills and abilities of community treatment staff to safely serve persons with mental illness and/or addiction disorders. The focus of training has been and will be the delivery of evidence-based practices throughout the substance abuse and mental health treatment system.
- Training is provided for commitment investigators and law enforcement personnel to ensure compliance with statutory requirements and appropriate police response to persons in crisis.

Quality assurance

- AMH is responsible for reviewing all CMHPs and MHO contracted services, and for licensing residential treatment facilities and adult foster homes serving persons with mental illnesses. Additionally, certification programs are administered for sub-contracted mental health and substance abuse providers, day treatment and nationally accredited psychiatric residential programs for children, acute care units, privately funded non-inpatient mental health and substance abuse providers, and facilities using hold rooms.

- OHP MHO contractors are required to develop comprehensive quality assurance plans and to collect utilization, performance and outcomes data. This information is compared to establish performance standards for access to services, quality of care, education, outreach, preventive care and coordination of available social services.

Oregon Administrative Rules

- Oregon Administrative Rules govern all services and activities administered by state agencies. AMH is working with stakeholders to revise the administrative rules related to substance abuse and mental health to eliminate discrepancies and redundant information, and to streamline record keeping. The goal is to reduce the amount of time spent on paperwork and to increase accountability.

Projects

Several key projects being led by Program Administration and Support include:

Oregon State Hospital Master Plan

As a result of the September 2004 recommendations of the Governor's Mental Health Task Force, the January 2005 Legislative Emergency Board funded an independent assessment of OSH. That assessment resulted in the Master Plan Phase I Report presented to the 2005 Legislature. The report noted that the buildings are unsafe, do not meet current earthquake standards, and are not conducive to modern psychiatric treatment.

The 2005 Legislature then funded a second study that resulted in the Oregon State Hospital Framework Master Plan Phase II Report. AMH worked with the independent consultants, Legislature and the Department of Administrative Services to gather data for the report.

As a result, the Governor and Legislature selected an option to replace the aging facility with two modern state psychiatric hospitals and at least two community-based 16-bed residential facilities.

In August 2006 a joint interim legislative committee held three meetings to establish site selection criteria. Beginning in August 2006 and concluding in December 2006, AMH held meetings for two separate workgroups to begin planning the community-based services necessary to support the new hospitals and meet the needs of central and eastern Oregon communities. The results of their work will be made available to the 2007 Legislature as it makes decisions on the siting and financing of the new state hospitals.

Child and Adolescent Mental Health System Change Initiative

This initiative started in 2003-2005 and continued in 2005-2007. A 2005 budget note directed DHS to increase the availability and quality of individualized, intensive and culturally appropriate home- and community-based services. The goal is to serve children and their families in their home communities and minimize institutional treatment. The care is to be managed and coordinated across all levels and types of placements. In response to the budget note, AMH adopted policies, placement criteria for determining intensive service needs, contract language, financial models and monitoring, and moved the intensive facility-based services into managed care October 1, 2005. Implementation has gone more smoothly in some areas of the state than others; continuing challenges are being resolved and monitored. Generally, children and their families are being supported in their communities and, when out-of-home placement is clinically required, it is coordinated and the lengths of stay are lower for children in managed care. AMH will continue to work with MHOs and stakeholders to resolve implementation issues.

Evidence-based practices (EBPs)

As directed by the 2003 Legislature, AMH worked with other agencies named in ORS 182.525 to develop criteria and a process for determining which substance abuse and mental health prevention and treatment practices are evidence-based. The state worked with stakeholders to make these determinations, develop implementation procedures for changing the system to one that delivers increasing amounts of evidence-based practices, determine the outcomes to be measured, and determining the method of measuring progress in implementing EBPs. There now are more than 100 approved practices, and the system is spending well more than the required 25 percent of state and federal resources on these practices.

Cultural competency

In order to improve the cultural competency of the state-funded addiction, mental health, and gambling prevention and treatment services, AMH conducted a cultural competency survey of each unit in accordance with the DHS Standards for Cultural Competency. AMH is developing action plans that will assist with the development of more culturally relevant and specialized services. The issues of culture have been integrated with the implementation of EBPs. This work respects and values differences among consumers, shares responsibility for addressing these differences, and measures success in addressing cultural differences. AMH will continue to strengthen communication and cooperation within various racial and ethnic communities.

Oversight of the OHP mental health benefit

The focus of the monthly meetings between AMH and the MHO contractors is the implementation of the federally mandated External Quality Review (EQR) activities. The state contracted with an independent medical professional review organization to

determine MHO compliance with federal Medicaid managed care regulations, as well as to validate MHO performance measures and the performance improvement projects undertaken by each MHO. The independent contractor also will review statewide mental health performance improvement projects. These efforts will result in reports to the state to improve the performance of the MHOs and to improve the quality of services to OHP members.

Settlement of *Harmon v. Fickle*

DHS was sued in 2005 by the Oregon Advocacy Center (OAC) on behalf of a class of OSH forensic patients. The suit focused on conditions for forensic patients due to crowding on the wards and lack of sufficient staff to provide optimal treatment. DHS and OAC entered into a settlement agreement June 7, 2006, to hire 30 new state hospital staff (with funding from the January 2006 Legislative Emergency Board) and to develop 41 community-based placements in addition to those funded in the 2005-2007 budget. As of January 1, 2007, OSH had filled 27 of the 30 positions and is bolstering recruitment for psychiatrists and psychologists. AMH also is developing 30 Intensive Case Management placements and 41 additional residential placements by June 30, 2007. As of February 1, 2007, the staff-to-patient ratio had improved to 1:1.24 from 1:1.09 in the fourth quarter of 2005. AMH continues to report progress monthly to OAC.

Recovery focus for alcohol and drug and mental health treatment systems

AMH adopted a policy on recovery and resiliency in July 2006 as the foundation for a recovery-focused system. AMH is realigning the state's clinical, administrative and financial infrastructure to support counties, providers and recovery advocates in adapting new models in their communities. Recovery-oriented services will improve outcomes for individuals, including those involved with multiple systems.

Distribution of alcohol and drug treatment funds

State funds to support local alcohol and drug treatment for indigent clients through county programs have been distributed based on disconnected actions established 10 or more years ago and continued each biennium. Per-capita funding ranged from a low of \$1.03 to a high of \$32.26 in the least-populated county. The current statewide per-capita average is just \$2.70. Counties that have experienced major population growth during the past 10 years are severely under-funded relative to those counties with a more stable population. AMH met with the counties and other providers for six months to develop a more rational approach. The Governor's Recommended Budget proposes funding to bring the lowest counties to the statewide average. Failing new resources, a more rational distribution of funds will be achieved over five years by reducing funding in 21 counties by 20 percent each year in order to add funding to the lowest-funded counties.

Problem gambling services for inmates

AMH worked with the Department of Corrections (DOC) to conduct a pilot project investigating the need, utility and efficacy of providing problem gambling intervention services to DOC inmates. The 2004-2005 pilot project demonstrated that persons with a history of problem or pathological gambling composed 32 percent of the incarcerated female population in Oregon. An intervention was offered to inmates who were within six months of release and had a history of problems related to gambling. This program consisted of four psycho-educational classes and the use of a self-change guide. As of January 2007, 275 individuals had enrolled in this program. An evaluation of the program found that the intervention was effective at increasing knowledge and changing attitudes, and 90 percent of the six-month follow-up sample reported being free of gambling problems following their release. Due to the success of the pilot program, the service was expanded in 2005 and 2006 to provide services in two additional DOC correctional facilities.

Residential gambling treatment

During the past six years, AMH developed an internationally recognized continuum of care for problem gamblers and their family members. Missing from this continuum, however, were specialized services directed at persons who had repeated outpatient treatment failures and persons with extremely complicated episodes of pathological gambling. In 2006 Oregon's first extended stay residential gambling treatment center opened its doors. AMH provided funding for seven beds in a new 11-bed, 30-day residential gambling treatment facility. With demonstrated effectiveness and adequate funding (one percent of state Lottery proceeds), the residential gambling treatment program will be expanded to fund the full 11 beds during the 2007-2009 biennium.

Performance Measures (PA&S)

AMH tracks the effectiveness of its services and programs using three key performance measures – one for alcohol and drug treatment, one for prevention services, and one for mental health treatment. AMH also has begun tracking a set of measures known as the National Outcome Measures (NOMs) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in cooperation with the states. The NOMs will be more fully described following the presentation of AMH's key performance measures.

The three performance measures for which AMH is primarily responsible are:

- KPM #18—Completion of alcohol and drug treatment
- KPM #19—8th Grader risk for alcohol and drug use
- KPM #28—Mental health client level of functioning

Other Performance Measures (PA&S)

The key performance measures represent a small set of the measures AMH uses to track service performance and guide service development. To create a broader view, AMH has adopted NOMs to track the performance of the state hospitals, community treatment services, and prevention services. SAMHSA developed the NOMs in collaboration with the states. The NOMs are important to AMH's performance monitoring for several reasons:

- In 2007 the NOMs will be required reporting for all states receiving mental health, substance abuse and prevention block grants.
- The NOMs provide a framework for describing a range of outcomes that are accessible and meaningful for each state.
- Because all of the outcomes are collected using similar methodologies, the NOMs will provide outcomes that can be compared across states.

The NOMs framework is supported by three categories of outcomes, which can be described in much the same way that a cross-section of a motor vehicle is described. This is appropriate given that AMH serves as a "vehicle" for providing addictions, mental health and prevention services.

The exterior design of the vehicle creates the first impression and can tell you what to expect in the way of performance. Outcome categories from the NOMs, such as employment, education, housing, criminal justice involvement and cost effectiveness, do the same thing. These are outcomes that define the ultimate goals of the services. These are outcomes that are important to everyone – in particular the people funding the services. But, the outside of the vehicle is only one perspective.

The interior of the vehicle is another perspective. It tells you how you are going to feel about being inside and going on the trip – vinyl or leather, wood or plastic, comfortable or bone jarring. This information is derived from the NOMs by collecting data from the people using the services. Clients' perceptions of care give AMH information it can use to make adjustments to the provider system so that it fits with the needs of the clients.

Finally, there are the mechanical and electrical systems that allow the vehicle to function. Nothing matters, for example, if the engine does not do its job and get the vehicle from "A" to "B". The engine performance is monitored by information on the dashboard or by an expert mechanic. Various technical indicators show how well the vehicle is doing, how long it's going to last and when maintenance or repairs are needed. Information about how many people are being served, how long they stay in service, and whether they have to come back after being discharged are all part of the

NOMs and act as basic measures of the system’s status. The information is integral to the evaluation of a vehicle’s performance.

Taken together, the NOMs present a complete picture of the service system and give a broad overview of how AMH services are making a difference for clients. The following table represents the different windows of system performance that can be viewed.

The National Outcome Measures Performance Categories				
Reduced Morbidity	Employment/ Education	Crime and Criminal Justice	Stability in Housing	Social Connectedness
Access/Capacity	Retention	Perception of Care	Cost Effectiveness	Use of Evidence- Based Practices

AMH uses performance measures in all of its programs, many more than can be summarized for this presentation. For overall system monitoring, AMH has adopted the NOMs as its framework for outcome tracking. AMH will submit data for these measures to SAMHSA on an annual basis beginning this year and will use this same information to guide its reporting to the Legislature.

While the data show good progress overall for treatment and prevention services, there is room for improvement. AMH will build on the framework offered by the NOMs to develop more specific measures to track performance at the provider level. The goal is to move more comprehensively toward performance-based contracting, which will hold AMH and its providers more accountable to the people who are served and to the funding sources. To some degree, this already has occurred with many alcohol and drug treatment contracts. However, AMH will be taking this effort to another level for all treatment and prevention services during the next biennium and will report on its progress at the next legislative session.

Quality and Efficiency Improvements (PA&S)

Evidence-based practices

AMH is committed to meeting the needs of people using state-funded services through the use of prevention strategies and treatment methods that are demonstrated by research to be effective. There are 49 mental health and addictions treatment practices and 106 prevention practices now approved for use by the community programs and the state hospitals. In 2005-2007, 56 percent of state funds for alcohol and drug treatment services were delivered using an approved evidence-based practice (EBP). Mental health providers report using 33 percent of the state treatment funds for EBPs.

AMH has improved the quality and efficiency of services by fostering the use of evidence-based practices in prevention and treatment services. AMH uses a variety of tools to move the service delivery system to adopt science-based approaches. These tools include defining EBPs, monitoring fidelity, redesigning rules, funding priorities, contracts, and workforce development strategies. During the 2007-2009 biennium the system will spend no less than 50 percent of public funds for services that are evidence-based. By the 2009-2011 biennium AMH aims to spend no less than 75 percent of public funding on evidence-based practices. This will result in better outcomes, more efficient service delivery, and a greater long-term impact for each dollar spent. As a result of the move to evidence-based service delivery, fewer people with substance abuse disorders will be incarcerated and there will be a decrease in the rate of emergency hospitalization for people with mental illness.

Performance-based contracting

For the past three years AMH has worked with the CMHPs and providers to change service contracts to be more performance based. For the 2007-2009 biennium AMH will raise the bar on performance by addiction and mental health contractors through the implementation of outcome-based contracts. In collaboration with stakeholders, AMH will revise and refine a set of objective measures for assessing the care provided by publicly funded programs. Establishing clear objective measures will allow AMH to set performance standards and incorporate those standards into its contracts. Using the new standards, AMH can design contracts that include financial incentives for high performance, along with direct consequences for contractors that cannot achieve the needed outcomes. Strengthening the connection between payment and outcomes means better programs, clearer accountability, and better outcomes for the clients and their families.

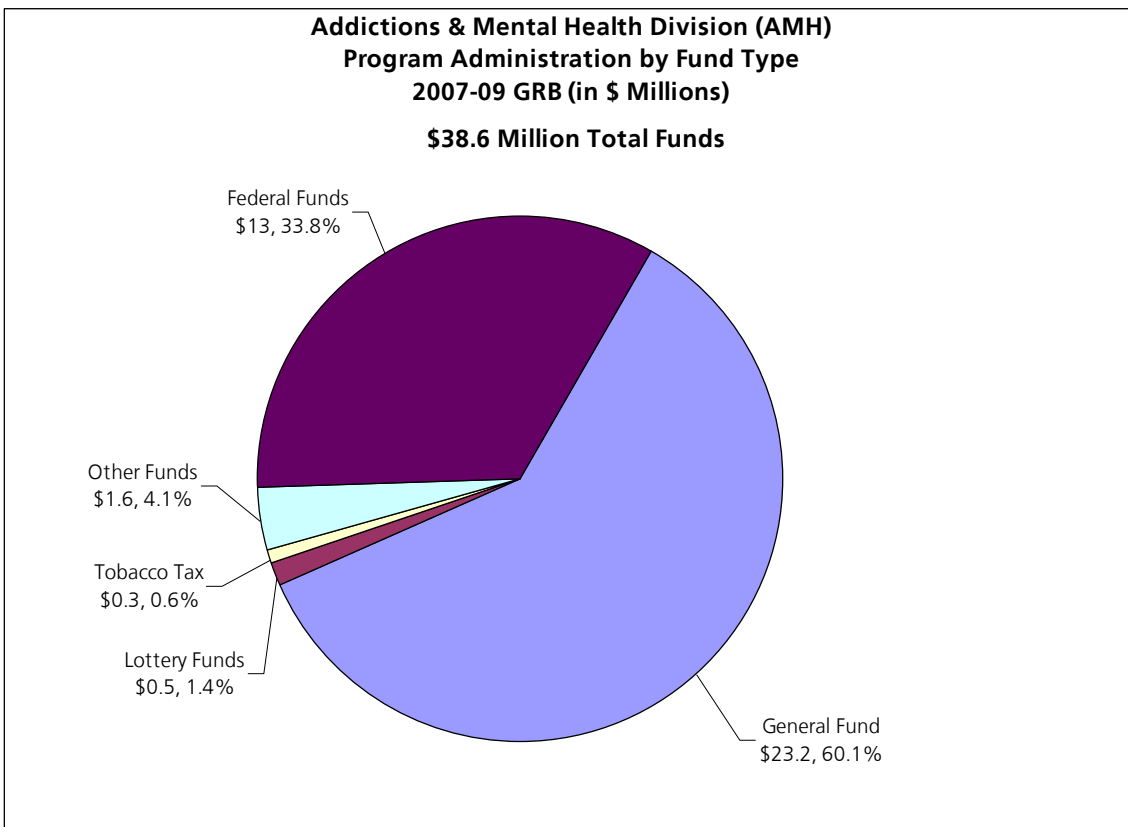
Administrative efficiencies

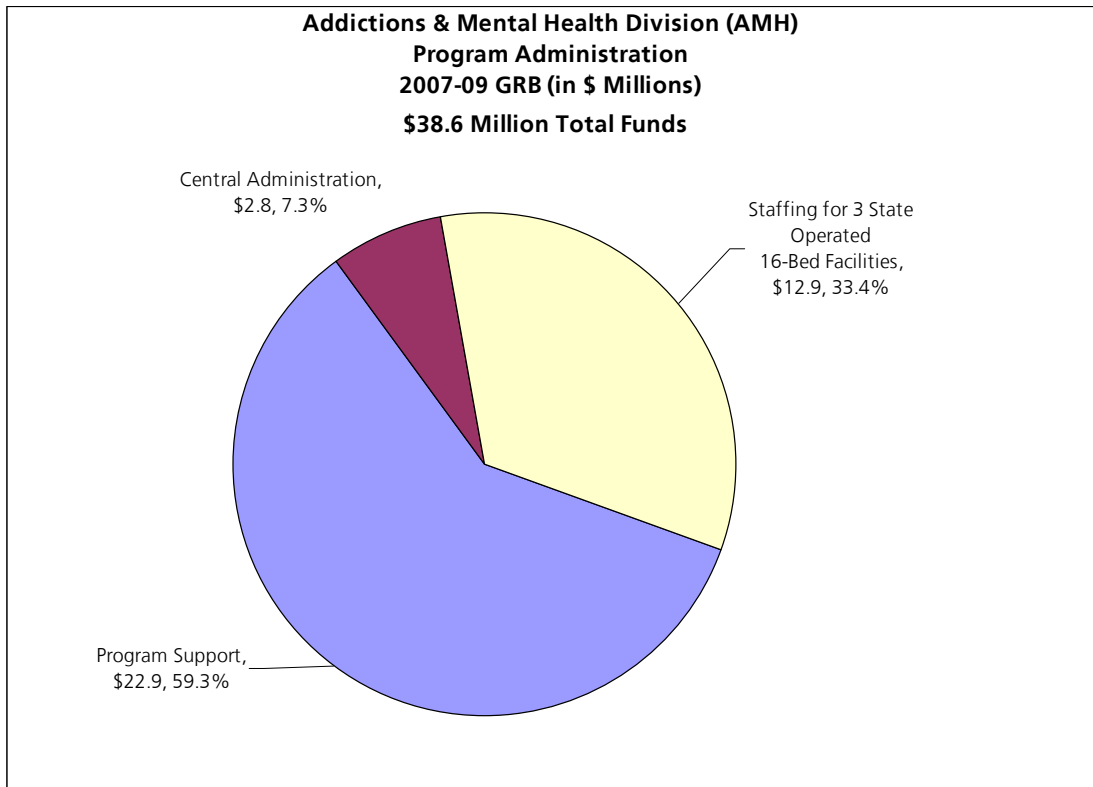
AMH is rewriting all of the Oregon Administrative Rules (OARs) that apply to CMHPs and the providers of addictions and mental health services. The goal of this process is to increase critical accountability, remove conflicting rules, develop a single set of rules for addiction and mental health services, eliminate detailed process requirements, focus on evidence-based practices and outcomes, and finally, dramatically reduce the amount of time clinical staff spend on paperwork. Providers report that clinical staff spend as much as 50 percent of their time meeting various paperwork requirements. The goal for the rule revision is to reduce that to 10 percent. Providers indicate they will be pleased if the process achieves 25 percent. The new rules will drive a reworking of the site review process for certifying providers of publicly funded addiction and mental health services.

AMH budget liaison and program development staff streamlined the process for initiating contracts and contract amendments to facilitate transition of OSH patients to community-based treatment facilities. Led by a DHS expert in Rapid Process

Improvement, the staff eliminated unnecessary steps, wait times, paper forms and inefficient communication methods. The result was a faster, leaner process. The leaner process means that staff can do more work with less time and effort. As a result of this improvement, AMH provides more timely service to the counties and providers who develop and deliver the community-based services. This ensures a higher volume of services to increasing numbers of clients, and speeds the effort to reduce crowding at OSH.

2007-2009 Budget Summary (PA&S)





Key budget drivers and issues

Lack of safe, affordable housing

The urban areas of Oregon are some of the most expensive for rental housing or home ownership in the country. A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addictions and mental disorders. When people have uncertainty about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them, their continued sobriety is at risk.

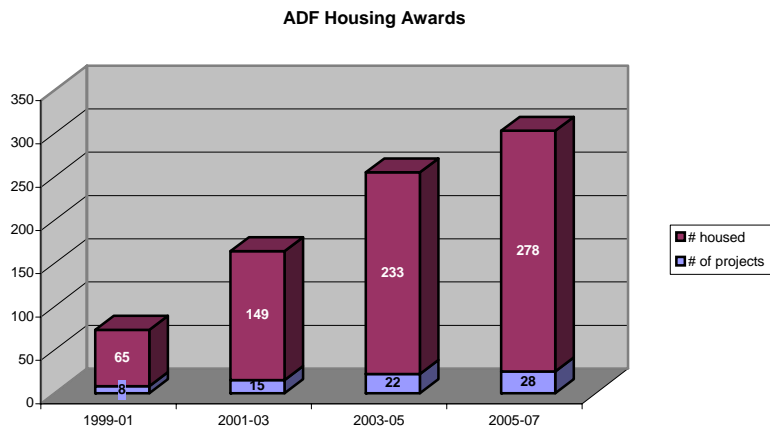
Unfortunately, most clients of Oregon's publicly funded system are exactly in these adverse living environments. Homeless people with mental illness are less likely to use medications appropriately and to continue in treatment services, thus risking further illness, mandated treatment and greater disability.

Lack of appropriate housing keeps people in expensive, structured treatment environments longer than necessary to treat and stabilize their illness. This causes delays in discharging people from the state hospital and means people are staying in the most restrictive and expensive level of care longer than necessary.

As a result of the cost of housing and the effects of the disorders, each year more than 8,000 people are homeless when they enter public addiction and mental health

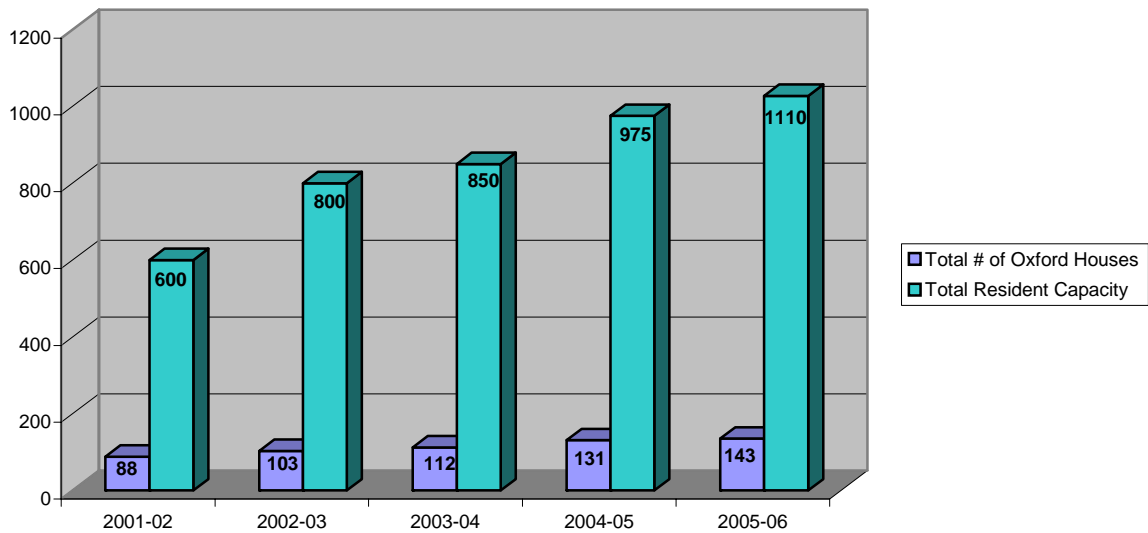
services. The state has undertaken the following initiatives to address housing for people with addiction and mental disorders:

- ◆ **Alcohol and Drug Free (ADF) Housing Development.** Each biennium since 1991-2001, AMH transfers funds to Oregon Housing and Community Services to develop “Alcohol and Drug Free” (ADF) housing to support people in recovery from serious addictions. During 2005-2007 six projects were funded and will provide 45 units of affordable ADF housing. The following chart shows growth of projects and capacity since 1999.



- ◆ **ADF Housing Assistance Services.** AMH funds eight projects in seven counties and one tribal community to support more than 500 people per year in recovery from addictions to obtain stable ADF housing as they transition to self-sufficiency.
- ◆ **Oregon Recovery Homes.** AMH contracts for two outreach coordinators who support the establishment of new Oxford Houses. There now are 143 of these homes in 15 Oregon counties accommodating approximately 1,110 people recovering from alcoholism and drug addiction. More than 300 children live in these homes. These homes operate on a self-governed, peer support model. The following chart shows growth of homes and capacity since 2001.

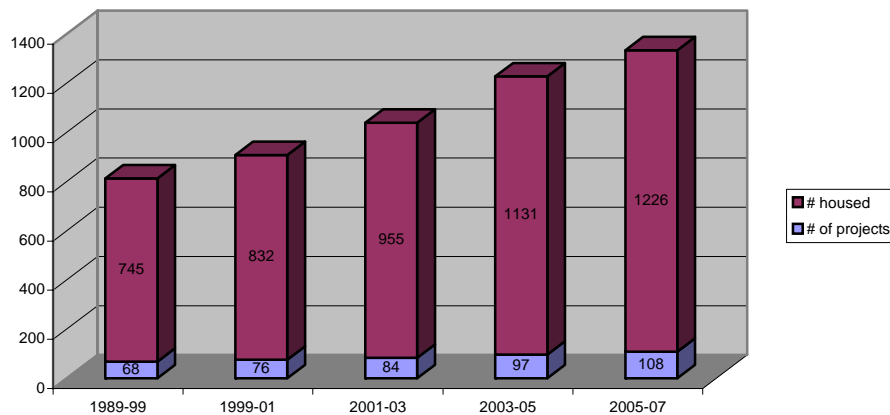
Oxford Houses/Oregon Recovery Homes



In the mental health area, AMH has two housing funds and an initiative on the former Dammasch State Hospital site in Wilsonville – the Villebois project.

- ◆ **Mental Health Services (MHS) Housing Fund.** Since 1989 AMH has provided grants to support the development of 108 housing projects in 25 counties accommodating 1,226 people with severe and persistent mental illnesses. The following chart shows growth of projects and capacity since 1989.

MHS Housing Fund



To date, AMH has invested \$3.6 million in the development of these projects. Each dollar invested leverages approximately \$20 from other sources.

- ◆ **Community Mental Health Housing Fund.** Established with the proceeds from the sale of the former Dammasch State Hospital property, the first three

rounds of awards totaling \$1,461,979 were made in March 2005, July 2006 and January 2007 to support 20 housing projects in 13 Oregon counties.

- ◆ **Villebois.** AMH is working with private developers to integrate community housing into the new urban village community at the former Dammasch site in Wilsonville. AMH expects to develop 20-24 projects during the next 10 years. The first project, a five-resident group home called Hearthstone, opened in August 2006. The second project, a 20-unit apartment complex, is expected to break ground in May 2007. Five more projects are in the pipeline.

Medicaid uncertainty

Medicaid-reimbursed services are the foundation of the community mental health system, including OHP, for an array of community services including medications, therapy, case management and acute psychiatric inpatient services. Medicaid-reimbursed services provide the treatment and personal care supports for adults with major mental illnesses in an array of residential settings. The system for children and adolescents relies primarily on Medicaid-reimbursed services for intensive treatment, residential and day treatment, and therapies for the child and family in the community. If there are major changes in the federal requirements that lessen the availability of these services as is currently reflected in the President's 2008 budget, the mental health system will be destabilized.

Medicaid-reimbursed services are important to the funding of the alcohol and drug treatment system. OHP covers alcohol and drug therapies in the community and medical detoxification services. The residential treatment system relies heavily on Medicaid-reimbursed supports for clients requiring structured 24-hour supports to maintain sobriety and work on recovery. These services are essential for parents who have lost or are in danger of losing their children to the child welfare system because of parental substance abuse.

During the last two years the federal Center for Medicare and Medicaid Services (CMS) has become more restrictive in its interpretation of Medicaid regulations. At this time, interpretations have been asserted that are not supported by the regulations or the Congressional intent. This creates problems in the addictions and mental health treatment system, which relies on Medicaid funding beyond OHP. The issues are more immediate and problematic in the mental health system. Recent interpretations of the uses of Personal Care, the Medicaid Option, the payment methodology that is acceptable, and the applicability to persons with severe persistent mental illness will potentially threaten the stability of the portion of the system that treats people requiring 24-hour supports in their living situations.

Similar issues are being raised about the states' use of the rehabilitative services option; early versions of proposed changes in the federal regulations indicate that much of the work done in Oregon and reimbursed under this state plan option would be excluded from reimbursement in the future. Rehabilitative services form the core Medicaid services for people with substance abuse disorders and mental health disorders. Such changes would destroy the fabric of the treatment system.

Restrictive funding sources

Children with mental and emotional disorders and their families confront numerous systems in order to find the assistance they and their children require. A family will be working with the mental health system and sometimes multiple providers within the system, the school, possibly juvenile justice or the child welfare system. In order to meet the needs of these families and children, resources from each of these systems must be integrated to provide the full array of services and supports to achieve the best outcomes for the child. Each agency has multiple funding sources, many of them federal, and all with restrictions and requirements on the use of the funds. This problem is often referred to as "funding silos." The Governor's Office is working with the advocates and state agencies on a strategy to find an alternative to these restrictions that will support integrated and managed treatment for these families. An Executive Order is expected within the next several weeks.

The funding silos also make it more complicated to treat adults with either substance abuse or mental disorders who are involved in multiple systems such as child welfare or criminal justice. The major problem is that the funding is tied to programs or categories of eligibility and not focused on individual needs in order to recover and use fewer public services.

Poor preparation of training programs

Oregon's colleges and universities are insufficiently prepared to train the next generation of workers for publicly funded programs that treat adults and children with substance abuse disorders including problem gambling and mental health disorders. The state and community programs are unable to hire sufficient numbers of nurses, pharmacists and physicians to provide the active psychiatric treatment that enables people to enter recovery. The problems also exist for counselors, social workers, and certified alcohol and drug abuse counselors. This problem is not limited to the addictions and mental health fields. Throughout the health care industry, the concern about the future of the professional workforce is growing. The scarcity of trained staff creates wage competition for the available staff, and increases the costs of services for all clients including those who are publicly funded.

Lack of competitive wages

The service rates for alcohol and drug treatment and mental health treatment, especially 24-hour care, are too low to support reasonable wages for the staff who work with the most vulnerable clients with the most intense treatment needs. As a result, recently graduated staff are working with the most ill populations. At times, residential treatment staff providing direct care are, like their clients, eligible for subsidized housing and food stamps due to low wages. These staff have very limited benefits including health care.

As a result, there are frequent staff turnovers. This disrupts treatment for the clients, especially for children and adolescents in residential care. The high turnover increases the training costs for the programs, further eroding the financial viability of the providers. Recently, one of the executive directors of an adolescent psychiatric residential program noted that staff are leaving the agency to work in the fast food industry for higher wages.

These problems result in reduced quality of care, longer lengths of stay in intensive and expensive services, and less effective treatment for those who need the most effective treatment.

Stigma

People are reluctant to admit they have a problem with alcohol or drugs, or that they are experiencing symptoms of mental illness. As a result, people often wait until their symptoms have worsened, and they may be arrested or forced into treatment against their will. The stigma associated with these disorders makes it difficult for people to openly seek help for their problems. Failure to seek help early in the course of these disorders creates more social disruption for the individual and increases the likelihood of mandated services or arrest.

Governor's Recommended Budget

Reductions

No reductions were proposed to this program in the Governor's Recommended Budget.

Policy option packages

104-44 Harmon Settlement (Federal Lawsuit)

104- 44 Harmon Settlement - (Fed Lawsuit): Provides funding for 17 additional OSH staff and to develop approximately 81 community placements over and beyond 2007-09 caseload growth development.				
	GF	OF	FF	TF
AMH Program & Admin	\$ 11.3		\$ 4.2	\$ 15.6
(\$ in millions)				

The administrative portion of this request, \$0.3 million total funds, is for two positions in program support. The positions will provide the central management functions for the three state-operated 16 bed community-based secure residential facilities including hiring house managers, assure the hiring of staff, training of staff, development of policies and procedures, and managing the budget for these programs.

104-46 State Hospital Facility and Data Systems Replacement

104- 46 State Hospital facility & data systems replacement: The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues with the complex on the Salem campus of the Oregon State Hospital. The Phase I Master Plan notes that the existing facilities on this campus have physical limitations that cannot be remediated to provide safe and secure treatment environments. In addition to the facilities replacement needs, the current State hospital has antiquated technology, which no longer meets the business needs of the hospitals. This request will allow for the issuance of a State bond to begin the replacement process. The Governor's Budget funds this package through Certificate of Participation funding.				
	GF	OF	FF	TF
AMH Program & Admin		\$ 0.6		\$ 0.6
(\$ in millions)				

The administrative portion of this request, \$0.3 million total funds, is for 1.5 FTE to provide central oversight of all of the work necessary to replace the state hospital; including monitoring the DAS staff, the contractors and assuring that the DHS perspective is included. Responsibilities include managing the entire project within the budget and working with FPA Budget to assure fiscal accountability and reporting for leadership. There are also moneys associated with the general services and supplies of these positions and includes resources for contracted specialists.

Division Summary

Anticipated legislative impacts

The major impact AMH envisions from the 2007 Legislative Assembly is the approval of the siting report and the plan to develop a new state hospital building to replace the 124-year-old Oregon State Hospital facility in Salem.

Budget notes and legislative actions

AMH was responsible for reporting on one Budget Note and two statutorily required reports.

Community mental health

House Bill 5023 (2003) included the following Budget Note:

The Department of Human Services (Office of Mental Health and Addiction Services) is directed to report to the Emergency Board on efforts to improve the coordination of care in the children's mental health system in response to directives from the 2003 Legislative Assembly. The report should describe the changes made to the system, the impact of these changes upon children, their families and services providers, as well as the work that still needs to be completed. The report should be presented no later than June 30, 2006.

As directed by the Legislative Emergency Board at its June 22, 2006, meeting, DHS provided an update on the activities in the children's mental health system change initiative. The report included a presentation by the Regional Research Institute at Portland State University on the results of their evaluation of the implementation of the change. The evaluation examined the processes for change at the state and local levels.

As required, the department reported to the June 2006 Legislative Emergency Board. A copy of the report is attached as Appendix A.

Statutory reports

- Alcohol and Drug Prevention
- Alcohol and Drug Treatment
- Community Mental Health
- State Hospitals

Evidence-based Practices - ORS 182.525 Mandatory expenditures for evidence-based programs; biennial report rules.

The department is required to submit this report no later than September 30 of each even-numbered year to the interim legislative committee dealing with judicial matters. As required, AMH reported to the September 20, 2006, Joint Interim Judiciary Committee. A copy of the report is attached as Appendix B.

Community Mental Health - ORS 430.640(1)(p) Duties of Department of Human Services in assisting and supervising community mental health and developmental disabilities programs.

The department is required to report biennially to the Governor and the Legislature on the progress of the local planning process and implementation of local county mental health plans, and the state planning process and performance measures. As required, that report is attached as Appendix C.

Oregon State Hospital

During the 2005-2007 biennium DHS reported to the Legislative Emergency Board regarding the remodel of the 6th floor of the Portland OSH campus at each meeting of the Legislative Emergency Board beginning with the October 27, 2005, meeting.

As directed at the October 2005 Legislative Emergency Board, AMH worked with an architectural firm to refine the cost of remodeling the 6th floor to turn medical treatment space into psychiatric treatment space and reported to the January 19, 2006, Legislative Emergency Board. At that meeting, DHS also presented "An Action Plan to Improve Patient Safety and Care at OSH." As a result of the first report, the Legislative Emergency Board released the funds reserved for the 6th floor remodel. Based on the second report, the Legislative Emergency Board awarded funds to add 30 clinical staff to OSH, four staff to AMH, and fund 71 additional community placements. The purpose of these actions was to:

- Provide treatment space in Portland to make it possible to transfer 100 patients from a portion of the OSH Salem "J" building most susceptible to earthquake damage;
- Improve the quality of care for Forensic patients at OSH;
- Improve the staff-to-patient ratio; and
- Assist in the settlement of a lawsuit against the hospital and department.

The lawsuit alleged overcrowding for patients, understaffing, lack of treatment and unsafe conditions. The Legislative Emergency Board action supported the department in reaching a settlement agreement in the *Harmon v. Fickle* lawsuit.

The department reported progress on the 6th floor remodel and the plan to improve patient care and safety at the April 6, 2006, June 22, 2006, September 21, 2006, and the November 30, 2006, meetings of the Legislative Emergency Board.

