

# **ADDICTIONS AND MENTAL HEALTH**

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## ***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;
- Reduce overall health care and societal costs through appropriate investments;
- Increase the availability, utilization and quality of community-based, integrated health care services;
- 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 through 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 the Oregon Health Authority (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 the Department of Human Services (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.

The last twenty years have been focused on developing and strengthening community-based services for people with substance abuse disorders, problem gambling behaviors and mental illness. The effort to establish systems of care rather than isolated service types has been slow due to economic circumstances that resulted in cycles of major service reductions throughout the 1990s and first 12 years of the 21<sup>st</sup> century.

Systems of care that are integrated, managed and able to serve people with complex and co-occurring disorders are most effective in producing the outcomes needed for people to be healthy, live independently and contribute to society. The most mature and effective systems of care are for children and adolescents. This is due in part to the fact that the majority of children served in the public system are Medicaid eligible and have a full array of managed, widely available and flexible services as intensive as the child and family needs to be successful. The services range from in-home and in-school supports, traditional therapies to intensive residential and inpatient when needed. Children are served in the least restrictive and most integrated setting and are less likely to be arrested, more likely to be successful in school and have improved family relationships as a result of these services.

The most effective manner of dealing with substance abuse and mental health disorders is to identify the issues early and provide proven effective treatment. There are two proven effective practices that show strong promise for making major changes in the life course of these disorders. When delivered to evidence-based standards, both Screening Brief Intervention and Treatment (SBIRT) and Early Assessment and Support Alliance (EASA) are very effective in diverting people from the effects of chronic substance abuse and chronic mental illness. People are more likely to complete their education, gain or retain employment,

avoid criminal justice involvement and form appropriate social relationships. This will be a major focus of innovation as the OHA works with the Coordinated Care Organizations in recognizing and serving substance abuse and mental health disorders in integrated settings in local communities.

Young adults who have long histories in various public systems are seldom well prepared for adult independence. This is most true for those young adults who have mental health disorders. AMH has been and will continue to focus on developing services that will help these young people manage their symptoms, learn the skills needed for independence and transition to integrated community settings with the supports needed to be successful. This is a challenge since some of these youth lose Medicaid coverage when they leave the child welfare system and thus have no coverage for needed treatment services.

AMH will continue to emphasize the very effective substance abuse treatment services for families who have lost or are in danger of losing custody of their children due to substance abuse disorders. Since 2010, Intensive Treatment and Recovery Services have allowed more than 1,800 children to be reunited with their families.

Oregon successfully opened a new psychiatric hospital for adults with major mental illness who have been civilly or criminally committed to the state for treatment. The new hospital replaced the Oregon State Hospital buildings in Salem, the oldest of which dated to 1883 and was still in use prior to building the new hospital. The hospital features central treatment malls and secure outdoor spaces for patient and family socialization. The culture is changing and increasing emphasis on recovery, patient experience and patient and staff safety. All patients have access to at least 20 hours of active treatment each week. Medical and nutritional services have been improved. The hospital is challenged as a result of the poor economy, which resulted in major budget reductions during the 2011 and 2012 Legislative Sessions.

Since 2010, AMH has focused on moving adults with major mental illness who live in structured residential settings to the appropriate level of care with the emphasis on independent, integrated community housing with the supports necessary for success. The goal is to ensure that adults with major mental illness live in the most integrated independent setting possible. Since September 2010, more than 1,000 people have transitioned to lower levels of care. More than half of these people transitioned to independent living.

Following the 2011 Session, AMH has been working to improve both the entry to the state hospital by individuals who have mental illnesses and have committed minor nonperson crimes and to discharge more rapidly, people who have been criminally committed to the state hospital for minor, nonviolent crimes. AMH worked with the Legislature during the 2011 Session to pass HB 3100. This legislation was focused on increasing the quality of evaluations conducted for individuals who have committed a crime and who may have a mental health disorder that supports a guilty except for insanity defense. The legislation also allows low-level nonperson Class C felonies and misdemeanors to be handled at the community level rather than being sent to Oregon State Hospital.

The 2011 Session also passed SB 420, which changes the hearing and discharge process at OSH for individuals who have committed lower level crimes that would not fall into more serious categories such as murder, manslaughter, assault, kidnapping and rape. These crimes were distinguished as Tier Two to separate them from more violent, person directed or dangerous crimes; known as Tier One. The offenders guilty of Tier One crimes remain exclusively under the jurisdiction of the Psychiatric Security Review Board (PSRB). The Tier Two offenders are under the jurisdiction of OHA and subject to a State Hospital Review Panel (SHRP) to determine readiness for full discharge or conditional release into the community. Those who are conditionally released are then under the jurisdiction of the PSRB.

The 2011 Session passed HB 3650, which set into motion a major transformation in the delivery of health care in Oregon beginning with the Medicaid population. The goal is to improve the health of Oregonians, improve the quality of care and lower the cost of care. The strategy is to integrate physical, behavioral health and by 2014, dental care under Coordinated Care Organizations (CCOs). These will be created and governed locally. There will be more flexibility in service delivery based on a global budget and increased accountability to deliver outcomes. This overall health system transformation provided the opportunity for AMH to work with county commissioners to define a process and goals for improving the flexibility and increasing the delivery of outcomes for the community-based addictions and mental health system that is funded by state General Funds, Beer and Wine Tax and federal block grants for people and services not eligible for Medicaid funding.

The magnitude of these changes requires that the OHA and AMH rethink the approach to our work and the structure of our organizations. This is also necessary

given the financial challenges and the need to flatten the management structure of the organization. Both OHA and AMH are well positioned to accomplish this by building on the foundation of widespread use of Lean principles and Lean Daily Management System. This provides the discipline to be clear about the scope of work projects, the roles and responsibilities of work group members, and accountability to accomplish the work that needs to be done in a timely manner.

Using this foundation, OHA is developing the Core Processes that are essential to accomplishing the key goals of health reform, developing the process and outcomes measures and the accountability structure to complete the work that is necessary and to become a learning organization that is data driven.

### *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 2011, 130,000 adults and 43,000 children and adolescents were served.

**AMH 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;
- Intensive community-based treatment services; and
- Longer term, hospital-level care to adults with mental illness who otherwise cannot be treated safely or successfully in community settings.

### ***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 and 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).

Addictions and mental health community services are provided in all 36 Oregon counties and with the 9 federally recognized tribes. Community mental health

programs (CMHPs), tribes and statewide contractors provide evidence-based services to prevent and treat the problematic use of alcohol and drugs, problem gambling disorders, and mental health disorders. These services and supports are based on local needs and developed through periodic comprehensive planning processes. The Oregon Health Plan (OHP) covers mental health and addiction services for eligible people with conditions funded under the Health Services Commission Prioritized List for all Medicaid and State Children’s Health Insurance Program (SCHIP) clients. The state General Fund, Beer and Wine Taxes, and federal block grants pay for services and individuals not covered by the OHP. The Medicaid service delivery system is undergoing transformation in response to HB 3650 (2011 Session) and SB 1580 (2012 Session). Addictions and mental health services for covered populations will be integrated with physical health care and delivered under the management of local Coordinated Care Organizations beginning in August 2012.

***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.

General Fund	\$431,399
Other Funds	\$1,224,074
Federal Funds	\$12,488,481
 Total Funds	 \$14,143,954

### ***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.

General Fund	\$43,544,406
Other Funds	\$16,073,596
Federal Funds	\$48,459,495

Total Funds	\$108,077,497
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### ***Problem gambling prevention and treatment***

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

Lottery Funds	\$8,772,526
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### ***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.

General Fund	\$336,051,636*
Other Funds	\$2,090,885
Federal Funds	\$192,658,033
 Total Funds	 \$530,800,554

*\*This amount reflects late changes anticipated for Policy Option Package 404 and therefore does not equal the amount in ORBITS.*

***State-delivered secure residential treatment program***

**Facility program**

The state-delivered secure residential treatment facility program was created by the 2007 Legislature as part of HB 5031, the DHS Budget. This authorized AMH to operate secure residential treatment facilities. There is a single 16-bed program in Pendleton on the grounds of the former Eastern Oregon Training Center, a closed facility that treated people with mental retardation. The secure mental health treatment program treats people who need a secure level of care as their first step out of the state hospital.

General Fund	\$5,596,522
Other Funds	\$494,210
Federal Funds	\$2,063,397
 Total Funds	 \$8,154,129
Pos	46
FTE	46.00

### ***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, or who have committed crimes and adjudicated as guilty except for insanity. To support the functions of the state hospitals, Oregon continues to work closely with counties and a variety of nonprofit and for-profit providers to identify the most appropriate housing alternatives in the most independent settings.

General Fund	\$395,357,468*
Other Funds	\$16,805,898
Federal Funds	\$29,124,514
Total Funds	\$441,284,880
Pos	2,406
FTE	2,139.15

*\*This amount reflects late changes anticipated for Policy Option Package 403 and therefore does not equal the amount in ORBITS.*

### ***Oregon State Hospital Replacement Project***

The director of AMH provides leadership and executive management to the Oregon State Hospital Replacement Project (OSHRP). For the 2013-15 biennium, the focus of the project will be the completion of the design and construction of the 174-bed hospital in Junction City.

Other Funds	\$79,401,530
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### ***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 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. The director also supervises OSHRP.

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.

AMH is engaged in reviewing all of the responsibilities of the program office to align core processes to achieve the goals of health care transformation and AMH system change. This work is likely to require changes in the structure in order to ensure increased accountability, streamline administrative requirements, and respond to the need for a flatter management structure and permanent reductions related to economic circumstances and legislative direction.

General Fund	\$21,653,816
Lottery Funds	\$2,711,193
Other Funds	\$8,020,341
Federal Funds	\$10,591,873
Total Funds	\$42,977,133
Pos	130
FTE	129.74

## ***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 126,454 Oregonians were provided access to broad-based prevention information during 2011. In addition, 10,125 people received selected prevention services, and another 1,417 received indicated prevention services.

### **How services are delivered**

Services are delivered by Community Mental Health Plans, 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 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 11<sup>th</sup> graders.

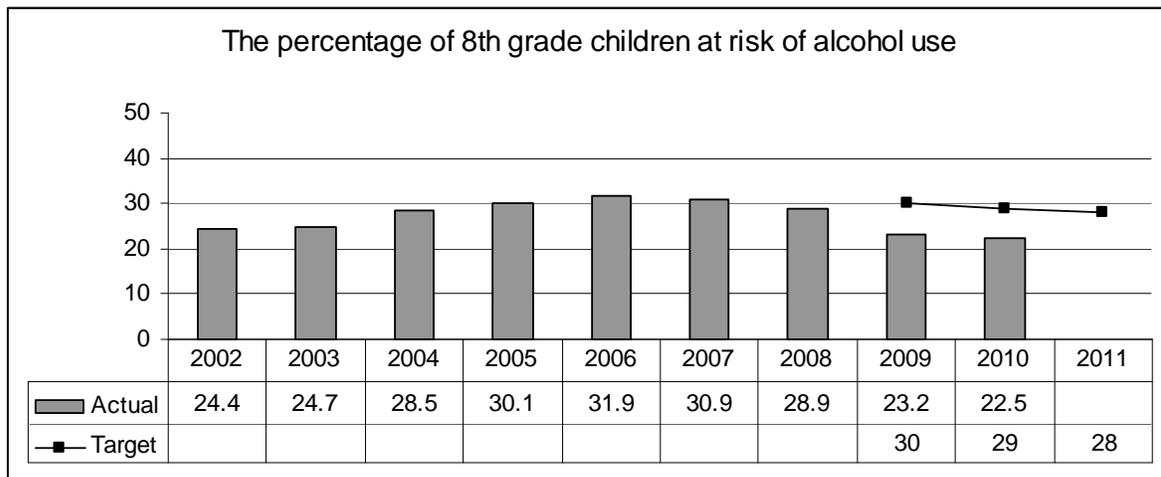
*Target:* The current target for this measure is 29 percent.

*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 as 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 the results shows in the data.



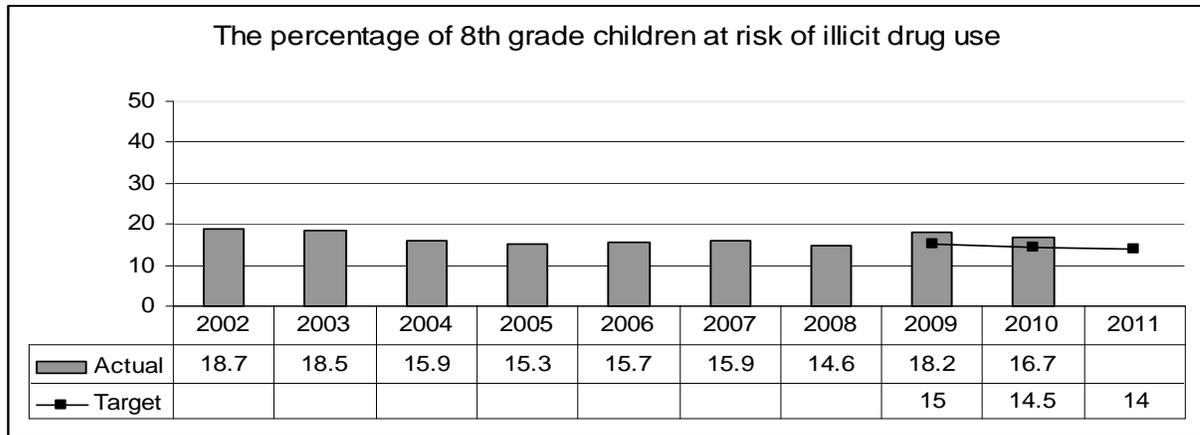
**KPM 6: Eighth-graders’ risk for illicit drug use**

*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 11<sup>th</sup> 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 14.5 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 8<sup>th</sup> 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**

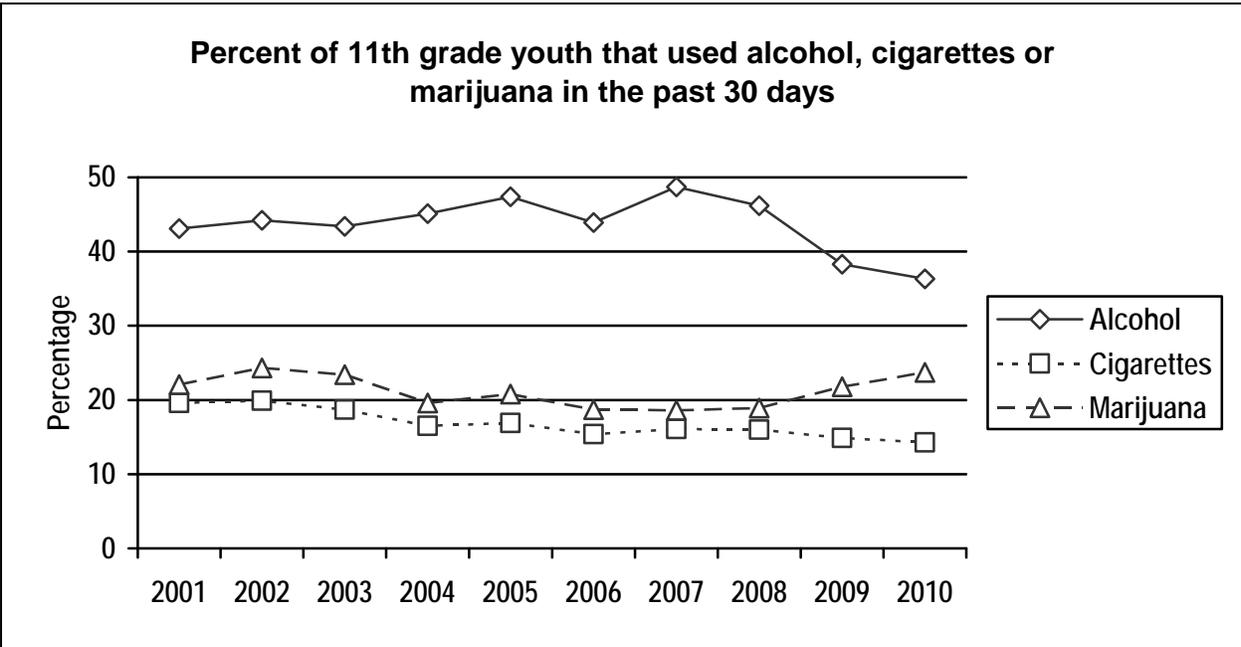
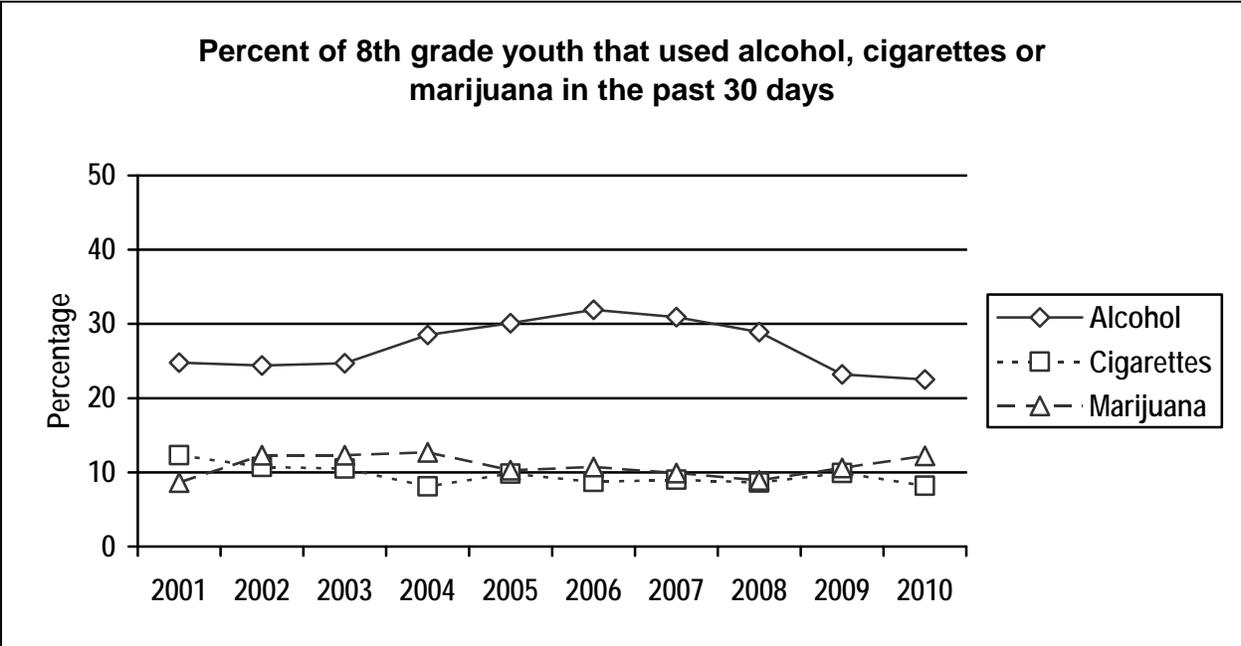
National outcome measures (NOMs) for prevention services include prevalence of substance use, consequences of use, and related risk and protective factors. Prevalence data tell the extent of a problem, such as the percentage of youth who drink. Consequence data provide information about the effect of 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, illicit drugs and non-medical use of prescription 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 7.3 percent of Oregon youth 12 to 17 years old abuse or are dependent on alcohol or drugs; 20.4 percent of young adults 18 to 25 and 7.3 percent of adults 26 or older abuse or are dependent on alcohol or drugs, requiring treatment (National Survey on Drug Use and Health, 2008-09).

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 following charts show the trends in alcohol, cigarette or marijuana use by eighth and 11<sup>th</sup> grade youth. Alcohol use is clearly the largest issue among both eighth and 11<sup>th</sup> 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 11<sup>th</sup> grade. In 2010, more than one in three 11<sup>th</sup> 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 11<sup>th</sup> 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 11<sup>th</sup> 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 11<sup>th</sup> 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 (62.4 percent) and half of women (54.3 percent) drink alcohol each month (Behavioral Risk Factor Surveillance System, 2010 preliminary data).

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 2010, 4.9 percent of men and 7.5 percent of women in Oregon were heavy drinkers (Behavioral Risk Factor Surveillance System, 2010 preliminary data).

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 2010, 18.4 percent of men and 10.5 percent of women in Oregon reported binge drinking (Behavioral Risk Factor Surveillance System, 2010 preliminary data).

## **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. The National Survey on Drug Use and Health shows past month use of illicit drugs such as heroin, cocaine and methamphetamine as well as nonmedical use of prescription pain relievers by youth and young adults in Oregon is higher than national rates. According to the 2010 Oregon Student Wellness Survey, 6.6 percent of Oregon 11th graders reported using prescription drugs to get high in the past 30 days. By comparison, 5.1 percent of 11th graders said they used illicit drugs other than marijuana in the past 30 days (includes use of one or more of the following drugs: inhalants, cocaine, ecstasy, heroin or methamphetamine). Throughout Oregon, prevention specialists have taken an active role in prescription drug take backs in an effort to reduce misuse of prescription drugs. Nationally there is a

growing concern about the risks of nonmedical use of prescription drugs (i.e. to get high or for performance enhancement). Adolescents are more likely than young adults to become dependent on prescription drugs.

## **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)

## ***ALCOHOL AND DRUG TREATMENT***

Alcohol and drug prevention, treatment and recovery services assist people in developing the life-long skills and abilities they need to manage their chronic health conditions. Like high blood pressure, asthma and diabetes, a cure remains elusive, but the disease of addiction can be managed. Those who manage their condition improve their health, enjoy a better quality of life and reduce and control the cost of their health care.

Addiction treatment holds value to the “triple aim” of better health, better care and reduced costs. Alcohol misuse and dependence, illicit drug abuse, tobacco use and other health risk behaviors with behavioral health underpinnings are among the top 10 leading causes of chronic illnesses and death. The implementation of coordinated care and person centered primary health homes will better serve members. Integration of preventive services to include the onset of chronic conditions or the severity of these conditions, will lead to reduced costs in healthcare.

Health transformation provides an opportunity to integrate addiction treatment into the broader healthcare system in a more meaningful way. Coordinated Care Organizations (CCOs) will be accountable to outcomes related to behavioral health (addictions and mental health) as well as physical health of members.

Information from national resources indicates substance use disorders affect 22 percent of those in medical settings. Individuals with untreated substance use disorders have higher medical costs than those without these disorders. Data indicates they use 8 times more healthcare services. Their families utilize health care at a rate more than 5 times higher than other families (Center for Policy Research and Analysis at the Treatment Research Institute 2009).

According to a 2011 survey conducted by NPC Research for the division, individuals who obtained publicly funded addictions services in Oregon maintained life-style changes 12 months after they left their programs. Individuals reported significant decreases in arrests, binge drinking, and use of illicit drugs. They located employment and surrounded themselves with clean and sober support systems. Of those surveyed, 90 percent abstained from non-medical drug use, and 72 percent reported abstinence from alcohol.

A recent analysis of a sample of OHP members who accessed additional treatment found significant cost-offsets in physical health expenditures, most notably as it relates to emergency rooms visits and hospitalization. The cost-offset was more than \$3,000 per person. Addiction treatment and recovery services are cost effective.

### **Services provided**

Services consist of outpatient, intensive outpatient, recovery support services, 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, buprenorphine, and injectable vivitrol as an alternative to chronic heroin and prescription opioid 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 2010, 43,235 adults age 26 and older were served; 14,824 young adults age 18 through 25 were served; and 6,053 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, health care costs related to untreated substance use disorders decrease. Local hospitals experience reduced use of emergency departments. 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. Individuals locate employment, safe and stable housing and improve the quality of their lives, which in turn strengthens the communities where they live.

## ***Intensive Treatment and Recovery Services (ITRS)***

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. Since 2010, more than 1,800 children were 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.

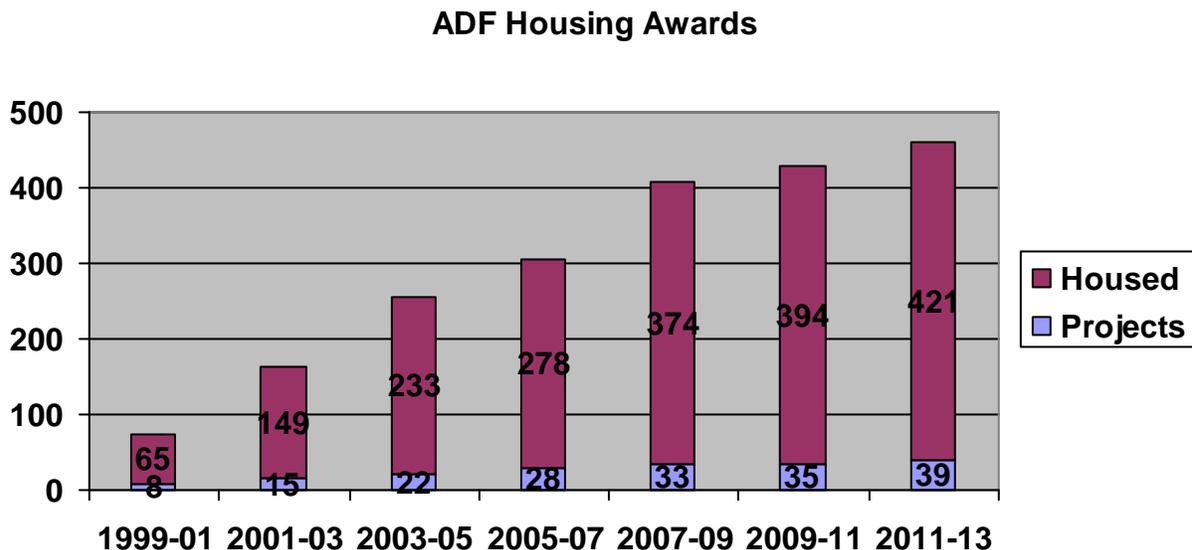
## Housing

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 5,000 people each year with these disorders are homeless. This represents nearly one-third of homeless individuals identified in the 2011 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 2011-13, four projects have been awarded funding. These projects total \$1,000,000 and will provide 27 units of affordable alcohol and drug free housing. The following chart reflects AMH's cumulative distribution of ADF housing development funds through the 2011-13 biennium.



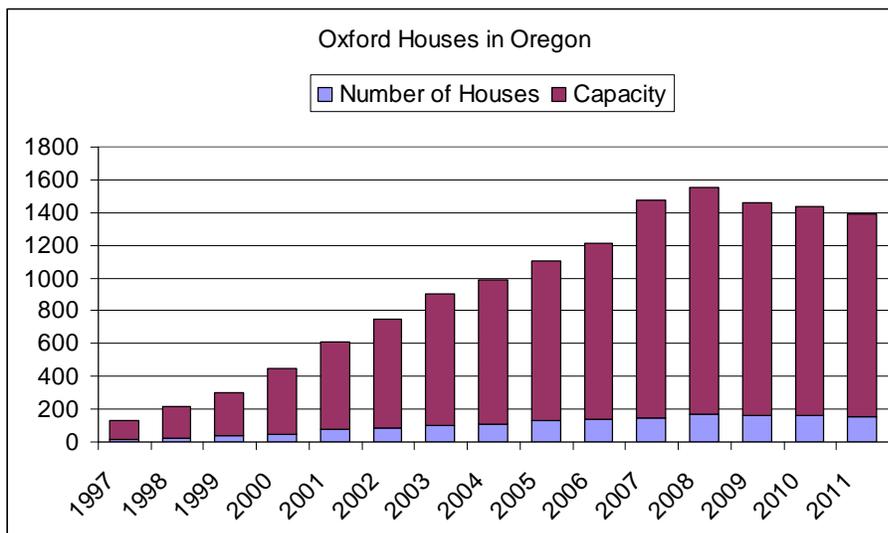
### ADF Housing Assistance Services

AMH funds eight projects in six counties to help people in recovery from substance use disorders obtain stable alcohol and drug free housing as they transition to self-sufficiency. From July 1, 2011, through March 31, 2012, approximately 167 individuals and 192 families with 283 children have received housing coordination and/or rental assistance through this program. Of those served, 39 percent were young adults in transition aged 18-25.

### **Oregon Recovery Homes (ORH)**

AMH currently contracts with Recovery Association Project (RAP) to manage the Oregon Recovery Homes project, which provides technical assistance and training to self-supporting, democratically-run alcohol and drug free housing. RAP has hired a fundraiser/marketing position in order to expand their ability to serve populations who benefit from the Oxford House model, but are not in recovery from substance abuse disorders. Some examples include domestic violence victims and homeless families. There are currently 157 Oxford Homes in 14 Oregon counties, accommodating approximately 1,236 people recovering from substance abuse disorders. In addition, more than 300 children live in these homes.

While the unemployment rate for the state has declined, unemployment remains high in many of Oregon's rural counties. This has significantly affected the viability of some Oxford Houses, as residents are unable to pay their equal share of expenses. This has resulted in an increase of vacancies and closure of some houses. The following chart shows the trend of homes and housing capacity since 1997.



## Performance measures

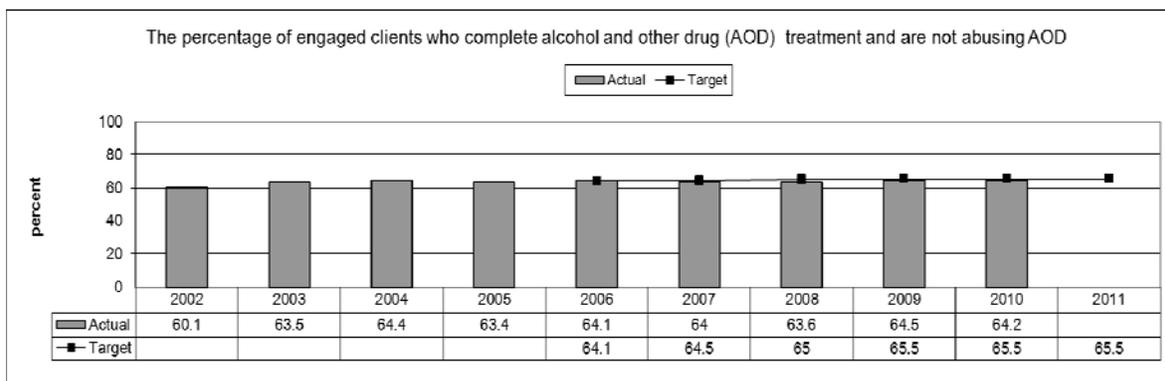
### *KPM 1: Completion of alcohol and drug treatment*

*Purpose:* Once an individual enters into alcohol and drug treatment service, the next goal is for the individual to complete treatment. Individuals 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 64 percent during the next few years.

*Results:* For purposes of this key performance measure, the 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 individuals 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.



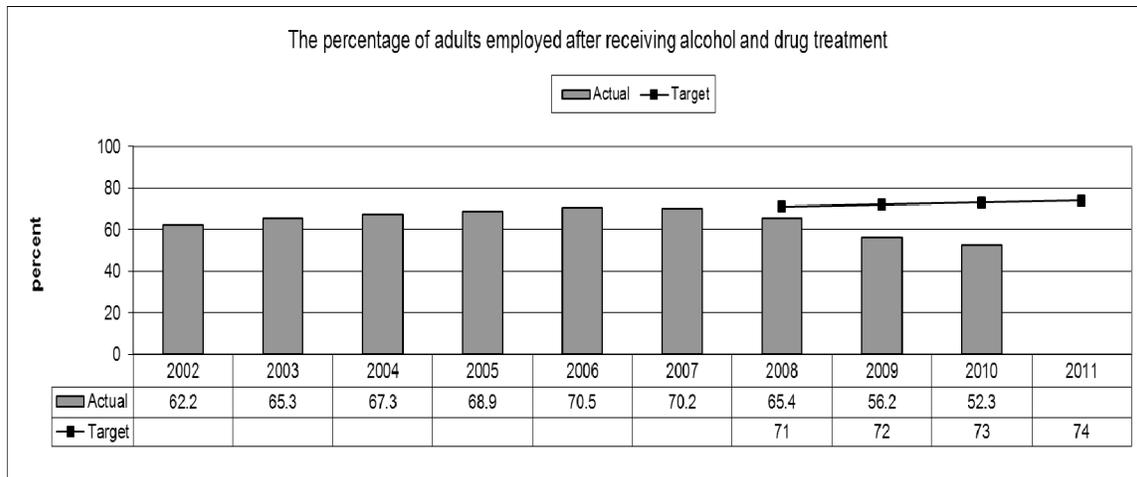
***KPM 2: Adults employed after alcohol and drug treatment***

*Purpose:* A key outcome for many individuals 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 individuals 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 2010, individuals who ended service employed had declined to 52.3 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).



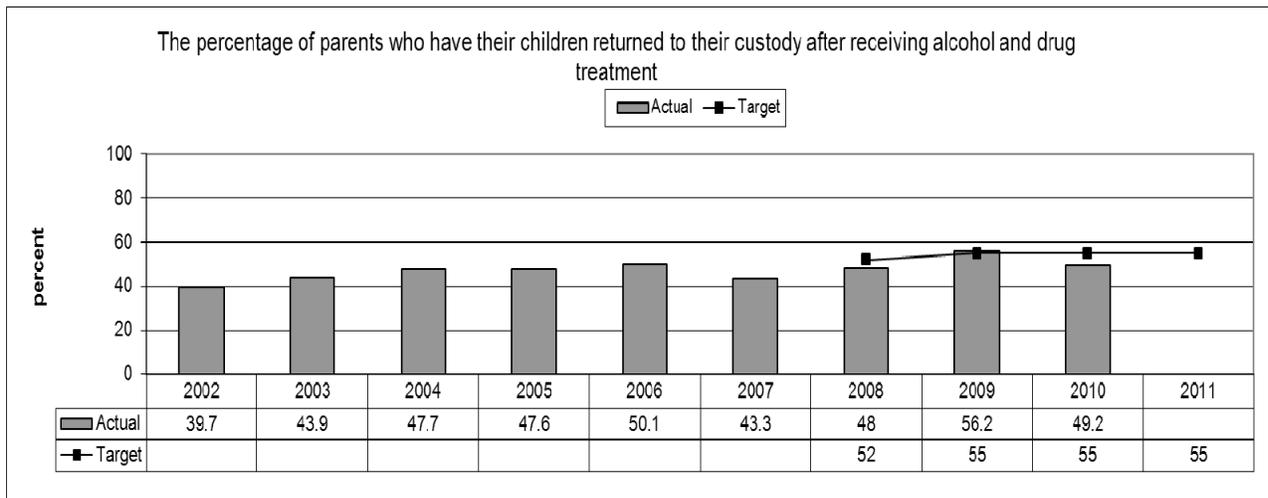
***KPM 3: Children returned to custody after parental alcohol and drug treatment***

*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 removing children from parental custody. 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 2010 shows that more parents each year were meeting treatment criteria that allowed reunification with their children, although AMH missed its goal for 2010 by 5.8 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.



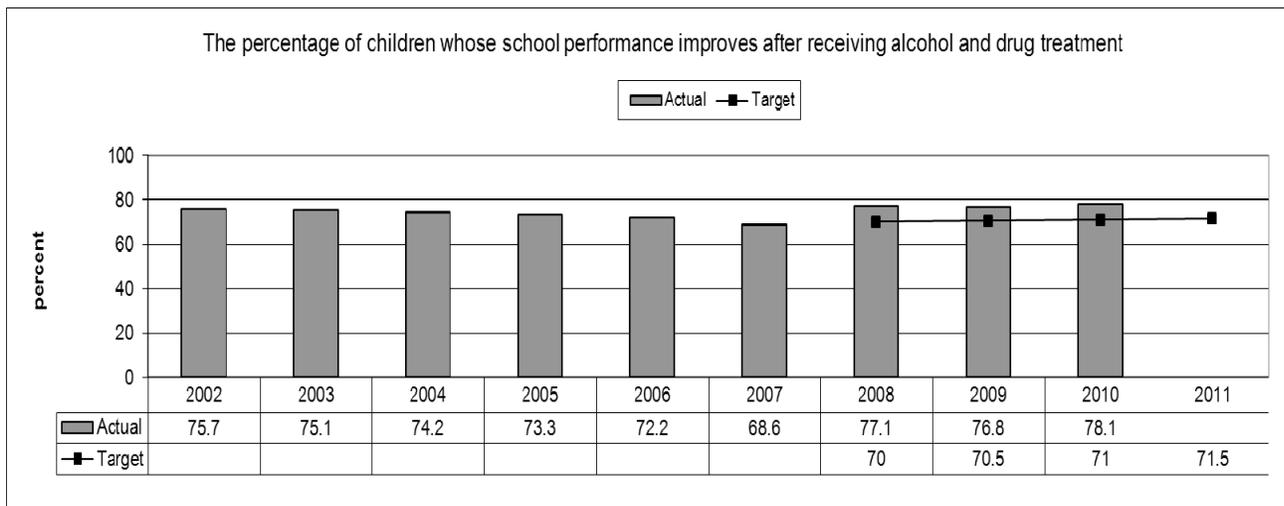
***KPM 4: Children with improved academic performance after alcohol and drug treatment***

*Purpose:* Alcohol and drug issues are a major barrier to academic achievement. Often, poor academic performance represents an initial flag for abuse of alcohol and drugs among teens. Treatment goals include providing children with the tools necessary to reach their full academic potential. Improved academic performance can help break the cycle of abuse of alcohol and drugs among teens.

*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 through 2010 exceeding those of previous years. In 2010, AMH showed 78.1 percent of children with improved school performance, exceeding the annual goal by 7.1 percentage points.

*How Oregon compares to other states:* This measure looks at academic performance. Most national data track only improvement in attendance, making 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 2013-15**

AMH proposes to measure the percent of individuals who do not engage in criminal activity during alcohol and drug treatment services. This is a critical measure of success for the treatment system as a substantial proportion of the people served 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 also proposes to measure the percent of individuals 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 8.7 percent of adolescents ages 12 to 17 (25,690) have substance abuse issues. Among young adults ages 18 to 25, 20.7 percent have substance abuse issues (84,972), while 7.4 percent of adults 26 and older have substance abuse issues (185,806). AMH currently serves 24 percent of the adolescents and children, 17 percent of the young adults, and 23 percent of the adults in need of public alcohol and drug treatment services.

### **Key budget drivers and issues**

In keeping with the 10-Year Plan for Oregon, the budget planning process begins with an outcome-based investment framework and includes the principals of fiscal sustainability, innovative solutions and informed decision. These principles are key to future planning. They include:

- Fiscal sustainability includes delivering programs and services efficiently with available resources and developing mechanisms to capture additional federal match which could build increased capacity for treatment.
- Innovative solutions prioritize investments in areas where change and innovation drive system or process improvements focusing on new ways of doing business or providing services.
- Informed decision making relies on evidence-based information to inform policy decisions and decision makers. Oregon is nationally recognized for its work in this area.

As the agency develops budgets, these principles guide our work as with AMH deals with the following 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 143 people across Oregon died in heroin-related deaths in 2011, 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 inappropriate use of opioid pain medications, continues to remain a 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.

### **Complex and multiple challenges among treatment populations**

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.

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. The full integration of addiction treatment and mental health treatment with physical medicine managed by Coordinated Care Organizations

provides the platform to improve treatment outcomes for members with co-occurring disorders.

### **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 number 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 an increased need for recovery support services with limited 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 7.4 percent of the adult population ages 26 and older requires alcohol and drug treatment services; in Oregon that is 185,806 people. For those age 18 to 25, the same research shows that 20.7 percent, or 84,972 people, are in need of treatment. The research also shows 8.7 percent of youth age 12 to 17 require treatment; in Oregon that is 25,690 youth. Public funds provided services for 43,235 adults (23 percent of the need), 14,824 young adults (17 percent of the need) and 6,053 youth (24 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**

Residents of urban areas in Oregon experience some of the most expensive rental housing and home ownership costs in the country. In rural areas of Oregon those

who locate housing find themselves without adequate transportation necessary to access services. Safe, affordable, alcohol and drug free housing serves as the foundation for people recovering from addictions and mental health disorders and helps them maintain their sobriety. As the economy has worsened, housing insecurity has become more pronounced for people with addictions and mental health disorders. Homeless people with mental illness and addictions 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 instability.

## **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)

## ***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 2011, 3,543 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 1,918 people during 2011.

## **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**

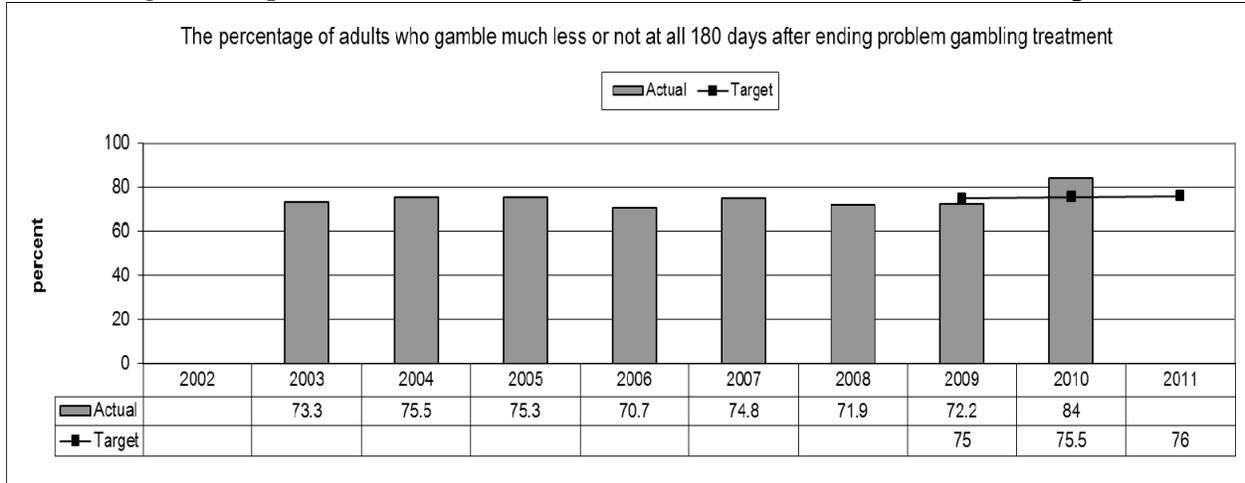
### ***KPM 10: Percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment***

*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 success in the past two years. In 2010, AMH showed 84 percent of adults not gambling or gambling less 180 days after ending services. This exceeds of the 75.5 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 53,430 adult Oregonians are problem gamblers and an additional 30,175 are pathological gamblers.
- FY 2010 data indicate 46.6 percent of people treated for problem gambling successfully completed treatment services.
- Six months post-treatment, more than 94 percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.
- For the treatment completers, 50.5 percent of those assessed at 12 months after treatment reported no gambling and another 40.2 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 69 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**

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.

## ***COMMUNITY MENTAL HEALTH PROGRAMS (CMHPs)***

### **Services provided**

Mental health services improve the daily lives for Oregonians of all ages 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 be successful with their family, education, employment and in their community, often reducing public safety problems and negative health related consequences.

Children with mental health issues are served in their local communities and are linked with other child and family serving systems. Each child can be screened and served within the integrated service array according to a standardized level of need determination for their mental health service and support needs. Services are child and family driven and team-based with a clear focus on providing a broad array of services and supports across a coordinated continuum of types and intensity of care.

Services and supports include those delivered by peers such as help establishing personal relationships, and help obtaining employment or education; independent living skills training such as cooking, recreation, shopping and money management; residential treatment services 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 2011, publicly-funded programs served 72,392 adults and 36,161 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 the 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, outpatient, and residential treatment to help people recover from their mental health disorders;
- Case management, care coordination, 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.

During 2011-13 there will be a major change in the system for delivering mental health services, the first major change since 1995. Services for the Medicaid population will no longer be managed separately from physical health care and

addiction services. Beginning August 2012, all three service areas will be integrated and managed by locally accountable Coordinated Care Organizations. While change of this magnitude will be a challenge, the state expects improved health, improved quality of health care and lowered costs for the Medicaid population.

## **Housing**

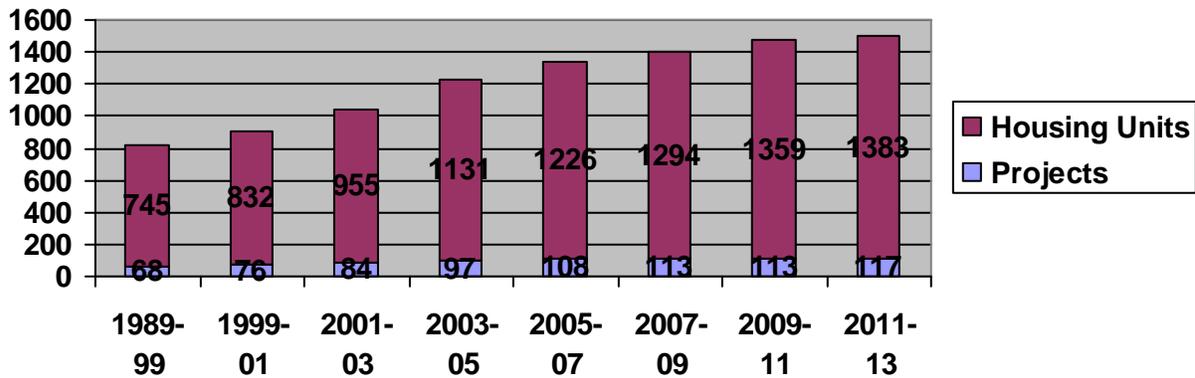
A safe and affordable place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments, their recovery is at risk. People with mental illness who do not have stable housing are less likely to use medications appropriately and less likely to continue treatment services, increasing the risk of further illness, mandated treatment and greater disability. To serve people with mental health disorders, 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 117 housing projects in 26 counties accommodating 1,383 people with severe and persistent mental illnesses. The following chart shows the growth of projects and capacity since 1989. To date, AMH has invested \$4.7 million in the development of these projects. Each dollar invested leverages approximately \$36 from other sources.

For the 2011-13 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 an application round in September and October 2011 and anticipates funding between 55-65 applications, which will serve between 540-560 residents.

### MHS Housing Fund



### Community Mental Health Housing Fund

Established with the proceeds from the sale of the former Dammasch State Hospital property, this AMH fund has awarded a total of \$2.9 million in support of 34 projects. During 2011-13, one application round was held for the development of supportive housing for people with mental illness. The round awarded \$232,230 toward the creation of 24 units of supportive housing, leveraging \$10 for every dollar invested for total housing worth \$2.7 million.

During the 2012 Legislative Session, \$5.7 million from the Community Mental Health Housing Trust Fund corpus was taken by the legislature in order to maintain community-based mental health programs funded with state general fund dollars. Due to the very low interest rates currently in effect, it will be several years before the Trust Fund generates enough interest earnings to fund the development of additional housing for people with mental illness.

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 has been working for more than ten years with private developers and the City of Wilsonville to integrate community housing into the new urban village community, Villebois, at the former Dammasch site in Wilsonville. Originally, AMH was given 10 acres and expected to develop 20 to 24 projects over a 10-year period beginning in 2005. Drastic changes in the housing market and the economy, which began in 2008, have halted most development activities at Villebois. Three multi-family projects have opened since 2008. All three offer varying levels of support services for residents, allowing them to live as independently as possible and have a key to their own door.

Integration challenges remain at Villebois. Due to the slowdown in building activity, the Village Center, a critical component of the community is missing. This has prevented public transportation from expanding to Villebois and employment opportunities from developing. Residents feel isolated and frustrated at the lack of those important amenities.

There are currently no AMH projects under development at Villebois, although a private developer currently is building 81 single-family homes. In 2010, AMH created the Villebois Housing Investment Workgroup, 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 was charged with providing recommendations to AMH regarding the remaining parcels and the best way to meet remaining obligations for community housing development at Villebois.

The work group has recommended that some of the existing parcels be held for future development of supportive housing for people with mental illness and sell the remaining parcels when feasible to support the development of supported housing for people with mental illness in other regions of the state.

## 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

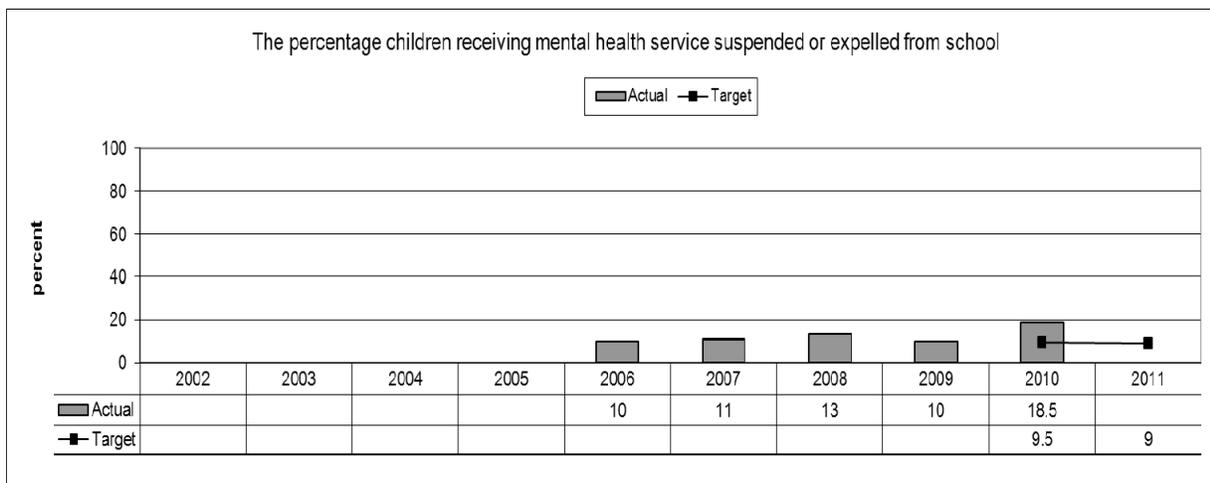
### ***KPM 7: Percent of children receiving mental health service suspended or expelled from school***

*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:* The results for 2010 indicated that roughly 18.5 percent of the children were suspended or expelled. This is much greater than expected. AMH will work to decrease this result.

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



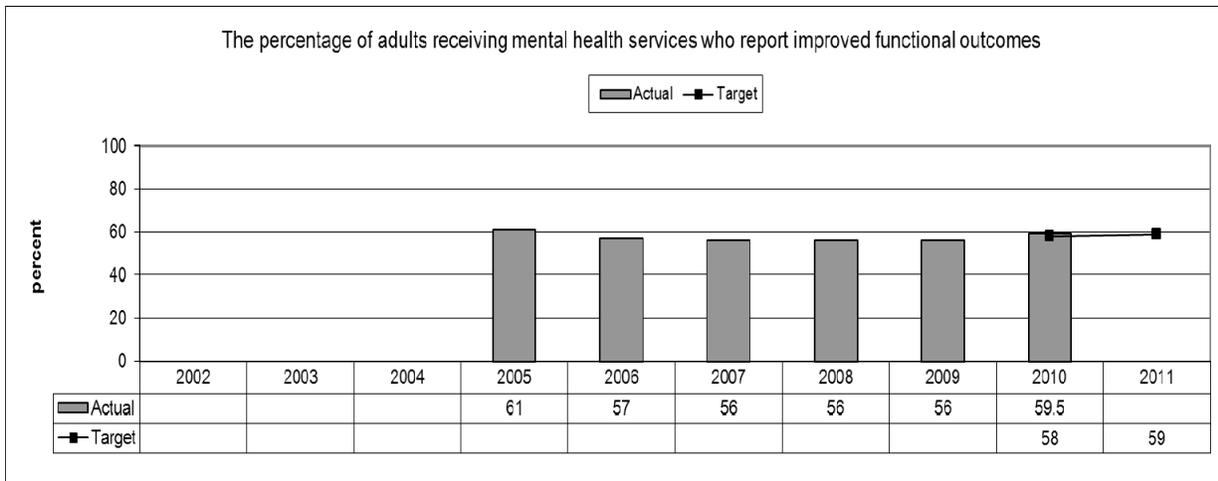
***KPM 8: Percentage of adults receiving mental health services who report improved functional outcomes as a result of those services***

*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:* In 2010, AMH found that 59.5 percent of adults felt they had experienced improved functional outcomes. This result exceeded the target of 58 percent.

*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***

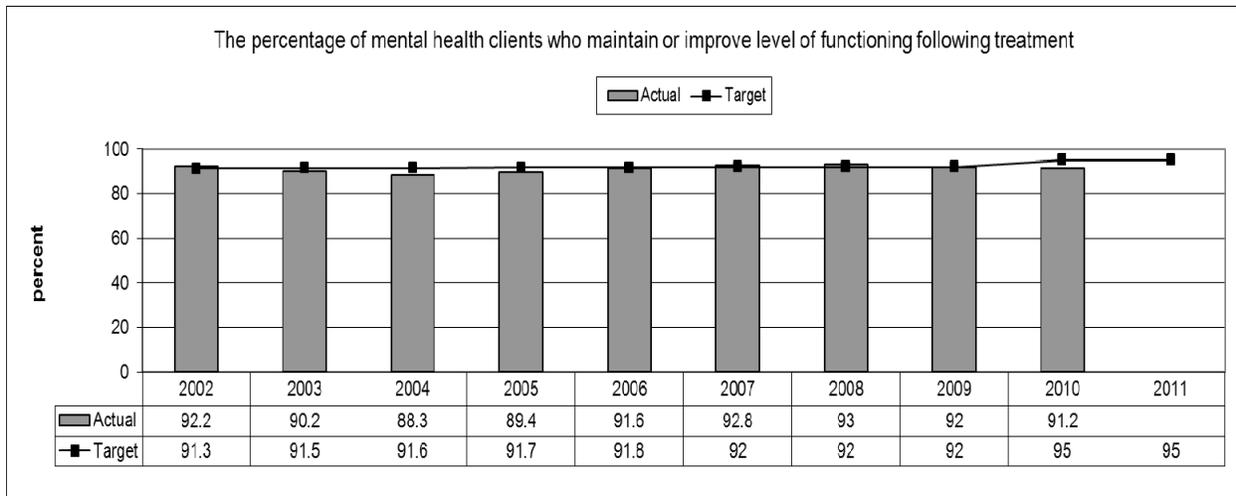
*Purpose:* Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children

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 been flat, 2010 did show a slight decline to 91.2 percent. This result did not meet 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 2013-15**

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 (103,968) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 5.4 percent (161,526) are estimated to have a severe mental illness.

AMH serves 35 percent of the children and adolescents and 45 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**

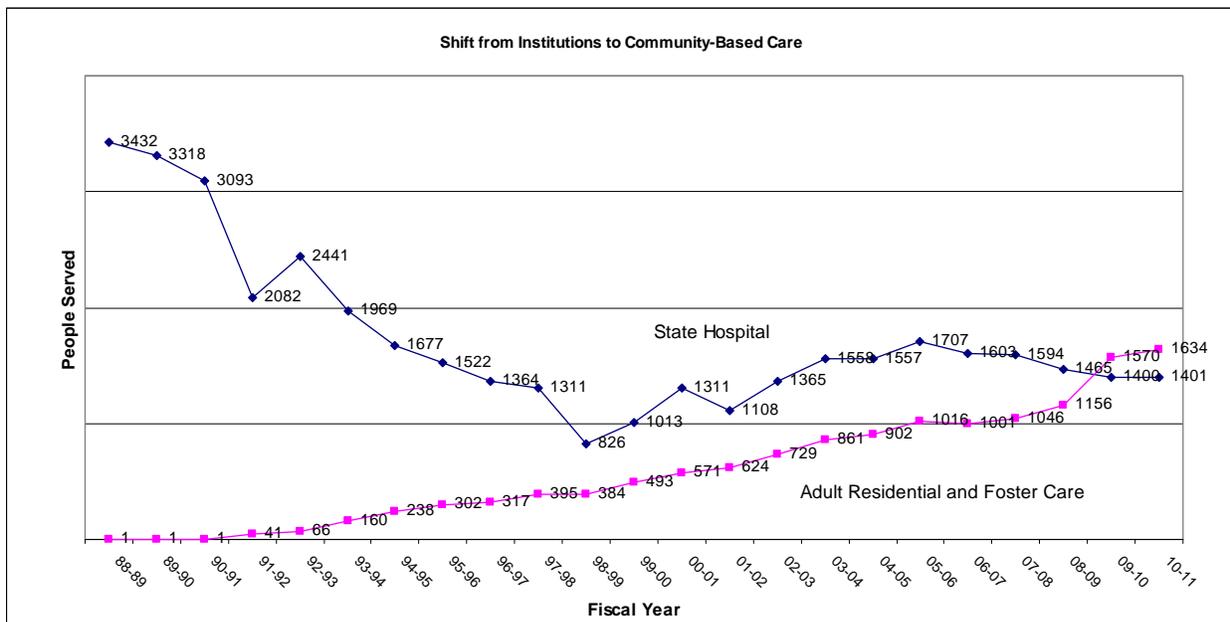
For the past 15 years, Oregon has systematically moved from an institution-based system to a community-based system, allowing people who need publicly funded mental health services to be served in their communities. Hospitalization for acute mental illness is provided in psychiatric units of local hospitals. Long-term treatment and stabilization for adults with major mental illnesses increasingly is provided in community-based settings, which 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. Oregon is developing a system that consistently assists adults with mental illness to live and receive services in the least restrictive environment appropriate for their needs through a project known as the Adult Mental Health Initiative, which is described in detail later in this document.

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 2011, 1,422 of the 72,392 adults who received treatment services in the community also were served in the state hospitals.

Since 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 adult residential and foster care system compared to relative stagnation in the state hospital system. 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 161,526 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 (103,968 youth) requires treatment for mental and emotional disorders. Public funds provided services for 72,392 adults (meeting 45 percent of the need) and 36,161 children and adolescents (meeting 35 percent of the need). Some of these individuals will be able to receive insurance-covered services. However, adults with major disabling mental illnesses frequently must rely on the publicly funded system. The lack of investment in early identification and treatment for these disorders increases social costs and pushes more people into 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 2011 Point in Time Count — more than 2,260 people or nearly 12 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.

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). A portion of these individuals are determined to need state hospital level of care and are admitted to one of the two state hospitals. Others are served in licensed residential or community outpatient settings.

During the past year, there were approximately 2,500 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 223 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 or for people under 18 years of age to a secure community inpatient facility 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, in a state hospital, or for people under 18 years of age, a secure community inpatient facility (ORS 161.319 and ORS 161.327).

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.

Senate Bill 420 was passed in the 2011 regular session, effective on January 1, 2012. This legislation changes the dispositional phase of the legal process for those who successfully assert the insanity defense as defined in Oregon Revised Statutes 161.315 through 161.400. It creates a two tier system based on the nature of the offense for which one is found “guilty except for insanity” of a crime, who continue to be affected by a mental disease or defect which, when active, causes them to pose a substantial danger to others. Those who commit Tier 1 offenses (i.e., aggravated murder or Ballot Measure 11 crimes) will continue to be placed under the jurisdiction of the PSRB, while jurisdiction of Tier 2 offenders (i.e., non-

Ballot Measure 11 crimes) will shift to the Oregon Health Authority (OHA) through the State Hospital Review Panel (SHRP) as defined in Oregon Administrative Rules 309-092-0000 through 309-092-0240. SHRP will be responsible for conducting the statutorily required hearings and making decisions regarding placement; including remaining in the hospital, conditional release or discharge of Tier 2 individuals. As is the case with the PSRB, SHRP shall consider public safety as its primary concern when making these determinations. Once conditionally released to the community, jurisdiction of Tier 2 offenders will transfer to the PSRB for monitoring and supervision responsibility.

House Bill 3100 also passed in the 2011 regular session, requiring all psychiatrists and licensed psychologists to be certified, in order to perform forensic evaluations for the purposes of determining competency and criminal responsibility. The forensic certification program is under the authority of AMH and was established by Oregon Revised Statute 161.309-161.370 and 419C.524 and is administered under Oregon Administrative Rules 309-090-0010 through 309-090-0090. These rules identify types and requirements of certification, the required content of evaluations, a Review Panel process for submitted evaluations, and requirements of the Forensic Evaluator Training Program. The goal of this certification is to provide standardization to the forensic evaluation process when determining if an individual is able to aid and assist in their own defense or criminally responsible at the time they committed the crime. The legislature funded this legislation to provide training and staff coordination of this program.

HB 3100 also provides instruction to the court regarding the disposition of individuals found guilty by reason of insanity of a misdemeanor. These individuals will be released from custody into their community, unless determined to be a substantial danger, at which time, the court will “commit” the individual to OSH. The superintendent will release these individuals when determined they no longer are a danger and OSH will notify the court. For individuals found guilty by reason of insanity of committing a Felony C crime, a community evaluation is ordered to consider if the individual is able to be conditionally released and if the community has adequate resources to meet the individual’s needs. This evaluation will be completed and reviewed by the court at sentencing to determine if the individual will be conditionally released or placed in the custody of Oregon State Hospital.

The PSRB caseload has reduced slightly over the last five years while increasing the number of individuals on conditional release from 49 percent to 55 percent of the total caseload.

### **Improving the community mental health system**

During the 2009-2011 biennium, AMH focused its efforts on the provision of mental health services in a very different way. In January 2010, together with consumers, Community Mental Health Programs, Mental Health Organizations (MHOs), providers and others, AMH embarked on an ambitious initiative to fundamentally change the adult mental health system. The Adult Mental Health Initiative (AMHI), known as “Aim High,” had multiple goals including:

- Developing a system that consistently assists adults with mental illness to live and receive services in the least restrictive environment appropriate for their needs;
- Infusing person-centered planning and care coordination throughout the adult system;
- Increasing the number of individual clients living successfully in the community;
- Increasing community engagement in helping individuals transition from high levels of care to lower levels of care based on the individual’s needs; and
- Increasing the availability of community services and supports that help individuals be successful in the community.

Nine months later, the MHOs took responsibility for assisting individuals in transitioning from the state hospital and licensed residential settings to more appropriate settings. At the same time that the MHOs took on this responsibility, AMH used existing funding to increase the availability of flexible community-based services and supports.

Between September 1, 2010, and March 31, 2012, the MHOs transitioned more than 1,024 individuals from the state hospital or licensed residential programs to lower levels of care. More than half of these individuals have transitioned to independent living in the community.

AMHI has had a significant impact on the adult mental health system and is changing outcomes for individuals. Prior to AMHI, Acumentra estimated that 60

percent of the adults in the residential system were in inappropriate levels of care. As of March 2012, that number has decreased to 28 percent.

The number of individuals ready to leave the state hospitals has increased from a low of 46 in 2009 to a high of 119 in 2011. At the same time, the average length of time that someone waits to leave the hospital has decreased.

Prior to AMHI, individuals who had been determined ready to transition (RTT) from the state hospital waited an average of 156 days to transition to a lower level of care. In 2011, the average length of stay post RTT was 67 days and for 2012, it is averaging less than 50 days.

The MHOs have also been successful in moving individuals to lower levels of care more timely. At the beginning of AMHI there were a significant number of individuals who had been waiting to leave the hospital for more than a year. Since mid-2011 no one has waited more than 220 days, and generally most individuals have transitioned in less than 60 days.

Number of Individuals RTT by LOS RTT				
CIVIL	February 2011		March 2012	
RTT <i>Less</i> than 60 days	22	52%	35	88%
RTT <i>More</i> than 60 Days	5	12%	2	5%
RTT More than 90 Days	3	7%	2	5%
RTT More than 120 Days	9	21%	1	3%
RTT More than 1 year	3	7%	0	0%
Total RTT	42		40	

AMHI was also one of the first steps AMH made towards performance-based contracting in the adult mental health system. AMH developed a methodology for counting individuals transitioning to lower levels of care and set targets for each MHO based on their regions’ historical utilization of the state hospital. AMH and the MHOs developed the term “qualifying event (QE)” to capture the concept of transitioning individuals from higher levels of care to lower levels of care that meet the contractual performance target under AMHI.

In 2010-2011, any individual transitioning from the state hospital waitlist, a state hospital or from a licensed residential program to the next lower level of care counted as a QE. In the first contract, the statewide QE target was set at 331, based on historical utilization of the state hospital. For 2011-2012, AMH increased the QE target to 657 by adding residential utilization. AMH also removed any transitions to Secure Residential Treatment Facilities from the QE criteria to provide additional incentives for serving individuals in the least restrictive setting possible. Therefore, AMH has made the target substantially higher and harder to achieve. However, the MHOs have risen to the challenge.

In the 10 months of AMHI Phase I, the MHOs reached 494 QEs, 150 percent of the initial target. Of these QEs:

- 51 percent of the individuals transitioned from the state hospital; and
- 60 percent transitioned to their own home or apartment.

In the 8 months of AMHI 2011-2012<sup>1</sup>, the MHOs have reached 549 QEs:

- 45% of these individuals transitioned from the state hospital;
- 65% transitioned to their own home or apartment.
- Based on current performance, the MHOs are expected to reach more than 685 QEs for the 2011-2012 fiscal year.

AMHI Key Metrics Year 1 versus Year 2			
METRIC	July 2011 – March 2012	September 2010- June 2011	% Change
Number of individuals RTT	42	45	7%
RTT Length of Stay (LOS)	38	143	74%
Number of individuals on the State Hospital (SH) Waitlist (WL)	20	28	29%
WL LOS	25	21	-17%
Number of SH Discharges	218	253	86%
Number QEs	530	494	107%

<sup>1</sup> As of 2/23/2012

Following the 2011 legislative session which initiated health care transformation for the Medicaid covered population, AMH worked with the Association of Oregon Counties and reached agreement on major changes to the system for non-Medicaid clients. This is known as AMH System Change.

The AMH System Change work is designed to integrate addiction and mental health treatment services and provide flexibility to local communities to enable them to better serve people with addictions and mental health needs. These improvements will be supported by flexible funding, allowing counties the discretion to put resources where they are most needed to serve people in their communities. The budgeting flexibility will be balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served.

### **Improved use of Medicaid reimbursable services**

An underpinning of changes to the community mental health system will be the changes available in the residential system through the use of an additional Medicaid State Plan Service.

In February 2012, Oregon received authority from the Centers for Medicare and Medicaid Services (CMS) to include 1915(i) Home and Community Based Services (HCBS) in Oregon's Medicaid State Plan. This new authority will allow Oregon to improve its community-based mental health services by achieving two key objectives – reimbursing for habilitative services for individuals in recovery as well as simplifying documentation requirements for providers.

Before the approval, Oregon had authority for rehabilitation and personal care services only. The approval adds habilitative services to the mix available for providers to meet the individual's need. Habilitative services include recreation, socialization and community survival skills. These services are essential to more fully integrate individuals in recovery who have spent time in an institution by providing the skills for them to successfully live independently.

The 1915(i) approval also simplifies the documentation requirements for providers in two ways. First, providers are no longer required to document each interaction with the individual as rehabilitation. The documentation of habilitative services will serve as justification for reimbursement. Secondly, AMH is using this

opportunity to collaborate with CMS to develop a combined reimbursement methodology. Currently providers are required to claim and document rehabilitative, personal care and general fund payments separately. The new methodology will combine those and habilitative services into one payment for serving the individual.

### **Continuing Challenges**

AMH continues to assess strengths and weaknesses in the system of care that serves adults with mental illness. Ongoing challenges remain in standardizing utilization of the residential system and supporting individuals in independent living.

To address the issue of standardizing utilization, AMH has developed standardized admission and continued stay criteria for all licensed residential programs. The policy took effect on April 1, 2012. To encourage more transitions to independent living, AMH is issuing a request for proposal for intensive in-home services. These intensive in-home services will use Medicaid funding in new and creative ways to serve individuals who would traditionally be served in residential settings in their own homes or apartments.

### **Early Assessment and Support Alliance (EASA)**

Psychosis is a common and potentially devastating illness, which usually begins between ages 12 and 25. Psychosis affects 3 in 100 people; 1 in 100 develop schizophrenia, and almost as many develop psychosis associated with bipolar disorder.

The good news is that Oregon is the first state in the country that has implemented a statewide approach to intervening early into critical and potential chronic disease. The Early Assessment and Support Alliance (EASA) is now available in 16 counties to 60 percent of Oregon's population, with numerous other counties at different phases of implementation. 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

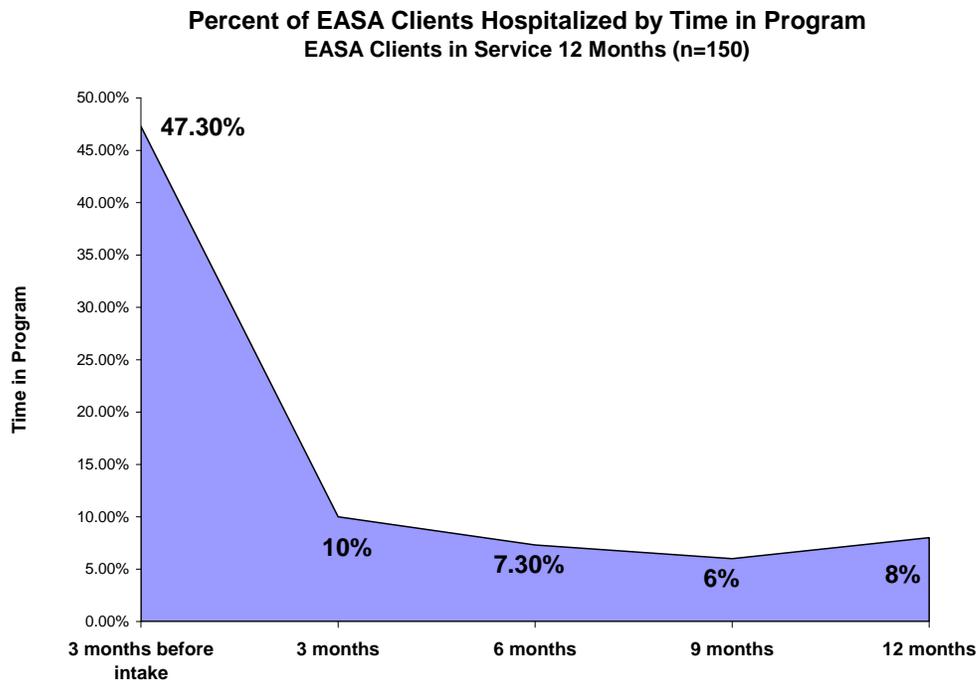
long term, this will have a dramatic effect on the reduced need for more institutionalized and expensive care while promoting recovery and resiliency.

From January 2009 through to December 2011, the programs received 1,376 referrals. Of those 1,376 referrals, 474 individuals and families were accepted into ongoing services with the remaining individuals being referred for appropriate case management and other services and supports. During this time period, EASA served 650 individuals and families. 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 with an additional four counties beginning to incorporate EASA like strategies.
- 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 graph below which shows an immediate 79 percent reduction in hospitalizations.
- 28 percent of EASA clients are under 18, and 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 over, 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.



## Young Adults in Transition

In Oregon and across the country, the age between 14 and 25 has been identified as a critical stage in a person’s life for development of a mental health disorder and other serious illnesses. At the same time, service systems struggle to provide services in a meaningful way to keep a young person engaged or get them engaged in the health care system. There are multiple system barriers that make it difficult for young adults to seek and continue in mental and physical health services and supports. AMH has focused the structural, administrative, financial and clinical barriers to developmentally appropriate services for young people. The goal is to provide access to services that are effective in supporting young adults in transition in gaining the skills to manage their illness, complete their education, gain employment and form healthy, appropriate social relationships. Since we began

this focused work in 2006, the number of 18-21 year olds receiving mental health services through the Oregon Health Plan has doubled.

An additional critical step toward a successful community reintegration is the work being done with Oregon State Hospital to improve services and discharge times for people ages 18-25. AMH has increased critically needed community services and supports through the development of four Young Adult Residential programs, with an additional three programs becoming operational by mid-2013. These programs focus on transitioning young adults into the community and providing them the skills they need to be successful as young adults in their community.

AMH is also working closely with YouthMOVE Oregon, a nationally affiliated young adult run organization, for leadership development, expansion of peer delivered services and training of young people focused upon succeeding while living in their community. Numerous communities now have young adult system specialists and have mobilized their communities to develop specialized services, with some counties developing community drop in centers, and others co-locating services to improve care and accessibility.

### **System of Care Development in Children's Mental Health**

AMH is committed to improving outcomes for children with mental health challenges and their families, promoting the development of Systems of Care to better meet the needs of children, youth, and families. A System of Care is defined as a coordinated network of community-based services and supports characterized by individualized care, and a wide array of services provided within the least restrictive environment, full participation and partnerships with families and youth, coordination among child-serving agencies and programs, and cultural and linguistic competence.

Implemented in 2005, the Children's System Change Initiative (CSCI) created a uniform process to assess the need for intensive services. The CSCI established a structure that utilizes care coordination, administered by Mental Health Organizations (MHOs) as the primary vehicle to accomplish better service integration across systems for children and their families. Those children who meet criteria for the Integrated Services Array (ISA) are referred to an Intensive Community-Based Treatment and Support (ICTS) services provider and assigned a care coordinator who organizes and facilitates child and family team meetings. Strengths, needs, and goals are identified and documented in service plans.

Access to the service array, including more intensive services, is managed locally or regionally with the goal of keeping children and youth in their communities. In cases where that is not possible, the community remains involved with planning and coordinates transitions to and from the community to ensure continuity of care.

Legislation passed in 2009 directs the Department of Human Services, Department of Education, Oregon Youth Authority, and the Oregon Commission on Children and Families to develop an integrated system of care in Oregon. This is being accomplished by collaboration with local communities to deliver coordinated services under a Wraparound planning model yielding more efficient and effective use of resources and positive outcomes for children, youth, and families.

Wraparound utilizes a facilitated team-based, family-driven process to identify the child and family's strengths and needs and formulate collaborative planning that is implemented by team members. It is rooted in Systems of Care values and principles.

The Statewide Children's Wraparound Initiative (SCWI) began in July 2010 with the selection of three demonstration sites: Washington County Wraparound, Mid-Valley WRAP (Marion, Polk, Yamhill, Linn, & Tillamook counties), and Rogue Valley Wraparound Collaborative (Jackson & Josephine counties).

The initial phase of the SCWI has focused on children, from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. Many of these children have a history of adverse childhood experiences, including abuse and trauma, and are at risk for developing emotional, behavioral, and substance use related disorders. Recent data analysis on children receiving services and supports through the project shows that, after 90 days, school performance improves, families receive improved supports, and expressed suicidal/homicidal intent by the children greatly decreases. Children in the project are able to decrease reliance on psychotropic medications within the first ninety days. Forty six percent of the children are also estimated as "improved" by caregivers by the end of just ninety days in the project.

The project demonstration sites are supported by DHS with workforce development training through Portland State University, and ongoing technical assistance from staff in the OHA Addictions & Mental Health division and staff in DHS Child Welfare.

The demonstration project sites will contribute “lessons learned” from the demonstration with the goal of using Wraparound as a foundation to implement System of Care in communities throughout Oregon.

### **The Child Trauma Academy**

The Adverse Childhood Experiences research by the Centers for Disease Control and Kaiser Permanente found a strong, graded relationship between increases in childhood exposure to adverse events and multiple physical and behavioral health problems over the lifespan. The public mental health system serves children and families with traumatic experiences, which impacts their development, relationships and functioning at school or work. AMH contracted with Dr. Bruce Perry, an internationally known neuroscientist and psychiatrist, and the Child Trauma Academy to train more than one hundred individuals at eight sites in “Understanding Traumatized and Maltreated Children.” Fourteen individuals currently participate in the multimedia train-the-trainer program. AMH is developing an increased focus on the effects of psychological trauma and appropriate screening, early intervention, and treatment of individuals who have adverse experiences that are affecting their daily lives.

### **Collaborative Problem Solving**

AMH recognizes the importance of supporting providers and families of children and young adults with challenging behaviors and has anchored training on Collaborative Problem Solving in conjunction with local community partners. With this practice, families and providers assume that “children will do well if they can” and understand that their challenging behaviors results from “lagging skills” rather than defiance or willfulness. The model teaches active collaboration with the child or young person to develop solutions that will work for the individual and those around them regardless of where the child is being supported. This practice is being used in multiple settings including hospitals, clinics, residential programs, schools, juvenile justice, and homes throughout the state.

## **Parent Child Interaction Therapy**

Disruptive behavior, including arguing, disobedience of adult requests, and anger is the most frequent cause of referral of young children to outpatient and inpatient services and is estimated to affect up to 23 percent of young children. Research indicates that parent-child interactions are one of the strongest determinants of the development of childhood behavior problems. Young children with these severe behaviors do not immediately “outgrow” the problem and unless treated, this behavior is likely to persist into adolescence and adulthood.

Four counties in Oregon are funded through the Oregon Children’s Plan to implement Parent Child Interaction Therapy (PCIT) with a focus on serving the Hispanic children and families in proportion to their presence in the county, and to develop a local and statewide training program. PCIT is effective clinically and financially for treating young children’s behavior problems. During sessions, the parents are observed as they play with their child and are coached in treatment skills. Treatment is performance based rather than time limited and does not end until parents demonstrate mastery of the skills and children no longer meet criteria for the disruptive behavior disorder. From April 1, 2010 through March 31, 2011, 244 children and their families received these services.

These innovative methods of improving services and outcomes for adults, children and adolescents will be a major focus of work done by AMH to support the newly-created Coordinated Care Organizations. There is considerable promise that health outcomes as well as mental health outcomes will improve as providers learn to recognize the signs of trauma, treat them effectively throughout the individuals’ lives and effectively assess adults, develop skills improvement and community supports needed for integrated independent living.

### **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.

## ***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. Effective 2011, individuals who have been civilly committed or committed by guardians are eligible for placement in order to better use the secured facility resources.

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

The program opened in Pendleton in early January 2009. The residents come from throughout the state. At this time, AMH is not planning additional state-delivered programs. The goal is to use current facilities more effectively and to serve more individuals in permanent integrated homes with supports to be successful.

### **Who receives services**

Services are provided to individuals under the jurisdiction of the PSRB who no longer need hospital-level care and to those who have either been civilly committed or guardian committed. Providing services to those individuals in the community lowers the census at the Oregon State Hospital. There are 16 people in the program at any one time.

## ***STATE HOSPITAL SERVICES***

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 Except for Insanity.

### **Key Changes at Oregon State Hospital**

#### **New Facility Completed**

A historic event took place in mid-March 2012 when the final patient moves occurred. This project began as the vision of key legislators and stakeholders dedicated to the health, safety and recovery of patients and staff at OSH. The new facility positions OSH well in the pursuit of its vision of Hope, Safety and Recovery for all.

#### **Organizational Structure**

In direct response to the findings of the Liberty Healthcare consultation in September 2010, the organizational chart of the Oregon State Hospital was significantly revised in August 2011, to clearly reflect reporting relationships and lines of authority. These changes include the establishment of a Chief Financial Officer/Chief Operating Officer (oversees all support services), a Deputy Superintendent (oversees Clinical administrators, Security and Family Liaison), a Chief Medical Officer (oversees all Clinical discipline heads, including a new position, Chief of Medicine), a Director of Quality Management (oversees Standards and Compliance, Health Information, Technology Services, Data and Analysis, and Performance Improvement), a Director of Forensics and Legal Affairs (oversees the Legal Affairs Department, Risk Management, Informed Consent, and Forensic Evaluation Services), a Treatment Mall Administrator (oversees the operation of the hospital's six Treatment Malls, where active treatment is provided to patients daily), and a Transition Coordinator (oversees the development of and implementation of plans to occupy the new facility in Salem, as well as the Junction City hospital.)

The hospital leaders now emphasize the importance of holding their subordinates accountable for the successful accomplishment of Cabinet-approved goals and objectives. To resolve one of the Liberty Healthcare report's noted deficiencies, issues of performance improvement have been clearly delineated and separated from issues of compliance. Clearly stated position descriptions have been developed, and an emphasis has been placed on performance evaluations for all staff. Thus, excellent job performance is recognized while deficient performance is identified and resolved.

In order to better organize and focus the work of the hospital Cabinet, the hospital's committee structure has been completely revamped (this was also a noteworthy deficiency listed in the Liberty Healthcare report). Each committee's role and charter was clarified and membership reformulated. In addition, a schedule of committee reports on progress or issues to the Cabinet has been established.

To align clinical services with the hospital's vision, all clinical discipline chiefs now answer to the Chief Medical Officer, who is responsible to assure accountability and coordination of these services. Each clinical discipline head is responsible for the services their staffs provide, and coordination takes place at regular meetings of the Clinical Executives, at the AM Huddle (Report) and in regular, project-based meetings with each other and the CMO.

### **Services provided**

With campuses in Salem and Portland, the Oregon State Hospital (OSH) provides inpatient and residential services with a budgeted operational capacity of 632 beds and a licensed capacity of 712 beds. OSH is accredited by the Joint Commission. Patient unit Butterfly 3 which provides neuropsychiatric 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 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 88 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. Eight beds providing acute nursing care for patients suffering from medical conditions are included on one of the neuropsychiatric 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.

The forensic psychiatric program 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 Psychiatric Security Review Board (PSRB) or the (State Hospital Review Panel) SHRP under the “guilty except for insanity” adjudication. These services consist of 426 beds on 17 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 approximately 26 patients in four cottages. These are transitional units, providing treatment to patients under the jurisdiction of the PSRB or SHRP who have shown substantial improvement in their conditions and require a less restrictive environment in preparation for placement in a community setting.

## **Legal Services Department**

The Department of Forensic and Legal Services was created in September of 2011. Considering that the overwhelming majority of the patient population is at OSH involuntarily by court order, this new department has several responsibilities:

- 1) To implement SB 420 that became law on January 1, 2012. This law created a new process for those individuals adjudicated as “guilty except for insanity” for tier two (non-measure 11) crimes. The jurisdiction for these individuals moved from the PSRB to the Oregon Health Authority. The newly created State Hospital Review Panel (SHRP) is responsible for conducting the statutorily required hearings and making decisions related to whether patients should remain in the hospital or be conditionally released to the community.
- 2) To interface between the hospital and the courts to address and resolve legal matters as they relate to legal sufficiency of court orders, end of jurisdiction issues, court proceedings, etc.
- 3) To provide, through Forensic Evaluation Services, in-patient and out-patient evaluations for individuals admitted to OSH for competency to stand trial or for restoration of such competency.
- 4) To coordinate all legal matters related to risk management, litigation, guardianship, and civil commitment with the Oregon Department of Justice.
- 5) To oversee, through the Risk Review Panel, the granting of privileges to patients as requested by treatment teams, ensuring that risks identified in assessment processes are mitigated and risk management plans that preserve the rights of patients for placement in a less restrictive environment are balanced with protecting the community.

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

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

## **OSH Advisory Board**

The Oregon State Hospital Advisory Board was created in 2009, by Senate Bill 25, and is responsible to:

“(1) periodically conduct a comprehensive review of federal and state laws concerning, and administrative rules, policies, procedures and protocols of the Oregon State Hospital related to, the safety, security and care of patients;

(2) make recommendations directly to the superintendent of the Oregon State Hospital, the Oregon Health Authority Director, the Legislative Assembly or interim committees of the Legislative Assembly concerning:

(a) Federal and state laws concerning, and administrative rules, policies, procedures and protocols of the hospital related to, the safety, security and care of patients;

(b) Performance measures related to the safety, security and care of patients;

(c) Goals for improvement in the safety, security and care of patients of the hospital and improvements that are under way; and

(d) Potential legislative proposals or budget packages related to the hospital; and

(3) report annually to an appropriate committee of the Legislative Assembly regarding the activities of the board.”

The Board meets every other month with the Superintendent and other hospital leaders, and receives information and data on census, admissions, discharges, overtime, seclusion, restraint, aggression, assaults, abuse and neglect, budget, staffing, transition to the new hospital, lean methodology, safety initiatives, electronic medical record, and other pertinent issues. Oregon State Hospital Advisory Board members have been invited to serve on hospital committees and on Performance Improvement Teams as well.

In early 2012, all Board vacancies were filled, after a period of time when as many as four vacancies developed. Nonetheless, the Board has continued to focus on important issues of concern (internal and external), and is a welcome partner in Oregon State Hospital improvement efforts.

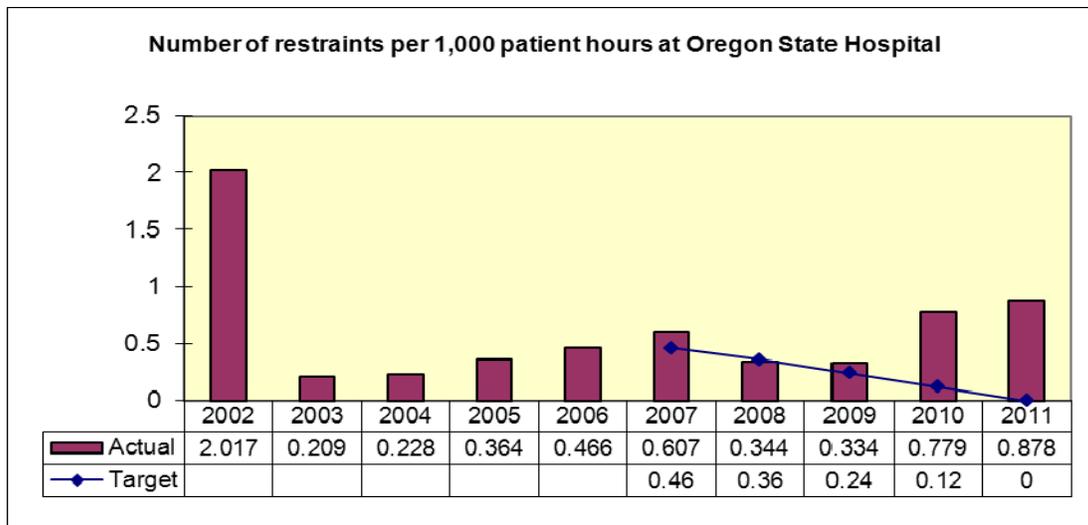
**Performance measures**

***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.

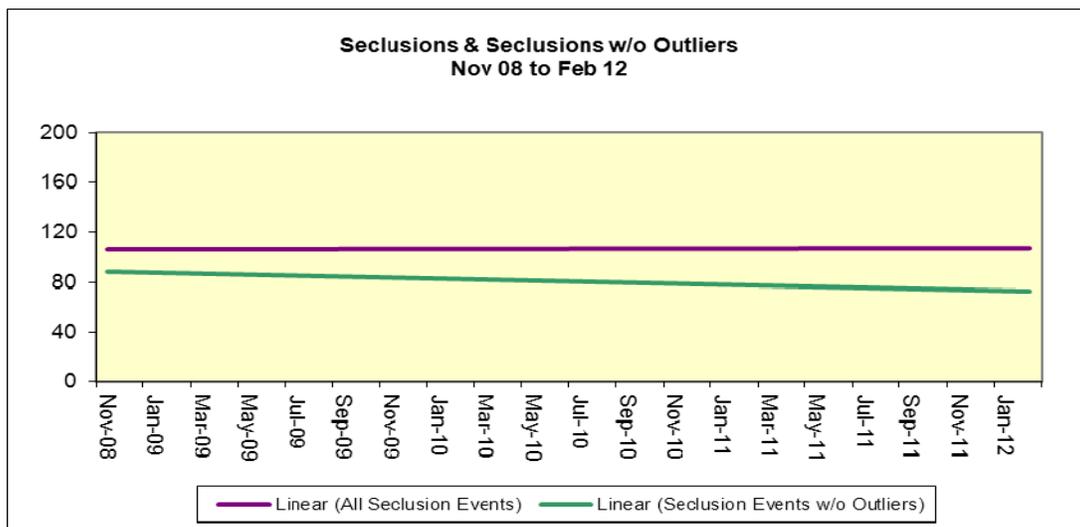
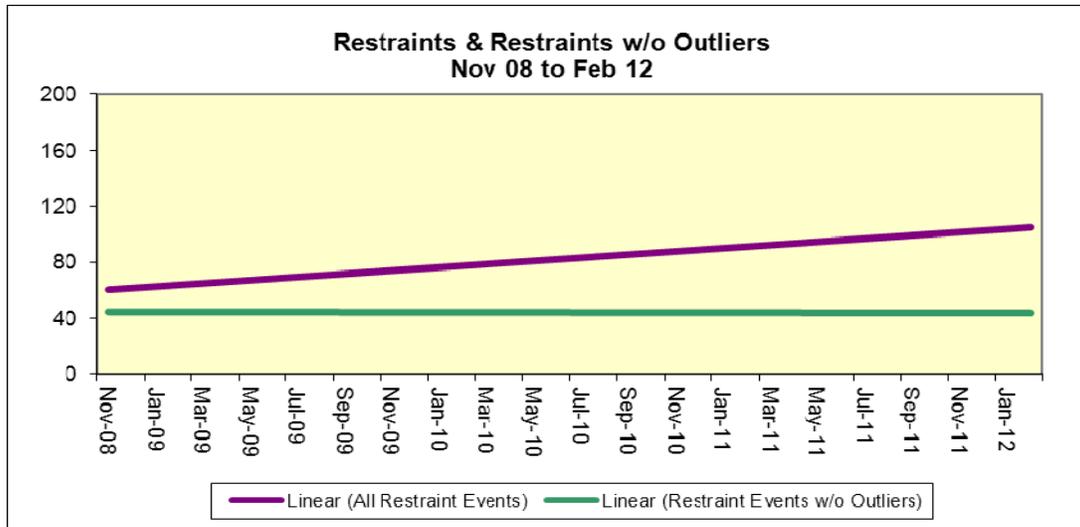
**Results:** OSH saw a significant increase in the use of restraints during 2010, and the numbers remain elevated in 2011. Specific attention has been required by a few patients who have an intractable pattern of violence leading to frequent restraints. Emphasis has been on developing alternative options 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. However, given the 2010 and 2011 elevation, a larger initiative, titled “culture of safety” was begun. It increases options for patients and staff to prevent violent incidents, bringing together strategies for outlier patients and hospital-wide, clinical practices.



## 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.

As noted previously, restraint use increased in 2010 and remains elevated in 2011, driven by a few patients with severely disordered behavior. When these patient outliers are removed from the data, it shows that restraint use has been on a steady decline in the rest of the hospital.



## **Additional Information on “Culture of Safety”**

This initiative brings together current and future projects that affect clinical, behavioral safety. The aim is twofold: 1) assure that all related projects share the same recovery-oriented philosophy and use mutually-reinforcing techniques; and 2) staff has new tools to prevent crises from spiraling into violent incidents. The approach is to consider each restraint use a problem and an indicator of needed improvements.

Examples of existing tools that were reviewed for alignment with our recovery-oriented care model include ProACT training, psychological “Behavioral Support Plans”, and active “Treatment Care Plan” revisions. Examples of new crisis tools that have been implemented include: updating the seclusion and restraint policy to clarify that use of these is a safety measure of last resort, not treatment; making clinical leadership available quickly as consultants on difficult cases; and restructuring the “Critical Incident Review” process, so the organization can better learn from each critical incident. Examples of tools in rapid development include: a “Safe Containment” program to assure that if a restraint is necessary, it is carried out as safely as possible for patients and staff, and a “Safe Together” practice of verbally helping patients regain control when a situation appears to be escalating toward violence.

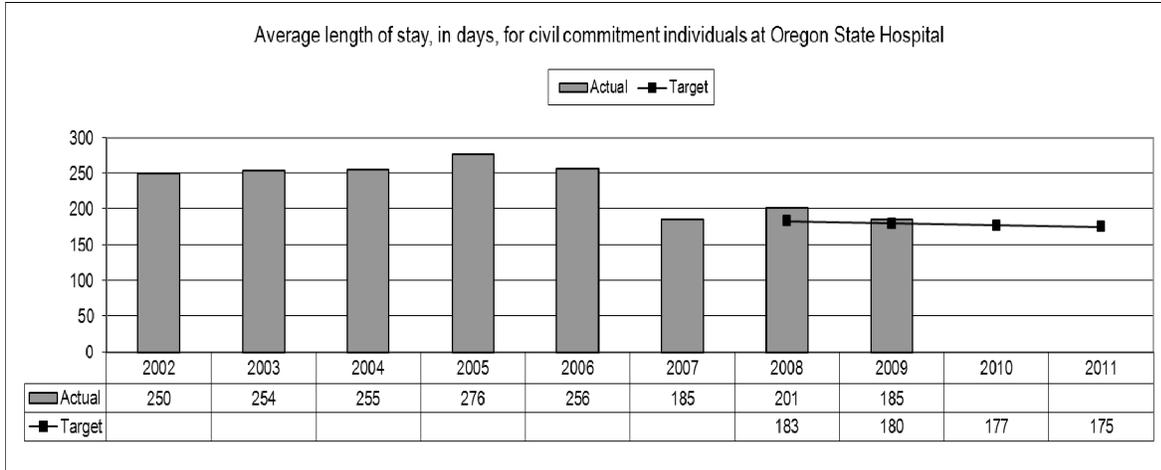
### ***KPM 12: Average length of stay, in days, for individuals civilly committed at Oregon State Hospital***

***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.

***Target:*** The current target for this measure is 180 days.

***Results:*** The length of stay calculated for this KPM is a projected length of stay based on all people currently in the hospital, not just discharges. The projections require some lag before calculations can be done, which is why the report only includes data through 2009. Based on the projections, the length of stay should continue at a low rate.

**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

The recent Joint Commission survey was completed in April 2009. The following is a summary of that survey:

#### Areas for Improvement:

- OSH was surveyed for 2,699 Elements of Performance (EP), and all but 29 were in compliance. OSH was aware of 16 of the 29 elements that were not in compliance and had started working on Plans For Improvement (PFI) to correct them before the survey. Several of the noncompliant areas involved the physical environment, and they were corrected before the survey was finished.
- Some of the identified elements involved the transitions—from paper to electronic health record, from old hospital to new and adding several hundred new employees. The surveyors acknowledged in the exit summary the significant number of transitions and changes OSH experienced and were overwhelmingly positive about these changes.
- Other areas of non-compliance were related to documentation, assessment, and policies needing revision or updates. As the physical environment changed, policies need to be revised to align with those changes.

### Strengths:

- The surveyors noted several best practices on the Treatment Malls, particularly the legal skills groups. They suggested that OSH consider submitting them to The Joint Commission for posting.
- The surveyors found the Treatment Care Plans to be thorough and highly individualized and were impressed with the Treatment Care Plan Specialists, saying this is the first hospital with this dedicated model.
- They were impressed with the effective application of data in Lean Methodology in the Performance Improvement section of Quality Management.
- The Emergency Preparedness Plan, with several staff trained to FEMA and Department of Homeland Security standards received positive comments.

OSH has developed plans to address all areas of non-compliance. The Joint Commission has accepted these plans and granted the hospital full accreditation, effective April 21, 2012.

### **Improved incident reporting and review system**

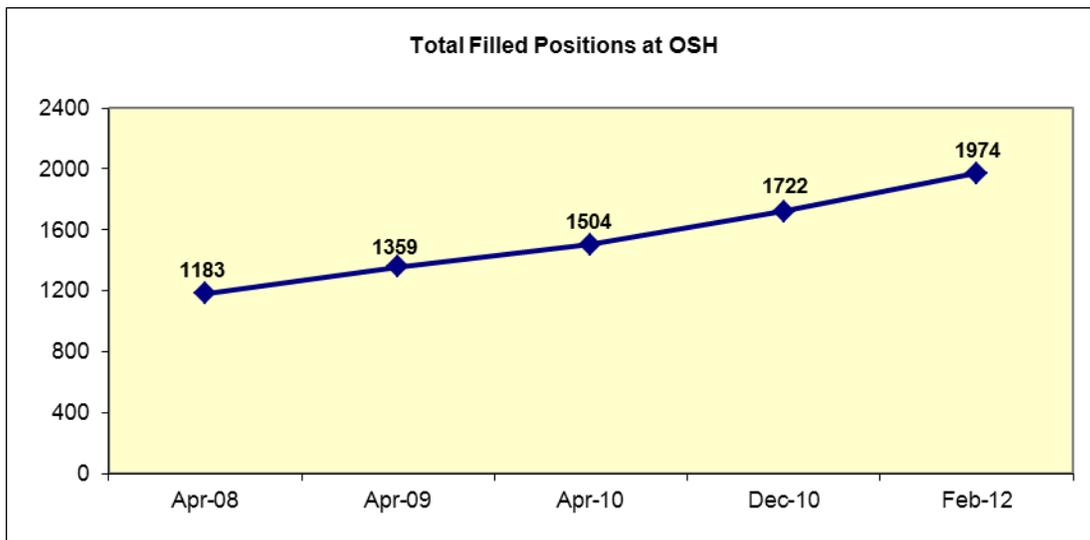
OSH has improved procedures for completing and submitting incident reports. Incidents are reported daily and follow-up, when necessary, can happen immediately. The Critical Incident Review Panel (CIRP) process has been recently updated and meets weekly to ensure incident reports and corrective actions are appropriately and reliably completed. The updated process brings into one meeting all individual cases requiring attention, including reports from the Office of Investigation and Training, Level 3 Incidents and Sentinel Events. Corrective actions resulting from these reports include system changes, such as changes in policies or procedures, clinical changes, such as modification in patient behavioral plans, medication regimens and supervision, as well as personnel actions when individuals' actions require correction.

Where the CIRP process relies on reports from individual incidents, a new Protection from Harm committee has been formed to attend to aggregated critical data. This group complements the individual incident reporting and review system by aggregating harm-related data, identifying potential risks, and monitoring safety issues. Areas of risk are identified as trends, patterns or significant occurrences that pose/may pose a danger or detrimental outcome to patients or the environment.

Once noted, corrective actions made and tracked to ensure they are completed. There is strong alignment between the CIRP and the Protection from Harm committee through shared membership to ensure that issues are reliably coordinated.

### Staffing at OSH

OSH continues to advertise, recruit and qualify candidates for key positions, including direct care nursing staff and other operationally critical positions within the hospital despite a statewide hiring freeze and difficult economic climate.



The Oregon State Hospital has continuously worked within a hiring freeze framework, and a recently implemented statewide hiring freeze, that required additional approvals to hire staff at all levels of the organization. Although this freeze continues today and slows the process for hiring additional and replacement staff, the hospital continues to maintain and/or increase its staffing levels where needed for patient and staff safety and maintains a hospital wide vacancy rate of less than 8.75 percent. With the current economic conditions and the delayed opening of two units and closure of two other units, the hospital has implemented a process to re-distribute direct care staff throughout the hospital to areas of need to address staffing shortages and overtime. Using data collected over the course of several months in late 2011, OSH leadership learned that the greatest contributor to mandatory overtime is staff distribution.

## **Staffing Distribution**

With some minor redistribution of staff, OSH expects to bring about more equity in staffing to each unit and shift, which is expected in turn to have a major impact on the amount of overtime expenditures. Union and Nursing leadership worked together to create a staffing plan which distributes staff across all units and shifts where needed. A plan was developed to move staff according to the grid. The implementation is currently in progress, and staff were re-distributed by late spring 2012.

## **Work Schedules**

During the spring of 2012, OSH nursing staff will begin moving to new work schedules, designed to ensure that every unit has the proper number of staff for every shift, as well as reduce the amount of floating between units. The majority of staff will have two options to choose from, and it is expected that the new schedules will benefit patient care and staff satisfaction in many ways including:

- More cohesive teams on the units and continuity of care for patients; the same groups of staff will be working together at all times;
- Reduction in overtime and call-ins as a result of staff having 4-days off in a row or weekends off;
- Increased ability to provide training for staff with the overlap from the Monday through Friday, and weekend schedules on Fridays and Mondays;
- Increased ability to fulfill leave requests without creating the need for overtime by encouraging staff to look at Mondays and Fridays where the two schedules overlap.

## **Staff and Stakeholder Communications**

In order for the OSH to more easily fulfill its mission, it is important and necessary that there be regular communication with important stakeholders, especially patients, families, staff (including Union leaders), and advocacy groups. The commitment of OSH leadership to step up the communications has produced a genuine sense of collaboration, as efforts to improve the hospital's performance advance.

Specifically, a series of “general staff” meetings, held quarterly, has also been implemented on all shifts, so that hospital leaders can share important information and solicit input and feedback. Written communications in various forms like the Recovery Times, Superintendent’s messages, Spotlight on Excellence, and other departmental newsletters, have contributed to the efforts toward improved communications across the organization.

Labor-Management meetings have faithfully taken place on a regular basis, and have proven to be invaluable in identifying and resolving a number of significant issues. The collaboration between Union leaders and hospital leaders has been remarkable.

Also, the Superintendent has attended every meeting of the OSH Consumer Council for the past eighteen months to hear and address patient concerns, and to share information of importance.

A program of Town Hall meetings, where family members are invited to meet with hospital leaders to receive important information and provide feedback has also been established. Additionally, several hospital leaders (including the Superintendent, the Chief Medical Officer, and the Chief of Medicine) have served as speakers at a number of community-based National Alliance on Mental Illness (NAMI) groups.

The solid collaboration between hospital leaders and staff, patients, Union leaders, families and other advocates has helped to shape the positive direction noted at Oregon State Hospital since 2010, and more progress is anticipated in the future.

### **Office of Investigations and Training (OIT) reporting**

For years, one of the chief complaints of patients, advocates, and, especially staff, had to do with the inordinately slow process of beginning and completing investigations into allegations of abuse and neglect. In early 2011, OSH and OIT implemented a strategy that provided the on-site presence of an investigator 20 hours a day, seven days a week. Thus, allegations are reported easily and quickly, the investigation begins in close proximity to the event, and is completed within the required 30 days in a high percentage of cases. It must be noted that the availability of video cameras in all common areas of Oregon State Hospital has greatly facilitated this work.

## **Person-centered treatment planning**

A Performance Improvement Team related to Person Centered Care was approved by the OSH cabinet in 2011. This Team is multi-disciplinary and includes consumers, consumer advocates, family members and treatment providers and is tasked with defining Patient Centered Care and how this approach is translated into our practices at every phase of hospitalization from admission to discharge.

## **Improvements in Medical Care**

Within the last three years, Oregon State Hospital has made the commitment to increase medical services provided to patients. As a result, there has been a marked reduction in the number of patient days for admissions to Salem Hospital; a metric that OSH is now in the process of tracking.

There has been continued expansion in the number of medical physicians and medical nurse practitioners at the Salem and Portland campuses. Including the Chief of Medicine, there are now 15 medical professionals providing care. There are also five licensed practical nurses assigned to the Medical Clinic in order to assist with the coordination of patient care.

The Medical Clinic at both campuses is open for patient care Monday through Friday, from 8:30 a.m. to 4:30 p.m. There is also medical-pager coverage for both campuses during all hours when the Medical Clinic is closed. This provides around the clock emergent medical consultation for psychiatrists on call.

Classes concerning Metabolic Syndrome (Hypertension, Hyperlipidemia, Obesity, and Diabetes Mellitus) are being run on all of the Treatment Malls for patients that are at risk for Metabolic Syndrome. These are taught by a multi-disciplinary team, including the Chief of Medicine, Medical Nurse Practitioners, Clinical Pharmacists, and Dieticians. The ultimate goal of these groups is to prevent complications from Metabolic Syndrome such as heart attacks and strokes.

The Chief of Medicine performs staff education concerning medical emergencies during Grand Rounds lectures. Topics that have been presented on thus far include Management of Cardiac Emergencies, Management of Respiratory Emergencies, Management of Neurologic Emergencies, Code Blue and Emergency Medical Response, as well as Pain Management at the End of Life. Medical education

seminars concerning the management of acute and urgent medical issues will continue during Grand Rounds.

Oregon State Hospital is currently implementing hospital-wide education concerning Code Blue Medical Emergencies. This pertains not only to responding to medical emergencies, but also recognizing the signs and symptoms of clinical deterioration. Medicine, Nursing, and Security have worked collaboratively to develop this protocol and training. Once training has been completed, performance improvement initiatives to improve delivery of emergent medical services will be undertaken.

Additionally, there have been meetings with Salem Emergency Medical Service providers, leading to the development of several Medical Staging Areas throughout the new hospital to facilitate transportation of patients in need of urgent and emergent medical care.

### **Electronic Health Record - Avatar**

November 2011 marked the official launch of the Avatar electronic health record at Oregon State Hospital. The work toward completion of the system and full integration into the business flow, treatment care planning for patients, and organizational reporting for compliance and data-informed decision making, continues, and Avatar is expected to be fully implemented during the 2011-13 biennium.

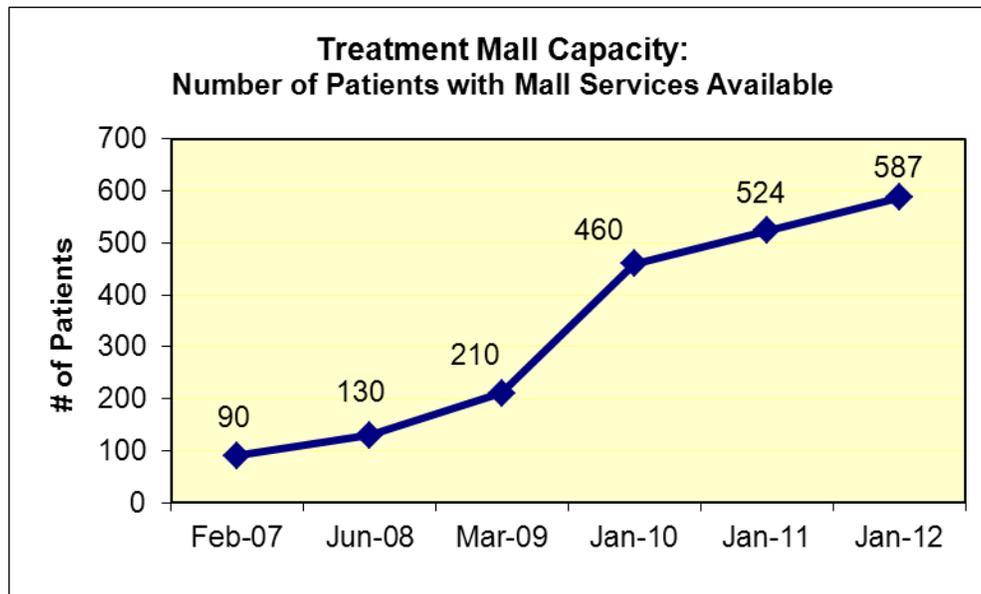
### **Centralized treatment malls**

A fundamental element of the hospital's treatment care planning is delivering centralized services at treatment malls. Five treatment malls now provide active treatment to a majority of OSH patients. The chart below shows the steady increase in the mall capacity to serve patients. Treatment mall capacity has grown steadily over the past five years, and is now available to serve all OSH patients.

To insure treatment at Oregon State Hospital is of the highest quality and serves patients as well as possible, Curriculum Oversight Committees have been chartered and started April 2012. The primary goals are as follows:

- Insure programs are evidence based or best practice;

- Insure programming in each mall meets the patient’s recovery needs;
- Insure competencies of group facilitators; and
- Maintain a library of current and all approved programs.



- 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

### **OSH Excellence Project**

The Oregon State Hospital Excellence Project was launched in December 2010 to help OSH with organizational cultural transformation and address the findings noted in the Liberty Healthcare report. Consulting firm Kaufman Global was awarded the Excellence Project contract, and implementation was completed in June 2011. Kaufman Global used Lean methodology as a foundation to fundamentally change the way the hospital operates and the way the hospital makes and sustains improvements.

As part of this effort, Kaufman Global trained the OSH Cabinet and all management staff with a general Lean overview designed to support and solidify a new continuous improvement culture. In addition, the OSH Cabinet participated in a variety of successful rapid process improvement events, ranging from creating the OSH Vision, Mission, Values and Goals to the creation of the leadership structure and governance to manage hospital improvement projects.

## **Performance Improvement**

The OSH Office of Performance Improvement was created in June 2011 to sustain the momentum created by the OSH Excellence Project and to further equip OSH staff with Lean Methodolgy. Performance Improvement plays a critical role in supporting the business needs of OSH. Lean Leaders conduct Rapid Process Improvement events (RPIs), Work Team Initiatives (WTIs), or Performance Improvement Teams (PITs) designed to increase the efficiency and effectiveness of hospital processes. The events are charted and prioritized through the OSH Cabinet which is led by the OSH Superintendent.

Lean Leaders are also responsible for equipping hospital staff with Lean continuous improvement tools and methods to sustain the new continuous improvement philosophy and to meet the operational demands of the new executive level governance structure. The OSH Cabinet "pulls" Lean Leaders as a resource to facilitate, coordinate, and lead improvement events, with an eye on rapid and sustainable improvements.

Lean Leaders provide ongoing Lean training for all OSH staff and lead the implementation of the Lean Daily Management System (LDMS); a systematic method for teams to measure and manage the work in their given units. LDMS is currently being implemented in 73 percent of the hospital. Lean Leaders provide LDMS training, implementation, and coaching across the organization to ensure that workgroups are measuring daily work with targets that are aligned with the OSH Vision, Mission and Goals.

## **Implement SB 420 – 2011 Legislative Session**

The 2011 legislative session passed SB 420 with an effective date of Januray 1, 2012. The law created two tiers of offenders who were or are found guilty except for insanity. Those who commite Tier One crimes, such as aggravataed murder or other Measure 11 crimes, remain under the jurisdiction of the Psychiatric Security

Review Board (PSRB). Those who commit lesser crimes – not Measure 11 – are now under the jurisdiction of OHA and are subject to hearings and determination processes conducted by the State Hospital Review Panel (SHRP). When the SHRP determines the individual is ready for conditional release, the jurisdiction in the community is under the PSRB.

### **Key budget drivers and issues**

A key issue for OSH is to provide excellent patient care and safety all while living within its biennial funding allocation. While spared budget cuts in the 2009-11 biennium, in 2011-13, OSH like other state agencies living with a slow-recovering state economy, is living with reductions in its operating budget where positions within its budget authority are not fully funded.

OSH leadership is focused on finding the right mix of staff to fill its most critical vacancies, with limited funding, that will ensure at least 20 hours of active psychiatric treatment is provided to patients, all while ensuring the operating efficiency of the hospital is maximized and OSH remains financially solvent throughout the 2011-13 biennium.

The key driver for the OSH budget is the reliance on overtime and nurse agency staff to ensure the provision of at least 20 hours of active psychiatric treatment per week is delivered to patients on an ongoing basis. OSH leadership is implementing a variety of management action items to redistribute staff, modify work schedules, and merge patient units together to maximize efficiencies and drive down the costs of overtime and nurse agency spending in the 2011-13 biennium.

### ***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. All 60 beds at BMRC are certified by the Centers for Medicare and Medicaid Services (CMS).

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; group 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, Psychiatric Mental Health Nurse Practitioners, local community medical providers and local hospitals.

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

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

### **Who receives services**

Blue Mountain Recovery Center 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**

Blue Mountain Recovery Center 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 155 admissions and discharges per year. This represents more than 17,000 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.

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.

## **Challenges**

Upon the completion of the second State Hospital in Junction City, BMRC is scheduled for closure. Early closure of BMRC has been considered for budgetary reasons every two years. OHA is working with Eastern Oregon stakeholders to consider the repurposing of BMRC resources when the facility closes.

Due to the rural Eastern Oregon location and the uncertain future of the hospital, BMRC has experienced difficulties in recruiting and retaining medical personnel and relies on a team of contracted physicians and Psychiatric Mental Health Nurse Practitioners to provide client care and treatment.

Blue Mountain Recovery Center was built in 1948 as the admission and treatment building for the 1,000+ bed Eastern Oregon State Hospital (now Eastern Oregon Correctional Institution). The physical lay-out of the BMRC necessitates most clients sharing a bedroom with three other individuals – a situation that is not optimal for a person’s recovery.

In 2011, BMRC was surveyed by the Center for Medicare and Medicaid Services (CMS), the Oregon Health Authority Public Health Division and the State Fire Marshal office. The State Fire Marshal’s report revealed repairable problems with

the facility's fire sprinkler system and electrical system among other general maintenance issues. All deficiencies cited by the State Fire Marshal have been or will be resolved in 2012, but the 64 year old facility will eventually need a major renovation, including building a new kitchen and modifying the residential units so clients have more privacy.

## ***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 Director for AMH supervises the state hospitals and the project to build the second new state hospital in Junction City. The Director 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;
- Providing leadership and policy direction for mental health and addictions services as the Oregon Health Authority transforms health care for the Medicaid-eligible population;
- 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;
- Providing technical assistance to community programs;
- 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.

The following description is based on the March 2012 Structure of AMH. Both AMH, due to major system changes, and the OHA, due to health care transformation, are in the midst of looking at organizing work base on critical core processes that directly relate to supporting the new Coordinated Care Organization and achieving the agency's goals of better health, better care and lower costs. It is expected that there may be structural changes as a result of this work as well as the need to flatten the structure to accommodate the major budget reductions taken in the 2011-13 biennium during both the 2011 and 2012 sessions of the Legislature

## **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 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 residential programs and services unit is responsible for the development of alcohol and drug-free housing and new community-based resources to treat adults with mental illness who are ready to be discharged into the community;
- Ensuring linkages between the state hospitals and communities and that people with mental illness live in the most integrated community setting possible; and
- The children's treatment system unit provides oversight, development, training and technical assistance to maximize the effective treatment of children in their home communities through the community-based system.

As of early 2012, 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.

- 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 306 programs and certify 640 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.

The director of AMH provides leadership and executive management to the Oregon State Hospital Replacement Project (OSHRP). For the next biennium, the focus of the project will be the completion of the design and construction of the 174-bed hospital in Junction City.

Program analysis and evaluation staff were recently moved to the new Office of Health Analytics. While the lines of authority have changed, they continue to work directly with AMH 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.

### **Initiatives**

AMH leadership provides direction and accountability for major initiatives to test or implement changes in the community-based treatment system and to change the state infrastructure to support more flexible and accountable ways of treating people with substance abuse and mental health disorders.

### **Strategic Prevention Framework State Incentive Grant (SPFSIG)**

AMH is currently implementing a five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) through working partnerships between the state and communities. The three SPF SIG goals are to: build prevention capacity and infrastructure at the state and community levels; reduce substance abuse-related problems in communities; and prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. Oregon's priority for the SPF SIG is high-risk drinking among 18-25 year olds, ultimately leading to the reduction of alcohol abuse and dependence.

## **Access to Recovery (ATR)**

In 2010, OHA/AMH was successful in securing a four-year \$3.3 million per year competitive federal grant award, Access to Recovery. This is a major federal initiative supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Oregon Access to Recovery (OR-ATR) has been implemented 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 guidance and support, and other services. OR-ATR is designed to increase access to substance abuse services emphasizing 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. As of April 9, 2012, ATR has served 3,342 individuals, which is 115 percent of target. We have completed six months follow-up interview with 832 individuals. Follow-up interviews show significant improvements for participants, particularly in two areas: Employment/Education: At intake, 25.2 percent were currently employed or attending school, and 6 months post intake that increased to 46.9 percent; Housing: At intake, 32.5 percent had a permanent place to live in the community, and six months post intake that increased to 57.7 percent.

## **AMH System Change**

The AMH System Change work is designed to integrate addiction and mental health treatment services and provide flexibility to local communities to enable them to better serve people with addictions and mental health needs. These improvements will be supported by flexible funding, allowing counties the discretion to put resources where they are most needed to serve people in their communities. The budgeting flexibility will be balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served.

From the start, the AMH System Change work engaged community stakeholders and partners. The work began with drafting system change principles with representatives from the Association of Oregon Counties (AOC) in June 2011, and since has continued with multiple advisory activities with stakeholders and partners. Participants representing consumers of mental health services, individuals

in recovery, outpatient providers for addictions and mental health, acute care hospitals, AOC, Association of Community Mental Health Programs, prevention programs, and other diverse groups continue to advise AMH in the design and implementation of the AMH System Change through structured advisory opportunities and contacts with key informants with critical expertise. The diversity and longevity of the engagement will result in developing a person-centered, strengths-based system of care in Oregon.

There will be changes in the manner in which AMH conducts business and approaches the work with the counties. There will be a shift in emphasis to contract compliance and technical assistance related to effective, evidence-based practices. One way that AMH is managing the changes from within the agency is by readying the staff to support the new processes required to operate a high functioning behavioral health system. Staff members are examining existing functions, looking at maintaining only what needs to be continued, while developing new, consolidated business practices. The goal is to increase efficiencies and decrease internal and external administrative burdens.

### **1915(i)**

1915(i) Medicaid home and community-based state plan amendment (SPA). The SPA was approved in February 2012 and creates a new approach to community-based treatment for people with serious mental illness and a need for daily service contact. The amendment will make an expanded array of services available in community-based settings to better meet the needs of consumers and allow the state to simplify the billing and documentation requirements for providers. The results of this initiative will support Oregon's efforts to serve people in the most independent setting.

## **Legislative Initiatives Carried Out**

### **HB 3100**

House Bill 3100 passed July 1, 2011, requiring all psychiatrists and licensed psychologists to be certified by January 1, 2012, in order to perform forensic evaluations for the purposes of competency and criminal responsibility. The forensic certification program is under the authority of Addictions and Mental Health and was established by Oregon Revised Statute 161.309-161.370 and 419C.524 and is administered under Oregon Administrative Rules 309-090-0010

through 309-090-0090. These rules identify types and requirements of certification, the required content of evaluations, a Review Panel process for submitted evaluations, and requirements of the Forensic Evaluator Training Program. Currently 110 applicants have been granted temporary certification until they complete the training and have three redacted forensic evaluations reviewed by the expert review panel. When all requirements are met, full certification will be granted. AMH is currently working with a training team at Pacific University and Northwest Forensic Institute to finalize the training curriculum. Two trainings will be held in July and August. The goal of this certification is to provide standardization to the forensic evaluation process when determining if an individual is able to aid and assist in his/her own defense or criminally responsible at the time of committing a crime.

The legislation allows people found guilty except for insanity of a misdemeanor to be treated in their local community as long as they do not present a substantial danger. In that case, they can be court-mandated to OSH. This process is also a possibility for persons committing a Class C Felony (nonperson crime).

### **SB 420**

Senate Bill 420 (2011) went into effect on January 1, 2012. The law created two tiers of offenders who were found guilty except for insanity. Under SB 420, “tier one” offenders remain under the jurisdiction of the PSRB, and the Oregon Health Authority acquires jurisdiction over “tier two” offenders who are in OSH. After a “tier two” offender is conditionally released, jurisdiction of tier two offenders transfers to the PSRB for monitoring and supervision in the community.

The Oregon Health Authority created the State Hospital Review Panel (SHRP) to provide due process to tier two offenders under its jurisdiction. SHRP is made up of a psychiatrist, a psychologist, an attorney, a probation officer, and a public member. The OSH Legal Affairs Director - a paralegal and a legal secretary - support the hearings conducted by SHRP by: gathering exhibits, arranging for witnesses, sending out notices, and communicating with patients, attorneys, and community partners. SHRP and its OSH staff endeavor to make the process as efficient as possible with the goal of moving patients determined to be ready for discharge and/or safe for release into the community as soon as possible.

After reviewing exhibits and testimony at formal hearings, SHRP determines when it is appropriate to discharge or conditionally release tier two patients. SHRP

balances the goals of the Americans with Disabilities Act to place mentally ill people in the least restrictive settings with the goals of public safety. It does this by determining whether the person:

- (a) Is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others;
- (b) Is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release; or
- (c) Has not recovered from the mental disease or defect, is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision.

**ORS 161.346(1).**

On January 1, 2012, the PSRB transferred 120 patients to the jurisdiction of the Oregon Health Authority's SHRP. Since that time SHRP has scheduled and conducted hearings in accordance with the statutory timelines.

When a patient is "conditionally released," the patient is released into the community and transferred to the jurisdiction of the PSRB. SHRP has conditionally released 12 patients, and approved two additional patients for conditional release who will be released when a bed becomes available for them in the community. SHRP has ordered that community evaluations be conducted for 26 patients. Before a patient may be conditionally released, a community evaluation must be conducted.

Occasionally, a person is discharged because SHRP determines that the person no longer meets the statutory criteria for jurisdiction (such as they do not have a major mental illness Axis 1 diagnosis, or they are no longer a danger to others). As of August 2012, SHRP had discharged seven individuals because they no longer meet the criteria for jurisdiction.

As of August 2012, SHRP has 118 OSH patients under its jurisdiction.

**Community Placement Budget Note**

During the 2011 session, a budget note to SB 5529 directed the Oregon Health Authority (OHA) to work with the Psychiatric Security Review Board (PSRB) to

determine the need for community placements for PSRB patients at the Oregon State Hospital for whom a hospital level of care is not necessary on an on-going basis. The note also directed OHA to develop recommendations for the potential need for additional 16-bed residential facilities as well as other types of facilities. The full joint report between OHA and PSRB is available at: [www.oregon.gov/OHA/legactivity/](http://www.oregon.gov/OHA/legactivity/) and was reported to Ways & Means in February of 2012.

AMH convened a workgroup to review data on 43 patients eligible for conditional release and facilities from a snapshot in time: September 1, 2011. The findings are as follows:

1. No additional 16-bed Secure Residential Treatment Facilities (SRTFs) are needed at this time. Based on the data reviewed, there is not a need to add additional SRTFs to the current capacity due to the patients' needs for placement upon discharge.
2. There is an immediate need for additional residential medical facilities to serve those persons who have significant medical needs. Future residential medical facilities must be staffed to include the medical skills to treat those consumers requiring medically-informed services. Future development will need to ensure that the medical needs of those persons leaving OSH are met.
3. There is a need for development of additional Residential Treatment Facilities (RTFs)/Residential Treatment Homes (RTHs) in proximity to the current SRTFs to assist in moving people to a lower level of care. Currently there are areas in the state where these lower-level facilities do not exist.
4. There is a need for current facilities and community residential providers to provide specific and specialized treatment (e.g. sex offender treatment) in facilities that currently treat other mental health needs. This will allow current providers to meet the needs of those being discharged while simultaneously meeting the community demand for services.
5. There is an immediate need for dedicated "crisis respite" facilities as part of the continuum of care located regionally at a minimum and preferably by county in those counties serving the greatest numbers on conditional release. This would allow the PSRB to use these facilities to avoid revocation, thereby maintaining people in the community with the necessary services and supports.
6. There is a need for additional Intensive Case Management and Assertive Community Treatment and the associated community supports and housing.

OHA will use these recommendations in future budget planning and will develop strategies to implement the recommendations identified by the workgroup.

### **Mental Health & Criminal Justice Budget Note**

During the 2011 session, a budget note to SB 5529 directed that the Oregon Health convene a statewide workgroup to identify the needs of people who are involved in the criminal justice system for minor violations, who have mental illness and could be placed more appropriately in settings where they could receive mental health treatment. The group is expected to develop recommendations for methods to divert this group from jails to appropriate and effective mental health care in the community. This report should be prepared for consideration in the 2013 legislative session.

AMH is in the process of collecting data from local criminal justice systems to identify individuals that would fall in the category required in the budget note. AMH is also identifying and reaching out to stakeholders that would be interested in participating in the workgroup.

### **Infrastructure Changes**

AMH, as part of the Oregon Health Authority, is in the midst of health care transformation and restructuring the community-based treatment system for people who are not eligible for Medicaid but have substance abuse, problem gambling, and/or mental health disorders. In order to implement and manage systems that have greater flexibility to deliver services that improve health outcomes and health care experiences while lowering costs, the OHA and AMH processes, ways of working and structure must change as well. These changes are also necessary given the financial challenges and the need to flatten the management structure. Nearly all AMH staff are engaged in accountable work groups to do a wide range of tasks to support these major changes. The tasks include, but are not limited to: work to ensure smooth transitions for members from the current OHP structure to CCOs, rewrite a single contract for CCOs to ensure both flexibility and increased accountability, define OHA and AMH core processes to support the transformation of service delivery, define Medicaid global budgets, define non-Medicaid flexible funds for non-Medicaid services and work with consumers and families to continue the improvement and focus of services for children, their families and adults with substance abuse, problem gambling and/or mental health disorders.

Flexibility and increased accountability must be supported by a modern data system to administer contracts, to collect critical data for system compliance, contract management, monitoring outcomes and supporting public providers to use electronic behavioral health records.

### **COMPASS Project**

To adapt and thrive under Oregon's Health System Transformation, the Addictions and Mental Health Division (AMH) is implementing a comprehensive behavioral health electronic data system that will interface with other health information systems in an effort to improve care, control cost and share information. The COMPASS project is a collaborative information technology approach to the administration, planning and monitoring of behavioral health programs and supports our ability to track performance outcomes, population served, and the cost effectiveness of services. The three main components of the project – an electronic health record (EHR) system, contracts administration, and data collection – will allow AMH to successfully account for these measures.

Currently, AMH has piloted the EHR with eleven providers and will add six new providers in spring 2012. The contracts administration business requirements are being determined, and the new contracts system will be piloted in fall 2012, with full implementation July 2013. Full implementation of the data collection component is planned for spring 2013. The contracts system replaces technology that is twenty-years-old and is unsupported since the company no longer exists. The data collection component replaces two more-than-thirty-year-old mainframe systems that are inflexible and impractical to reprogram to provide the data needed to manage behavioral health services in the 21<sup>st</sup> century. This was discussed with the Legislature during the 2011 session.

# **CAPITAL CONSTRUCTION**

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## ***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 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 released a report in 2004 recommending changes to OSH.

Ongoing concern about the hospital prompted the November 2004 Legislative Emergency Board to allocate funds to DHS/OHA 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 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/OHA 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 was completed in December 2011, and the Junction City facility is scheduled to be completed at the end of 2014 with patients moving in early 2015. Both are designed, 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. This reduction is achieved by recommending an additional 186 beds in the community to serve those individuals whose needs can be met at a lower-than-hospital level of care.

Although the historic state hospital 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**

The Salem hospital was completed in December 2011 and the Junction City hospital is scheduled to be completed by the end of 2014. Site preparation work for Junction City construction is under way.

### **Centralized treatment model**

The design of the hospital supports the delivery of centralized services at treatment malls within the secure perimeter.

The entire design of the facility supports patients participating in active psychiatric treatment and having sufficient privacy and personal space.

The hospital, replacement project, through the replacement project's Behavioral Health Integration Project (BHIP), began the use of the Avatar Electronic Health Record in November 2011. The work to complete the full implementation of the hospital management system and full integration into the business flow, treatment care planning, and reporting for organizational compliance, and data-informed decision making will be completed in the 2011-13 biennium. Work will be ongoing with additional systems that work with the electronic health record.

### **Challenges**

There are a number of cost drivers that may affect the financial bottom line of this project. The major one influencing the costs for Junction City is the additional 100,000 square feet of treatment space to support twenty hours per week of active psychiatric treatment and the staff to carry out this mandate.

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.

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/OHA to proceed with construction of facilities in Salem and Junction City.

Construction of the replacement hospital is financed with Certificates of Participation (COP) and General Obligation Bonds (GOB) requiring accurate and specific recording and accountability for expenditures of COP/GOB proceeds. COP/GOBs 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 more than \$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 approximately \$50 million in COP/GOB sales for the project as a whole. We continue to work on this issue by looking for additional construction savings.

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 individuals committed under forensic statutes.

## **Opportunities**

### **Junction City**

The major opportunity in Junction City is realized by the analysis, based on more recent data, of the original assumptions that there is a need for 360 hospital beds. In January 2011, OHA presented an analysis that indicates additional patients under the PSRB and those currently served in the neuropsychiatric program could be served in the community with proper investment, leaving a need for 174 beds at Junction City. In addition to the current partnership with Department of Corrections (DOC) for site preparation, AMH is examining opportunities in the design of the Junction City facility that could allow for alternate uses if the future need for state hospital level of care decreases and support for community services increases.

### **Reusable materials**

Throughout the project, OSH staff found many reusable materials from previous construction and maintenance projects were being transferred to the general contractor for use on the replacement project, resulting in a cost reduction for the project of more than \$100,000 to date. Examples of such items include fencing materials, electrical wire, drainpipe and electric gates. Some construction materials and equipment purchased for the Salem site will be reused at the Junction City site.

### **Behavioral Health Integration Project**

The completion of the BHIP project with the full implementation of Avatar at the Salem site will make an operational electronic health record and hospital management system available at minimal added cost for Junction City.

### **Value engineering study**

The benefits to the cost-containment of the Salem project will be continued and other value engineering opportunities will be incorporated into the design and construction of Junction City.

### *Summary*

Replacing the Oregon State Hospital is critical to growing a mental health system of care, which has been a priority of the governor, the legislature, and the agency director. 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 created a project that meets its state mandate to build a hospital on the existing OSH Salem site and 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.