

2011 Presentation

Joint Legislative Committee on Ways and Means

Reference Document

AMH contributions to the OHA mission

The OHA Addictions and Mental Health division (AMH) provides Oregonians access to health, mental health and addiction services and supports meeting the needs of adults and children to live, be educated, work and participate in their communities and to help them achieve optimum physical, mental and social well being. This is done by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities.

AMH is responsible for these key areas:

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

The need for these services

Recent findings from a comprehensive study of Oregon's need for addictions services indicate that a staggering \$5.93 billion is spent annually on untreated alcohol and drug abuse — \$813 million for health care, \$4.15 billion in lost earnings and \$967 million for law enforcement, criminal justice, social welfare and other expenditures. Public funds provide services for less than 20 percent of the need. Oregon's underage drinking rate exceeds the national rate; more eighth graders, particularly girls, are drinking than ever before.

Public funds provide mental health services for 31 percent of the children and adolescents and 46 percent of the adults with severe emotional disorders or severe mental illness. A comprehensive community mental health system is essential for the operation of the new psychiatric treatment facility under construction in Salem.

The need in Oregon for addictions and mental health treatment can be seen in the following numbers:

- 205,919 adults have substance abuse or dependence issues;
- 27,592 youth age 12 to 17 and 67,976 age 18 to 25 have substance abuse or dependence issues;
- 23.2 percent of eighth graders drank alcohol during the past month;
- 9 percent of adolescents ages 12 to 17 suffer from illicit drug abuse or dependence;
- 77,000 Oregonians have problem gambling issues;
- 106,000 children and adolescents are diagnosed with a severe emotional disorder in any year; and
- 157,000 adults are diagnosed with a severe mental illness in any year.

Responding to these needs

During the 2009-11 biennium AMH worked with the community mental health programs to strengthen the oversight of services funded by the 2009 Legislature. The agency provided publicly funded addictions treatment for 54,108 people each year, Adults and children received treatment for mental health disorders in their communities (72,207 adults and 33,243 children). Additionally, 1,400 people were treated at the state hospitals.

For adults who have received addictions treatment:

- More than 56 percent report working at the end of treatment; and
- 56 percent of parents met child reunification requirements.

For youth who completed addictions treatment:

- 77 percent had improved school performance.

For adults receiving mental health services:

- 54 percent found housing when given housing assistance services; and
- 57 percent of those arrested in the 12 months prior to services were not arrested in the 12 months following services.

For children receiving mental health services:

- 56 percent of those arrested in the 12 months prior to services were not arrested in the 12 months following services; and
- Roughly 10 percent of individuals were suspended or expelled while in services, which is equivalent to the general population.

OHA Continuous Improvement Initiative

AMH is using the information, skills and resources available through the Transformation Initiative to continuously improve processes and quality related to services for those with addiction disorders and mental illness. The structure and discipline inherent in continuous improvement provided detailed analyses of critical areas of the system that are not working well and allowed improvements essential to improving patient care. These techniques were used to keep the focus on changes and the benefits that accrue in terms of cost savings, improvements for people, improvement in quality of work and improvement in services.

AMH is managing two complementary continuous improvement projects, one focused on Oregon State Hospital and the other focused on the community-based system and the functioning of critical work done by program staff. There have been significant improvements in the efficiency and quality of work done by staff and in work with community partners. For example, at OSH the time it takes to hire mental health technicians was cut in half by utilizing tools provided by our transformation experts. The ability to fill these critical direct care positions has contributed to the decrease in the need for mandated overtime.

2009-11 investments

The 2009 Legislature made a modest investment, just under \$500,000 in the community mental health budget, to improve funding for a statewide Suicide Prevention Line. In addition, the Legislature invested \$321,886 for the WorkHealthy Oregon Program to improve the ability of employers to hire alcohol and drug-free workers. An estimated \$36.1 million was dedicated to OSH in order to fund 527 positions for Oregon State Hospital. These positions are necessary to begin addressing the need to provide 20 hours of active psychiatric treatment to the patients. The added staff also will provide critical treatment and support in the new hospital.

2009-11 reductions

There were five reductions that affect the stability of the community-based mental health and addiction system.

- The Legislatively Adopted Budget (LAB) removed \$2.3 million General Fund from the Alcohol and Drug Prevention System, thereby ending the successful Strengthening Families Program (keeping families together).
- The LAB reduced by \$1 million supported employment services for adults with mental illness.

-
- The LAB reduced Lottery Funding for problem gambling prevention and treatment by 15 percent, or \$1.6 million. Reduced Lottery revenues resulted in further reductions to these programs.
 - The LAB eliminated the cost-of-living adjustment for addictions and mental health provider contracts. This resulted in a \$17.8 million Total Fund loss to the system and further weakens the community-based infrastructure.
 - The LAB reduced the AMH Central Office budget by \$2.9 million Total Funds. This resulted in loss of training and technical assistance opportunities for community programs.

System challenges

The addictions and mental health system faces a wide range of challenges in the coming biennium. The major challenge for the overall system in 2011-13 will be working with OHA leadership and the Governor's Office to include addiction and mental health services in a regionally accountable system of care that fully integrates addiction and mental health services with physical, dental health and long term care. The goal will be to deliver improved access and quality of care while decreasing the overall cost of care.

The major challenge in the community mental health system will be to overcome the over-reliance on long-term residential services created as a response to deinstitutionalization and the closure of state hospitals. These services are expensive and inflexible and limit our ability to help more Oregonians living with mental illness. Investment in these services has limited the ability to invest in permanent housing and the support services necessary for recovery and greater independence.

A major challenge for Oregon State Hospital in 2011-13 will be funding the infrastructure for the full implementation of the Behavioral Health Integration Project (BHIP) appropriately. The positions and funds to pay for these projects and the increased charges from the State Data Center are not included in the Governor's Balanced Budget due to revenue constraints.

The addictions and mental health system is not meeting the needs of Oregonians in crisis. Without investment in prevention, early intervention and treatment services, and housing and supports, individuals are more likely to end up incarcerated, in need of expensive long-term services, or in need of expensive hospital care.

Oregon's prevention system aspires to:

- Screen and provide brief intervention and treatment services for returning veterans and uninsured workers;
- Create and disseminate targeted programs for minority parents with children ages 10-14;
- Develop a methamphetamine prevention curriculum for Oregon's children;
- Provide better workplace prevention training and assistance to employers; and
- Supply a consistent statewide prevention program for all communities.

Oregon's addictions treatment system aspires to:

- Provide appropriate family-based treatment for youth with co-occurring (addictions and mental health) disorders;
- Appropriately serve more than 400 adults with co-occurring disorders;
- Provide outpatient addictions treatment for individuals in under-served populations;
- Provide culturally and linguistically competent addictions treatment to reduce health disparities;
- Ensure provider pay reflects the cost of providing efficient and effective services;
- Provide sufficient alcohol- and drug-free housing to support recovery; and
- Collect comprehensive data and use it for management of performance.

The problem gambling prevention and treatment system aspires to:

- Strengthen Oregon's problem gambling prevention and treatment system; and
- Address the needs of minority populations.

Oregon's community mental health treatment system aspires to:

- Provide the necessary array of community services to ensure the success of the new state hospital;
- Fully develop a broad array of peer recovery support services;
- Improve access to community-based mental health services for children and their families;
- Increase the capacity of communities to provide intensive mental health services;

-
- Provide tele-psychiatry for primary care physicians, especially in rural and frontier communities;
 - Ensure access to care by increasing payment rates to reflect the cost of providing critical services;
 - Provide statewide early intervention services targeted to adolescence and young adults; and
 - Collect comprehensive data and use it for management of performance.

Strengthening the state hospital's ability to provide quality care

The 2009-11 Legislatively Adopted Budget (LAB) provided critical funding for the state hospital. The budget funded the first phase of staffing, equipment and technology for the state's new psychiatric treatment and recovery facility. With the additional staff the hospital made major gains in meeting the federal requirement to provide 20 hours a week of active psychiatric treatment. The investments in the hospital support a new treatment model that will help patients recover in a timely manner and ease transitions back into their communities. However, it will not be possible to operate the state hospital and support treatment without the resources to support the electronic medical record and related hospital management systems.

It is with the goal of helping Oregonians recover from addictions and mental illnesses that I respectfully submit this AMH budget.



Richard L. Harris
OHA Assistant Director for Addictions and Mental Health Services

Mission

The mission of AMH is to assist Oregonians to achieve optimum physical, mental and social well being by providing access to health, mental health and addiction services and supports, to meet the needs of adults and children to live, be educated, work and participate in their communities.

The mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to accomplish the following goals:

- Improve the lifelong health of all Oregonians;
- Improve the quality of life for the people served;
- Increase the availability, utilization and quality of community-based, integrated health care services;
- Reduce the overall health care and societal costs of mental health and addiction through appropriate system investments;
- Increase the effectiveness of the integrated health care delivery system;
- Increase the involvement of individuals and family members in all aspects of health care delivery and planning;
- Increase accountability of the health care system; and
- Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

Overview of AMH programs

AMH oversees public delivery of addictions prevention and treatment, gambling prevention and treatment, and child and adult mental health treatment for approximately 166,000 Oregonians annually.

Promoting key addictions and mental health treatment strategies, such as early intervention for young people, and using practices that are scientifically proven and effective improves outcomes for clients, their families, communities and Oregon society. Treatment programs save Oregonians millions of dollars annually by integrating people in recovery into the community and the workforce as contributors to society.

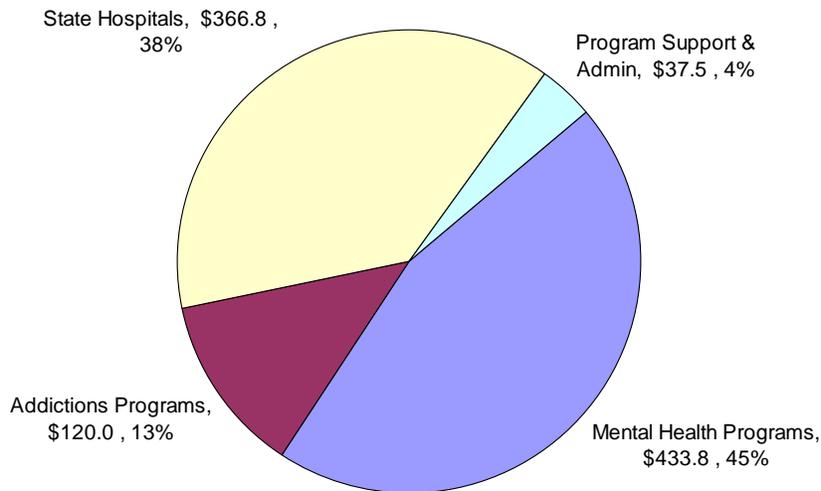
Addictions prevention and treatment and mental health treatment are delivered through county-based systems of care in which services may be delivered by nonprofit organizations employing psychiatrists and psychologists; drug, alcohol

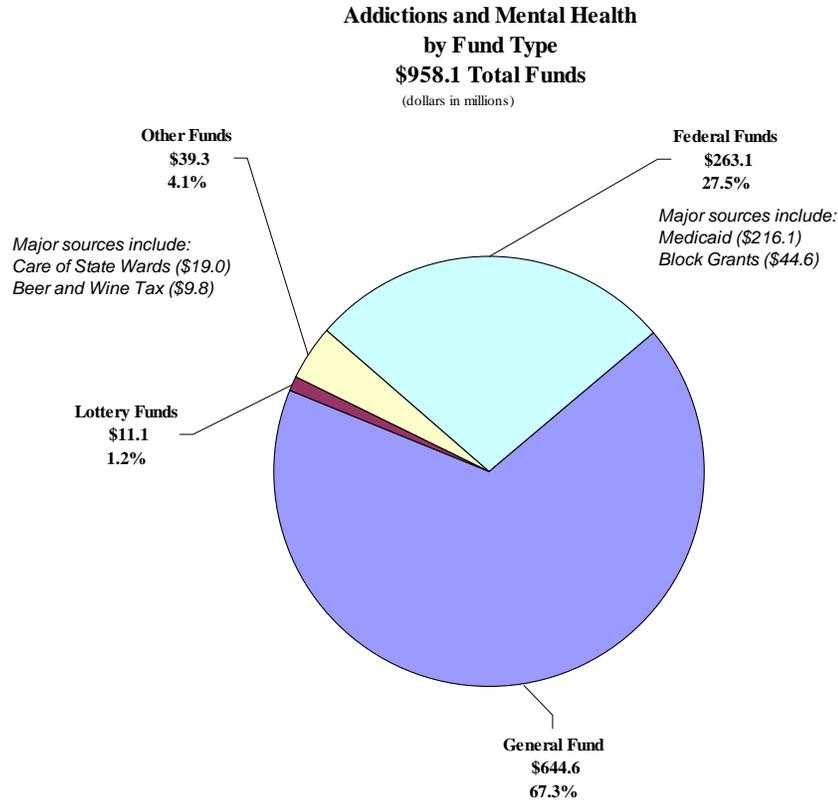
and mental health counselors; group home operators; local hospitals and clinics; peer recovery support specialists; and home health care providers.

As AMH meets its goals they make significant contributions to the OHA mission of improving the lifelong health of all Oregonians; increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the costs of care so it is affordable to everyone.

Budget charts

**Addictions and Mental Health
by Fund Type
\$958.1 Total Funds**
(dollars in millions)





Alcohol and drug prevention

Alcohol and drug prevention services are designed to promote healthy choices by Oregonians who are tempted to use drugs or to drink inappropriately. During 2009, 97,800 people received broad-based prevention services; 23,287 people received selected prevention services; and 3,216 received targeted prevention services because of known risk factors.

In 2009 the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Oregon Department of Human Services, Addictions and Mental Health division (AMH) a five-year Strategic Prevention Framework State Incentive Grant (SPF SIG). The SPF SIG supports an array of activities for delivering effective substance abuse prevention services and reducing substance abuse problems. The grant is \$2.1 million per year.

Alcohol and drug treatment

Alcohol and drug treatment services assist people in recovering from addictive behaviors. People in recovery improve their functioning in society and at work, do a better job parenting their children, and stop committing crimes. Their health

improves, which reduces health care costs, including the cost of expensive emergency room visits. During 2009, 54,108 Oregonians received publicly funded alcohol and drug treatment.

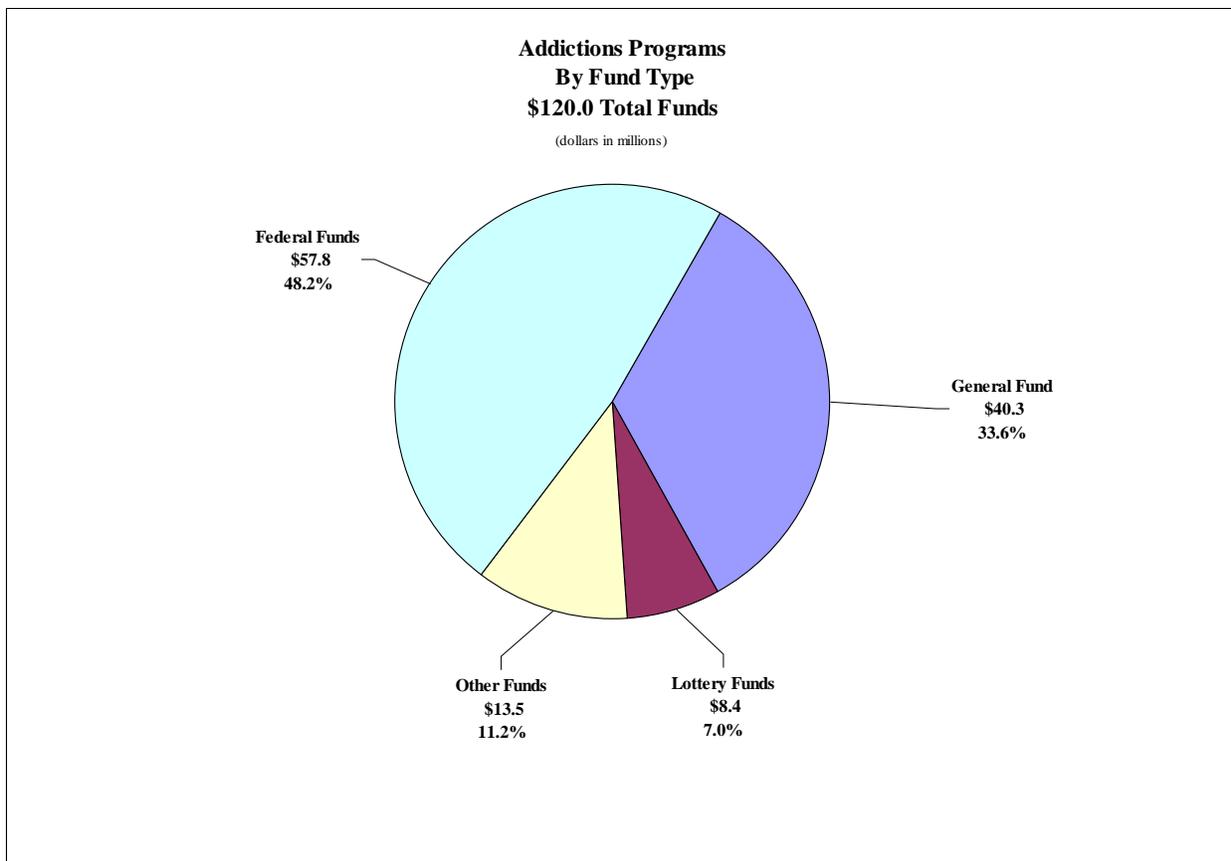
Recent alcohol and drug treatment successes include:

- Oregon participated in a national clinical trial research project funded by the National Institute on Drug Abuse designed to evaluate the cost effectiveness of field-tested process improvement strategies for addiction treatment providers. This project, known as the NIATx 200 Study, involves 200 provider organizations across five states — Massachusetts, Michigan, New York, Oregon and Washington — including 31 Oregon providers.
- Several Oregon providers experienced positive outcomes as a result of NIATx 200 study. For example, LifeWorks Northwest of Hillsboro created changes that increased client retention, almost doubled their revenue for contract services, and increased their fee-for-service revenue from the previous year. Emergence Addiction and Behavioral Therapies of Eugene decreased the wait-time for intake appointments by half (six days versus 12 days), while decreasing no show rates by 10 percent. BestCare Treatment Services increased admissions and expects a 60 percent increase in revenue as a result.
 - In September of 2010, Oregon Health Authority, Addictions and Mental Health division was awarded a \$13 million, four-year competitive grant called Access to Recovery. This major federal initiative is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Oregon's Access to Recovery program (OR-ATR) will be piloted in five counties: Multnomah, Lane, Umatilla, Douglas and Jackson. OR-ATR is a person-centered, community-based alcohol and drug recovery program involving clinical treatment, faith-based support, and other recovery support services.
- AMH implemented performance-contracting and strengthened performance management methods to promote improved clinical and system outcomes for services to parents who are at risk or involved in the child welfare system. This initiative was funded by the 2007 Legislature. More than 1,800 children have been reunited with parents who accessed services and achieved recovery, representing a cost-offset to the foster care system of \$1.7 million per month.

Problem gambling prevention and treatment

Problem gambling treatment and prevention services prevent people from becoming addicted to gambling and help them recover if they are addicted. People in recovery find or maintain jobs, repair family relationships and stop committing crimes. During 2009, 2,240 people used the professionally staffed Problem Gambling Helpline; problem gambling treatment services were delivered to 1,756 people in outpatient services; 331 family members were served as outpatients; 83 people received residential services; and 29 people received respite care services. In 2008-09, state and regional efforts exposed 2.1 million Oregonians to problem gambling prevention information.

Budget reductions have limited efforts to staff and implement strategic plans for the Latino Advisory Group and Asian-American Advisory Group. The focus has been on keeping infrastructure in place and functioning with minimal support. A pilot effort with Oregon Tribes also has been on hold due to lack of funding.

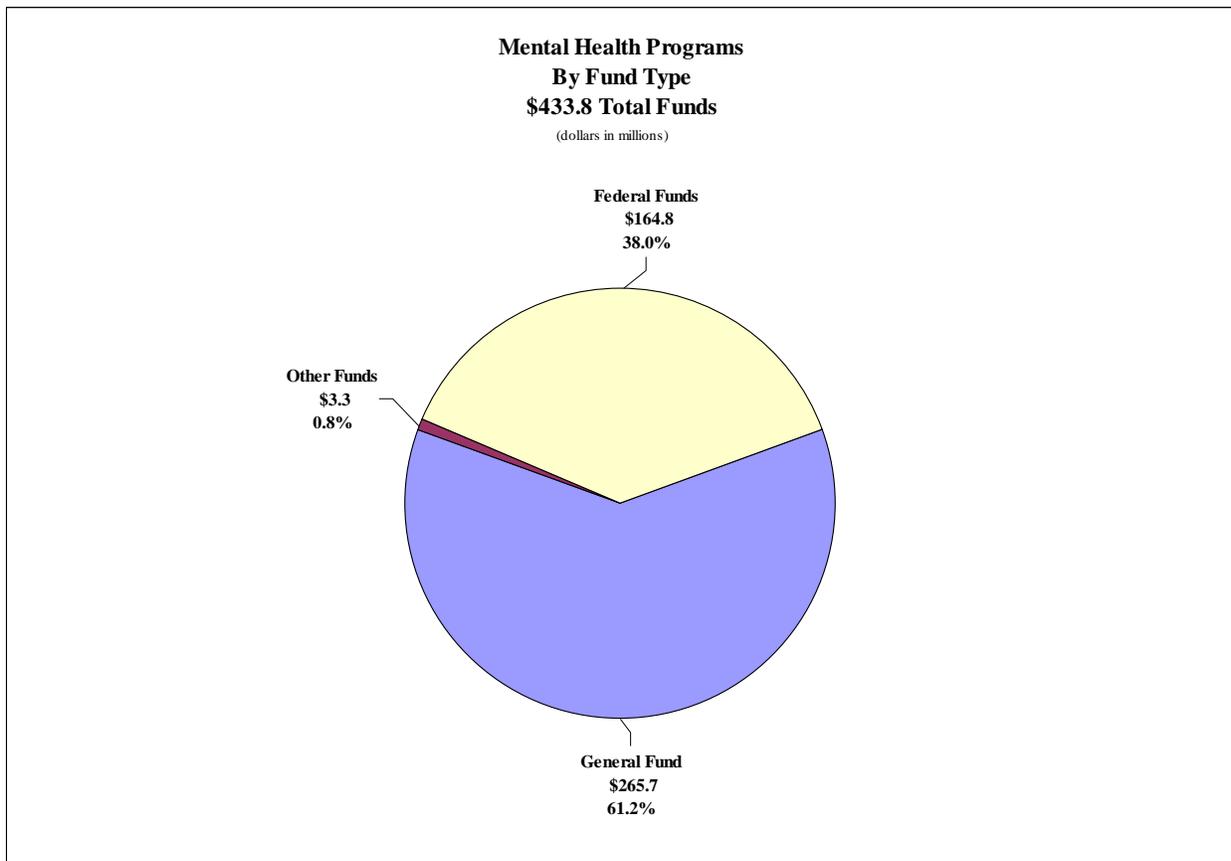


Community mental health services

Clients include indigent adults with serious mental illness who are a danger to themselves or others, and children with serious emotional disorders in danger of being removed from their homes due to those disorders. AMH contracts with community mental health programs for services such as acute in-patient and residential treatment, adult foster care, outpatient therapy, supports for successful community living, medications, case management, housing assistance, employment, education and social support. During 2009, 72,209 adults and 33,243 children received these services.

Accomplishments include:

- Sustaining early psychosis services in 13 counties to engage young people at their first psychotic episode and provide treatment and supports to help them avoid the disabling effects of major illness; and
- Establishing programs to divert people with mental illness from inappropriate jail stays.

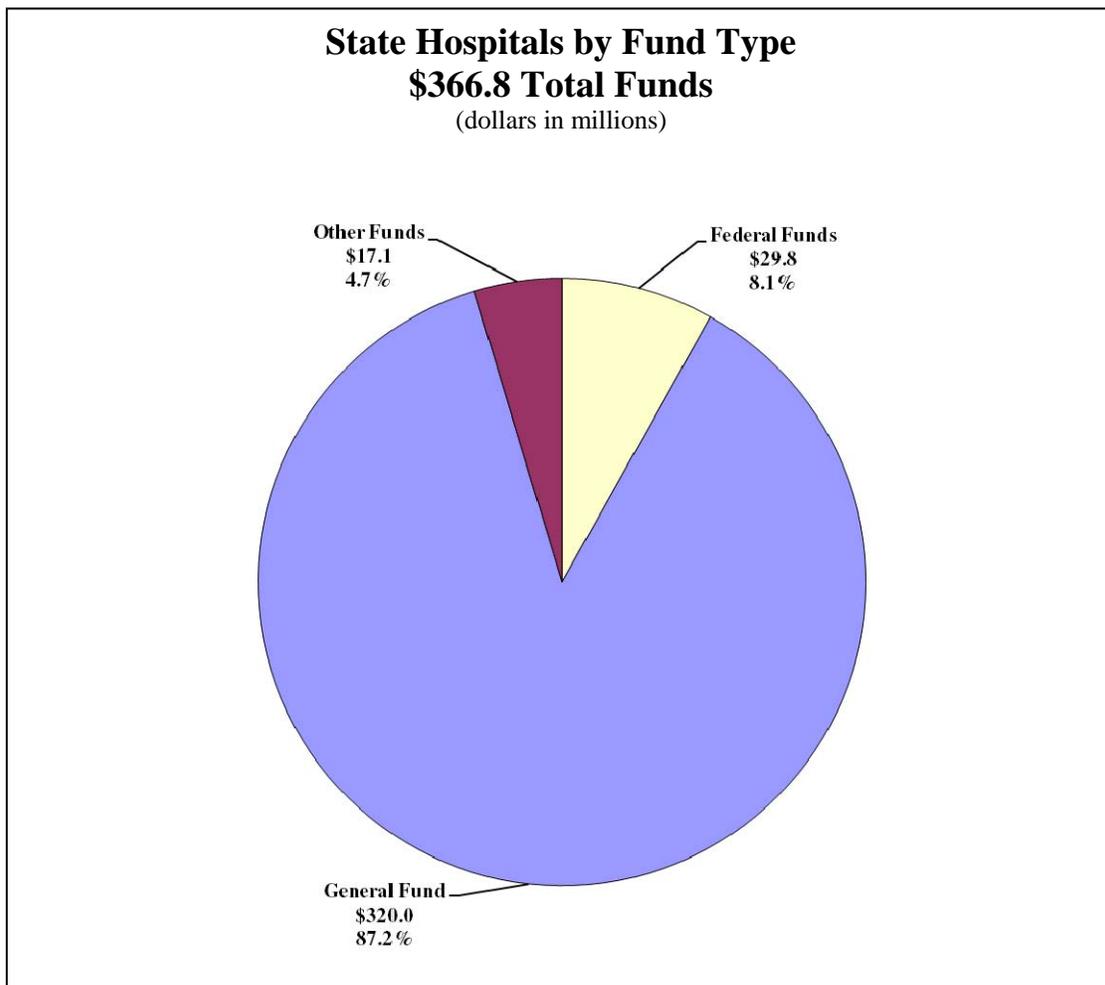


State-delivered community-based secure residential treatment programs

In order to reduce the need for institutional services for individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB) and not easily discharged from Oregon State Hospital, the first state-delivered 16-bed Secure Residential Treatment Facility opened in January 2009. A full range of counseling, medication, skills training and supports are provided to assist people in making progress toward recovery.

State hospital services

Adults in need of long-term psychiatric treatment for severe and persistent mental illness who are civilly or criminally committed to OHA receive treatment at Oregon State Hospital in Salem and Portland and the Blue Mountain Recovery Center in Pendleton. A total of 1,400 people received treatment during 2009.



Recent OSH successes include:

- Earning full certification from CMS as compliant with the federal requirements for hospitals participating in Medicare and Medicaid programs;
- Clearing the last of 19 Requirements for Improvement from the Joint Commission, thereby achieving full accreditation; and
- Using Lean rapid process improvement techniques to improve the process for hiring registered nurses and reducing the vacancy rate from 21 percent to 0 for the last three quarters.

Continuous Improvement Initiative

The structure and discipline inherent in structured continuous improvement will support AMH in detailed analyses of critical areas of the system and ensure that measurable benchmarks and goals are established. These techniques will keep the focus on required changes and the benefits that accrue in terms of cost savings, improvements for people, improvement in quality of work, and improvements in services.

Environmental scan

To ensure that individuals with addictions and mental health issues live safely and independently in their communities, AMH works closely with the Oregon Legislature, partners and stakeholders to identify challenges facing the division, opportunities for addressing those challenges, and proposed actions.

Challenges

The challenges the division faces are a result of many years of limited funding, a growing forensic population and inadequate community resources. These challenges include:

- The need for a new treatment and recovery facility to replace the state's obsolete and inefficient paper-based system for tracking patient mental health care with an electronic medical record that lists the care, treatment and medications for every patient. The Governor's Balanced Budget does not support the implementation of a modern hospital data system based on an electronic medical record, the Behavioral Health Integration Project (BHIP).
- Hiring and training sufficient staff within the state hospital system to provide active treatment and keep patients and staff safe.
- Implementing new programs and changing the culture to achieve major and lasting changes at the state hospital.

- The need to restructure the management of the existing community-based residential system to determine appropriate lengths of stay; equitably distribute resources and responsibilities for programs serving people under PSRB; and establish additional supportive housing.
- Lack of an Office of Consumer Affairs for users of mental health services.
- Lack of support for peer- or family-delivered addictions and mental health recovery services.
- Community programs for addictions and mental health that meet less than half the need for services with available funding.
- Insufficient payment rates for community residential providers for all levels of care.
- Potential lawsuits from advocates for failure to place people in mental health treatment in the least restrictive setting.
- Continued scrutiny from the US Department of Justice and the threat of court action if improvements are not made at the state hospital.
- Providers failing financially or withdrawing from the public system due to low reimbursement for services provided.
- Lack of sufficient alcohol- and drug-free housing to support recovery.
- Lack of sufficient focus on the wellness of people receiving publicly funded addictions and mental health services.
- A better understanding of the changes that are needed to ensure that people who enter the mental health system through the courts as a result of the individual's inability to aid and assist in their defense are dealt with at the most appropriate level of care rather than automatically being sent to the state hospital.

Restrictive funding sources

Children with mental and emotional disorders and their families confront numerous systems to find the assistance they require. A family working with the mental health system may need to work with multiple providers within the system, as well as the school, juvenile justice or the child welfare system. In order to meet the needs of these families and children, resources from each of these systems must be integrated to provide the full array of services and supports to achieve the best outcomes for the child. Each agency has multiple funding sources, many of them federal, all with restrictions and requirements on the use of the funds. This problem is often referred to as "funding silos."

The implementation of HB 2144 passed by the 2009 Legislature (the Governor's Statewide Wraparound Initiative) will result in the development and implementation of specific operational, administrative and fiscal strategies to integrate services and

supports across child-serving systems. The goal is a pooled funding approach that will maximize the systems' limited revenue sources.

Funding silos also make it more complicated to treat adults with either substance abuse or mental health disorders who are involved in multiple systems such as child welfare or criminal justice. Funding is tied to programs or categories of eligibility rather than being focused on the individual's need to recover and the goal of using fewer public services. These funding arrangements make it complicated to treat people with both substance abuse and mental health disorders.

Need to integrate services

People with addictions and mental health disorders suffer from poor health and a lack of access to medical and dental care. In order to improve outcomes through earlier identification of these disorders and to improve the overall wellness of publicly-funded clients, it will be important to fully integrate addictions and mental health services and physical health care. In doing this work, it is important to preserve and improve access to appropriate care, to protect the rights of people with these disorders to participate in the planning of their services as well as planning and governance of the service delivery system.

Outdated and inflexible state data system

AMH is using a mainframe data system designed and initiated in the late 1970s. The system is inflexible, does not easily accommodate the addition of new services or provide information necessary to track outcomes, and is staff-intensive to support at the state and local levels. It does not interface with the electronic medical records used by some community programs, requiring additional work by counties to provide the state with critical demographic information and data used to monitor treatment programs.

Lack of support for training programs

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

Lack of competitive wages

The service rates for alcohol and drug treatment and mental health treatment, especially 24-hour care, are too low to support reasonable wages for staff who work with the most vulnerable clients with the most intense treatment needs. As a result, the least experienced members of the workforce are working with the most ill or fragile populations. At times, residential treatment staff members providing direct care are, like their clients, eligible for subsidized housing and food stamps. These staff members have very limited benefits, including health care. Recently, one of the executive directors of an adolescent psychiatric residential program noted that staff members are leaving the agency to work in the fast food industry for higher wages.

As a result, turnover is high. This disrupts treatment for the clients, especially for children and adolescents in residential care. This revolving door increases the training costs for the programs, further eroding the financial viability of the providers. These problems result in reduced quality of care, longer lengths of stay in intensive and expensive services, and less effective treatment for those who need the most effective treatment.

Stigma

Because of the social stigma associated with mental illness and substance use disorders, people are reluctant to admit they have a problem with alcohol or drugs, or that they are experiencing symptoms of mental illness. . Failure to seek help early in the course of these disorders creates more social disruption; people often wait until their symptoms create significant problems that result in their arrest or their being forced into treatment against their will.

Response to critical challenges

The current economic situation caused a decline in revenues and a related budget shortfall. The magnitude of the situation requires that AMH leadership rethink the publicly-funded prevention and treatment system. This includes the opportunity to organize services and financing in a manner that provides greater accountability and improved access to higher quality services delivered to the right person in the right amount for the right amount of time.

Opportunities

The continuation of funding for the construction of the first new psychiatric treatment and recovery facility in more than 50 years is requested in this budget. There also is a request for funding for the additional staff, equipment and supports needed to operate the new hospital, and allow progress toward meeting the federally

mandated minimum of 20 hours of active psychiatric treatment per person per week. These resources will help patients recover and gain the skills needed for successful community living. The new hospital is designed with patients in mind, including nutritious food, access to education, assistance in reaching personal goals, and access to open outdoor space and fresh air in a secure, nurturing environment.

Unmet need

The division, in partnership with consumers, counties, providers and other stakeholders, developed investment strategy documents that provide a blueprint for investments to meet the needs of Oregonians with substance use disorders and mental illness. The current economic climate makes it unlikely that there will be substantial investments in community-based services in the next two years. As a result of not addressing these needs, many individuals will not receive vital services, with the end result of increased crime, homelessness and premature death.

Many of Oregon's societal and health problems, such as lost productivity and escalating law enforcement and medical costs, are linked to abuse of alcohol and other drugs. During 2008, more than 150 Oregonians helped create an Alcohol and Drug Strategic Plan, which addresses these serious health and safety issues. This strategic plan highlights the unmet need for addictions prevention and treatment services in Oregon. Specific recommendations include increased funding for:

- Family-based treatment for 3,500 youth with addictive disorders or co-occurring addictive and mental health disorders;
- Treatment for 400 adults with co-occurring addictive and mental health disorders;
- Screening, brief intervention and treatment for 2,000 returning veterans and uninsured workers;
- Outpatient addictions treatment for 5,500 individuals from under-served populations including ethnic minorities, individuals in rural and frontier communities, youth and women;
- Specialized outpatient treatment for 3,333 medium- and high-risk addicted offenders on probation or post-prison supervision and participants in drug treatment courts; and
- Rate increases for both adult and youth residential services to support sustainability and quality improvement.

Individuals with untreated mental illness also cause societal and health problems such as increases in law enforcement and emergency hospital costs, premature death and family breakdowns. During 2007 and 2008, the Community Services Workgroup met to design a road map that would ensure a stable, appropriate system of timely treatment services for adults with mental illness and minimize the number who will require hospital-level care. These investments are essential to support the size of the new psychiatric treatment and recovery facility scheduled to open in 2011. Specific recommendations include increased funding for:

- Expansion of early assessment and mental health services for young adults to prevent more severe and chronic mental illness;
- Increasing crisis services to meet 50 percent of the unmet need;
- Increasing regional acute care capacity by 10,036 bed days;
- Adding additional Assertive Community Treatment (ACT) teams to provide services to 300 additional adults, and increasing funding to serve 25 percent of unmet case management need, affecting 4,464 persons;
- Providing supported employment services to meet 50 percent of the need, affecting 3,875 persons;
- Providing 50 percent of the need for forensic intensive case management for 515 persons as an alternative to involvement in the criminal justice system;
- Providing indigent funding for 25 community detox beds for persons with co-occurring disorders;
- Providing safe, affordable and permanent housing for 5,420 persons, including monthly subsidies and supportive housing, to meet 50 percent of the need;
- Establishing 33 mental health specialists for transition-aged youth; and
- Overseeing contractual implementation of all of the above.

The division has repeatedly sought resources to establish peer recovery support services: two offices for Consumer Affairs; peer-delivered services; family navigator programs to assist families of children with serious emotional disorders find and advocate for the services their children need; peer mentoring for child welfare families in recovery; addictions recovery center; and expansion of Oregon Recovery Homes.

2009-11 accomplishments

Oregon Access to Recovery (OR-ATR)

In September of 2010 Oregon Health Authority, Addictions and Mental Health division was awarded a \$13 million, four-year competitive grant called Access to

Recovery. This major federal initiative is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Oregon's Access to Recovery program (OR-ATR) will be piloted in five counties: Multnomah, Lane, Umatilla, Douglas and Jackson. OR-ATR is a person-centered, community-based alcohol and drug recovery program involving clinical treatment, faith-based support, and other recovery support services. OR-ATR is designed to increase access to addiction recovery, emphasizing free participant choice of recovery support and clinical service providers; extensive service linkages with faith based and community-based organizations; and funding services through an electronic voucher management system. OR-ATR will serve between 1,319 and 1,517 clients in the first year and more than 9,000 during the course of the four-year initiative. Oregon's project focuses on three priority populations:

- Veterans, particularly returning soldiers from Afghanistan and Iraq;
- Parents involved in the child welfare system who have accessed treatment through ITRS; and
- Inmates transitioning to communities from correctional institutions who have addiction disorders and have either accessed treatment inside the walls or who need both clinical treatment and recovery support services upon release from prison.

Alcohol and drug policy

AMH initiated the Alcohol and Drug Policy Commission established by HB 3353 (2009) and supported the activities until the executive director was hired. The Commission reviewed prevention and treatment policy, financing, and management of services across all of the state agencies involved in substance abuse treatment and prevention. The Commission will report to the 2011 Legislature and make recommendations for changes to improve the coordination and focus of publicly funded services to prevent and treat substance abuse disorders.

Impaired health professionals

AMH established a consolidated and independent impaired health professionals program as defined in HB 2345-B passed by the 2009 Legislature. The program monitors the substance use disorder and mental health treatment of impaired health professionals who are either self-referred or diverted to treatment by their licensing boards in lieu of disciplinary action. The goal of this program is to promote the health and safety of patients treated by medical professionals in Oregon.

Strategic prevention framework: system improvement grant

AMH obtained five years of federal funding to support major improvements in defining a common framework for assessing state and local needs and priorities for prevention services, and making data-driven decisions in selecting the evidence-based practices that are to be delivered to the right audiences. This will mobilize communities and tribes to implement programs that will improve prevention outcomes both locally and statewide. The grant funds assessment of 10 communities, including at least one tribal community and representative rural communities. The results will inform increased investments in prevention services in the future.

Children's Wraparound Services

AMH worked with DMAP and CAF to implement phase I of the new method for delivering services to children with behavioral health needs who participate in multiple state agencies. This initiative begins to implement the requirements of HB 2144 passed by the 2009 Legislature. Approximately 385 children in eight communities will be served in a coordinated fashion that blends funding. Children who are part of the initiative have either been in the child welfare system for at least a year and experienced at least four moves or came into the system requiring the most intensive level of behavioral health services. The learning from this phase will inform the further implementation of the Wraparound evidence-based practice as required by statute.

Integrated services and management demonstration

AMH worked with legislative leadership to respond to a budget note and develop a system change effort to integrate the management and service model including health, mental health and addictions services. AMH has been working with local demonstration sites to test different methods of integrating management, financing and services. The goal is to discover system improvements that will yield improved health and behavioral health outcomes and methods of containing costs.

Adult Mental Health Initiative

AMH worked with the nine regional mental health organizations and other key stakeholders to create major systems change in the adult mental health system in Oregon. A key strategy under AMHI is to transfer the full responsibility for managing residential services to the MHOs. Phase I started this process on September 1, 2010 by transferring the referral process between levels of care from AMH to the MHOs, including referrals from acute care, state hospitals, or between different facilities. AMH's goal in partnering with MHOs on these responsibilities is to improve

coordination and community responsibility for adult mental health services at all levels of care in the system. The system also is designed to increase the availability and quality of individualized community-based services and supports so adults with mental illness are served in the least restrictive environment appropriate for their needs and desires. AMHI is expected to help 331 individuals transition to appropriate levels of care from September 1, 2010 through June 30, 2011. MHOs will be working with more than 1,500 individuals through AMHI.

Oregon State Hospital improvements

OSH used the technology and skills learned as part of the Transformation project to transform hiring processes for critical health care personnel. As a result, registered nurses and certified nursing assistants are hired in a timely process and the vacancy rate has been reduced to near zero. The same rapid process improvement technology was applied to the hiring of critical direct care certified nursing assistant staff. There is more to do to improve the quality of patient care in addition to hiring direct care staff. The hospital recently hired a new hospital superintendent, experienced in system change. Work is needed to take quality of patient care beyond improved compliance with the requirements of accreditation and certification bodies and their policies and procedures.

Young adults in transition

AMH embarked on an initiative for young adults age 14 to 25 to promote access to a system of services and supports that are specifically directed and developmentally appropriate, coordinated and effective. This initiative is bridging the adult and children's systems through the development of services and supports that minimize the dramatic drop off in service utilization that occurs as someone reaches the age of 18. In 2010, a nationally unique program opened that provides active psychiatric treatment and independent living skills for 12 young adults as an alternative to the Oregon State Hospital. An additional supportive treatment program is scheduled to open in April 2011 bringing the total number of beds throughout the state to 27. The goal is to provide young adults with appropriate services and supports so they assist in the management of their illness, complete their education, and gain employment and other life skills. Through achieving these goals young adults are set on a trajectory towards living independently and managing their lives free from the need of long term care.

Lean Daily Management System (LDMS)

AMH has implemented huddles and visual display boards and the other requirements of LDMS in 100 percent of the units within the office. Planning is

underway at OSH to utilize LDMS in improving the quality of the treatment provided to the patients, streamline existing processes and create new processes as the hospital staff moves into the new facilities.

Housing

During 2009-11, AMH initiated or completed several residential development projects to transition people from institutional settings and homelessness. AMH provided funding for a total of 26 projects in 12 counties, which created 224 beds for people transitioning from OSH through the residential care system. Of that number, 17 facility-based programs were completed, providing 101 beds for people transitioning through the residential care system. Two other projects were initiated using Alcohol and Drug Free Housing Funds to serve 20 additional individuals in recovery from alcohol and drug addiction. AMH invested \$600,000 in interest earnings from the Community Mental Health Housing Fund toward the development of housing valued at \$29 million, for 86 residents with mental illness transitioning to supportive housing. AMH will award \$330,000 in the last half of the biennium for the development of supportive housing. AMH will award approximately \$219,191 in Mental Health Services Funds to facility-based programs to address licensing health and safety issues. In addition, Oregon Recovery Homes outreach coordinators have worked hard to reduce the number of peer-run Oxford Houses closures due to the recession. Since July 1, 2009, 15 Oxford Houses have closed and 15 have opened for a net zero increase in Oxford Houses.

Evidence-based practices

The addictions and mental health treatment systems met and exceeded the statutory requirements (ORS 182.525) to deliver evidence-based practices with at least 75 percent of the 2009-11 budget. There are more than 150 approved practices from which providers may choose. AMH currently is reviewing the fidelity with which providers are delivering the approved practices. AMH worked with consumers, people in recovery, family members, community mental health program directors, providers, mental health organization directors, higher education, and private research firms to develop procedures for evaluating and approving practices, contract language, fidelity monitoring and readiness assessment. The division continues to work with stakeholders to refine the application of evidence-based practices.

Reductions proposed by this budget

Governor's Balanced Budget

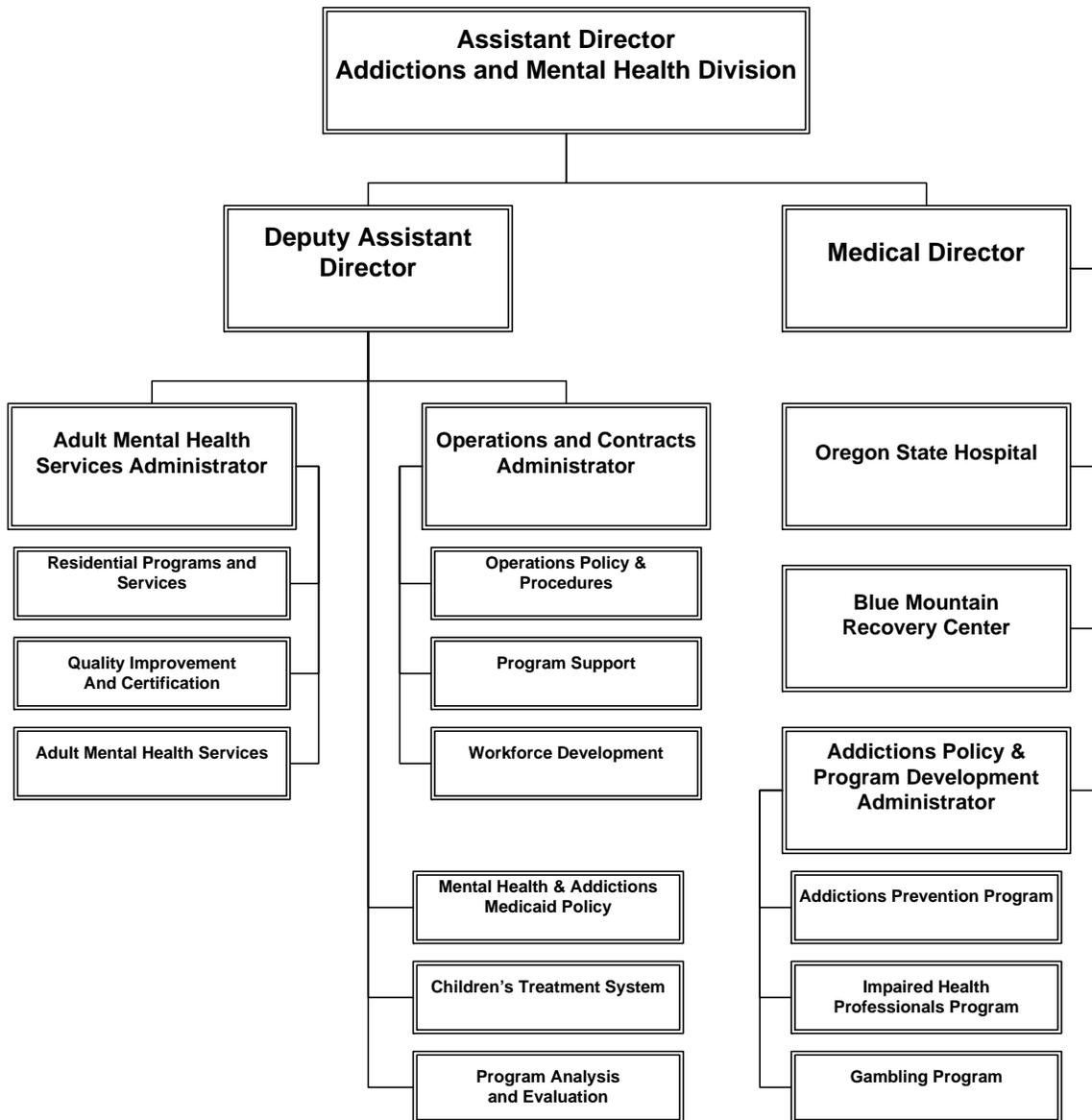
The Governor's Balanced Budget makes modest reductions in benefits delivered by the community-based treatment systems and more substantial targeted administrative reductions in the Oregon State Hospital budget. These are in addition to the continuation of the 2009-11 reductions required to balance the budget and the lack of a cost-of-living increase.

As a result of these reductions, the state will not open two state delivered secure residential treatment facilities. The Medicaid Personal Care 20 program will be eliminated. This program supports adults with mental illness in hiring personal care providers who deliver up to 20 hours per week of assistance with activities such as shopping and cleaning and managing medications and diet. These modest supports allow people with severe persistent mental illness to live more independently.

The GBB also assumes a savings in community mental health provider administrative costs.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the US Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. The package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

Organizational structure



The Addictions and Mental Health division used the broad policy objectives listed below to prioritize programs that represent AMH's contribution to the OHA mission of helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care. However, it must be noted that AMH programs, as well as Department of Human Services programs such as vocational rehabilitation, self sufficiency and health care, are interdependent and together help provide solutions to the complex issues facing Oregon's most vulnerable citizens.

Policy objectives

- Prevent and reduce the negative effects of alcohol, other drugs, gambling addiction and mental health disorders.
- Promote recovery and self-sufficiency through culturally competent, integrated, evidence-based treatments of addictions, pathological gambling, mental illness and emotional disorders.
- Whenever possible, ensure the delivery of services through a managed community-based system that is accountable and responsive to the needs of clients and their families.

Oregon Health Authority																			Agency Number:	44300
Addictions and Mental Health																				
2011-2013 Biennium																				
Department-Wide Priorities for 2011-13 Biennium																				
	1	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19	20
Priority (ranked with highest priority first)	Dept. (cluster)	Program/Div (Orbits B Level)	(Orbits A Level Title)	(Orbits Sub-A Level Title)	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, F, or D)	Comments
4	HS	Addictions and Mental Health Program	Alcohol and Drug Treatment		Alcohol and drug treatment programs provide an array of services tailored to the clients' needs. These include: assessment; detoxification; individual, group and family counseling; residential treatment; and medications.	Completion of alcohol and drug treatment, Alcohol and drug treatment effectiveness: Employment, Child reunification, School performance	12	41,345,343		12,683,793		42,768,723		\$ 96,797,859			N	Y	S,F	
5	HS	Addictions and Mental Health Program	Community Mental Health	Child Mental Health Services	Community programs provide a range of services tailored to the consumer's needs, including community/outpatient intervention and therapy, case management, residential and foster care, supported education, acute hospital care, and crisis and pre-commitment services. The community also provides supervision and treatment for persons under the jurisdiction of the Psychiatric Security Review Board.	Mental health client level of functioning, Child mental health services	12	17,006,015		0		7,037,519		\$ 24,043,534			N	Y	S,F	
6	HS	Addictions and Mental Health Program	Community Mental Health	Adult Mental Health Services	Community programs provide a range of services tailored to the consumer's needs, including community or outpatient intervention and therapy, case management, child and adolescent day treatment, residential and foster care, supported education, acute hospital care, and crisis and pre-commitment services. The community also provides supervision and treatment for persons under the jurisdiction of the Psychiatric Security Review Board.	Mental health client level of functioning, Adult mental health services	12	282,796,282		3,423,938		177,705,265		\$ 463,925,485			N	Y	S,F	
7	HS	Addictions and Mental Health Program	Alcohol and Drug Prevention		Alcohol and drug prevention programs target people who have not been diagnosed with a substance abuse disorder. Services may target an entire population, specific groups of people who are at above-average risk of involvement with alcohol and other drugs, or specific individuals who show signs of involvement with alcohol or other drugs, but who have not been diagnosed with abuse or dependence.	Completion of alcohol & drug treatment, 8th grader use of alcohol, 8th grader use of illicit drugs	12	41,159		1,185,889		11,050,816		\$ 12,277,864			N	Y	S,F	
13	HS	Addictions and Mental Health Program	Oregon State Hospital		The State Hospitals, located in Salem and Portland, provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed to the Department as a danger to themselves or others, including people who have been found guilty except for insanity.	OSH restraint rate, OSH length of stay	12	354,962,360		14,229,141		33,360,864		\$ 402,552,365	2,041	2,038.33	Y	Y	S,F	
14	HS	Addictions and Mental Health Program	Blue Mountain Recovery Center		The Blue Mountain Recovery Center, located in Pendleton, provides 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed to the Department as a danger to themselves or others, including people who have been found guilty except for insanity.		12	22,051,886		3,852,119		1,495,502		\$ 27,399,507	141	131.36	N	Y	S,F	
15	HS	Addictions and Mental Health Program	State Delivered SRTF's		The state operated 16-bed facilities permit the safe movement of persons from the State Hospital(s) into the community that current providers choose not to serve.		12	13,472,088		0		7,047,061		\$ 20,519,149	108	108.00	Y	N	S,F	
16	HS	Addictions and Mental Health Program	Gambling Treatment and Prevention		Gambling treatment and prevention programs provide an array of services tailored to the clients' needs. These include: assessment; individual, group and family counseling; and residential treatment.	Gambling treatment effectiveness	12	0	8,628,573	0		0		\$ 8,628,573			N	N	S	
18	HS	AMH Program Support & Administration	AMH Program Support & Admin					21,290,809	2,823,986	5,693,142		10,349,739		\$ 40,157,676	137	133.97				

Oregon Health Authority																				
Addictions and Mental Health																			Agency Number: 44300	
2011-2013 Biennium																				
Department-Wide Priorities for 2011-13 Biennium																				
	1	2	3		4	5	6	7	9	10	11	12	13	14	15	16	17	18	19	20
Priority (ranked with highest priority first)	Dept. (cluster)	Program/Div (Orbits B Level)	(Orbits A Level Title)	(Orbits Sub-A Level Title)	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program- Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, F, or D)	Comments
								752,965,942	11,452,559	41,068,022	-	290,815,489	-	1,096,302,012	2,427	2,411.66				

In prioritizing its programs, the department continued to use the basic criteria used in prior prioritizations that includes: fulfillment of mandates, long term implications, number of clients served, level of need of those served, and degree of Federal financial participation. In addition to these criteria, the department also considered:

1. Maintaining our current investment - continued operation of basic programs.
2. The capacity to provide basic services statewide - expanding coverage to more vulnerable populations.
3. Prevention - preventing higher costs downstream - front-end services (including non-Medicaid programs).
4. Technological advances to better serve clients and providers - addressing critical information needs.
5. Maintaining protection - keeping vulnerable populations (kids, seniors, disabled, etc) safe.
6. Adequate administrative capacity - linking administrative support to program priorities.
7. Improved health care - improving access for all Oregonians.
8. Lower priority for new initiatives to our current portfolio.

While these criteria were considered in prioritization, the wide array of programs that DHS provides and the diverse populations served make application of any set of criteria difficult.

- 7. Primary Purpose Program/Activity Exists**
- 1 Civil Justice
 - 2 Community Development
 - 3 Consumer Protection
 - 4 Administrative Function
 - 5 Criminal Justice
 - 6 Economic Development
 - 7 Education and Skill Development
 - 8 Emergency Services
 - 9 Environmental Protection
 - 10 Public Health
 - 11 Recreation, Heritage, or Cultural
 - 12 Social Support

- 19. Legal Requirement Code**
- C Constitutional
 - F Federal
 - D Debt Service
 - S State

2011-13 Governor's Balanced Budget

	<u>GF/LF</u>	<u>OF</u>	<u>FF</u>	<u>TF</u>
2009-11 LAB (Dec 2010 E-Board)	636.74	36.09	283.19	956.02
Less: 2009-11 Governor's Allotment Reductions	<u>(42.00)</u>	<u>-</u>	<u>-</u>	<u>(42.00)</u>
2009-11 Spending level	594.74	36.09	283.19	914.02
One-time money	26.29	-	(26.29)	-
Caseload changes (at current rates)	<u>85.07</u>	<u>3.59</u>	<u>21.99</u>	<u>110.65</u>
Subtotal	706.10	39.68	278.89	1,024.67
Administrative/ Efficiency - OSH	(36.00)	-	(4.80)	(40.80)
Administrative/ Efficiency - CMH	(7.74)	(0.42)	(5.87)	(14.03)
Benefit Reduction	<u>(6.58)</u>	<u>-</u>	<u>(5.11)</u>	<u>(11.69)</u>
*2011-13 GBB	655.78	39.26	263.11	958.15

* Adjusted to correct errors in ORBITS system.

Integration of services

Under new leadership, the Addictions and Mental Health division (AMH) is initiating efforts to increase the integration of medical and behavioral health services, and is restructuring the delivery of adult mental health services to improve the efficient use of residential treatment. The purpose is to ensure people are served at the right level of care, for the right amount of time, and that risks, resources and incentives are aligned. These efforts are critical to meeting the needs of Oregonians with addiction or mental health disorders and will support the success of the state hospital. Improving the delivery and management of services is even more important in difficult economic times.

Alcohol and Drug Policy Commission

HB 3353 passed during the 2009 session establishing the Alcohol and Drug Policy Commission and abolishing the Governor's Council on Alcohol and Drug Abuse Programs. The Alcohol and Drug Policy Commission was staffed by AMH prior to hiring the executive director and is charged with developing a blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon. This includes a strategy for organizing, financing and delivering state-funded substance abuse prevention, addiction treatment and recovery services.

Impaired health professionals program

The 2009 Legislature passed HB 2345-B, which became effective July 1, 2010. HB 2345-B required AMH to establish a consolidated impaired health professionals program. This program monitors the substance use disorder and mental health treatment of impaired health professionals who are either self-referred or diverted to the program by their licensing boards in lieu of disciplinary action. AMH worked closely with the health licensing boards to develop a consolidated program including a plan that transitioned participants who were participating in the separate programs on July 1, 2010.

Children's Statewide Wraparound

Implementation of HB 2144 (2009) used the department's transformation project management infrastructure as a cross division project between AMH and CAF. This project was implemented July 1, 2010 through three demonstration sites using the Oregon Health Plan mental health organization structure. High fidelity Wraparound planning process is being used to serve 300 children and their families through intensive care coordination and child and family team driven services and supports.

The children are in custody of DHS child welfare, have complex behavioral health needs and are involved in multiple child serving systems. Outcomes being tracked in this project include placement stability, caregiver support, cost of care, time in foster care, academic performance, legal involvement, and mental health.

Demonstration projects

AMH worked with legislators and stakeholders to develop a policy note directing AMH to test models of an integrated management and service delivery system through two or three local demonstration projects with willing communities. The goal is to work through local health, mental health and addictions treatment systems to increase the availability, access and quality of addictions and mental health services, improving health outcomes and access to primary care and decreasing the use of institutional care.

Acute care

AMH was directed by the Legislature through a policy note to work with local mental health authorities and stakeholders to develop an equitable formula and distribution method for regional acute psychiatric inpatient treatment funds for all Oregon counties, including a cost estimate for implementing a new methodology. AMH convened the workgroup and reported to the Legislature as directed in February 2010.

Critical needs and budget challenges

The addictions and mental health treatment systems have not been funded fully to meet the need for publicly funded treatment services. When untreated, these disorders reduce the ability of the Oregon Health Authority to achieve its mission and affect the demand on Department of Human Services divisions, other state agencies and local governments.

Addictions treatment — unmet needs

Many of Oregon's societal and health problems, such as lost productivity and escalating law enforcement, child welfare and medical costs, are linked to abuse of alcohol and other drugs. During 2008, more than 150 Oregonians helped create an Alcohol and Drug Strategic Plan, which addresses these serious health and safety issues. This strategic plan highlights the unmet need for addictions prevention and treatment services in Oregon. Oregon currently meets less than 20 percent of the need.

Mental health treatment — unmet needs

Individuals with untreated mental illness also cause societal and health problems such as increases in law enforcement and emergency hospital costs, premature death, and family breakdowns. During 2007 and 2008, the Community Services Workgroup met to design a road map that would ensure a stable, appropriate system of timely treatment services for adults with mental illness and minimize the number of individuals who require hospital-level care. These investments are essential to support the size of the new psychiatric treatment and recovery facilities.

Mandated treatment

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

Since July 1, 2007, AMH has provided on-demand treatment and support services to youth who are under the jurisdiction of the Juvenile Psychiatric Security Review Board. These youth, who have committed crimes and have been found responsible except for a serious mental condition, present substantial danger to others. The growth in the caseloads of these mandated groups is projected by DHS. The growth drives the demand for the most expensive levels of treatment in secure community settings or in the state hospital. AMH struggles with managing the admission and discharge of these groups due to external controlling factors created by the courts or the PSRB.

Oregon State Hospital

While there was substantial investment in OSH staffing in the 2009-11 budget, achieving appropriate staffing levels, delivering sufficient hours of active psychiatric treatment, and ensuring staff, patient and public safety will require an additional investment by the 2011 Legislature.

Federal policy and funding changes

Since late 2006 the state has been working to improve the quality of treatment, and staff and patient safety at OSH. This work began prior to the US Department of Justice (USDOJ) Civil Rights of Institutionalized Persons Act (CRIPA) review of conditions for patients at OSH. To guide this work, OSH created a Continuous Improvement Plan (CIP). Based on the report from the USDOJ and the recommendations in the CIP, the February 2008 Supplemental Session invested in the first of a series of staffing improvements at OSH. The state continues to work

with USDOJ to conclude their investigation without a federally monitored court settlement.

In mid-November 2010, Oregon received formal notice that USDOJ was expanding its investigation to include issues under the Americans with Disabilities Act (ADA) and the Olmstead Supreme Court decision. Their intention is to bring a team of experts to Oregon to examine the adequacy of community-based mental health services and the timeliness of discharge from the state hospital. The review is tentatively expected in February 2011. The USDOJ made an informal visit to Oregon and talked with community stakeholders and advocates.

Program and policy strategies responding to needs and challenges

In response to the unmet needs and the challenges described above, AMH in its 2011-13 Governor's Recommended Budget seeks to find new models of service delivery including integration of addictions, mental and physical health, and long-term care in order to manage access, increase early identification, improve quality of treatment, increase accountability for outcomes, and lower costs.

The construction of the first new psychiatric treatment and recovery facility in more than 50 years was funded in the 2009-11 budget. This budget funded additional staff, equipment and supports needed to operate the new hospital and allow progress toward meeting the federally mandated minimum of 20 hours of active psychiatric treatment per person per week. These resources will help patients recover and gain the skills needed for successful community living. The new hospital is designed with patients in mind, including healthy food, access to education, assistance in reaching personal goals, and access to open outdoor space and fresh air in a secure, nurturing environment.

The new treatment and recovery facility must replace the state's obsolete and inefficient paper-based system for tracking patient mental health care with an electronic medical record that lists the care, treatment and medications for every patient. This budget does not support the implementation of a modern electronic data system to manage hospital operations including the electronic medical record, the Behavioral Health Integration Project (BHIP).

Continuous improvement: Improving processes and reinvesting in workforce and service quality

AMH adopted the tools of continuous improvement and actively joined the department's pursuit of becoming world-class in health and human services delivery. Transforming our work is critical to improving access to high quality, cost effective services that will assist Oregonians with addiction and mental health disorders to achieve optimum physical, mental and social well being. AMH has allocated one project manager, and 12 Lean practitioners to work with AMH staff to implement changes in the central office and community-based treatment system; the Oregon State Hospital has two Lean leaders and a LDMS coach to assist with managing process improvements and quality improvement efforts.

AMH reviewed the original Transformation initiatives and added strategic initiatives that are improving access to services and flow through the system. These improvements and transformation efforts include community stakeholders and partners. The current AMH initiatives include:

- **AMH-01** — Improve and streamline transition for adults with long term mental illness from the state hospital to the appropriate level of community-based care.
- **AMH-03** — Apply Lean principles to streamline administrative processes at the Oregon State Hospital.
- **AMH-04** — Develop and implement standards for quality of care delivered by the Oregon State Hospital staff.
- **AMH-08** — Improve and streamline AMH central office processes.
- **AMH-09** — Implement Lean Daily Management System (LDMS) throughout the central office and state hospitals.
- **AMH-010** — Implement new policies and procedures to reduce payments for vacant beds in residential treatment programs.
- **AMH-011** — Expand the adoption of a single evidence-based process improvement model to improve access to and retention in alcohol and drug treatment.
- **AMH-012** — Improve the utilization of facility-based community treatment for adults with mental illness and increase the availability and use of supportive housing.
- **AMH-014** — Develop a new model of integrated treatment for the elderly or younger adults with deteriorating neurological disorders. While these people are eligible for services in the Seniors and People with Disabilities system, the current system is unable to successfully manage the behavioral manifestations of these disorders.

AMH is beginning to see positive results from the work of several of these initiatives.

As part of the initiative to transition adults into the level of care to meet their service and treatment needs, a standardized level of care assessment tool has been adopted. OSH has adopted and is using standardized ready-to-place criteria. The state and the county programs have agreed to a standardized method to hold counties accountable for the timely discharge of their residents from the state hospitals. These changes are expected to reduce the time that people who are ready for discharge from the hospital must wait for admission to community-based treatment and will reduce the number of people and the amount of time they wait in a psychiatric acute care unit for admission to the state hospital.

The initiative to improve processes at Oregon State Hospital is yielding major improvements in the hiring of registered nurses (RN) and certified nursing assistants (CNA), both critical types of employees for safe, effective quality treatment for people at the state hospital. The RN hiring process improvement resulted in nursing vacancies going from 21 percent at the point the initiative started to achieving five consecutive quarters with no nursing vacancies. The CNA hiring process improvement work resulted in 139 CNA hires since May 2010, exceeding the goal. They were able to reduce the average time to hire this position from 88 days to 34 days. This results in the reduction of overtime and reliance on contract staff and improves the quality of patient care.

The initiative to improve quality at OSH has improved the dietary consultation process by decreasing the average time for a request for a consult from 180 days to an average of 33 days. This improvement allows fewer dieticians to complete necessary consultations in a timely manner, thus improving the efficiency of the process.

AMH completed work on the vacancy exception initiative with the adoption of an Oregon Administrative Rule and new procedures to support the payment for vacant beds. As a result, AMH spends fewer dollars in holding beds vacant, processes fewer vacancy payment requests and expects to improve the utilization of existing capacity.

Phase I of the Adult Mental Health Initiative (AMHI) became effective on September 1, 2010. On this date AMH transferred responsibility for managing access to and from facility-based residential services to the mental health organizations. The AMHI initiative is a multi-phase, multi-biennium project to fundamentally restructure

the adult mental health system, by infusing person-centered planning, improving utilization of restrictive settings and standardizing criteria across all levels of care. Statewide data shows that many individuals stay too long in highly controlled licensed settings such as residential treatment facilities. The AMHI initiative is expected to transition 331 individuals in the first 10 months. In coming biennia, the MHOs will be responsible for transitions of all individuals in licensed settings. In future phases they will also become responsible for direct payment to community providers and will become financially at risk for managing utilization.

AMHI is about more than transitioning individuals and managing the residential system. A core goal is to help individuals be as successfully independent as possible to help the mental health system embrace the concept of recovery. To ensure that individuals can leave residential services when they are ready and that expensive resources are utilized only by those that need them, AMH has provided the MHOs with resources to provide community-based services such as supported housing, rental assistance, supported employment, and assertive community treatment.

In the first four months, the MHOs successfully transitioned 180 individuals from the state hospital or a community licensed care setting. Fifty-six percent of the individuals left the state hospitals and 44 percent left licensed community care. Thirty-six percent moved to independent living with appropriate community services and supports.

Strategic initiatives and program design considerations

In response to the issue of unmet needs and a system that continues to deal with addiction and mental health disorders separately, AMH is examining what can be accomplished with limited resources to improve the integration of services and system management to maximize access to quality, effective treatment.

There are 12 strategic initiatives that are managed in a structured accountable manner focused on improving the infrastructure of the system, testing critical system changes to improve access and quality of services, and planning for important system changes in the future. Six of the initiatives are focused on the future.

Integrated services and management demonstration

This initiative is working with two regions to fully integrate physical health, mental health and addiction services. The Central Oregon region has a broad-based

coalition including the public and private providers in Deschutes, Jefferson and Crook Counties. Coalition work is resulting in changes in governance, contracting, service management and coordination and has resulted in the development of a Regional Health Authority for the three counties including public health, mental health and addiction services. The new service coordination model will begin with an agreed-upon group of clients who have extensive service histories across all components of the system with limited success. It is anticipated that integrated treatment and management will improve the outcomes for these clients and decrease the costs to the system.

Peer delivered services

This initiative will focus Oregon's efforts to strengthen and expand a key component of a successful service delivery system and an important addition to the health care work force. AMH is working with stakeholder groups to develop strategies to increase the use and availability of peer delivered services. This work is in the initial stages of building on existing peer delivered services in the state and looking at a variety of funding strategies and options.

Strategic prevention framework

Oregon was awarded a five year State Prevention Framework Grant on July 1, 2009. The grant will be implemented through work with 10 counties and tribes. The result will be a common framework for assessing state and local needs and priorities, making data-driven decisions about the right evidence-based prevention programs delivered to the right audiences and mobilizing communities and tribes to implement these programs and improve outcomes in their communities. During the implementation of the grant, the state's understanding about the most effective prevention strategies will be improved. As a result of this work, AMH will focus all prevention efforts on effective, evidence-based strategies that will prevent addiction to substances and assist Oregonians in achieving optimum physical, mental and social well being.

Wellness

AMH has engaged consumers, providers, counties and other stakeholders in the development of consumer-driven efforts to improve the health and well being of people with mental illness and addiction disorders. The early focus of this work will be Tobacco Freedom, an initiative to provide people with the treatment, skills and resources they need to achieve a tobacco-free life and environment. The emphasis on wellness will improve the overall health outcomes for people with mental illness and addiction disorders, who die 25 years earlier than the average Oregonian.

Young adults in transition

Young adults in transition includes those age 14 to 25. This initiative promotes access to a system of services and supports that are young adult-directed and developmentally appropriate. This initiative is eliminating barriers to treatment access and creating effective services and supports for this population, which has not been well served in the public system in the past. Failure to serve this group of people effectively results in homelessness, incarceration and years of lost productivity. With the advent of these new service approaches, improved outcomes are expected for this population.

Criminal justice door to the mental health system

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined unfit to aid and assist in their defense at trial or who have been found guilty except for insanity. These court related entry points do not necessarily result in the most appropriate treatments for individuals entering the system. The work under this initiative will engage all parties, including consumers, the court system, community mental health programs and law enforcement to explore alternative processes that may result in more effective and appropriate placement and services for people with mental illness who come in contact with the criminal justice system as a result of their mental illness.

This initiative resulted in a legislative concept that, if passed into law, will help ensure that the most appropriate people are served in the state hospital, and that those who are not dangerous will be served in the local community at less cost and with good outcomes.

Conclusion

Addictions and mental health disorders, if untreated, affect the ability of families to retain custody of their children, drive health care costs, drive the number of admissions to the state hospital, contribute to unemployment, and increase costs in the local and state criminal justice systems. It is essential that an integrated, well-managed system of care is funded to provide the evidence-based prevention and treatments that demonstrate improved outcomes for people with addictions and mental health disorders or at risk of developing these disorders. These treatments work. People in recovery are more likely to be employed, less likely to be arrested or jailed, have more stable family relationships, and are more likely to regain or retain custody of their children.

Mission

The mission of AMH is to assist Oregonians to achieve optimum physical, mental and social well-being by providing access to health, mental health and addiction services and supports, to meet the needs of adults and children to live, be educated, work and participate in their communities.

The mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to fulfill AMH goals.

AMH goals:

- Improve the lifelong health of all Oregonians;
- Improve the quality of life for the people served;
- Increase the availability, utilization and quality of community-based, integrated health care services;
- Reduce overall health care and societal costs through appropriate investments;
- Increase the effectiveness of the integrated health care delivery system;
- Increase the involvement of individuals and family members in all aspects of health care delivery and planning;
- Increase accountability of the health care system; and
- Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

History

Oregon's mental health system has been in existence for 160 years. A portion of the Oregon State Hospital facility built in 1883 remained in use throughout 2008. Prior to the mid-20th century, virtually all people with mental illness received treatment in institutional settings. In 1971, the state created the community mental health system and included both mental health and addictions treatment as part of that system. Services are financed and regulated by OHA and delivered through county-based community mental health programs (CMHP) or their subcontractors. Mental health and addictions policy, prevention and treatment services have been combined, separated and recombined — most recently in 2001 — and now include problem gambling policy, prevention and treatment.

The emphasis on community-based treatment for these disorders grew in the 1980s based on recommendations by a series of commissions, task forces appointed by

the Governor and DHS, and Executive Orders. In the mental health treatment area, more people are treated in the community than in institutions, and approximately 73 percent of public funding goes to community-based services.

Major trends include the focus on recovery-oriented and resiliency-oriented services, consumer-driven services, peer-delivered recovery services, and services for children based on strengths and input from their families and delivered in the most natural setting nearest their homes.

Since the 2003 passage of evidence-based practices (EBPs) legislation, prevention and treatment services that have proved effective are provided for people with substance use disorders, problem gambling behaviors and mental health disorders. These services are directed at juveniles and adults who have a propensity to commit crimes, or who experience emergency mental health services. AMH, the community mental health system and providers have made major changes to focus on proven prevention and treatment methodologies. During 2005-07 the system exceeded the requirement that at least 25 percent of state and federal funds be spent on EBPs. During 2005-07, 56 percent of addiction treatment services and 33 percent of mental health services were evidence-based. During 2007-09 the system spent at least 50 percent of state and federal funds on evidence-based services. For 2009-11 the system met the requirement that at least 75 percent of state and federal funds be spent on evidence-based practices.

The 2003 Legislature directed AMH to reform the children's mental health system 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."

The Children's Mental Health System Change Initiative (CSCI) ensures that youth and families receive services locally through local or regional mental health organizations with built-in accountability. CSCI created a standardized method to determine a child's and family's level of service needs, ensure care coordination, increase service flexibility and interagency collaboration, and increase accountability at the local and state levels. Meaningful family and youth involvement is emphasized at all levels of the system, from the child and family teams through the state system advisory committees. This altered system is forming the basis for the initial efforts to meet the statutory requirements for Children's Wraparound passed as HB 2144 by the 2009 Legislature.

As the mental health system has evolved in Oregon during the past 40 years, the system of local mental health services also developed. The closure of Dammasch State Hospital in 1995 was a landmark step in moving from state hospital care to community mental health services. The “deinstitutionalization” movement in Oregon paralleled a national movement. While the community mental health movement was assisted with federal incentives to local communities in many states, Oregon did not fully take advantage of the federal incentives to establish community mental health programs and services. The lack of federal investment in setting up a comprehensive mental health system has had a profound effect on Oregon’s system of community mental health services.

Oregon’s system is under stress due to the current economic picture. This creates the opportunity to adjust the management of community-based residential services including those serving people under the Psychiatric Security Review Board (PSRB).

The service delivery system has historically relied on the use of residential facilities, which are less flexible and more costly than a community-based system grounded in housing with supports. The system is in the process of redeploying resources that keep people living in their homes rather than small or large group settings. The mental health system at present is meeting less than 50 percent of the need for public services for adults and children.

The current average length of stay in Oregon’s residential treatment programs varies by the type of facility and ranges from just under 350 days in residential treatment homes to nearly 600 days in residential treatment facilities. The average length of stay in Oregon state hospitals for the civilly committed population is just over 200 days. The time many people are staying in these settings is far too long. The length of stay will be reduced by investing in supportive housing resources.

Housing opportunities in the community with an array of supportive services not only enable more effective treatment for many, but provide an increase in capacity by reducing the length of stay in residential facilities through providing more permanent housing plus services. By investing in supportive housing, intensive outpatient and peer services, Oregon will be able to move individuals from state or community facilities to self-sufficiency. This understanding is the driving force behind the AMH initiative to redesign the management of adult residential services.

Many communities around the state have begun developing integrated care models. The local system combines physical health care with addictions treatment

and recovery services, mental health services, employment and supportive housing into an integrated system. These integrated delivery models show promise because individuals, regardless of the type of problems, enter the right door for service.

Better use of current mental health and addiction capacity also needs close examination. The recent changes in the children's mental health system may provide the experience and lessons needed to reconfigure the adult mental health delivery system. Oregon will benefit from a cost-effective system that is right-sized to best serve the needs of people with mental illness and addictions.

As a result of Governor Kulongoski's 2004 Mental Health Task Force, the state entered into a process to replace the aging and unsafe buildings of Oregon State Hospital (OSH) and strengthen the community-based mental health system to support future population growth and the treatment of people requiring long-term psychiatric care nearer their homes. The 2007 Legislature approved Certificate of Participation (COP) financing to build two new state-of-the-art psychiatric treatment and recovery facilities to replace the Oregon State Hospital. The first facility, located in Salem on the grounds of the original hospital, will have the capacity to treat 620 people in programmatically unique areas with separate residential areas and centralized treatment malls. The first patients moved into the new facilities in January 2011. The second facility, scheduled to open in 2013, will be located in Junction City. The new facilities will be supported by an integrated electronic hospital management system with an electronic health record at its core. The Behavioral Health (Data) Integration Project (BHIP) was approved for COP financing and will be operational before the new Salem facility is fully open.

Additionally, since January 1, 2007, coverage of alcohol and drug and mental health treatment services are all provided by Oregon-based group insurance carriers. The services are managed based on medical necessity using methods similar to those used for physical health care.

In 2009, the Oregon Legislature passed statewide health reform and included addiction and mental health services as part of health care managed by the Oregon Health Authority. This framework supports the integrated treatment of people with addiction and mental disorders in order to:

- Improve the health of Oregonians;
- Increase the quality, reliability and availability of care; and
- Lower or contain the cost of care.

The 2009 Legislature also created the Alcohol and Drug Policy Commission, abolishing the Governor's Council on Alcohol and Drug Abuse (HB 3353).

The Commission structure was established in late 2009 and early 2010 and began meeting under the joint leadership of the attorney general and the directors of the Department of Corrections and Department of Human Services/Oregon Health Authority. The commission provided a preliminary report in May 2010. The report provides a blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon.

Services

AMH's services restore functioning; promote resiliency, health and recovery; and protect public safety by serving adults, children and adolescents, with substance use disorders, mental and emotional disorders, and problem gambling disorders as well as providing resources to their families. During 2009, 122,052 adults and 38,906 children and adolescents were served.

AMH:

- Provides longer term, hospital-level care to adults with mental illness who otherwise cannot be treated safely or successfully in community settings.
- Contracts with county mental health programs, tribes, mental health organizations (MHOs), and private nonprofit agencies to provide community-based services to Oregonians who have mental illness, emotional and substance use disorders, or an addiction to gambling. The services available include:
 - Early intervention;
 - Prevention;
 - Outpatient treatment;
 - Day treatment and residential treatment;
 - Acute psychiatric treatment in local hospital specialty units;
 - Medications and medication management;
 - Case management;
 - Housing and supports;
 - Peer supports and peer-delivered services;
 - Employment and education supports;
 - Psychiatric residential treatment;
 - Psychiatric day treatment;
 - Care coordination;
 - Crisis services;

-
- Skill training; and
 - Intensive community-based treatment services.

Programs

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

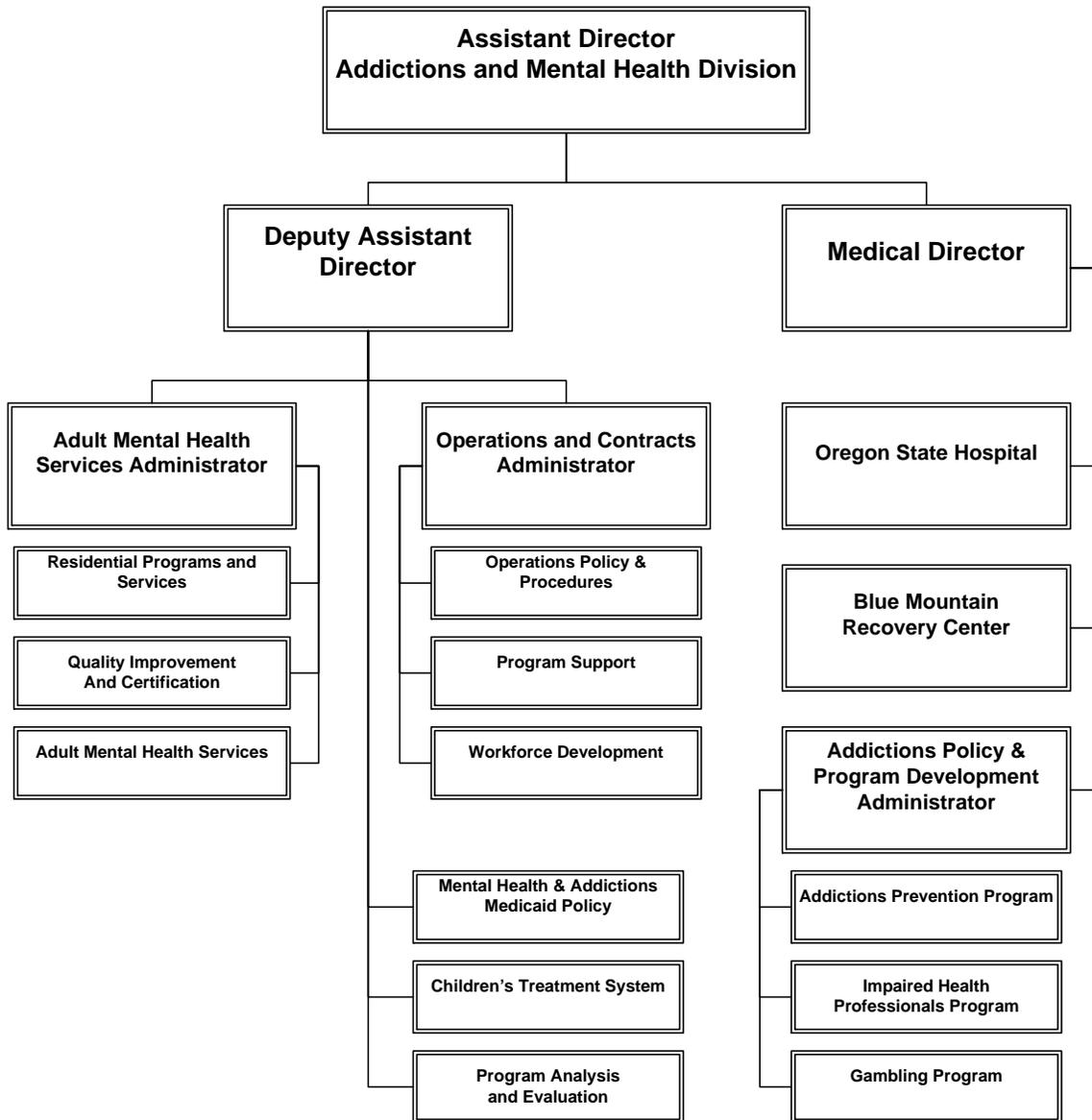
- Be successful at school and work;
- Live safely and productively in the community;
- Avoid repeated cycles of arrest and incarceration;
- Maintain stable relationships and living situations;
- Maintain or obtain appropriate parenting skills;
- Reduce their risk of infectious diseases and chronic health conditions; and
- Reduce the use of acute psychiatric hospitals for crisis stabilization.

Services aim to promote health by helping Oregonians avoid the use of alcohol and other drugs, enter into recovery when necessary and adopt safe and healthy lifestyles.

AMH has six primary program areas:

- Alcohol and drug prevention;
- Alcohol and drug treatment;
- Problem gambling prevention and treatment;
- Community mental health treatment;
- State-delivered secure residential treatment; and
- State hospital services at the Oregon State Hospital (OSH) and Blue Mountain Recovery Center (BMRC).

Organizational structure



Alcohol and drug prevention

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

Services provided

Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. AMH administers prevention services aimed at people who have not yet been diagnosed with alcohol or drug problems. These services reduce the rate of underage drinking and the development of substance use disorder and associated social problems.

Where service recipients are located

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

Who receives services

Services to both prevent and end use of addictive substances are available to all Oregonians, with a focus on youth. The audiences for prevention services are:

- The entire population through public education and awareness campaigns;
- Subgroups of people who are at above-average risk of involvement with alcohol and other drugs; and
- Individuals who show minimal but detectable signs of involvement with alcohol and other drugs, but do not meet diagnostic criteria for abuse or dependence, through prevention services such as substance abuse educational programs for youth who receive a Minor in Possession (MIP) violation.

More than 97,800 Oregonians were provided access to broad-based prevention information during 2009. In addition, 23,287 people received selected prevention services and another 3,216 received indicated prevention services.

How services are delivered

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

Why these services are significant to Oregonians

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

Performance measures

KPM 5: Eighth graders' risk for alcohol use

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

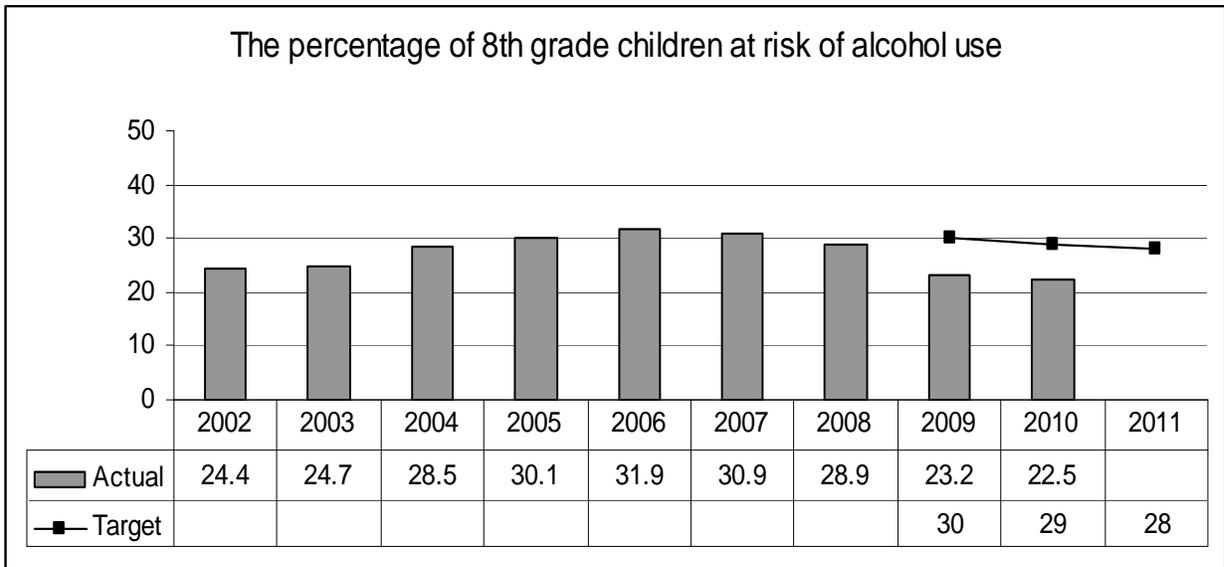
Target: The current target for this measure is 29 percent.

Results: After remaining steady in the low 30 percent range for several years, this measure peaked in 2006 at 31.9 percent, but has since dropped to 22.5 percent. This is below the goal rate of 29 percent. This is despite the fact that state funding for substance abuse prevention has been reduced, the population in Oregon has grown and other prevention programs have been cut, including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. During this same period, marketing and advertising efforts

promoting alcohol and tobacco have increased, particularly advertising for distilled spirits and hard liquor.

Comment: The 2009 Legislature approved changes to the key performance measures that strengthened the measures by separating the measure for alcohol from that for drug use. This allows the state to assess the two measures separately since they show very different findings, with the overall trend for illicit drug use decreasing while alcohol use has been on the rise.

How Oregon compares to other states: When alcohol use within the past 30 days is compared between Washington and Oregon eighth graders, Oregon does not compare favorably — 15.4 percent versus 22.5 percent — although as noted above, Oregon has shown considerable improvement. Washington has maintained funding for its prevention efforts, and it shows.



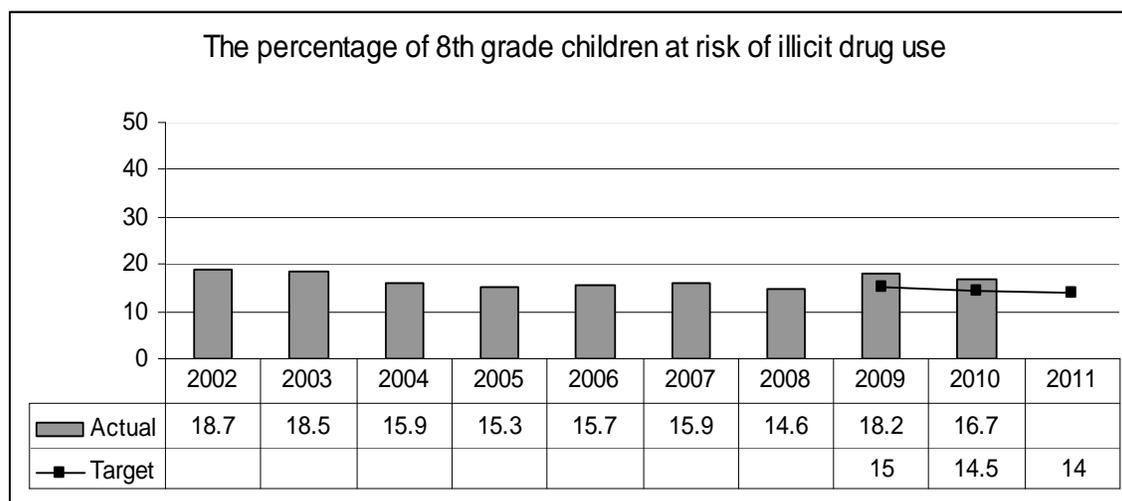
KPM 6: Eighth-graders’ risk for illicit drug use

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

Target: The current target for this measure is 14.5 percent.

Results: This rate has remained fairly steady in the mid- to high-teens over the past eight years. The latest rate is 16.7 percent. This is above the goal rate of 15 percent. As noted, state funding for substance abuse prevention has been reduced, the population in Oregon has grown and other prevention programs have been cut including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. There is not a clear trend for this rate, unlike the rate for alcohol use among eighth graders.

How Oregon compares to other states: The percentage is significantly higher than national rates of 7.6 percent for 2008, which was published in *Monitoring the Future* national survey results on drug use.



Other performance measures

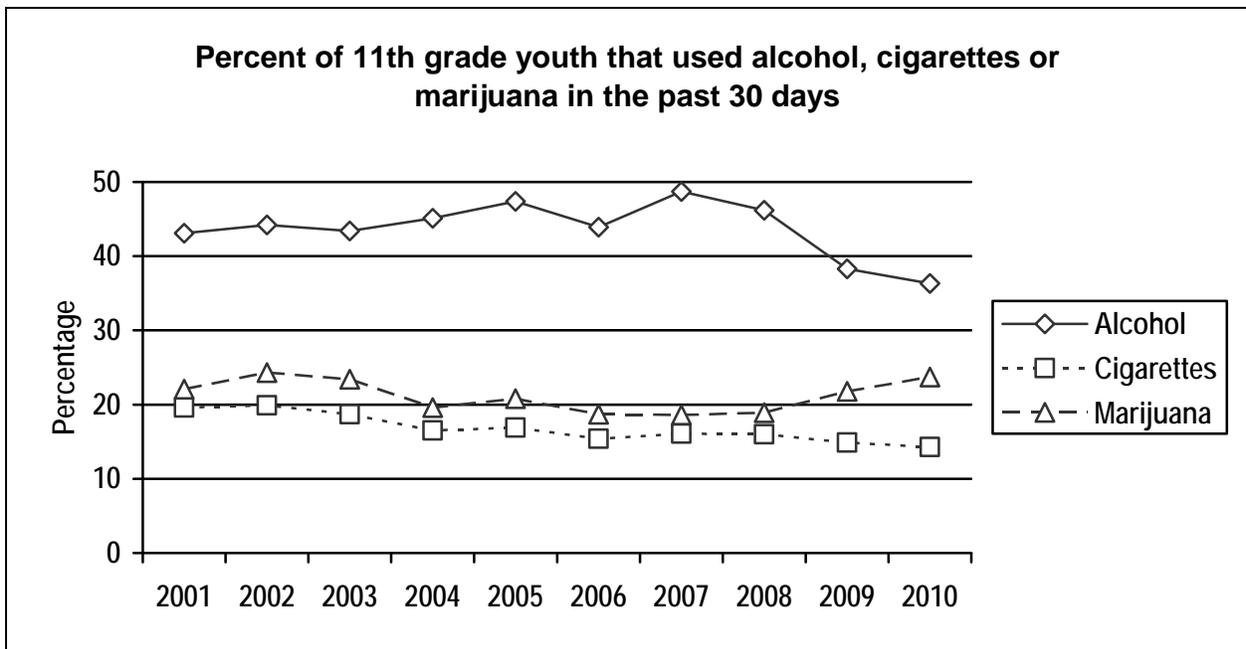
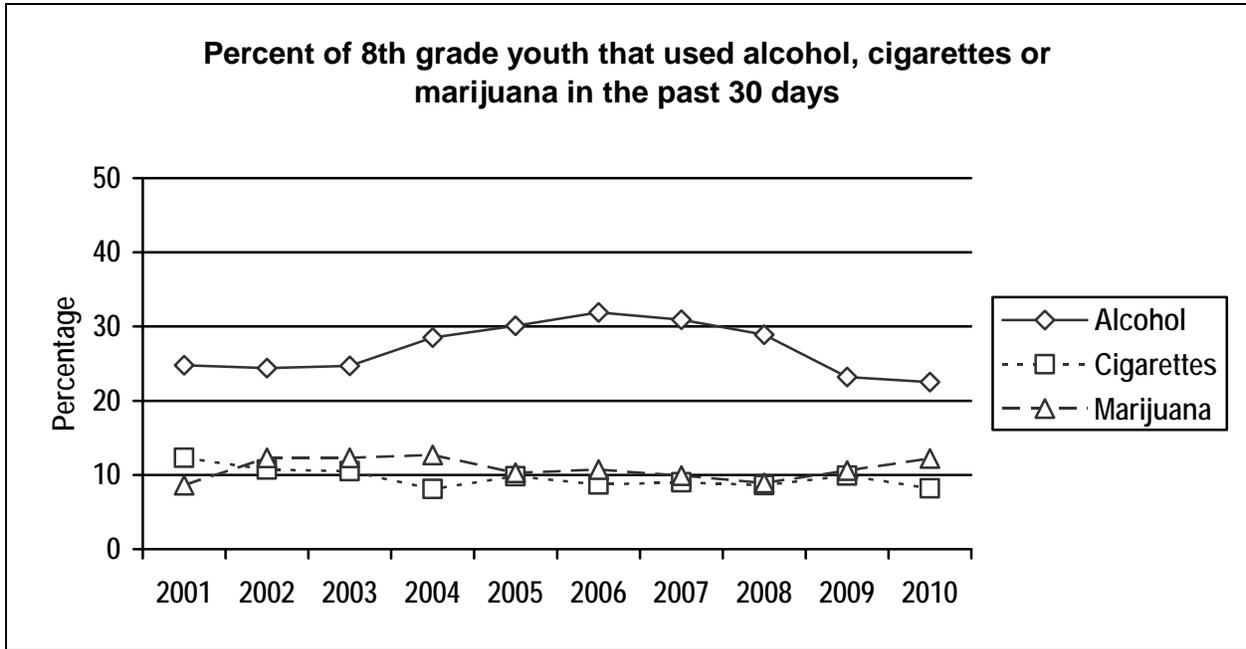
National outcome measures (NOMs) for prevention services include prevalence of substance use, consequences of use, and related risk and protective factors. Prevalence data tell the extent of a problem, such as the percentage of youth who drink. Consequence data provide information about the effect of use on individuals such as alcohol-related motor vehicle fatalities. Risk factors are conditions that increase the likelihood of substance use or related negative consequences; protective factors are conditions that support healthy behaviors and outcomes. In all cases the information helps AMH direct its prevention efforts.

Use of alcohol, tobacco and illicit drugs affects families, schools, workplaces and communities. It causes long-term health problems; leads to premature death; contributes to injuries, violence and abuse; and can lead to addiction that erodes an individual's ability to function normally.

Substance abuse and dependence affect Oregonians of all ages. Approximately 9 percent of Oregon youth 12 to 17 years old abuse or are dependent on alcohol or drugs; 22 percent of young adults 18 to 25 and 8 percent of adults 26 or older abuse or are dependent on alcohol or drugs, requiring treatment (National Survey on Drug Use and Health, 2007-08).

Initiation of alcohol, tobacco or marijuana use at young ages has been linked to more intense and problematic levels of use in adolescence and adulthood. The charts below show the trends in alcohol, cigarette or marijuana use by eighth and 11th grade youth. Alcohol use is clearly the largest issue among both eighth and 11th grade youth. Since 2006, alcohol use among eighth graders has declined four consecutive years. However, in 2010 more than one in five youth reported drinking alcohol in the past month. In 2010, past-month marijuana use (12.2 percent) was 50 percent higher than cigarette use (8.2 percent) (Oregon Student Wellness Survey, 2010).

Rates of past-month alcohol, cigarette and marijuana use increase substantially between eighth and 11th grade. In 2010, more than one in three 11th graders reported drinking alcohol in the past month (36.3 percent); approximately one in four reported smoking marijuana (23.7 percent); and one in seven reported smoking cigarettes (14.3 percent) (Oregon Student Wellness Survey, 2010).



An American Medical Association (AMA) report shows that adolescent drinkers perform worse in school, are more likely to fall behind and have an increased risk of social problems, depression, suicidal thoughts and violence. Even occasional heavy drinking injures young brains.

Young people who consume alcohol are more likely than adults to drink heavily. Youth who binge drink are much more likely to engage in other risky behaviors such as drug use, risky sexual behavior and aggressive antisocial behavior. Oregon youth who binge drink are more likely to report attempting suicide than youth who do not.

Oregon youth begin drinking at very young ages and are more likely to start drinking before 13 years of age than to start smoking cigarettes. During 2010, 13.1 percent of 11th graders reported they first drank alcohol before the age of 13 versus 7.0 percent who first smoked a cigarette before 13 (Oregon Student Wellness Survey, 2010).

Three factors known to influence the likelihood of underage alcohol use are perceived risk of harm, parents' disapproval of drinking and accessibility to alcohol. Oregon eighth and 11th graders are more likely to report lower risk of harm and less parent disapproval for alcohol than for cigarette use. Despite the fact that sales of alcohol to minors are illegal, 47.1 percent of eighth graders and 72.3 percent of 11th graders say it is "sort of easy" or "very easy" to get beer, wine or hard liquor (Oregon Student Wellness Survey, 2010).

Alcohol is the most widely used addictive substance among adults in Oregon. Alcohol is a known carcinogen and a leading cause of chronic liver disease. It is toxic to many organ systems including the heart, stomach, pancreas and nervous system. Each year about 1,400 Oregonians die from alcohol-related causes. (Alcohol Related Disease Impact software) Deaths from alcohol-induced diseases are one of the 10 leading causes of death for men and women in Oregon.

Even moderate alcohol consumption can lead to negative consequences such as alcohol-related motor vehicle crashes, birth defects and harmful interactions with medications. Approximately two-thirds of Oregon men (65.8 percent) and half of women (52.1 percent) drink alcohol each month (Behavioral Risk Factor Surveillance System).

By far, heavy drinking and binge drinking are most closely linked to negative health consequences and contribute to crime and violence against persons. Heavy

drinking is associated with heightened levels of all-cause mortality. Heavy use of alcohol refers to alcohol consumption at levels that exceed U.S. Dietary Guidelines. Men who drink more than two drinks per day and women who drink more than one drink per day are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence. In 2009, 6.0 percent of men and 6.4 percent of women in Oregon were heavy drinkers (Behavioral Risk Factor Surveillance System).

Binge drinking is strongly associated with injuries, motor vehicle crashes, violence, Fetal Alcohol Spectrum Disorder (FASD), chronic liver disease and a number of other chronic and acute conditions. Binge drinking is defined as consumption of five or more drinks by men and four or more by women in a short time span. In 2009, 18.9 percent of men and 11.2 percent of women in Oregon reported binge drinking (Behavioral Risk Factor Surveillance System).

Key budget drivers and issues

Underage drinking

Oregon youth are continuing to drink at rates above the national average, with eighth grade girls drinking at higher rates than boys. These youth will continue to use and abuse alcohol and other drugs, which will increase the demand for treatment services. There will be added social costs including increased teen pregnancy, motor vehicle accidents and death, school failure, entry into the juvenile justice system, and continued high rates for adolescent suicide. It is critical to restore funding for effective, evidence-based prevention and early intervention services to reverse the trend in underage drinking and improve the associated social indicators.

Prescription drug abuse

Both chronic and occasional drug use can result in serious medical conditions. Youth and young adults in Oregon have higher rates of illegal use of drugs such as heroin, cocaine and methamphetamine as well as prescription drugs used (without a doctor's orders) to get high than their younger or older counterparts. Prescription drug abuse is a growing concern in Oregon. Eight percent of Oregon 11th graders reported using prescription drugs to get high in the past 30 days, according to the 2009 Oregon Healthy Teens Survey. By contrast, 5 percent of 11th graders said they used illicit drugs other than marijuana in the past 30 days. Adolescents are more likely than young adults to become dependent on prescription drugs. National studies and published reports indicate that the intentional abuse of prescription drugs to get high is a growing concern.

Governor's Balanced Budget

The Governor's Balanced Budget continues support for alcohol and drug prevention services mainly through the use of federal funds. There are no reductions.

Alcohol and drug treatment

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

Services provided

Services consist of outpatient, intensive outpatient, residential and detoxification services. Different options are needed to help individuals recover from their addictions. Some individuals may need residential services, while others may need outpatient; both are needed for individuals to successfully recover and manage their disease. Outpatient services include specialized programs that use synthetic medications such as methadone as an alternative to chronic heroin addiction. Education and treatment are available for people who are convicted of driving under the influence of intoxicants (DUII).

Where service recipients are located

Community mental health programs (CMHPs), tribes and county-designated nonprofit organizations provide treatment for alcohol and drug abuse problems in all 36 counties and in statewide and regional residential treatment programs.

Who receives services

Children and adults of all ages who have a diagnosed substance use disorder may be eligible for services. Any person eligible for the Oregon Health Plan (OHP) or the State Children's Health Insurance Program (SCHIP) has access to the OHP substance abuse benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services under the federal Substance Abuse Prevention and Treatment block grant. There are specialized services designed to meet the needs of women, parents with children, minorities and adolescents. During 2009, 36,238 adults age 26 and above were served; 12,207 young adults age 18 through 25 were served; and 5,663 adolescents age 12 through 17 were served.

How services are delivered

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

Why these services are significant to Oregonians

As a result of these services, fewer children are admitted to foster care due to parental substance abuse. State and local jurisdictions see reduced costs to the criminal justice system for adults and juveniles. Local hospitals experience reduced use of emergency departments.

Intensive treatment and recovery services

AMH continues to implement the 2007-2009 Legislatively Adopted Budget initiative to increase access to addictions treatment for parents who are involved in the child welfare system or at risk of involvement in that system. Increased outpatient capacity now exists in each county, and residential capacity has increased for approximately 120 adults and 80 dependent children who access treatment with their parents. Eighteen additional recovery homes have been developed for families with addictions issues who are at risk of becoming homeless and need a supportive recovery environment. AMH worked closely with the Children, Adults and Families Division (CAF) to implement these services and monitor systems outcomes.

Outcomes and effects

Addiction treatment and recovery services have been accessed by 4,440 parents. Currently, 1,734 parents are engaged in treatment and recovery services. More than 900 children have been reunited with their parents and are no longer in family foster care; these are families who have either completed treatment or are still engaged in treatment through Intensive Treatment and Recovery Services (ITRS). Eighteen family-focused recovery homes have been developed (compared to a target of 14). The return of the children to their families represents a cost-offset to the foster care system of \$1.7 million per month. This means that providing addiction treatment and recovery supports for this population group paid for itself within a period of six months.

Housing

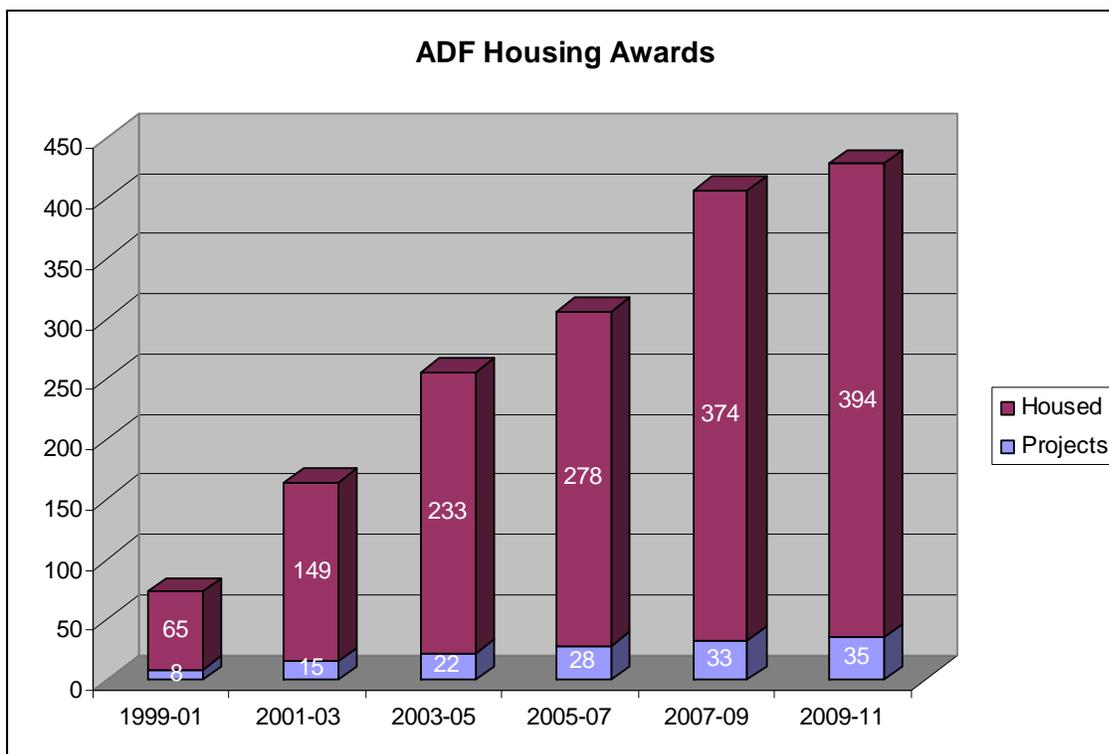
A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addiction disorders. When people are uncertain about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them,

their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system are in these adverse living environments.

As a result of the cost of housing and common problems associated with mental illness or substance use disorders, more than 6,000 people each year with these disorders are homeless. This represents nearly one-third of homeless individuals identified in the 2010 Point in Time Count. The state has undertaken the following initiatives to address housing for people with addiction disorders:

Alcohol and drug free (ADF) housing development

These funds are used to create alcohol and drug free (ADF) housing to support people in recovery from serious addictions. For 2009-11 two projects were recommended for funding. These projects have a total cost of \$450,000 and will provide 20 units of affordable alcohol and drug free housing. Fewer applications were submitted for funding due to the recession, changes in financial markets and timing of other funding sources. The following chart reflects AMH's cumulative distribution of ADF housing development funds through the 2009-11 biennium.



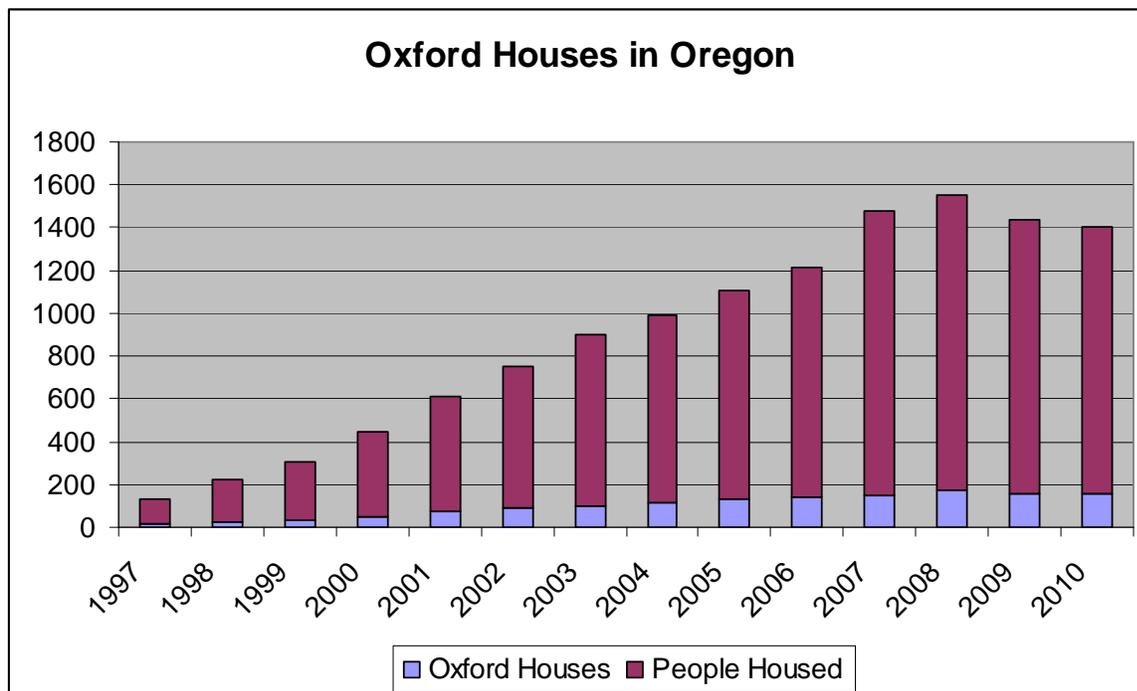
ADF housing assistance services

AMH funds eight projects in seven counties and one tribal community to help more than 456 people each year in recovery from addictions obtain stable ADF housing

as they transition to self-sufficiency. An RFP for this program was released in October 2010 and awards for the 2011-13 biennium will be announced the end of February 2011.

Oregon Recovery Homes (ORH)

Through the Intensive Treatment and Recovery Services Initiative approved by the 2007 Legislature, Oregon Recovery Homes were able to increase their staff outreach coordinators from two to five full-time employees. With the help of a grant from the Spirit Mountain Community Fund, ORH was able to add a sixth outreach coordinator, who works exclusively with homes serving women and the challenges of housing women with children who are in recovery. There are now 160 Oxford Homes in 14 Oregon counties accommodating approximately 1,244 people recovering from alcoholism and drug addiction. More than 300 children live in these homes. The drop in houses represents a 6 percent decrease in ORH housing from the 2007-09 biennium. The loss of 10 of the 15 houses can be attributed to the economy. Many residents rely on minimum wage or labor-related jobs, and with fewer jobs available, many houses were not able to remain viable. Several houses consolidated members, avoiding the loss of even more beds. These homes operate on a self-governed, peer support model. The following chart shows the trend of homes and housing capacity since 2001. While the number of houses remained the same in 2009 and 2010 there was a slight decrease in capacity. The decrease resulted from less capacity in the houses that opened than what had been available in the houses that were closed.



Performance measures

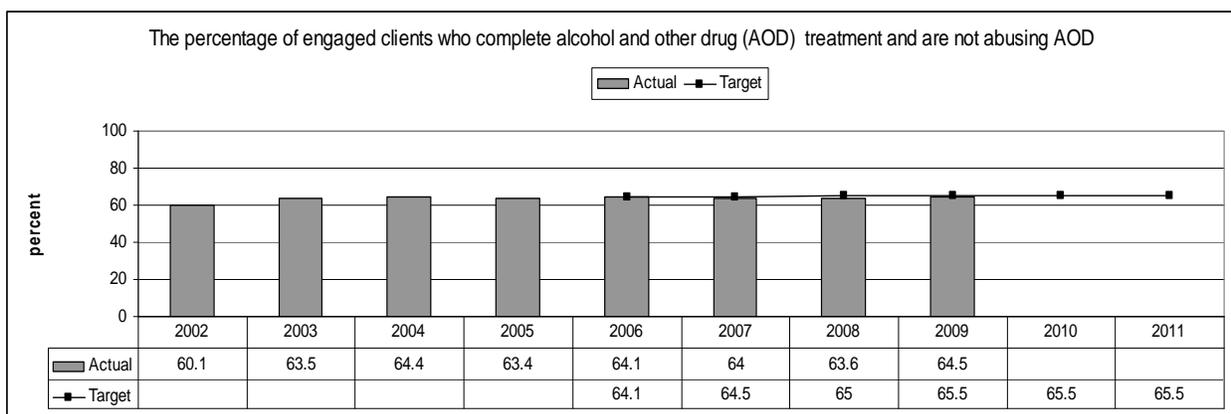
KPM 1: Completion of alcohol and drug treatment

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

Target: AMH's target is to push overall completion rates to 65-66 percent and beyond during the next few years.

Results: For purposes of this key performance measure, completion rate is aggregated across all alcohol and drug services and has been in the low- to-middle-60 percent range for the past several years. It currently is 65 percent. It is expected to increase during the next few years as more providers implement evidence-based practices and quality improvement efforts designed to retain clients in treatment.

How Oregon compares to other states: One reason the completion rate has not changed substantially during the past several years is that it already is very high, making more improvement difficult. Nationally, the completion rate for alcohol and drug treatment services is 51 percent, based on data submitted by states to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.



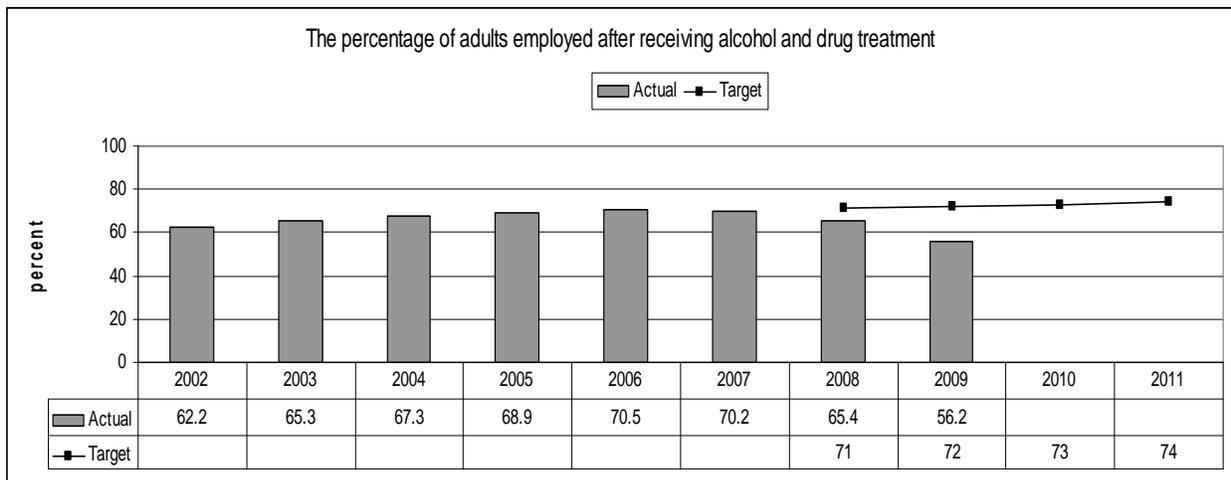
KPM 2: Adults employed after alcohol and drug treatment

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

Target: AMH’s target is to push overall employment rates to 72 percent and beyond during the next few years. It will be difficult to reach this target in this economic environment.

Results: From 2002 through 2007 a greater percentage of clients were employed when they were discharged from treatment. This changed in both 2008 and 2009 as actual rates of employment declined substantially in each year due in large part to the economic climate in Oregon. Starting in 2008 the percentage dropped and in 2009 was 56.2 percent after peaking at 71 percent.

How Oregon compares to other states: Despite the drop, Oregon’s rate of employment at discharge is higher than the national rate of 42.8 percent (2008).



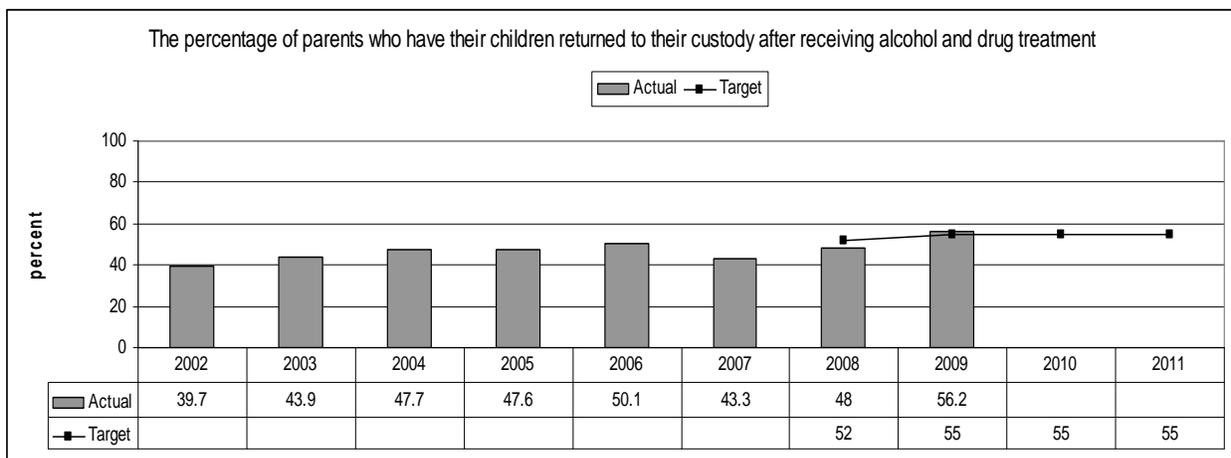
KPM 3: Children returned to custody after parental alcohol and drug treatment

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

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

Results: The trend through 2009 shows that more parents each year were meeting treatment criteria that allowed reunification with their children. AMH surpassed its goal for 2009 by 1.2 percent. The implementation of Intensive Treatment and Recovery Services, funded by the 2007 Legislature as a treatment strategy, focused on people at risk of or whose children were taken into state custody as a result of parental substance abuse made these results possible. In 2008, 48 percent of parents had their children returned following successful conclusion of substance abuse treatment and in 2009 the number climbed to 56.2 percent. The rate in 2007 was 43 percent.

How Oregon compares to other states: There are no national data for comparison.



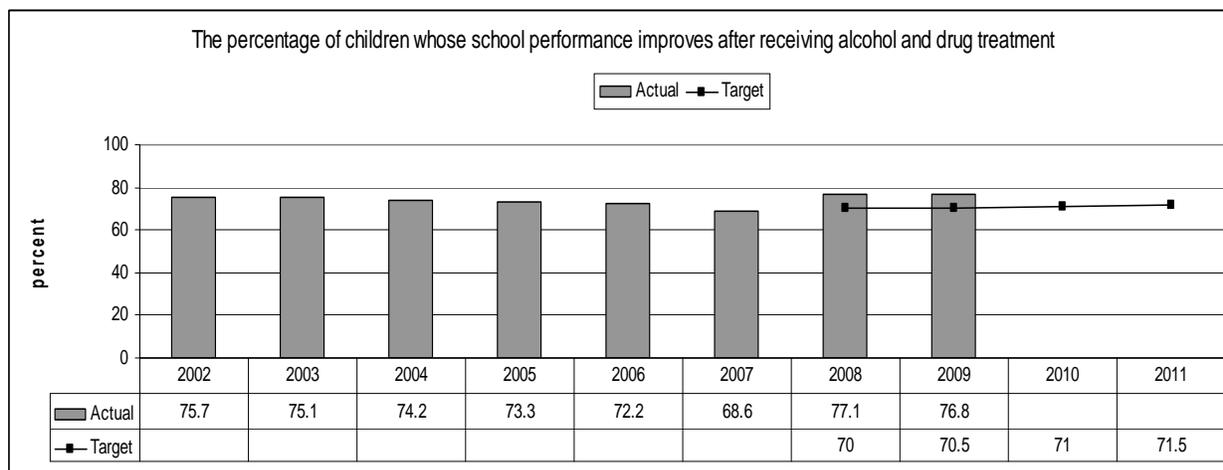
KPM 4: Children with improved academic performance after alcohol and drug treatment

Purpose: Alcohol and drug issues are a major barrier to academic achievement. Poor academic performance often is an initial flag for abuse of alcohol and drugs among teens. A goal of treatment is to help a child perform to his or her potential. Improved academic performance is definitely a step in the right direction.

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

Results: The downward trend seen since 2002 appears to be changing with the rates for 2008 and 2009. In 2009, AMH showed 76.8 percent of children with improved school performance, which exceeded the goal by 6.3 percent.

How Oregon compares to other states: This measure looks at academic performance. Most national data track only improvement in attendance. This makes comparisons difficult.



Many of the key performance measures are part of a larger set of federal measures known as the national outcome measures (NOMS). These measures are available upon request and are reported annually by AMH.

Proposed key performance measures for 2011-13

AMH proposes to measure the percent of clients who remain crime-free during alcohol and drug treatment services. This is a critical measure of success for the treatment system since a substantial proportion of the people served in the system are referred by the criminal justice system. Successful engagement in treatment should result in an elimination of criminal activity. Data collected in 2009 will be used to establish a baseline from which targets will be set.

AMH proposes to measure the percent of clients whose income increases by the completion of alcohol and drug treatment services. One of the goals of successful treatment is employment or improvement in employment, which should result in an increase in legal income. Data collected in 2009 will be used to establish a baseline from which targets will be set.

Alcohol and drug treatment services

Approximately 9.0 percent (or 27,592) of adolescents ages 12-17 have substance abuse issues. Among young adults ages 18-25, 21.8 percent (or 67,976) have substance abuse issues, while 8.2 percent (or 205,919) of adults 26 and older have substance abuse issues. AMH currently serves 21 percent of the adolescents and children, 18 percent of the young adults, and 18 percent of the adults in need of public alcohol and drug treatment services.

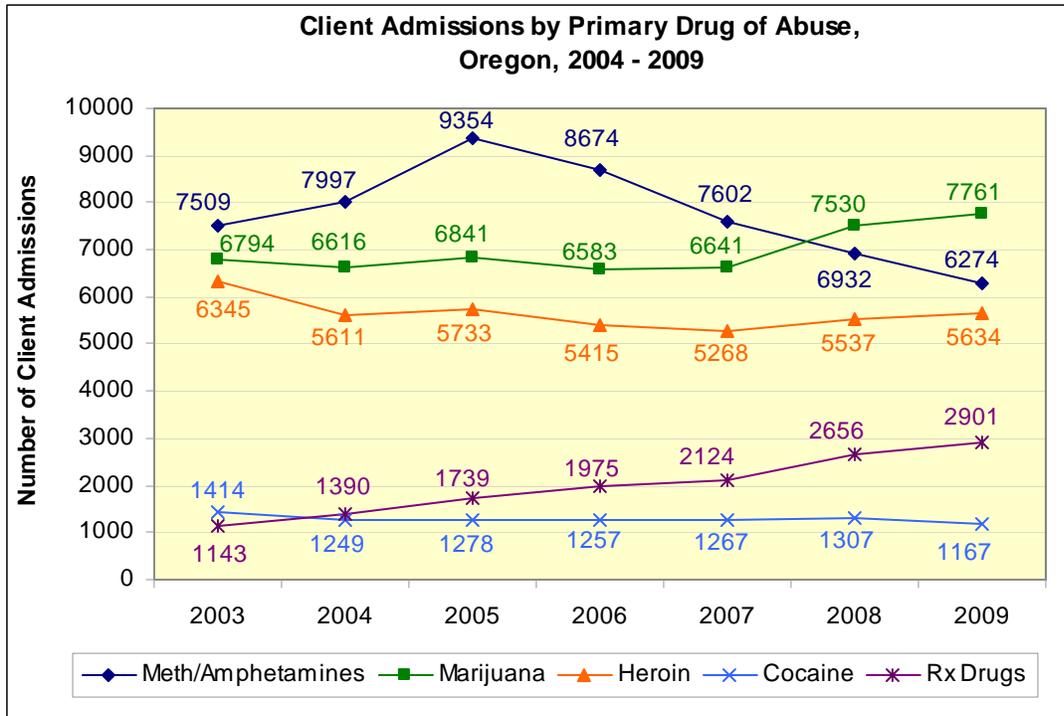
Key budget drivers and issues

Heroin and other opioid drugs

Since 1999, the rate of unintentional drug poisoning deaths has more than doubled, from 4.5 to 9.3 deaths per 100,000. Heroin-related deaths in Oregon are the highest they have been since 2000. Nearly 130 people across Oregon died in heroin-related deaths in 2009, more than twice the amount of all other drug-related deaths combined. Prescription opioid analgesics are increasingly implicated in drug poisoning deaths as well. Prescription drug abuse, particularly related to opioid pain medications, is a growing concern among addiction treatment providers and stakeholders in Oregon. Prescription pain relievers are Oregon's fourth most prevalent substance of abuse following alcohol, tobacco and marijuana. Compared to the rest of the nation, Oregon ranks among the top 10 states for:

- Annual abuse of prescription drugs for all ages (228,000 persons per year);
- Past-year abuse of prescription drugs by youth 12 to 17 (34,000 persons per year); and
- Past-year abuse of prescription stimulants (55,000 persons per year).

The rate of non-medical use of pain relievers in Oregon is higher than that of the nation. The 18- to 25-year age group is of particular concern with 15 percent reporting non-medical use of pain relievers in the past year. The rate of treatment admissions with prescription drugs as the primary substance of abuse has risen by 142 percent from 2003 to 2009 (see following figure). By contrast, since 2005 the rate of admissions with methamphetamine as a primary substance has declined by 20 percent.



Complex and multiple challenges among treatment populations

Co-occurring mental and physical conditions

A growing number of individuals who enter addiction treatment have multiple and complex physical and mental health needs in addition to their substance use disorders. It is more common for individuals entering treatment to report having issues of dependence related to more than one type of substance. More individuals who enter treatment have physical health concerns or complications such as the Hepatitis C virus, HIV/AIDS, pregnancy, serious dental issues, chronic pain and diabetes. The provider system is hopeful about the effect of federal health reform on their ability to serve more Oregonians with a health benefit and to coordinate care with a growing number of physical health providers. In the meantime, the system is challenged to hold on to existing capacity with reduced budgets and increased fixed costs.

In addition, according to the National Survey on Drug Use and Health (NSDUH) 20 percent of Oregonians age 18 to 25 reported experiencing serious psychological distress in the past year and more than 10 percent experienced a major depressive episode. Unfortunately, Oregon ranks among the highest states for this measure. An estimated 30 to 40 percent of individuals who enter addiction treatment also have a co-occurring mental health disorder. Under the current rate structure, providers are challenged to meet the clinical and medical staffing needs that will adequately serve these populations and to provide the level of service intensity

required to address complex and multiple issues facing individuals accessing treatment.

Returning veterans

Oregon has a significant population of veterans, but since there is no in-state military base, many veterans lack access to services and support. Oregon has 333,752 veterans, of whom approximately 60,000 are under age 44 (Veterans Administration, 2007). Approximately 30 percent of Iraq and Afghanistan War veterans report symptoms of Post Traumatic Stress Disorder (PTSD), traumatic brain injury, depression or other mental illness. Nearly 19 percent of current conflict veterans who received VA care were diagnosed with substance abuse or addiction disorders. The United States Army reports a 56 percent increase in diagnosed alcohol disorders from 2003 to 2009, leading to a need for more substance abuse counselors. From March to December 2009, 357 veterans and 28 family members of veterans contacted Oregon Partnership Helpline for substance abuse needs. However, interviews with VA staff, Oregon National Guard staff and recently returning veterans indicate reluctance to access treatment services offered by the military. This situation is complicated by the fact that one in eight (approximately 13 percent) of non-elderly veterans are uninsured and about half of those are not eligible for VA healthcare. As such, their mental health and addiction needs go untreated, leading to higher incarceration rates, increased homelessness, family conflict, suicide and poor health. The addiction treatment system has insufficient capacity to serve a growing number of veterans. Due to budget reductions and constraints, work force development initiatives have not kept pace with providing the unique skills and competencies needed to treat veterans with complex needs.

Reentry for incarcerated individuals

Individuals who have been incarcerated experience significant obstacles reentering the community. Oregon currently has 13,927 incarcerated individuals, nearly double the population in 1995. Nearly 40 percent of people in jail are there on drug charges, representing 5,570 individuals (Department of Corrections, 2009). At any given time there are also some 19,000 individuals on parole and probation throughout the state (Department of Corrections, 2009). In February 2010, AMH conducted a focus group with inmates, seeking input about their fears and hopes. As individuals approach parole, they grow anxious regarding housing, staying clean and sober, getting a job, developing sober support systems, and reintegrating with the broader community. They report a high need for recovery support services, with little access.

Population increase and unmet need

As Oregon's population grows, there will be an increase in the number of people with addiction disorders. However, funding for the basic community treatment services needed to treat these disorders has not increased in relation to the need for services. National research that looks at the need for services indicates 8.2 percent of the adult population age 26 and older requires alcohol and drug treatment services; in Oregon that is 205,919 people. For those aged 18 to 25, the same research shows that 21.8 percent or 67,976 people are in need of treatment. That research also shows 8.8 percent of youth ages 12 to 17 require treatment; in Oregon that is 27,591 youth. Public funds provided services for 36,238 adults (18 percent of the need), 12,207 young adults (18 percent of the need) and 6,663 youth (21 percent of the need). Some of these people will have insurance and, with the approval of equal access to treatment for these disorders, more will obtain treatment paid by their insurance company. However, many people with addiction disorders do not seek treatment until they have lost their jobs, insurance and families; and when they seek or are mandated to treatment, they must rely on publicly funded services.

Lack of safe, affordable housing

The urban areas of Oregon are some of the most expensive for rental housing and home ownership in the country. A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addictions and mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system live in these adverse living environments. As the economy has worsened, housing insecurity has become more pronounced for people with addictions and mental health disorders. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue in treatment services, thus increasing the risk of more illness, mandated treatment and greater disability.

Governor's Balanced Budget

The Governor's Balanced Budget continues support for alcohol and drug treatment programs. It will be challenging for the community system to continue services without a cost-of-living increase combined with the 2009-11 reductions required to balance the budget. This level of support positions the system to participate in the transformation of the health care system that is anticipated in the Governor's Balanced Budget. Support for these services is clear recognition of the importance of alcohol and drug treatment in improving the health of Oregonians, increasing the quality of care and containing the cost of health care.

Problem gambling prevention and treatment

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

Services provided

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

Where service recipients are located

Community mental health programs (CMHPs) for-profit and nonprofit providers deliver problem gambling prevention and treatment services in all 36 counties and in one statewide residential treatment program. Treatment to reduce the effects of problem gambling is funded through a statutory 1.0 percent set-aside of state Lottery revenues.

Who receives services

During 2009, 2,240 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 2,195 people during 2009.

How services are delivered

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

Why these services are significant to Oregonians

Oregonians with problem or pathological gambling behaviors put themselves and their families at financial risk, experience family relationship disruptions, lose their jobs, are at risk of suicide and sometimes commit crimes to pay for their gambling addictions. The majority of Oregonians post-treatment reported reduction of

gambling debt, reduction in suicide ideation and improvement in relationships, physical health, emotional well-being and spiritual well-being.

Performance measures

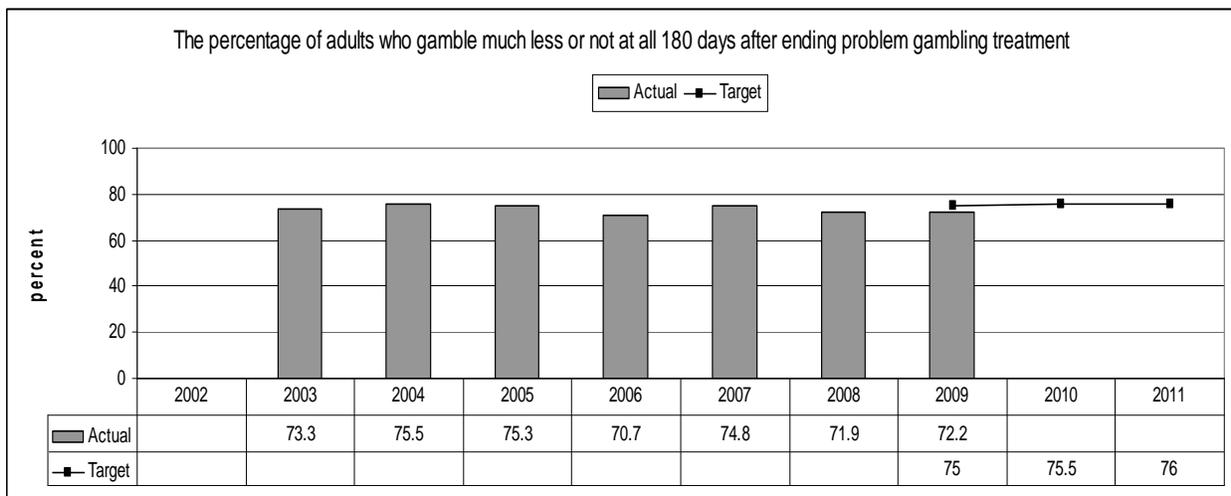
KPM 10: Percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment

Purpose: Problem gamblers and their families experience a complex array of mental health, social, financial and legal issues. The estimated social-economic cost of each pathological gambler is up to \$11,000 a year. Increasing the effectiveness of treatment contributes to the overall health of the community by eliminating these social-economic costs by aiding those treated to remain abstinent from gambling. Our partners in this effort are county and private-not-for-profit community agencies that provide treatment for problem gamblers and their families.

Target: AMH’s target is to push overall improvement rates to 75 percent and beyond during the next few years.

Results: Results have shown some decline in the past two years. In 2009, AMH showed that 72.2 percent of adults were not gambling or gambling less than 180 days after ending services. This falls short of the 75 percent goal.

How Oregon compares to other states: There is no national data to compare.



Other performance measures

AMH collects additional data to measure the effectiveness of problem gambling treatment. For example:

- An estimated 50,143 adult Oregonians are problem gamblers and an additional 29,496 are pathological gamblers.
- FY 2009 data indicate 49.9 percent of problem gamblers successfully completed treatment services.
- Six months post-treatment, more than 87 percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.
- For the treatment completers, 47.4 percent of those assessed at 12 months after treatment reported no gambling and another 42.9 percent reported “much less” gambling than before treatment.
- Approximately two-thirds of the participants reported satisfaction with their relationships, physical health, emotional well-being and spiritual well-being.
- Approximately 62.7 percent reported a return to paying bills on time.
- Importantly, at the 12-month post-treatment follow-up, people who completed service reported no significant deterioration in these indicators and, in fact, reported additional improvements in feelings of restlessness or irritability regarding not gambling.

Key budget drivers and issues

The increasing access to highly addictive gambling games online in numerous locations throughout the state create easy access for people who are interested in gambling and reinforce the behaviors that lead to addictive gambling. The increase in Internet gambling is attracting more and more young people who are showing increases in problem gambling behaviors that interfere with education and social relationships.

Governor’s Balanced Budget

The Governor’s Balanced Budget restores support for problem gambling prevention and treatment programs based on projections of Lottery revenue.

Community mental health programs (CMHPs)

Services provided

Mental health services improve functioning for Oregonians with severe mental health disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for more treatment and whether other supportive services will be provided. These ongoing supports and services improve people's ability to function in their families and communities, often reducing public safety problems and negative consequences.

Children with mental health issues are served in their local communities. Each child is screened for and served within the Integrated Service Array according to a standardized level of need determination for their mental health service needs.

Services and supports include those delivered by peers such as help establishing personal relationships and help obtaining employment or schooling; independent living skills training such as cooking, shopping and money management; residential or adult foster care; and supervision of people who live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, doctor offices and clinics, schools, drop-in centers and homes. The Oregon Health Plan (OHP) covers mental health services for eligible persons with conditions funded under the Health Services Commission Prioritized List for all Medicaid and SCHIP clients. The state General Fund pays for services and individuals not covered by OHP.

Where service recipients are located

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

Who receives services

Community mental health programs (CMHPs) provide mental health services for adults and children who have serious emotional and mental health disorders and

are a danger to themselves or others, are unable to meet their needs, or are in danger of being removed from their homes due to emotional disorders. During 2009, publicly funded programs served 72,207 adults and 33,243 children and adolescents.

How services are delivered

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

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

Services are delivered in every county through the 32 CMHPs and Warm Springs Tribal Clinic. Services are provided by a combination of county employees and subcontracted private agencies.

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

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

Why these services are significant to Oregonians

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

Housing

A safe and affordable place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments, their recovery is at risk. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue

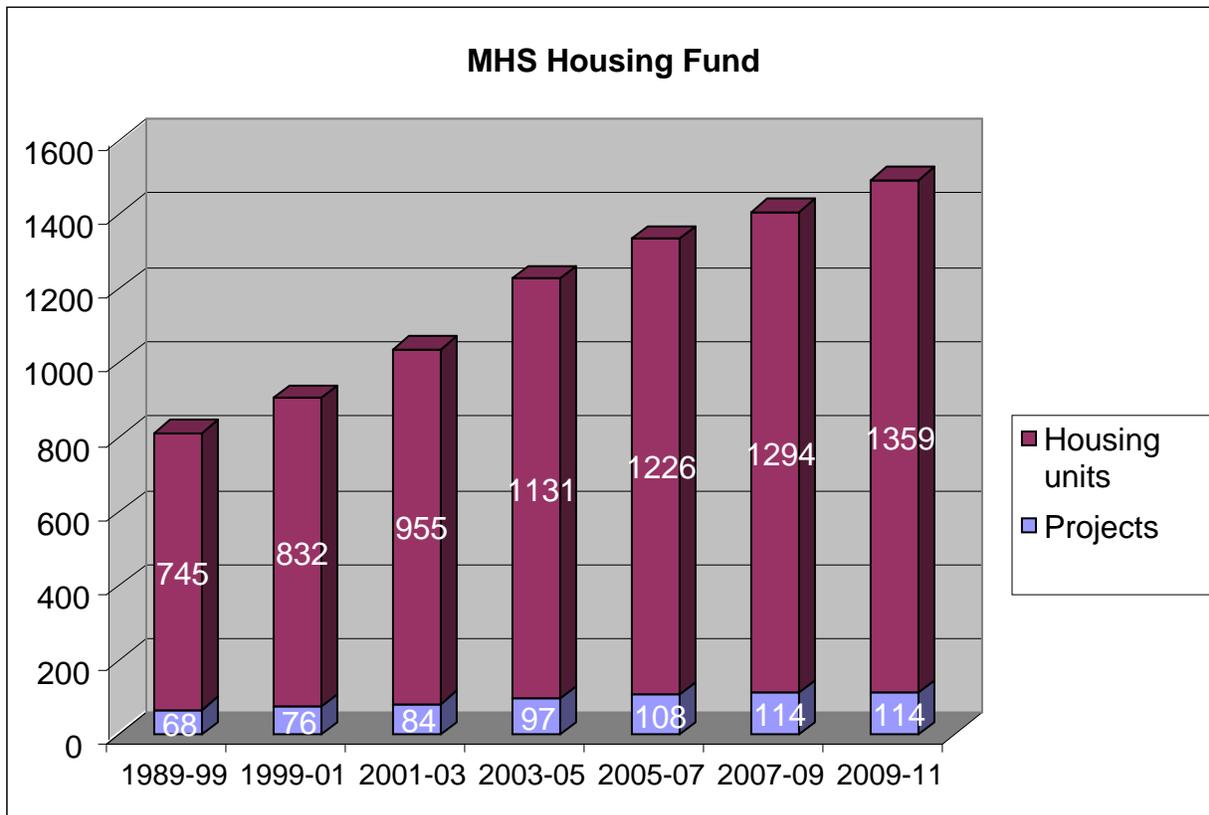
treatment services, thus increasing the risk of more illness, mandated treatment and greater disability.

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

Mental Health Services (MHS) Housing Fund

Since 1989 AMH has provided grants to support the development of 108 housing projects in 25 counties accommodating 1,226 people with severe and persistent mental illnesses. The following chart shows the growth of projects and capacity since 1989. To date, AMH has invested \$4.4 million in the development of these projects. Each dollar invested leverages approximately \$38 from other sources.

For the 2009-11 biennium, AHM set aside \$300,000 in MHS funds for Housing Renovation Grants. These grants are capped at \$4,999 per project and are available to address health and safety repairs to adult foster homes, residential treatment homes and facilities within the mental health residential system of care. AMH conducted two renovation fund application rounds in July and September 2010. Sixty-five applications were received for a total of \$267,423. Fifty-nine applications were awarded funding for a total of \$219,191. The 59 facilities serve 554 residents in the residential system. The remaining MHS funds will be used during the last half of the 2009-11 biennium to address special development needs for patients transitioning from Oregon State Hospital.



Community Mental Health Housing Fund

Established with the proceeds from the sale of the former Dammasch State Hospital property, this AMH fund has awarded an additional \$2.4 million in support of 32 projects. During 2009-11, two application rounds provided opportunities to increase housing for people with mental illness. The first round awarded \$600,000 toward the creation of 86 units of supportive housing, leveraging \$47 for every dollar invested for total housing worth \$29 million. The second round applications are due in February. AMH is offering \$330,000 for the development of supportive housing and hopes to fund at least three projects.

The principal amount is held in the Oregon Short Term Fund (OST) with these guiding principles in priority order — preservation of principal, liquidity and yield. Additional conditions that guide the investment include the following:

- The OST fund has to maintain an average credit quality of “double-A.”
- A maximum 50 percent of the portfolio can be in corporate (non-government agency) securities.
- A maximum of 5 percent exposure can be maintained to any commercial paper or corporate note issuer.
- All investments are U.S.-dollar denominated.

- Fifty percent of the portfolio must mature within 93 days.
- No investment may be greater than three years to maturity.

Villebois

AMH is working with private developers to integrate community housing into the new urban village community at the former Dammasch site in Wilsonville. Originally AMH expected to develop 20 to 24 projects over a 10-year period beginning in 2005. Drastic changes in the housing market and the economy have halted most development activities at Villebois. Three multi-family projects opened in 2008 and 2009. Renaissance Court opened in June 2008 and serves 20 people with mental illness. The Charleston opened in May 2009 and has 15 of the 52 units set aside for people with mental illness. The Rain Garden opened in June 2009 and provides intensive support services to 29 people with mental illness, allowing them to live independently and have a key to their own door. There are currently no AMH projects under development at Villebois, although a private developer is currently building 81 single family homes. AMH is committed to fulfilling its remaining obligations regarding community housing at Villebois and, to that end, created the Villebois Housing Investment Work Group. The work group is a diverse group of individuals representing consumers of mental health services, family members, the banking and real estate fields, affordable housing, Clackamas County and the City of Wilsonville. The work group had its first meeting in January and is charged with providing recommendations to AMH regarding the best way to meet remaining obligations for community housing development at Villebois.

Performance measures

KPM 7: The percent of children receiving mental health service suspended or expelled from school

Purpose: The overall goal of the children's mental health system is to keep children at home, in school and out of trouble with friends. This measure demonstrates the success of keeping children in school.

Target: This is a new measure and AMH wanted to establish a baseline. Based on the baseline information the target for next year will be that only 9.5 percent of the children are expelled and/or suspended.

Results: Baseline information from the past four years shows that typically 10 to 13 percent of the children in mental health services are expelled and/or suspended. This is roughly equivalent to the rate for the general school population and should be considered good.

How Oregon compares to other states: There are not any state-level or national data for children receiving mental health services to use for comparison.

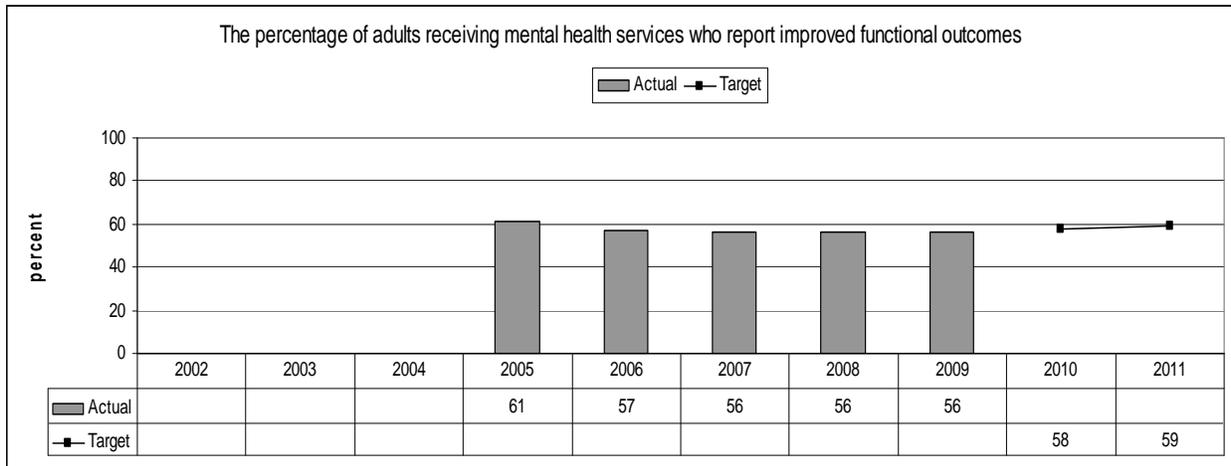
KPM 8: The percentage of adults receiving mental health services who report improved functional outcomes as a result of those services

Purpose: Functional outcomes are really outcomes that everyone wants: good relationships with family and friends, good housing, a job, etc. This measure tracks individuals' perception of whether or not they have achieved those goals.

Target: This is a new measure and AMH wanted to establish a baseline. Based on the baseline information, the target for next year will be that 58 percent of the adults experience improved outcomes.

Results: Baseline information from the past five years shows that typically 56 to 60 percent of the adults experience improved outcomes during mental health services.

How Oregon compares to other states: National statistics show that roughly 71 percent of adults experience improved outcomes. This indicates the Oregon has some work to do. A great deal of caution should be used in looking at comparative data from other states because of the variance in available services as well as the methodology for administering the survey.



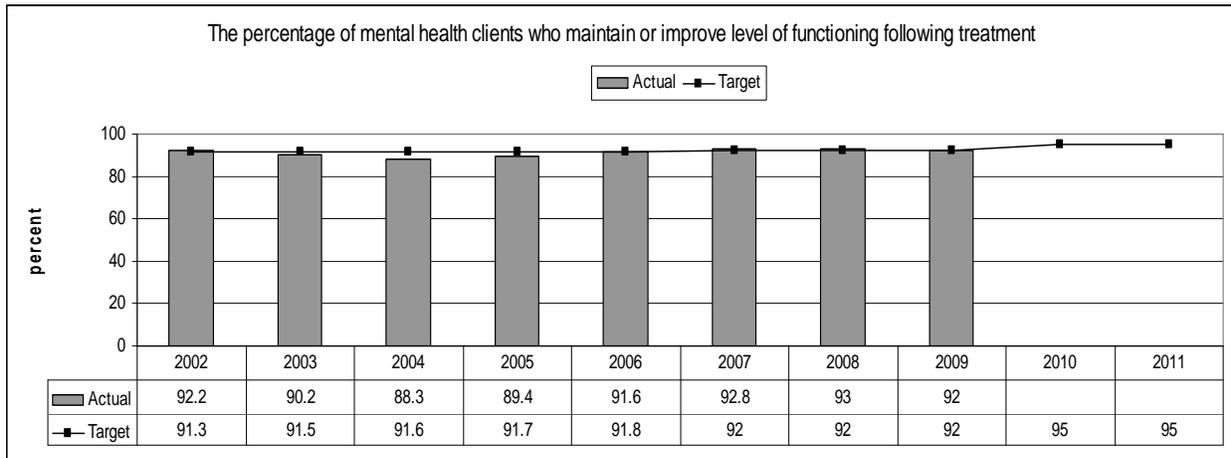
KPM 9: Mental health client level of functioning

Purpose: Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children use a similar tool called the Children’s Global Assessment Scale (CGAS). These tools are used to gather information during the initial assessment and throughout treatment. AMH is able to determine clients’ improvement over time by looking at changes to the GAF and CGAS scores. The goal is to demonstrate maintenance of functioning or improved functioning.

Target: The current target for this measure is 92 percent.

Results: In recent years the percentage of clients who maintain or improve functioning has steadily increased, although the most recent results (2009) did show a slight decline to 92 percent. This result still meets AMH’s goal. There is a concern that this tool, while in broad use, is not very sensitive to changes. AMH is exploring other ways to assess clients’ general improvement as a result of treatment.

How Oregon compares to other states: There are not any state-level or national data for comparison.



Proposed key performance measure for 2011-13

AMH proposes three new measures for inclusion as key performance measures (KPMs). The measures include the percentage of dollars spent on facility-based mental health services compared to community-based mental health services; the percentage of people with severe emotional disorders or severe mental illness served within the public mental health system; and the percentage of children demonstrating a decrease in the number of arrests in the 12 months following initiation of mental health services.

Other performance measures

Approximately 12 percent (106,124) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 5.4 percent (156,962) are estimated to have a severe mental illness.

AMH serves 31 percent of the children and adolescents and 46 percent of the adults with a severe emotional disorder or severe mental illness.

Involvement with criminal justice for both adults and adolescents is an important issue for AMH services to address. Caregivers of adolescents indicated that approximately 56 percent of the children arrested in the year prior to services were not arrested in the year after services. Adults had similar success, with approximately 54 percent indicating that they were not arrested in the year following services.

Housing is another important outcome. Of the adults needing improved or better housing, 54 percent of those receiving help found new housing. Homelessness is still a major issue for people receiving mental health services; encouragingly, 60 percent of children who began services homeless were not homeless by the end of services.

Quality and efficiency improvements

Community-based services

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

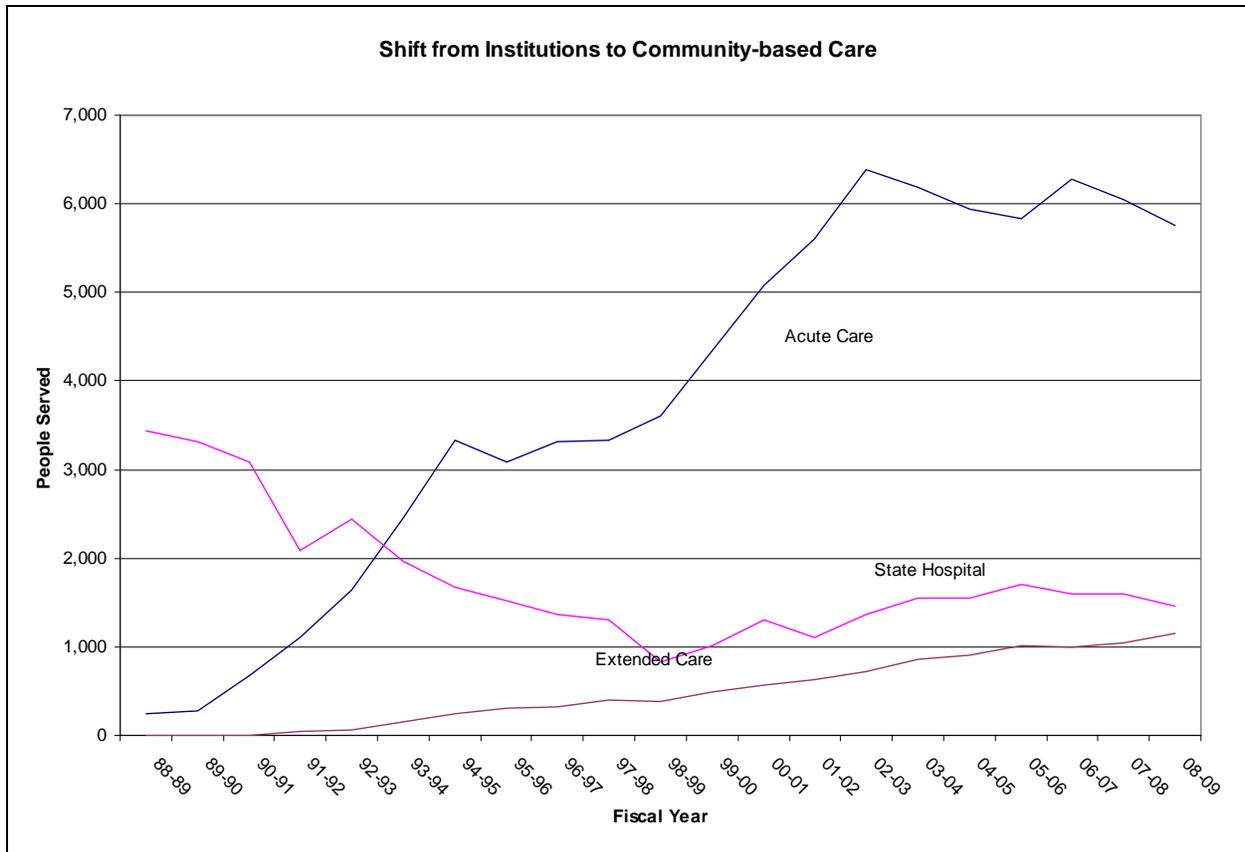
engaged in their community and, when possible, to work. Community-based services are proven to be more effective in assisting people to recover from mental illness and to live independent lives. Much of the community services created in the past 10 years have been facility-based. During the 2009-11 biennium several critical AMH Initiatives focused on creating more community-based services and moving people through facility-based services to greater independence with permanent affordable housing and the supports necessary to be successful in living more independently.

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

During 2009, 72,207 adults received treatment services in the community and 1,400 people were served in the state hospitals.

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

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



Key budget drivers and issues

As Oregon’s population grows, there will be an increase in the number of people with mental health disorders. National research that looks at the need for mental health services indicates that 156,962 Oregonians require treatment for a mental disorder. For children and adolescents, national estimates indicate that 106,124 youth require treatment for mental and emotional disorders. Public funds provided services for 72,207 adults, meeting 46 percent of the need; 33,243 children and adolescents received publicly funded services, meeting 31 percent of the need. Some of these individuals will be able to receive insurance-covered services. However, adults with major disabling mental illnesses frequently must rely on the publicly funded system.

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

Housing

A safe, affordable, alcohol- and drug-free place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in unpredictable and dangerous environments, their continued recovery is at risk. Unfortunately, most clients of Oregon's publicly funded system are in these adverse living environments.

People with mental health disorders make up a substantial proportion of people identified as homeless in the 2010 Point in Time Count: more than 3,000 people or nearly 18 percent of those identified as homeless.

Mandated treatment

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

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

Over the past year there were approximately 2,100 civilly committed people served in state hospitals or other 24-hour community settings including enhanced care, adult residential and foster care. Based on the civil commitment forecast, an increase of about 350 people is expected during the next biennium. Many of these people will need 24-hour community or state hospital services.

Since July 1, 2007, AMH has provided on-demand treatment and support services to youth who are under the jurisdiction of the Juvenile Psychiatric Security Review Board (PSRB) support. These are youth who have committed crimes and have been found responsible except for serious mental condition, and who present substantial danger to others.

The criminal commitment caseload is based on two separate categories of criminal commitments. The first group, known as "Aid and Assist," includes people mandated to OSH for assessment and treatment until they are able to assist in their defense (ORS 161.370). The second group consists of people who have been

found “guilty except for insanity” of a crime by a court (ORS 161.315). These individuals are placed under the jurisdiction of the PSRB. AMH is required by Oregon law to provide treatment and supervision for these individuals either in the community or in a state hospital (ORS 161.319 and ORS 161.327).

The PSRB caseload has been increasing steadily for many years, although there has been a modest slowing during the past two years.

Improving the community mental health system

The 2007 Legislature funded improvements in community mental health that included jail diversion, acute care, crisis services, case management services, supported employment, early psychosis projects and children’s mental health. The funding was distributed to county programs through a formula that weighed both the needs of the community, as demonstrated through prevalence of severe mental illness, and the population.

Other than the loss of \$17.8 million needed for cost-of-living increases and a \$1.0 million reduction in supported employment services, the 2009 Legislature continued funding this investment in community mental health services. The services continue to meet the increasing demand for treatment and supports in local communities.

Without continued funding at the current service levels, the following outcomes will not be replicated:

Oregon has 14 evidence-based supported employment sites across the state. From January 2008 through June 2009, 4,096 people accessed evidence-based supported employment services. For the 2009-11 biennium, 165 unduplicated people accessed evidence-based supported employment services. The 2009 Legislature reduced this funding stream by \$1 million. Without these services thousands of Oregonians will not receive the essential employment training they need to become self-sufficient citizens. This, in turn, will add to the already high unemployment numbers facing Oregon.

Oregon has three evidence-based Supported Education programs — Cascadia (Multnomah County), LifeWorks (Washington County) and Options for Southern Oregon (Josephine County). For the 2009-11 biennium, 131 unduplicated consumers with severe mental illness received supported education services. Approximately 45 percent were enrolled in an educational program (GED, adult high school or post-secondary).

The state has directly developed or made available 193 supportive housing beds since July 1, 2007. Through the Adult Mental Health Initiative (AMHI) Oregon expects to serve 160 clients through supportive housing services or rental assistance. Without these supportive housing beds, Oregonians in need of treatment will occupy more costly residential beds that will add a financial burden to the already strained residential system.

Jail diversion dollars have been distributed to 36 counties throughout Oregon. By county report, approximately 3,117 people have been served with these funds, including diversion activities preventing incarceration. Without these supports and interventions, thousands of Oregonians will enter the criminal justice system instead of receiving the needed mental health treatment.

The Avel Gordly Center for Healing provides between 550 and 600 units of culturally competent clinical service every three months to African and African-American individuals and their families.

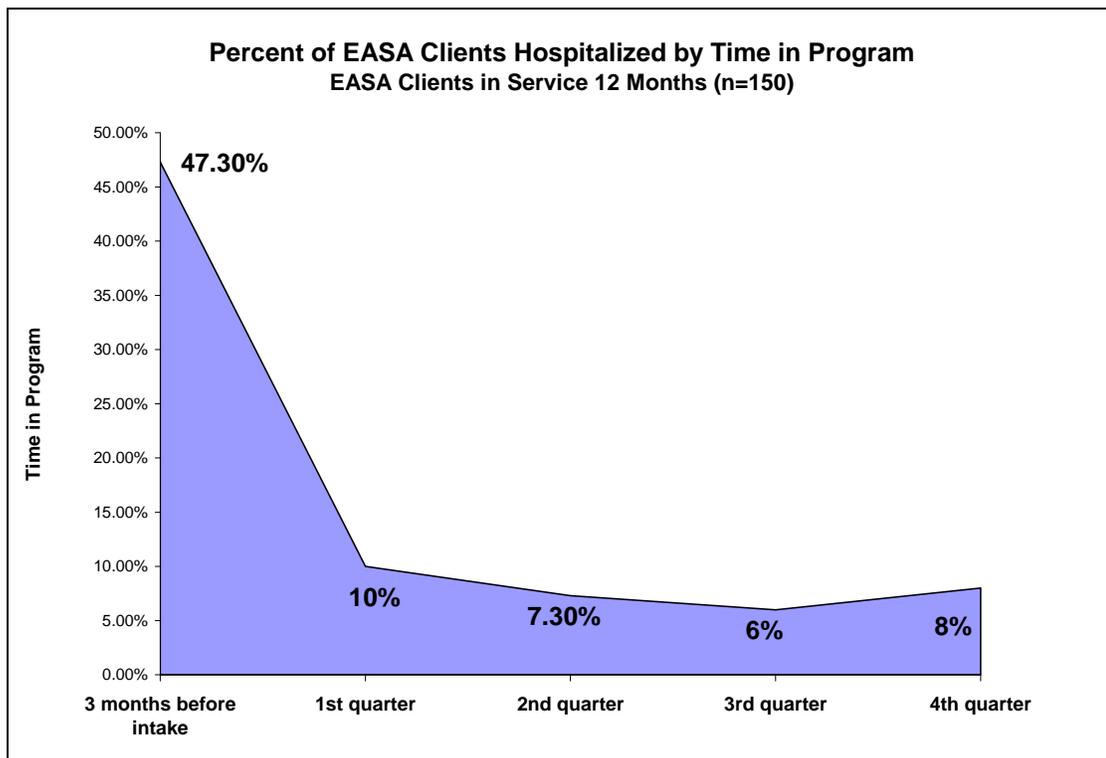
Early Assessment and Support Alliance (EASA)

EASA is modeled after a successful program implemented by Mid-Valley Behavioral Health Care Network (MVBCN), which identifies individuals in the early stages of schizophrenia and other psychotic disorders and ensures they and their families have the proper resources to effectively deal with the illness. This program greatly improves communities' education about and awareness of mental illness by using EASA as an early warning system that guides individuals to appropriate services and supports. In the long term this will have a dramatic effect on the reduced need for more institutionalized and expensive care, while promoting recovery and resiliency.

From January 2008 through to December 2010, the programs received 1,200 referrals. Of those 1,200 referrals, 425 individuals and families were accepted into ongoing services with the remaining individuals receiving case management and other services and supports. EASA services and supports include outreach and engagement; assessment and treatment using a multi-disciplinary team consisting of a psychiatrist, social worker, occupational therapist, nurse and vocational specialist; multi-family psycho-education; cognitive behavioral therapy; vocational and educational support; prescribing medication using a low-dose protocol; and support for individuals in home, community, school and work settings.

Current outcomes demonstrate that:

- Evidence-based early intervention for psychosis now exists in 16 counties (five original EAST and 11 EASA).
- EASA diverts people from the hospital. Since 2008, 47 percent of participants were hospitalized in the three months prior to beginning service. In the first three months into the program, hospitalizations are consistently reduced and continue to decrease over time. See the following graph that shows an immediate 79 percent reduction in hospitalizations.



- 28 percent of EASA clients are under age 18, the average age at intake is 20. Approximately 40 percent are enrolled as students in secondary or post-secondary settings.
- Of EASA clients age 18 and older, 19 percent were employed at intake. In the first three months of the program, this figure increased to 28 percent, reaching 33 percent by nine months. All EASA clients are encouraged and supported to identify and pursue a career.
- Once individuals are part of EASA, there is a dramatic and sustained drop in legal involvement. Of EASA clients 18 and older, 23 percent had legal involvement in the three months prior to intake, and 13 percent were arrested or incarcerated. In the first three months of service, these figures dropped to 13 percent with any legal involvement and 1.9 percent with any arrest or

incarceration during the three-month period. This reduction is sustained over time.

- 91 percent of all EASA participants maintain active family involvement in treatment.
- 63.5 percent were not planning to apply for public assistance through the disability system at 12 months; for those who need the support of the disability system, EASA approaches it as a short-term bridge to self-sufficiency.

Governor's Balanced Budget

The Governor's Balanced Budget makes modest reductions in benefits delivered by the community-based treatment systems and more substantial targeted administrative reductions in the Oregon State Hospital budget. These are in addition to the continuation of the 2009-11 reductions required to balance the budget and the lack of a cost-of-living increase.

As a result of these reductions, the state will not open two state-delivered secure residential treatment facilities. The Medicaid Personal Care 20 program will be eliminated. This program supports adults with mental illness allowing them to hire personal care providers who deliver up to 20 hours per week of assistance with activities such as shopping and cleaning and managing medications and diet. These modest supports allow people with severe persistent mental illness to live more independently.

The GBB also assumes a savings in community mental health provider administrative costs.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the US Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

The modest reductions in community mental health services allow system members to be strong participants in the transformation of the health care system anticipated by the Governor's Balanced Budget. The availability of appropriate community treatment for people with mental health disorders is critical to the success of integrated health care and long-term care. Mental health is critical to overall population health. Strong community-based mental health care integrated with health care will allow people to be served early in the course of these illnesses. The providers will contribute to health care cost containment by delivering community-based alternatives to more expensive hospital and institutional care and improving the experience of care for the consumer.

State-delivered secure residential treatment program

Facility program

The state-delivered secure residential treatment facility program was enacted through HB 5031, the DHS Operating Budget. In passing HB 5031, the 2007 Legislature approved the program authorizing AMH to operate secure residential treatment facilities.

Services provided

State-delivered secure residential treatment services provide long-term treatment for individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB) who have been deemed ready for conditional release. These individuals actively participate in an array of treatment options while under the jurisdiction of the PSRB. The PSRB closely monitors the progress these individuals make in their treatment and play a role in the evaluation process to determine when residents are ready to transition to a lower level of care.

Where service recipients are located

The program opened in Pendleton in early January 2009. Additional programs have not been sited at this time due to the economic situation and the vacancies in other facilities serving the same population.

Who receives services

Under the jurisdiction of the PSRB, services are provided to people who no longer need hospital-level care. Providing services to those under the PSRB jurisdiction in the community lowers the census at the Oregon State Hospital. There are 16 people in the first program.

Governor's Balanced Budget

The Governor's Balanced Budget continues support for the state-delivered secure residential treatment program in eastern Oregon. It does not include funding for two additional state-delivered programs. The state's efforts to more effectively use existing secure residential treatment programs should make it possible for people needing this level of care to receive it in existing facilities.

State hospital services

Mental health services for adults who need long-term psychiatric hospitalization are provided in both extended community care services and state hospitals with campuses in Salem, Portland and Pendleton. These services are essential to restoring patients to a level of functioning that allows successful community living. These services in a secure setting promote public safety by treating people who are dangerous to themselves or others, and who have committed crimes and are adjudicated guilty and insane. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of nonprofit and for-profit providers.

Oregon State Hospital (OSH)

Services provided

With campuses in Salem and Portland, the Oregon State Hospital (OSH) provides inpatient and residential services with a budgeted capacity of 641 beds and a licensed capacity of 732 beds. OSH is accredited by the Joint Commission. Patient ward 34C in geropsychiatric treatment services is certified to receive Medicaid Title XIX funding by the Centers for Medicare and Medicaid Services (CMS). OSH is part of the Oregon State Hospital System and is operated by the Oregon Health Authority (OHA) Addictions and Mental Health division.

Adult treatment services are provided in a 92-bed leased facility in Portland. This program provides hospital-level psychiatric services for 92 adult patients with major psychiatric illnesses who are age 18-65 years. Patients treated in this program are unable to be treated in a less structured environment; they are civilly committed and assigned to hospital-level care. This program provides intermediate and long-term state hospital treatment for patients transferred from community acute care hospitals.

Neuro/medical services are provided in 114 beds in four units of specialized active inpatient treatment for elderly persons with mental illness and a specialty unit for

neurologically impaired patients of all ages. Five beds providing acute nursing care for patients suffering from medical conditions are included on one of the geropsychiatric wards. Inpatient services are available to older adults who have major psychiatric disorders and adults over age 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive nursing home environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical/surgical hospital.

Forensic psychiatric services provides hospital treatment services to patients committed by the courts for evaluation or treatment to be able to aid and assist in their own trials or to the jurisdiction of the PRSB under the “guilty except for insanity” adjudications. These services consist of 399 hospital-level beds on 11 treatment units. A full array of treatment services is offered in maximum and medium security levels. In addition, this program provides services for some civilly committed patients who are either too dangerous or too difficult to manage in the less restrictive and secure environment of a general adult hospital program. Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors.

Forensic residential transitional services provide treatment for 36 patients in six cottages. These are transitional units providing treatment to patients under the PSRB who have shown substantial improvement in their conditions and who require a less restrictive environment in preparation for placement in a community setting.

Where service recipients are located

Clients residing at OSH are admitted from all areas of the state.

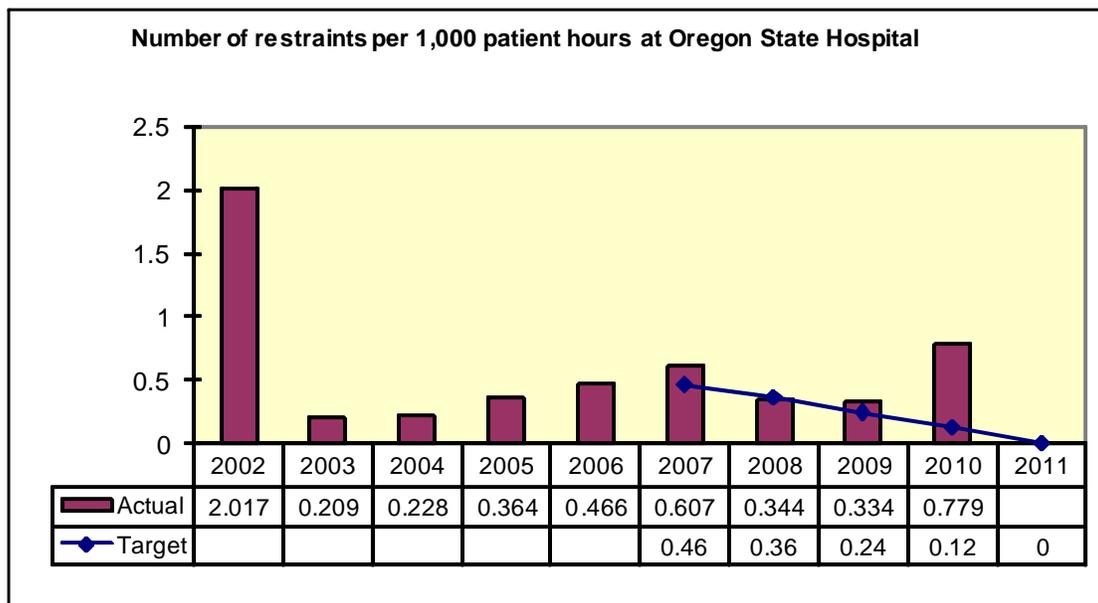
KPM 11: Number of restraints per 1,000 patient hours at Oregon State Hospital

Purpose: The goal is to reduce and eventually eliminate the use of emergency restraint. All employees are trained in a technique known as ProACT to help implement this goal. ProACT teaches staff to use the least restrictive approaches to controlling aggression, including early intervention to prevent the escalation of aggressive behavior

Target: The long-term hospital goal is to not use restraints in our care of patients.

Results: OSH saw a significant increase in the use of restraint during 2010. Specific attention has been placed on patients who frequently experience restraints with an emphasis on developing alternative options for both the patient and staff. The Seclusion and Restraint Committee makes use of data to target the appropriate patients and units and has brought in national experts to help the reduction effort. During the second half of 2010, some success was achieved through these efforts and a downward trend was seen.

How Oregon compares to other states: Based on monthly data collected through the National Research Institute of the National Association of State Mental Health Program Directors, OSH's restraint rate has been above the national rate. National comparisons are difficult because of the variability (size and function) in hospitals across the states.



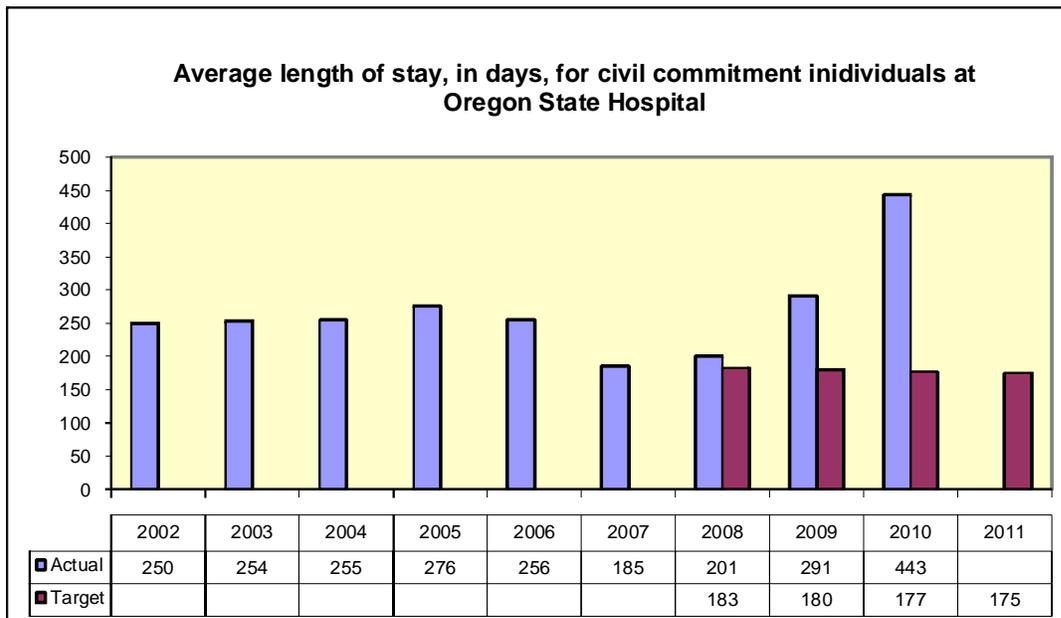
KPM 12: Average length of stay, in days, for civil commitments at Oregon State Hospital

Purpose: The goal is to reduce the projected length of stay for individuals at OSH and ensure they are at the most appropriate level of care. Decreasing the length of stay will allow the hospital to better achieve census goals, particularly as the hospital transitions to the new facility.

Target: The current target for this measure is 177 days.

Results: OSH did not achieve the target for 2009 or 2010. Length of stay, based on patient's discharged, actually rose significantly during this period. The rise is due to the extraordinary efforts of hospital and community staff in finding appropriate housing for patients who — due to being medically compromised, especially aggressive, or a sex offender — were difficult to place in the community and thus spent significant time at OSH.

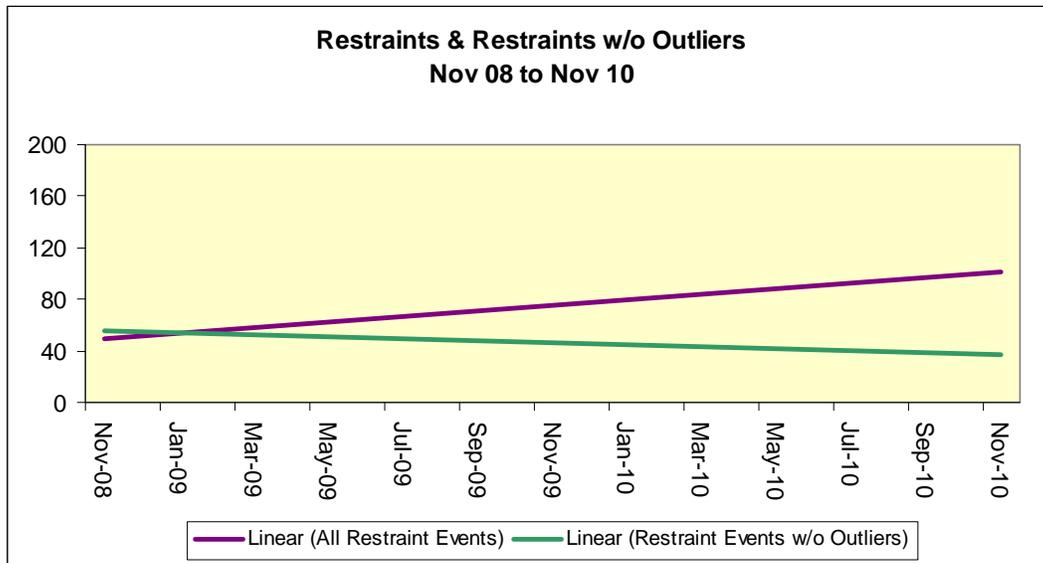
How Oregon compares to other states: While there is national data for lengths of stay, it would not be good to compare because of the varying nature and population at other state hospitals.



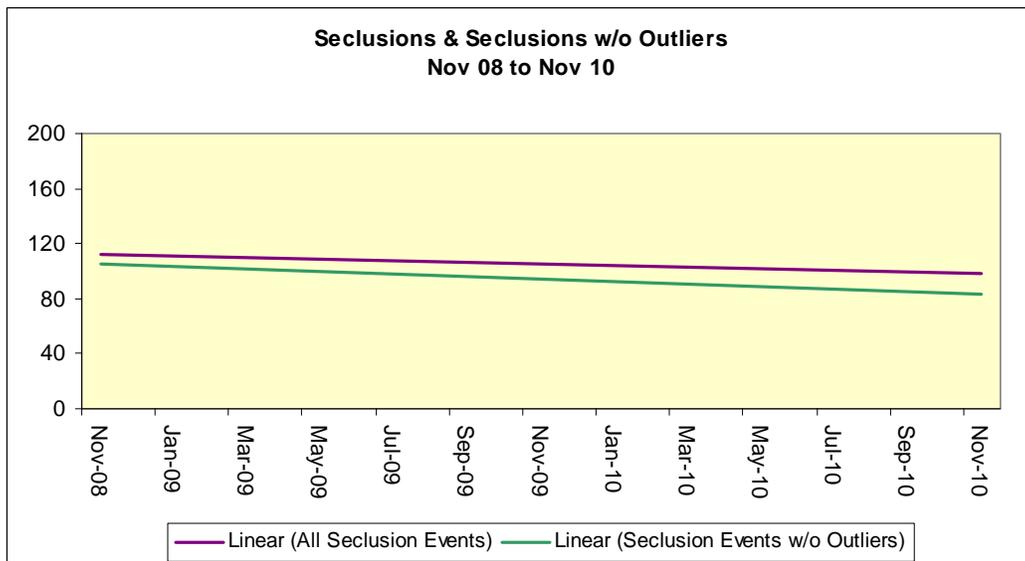
Additional information regarding restraint use and seclusions

As required by the Joint Commission, OSH submits data on restraints and seclusion to the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. OSH data, along with data from hospitals around the country, are analyzed and reported back to OSH, resulting in a delay in the publishing of recent OSH results.

Overall restraint use has increased at OSH, heavily affected by a small number of patients with difficult-to-manage behavior. When these patients (outliers) are removed from the data, it shows that restraint use has been on a steady decline throughout the rest of the hospital.



The use of seclusion has held steady at OSH with the most significant change seen in the rate of use in the outlier category of patients. Through the extensive efforts of staff and the counsel of a national expert, strides have been made to reduce the use of seclusion in this difficult patient population.



Quality and efficiency improvements

OSH compliance with oversight agencies

OSH completed a Continuous Improvement Plan (CIP) in January 2008 that had been drafted in late 2006 and revised following the November 2006 review by the U.S. Department of Justice (US DOJ). The hospital's CIP, a multi-year effort, is guiding improvements in the following areas:

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

A team of two CMS surveyors made an unannounced visit to OSH June 16-18, 2008, to follow up on CMS surveys conducted in February and April 2008. The survey team found that patient ward 34C was acceptable for certification.

The Joint Commission conducted its full and unannounced survey in February 2009. The survey team requested Requirements for Improvement that were all subsequently met and full accreditation was granted retroactive to February 2009. The hospital's clinical laboratory was also surveyed and granted full accreditation.

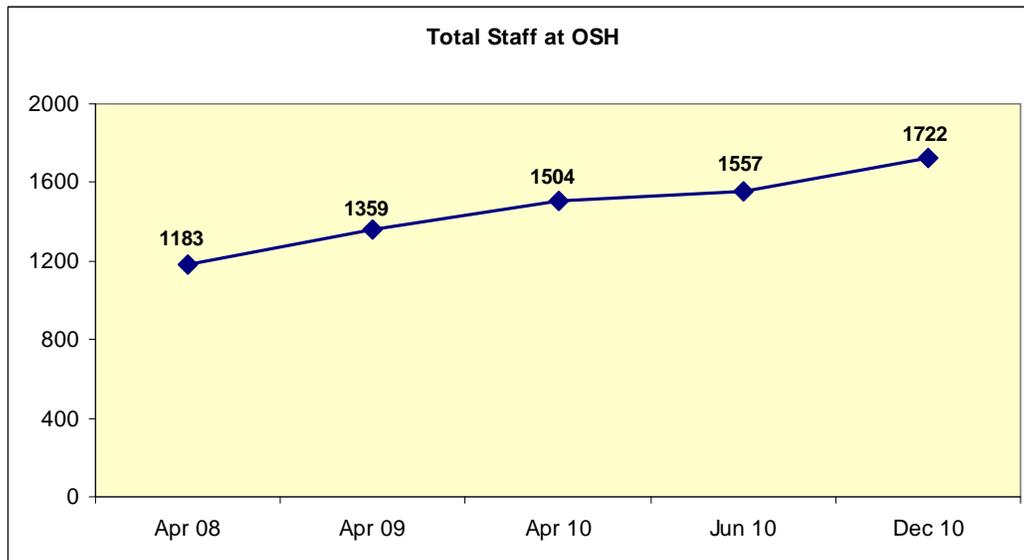
Currently, the hospital is preparing for its upcoming Periodic Performance Review with the Joint Commission.

Improved incident reporting system

OSH has improved procedures for completing and submitting incident reports. Incidents are reported daily and follow-up, when necessary, can happen immediately. The Critical Incident Review Panel meets regularly and in a timely manner to ensure incident reports and corrective actions are comprehensive and appropriate. Corrective actions have included modification in patient behavioral plans, medication regimens and supervision, as well as enhancements to physical characteristics of select areas of the hospital. The Critical Incident Review Panel is educating staff about incident trends as well as evaluating whether reviewed corrective actions have been effective in reducing the number of hospital incidents, both on an individual patient and system-wide basis.

Staff additions at OSH

OSH continues to advertise, recruit and qualify candidates for certain key positions such as registered nurses, physicians and pharmacists. Nearly all administrative positions at the hospital have been frozen.



In 2009, the hospital's policy option package was funded with 527 new positions. Since OSH received the appropriation, 355 positions have been filled. Of the remaining 172 vacancies, 161 are frozen in order to address reclassification of revised positions to better meet hospital need since the original request; 11 are frozen due to the general hiring freeze.

Response to Office of Investigations and Training (OIT) report

In response to a report issued by the Office of Investigations and Training that investigated an October 2009 patient death, OSH created a comprehensive follow-up action plan. A number of improvements were made including the revising of the Continuous Rounds Policy to monitor patients; establishment of morning report for all patient units to improve communications among staff; hiring of 22 Treatment Care Plan Specialists (TCPS), with plans to hire an additional seven, to facilitate Interdisciplinary Treatment Teams (IDTs); auditing of all patient records to determine if patient's medical care issues are being actively addressed (initial audit showed 91 percent compliance); revision of frequency of documentation standards and establishment of required elements of documentation; revision of the Communication with Patient's Family policy and the Interpreter Services policy.

Improved patient assessment compliance

Patient assessments are critical to effective mental health treatment. At the time of admission, clinical disciplines conduct assessments of all patients. Within the first 10 days of admission, the following assessments are completed — a psychiatric admission note and history (psychiatric), a medical history and physical exam (nurse practitioner), a comprehensive nursing assessment (registered nurse), a psychosocial history (social worker), a rehabilitation services assessment (rehabilitation therapist), a patient education assessment (assigned staff), and any psychological testing ordered by the physician (psychologist).

Completion rates for all assessments are tracked by the Quality Improvement Department. In 2010, the completion rate was 90.5 percent as compared to 93.3 in 2009 and 91.2 in 2008.

Increased use of behavioral support plans

The OSH Continuous Improvement Plan included as a high priority the development of behavioral support plans for identified patients. Behavioral support plans (BSPs) provide specific treatment strategies for patients whose behavior is difficult to manage. Use of BSPs is expected to contribute to a decrease in aggressive acts by patients and the use of restraints and seclusion. The initial focus was on patients within the geropsychiatric treatment services program on the Salem campus, and the four units on the Portland campus. The focus was expanded to include patients in the forensic psychiatric services program. During 2010, BSP have assisted 48 patients to be discharged from OSH.

Improved master treatment care plans

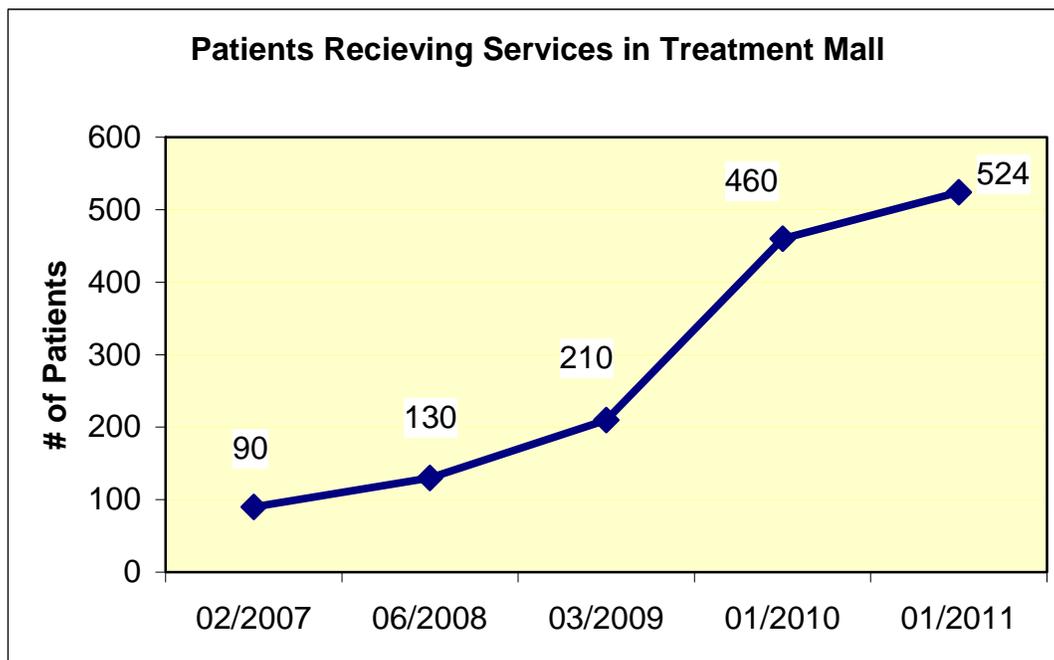
OSH provides recovery and rehabilitation to the patients it serves through active treatment. Central to effective treatment is patient care planning. With input from two nationally recognized consultants, changes have been made to the functioning of treatment teams, and to the form and content of treatment care plans.

A new electronic Master Treatment Care Plan format was piloted in geropsychiatric treatment services in November 2009. The revised format ensures that care is patient-centered, individualized and responsive to patient needs. As a result of these positive outcomes, it was decided to implement the new format hospital-wide. Implementation dates occur as wards are assigned employees in their newly created treatment care plan specialist (TCPS) positions. The TCPS coordinates the functioning of the Interdisciplinary treatment team, ensures the team meets regularly, has pertinent patient information, and communicates with treatment staff to ensure continuity of care.

The new Master Treatment Care Plan has been implemented in all areas where TCPSs are on board and ready to use the system. As more treatment care plan specialists are hired, the new format will be implemented in the remaining six units.

Centralized treatment malls

A fundamental element of the hospital's Continuous Improvement Plan is delivering centralized services at treatment malls. Four treatment malls now provide active treatment to a majority of OSH patients. The chart below shows the steady increase in the number of patients served.

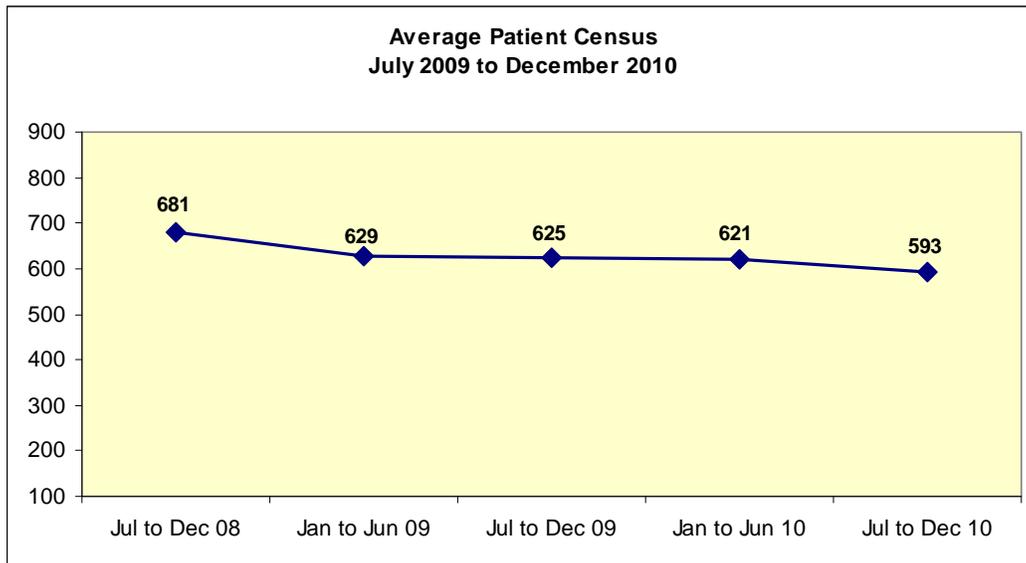


- Portland Mall opened February 2007
- Geriatric Mall opened June 2008
- Transition Mall opened March 2009
- Forensic Mall opened January 2010
- Harbors Mall opened January 2011

Patient census

During the past 30 months, OSH has experienced a 13 percent decrease in patient census due to multiple factors. Improved discharge planning at OSH, the implementation of a Peer Bridger Program, participation in a Transformation Initiative O1 to Transition Patients, and increased cooperation with the Blue Mountain Recovery Center, the Psychiatric Security Review Board and community

partners have all contributed to reduced patient census. There remains a group of patients whose histories and complex needs are a challenge for timely discharge. During this period of decreased census, the number of patients waiting for admission has remained low.



Transformation Initiative

In collaboration with the DHS Transformation Initiative, hospital staff have undertaken five rapid process improvements (RPIs). An RPI is a multi-day focused effort that brings together multiple disciplines and stakeholders to map out a current work process, eliminate waste and build a new streamlined process. Four of the RPIs have focused on process improvements and one on quality improvements.

Process improvements

OSH is using rapid process improvement events and Lean principles to improve existing processes and streamline processes as part of the planning to move into the new facility. The work design has resulted in dramatic improvements in the process for hiring RNs, physician billing for Medicare covered services, the documentation of group treatment in the treatment malls and, most recently, the hiring of direct care certified nursing assistants.

The RN hiring and the certified nursing assistant hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates by improving the hiring processes. Since the RN hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA hiring rapid process improvement event

was launched in May 2010. A streamlined hiring process was used to meet the goal of filling 85 vacant CNA positions by August 2010, three months ahead of schedule. During May through October 2010, the streamlined hiring process resulted in 139 hires.

The group documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation processes into one streamlined process and format that is now used across clinical disciplines.

The MD billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

Quality improvements

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients, made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their dietary consultation process improvement efforts in 2008; dieticians are completing twice as many consultations every month and people receive their dietary consultations 90 percent more quickly than before the process improvement efforts.

Key budget drivers and issues

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

Governor's Balanced Budget

The Governor's Balanced Budget assumes substantial reductions through reduced administrative costs and increased efficiencies in the OSH budget. OSH continues working to improve accountability and efficiency in all areas of hospital operations. The hospital is prepared to make additional changes to operate within the budget available for 2011-13.

There is one aspect of the GBB that is a major challenge, jeopardizing hospital operations. The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of the Oregon State Hospital would be staffed at levels acceptable to the US Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

Blue Mountain Recovery Center (BMRC)

Services provided

Blue Mountain Recovery Center (BMRC) in Pendleton, formerly known as the Eastern Oregon Psychiatric Center (EOPC), is an inpatient adult psychiatric hospital built in 1948. Clients reside on two 30-bed units and attend groups and activities throughout the facility. BMRC is part of the Oregon State Hospital System and is operated by the OHA Addictions and Mental Health division.

Specific services provided by BMRC include: medication management, evidence-based educational classes, life skills training, vocational services, physical and recreational activities, alcohol and drug counseling, individual cognitive-behavioral therapy and spiritual counseling. Transition services are provided to prepare clients for successful discharge into community-based services. Medical services are provided by contract physicians and local community hospitals.

Where service recipients are located

Clients residing at BMRC are admitted from all areas of the state.

Who receives services

BMRC provides long-term treatment for civilly committed clients who, due to a mental disorder, are deemed dangerous to themselves or others, or are unable to care for themselves. These individuals actively participate in an array of treatment options at BMRC until they are able to manage their psychiatric symptoms and maintain their mental health in community settings. In addition, BMRC provides care and treatment for a small number of forensic clients who have close family ties in eastern Oregon.

How services are delivered

BMRC embraces the recovery model, which supports clients learning to live well with the least amount of professional intervention. Dedicated physicians, nurses, therapists and other staff members at BMRC help clients start their road to recovery from acute exacerbations of psychiatric illness. The goal is to return clients to the fullest possible participation in their families, jobs and community as quickly as possible. Clients learn how to take charge of their lives by managing emotions across settings, staying out of conflicts, using medications wisely, and avoiding drugs and alcohol. This delivery system is in direct alignment with all of the OHA goals for Oregonians, of which BMRC clients are a distinct subset.

Why these services are significant to Oregonians

One of the primary functions of BMRC is to ensure that individuals with psychiatric disabilities are kept safe until they are able to manage their symptoms and behaviors in a community setting. Another primary function is to ensure public safety through secure, intensive treatment of clients while they regain psychiatric stability.

Since the beginning of 2008, BMRC has averaged 145 admissions and discharges per year. This represents more than 18,000 inpatient days per year, a figure that cannot easily be absorbed by existing facilities in the community, or by the other two state hospital campuses.

Furthermore, BMRC is the primary state hospital resource for central and eastern Oregon. Clients from St. Charles Bend are given preferential admission in order to maintain open acute psychiatric beds in the region.

One of the desired outcomes of the use of evidence-based practices is that funded programs “improve the mental health of a person with the result of reducing the likelihood that the person will commit a crime or need emergency mental health

services.” BMRC provides vital psychiatric services that achieve that very outcome. The BMRC current treatment model has resulted in fewer 30-day readmission rates, longer stays in the community between hospital readmissions, shorter stays in the hospital and, overall, a better quality of life for one of Oregon’s most vulnerable populations, persons with psychiatric disabilities.

Governor’s Balanced Budget

The Governor’s Balanced Budget assumes modest administrative efficiencies in the BMRC budget. The operation of BMRC also will be affected if funding is not available to implement BHIP, which is scheduled to provide electronic medical records for the hospital.

Oregon State Hospital Replacement Project

History

Oregon has been in critical need of a new hospital for its citizens with mental illness. The Oregon State Hospital (OSH) is one of the oldest, continuously used mental health hospitals on the West Coast. It also had the dubious distinction of being one of most decrepit mental health facilities in the nation. More than 40 percent of the building space was unusable, with water leaks from roofs, crumbling walls, and the toxic hazards posed by the presence of asbestos and lead.

For decades, state lawmakers heard from patients, advocates, citizens and staff about the inadequacy of the state hospital. In addition, the state has faced several challenges including legal suits over a variety of hospital deficiencies. The Governor, Oregon Legislature and DHS/OHA have collectively acknowledged the critical need for new mental health facilities.

During 2003 the Governor established, by executive order, a 21-member Mental Health Task Force to identify key problems in the state’s mental health system and recommend improvements. The task force report released in 2004 recommended changes to OSH.

Ongoing concern about the hospital prompted the November 2004 Legislative Emergency Board to allocate funds to DHS for an independent examination of the mental health system with a specific focus on OSH.

With those funds, the Governor and Legislature commissioned KMD Architects, a firm with more than 40 years’ experience in 15 states, to begin preparing a master plan for replacing OSH.

The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues, including a potential that the “J” Building complex on the Salem campus would collapse in an earthquake. In addition, the Phase I Master Plan notes that the existing facilities on this campus have physical limitations that could not be remediated to provide safe and secure treatment environments. Along with these issues, the 92-bed Portland campus lease ends in March 2015, requiring the relocation of the 92 patients housed there. The Phase II Report on the Framework Master Plan was released on March 1, 2006. That report provided the Governor and legislative leadership with three options to consider for replacing OSH. The leadership provided direction to DHS to proceed using the configuration listed in the document as “Option 2”: one 620-bed facility located in the North Willamette Valley, one 360-bed facility located south of Linn County on the west side of the Cascades, plus two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

Based on recommendations from a Joint Legislative and Executive Branch Task Force, the 2007 Oregon Legislature authorized Certificate of Participation (COP) financing estimated at \$458.1 million to build two new state-operated psychiatric facilities. The first Salem hospital residential units opened in January 2011. The Salem hospital will be completed in December 2011 and the Junction City facility is scheduled to be completed the end of 2013. They will be structured, along with a strengthened community mental health system, to support healing, recovery and a return to successful community living.

As the project moves forward, the replacement team continues to look for opportunities to improve patient care and reduce state costs. Based on a recent analysis of need for hospital level of care and changes in discharge practice, OHA leadership recommended a reduction in the size of the Junction City hospital from 360 to 174 beds.

Although the current state hospital was inadequate for long-term, continued use for the care and treatment of those with mental illness, the OSH Salem campus was selected as the best site for construction of the new 620-bed facility. Using legislatively mandated selection criteria developed with public input, this site scored highest among those considered. The Salem site maximizes opportunities to attract and retain quality professional staff and places 55 percent of patients reasonably close to their home communities. In addition, the larger Salem community is accustomed to having a large psychiatric hospital on this site and is generally supportive of the hospital being there.

Historic preservation

OHA is committed to protecting and preserving valued historic and cultural resources while investing and growing a mental health system of care to serve Oregonians now and in the future. Using the current OSH site provided an optimal opportunity to include historic buildings and structures in the design of the new facility and to include an above-ground memorial for cremains as well as a museum for the history of the West Coast's oldest, continually operating psychiatric hospital.

Status

To date, the hospital replacement team has enlisted expertise from renowned architectural, construction and engineering firms, including numerous subcontractors. These construction experts are working together to find ways to keep the project on time, address budget issues and deliver the best mental health facility for Oregonians. To date, the project has opened the new kitchen, central plant, warehouse, vocational rehabilitation center, first residential units and mall, and the new administration offices in the Kirkbride building.

The building of replacement hospital facilities in Salem and Junction City, repurposing of facilities on the present OSH campus and planning for the transition to the new facilities is in process and on target to be completed at the end of 2013.

Centralized treatment model

OHA has adopted a centralized services model with "neighborhood" and "downtown" treatment concepts, within a secure perimeter, for the new facility. This model supports providing comprehensive and consistent therapeutic opportunities to all patients. In keeping with the recovery model for mental health, the design for the new facility and its campus was driven by programming needs to ensure a patient-first, patient-driven and patient-focused mental health system. With this model, patients live on a unit but receive their treatment and meals and attend activities or classes elsewhere in the facility away from the unit.

The new design requires patients to participate in their treatment and function during the day in a manner similar to that of daily life outside the hospital. The "downtown" includes large and small group activity rooms, a gymnasium, fitness center, library with required legal materials, nutrition center, classrooms, and music and art therapy rooms.

Because patients do not have access to bedrooms, TV rooms and other non-treatment rooms and activities during treatment hours, patients are motivated to

engage in treatment. The idea is to provide a place adjacent to the residential areas where a larger number of patients can go each day to participate in treatment programs. The new facilities are designed with smaller areas for treatment so clinicians will have a manageable number of patients at any one time. The new hospital design also includes better security, more secure open space, one- and two-patient rooms, more quiet space, more light in patient rooms, and modern heating and air conditioning.

Behavioral Health Integration Project

In addition to the facilities replacement needs, the current OSH has antiquated technology for collecting information, referred to as the Oregon Patient/Resident Care System (OP/RCS), as well as a reliance on paper charts that no longer meet the business needs of the hospital. Dependence on these obsolete systems presents considerable risks in relation to licensing and patient care. The Joint Commission (TJC) has cited the information system as a major deficit jeopardizing future accreditations, which are a severe financial risk to OHA and a health risk to the state's mental health service recipients. The US Department of Justice (US DOJ) Civil Rights Division submitted a report in January 2008 for an investigation conducted in 2006 under the Civil Rights of Institutionalized Persons Act (CRIPA). This report stated that OSH's ability to address patient safety is hampered by inadequate incident management and quality assurance systems. In order to support integrated treatment for clients, there is a need for a data system that can share client information throughout the system of care.

The Behavioral Health Integration Project (BHIP) is a subset of the overall OSH Replacement Project with a business goal of improving the ability to document services provided to individuals in the Oregon State Hospital, increase time spent by hospital personnel in treatment activities, and improve the ability of the state to report accurate and timely information to a variety of funding sources. BHIP has identified a vendor for a commercial off-the-shelf (COTS) product and is currently working to implement the new system, ensuring that it meets the needs of the Oregon State Hospital System and the individuals served. The system is currently scheduled to go-live in spring 2011.

Challenges

There are a number of cost drivers that may affect the financial bottom line of this project. Examples of these are found in the US DOJ report from January 2008, which identified the need for improvements in the facilities, treatment plan and record keeping. As reported previously to the Joint Ways and Means Committee,

an important aspect of the new hospital facilities is the additional 200,000 square feet of treatment spaces on the Salem campus and 100,000 square feet at the Junction City campus that will be needed to provide the minimum of 20 hours per week of patient treatment activities, as well as accommodate the additional staffing needs. The minimum standard of 20 hours of active patient treatment has become the accepted measure for modern psychiatric facilities, and is set forth in the hospital's continuous improvement plan. This will be a critical part of the improved care for patients and will create a climate of recovery and provide patients the needed skills to make successful transitions back to their own communities. Various experts agreed that the only way to ensure the number of treatment hours expected in industry standards was by using a centralized treatment model.

In addition to the increased space, the project has other requirements such as the Center to State Street connector road, historic district requirements, significant site improvements and energy costs. The Junction City site must meet the requirement of the solar energy bill (ORS 279C.527 to 279C.528) that adds costs not included in the original budget approved by the Legislature.

A final cost driver comes as a direction from the Legislature to absorb the cost of furniture, fixtures and equipment (FF&E) into the budget. The rough estimate in 2007 for FF&E was \$10.5 million — \$7.5 for Salem and \$3 million for Junction City.

The US DOJ report also identified the need for adequate tracking of patient treatment plans, medication management and connection of various data collection methods throughout the hospital. The project includes the design of a new OSH computer system that will address data management, risk management, training, quality management, and maintenance and support issues, as well as treatment plans and medication management.

In addition to challenges presented by these and other cost drivers, the success of the replacement treatment facilities is dependent on significant investments in the entire mental health service system. These investments must continue to build the community system that prevents individuals from needing hospital-level services. It also must build capacity to help patients transition successfully back to the community. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of nonprofit and for-profit providers.

Funding

The 2007 Legislature passed SB 5504 and HB 5006, which provided the budgetary authority of \$458.1 million for DHS to proceed with construction of facilities in Salem and Junction City to replace the existing OSH.

Construction of the two new facilities will continue to be financed with certificates of participation (COP) requiring accurate and specific recording and accountability for expenditures of COP proceeds. COPs are a principal means of financing government projects and are used for many state facilities that are expected to have 40 to 60 years of useful service.

The project has been working diligently to mitigate the various programming and site impacts listed above. From the first evaluation it was clear that these additional needs had the potential to add over \$150 million in additional project costs to Salem alone. Through aggressive management of all areas from design to individual subcontractor selection we have been able to reduce this to a request for an increase of \$66 million in COP sales for the project as a whole. We continue to work on this issue and believe through construction savings and reduction of the facility's size we will be able to reduce this by several million dollars.

Actual operating costs will depend on many factors including legislative decisions about staffing, salaries, wages and community supports that relieve pressure on the facilities. Additional pressures on operating costs could come in the form of rising fuel and utility costs and a possible increase in the number of forensic commitments.

Opportunities

Junction City

Both DOC and OHA are on time and proceeding with the legislatively approved projects related to the Junction City site, where corrections facilities and the psychiatric hospital will be co-located. One of the directions DOC and OHA received from the Legislature was to maximize the benefits of a collaborative partnership in developing this site. By building the OHA hospital and the DOC minimum and medium security facilities on the same site, there are potential efficiencies and savings associated with the infrastructure. There also is the ability for DOC to provide laundry services for both their facilities and OSH. In addition, it is possible for both facilities to share one warehouse rather than building redundant facilities. DOC and OHA estimate the joint savings of a single site development at

approximately \$20-\$25 million. These savings will be challenged should either project be delayed.

Reusable materials

In recent months OSH staff have found many reusable materials from previous construction and maintenance projects that are being transferred to the general contractor for use on the replacement project. This has resulted in a cost reduction for the project of more than \$100,000. Examples of such items include fencing materials, electrical wire, drainpipe and electric gates.

BHIP

BHIP is approved as part of the COP funding at \$27.9 million. However, the project is looking for ways to implement BHIP for \$25.9 million at the direction of the Legislature. Unless needed by BHIP, the \$2 million savings will be used to help address the budget challenges facing the construction budget.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of the Oregon State Hospital would be staffed at levels acceptable to the US Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

Value engineering study

Draft value engineering studies were conducted in August 2008 for Salem and July 2010 for Junction City in which the project team, with assistance from the consultants, analyzed all aspects of the design of the facilities to ensure that no critical features were missed and to identify opportunities to reduce construction costs and improve operational efficiencies. Opportunities identified from the Salem value engineering have been incorporated where feasible. The results of the Junction City value engineering study are being analyzed, and opportunities for reductions and improvements will be incorporated into the project.

Summary

Replacing the Oregon State Hospital is critical to growing a mental health system of care, which was a priority of Governor Kulongoski during his eight years in office. By integrating the new facility in Salem with most of the historic buildings within the district and restoring and putting the Kirkbride U into full use again, OHA creates a project that will meet its state mandate to build a hospital on the existing OSH Salem site while creating a project that protects the historic significance of the site. The agency will also continue to develop the Junction City campus as mandated, working with DOC to maximize all co-location efficiencies. At the same time, information technology is critical to the operation of a modern, accredited and certified state hospital. The Behavioral Health Integration Project will also ensure patient safety and quality of care by bringing a modern information system to the hospital.

Program administration and support

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

AMH program administration and support (PAS) is responsible for:

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

PAS staff share responsibility with the counties for developing and managing community programs as part of the overall state mental health and addictions system. If a county is unable to operate a program area, AMH is responsible for

contracting for services directly with providers. PAS is responsible for protecting the safety of clients and ensuring quality of care.

PAS ensures the efficient and effective functioning of the program office and the necessary supports to the program and policy staff. AMH central administration staff work closely with the department budget staff and contract administration staff to ensure sound financial management of the addictions and mental health services community and state hospital program budgets, and the appropriate implementation of community treatment programs through contractual relationships.

PAS is composed of four policy sections — alcohol and drug prevention, alcohol and drug treatment, problem gambling prevention and treatment, and community mental health.

This is accomplished through:

- Program development;
- Administrative rules development;
- Planning and policy development;
- Coordinating policy and contracts for all Medicaid-covered services, including the Oregon Health Plan, for mental health and addictions services;
- Strengthening coordination between the state hospitals and the community mental health programs to ensure appropriate admission to and timely discharge from the hospitals;
- Conducting site reviews;
- Conducting licensing and certification inspections;
- Providing training and technical assistance;
- Providing administrative oversight;
- Overseeing quality improvement;
- Developing program management data;
- Conducting research on effective programs and measuring outcomes;
- Providing technical assistance to community programs;
- Implementing evidence-based practices as required by ORS 182.525;
- Managing development of alcohol- and drug-free community housing for individuals with addiction disorders and those with mental illness; and
- Collaborating with state and local partners to reduce and end homelessness.

Alcohol and drug prevention

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based and statewide alcohol

and drug prevention programs. These programs work closely with local partners including the state and local Commissions on Children and Families, and the tribes.

Alcohol and drug treatment

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based alcohol and drug treatment system providing services in all Oregon counties and to the tribes.

Problem gambling prevention and treatment

This unit within the alcohol and drug treatment section is responsible for setting policy and developing programs that prevent problem gambling in Oregon and overseeing the service delivery system for the treatment of problem gambling.

Community mental health

This section of PAS provides oversight, policy direction, program development and technical assistance to the community mental health system for both adults and children. Specific units within this section include the:

- Adult mental health services unit ensures linkages between the state hospitals and communities;
- Residential programs and services unit is responsible for the development of new community-based resources to treat adults who are ready to be discharged into the community;
- Children's treatment system provides oversight, development, training and technical assistance to the community-based system to maximize the effective treatment of children in their home communities.

Four units support all of the program areas:

- The mental health and substance abuse Medicaid policy staff members ensure appropriate policy considerations in rate setting for managed care, contract for managed mental health services, and monitor federal Medicaid and Medicare policy affecting services to people with mental health and substance abuse problems;
- Program analysis and evaluation staff are responsible for the extraction and analysis of data to support program decision making, meet federal and state reporting requirements, develop performance measures and answer legislative questions;

-
- Quality improvement and certification staff are responsible for reviewing a full range of community programs to ensure that state-funded services are delivered in a safe and effective manner. Staff license 356 and certify 665 programs;
 - Operations and contract administration staff are responsible for contract implementation, development of administrative rules, standardized policies and procedures, community work force training and secretarial support for the policy and program staff.

Continuous Improvement Initiative

AMH has integrated the tools, skills learned and resources available as a result of the Transformation Initiative to manage nine active initiatives and one cross-divisional initiative. These tools also are used to manage 12 key strategic initiatives that will drive system improvement and are in response to legislative direction. The implementation of the Lean Daily Management System throughout the office has empowered staff to resolve process problems, streamline and improve the quality of work. Staff are building new skills and finding more efficient and effective ways to do critical work in times of scarce resources that require holding positions vacant and reprioritizing and shifting critical work functions to remaining staff.

Transformation Initiatives

O1 — Transitioning people

Staff members in the AMH central office and at OSH worked with key community stakeholders to develop and implement improved methods for timely transition of people from the state hospital into community-based treatment. The goal is to provide access to the right type of services in the most appropriate environment, for the right amount of time. The work has resulted in the use of standardized tools for decision making, agreed-upon criteria for when an individual is ready for discharge from the state hospital, and full implementation of a co-Management plan that holds counties accountable for timely discharge of their members from the hospital. The initiative has resulted in improved communication regarding available community resources. The work started in late 2009 and continued through the winter and spring of 2010 with full implementation in September 2010.

O3 — OSH process improvement

OSH is using rapid process improvement events and Lean principles to improve existing processes and streamline process as part of the planning to move into the new facility. The work has resulted in dramatic improvements in the process for hiring RNs, physician billing for Medicare covered services, the documentation of

group treatment in the treatment malls, and most recently the hiring of direct care certified nursing assistants.

The RN hiring and the certified nursing assistant hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates by improving the hiring processes. Since the RN hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA hiring rapid process improvement event was launched in May 2010. A streamlined hiring process was used to meet the goal of filling 85 vacant CNA positions by August 2010, three months ahead of schedule. The streamlined hiring process has already resulted in 139 hires from May through October 2010.

The group documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation processes into one streamlined process and format that is now used across clinical disciplines.

The MD billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

O4 — OSH quality improvements

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their dietary consultation process improvement efforts in 2008; dietitians are completing twice as many consultations every month and people receive their dietary consultations 90 percent more quickly than before the process improvement efforts.

O8 — AMH central office process improvements

This initiative provides the structure for rapid process improvements to streamline administrative work, reduce errors and time needed. This initiative resulted in major reductions in paper files with the move to a fully electronic filing system for all office

correspondence. This will be the home for other cross-unit improvements that are recognized during team daily huddles.

O9 — Lean Daily Management System rollout

AMH joined the other divisions in both the Oregon Health Authority and Department of Human Services in adopting a Lean Daily Management System (LDMS). All components of the office have implemented huddles, visual display boards, continuous improvement sheets, skill assessment and the development of unit “business goals” with the assistance of trained Lean practitioners. This model allows more staff to be trained and take leadership roles in Transformation activities. AMH central office and OSH are now training managers to lead in a new environment with empowered staff and to develop 20 Keys for the units. This will be supported by training and coaching from highly trained staff. This work will be more critical as we look forward to additional years of scarce resources and increased demands for services.

O10 — Vacancy exceptions

As a result of this initiative, a new administrative rule governing the occupancy payments for residential treatment has been adopted and is being implemented to minimize the payment for vacant beds in community-based residential treatment programs and maximize the use of these valuable resources.

O11 — NIATx expansion

This initiative will build on a pilot program that successfully improved the quality of services, the efficient use of capacity and improved access to and retention in treatment for people with addiction disorders. The Network for the Improvement of Addiction Treatment (NIATx) is a nationally known effective model for improving services and assisting states and programs in improving the tracking and communication of improvements.

O12 — Adult Mental Health Initiative

This initiative will promote the more effective use of current capacity in facility-based treatment settings, increase care coordination and increase accountability at the local and state level. The first phase of this initiative became effective Sept. 1, 2010, when the mental health organizations (MHOs) became responsible for assisting individuals in transitioning from the state hospitals and licensed community settings to other service options. The MHOs will be working with individuals while they are at the Oregon State Hospital to help those individuals identify treatment goals and plans for discharging as soon as appropriate. Once an individual has been determined ready to leave the state hospital, the MHOs will assist that individual in

transitioning to a licensed or independent setting. The MHOs will be responsible for ensuring that individuals receive the appropriate services and supports necessary for their ongoing well-being.

From September 1, 2010 through June 30, 2011, the MHOs will assist 331 individuals transition from highly restrictive settings to more independent settings and help these individuals on their path toward recovery. AMHI includes performance outcomes and incentives to help ensure that the initiative reaches its desired outcome.

In the first four months, the MHOs exceeded the projected numbers, successfully transitioning 180 individuals from the state hospital or a community licensed care setting (54 percent of the total number). At this rate the MHOs should be able to assist more than 420 individuals by the end of the biennium.

Of those individuals that the MHOs have currently assisted:

- 56 percent left the state hospitals;
- 44 percent transitioned from licensed community care; and
- 36 percent moved to independent living with appropriate community services and supports.

On average, community services and supports cost less than 25 percent of keeping someone at the state hospital.

O14 — OSH Diversion - NewPATH

This initiative is being done between AMH, the Oregon State Hospital Replacement Project (OSHRP), OSH and DHS, and Seniors and People with Disabilities (SPD). The purpose is to develop a new model of serving people in the community who are not best served in the Oregon State Hospital. These are patients who have either maximally benefited from active psychiatric treatment at the hospital or who are admitted to the hospital because the existing community treatment programs are unable to manage aggressive and/or sexual acting-out behaviors. A new model of service delivery is to be developed.

Cross-organization initiative — Children's Wraparound

This initiative is the first phase of implementing the requirements of HB 2144 passed by the 2009 Legislature that established the Children's Wraparound Initiative in state law. It is a collaboration between AMH, Medical Assistance Programs and DHS Children Adults and Family. The purpose is to increase system

efficiency and outcomes for children and their families. This is being accomplished through a child and family team-driven planning process based on the national evidence-based practice known as wraparound, care coordination across local child serving agencies, and flexible community services and supports. This effort begins with children in the custody of DHS for more than one year who have had at least four placements or who have come into custody and immediately need specialized behavioral health services and supports. The program was initiated in three areas of the state in July 2010 and by July 1, 2011 will serve 385 children on a daily basis in eight counties.

Strategic planning 2009-11 initiatives

AMH used the skills and tools of transformation to assure the successful conclusion or progress of 12 key system change initiatives. The implementation of the Alcohol and Drug Policy Commission resulted in the hiring of the executive director and turning over the ongoing work of supporting the commission.

The work needed for the successful July 1, 2010, implementation of the Impaired Health Professionals program as required by HB 2345-B was completed on time. The program established contracts for independent monitoring of the program that provides treatment for substance use disorders and mental health issues of impaired health professionals who are either self-referred or diverted by their licensing boards in lieu of disciplinary action. This work was done in complete collaboration with the health licensing boards to allow the successful transition of participants in the board programs to the new independent program on July 1, 2010.

The adoption of the Integrated Services and Supports Rule in March 2010 ended a two-year stakeholder-driven process to create a single set of administrative rules across all addiction and mental health program areas that were coordinated with the Medicaid payment requirements and allowed the abolishment of 10 conflicting rules.

The utilization analysis initiative implemented an independent, comprehensive review of adult mental health residential services. As a result of the analysis, AMH gained an independent and improved understanding of rate of admission to and discharge from programs, movement between the levels of care, and length of stay, and will be able to do financial modeling. The initiative is complete and the results of the study informed the final structure of the Adult Mental Health Initiative (AMHI) to achieve local management and accountability for the use of residential treatment options.

The remaining initiatives include:

1915(i) Medicaid home and community-based state plan amendment

This initiative will create a new approach to community-based treatment for people with serious mental illness, a history of hospitalization and a need for daily service contact through the submission of a Medicaid state plan amendment to the federal Centers for Medicare and Medicaid Services. When approved, the amendment will make an expanded array of services available in community-based settings to better meet the needs of consumers and to simplify the billing and documentation requirements for providers. The amendment was submitted in July 2010. The results of this initiative will support Oregon's efforts to serve people in the most independent setting and will support the work of the initiative to redesign the adult mental health system.

Blue Mountain Recovery Center: The future

This initiative created a collaborative process with local and regional stakeholders to consider alternative use of the facility and program and to determine the use that would best meet the needs of the local community, state and region, patients and staff. It will result in a plan for the future of the hospital. The initial plan will be available for use during the 2011 legislative session. The final phase of the work will be to engage legislative leadership in adopting a plan for the future of BMRC.

Integrated services and management demonstration

AMH worked with legislative leadership in the 2009 Session to recommend a system change effort focused on integrating the management and service model including health, mental health and addiction services. The Legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in improved access, quality and outcomes, and the containment of costs.

Peer-delivered services

Peer-delivered services are a key component of a successful service delivery system and an important addition to the health care workforce. AMH is working with service population stakeholder groups to develop strategies to increase the use and availability of peer-delivered services. This work is in the initial stages and is building on existing peer-delivered services in the state and looking at a variety of funding strategies and options.

Strategic prevention framework

Oregon was awarded a five-year federal State Prevention Framework Grant on July 1, 2009. This work will engage 10 counties, communities and tribes. The result will be a common framework for assessing state and local needs and priorities, making data-driven decisions about the right evidence-based prevention programs delivered to the right audiences and mobilizing communities and tribes to implement these programs to improve the outcomes in their communities. During the implementation of the grant the state's understanding about the most effective prevention strategies will be improved. This allows a focused approach to preventing and reducing the disabling effects of substance use and abuse.

Wellness

This initiative builds on the integration efforts between physical and behavioral health. The work is being carried out by a broad group of stakeholders and is driven by consumers of mental health and addiction services. The work is critical to improve the health disparities among people who are served in the publicly funded behavioral health system. This work will improve access to appropriate care, improve the quality of care that people receive and contribute to the health and well-being of the public clients.

Young adults in transition

Young adults between the ages of 14 and 25 face multiple system barriers that make it difficult for them to seek and continue with treatment for mental health issues. AMH has focused on looking at structural, administrative, financial and clinical barriers to appropriate services. The goal is to provide access to services that are effective in supporting young adults in gaining the skills to manage their illness, complete their education, gain employment, and form healthy appropriate social relationships. AMH has created administrative rules and contract language that support the development of an age-appropriate system of services and supports. AMH is working closely with YouthMOVE Oregon for leadership development, expansion of peer delivered services and training of young people. , As the final step toward a successful community reintegration, AMH currently is integrating supported housing and supported employment services tailored toward this population. The development of a system of services and supports has spread across Oregon, numerous communities now have young adult system specialists and have mobilized their communities to developed specialized services. This work is ongoing and necessary.

Criminal justice door to the mental health system

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to aid and assist in their defense at trial or who have been found “guilty except for insanity.” These two entry points do not necessarily result in the most appropriate treatment or location for the individual entering the system through these court processes. The work under this initiative will engage all parties — including consumers, the court system, community mental health programs and law enforcement — to explore alternative processes that may result in more effective and appropriate placement and services for people with mental illness who come in contact with the criminal justice system as a result of their mental illness.

Governor’s Balanced Budget

The Governor’s Balanced Budget makes substantial reductions in program support. In responding to these ongoing reductions, the division reprioritized projects and restructured staff to focus on the most critical work. However, a substantial number of vacant positions are not being filled in order to operate within available funds. This will create delays in reviewing community programs and responding to questions, requests for data and complaints. This budget also assumes administrative efficiencies will be obtained by reducing contracts for services such as psychiatric participation in site reviews, services to employers in developing drug-free work places and consultation from Oregon Health and Science University.

ALCOHOL AND DRUG PREVENTION

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

Services provided

Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. AMH administers prevention services aimed at people who have not yet been diagnosed with alcohol or drug problems. These services reduce the rate of underage drinking and the development of substance use disorder and associated health and social problems.

Where service recipients are located

Prevention services are available in every Oregon county. Community mental health programs (CMHPs), tribes and statewide contractors provide evidence-based services to prevent the problematic use of addictive substances and activities including alcohol and drugs. These services support and are integrated with the priorities set forth in each county's comprehensive plan as developed by the local Commission on Children and Families.

Who receives services

Services to both prevent and end the use of addictive substances are available to all Oregonians, with a focus on youth. The audiences for prevention services are:

- The entire population through public education and awareness campaigns;
- Sub-groups of people who are at above-average risk of involvement with alcohol and other drugs through selected prevention services such as family management programs for families with youth who have poor academic performance; and
- Individuals who show minimal but detectable signs of involvement with alcohol and other drugs, but do not meet diagnostic criteria for abuse or dependence, through indicated prevention services such as substance abuse

educational programs for youth who receive a Minor in Possession (MIP) violation.

More than 97,800 Oregonians were provided access to broad-based prevention information during 2009. In addition, 23,287 people received selected prevention services and another 3,216 received indicated prevention services.

How services are delivered

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

Why these services are significant to Oregonians

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

Performance measures

KPM 5: Eighth-graders' risk for alcohol use

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

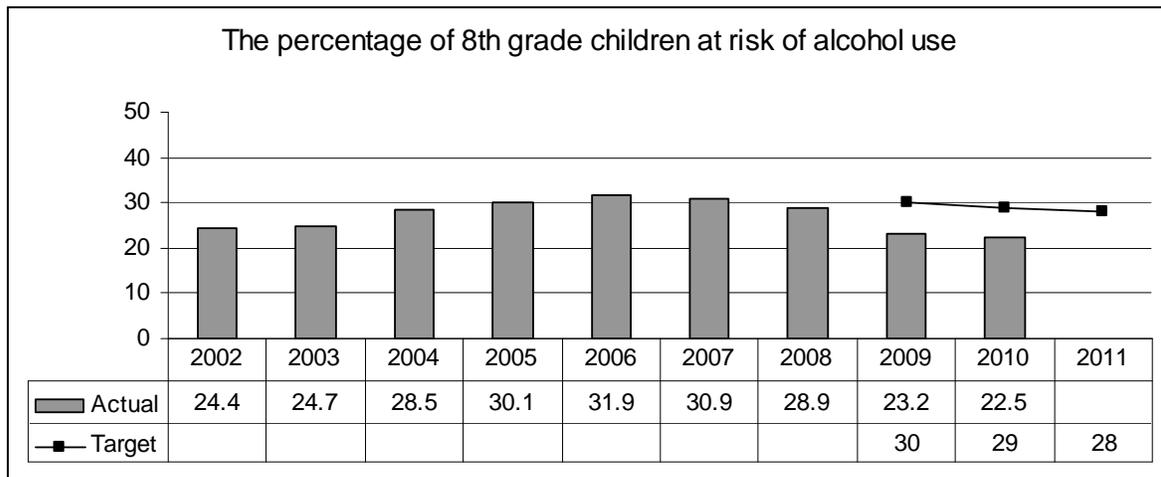
Target: The current target for this measure is 29 percent.

Results: After remaining steady in the low 30 percent range for several years, this measure peaked in 2006 at 31.9 percent, but has since dropped to 22.5 percent. This is below the goal rate of 29 percent. State funding for substance abuse prevention has been reduced, the population in Oregon has

grown and other prevention programs have been cut, including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. During this same period, marketing and advertising efforts promoting alcohol and tobacco have increased, particularly advertising for distilled spirits and hard liquor.

Comment: The 2009 Legislature approved changes to the key performance measures that strengthened the measures by separating the measure for alcohol from that for drug use. This allows the state to assess the two measures separately since they show very different findings, with the overall trend for illicit drug use decreasing while alcohol use has been on the increase.

How Oregon compares to other states: When alcohol use within the past 30 days is compared between Washington and Oregon eighth graders, Oregon does not compare favorably — 15.4 percent versus 22.5 percent — although as noted above, Oregon has shown considerable improvement. Washington has maintained funding for its prevention efforts, and it shows.



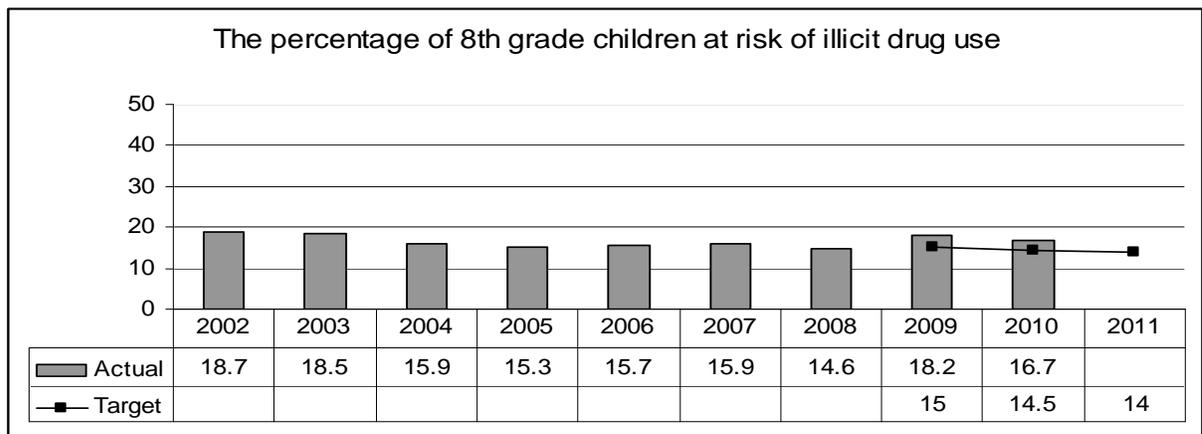
KPM 6: Eighth-graders’ risk for illicit drug use

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

Target: The current target for this measure is 14.5 percent.

Results: This rate has remained fairly steady in the mid to high teens over the past eight years. The most recent rate is 16.7 percent. This is above the goal rate of 15 percent. As noted, state funding for substance abuse prevention has been reduced, the population in Oregon has grown and other prevention programs have been cut including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. There is not a clear trend for this rate, unlike the rate for alcohol use among 8th graders.

How Oregon compares to other states: The percentage is significantly higher than national rates of 7.6 percent for 2008, which was published in *Monitoring the Future* national survey results on drug use.



Other performance measures

National outcome measures (NOMs) for prevention services include prevalence of substance use, consequences of use, and related risk and protective factors. Prevalence data tell the extent of a problem, such as the percentage of youth who drink. Consequence data provide information about the impact of use on individuals such as alcohol-related motor vehicle fatalities. Risk factors are conditions that increase the likelihood of substance use or related negative consequences; protective factors are conditions that support healthy behaviors and outcomes. In all cases the information helps AMH direct its prevention efforts.

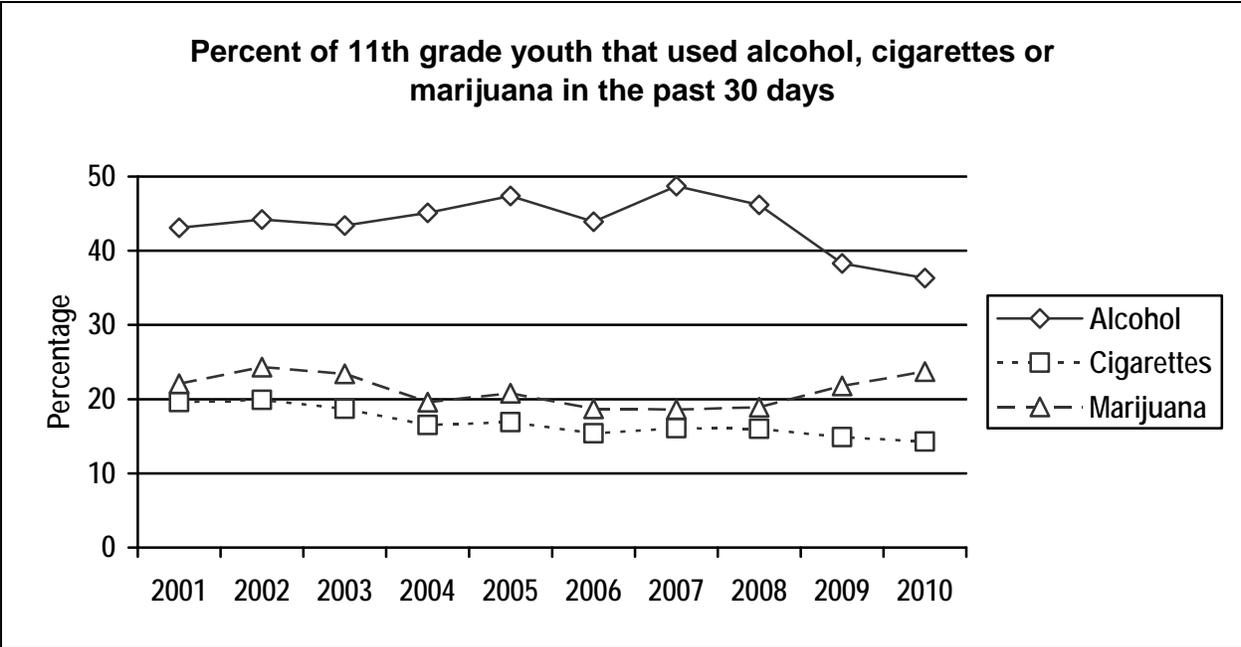
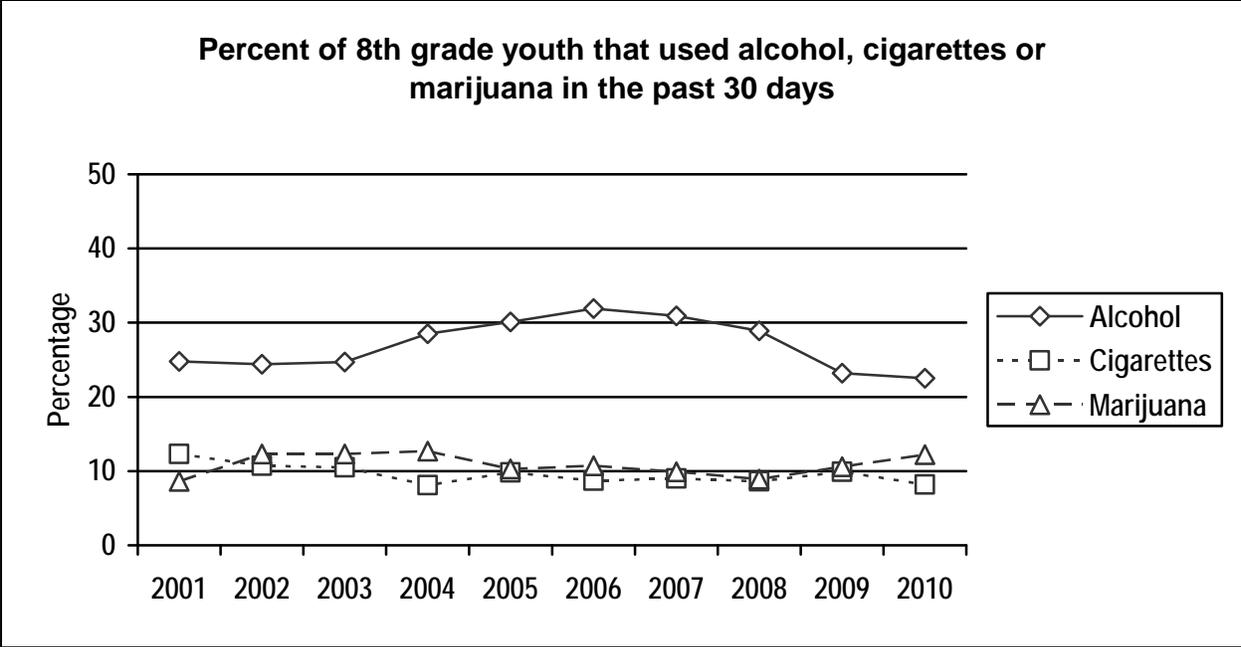
Use of alcohol, tobacco and illicit drugs impacts families, schools, workplaces and communities. It causes long-term health problems, leads to premature death,

contributes to injuries, violence and abuse, and can lead to addiction that erodes an individual's ability to function normally.

Substance abuse and dependence affect Oregonians of all ages. About 9 percent of Oregon youth 12 to 17 years old, 22 percent of young adults 18 to 25 and 8 percent of adults 26 or older abuse or are dependent on alcohol or drugs, requiring treatment. (National Survey on Drug Use and Health, 2007-2008)

Initiation of alcohol, tobacco or marijuana use at young ages has been linked to more intense and problematic levels of use in adolescence and adulthood. The charts below show the trends in alcohol, cigarette or marijuana use by eighth and 11th grade youth. Alcohol use is clearly the largest issue among both eighth and 11th grade youth. Since 2006, alcohol use among eighth graders had declined four consecutive years. However, in 2010 more than one in five youth reported drinking alcohol in the past month. In 2010, past month marijuana use (12.2 percent) was 50 percent higher than cigarette use (8.2 percent). (Oregon Student Wellness Survey, 2010)

Rates of past month alcohol, cigarette and marijuana use increase substantially between eighth and 11th grade. In 2010, more than one in three 11th graders reported drinking alcohol in the past month (36.3 percent); about one in four reported smoking marijuana (23.7 percent); and one in seven reported smoking cigarettes (14.3 percent). (Oregon Student Wellness Survey, 2010)



An American Medical Association (AMA) report shows that adolescent drinkers perform worse in school, are more likely to fall behind and have increased risk of social problems, depression, suicidal thoughts and violence. Even occasional heavy drinking injures young brains.

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

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

Oregon youth begin drinking at very young ages and are more likely to start drinking before 13 years of age than to start smoking cigarettes. During 2010, 13.1 percent of 11th graders reported they first drank alcohol before the age of 13 versus 7.0 percent who first smoked a cigarette before 13. (Oregon Student Wellness Survey, 2010)

Three factors known to influence the likelihood of underage alcohol use are the perceived risk of harm, parents' disapproval of drinking, and accessibility to alcohol. Oregon eighth and 11th graders are more likely to report lower risk of harm and less parent disapproval for alcohol than for cigarette use. Despite the fact that sales of alcohol to minors are illegal, 47.1 percent of eighth-graders and 72.3 percent of 11th-graders say it is "sort of easy" or "very easy" to get beer, wine or hard liquor. (Oregon Student Wellness Survey, 2010)

Alcohol is the most widely used addictive substance among adults in Oregon. Alcohol is a known carcinogen and a leading cause of chronic liver disease. It is toxic to many organ systems including the heart, stomach, pancreas and nervous system. Each year about 1,400 Oregonians die from alcohol-related causes. (Alcohol Related Disease Impact software) Deaths from alcohol-induced diseases are one of the 10 leading causes of death for men and women in Oregon.

Even moderate alcohol consumption can lead to negative consequences such as alcohol-related motor vehicle crashes, birth defects and harmful interactions with medications. Approximately two-thirds of Oregon men (65.8 percent) and half of women (52.1 percent) drink alcohol each month. (Behavioral Risk Factor Surveillance System)

By far, heavy drinking and binge drinking are most closely linked to negative health consequences and contribute to crime and violence against persons. Heavy drinking is associated with heightened levels of all-cause mortality. Heavy use of alcohol refers to alcohol consumption at levels that exceed U.S. Dietary Guidelines. Men who drink more than two drinks per day and women who drink more than one drink per day are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence. In 2009, 6.0 percent of men and 6.4 percent of women in Oregon were heavy drinkers. (Behavioral Risk Factor Surveillance System)

Binge drinking is strongly associated with injuries, motor vehicle crashes, violence, Fetal Alcohol Spectrum Disorder (FASD), chronic liver disease and a number of other chronic and acute conditions. Binge drinking is defined as consumption of five or more drinks by men and four or more by women in a short time span. In 2009, 18.9 percent of men and 11.2 percent of women in Oregon reported binge drinking. (Behavioral Risk Factor Surveillance System)

Key budget drivers and issues

Underage drinking

Oregon youth continue to drink at rates above the national average, with eighth-grade girls drinking at higher rates than boys. These youth will continue to use and abuse alcohol and other drugs increasing the demand for treatment services. There will be added social costs including increased teen pregnancy, motor vehicle accidents and death, school failure, entry into the juvenile justice system, and continued high rates for adolescent suicide. It is critical to restore funding for effective, evidence-based prevention and early intervention services to reverse the trend in underage drinking and improve the associated social indicators.

Prescription drug abuse

Both chronic and occasional drug use can result in serious medical conditions. Youth and young adults in Oregon have higher rates of illegal use of drugs such as heroin, cocaine and methamphetamine as well as prescription drugs used (without a doctor's orders) to get high than their younger or older counterparts. Prescription drug abuse is a growing concern in Oregon. Eight percent of Oregon 11th graders reported using prescription drugs to get high in the past 30 days according to the 2009 Oregon Healthy Teens Survey. By contrast, 5 percent of 11th graders said they used illicit drugs other than marijuana in the past 30 days. Adolescents are more likely than young adults to become dependent on prescription drugs. National studies and published reports indicate that the intentional abuse of prescription drugs to get high is a growing concern.

Major funding sources

Federal Funds

Substance Abuse and Mental Health Services Administration

- Substance Abuse Prevention and Treatment (SAPT) block grant

US Department of Health and Human Services

- Temporary Assistance for Needy Families (TANF)

US Department of Education

- Office of Safe and Drug Free Schools

US Office of Juvenile Justice and Delinquency Prevention

- Enforcing Underage Drinking (UAD)

Governor's Balanced Budget

The Governor's Balanced Budget continues support for alcohol and drug prevention services mainly through the use of federal funds. There are no reductions.

Key budget drivers and issues

Oregon youth are continuing to drink at rates above the national average, with 8th grade girls drinking at higher rates than boys. These youth will continue to use and abuse alcohol and other drugs, which will increase the demand for treatment services. There will be added social costs including increased teen pregnancy, motor vehicle accidents and death, school failure, entry into the juvenile justice system, and continued high rates for adolescent suicide. It is critical to restore funding for effective, evidence-based prevention and early intervention services to reverse the trend in underage drinking and improve the associated social indicators.

ALCOHOL AND DRUG TREATMENT

Alcohol and drug treatment services assist people in recovering from addiction. People in recovery improve their functioning in society and at work, do a better job parenting their children, and are less likely to commit crimes. Their physical health improves, which reduces medical care costs and use of emergency departments.

Services provided

Services consist of outpatient, intensive outpatient, residential and detoxification services. Different options are needed to help individuals recover from their addictions. Some individuals may need residential services, while others may need outpatient; both are needed for individuals to successfully recover and manage their disease. Outpatient services include specialized programs that use synthetic medications such as methadone as an alternative to chronic heroin addiction. Education and treatment are available for people who are convicted of driving under the influence of intoxicants (DUII).

Where service recipients are located

Community mental health programs (CMHPs), tribes and county-designated nonprofit organizations provide treatment for alcohol and drug abuse problems in all 36 counties and in statewide and regional residential treatment programs.

Who receives services

Children and adults of all ages who have a diagnosed substance use disorder may be eligible for services. Any person eligible for the Oregon Health Plan (OHP) or the State Children's Health Insurance Program (SCHIP) has access to the OHP substance abuse benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services under the federal Substance Abuse Prevention and Treatment Block Grant. There are specialized services designed to meet the needs of women, parents with children, minorities and adolescents. During 2009, 36,238 adults age 26 and older were served; 12,207 young adults age 18 through 25 were served; and 5,663 adolescents age 12 through 17 were served.

How services are delivered

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

Why these services are significant to Oregonians

As a result of these services, fewer children are admitted to foster care due to parental substance abuse. State and local jurisdictions see reduced costs to the criminal justice system for adults and juveniles. Local hospitals experience reduced use of emergency departments.

Intensive treatment and recovery services

AMH continues to implement the 2007-09 Legislatively Adopted Budget initiative to increase access to addictions treatment for parents who are involved in the child welfare system or at risk of involvement in that system. Increased outpatient capacity now exists in each county, and residential capacity has increased for approximately 120 adults and 80 dependent children who access treatment with their parents. Eighteen recovery homes have been developed for families with addictions issues at risk of becoming homeless and in need of a supportive recovery environment. AMH works closely with the Children, Adults and Families Division (CAF) to implement these services and monitor systems outcomes.

Outcomes

5,325 parents have accessed addiction treatment and recovery services. 1,463 parents are currently engaged in treatment and recovery services. More than 1,800 children reunited with their parents and are no longer in family foster care. Their parents accessed addiction treatment and recovery services with ITRS providers (as reported by CAF). These services create a cost offset of \$1.7 million a month in family foster care for these children. Providing addiction treatment and recovery supports for this population group paid for itself within a period of six months.

Housing

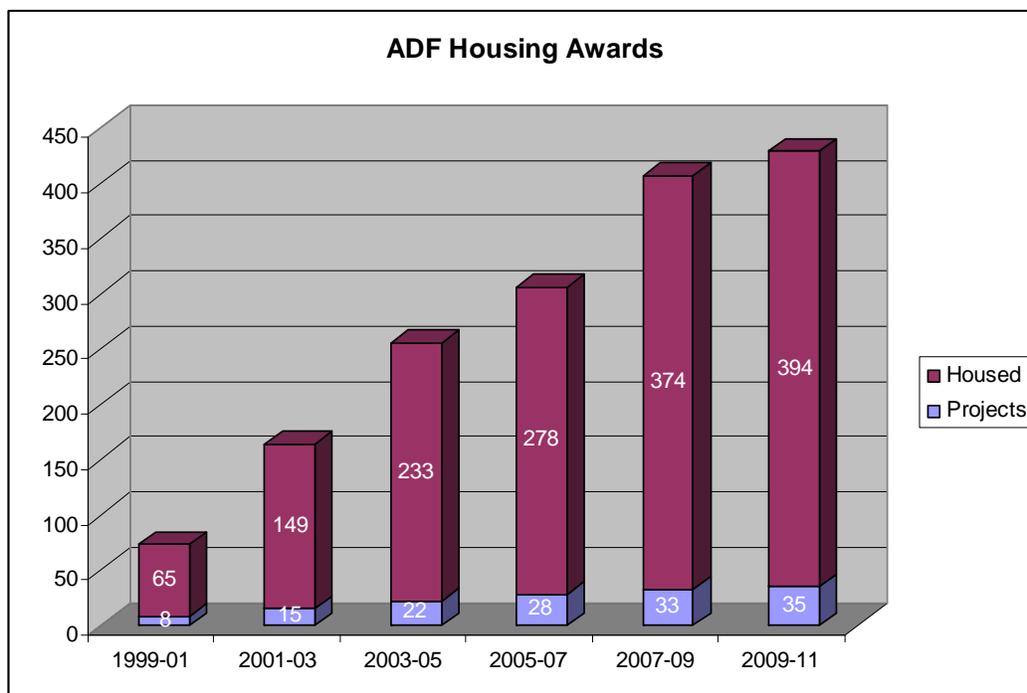
A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addiction disorders. When people are uncertain about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system are in adverse living environments.

As a result of the cost of housing and common problems associated with mental illness or substance use disorders, more than 6,000 people each year with these disorders are homeless. This represents nearly one-third of homeless individuals

identified in the 2010 Point in Time Count. The state has undertaken several initiatives to address housing for people with addiction disorders.

Alcohol and drug free (ADF) housing development

These funds are used to create alcohol and drug free (ADF) housing to support people in recovery from serious addictions. For 2009-11 two projects have been recommended for funding. These projects total \$450,000 and will provide 20 units of affordable alcohol and drug free housing. Fewer applications were submitted for funding due to the recession, changes in financial markets and timing of other funding sources. The following chart reflects AMH's cumulative distribution of ADF housing development funds through the 2009-11 biennium.



ADF housing assistance services

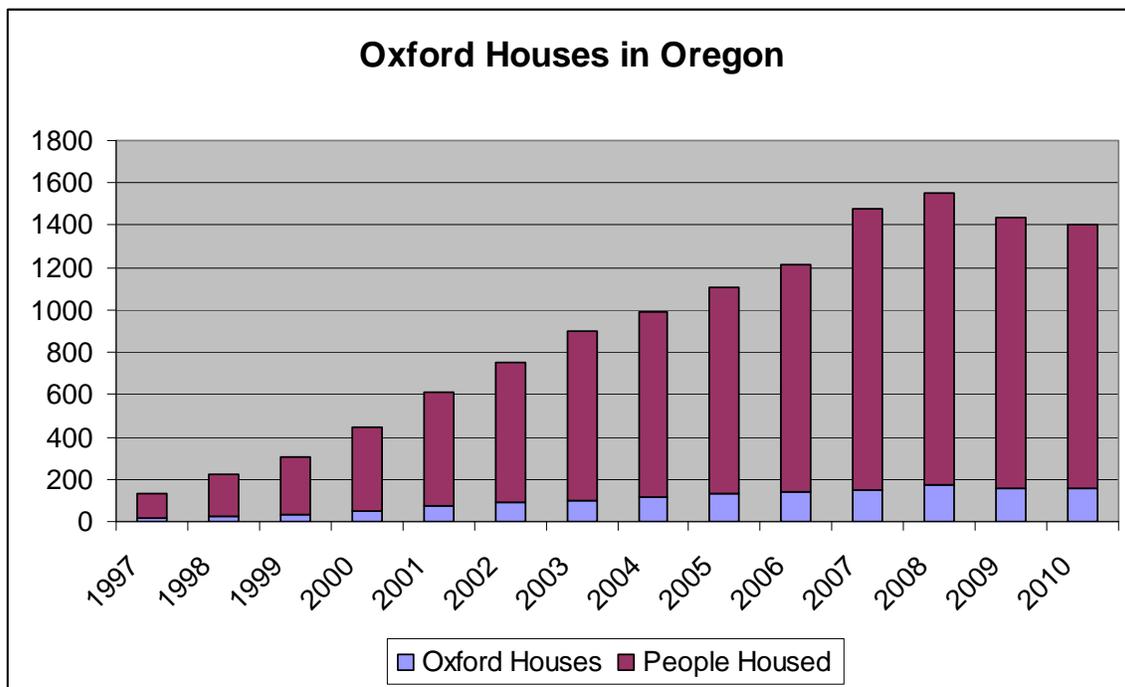
AMH funds eight projects in seven counties and one tribal community to help more than 456 people each year in recovery from addictions obtain stable ADF housing as they transition to self-sufficiency. An RFP for this program was released in October 2010 and awards for the 2011-13 biennium will be announced at the end of February 2011.

Oregon Recovery Homes (ORH)

Through the Intensive Treatment and Recovery Services initiative approved by the 2007 Legislature, Oregon Recovery Homes were able to increase their staff

outreach coordinators from two to five full-time employees. With the help of a grant from the Spirit Mountain Community Fund, ORH was able to add a sixth outreach coordinator, who works exclusively with homes serving women in recovery who live with their children. There are now 160 Oxford Homes in 16 Oregon counties accommodating approximately 1,280 people recovering from alcoholism and drug addiction. More than 300 children live in these homes. There was a 6 percent decrease in ORH housing from the 2007-09 biennium.

The loss of 10 of the 15 houses can be attributed to the economy. Many residents rely on minimum wage or labor-related jobs and with fewer jobs available many houses were not able to remain viable. Several houses consolidated members, avoiding the loss of more beds. These homes operate on a self-governed, peer support model. The following chart shows the growth of homes and housing capacity since 2001. While the number of houses remained the same in 2009 and 2010 there was a slight decrease in capacity. The decrease resulted from less capacity in houses that opened than what was available in the houses that closed.



Performance measures

KPM 1: Completion of alcohol and drug treatment

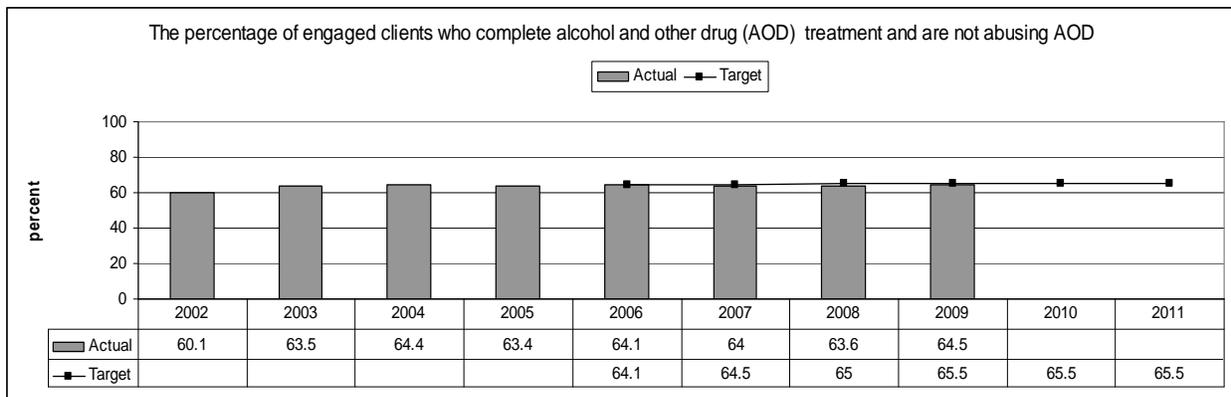
Purpose: Once a client enters into alcohol and drug treatment service, the next goal is for the client to complete treatment. Clients who complete treatment have

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

Target: AMH’s target is to push overall completion rates beyond 65 percent during the next few years.

Results: For purposes of this key performance measure, completion rate is aggregated across all alcohol and drug services and has been in the low to middle 60 percent range for the past several years. It currently is 65 percent. It is expected to increase during the next few years as more individuals have access to a health benefit, providers implement evidence-based practices and implement quality improvement efforts designed to retain clients in treatment.

How Oregon compares to other states: One reason the completion rate has not changed substantially during the past several years is that it already is very high, making further improvement difficult. Nationally, the completion rate for alcohol and drug treatment services is 51 percent. This is based on data submitted by states to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.



KPM 2: Adults employed after alcohol and drug treatment

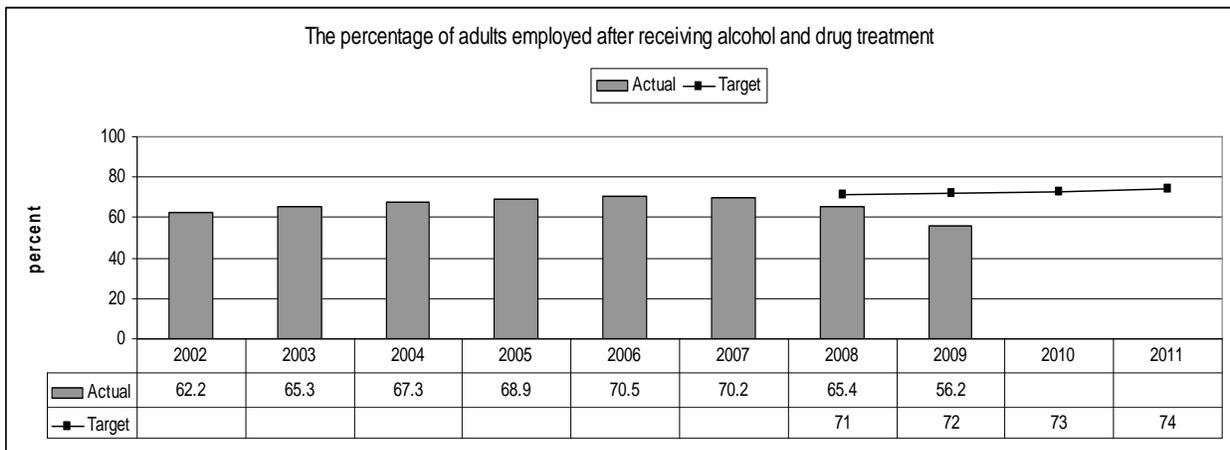
Purpose: A key outcome for many clients is their ability to maintain or gain employment as a result of their treatment. AMH’s strategy relates to the Oregon

Business Plan initiative to increase access to treatment and intervention services for Oregon workers who have alcohol and drug problems but no insurance.

Target: AMH's target is to push overall employment rates beyond 72 percent during the next few years. It will be difficult to reach this target in this economic environment.

Results: From 2002 through 2007 a greater percentage of clients ended service employed. This changed in both 2008 and 2009 as actual rates of employment declined substantially in each year, due in large part to the economic climate in Oregon. In 2009 clients who ended service employed had declined to 56.2 percent after peaking at 71 percent.

How Oregon compares to other states: Despite the drop, Oregon's rate of employment at discharge is higher than the national rate of 42.8 percent (2008).



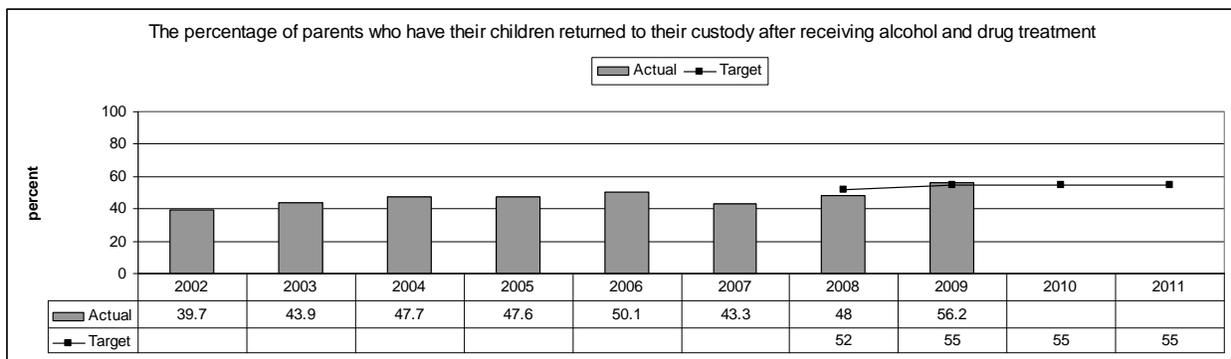
KPM 3: Children returned to custody after parental alcohol and drug treatment

Purpose: During the past few years alcohol and drug issues have become one of the most common reasons cited for child abuse and neglect leading to DHS taking custody of children. Alcohol and drug treatment and meeting the goals of treatment play a major role in the reunification of families.

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

Results: The trend through 2009 shows that more parents each year were meeting treatment criteria that allowed reunification with their children. AMH surpassed its goal for 2009 by 1.2 percent. The implementation of Intensive Treatment and Recovery Services program, funded by the 2007 Legislature as a treatment strategy focused on families with children in state custody or at risk of being taken into state custody as a result of parental substance abuse, resulted in reunification rates of 48 percent in 2008 and 56.2 percent in 2009. The rate in 2007 was 43 percent.

How Oregon compares to other states: There are no national data for comparison.



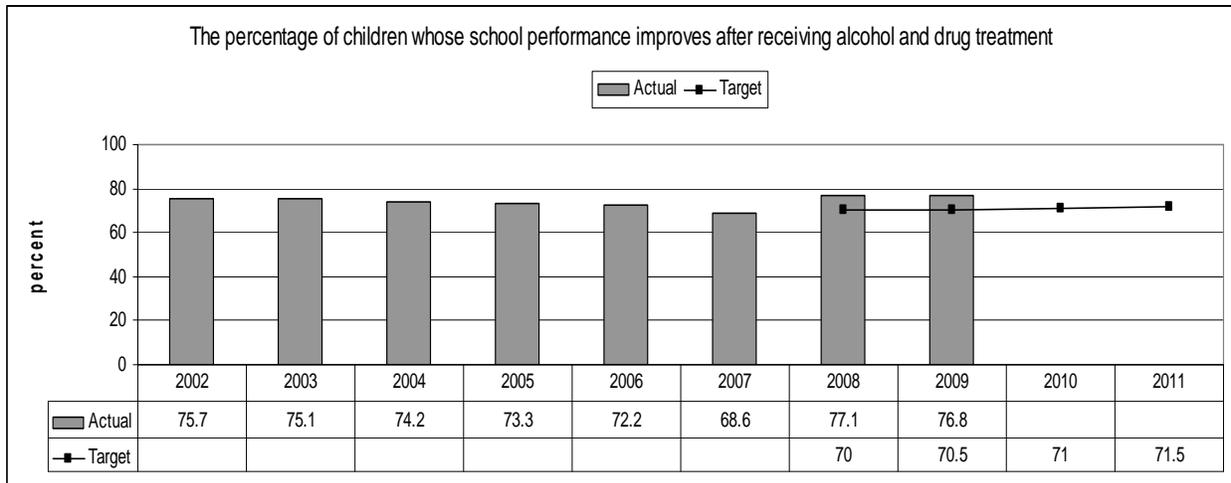
KPM 4: Children with improved academic performance after alcohol and drug treatment

Purpose: Alcohol and drug issues are a major barrier to academic achievement. Poor academic performance often is an initial flag for abuse of alcohol and drugs among teens. One goal of treatment is to help children perform to their potential. Improved academic performance is definitely a step in the right direction.

Target: AMH's target is to push overall improvement rates beyond 70 percent during the next few years.

Results: The downward trend that began in 2002 appears to be reversing with the rates for improved academic performance after treatment in 2008 and 2009 exceeding those of previous years. In 2009, AMH showed 76.8 percent of children with improved school performance, exceeding the annual goal by 6.3 percent.

How Oregon compares to other states: This measure looks at academic performance. Most national data track only improvement in attendance. This makes comparisons difficult.



Many of the key performance measures are part of larger set of federal measures known as the national outcome measures (NOMS). These measures are available upon request and are reported annually by AMH.

Proposed key performance measures for 2011-13

AMH proposes to measure the percent of clients who remain crime-free during alcohol and drug treatment services. This is a critical measure of success for treatment system since a substantial proportion of the people served in the system are referred by the criminal justice system. Successful engagement in treatment should result in an elimination of criminal activity. Data collected in 2009 will be used to establish a baseline from which targets will be set.

AMH proposes to measure the percent of clients whose income increases by the completion of alcohol and drug treatment services. One of the goals of successful treatment is employment or improvement in employment, which should result in an increase in legal income. Data collected in 2009 will be used to establish a baseline from which targets will be set.

Alcohol and drug treatment services

Approximately 9 percent of adolescents ages 12 to 17 (27,592) have substance abuse issues. Among young adults ages 18 to 25, 21.8 percent have substance abuse issues (67,976), while 8.2 percent of adults 26 and older have substance abuse issues (205,919). AMH currently serves 21 percent of the adolescents and

children, 18 percent of the young adults, and 18 percent of the adults in need of public alcohol and drug treatment services.

Key budget drivers and issues

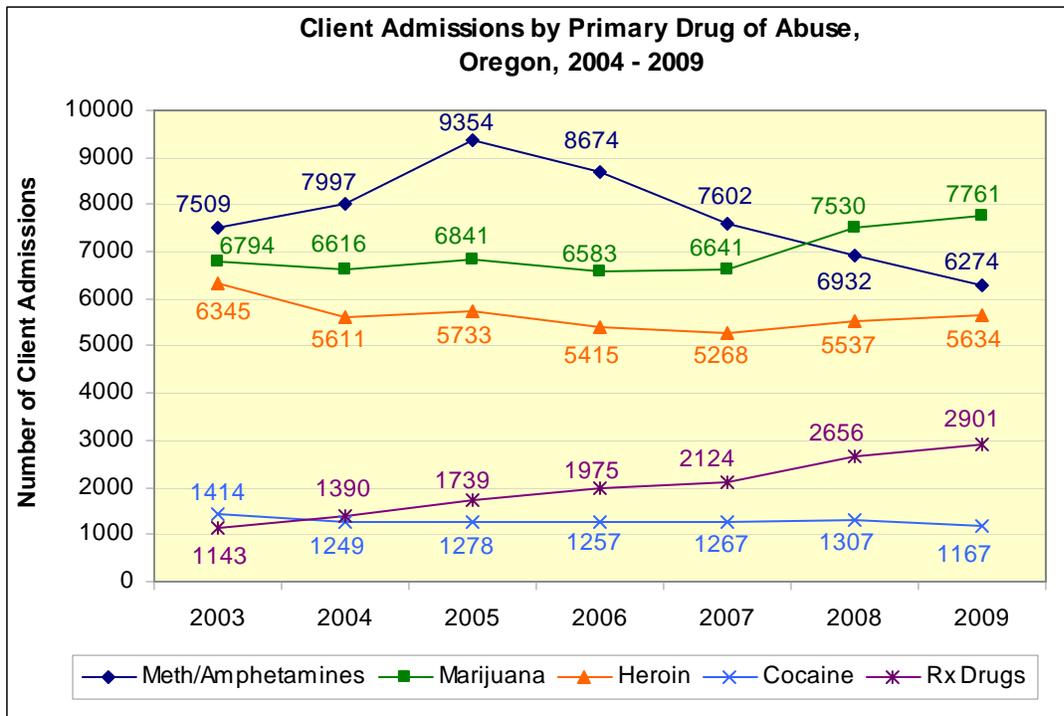
Heroin and other opioid drugs

Since 1999, the rate of unintentional drug poisoning deaths has more than doubled, from 4.5 to 9.3 deaths per 100,000. Heroin-related deaths in Oregon are the highest they have been since 2000. Nearly 130 people across Oregon died in heroin-related deaths in 2009, more than twice the amount of all other drug-related deaths combined. Prescription opioid analgesics are increasingly implicated in drug poisoning deaths as well. Prescription drug abuse, particularly related to opioid pain medications, is a growing concern among addiction treatment providers and stakeholders in Oregon. Prescription pain relievers are Oregon's fourth most prevalent substance of abuse following alcohol, tobacco and marijuana.

Compared to the rest of the nation, Oregon ranks among the top 10 states for:

- Annual abuse of prescription drugs for all ages (228,000 persons per year);
- Past year abuse of prescription drugs by youth 12 to 17 (34,000 persons per year); and,
- Past year abuse of prescription stimulants (55,000 persons per year).

The rate of non-medical use of pain relievers in Oregon is higher than that of the nation. The 18 to 25 year age group is of particular concern with 15 percent reporting non-medical use of pain relievers in the past year. The rate of treatment admissions with prescription drugs as the primary substance of abuse has risen by 142 percent from 2003 to 2009. By contrast, since 2005 the rate of admissions with methamphetamine as a primary substance has declined by 20 percent.



Complex and multiple challenges among treatment populations

Co-occurring mental and physical conditions

A growing number of individuals who enter addiction treatment have multiple and complex physical and mental health needs in addition to their substance use disorders. It is more common for individuals entering treatment to report having issues of dependence related to more than one type of substance. More individuals who enter treatment have physical health concerns or complications such as Hepatitis C Virus, HIV/AIDS, pregnancy, serious dental issues, chronic pain, and diabetes. While the provider system is hopeful about the impact of federal health reform on their ability to serve more Oregonians with a health benefit and to coordinate care with a growing number of physical health providers, the system is challenged to hold on to existing capacity with reduced budgets and increased fixed costs in the meantime.

In addition, according to the National Survey on Drug Use and Health (NSDUH) 20 percent of Oregonians age 18 to 25 reported experiencing serious psychological distress in the past year and more than 10 percent experienced a major depressive episode. Unfortunately, Oregon ranks among the highest in the states for this measure. An estimated 30 to 40 percent of individuals who enter addiction treatment also have a co-occurring mental health disorder. Under the current rate structure, providers are challenged to meet the clinical and medical staffing needs that will adequately serve these populations and to provide the level of service

intensity required to address complex and multiple issues facing individuals accessing treatment.

Returning veterans

Oregon has a significant population of veterans, but since there is no military base in-state many veterans lack access to services and support. Oregon has 333,752 veterans, of whom approximately 60,000 are under age 44 (Veterans Administration, 2007). Approximately 30 percent of Iraq and Afghanistan War veterans report symptoms of Post Traumatic Stress Disorder (PTSD), traumatic brain injury, depression, or other mental illness. Nearly 19 percent of current conflict veterans who received VA care were diagnosed with substance abuse or addiction disorders. The United States Army reports a 56 percent increase in diagnosed alcohol disorders from 2003 to 2009, leading to a need for more substance abuse counselors. From March to December 2009, 357 veterans and 28 family members of veterans contacted Oregon Partnership Helpline for substance abuse needs. However, interviews with VA staff, Oregon National Guard staff, and recently returned veterans indicate reluctance to access treatment services offered by the military. This situation is complicated by the fact that one in eight (about 13 percent) of non-elderly veterans are uninsured and about half of those are not eligible for VA healthcare. As such, their mental health and addiction needs go untreated, leading to higher incarceration rates, increased homelessness, family conflict, suicide and poor health. The addiction treatment system has insufficient capacity to serve a growing number of veterans. Due to budget reductions and constraints, workforce development initiatives have not kept pace with providing the unique skills and competencies needed to treat veterans with complex needs.

Re-entry for incarcerated individuals

Individuals who have been incarcerated experience significant obstacles re-entering the community. Oregon currently has 13,927 incarcerated individuals, nearly double the population in 1995. Nearly 40 percent of people in jail are there on drug charges, representing 5,570 individuals (Department of Corrections, 2009). At any given time there are also some 19,000 individuals on parole and probation throughout the state (Department of Corrections, 2009). In February 2010, AMH conducted a focus group with inmates seeking input about their fears and hopes. As individuals approach parole, they grow anxious regarding housing, staying clean and sober, getting a job, developing sober support systems, and reintegrating with the broader community. They report a high need for recovery support services with little access.

Population increase and unmet need

As Oregon's population grows, there will be an increase in the number of people with addiction disorders. However, funding for the basic community treatment services needed to treat these disorders has not increased in relation to the need for services. National research that looks at the need for services indicates 8.2 percent of the adult population ages 26 and older requires alcohol and drug treatment services; in Oregon that is 205,919 people. For those age 18 to 25, the same research shows that 21.8 percent or 67,976 people are in need of treatment. The research also shows 8.8 percent of youth age 12 to 17 require treatment; in Oregon that is 27,591 youth. Public funds provided services for 36,238 adults (18 percent of the need), 12,207 young adults (18 percent of the need) and 6,663 youth (21 percent of the need). Some of these individuals have insurance and with the approval of equal access to treatment for these disorders, more will obtain treatment paid by their insurance company. However, many people with addiction disorders do not seek treatment until they have lost their jobs, insurance and families and when they seek or are mandated to treatment, they must rely on publicly funded services.

Lack of safe, affordable housing

The urban areas of Oregon are some of the most expensive for rental housing and home ownership in the country. A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addictions and mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system live in these adverse environments. As the economy has worsened, housing insecurity has become more pronounced for people with addictions and mental health disorders. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue in treatment services, thus increasing the risk of further illness, mandated treatment and greater disability.

Major funding sources

Federal Funds

Substance Abuse and Mental Health Services Administration

- Substance Abuse Prevention and Treatment (SAPT) block grant

US Department of Health and Human Services

- Temporary Assistance for Needy Families (TANF)

US Department of Education

- Office of Safe and Drug Free Schools

US Office of Juvenile Justice and Delinquency Prevention

- Enforcing Underage Drinking (UAD)

Governor's Balanced Budget

The Governor's Balanced Budget continues support for alcohol and drug treatment programs. With the continuation of the 2009-11 reductions required to balance the budget and no cost-of-living increase it will be challenging for the community system to continue providing services. However, this level of support positions the community alcohol and drug treatment system to participate in the transformation of the health care system anticipated in the Governor's Balanced Budget. Support for these services is a clear recognition of the importance of alcohol and drug treatment in improving the health of Oregonians, increasing the quality of care and containing the cost of health care.

PROBLEM GAMBLING PREVENTION AND TREATMENT

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

Services provided

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

Where service recipients are located

Community mental health programs (CMHPs), for-profit and nonprofit providers deliver problem gambling prevention and treatment services in all 36 counties and in one statewide residential treatment program. Treatment to reduce the effects of problem gambling is funded through a statutory one percent set-aside of state Lottery revenues.

Who receives services

During 2009, 2,240 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 2,195 people during 2009.

How services are delivered

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

Why these services are significant to Oregonians

Oregonians with problem or pathological gambling behaviors put themselves and their families at financial risk, experience family relationship disruptions, lose their jobs, are at risk of suicide and sometimes commit crimes to pay for their gambling

addictions. The majority of Oregonians post-treatment reported reduction of gambling debt, reduction in suicide ideation and improvement in relationships, physical health, emotional well-being and spiritual well-being.

Performance measures

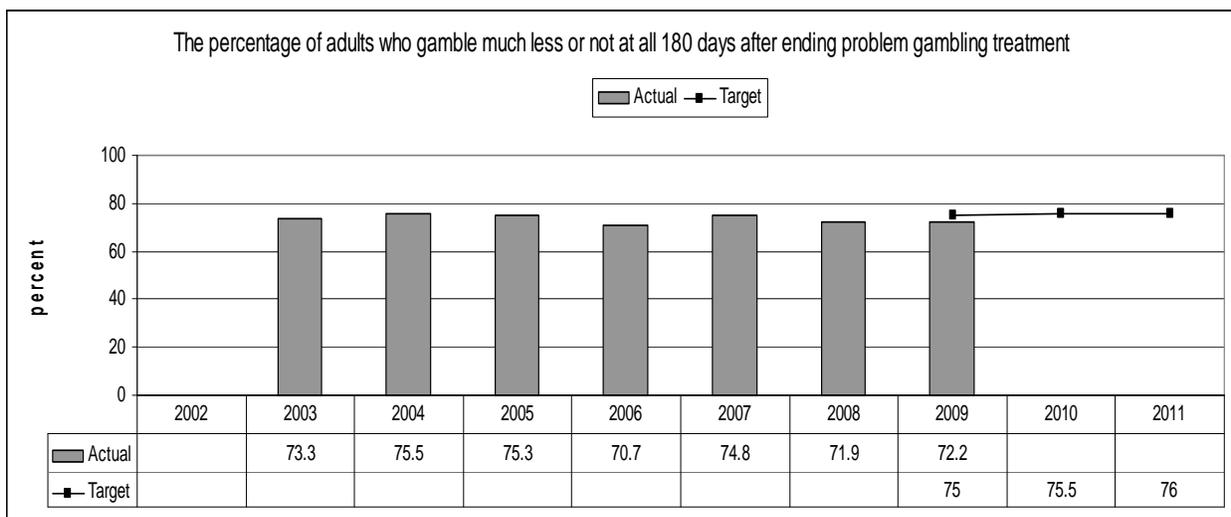
KPM 10: Percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment

Purpose: Problem gamblers and their families experience a complex array of mental health, social, financial and legal issues. The estimated social-economic cost of each pathological gambler is up to \$11,000 a year. Increasing the effectiveness of treatment contributes to the overall health of the community eliminating these social-economic costs by aiding those who receive treatment in remaining abstinent from gambling. Agency partners in this effort are county and private not-for-profit community agencies who provide treatment for problem gamblers and their families.

Target: AMH’s target is to push overall improvement rates beyond 75 percent during the next few years.

Results: Results have shown some decline in the past two years. In 2009, AMH showed 72.2 percent of adults not gambling or gambling less 180 days after ending services. This falls short of the 75 percent goal.

How Oregon compares to other states: There is no national data to compare.



Other performance measures

AMH collects additional data to measure the effectiveness of problem gambling treatment.

- An estimated 50,143 adult Oregonians are problem gamblers and an additional 29,496 are pathological gamblers.
- FY 2009 data indicate 49.9 percent of problem gamblers successfully completed treatment services.
- Six months post-treatment, more than 87 percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.
- For the treatment completers, 47.4 percent of those assessed at 12 months after treatment reported no gambling and another 42.9 percent reported “much less” gambling than before treatment
- Approximately two-thirds of the participants reported satisfaction with their relationships, physical health, emotional well-being and spiritual well being.
- Approximately 62.7 percent reported a return to paying bills on time.
- Importantly, at the 12-month post-treatment follow-up, people who completed service reported no significant deterioration in these indicators and, in fact, reported additional improvements in feelings of restlessness or irritability regarding not gambling.

Key budget drivers and issues

The increasing access to highly addictive gambling games online and in numerous locations throughout the state create easy access for people who are interested in gambling and reinforce behaviors that lead to addictive gambling. The increase in internet gambling is attracting more and more young people who are showing increases in problem gambling behaviors that interfere with education and social relationships.

Governor’s Balanced Budget

The Governor’s Balanced Budget restores support for problem gambling prevention and treatment programs based on projections of lottery revenue.

COMMUNITY MENTAL HEALTH PROGRAMS (CMHPs)

Services provided

Mental health services improve functioning for Oregonians with severe mental health disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for further treatment and whether other supportive services will be provided. These ongoing supports and services improve a person's ability to function in their family and community, often reducing public safety problems and negative consequences.

Children with mental health issues are served in their local communities. Each child is screened for and served within the integrated service array according to a standardized level of need determination for their mental health service needs.

Services and supports include those delivered by peers such as help establishing personal relationships, and help obtaining employment or schooling; independent living skills training such as cooking, shopping and money management; residential or adult foster care; and supervision of people who live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, doctor offices and clinics, schools, drop-in centers and homes. The Oregon Health Plan (OHP) covers mental health services for eligible persons with conditions funded under the Health Services Commission Prioritized List for all Medicaid and SCHIP clients. The state General Fund pays for services and individuals not covered by OHP.

Where service recipients are located

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

Who receives services

Community mental health programs provide mental health services for adults and children who have serious emotional and mental health disorders and are a danger

to themselves or others; are unable to meet their needs; or are in danger of being removed from their homes due to emotional disorders. During 2009 publicly-funded programs served 72,207 adults and 33,243 children and adolescents.

How services are delivered

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

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

Services are delivered in every county through the 32 CMHPs and Warm Springs Tribal Clinic. Services are provided by a combination of county employees and subcontracted private agencies.

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

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

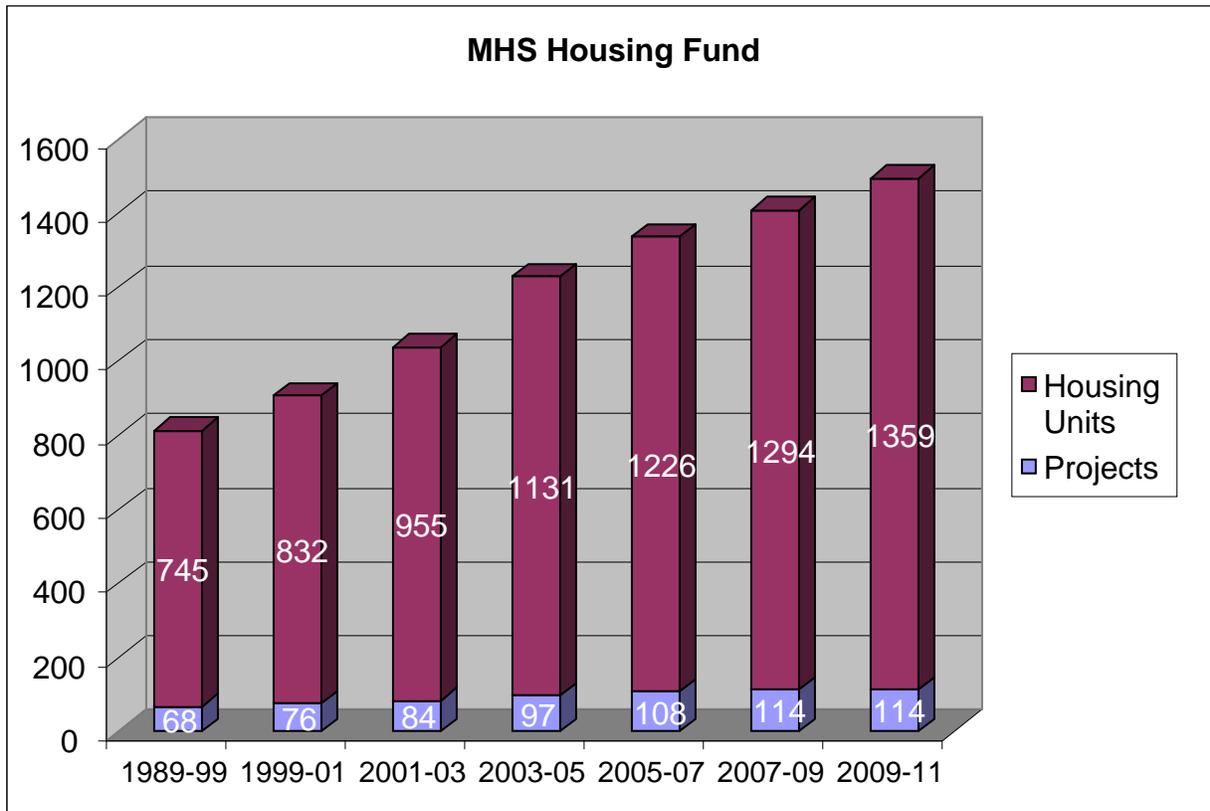
Housing

A safe and affordable place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments, their recovery is at risk. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue treatment services, thus increasing the risk of further illness, mandated treatment and greater disability. For mental health, AMH has two housing funds and an initiative on the former Dammasch State Hospital site in Wilsonville — the Villebois project.

Mental Health Services (MHS) Housing Fund

Since 1989 AMH has provided grants to support the development of 108 housing projects in 25 counties accommodating 1,226 people with severe and persistent mental illnesses. The following chart shows the growth of projects and capacity since 1989. To date, AMH has invested \$4.4 million in the development of these projects. Each dollar invested leverages approximately \$38 from other sources.

For the 2009-11 biennium, AMH set aside \$300,000 in MHS funds for housing renovation grants. These grants are capped at \$4,999 per project and are available to address health and safety repairs to adult foster homes, residential treatment homes and facilities within the mental health residential system of care. AMH conducted two renovation fund application rounds in July and September 2010. Sixty-five applications were received for a total of \$267,423. Fifty-nine applications were awarded funding for a total of \$219,191. The 59 facilities serve 554 residents in the residential system. The remaining MHS funds will be used during the last half of the 2009-11 biennium to address special development needs for patients transitioning from Oregon State Hospital.



Community Mental Health Housing Fund

Established with the proceeds from the sale of the former Dammasch State Hospital property, this AMH fund has awarded an additional \$2.4 million in support of 32 projects. During 2009-11, two application rounds provided opportunities to increase housing for people with mental illness. The first round awarded \$600,000 toward the creation of 86 units of supportive housing, leveraging \$47 for every dollar invested for total housing worth \$29 million. The second round applications are due in February. AMH is offering \$330,000 for the development of supportive housing and hopes to fund at least three projects.

The principal funds are held in the Oregon short term fund (OST) with these guiding principles in priority order — preservation of principal, liquidity, and yield. Additional conditions guide the investment fund:

- The OST fund must maintain an average credit quality of “double-A”;
- A maximum 50 percent of the portfolio can be in corporate (non-government agency) securities;
- A maximum of 5 percent exposure can be maintained to any commercial paper or corporate note issuer;
- All investments must be US dollar denominated;
- Fifty percent of the portfolio must mature within 93 days; and
- No investment will require more than three years to mature.

Villebois

AMH is working with private developers to integrate community housing into the new urban village community at the former Dammasch site in Wilsonville. Originally AMH expected to develop 20 to 24 projects over a 10-year period beginning in 2005. Drastic changes in the housing market and the economy have halted most development activities at Villebois. Three multi-family projects opened in 2008 and 2009. Renaissance Court opened in June 2008 and serves 20 people with mental illness. The Charleston opened in May 2009 and has 15 of the 52 units set aside for people with mental illness. The Rain Garden opened in June 2009 and provides intensive support services to 29 people with mental illness, allowing them to live independently and have a key to their own door. There are currently no AMH projects under development at Villebois, although a private developer currently is building 81 single family homes. AMH is committed to fulfilling its remaining obligations regarding community housing at Villebois and to that end created the Villebois Housing Investment Workgroup. The workgroup is a diverse group of individuals representing consumers of mental health services and their family members, individuals from banking, real estate, affordable housing, Clackamas

County and the City of Wilsonville. The workgroup had its first meeting in January and is charged with providing recommendations to AMH regarding the best way to meet remaining obligations for community housing development at Villebois.

Why these services are significant to Oregonians

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

Performance measures

KPM 7: Percent of children receiving mental health service suspended or expelled from school

Purpose: The overall goal of the children's mental health system is to keep children at home, in school and out of trouble with friends. This measure demonstrates the success of keeping children in school.

Target: This is a new measure and AMH wanted to establish a baseline. Based on the information gathered the target for next year will be for only 9.5 percent of the children to be expelled or suspended.

Results: Baseline information from the past four years shows that typically 10 to 13 percent of the children in mental health services are expelled or suspended. This is roughly equivalent to the rate for the general school population and should be considered good.

How Oregon compares to other states: There is no state or national data for children receiving mental health services to use for comparison.

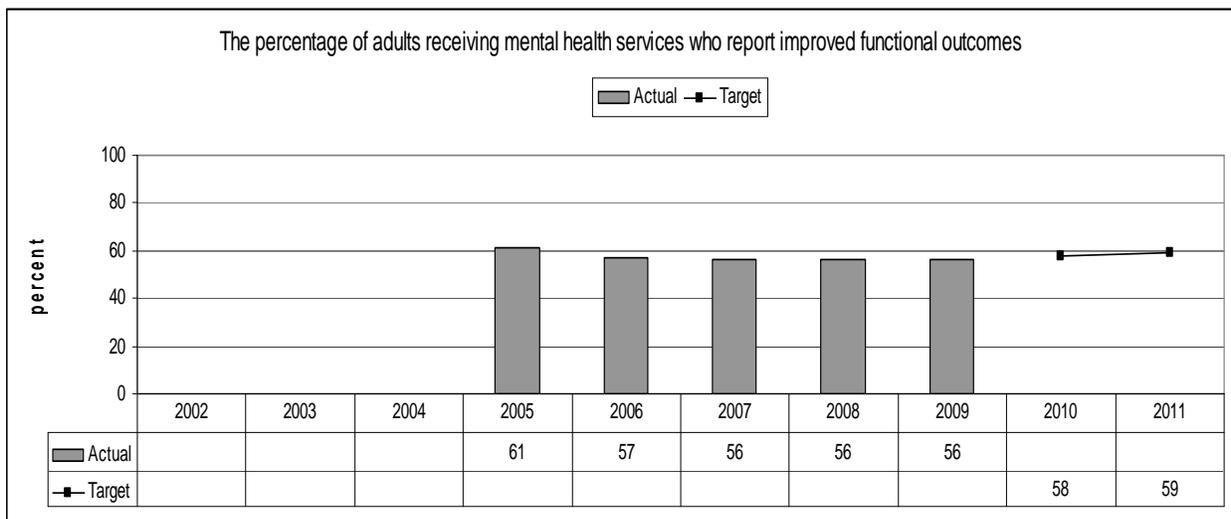
KPM 8: Percentage of adults receiving mental health services who report improved functional outcomes as a result of those services

Purpose: Functional outcomes are outcomes that everyone wants — good relationships with family and friends, good housing, and a job for example. This measure tracks individuals' perception of whether or not they have achieved those goals.

Target: This is a new measure and AMH wanted to establish a baseline. Based on the information gathered the target for next year will be that 58 percent of adults experience improved outcomes.

Results: Baseline information from the past five years shows that typically 56 to 60 percent of the adults experience improved outcomes during mental health services.

How Oregon compares to other states: National statistics show that roughly 71 percent of adults experience improved outcomes. This indicates Oregon has some work to do. A great deal of caution should be used in looking at comparative data from other states because of the variance in available services as well as the methodology for administering the survey.



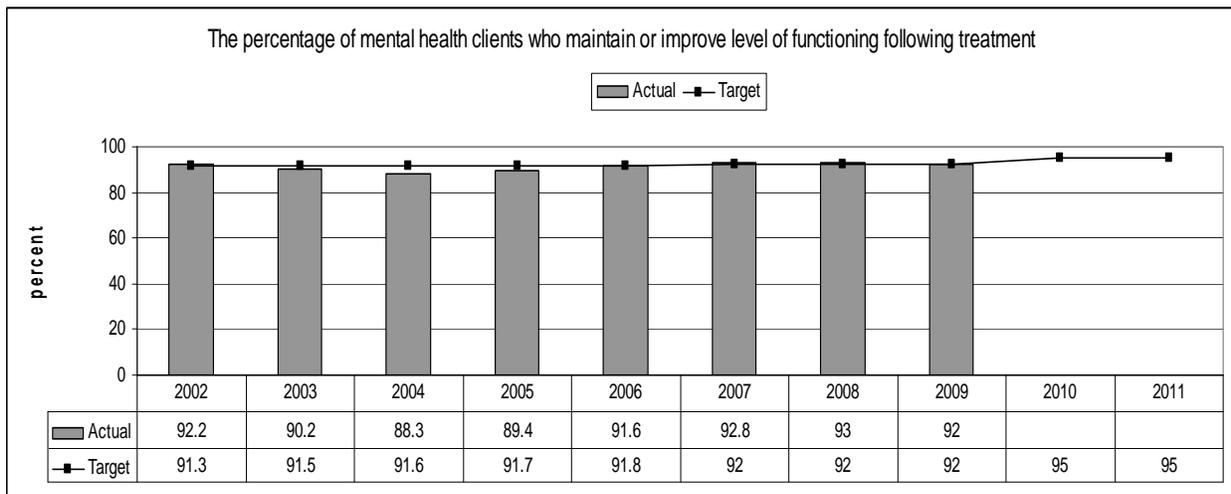
KPM 9: Mental health client level of functioning

Purpose: Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children use a similar tool called the Children’s Global Assessment Scale (CGAS). These tools are used to gather information during the initial assessment and throughout treatment. AMH is able to determine clients’ improvement over time by looking at changes to the GAF and CGAS scores. The goal is to demonstrate maintenance of functioning or improved functioning.

Target: The current target for this measure is 92 percent.

Results: In recent years the percentage of clients who maintain or improve functioning has steadily increased, although 2009 did show a slight decline to 92 percent. This result still meets AMH’s goal. There is a concern that this tool, while in broad use, is not very sensitive to changes. AMH is exploring other ways to assess clients’ general improvement as a result of treatment.

How Oregon compares to other states: There is no state or national data for comparison.



Proposed key performance measure for 2011-13

AMH proposes three new measures for inclusion as key performance measures (KPMs). The percentage of dollars spent on facility-based mental health services compared to community-based mental health services, the percentage of people with severe emotional disorders or severe mental illness served within the public mental health system, and the percentage of children demonstrating a decrease in the number of arrests in the 12 months following initiation of mental health services.

Other performance measures

Approximately 12 percent (106,124) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 5.4 percent (156,962) are estimated to have a severe mental illness.

AMH serves 31 percent of the children and adolescents and 46 percent of the adults with a severe emotional disorder or severe mental illness.

Involvement with criminal justice for both adults and adolescents is an important issue for AMH services to address. Caregivers of adolescents indicated that approximately 56 percent of the children arrested in the year prior to services were not arrested in the year after services. Adults had similar success with approximately 54 percent indicating that they were not arrested in the year following services.

Housing is another important outcome. Of the adults needing improved housing, 54 percent of those receiving help found new housing. Homelessness is still a major issue for people receiving mental health services; encouragingly, 60 percent of children who began services homeless were not homeless by the end of services.

Quality and efficiency improvements

Community-based services

For the past 15 years Oregon has systematically moved from an institution-based system to a community-based system. This allows people who need publicly funded mental health services to be served in their communities. Hospitalization for acute mental illness is provided in psychiatric units of local hospitals. Long-term treatment and stabilization for adults with major mental illnesses increasingly is provided in community-based settings. This allows people the opportunity to stay connected with family, learn the skills needed to be more independent, be engaged in their community and, when possible, work. Community-based services have proven to be effective in assisting people to recover from mental illness and to live independent lives. Many of the community services created in the past 10 years have been facility-based. During the 2009-11 biennium several critical AMH initiatives focused on creating more community-based services and moving people through facility-based services to greater independence with permanent affordable housing and the supports necessary to be successful in living more independently.

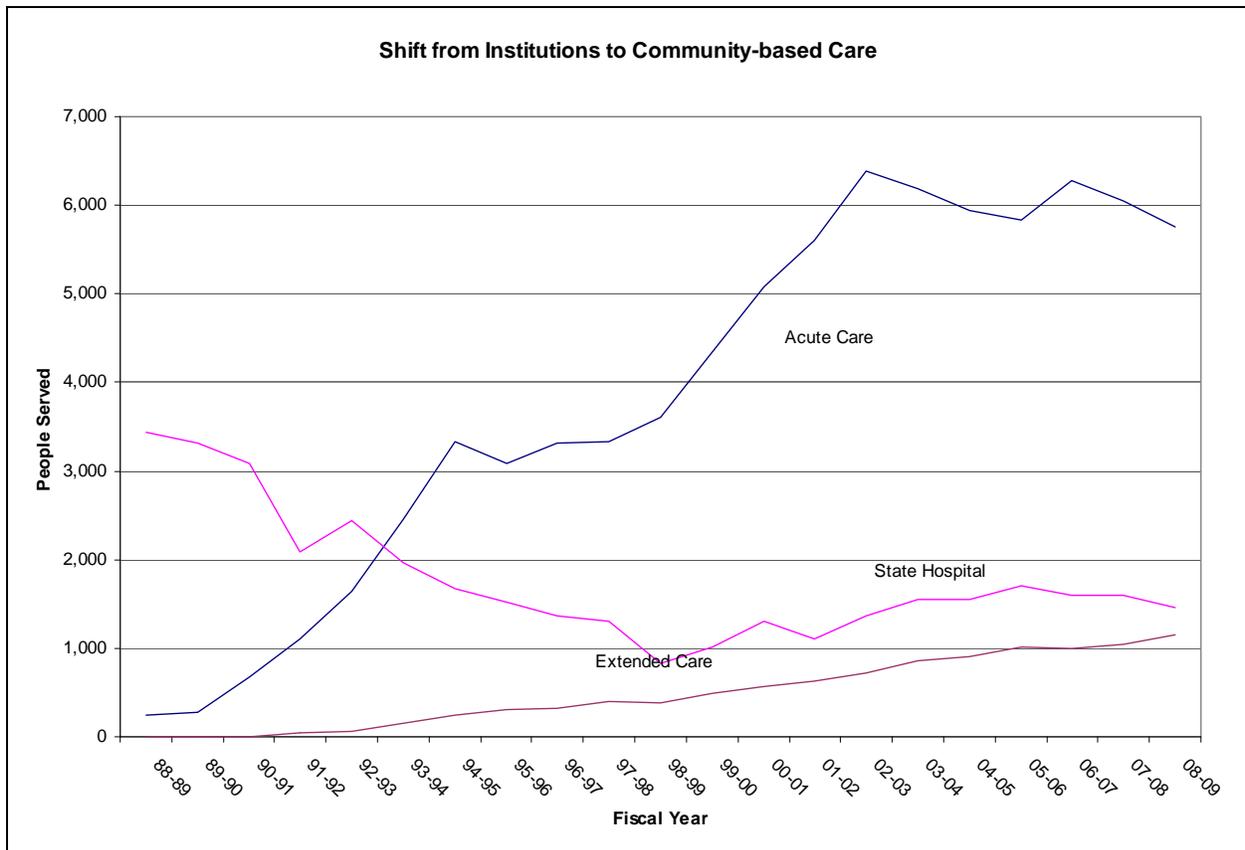
The cost to the system is less for community services than it is for institutional services. In addition, the services needed in community settings often can be supported with federal Medicaid funds not available for institutional services.

During 2009, 1,400 of the 72,207 adults who received treatment services in the community also were served in the state hospitals.

As of March 2005 Oregon no longer serves children or adolescents in a state psychiatric hospital. All Oregon youth, including those who need intensive, medically directed treatment in a secure setting, are treated in community programs. The length of stay is shorter and children are more quickly returned to

their home communities where they and their families receive the treatment and supports required for successful community living.

The following chart displays the admission trends in the system since 1988-89 and shows the growth in community-based acute and extended care. The numbers reflect unduplicated individuals — an individual is counted once per year even if admitted more than one time.



Key budget drivers and issues

Increasing population

As Oregon’s population grows, there will be an increase in the number of people with mental health disorders. National research that looks at the need for mental health services indicates that 156,962 Oregonians (5.4 percent of the adult population) require treatment for a mental disorder. For children and adolescents, national estimates indicate that 12 percent of the population (106,124 youth) requires treatment for mental and emotional disorders. Public funds provided services for 72,207 adults (meeting 46 percent of the need) and 33,243 children and adolescents (meeting 31 percent of the need). Some of these individuals will be

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

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

Housing

A safe, affordable, alcohol- and drug-free place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in unpredictable and dangerous environments, their continued recovery is at risk. Unfortunately, most clients of Oregon's publicly funded system are in adverse living environments. People with mental health disorders make up a substantial proportion of people identified as homeless in the 2010 Point in Time Count — more than 3,000 people or nearly 18 percent of those identified as homeless had mental health disorders.

Mandated treatment

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

Since July 1, 2007, AMH has provided on-demand treatment and support services to youth who are under the jurisdiction of the Juvenile PSRB. These young people have committed crimes and been found responsible except for a serious mental condition and to present a substantial danger to others.

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

During the past year there were approximately 2,100 civilly committed people served in state hospitals or other 24-hour community settings, including enhanced care, adult residential and foster care. Based on the civil commitment forecast, an

increase of about 350 people is expected during the next biennium. Many of these people will need 24-hour community or state hospital services.

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

The PSRB caseload has been increasing steadily for many years, although there has been a modest slowing during the past two years.

Improving the community mental health system

The 2007 Legislature funded improvements in community mental health that included jail diversion, acute care, crisis services, case management services, supported employment, early psychosis projects and children’s mental health. The funding was distributed to county programs through a formula that weighed both the needs of the community, as demonstrated through prevalence of severe mental illness, and the population.

Other than the loss of \$17.8 million needed for cost of living increases and a \$1.0 million reduction in supported employment services, the 2009 Legislature continued funding this investment in community mental health services. The services continue to meet the increasing demand for treatment and supports in local communities.

Without continued funding at the current service levels, the following outcomes will not be replicated:

Oregon has 14 evidence-based supported employment sites across the state. For the 2009-11 biennium, 1,165 unduplicated people accessed evidence-based supported employment services. Without these services thousands of Oregonians will not receive the essential employment training they need to allow them to become self-sufficient citizens. This in turn adds to the already high unemployment numbers facing Oregon.

Oregon has three evidence-based supported education programs — Cascadia (Multnomah County), LifeWorks (Washington County) and Options for Southern

Oregon (Josephine County). During the 2009-11 biennium 131 unduplicated consumers with severe mental illness received supported education services. Approximately 45 percent were enrolled in an educational program (GED, adult high school or post-secondary).

The state has directly developed or made available 193 supportive housing beds since July 1, 2007. Through the Adult Mental Health Initiative (AMHI) Oregon expects to serve 160 clients through supportive housing services or rental assistance. Without these supportive housing beds, Oregonians in need of treatment will occupy more costly residential beds adding a financial burden to the already strained residential system.

Jail diversion dollars have been distributed to 36 counties throughout Oregon. By county report, approximately 3,117 people have been served with these funds, preventing higher incarceration rates. Without these supports and interventions, thousands of Oregonians will enter the criminal justice system instead of receiving the needed mental health treatment.

The Avel Gordly Center for Healing provides between 550 and 600 units of culturally competent clinical service every three months to African and African-American individuals and their families.

Early Assessment and Support Alliance (EASA)

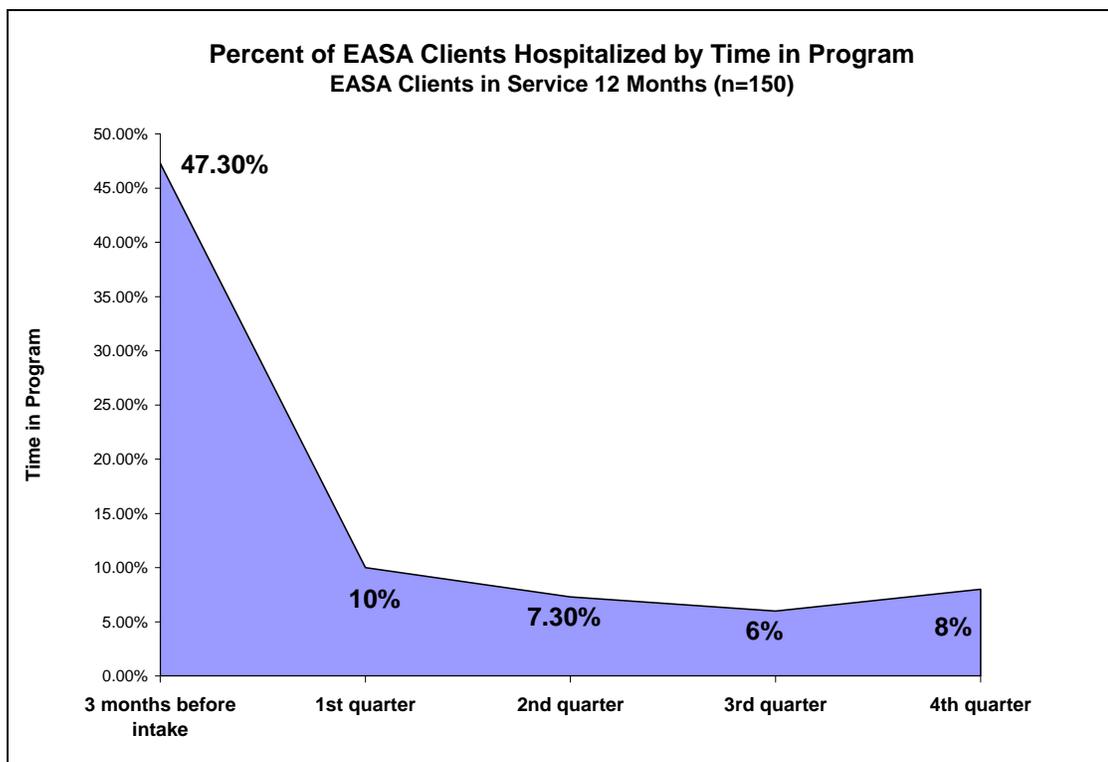
EASA is modeled after a successful program implemented by Mid-Valley Behavioral Health Care Network (MVBCN), which identifies individuals in the early stages of schizophrenia and other psychotic disorders and ensures they and their families have the proper resources to effectively deal with the illness. This program greatly improves community education about and awareness of mental illness by using EASA as an early warning system that guides individuals to appropriate services and supports. In the long run this will have a dramatic effect on reducing need for more institutionalized and expensive care, while promoting recovery and resiliency.

From January 2008 through to December 2010, the program received 1,200 referrals. Of those 1,200 referrals, 425 individuals and families were accepted into ongoing services with the remaining individuals receiving case management and other services and supports. EASA services and supports include outreach, engagement and assessment and treatment using a multi-disciplinary team that includes a psychiatrist, social worker, occupational therapist, nurse and vocational specialist. The program also provides multi-family psycho-education; cognitive behavioral therapy; vocational and educational support; prescribed medication

using a low dose protocol; and support for individuals in home, community, school and work settings.

Evidence-based early intervention for psychosis now exists in 16 counties (five original EAST and 11 EASA). Current outcomes demonstrate that:

- EASA diverts people from the hospital. Since 2008, 47 percent of participants were hospitalized in the three months prior to beginning service. In the first three months of participation in the program, hospitalizations are consistently reduced and continue to decrease over time. See graph below which shows an immediate 79 percent reduction in hospitalizations.



- 28 percent of EASA clients are under age 18, the average age at intake is 20. Approximately 40 percent are enrolled as students in secondary or post-secondary settings.
- Of EASA clients age 18 and older, 19 percent were employed at intake. In the first three months of the program, this figure increased to 28 percent, reaching 33 percent by nine months. All EASA clients are encouraged and supported to identify and pursue a career.
- Once individuals are part of EASA, there is a dramatic and sustained drop in legal involvement. Of EASA clients 18 and older, 23 percent had legal

involvement in the three months prior to intake, and 13 percent were arrested or incarcerated. In the first three months of service, these figures dropped to 13 percent with any legal involvement and 1.9 percent with any arrest or incarceration during the three month period. This reduction is sustained over time.

- 91 percent of all EASA participants have family actively involved in treatment.
- 63.5 percent of participants were not planning to apply for public assistance through the disability system at 12 months; for those who need the support of the disability system, EASA approaches it as a short-term bridge to self-sufficiency.

Major funding sources

Federal Funds

Centers for Medicare and Medicaid Services

- Medicaid Title XIX

Substance Abuse and Mental Health Services Administration

- Community Mental Health Services (CMHS) Block Grant
- Project for Assistance in Transition from Homelessness (PATH) grant.

Governor's Balanced Budget

The Governor's Balanced Budget makes modest reductions in benefits delivered by the community-based treatment system and anticipates savings through more substantial targeted administrative efficiencies in the Oregon State Hospital budget. These are in addition to the continuation of the 2009-11 reductions required to balance the budget and the lack of a cost-of-living increase.

As a result of these reductions, the state will not open two state delivered secure residential treatment facilities. The Medicaid Personal Care 20 program will be eliminated. This program supports adults with mental illness in hiring personal care providers who deliver up to 20 hours of assistance weekly with activities such as shopping, cleaning, managing medications and diet. These modest supports allow people with severe persistent mental illness to live more independently.

The GBB also assumes savings in community mental health provider administrative costs.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system

for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the United States Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

The modest reductions in community mental health services will allow the system to be a strong participant in the transformation of the health care system anticipated by the Governor's Balance Budget. The availability of appropriate community treatment for people with mental health disorders is critical to the success of integrated health care and long term care. Mental health is critical to over all population health. Strong community-based mental health care integrated with health care will allow people to be served early in the course of these illnesses. The providers will contribute to health care cost containment by delivering community-based alternatives to more expensive hospital and institutional care and improve the experience of care for the consumer.

STATE-DELIVERED SECURE RESIDENTIAL TREATMENT

Facility Program

The State-Delivered Secure Residential Treatment Facility Program was enacted through HB 5031, the DHS Operating Budget. In passing HB 5031, the 2007 Legislature approved the program authorizing AMH to operate secure residential treatment facilities.

Services provided

State-delivered secure residential treatment services provide long-term treatment for individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB) who have been deemed ready for conditional release. These individuals actively participate in an array of treatment options while under the jurisdiction of the PSRB. The PSRB closely monitors the progress these individuals make in their treatment and plays a role in the evaluation process to determine when residents are ready to transition to a lower level of care.

Where service recipients are located

The program opened in Pendleton in early January 2009. Additional programs have not been sited at this time due to the economic situation and the vacancies in other facilities serving the same population.

Who receives services

Services are provided to individuals under the jurisdiction of the PSRB who no longer need hospital-level care. Providing services to those under PSRB jurisdiction in the community lowers the census at the Oregon State Hospital. There are 16 people in the first program.

Governor's Balanced Budget

The Governor's Balanced Budget continues support for the state-delivered secure residential treatment program in eastern Oregon. It does not include funding for two additional state-delivered programs. The state's efforts to more effectively use existing secure residential treatment programs should make it possible for people needing this level of care to receive it in existing facilities.

Mental health services for adults who need long-term psychiatric hospitalization are provided in both extended community care services and the state hospitals with campuses located in Salem, Portland and Pendleton. These services are essential to restoring patients to a level of functioning that allows successful community living. Services in a secure setting promote public safety by treating people who are dangerous to themselves or others, who have committed crimes, and are adjudicated guilty and insane. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of non-profit and for-profit providers.

Services provided

With campuses in Salem and Portland, the Oregon State Hospital (OSH) provides inpatient and residential services with a budgeted capacity of 641 beds and a licensed capacity of 732 beds. OSH is accredited by the Joint Commission. Patient ward 34C in geropsychiatric treatment services is certified to receive Medicaid Title XIX funding by the Centers for Medicare and Medicaid Services (CMS). OSH is part of the Oregon State Hospital System and is operated by the Oregon Health Authority (OHA) Addictions and Mental Health division.

Adult treatment services are provided in a 92-bed leased facility in Portland. This program provides hospital-level psychiatric services for 92 adult patients with major psychiatric illnesses who are 18 to 65 years of age. Patients treated in this program are unable to be treated in a less structured environment; they are civilly committed and assigned to hospital-level care. This program provides intermediate and long-term state hospital treatment for patients transferred from community acute care hospitals.

Neuro/medical services are provided in 114 beds in four units of specialized active inpatient treatment for elderly persons with mental illness and a specialty unit for neurologically impaired patients of all ages. Five beds providing acute nursing care for patients suffering from medical conditions are included on one of the geropsychiatric wards. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive nursing home environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

Forensic psychiatric services provides hospital treatment services to patients committed by the courts for evaluation or treatment in order to aid and assist in their own trials or committed to the jurisdiction of the PRSB under the “guilty except for insanity” adjudication. These services consist of 399 hospital-level beds on 11 treatment units. A full array of treatment services is offered in maximum and medium security levels. In addition, this program provides services for some civilly committed patients who are either too dangerous or too difficult to manage in the less restrictive secure environment of a general adult hospital program. Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors.

Forensic residential transitional services provide treatment for 36 patients in six cottages. These are transitional units, providing treatment to patients under the jurisdiction of the PSRB who have shown substantial improvement in their conditions and require a less restrictive environment in preparation for placement in a community setting.

Where service recipients are located

Clients residing at OSH are admitted from all areas of the state to facilities in Portland or Salem.

Performance measures

KPM 11: Number of restraints per 1,000 patient hours at Oregon State Hospital

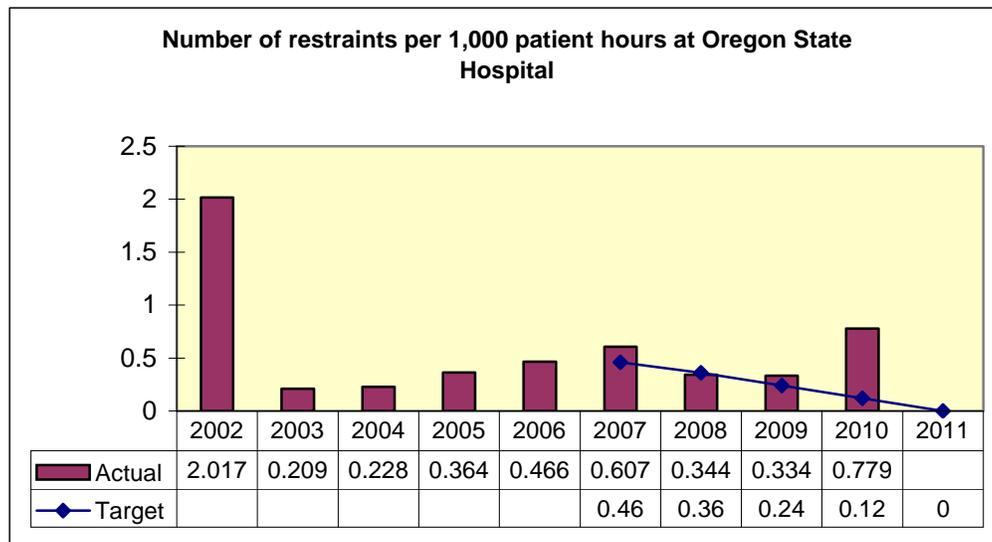
Purpose: The goal is to reduce and eventually eliminate the use of emergency restraint. All employees are trained in a technique known as ProACT to help implement this goal. ProACT teaches staff to use the least restrictive approaches to controlling aggression, including early intervention to prevent the escalation of aggressive behavior

Target: The long term hospital goal is to not use restraints in our care of patients.

Results: OSH saw a significant increase in the use of restraints during 2010. Specific attention has been placed on patients who frequently experience restraints with an emphasis on developing alternative options for both the patient and staff. The Seclusion and Restraint Committee makes use of data to target the appropriate patients and units and has brought in national experts to help the

reduction effort. During the second half of 2010, some success was achieved through these efforts and a downward trend was seen.

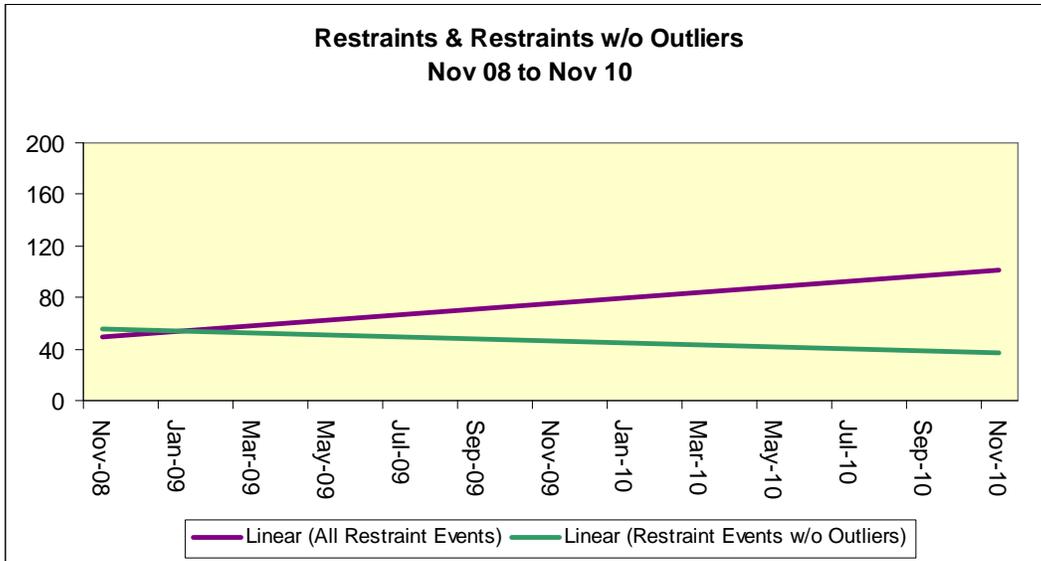
How Oregon compares to other states: Based on monthly data collected through the National Research Institute of the National Association of State Mental Health Program Directors, OSH’s restraint rate has been above the national rate. National comparisons are difficult because of the variability (size and function) in hospitals across the states.



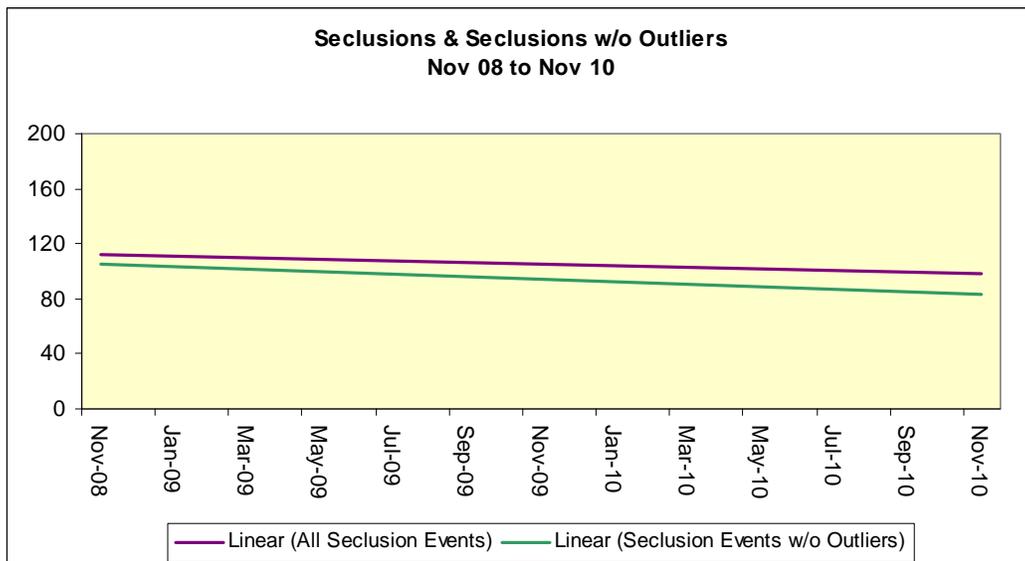
Additional information regarding restraint use and seclusions

As required by the Joint Commission, OSH submits data on restraints and seclusion to the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. OSH data, along with data from hospitals around the country, are analyzed and reported back to OSH, resulting in a delay in the publishing of recent OSH results.

Overall restraint use has increased at OSH, impacted heavily by a small number of patients with difficult to manage behavior. When these patients (outliers) are removed from the data, it shows that restraint use has been on a steady decline in the rest of the hospital.



The use of seclusion has held steady at OSH with the most significant change seen in the rate of use in the outlier category of patients. Through the extensive efforts of staff and the counsel of a national expert, strides have been made to reduce the use of seclusion in this difficult patient population.



KPM 12: Average length of stay, in days, for individuals civilly committed at Oregon State Hospital

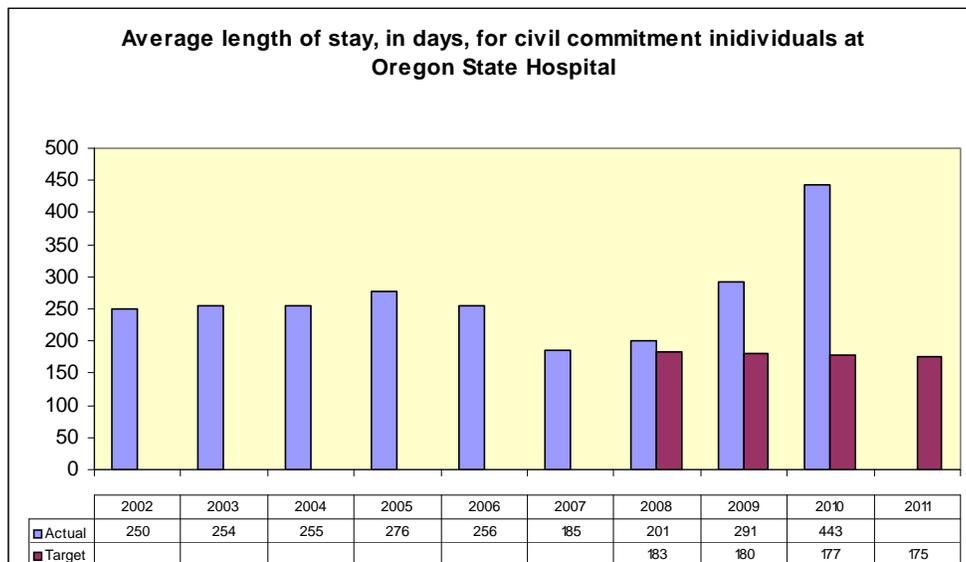
Purpose: The goal is to reduce the projected length of stay of individuals at OSH and ensure they are in the most appropriate level of care. Decreasing the

length of stay will allow the hospital to better achieve census goals, particularly as the hospital transitions to the new facility.

Target: The current target for this measure is 177 days.

Results: OSH did not achieve the target for 2009 or 2010. Length of stay based on patient discharge, actually rose significantly during this period. The rise is due to the extraordinary efforts of hospital and community staff to finding appropriate housing for patients who are medically compromised, especially aggressive, or a sex offender and difficult to place in the community; these patients spend significant time at OSH.

How Oregon compares to other states: While there is national data for lengths of stay, it is difficult to compare because of the varying nature and population of other state hospitals.



Quality and efficiency improvements

OSH compliance with oversight agencies

OSH completed a Continuous Improvement Plan (CIP) in January 2008 following the November 2006 review of the US Department of Justice (USDOJ). The hospital's CIP, a multi-year effort, is guiding improvements in multiple areas:

- Adequately protecting patients from harm;
- Providing appropriate psychological care and treatment;

-
- Use of seclusion and restraints in a manner consistent with generally accepted professional standards;
 - Providing adequate nursing care; and
 - Providing discharge planning to ensure placement in the most integrated settings.

A team of two CMS surveyors made an unannounced visit to OSH June 16-18, 2008, to follow up on CMS surveys conducted in February and April 2008. The survey team found that patient ward 34C was acceptable for certification.

The Joint Commission conducted its full and unannounced survey in February 2009. The survey team requested Requirements for Improvement that were all subsequently met and full accreditation was granted retroactive to February 2009. The hospital's clinical laboratory was also surveyed and granted full accreditation.

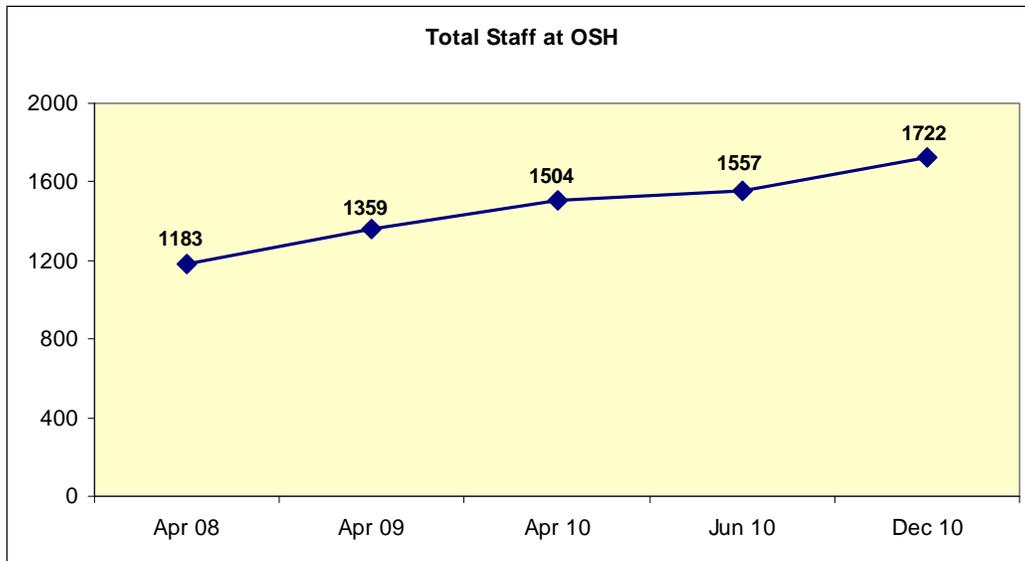
Currently, the hospital is preparing for its upcoming periodic performance review with the Joint Commission.

Improved incident reporting system

OSH has improved procedures for completing and submitting incident reports. Incidents are reported daily and follow-up, when necessary, can happen immediately. The Critical Incident Review Panel meets regularly to ensure incident reports and corrective actions are comprehensive and appropriate. Corrective actions include modification in patient behavioral plans, medication regimens and supervision, as well as enhancements to physical characteristics of select areas of the hospital. The Critical Incident Review Panel is educating staff about incident trends as well as evaluating whether reviewed corrective actions have been effective in reducing the number of hospital incidents, both on an individual patient and system-wide basis.

Staff additions at OSH

OSH continues to advertise, recruit and qualify candidates for certain key positions such as registered nurses, physicians and pharmacists. Nearly all administrative positions at the hospital have been frozen.



In 2009, the hospital's policy option package was funded with 527 new positions. Since OSH received the appropriation, 355 positions have been filled. Of the remaining 172 vacancies, 161 are frozen in order to address reclassification of revised positions to better meet the hospital need since the original request; 11 are frozen due to the general hiring freeze.

Response to Office of Investigations and Training (OIT) report

In response to a report issued by the Office of Investigations and Training that followed the investigation of a patient death in October 2009, OSH created a comprehensive follow-up action plan. Improvements implemented include revising the Continuous Rounds Policy to monitor patients; establishing morning report for all patient units to improve communications among staff; hiring 14 treatment care plan specialists (TCPS) to facilitate interdisciplinary treatment teams (IDTs) with plans to hire an additional nine; auditing all patient records to determine if patient's medical care issues are being actively addressed (initial audit showed 91 percent compliance); revising frequency of documentation standards and establishing required elements of documentation; and revising the Communication with Patient's Family policy and the Interpreter Services policy.

Improved patient assessment compliance

Patient assessments are a critical element to effective mental health treatment. At the time of admission, clinical disciplines conduct assessments of all patients. Within the first 10 days of admission, the following are completed: a psychiatric admission note and history (psychiatric); a medical history and physical exam (nurse practitioner); a comprehensive nursing assessment (registered nurse); a psychosocial history (social worker); a rehabilitation services

assessment (rehabilitation therapist); a patient education assessment (assigned staff); and any psychological testing ordered by the physician (psychologist).

Completion rates for all assessments are tracked by the Quality Improvement Department. In 2010 the completion rate was 90.5% as compared to 93.3 in 2009 and 91.2 in 2008.

Increased use of behavioral support plans

The OSH Continuous Improvement Plan includes as a high priority the development of behavioral support plans for identified patients. Behavioral support plans (BSPs) provide specific treatment strategies for patients whose behavior is difficult to manage. Use of BSPs is expected to contribute to a decrease in both aggressive acts by patients and the use of restraints and seclusion. The initial focus was on patients within the geropsychiatric treatment services program on the Salem campus and the four units on the Portland campus. The focus was expanded to include patients in the forensic psychiatric services program. During 2010, BSP assisted 48 patients in their discharge from OSH.

Improved master treatment care plans

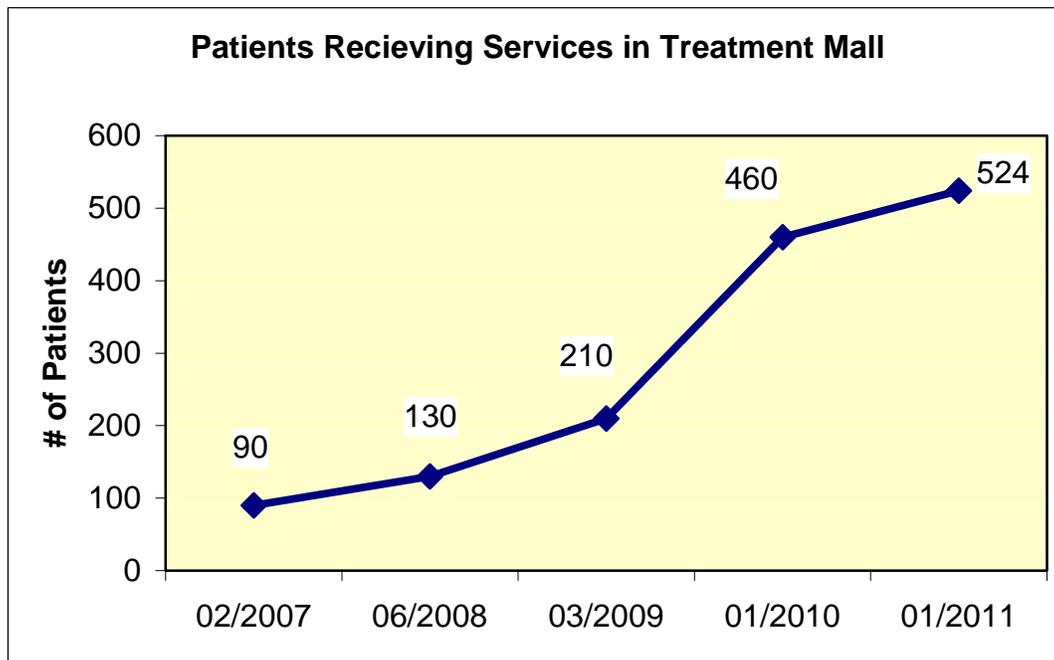
OSH provides recovery and rehabilitation to the patients it serves through active treatment. Central to effective treatment is patient care planning. With input from two nationally recognized consultants, changes have been made to the functioning of treatment teams and to the form and content of treatment care plans.

A new electronic master treatment care plan format was piloted in geropsychiatric treatment services in November 2009. The revised format ensures that care is patient-centered, individualized and responsive to patient needs. As a result of these positive outcomes, it was decided to implement the new format hospital-wide. Implementation dates occur as wards are assigned employees in their newly created treatment care plan specialist (TCPS) positions. The TCPS coordinates the functioning of the Interdisciplinary Treatment Team, ensures the team meets regularly, has pertinent patient information, and communicates with treatment mall staff to ensure continuity of care. The new master treatment care plan has been implemented in all areas where TCPSs are on board and ready to use the system. As more treatment care plan specialists are hired the new format will be implemented in the remaining six units.

Centralized treatment malls

A fundamental element of the hospital's Continuous Improvement Plan is delivering centralized services at treatment malls. Four treatment malls now provide active

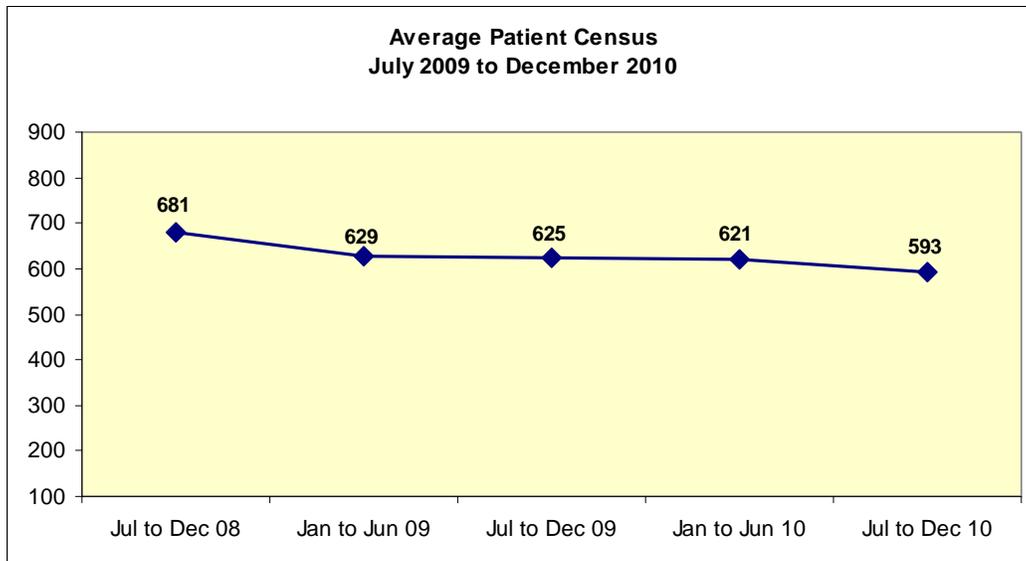
treatment to a majority of OSH patients. The chart below shows the steady increase in the number of patients served.



- Portland Mall opened February 2007
- Geriatric Mall opened June 2008
- Transition Mall opened March 2009
- Forensic Mall opened January 2010
- Harbors Mall opened January 2011

Patient census

During the past 30 months, OSH has experienced a 13 percent decrease in patient census. Improved discharge planning; the implementation of a peer bridger program; participation in the Transformation Initiative; and increased cooperation with the Blue Mountain Recovery Center, the Psychiatric Security Review Board and community partners have all contributed to reduced patient census. There remains a group of patients whose histories and complex needs are a challenge for timely discharge. During this period of decreased census, the number of patients waiting for admission has remained low.



Transformation Initiative

In collaboration with the DHS Transformation Initiative, hospital staff have undertaken five rapid process improvements (RPIs). An RPI is a multi-day focused effort that brings together multiple disciplines and stakeholders to map out a current work process, eliminate waste and build a new streamlined process. Four of the RPIs have focused on process improvements and one on quality improvements.

Process improvements

OSH is using rapid process improvement events and Lean principles to improve and streamline existing processes as part of the planning to move into the new facility. The work design has resulted in dramatic improvements in the process for hiring RNs, physician billing for Medicare covered services, the documentation of group treatment in the treatment malls, and most recently the hiring of direct care certified nursing assistants.

The RN hiring and the certified nursing assistant hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates. Since the RN hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA hiring rapid process improvement event was launched in May 2010 and filled 85 vacant CNA positions by August 2010, three months ahead of schedule. The streamlined hiring process resulted in 139 hires between May and October 2010.

The group documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation

processes into one streamlined process and a format that is now used across clinical disciplines.

The MD billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

Quality improvements

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients, made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their dietary consultation process improvement efforts in 2008; dietitians are completing twice as many consultations every month and people receive their dietary consultations 90 percent more quickly than before the process improvement efforts.

Key budget drivers and issues

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

Governor's Balanced Budget

The Governor's Balanced Budget assumes savings from substantial administrative reductions and additional efficiencies in the OSH budget. The hospital is working to improve accountability and efficient operations throughout the hospital. Staff are prepared to continue to change to operate within the budget available for 2011-13.

There is one major challenge in the GBB that jeopardizes the operation of the hospital.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the United States Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. The package could not be funded under current revenue projections. Work by the recently hired Superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

Blue Mountain Recovery Center (BMRC)

Services provided

Blue Mountain Recovery Center (BMRC) in Pendleton, formerly known as the Eastern Oregon Psychiatric Center (EOPC), is an inpatient adult psychiatric hospital built in 1948. Clients reside on two 30-bed units and attend groups and activities throughout the facility. BMRC is part of the Oregon State Hospital System and is operated by the OHA Addictions and Mental Health Division.

Specific services provided by BMRC include: medication management; evidence-based educational classes; life skills training; vocational services; physical and recreational activities; alcohol and drug counseling; individual cognitive-behavioral therapy; and spiritual counseling. Transition services are provided to prepare clients for successful discharge into community-based services. Medical services are provided by contract physicians and local community hospitals.

Where service recipients are located

Clients residing at BMRC are admitted from all areas of the state.

Who receives services

BMRC provides long-term treatment for civilly committed clients who, due to a mental disorder, are deemed dangerous to themselves or others or are unable to care for themselves. These individuals actively participate in an array of treatment options at BMRC until they are able to manage their psychiatric symptoms and maintain their mental health in community settings. In addition, BMRC provides care and treatment for a small number of forensic clients who have close family ties in eastern Oregon.

How services are delivered

BMRC embraces the Recovery Model, which supports clients learning to live well with the least amount of professional intervention. Dedicated physicians, nurses, therapists and other staff members at BMRC help clients start their road to recovery from acute exacerbations of psychiatric illness. The goal is to return clients to the fullest possible participation in their families, jobs and communities as quickly as possible. Clients learn how to take charge of their lives by managing emotions across settings, staying out of conflicts, using medications wisely and avoiding drugs and alcohol. This delivery system is in direct alignment with all of the OHA goals for Oregonians, of which BMRC clients are a distinct subset.

Why these services are significant to Oregonians

One of the primary functions of BMRC is to ensure that individuals with psychiatric disabilities are kept safe until they are able to manage their symptoms and behaviors in a community setting. Another primary function is to ensure public safety through secure, intensive treatment of clients while they regain psychiatric stability.

Since the beginning of 2008, BMRC has averaged 145 admissions and discharges per year. This represents more than 18,000 inpatient days per year, a figure that cannot easily be absorbed by existing facilities in the community or by the other two state hospital campuses.

Furthermore, BMRC is the primary state hospital resource for central and eastern Oregon. Clients from St. Charles Bend are given preferential admission in order to maintain open acute psychiatric beds in the region.

One of the desired outcomes of the use of evidence-based practices is that funded programs “improve the mental health of a person with the result of reducing the likelihood that the person will commit a crime or need emergency mental health services.” BMRC provides vital psychiatric services that achieve that very outcome. The BMRC current treatment model has resulted in fewer 30-day readmission rates, longer stays in the community between hospital readmissions, shorter stays in the hospital and, overall, a better quality of life for one of Oregon’s most vulnerable populations, persons with psychiatric disabilities.

Governor's Balanced Budget

The Governor's Balanced Budget assumes modest administrative efficiencies in the BMRC budget. The operation of BMRC also will be influenced if the funding is not available to implement BHIP which is intended to provide electronic medical records for the hospital.

PROGRAM ADMINISTRATION AND SUPPORT

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

AMH Program Administration and Support (PAS) is responsible for:

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

PAS staff share responsibility with the counties for developing and managing community programs as part of the overall state mental health and addictions system. If a county is unable to operate a program area, AMH is responsible for contracting for services directly with providers. PAS is responsible for protecting the safety of clients and ensuring quality of care.

PAS ensures the efficient and effective functioning of the program office and the necessary supports to the program and policy staff. AMH central administration staff work closely with the department budget staff and contract administration staff to ensure sound financial management of the addictions and mental health services community and state hospital program budgets, and the appropriate implementation of community treatment programs through contractual relationships.

PAS is composed of four sections — Alcohol and Drug Prevention, Alcohol and Drug Treatment, Problem Gambling Prevention and Treatment, and Community Mental Health — responsible for:

-
- Program development;
 - Administrative rules development;
 - Planning and policy development;
 - Coordinating policy and contracts for all Medicaid-covered services including the Oregon Health Plan for mental health and addictions services;
 - Strengthening coordination between the state hospitals and the community mental health programs to ensure appropriate admission to and timely discharge from the hospitals;
 - Conducting site reviews;
 - Conducting licensing and certification inspections;
 - Providing training and technical assistance;
 - Providing administrative oversight;
 - Overseeing quality improvement;
 - Developing program management data;
 - Conducting research on effective programs and measuring outcomes;
 - Providing technical assistance to community programs;
 - Implementing evidence-based practices as required by ORS 182.525;
 - Managing development of alcohol and drug free community housing for individuals with addiction disorders and those with mental illness; and
 - Collaborating with state and local partners to reduce and end homelessness.

Alcohol and drug prevention

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based and statewide alcohol and drug prevention programs. These programs work closely with local partners including the state and local Commissions on Children and Families, and the tribes.

Alcohol and drug treatment

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based alcohol and drug treatment system providing services in all Oregon counties and to the tribes.

Problem gambling prevention and treatment

This unit within the Alcohol and Drug Treatment section is responsible for setting policy and developing programs that prevent problem gambling in Oregon and overseeing the service delivery system for the treatment of problem gambling.

Community mental health

This section of PAS has specific units that provide oversight, policy direction, program development and technical assistance to the community mental health system for both adults and children:

- The adult mental health services unit ensures linkages between the state hospitals and communities.
- The residential programs and services unit is responsible for the development of new community-based resources to treat adults who are ready to be discharged into the community.
- The children's treatment system provides oversight, development, training and technical assistance to maximize the effective treatment of children in their home communities through the community-based system.

There are four units that support all of the program areas:

- Mental health and substance abuse Medicaid policy staff members ensure appropriate policy considerations in rate setting for managed care; contract for managed mental health services; and monitor federal Medicaid and Medicare policy affecting services to people with mental health and substance abuse problems.
- Program analysis and evaluation staff are responsible for the extraction and analysis of data to support program decision making; meet federal and state reporting requirements; develop performance measures; and answer legislative question.
- Quality improvement and certification staff are responsible for reviewing a full range of community programs and ensuring that state-funded services are delivered in a safe and effective manner. Staff license 356 programs and certify 665 programs.
- Operations and contract administration staff are responsible for contract implementation; development of administrative rules; standardized policies and procedures; community workforce training; and secretarial support for the policy and program staff.

Transformation Initiative

AMH has integrated the tools, skills learned and resources available as a result of the Transformation Initiative to manage nine active transformation initiatives and one cross-divisional initiative. These tools also are used to manage 12 key strategic initiatives that will drive system improvement in response to legislative direction.

The implementation of the Lean Daily Management System throughout the office has empowered staff to resolve process problems and streamline and improve the quality of work. Staff are building new skills and finding more efficient and effective ways to do critical work in times of scarce resources that require holding positions vacant, reprioritizing and shifting critical work functions to remaining staff.

Transformation initiatives

O1 — Transitioning people

Staff members in the AMH central office and at OSH worked with key community stakeholders to develop and implement improved methods for timely transition of people from the state hospital into community-based treatment. The goal is to provide access to the right type of services in the most appropriate environment, for the right amount of time. The work has resulted in the use of standardized tools for decision making, agreed-upon criteria for when an individual is ready for discharge from the state hospital, and full implementation of a co-management plan that holds counties accountable for timely discharge from the hospital. The initiative has resulted in more timely communication regarding available community resources. The work started in late 2009 and continued through full implementation by September 2010.

O3 — OSH process improvement

OSH is using rapid process improvement events and Lean principles to improve existing processes and streamline process as part of the planning to move into the new facility. The work has resulted in dramatic improvements in the process for hiring RNs, physician billing for Medicare covered services, the documentation of group treatment in the treatment malls, and most recently the hiring of direct care certified nursing assistants.

The RN hiring and the certified nursing assistant hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates by improving the hiring processes. Since the RN hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA hiring rapid process improvement event was launched in May 2010. The streamlined hiring process resulted in 139 hires from May through October 2010, exceeding the goal of 85 hires by the end of December.

The group documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation

processes into one streamlined process and format that is now used across clinical disciplines.

The MD billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

O4 — OSH quality improvements

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their dietary consultation process improvement efforts in 2008; dietitians are completing twice as many consultations every month and people receive their dietary consultations 85 percent more quickly than before the process improvement efforts.

O8 — AMH central office process improvements

This initiative provides the structure for rapid process improvements to streamline administrative work, reduce errors and time needed to complete tasks. This initiative resulted in major reductions in paper files with the move to a fully electronic filing system for all office correspondence. This will be the home for other cross unit improvements that are recognized during team daily huddles.

O9 — Lean Daily Management System roll out

AMH joined the other divisions in both the Oregon Health Authority and Department of Human Services in adopting a Lean Daily Management System (LDMS). All components of the office have implemented huddles, visual display boards, continuous improvement sheets, skill assessment and the development of unit “business goals” with the assistance of trained Lean Practitioners. This model allows more staff to be trained and take leadership roles in Transformation activities. AMH central office and OSH are now training managers to lead in a new environment with empowered staff and to develop 20 Keys for the units. This will be supported by training and coaching from highly trained staff. This work will be more critical as we look forward to additional years of scarce resources and increased demands for services.

O10 — Vacancy exceptions

As a result of this initiative, a new administrative rule governing the occupancy payments for residential treatment has been adopted and is being implemented with new policies and procedures which will minimize the payment for vacant beds in community-based residential treatment programs and maximize the use of these valuable resources.

O11 — NIATx expansion

This initiative will build on a pilot program that successfully improved the quality of services, the efficient use of capacity and improved access to and retention in treatment for people with addiction disorders. The Network for the Improvement of Addiction Treatment (NIATx) is a nationally known effective model for improving services and assisting states and programs in improving the tracking and communication of improvements.

O12 — Adult Mental Health Initiative

This initiative will promote the more effective utilization of current capacity in facility-based treatment settings, increase care coordination and increase accountability at the local and state level. The first phase of this initiative became effective on September 1, 2010 when mental health organizations (MHOs) became responsible for assisting individuals in transitioning from the state hospitals and licensed community settings to other service options. As an example, the MHOs will be working with individuals while they are at the Oregon State Hospital to identify treatment goals and plans for discharge as soon as appropriate. Once an individual is ready to leave the state hospital, the MHOs will assist that individual in transitioning to a licensed or independent setting. The MHOs will be responsible for ensuring that individuals receive the appropriate services and supports necessary for their ongoing well-being.

From September 1, 2010 through June 30, 2011, the MHOs will assist 331 individuals transition from highly restrictive settings to more independent settings and help these individuals on their path towards recovery. AMHI includes performance outcomes and incentives to help ensure that the initiative reaches its desired outcome.

In the first four months of the program, the MHOs exceeded the projected numbers. The MHOs successfully transitioned 180 individuals from the state hospital or a community licensed care setting (54 percent of the total number). At this rate the MHOs should be able to assist more than 420 individual by the end of the biennium. Of those individuals that the MHOs have currently assisted:

- 56 percent of the individuals left the state hospitals;
- 44 percent transitioned from licensed community care; and
- 36 percent moved to independent living with appropriate community services and supports.

On average, community services and supports are 25 percent less than keeping someone at the state hospital.

O14 — OSH diversion — NewPATH

This initiative is being done as a partnership between AMH, the Oregon State Hospital Replacement Project (OSHRP), OSH and DHS, and Seniors and People with Disabilities (SPD). The purpose is to develop a new model for serving people in the community who are not best served in the Oregon State Hospital. These patients have either maximally benefited from active psychiatric treatment at the hospital or are admitted to the hospital because the existing community treatment programs are unable to manage aggressive and/or sexual acting-out behaviors.

Cross-organization initiative — Children’s Wraparound

This initiative is the first phase of implementation of HB 2144 passed by the 2009 Legislature establishing the Children’s Wraparound Initiative in state law. A collaboration between AMH, Division of Medical Assistance Programs and DHS, Children Adults and Family, the purpose is to increase system efficiency and outcomes for children and their families. This is accomplished through a child and family team-driven planning process, care coordination across local child serving agencies, and flexible community services and supports. The effort begins with children in the custody of DHS for more than one year who have had at least four placements or who have come into custody and immediately need specialized behavioral health services and supports. The first three areas of the state began implementation in July 2010; by July 1, 2011 these eight counties will serve 385 children on a daily basis.

Strategic planning 2009-11 initiatives

AMH used the skills and tools of transformation to assure the successful conclusion or progress of twelve key system change initiatives. The implementation of the Alcohol and Drug Policy Commission resulted in the hiring of the executive director and turning over the ongoing work of supporting the commission.

The work needed for the successful July 1, 2010, implementation of the Impaired Health Professionals program as required by HB 2345-B was completed on time. The program established contracts for independent monitoring of the substance use

disorder and mental health treatment of impaired health professionals program; participants are either self referred or diverted by their licensing boards in lieu of disciplinary action. This work was done in complete collaboration with the health licensing boards to allow the successful transition of participants in the board programs to the new independent program on July 1, 2010.

The adoption of the Integrated Services and Supports Rule in March, 2010 ended a two-year stakeholder-driven process to create a single set of administrative rules across all addiction and mental health program areas, coordinated with the Medicaid payment requirements. Ten conflicting rules were abolished.

The utilization analysis initiative implemented an independent, comprehensive review of adult mental health residential services. As a result of the analysis, AMH gained an independent and improved understanding of rate of admission to and discharge from programs, movement between the levels of care and length of stay and will be able to do financial modeling. The initiative is complete and the results of the study informed the final structure of the Adult Mental Health Initiative (AMHI) to achieve local management and accountability for the use of residential treatment.

Remaining initiatives

1915(i) Medicaid home and community based state plan amendment

This initiative will create a new approach to community-based treatment for people with serious mental illness, a history of hospitalization and a need for daily service contact through the submission of a Medicaid State Plan Amendment to the federal Centers for Medicare and Medicaid Services. When approved, the amendment will make an expanded array of services available in community-based settings to better meet the needs of consumers and to simplify the billing and documentation requirements for providers. The amendment was submitted in July 2010. The results of this initiative will support Oregon's efforts to serve people in the most independent setting and will support the work of the initiative to redesign the adult mental health system.

Blue Mountain Recovery Center: The future

This initiative created a collaborative process to consider alternative use of the facility and program and to determine the use that would best meet the needs of the local communities, state and region, as well as patients and staff. It will result in a plan for the future of the hospital. The initial plan will be available during the 2011 legislative session. The final phase of the work will be to engage legislative leadership in adopting a plan for the future of BMRC.

Integrated services and management demonstration

AMH worked with legislative leadership in the 2009 Session to recommend a system change effort focused on integrating the management and service model including health, mental health and addiction services. The Legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in improved access, quality, and outcomes while containing costs.

Peer delivered services

Peer delivered services are a key component of a successful service delivery system and an important addition to the health care workforce. AMH is working with stakeholder groups to develop strategies increasing the use and availability of peer delivered services. In the initial stages, this work will build on existing peer delivered services in the state and look at a variety of funding strategies and options.

Strategic prevention framework

Oregon was awarded a five year federal State Prevention Framework Grant on July 1, 2009. This work will engage stakeholders from 10 counties, multiple communities and tribes. The result will be a common framework for assessing state and local needs and priorities; making data-driven decisions about the right evidence-based prevention programs delivered to the right audiences; and mobilizing communities and tribes to implement these programs and improve the outcomes in their communities. During the implementation of the grant the state's understanding about the most effective prevention strategies will be improved. This will allow a focused approach to preventing and reducing the disabling effects of substance use and abuse.

Wellness

This initiative builds on efforts to integrate physical and behavioral health. The work is being carried out by a broad group of stakeholders and is driven by consumers of mental health and addiction services. The work is critical to decrease the health disparities among people served in the publicly funded behavioral health system. This work will improve access to appropriate care and the quality of care that people receive and will contribute to the health and well-being of the public clients.

Young adults in transition

Young adults between the ages of 14 and 25 face multiple system barriers that make it difficult for them to seek and continue treatment for mental health issues. AMH has focused on structural, administrative, financial and clinical barriers to development of appropriate services. The goal is to provide access to services that

are effective in allowing young adults to gain the skills to manage their illness, complete their education, gain employment, and form healthy appropriate social relationships. AMH has created administrative rule and contract language that support the development of an age appropriate system of services and supports. AMH is working closely with YouthMOVE Oregon for leadership development, expansion of peer delivered services, and training of young people. AMH is currently integrating supported housing and supported employment services tailored towards this population, as the final step toward a successful community reintegration. The development of a system of services and supports has spread across Oregon. Numerous communities now have young adult system specialists and have mobilized their communities to developed specialized services. This work is ongoing and necessary.

The criminal justice door to the mental health system

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to aid and assist in their defense at trial or who have been found Guilty Except for Insanity. These two court-related entry points do not necessarily result in the most appropriate treatment or location for the individual entering the mental health system. The work under this initiative will engage all parties, including consumers, the court system, community mental health programs and law enforcement, to explore alternative processes that may result in more effective and appropriate placement and services for people with mental illness who come in contact with the criminal justice system as a result of their mental illness.

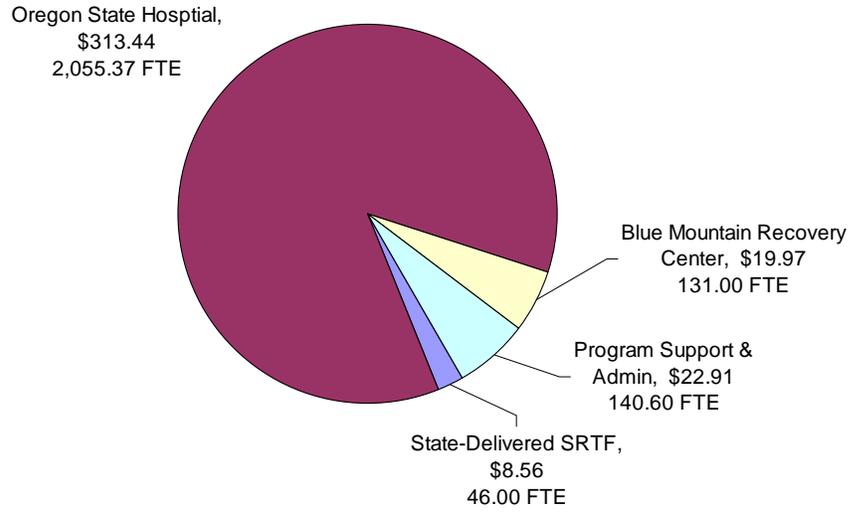
Governor's Balanced Budget

The Governor's Balanced Budget makes substantial reductions in program support. In responding to these ongoing reductions, the division reprioritized projects and restructured staff to focus on the most critical work. However with the substantial number of vacant positions that are not being filled in order to operate within available funds there will be delays in reviewing community programs and responding to questions, requests for data and complaints. This budget also assumes administrative efficiencies will be obtained by reducing contracts for services such as psychiatric participation in site reviews, services to employers in developing drug free work places and consultation from Oregon Health and Sciences University.

2011-13 Budget Summary (PA&S)

**Addictions and Mental Health
Personal Services
\$364.88 Total Funds
2,372.97 FTE**

(dollars in millions)



Oregon State Hospital Replacement Project

History

Oregon has been in critical need of a new hospital for its citizens with mental illness. The Oregon State Hospital (OSH) is one of the oldest, continuously used mental health hospitals on the West Coast. It also had the dubious distinction of being one of the most decrepit mental health facilities in the nation. More than 40 percent of the building space was unusable, with water leaks from roofs, crumbling walls and the toxic hazards posed by the presence of asbestos and lead.

For decades, state lawmakers heard from patients, advocates, citizens and staff about the inadequacy of the state hospital. In addition, the state has faced several challenges, including legal suits, over a variety of hospital deficiencies. The Governor, Oregon Legislature and DHS/OHA have collectively acknowledged the critical need for new mental health facilities.

During 2003 the Governor established, by executive order, a 21-member Mental Health Task Force to identify key problems in the state's mental health system and recommend improvements. The task force report released a report recommending changes to OSH in 2004.

Ongoing concern about the hospital prompted the November 2004 Legislative Emergency Board to allocate funds to DHS for an independent examination of the mental health system with a specific focus on OSH.

With those funds, the Governor and Legislature commissioned KMD Architects, a firm with more than 40 years' experience in 15 states, to begin preparing a master plan for replacing OSH.

The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues, including a potential that the "J" Building complex on the Salem campus would collapse in an earthquake. In addition, the Phase I Master Plan notes that the existing facilities on this campus have physical limitations that could not be remediated to provide safe and secure treatment environments. Along with these issues, the 92-bed Portland campus lease ends in March 2015, requiring the relocation of the 92 patients housed there. The Phase II Report on the Framework Master Plan was released on March 1, 2006. That report provided the Governor and legislative leadership with three options to consider for replacing OSH. The leadership directed DHS to proceed using the configuration listed in the document

as “Option 2”: one 620-bed facility located in the North Willamette Valley, one 360-bed facility located south of Linn County on the west side of the Cascades, plus two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

Based on recommendations from a Joint Legislative and Executive Branch Task Force, the 2007 Oregon Legislature authorized Certificate of Participation (COP) financing estimated at \$458.1 million to build two new state-operated psychiatric facilities. The first Salem hospital residential units opened in January 2011. The Salem hospital will be completed in December 2011 and the Junction City facility is scheduled to be completed the end of 2013. They will be structured, along with a strengthened community mental health system, to support healing, recovery and a return to successful community living.

As the project moves forward, the replacement team continues to look for opportunities to improve patient care and reduce state costs. Based on a recent analysis of need for hospital level of care and changes in discharge practice, OHA leadership recommended a reduction in the size of the Junction City hospital from 360 to 174 beds.

Although the historic state hospital facilities was inadequate for long-term, continued care and treatment of those with mental illness, the OSH Salem campus was selected as the best site for construction of the new 620-bed facility. Using legislatively mandated selection criteria developed with public input, this site scored highest among those considered. The Salem site maximizes opportunities to attract and retain quality professional staff and places 55 percent of patients reasonably close to their home communities. In addition, the larger Salem community is accustomed to having a large psychiatric hospital on this site and is generally supportive of the hospital being there.

Historic preservation

OHA is committed to protecting and preserving valued historic and cultural resources while investing and growing a mental health system of care to serve Oregonians now and in the future. Using the current OSH site provided an optimal opportunity to include historic buildings and structures in the design of the new facility and an opportunity to include both an above-ground memorial for cremains and a museum for the history of the West Coast’s oldest continually operating psychiatric hospital.

Status

To date, the hospital replacement team has enlisted expertise from renowned architectural, construction and engineering firms, including numerous subcontractors, who are working together to find ways to keep the project on time, address budget issues and deliver the best mental health facility for Oregonians. To date, the project has opened the new kitchen, central plant, warehouse, vocational rehabilitation center, first residential units and mall, and the new administration offices in the Kirkbride building.

The building of replacement hospital facilities in Salem and Junction City, repurposing of facilities on the historic OSH campus, and planning for the transition to the new facilities is in process and on-target to be completed at the end of 2013.

Centralized treatment model

OHA has adopted a centralized services model with “neighborhood” and “downtown” treatment concepts, within a secure perimeter, for the new facility. This model supports providing comprehensive and consistent therapeutic opportunities to all patients. In keeping with the recovery model for mental health, the design for the new facility and its campus was driven by programming needs to ensure a patient-first, patient-driven and patient-focused mental health system. With this model, patients live on a unit but receive their treatment and meals and attend activities or classes elsewhere in the facility, away from the unit.

The new design requires patients to participate in their treatment and function during the day in a manner similar to that of daily life outside the hospital. The “downtown” includes large and small group activity rooms, a gymnasium, fitness center, library with required legal materials, nutrition center, classrooms, and music and art therapy rooms.

Because patients do not have access to bedrooms, TV rooms and other non-treatment rooms and activities during treatment hours, patients are motivated to engage in treatment. The idea is to provide a place adjacent to the residential areas where a larger number of patients can go each day to participate in treatment programs. The new facilities are designed with smaller areas for treatment so clinicians will have a manageable number of patients at any one time. The new hospital design also includes better security, more open space, one- and two-patient rooms, more quiet space, more light in patient rooms, and modern heating and air conditioning.

Behavioral Health Integration Project

In addition to the facilities replacement needs, at the beginning of the replacement project OSH had antiquated technology for collecting information, referred to as the Oregon Patient/Resident Care System (OP/RCS), as well as a reliance on paper charts that no longer met the business needs of the hospital. Dependence on these obsolete systems presents considerable risks in relation to licensing and patient care. The Joint Commission (TJC) cited the information system as a major deficit jeopardizing future accreditations, which are a severe financial risk to OHA and a risk to the state's mental health service recipients. The US Department of Justice (USDOJ) Civil Rights Division submitted a report in January 2008 for an investigation conducted in 2006 under the Civil Rights of Institutionalized Persons Act (CRIPA). This report stated that OSH's ability to address patient safety is hampered by inadequate incident management and quality assurance systems. In order to support integrated treatment for clients, there is a need for a data system that can share client information throughout the system of care.

The Behavioral Health Integration Project (BHIP) is a subset of the overall OSH Replacement Project with business goals of improving the ability to document services provided to individuals in the Oregon State Hospital; increasing time spent by hospital personnel in treatment activities; and improving the ability of the state to report accurate and timely information to a variety of funding sources. BHIP has identified a vendor for a commercial-off-the-shelf (COTS) product and is currently working to implement the new system, ensuring that it meets the needs of the Oregon State Hospital System and the individuals served. The system is currently scheduled to go-live in spring 2011.

Challenges

There are a number of cost drivers that may affect the financial bottom line of this project. Examples of these are found in the USDOJ report in January 2008, which identified the need for improvements in the facilities, treatment plan and record keeping. As reported previously to the Joint Ways and Means Committee, an important aspect of the new hospital facilities is the additional 200,000 square feet of treatment spaces on the Salem campus and 100,000 square feet at the Junction City campus that will be needed to provide the minimum of 20 hours per week of patient treatment activities, as well as accommodate the additional staffing needs. The minimum standard of 20 hours of active patient treatment has become the accepted measure for modern psychiatric facilities, and is set forth in the hospital's Continuous Improvement Plan. This will be a critical part of the improved care for patients and will create a climate of recovery and provide patients the needed skills

to make successful transitions back to their own communities. Various experts agreed that the only way to ensure the number of treatment hours expected in industry standards was by using a centralized treatment model.

In addition to the increased space, the project has further requirements: a Center to State Street connector road, historic district requirements, significant site improvements, and energy costs. The Junction City site must meet the requirements of the solar energy bill (ORS 279C.527 to 279C.528) adding costs not included in the original budget approved by the Legislature.

Another cost driver comes as a direction from the Legislature to absorb the cost of furniture, fixtures and equipment (FF&E) into the budget. The rough estimate in 2007 for FF&E was \$10.5 million – \$7.5 for Salem and \$3 million for Junction City.

The USDOJ report also identified the need for adequate tracking of patient treatment plans, medication management and connection of various data collection methods throughout the hospital. The project includes the design of a new OSH computer system, which will address data management, risk management, training, quality management, and maintenance and support issues, as well as treatment plans and medication management.

In addition to challenges presented by these and other cost drivers, the success of the replacement treatment facilities is dependent on significant investments in the entire mental health service system. These investments must continue to build the community system that prevents individuals from needing hospital-level services. It also must build capacity to help patients transition successfully back to the community. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of non-profit and for-profit providers.

Funding

The 2007 Legislature passed SB 5504 and HB 5006, which provided the budgetary authority of \$458.1 million for DHS to proceed with construction of facilities in Salem and Junction City.

Construction of the two new facilities will continue to be financed with certificates of participation (COP) requiring accurate and specific recording and accountability for expenditures of COP proceeds. COPs are a principal means of financing government projects and are used for many state facilities expected to have 40 to 60 years of useful service.

The project has been working diligently to mitigate the various programming and site impacts. From the first evaluation it was clear that additional needs had the potential to add over \$150 million in additional project costs to Salem alone. Through aggressive management of all areas, from design to individual sub-contractor selection, AMH has been able to reduce this to a request for an increase of \$66 million in COP sales for the project as a whole. Work continues on this issue and it is believed that through construction savings and reduction of the facility's size this cost will be reduced by several million dollars.

Actual operating costs will depend on many factors, including legislative decisions about staffing and salaries, and community supports that relieve pressure on the facilities. Additional pressures on operating costs could come in the form of rising fuel and utility costs and a possible increase in the number of individuals committed under forensic statutes.

Opportunities

Junction City

Both DOC and OHA are on time and proceeding with the legislatively approved projects related to the Junction City site, where corrections facilities and the psychiatric hospital will be co-located. One of the directions DOC and OHA received from the Legislature was to maximize the benefits of a collaborative partnership in developing this site. By building the OHA hospital and the DOC minimum and medium security facilities on the same site, there are potential efficiencies and savings associated with the infrastructure. There also is the ability for DOC to provide laundry services for both their facilities and OSH. In addition, it is possible for both facilities to share one warehouse rather than building redundant facilities. DOC and OHA estimate the joint savings of a single site development at approximately \$20-\$25 million. These savings will be challenged should either project be delayed.

Reusable materials

In recent months OSH staff have found many reusable materials from previous construction and maintenance projects that are being transferred to the general contractor for use on the replacement project. This has resulted in a cost reduction for the project of more than \$100,000. Examples of such items include fencing materials, electrical wire, drainpipe and electric gates.

Behavioral Health Integration Project

BHIP is approved as part of the COP funding at \$27.9 million. However, the project is looking for ways to implement BHIP for \$25.9 million at the direction of the Legislature. Unless needed by BHIP, the \$2 million savings will be used to help address the challenges facing the construction budget.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the United States Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

Value engineering study

Draft value engineering studies were conducted in August 2008 for Salem and July 2010 for Junction City; the project team, with assistance from the consultants, analyzed all aspects of the facilities design to ensure no critical features were missed and to identify opportunities to reduce construction costs and improve operational efficiencies. Opportunities identified from the Salem value engineering have been incorporated where feasible. The results of the Junction City value engineering study are being analyzed, and opportunities for reductions and improvements will be incorporated into the project.

Summary

Replacing the Oregon State Hospital is critical to growing a mental health system of care, which was a priority of Governor Kulongoski during his eight years in office. By integrating the new facility in Salem with most of the historic buildings within the district, and restoring and putting the Kirkbride U into full use again, OHA creates a project that will meet its state mandate to build a hospital on the existing OSH Salem site and a project that protects the historic significance of the site. The agency will also continue to develop the Junction City campus as mandated, working with DOC to maximize all co-location efficiencies. At the same time, information technology is critical to the operation of a modern, accredited and certified state hospital. The Behavioral Health Integration Project will further ensure

patient safety and quality of care by bringing a modern information system to the hospital.

2011-13 budget summary

The GBB supports the final phase of construction for the Oregon State Hospital Replacement Project.

The key challenge in the GBB is the lack of funding to support the operation of the electronic hospital management systems and the electronic medical records system for the state hospital (BHIP). These resources were requested as part of a policy option package to ensure all campuses of Oregon State Hospital would be staffed at levels acceptable to the United States Department of Justice following their review of OSH under the Civil Rights of Institutionalized Persons Act (CRIPA) in 2006. That package could not be funded under current revenue projections. Additional work by the recently hired superintendent indicates that the hospital can manage within the direct care staff currently funded by accepting a certain level of risk. It is critical that the Office of Information Systems in OHA and the hospital be staffed to support BHIP and that the hosting costs for the State Data Center be available.

BUDGET NOTES AND AUDITS

SB 5529-A directed the Department of Human Services, Addictions and Mental Health division to implement two or three demonstration projects with willing local mental health authorities, mental health organizations, fully capitated health plans, federally qualified health clinics and mental health, addiction and health care providers in the communities for the purpose of developing an integrated management and service delivery system including physical health and addictions and mental health treatment and recovery services by June 30, 2011. DHS also was directed to report on progress in implementing these demonstration projects at the last scheduled Emergency Board or Joint Committee on Ways and Means meeting prior to the 2011 legislative session.

As directed, DHS reported at the December 2010 Emergency Board.

SB 5529-A also directed the Department of Human Services, Addictions and Mental Health division to work with local mental health authorities and stakeholders to develop an equitable formula and distribution method for regional acute psychiatric inpatient treatment funds for all Oregon counties. DHS was directed to report to the Emergency Board or Joint Committee on Ways and Means by February 2010 on this new method and include a cost estimate for implementation.

As directed, DHS reported to the Joint Committee on Ways and Means in January of 2010.

The February 2010 Supplemental Session, HB 5100-A directed the Department of Human Services, Addictions and Mental Health division to work with Oregon's county mental health departments to develop a proposal for these departments to submit encounter data, or service data, about their non-Medicaid eligible clients to DHS. AMH was directed to discuss this proposal in a report to the 2011 Legislative Assembly's Joint Committee on Ways and Means' DHS hearings as well as appropriate legislative policy committees.

This report has not yet been scheduled for delivery.

Audits

The Secretary of State started information gathering about behavioral health services funded and managed through Addictions and Mental Health in December 2010. This review is in the information gathering stage and will determine whether

there will be an audit and the focus of any audit performed. A determination is expected in the late spring of 2011.

In January 2011, Acumentra began an external quality review of physical and mental health managed care. Every year Acumentra validates the physical and mental health performance improvement project (PIP) each managed care plan conducts. Each PIP is reviewed for valid and reliable conduct to determine the validity of program results. An audit report will be available January 2012 after all managed care organizations have been reviewed.

Acumentra is also conducting the biennial information system capabilities assessment in 2011.

STATUS OF REQUIRED REPORTS

Statutory reports

- Alcohol and drug prevention
- Alcohol and drug treatment
- Community mental health
- State hospitals

Evidence-based practices

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

The department is required to submit this report no later than September 30 of each even-numbered year to the interim legislative committee dealing with judicial matters. As required, AMH submitted the "Progress Report on the Implementation of Evidence-Based Practices" to the December 2010 Joint Interim Judiciary Committee.

Community mental health

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

The department is required to report biennially to the Governor and the Legislature on the progress of the planning process and implementation of local county mental health plans, the state planning process and performance measures. The report is to be submitted during the Legislative Session. The title of the report is, "Report to the Oregon Legislature on Planning for Mental Health Services."

The 1999 Oregon Legislative Assembly passed a bill creating a Community Mental Health Housing Fund within the Oregon State Treasury with funds from the sale of the former Dammasch State Hospital property in Wilsonville. The bill, codified as ORS 426.502 through 426.508, specifies that 5 percent of the net sale proceeds of Dammasch could be used for community housing (70 percent) and to improve the lives of state hospital patients (30 percent). The interest earned is to be used for community housing for people with serious mental illness. The restricted reserve was opened July 2004. The first housing awards were issued in March 2005.

2009–11 MANDATORY SPECIAL REPORT ON COMMUNITY MENTAL HEALTH	
Treasury Account Report	
July 2009 to December 2011	
Per ORS 426.506 Community Mental Housing Fund; Community Housing Trust Account	
Restricted Funds- Permanent Fund Principle	\$ 11,453,172
Unrestricted 2007-09 Balance Forward	1,014,533
Interest: Actual July 2009 through December 2010	115,677
Projected January 2011 through June 2011	30,000
Total Revenue	\$ 12,613,382
Awarded Amounts Funded July 2009 to December 2010	660,299
Amount reserved for awarded housing development	115,000
Amount reserved for awarded institutional housing	0
Available to be Awarded	384,911
Restricted Funds- Permanent Fund Principle	11,453,172
Total Expenditures	\$ 12,613,382

Community Housing and Institutional Improvement Awards Granted from interest and Allowable Principle

	Projects	Type	Individuals Served	CMHHF Awards	Leveraged Funding	Counties
Round 1 Mar 2005	7	5 Supp Housing 2 facility based	79	\$600,000	\$9.3 mil \$1 = \$15.46	7
Round 2 Jul 2006	5	3 Supp Housing 2 facility based	32	\$332,507	\$3.2 mil \$1 = \$9.76	5
Round 3 Jan 2007	7	2 Supp Housing 5 facility based	102	\$509,472	\$15.8 mil \$1 = \$31.10	5
Round 4 Mar 2008	4	2 Supp Housing 2 facility based	38	\$242,970	\$4.7 mil \$1 = \$19.18	4
Non-comp Nov 2008	1	1 facility based	14	\$42,000	\$42,000 \$1 = 1.00	1
Round 5 Jan 2009	6	6 Supp Housing	86	\$600,000	\$29 mil \$1 = \$47.37	6
Total Undup'd	30	18 Supp Housing 12 facility based	351	\$2.32 mil	\$62.5 mil \$1 = 25.08	20

Institutional Housing Awards Granted from Interest

	Type	CMHHF Awards	Use
EOPC Jan 2007	Renovation	\$73,701	Replace beds and wardrobes in patient living quarters.
OSH – Salem Jan 2007	Renovation	\$81,675	Install air conditioning in patient treatment areas.
OSH – Salem Jan 2007	Renovation	\$144,296	Install air conditioning in patient treatment areas.
EOPC Dec 2008	Renovation	\$16,804	Purchase exercise equipment for patients.
OSH – Salem Apr 2010	Renovation	\$3,871	Install air conditioning in patient treatment areas.
OSH – PDX April 2010	Renovation	\$6,700	Carpet replacement project in P1B day room.
BMRC Apr 2010	Renovation	\$4,728	Patio remodeling project (pergola and outdoor furniture).
Total	Renovation	\$331,775	

**REPORT TO THE OREGON LEGISLATURE ON PLANNING
FOR MENTAL HEALTH SERVICES**

In accordance with ORS 430.640 (1) (p)

**Department of Human Services-Oregon Health Authority
Addictions and Mental Health Division
February 1, 2011**

Overview

Mental health service planning in Oregon occurs at both the local and state level. Local plans are reviewed and approved by the Addictions and Mental Health Division (AMH) on a biennial basis. In addition to local planning efforts, Oregon is engaged in transformational planning under the Statewide Children's Wraparound Initiative, as well as developing and implementing treatment and recovery service models for the facilities replacing the deteriorating state hospital, and the Adult Mental Health Initiative (AMHI) facilitating community integration. In accordance with ORS 430.640 (1) (p), this report provides an update on both local and state planning processes, and gives an overview of Oregon's progress in meeting National Outcome Measures.

History of Report to the Legislature

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.

Since the statute was originally adopted in 1961, it has been amended multiple times. With the inclusion of substance abuse, problem gambling, prevention and treatment with mental health as a unified division of the Department of Human Services (DHS)-Oregon Health Authority (OHA), local plans now exhibit a collaborative and integrative approach in addressing these issues. However, germane to the statute referenced above, this report focuses specifically on mental health services.

Local Planning Process

Local plans serve as a basis for collaboration between AMH and the counties in implementing and improving mental health and addiction prevention and treatment services and supports. The plans must be grounded in local county data and propose treatment and prevention services and supports for mental health, addictions and problem gambling for the coming biennium. The plans also serve as a framework for the allocation of funding and other resources.

AMH, with input from the counties, develops guidelines for the local plans. This biennium AMH moved to a streamlined electronic survey submission process, which will allow the division to create standardized reports. Communities must consult data sources to substantiate how funds are utilized. The survey contains a check-list for inclusion of consumers, family members, advocates, community coalitions and other stakeholder groups in the development of the plan. County plans must address culturally competent service access and delivery. Plans also include a description of current functional linkages with the state hospital system and mental health acute care inpatient services. High priority needs for each program area (mental health, substance use prevention and treatment, and problem gambling services) are identified, as well as a summary of how local programs will allocate and use resources provided by the division. Finally, plans must undertake a rigorous review and endorsement protocol, culminating in approval by the Board of County Commissioners.

Examples of Local Plan Innovations

This biennium's move to an electronic submission process allows AMH to collect and analyze data across counties. The survey also includes a new question addressing the integration of physical and behavioral health care, and requests a description of mental health and addiction services for specific populations not addressed in statute: young adults in transition (YAT: formerly called Transition Age Youth), veterans and individuals with co-occurring disorders. The complete county reports can be viewed at

<http://www.oregon.gov/DHS/mentalhealth/data/cc-plans/main.shtml>.

While every plan is unique in its approach to comprehensive community planning and delivery of services and supports, the following examples illustrate mental health system strengths and innovations:

Integration

- **Benton County:** Developing a comprehensive, integrated Health Home providing primary care, addictions, mental health and public health services.
- **Clatsop County:** Every client of community mental health is referred to a primary care physician, and clinical records are sent to that physician with client permission.
- **Wallowa County:** Cross education, including mental health education for primary care providers and training related to physical health and primary care culture for mental health providers.
- **Warm Springs:** The Community Counseling Center (CCC) works in conjunction with Indian Health Services (IHS). IHS relies on CCC for psychiatry, alcohol and drug treatment and case management services while IHS provides dental services.

Children (0-6 years)

- **Polk County:** Early Childhood Advisory Group meets monthly to identify community needs and share resources.
- **Grant County:** Provides mental health services in day care settings to reduce barriers to treatment and increase community awareness of services.

Young Adults (14-25 years)

- **Multnomah County:** Provides a specialized program for this population offered through Outside In, an agency that primarily serves homeless youth.
- **Marion County:** The county has started a YAT program designed for 30 youth who have a primary mental health diagnosis and are preparing to age out of the DHS Child Welfare or Oregon Youth Authority programs.

Older Adults

- **Clackamas County:** Uses a senior peer delivered services model coupled with a treatment team. Services are delivered in senior community centers and locations where seniors naturally congregate.
- **Linn County:** Will increase the county's focus on senior outreach services provided in an older adult's residence (home or facility based). Services will include assessment, counseling and consultation with family and care staff.

Programs for Specific Cultural Groups

- **Umatilla County:** Offers bilingual/bicultural translation for the Hispanic population. The county is recruiting a bilingual/bicultural therapist. American

Sign Language translation is offered for hearing impaired clients and their families.

- **Washington County:** Contracts with culturally specific providers, Asian Health Services Center and Oregon Health Sciences University (OHSU) Intercultural Psychiatric Program for youth and adults with chronic mental illness.

Programs for Individuals with Co-occurring Disorders

- **Columbia County:** Employs dual diagnosis therapists and offers evidence-based dual diagnosis classes.
- **Tillamook County:** Offers individual, family and group dual diagnosis counseling services, Medication Management classes (Evidence-Based Practice) and crisis services.

Programs for Veterans

- **Douglas County:** Offers Medication Management classes (Evidence-Based Practice), care coordination and case management services for veterans. Holds regular PTSD therapy groups.
- **Union County:** The county's Veteran's Service Officer is a staff member of the mental health agency. While the agency does not offer specific treatment programs for veterans, it works closely with the Veteran's Service Officer to coordinate treatment services for veterans and their families.

Identified Gaps in Mental Health Services

The following gaps and priorities were common themes in a majority of local plans:

- Almost universally, every local plan talked about the gap in mental health services for its older adult population (even those with programs for this particular population). According to US census data, among the 50 states and the District of Columbia, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Oregon needs to position itself to provide more services and supports for this age cohort. Rural counties in particular noted transportation as the major barrier the elderly face in being able to access services. Included in this gap is the need to address prevention efforts related to addiction issues, specifically poly-pharmacy use and alcohol abuse.

- Approximately half the plans noted a gap in mental health and addiction services for youth and young adults in transition (YAT) and/or homeless youth. The importance of integrating physical health care strategies is of particular importance to young adults. National and state research indicates that people with mental health and substance abuse disorders are at risk for early death, when compared to the general population¹. Integration of physical and mental health/addictions services is important for the prevention of physical disease associated with mental health/addictions disorders and their treatment. The importance of providing continuity of care for this population was noted repeatedly, however, “siloes” policies, funding streams and systems are barriers that need to be eradicated. Local plans noted that mental health and addiction services must be tailored to the unique needs of young adults.
- Workforce development, specifically recruitment and training of bi-lingual and bi-cultural staff, is an ongoing issue facing all counties. Related to this is the retention of qualified staff, particularly those with specialized training (i.e. geriatric mental health specialists, school-based prevention counselors, early childhood expertise, etc.). Many counties noted high staff turnover related to compensation issues.

Statewide Transformational Planning: Oregon State Hospital

Senate Bill 25, passed during the 2009 Legislative Session, created the Oregon State Hospital Advisory Board. This sixteen member board may make recommendations directly to the Superintendent of the Oregon State Hospital, the Director of the Oregon Health Authority and the Legislature. The board is tasked with the following:

- Periodic review of federal and state laws, administrative rules, and policies and procedures related to the safety, security and care of patients;
- Making recommendations on performance measures related to the safety, security and care of patients;
- Development and review of goals for improvement in the safety, security and care of patients; and
- Proposal of legislation and Policy Option Packages related to the Oregon State Hospital.

The hospital’s Continuous Improvement Plan (CIP) is a comprehensive quality improvement and planning document encompassing all areas of hospital

¹ http://www.oregon.gov/DHS/addiction/publications/msur_pre_mort_6_2008.pdf

administration and treatment at OSH: physical plant and safety; leadership and organization; staffing; admissions and assessments; formulation and treatment care planning; active care and treatment; transition, discharge and community reintegration; integrated physical health care; protection from harm; medical records, documentation and information management; and staff education and development. The CIP originated as a five plus year plan to improve quality in all aspects of OSH operations, and includes measurable benchmarks. Once the Hospital Replacement Project is completed in 2011, the CIP will continue to track progress on hospital outcomes and patient recovery.

The CIP includes the hiring of additional direct care staff, psychologists, social workers, psychiatrists and nurses, who will improve the effectiveness of treatment and better prepare patients for discharge. The 2009 Legislature approved an additional 527 OSH positions, which are being hired to coordinate with opening of new units.

A key goal of the CIP is that all patients will receive at least 20 hours per week of active treatment. The CIP is currently on track with this goal with patients receiving 20 hours of active treatment per week, 5.5 of which is delivered by nurses.

Traditionally, OSH has not had the technological infrastructure to track patient progress across treatment domains. The implementation of the Behavioral Health Integration Project (BHIP), which is an element of the OSH Replacement Project, will provide modern technology for hospital management. BHIP is a hospital information technology system that once operational, will support patient treatment and recovery outcomes through an electronic medical record. A contract was signed with Netsmart for the new electronic medical record system, with an anticipated "go-live" date of the BHIP system May 2011.

OSH places many patients into employment settings. Some patients work in sheltered employment settings, which provide training in job skills needed for community employment. Many patients also have the ability to work in a competitive environment, providing them with economic reward for their hard work. Patients who participate in employment receive the opportunity for social interaction with multiple individuals, learn how to accept feedback responsibly, work cooperatively with others and become more flexible in dealing with change. Currently 192 patients are involved in vocational programs.

OSH provides educational options for patients: a General Education Diploma (GED) program, and a college degree option offered in conjunction with Chemeketa Community College. These options allow patients to develop skills which play a critical role in successful transition to the community. Currently 133 patients are involved in a supported education program.

OSH completed restoration of six cottages on the Salem campus in spring 2009. The cottages have been completely remodeled, are ADA accessible and can accommodate five or eight patients. The cottages denote a marked shift in transition of patients to the community. Since the closure of the Transitional Living Cottage as a result of the 2003 budget cuts, OSH patients were discharged directly from the hospital into the community. The cottages represent a new pre-community placement option for low-risk individuals who have progressed in treatment and are nearing hospital discharge. Although patients will be living in a home-like setting, their schedules will be highly structured and supervised. Individuals residing in the cottages will learn valuable life skills (including meal preparation and clean-up), attend classes or meetings and participate in group activities. This type of residential setting affords greater opportunities to socialize and better prepares patients to leave the state hospital setting.

In 2008 OSH created a program modeled on New York's highly successful Peer Bridgers Program. Oregon's program uses peers who have received inpatient public mental health services to formally support and mentor patients ready to be discharged. OSH currently employs four Peer Recovery Support Specialists, and federal Mental Health Block Grant funds will be used to create community transition services through a Mental Health Organization (MHO) and peer run programs located in the community.

Statewide Transformation Planning: Adult System

During 2010, AMH initiated a systems reform effort for mental health and addictions services.

With input from stakeholder groups (meeting the 20 percent consumer and family participation required by statute²), the division revisited its agency vision, mission and goals statement to align with the newly created OHA. The new document is

² Oregon Revised Statute (ORS) 430.075

reflective of a prevention oriented, recovery and resiliency focused approach for the provision of services and supports that are consumer and family-driven.³

In February 2010 the division adopted new rules governing Integrated Services and Supports. As defined by Oregon Administrative Rules 309-032-1500 the purpose of these updated rules is to:

(1)(a) Promote recovery, resiliency, wellness, independence and safety for individuals receiving addictions and mental health services and supports; (b) Specify standards for services and supports that are person-centered, youth guided, family-driven, culturally competent, trauma-informed and well-informed; and (c) Promote functional and rehabilitative outcomes for individuals throughout a continuum of care that is developmentally appropriate.⁴

AMH recommended to the 2009 Legislature a system reform effort focused on an integrated management and service model including physical health, mental health and addictions services. The Legislature subsequently issued a budget note, directing the division to initiate demonstration projects to test different methods of integrating management, financing and services. A primary goal of the demonstration projects is to increase the availability, access and quality of health care services and outcomes by improving coordination between addictions and mental health treatment and recovery services and physical health.

Oregon has two regional (multi-county) demonstration sites: Central Oregon and Eastern Oregon. Central Oregon is working on integrating Medicaid service contracts into one shared entity. The region has adopted a plan to develop a Regional Health Authority that will manage Medicaid contracts, and in the future will include the Local Mental Health Authority and Public Health Authority to improve population health for the region. Eastern Oregon is approaching integration based on the needs of primary care and behavioral health contacts in two of its rural frontier counties. A key strategy for this region is developing relationships between physical health and mental health care providers.

Since the beginning of 2010, AMH has been working with a diverse group of stakeholders to implement the Adult Mental Health Initiative (AMHI). AMHI is designed to promote more effective utilization of current capacity in facility-based

³ www.oregon.gov/DHS/mentalhealth/amh-vmg.pdf

⁴ www.oregon.gov/DHS/addiction/rule/issr-rule.pdf

treatment settings, increase care coordination and increase accountability at the local and state level. It also is designed to promote the availability and quality of individualized community-based services and supports so that adults with mental illness are served in the most integrated community setting possible and the use of long-term institutional care is minimized.

To accomplish these goals, AMH is transferring many of the responsibilities regarding utilization of licensed facility-based treatment setting to regional Mental Health Organizations (MHO) who will be responsible for assisting individuals in transitioning between treatment and living settings, including those individuals transitioning from the state hospitals. Under AMHI, MHOs will provide:

- supported housing, including limited rental assistance;
- supported employment;
- assertive community treatment; and
- increased outpatient services.

Phase I of AMHI became operational on September 1, 2010. As of December 31, 2010 the MHOs assisted 172 individuals in moving to lower levels of care, including 92 individuals who were discharged from the state hospital to the community, and 63 individuals who were moved to independent living. AMH expects the MHOs to assist 331 individuals in the months remaining in the 2009-2011 biennium.

An important component of AMHI is understanding how people transition to more independent settings within Oregon's community residential system.

During September 2009, AMH conducted a pilot utilization review of ten residential care providers representing five residential treatment facilities, two secure residential treatment facilities and three residential treatment homes. Facilities were selected because their residents typically experience unusually long lengths of stay. Subsequently, AMH contracted with Acumentra Health, a non-profit organization whose focus is improving the quality and effectiveness of health care by providing external quality reviews of services and supports, to conduct a more comprehensive review. Acumentra released their draft *Adult Residential Care Study Report*⁵ in September 2010. The report provides AMH,

⁵ http://www.oregon.gov/DHS/mental_health/data/2010/adult-resident-mh-carestudy.pdf

MHOs and community mental health providers information on how to support the successful transition of people to lower levels of care and/or independent living.

Statewide Transformational Planning: Children's System

- **Children's System Reform Efforts**

AMH is engaged in two broad scale processes to provide more integrated community-based systems of care for children and their families. The Children's System Change Initiative (CSCI) formally began operation on October 1, 2005. The goal of this reform effort is to increase the availability and quality of individualized, intensive and culturally competent home and community-based services so children will be served in the most natural environment possible, with minimal use of institutional care. The system utilizes a multi-disciplinary collaborative approach promoting 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 Statewide Children's Wraparound Initiative (SCWI) is being implemented with children with intensive mental health needs in the custody of child welfare. The work is in three project sites, with an initial population of 340 children in eight counties who meet the focal criteria of being in child welfare custody for one year, with four or more placements, or who, upon being brought into custody, immediately had a need for the most intensive levels of child welfare and/or mental health services.

The goals of SCWI are to create a system of care for children utilizing high fidelity Wraparound planning to organize and manage necessary services and supports. Implementation is initially being conducted through collaboration across divisions in the Department of Human Services and the Oregon Health Authority between Children, Adults and Families (CAF) and AMH. Subsequent phases of the project will bring in other system partners.

This initiative will expand the availability of care coordination, increase workforce development in Wraparound principles and practices statewide, and expand systemic efforts to develop culturally competent, family and youth driven care. Methods needed to create blended funding are being explored concomitantly with the SCWI implementation.

- **Family Driven and Youth Guided Care**

AMH was an active proponent of family-driven and youth guided care prior to the inception of the CSCI reform effort. A policy on Meaningful Family Involvement written in 2004 and amended in 2006 incorporated the Federation of Families for Children's Mental Health national organization's statement on family driven care. Recently this policy was amended further to incorporate youth driven principles. Local, regional and state Children's System Advisory Committees have been formed with 51 percent membership of family members/advocates. Oregon Family Support Network (OFSN) continues to train and develop family member advocates to serve on advisory councils and committees.

Additionally, AMH has partnered with OFSN to develop and conduct three statewide training curricula. Family Navigators is specialized training for parents or primary caregivers of a child or youth who is or has been involved with multiple child-serving agencies. Family Navigators empower other families caring for children with special needs to successfully advocate for their child's care and treatment across multiple systems. Candidates for this training earn their Family Navigator certification by completing a series of classes. Family Navigators is a peer delivered services project. Youth and Professionals as Policy Partners (YP3) and Parents and Professionals as Policy Partners (PP3) instruct youth and parents on policy development and how to effectively engage in policy development with policy makers and professionals.

- **Early Childhood: Parent-Child Interactive Therapy (PCIT)**

Children who demonstrate persistently high levels of disruptive behavior early in life are at high risk for problems in social, emotional and educational domains. Based on D. Baumrind's developmental theory and research, PCIT focuses on promoting an authoritative parenting style, rather than authoritarian or permissive styles, to meet a child's need for both nurturance and limits. Parents are observed as they play with their child and are coached in parenting skills. Treatment is performance based and is considered finished when parents demonstrate mastery of specific skills and children no longer meet criteria for disruptive behavior disorder.

Four counties (Jackson, Marion, Washington and Yamhill) are implementing this evidence based practice for children ages 2 through 8 who are not Medicaid eligible and who have no other resources to pay for services. Development of the infrastructure for implementing PCIT includes training of therapists to become local and regional trainers. Three counties have one or more therapists

endorsed by national PCIT trainers to provide training both within their agency and outside of their agency. The fourth county has therapists with endorsement to provide within-agency training in PCIT.

The counties must demonstrate outreach and access to the Hispanic/Latino population, and link participating families with family-run organizations that offer children's mental health services and supports. Referrals to other service providers are made for children and families with empirically demonstrated risk factors. Standardized data collection instruments are used across the sites to determine project outcomes.

All four counties received a fidelity site review in 2010 including record review of therapists training, PCIT supervision schedule, chart review for inclusion of data developed through the use of the Eyberg Child Behavior Inventory and the Dyadic Parent Child Interaction Coding System, appropriate room, toys and equipment for parent coaching. All sites demonstrated outreach and access by Hispanic/Latino clients. Thirty-nine percent of clients served were identified as Hispanic/Latino.

Forty-two therapists have been trained in PCIT. Fourteen of these therapists are either bi-lingual English-Spanish or are bi-cultural.⁶ In order to develop sustainability, the PCIT project focused on the development of trainers who will be able to train locally.

The outcomes of PCIT are decreases in externalizing behaviors (generally typified by aggressive, defiant, and impulsive behaviors), parenting stress, and risk for abuse in families. The practice generalizes to other settings and other individuals and is effective for both biological and foster parents.

Disruptive behavior has been found to be the most frequent cause of child outpatient or inpatient referral and is estimated to affect up to 23 percent of young children. Estimates indicate that a child with severe behavioral problems is about ten times more expensive to treat than a child without such problems. Disruptive behaviors worsen with age and impair educational, social and self-help skills over time. For parents, live coaching with immediate feedback regarding actual parent-child interactions is a critical element for the retention of useful skills and knowledge of behavioral management.

⁶ Defined as having life experience with two distinct cultures.

PCIT is cost effective. A recent cost analysis indicated that the cost of PCIT was below the usual cost of services within a system of care model, by \$600 per child. The expected indirect monetary benefits of PCIT over a child's subsequent years include decreased abuse and neglect of this same child, reduced rate of committing crimes, less likelihood of engaging in substance abuse and improved educational outcomes. These all add up to substantial savings for the aggregate human services system over time, as children grow into adulthood at much lower risk for multi-system involvement.

- **Workforce Development in an Integrated Neurobiological Perspective**

Dr. Bruce Perry from the Child Trauma Academy has been enlisted to begin a capacity building project in the assessment and intervention of children who have experienced trauma or struggle with other neuro-developmental challenges. Dr. Perry's work focuses around the Neurosequential Model of Therapeutics (NMT).

AMH contracted with the Child Trauma Academy to fund eight project sites in twenty Oregon counties following an initial training conference in June 2010. Staff at the sites are being trained by and will consult with Dr. Perry during a one year training period. Two additional sites with the Umatilla Tribe and the Native American Rehabilitation Association, which provide services to urban Native American groups, will bring these skills to work with Native American children. Pre and post assessments of this work will be conducted to evaluate success of the training effort.

- **Collaborative Problem-Solving**

Children and adolescents with social, emotional and behavioral challenges frequently are misunderstood. Standard approaches to treatment often do not satisfactorily address their needs and may actually worsen their difficulties. Such children have very adversarial interactions with parents, teachers, siblings and peers and are at risk for poor long-term outcomes. Research suggests that such children may lack crucial cognitive skills essential to handling frustration, solving problems and mastering situations requiring flexibility and adaptability.⁷

In order to address these issues, Oregon is assisting providers in implementing the Collaborative Problem Solving Model (CPS). The model sets forth two major tenets: children will do well *if they can* (as opposed to a more commonly

⁷ www.explosivechild.com

held belief that children do well if they want to); and if a child is not doing well, their challenges are best addressed by identifying and teaching them the skills they lack.

The model launched in June 2007 with a two-hour introductory video conference attended by local teams of professionals in the fields of education, child welfare, community mental health, Oregon Youth Authority, and alcohol and drug treatment providers. Since that time twelve scholarships have been awarded to child serving agencies including psychiatric treatment programs, schools and addiction treatment providers to assist in implementing the CPS model.

To date, child welfare, education, residential and day treatment providers, community mental health and juvenile justice, alcohol and drug treatment providers are just a sampling of participants actively involved in this project. Over a three year period the use of CPS has grown from two sites to approximately 27 child serving sites and 33 family driven teaching groups.

CPS is producing positive outcomes. For example, over a four month period one psychiatric residential treatment program reported the following: holds decreased from 94 in a month to four; seclusions decreased from 34 to two; aggressive behaviors decreased from 103 incidents to 12. They also report significant improvement in staff morale. Similar outcomes are reported in school settings and day treatment programs. Families state their children would not have been able to remain safely in the home without the skills they have learned through Collaborative Problem Solving. Clearly the use of CPS model in Oregon is contributing to a decrease in facility-based care.

Seven trainers certified in this model are available, and approximately 150 people have taken advanced training in this work. Partnership with the Oregon Family Support Network has evolved into providing parent-to-parent book clubs for families in over 30 communities. The focus has been to expand the use of the model and to develop sustainable practice.

- **Policy and Programs for Youth and Young Adults in Transition**

AMH is working in partnership with youth and professionals to develop policies for the coordinated transition of services between the child and adult mental health systems, through a cross division initiative designed to better serve Young Adults in Transition (YAT), ages 14 to 25. AMH is implementing strategies that promote a Young Adult system through the elimination of barriers to access and through the

creation of developmentally appropriate and effective services and supports. The initiative promotes access to a system of services and supports that are both young adult-directed and developmentally appropriate. This initiative is working effectively to bridge adolescent and adult systems and thereby provide young adults with opportunities to realize their full potential and lead healthy, productive lives.

AMH has, in accordance with this initiative, developed funding priorities that establish an array of treatment services and supports needed by this developmental age group, and created sequential steps to the development of expanded residential options. This led to the first YAT specific program that has gone beyond traditional residential services. The "Three Bridges" level one residential program in Grants Pass opened in March 2010. It serves as an alternative to state psychiatric hospitalization while providing care that is developmentally appropriate in a setting more conducive to therapeutic and skill oriented care.

Oregon also has developed specialized community-based residential programs serving 22 clients in three counties. There is a strong and growing need for facilities to address the specific developmental considerations of this population to prevent ongoing need for mental health services throughout adulthood. Housing, employment and socialization needs are paramount for young adults as they acquire skills that will serve them the rest of their lives.

AMH is also developing a training and community education component specific to YAT. AMH has developed a state listserve, partnered with YouthM.O.V.E. (Motivating Others Through Voices of Experience) Oregon to develop and link with its Web site, and is building a social networking presence through Twitter and Facebook. The latest component of the social networking emphasis is a YAT developed training video for community stakeholders, designed to offer best practices and approaches for supporting young adults.

The Oregon YAT listserve is an electronic discussion list for professionals and young adults who are working to promote access to a system of services and supports that are young adult-directed and developmentally appropriate. This listserve provides its members a means to easily collaborate with one another, ask questions, share information, experiences, and resources to enhance knowledge and perspectives in working with Young Adults in Transition.

The Early Assessment and Support Alliance (EASA) and Early Assessment and Support Team (EAST) programs intervene early to prevent the tremendous social and economic consequences of untreated schizophrenia and related psychotic disorders. Psychosis is a potentially disabling condition that affects 3 in 100 young adults. The focus for young adults is on maintaining progress in school, work and independent living, while at the same time providing support to the person's family.

The Early Assessment and Support Alliance (EASA) program offers evidence-based treatment to young adults who have had a first experience with psychosis within the previous 12 months. Services include intensive community education, outreach and engagement, medical assessment and prescribing, counseling and case management, vocational and academic support, and occupational therapy. The programmatic focus leads to increased community tenure, and diverts young adults from the multiple challenges associated with institutionalization.

EAST/EASA services, funded by the 2007 Legislature, are currently available in the following 16 counties: Clatsop (Project Intercept), Columbia, Crook, Deschutes, Hood River, Jefferson, Linn, Marion, Multnomah, Polk, Sherman, Tillamook, Union, Washington, Wasco, and Yamhill. Results include a decrease in psychiatric hospitalization rates from 50 percent in the first three months to 5 percent after 10-12 months; increases in school and work engagement and decreases in legal involvement. After one year, 74 percent of participants are in remission or have experienced only mild disruption and 95 percent have maintained strong family support and involvement.

Performance Measures

The National Outcome Measure (NOM) reporting system was developed jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the states, to track and measure outcomes for people in recovery from mental health and substance abuse disorders. The NOMs allow AMH to monitor the functioning of the mental health system in Oregon. The data is important for several reasons:

- Since 2007 the NOMs have been required reporting for all states receiving mental health, substance abuse and prevention Block Grants.

- The NOMs provide a framework for describing a broad range of outcomes that are accessible and meaningful for each state.
- Because all of the outcomes are collected using similar methodologies, the NOMs potentially provide outcomes that can be compared across states where appropriate.

In Oregon 156,962 adults are estimated to have a severe mental illness; AMH serves approximately 46 percent (72,207) in the publicly funded mental health care system. The current estimate of the number of children with a serious emotional disorder residing in Oregon is 106,124. Approximately 31 percent (33,243) are served in the publicly funded mental health care system.

An important NOM has to do with increasing the use of Evidence Based Practices (EBPs). In 2003 Oregon passed legislation (SB 267)⁸ directing AMH, among other stakeholders, to spend public funds on EBPs. The legislation was to be phased in incrementally, culminating in the 2009-2011 biennium when 75 percent of public funds were to be spent on EBPs. A recent survey of the populations referenced in the statute (alcohol and drug, criminal justice referral clients, adult mental health priority one clients and Integrated Services Array clients: children’s high-intensity) indicate that Oregon has met its legislative mandate.

The Mental Health Statistics Improvement Project (MHSIP) conducts an annual survey distributed to adults with serious mental illness (SMI) who have utilized publicly funded services, and parents or caregivers of children with serious emotional disorders (SED) who have accessed publicly funded services on behalf of their child. The following table illustrates outcome data for both the adult and children’s mental health systems for the designated fiscal year (FY).

NOM	Adult FY 2008	Adult FY 2009	Child FY 2008	Child FY 2009
Increase the percentage reporting positive outcomes	56%	57.2%	65%	68%
Percentage reporting increased social connectedness	58.7%	60.1%	81.8%	84.5%
Percentage reporting improved functioning	55.1%	57%	56.5%	59.5%

⁸ <http://www.leg.state.or.us/03reg/pdf/ESB267.pdf>

Success in school is a key NOM for children with SED. The percentage of parents or caregivers reporting their child's school attendance improved following the initiation of mental health services increasing from 30.4 percent in FY 2008 to 35 percent in FY 2009.

Readmission rates for adults to the Oregon State Hospital at 30 and 180 days are key performance measures. This information gives insight into the quality of discharge planning and the coordination of services with the community. The 30 day readmission rate declined from 2.3 percent in FY 2008 to 1.1 percent in FY 2009. The 180 day readmission rate has decreased from 11 percent in FY 2008 to 10.3 percent in FY 2009.

For adults, employment and housing stability are integral to the recovery process. Unemployment remains higher than the national average; Oregon lingers in the midst of an economic recession. Last year the methodology for calculating the number of adults with mental illness who are competitively employed changed from a percentage to a raw number (no denominator). FY 2009 provides baseline data. Based on aggregate statewide economic data, an assumption can be made that declining employment is expected during the course of the next several years. The number of adults reporting increased housing stability on the MHSIP survey declined 3.5 percent between FY 2008 and FY 2009, again reflective of aggregate statewide economic trends.

Risk

The progress on planning and service delivery reported here is threatened by Oregon's current economic situation and reduced revenue projections. As a result, the division's Agency Request Budget for 2011-2013 includes the required list of major reductions in community mental health treatment for children and adults to meet the Governor's direction to prepare lists equal to 30 percent reductions in state General Fund. If enacted, these reductions will result in fewer people served and more people placed at risk for poor outcomes. County programs and their ability to plan, manage and monitor services will be jeopardized.

Summary

This report indicates that local mental health authorities are complying with the planning requirements outlined in ORS 430. Collaborative planning and service delivery is evident at the local level. AMH will continue to use the Mental Health Planning and Management Advisory Council for planning and monitoring of the statewide mental health system. The Statewide Children's Wraparound Initiative and State Hospital Master Plan implementation and Adult Mental Health Initiative will require continuous monitoring and planning to build on progress to date. As reported, AMH will continue to collect, review and report data related to the NOMs as part of quality improvement and systems planning.

HB 2103: Third party resource for Medicaid clients for chemical dependency

Currently OHP clients can access chemical dependency services if they have a substance abuse disorder diagnosis. Under current law, OHP clients cannot utilize their Medicaid chemical dependency benefits to obtain the required assessment and treatment for chemical dependency needed as a result of a DUII charge. The law states that a person must pay for this treatment but is silent on the question of whether third party health insurance resources, including OHP coverage, may cover payment. This concept will allow individuals to utilize Oregon Health Plan (OHP) benefits for chemical dependency services needed as a result of DUII charges. There is no fiscal impact.

HB 2104: DUII offender fee increase

This concept will increase the fees for DUII offenders from \$130 to \$315, which would raise the portion the Oregon Health Authority collects from \$25 to \$210, generating additional revenue to support indigent DUII treatment and interpreter services. It will also ensure that the new revenue is dedicated to the Intoxicated Driver Program Fund (IDPF) for these purposes. This will generate a revenue increase of approximately \$11 million per biennium.

HB 2105: Integrated management and service demonstration

This concept allows OHA to approve regional accountable health authorities submitted by local communities. These health authorities will be able to coordinate care, drive population health improvement initiatives, and integrate physical health, mental health, dental services and substance abuse services under one comprehensive umbrella to ensure that individuals have access to services that meet their needs. There is no fiscal impact.

HB 2106: Criminal justice door to the mental health system

This concept allows the state mental health system to assist in the process that sends someone to the state hospitals by aiding in determining the appropriate initial placement and level of treatment for these individuals through quality and objective assessments. AMH, in consultation with the PSRB, will develop rules to certify psychologists and psychiatrists to conduct Guilty Except for Insanity (GEI) and aid and assist evaluations and implement a standardized format for forensic evaluations. This concept also allows for individuals who are found GEI of a misdemeanor to be committed to the state hospital or other facility designated by the Oregon Health Authority (OHA) if the person is a danger to self or others

rather than placed under the jurisdiction of the PSRB. The fiscal impact for 2011-13 will be \$323,051.

HB 2107: Advanced mental health care directives

This concept modifies statutory language by clarifying that a mental health advance directive does not need to be followed in the Oregon State Hospital (OSH) for patients who are committed under forensic statutes. Current statute indicates that a facility may disregard a mental health advance directive for persons committed to the Oregon Health Authority (OHA) under civil commitment statutes but is silent on OHA's authority to disregard mental health advance directives for those committed under forensic statutes. There is no fiscal impact.

HB 2108: Juvenile aid and assist

This concept will establish standards and procedures in the Juvenile Code for determining fitness of youth to proceed on a delinquency petition. It also develops guidelines on how to conduct an evaluation of fitness of youth to proceed and administers a program to provide restorative services to youth who are determined unfit to proceed and who present substantial probability of gaining or regaining fitness. The fiscal impact for 2011-13 is estimated to be \$644,238 (\$180,134 GF).

HB 2109: Alcohol and drug criminal history checks

HB 2442 (2009) created an exclusionary list of crimes relating to individuals hired to care for vulnerable populations, including those at Residential Treatment Facilities. HB 3698 (2010) exempted individuals working at Alcohol and Drug Residential Treatment Facilities from HB 2442 for the period of 5/27/10 – 7/1/11. This concept would create a permanent exemption. It also removes alcohol and drug providers from having criminal records checks done by OHA and removes "alcohol and drug abusers" from the definition of an elderly person with a disability. There is no fiscal impact.

OHA PROPOSED 2011-13 KEY PERFORMANCE MEASURES

PROPOSED 2011-13 KPM	MODIFICATION and NOTES
Alcohol and drug treatment effectiveness (school performance) — The percent of children whose school performance improves after receiving alcohol and drug treatment.	No change from 2009-11.
Alcohol and drug treatment effectiveness (employment) — The percentage of clients whose income increases after completing alcohol and drug treatment services.	Improvements in income for people receiving alcohol and drug services are a demonstrable outcome of treatment services.
Alcohol and drug treatment services (crime-free) — Percentage of clients who remain crime free during alcohol and drug services.	People in alcohol and drug treatment services are often referred by criminal justice authorities. Decreased arrest rates while in treatment demonstrates the benefit of being in treatment.
Alcohol and drug treatment effectiveness —Percentage of children reunited with parents participating in Intensive Treatment Recovery Services.	This modifies a previous KPM to make this outcome specifically the reunification of children with parents.
8th grader use of alcohol within the past 30 days	No change from 2009-11.
8th grader use of illicit drugs within the past 30 days	No change from 2009-11.
Dollars spent on mental health services (facility vs. community) — Percentage of dollars spent on facility-based mental health services compared to community-based mental health services.	A general goal for people participating in mental health services is recovery. People in recovery should be living in the most independent setting possible while receiving the services they need. One of the goals of AMH is to direct more resources toward community services compared to institutional or facility services to allow more opportunity for recovery.
Child mental health services —The percent of children receiving mental health services whose attendance at school improves.	Attendance at school demonstrates a positive outcome for a child receiving mental health services.
Youth mental health services (arrests) —Percentage of children demonstrating a decrease in the number of arrests in the 12 months following the initiation of mental health services.	A key goal for mental health services for children and families is to facilitate recovery and resiliency. Decreasing arrest rates while the child is in treatment demonstrates the benefit of being in treatment.
Access to mental health system —Percentage of people with severe emotional disorders or severe mental illness served within the public mental health system.	A large percentage of people who need mental health services do not receive them. This measure tracks the percentage who receive services with public dollars made available through OHA.
Gambling treatment effectiveness – Percent of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	This measure follows up with people who have received problem gambling treatment 180 days after the treatment ends to see if treatment had an impact.

State hospital restraints – Number of restraints per 1,000 patient hours in state hospital.	Restraint techniques never provide beneficial patient treatment, although restraint is used at times for patient safety. The goal at OSH is to minimize the use of restraint. All staff has been trained in techniques to avoid the use of restraint.
State hospital seclusions —Occurrences of seclusions per 1,000 patient hours in facility-based mental health care.	Seclusion techniques never provide beneficial patient treatment, although they can be used at times for patient safety. The goal within all AMH facility-based care is to minimize the use of seclusion.
Length of stay in state hospital	Reducing the length of stay in the state hospital demonstrates efficient and effective care, helping to move individuals to the least restrictive level of care needed. Most OSH admits are controlled by judicial decisions and discharges are dependent on bed availability in community mental health agencies.

PROPOSED KPM DELETION	RATIONALE
Completion of alcohol and drug treatment – The percentage of engaged clients who complete alcohol and other drug abuse treatment and are not abusing alcohol or drugs.	This measure is being dropped in favor of more specific outcomes related to completion of alcohol and drug treatment.
Alcohol and drug treatment effectiveness (adult employment) – The percentage of adults employed after receiving alcohol and drug treatment.	This measure is being dropped in favor of one that focuses on demonstrating increased income.
Alcohol and drug treatment effectiveness (child reunification) – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.	This measure actually looked at whether or not the parent(s) completed alcohol and drug treatment, which is usually only one of many requirements to regain custody of their children. A new measure has been proposed that actually tracks reunification.
Mental health client level of functioning – The percentage of mental health clients who maintain or improve level of functioning following treatment.	This measure was dropped because it does not demonstrate enough sensitivity to show changes in outcomes.
Child mental health services – The percentage of children receiving mental health services who are suspended or expelled from school.	AMH proposed to drop this KPM for one that reports improved attendance at school for children.
Adult mental health services – The percentage of adults receiving mental health services who report positively about the outcomes of those services.	AMH proposed to drop this KPM in favor of more specific measures relating to the outcomes of mental health services.

GLOSSARY OF TERMS

The following list of acronyms includes those used in this reference document as well as some common acronyms used in Oregon's many addiction and mental health programs.

A

ACT:	Assertive community treatment
ADF:	Alcohol- and drug-free
AFSCME:	American Federation of State, County and Municipal Employees
AG:	Attorney General
AMA:	American Medical Association
AMH:	OHA Addictions and Mental Health
AMHI:	Adult Mental Health Initiative
ARB:	Agency Request Budget
ARRA:	American Recovery and Reinvestment Act of 2009
ASD:	DHS/OHA Administrative Services Division

B

BAM:	DAS Office of Budget and Management
BHIP:	Behavioral Health Integration Project
BMRC:	Blue Mountain Recovery Center
BSP:	Behavioral support plan

C

CAF:	DHS Children, Adults and Families Division
CGAS:	Children's Global Assessment Scale
CHES:	Community housing and employment support
CIP:	Continuous improvement plan
CLAS:	Culturally and linguistically appropriate services
CMHP:	Community mental health program
CMS:	Centers for Medicare and Medicaid Services
COLA:	Cost-of-living adjustment
COP:	Certificate of Participation
CPI:	Consumer price index
CRIPA:	Civil Rights of Institutionalized Persons Act
CSCI:	Children's Mental Health System Change Initiative
CSCS:	Children's System Change Initiative
CTC:	Communities That Care
CY:	Calendar year

D

DAS:	Oregon Department of Administrative Services
DDA:	Dual Diagnosis Anonymous
DHHS:	US Department of Health and Human Services

- DHS:** Oregon Department of Human Services
- DMAP:** OHA Medical Assistance Programs
- DOC:** Oregon Department of Corrections
- DOJ:** Oregon Department of Justice
- DUII:** Driving under the influence of intoxicants

E

- EASA:** Early Assessment and Support Alliance
- EAST:** Early assessment screening and treatment
- EBL:** Essential budget level
- EBP:** Evidence-based practice
- EO:** Governor's Executive Order

F

- FASD:** Fetal Alcohol Spectrum Disorder
- FF:** Federal funds
- FMAP:** Federal medical assistance percentage

G

- GAF:** Global assessment of functioning
- GF:** General Fund
- GO:** Governor's Office

GRB: Governor's Recommended Budget

H

HB: House Bill

HIPAA: Health Insurance Portability and Accountability Act

HSC: Health Services Commission

I

ITRS: Intensive treatment and recovery services

K

KPM: Key performance measure

L

LAB: Legislatively Adopted Budget

LDMS: Lean Daily Management System

LF: Lottery Funds

M

MHO: Mental health organization

MHS: Mental health services

MIP: Minor in possession

MOE: Maintenance of effort

MVBCN: Mid-Valley Behavioral Health Care Network

N

NASMHPD: National Association of State Mental Health Program Directors

NIDA: National Institute on Drug Abuse

NOM: National outcome measure

NSPL: National Suicide Prevention Line

O

OAHHS: Oregon Association of Hospital and Healthcare Systems

OAR: Oregon administrative rule

OF: Other Funds

OHCS: Oregon Housing and Community Services

OHA: Oregon Health Authority

OHP: Oregon Health Plan

OHSU: Oregon Health & Science University

OPEU: Oregon Public Employees Union

ORH: Oregon Recovery Homes

ORS: Oregon Revised Statute

OSH: Oregon State Hospital

OST: Oregon Short-Term Fund

OYA: Oregon Youth Authority

P

PAS:	Program Administration and Support
PATH:	Project to Assist/Transition from Homelessness
PERS:	Public Employees Retirement System
PHD:	OHA Public Health Division
PICS:	Position inventory control system
POP:	Policy option package
PSRB:	Psychiatric Security Review Board

Q

QA:	Quality assurance
QC:	Quality control
QI:	Quality improvement
QMHA:	Qualified mental health assistant
QMHP:	Qualified mental health professional

R

RFI:	Requirement for improvement
RN:	Registered nurse
ROI:	Return on investment
RPI:	Rapid process improvement

RTF: Residential treatment facility

RTH: Residential treatment home

S

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPT: Substance Abuse Prevention and Treatment

SB: Senate Bill

SCHIP: State Children's Health Insurance Program

SEIU: Service Employees International Union

SPD: DHS Seniors and People with Disabilities

SRTF: Secure residential treatment facility

T

TANF: Temporary Assistance to Needy Families

TF: Total Funds

TI: Transformation Initiative

U

UAD: Underage drinking

US DOJ: US Department of Justice