

# Addictions and Mental Health Division

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## 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.

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## 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.
- Replace state hospital with state-of-the-art psychiatric treatment and recovery facilities.
- 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 75 percent of expenditures for mental health and substance abuse treatment in 2009-2011 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 2009-2011 by 25 percent over the 2007-2009 rates.
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## **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 county-based 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 62 percent of public funding goes to community-based services.

Major trends include the focus on recovery-oriented services, consumer-driven services, peer-delivered recovery 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. The preliminary results for 2005-07 suggest that AMH has met the 50 percent requirement for that time period, however results are still being tabulated and will be finalized in mid-September 2008.

As a result of Governor Kulongoski's 2004 Mental Health Task Force, the state 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 2007 Legislature approved Certificate of Participation (COP) financing to build two new state-of-the-art psychiatric treatment and recovery facilities to replace the Oregon State Hospital. The first facility with capacity to treat 620 people in programmatically unique areas with separate residential areas and centralized treatment malls will open in 2011 and is located in Salem on the grounds of the current hospital. The second facility will treat 360 people and will be located in Junction City. This facility is scheduled to open in 2013. The new facilities will be supported by an integrated electronic hospital management system with an electronic health record at its core. The Behavioral Health (Data) Integration Project was approved for COP financing and will be operational before the new facility opens.

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.

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## 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 2007-2008, 120,000 adults and 41,000 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 treatment,

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.

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## 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:

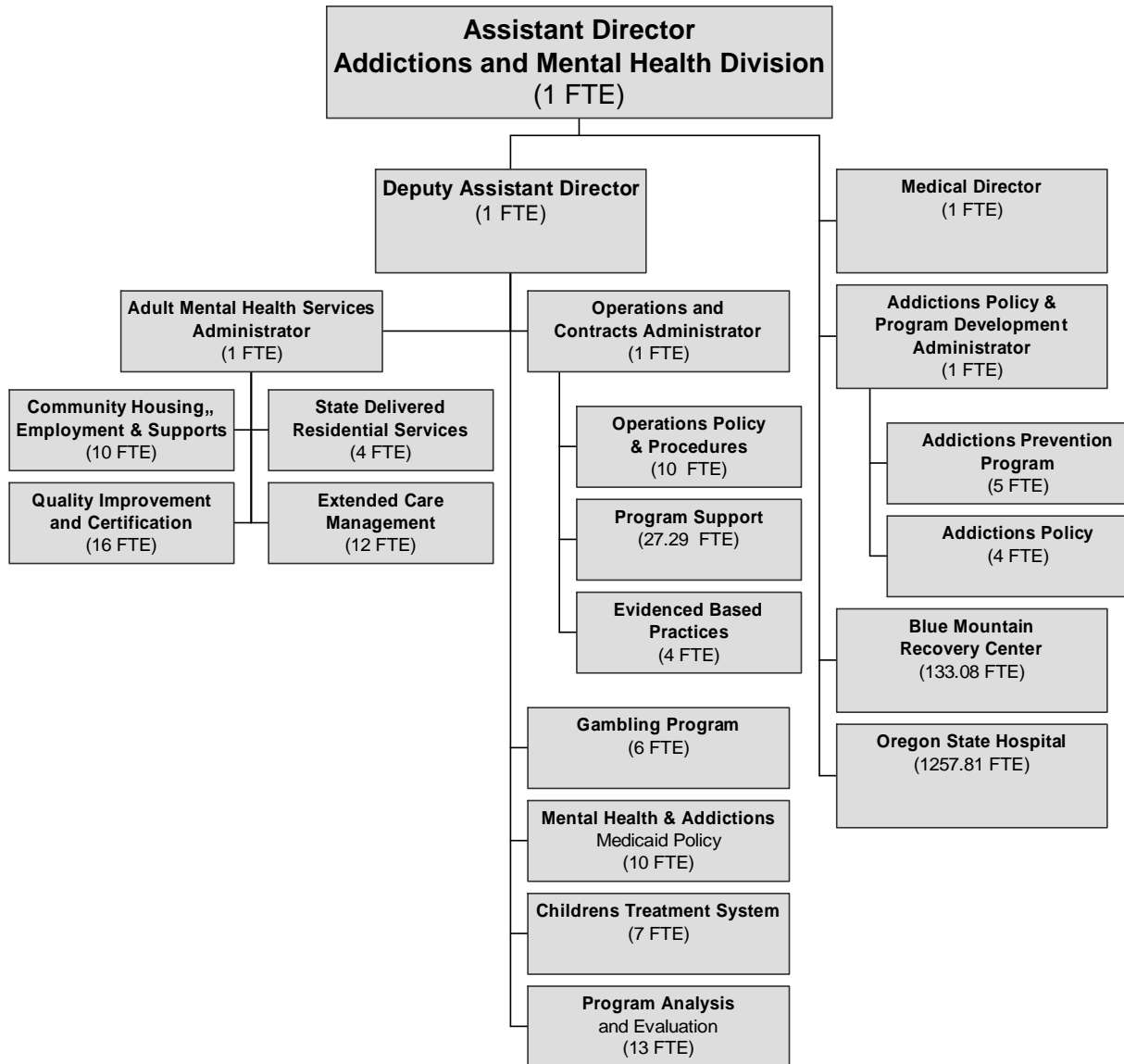
- Become employed,
- Live safely in the community,
- Avoid repeated cycles of arrest and incarceration,
- Become good parents, and
- Reduce the use of acute psychiatric hospitals for crisis stabilization.

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 five primary program areas:

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

# Organizational Structure



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## **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 and drugs. 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 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 235,515 Oregonians were provided access to broad-based prevention information during 2007-2008. In addition, 32,266 people received selected prevention services; and another 5,611 received indicated prevention services.

## **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 #22 – 8<sup>th</sup> 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**

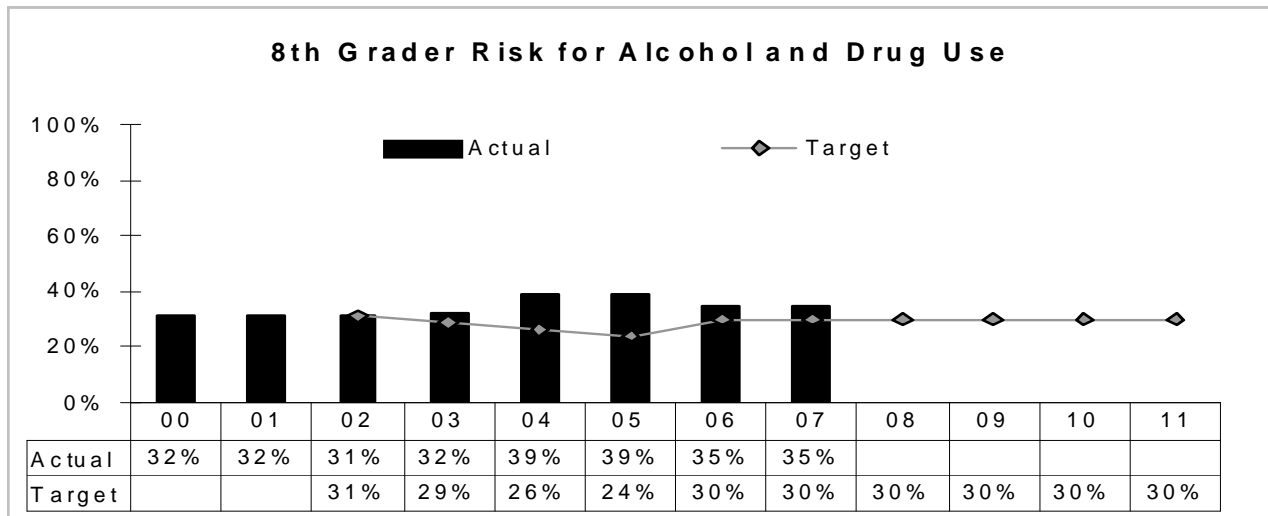
The current target for this measure is 30 percent.

## **Results**

After remaining steady in the low 30 percent range for several years, this measure peaked in 2005 at 39 percent, but has since dropped to 35 percent. This is still above the goal rate of 30 percent. 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 –15.4 percent versus 31 percent. Washington has maintained funding for its prevention efforts, and it shows.



## Other Performance Measures

Prevention services outcomes within the National Outcome Measures (NOMs) include data on prevalence of substance use, consequences of use, and risk and protective factors. Prevalence data tells the extent of a problem, such as the percentage of youths who drink. Consequence data provides information about the impact of use on individuals. Risk factors are conditions that increase the likelihood of a young person becoming involved in substance use and protective factors are conditions that support the development of healthy behaviors. In all cases the information helps AMH direct its prevention efforts.

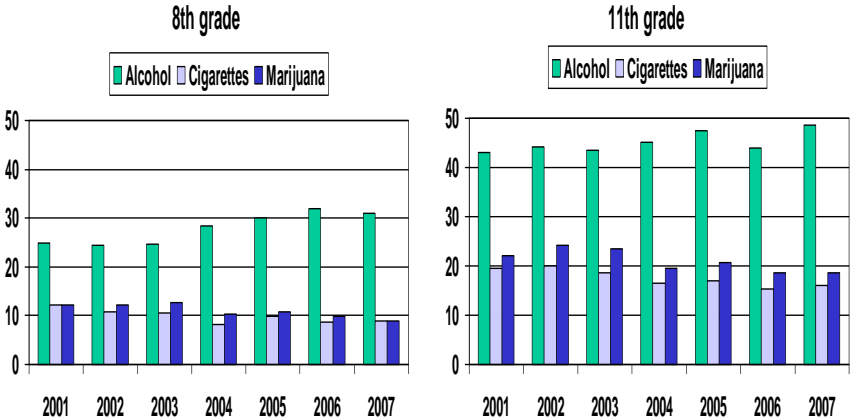
Alcohol, tobacco and illicit drug use impact families, schools, workplaces and the community. It causes long-term health problems, leads to premature death, contributes to injuries, violence and abuse, and can lead to addiction that erodes an individual's ability to function normally.

Substance abuse and dependence are diseases that affect Oregonians of all ages. About 9 percent of Oregon youth 12 to 17 years old abuse or are dependent on alcohol or drugs; 20 percent of young adults 18 to 25 and 6 percent of adults 26 or older abuse or are dependent on alcohol or drugs, requiring treatment.

Initiation of alcohol, tobacco or marijuana use at young ages has been linked to more intense and problematic levels of use in adolescence and adulthood. The charts below show trends in the percent of 8th and 11th grade youth who use

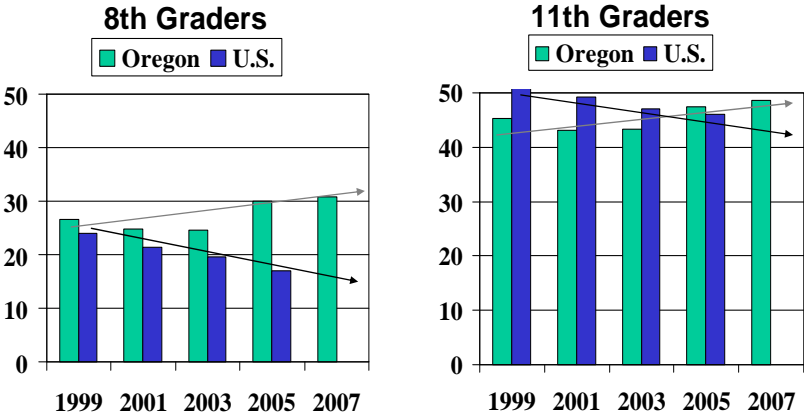
alcohol, cigarettes or marijuana. Alcohol use is clearly the largest issue, has been increasing and is higher than national rates.

### Percent of youth using alcohol, cigarettes, or marijuana in the past month



Data Sources: Oregon Healthy Teens Survey, Monitoring the Future, Youth Risk Behavior Survey

### Percent of Youth Drinking Alcohol in Last 30 Days



Data Sources: Oregon Healthy Teens Survey, Monitoring the Future, Youth Risk Behavior Survey

An American Medical Association report shows that adolescent drinkers perform worse in school, are more likely to fall behind and have an increased risk of

social problems, depression, suicidal thoughts and violence. Even occasional heavy drinking injures young brains.

Young people who consume alcohol are more likely than adults to drink heavily. Youth who binge drink are much more likely to engage in other risky behaviors such as drug use, risky sexual behavior and aggressive antisocial behavior.

Oregon youth who binge drink are more likely to report attempting suicide than youth who do not.

Oregon youth begin drinking at very young ages and are more likely to start drinking before 13 years of age than to start smoking cigarettes (27 percent for alcohol use vs. 10 percent for cigarette use). In 2007, 31 percent of 8th graders reported drinking alcohol on one or more occasions in the past 30 days and 13 percent reported binge drinking. Among 11th graders, 49 percent reported drinking in the past month, 27 percent reported binge drinking and 10 percent reported driving after they had been drinking.

Three factors known to influence the likelihood of underage alcohol use are: accessibility to alcohol, perceived risk of harm and parents' disapproval of drinking. Oregon 8th and 11th graders are more likely to report lower risk of harm and less parent disapproval for alcohol than for cigarette use. Despite the fact that sales of alcohol to minors are illegal, 64 percent of 8th graders and 82 percent of 11th graders say it is "sort of easy" or "very easy" to get beer, wine or hard liquor.

Parents play an influential role in preventing underage drinking. Youth who know their parents disapprove of underage drinking are less likely to drink alcohol, especially at an early age. Oregon 8th graders who believe their parents think it is "wrong" or "very wrong" if they drank alcohol were half as likely to drink as youth who believe their parents think it is "a little bit wrong" or "not wrong at all."

Alcohol is the most widely used addictive substance among adults in Oregon. Alcohol use, especially heavy drinking and binge drinking, results in negative health consequences and contributes to crime and violence against persons. Alcohol is a known carcinogen and a leading cause of chronic liver disease. It is toxic to many organ systems including the heart, stomach, pancreas and nervous system. In addition, unintended injuries, suicide and diabetes are leading causes of death associated with alcohol use. Even moderate alcohol consumption can

lead to negative consequences such as alcohol-related motor vehicle crashes, birth defects and harmful interactions with medications.

Each year more than 1,000 Oregonians die from alcohol-related causes. In 2004, the most recent year that data are available, Oregon had the fourth highest rate of death due to alcohol-induced disease. Deaths from alcohol-induced diseases are one of the ten leading causes of death for men and women in Oregon.

By far heavy drinking and binge drinking are most closely linked to negative health consequences from alcohol. Heavy drinking is associated with heightened levels of all-cause mortality. Heavy use of alcohol refers to alcohol consumption at levels that exceed U.S. Dietary Guidelines. Men who drink more than two drinks per day and women who drink more than one drink per day are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence.

Binge drinking is strongly associated with injuries, motor vehicle crashes, violence, Fetal Alcohol Spectrum Disorder (FASD), chronic liver disease and a number of other chronic and acute conditions. Binge drinking is defined as consumption of five or more drinks by men and four or more by women in a short time span.

In 2006, six percent of men and five percent of women in Oregon were heavy drinkers, and

Nineteen percent of men and 10 percent of women in Oregon reported binge drinking.

## **Quality and Efficiency Improvements (ADP)**

### **Funding for prevention**

The Agency Request Budget includes a comprehensive policy option package for evidence-based prevention services. The package supports strategies including community involvement, skill building for parents and youth, changes to underage drinking norms and drug free workplace initiatives.

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.

For every dollar spent on these effective strategies there will be a return in savings from \$2 - \$28. 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.

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);
  - 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.

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## **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).

### **Where service recipients are located**

CMHPs and county-designated nonprofit organizations provide treatment for alcohol and drug abuse problems 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 2007-2008, 41,248 adults age 26 and above were served; 14,890 young adults age 18 through 25 were served; and 6,635 adolescents age 12-17 were served. 2,308.

## **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.

## **Performance Measures (ADT)**

### ***KPM #19 – Completion of alcohol and drug treatment***

#### **Purpose**

Once a client enters 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 65/66 percent and beyond during the next few years.

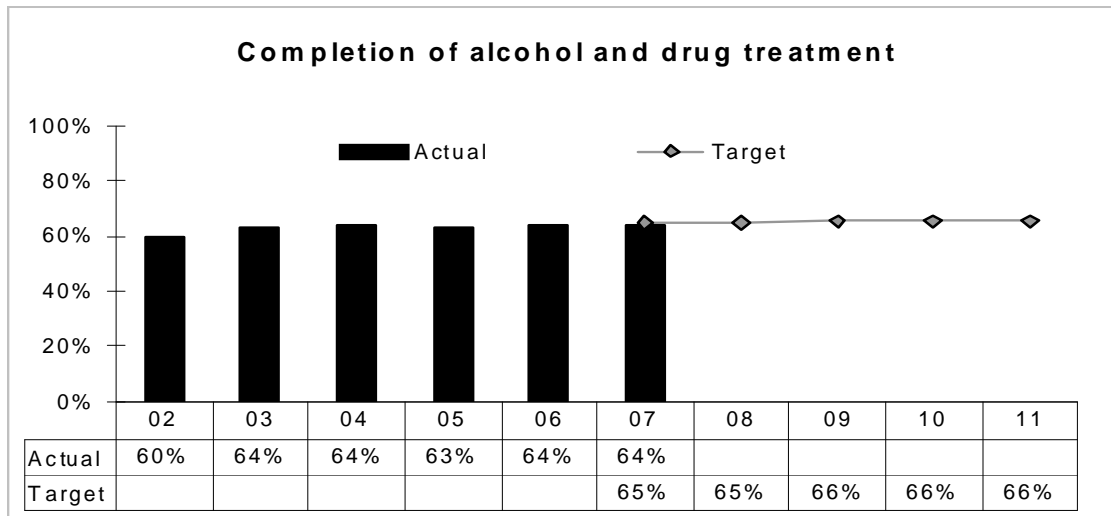
#### **Results**

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 60 percent range for the past several years. It is currently 64 percent. It is expected to

increase during the next few years as more providers implement evidence-based practices and implement quality improvement efforts designed to retain clients in treatment.

## 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 51percent. This is based on data submitted by states to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.



## *KPM #20 – Adults Employed after Alcohol and Drug Treatment*

### Purpose

A key outcome for many clients is to maintain or gain employment, as a result of their treatment. AMH’s strategy relates to the Oregon Business Plan initiative to increase access to treatment and intervention services for Oregon workers who have alcohol and drug problems but no insurance.

## Target

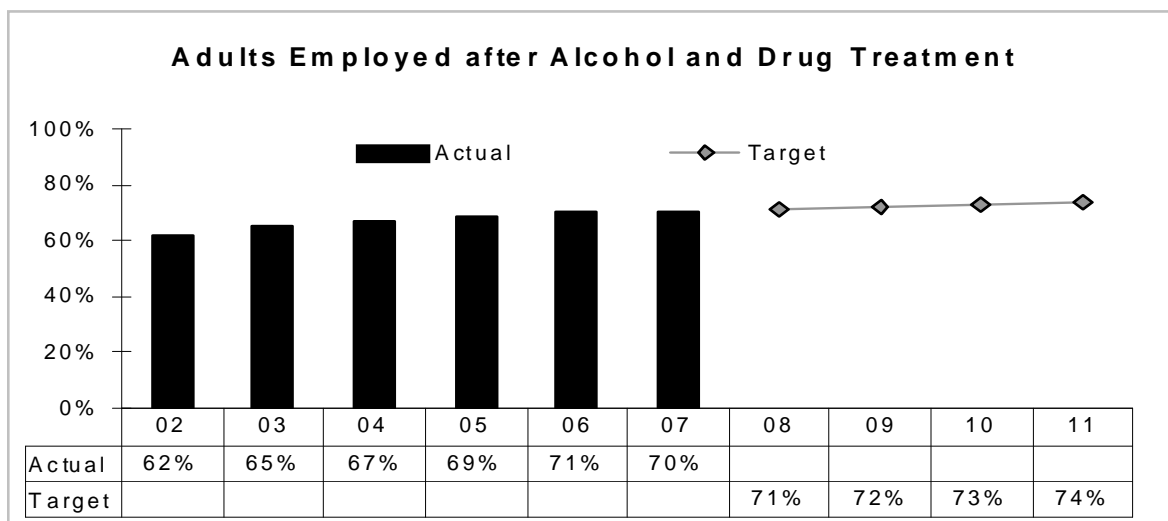
AMH's target is to push overall employment rates to 71 percent and beyond during the next few years.

## Results

Each year since 2002, a greater percentage of clients have ended service employed.

## How Oregon compares to other states

Oregon's rate of employment at discharge is higher than the national rate.



## *KPM #21 – Children returned to custody after Alcohol and Drug Treatment*

### Purpose

Over the past few years, alcohol and drug issues have become one of the most common reasons cited for child abuse and neglect, leading to DHS taking custody of children. Alcohol and drug treatment and meeting the goals of treatment play a major role in the reunification of a child and his or her parents.

## Target

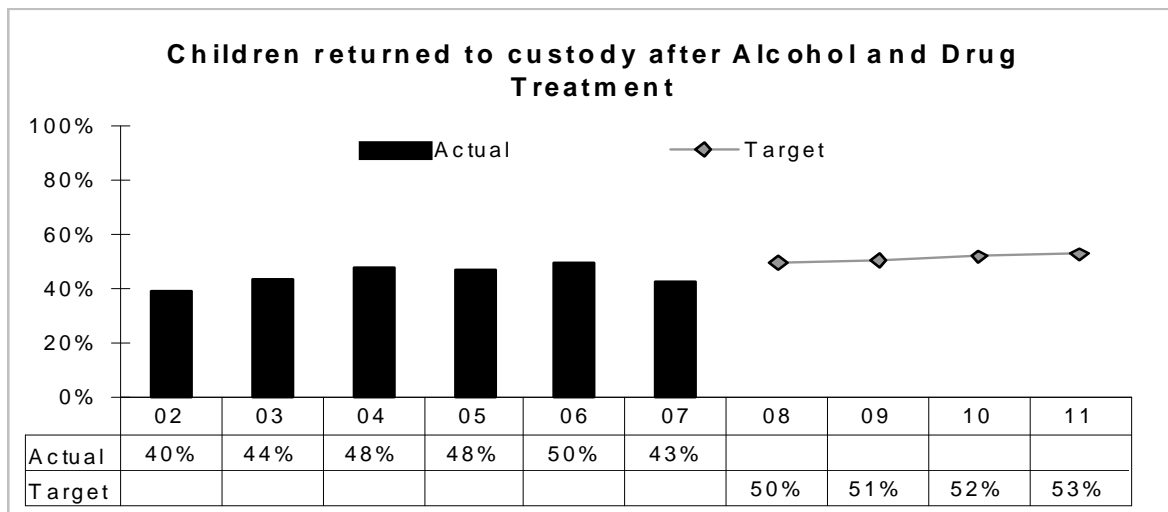
AMH's target is to push overall return rates to 50 percent and beyond during the next few years.

## Results

The trend up until 2007 showed that more parents were meeting treatment criteria that allowed reunification with their children. In 2007, the rate decreased. Whether or not this represents a new trend down or a temporary drop in an overall upward trend will have to be examined in the coming year.

## How Oregon compares to other states

We do not have any national data for comparison.



## *KPM #23 – Children with improved academic performance after Alcohol and Drug Treatment*

### Purpose

Alcohol and drug issues are a major barrier to academic achievement. Poor academic performance is often an initial flag for abuse of alcohol and drugs

among teens. A goal of treatment is help a child perform to his or her potential. Improved academic performance is definitely a step in the right direction.

## Target

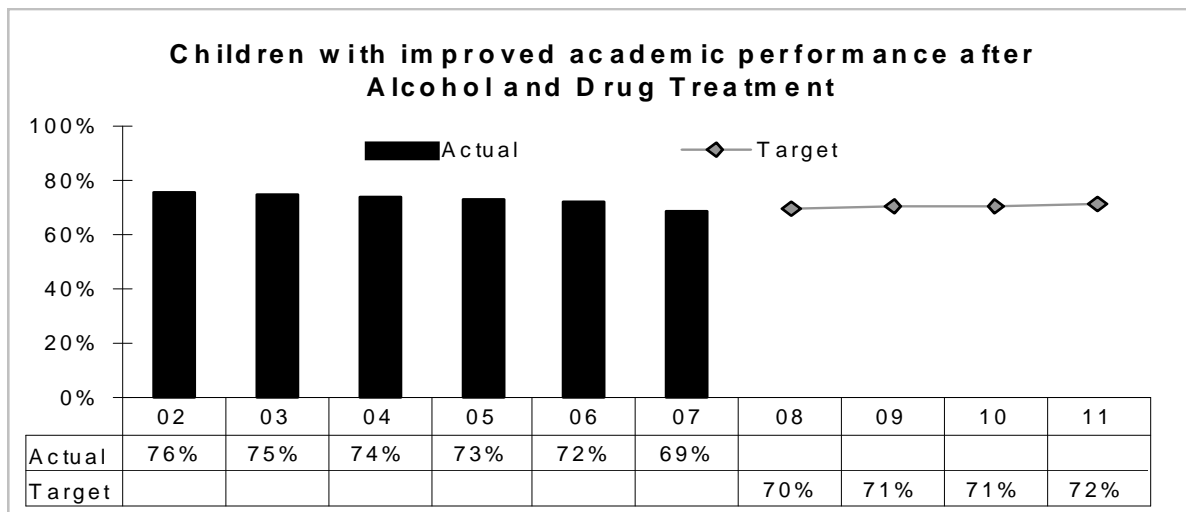
AMH’s target is to push overall improvement rates to 70 percent and beyond during the next few years.

## Results

Not as good as expected, each year since 2002 the trend appears to be down.

## How Oregon compares to other states

This measure looks at academic performance. Most national data only track improvement in attendance. This makes comparisons difficult. Using past performance as an indicator, improvements need to be made.



## Other Performance Measures (ADT)

### Alcohol and drug treatment services

Approximately 8.8 percent (or 26,765) of adolescents ages 12 to 17 have substance abuse issues. Among young adults ages 18 to 25, 20.1 percent (or 83,743) have substance abuse issues, while 6.2 percent (or 151,773) of adult 26 and older have substance abuse issues.

AMH serves 25 percent of the adolescents and children, 18 percent of the young adults, and 27 percent of the adults in need of public alcohol and drug treatment services.

## **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 23 percent of the treatment demand among adults.

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, a 32 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 five 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 508 adult residential beds statewide. The capacity was recently increased 30 beds. Much of the capacity increase was driven by the need to treat people with methamphetamine issues and children. 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 6.2 percent of the adult population age 26 and above requires alcohol and drug treatment services. In Oregon that is 151,773 people. For ages 18 through 25, the same research shows that 20.1 percent or 83,743 people are in need of treatment. That research also shows 8.8 percent of youth age 12 through 17 require treatment. In Oregon that is 26,765 youths. Public funds provided services for 41,248 adults (27 percent of the need), 14,890 young adults (18% of the need) and for 6,635 youth (25 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.

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.

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## **Problem Gambling Prevention and Treatment**

Problem gambling prevention and treatment services prevent people from becoming addicted to gambling and assist people who are addicted in recovering from addictive and pathological gambling. People who are in recovery find or maintain jobs, repair family relationships and stop committing crimes. Their mental health improves and the potential for suicide decreases.

### Services provided

Problem gambling prevention and treatment services include evidence-based prevention strategies to decrease the probability that young people will begin gambling at young ages and that adults of all ages will be aware of the addictive nature of gambling, particularly on-line games and video poker. Treatment services include outpatient individual and group therapies, intensive therapies and statewide access to residential treatment for those who are at risk because of pathological gambling.

### Where service recipients are located

CMHPs and nonprofit providers deliver problem gambling prevention and treatment services in all 36 counties and in one statewide residential treatment program. Treatment to reduce the effects of problem gambling is funded through a statutory one percent set-aside of state Lottery revenue.

### Who receives services

In 2007-08, 2,435 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 2,308 people in 2007-08.

### How services are delivered

Services are delivered by CMHPs, nonprofit programs and regional or statewide contractors in outpatient programs, and in one residential treatment program.

### Why these services are significant to Oregonians

Oregonians with problem or pathological gambling behaviors put themselves and their families at financial risk, experience family relationship disruptions, lose their jobs, are at risk of suicide and sometime commit crimes to pay for their gambling addiction. With treatment these risks will be minimized and there will be fewer bankruptcies related to problem gambling and more people will be working.

#### Performance Measures (Problem Gambling Treatment)

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 48,380 adult Oregonians are problem gamblers and an additional 28,459 are pathological gamblers.
- FY 2007 data indicate 35 percent of problem gamblers successfully completed treatment services. Six months after gamblers left treatment, more than 81percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.
- For the treatment completers, 57.7 percent of those assessed at 12-months post-treatment reported no gambling and another 30.0 percent reported “much less” gambling than before treatment.
- Additional findings support the notion that a majority of the past clients were satisfied with the treatment program and made life changes that benefited themselves, their family, and their community. About two-thirds of the participants reported satisfaction with their relationships, physical health, emotional well being, and spiritual well being. Approximately 73.2 percent reported a return to paying bills on time.
- Importantly, at 12-month follow-up, people who completed service reported no significant deterioration in these indicators, and, in fact, reported additional improvement in feelings of restlessness or irritability regarding not gambling.

#### Key budget drivers and issues

The increasing access to highly addictive gambling games that are available online in numerous locations through out the state create easy access for people

who are interested in gambling and reinforce the behaviors that lead to addictive gambling. The increase in Internet gambling is attracting more and more young people who are showing increases in problem gambling behaviors that interfere with education and social relationships

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# **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 those delivered by peers, 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 2007-2008, publicly funded programs served 71,204 adults and 34,617 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

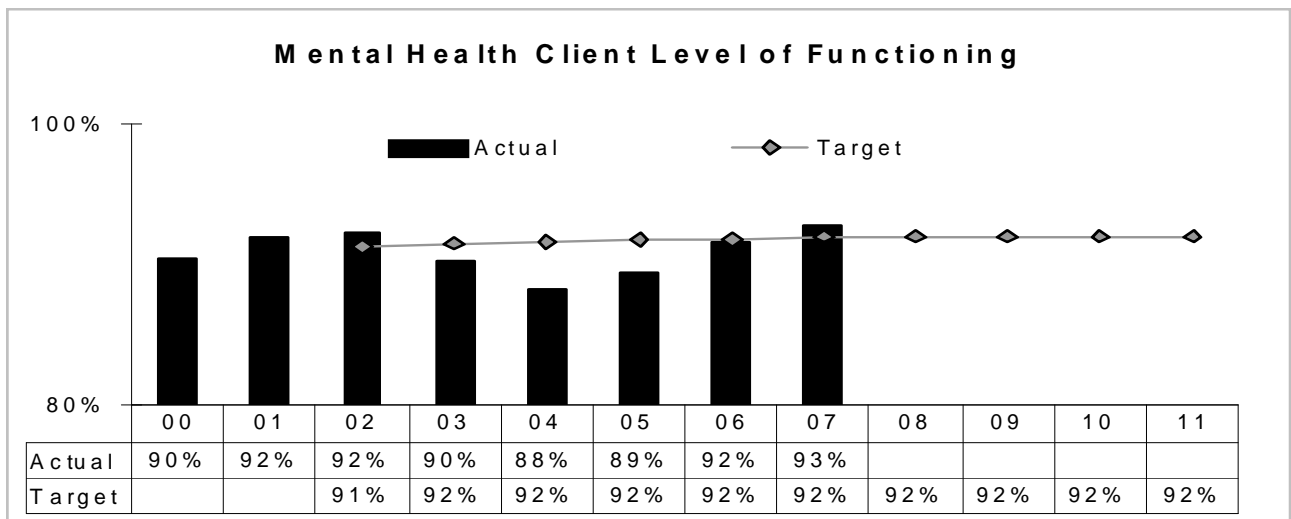
Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children use a similar tool called the Children’s Global Assessment Scale (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 steadily increased. The most recent year exceeds the goal. 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:

- 56 percent of adults were satisfied with outcomes, and
- 59 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 2006. Data from a few similar states are presented below:

- In Washington, 60.2 percent of adults and 59.1 percent of caregivers of children were satisfied with outcomes.
- In Utah, 75.9 percent of adults and 63.3 percent of caregivers of children were satisfied with outcomes.
- In Colorado, 60.4 percent of adults and 53.8 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 (105,306) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 5.4 percent (154,867) are estimated to have a severe mental illness.

AMH serves 33 percent of the children and adolescents and 46 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 employed, were looking for employment, or needed assistance in finding employment when they sought mental health services. Of those expecting help finding a job from their provider, 32 percent became employed and another 32 percent received active help, although they were unsuccessful in finding employment.
- AMH's most recent data found that 19 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. Roughly 80 percent of the caregivers of these children have indicated that coordination with educators is a key for services. Based on caregiver reports for youths receiving services:

22 percent indicated that their child's attendance at school had improved.

Only 11% of the children were expelled or suspended from school in the year after services began, compared to 18.5% in the year prior to services

Involvement with criminal justice for both adults and adolescents is another important issue for AMH services to address. Among caregivers of adolescents, roughly 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 (2.9 percent) compared to the year prior to services (5.8 percent).

Based on a self-report, adults indicated a decrease in the number arrested within the year after services began (1.3 percent) compared to the year prior to services (12.6 percent). This is consistent with many other reports on the effect of services to adults.

Adults also spent less time in jail in the year following initiation of mental health treatment. A representative sample of clients indicated that they spent an average

of 5.54 days in jail during the year prior to treatment beginning, but only an average of 0.37 days in jail during the year following treatment starting.

Housing is another important outcome. Almost 58 percent of people receiving services agreed or strongly agreed that as a direct result of (mental health) services received their housing situation has improved. Of the people who had expected help from their provider, 75 percent received help and 80 percent of those receiving help found new housing. Homeless is still a major issue for people receiving mental health services. Of the adults and children who started services in 2007, 3,281 were homeless at the time.

## **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.

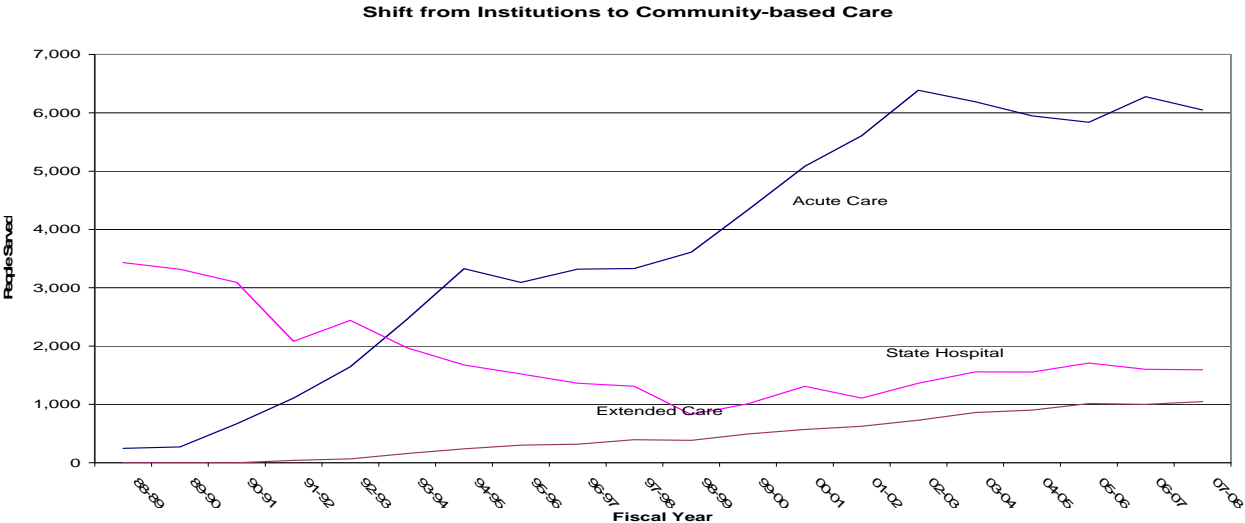
The cost to the system is less for community services than it is for institutional services. In addition, the services needed in community settings often can be supported with federal Medicaid funds that are not available for institutional services.

During FY 2007-2008, 1,594 people were served in the state hospitals. All of the other 71,204 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.



**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 154,867 Oregonians (5.4 percent of the adult population), require treatment for a mental disorder. For children and adolescents, national estimates indicate that 12 percent of the population, (105,306 youth) require treatment for mental and emotional disorders. Public funds provided services for 71,204 adults (meeting 46 percent of the need) and services for 34,617 children and adolescents (meeting 33 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.

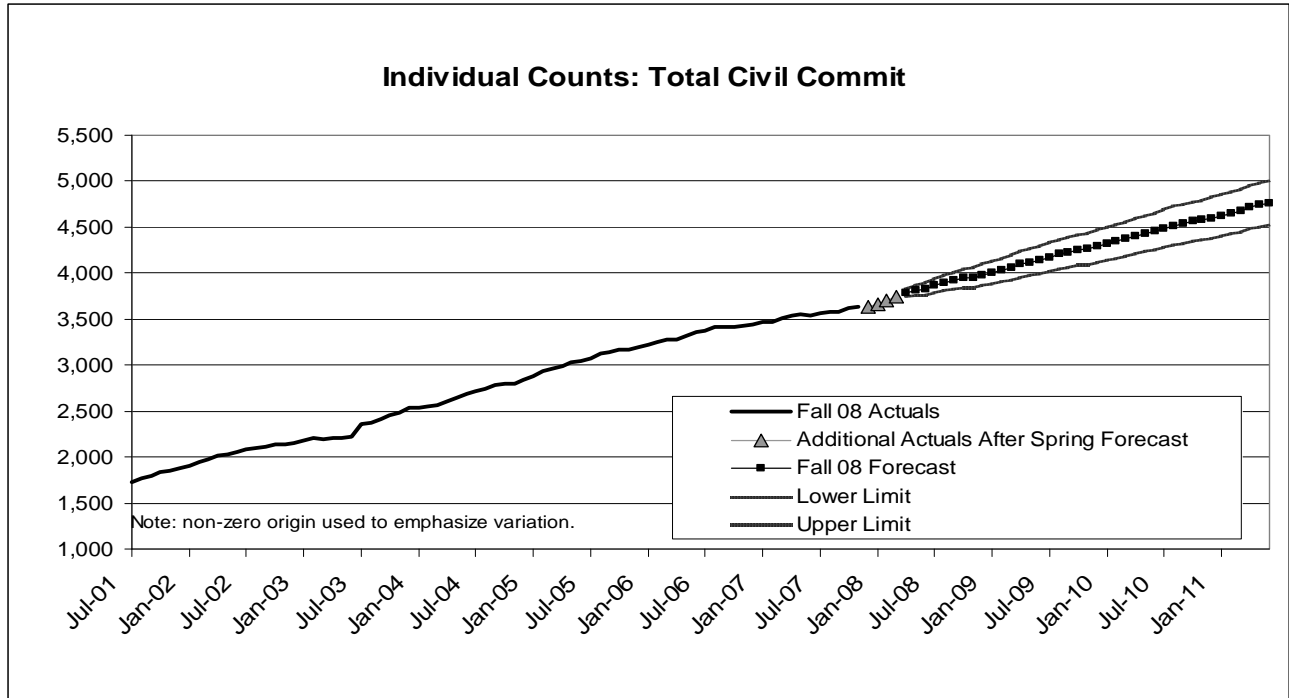
### **Mandated treatment**

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.

Since July 1, 2007, AMH has to provided 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.

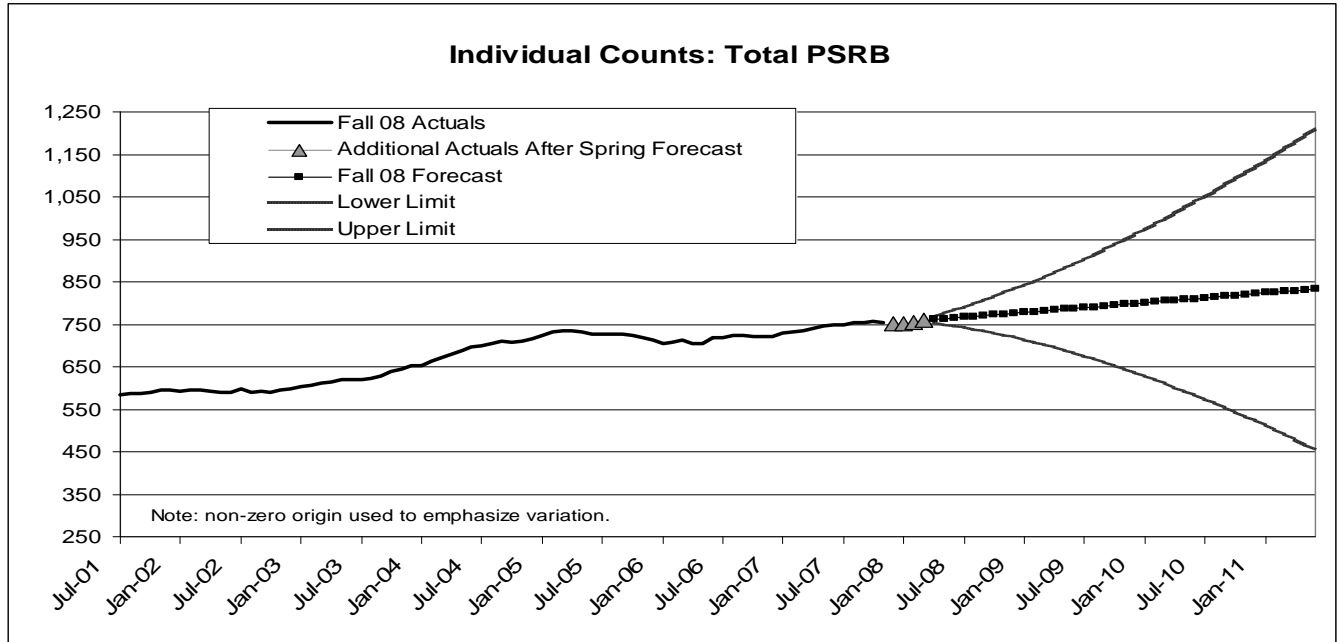
The civil commitment caseload includes people who are found through a civil court process to be dangerous to themselves or others, or to be unable to care for themselves as a result of mental illness. Through this process the individuals are mandated by court to treatment (ORS 426.070). People on this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

Currently there are approximately 1,600 civilly committed people in state hospitals or other 24-hour community settings including enhanced care, adult residential and foster care. Based on the civil commitment forecast, an increase of 600 people is expected in the next biennium. Many of these people will need 24-hour community and or state hospital services. 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.



**Major Federal Fund (FF) Revenues consist of:**

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

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## 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 1,400 extended care placements provided by counties and a variety of non-profit and for-profit providers.

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## Oregon State Hospital (OSH)

### Services provided

With campuses in Salem and Portland, OSH provides inpatient and residential services with a budgeted capacity of 675 beds and a licensed capacity of 766 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.

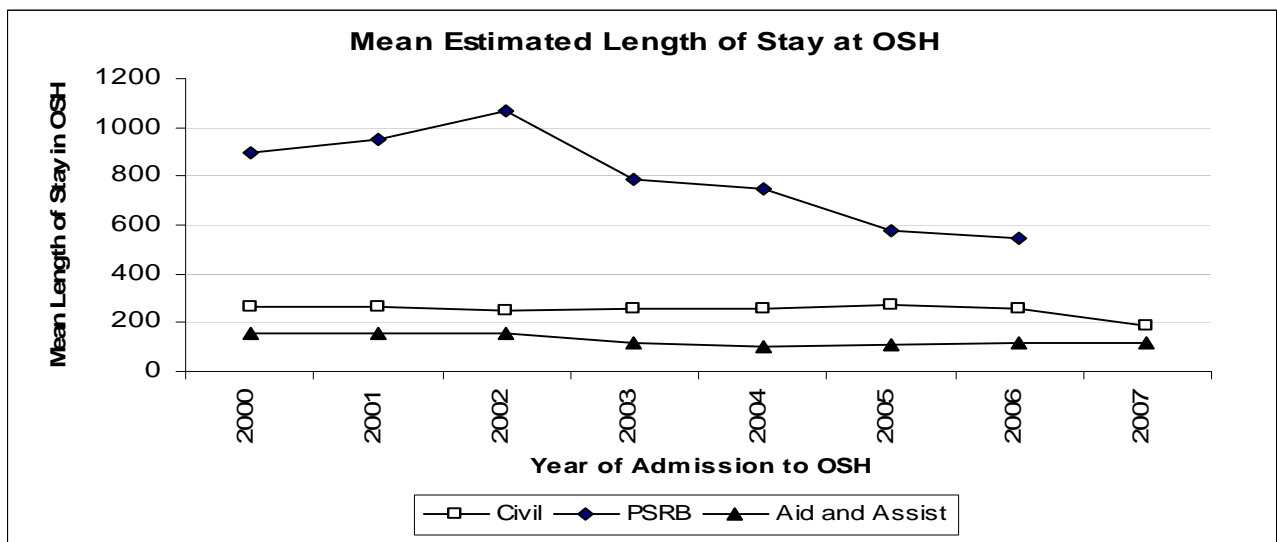
- **Adult Treatment Services:** These services are provided in two adult general psychiatric units on the Salem campus (30 beds) and at a 92-bed leased facility in Portland. This program provides hospital-level psychiatric services for 122 adult patients with major psychiatric illnesses who are between 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 14 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.

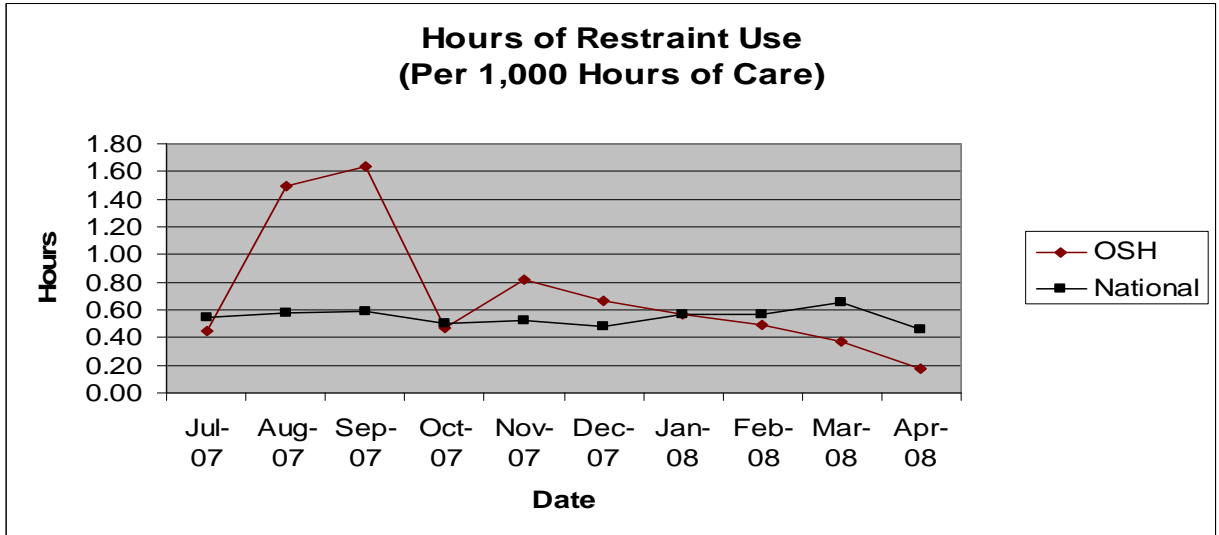
- **Forensic Psychiatric Services:** This program, provides hospital and residential treatment services to patients committed by the courts for evaluation or treatment to be able to aid and assist in their own trials or to the jurisdiction of the Psychiatric Security Review Board (PSRB) under the “guilty except for insanity” adjudications.
  - **Forensic Hospital Services:** These services consist of 339 hospital-level beds on six treatment units. A full array of treatment services 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 and placed in the custody of OSH. 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). Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors.
  - **Forensic Residential Services:** These services provide treatment for 70 patients on two treatment units licensed as residential facilities . These are transitional units providing treatment to PSRB patients who have shown substantial improvement in their conditions and who require a less restrictive environment in preparation for placement in a community setting..

## Performance Measures (OSH)

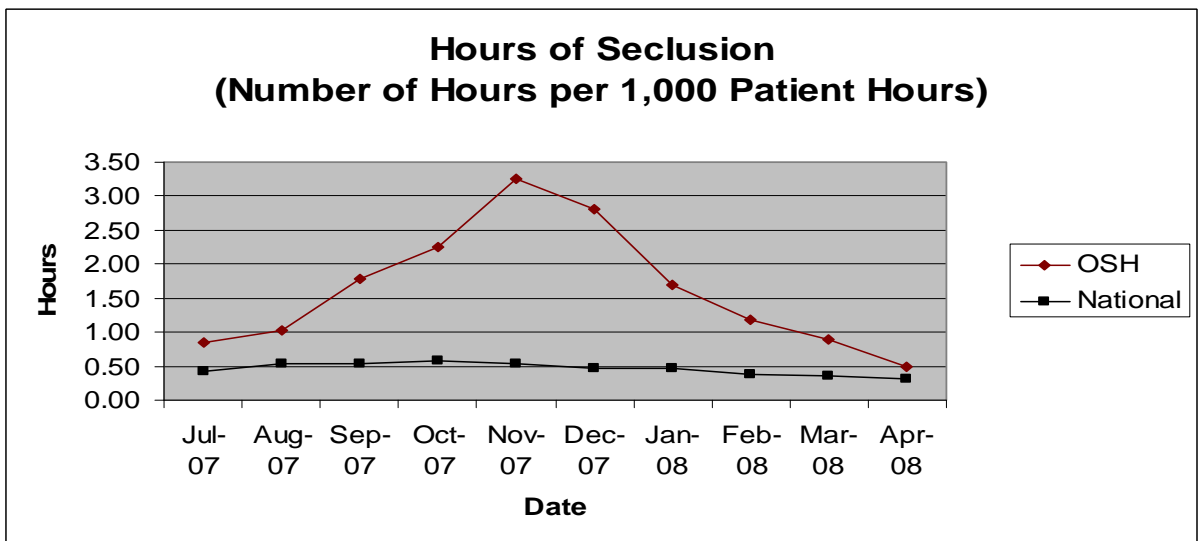
Two important performance measures at OSH are length of stay and the rate of restraint and seclusion usage. Decreasing the length of stay will allow the hospital to better achieve census goals, particularly as preparations are being made to transition to the new facility. More importantly it fits with the goal of serving people at the least restrictive level of care they need. Currently people are often in the hospital longer than clinically necessary. The chart below shows that the estimated time spent in the hospital by year of admission has slowly been decreasing, particularly people under the Psychiatric Security Review Board (PSRB).



In the past five months, OSH has experienced a 75% reduction in the number of hours of patient restraint. The number of hours of restraint at OSH is now below the national average.



As required by The Joint Commission, OSH submits data on restraints and seclusion to the NASMHPD Research Institute. OSH data, along with data from hospitals around the country is analyzed and reported back to OSH resulting in a delay in the publishing of recent OSH results.



OSH has experienced an 80% reduction in the number of hours of patient seclusion used in the past six months. The number of hours of seclusion at OSH is now at the national average.

## **Quality and Efficiency Improvements (OSH)**

### **OSH COMPLIANCE WITH DOJ, CMS, TJC**

The State Hospital finalized a Continuous Improvement Plan (CIP) in January 2008 that had been drafted in late 2006 and revised following the November 2006 review by the United States Department of Justice (USDOJ). The Hospital's CIP, a multi-year effort, is guiding improvements in the following areas:

- Adequately protecting patients from harm;
- Providing appropriate psychiatric and psychological care and treatment;
- Use of seclusion and restraints in a manner consistent with generally accepted professional standards;
- Providing adequate nursing care; and
- Providing discharge planning ensuring placement in the most integrated settings.

A team of two Centers for Medicare and Medicaid Services (CMS) surveyors made an unannounced visit to OSH June 16-18, 2008. The team was following-up on CMS surveys conducted in February and April of 2008. The survey team found OSH was in compliance with federal requirements for hospitals participating in Medicare and/or Medicaid programs.

The Joint Commission conducted its triennial survey of OSH in August 2006. The survey resulted in 19 Requirements for Improvement (RFI). Eighteen of the RFIs had been successfully satisfied by October 2007. On June 30, 2008, The Joint Commission resurveyed OSH for the last remaining RFI regarding medical record deficiencies. On July 11, 2008 OSH was notified by the Joint Commission that the RFI had been met and OSH was granted full accreditation.

### **STAFF ADDITIONS AT OSH**

Providing new leadership at OSH, several key positions have been filled in 2008 these include: the Superintendent, Chief Financial Officer, Director of Strategic Planning, Director of Pharmacy, Director of Infection Control and Director of

Security. The Hospital has also added Supervising Psychiatrists and Supervising Psychologists to improve clinical outcomes. Critical shortages in a number of job classifications continue to drive overtime and compromise employee job satisfaction.

As of August 4, 2008 OSH has hired 64 of the 211 CIP new positions approved by the February 2008 Supplemental Session.

In addition to the CIP hires, 97 additional staff positions have been filled by new staff at Oregon State Hospital. Of these 97 new staff members, 15 were Mental Health Registered Nurses and 15 were Mental Health Therapy Technicians providing direct patient care.

OSH continues to advertise, recruit and qualify candidates for the remaining positions and the existing vacancies at the hospital.

In May 2008, OSH entered into a Letter of Agreement with SEIU OPEU Local 503 to create the Acuity and Security Program, which allows OSH to hire 119 staff without regard to seniority into the following positions:

- 88 Mental Health Therapy Technicians
- 9 Mental Health Security Technicians
- 22 Transporting Mental Health Aides

Seven of the Mental Health Therapy Technician positions have been filled. Interviews are currently being held for seven additional Mental Health Therapy Technician positions which have a phase-in date of October 2008.

In order to enhance recruitment efforts, OSH continues to train Certified Nursing Assistants (CNAs) due to a significant shortage in the marketplace. OSH has two trainers, one recently hired, who can each train up to 20 students at a time.

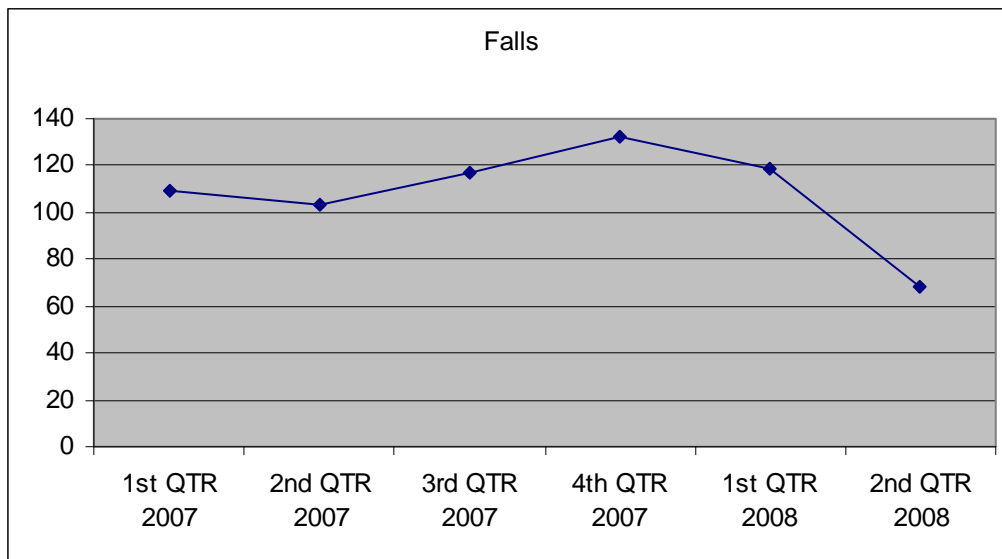
## **INCIDENT REPORTING SYSTEM IMPLEMENTED**

The improved procedure for completing and submitting incident reports is now in place. Incidents are reported daily and follow-up, when necessary, can happen

immediately. The Critical Incident Review Panel meets regularly and in a timely manner to assure incident reports and corrective actions taken are comprehensive and appropriate. Corrective actions taken have included modifications in patient behavioral plans, medication regimens and supervision, as well as enhancements to physical characteristics of select areas of the hospital. The Critical Incident Review Panel is educating staff about incident trends as well as evaluating whether reviewed corrective actions have been effective in reducing the number of hospital incidents, both on an individual patient and system-wide basis.

### PATIENT FALLS DECREASED

OSH has improved several procedures with the goal of reducing falls. Two significant changes are nursing staff training in strategies to prevent patient falls and the patient assessment form used by nurses now requires a full patient fall risk assessment. Results show a significant reduction in patient falls occurred for the second quarter in a row (see Falls chart). It is important to note that none of the falls resulted in a serious injury to a patient or a need to change a patient’s medication. The reduction in falls can be attributed to staff training, improved assessment, identification of patients at-risk for falling, and follow-up on patient fall incidents.



## IMPROVED PATIENT ASSESSMENT COMPLIANCE

Patient assessments are a critical element to effective mental health treatment. At the time of admission, clinical disciplines conduct assessments of all patients. Within the first ten days of admission, the following assessments are completed: a psychiatric admission note and history (psychiatrist), a medical history and physical exam (nurse practitioner), a comprehensive nursing assessment (RN), a psychosocial history (social worker), a rehabilitation services assessment (rehabilitation therapist), a patient education assessment (assigned staff), and any psychological testing ordered by the physician (psychologist).

Completion rates for all assessments are tracked by the Quality Improvement Department. The rates for the quarter from March to May, 2008, were 92%. The 2008 rate is an improvement when compared to a 90% completion rate in 2007. Lack of timely completion is usually due to staff vacancies.

## INCREASED USE OF BEHAVIORAL SUPPORT PLANS

The OSH Continuous Improvement Plan included, as a high priority, the developing and implementing of behavioral support plans for identified patients in 2008. Behavioral Support Plans provide specific treatment strategies for patients whose behavior is difficult to manage. Use of Behavior Support Plans is expected to contribute to a decrease in aggressive acts by patients and the use of restraints and seclusion. The initial focus was on patients within the Geropsychiatric Treatment Services Program on the Salem campus, and the four units on the Portland campus. The focus will now be expanded to include patients in the Forensic Psychiatric Services Program. There are currently thirty-two patients with behavioral support plans, and twenty-two of those plans were initiated within the last quarter. The Psychology Department has created a Behavioral Support Plan service, which will include 26 positions: 1 manager, 3 psychologists, and 22 mental health therapists. To date, the manager has been hired, the 3 psychologists have been hired, and 9 of the mental health specialists have been hired. An additional 4 mental health specialists have been selected for hire.

## IMPROVED MASTER TREATMENT CARE PLANS

OSH provides recovery and rehabilitations to the patients it serves through active treatment. Central to effective treatment is patient care planning. With input from two nationally recognized consultants, changes have been made to the functioning of treatment teams, and to the form and content of treatment care plans. A new Master Treatment Care Plan format was implemented in Geropsychiatric Treatment Services. The new format and care plan will be used in Forensics Services as the new treatment mall is implemented. These revised treatment care plans ensure that care is individualized and patient-centered. This results in all staff being informed about, and participating in, the patient's active treatment.

## IMPROVED PHYSICIAN RECRUITMENT

OSH entered into agreements 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. The February 2008 Supplemental Session approved funding for an additional six OHSU psychiatrists for a total of 12. As of August 5, 2008 there are five psychiatrists in place at OSH with a sixth scheduled to start in September 2008. OHSU is actively recruiting to provide the additional six psychiatrists.

## **Key budget drivers and issues**

The key driver for the OSH Budget is the requirement to hire sufficient staff to open the new facility in late 2010 and early 2011. The new facility includes four smaller programs inside of the 620-bed facility. Within each program there are small residential units for 20 to 25 people in either single or double rooms. The patients will leave the residential units each day to participate in treatment in program specific central treatment malls. The facility will be staffed adequately to assure the provision of at least 20 hours of active psychiatric treatment per week.

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## **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. 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.

Until BMRC is able to hire sufficient physicians it is unable to provide acute psychiatric admissions for 16 Eastern Oregon counties. BMRC provides longer term 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 are provided 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.

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## **Program Administration and Support (PA&S)**

AMH, in collaboration with external partners and stakeholders, creates the vision for mental health and substance abuse and problem gambling 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,
- Mental Health Policy,
- Extended Care Management,
- Quality Improvement and Certification,
- Mental Health Community Housing, Employment & Supports,
- Program Analysis and Evaluation,
- Evidence-Based Practices,
- Program Support Services,
- Problem Gambling Prevention and Services,
- Forensic Mental Health Policy,
- Children’s System Development,
- Mental Health and Addictions Medicaid Policy,
- Prevention Services,
- 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.

### **Problem Gambling Prevention and Treatment**

This section of AMH is responsible for policy direction, program development, technical assistance and oversight of the community-based and statewide treatment resources. This section is responsible for setting policy and developing programs that prevent problem gambling in Oregon. This section is also 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.

### **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 developed treatment services and monitoring systems for youth who are committed through the Juvenile PSRB. The services have been available since 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 or begin gambling 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 20 specialty programs in 11 counties: nine located in SPD-licensed facilities and 11 Enhanced Care outreach 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 Replacement Project**

As a result of the Oregon State Hospital Framework Master Plan Phase II Report funded by the 2005 Legislature, the Governor and Legislature selected to replace the aging Oregon State Hospital (OSH) with two modern state psychiatric hospitals and proposed the development of at least two community-based 16-bed residential facilities. The 2007 Oregon State Legislative Assembly approved Certificate of Participation financing to design and build two modern psychiatric treatment facilities -- a 620-bed facility in Salem and a 360-bed facility in Junction City. In addition, the Legislature directed DHS to provide reports to the Legislature and the Interim Emergency Board on the Oregon State Hospital Replacement Project (the project) related to financing, expenditures and other significant issues. These reports are in addition to the joint reporting required by the policy note of DHS and the Oregon Department of Corrections (DOC) on the Junction City property.

The project has now completed the schematic and development design phases and is currently in the construction documents phase for the Salem Campus. In March

2008, the entire OSH campus was designated as a historic district. To comply with this designation, the project completed multiple hearings before the Salem Historic Landmarks Commission resulting in the project being able to move forward with renovation, relocation, and demolition of various structures.

The DOC and DHS are working collaboratively on the Junction City facilities to ensure the agencies maximize all appropriate opportunities for shared efficiencies.

In addition the project is working to replace the OP/RCS system with the Behavioral Health (Data) Integration Project (B-HIP). The new system will integrate the information technology architecture and structure for a system of care providing behavioral health treatment services and data collection and reporting for clients with the State system. The new hospital management system will be centered around an electronic health record and include components necessary to manage all health care services for the patients including pharmacy, laboratory, and others in an integrated system that provides management reports to hospital leadership and supports performance measurement.

The Salem facility is scheduled to be completed September 2011 and the Junction City site in 2013. BHIP will be implemented prior to the opening of the Salem facility.

### **Child and Adolescent Mental Health System Change Initiative**

The Children's System Change Initiative (CSCI) began through a legislative directive in 2003. CSCI system structures were formally put into place in the fall of 2005 that integrated the financing and administration into the local or regional Oregon Health Plan Mental Health Organizations. Key structural aspects of the initiative also included: the involvement of children and families in service delivery and system operation, a uniform level of need determination process, child and family teams, care coordination, coordinated service plans, community care coordination committees, children's system advisory committees, and a system-wide focus on outcomes and data dissemination.

An analysis of trends and services before and after the initiative demonstrated that more children are receiving mental health services. Approximately 13,000 children each quarter during the first half of 2007 received mental health service, up 11.2

percent from an average 11,550 per quarter during 2005. More children are receiving a diverse array of intensive community-based services and are spending less time in facility-based care. More parents who are satisfied with coordination among mental health services, family participation in treatment, and outpatient treatment programs; and more parents who believe that youth entry into treatment leads to improved school attendance, less chance of suspension or expulsion from school, and a reduction in the likelihood of arrest by police.

The Governor's Statewide Wraparound Initiative is the next step to create a working system of care in Oregon. This work entails true integration of all child serving systems' services and supports for the benefit of children birth through 17 who have or emotional, behavioral, or substance abuse related needs and are involved in two or more systems. The tasks of this initiative include specific administrative, operational, and fiscal strategies to provide an integrated system of services and supports across agencies to children and their families.

### **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 2007-09 goal is 50 percent of treatment funds support evidence-based practices. AMH is preparing a report documenting its status in regards to this goal. Early analysis indicates that it has, however regardless of the results of analysis there has been a change within the treatment delivery system. Providers are focused on delivering services that are evidence-based and more importantly documenting progress and outcomes. AMH has worked closely with providers to deliver technical assistance in this process and, when possible, used provider expertise to train other providers on particular practices. Staff review programs to assess the fidelity with which specific practices are delivered.

### **DHS Transformation Initiative**

AMH has participated in the DHS Transformation Initiative with great interest. The mental health and addictions treatment systems, as well and the prevention system have been going through transformations for many years. The focus has been on moving toward community-based services as opposed to institutional-based services and recovery as opposed to management or maintenance of people. The DHS Transformation Initiative has offered AMH an opportunity to explore how it can more effectively achieve these goals. Initiatives developed

during the first six months of the Transformation Initiative focus on streamlining processes such as contracting and quality improvement efforts. But, in addition, some of the more ambitious initiatives look at the broad service system and challenge current payment strategies and rules that may be barriers to quality, individualized services. The Transformation Initiative is beginning to implement the prioritized initiatives through the use of the Lean rapid process improvement technology and the development of metrics for the initiatives in order to monitor progress in achieving the goals for each. The state hospital initiatives will form the foundation for lasting culture change as the new programs and facilities are implemented. AMH has committed resources towards achieving as many of the initiatives as possible.

### **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 contracts 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 reviews statewide mental health performance improvement projects. These efforts result in reports to the state to improve the performance of the MHOs and to improve the quality of services to OHP members.

## **Strengthening the alcohol and drug abuse prevention system**

Expanding and strengthening community coalitions to engage community members in the health and well being of children and families is an important component of local prevention efforts. Community-based prevention, specifically Communities That Care (CTC), has been extensively researched and proven to be an effective and sustainable means to address alcohol and drug abuse prevention at an early age. Disseminating new research findings and training community coalitions in CTC will be a focus for AMH in the 2009 – 2011 biennium.

The 2007 Legislature made investments to implement the evidence-based family prevention strategy Strengthening Families Program 10 - 14 (SPF 10 – 14) for parents of ten to 14 year olds. Typically youth initiate alcohol and tobacco use between 10 to 14 years old. SPF 10 – 14 helps families in addressing the early initiation. Twenty-five counties and two Tribes have committed to provide the Strengthening Families Program to over one thousand three hundred families. AMH contracted with Washington State University to evaluate the program.

## **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**

Prior to the 2007-09 biennium, state funds to support local alcohol and drug treatment for indigent clients through county programs had 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. During the 2007-09 biennium AMH was able to bring the lowest funded counties up to the statewide average with new investments made by the 2007 Legislature.

## **Problem gambling prevention and treatment services**

Problem Gambling Prevention and Treatment Services

Problem gambling services have developed into a good overall system of care. Our efforts now turn towards reaching underserved populations via two key initiatives:

Develop or improve services in following areas:

**Frontier/Rural Oregon:** The current reimbursement system is not working for frontier/rural Oregon. A fundamental re-design of the funding allocation methodology is underway, with provider participation and staff support a more equitable and effective system will be proposed and implemented.

**Services for Latinos:** Oregon's largest and fastest growing ethnic group is underrepresented in current treatment programs. A statewide Latino Advisory Group for Problem Gambling Services has been established. This group has already identified several key activities including targeted outreach developed by Latinos for Latinos and increasing the number and improving qualifications of Latino problem gambling counselors.

**Native American:** Pilot efforts are underway to develop and deliver more culturally relevant treatment for Native American problem gamblers. Problem Gambling Prevention funds, which had previously been awarded only to counties, are now available for Oregon Tribal Governments.

**Asian-American:** Plans are underway for a department-sponsored first ever Community Forum on Problem Gambling in the Asian community. Pilot or Demonstration grants will follow as the Asian community assists AMH-Problem Gambling Unit in assessing the needs and identifying the appropriate treatment approach.

Develop and implement a screening and referral program that operates throughout all State Human Services units.

Individuals and their families that are experiencing problems related to gambling often have one or more other problems for which they may be receiving help. Identifying and addressing this issue earlier in the treatment episode will increase the likelihood for long-term resolution to their problems. Initial efforts are underway with Seniors and People with Disabilities.

## **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 #19—Completion of alcohol and drug treatment
- KPM #20—Employed at the end of alcohol and drug treatment
- KPM #21—Met requirements for child custody at the end of alcohol and drug treatment
- KPM #22—8<sup>th</sup> Grader risk for alcohol and drug use
- KPM #23—Improved academic performance at the end of alcohol and drug treatment
- KPM #32—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.

## 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 management and improvement**

For the past two bienna AMH has worked with the CMHPs and providers to change service contracts to be more performance based. In collaboration with stakeholders, AMH revised and refined a set of objective measures for assessing the care provided by public programs funded with the new investments made by the Legislature during the 2007 Legislative Session. Establishing clear objective measures allows AMH to set performance standards and incorporate those standards into its contracts. AMH quarterly reports for all of the Community Mental Health Programs include trends on specific performance measures associated with quality care and successful clinical outcomes. AMH is in the second year of participating in a landmark national study funded by the National Institute on Drug Abuse called the Network for the Improvement of Addiction Treatment (NIATx) with five other states managed by the University of Wisconsin and evaluated by Oregon Health and Science University. This study will demonstrate which process improvement methods work best to stimulate sustained business and clinical improvements within addiction treatment programs, providing valuable insights on effective process improvement strategies that will be used to inform providers and policy makers across the country.

## **Enhanced treatment capacity for parents involved in the child welfare system**

AMH implemented the Intensive Treatment and Recovery Services (ITRS) initiative during the 2007 – 2009 biennium with a new investment made by the 2007 legislature. Each Community Mental Health Program received funds to implement new intensive outpatient services for addicted parents involved in the child welfare system with an emphasis on safely reuniting children with their parents who are working on recovery goals, working closely with local child welfare partners. New residential treatment capacity was also implemented to serve parents and their dependent children where parental addiction is more severe, requiring 24-hour care and monitoring.

## **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. The new rule is scheduled to be adopted in early 2009. In the past two years AMH has eliminated 27 rules that are no longer applicable.

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. As a result of this improvement, the time frame for processing contracts, contract amendments and requests for funding has gone from three to nine months to an average of 30-60 days. This ensures more timely payment for new programs and supports a higher volume of services to increasing numbers of clients, and speeds the effort to reduce crowding at OSH.

AMH developed and implemented an electronic filing system for paper documents. This system has saved time and eliminated the need to distribute multiple paper copies. All staff has been trained and the electronic copies are available on the shared drive for easy access.

AMH developed a centralized database that contains mailing addresses, telephone numbers and e-mail addresses for providers, stakeholders, community partner, etc. This supports more efficient and timely communication.

## **Key budget drivers and issues**

### **Lack of safe, affordable housing**

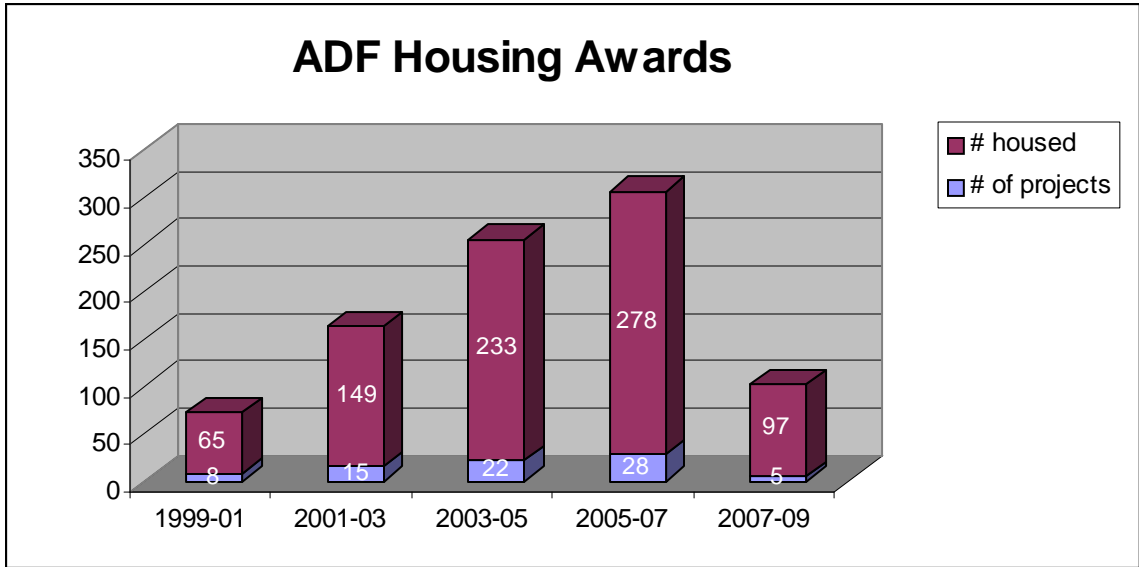
The urban areas of Oregon are some of the most expensive for rental housing or home ownership in the country. A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addictions and mental disorders. When people have uncertainty about where they will live or are forced to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

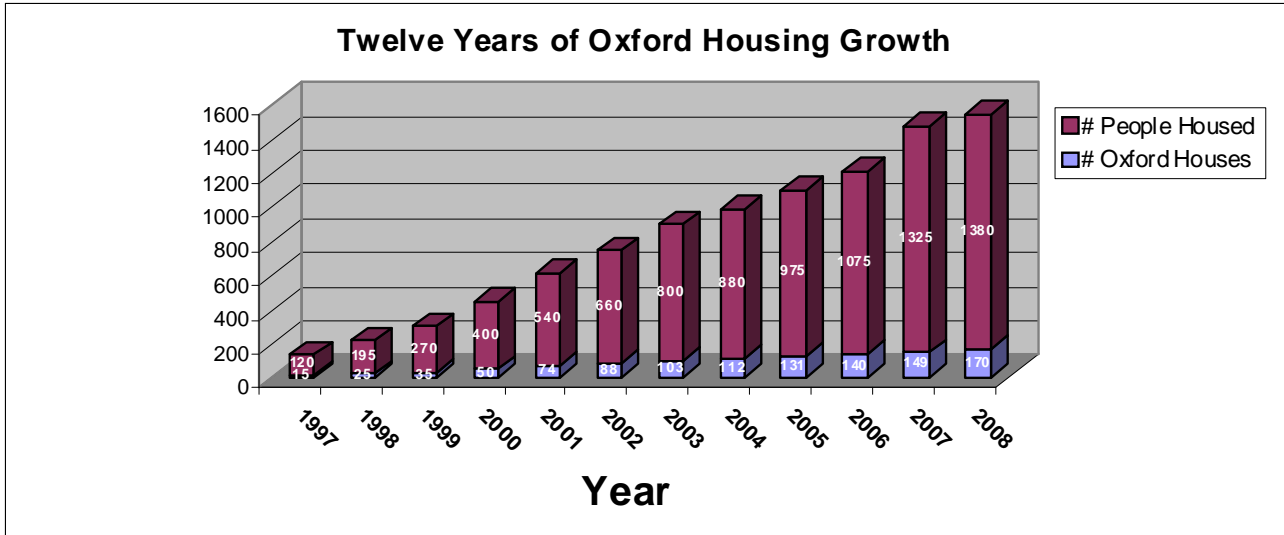
As a result of the cost of housing and the effects of the disorders, each year more than 8,000 people are homeless when they enter public addiction and mental health services. The state has undertaken the following initiatives to address housing for people with addiction and mental disorders:

**Alcohol and Drug Free (ADF) Housing Development.** Each biennium since 1991-2001, AMH transfers funds to Oregon Housing and Community Services (OHCS) to develop “Alcohol and Drug Free” (ADF) housing to support people in recovery from serious addictions. During 2007-2009 Community Housing, Employments & Supports (CHES) served as administrator to ADF housing awards. Five projects were funded and will provide 97 units of affordable alcohol and drug free housing. The following chart reflects the separation of CHES from the added resources available to OHCS, and reflects AMH’s distribution of ADF Housing Development funds for 2007-2009 projects.



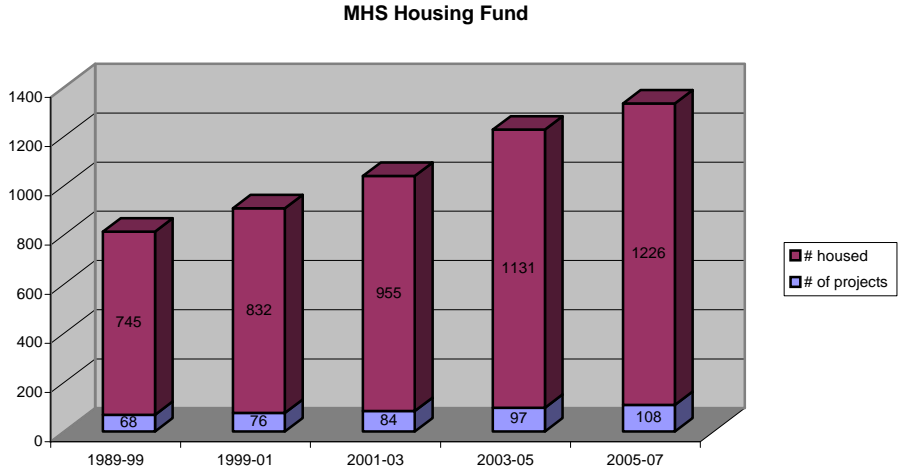
**ADF Housing Assistance Services.** AMH funds eight projects in seven counties and one tribal community to support more than 500 people per year in recovery from addictions to obtain stable ADF housing as they transition to self-sufficiency.

**Oregon Recovery Homes.** Through the Children’s Health and Safety Initiative approved by the 2007 Oregon Legislative Assembly, Oregon Recovery Homes (ORH) were able to increase their staff of outreach coordinators from two to five full-time employees, who support the establishment of new Oxford Houses. There are now 170 of these homes in 16 Oregon counties and they are accommodating approximately 1,380 people recovering from alcoholism and drug addiction, a 24 percent increase in ORH housing from the 2005-2007 biennium. 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 housing capacity since 2001.



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. AMH has committed an additional \$413,000 for the development of 5 projects and providing housing for an additional 51 persons. The following chart shows growth of projects and capacity since 1989.



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. An additional round was opened in November, 2007 with applications due by January 28, 2008. From the applications received AMH committed \$542,970 to develop 6 additional housing projects for 48 persons in 15 counties. Total funds committed for housing development including the last round totals \$2,004,949 and providing overall housing for 277 residents and leveraging \$16.78 for every dollar invested.

**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. Since our previous reporting AMH is still developing additional projects within Villebois. The second project called Renaissance Court opened in April, 2008. The remaining five projects in the pipeline include two projects that are currently proceeding to ground breaking and are tentatively scheduled to open in August, 2009. AMH continues to work with developers for more community housing projects within Villebois. The current market has had some negative impact in the development of new projects within the community, but we continue to seek developers to develop community housing within Villebois.

### **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 Children’s System Change Initiative (CSCI) brought new attention at the state and local level to children’s mental health issues. However, this work was largely done without the infusion of additional state funds. Communities, families and youth, providers, Mental Health Organizations, and agency system partners invested their available resources to address the challenges and opportunities of the CSCI. Requirements of the CSCI have led to service improvements but also have caused strain in some communities. Consequently there are sentiments throughout the state that without additional resources or further integration of resources, the improvements made to date could be at risk and identified gaps in the system could widen even further.

The Governor’s Statewide Wraparound Initiative is designed to develop and implement specific operational, administrative, and fiscal strategies that will integrate services and supports across child serving systems. A pooled funding approach will maximize the systems’ limited revenue sources.

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 staffs 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.

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## **Division Summary**

### **Anticipated legislative impacts**

The major impact AMH envisions from the 2009 Legislative Assembly is the funding to provide sufficient staff to open the new psychiatric treatment and recovery facility, which will replace OSH. .

### **Budget notes and legislative actions**

AMH was responsible for reporting on two Policy Note Directives, jointly responsible for two other Policy Note Directives, and two statutorily required reports.

### **Oregon State Hospital**

HB 5031 directed the Department of Human Services to report to the 2008 Supplemental Session and to the Emergency Board at each of its meetings during the 2007-09 interim on the Oregon State Hospital Replacement project. The report should include information on financing, expenditures and other significant project issues. This report is in addition to the joint reporting required by policy note on the department and the Department of Corrections on the Junction City property.

As directed the department has reported at the 2008 Supplemental Session and each meeting of the Emergency Board.

HB 5031 directed the Department of Human Services to report to the 2008 Supplemental Session and to the Emergency Board on Oregon State Hospital actual revenue and costs as compared to budgeted amounts. The reports shall coincide with, but be in addition to, the Department's budget rebalance requests.

As directed the department has reported at the 2008 Supplemental Session and each meeting of the Emergency Board at which the Department presents its budget rebalance request.

HB 5006 directs the Department of Corrections and the DHS to report to the Interim Joint Committee on Ways and Means or the Emergency Board on the status of both projects. The report must include: (1) current plans for each facility in terms of sizing and timing; (2) ongoing joint activities in developing the

property, specifically in site and infrastructure design; (3) future joint activities and shared facilities that are under discussion and consideration and (4) an estimate of the saving from the joint activities. If the Certificates of Participation are issued for this project, the DAS is requested to unscheduled \$6.5 million of the expenditure limitation for the Department of Corrections allocated for the prison's planning and design until the agencies have made their report.

As directed the department is working with the Department of Corrections to develop the first report to the Legislature Emergency Board.

### Alcohol and Drug Community Based Treatment

SB 5507 directs the Criminal Justice Commission, Oregon Judicial Department and the Department of Human Services are instructed to develop a long-term plan for the administration for the drug courts and related services currently funded through the Commission's grant programs. The plan must address (1) whether the programs initially funded as grants should be transitioned into an ongoing program, (2) the current legal authority of the potential host agencies, and (3) the operation of the current drug courts not funded through this grant program. The agencies are to report on the plan to the Emergency Board or to a meeting of the Interim Joint Committee on Ways and Means. The development of the 2009-2011 Governor's Recommended Budget should take into account this long-range plan for the administration of the drug courts.

As directed the department worked with the Criminal Justice Commission and Oregon Judicial Department to develop a long-term plan for the administration of the drug courts and related services currently funded through the commission's grant programs. The report and recommendations will be presented by the three agencies to the Joint Ways and Means Committee.

### **Oregon State Hospital**

The February 2008 Supplemental Session awarded \$ 6.7 million to the department for the implementation of the Continuous Improvement Plan (CIP). The department was also directed to report to the June 2008 meeting of the Emergency Board. As directed the department reported progress on the first phase of the CIP and requested release of the funding in the Special

Appropriation for the second phase of the CIP. The department reported progress on the CIP including early achievements in reduction of seclusion and restraint and patient falls to the September 2008 Emergency Board and requested release of the final portion of the funding in the Special Appropriation.

The February 2008 Supplemental Session awarded \$3.3 million to the department to support the additional costs of a revised process for administering significant treatment procedures including medication that a patient does not agree to take. The revised process includes increased patient education about the medications from the patient's physician and from a medication educator. In addition the patient has the opportunity to request a hearing conducted by an administrative law judge and have a lay advocate participate on his/her behalf. The department was directed to report to the June 2008 meeting of the Emergency Board regarding the progress and status in implementing these new procedures. The department reported as directed.

### **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 will submit the report to the required meeting of the Joint Interim Judiciary Committee.

### **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. The report will be submitted during the Legislative Session.