

## **Executive Summary**

The 2009 state plan for mental health services in Oregon contains measurable goals and performance indicators to guide and assess the development and implementation of a comprehensive system of mental health care during the next two years. These objectives reflect Oregon's continued commitment to provide persons with mental illness the greatest opportunity to pursue independent and meaningful lives. However this commitment has become increasingly challenged given the economic climate of the state, and recent budget cuts to every state agency. Oregon's economy has not yet stabilized, as evidenced by the fact that the state has the second highest unemployment rate in the nation, behind Michigan. The state budget was balanced, in part, with the Legislature passing four new taxes. Tax activists are aggressively pursuing the option of referring these taxes to the voters. If voters overturn the taxes, then it's back to the proverbial "drawing board." Nothing is certain in these times.

Major issues facing AMH, within the above stated economic context, include:

- transforming to a mental health system that provides services that are person and family facilitated and directed, trauma informed and focused on wellness and recovery;
- improving the quality of the services provided to adults and children through the increased use of Evidenced-Based Practices;
- improving the timeliness and rate of discharge from the state hospital for people who have achieved maximum benefit from that level of care by creating additional housing and community-based alternatives, and through improved discharge processes, increased utilization review and analysis of current community housing;
- increasing supported employment and education opportunities for adults;
- increasing transitional services for young people age 14-25 who are leaving the children's mental health system and moving into the adult mental health system;

- developing enhanced services for persons with mental illness in local jails and community corrections systems;
- enhancing treatment efforts for persons with co-occurring mental illness and substance abuse disorders;
- increasing access and providing appropriate mental health services for older Oregonians;
- developing and supporting a workforce that is culturally diverse and skilled in addressing the unique needs of Oregon's growing ethnic and aging populations; and
- improving conditions for persons residing in the Oregon State Hospital.

Oregon is moving ahead with actions to transform the public mental health system. Some of these actions include:

- The Legislature continues to fund the State Hospital Replacement Project. Construction of the new Salem State Hospital Treatment and Recovery Center began in September 2008. Three new treatment malls have opened over the last year. Construction of the 620 person facility will be completed in 2011. Construction of second 360 person facility is targeted to be completed by 2013.
- AMH continues to monitor full implementation of the Children's System Change Initiative integrating children's Intensive Treatment Services into a community-based system of care. In the past year, focus groups were conducted throughout Oregon for the purpose of providing input and feedback for further implementation success.
- The Governor established the Statewide Children's Wraparound Initiative in 2007 to develop an integrated statewide system of addictions and mental health care across state and local child serving agencies. A Market Assessment and Information System Assessment were conducted in the past year. Legislation was passed into law June 2009 mandating the creation of a statewide system of care requiring specified state agencies and commissions to participate in a wraparound initiative for provision of youth services, establishing core values and principles, imposing

requirements on state agencies to implement and sustain this initiative, to ensure cultural competence in provision of services and to collect and evaluate data. The legislation authorizes pooling of resources from partner agencies, and establishes a Children's Wraparound Initiative Advisory Committee which will report annually to Governor and Legislative Assembly on implementation of this initiative.

- Oregon is continuing to implement Evidence Based Practices (EBP). AMH recently approved an EBP Strategic Direction Proposal that directs AMH to focus implementation of EBP on populations specifically referenced in the 2003 legislation which are targeted to reduce juvenile and adult crime, reduce recidivism and reduce the utilization of emergency mental health facilities.

Section II. Set-Aside for Children's MH Report  
Section III. MOE

### **3. Planning Council Charge, Role and Transformation Activities**

The Mental Health Planning and Management Advisory Council (MHPAMAC) meets every other month and has two working sub-committees: the Adult Services Advisory Committee (ASAC), and the Children's System Advisory Committee (CSAC). The sub-committees meet monthly, and route recommendations to MHPAMAC for consideration and action. This configuration has assisted MHPAMAC to address overall mental health system issues and to take action on the work conducted by the two sub-committees. The two sub-committees have been active by addressing the issues for their population group.

In 2007 MHPAMAC arranged for a technical assistance visit from the National Association of Mental Health Planning Councils. After the consultation, vacant council positions were recruited. A strategic planning session was held at the end of 2008, and Wellness (including prevention and recovery) was identified as a top priority for 2009. While the 2009 legislative session and concomitant approval of the division's budget has eclipsed many issues, the council did forward four wellness policy recommendations to AMH management in April. Action is underway to implement these recommendations.

In its third year of operation, ASAC has sharpened its focus on system transformation and aligned its attention to projects that are gaining momentum as Oregon's mental health system continues to develop. ASAC spent significant amounts of time on the following projects:

- Memo on Oregon State Hospital (OSH) mandatory overtime from a patient's perspective. A memo was drafted and forwarded to MHPAMAC for approval. Once approved, it was forwarded to the OSH Superintendent, who responded to the concerns outlined by ASAC. ASAC continues to receive staffing updates.
- Guardianship is a standing issue for ASAC. The committee tracked two pieces of legislation during the 2009 session that addressed this issue. House Bill 2883 was the legislation which passed. It creates a Public Guardian Conservator Task Force. A member of ASAC has been nominated by the Superintendent of the state hospital to serve on the task force.

- ASAC is becoming more involved in issues surrounding Young Adults in Transition (a term youth developed to replace Transition Age Youth), working on ways to collaborate with CSAC.
- ASAC members participated in several community forum advocacy efforts around the department's budget development process, in preparation for the recent legislative session. Members were very active in the division's weekly legislative conference calls and received legislative updates at their monthly meetings from the division's Governmental Affairs Manager.
- ASAC prioritized discretionary adult system projects to be funded with MHBG dollars through the end of the 2009-2011 biennium.
- ASAC will continue to work on developing outcomes measures for peer delivered service contracts using MHBG funds.

CSAC conducted the following activities during the last year:

Across all state CSAC 2009 Accomplishments (January – June 2009)

- Work Plan 2009 – CSAC members identified and prioritized system issues as a focus of committee work. These included: 1) CSCI mid-course revision/outcomes; 2) Young Adults in Transition; 3) Family Navigator Program/ peer-to-peer delivered services; 4) Integration of medical, dental, primary care/child psychiatry mental health.
  - #1 -- Through an Issue Brief brought to CSAC, AMH conducted statewide focus groups offering communities the opportunity to work through some of the issues, resolve some of them at the meetings, and bring other issues to AMH for additional discussion. AMH will compile data and e-mail to each attendee from their area focus group.
  - #2 – Young Adults in Transition have been given a more active role in the planning and implementation of CSAC meetings
  - #3 – CSAC was given an up-date on the Family Navigator Program, currently there are three pilot counties.
  - #4 –The CSAC September meeting will be devoted to the integration model of medical, primary care, and child psychiatry mental health.
- CSAC members participated in the development of the Integrated Services and Supports Rule (ISSR). CSAC members wanted to actively participate in the rule development workgroup.
- Members were given an up-date on the AMH Trauma Policy.

- CSAC members continue to receive ‘data information’ at each monthly meeting. Some of the points presented have included: expenditure report including the percentage of dollars being spent on children and adolescents as compared to adults; Children’s Mental health fact sheet; Issue Brief Focus Group information; Transition Age Youth; Youth Services survey; Psychotropic meds for Children in foster Care.
- An up-date on the Collaborative Problem Solving statewide implementation project was given, with locations identified.
- Statewide Wraparound Initiative – many members, including family members helped in the passage of major state legislation to insure the Wraparound philosophy of service delivery and collaborative efforts across all state child-serving agencies.

#### **4. Public Comment on the State Plan**

Oregon’s State Plan is posted on the Department of Human Services website at the time the application is submitted to the Center for Mental Health Services. The plan is open for comment during the Legislative Session as part of the Agency’s budget presentation to the Legislature. There is opportunity for public comment at that time. The feedback from the public comment will be incorporated into any modifications to the State Plan. AMH will notify the Center for Mental Health Services of any State Plan modifications made in response to public comment.

### **STATE PLAN**

#### **I. ADULT STATE SERVICE SYSTEM**

##### **1. OVERVIEW**

##### Organizational Structure

The Oregon Addictions and Mental Health Division (AMH) is located within the Department of Human Services (DHS), which reports to the Governor.<sup>1</sup> DHS is made up of the following program areas: Children,

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<sup>1</sup> As described in Section I.3, legislation passed during the 2009 Legislative Session created a new agency: the Oregon Health Authority. AMH will become part of that agency.

Adults and Families; Seniors and People with Disabilities; AMH, the Division of Medical Assistance Programs (State Medicaid Agency) and the Public Health Division.

Capitated mental health services for persons who are Medicaid-eligible are administered through contracts between AMH and Mental Health Organizations. All other non-capitated services are administered through contracts with the counties and direct contracts with service providers for community hospitals for acute psychiatric care and a small number of residential programs.

The State is required by Oregon Revised Statute 430.640 to establish a contractual relationship with every community mental health program in each county, or Native American Tribe on request by the Tribe, to assure the provision of community mental health services. State funds for nonresidential services are allocated to counties using a "block grant" approach. This method of allocation provides the greatest flexibility for counties or community mental health programs in managing resources to best meet the needs of consumers. AMH currently contracts with 36 counties or consortium of counties, one community mental health program and one tribe.

### Funding Mental Health Services

Throughout the 1980s and early 1990s, an increasing amount of state General Fund was used to match federal Medicaid funds for community mental health services. Considerable expansion of the public mental health care systems resulted. Escalating health care costs, however, required new strategies for cost effective and appropriate public health care. The Oregon Health Plan (OHP), developed in the late 1980s, provides a rational method for allocating public resources for health care. OHP devotes resources to services that are most effective in treating covered conditions, provides incentives to intervene early, and extends coverage for some of low income Oregonians in need of mental health services.

Since 1989 the Health Services Commission has prioritized medical conditions and associated treatments. Condition and treatment pairs are ranked according to the state of medical technology, the effectiveness and cost of treatment, public values, and advice from medical specialists and

ethicists. Since 1993, a prioritized list has served as the basis for the allocation of health, mental health, and chemical dependency services.

OHP includes an expanded mental health benefit that covers all OHP eligibles. As of May 2009, 92% of persons who are Medicaid-eligible received their Medicaid mental health benefit through an at-risk managed care Mental Health Organization (MHO).

Not all individuals requiring public mental health services meet Medicaid eligibility criteria. Mental health services continue to be made available to persons ineligible for OHP according to risk criteria defined in state law. However, with Legislative funding last biennium of Early Assessment and Support Teams, the state is beginning to prioritize early intervention and a more foresighted approach to longer-term risk management. State general funds, various federal grants (including this grant), local funds, and private insurance payments provide additional sources of revenue for Community Mental Health Programs to serve people who have mental health needs, but are not eligible for Medicaid or other third party payments.

#### Summary of Areas Previously Identified by the State as Needing Attention

- Improved access to mental health and chemical dependency services for older adults.
- Gap in planning and age appropriate services for young adults in transition (formerly called transition age youth).
- Improved rate of discharge for people ready to leave the state hospital, who are deemed “ready to place.”
- Lack of affordable housing and residential options for people with severe and persistent mental health challenges.
- Decreased waiting periods for those in acute care hospitals waiting to transfer to the Oregon State Hospital.

#### 2. New Developments and Issues

- **Transformational Planning at Oregon State Hospital**  
The Oregon State Hospital Replacement Project held a ground breaking ceremony in Salem during September 2008. The ceremony followed months of careful planning and preparation, including a series of community meetings with hospital staff and

patients, neighbors, elected officials, and community stakeholders. The new 620 person facility is anticipated to be completed in 2011. A second 320 person facility is being developed in Junction City.

The 2007 Oregon State Legislative Assembly directed DHS to provide reports to the Legislature and Interim Emergency Board on the project related to financing, expenditures and other significant issues. DHS' primary goal is to design a state-of-the-art treatment and recovery facility on time while working to stay within a \$458 million budget. One of the primary cost-drivers associated with the State Hospital Replacement Project is construction costs, which have continued to rise much faster than the consumer price index or the producer price index for finished goods.

The Behavioral Health Integration Project (BHIP) is an element of the Replacement Project, allowing for the acquisition and implementation of a new hospital information technology system. BHIP will support resident treatment and recovery outcomes through transparency of electronic medical records, pharmacy services, laboratory reports and dietary regimens.

Implementation of the Continuous Improvement Plan (CIP) at the State Hospital has been in effect since July 2007 and is designed to improve quality of care, meet professional standards and elevate overall organizational performance. A primary component of the CIP is the hiring of additional staff, increasing staff to patient ratios and allowing for the delivery of 20 hours of treatment per week per patient. As part of the staffing increase, Oregon has implemented the Peer Bridgers program and will be one of three states in the nation utilizing a model in which peers who have accessed inpatient public mental health care, formally support and mentor residents ready to be discharged. Additionally, a third new treatment mall opened in spring 2009 utilizing a "classroom" model of service delivery.

Funding for the Oregon State Hospital Replacement Project, BHIP and the Continuous Improvement Plan was included in the 2009-2011 Legislatively Approved Budget.

- **Peer Delivered Services for Recovery and Wellness**

Building on the research contained in the 2006 National Association of State Mental Health Program Director's (NASMHPD) report, *Morbidity and Mortality in People with Serious Mental Illness*, AMH released a statewide report in June 2008 detailing years per life lost for Oregonians who receive public mental health and/or addictions treatment. The risk factors associated with early death (smoking, obesity, lack of exercise, etc.) can be managed, and if managed, would make a difference in the overall health of mental health consumers. The Oregon study concludes that premature mortality among this population is a health care crisis and recommends AMH (via a Wellness Task Force) work with community agencies to implement changes in care coordination, wellness screening and use of peer-to-peer support services to empower people with serious mental illness and/or substance use disorders in achieving lifestyle changes that will improve their overall health. In a draft report of the 2008 federal monitoring review of the block grant, it was noted that, "the creation of a Wellness Initiative as a consumer-directed effort to address the issues of mortality and morbidity in individuals with mental illness is forward thinking and among the first in the nation."

Research indicates that the delivery of peer support by people who have themselves experienced mental illness is a successful model.<sup>2</sup> Towards this end, AMH distributed a solicitation in 2007 to award federal Mental Health Block Grant funds to assist with the expansion of peer delivered services. Awards were made to Benton, Malheur, Lane and Josephine counties. Additional block grant monies were used to staff a peer operated Warm Line in eastern Oregon. Initially in operation only five hours a week, the Greater Oregon Behavioral Care Network (GOBHI), an MHO and Community Counseling Solutions each donated \$30,000 to expand the David Romprey Oregon Warm Line to statewide operation. Counties may purchase five hour blocks of time to provide peer counselor training.

AMH is in the process of implementing rules, policies and procedures to promote and increase the utilization of peer delivered services (PDS) in Oregon. AMH aligns its focus with national and

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<sup>2</sup> Brown, L.D., Shephard, M.D., Merkle, E.C., Wituk, S.A., & Meissen, G. (2008). Understanding How Participation in a Consumer-Run Organization Relates to Recovery. *American Journal of Community Psychology*; 42 (1-2), 167-178.

international recovery thinking, person-centered health care planning, client self-determination and a holistic wellness approach in its mental health and addiction services delivery transformation. Part of this service delivery transformation is demonstrated by a policy and procedure for reviewing and approving peer delivered services training and curricula which meet Center for Medicaid Service and national consumer run organization standards. AMH is currently streamlining and consolidating service delivery administrative rules, including language defining peer delivered services and identifying service areas for employment and volunteer opportunities.

- **Integration of Physical and Behavioral Health Care**

In fall 2008, the Director of DHS created a special position related to Health Services Integration. A Core Integration Team provides expertise and input into an Oregon model that will integrate mental health, addictions, dental and physical health services. In addition to the statewide demonstration projects noted below, DHS has identified 130 local integration initiatives currently underway.

The 2009 Legislature requested that AMH develop an integrated management and service delivery model concept paper for the Joint Committee on Ways and Means Subcommittee on Human Services. The paper recommends the establishment of two to three collaborative demonstration projects that meet specified criteria. At the end of the demonstration, AMH expects to:

- Integrate the addictions, health and mental health service payment system;
- Develop an outcomes-based contracting and payment system;
- Develop a consolidated funding and management system;
- Understand the restrictions on funding services that must be changed to allow greater flexibility in service delivery while meeting federal requirements; and
- Identify a model to braid funding, including the use of federal waivers if necessary while identifying cost savings and efficiencies in service delivery.

The 2009 Legislature used a budget note on the DHS Budget bill to direct AMH to establish two to three demonstration projects.

- **Young Adults in Transition (TAY) Age 14-25 with Mental/Emotional Disorder (SED)**

Oregon has made significant progress in making positive changes in the service delivery system for young adults in transition. Yet, there is much more to be done. Oregon was one of six states selected to attend a one week Policy Academy at Georgetown University in December 2008. The academy brought together youth and professionals that work with youth, and provides ongoing technical assistance with Oregon policy development. With the strong advocacy of the Policy Academy Advisory Committee and cross-agency agreement on shared values and principles, Oregon is in a strong position to move forward. Youth M.O.V.E. (Motivating Others through voice of Experience), Oregon Family Support Network (OFSN), the Children’s System Advisory Committee (CSAC) and the Adult System Advisory Committee (ASAC) are all advocating a system of care for young adults in transition that is youth driven, coordinated, developmentally appropriate and effective.

Youth in Oregon have been supporting each other, working to improve mental health services, reduce stigma and educate their communities. At a recent Governor’s Wraparound Initiative Youth Workgroup meeting, youth from across the state met and chose to be formally recognized as Youth M.O.V.E. Oregon. Youth M.O.V.E. Oregon has as its goal to unite groups across the state and establish a strong youth voice for improving all youth systems in Oregon. The group is organizing under the OFSN, a statewide family driven non-profit agency, until they are ready to form their own organization.

### 3. Legislative Initiatives and Changes

The Oregon Legislature convenes on a biennial basis, during odd numbered years. In February 2008 legislators convened for a four-week “Supplemental Session.” Legislation arising from this session required AMH to solicit a consultant to perform an assessment of Oregon’s adult community mental health system, as well as an investment analysis of both Medicaid and non-Medicaid funded mental health care. The final report was published in November 2008. A summary of findings<sup>3</sup> indicates:

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<sup>3</sup> Many of these report findings were subsequently addressed in the 2009 Legislative Session.

- Overall, the mental health system in Oregon does not have the funding to serve all individuals in need. While individuals covered by the Oregon Health Plan (OHP) are entitled to receive a fairly comprehensive package of mental health services, limitations in the availability of service providers and barriers created by geography, cultural and ethnic differences inhibit access and availability of services, all of which vary dramatically from county to county (Oregon has 36 counties).
- There is a lack of clear vision as to what the overall statewide mental health care delivery system should include and how it should operate.
- While Oregon provides a variety of mental health services at relatively reasonable costs, many individuals do not have access to preventative and maintenance services which leads to accessing higher cost care via the emergency room, hospital inpatient psychiatric services and state psychiatric hospitals.

Legislation passed during the 2009 Legislative Session, which ended June 29, 2009 includes:

- Creation of an Oregon Health Authority, transferring health functions from DHS to the new agency (including the Addictions and Mental Health Division);
- Establishment of an Advisory Board for the Oregon State Hospital;
- Provision for a more inclusive community-based system for planning and siting housing and facilities for people under the jurisdiction of the Psychiatric Security Review Board (PSRB);
- Expansion of the Oregon Health Plan (OHP) to add approximately 35,000 more adults to the OHP Standard Program (includes mental health services).

The 2001 State Legislative Assembly passed HB 3024, now codified as Oregon Revised Statutes (ORS) 430.630 and 430.640, requires a statewide comprehensive plan based on local community-based plans. ORS 430.630 (10) (b) requires each Local Mental Health Authority (LMHA) to develop a biennial plan for comprehensive mental health services. The plan must address local needs and service delivery methods for children, families, adults and older adults. The purpose of the local

plan is to create a blueprint for the provision of community-based mental health services that are responsive to the needs of individuals residing in the community served by the local plan. ORS 430.640 (1) (p) requires AMH to report biennially to the Governor and the Legislative Assembly on the progress of the local planning process and the implementation of the local plans, as well as the state planning process and performance data. AMH reviews these plans as the statewide plan is developed.

#### 4. Agency Leadership

AMH provides leadership in the delivery of mental health services through the establishment of administrative rule and contracts, the provision of training and technical assistance, the development of Statewide Mental Health Services and the initiation of various workgroups. This section will briefly describe each of these areas of leadership.

Administrative rules and contracts establish standards for community mental health services. The AMH Quality Improvement and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Certificates of Approval are issued to community mental health programs and sub-contracted providers, children's psychiatric day treatment, and nationally accredited psychiatric residential treatment programs for children, inpatient psychiatric acute care programs, psychiatric hold rooms used for seclusion or restraint, and private outpatient mental health providers. Licenses are issued to Residential Treatment Facilities and Adult Foster Homes serving adults with mental illness. Quality Improvement staff conduct site reviews of these programs to ensure compliance with contract conditions and state regulations. This section also approves individuals in the state to conduct investigations and examinations for civil commitment proceedings and for individual clinicians to authorize the use of seclusion or restraint for children in approved facilities. The Mental Health Organizations that are contracted to manage the mental health benefit of the Oregon Health plan are also reviewed regularly for contract compliance.

In 2003 Oregon passed legislation (SB 267) that directed AMH, among other agencies, to spend public funds on evidence-based

practices (EBPs). The goal for the 2007-2009 biennium was that 50% of mental health, alcohol and drug treatment and prevention funding is spent on EBPs. According to a survey of providers that was conducted during the summer of 2008, Oregon has exceeded its statutory goal. By the end of the 2009 – 2011 biennium, AMH needs to demonstrate that 75% of the public funding is spent on EBPs. AMH has been engaged in a process with statewide community partners input to define, identify and implement EBPs. Currently there have been 167 EBPs identified that meet the state definition. AMH recently approved an EBP Strategic Direction Proposal that directs AMH to focus implementation of EBP on populations specifically referenced in the 2003 legislation which are targeted to reduce juvenile and adult crime, reduce recidivism and reduce the utilization of emergency mental health facilities.

Each biennium AMH evaluates the mental health training needs in the state. The Workforce Development Unit develops a plan to provide the training necessary to equip the mental health workforce to deliver the services needed to carry out the statewide mental health initiatives. A proposed 2009-2011 training plan is included in this application.

AMH establishes task forces and workgroups to develop plans and build consensus for mental health initiatives. Some of the workgroups established include the State Hospital Master Plan Community Services Workgroup and the H.E.A.R.T. (Health Empowerment and Recovery Team) & MIND Wellness Initiative Task Force. Oregon is currently refining and strengthening its Olmstead Plan.

## **II. IDENTIFICATION AND ANALYSIS OF SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES**

### **1a. Strengths**

- **Continuing Deinstitutionalization**

Oregon (AMH) continues to transform the mental health system by moving from institution-based care to community-based care. Since 2003, the Department of Human Services, Addiction and Mental Health Division, in

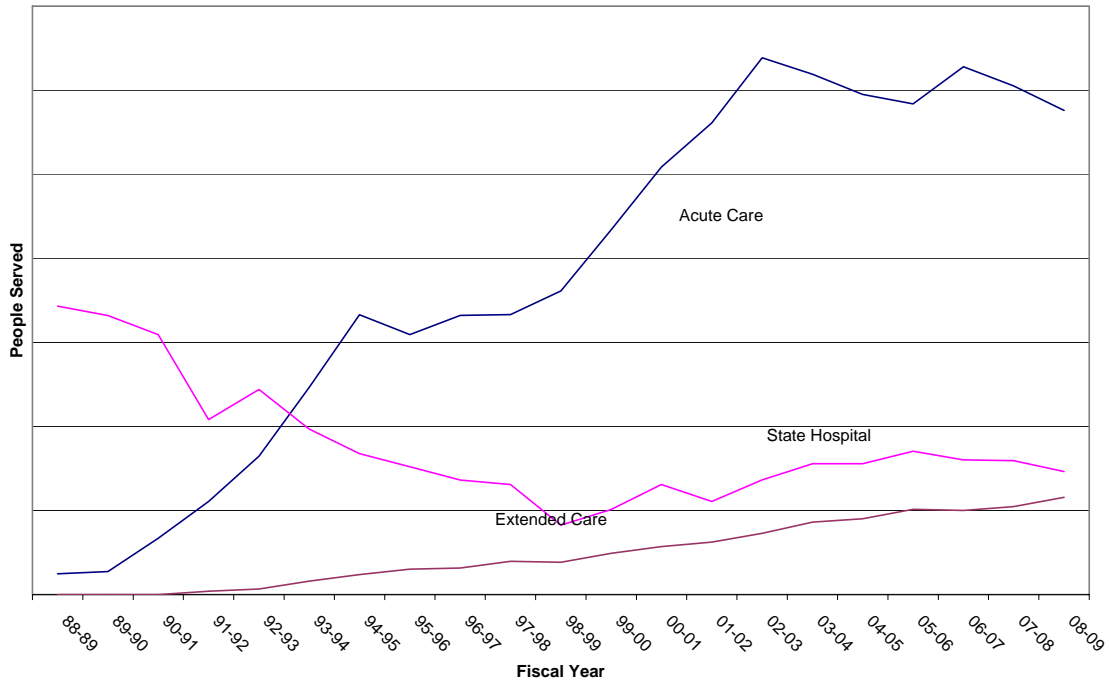
partnership with local governments, has developed more than 700 new community-based placement options for adults with severe and persistent mental illness. The Legislatively Approved Budget includes funding to complete an additional 314 community placements during the 2009-2011 biennium:

- 42 PSRB Adult
- 5 PSRB Youth
- 267 Civil Commitment

The Extended Care Management Unit (ECMU) maintains responsibility for individual placement approvals and for conducting utilization reviews of adults in extended and enhanced care placements. AMH added 164 new ECMU community placements in the 2007 – 2009 biennium, serving a total of 740 people, 110 of which are supported housing slots. AMH contracts for mental health services in ten enhanced care facilities licensed by Seniors and People with Disabilities, serving a total of 238 people.

Deinstitutionalization has resulted in resources being shifted from state hospitals to community programs. The percentage of the division's total dollars expended on adult and children's community mental health services (community mental health and Oregon Health Plan) has remained relatively constant at 73% for the 2007-2009 biennium, and 74% for the 2005-2007 biennium. The following graph demonstrates the historical shift from institutions to community-based care.

Shift from Institutions to Community-based Care



- **Co-Management Plan**

AMH worked with the CMHPs to address the issue of state hospital utilization and continuity of care for civilly committed (though not forensic or criminally committed) county residents. The Financial Assistance Agreements (FAA) with the CMHPs were modified to share financial risk for those civilly committed patients that remain in the state hospital when they are ready to return to the community and the community resources and supports are available. This FAA modification is based on the Co-Management Plan which establishes county and regional targets for state hospital Average Daily Population and establishes a utilization review process for persons approved for state hospitalization. This and other efforts of the local CMHPs and AMH have led to a reduction in the number of people waiting in local acute care hospitals to enter the state hospital. Using 2004 as an historical point in time reference, the average number of people on the wait list was 30. In 2008 the average number of people on the waitlist was 25 and through June 2009 the average number on the waitlist is 14.

- **Safe, Affordable and Permanent Housing**

Since 1989 AMH has directly awarded modest grants to assist with housing options for persons with mental illness. During the 2007-2009 biennium a total of \$5.9 million was dispersed statewide to provide an additional 304 beds in residential facilities. Funding for these efforts comes from state, federal and trust funds. For the 2007-2009 biennium, AMH additionally awarded a total of \$163,000 to 41 housing operators for renovations to correct health, safety or accessibility problems. The estimated number of people affected by these renovations is 470. AMH also has a small fund to assist with improvements to living arrangements in institutional facilities. This funding is a portion of a mandated amount from the Community Mental Health Housing Fund (CMHMF) which was established from the sale of the Dammasch State Hospital.

The CMHMF was created by the 1999 Legislature from the sale of the former Dammasch State Hospital and is codified in ORS 426.502 through 426.508. The statute directs 70 percent of interest earned to community housing purposes and 30 percent to improve living conditions for state hospital patients. The Legislature statutorily reserved not more than ten acres for the development of housing for persons with serious mental illness at Villebois: a community developed on former state hospital grounds.

In 2007-2009, AMH initiated several residential development projects to provide housing resources for individuals transitioning from institutions and homelessness, and to create additional housing opportunities for people with barriers to residential stability. Forty-six projects were initiated in seventeen counties accommodating 430 people with serious mental illness, including residential capacity to serve 214 individuals leaving the psychiatric hospital facilities. The projects include eleven Residential Treatment Facilities, eleven Residential Treatment Homes, and nineteen supported housing projects. Additionally, Oregon Recovery Homes outreach coordinators have increased the number of peer-run Oxford Houses in Oregon to 178, the highest per capital of any state and second in overall development.

For the 2007-2009 biennium, an integrated application process was developed to distribute various sources of funding. The 2007-2009 Expanding Community Living Opportunities (ECLo) Awards disbursed approximately \$413,000 in Mental Health Services Housing Development Funds (MHS), \$1 million in Supported Housing Services funding for non-

Medicaid individuals and \$31.3 million in Caseload Growth Funds. A portion of the Caseload Growth Fund had already been committed for projects initiated in the 2005-2007 biennium.

ECLO funding resulted in the following outcomes:

- 53 supported housing placements for people with psychiatric disabilities who are without Medicaid coverage in six counties;
- provision of five new housing projects for 57 people with mental illness in five counties;
- increase in Villebois funding to accommodate five more people in a residential treatment setting;
- increase of 39 new PSRB/forensic community beds; and
- 22 new programs in eleven counties that will serve 211 individuals who are under civil commitment, requiring less structured residential resources or prioritized as Young Adults in Transition.

- **Supported Education and Employment**

In 2007 AMH funded a three year initiative designed to assist community mental health programs implement supported education for people with severe mental illness. Supported education, which is an evidence-based practice, assists people to receive the education/training they need to meet their recovery goals by completing their adult education plan, attaining a GED or postsecondary degree with the goal of becoming gainfully employed in the career or job of their choice.

Research demonstrates that supported education is twice as effective as prevocational training at helping people with severe mental illness obtain competitive employment.<sup>4</sup> There are currently three programs in operation in the following counties: Josephine, Multnomah and Washington. After one year, 141 people had completed intakes for supported education services. Sixty-five percent of those enrolled in classes for college credit completed their coursework, with a grade point average of 3.2.

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<sup>4</sup> Crowther, R.E., Marshall, R., Bond, G.R., and Huxley, P. (2001). Helping People with Severe Mental Illness to Obtain Work: Systematic Review. *British Medical Journal*; 332, 204-208.

In 2007 AMH issued a competitive Request for Proposals for a statewide Supported Employment Center for Excellence. Southern Oregon Options was awarded a contract to provide training and technical assistance to local providers on the delivery of supported employment, an EBP, with fidelity. Options is working in partnership with Portland State University to offer technical assistance and fidelity monitoring for fourteen supported employment programs, assisting individuals with the necessary skills and tools needed to obtain and maintain competitive employment.<sup>5</sup> According to Options data, of the 646 individuals participating in these programs, approximately 40% have obtained competitive employment.

As part of active treatment, the Oregon State Hospital also continues to develop and expand vocational and educational services for residents. Three hundred and thirty six clients were served in the past year by the vocational program. During 2008, 30 clients were enrolled in college and a total of 134 class hours per week have been completed, an increase of 319 percent or 102 credits from the previous year.

The Oregon State Hospital tries to place as many patients as possible into employment settings. By participating in employment opportunities, residents develop skills in structuring their time and learning to responsibly accept feedback, as well as enhance their social interaction and cooperation skills-all of which empower people when they return to the community. An average of 177 residents have been employed throughout 2008, representing an 11 percent increase from 2007. Of these, 120 residents have been employed in sheltered workshops and 57 have been employed in competitive jobs.

- **Co-occurring Disorders (COD)**

People struggling with both mental illness and chemical dependency have unique issues that need to be addressed simultaneously. Oregon initiatives to address and expand COD services are progressing in both mental health and substance use treatment programs. AMH sent a voluntary COD survey was sent to all mental health and substance

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<sup>5</sup> Coos, Crook, Deschutes, Josephine, Lane, Malheur, Marion, Multnomah, Washington and Yamhill counties, and the Mid-Columbia Region (Gilliam, Hood River, Sherman and Wasco counties).

use treatment providers in spring 2007. The results were published in 2008.<sup>6</sup> Screening to identify people with COD is occurring in most programs responding to the survey, and many programs are already implementing integrated comprehensive assessments. The survey report indicates that 33/36 Oregon counties have providers that serve adolescent and adult clients with COD: 106 treatment providers serve adult clients, and 69 treatment providers serve adolescents. Dual Diagnosis Anonymous recovery support is available in 32 Oregon counties and currently offers 450 meetings each month, reaching over 3500 people. AMH provides financial support to Dual Diagnosis Anonymous of Oregon, Incorporated (DDA) to help disseminate this effective model, and establish additional programs.

- **Policy and Programs for Young Adults in Transition<sup>7</sup>**

AMH is working in partnership with youth and professionals working with youth, to develop policies for the coordinated transition of services between the child and adult mental health systems. One of the largest barriers that the 14-24 year old population faces is the loss of Medicaid benefits at 18 years of age. In August 2008 AMH, in concert with the Oregon Family Support Network (OFSN), held Oregon's first statewide youth planned and delivered conference entitled *YOUTHSPEAK: Building a Responsive System for Transition Age Youth (TAY)*. Seventy-five youth and professionals attended a half day Youth and Professionals as Policy Partners training prior to the conference, and over 104 people attended the day long conference featuring youth keynotes and youth led workshops. A small focus group of ten youth and five professionals working with youth met two weeks later to develop draft policy recommendations. At the same time Oregon was selected to send a delegation to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) TAY Policy Academy at Georgetown University in December 2008.

The Early Assessment and Support Team (EAST) program intervenes early to prevent the tremendous social and economic consequences of untreated schizophrenia and related psychotic disorders. The program

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<sup>6</sup> [www.oregon.gov/DHS/addiction/docs/co-ocr-dir\\_2008.pdf](http://www.oregon.gov/DHS/addiction/docs/co-ocr-dir_2008.pdf)

<sup>7</sup> Note that the children's system section of the grant will discuss the youth generated term *Young Adults in Transition* to replace Transition Age Youth (TAY). For purposes of consistency with work undertaken prior to this occurrence, the adult section uses the terminology TAY.

offers evidence-based treatment to teens and young adults who have had a first experience with psychosis within the past twelve months. The focus for youth is on maintaining progress in school, work and independent living, while at the same time supporting the family. The EAST program teaches skills needed for long-term success, as well as the prevention of future hospitalizations and acute episodes. This programmatic focus leads to increased community tenure, and diverts young adults from the multiple challenges associated with institutionalization. EAST's replication effort is called the Early Assessment and Support Alliance (EASA). Services include intensive community education, outreach and engagement, medical assessment and prescribing, counseling and case management, vocational and academic support, and occupational therapy. EAST/EASA services, funded by the 2007 Legislature, are currently available in 16 Oregon counties, covering 60 percent of Oregon's population. As of May 2009 there were 411 families being served in EAST and EASA programs, with 220 receiving ongoing services.

#### 1b. Weaknesses

The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for seniors is a critical area of improvement for Oregon's mental health system. It is also imperative that AMH begin to look at this issue now, before Oregon's growing elderly population elevates it to a crisis level. Over the past year, AMH has cultivated a collaborative relationship with the Seniors and People with Disabilities Division (SPD). A representative from SPD, as well as the Governor's Commission on Senior Services, serves on the Mental Health Planning and Management Advisory Council. The Mental Health Planner has been regularly attending Wellness Subcommittee meetings of the Governor's Commission. In FFY 2010, a portion of adult discretionary block grant funds will be dedicated to projects which increase access of this population to mental health services.

There continues to be an issue of individuals needing long-term care without ready access to admission to a state hospital. Once approved for long term care at the state hospital, persons are waiting an average of 25 days in an acute care hospital prior to transfer to the State Hospital. More needs to be done to reduce or eliminate the wait list. The time a person spends in an

acute care hospital waiting for a bed at the state hospital negatively impacts acute care access for those in need of that level of care.

The lack of affordable housing and community residential settings for people with severe and persistent mental illness continues to present a serious challenge in Oregon and results in too many individuals becoming homeless or incarcerated. Without a housing subsidy, an individual with an SSI income cannot find affordable housing anywhere in Oregon through the private housing market. A 2005 AMH housing survey (conducted every five years) assessed the housing needs of children and adults receiving publicly funded mental health services. Results from this survey included an estimate that a total of 2,972 adults with mental illness are homeless at any point in time. The survey also estimated that 12,861 adults were in immediate need of affordable housing, 1,940 were in need of supportive housing, and 577 were in need of structured "group home" settings. On the positive side, community mental health programs reported that 92 housing projects for persons with mental illness were developed in the previous five years and 24 additional projects were under development. These recent and current projects have the capacity to house 1,142 persons.

Although the increase in residential development across the state has improved the rate of discharge for patients deemed "ready to place" at the state hospital, there is a population of patients (approximately 26%) on the ready to place list who have exceptional barriers to discharge. These barriers include sexual offenses, compromised medical conditions, aggressive behaviors, and low cognitive functioning. AMH has created an exceptional barriers team that includes representatives from the state hospital and AMH ECMU and development staff. The purpose of this team is to problem-solve and eliminate barriers to discharge. Additionally, the Governor's work group on PSRB siting has identified improvements to the notification system, and has developed principles and guidelines for involving affected communities, neighborhoods, counties, cities, other public entities and any other involved parties in the siting process.

## 2. Unmet Service Needs<sup>8</sup>

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<sup>8</sup> Unless otherwise noted, all data cited is from the following independent report: Public Consulting Group. (2008). State of Oregon Department of Human Services Addiction and Mental Health Division: Assessment and Evaluation of the Mental Health Care Delivery System in Oregon. [www.oregon.gov/DHS/mentalhealth/legislative-info/pcg-report](http://www.oregon.gov/DHS/mentalhealth/legislative-info/pcg-report).

- Low utilization of mental health and chemical dependency services and age appropriate services for older adults. The physical manifestations of the aging process, combined with depression and poly-pharmacy use, make this population particularly vulnerable to co-occurring disorders. Recent literature published by SAMHSA indicates that as the baby boomers age, the current trend of alcohol abuse among seniors is being complimented with marijuana use and abuse of harder drugs.
- Gap between the need for mental health services for people with serious mental illness and utilization of community mental health services. Resources to address the mental health needs of all those who need them have not been sufficient since the massive budget cuts to the division in the early 1990s.
- Access to, and utilization of, mental health services by returning veterans from Iraq and Afghanistan. While the federal government is working to meet the mental health needs of veterans and their families, some of those needs will undoubtedly have to be met through the use of state and local resources. Recent studies published by SAMHSA note the increased psychological stress associated with multiple tours of duty, and the stigma associated with veteran's accessing mental health services.
- Access to integrated care (mental health, physical health and chemical dependency services) is very limited. Some Oregon counties, such as Benton County (visited by the federal block grant site review team), are already doing this. National and AMH research indicate people with serious mental illness and/or substance abuse disorders are dying an average of 25 years earlier than the general population, and have health risk factors that can be mitigated.
- Trauma informed services and care prevent people from cycling through the mental health system. Currently there is limited access to these services (AMH's Trauma Policy and Trauma Informed Services Strategic Plan addresses this issue).

### 3. Plan to Address Unmet Needs

As a result of the findings from the mental health consultation report cited above, a similar study of the addictions system and the 2009 Legislative Session, AMH will implement a systems change demonstration as early as this fall. The focus of the systems change is an integrated service delivery model (health, mental health and addictions services) and movement to an

integrated service management and payment system. These two changes will result in a simpler, more efficient use of state, federal and local resources and better services to those in need.

Existing State, Federal, Other and Medicaid funds currently administered by AMH and the Division of Medical Assistance Programs (DMAP) will be managed through a limited number of managed care entities to purchase a continuum of core health, mental health and addictions services, as well as wraparound services for housing, employment/education assistance. For the core services the state, AMH/DMAP, would consolidate administration of both federal and state service dollars through contracts with managed care entities on a regional/community basis. The managed care entity would purchase services through the current provider network combining management of both Medicaid and non-Medicaid funds.

A major change within the managed care process will be to develop outcome-based financial incentives for selected outcomes to the extent feasible in a Medicaid-funded environment. Where possible, all payments through the managed care entities will be based on individual treatment outcomes so that providers have a high degree of accountability and financial motivation to move individuals through a continuum of services that maximizes outcomes in a cost-effective way.

A major change will be the integration of mental health and addictions services with primary health care services, both in delivery of services and payment through the managed care entity.

The demonstration projects will be in at least two regions/counties around the state, with the goal of treatment and recovery being to provide opportunities for individuals to become self-sufficient.

#### 4. Recent Significant Achievements

- Pendleton Cottage, a 16 bed state-operated secure residential facility opened last fall, and is currently operating at capacity.
- Based on findings from a review of the Oregon State Hospital (OSH) by the Federal Department of Justice under the Civil Rights of Institutionalized Persons Act, OSH has hired more than 300 staff over the course of the last year (CY 2008) including nurses, physicians, psychologist, lab technicians and direct care ward staff.

- In order to address health disparities and premature mortality and morbidity among people with serious mental illness, AMH and the Public Health Division have begun discussions about mutual wellness goals.
- AMH has been an active partner in developing a youth voice for Young Adults in Transition. A state chapter of the Youth M.O.V.E. organization is in the process of being established in Eugene.
- Unlike many other state agencies and divisions within state agencies (both inside and outside DHS), mental health did not experience deep budget cuts during the 2009 Legislative Session.

#### 5. Vision for Future

- Mental Illness is treatable, often at a low direct cost.
- Recovery and wellness are possible and are the goals of all mental health services.
- Services are driven by the strengths and needs of consumers and their families, rather than by funding silos or the organization of service agencies.
- Services are culturally, age and gender specific.
- Services are available in the communities where people live.
- Services are preventative and offered as early as possible.
- Services reflect evidence-based practices with fidelity.
- Services are holistic and respond to a person's universe of strengths and needs.
- Services are based on conditions and outcomes, not diagnosis.
- Services are available without regard to ability to pay.
- For individuals who are dangerous to themselves or others, services must reflect public safety concerns.
- Recovery from mental illness also requires recovery from substance abuse and physical illness, if present. Thus, coordination and integration of services is essential.
- Outcomes can be measured, both in terms of individual recovery and improved population health. In public health terms the most important outcome is that substantial numbers of individuals achieve recovery and function as self-sufficiently as possible.

### **III. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE SYSTEM**

AMH would like to respond to reviewer comments concerning several performance measures in our FY2008 report.

For several measures, such as “reduced utilization of psychiatric inpatient beds within 30 days” and “client perception of care”, the denominator was listed as “100”. This prompted several reviewers to question AMH’s results and methodology. Data was reported this way because at the time the staff preparing the report only had percents available to them and not the raw data. So, if the percent of clients who felt that their functioning had improved was 64 percent, it was expressed as 64 out of 100. AMH did survey more than a hundred people and did look at more than 100 discharges to assess readmission rates. The raw data for all the measures questioned is in the Uniform Reporting System tables for your review.

Other comments related to the lack of counts associated with evidence based practices. AMH has struggled to report on the number of people being served by evidence based practice, while having a fairly good accounting of whether not evidence based practices are being delivered through contractual requirements and site reviews. AMH is able to report counts for some practices since they are billed for through our data systems, but this isn’t true for all the practices implemented in Oregon. AMH’s goal is to implement a new data system that would allow for better accounting of those served with evidence based practices. AMH will keep CMHS apprised of these efforts, as it seeks funding to implement a new system.

#### **Criterion 1: System of Care and Available Services**

- **Outpatient Services**

Clients are provided with an array of outpatient services, including assessment and evaluation, individual and group therapy, medication management, case management, and daily support and skills training. Services for clients experiencing acute psychiatric conditions include 24-hour crisis assistance, community-based respite care, sub-acute psychiatric care, and inpatient services. A promising feature of the OHP is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments

and alternative services suggested by contractors, allowing for less costly, and more effective service delivery when appropriate. These services, coupled with residential placements, where needed, and other supportive services such as supportive housing and supported employment aid individuals with mental illness in maintaining their tenure and stability in the community.

- **Case Management and Rehabilitation Services**

Case Management and rehabilitative services in the state of Oregon have been part of the care available to adults with severe and persistent mental illness. In the past services have relied on the traditional models of care. Research literature suggests that the traditional models have limited success in moving people to recovery and increased independence. In recent years, Oregon has promoted wellness and recovery models, and Evidence-Based Practices (EBP), as a more effective method of service delivery that results in improved progress for consumers and greater system accountability and performance. As a result of this, we are working with providers to deliver assertive community case management to meet individual consumer needs and to engage consumers in work with supports rather than months and years of day treatment in preparation for sheltered workshop employment.

Just as rehabilitation services are being influenced by EBP and recovery modalities, case management services throughout the State of Oregon continue to be influenced as well. There are many aspects to the case management process, as outlined in the administrative rules that have as its focus client participation and agreement as means to attain goals leading to recovery. Case Managers assist clients in:

1. Resource Acquisition (Social Security, food stamps, housing assistance, personal care services);
2. Symptom management and recovery;
3. Supported Employment and Vocational Rehabilitation Services;
4. Development of personal crisis plans and Declaration for Mental Health Treatment;
5. Active discharge planning in the event of a hospitalization; and
6. Constant monitoring of health and safety needs relative to their housing environment.

- **Intensive Treatment Services**

In addition to the services outlined above, a comprehensive system of intensive community-based, residential, and inpatient programs is

maintained. As of June 2009, approximately 682 extended care placements located in secure residential, foster care, and supported-living programs were available for adults. An additional 228 placements were maintained in nursing homes or other settings funded jointly with the Seniors and Persons with Disabilities Division for clients requiring nursing and psychiatric care. A statewide system of regional acute care units provides 278 beds for short-term inpatient psychiatric services. For adults who are civilly committed and in need of long-term secure treatment, 182 state hospital beds are also available in two state psychiatric hospitals (excluding geriatrics). In addition to residential development, the Local Mental Health Authorities and AMH have agreed on a co-management plan to link the community service system with the State Hospital.

- **Supported Employment and Supported Education**

See Section II.A.1: Strengths; Supported Education and Employment

- **Adult Services for Co-Occurring Mental Health and Substance Use Disorders**

See Section II.A.1: Strengths; Co-occurring Disorders (COD)

- **The Psychiatric Security Review Board (PSRB).**

The PSRB maintains jurisdiction for individuals adjudicated "Guilty Except for Insanity". As of May 1, 2009 there were 751 individuals under the jurisdiction of the PSRB in the State of Oregon. Approximately 49% of the PSRB population resides at the state hospital in Salem (OSH). The rest of the PSRB population resides in the community observing the requirements outlined in their individual conditional release plans and through supervision and supports offered by local Community Mental Health Programs (CMHP). The PSRB reports to the Governor and uses a variety of resources to manage people successfully under its jurisdiction. AMH, in close coordination with the PSRB, provides mental health services to such individuals. The state also provides assessment of persons for the PSRB and the court to determine if treatment in the community is appropriate. Determination of the supervision requirements of each placement, and treatment for persons conditionally released into the community is also provided. Individualized community placements include evaluation, supervision, case management, psychotherapy, supported employment services, alcohol and drug treatment, and medication management.

Recognizing that almost half of the PSRB population resides at the state hospital, AMH continues its commitment to develop new residential placements that will provide the necessary supports for this population to transition to community. An additional 47 community placements will be opened during the 2009-2011 biennium.

- **Other Health Services**

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and chemical dependency treatment providers. Thus, enrollment in a MHO provides coordination between medically appropriate treatment services for adults eligible for Medicaid and many of the social supports necessary so adults with serious mental illness can remain in their community. The OHP benefit package includes a full array of services such as:

1. Preventive services
2. Diagnostic services
3. Medical and surgical care
4. Dental services and
5. Outpatient chemical dependency services.

Criterion 1: Goals, Objectives, and Performance Indicators

Goal 1. Increase the number of advisory groups with consumer participation, particularly in rural areas. TRANSFORMATION OUTCOME MEASURE

Population	Adults (age 18+) with severe mental illness participating in statutory mental health advisory groups at the county or regional level (ORS 430.075).
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Determine the number of statutory mental health advisory boards in rural Oregon counties (as defined by OMB= 25/36 counties) with consumer membership.
Measure	The number of statutory mental health advisory boards in rural counties with consumer membership.
Numerator	The number of statutory mental health advisory boards in rural counties with consumer membership.

Denominator	Total number of Oregon counties.
Sources of Information	Informal survey data will be used to collect this information, along with site visit data collected during the county mental health program's quality certification/monitoring process.
Special Issues	SB 364 (2007), established the DHS Consumer Survivor Advisory Council, and requires a 20% consumer membership requirement for all mental health/addictions public task forces, commissions, advisory groups and committees. Additionally, the statewide Oregon Mental Health Consumer/Psychiatric Survivor Coalition was formed in April 2008, and will specifically advocate for consumers at all systems levels. The Oregon Consumer Survivor Network is a federally sponsored entity that provides training and technical assistance for individuals to participate on mental health advisory bodies. An additional challenge is that ten (10) of Oregon's 25 rural counties are considered to be frontier counties, with an average population of 2.1 persons per square mile.
Significance	It is essential that there be broad participation in mental health system planning from all areas of the state. There is concern participation is more difficult for individuals from rural areas of the state where communication and transportation networks are less developed. The information derived from this measure will allow ASAC to gain a clear understanding of the current level of rural consumer participation in advisory groups. ASAC can then report to the Planning and Management Advisory Council, who in turn will advise the division on the need and course for further direction regarding this issue.
Action Plan	An informal email survey was sent to all 36 CMHPs in February 2009. Only 15 responded, and of those who responded, five counties were not in compliance with the 20% requirement noted in the Special Issues section. A second survey will be conducted next year. Beginning in 2011, all CMHPs will be required to include this information in their biennial Implementation Plan. This will give AMH accurate baseline data, and allow compliance requirements to focus on counties not in compliance.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
The number of consumers from rural	N/A	N/A	N/A	<b>Initial informal</b>	<b>Second informal</b>	<b>True Baseline. All CMHPs</b>

counties participating mental health advisory boards				<b>survey. Note results in Action Plan</b>	<b>survey</b>	<b>required to report advisory board membership as part of biennial Implementation Plan</b>
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Goal 2. Increase the number of programs available in which consumers receive and provide peer-delivered support services. TRANSFORMATION OUTCOME MEASURE

Population	Adults with severe mental illness participating in programs in which they both provide and receive mental health services. Peer delivered services are defined as service offered by someone as a mental health consumer/survivor to someone else identifying as a mental health consumer/survivor.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Establish the baseline number regarding the availability of peer-operated programs throughout Oregon (2007 CMHP survey). Conduct annual follow-up surveys.
Measure	The number of peer-operated service programs offered throughout Oregon.
Numerator	The number of peer-operated service programs offered throughout Oregon.
Denominator	Not applicable.
Sources of Information	Informal surveys of CMHPs and other service providers regarding peer delivered services that their programs offer; OHP Encounter Codes; quarterly reports from Benton, Lane, Malheur and Union counties regarding progress on contractual performance measures; anecdotal information from other programs offering technical assistance or training on peer delivered services (i.e. Mental Health America of Oregon, NAMI, etc.).
Special Issues	AMH has spent considerable time and energy this year streamlining Administrative Rules and developing clear and concise definitions of peer delivered services, with multiple opportunities for input from stakeholders. These rules are close to being complete. The Division has also developed policy and procedures for review of PDS training curricula.
Significance	While the survey was not replicated this year, AMH demonstrated commitment to developing a common definition so that there will be clarity for future outcomes/performance measures.
Action Plan	PDS will play a critical role in the development of a new wellness charter currently being planned in partnership with public health, stakeholders and consumers. Ongoing

	measurement of key health indicators will be part of the charter, and could include a component on the significance of PDS to recovery and wellness. This performance measure may be revised in the future to reflect these policy changes.
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Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
The number of peer-operated services offered throughout Oregon	N/A	Baseline = 32*	N/A	N/A AMH updating Admin. Rule	PDS included in Wellness Charter	Baseline, or change performance measure

\* ASAC revised its definition of peer delivered services for the 2009 block grant, so the baseline number reported from the 2007 survey may not be accurate according to the new definition.

### Goal 3. Supported Employment

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The number of people being served by supported employment.
Measure	Number of respondents reporting that their employment situation has improved.
Numerator	The number of respondents competitively employed full or part time.
Denominator	N/A
Sources of Information	Claims data
Special Issues	Stable employment is a primary factor for facilitating recovery for persons with a serious and persistent mental illness.
Significance	Oregon has clearly identified employment as a key factor for persons with a serious mental illness recovering.
Action Plan	Supported Employment Evidence Based Practice Initiative.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Number of respondents reporting that their employment situation has improved.	N/A	557	732	<b>740</b>	<b>745</b>	<b>750</b>

Goal 4. Increase the percentage of adults with severe mental illness reporting positively on outcomes.

Population	Adults who received Medicaid mental health services within the past year.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The outcome performance domain of the MHSIP Adult Outpatient Consumer Survey.
Measure	Percentage of adults reporting positive perception of outcomes.
Numerator	The number of adults reporting positive perception of outcomes.
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Outpatient Consumer Survey.
Special Issues	This will be the fourth time the MHSIP Adult Survey will have been used; because of this, the MHSIP data will provide administrators and stakeholders with meaningful, consistent information on trends in consumers' perceptions of outcomes over the past three years.
Significance	Consumers' perception of outcomes is one of the most basic performance measures the Division can use to track the success of services. This measure has historically been low, leaving much room for improvement.
Action Plan	AMH will work with the Consumer Advisory Council (CAC) and the Adult Services Advisory Committee (ASAC) to monitor the results of this survey as an indicator of system transformation.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percentage of adults reporting positive perception of outcomes.	57%	56%	56.3%	<b>58%</b>	<b>59%</b>	<b>60%</b>

Goal 5. Increase reported Social Connectedness. (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The social connectedness domain of the MHSIP survey.
Measure	Percentage of adults with positive response to the Social Connectedness questions on the MHSIP
Numerator	Number of adults with positive response to the Social Connectedness questions on the MHSIP
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	This is a new domain on the Adult MHSP survey.
Significance	Recovery means that individuals have a place in the community. People feel empowered to make choices and feel hope for the future. People have meaningful relationships and feel connected to their community.
Action Plan	ASAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percentage of adults with positive response to the Social Connectedness questions on the MHSIP.	59%	58%	58.5%	<b>59%</b>	59.5%	60%

Goal 6. Improved Functioning. (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The functioning domain of the Adult MHSIP Survey.
Measure	Percentage of adults with positive response to the Functioning questions on the MHSIP
Numerator	Number of adults with positive response to the Functioning questions on the MHSIP
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	This is a new domain on the Adult MHSP survey.
Significance	Recovery means that individuals have a place in the community. People feel empowered to make choices and feel hope for the future. People have meaningful relationships and feel connected to their community.
Action Plan	ASAC and CAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percentage of adults with positive response to the Functioning questions on the MHSIP	57%	55%	55.5%	<b>60%</b>	<b>60.5%</b>	<b>61%</b>

Goal 7. Decrease the rate of re-admission of adults to the state psychiatric hospitals within 30 days and 180 days. (NOM)

Population	Adults discharged from the Oregon state psychiatric hospitals.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	30 day and 180 day re-admission rates into the state psychiatric hospitals.
Measure	Percentage of adults discharged from state psychiatric hospitals who return to the state hospital within 30 or 180 days
Numerator	The number of civilly committed adults discharged from the state psychiatric hospitals who return within 30 or 180 days.
Denominator	The number of civilly committed adults discharged from the state psychiatric hospitals
Sources of Information	Oregon Patient/Resident Care System (OP/RCS)
Special Issues	The Supreme Court's <i>Olmstead Decision</i> requires people to be treated at service levels that are appropriate to their needs. This measure is one indicator to judge the adequacy of discharge planning that occurred as people transition from institutional level care to community services.
Significance	AMH has placed special emphasis on integrating state hospital and community services. This is a key proxy measure to insure that communication between community providers and the state hospital is adequate to create successful discharges from the state hospitals.
Action Plan	Will continue the development of residential support services to move people out of the state hospital and into the community. In addition, AMH has implemented a new Peer Bridgers Program in Oregon, which will improve patients' return to the community. Oregon is also in the process of refining and strengthening its Olmstead Plan.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
30 day readmission rate	3.1%	3.4%	3.4%	<b>3.2%</b>	<b>3.0%</b>	<b>2.8%</b>
180 day readmission rate	10.6%	15.4%	11.6%	<b>11.5%</b>	<b>11.3%</b>	<b>11.1%</b>

Goal 8. Decrease the rate of recidivism among clients with severe mental illness who have been released from state correctional facilities.

Population	Adults with severe mental illness discharged from state correctional facilities.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Recidivism into state correctional institutions.
Measure	The percentage of clients with severe mental illness who recidivate into state correctional facilities within 36 months.
Numerator	The number of adults with severe mental illness released from state correctional facilities who are convicted of a felony within 36 months.
Denominator	The number of adults with severe mental illness released from state correctional facilities.
Sources of Information	Oregon Department of Corrections Data system.
Special Issues	Oregon legislation passed in 2003 (SB 267) required the increased use of evidence-based practices. One goal of this legislation was to decrease recidivism into the criminal justice system. This measure will help us track progress for people with severe mental illness.
Significance	Roughly 13% of Oregon’s inmates released suffer from severe mental illness. Persons with psychiatric disabilities and a history of corrections involvement are among the “hardest to house”, increasing the likelihood that individuals emerging from corrections are likely to re-enter the institutional systems. The Olmstead Decision requires states to provide appropriate services for persons at-risk of institutionalization. The performance indicator measures of those 13%, what percentage comes back in three years.
Action Plan	AMH will coordinate with the Governor’s Re-Entry Council established in May 2007 to improve access to mental health services for prisoners being released from prison.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
DOC recidivism rate	26.9%	26.4%	21.4%	<b>20%</b>	<b>19%</b>	<b>18%</b>

Goal 9. Decreased Criminal Justice Involvement (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Criminal justice involvement questions of the Adult MHSIP Survey.
Measure	Reduction in arrest rate in the year prior to initiation of treatment to the year following initiation of treatment, expressed as a percentage of the arrest rate in the year prior to initiation of treatment.
Numerator	Difference between the number of adult consumers (contained within the population described below) arrested in the year preceding treatment and the number of adult consumers (contained within the population described below) arrested in the year following treatment.
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey who indicated: (1) When they initiated treatment with the most recent mental health service provider; (2) Whether they were arrested in the year before initiation of the most recent mental health treatment episode; and (3) Whether they were arrested in the year following initiation of the most recent mental health treatment episode.
Sources of Information	MHSIP Adult Survey
Special Issues	Expressing the reduction in arrest rate as a percentage of the arrest rate in the year prior to treatment required weighting the ratio of the numerator to the denominator by the ratio of the denominator to the number of adults arrested in the year prior to treatment. On the survey for FY 2008, consumers were asked whether they had been arrested since initiation of treatment. When the difference between the arrest rate in the year prior to treatment and the arrest rate in the year following treatment is weighted, there is an approximate 63.5% reduction in the arrest rate from the year prior to treatment to the year after treatment.
Significance	In Oregon as in other parts of the country police are often times the default mental health crisis system. This results in increasing numbers of people with a serious mental illness being incarcerated when mental health services may have been more appropriate. Effective treatment reduces a consumer's

	likelihood of being involved in the criminal justice system.
Action Plan	FY 2008 provided baseline data for this measure. Since this is a new measure, and AMH cannot ascertain trend, projections are conservative. AMH will work with CMHPs to provide services that assist people with a serious mental illness in transitioning out of jail and diverting people from jail. AMH will monitor the implementation and outcome of these services.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Reduction in arrest rate from the year preceding treatment initiation to the year following treatment initiation	N/A	N/A	13.8%	<b>13.5%</b>	<b>13.2%</b>	<b>13%</b>

Goal 10. Percent of Adult Clients Who are Competitively Employed

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Percent of adult clients employed full or part time.
Measure	Percent of adult clients who are competitively employed.
Numerator	Number of adult clients competitively employed full or part time (includes supported employment).
Denominator	Number of adults competitively employed full or part-time (includes supported employment) plus the number of persons unemployed plus number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops, and other). Excludes person whose employment status was “not available).
Sources of Information	URS Table 4
Special Issues	Stable employment is a primary factor for facilitating recovery for persons with a serious and persistent mental illness.
Significance	Oregon has clearly identified employment as a key factor for persons with a serious mental illness recovering.
Action Plan	Although state General Fund support for Supported Employment was virtually eliminated during the 2009 Legislative Session, Oregon will continue to advocate for this support, which is critical to personal empowerment and recovery

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percent of adult clients who are competitively employed.	N/A	N/A	20.5 %	<b>22%</b>	<b>19%</b>	<b>17%</b>

Goal 11. Co-Occurring Disorders

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Number of people receiving integrated dual diagnosis treatment.
Measure	Oregon will develop a methodology to collect this data.
Numerator	Number of people receiving dual diagnosis treatment.
Denominator	
Sources of Information	Oregon is currently in the process of developing a methodology to track this data.
Special Issues	Oregon needs to better understand how the national prevalence data is gathered and counted. This fall, staff from the data, mental health and substance abuse units will begin conversations on how to use existing sources of data to obtain meaningful information about the prevalence of COD in Oregon.
Significance	National prevalence numbers indicate that 50-70% of individuals with severe mental illness are also affected by substance abuse.
Action Plan	Oregon attempted to measure COD this year, however, the sample size was too small to report with fidelity. National prevalence numbers were applied to Oregon population size and some gross estimates were made. Oregon is still attempting to define an accurate methodology for these numbers.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percentage of adults receiving treatment for both mental illness and substance abuse.	N/A	N/A	Baseline (Statistic not valid)	<b>Refine research methodology</b>	<b>Baseline</b>	<b>Match/ Exceed Baseline</b>

## Goal 12. Supported Housing

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The number of people receiving supported housing.
Measure	Oregon will develop a methodology to collect this data.
Numerator	The number of people receiving supported housing.
Denominator	
Sources of Information	Oregon is currently in the process of developing a methodology to track this data.
Special Issues	Stable housing is a primary factor for facilitating recovery for persons with a serious and persistent mental illness. AMH can track supported housing slots that are funded by the Division, but has not yet developed a methodology to link with the CMHPs.
Significance	Oregon has clearly identified housing as a key factor for persons with a serious mental illness recovering.
Action Plan	Developing a methodology to track this data statewide, and “map” areas of the state that provide supported housing, has been an issue identified by AMH’s Residential Services Manager.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percent of respondents reporting that their housing situation has improved.	N/A	N/A	N/A	<b>Baseline</b>	<b>Match/ Exceed Baseline</b>	<b>Match/ Exceed Baseline</b>

## **Criterion 2: Mental Health System Data Epidemiology**

- Estimate of Prevalence and Quantitative Targets

Pursuant to section 1912 (c) of the Public Health Service Act, adults with serious mental illness (SMI) are persons: (1) age 18 and over; (2) who currently have, or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent; and (3) that results in functional impairment, which substantially interferes with or limits one or more major life activities. This definition is used in determining prevalence, need and access. The current estimate of the number of adults (age 18 and older) with a serious mental illness living in Oregon is 156,962. During SFY 2007-2008, 71,204 adults were served in Oregon's public mental health system.

The majority of the population in Oregon is Caucasian with the remaining population being African American, Hispanic, Native American, Asian, etc. A comparison of the ethnic composition of Oregon's population and persons receiving mental health services by age group is provided in Table 2 of Appendix B. Oregon Administrative Rules state that community mental health programs are to provide culturally competent services. AMH requires information be provided to potential consumers, family members and allied agencies regarding the availability of services in a multi-lingual format.

At the direction of the AMH management team, the AMH Cultural Competency Work Group (ACCWG) was created and has been meeting monthly to develop recommendations for the AMH Cultural Competency Plan (ACCP). The plan was recently revised, and is currently being implemented.

The purpose of the plan is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from, or that are under contract with AMH, including county social services organizations and their vendors or contractors, managed care organizations and their provider networks, and community-based organizations. The intent is that this will serve as a planning document to assist AMH, county governments, and provider networks to develop and implement an individualized cultural

competence plan as addressed in each county’s biennial implementation plan, with its goal to enhance treatment outcomes for all patients.

The AMH Cultural Competency Plan identifies eight core sections that need to be addressed, in order to move cultural competence forward.

These are:

1. Planning
2. Evaluation
3. Services to Clients
4. Retention, Recruitment & Promotion
5. Education & Training for AMH staff/providers
6. Collaborative Partnerships & Informing the Public
7. Data Collection & Operation
8. ADA Compliance

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 the success in addressing cultural differences.

The DHS Office of Multicultural Health recently announced a new administrator. Under the new administration, the office will provide statewide leadership and advocacy to improve health status and access to health and human services for underrepresented populations in Oregon. The office is also responsible for affirmative action, diversity initiatives and cultural competency.

**Criterion 2: Goals, Objectives, Performance Indicators**

Goal 13. Increase the percentage of adults with severe mental illness who are served in the publicly funded mental health system. (NOM)

Population	Adults with severe mental illness served in the public mental health system.
Criterion	2. Mental Health System Data Epidemiology
Indicators	Severely mentally ill adults’ access to publicly funded services.
Measure	The percentage of adults with severe mental illness accessing publicly funded services.

Numerator	The number of adults with severe mental illness accessing publicly funded services.
Denominator	The number of adults with severe mental illness.
Sources of Information	CMHS adult severe mental illness prevalence information for adults. State mental health data systems.
Special Issues	Access to services for adults has diminished with recent restrictions to Medicaid benefits for Oregon's wavier population.
Significance	Individuals identified with a severe mental illness benefit from community mental health services that are specific to their needs and desires. These services assist individuals in avoiding institutionalization and promote a path to recovery.
Action Plan	With the expansion of the Oregon Health Plan for 20,000 adults, approved during the 2009 Legislative Session, AMH anticipates increased access to mental health services. The projections below are conservative at this point in time.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
% of adults with severe mental illness receiving publicly funded services	44%	44%	46%	<b>46.5%</b>	<b>50%</b>	<b>55%</b>

Goal 14. To maintain or increase the proportion of adults from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded culturally competent mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's adults within the same ethnic population.

Population	Adults with severe mental illness served in the public mental health system.
Criterion	2. Mental Health System Data Epidemiology
Indicators	Percentage share of adults within ethnic categories who are receiving mental health services compared to the percentage share of adults within ethnic categories for the general population.
Measure	Compare the percentage share among ethnic groups of adults receiving mental health service to the percentage share among ethnic groups in the general population.

Numerator	Not applicable.
Denominator	Not applicable.
Sources of Information	CPMS, MMIS, PSU Population Research Center.
Special Issues	In 2005, the proportion of adults receiving mental health services with a Hispanic ethnic background was low compared to the proportion of adults with the same ethnic background in the State's adult population. At the same time African Americans appear over represented in the mental health service population.
Significance	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of adults with diverse ethnic backgrounds.
Action Plan	AMH will proceed with the implementation of the Cultural Competency Plan: <a href="http://www.oregon.gov/DHS/mentalhealth/cc-plan.pdf">www.oregon.gov/DHS/mentalhealth/cc-plan.pdf</a> . AMH convened a task force to develop a five to ten year strategic plan to increase access and quality of mental health services to the Latino/Hispanic population. The work of the task force is in progress.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010-2011
Maintain or increase the proportion of adults receiving mental health services from each ethnic background such as: Native American, Hispanic, African American, and Asian compared to adults with the same ethnic background in the State.	N/A	Access to public mental health services by African American adults exceeds census data. For Hispanic and Asian adults, the access rate is below	Access to public mental health services by African American adults exceeds census data. For Hispanic and Asian adults, the access rate is below	Access to public mental health services by African American adults exceeds census data. For Hispanic and Asian adults, the access	May see trends shift

		census figures.	census figures.	rate is below census figures.	
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**Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations**

- **Rural Area Services**

Oregon has 36 counties, 11 counties are considered urban. The other 25 counties are considered rural and approximately 23% of the State’s population resides in these counties. In rural areas, distances and lack of transportation can become barriers for adults with severe mental illness to access mental health services. The MHOs and CMHPs provide a full continuum of services to persons. The MHOs are required by contract to meet the medically-appropriate needs of their members. Regardless of the rural nature of the person’s community, the intent of the MHO contract is that a full array of services is available to all members needing mental health services. In addition to local programs, all persons have access to appropriate statewide resources such as acute psychiatric hospitalization, state hospital programs and intensive community and residential programs, although persons may travel many miles to receive these services.

Individuals in rural areas continue to face barriers to receiving services such as psychiatric evaluation, extended care and acute care. Oregon has increasingly used teleconference technology for psychiatric evaluations. Additionally, a majority of Oregon’s rural counties have received federal designation as mental health professional shortage areas to assist in recruiting psychiatrists for areas that lack coverage by physicians without regard to specialty.

Rural Eastern Oregon counties have developed an integrated community mental health service delivery system. A quasi-public benefit corporation, Greater Oregon Behavioral Healthcare, Inc. (GOBHI), purchases and manages mental health care in many rural Oregon counties under the Oregon Health Plan. Through the pooling of resources, the fourteen counties that comprise GOBHI are able to provide mental health services across an area that makes up more than half of the landmass of the state. GOBHI’s base of coverage also includes some rural counties in northwestern Oregon.

- Outreach to Homelessness

Homelessness among persons with serious mental illness continues to be a significant problem in Oregon. Enrollment of homeless persons with mental illness into community mental health services has been encouraged. Goal 9 in Oregon's Block Grant plan is to "increase transitional and long-term housing for adults with severe mental illness who are identified as homeless".

According to the Client Process Monitoring Systems database (CPMS), each year 54,205 adults enroll in mental health services; this includes 4,811 people who are homeless at time of enrollment. Table I shows trends in public mental health service enrollment of homeless adults and the total number served over a seven-year period. The post-September 11th recession resulted in mental health service reductions in 2002-03 and 2003-04. Since that time, mental health service capacity has increased by approximately 43% and enrollment of homeless people with serious mental illness in community mental health programs has increased-by 36%. These statistics illustrate the effort made by local service providers to serve homeless individuals with serious mental illness.

Table I: CPMS Data on Homelessness, CY's 1999-2000 through 2007-2008			
	Enrollment Data, Adult Mental Health Clients		
	# Homeless Served	% of Total Served	Total # Served
1999-00	3,253	5.9%	55,115
2000-01	3,369	5.8%	57,992
2001-02	3,916	6.5%	60,065
2002-03	3,542	6.3%	55,979
2003-04	3,376	7.4%	45,771
2004-05	4,457	8.5%	52,204
2005-06	4,807	8.9%	54,205
2006-07	5,333	9.1%	58,480
2007-08	5,051	8.6%	58,996

2008-09	4,811	7.7%	62,409
<i>Increase 2003-04 to 2007-09</i>	43%	--	36%

The Oregon Housing and Community Services Department conducts counts of persons accommodated in and turned away from homeless shelters throughout the state. The most recent count available is the January 2008 count. It identified a total of 12,529 homeless persons who were sheltered or turned away. Of these 7,663 were adults, 3,831 were children and 1,035 were of unknown age. Of the 7,663 homeless adults identified in this count, 1,582 self-disclosed that they had a mental or emotional disorder, 2,194 indicated that they had a substance abuse problem, and an additional 814 indicated that they had a dual diagnosis.

AMH is using its 2009 federal PATH (Projects for Assistance in Transition from Homelessness) dollars to provide support services to an estimated 1,005 persons with serious mental illness who are homeless or are at imminent risk of being homeless in six Oregon counties.

Other specific strategies employed by AMH to address homelessness include the following:

1. Community mental health program (CMHP) staff is encouraged to participate in their local HUD Homeless Assistance Continuum of Care planning process.
2. CMHPs are required to address housing needs in their local mental health planning process.
3. AMH provides data, technical assistance and grants to support housing development.
4. AMH facilitates partnership between mental health service providers, homeless service providers and housing providers at the state and local level by arranging meetings and training.
5. The AMH housing and homeless services manager is a member of the Governor's Ending Homelessness Advisory Council.

- **Older Adult Services**

Older adult mental health services are delivered through Oregon's community mental health programs (CMHP). Every two years the community mental health programs are required to submit a Biennial Implementation Plan that outlines the delivery of mental health and addiction services. The CMHPs are required to specifically address the provision community mental health services for older adults. In reviewing the 2009-2011 local plans, almost every county addressed the gap in mental health services for its older adult population. Multiple counties talked about the use of the *Age Wise, Age Well* peer counseling program as a strategy to address this gap, which incorporates both physical and behavioral health. In order to address this deficit, a portion of the adult discretionary MHBG funds will be dedicated to fund older adult mental health pilot projects.

AMH currently has 228 Enhanced Care community placements for older adults or physically disabled persons with serious mental illness, with 61 people residing in nursing facilities, 79 people in residential facilities and 88 people in Enhanced Care Outreach slots (living in Seniors and People with Disabilities Division licensed community facilities). This is a joint project between DHS Seniors and People with Disabilities (SPD) and AMH. The people in this program are eligible for structured residential services provided by SPD and AMH funds the mental health services for these individuals.

**Criterion 4: Goals, Objectives, Performance Indicators**

Goal 15. Increase transitional and long-term housing for adults with severe mental illness who are identified as homeless.

Population	Adults with severe mental illness who are identified as homeless.
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	The amount of newly developed housing for adults with severe mental illness who are identified as homeless.
Measure	New units of supportive housing in rural and urban areas provided for adults with severe mental illness through AMH and/or county programs.
Numerator	New units of supportive housing in rural and urban areas provided for adults with severe mental illness through AMH and/or county programs.
Denominator	Not applicable.
Sources of Information	Tracked by AMH Housing and Homeless Services Unit staff.
Special Issues	Findings from the 2005-2006 Mental Health Housing Survey indicate that as many as 4,807 adults with mental illness and 4,469 adults with substance use disorders were estimated to be “currently homeless” at the time the survey was completed.
Significance	It is difficult for people disabled by serious mental illness to benefit from mental health and addiction treatment when they do not have stable, safe housing. The Oregon Supportive Housing Evaluation Study demonstrated that supportive housing decreases homelessness and residential instability. While Oregon has several successful housing initiatives, this goal will target efforts toward creating supportive housing for people with serious mental illness who are experiencing or at imminent risk of homelessness.
Action Plan	Oregon will receive an increase in funding for the PATH grant in FY 2009, which will allow us to serve more people. The estimates are conservative at this time.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
New units of supportive housing in rural and urban areas provided for adults with severe mental illness.	N/A	81	127	<b>132</b>	<b>135</b>	<b>140</b>

Goal 16. Increased Housing Stability (NOM)

Population	Adults with severe mental illness.
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	The percent of respondents reporting that their housing situation has improved will increase.
Measure	Percent of respondents reporting that their housing situation has improved.
Numerator	Percent of respondents to the MHSIP Adult Outpatient Consumer Survey that agree or strongly agree with the survey item: “My housing situation has improved.”
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey that provided a non-missing response to the survey item: “My housing situation has improved.”
Sources of Information	MHSIP Adult Survey
Special Issues	Stable housing is a primary factor for facilitating recovery for persons with a serious and persistent mental illness.
Significance	Oregon has clearly identified housing as a key factor for persons with a serious mental illness recovering.
Action Plan	Oregon received state funding for a 16 bed secure residential facility last Legislative Session. Last fall Pendleton Cottage opened and is currently operating at capacity.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Percent of respondents reporting that their housing situation has improved.	N/A	N/A	56.6%	<b>5% over baseline</b>	<b>8% over baseline</b>	<b>10% over baseline</b>

Goal 17. Increase the percentage of adults with severe mental illness living in rural counties who are employed in competitive employment (NOM)

Population	Adults with severe mental illness in rural counties
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	Adults with severe mental illness and living in rural counties who are employed in competitive jobs
Measure	Percentage of adults with severe mental illness living in rural counties who are employed in competitive jobs
Numerator	The number of adults with severe mental illness living in rural counties who are employed in competitive jobs
Denominator	The number of adults with severe mental illness living in rural counties
Sources of Information	State mental health service data systems and the state Department of Employment records
Special Issues	Employment in rural areas presents many more barriers than in many urban areas.
Significance	Employment is an important factor in increasing self-determination and enhancing the quality of life for persons with severe mental illness. Efforts to decrease the use of adult day treatment services and increase the use of supported employment services requires a culture shift at the local level.
Action Plan	AMH will insure that a portion of new supportive employment funding is awarded to rural programs.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
% of rural adults with severe mental illness competitively employed	Not available	18.5%	22%	23%	25%	27%

### **Criterion 5: Management Systems**

- **Resources for Providers**

In 2003 Oregon passed legislation that directed AMH, among other agencies, to spend public funds on evidence-based practices (EBPs) defined as follows: *“Evidence-based program” means a program that: (a) Incorporates significant and relevant practices based on scientifically based*

*research; and (b) Is cost effective.*” AMH currently has 167 EBPs catalogued. All workforce development efforts provide support for identification, implementation and sustainability of EBPs delivered in an age and gender appropriate, culturally competent, and trauma-informed manner.

The strategies used to support the delivery of EBPs include the following:

1. Immersion projects that provide ongoing training and technical assistance onsite by local and national experts, AMH staff and consumers. Projects include: Integrated Dual Diagnosis Treatment (IDDT), Supported Employment and Starting Early Starting Smart (SESS).
2. Service Improvement Projects that work with providers to use systems change models (Addiction Technology Transfer Centers - ATTCs) change book and the Network for the Improvement of Addiction Treatment (NIATX) to improve service delivery and implement select EBPs. Projects include increase in family participation in treatment and implementing the EBP “Seeking Safety.” Consumer focus groups and feedback are included in the change and implementation process.
3. Program specific training deliveries, as identified by the program, including technical assistance via phone and e-mail. Projects include American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) and trauma-informed services.

AMH efforts to improve consumer and community outcomes, including the SAMHSA National Outcomes, include work with consumers, providers and institutions of higher education, to influence curriculum, pre-service preparation at both undergraduate and graduate levels, and continuing education standards. Initial gatherings, which include consumers in leadership roles, have reviewed the Annapolis Coalition Recommendations, have drafted competencies for identified services and have scheduled executive meetings. Next steps include continued work with Oregon’s colleges, the Governor’s Health Care Workforce Initiative and the Oregon Health Care Workforce Institute to improve the Behavioral Healthcare Workforce.

The proposed AMH 2009-2011 Workforce Development Plan is attached as **Appendix C**.

- **Management Information System**

Data on persons with psychiatric and emotional disorders and the services

they receive are collected and stored in three primary databases:

The Medicaid Management Information System (MMIS) provides information on persons who receive health insurance benefits under the Oregon Health Plan. In December 2008, Oregon implemented a new MMIS system to collect Medicaid services. At that point Medicaid data through, roughly, March 2008 was complete. Since then AMH has experienced many issues that arise from the implementation of a new data system. This is particularly true for Medicaid managed care data. At this point in time, AMH is still missing a considerable portion of calendar year 2008 data. This is data that AMH would normally use for the block grant application.

The Oregon Health Plan provides coverage to people who are categorically eligible for Medicaid. The plan also provides coverage to an “expansion population” of poverty-level adults who do not qualify for traditional Medicaid and are eligible by virtue of poverty, the OHP standard population. MMIS includes information on eligibility status, services rendered and fee-for-service actual or capitation payments. MMIS also includes information about chemical dependency, pharmacy, dental and physical health service expenditures. MMIS data is accessed via a decision support surveillance utilization review system known as DSSURS.

The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs. The CPMS also includes records of care in chemical dependency and developmental disability programs.

CPMS is submitted on various standardized forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode and monthly during an episode of service.

The Oregon Patient/Resident Care System (OP/RCS) includes records for all publicly funded psychiatric inpatient care delivered in the State Hospital and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment.

Each of these systems contains unique client level identifiers. The AMH Program Analysis and Evaluation Unit uploads data from each of the systems to a central SQL server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

- **Staffing**

Four types of staff provide services and support to child and adult consumers of mental health services in Oregon through the Community Mental Health programs. These include programs that are integrated, blending services for mental health, alcohol and drug and gambling recovery. Funding for Community Mental Health programs and services come from Medicaid, Medicare, State and County General Fund, Federal Block Grant, and private grants and insurances.

AMH requires the Mental Health Organizations to submit an annual Provider Capacity Report assessing the availability and adequacy of services. This assessment includes:

1. maintenance and monitoring of an adequate and appropriate network of providers for all covered services performed;
2. provisions for adequate and timely coverage of services provided out-of-network, when the network is unable to provide those services;
3. requirements and monitoring procedures for providers in meeting state standards for timely access to care and services, taking into account routine, emergent and urgent needs;
4. status of any corrective actions taken in the last contract year;
5. current activities to provide delivery of services in a culturally competent manner to all enrollees;
6. monitoring procedures for any delegated activities related to provider capacity; and
7. an annual provider list of licensed medical practitioners and qualified mental health professionals.

- **Emergency Service Provider Training**

AMH recently updated its 2007 *Behavioral Health Emergency Response Field Guide*. Over the past year AMH has supported training of emergency

first responders, which is conducted by local Community Mental Health Programs as well as some public health regions:

- Crisis Intervention Team (CIT) Training for police officers. AMH, NAMI, peers/consumer run organizations and counties support this kind of training.
- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE and other AMH sponsored training.
- “Addictions and Mental Health Basics” training to front-line case management staff of DHS-Child Welfare, TANF Program.

This Office has participated and/or developed community education programs as described above since 1999. The AMH Workforce Development Unit is currently finalizing an education plan for 2009-2011. It will include aspects of all of the above.

**Criterion 5: Goals, Objectives, Performance Indicators**

Goal 17. Reduce the reliance on mandated treatment for adults with severe mental illness through civil commitment and aid and assist process.

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Civil commitment investigations started by community mental health programs.
Measure	a. The rate of civil commitment investigations per 100,000 population. b. The number of Aid and Assist admissions.
Numerator	a. The number of civil commitment investigations. b. The number of Aid and Assist admissions.
Denominator	a. Total adults living in Oregon ('population') divided by 100,000. b. N/A
Sources of Information	State mental health service data systems and state census information.
Special Issues	Resources associated with treatment in higher-level services such as the state hospitals have been over-utilized.
Significance	Reliance on the state hospital system for criminally committed persons has grown steadily in recent years and will continue to increase whether or not there are any changes to the statewide system of care simply because of population growth. With a focus on community-based resources to facilitate more efficient and effective use of state hospital and other residential services, the need for and use of civil commitment could decrease over time. Some preliminary data analysis suggests that while civil commitments may decrease, some court jurisdictions are directing persons with minor charges to the state hospital for aid and assist evaluations and treatment under criminal commitment code.
Action Plan	AMH allocates State General Funds for community mental health services with the expectation that more persons will receive appropriate mental health services at the local level.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
a. Rate of civil commitment investigations per 100,000 population	211.2	232.6	244	245.9	<b>245</b>	<b>243</b>
b. Number of admissions to the state hospital for Aid and Assist evaluation and treatment.	295	315	315	312	<b>310</b>	<b>310</b>

## STATE PLAN

### II. CHILDREN'S STATE SERVICE SYSTEM

#### 1. OVERVIEW

##### Organizational Structure

The Oregon Addictions and Mental Health Division (AMH) is located within the Department of Human Services (DHS), which reports to the Governor. DHS is made up of the following program areas: Children, Adults and Families (CAF) Division; Seniors and People with Disabilities Division; AMH, the Division of Medical Assistance Programs (State Medicaid Agency) and the Public Health Division.

Capitated mental health services for persons who are Medicaid-eligible are administered through contracts between AMH and Mental Health Organizations (MHO). All other non-capitated services are administered through contracts with the counties. Two Portland hospitals provide acute psychiatric care services for youth under age 18. Outpatient mental health services are provided under contracts with the counties. Non-capitated services for psychiatric day treatment and psychiatric residential treatment are provided under contract with providers.

The State is required by Oregon Revised Statute 430.640 to establish a contractual relationship with every community mental health program in each county, or Native American Tribe on request by the Tribe, to assure the provision of community mental health services. State funds for nonresidential services are allocated to counties using a "block grant" approach. This method of allocation provides the greatest flexibility for counties or community mental health programs in managing resources to best meet the needs of consumers. AMH currently contracts with 31 counties or consortia of counties, one community mental health program and one tribe.

##### Funding Mental Health Services

Throughout the 1980s and early 1990s, an increasing amount of state General Fund was used to match federal Medicaid funds for community mental health services. Considerable expansion of the public physical and mental health care systems resulted. Escalating health care costs,

however, required new strategies for cost effective and appropriate public health care. The Oregon Health Plan, developed in the late 1980s, provides a rational method for allocating public resources for health care. The Plan devotes resources to services that are most effective in treating covered conditions, provides incentives to intervene early, and extends coverage for low income Oregonians in need of mental health services.

Since 1989 the Health Services Commission has prioritized medical conditions and associated treatments. Condition and treatment pairs are ranked according to the state of medical technology, the effectiveness and cost of treatment, public values, and advice from medical specialists and ethicists. Since 1993, a prioritized list has served as the basis for the allocation of health, mental health, and chemical dependency services.

The Oregon Health Plan includes an expanded mental health benefit that covers all who are eligible for the Oregon Health Plan. As of January 2009, 34,617 persons under age 18 who are Medicaid-eligible received their Medicaid mental health benefit through an at-risk managed care Mental Health Organization.

Not all individuals requiring public mental health services meet Medicaid eligibility criteria. Mental health services continue to be made available to persons ineligible for the Oregon Health Plan according to risk criteria defined in state law. The state is beginning to prioritize early intervention and use more foresight in longer-term risk management. State general funds, various federal grants (including this grant), local funds, and private insurance payments provide additional sources of revenue for Community Mental Health Programs to serve people who have mental health needs, but are not eligible for Medicaid or other third party payments.

## 2. New Developments and Issues

- **Governor's Summit on Early Childhood**

The Governor's Summit on Early Childhood: Healthy Kids Ready for School was held in March 2008. Three committees (Health Matters (inclusive of Mental Health), Early Learning Matters and Family Matters) were developed to encompass key domains of early childhood and incorporate input on priorities for the next several years.

Priorities for Health Matters are to:

- Provide all young children and their families with a regular source of coordinated, comprehensive, quality healthcare through improved early childhood linkages with health system and healthcare reform efforts.
  - Promote social-emotional development in all early childhood settings by developing statewide availability of health and mental health consultation to providers serving young children and their families.
  - Build on current initiatives within the public health system for implementing universal standardized screening, referral & follow-up services and to develop a replicable process for providing primary care providers the standardized early childhood screenings conducted by local health departments.
  - Collaborate with the Public Health Perinatal Depression Initiative to increase cross-system capacity for maternal mental health during and after pregnancy, screening, referral and follow-up in support of the objectives of the 2009 Perinatal Depression Symposium.
- 
- Parent Child Interaction Therapy

In March 2008, the Department of Human Services, Addictions and Mental Health Division issued a Request for Proposals to select up to five (5) projects for the state fiscal year 2008-2009 for:

- Development of the infrastructure for implementing the identified evidence-based practice, Parent Child Interaction Therapy (PCIT).
- Implementation of the evidence-based practice PCIT with Fidelity Review, and provision of PCIT services to families.
- Demonstration of outreach to and access by identified ethnic, linguistic or cultural minorities.
- Demonstration of links and supports for family members through referral to a family-run organization.
- Certification of at least two clinicians in PCIT, including one from an ethnic, cultural or linguistic population or experience and links with the cultural/linguistic population.
- Development of a local and statewide training program in PCIT.

Four counties were selected in this process. Thirty-three (33) therapists have been trained and provide PCIT services to families; 11 of these therapists provide services in Spanish. A presentation on the previously established

Promotora Program by Lifeworks NW is stimulating development of paraprofessional Hispanic staff to support the work of clinicians. Pending finalization of the AMH budget, these sites anticipate continuation in the coming biennium.

- Early Childhood Service Intensity Instrument-Implementation

Ongoing consultation to AMH by our medical director, Dr. Nancy Winters, about service intensity determination in Oregon's system of care has included adding language to the MHO contract to require the use of the Early Childhood Service Intensity Instrument (ECSII)/ Child and Adolescent Service Intensity Instrument (CASII) as clinical tools for service planning. Dr. Winters was involved in development and testing of the early childhood version of the CASII, the Early Childhood Service Intensity Instrument for children ages 0-5, which will be implemented in Oregon January 1<sup>st</sup>, 2010.

The ECSII, like the CASII, determines service intensity needs, but offers even more specific guidance for comprehensive, individualized service planning for young children and their families. Dr. Winters will provide training for up to 200 people. In addition, 15 people will be trained as in-state trainers and will be available to train the rest of the state mental health clinicians. It is hoped that clinicians from other agencies such as child welfare, early childhood education and rehabilitation services, and primary care nursing, will also be trained on the ECSII. Cross-training clinicians from different agencies on the ECSII will be a good vehicle for early childhood system integration.

- CAF Child Welfare and AMH System Integration

In October 2007, public concerns emerged about the approximately 30% rate of psychotropic medication use reported in Oregon children in foster care. The Department of Human Services (DHS) Director set up a Medication Work Group. The Work Group generated a report entitled "Psychotropic Medications for Foster Children" which stressed the importance of ensuring the safety of children in foster care on medications, and of improving the quality of their mental health care to enhance health and mental health outcomes. It also emphasized that pharmacotherapy should only be one part of a comprehensive approach for these children, should be integrated with

other behavioral health services and would benefit from alignment with other state initiatives such as the state Wraparound Initiative.

Dr. Nancy Winters began serving as interim Medical Director in 2009 for CAF to set up processes that would address recommendations in the report. Splitting Dr. Winters' time between AMH and CAF is beneficial, as it allows more effective integration with CAF of the children's system of care and system of care strategies for children with complex emotional and behavioral needs. This dual role highlights across the two Divisions specific barriers that children in foster care face in accessing psychosocial interventions that could help prevent unnecessary or excessive psychotropic medication use. Reviews of cases that exceed the current prescribing guidelines have been conducted, as determined by the prior Medication Work Group.

HB 3144 was passed in the 2009 Legislative Session and protects children in foster care from inappropriate psychotropic prescribing practices. It mandates that for children in foster care: 1) more than one new psychotropic medication or any new antipsychotic prescription cannot be prescribed without first obtaining a formal mental health assessment as stipulated in the Oregon administrative rules, and 2) there must be an annual review of all psychotropic medications of children under 6 years old or receiving more than 2 psychotropic medications.

Subsequent to the first data set on psychotropic medication prescription rates in Oregon children in foster care, the data was re-analyzed, subtracting a group of children in financially supported adoptions that was inadvertently included in the original data; the resulting rate of psychotropic prescriptions fell to 19.5%. Thus, Oregon children in foster care receive psychotropic medication at approximately 1.5 times the rate as children in the general Medicaid population. This compares favorably with national ratios, which range from 2-4 times higher. Also important is recognizing that 40-60% of children in foster care have psychiatric disorders whereas 20% of the general child population have a diagnosable psychiatric condition; it is reasonable to expect children in foster care to have higher rates of psychotropic medication use. Based on these data, Oregon does not have an overall problem with excessive prescriptions. This means that quality of care can be emphasized and providers can work on ensuring that children in foster care on medications also have an appropriately comprehensive mental health plan of care and receive wraparound planning.

Department of Human Services (DHS) policy and contracts require that children who are placed in substitute care receive a mental health assessment. Child welfare policy states that all children in paid substitute care will be referred for a mental health assessment within 60 days. Mental health contracts require that comprehensive mental health assessments for children placed in substitute care be provided no later than 60 days following the date of placement. This inconsistency in policy and contracts may be contributing to the fact that mental health assessments are not being completed in a timely manner, based on service utilization data and results from the 2007 Child and Family Service Review (CFSR) State Assessment.

A workgroup comprised of DHS staff and other stakeholders familiar with the problem has examined the issue and has made recommendations to improve compliance with the requirement. A service improvement goal has been set to increase the percentage of children who receive a timely mental health assessment to 70% by June 2009 and 80% by December 2009.

Short term goals identified in the recommendations include changing the existing CAF policy so that children in substitute care are referred for a mental health assessment within 21 days of being placed in substitute care, that referrals for children age 3 and older be done through the local public mental health system, that children younger than 3 be referred to Early Intervention (EI) for a development screening (and then for a mental health assessment if recommended by EI) and that mental health programs prioritize referrals and treatment services for children in DHS custody. The group further recommended that an assessment “update” meets the assessment requirement if children are already receiving mental health services when they are brought into care. Tracking recommendations were also made to insure that these requirements are met.

Longer term goals include use of the Early Childhood Service Intensity Instrument (ECSII) when it is available for ages birth to 5, that capacity for mental health assessments for children younger than three be developed, and that system changes extend beyond improving compliance with the assessment requirement and lead to increased capacity to provide appropriate treatment for traumatized children.

- Collaborative Problem Solving

AMH facilitated a monthly Statewide Implementation Committee which began meeting in March 2008 and included stakeholders statewide via video conference. The Implementation Committee has achieved the following goals:

- Provided a single point for discussion and planning of implementation.
- Focused on the need for fidelity, sustainability and access to training for families and multiple child serving agencies.
- Identified a group of trainers to serve as lead trainers/consultants for 12 pilot sites
- Contracted with Dr. Stuart Ablon to provide supervision to identified trainers for a period of one year.
- Developed an RFP funding twelve sites in implementing the Collaborative Problem Solving model. Sites were representative of multiple systems including community mental health, psychiatric residential and day treatment programs, addictions treatment providers and education.
- Contracted with Oregon Family Support Network to provide Parent-to-Parent Book Clubs for each of the twelve sites.
- Contracted with Portland State University to add an Organizational Development component for our trainer/consultants.
- Identified an Executive Council to provide oversight of implementation efforts.

### 3. Legislative Initiatives and Changes

HB 2116, Healthy Kids Plan, was passed during the 2009 legislative session, authorizing extension of health care benefits to 80,000 children under the Medicaid program by increasing eligibility criteria to 200% of Federal Poverty Level (FPL). Coverage will also be available with partial subsidies for those families with incomes between 200-300% FPL, and coverage can be purchased for those with incomes over 300% FPL, insuring that children whose parents do not have health insurance available through their employer will still be able to obtain medical care coverage. Benefits will be comprehensive and comparable to the OHP Plus benefit package, and will include regular check-ups, preventive care services, prescription drugs,

medical equipment and supplies, dental care, and mental health and chemical dependency services.

HB2144, Statewide Wraparound Initiative- This legislation directs child serving state agencies to organize and operate a system of care so that children and their families can receive integrated services and supports in their communities. Child serving state agencies include the Department of Human Services, Department of Education, Oregon Youth Authority and the Commission for Children and Families.

Establishing the principles of the Children’s Wraparound initiative in law:

- Assures sustainability of system of care implementation when Executive Branch leadership changes;
- Provides authority to partner agencies to combine funds;
- Provides rule making authority for agencies to operationalize the change;
- Gives clear legislative direction to reform the system of services and supports;
- Require systemic cultural change of the system in financing, organization, language, and training;
- Provide flexibility to community systems to integrate services and supports to achieve efficiency and effectiveness; and
- Provides a clear statement of the state’s intent to provide integrated services to children who are served by multiple agencies.

#### 4. Description of State Agency’s Leadership

AMH provides leadership in the delivery of mental health services through establishing administrative rules and contracts, providing training and technical assistance, developing statewide mental health services and initiating workgroups.

AMH actively engages with the community to transform mental health system services and supports to a family-driven and youth-guided model. AMH is dedicated to continually improving the quality of services provided to children and adolescents through expanding family- and youth-driven policy and service development, focusing on children, youth and families’ individualized strengths and needs, using evidence-based and promising and

emerging practices, and by being present in the communities where services are provided and received.

AMH works directly with providers, both public and non-profit, in communities throughout Oregon to improve the quality of services. Services are available in every county through 32 Community Mental Health Programs (CMHPs) or a county commissioner-designated substance abuse provider. Services may be provided by county employees or subcontracted to private nonprofit agencies. CMHPs plan and coordinate local systems of care to prevent substance abuse and serve children, adults and seniors and their families. CMHPs offer services to people with mental health and substance abuse disorders by providing crisis evaluation, stabilization and civil commitment functions; by providing medication, therapy and other necessary outpatient and residential treatment; by providing case management, housing and employment/educational assistance; and by providing prevention or treatment services for people at risk of or affected by problem gambling behaviors.

Oregon is fortunate to be home to The Research and Training Center on Family Support and Children's Mental Health. It was established in 1984 at Portland State University, Portland, Oregon. The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders. This goal is accomplished through collaborative research partnerships with family members, service providers, policy makers, and other concerned persons.

## **SECTION II. IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS NEEDS AND PRIORITIES**

### 1. Service System's Strengths and Weaknesses

- Children's System Change Initiative

AMH is engaged in a broad scale planning and implementation process to provide a more integrated community-based system of care for children and their families, which began October 1, 2005.

The Children's System Change Initiative (CSCI) ensures that the management of resources, decision-making and delivery of services occur at the local level—through local or regional Mental Health Organizations and Community Mental Health Programs managing resources for intensive treatment services with single points of access, authority, and accountability. This system promotes early identification and proactive planning to identify children who may need mental health services so that the right kind of services can be provided in the right location for the right amount of time and intensity.

The CSCI system structure includes the use of child and family teams, care coordination at multiple levels, and system oversight. A statewide community-based level of need determination process has been established utilizing the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry. Oregon is also preparing to implement use of the Early Childhood Service Intensity Instrument (ECSII), which will allow for level of need determination in the early childhood population, 0-5 years of age. Training will be conducted statewide in the Fall of 2009, with implementation of the ECSII in the calendar year 2010.

The CSCI requires the collaboration of state and county child-serving agencies and providers of services across the continuum of care from least restrictive and intensive (prevention /outpatient services) to most restrictive and intensive (acute hospitalization and psychiatric residential and day treatment services). The goal is to make every effort to serve the child and family in their community. In recent years, there is a trend toward many more children and families being served in community-based settings with decreased reliance on residential levels of care under a case management model utilizing locally placed care coordinators.

AMH is continuing to work with system stakeholders to increase the availability and quality of individualized, culturally competent, family-driven and youth guided intensive home and community-based services to serve children in the most natural environment possible and to minimize the use of institutional care.

AMH continues to work closely with Child Welfare, Education, Juvenile Justice, and Family Advocacy organizations to improve intersystem coordination.

Memoranda of understanding exist between AMH and Child Welfare, and between AMH and the Oregon Department of Education.

Stakeholders from child welfare, education, juvenile justice, family advocacy organizations and youth/family members are integral participants in the Children's System Advisory Committee (CSAC) of the Planning and Management Advisory Council for AMH. Local advisory bodies are also inclusive of these child-serving agencies, family members and family advocates.

Efforts continue locally and statewide to be inclusive of representatives from adolescent alcohol and drug treatment agencies, developmental disabilities, and other child-serving agencies. Efforts to maintain a diverse and culturally competent representation on CSAC and local advisory bodies will be ongoing. Local, regional and State Children's System Advisory Committees have been formed with 51% membership of family members/advocates.

Passage of HB 2144, the Statewide Wraparound Initiative, mandates agencies work together to coordinate children's services and supports, and authorizes the formation of shared funding at all levels of the system.

AMH promotes family-driven and youth guided care in the process of implementing a coordinated system of care. Eight newly trained youth advocates are participating in local advisory councils and CSAC. 19 youth were trained this year, and recruited for appointments to advisory councils at all levels. Ten youth are participating in local system advisory councils, and two are participating at the State level.

Formal agreements have been written between the Oregon Family Support Network and five Oregon counties. Five Community Mental Health Programs, five Mental Health Organizations and one provider have hired family members as family partnership specialists. AMH has a family advocate filling the position of Family Partnership Specialist, to provide effective family-driven technical assistance and policy leadership in all areas of the state.

A policy on Meaningful Family Involvement written in 2004 was amended in 2006 to incorporate the Federation of Families for Children's Mental Health national organization's statement on family driven care. A policy

brief on youth guided system involvement was introduced to CSAC in June 2007. A youth directed policy brief is currently being introduced.

## 2. Unmet Service Needs

- Further development of peer delivered services for youth and family navigators for family members is needed. (family member/youth feedback)
- Adolescent co-occurring disorder treatment and adolescent detoxification services are needed. (survey conducted by AMH in 2007)
- Additional intensive community-based mental health services, especially psychiatric day treatment, are needed to complete the system of care in 21 counties. (lack of available psychiatric day treatment services)
- Blended funding pools do not currently exist between most child serving state agencies. (anecdotal information)
- The system needs more care coordinators with adequate levels of training and supervision. (survey of care coordinators in spring 2008)
- There is a critical need for developmentally appropriate services for young adults in transition (YAT). (anecdotal information)
- The psychiatric residential and day treatment facilities have identified the need for additional tools / models / skills for behavior support in order to reduce the use of seclusion and restraint. (data as reported by facilities)
- There is a need for services that reflect the cultural and linguistic characteristics of clients in non-dominant groups, including youth with special needs and gay, lesbian, transgender, bi-sexual and questioning youth. (anecdotal information)
- There is a need for improved workforce development to increase the use of an integrated neurobiological perspective, including physical health, prenatal exposure to drugs and alcohol, and the effects of trauma in treatment facilities and approaches; lack of workforce development in these areas. (requests from stakeholders; anecdotal information)

### **Plans to Address Unmet Needs**

In order to meet the unmet needs identified in the previous section:

- OFSN and Youth M.O.V.E. Oregon are working together to create family navigator and youth peer specialist training and role development guidelines.
- Adolescent Co-occurring disorder (COD) treatment: A COD competency guideline is being developed for workforce development purposes by a workgroup consisting of AMH addictions and mental health staff as well as community stakeholders. Funding is not currently available for the development of detoxification services for adolescents.
- Additional intensive community-based mental health services, especially psychiatric day treatment, are needed to complete the system of care in 21 counties. Efforts are underway in several counties to utilize school based programs to provide integrated mental health and education treatment services.
- Blended funding pools do not currently exist between most child serving state agencies, but implementation has been legislatively mandated.
- The system needs more care coordinators with adequate levels of training and supervision. Workforce development efforts provided training to multiple communities on collaboration skills during the prior fiscal year. Plans are in place for training in the coming fiscal year in the level of need determination process.
- There is a critical need for developmentally appropriate services for young adults in transition (YAT). Oregon was selected and attended the SAMHSA Policy Academy in December 2008. Oregon was one of six states chosen to attend this Policy Academy. Focused progress has been made on the work plan developed through the Academy. There is an ongoing work group of AMH staff and stakeholders to review systemic concerns and service delivery for this population.
- The psychiatric residential and day treatment facilities have identified the need for additional tools / models / skills for behavior support in order to reduce the use of seclusion and restraint. Oregon has important goals for statewide implementation of Collaborative Problem Solving which will assist multiple systems of care in reduction in the use of seclusion and restraint to manage severe

emotional and behavioral difficulties in children and adolescents, and minimization of the risk of further traumatization of these children. These goals are outlined in the strengths section of this document.

- There is a need for services that reflect the cultural and linguistic characteristics of clients in non-dominant groups, including youth with special needs and gay, lesbian, transgender, bi-sexual and questioning youth (LGBTQ). There is a Cultural Competency Plan within AMH described elsewhere in this document. Further development is needed in this area, particularly with LGTBQ youth.

The current Oregon Children's Plan focuses on implementing the evidence-based practice Parent Child Interaction Therapy (PCIT) which has published research supporting the use or tailoring of the practice for families with various ethnic backgrounds. All four of the implementing sites are required to demonstrate outreach to and access by one or more identified ethnic, linguistic or cultural minority population. Each site will train and certify at least two clinicians in PCIT, and at least one from the identified population or with experience and links to the population.

- There is a need for improved workforce development to increase the use of an integrated neurobiological perspective, including physical health, prenatal exposure to drugs and alcohol, and the effects of trauma in treatment facilities and approaches. The coming fiscal year will include implementation of the AMH Strategic Plan for Trauma Informed care. Workforce development in this area is also planned within the next year.

#### 4. Recent Significant Achievements

- **Services for young adults in transition ages 14-25 with mental/emotional disorder (SED)**

Oregon is making positive changes in the service delivery system for young adults in transition. Oregon is in a position to move forward due to the strong advocacy of the Policy Academy Advisory Committee and cross-agency agreement on shared values and principles. Youth M.O.V.E. (Motivating Others through Voice of Experience) Oregon, Oregon Family Support Network (OFSN), the Children's System

Advisory Committee (CSAC), and the Adult System Advisory Committee (ASAC) are prioritizing a system of care for young adults in transition that is youth driven, coordinated, effective and developmentally appropriate.

Early Assessment and Stabilization Alliance (EASA) is the statewide dissemination of the EAST Program (Early Assessment and Support Team) funded by the Oregon Legislature in the 2007 session. Developed by Mid-Valley Behavioral Care Network in 2001, the EAST Program supports teens and young adults who have recently developed symptoms of schizophrenia and related psychotic illness. EASA supports teens developing a psychotic illness to remain in school and at work, supports families, and prevents unnecessary suffering and disability. The program is based on international evidence-based research.

- **Development of youth directed services and inclusion of youth voice**

Nationally, the average transition age client is defined as between the ages of 16 and 24. Oregon has adopted the ages 14 to 25 to more closely align with Child Welfare, who begins transition planning at age 14, and the Oregon Youth Authority, who can have custody of young adults to age 25. As a result of being included in decision making, these youth recommended to the state that Young Adults in Transition is a preferable term to Transition Age Youth, for use. The term Young Adults in Transition describes movement through a transition as a process as opposed to a single intervention, and is more active, not static, in its meaning. Young Adults in Transition (YAT) will therefore be used to describe this group of youth and young adults.

Youth in Oregon have been supporting each other, working to improve mental health services, reduce stigma, and educate their communities. Youth from across the state met and chose to be formally recognized as Youth M.O.V.E. (Motivating Others through Voice of experience) Oregon. Youth M.O.V.E. Oregon has a goal to unite groups of youth across the state and establish a strong youth voice for improving all youth systems in Oregon. The group is organizing under the Oregon Family Support network (OFSN), a statewide family driven organization, until they are ready to branch out on their own.

- **Working relationship and collaboration with Oregon Department of Education (ODE)**

The local school district is responsible for any educational service under an Individual Education Plan (IEP). Each school district uses a variety of assessment tools and strategies to gather relevant information about the child. The Oregon Department of Education funds the education services through the local Education Service District (ESD) or the school district, in Psychiatric Residential and Psychiatric Day Treatment programs.

Based on the evaluation results, the IEP team, which includes the family, decides which services the child needs in order to benefit from a free and appropriate public education. This may include developmental, corrective or supportive services as required in assisting a child with a disability to benefit from special education. The IEP team then determines the least restrictive environment in which services can be provided to meet the educational needs of the child.

A representative from AMH attends quarterly Statewide Advisory Council on Special Education (SACSE) meetings and serves on the executive committee. An AMH representative attended a recent Confederation of Oregon School Administrators (COSA) conference to conduct a breakout on the Wraparound Initiative. ODE is one of the system partners named in HB 2144, the Statewide Wraparound Initiative legislation enacted in the 2009 legislative session, creating a system of care for child serving systems in Oregon.

There are 44 School Based Health Centers in Oregon. Twenty-eight of them have mental health providers on staff. Of the total, seven are in elementary schools of which five have mental health providers, six are in middle schools of which one has mental health providers, and 27 are in high schools of which 13 have mental health providers. One is in a K-12 program and one is in a combined elementary/middle school program. The most commonly seen categories of mental health problems addressed in school based health centers are: 1) social, interpersonal or family problems, 2) anxiety, stress or school phobia, and 3) mood disorders.

- The Coordinated School Health Program, Healthy Kids Learn Better

(HKLB) is a partnership between ODE and Public Health Division of DHS, developed under a cooperative agreement with Centers for Disease Control's Division of Adolescent and School Health. HKLB has achieved statewide recognition through the existing demonstration project schools and the statewide HKLB Coalition. It has documented the model's ability to achieve local school/community outcomes and impacts specific to identified health areas (i.e. nutrition). HKLB has influenced local and state policy development.

- **Expansion of range of mental health services provided in less traditional settings**

Since the implementation of the Children's System Change Initiative in October 2005, many communities have expanded the range of mental health services that they provide in less traditional settings, such as in schools and homes, where therapists travel to the child/family home and deliver services in that setting. Integration of school based health centers with mental health service provision provided by community program staff and day treatment programs with existing school programs has become more commonplace. Resources are stretched within the existing system, but providers remain committed to providing services in settings that are more agreeable and convenient for children and families.

- **Recruitment and training of effective family advocates**

This past year 20 family members and 19 youth were trained using the *Family/Youth and Professionals as Policy Partners* curriculum. Currently, there are 13 new family members and 8 new youth or young adults serving on local, regional or state level policy-making committees.

OFSN contracts to develop and train family members in the *Family Navigator Program*, through three pilot sites that assist family members and youth to access services and receive support in a timely manner. The core curriculum includes a thirty-five hour training, plus three additional trainings in Medicaid billing, strength-based cultural competency, and HIPAA requirements/insurance information. Thirty-five family members have attended the training. Five are currently employed through OFSN contracts with county mental health programs.

- **Improvement in cultural competency of mental health services provided to children and their families**

In March 2008, the Department of Human Services, Addictions and Mental Health Division issued a Request for Proposals to select up to five (5) projects for the state fiscal year 2008-2009 for:

- Development of the infrastructure for implementing the identified evidence-based practice, Parent Child Interaction Therapy (PCIT).
- Implementation of the evidence-based practice PCIT with Fidelity Review, and provision of PCIT services to families.
- Demonstration of outreach to and access by identified ethnic, linguistic or cultural minorities.
- Demonstration of links and supports for family members through referral to a family-run organization.
- Certification of at least two clinicians in PCIT, including one from an ethnic, cultural or linguistic population or experience and links with the cultural/linguistic population.
- Development of a local and statewide training program in PCIT.

Four counties were selected. Thirty-three (33) therapists have been trained and provide PCIT services to families; 11 of these therapists provide services in Spanish. A presentation on the previously established Promotora Program by Lifeworks NW is stimulating development of paraprofessional Hispanic staff to support the work of clinicians.

- **Improved collaboration between state and local Child Welfare and AMH**

In October 2007, public concerns emerged about the approximately 30% rate of psychotropic medication use reported in Oregon children in foster care. The Department of Human Services (DHS) Director set up a Medication Work Group to develop recommendations as to how CAF might address this issue.

Subsequent to the first data set on psychotropic medication prescription rates in Oregon children in foster care, the data was re-analyzed,

subtracting a group of children in financially supported adoptions that was inadvertently included in the original data; the resulting rate of psychotropic prescriptions fell to 19.5%. Thus, Oregon foster children receive psychotropic medication at approximately 1.5 times the rate as children in the general Medicaid population. This compares favorably with national ratios, which range from 2-4 times higher.

The Work Group generated a report entitled “Psychotropic Medications for Foster Children” which stressed the importance of ensuring the safety of foster children on medications, and of improving the quality of their mental health care to enhance health and mental health outcomes. It also emphasized that pharmacotherapy should only be one part of a comprehensive approach for these children and should be integrated with other behavioral health services. This work will benefit from alignment with other state initiatives such as the Statewide Wraparound Initiative.

Dr. Nancy Winters is serving as Interim Medical Director, setting up processes that address recommendations in the report. Splitting Dr. Winters’ time between AMH and CAF is beneficial, as it allows more effective integration with CAF of the children’s system of care and system of care strategies for children with complex emotional and behavioral needs. This dual role highlights across the two Divisions specific barriers that children in foster care face in accessing psychosocial interventions that could prevent unnecessary or excessive psychotropic medication use. Cases have been reviewed that exceed the current prescribing guidelines as determined by the Medication Work Group.

HB 3144 was passed in the 2009 Legislative Session and protects children in foster care from inappropriate psychotropic prescribing practices. It mandates that for children in foster care: 1) more than one new psychotropic medication or any new antipsychotic prescription cannot be prescribed without first obtaining a formal mental health assessment as stipulated in the Oregon administrative rules, and 2) there must be an annual review of all psychotropic medications of children under 6 years old or receiving more than 2 psychotropic medications. Recognizing that 40-60% of children in foster care have psychiatric disorders, whereas 20% of the general child population have a diagnosable psychiatric condition, it is reasonable to expect children in foster care to have higher rates of psychotropic medication use. Based on

these data, Oregon does **not** have an overall problem with excessive prescriptions. This means that quality of care can be emphasized and providers can work on ensuring that children in foster care on medications also have an appropriately comprehensive mental health plan of care and receive wraparound planning.

- Implementation of statewide Trauma Policy and development of trauma informed care

Due to administrative transition, the progress of the Trauma Policy Advisory Committee was largely suspended during the fiscal year. Efforts are on track at this point to begin to move forward on the Trauma Policy Strategic Plan, now approved for implementation. AMH has consulted with Ann Jennings and Roger Fallot in the development of the Trauma Policy Strategic Plan. The plan consists of detailed activities designed to implement a trauma informed service system with trauma sensitive services and supports.

Within DHS, the notion of trauma informed services is moving throughout the organization (which includes Public Health, services for Seniors and People with Disabilities, and Child Welfare) with a draft psychological trauma policy and partnering with AMH to work on an "implementation" plan for all human services divisions under DHS.

Additionally, a number of trainings on trauma and trauma informed services have been conducted by AMH staff for a variety of stakeholders throughout Oregon to promote a trauma informed system and services at the local level. An administrative rule revision currently in process has been infused with language supporting trauma informed services.

### **State's Vision for the Future**

- Critical components to recovery and resilience in children's mental health needs to be acknowledged and supported.
- An integrated service delivery system is developed.
- Integrated physical and behavioral health care is routine for all clients.
- Co-occurring disorder treatment availability is more widespread for adolescents.
- Prevention and early intervention is easily accessible and readily

- available.
- Decreased reliance on residential care and a wider array of community-based treatment options is commonplace.
  - An integrated wraparound approach exists in every county.
  - Services are evidence-based.
  - Functional outcomes are measured and guide system development.
  - Families and youth drive planning and service delivery.
  - Young Adults in transition are provided developmentally appropriate services.

### **Section III**

AMH would like to respond to reviewer comments concerning several performance measures in our FY2008 report.

For several measures, such as “reduced utilization of psychiatric inpatient beds within 30 days” and “client perception of care”, the denominator was listed as “100”. This prompted several reviewers to question AMH’s results and methodology. Data was reported this way because at the time the staff preparing the report only had percents available to them and not the raw data. So, if the percent of clients who felt that their functioning had improved was 64 percent, it was expressed as 64 out of 100. AMH did survey more than a hundred people and did look at more than 100 discharges to assess readmission rates. The raw data for all the measures questioned is in the Uniform Reporting System tables for your review.

Other comments related to the lack of counts associated with evidence based practices. AMH has struggled to report on the number of people being served by evidence based practice, while having a fairly good accounting of whether not evidence based practices are being delivered through contractual requirements and site reviews. AMH is able to report counts for some practices since they are billed for through our data systems, but this isn’t true for all the practices implemented in Oregon. AMH’s goal is to implement a new data system that would allow for better accounting of those served with evidence based practices. AMH will keep CMHS apprised of these efforts, as it seeks funding to implement a new system.

### **Child Plan**

## 1. Current Activities

### Criterion 1: Comprehensive community-based mental health services

#### Establishment of System of Care

Oregon manages a comprehensive community-based children's mental health system with the goal of maintaining the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system is family driven, youth guided and community-based with the needs of the child and family determining the types and mix of services provided. These services are individualized and may be as intensive and frequent as necessary and appropriate to sustain the child in treatment in the community.

The Legislature directed DHS through a Budget Note in 2005 to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive and culturally competent home and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized".

To assist in implementing the Budget Note, Psychiatric Residential Treatment Services and Psychiatric Day Treatment Services funding has been transferred to the Oregon Health Plan and is managed through MHOs. AMH contracts with private non-profit agencies for Stabilization and Transition Services, Secure Children's Inpatient Program and Secure Adolescent Inpatient Program, with admissions being reviewed and approved by AMH children's mental health specialists.

The CSCI requires the collaboration of state and county child-serving agencies and providers of services across the continuum of care from least restrictive and intensive (prevention /outpatient services) to most restrictive and intensive (acute hospitalization and psychiatric residential and day treatment services). The goal is to make every effort to serve the child and family in their community. In recent years, there is a trend toward many more children and families being served in community-based settings with decreased reliance on residential levels of care under a case management model utilizing locally placed care coordinators.

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and chemical dependency treatment providers. Thus, enrollment in a MHO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary so children with severe emotional disorders can remain in their community. The OHP benefit package includes a full array of services such as:

- Preventive services
- Diagnostic services
- Medical and surgical care
- Dental services and
- Outpatient addictions treatment services

In addition, the State is required by ORS 430.640 to establish a contractual relationship with each county to assure the provision of community mental health services. State funds are allocated to counties.

### Available Services

Children and youth in Oregon may obtain a range of mental health services specific to their needs as determined by a mental health assessment, and level of need determination process. Available services include peer delivered support, skills training, medication management, community-based services which vary by community, but include home based, school based and other community located service delivery; intensive outpatient services, behavioral support services, psychiatric day treatment, psychiatric residential treatment, including proctor care model; sub-acute and acute hospitalization and hospital-based emergency services, crisis stabilization and crisis respite; and two secure longer term inpatient programs (one for children under age 14 and one for youth ages 14-17) that are housed in community residential facility settings. In many communities, intensive community-based services are provided using a wraparound model of care.

Treatment Foster Care is a collaborative effort with the Department of Human Services, Children, Adults and Families Division. Considered the least restrictive of residential treatment options for children in the care and custody of the state, Treatment Foster Care is provided by trained

foster parents, supervised by the local Community Mental Health Program. It is a critical treatment option for children, especially in rural counties.

Young adults in transition face many challenges, including lack of educational opportunities, addiction, high poverty rates and skyrocketing pregnancy rates. They also face challenges in obtaining and keeping adequate employment; they experience fewer opportunities than their counterparts outside the mental health and addiction system.

In 2008-2009 Oregon experienced a record rise in unemployment rates and is now within the top three states in the nation. The Youth Transition Program (YTP) offers services through the Oregon Office of Vocational Rehabilitation Services to prepare high school youths with Disabilities for employment, career or post-secondary education. Youth become ineligible for these services when they turn 18. To further exacerbate this issue, the Oregon budget shortfall has resulted in cuts to Supported Employment services. This leaves young adults in transition already coping with SED with little supports and an extremely difficult employment climate in which to attempt to establish some of the most basic of necessities.

Should Oregon be awarded the Healthy Transitions Initiative grant, this concern will be addressed by building on the "Transitional Age Housing" project, which offers skill building to young adults in a residential setting, and expand upon Supported Housing through a brokerage model designed to broker community based supports, including employment. The expansion of these two pilot projects will allow a blueprint to be built for future services to this undeserved population throughout Oregon.

AMH is involved in multiple planning and program development Initiatives for housing including Oregon's Homeless Policy Academy and Shelter Services Partnership for Youth. Many communities provide multi-agency based programs for homeless youth.

AMH continues to pursue additional housing resources through liaison with the Department of Housing and Community Services and local Housing and Urban Development (HUD) agencies. Many of the Community Mental Health Programs collaborate with the homeless and domestic violence shelters to serve these homeless youth.

AMH also distributes funds through Mental Health Services housing awards. Housing Funds were recently made available to assist with the acquisition, rehabilitation and/or construction of new housing for young adults with serious psychiatric disabilities transitioning to independent living and the adult mental health system. These funds are being made available in recognition that shelter is a basic need and current economic conditions make it very difficult for individuals served in local community mental health programs to acquire safe and adequate housing.

Three youth suicide prevention coordinators are funded through the Garrett Lee Smith Memorial Act grant, and a number of Oregon counties are actively involved in training and community coalitions for suicide prevention. The Question, Persuade, Refer (QPR) training program is being used in a train-the-trainer model to disseminate QPR, a suicide intervention program in multiple areas of the state. Several regions are also conducting ASIST (Applied Suicide Intervention Skills Training), a two day training that teaches direct intervention skills to those most likely to come into contact with suicidal persons, such as school counselors, mental health professionals, and juvenile justice staff and law enforcement officers.

A promising feature of the Oregon Health Plan is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments and alternative services suggested by contractors, allowing for less costly and more effective service delivery when appropriate.

## Goals, Targets and Action Plans

Goal 1: Increase the percentage of children with severe emotional disorders (SED) who receive mental health services while residing in a family-like setting.

Population:	Children and their families
Criterion	1. Comprehensive Community based mental health services
Indicator/Target	Percentage of children with SED receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 89%.
Measure	Number of children receiving outpatient mental health services while residing in a family-like setting.
Numerator	Number of children receiving outpatient mental health services while residing in a family-like setting.
Denominator	Number of children with SED receiving public mental health services.
Sources of Information	Client Process Monitoring System (CPMS)
Special Issues	A number of counties have limited community-based mental health services for children to enable children with severe emotional disorders to stay in their communities.
Significance	The Department of Human Services, Addictions and Mental Health Division is committed to serving children with severe emotional disorders in a family-like setting in the community. Providing mental health services to children who are at home or residing in a homelike environment is an essential component of community-based services.
Action Plan	Continued implementation of the Children's System Change Initiative; Statewide Wraparound Project Steering Committee; Technical assistance to counties.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Goal	FY2011 Goal
Percentage of	95%	95%	94%	96%	96%

children with SED receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 89%.					
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Goal 2: The number of children who receive therapeutic foster care services is maintained. NOM #3

Population	Children and their families
Criterion	1. Comprehensive, Community-based Mental Health System
Indicator/Target	The number of children receiving therapeutic foster care services.
Measure	The number of children receiving therapeutic foster care services.
Numerator	Number of children with SED who receive therapeutic foster care services
Denominator	1
Sources of Information	Medicaid Management Information System (MMIS)
Special Issues	Therapeutic Foster Care is an evidence-based practice that must be reported.
Significance	The Department of Human Services, Addictions & Mental Health Division is committed to serving more children with serious emotional disorders with intensive community-based services. Therapeutic Foster Care is an evidence-based practice that is community-based.
Action Plan	Continue to work with Children, Adults & Families (child welfare) to implement therapeutic foster care services.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY2011 Target
Number of children receiving therapeutic foster care services	69	75	80	85	90

Goal 3: Increase the array of community-based mental health services available to and delivered to children with serious emotional disorders.

NOM #1

Population	Children and their families
Criterion	1. Comprehensive, Community-based Mental Health System
Indicator/Target	The percentage of children with SED who receive three or more types of community-based mental health services over the course of a year will match or exceed baseline.
Measure	The percentage of children with SED who receive three or more types of community-based mental health services.
Numerator	Number of children with SED who receive three or more types of community-based mental health service
Denominator	Number of children with SED
Sources of Information	Client Process Monitoring System (CPMS) and Medicaid Management Information System (MMIS)
Special Issues	Some Oregon communities have a very limited array of services available to children with SED and their families.
Significance	The Department of Human Services, Addictions & Mental Health Division is committed to serving more children with serious emotional disorders with intensive community-based services. Increasing the array of intensive community-based services to children and their families remains crucial in implementing the children's system change. NOM 1. Increased access to services.
Action Plan	Workforce development; technical assistance; Statewide Wraparound Project Steering Committee.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
The percentage of children with SED who receive three or more types of community-based mental health services over the course of a year will match or exceed baseline.	38% Received <b>any</b> community-based service	61%	65%	70%	75%

Goal 4: Increase parents’ or guardians’ perception of care for children receiving public mental health services. NOM #4

Population	Children and their families
Criterion	1. Comprehensive, community-based mental health system
Indicator/Target	Increase the percentage of parents or guardians of children receiving public mental health services who respond positively, overall, to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.
Measure	Percentage of parents or guardians of children receiving public mental health services who agree or strongly agree, as a whole, to the Youth Services Survey for Families questions measuring appropriateness of service: <i>1. I have been satisfied with the services my child receives. 4. The people helping my child stuck with us no matter what. 5. I felt my child had someone to talk to when s/he was troubled. 7. The services my child and/or family received were right for us. 10. My family got the help we wanted for my child. 11. My family got as much help as we needed for my child.</i>
Numerator	Number of parents / guardians who provide an overall response of “agree” or “strongly agree” to the questions measuring appropriateness of service on the Youth Services Survey for Families.
Denominator	Number of parents / guardians who provide valid responses to the items of the Youth Services Survey for Families pertaining to appropriateness of service.
Sources of Information	MHSIP Youth Services Survey for Families
Special Issues	The Department of Human Services, Addictions and Mental Health Division distributes the MHSIP Youth Services Survey For Families annually. Though this survey reflects only the opinions of those who choose to fill out and return the survey, the return has represented a statistically significant sample.

Significance	Assuring that children and their parents or guardians who receive public mental health services rate the appropriateness and quality of services as effective is critical to Oregon's system of care.
Action Plan	System monitoring activities: local/regional advisory councils, Children's System Advisory Council, quality assurance activities

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Increase the percentage of parents or guardians of children receiving services through the Oregon Health Plan who respond positively to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.	63%	65%	67%	69%	70%

Goal 5: To increase service coordination and delivery for those persons aged 14-25 with a severe emotional, behavioral and/or mental disorders and who are transitioning into the adult community mental health service system.

NOM #1

Population	Transition age youth (14-25) and their families
Criterion	1. Comprehensive, Community-based Mental Health Services System
Indicators/ Target	Establish and increase the number of YAT served in specific community placements.
Measure	Number of YAT served in specific community placements.
Numerator	Number of YAT with severe emotional, behavioral and/or mental disorders who are transitioning into the adult service system and who are served in specific community placements.
Denominator	N/A
Sources of Information	AMH Workgroup on YAT; AMH funded specific community placements-annual reports; Policy Academy Work Plan.
Special Issues	Young adults in transition services go beyond treating high-risk behaviors by providing opportunities and supports for youth to transition smoothly into adulthood and live productive, functional lives.
Significance	This model will address a service need that is currently not met in Oregon. For young adults in transition, it will likely reduce their encounters with the acute care and criminal justice systems while improving educational, vocational and functional outcomes and life satisfaction. NOMS 1. Increased Access to Services.
Action Plan	Use of pilot community placements; technical assistance; AMH workgroup

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Establish and increase the number of YAT served in specific community placements.	No available placements	14*	19*	20	25

\* Numbers may reflect same client in two different FY

Goal 6: To increase number of parents / guardians of children with SED who agree or strongly agree that mental health services have been family-driven. NOM #4

Population	Children and their families
Criterion	1. Comprehensive, Community-based Mental Health System
Indicator/Target	Increase the percentage of caregivers of children with SED who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven: <i>Please indicate the extent to which you agree or disagree with the following statement: The child’s parent or caregiver directed the child’s mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.</i>
Measure	The percentage of caregivers of children with SED who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven:  <i>Please indicate the extent to which you agree or disagree with the following statement: The child’s parent or caregiver directed the child’s mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.</i>
Numerator	Number of parents / guardians who provide an overall response of “agree” or “strongly agree” to a survey item indicating that services were family-driven.
Denominator	Number of parents / guardians who provide a valid response to a survey item indicating that services were family-driven.
Sources of Information	YSS-F survey for families as amended by AMH for 2008
Special Issues	Family-driven services remain a primary goal of the Children’s System Change. Meaningful family involvement means that families have a primary decision making role in the mental health care of their own children.

Significance	The Department of Human Services, Addictions and Mental Health Division is committed to increasing the breadth of services which are deemed family-driven at all levels of the children's mental health system. NOMS 4. Client Perception of Care
Action Plan	Family and caregiver input on YSS-F

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
The percentage of caregivers of children with SED responding to the YSS-F who respond agree or strongly agree to an item indicating that services were family-driven.	Not Measured	Baseline 81 %	87%	90%	93%

Goal 7: Caregivers of children with SED report increase in Social Connectedness. NOM #8

Population	Children with a serious mental disorder
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicator/Target	The social connectedness domain of the YSS-F survey.
Measure	Percentage of caregivers of children with SED with positive response to the Social Connectedness questions on the YSS-F survey.
Numerator	Number of caregivers of children with SED with positive response to the Social Connectedness questions on the YSS-F survey
Denominator	The number of caregivers of children with SED responding to the YSS-F survey
Sources of Information	YSS-F survey
Special Issues	This is a newer domain on the YSS-F survey.
Significance	Recovery means that individuals have a place in the community. People need to feel that they have meaningful relationships and have a place in the community.
Action Plan	CSAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Percentage of caregivers of children with SED with positive response to the Social Connectedness questions on the YSS-F survey.	N/A	Baseline year 81.8%	86.8%	91.8%	91.8%

Goal 8: Parents/guardians of children with SED will report improved functioning of their children. NOM #9

Population	Children with a serious emotional disorder
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The functioning domain of the YSS-F survey.
Measure	Percentage of caregivers of children with SED with positive response to the Functioning questions on the YSS-F survey.
Numerator	Number of caregivers of children with SED with positive response to the Functioning questions on the YSS-F survey
Denominator	The number of caregivers of children with SED responding to the YSS-F survey
Sources of Information	YSS-F survey
Special Issues	This is a newer domain on the YSS-F survey.
Significance	Recovery is more than just feeling better. Persons in recovery are able to do more and do better those activities that are meaningful.
Action Plan	CSAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Percentage of caregivers of children with serious emotional disorders with positive response to the Functioning questions on the YSS-F survey.	N/A	Baseline 56.5%	66.5%	68.5%	71.5%

Goal 9: The population of children with SED will show improved participation in school following mental health treatment. NOM #5

Population	Children with serious emotional disorders
Criterion:	1. Comprehensive Community-Based Mental Health Service Systems. 3. Children’s Services—educational
Indicator/Target	The number of parents / guardians who report that their child’s school attendance improved following the initiation of mental health treatment will meet or exceed baseline increase.
Measure	The percentage of parents / guardians who report that their child’s school attendance worsened following the initiation of mental health treatment.
Numerator	The number of parents / guardians who report that their child’s school attendance improved following the initiation of mental health treatment.
Denominator	Number of parents / guardians who provide a valid response to a survey item indicating that services were family-driven.
Sources of Information	YSS-F item: <i>“Since my child started to receive mental health services from this provider, the number of days my child has been in school is:</i> <input type="checkbox"/> <i>a. Greater than before</i> <input type="checkbox"/> <i>b. About the same as before</i> <input type="checkbox"/> <i>c. Less than before</i> <input type="checkbox"/> <i>d. Does not apply”</i>
Special Issues	Many children who need mental health services are not willing or able to participate in school.
Significance	Oregon is committed to increasing access to educational services for children with serious emotional disorders. NOMS 5. Return to/stay in school.
Action Plan	Continue to support statewide provision of educational services and supports to children with SED

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
The percentage of parents / guardians who report that their child's school attendance improved following the initiation of mental health treatment will meet or exceed baseline increase.	61.1%	75%	80%	83%	85%

## **Criterion 2: Mental health system data epidemiology**

### **Estimate of prevalence**

#### **Serious Emotional Disorder (SED)**

The State of Oregon uses the Federal definition of Serious Emotional Disorder, which includes children and youth from birth to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within DSM-IV that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder alone does not constitute a serious emotional disorder although one or more of these two disorders may coexist with a serious emotional disorder. This definition is used in determining prevalence, need and access.

The 2008 estimate of the number of children with a serious emotional disorder living in Oregon is 104,606 children.

### **Quantitative Targets**

#### **Access for Minorities**

The majority of the population in Oregon is Caucasian with the remaining population being African American, Hispanic, Native American, Asian, and other. A comparison of the ethnic composition of Oregon's population and persons receiving mental health services by age group will be provided in the December 2008 Implementation Report. Oregon Administrative Rules state that community mental health programs are to provide culturally competent services. AMH requires information be provided to potential consumers, family members and allied agencies regarding the availability of materials in a multi-lingual format.

At the direction of the AMH management team, the AMH Cultural Competency Work Group (ACCWG) was created and has been meeting monthly to develop recommendations for the AMH Cultural Competency Plan (ACCP). The ACCP is being developed in response to the DHS

Standards and Guidelines for Cultural Competency and Gender Specific Services, which were approved by the DHS Cabinet in September of 2003.

The purpose of the plan is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from, or that are under contract with AMH, including county social services organizations and their vendors or contractors, managed care organizations and their provider networks, and community-based organizations. The intent is that this will serve as a planning document to assist AMH, County Governments, and provider networks to develop and implement an individualized cultural competence plan as addressed in each County's biennial implementation plan, with its goal to enhance treatment outcomes for all patients.

The AMH Cultural Competence Plan identifies eight core sections that would need to be addressed to move cultural competence forward. These are planning, evaluation, services to clients, retention, recruitment & promotion; education & training for AMH staff/providers, collaborative partnerships & informing the public; data collection & operation; ADA compliance.

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 the success in addressing cultural differences. AMH will continue to strengthen communication and cooperation within racial and ethnic communities.

In the Children's Mental Health System Change Initiative two of the eight tasks focus on developing culturally competent services. They are:

1. Requiring culturally competent skills-based staff training on evidence-based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.
2. Encourage local or regional managed care organizations to create a flexible funding pool to contract with one or more non-traditional providers who are positioned to provide culturally competent flexible response on a 24 hour, seven day per week basis without requiring the children to enter a facility to access the services.

### Gender Specific Services

The Addictions & Mental Health Division participates in the Coalition of Advocates for Equal Access for Girls. The mission and activities of the Coalition aims to ensure that girls receive equal access to all of the appropriate gender specific support and services they need to develop to their full potential. Coalition membership includes representatives from AMH, other state agencies, and private non-profit organizations. This coalition also has legislative support.

The Coalition meets at least 6 times a year and publishes *The Girls' Advocate*, a quarterly newsletter that aims to inform members and others regarding the activities that either support or threaten service access for girls. AMH continues to revise and monitor administrative rules and contract provisions to enhance gender responsive services. The current Oregon Administrative Rules for Children's Intensive Mental Health Treatment Services, [OAR 309-032-1120 (16)] and Children's Intensive Community Based Treatment and Support Services Providers, [OAR 309-032-1250 (15)] include standards for gender responsiveness.

AMH contracts with Girls, Inc. of NW Oregon to implement an evidence-based prevention program: Friendly PEERsuasion. Friendly PEERsuasion is being utilized in six Oregon counties and is geared toward female adolescents. This effort is focused on reducing under age drinking rates for girls, especially middle school age youth.

### Tribal Liaisons

AMH has identified two staff to serve as liaisons with the Tribes. When working with Tribes and tribal organizations, AMH staff solicits assistance and guidance from the liaisons to assure that cultural issues are identified and addressed. AMH tribal liaisons coordinate with the DHS tribal liaison.

At least one of the AMH tribal liaisons is present at tribal functions to continue building understanding and relationships. The tribal liaison answers questions and assists with overcoming system barriers for the Tribes. The CSCI referral and enrollment protocol has caused some barriers in service access, as the Tribes had previously been able to access treatment directly. They are accessing the local CMHP or MHO for authorization for services. Some options are being considered regarding the requirement for the local mental health authority to make referrals for residential and day treatment

services, and how that can be changed to better meet the cultural needs of the nine federally recognized Tribes in Oregon.

**ii. Goals, Objectives, Implementation Plan**

Goal 10: To maintain or increase the proportion of children from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State’s children within the same ethnic population.

Population	Children
Criterion	2. Mental Health System data Epidemiology
Indicator/Target	The percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children within ethnic categories for the general population.
Measure	Percentage share of children within an ethnic / racial group who are receiving publicly funded mental health services compared to the percentage share of children within ethnic categories for the general population.
Numerator	Within each ethnic / racial group, the number of Medicaid-eligible children who receive publicly funded mental health services.
Denominator	Within each ethnic / racial group, the number of Medicaid-eligible children.
Sources of Information	CPMS, MMIS, Portland State University Population Research Center.
Special Issues	Whites, Asians and Hispanics are under represented in the service population, while African-Americans and Native Americans are over represented. Services must be modified to become culturally sensitive and culturally competent so that those seeking services will find services that address their cultural needs and needs for ethnic diversity.
Significance	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of children with diverse ethnic backgrounds. NOMS 1. Increased Access to Services.
Action Plan	Expansion of cultural competency workforce development and increased access to services for children who are ethnically or culturally diverse in their background.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children within ethnic categories for the general population.	Whites and Asians are under represented in the service population, while African-Americans, Hispanics, and Native American are over-represented	To be reported in Dec. 2009	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.

### **Criterion 3: Children's Services**

#### System of Integrated Services

Oregon uses the Federal definition for serious emotional disturbance (SED) to describe the population of children under age 18 who receive services. In this document the term “children with severe emotional disorders” is synonymous with SED. The majority of the children served have diagnosed disorders on Axis I of the DSM-IV.

- **Children in Child Welfare Service**

Children in the care, custody and supervision of the Department of Human Services comprise a majority of all children receiving mental health treatment services. AMH works with child welfare to co-finance and co-manage much of the out-of-home psychiatric treatment services provided to these children. The Department of Human Services, Children, Adults and Families contracts with public and private child serving agencies to provide Behavior Rehabilitation Services (BRS) for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

DHS/CAF Office of Safety & Permanency for Children added 43 “slots” to the BRS foster care system in 2008. Intensive Community Care (ICC) targets a resource gap for children that qualify for the children's mental health Integrated Service Array (ISA) and have child welfare and mental health needs that can more effectively be met in a community-based setting. ICC will provide highly structured living environments with foster parents that are specially trained in behavioral support, in a placement that is conducive to the provision of in-home, intensive mental health services.

AMH is partnering with Child Welfare District Managers to work on the requirements for their Federal Performance Improvement Plan (PIP). Federal regulation and state policy and contracts require that children who are placed in substitute care by DHS receive a mental health assessment no later than 60 days following the date of placement. This requirement is currently not

being met in Oregon based on service utilization data and results from the 2007 CFSR State Assessment, however the number of timely assessments is improving.

A workgroup comprised of DHS staff and other stakeholders familiar with the problem has examined the issue and is making recommendations to improve compliance with the mental health assessment requirement. The service improvement goal is to increase the percentage of children who receive a mental health assessment over time.

- **State Target Planning and Consultation Committee**

AMH participates as a member of DHS, Children, Adults and Families Target Planning and Consultation Committee. This committee approves and funds individualized service plans for children in state custody up to age 21, for whom there are no appropriate and/or available funded resources or services.

- **Children in the Juvenile Justice System**

The Integrated Treatment Court model was developed and pilot projects established in seven Oregon counties: Clackamas, Coos, Crook, Douglas, Jackson, Josephine and Marion. Integrated Treatment Courts combine “juvenile drug court” concepts and service integration principles in order to increase accountability, promote service coordination across agencies and systems, promote the use of evidence-based practices and provide individualized behavioral health services for youth and families involved in the juvenile justice system.

AMH representation has been added to the Oregon Youth Authority Advisory Council. This council is composed of state and local partners including judges and victims. The council provides oversight and advice to the Director of the Oregon Youth Authority in the management and development of new services and programs to serve youth offenders more appropriately and increase the potential for reformation. AMH is also represented at the Juvenile Department Directors monthly meeting to provide information sharing and collaboration among the systems. AMH collaborates with OYA in case planning with their Resource Development Coordination Committee.

- **Individuals with Disabilities Education Act Partnership**

In October 2002, DHS and the Oregon Department of Education (ODE) were awarded a seed grant from the National Association of State Directors of Special Education. ODE and DHS convened statewide forums that addressed children's education needs for a successful transition from residential treatment facilities back to their school within their community and an action plan was created to ensure successful transitions. AMH and ODE continue to use this action plan to coordinate children's mental health services and improve educational opportunities for children.

AMH participates in the State Advisory Council for Special Education (SACSE). This Council reviews all aspects of the statewide program of special education, and also provides policy guidance with respect to special education and related services for children with disabilities. Each year SACSE provides recommendations to superintendents and the State Board of Education.

An AMH representative participates on the State Interagency Coordinating Council that is advisory to the Superintendent of Public Instruction and the State Board of Education on unmet needs in early childhood special education and early intervention programs for preschool children with disabilities.

- **System Alternatives to State Hospitalization**

AMH has developed the following alternatives to state hospitalization for children:

1. The Secure Children's Inpatient Program (SCIP) provides services to 12 children under age 14. The services are provided on a campus and within a program specifically designed for children. SCIP utilizes a child and family focused, community-based model with integrated linkages to a continuum of care. This ensures that each child receives treatment in the most clinically appropriate and least restrictive setting possible.
2. The Secure Adolescent Inpatient Program (SAIP) provides services to up to 17 adolescents ages 14 through 17 on a campus and within a program specifically designed for adolescents. SAIP utilizes a child and family focused, community-based model with integrated linkages

to a continuum of care.

AMH developed enhanced residential services at the time these treatment settings were relocated to the community from the state hospital. Stabilization and Transition Services (STS) are enhanced residential treatment resources: 1) to divert children/adolescents from SCIP/SAIP when clinically appropriate and to treat them in a less restrictive setting, or 2) to provide additional funding to assist with transition needs for children/adolescents who are ready for discharge from SCIP/SAIP but who might not be accepted into lower levels of care without additional funding incentives.

STS funding has been used to allow children/adolescents the ability to receive higher levels of care in the least restrictive environment. STS funding is used to adequately treat youth in their current setting (sparing them a move to yet another treatment program) with additional funds to pay for enhanced services.

- **Adolescent Services For Co-Occurring Mental Health And Substance Use Disorders (COD)**

The state of Oregon provides fully integrated services for adolescents who present with both mental health and substance use issues in the alcohol and drug residential treatment programs. The state amended contract language and increased the daily rate to support the provision of competent programs capable of delivering adequate and appropriate services.

Mental health providers screen for co-occurring substance use problems and make appropriate referrals for treatment to outpatient programs. Additionally, the Oregon Youth Authority is moving toward providing specific treatment for incarcerated youth who present with COD. They have hired qualified mental health professionals (QMHP) in all institutions to support this effort.

- **Interagency Care for Children**

AMH is creating a coordinated system of care to meet the needs of children served by multiple child serving agencies. Mental health, education, child

welfare, juvenile justice, family support organizations, and families continue to work together to establish meaningful service planning at the individual, local and state levels. The Statewide Wraparound Initiative legislation was passed in 2009 underscoring the importance of this work.

The Children's System Advisory Committee was established in 2005 as a permanent committee of the Planning and Management Advisory Council. This committee provides oversight of children's mental health system planning, coordination, policy development, fiscal development and evaluation of service delivery/functioning. The committee also addresses specialized issues and services for young adults in transition

The Children's System Advisory Committee membership includes child welfare, juvenile justice, education, family members, youth, advocates, and providers, and this is replicated at the regional and local advisory councils. Workforce development activities have also been initiated with interagency input.

#### Geographic Area Definition

Children and youth are served throughout the contiguous geographic area of the state of Oregon without exception; services are administered through community mental health programs located in 36 counties, conducted either directly or through sub-contractual agreements.

Goal 11: The population of children with serious emotional disturbance will experience a lower likelihood of arrest following initiation of mental health treatment. NOM #6

Population	Youth with SED who come in contact with the Juvenile Justice System.
Criterion	3. Children's Services
Indicator/ Target	The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2, will increase.
Measure	The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2.
Numerator	The number of children, as reported by parents or guardians, with no arrests for a year after starting treatment.
Denominator	The number of children, as reported by parents or guardians, who were arrested within a year prior to mental health treatment.
Sources of Information	YSS-F as amended by Oregon Department of Human Services Addiction and Mental Health Division.
Special Issues	The Oregon Department of Human Services Addictions and Mental Health Division and the Oregon Youth Authority are interested in the various factors affecting youth with mental health needs and their involvement in the juvenile justice system.
Significance	Youth who come in contact with the juvenile justice system have a high occurrence of mental health needs. Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system. Improved mental health services are expected to decrease criminal activity. NOM #6 Decreased Criminal Justice Involvement
Action Plan	Evaluate whether treatment has an impact on likelihood of arrest. Evaluate other factors that may be contributing to the likelihood of arrest.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2, will increase.	N/A	34.8%	36%	38%	40%

Goal 12: Children in Child Welfare with SED will receive a mental health assessment upon entry into substitute care. NOM #1

Population	Children with SED entering Substitute Care from the Child Welfare System.
Criterion	3. Children's Services
Indicator/Target	Maintain or increase the percentage of children involved in the child welfare system who receive timely initial mental health assessments.
Measure	Percentage of children involved in the child welfare system who receive timely initial mental health assessments.
Numerator	Number of children with SED entering substitute care from the DHS Child Welfare system who receive a mental health assessment within 60 days of entering care.
Denominator	Number of children with SED entering substitute care from the DHS Child Welfare system.
Sources of Information	MMIS and administrative data maintained within the Division of Children, Adults and Families.
Special Issues	Child welfare has a federal requirement that a child must have a mental health assessment completed within 60 days of substitute care placement. Oregon has not met this measure and is working collaboratively to meet this goal.
Significance	Children in substitute care with DHS child welfare need to have a mental health assessment completed to determine the need for mental health services. NOMS 1. Access to services.
Action Plan	Determine method to increase number of completed mental health assessments.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Maintain or increase the percentage of children with SED involved in the child welfare system who receive timely initial mental health assessments.	21.3%	35.7%	70%	90%	100%

Goal 13: Increase the provision of evidence-based practices to children with serious emotional disorders. [TRANSFORMATION OUTCOME MEASURE] NOM #3

Population	Children and their families
Criterion	3. Children's Services
Indicator	Percentage of children with SED receiving evidence-based practices.
Measure	Percentage of children receiving evidence based practices.
Numerator	Number of children receiving evidence-based practices.
Denominator	Number of children receiving public mental health.
Sources of Information	List of treatment practices approved as evidence-based by AMH; expenditure and demographic reports on evidence-based practices submitted to AMH by Community Mental Health Programs.
Special Issues	A law enacted by the 2003 Oregon Legislature requires that, by 2009, at least 75% of the treatment funds expended by AMH be for evidence-based practices. AMH has created a statewide list of approved evidence-based practices. Implementation of evidence-based practices is occurring with 167 approved practices encompassing mental health, addictions, co-occurring disorders and prevention practices.
Significance	AMH is required to demonstrate that funds are being used cost-effectively for treatment services that are based upon empirical research demonstrating the effectiveness of the practices in treating people with psychiatric disabilities. NOMS 3. Use of Evidence-Based Practices.
Action Plan	Survey of publicly funded providers regarding numbers of clients served in evidence-based practice treatment and percentage of funds used in delivery of these practices.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Percentage of children with SED receiving evidence-based practices	25%	54%	New methodology		

Goal 14: Reduce the rates of readmission within 30 days and within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP). NOM #2

Population	Children with serious emotional disorders
Criterion	3. Children's Services
Indicators	a. Reduce the percentage of readmission within 30 days and b. Within 180 days for children with SED to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).
Measure	a. Percentage of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year. b. Percentage of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year.
Numerator	a. Number of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year. b. Number of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year.
Denominator	a. Number of children with SED who are discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year. b. Number of children with SED who are discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year.
Sources of Information	MMIS and CPMS
Special Issues	Oregon is working with Community Mental Health Programs; Mental Health Organizations and Intensive

	Community Based Treatment Services (ICTS) providers to ensure children discharged from SCIP and SAIP have good transition plans to assure successful community tenure.
Significance	It is important that children with SED have effective transition planning upon discharge from the Secure Children's Inpatient Program or Secure Adolescent Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the child's mental health needs and strengths. NOMS 2. Reduced Utilization of Psychiatric Inpatient Beds.
Action Plan	Monitor discharge planning at SCIP/SAIP through technical assistance; continue to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP.

Performance Indicator	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
a. Decrease the percentage of children with SED who are readmitted to SCIP and SAIP within 30 days of their first discharge of the fiscal year.	8.8 %	<1%	<1%	<1%
b. Decrease the percentage of children with SED who are readmitted to SCIP and SAIP within 180 days of their first discharge of the fiscal year.	21.6 %	3%	<3%	<3%

## **Criterion 4: Targeted Services to rural and homeless population**

### Homeless Youth and Children

Homeless children and adolescents are a diverse group facing many challenges. Often these children are in need of mental health and other health and social services. Some homeless children are members of homeless families, and some are children who have run away from home for an extended period and/or have been abandoned by their parents. Estimates of the number of homeless and runaway youth vary widely due to the difficulty in locating and quantifying this population.

Identifying the provision of mental health services to homeless children is also difficult to quantify. AMH uses the Client Process Monitoring System, which defines place of residence or lack thereof for all clients. AMH is involved in multiple planning and program development initiatives including Oregon's Homeless Policy Academy and Shelter Services Partnership for Youth. Many communities provide multi-agency based programs for homeless youth.

AMH continues to pursue additional housing resources through liaison with the Department of Housing and Community Services and local Housing and Urban Development (HUD) agencies. Many of the Community Mental Health Programs collaborate with the homeless and domestic violence shelters to serve these homeless youth.

AMH also distributes funds through Mental Health Services housing awards. Housing Funds were recently made available to assist with the acquisition, rehabilitation and/or construction of new housing for young adults with serious psychiatric disabilities transitioning to independent living and the adult mental health system. These funds are being made available in recognition that shelter is a basic need and current economic conditions make it very difficult for individuals served in local community mental health programs to acquire safe and adequate housing.

## Rural Services to Children

Oregon has 36 counties. Eleven counties have a population of over 96,000 citizens, and are considered urban. The other 25 counties are considered rural with 23% of the State's population residing in these counties. In rural areas, distances and lack of transportation are barriers for children with serious emotional disorders and their families to access mental health services.

The MHOs provide a full continuum of services to eligible children with serious emotional disorders. The MHOs are required by contract to meet the medically appropriate needs of these children. Regardless of the rural nature of a child's community, the intent of the contract is that a full array of services is available to all children and families who need mental health services. The MHOs provide mental health services directly through the Community Mental Health Program or a contract entity under approval of the Community Mental Health Program and AMH.

Access to mental health services in rural areas is generally comparable in Oregon to that in urban areas. In addition to local programs, all children have access to appropriate statewide resources such as acute psychiatric hospitalization, inpatient psychiatric treatment programs, psychiatric residential and day treatment services, and intensive community-based services, although children and families may travel many miles to receive these services.

Individuals in rural areas continue to face barriers to receiving services such as intensive community-based services, child psychiatry services and acute care. Oregon has increasingly used teleconference technology for child psychiatric evaluations in rural parts of the state. In 2006 teleconference capacity for psychiatric evaluations of children and adolescents increased. Additionally, a majority of Oregon's rural counties have received federal designation as mental health professional shortage areas to assist in recruiting psychiatrists for areas that lack coverage by physicians without regard to specialty.

The EAST (Early Assessment and Support Team) program is an early intervention program serving young people between age 15 and 30 who have

had a first experience with psychosis within the past twelve months. Its primary purpose is to reduce the disability associated with psychosis. The 2007-2009 Legislative Assembly recognized the benefit of and need for this service and allocated an additional \$4.3 million to expand the Early Assessment and Support Alliance (EASA) program now operating in 16 counties.

**ii. Goals, Objectives, Performance Indicators**

Goal 15: The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State’s population of children who live in rural areas.

Population	Children who live in rural areas receiving mental health services
Criterion	4. Targeted Services to Rural and Homeless Populations
Indicator/ Target	The proportion of the children receiving mental health services who live rural areas will match or exceed the proportion of the State’s population of children who live in rural areas.
Measure	The proportion of children receiving mental health services who live in rural areas will match or exceed the proportion of the State’s population of children who live in rural areas.
Numerator	a. For the proportion of children receiving mental health services who are from rural areas: The number of children receiving mental health services who live in rural areas. b. For the proportion of children living in rural areas: The number of children living in rural areas.
Denominator	a. For the proportion of children receiving mental health services who are from rural areas: The number of children receiving mental health services. b. For the proportion of children living in rural areas: The number of children living in Oregon.
Sources of Information	Client Process Monitoring System, Oregon Patient/Resident Care System, Medicaid Management Information System, and public sources of data on the number of children living in various areas across the State.
Special Issues	Rural areas of Oregon have unique issues in the provision of mental health services.
Significance	Because of the small population density in areas of rural Oregon, the assurance of comparable rates of service utilization between children in rural and urban areas is a key indicator. The geographic area requires collaborative interagency involvement, planning, outreach, and unique service delivery mechanisms to ensure that the mental health needs of children and their families are identified and

	addressed. NOMS 1. Increased Access to Services
Action Plan	Formation of regional oversight committees; telemedicine; videoconferencing for interagency collaboration

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
The proportion of children receiving mental health services who live in rural areas will match or exceed the proportion of the State's population of children who live in rural areas.	Proportion of rural children served exceeded proportion of child population that is rural by 4.7%	Proportion of rural children served exceeded proportion of child population that is rural by 5.6%	Proportion of rural children served will exceed proportion of child population that live in rural areas by 6.5%	Proportion of rural children served will exceed proportion of child population that live in rural areas by 7.0%	Proportion of rural children served will exceed proportion of child population that live in rural areas By 7.5 %

Goal 16: Decrease homelessness among children who receive publicly funded outpatient mental health services.

Population	Children who are homeless.
Criterion	4. Target services to homeless and rural populations.
Indicator/ Target	Identify the number of children who are no longer homeless at the termination of services out of the total number identified as homeless at the initiation of service.
Measure	Proportion of children identified as homeless upon initiation of outpatient mental health services that are no longer homeless at the termination of services.
Numerator	Number of children completing an episode of outpatient mental health service that were identified as homeless upon initiation of that service episode and identified as no longer homeless upon termination of that service episode.
Denominator	Number of children completing an episode of outpatient mental health service who were identified as homeless upon initiation of that service episode.
Sources of Information	Client Process Monitoring System
Special Issues	For a variety of reasons, the impact of the provision of mental health services on homelessness is difficult to measure. Homeless children entering the outpatient mental health system may not be representative of the broader population of homeless children. Children receiving mental health services are likely to receive services from other service delivery systems prior to, during, and/or following receipt of mental health services; the services provided through these other service delivery systems could also have an impact on homelessness. Data on homelessness within the mental health service population are collected only at the beginning and at the end of an outpatient mental health service episode; changes in housing status within the service episode are not known.
Significance	An increase in the proportion of homeless SED children who are no longer homeless upon completion of mental health services would suggest that mental health services have the direct or indirect effect of reducing homelessness within a

	subset of the children living in Oregon.
Action Plan	Technical assistance to provider agencies; collaboration with Commission on Children and Families.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Identify/Increase the number of children who are no longer homeless at the termination of services out of the total number identified as homeless on initiation of service.	N/A	45%	55%	60%	>60 %

## **Criterion 5: Management Systems**

### Resources for Providers

#### Current Children's Mental Health System Training

AMH's mission for training and community education is to disseminate information, provide technical assistance, and make available skills training to implement current, evidence-based, and culturally competent prevention and treatment services. AMH training promotes practices fostering quality of life, facilitating self-determination, and building on individual, family, and community strengths.

Workforce Development efforts in Children's Mental Health continue to focus on system change and the implementation of evidence-based practices. The Children's Mental Health team and the Workforce Development team will provide training and technical assistance to providers via an individual "change" projects called CSIP (Children's System Improvement Project). AMH also maintains a Child/youth Behavioral Health Workforce Development committee and educational conference.

Additionally, training and technical assistance will be offered in the following areas that support the Children's System Change Initiative and implementation of evidence-based practices:

- ECSII (Early Childhood Service Intensity Instrument)
- Trauma Informed Services
- Collaborative Problem Solving
- Young Adults in Transition
- Wraparound Initiative Implementation

Oregon is fortunate to be home to The Research and Training Center on Family Support and Children's Mental Health. It was established in 1984 at Portland State University, Portland, Oregon. The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders. This goal is accomplished through collaborative research partnerships with family members, service providers, policy makers, and other concerned persons.

## Emergency Service Provider Training

AMH recently updated its 2007 *Behavioral Health Emergency Response Field Guide*. Over the past year AMH has supported training of emergency first responders, which is conducted by local Community Mental Health Programs as well as some public health regions:

- Crisis Intervention Team (CIT) Training for police officers. AMH, NAMI, peers/consumer run organizations and counties support this kind of training.
- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE and other AMH sponsored training.
- “Addictions and Mental Health Basics” training to front-line case management staff of DHS-Child Welfare, TANF Program.

This Office has participated and/or developed community education programs as described above since 1999. The AMH Workforce Development Unit is currently finalizing an education plan for 2009-2011. It will include aspects of all of the above.

## Training Family Members

Oregon Administrative Rules and Mental Health Organization contractual language requires family members of children with serious emotional disorders to participate on advisory councils, quality management committees and other mental health delivery system decision-making bodies.

AMH funds the Oregon Family Support Network (OFSN) to train family members/caregivers/youth and professional mental health staff about effective partnering for policy-making. The educational curriculum provided by OFSN enhances family member/youth and provider ability to be engaged in collaborative organizational decision-making and analysis critical to continuous quality improvement of services to children with SED and their families. A train-the-trainer model is being used to increase the provision of this effective training.

OFSN is developing and training family members in the *Family Navigator Program*, which currently has three pilot sites that assist family members and youth access and receive support in a timely manner. The core curriculum includes a 35 hour training, plus three additional trainings in Medicaid billing (encounter codes/treatment plan goals/progress notes), strength-based cultural competency, and HIPAA requirements/insurance information. Thirty-five family members have attended the training, with five currently employed through contracts OFSN maintains with county mental health programs.

OFSN collaborates with representatives from CMHPs, MHOs and integrated service array providers to increase family members/caregivers/youth membership on local or regional committees. OFSN recruits, mentors and supports family members/caregivers/youth with financial assistance for expenses including travel, childcare, and other expenses as family members/caregivers/youth participate in policy decision-making committees.

### Quality Improvement

The AMH Quality Improvement and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Certificates of Approval are issued to Community Mental Health Programs and sub-contracted providers, children's Psychiatric Day Treatment (PDTS), and Psychiatric Residential Treatment (PRTS) programs for children, inpatient psychiatric acute care programs, and private outpatient mental health providers. Quality Improvement and Certification staff conduct site reviews of these programs to ensure compliance with contract conditions and state regulations. This section also approves individual clinicians to authorize the use of seclusion or restraint for children in approved facilities.

Reportable incidents from PDTS and PRTS providers are reported and processed by the Quality Improvement and Certification unit. Seclusion and restraint data from the PRTS programs is reviewed and analyzed on a quarterly basis.

MHOs, under contract with AMH, are required to submit annual quality improvement work plans that are reviewed and approved by the Quality Assurance Specialist in the Medicaid Policy Unit. AMH also analyzes the annual quality improvement work plan reports, other periodic reports from

the MHOs and data from utilization reports. These and other outcome measures are used in quality improvement and monitoring activities.

Currently, AMH contracts with an external quality review organization to conduct site reviews of the compliance with contract expectations and to assess quality of services, including performance improvement projects. Each MHO is required to have quality improvement and advisory committees that include representation from community stakeholders, consumer and family members and practitioners. Information is gathered and used to monitor performance standards relating to access to services, quality of care, prevention, education and outreach and integration and coordination with other community services.

AMH is writing a quality management plan with strategic actions to be conducted within the children's mental health system administrative section of the office.

### Management Information System

Data on persons with psychiatric and emotional disorders and the services they receive are collected and stored in three primary databases:

The Medicaid Management Information System (MMIS) provides information on persons who receive health insurance benefits under the Oregon Health Plan. Oregon has recently replaced its MMIS system. In December of 2008, Oregon implemented a new MMIS system to collect Medicaid services. At that point Medicaid data through, roughly, March 2008 was complete. Since then, the many issues that may occur with the implementation of a new data system have plagued Oregon. This is particularly true of the Medicaid Managed Care data. A considerable portion of calendar year 2008 data is missing at this point. This is data that would normally be used for block grant reporting. It will hopefully be complete for the implementation report due in December 2009. Another data system (CPMS, described below) for community services is available which overlaps with the MMIS data, but the overlap is not complete.

The Oregon Health Plan provides coverage to people who are categorically eligible for Medicaid. The plan also provides coverage to an "expansion population" of poverty-level adults who do not qualify for traditional Medicaid and are eligible by virtue of poverty, the OHP standard population. MMIS includes information on eligibility status, services rendered and fee-for-service actual or capitation payments. MMIS also includes information

about chemical dependency, pharmacy, dental and physical health service expenditures. MMIS data is accessed via a decision support surveillance utilization review system known as DSSURS.

The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs. The CPMS also includes records of care in chemical dependency and developmental disability programs. CPMS is submitted on various standardized forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode.

The Oregon Patient/Resident Care System (OP/RCS) includes records for all publicly funded psychiatric inpatient care delivered in the state hospitals and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment.

Each of these systems contains unique client level identifiers. The AMH Program Analysis and Evaluation Unit uploads data from each of the systems to a central SQL server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

AMH collects other information. Specific data relevant to the CSCI is being tracked in accordance with the Outcomes Policy, and it includes level of need determination data, process measures, family perception of outcomes and integrated service array outcomes. Oversight of data issues throughout the system is provided through the CSAC and through periodic reporting to stakeholders.

Outcome and performance measure data are gathered through the Mental Health Statistics Improvement Project (MHSIP) Youth Services Survey for Families (YSS-F), which is administered annually. YSS-F results are used to: 1) provide feedback to those who are affected by AMH performance measures; 2) identify areas in need of improvement or attention; 3) track improvement in the well-being of children served with public funds; 4)

recognize those programs which are doing well; and 5) communicate results to the Governor, the Legislature, department contractors, and the public.

### Staffing

Four types of staff provide services and support to child and adult consumers of mental health services in Oregon through the Community Mental Health programs. These include programs that are integrated, blending services for mental health, alcohol and drug and gambling recovery. However, numbers represented here exclude staff solely funded by alcohol, drug and gambling recovery. Funding for Community Mental Health programs and services come from Medicaid, Medicare, State and County General Fund, Federal Block Grant, and private grants and insurances.

AMH requires the Mental Health Organizations to submit an annual Provider Capacity Report assessing the availability and adequacy of services. This assessment includes:

- maintenance and monitoring of an adequate and appropriate network of providers for all covered services performed;
- provisions for adequate and timely coverage of services provided out-of-network, when the network is unable to provide those services;
- requirements and monitoring procedures for providers in meeting state standards for timely access to care and services, taking into account routine, emergent and urgent needs;
- status of any corrective actions taken in the last contract year;
- current activities to provide delivery of services in a culturally competent manner to all enrollees;
- monitoring procedures for any delegated activities related to provider capacity; and
- an annual provider list of licensed medical practitioners and qualified mental health professionals.

Goal 17: Increase the participation of children with SED and their families in mental health services planning and monitoring.

Population	Family members of children with serious emotional disorders, youth with SED
Criterion:	5. Management Systems
Indicator/Target	a. Increase the participation of trained family members of children with SED on advisory councils, quality management committees, and other mental health delivery system decision-making bodies. b. Increase the participation of trained youth (ages 16-24) who have had or who are currently receiving mental health services with SED on advisory councils, quality management committees, and other mental health delivery system decision-making bodies.
Measure	a. Number of trained family members participating on policy-making committees. b. Number of trained youth participating on policy-making committees.
Numerator	a. Not Applicable. b. Not Applicable.
Denominator	a. Not Applicable. b. Not Applicable.
Sources of Data	Oregon Family Support Network Project Reports and training rosters, rosters of policy-making committees
Special Issues	Contracts require the participation of family members/youth in advisory councils. Family members/youth may also participate in quality management committees and other means of influencing the mental health delivery systems.
Significance	Family members/youth and mental health service providers together need training to ensure effective family member/youth participation on policy-making councils and advisory committees. Family member/youth involvement in organizational decision-making and analysis is critical to continuous quality improvement of services to children with SED and their families. The Children's System Change Initiative endorses meaningful family involvement. Participation on decision-making bodies is one means to achieve meaningful

	family/youth involvement. Youth directed services are increasingly being valued and implemented nationally.
Action Plan	Training of youth and family members; recruitment of youth for advisory councils

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Increase the number of family members on policy-making committees.	28	50	35	40	45
Increase the number of trained youth who are on policy-making councils or committees.	10	8	16	18	20

Goal 18: Increase access to publicly-funded mental health services by children and their families. NOM #1

Population	Children with serious emotional disorders
Criterion	5. Management Systems
Indicator/ Target	Increase the percentage of children with SED served in the publicly funded mental health system
Measure	Percentage of children with SED served in the publicly funded mental health system
Numerator	The number of children with SED receiving publicly funded mental health services.
Denominator	The estimated number of children with SED.
Sources of Information	Contracts, Medicaid encounters and claims (CPMS and MMIS data).
Special Issues	Many children enrolled in mental health organizations who may need mental health services are not accessing those services. A number of communities are lacking community-based services and supports to meet the needs of children with SED and their families.
Significance	Oregon is committed to both increasing access to mental health services and increasing the number of communities offering a wide array of community-based services. NOM 1. Increased access to services.
Action Plan	Continue to support statewide expansion of community-based services and support MHOs in service provision to enrollees.

Performance Indicator	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Increase the percentage of children with SED served in the publicly funded mental health system	35%	33%	38%	39%	40 %

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