Oregon

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 09/01/2015 5.24.30 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State SAPT DUNS Number

Number	964093350
Expiration Date	8/17/2016

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Oregon Health Authority
Organizational Unit	Health Policy and Analytics
Mailing Address	500 Summer Street NE E-65
City	Salem
Zip Code	97301-1118

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Pamela A.
Last Name	Martin
Agency Name	Oregon Health Authority Health Policy and Analytics
Mailing Address	500 Summer Street NE E-65
City	Salem
Zip Code	97301-1118
Telephone	503-945-5879
Fax	503-945-5872
Email Address	pamela.a.martin@state.or.us

State CMHS DUNS Number

Number	964093350
Expiration Date	8/17/2016

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Oregon Health Authority
Organizational Unit	Health Policy and Analytics
Mailing Address	500 Summer Street NE, E-65
City	Salem
Zip Code	97301

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Pamela A.
Last Name	Martin
Agency Name	Oregon Health Authority Health Policy and Analytics
Mailing Address	500 Summer Street NE, E-86

City	Salem
Zip Code	97321
Telephone	503-945-9727
Fax	503-945-5872
Email Address	pamela.a.martin@state.or.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	7/1/2013
To	6/30/2014

IV. Date Submitted

Submission Date	8/31/2015 4:58:34 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Jackie
Last Name	Fabrick
Telephone	503-756-2822
Fax	503-945-5872
Email Address	jackie.fabrick@state.or.us

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Pamela A. Martin , Ph.D., ABPP

Signature of CEO or Designee[1]: _____

Title: Behavioral Health Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

KATE BROWN
Governor

August 19, 2015

Virginia Simmons, Grants Management Specialist
Division of Grants Management OPS
SAMHSA
1 Choke Cherry Road, Room 7–1091
Rockville, MD 20857

RE: Oregon's Combined Block Grant Application

Dear Ms. Simmons:

This letter is regarding the state of Oregon's combined application for funds under the Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. I have designated the Behavioral Health Director for Health Policy and Analytics, Pam Martin, Ph.D., ABPP, to sign the set of agreements that certify Oregon's compliance with requirements for receiving the Block Grants on my behalf.

Sincerely,

Governor Kate Brown

c: Thomas Long, MA, MHSA, SAMSHA
Ernest Fields, SAMHSA
Lynne Saxton, OHA
Pamela A. Martin, Ph.D., ABPP, OHA
Jackie Fabrick, OHA
File

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Pamela A. Martin , Ph.D., ABPP

Signature of CEO or Designee[1]: Pamela A Martin

Title: Behavioral Health Director

Date Signed: 08/24/2015
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Pamela A. Martin, Ph.D., ABPP

Signature of CEO or Designee[1]: _____

Title: Behavioral Health Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

KATE BROWN
Governor

August 19, 2015

Virginia Simmons, Grants Management Specialist
Division of Grants Management OPS
SAMHSA
1 Choke Cherry Road, Room 7–1091
Rockville, MD 20857

RE: Oregon's Combined Block Grant Application

Dear Ms. Simmons:

This letter is regarding the state of Oregon's combined application for funds under the Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. I have designated the Behavioral Health Director for Health Policy and Analytics, Pam Martin, Ph.D., ABPP, to sign the set of agreements that certify Oregon's compliance with requirements for receiving the Block Grants on my behalf.

Sincerely,

Governor Kate Brown

c: Thomas Long, MA, MHSA, SAMSHA
Ernest Fields, SAMHSA
Lynne Saxton, OHA
Pamela A. Martin, Ph.D., ABPP, OHA
Jackie Fabrick, OHA
File

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Pamela A. Martin, Ph.D., ABPP

Signature of CEO or Designee[1]: Pamela A Martin

Title: Behavioral Health Director

Date Signed: 08/24/2015
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Pamela A. Martin, Ph.D., ABPP
Title	Behavioral Health Director
Organization	Oregon Health Authority Health Policy and Analytics

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

STEP ONE

Improving Behavioral Health Care in Oregon

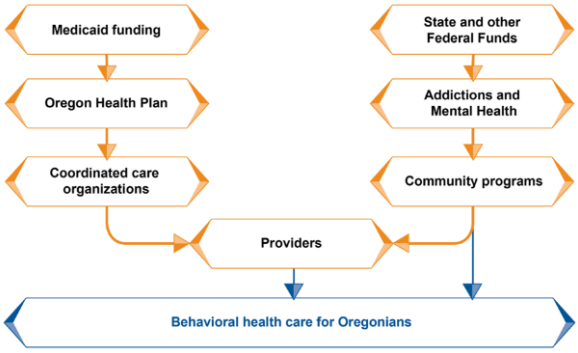
Oregon's health care transformation has changed how health care is conceptualized, managed, delivered and financed in Oregon. There has been a significant increase in the number of people eligible for Medicaid funded health services with more than 434,000 Oregonians enrolled in the Oregon Health Plan (Medicaid) since January 2014 and currently, 1.1 million people enrolled in Medicaid. Prevention, treatment and recovery services have a solid evidence base on which to build a system that promises better outcomes for people who have been diagnosed with or who are at risk for mental illness, substance use, gambling disorders and co-occurring disorders.

Oregon's Behavioral Health System

Oregon's behavioral health system weaves together federal, state and local dollars to provide mental health and addiction services. The Oregon Health Authority (OHA) is currently in the midst of a major effort to restructure the agency. This application does not reflect all of the changes, as the restructure is taking place concurrently with the application submission. An update on the final structure will be submitted with the Annual Report.

The Oregon Health Authority serves as the Single State Authority (SSA) and State Mental Health Authority (SMHA) for Oregon.

Figure 1: How Funding Turns into Services



Medicaid/Oregon Health Plan – For people on the Oregon Health Plan (OHP), behavioral health services are covered by their Coordinated Care Organizations (CCOs) if the services are covered by Medicaid. CCOs are local health entities that deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs are a new development for the Oregon Health Plan beginning in 2012. They are the umbrella organizations that govern and administer care for OHP members in their local communities. Sixteen coordinated care organizations have been successfully launched statewide.

CCOs are accountable for health outcomes of the population they serve. They have a global budget that grows at a fixed rate for mental, physical and dental care. CCOs are introducing new models of care that are patient-centered and team-focused. They have flexibility within the budget to deliver defined outcomes and are accountable for 33 metrics, 17 of which are incentivized, with five of these being focused on behavioral health outcomes.

By integrating behavioral and physical health care for their members, CCOs are better able to treat the whole person, resulting in improved health outcomes. As the state continues to expand the coordinated care model, CCOs are assuming responsibility for more behavioral health services, such as substance use disorders and mental health residential treatment.

All CCOs showed improvements in the metrics and 13 of the 16 CCOs earned 100% of their incentive payments in 2014. Emergency department visits rates for people served by CCOs decreased 22% compared to 2011 baseline data. Hospital admissions for short-term complications from diabetes decreased 26.9% and hospital stays due to chronic obstructive pulmonary disease or asthma decreased by 60% over the same period. Enrollment in patient-centered primary care homes has increased 56% and a higher percentage of services were delivered in primary care setting. The percentage of adults receiving Screening, Brief Intervention, and Referral to Treatment (SBIRT) also increased.

Until June 2015, the Oregon Health Authority had a separate Addictions and Mental Health Division (AMH). As of July 2015, OHA combined the Medicaid and Addictions and Mental Health Divisions into the Health Systems Division (HSD). The AMH biennial budget of $980 million will be managed in two parts. The Superintendent of the Oregon State Hospital now reports directly to the Director of the Oregon Health Authority. The Oregon State Hospital employs over 2,000 people and has a biennial budget of $500 million. The new Health Services Division (HSD) will manage the remaining federal and state funds and all Medicaid funding. This new division includes member and provider services, compliance and regulation, including a contracting section, operations support and a section devoted to data systems. HSD contracts with community providers including thirty-six community mental health programs and the sixteen Coordinated Care Organizations.

The AMH policy team is now in Health Policy and Analytics under the Behavioral Health Director. Health Policy and Analytics also includes the Dental Director, Chief Medical Officer and Medicaid Director, Quality Improvement and Health Analytics team.

Local mental health authorities (LMHA) are typically comprised of the County Board of Commissioners, who are responsible for the management and oversight of the public

system of care for mental illness, intellectual/developmental disabilities, and substance use disorders at the community level. Local mental health authorities must plan, develop, implement, and monitor services within the area served by the local mental health authority to ensure expected outcomes for consumers of services, within available resources.

Community mental health programs (CMHP) provide care coordination and treatment for people with mental illness, intellectual/developmental disabilities, and substance use disorders. Core services include screening, assessment, and referral to providers and community organizations, as well as emergency or crisis services. All members of a community can access core services from community mental health programs, subject to the availability of funds. These safety net and crisis services play a key role in the overall behavioral health system.

Oregon State Hospital provides an essential service to Oregonians who need longer term hospital level care, which cannot be provided in the community. For adults needing intensive psychiatric treatment for severe and persistent mental illness, hospital level care provides twenty four hour on-site nursing and psychiatric care, credentialed professional and medical staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services. The role of the hospital is to restore patients to a level of functioning that allows a successful transition back to the community.

The Oregon State Hospital campuses are located in Salem and Junction City, and they have a combined capacity for 659 adults. People who have been civilly committed and those judged guilty except for insanity receive inpatient services, along with people who require assessment and treatment for their ability to aid and assist in their own defense.

New Investments in 2013

In 2013, Governor Kitzhaber and the legislature made an unprecedented investment in mental health services, with almost $40 million going to the community mental health system. The budget identifies specific services and system expansions that focus on promoting community health and wellness, keeping children healthy and helping adults with mental illness live successfully in the community. During the September 2013 special session, the legislature increased the cigarette tax to fund community mental health services by an additional $20 million for the 2013-2015 biennium.

These investments filled gaps and provided an opportunity for OHA to work with both established and new partners as the system adapts to the changing landscape of behavioral health and the implementation of CCOs.

The goals of these investments were to:

- Promote better inter-agency partnerships among local child and family serving entities;
- Build additional capacity to screen and provide interventions at all levels where supports are needed;
- Provide an opportunity for tribes who had not yet implemented mental health services to meet the growing needs among the populations they serve;
- Increase the workforce so that more help is available to children, families and individuals; and,
- Increase the knowledge base and equip practitioners who are implementing evidence-based practices and assisting people who have experienced psychological trauma.

The investments provide an opportunity for OHA to work with new partners and respond to the changing landscape of behavioral health and the advent of CCOs. OHA is committed to building strong partnerships among CCOs, CMHPs, people in recovery, consumers, and service providers.

OHA is administering the investments with an emphasis on accountability, outcomes and system integration. The investments were made in the adult and children mental health systems in the following areas:

Mental health promotion and prevention folds mental health promotion and prevention into the existing prevention system so communities can foster mental health and identify early indications of behavioral health problems. Existing partners, including CMHPs, were able to compete for grants.

Investments in Children and Young Adults were used to develop statewide programs that emphasize prevention, early identification and intervention, and training and technical assistance for health care providers. Investments include:

- Parent-Child Interaction Therapy (PCIT);
- Trauma Initiative (Trauma Informed Oregon);
- Oregon Psychiatric Access Line about Kids (OPAL-K);
- School access to mental health services;
- Technical assistance for Collaborative Problem Solving;
- System of Care and Wraparound;
- Training for adolescent depression screening;
- Early Assessment and Support Alliance (EASA);
- Technical assistance for youth peer-delivered support for young adults;
- Technical assistance for family peer-delivered support; and,
- Young adult community hubs.

Adult investments focus on strengthening community mental health services and helping people with mental illness live successfully and independently in the community. Adult investments include:

- Mental health promotion and prevention;
- Crisis services;
- Jail diversion;
- Supported housing and peer-delivered services;
- Supported employment services; and,
- Assertive community treatment/case management.

The funding provides prevention, behavioral health promotion, community treatment, residential treatment and recovery supports services for Oregonians.

The 2015 legislative session saw continued new investments in behavioral health services in Oregon, including $20 million in bond sales for the development of housing for people with mental illness and substance use disorders and $22.2 million additional funding for the expansion of these community services:

- Oregon Psychiatric Access Line about Kids (OPAL-K);
- Crisis services;
- Jail diversion;
- Rental assistance;
- Sobering facilities; and,
- Addictions peer support.

Oregon's Mental Health and Substance Abuse Services

Mental health and substance abuse services in Oregon include behavioral health promotion, prevention, treatment, and recovery support services. Oregon is focused on developing healthy communities and offers services to families as well as the individual. New investments and the implementation of the Affordable Care Act has allowed for additional investments in a comprehensive system of care.

Substance Abuse Prevention

OHA is active in the area of prevention. More than 369,000 Oregonians participated in community prevention services in the last biennium from July 2013 through June 2015. In addition, prevention professionals serve Oregon youth, ages 10 to 25, prior to the onset of any disorder. Prevention professionals work with community partners to limit youth access to gambling, alcohol and other drugs throughout the state, and to foster community environments, which support behavioral health and the ability of individuals to withstand challenges.

The six strategies of the Center for Substance Abuse Prevention (CSAP) including alternatives, community-based processes, education, environmental, information

dissemination, and problem identification and referral are used to categorize prevention planning. CMHPs and tribes utilize data to select risk, protective and causal factors to target specific problem behaviors. Oregon provides services in each of the Institute of Medicine defined Universal, Selective, and Indicated populations, and OHA encourages the use of evidence-based and tribal best practices. OHA continues to provide dedicated prevention funding for all 31 CMHPs and nine federally-recognized Native American tribes.

The Strategic Prevention Framework (SPF) guides Oregon's prevention efforts. The SPF has been integrated into the Local Plan that is required by all funded counties and tribes. Oregon most recently was awarded a Partnership For Success (PFS)-SPF grant that will focus on underage drinking and high risk drinking for 12 to 25 year olds and prescription drug misuse and abuse among persons aged 12 to 25.

In order to catalyze change in the entire prevention system and assess the possible impact on different populations, the PFS allocation model will continue to allow SPF to reach high priority areas of need in all corners of the state. Details of this model will be identified by the revitalized SPF Advisory Council and the State Epidemiological Workgroup.

mORe Project

The Oregon Health Authority (OHA) is partnering with the Center for Health and Safety Culture at Montana State University in a multi-year project to transform attitudes related to underage drinking. Training on the Positive Community Norms (PCN) framework has been provided to cities, counties and tribes across the state and OHA has had inquiries from neighboring states as well. The process has involved the development and implementation of baseline surveys to measure existing positive norms, perceived norms, and critical gaps regarding underage drinking across the social ecology; and has developed multiple communications campaigns to guide conversations about the issue.

The mORe Project communicates to Oregon communities that most underage young people don't drink. The campaign endeavors to guide conversations about underage drinking and correct misperceptions[1]. The mORe Project is designed to confront the seriousness of underage drinking and to build hope that communities can work together to reduce risk and create positive change.

Toolkits to support the long-term media campaign have been developed specific to community building, adults, students and parents. Additional toolkits in development include:

- Law Enforcement (Summer 2015);
- School (Summer 2015);

[1] For more information visit www.oregonmore.org.

- Alcohol Retailers (Fall 2015);
- State and Local Organizations (Fall 2015); and,
- Health Care Providers (2015/16).

Problem Gambling Prevention

The prevention system in Oregon includes a focus on problem gambling prevention to address emerging and risky behaviors among Oregon youth, and to increase community awareness that problem gambling is a significant public health concern. Problem gambling prevention efforts use the same framework as the CSAP's six core prevention strategies. Problem gambling prevention best practices are being developed. As research indicates that many risk and protective factors are shared between generalized problem behaviors and problem gambling whose efficacy is well documented, Oregon relies on principles of alcohol and drug abuse prevention programs. The Oregon Student Wellness Survey and Oregon Healthy Teens Survey data consistently shows that over thirty percent of 6^{th}-11^{th} graders gamble and that those who do are much more likely (in some cohorts, twice as likely) to use alcohol, binge drink, skip school, get in fights, or engage in other risky behaviors. The Oregon Administrative Rules governing prevention now include problem gambling and substance abuse prevention.

Providers develop and implement locally specific prevention plans that include measurable goals and objectives aimed at prevention of problem gambling throughout the lifespan. Local prevention activities include infusing problem gambling prevention into existing substance abuse prevention efforts, working with schools on gambling prevention education, incorporating gambling prevention into activities aimed at other youth risk factors and working with groups of older adults on gambling education.

Tobacco Prevention, Education and the Synar Amendment

Oregon began Synar inspections in 1994-1995. The initial Retail Violation Rate (RVR) was 38.9%. During 1997-1998, Synar non-compliance rates jumped to 28.7%, over the maximum allowable and negotiated rate and Oregon was found in non-compliance with the Synar Amendment. As a result, Oregon infused nearly $1 million into merchant education and additional retail tobacco inspections. From 2000-2004, all known tobacco retail outlets were inspected at least once, and those found non-compliant were inspected a second time. By 2005-2006, the RVR reached 11%, the lowest rate since the beginning of the inspections.

In 2009, the Oregon State Police (OSP) notified OHA that they were no longer able to provide Synar Inspections. OHA hired inspectors as temporary employees with no citation authority, and non-compliance rates rose to 19.3% in 2009 and as high as 22.5% by 2012.

In January 2015, OHA hired a full-time, dedicated coordinator for the Synar Program. The Synar Coordinator is currently developing updated merchant educational materials in the form of a toolkit to be distributed to every retailer in the state that sells tobacco products. In addition, OHA has submitted a proposal to the Food and Drug Administration (FDA) to obtain a direct contract to conduct Tobacco Retailer Compliance Inspections for the state of Oregon. If awarded, this contract would increase tobacco inspections in Oregon by 100%.

OHA is also exploring a comprehensive database tool that will allow all inspection data including Synar, Enforcement and FDA to be combined in order to run more comprehensive reports and map retail locations. The database tool would also allow inspections to be completed on digital devices instead of using paper forms.

The Synar Coordinator is working in collaboration with the Oregon Liquor Control Commission (OLCC) to conduct a pilot training program for retailers focusing on selling age restricted products including tobacco, alcohol and lottery tickets. In addition, OHA has continued to improve communication with county prevention coordinators and tobacco coordinators to inform local communities in a timely manner regarding inspection results and to work together to address concerns.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

OHA supports a continuum of care based on the Institutes of Medicine model[2], which incorporates behavioral health promotion, prevention, treatment, recovery and maintenance. Behavioral health promotion is a broad concept with specific strategies, supporting wellness, early intervention and prevention of mental and substance use disorders.

Behavioral Health Promotion

Mental health promotion is one of the keys to maintaining positive mental health and is protective against the loss of mental health. Good mental health is a necessary condition providing a foundation for health and wellness. Mental health is protective against the development of mental illness, pathological gambling and substance abuse disorders. It is also protective against the development of physical illness. Behavioral health promotion is integral to the promotion of health, which in turn is an important component in assurance of public health, or the health of the population.

[2] National Research Council and Institute of Medicine (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, D.C.: The National Academies Press.

Mental Illness Prevention

Each Community Mental Health Program (CMHP), subject to the availability of funds, is required to provide or ensure the provision of the following services to persons with mental disorders:

- Prevention of mental disorders and promotion of mental health;
- Preventive mental health services for children and adolescents, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional, behavioral and cognitive disorders, and suicide attempts in children; and
- Preventive mental health services for older adults, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional and behavioral disorders and suicide attempts in older adults.

Mental Health Promotion and Prevention Programs

Nearly $3 million in state funds has been allocated for Mental Health Promotion and Prevention awards spanning eighteen different projects and twenty counties across the state. While each of the eighteen projects is unique, many share common programs. These include Mental Health First Aid, Parenting Programs, Bullying Prevention Programs, Suicide Prevention Programs, Culturally-Specific Services and Mental Health Promotion Activities. In addition, two projects intend to create and promote social marketing messages to reduce stigma and promote public awareness of mental health issues.

Mental Health Promotion and Prevention Programs

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

The ACE Study arose from more than seventeen thousand Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination who chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation

can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Oregon created a center of excellence named Trauma Informed Oregon (www.traumainformedoregon.org) as a centralized resource for providers, families, adult consumers, and other stakeholders statewide, to have a reliable source of information and conduct training for communities about the impact of trauma and Adverse Childhood Experiences.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is an empirically supported treatment for young children with emotional and behavioral disorders and is focused on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT provides live practice for parents through coaching with a wireless communication device by the therapist who views the parent and child (ages two-seven) through a one-way mirror. It teaches parents to develop a warm, responsive relationship with their children, to selectively reinforce pro-social and adaptive behavior while also learning to safely and consistently provide developmentally appropriate consequences to change children's negative behaviors. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during the course of treatment.

Preliminary research indicates PCIT can be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum who are high functioning, children who have experienced chronic trauma, families who are involved with child welfare because of harsh physical discipline, and mother-child dyads following episode(s) of domestic violence.

In 2008, four Oregon counties began to implement PCIT. In April 2014, PCIT was expanded to four additional agencies with sites in five counties, which previously did not have PCIT programs. In July 2014 seven more counties were granted funding to develop PCIT programs. These 12 PCIT sites receive on-going consultation and training during this initial phase of providing PCIT to Medicaid eligible families.

Between 2012 and the beginning of 2014, the number of trained PCIT therapists in the four initial OHA funded PCIT sites expanded from 33 to 45. Thirteen of these therapists speak Spanish. There are PCIT therapists fluent in other languages including Dutch, German, Korean, and Vietnamese. Sites provide outreach to multiple agencies serving children and families, including those that serve Hispanic/Latino families. Each of these four counties provided OHA PCIT funding has one or more *promotores*, community health workers linking with the Hispanic community. As of April of 2015, Oregon has 85 masters level therapists fully trained in PCIT.

A PCIT training site has been established in Jackson County, the county that has the most extensive experience providing PCIT in Oregon. One PCIT trainer at this site is authorized by PCIT International to train throughout Oregon and oversees the training of 49 clinicians at 17 agencies across 16 counties. Six additional PCIT therapists in four counties are trained as PCIT trainers and authorized to train within their local agency. One additional county received an early childhood grant through Project LAUNCH from 2010-2014. This grant was designed to achieve fundamental and sustainable practice changes in support of improved wellness for children ages zero through eight and their families. Utilizing some of the Project LAUNCH funding, Deschutes County established seven PCIT sites and trained 16 therapists and three local PCIT trainers.

Oregon has taken significant steps to overcome previous inconsistencies in prior data reported for PCIT. The Behavioral Report (Implementation Report) will report more extensive PCIT data. Barriers to consistent data collection in the previous block grant cycle included a year-long vacancy in the PCIT Coordinator position at the SMHA, along with a new reporting requirement. Prior to 2014, Oregon reported data from only four counties and data provided was inconsistent.

A new data reporting system was implemented in 2014. Between October 1, 2013 and March 31st, 2015, 991 children received PCIT services with at least one parent in OHA funded PCIT sites. Of these, 56% are boys, and 91% are between the ages of three and seven; 22% of the children are of Hispanic ethnicity.

According to the Parenting Stress Index scores, the majority of parents entered PCIT services with their stress level in the clinical range, and left with their stress reduced to within the typical range. This was true whether or not they completed PCIT. The average improvement in Eyberg Child Behavior Inventory (ECBI) scores for families who completed treatment was 48%. Today there are 16 counties with 30 locations providing PCIT.

Mental Health First Aid

The Association of Oregon Community Mental Health Programs (AOCMHP) was contracted to provide statewide trainings to train Mental Health First Aid (MHFA) instructors. To date 2,619 Oregon Mental Health First Aid responders have completed the training and 110 MHFA instructors have been certified to teach the eight hour course. AOCMHP hosts monthly Learning Collaboratives for instructors and provides support for the statewide courses. The first annual Mental Health First Aid summit was held in November 2014.

AOCMHP will be hiring a full-time coordinator to meet the demand for MHFA courses, to conduct community outreach, and to provide support for the increased number of new instructors.

There are adult and youth versions of the MHFA instructor trainings. AOCMHP has invested considerable training and outreach time to youth MHFA in addition to targeting special populations who work with youth, including school administrators, faculty and staff, parents, and after school programs. Adult specific outreach efforts have included law enforcement, older adult behavioral health specialists, Veterans Administration, National Guard, and higher education.

MHFA trains individuals in the following:

- Skills to recognize the signs, symptoms and risk factors of behavioral health disorders;
- Community, professional, and self-help resources;
- Crisis de-escalation; and,
- Help to shatter stigma of behavioral health disorders.

Early Identification and Intervention

Screening, Brief Intervention and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is used to prevent, identify and reduce alcohol and drug use. OHA has partnered with CCOs and the Oregon Association of Hospitals and Health Systems to train staff and implement SBIRT in primary care, Patient Centered Primary Care Homes settings, and specialty care such as obstetrics and pediatrics. SBIRT is applied throughout all settings from fee-for-service clinics to Federally Qualified Health Centers, Rural Health Centers and tribal clinics. Hospital implementation is focused on emergency departments, beginning with Diagnosis-Related Group (DRG) hospitals throughout the state.

SBIRT implementation has included collaboration with other healthcare initiatives, including consumer and peer involvement. The OHA SBIRT coordinator has worked with the CCO Consumer Advisory Committees, Peer Support and Wellness Specialists, Traditional Healthcare Workers, licensing boards and the rehabilitation of medical and behavioral professionals.

SBIRT in Oregon promotes the use of technology to address healthcare challenges. The SBIRT Dashboard tracks implementation progress for each CCO by clinic and identifies patterns of reimbursement to problem solve the challenges of encountering SBIRT services. Telehealth has been used to improve the availability for on-demand behavioral health screening and services. Telehealth links medical clinics and community behavioral specialty care for consultation, referral and coordination of ongoing care and allows for the promotion of consultation between medical clinics for SBIRT service improvement.

Implementation of SBIRT in both CCO and hospital emergency departments are incentivized through quality pools. CCOs and hospitals can receive incentive payments for achieving SBIRT-focused benchmarks or improvement targets. Improvement targets are set at three percentage point increases from the prior year performance toward a benchmark of twelve percent.

The CCO metric tracks full (secondary) screenings and/or brief interventions performed in outpatient settings. The hospital metric tracks SBIRT internally. The hospital SBIRT measure currently includes brief and/or full screenings. Hospitals also report the brief intervention rate, but there is not an accompanying target for performance.

The 2014 CCO performance report indicated that screening for alcohol or other substances increased from 2013 to 2014, with statewide performance improving from 2% to 7.3%. This is still below the benchmark of 13%but shows progress. Screening increased across all races and ethnicities. Fifteen CCOs improved their performance in 2014, and 13 met their improvement target. The baseline hospital performance report was published in April 2015; 17 of 27 DRG hospitals with emergency departments had already implemented SBIRT in the baseline year.

Young Adult Mental Health Hub Program

A new mental health investment authorized in 2013 by the Oregon legislature establishes four regional mental health service and access *hubs* for young adults ages 17 through 25. This funding is focused on outreach and engagement and provides responsive, relevant and intensive community and peer-based support to young adults whose life experience has diverted their development away from a healthy and appropriate path.

This community and peer-based supportive access point is grounded in positive youth development, is strength-based and young adult focused with a goal of the program incorporating principles of trauma informed care. This philosophy is reflected in asset and strength enhancement and interpersonal connectivity and an emphasis on peer support. Four regional young adult hubs are providing mental health and medical services to approximately 200 young people.

The primary populations served are young adults who ages 17 to 25 who have:

- Spent a significant amount of time in state or local child-serving systems and as a result of that experience have lagging skills and developmental progress;
- Been referred to Early Assessment and Stabilization Alliance (EASA) but have been screened out diagnostically; and,
- Mental health and interpersonal needs which are intensive enough to place them at risk for involvement in the justice system, at risk for homelessness, and at risk for increasing marginalization.

The Family Search & Engagement program works to locate life-long connections for youth served by the hubs and fosters engagement with supportive family members and natural supports. Family Search & Engagement services are available for youth in Multnomah, Clackamas, Washington, Marion, and Lane County.

Youth hubs will supplement billable services and other funding resources and create a responsive and accessible continuum of care, including physical health, for young adults. The hubs are predicated on the idea that work to be done with marginalized young adults is outside of encounters or billable services, or prior to, between, or following the close of formalized services. The hubs are intended to close gaps between supports, and bridge resources as young adults move from one support system to another.

Figure 1.

RECOMMENDED USE OF RESOURCES FOR HUB CLIENTS

Emphasis for the first six months of the project was on the development of sites and program structure, hiring staff, including peer support workers, and conducting community education and referral processes. In September 2014, all hub staff participated in training in Transition to Independence (TIP) Model and will use that training to ensure that all hubs have similar practices, language, and philosophies. Forty-five hub staff and peers attended training and planning summit in May 2015. Attendees were trained in serving LGBTQ (Lesbian, Gay, Bisexual, Transsexual, and Questioning) young adults and assisted with identifying outcome measures for all of the hubs' services. Hub managers have a monthly collaborative learning call during which

challenges and successes are highlighted and work on a state vision for young adult mental health services occurs.

The outcome areas identified for the hubs include:

- Employment and education opportunities;
- Housing stability;
- Reduction in acute care services;
- Establishing and maintaining a healthy response to mental illness;
- Reconnecting or connecting with individuals and community resources by increasing meaningful and supportive relationships, including use of family search and engagement services; and
- Avoiding the social settings that reinforce increased symptomatology, and decreased adaptation and resilience, such as inpatient psychiatric care, emergency department visits, incarceration or involvement with law.

Early survey data indicates that the hubs are reaching the populations they are intended to serve and conducting activities consistent with the outcome areas listed above.

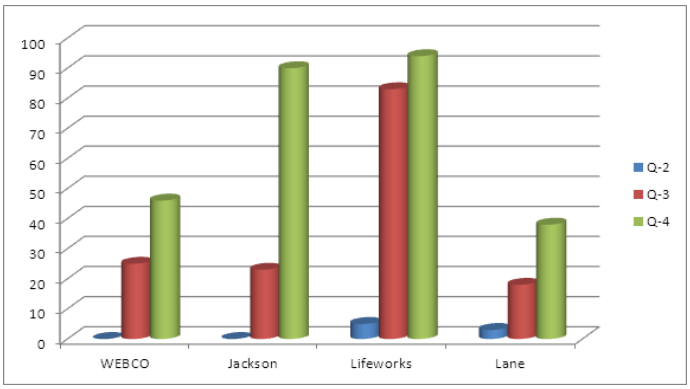
The following two tables indicate preliminary areas of strength, challenges and impact as cited by hub programs managers (Table 1) and the numbers of individuals served (Table 2).

Table 1.

Outcome Questions	Areas of Challenge, Strength and Impact					
The five most significant barriers to well-being	Unsupportive Family	Unstable Living/Homeless/Poverty	Mental Illness	Interpersonal & Self-Efficacy	Limited Support System-Access	
	20%	24%	16%	24%	23%	
How does your program impact or target those?	Peer Support	Engagement in Services*	Empowerment &Relationship Development	Respite	Family Support	Structured Events
	27%	32%	27%	5%	23%	23%
The five most noticeable strengths you see in your program participants	Resourcefulness	Resilient & Goal Directed	Desire for a Better Life	Positive Attitude	Strongly Connected to Program	Making a Difference to Others
	11%	16%	26%	26%	5%	11%
What is getting better because of your work?	Reduced Symptoms	Connectivity-No Other Place Like This	Incorporating Positive Changes	Community Education	Youth Are Becoming Leaders	Relationships are Improving
	20%	25%	20%	15%	10%	10%

Table 2.

Hub Intake Numbers
January-December 2014



Early Assessment and Support Alliance

In 2007, the Oregon Legislature funded Early Assessment and Support Alliance (EASA) to provide community education, outreach and engagement, evidence-based treatment, and transition into ongoing care for youth and young adults experiencing early signs of psychosis.

EASA uses an intensive multidisciplinary approach during what is known as the "critical period," where intervention is most effective and may prevent the long-term morbidity associated with chronic psychotic illness. Early intervention and treatment of psychosis assists individuals in becoming independent, healthy and safe. The restoration of normal functioning helps individuals maintain employment and support themselves and their families.

EASA's current structure offers the most robust and efficient model of care while mirroring many public health strategies through an integration of physical and mental health care. Utilization of this model has resulted in dramatic outcomes such as decreased hospitalization rates. The model is cost-effective in the short term and results in cost savings in the long term.

The EASA Program was expanded to 32 of 36 counties across Oregon, and has a new Center for Excellence (CfE) housed at Portland State University's Regional Research Institute. EASA partners are engaged with others around the country moving toward a national strategy. Oregon's set aside of MHBG for early intervention in psychosis is currently 5%. That investment has enabled much of the progress being made in developing the EASA program statewide.

EASA Services Data

EASA's established programs are showing impressive results, with tremendous benefits in improvement of human lives and financial outcomes. Twenty-nine percent of EASA participants are under age 18, and 42% are between the ages of 18 and 21.

Approximately one third of EASA participants were enrolled as students in secondary or post-secondary settings at intake. Forty-four percent of EASA clients were employed or in school at intake, this figure increased to 56% at the time the participants left the program. All EASA participants are supported to identify and pursue a career, and EASA programs are incorporating the evidence-based model of Individual Placement and Supports and Supported Employment to increase competitive employment opportunities.

Fifteen percent of EASA participants experienced legal involvement in the three months prior to intake and 6% of EASA participants were arrested in the three months prior to intake. The percentage of those arrested dropped to 3% in the three months prior to leaving the program.

Fifty-four percent of EASA participants were not planning to apply for public assistance through the disability system when they exited the program; for those who need the support of the disability system, EASA approaches it as a short-term bridge to self-sufficiency.

Seventy-seven percent of all EASA participants had family involvement in treatment.

EASA Center for Excellence National and International Work

The EASA Center for Excellence (CfE) was created and placed within Portland State University's Regional Research Institute in 2013. As a result, EASA CfE is now part of the Technical Assistance Network for Children's Mental Health, has a strong affiliation with the federal initiatives Reclaiming Futures and Pathways to Positive Futures federal grant projects, and has become increasingly involved in national technical assistance activities.

EASA CfE staff developed a series of three webinars (links available on the EASA website, www.easacommunity.org). The EASA CfE is working with the National Institute of Mental Health (NIMH), the Robert Wood Johnson Foundation, SAMHSA and other national organizations to create a new national network called PEPPNET. One of the projects of this network includes the vision of a "learning healthcare system" of early psychosis providers, researchers and policymakers/funders. It is based in part on the conceptual model of work in the fields of cancer and heart disease, sharing data and actively working to improve services. There is discussion about the possibility of Oregon providing a pilot site for this concept.

EASA CfE staff have been working with researchers in Calgary, Canada to articulate core elements of first episode programs. The Calgary researchers are coming to Oregon to join in a fidelity review process with four to five sites. The goal is to create a consensus fidelity tool, which could have broad use in both research and clinical settings and integrated as part of EASA's own fidelity tool.

The Center for Excellence is collaborating with Oregon Supported Employment Center for Excellence (OSECE) on Cognitive Enhancement Therapy research, helped to coordinate a U.S. services symposium at the 2014 International Early Psychosis Association conference, and is doing a small untreated psychosis study.

Statewide Training

EASA CfE continues to train staff at existing and new Oregon locations. Introductory trainings are held for new staff as needed, with an average of four trainings a year. EASA staff is also trained in multi-family group psycho-education and differential diagnosis/SIPS. Webinars, videos and written handouts are available on the Internet to provide additional training material for new clinicians and participants. Customized training is provided to new sites. Staff provides training at the state Vocational Rehabilitation and Oregon Supported Employment Center for Excellence Conferences.

Center for Excellence staff are working closely with OHA staff to implement new programs. Seventeen additional EASA sites were funded as a result of the 2013 mental health new investments: Lane, Clackamas, Douglas, Klamath, Jackson and Josephine, and eleven Eastern Oregon counties. There are four remaining counties that are currently engaged in a planning conversation: Benton, Lincoln, Coos, and Curry.

The Center for Excellence provides consultation calls every week focused on screening, clinical supervision, and clinical services, including multi-family psycho-education. CfE is maintaining a centralized registry of credentialing status for all EASA clinicians. A database for the credentialing process has been developed at PSU, and historical information has been entered.

The Center for Excellence developed a partnership with Oregon Health and Sciences University's School of Child Psychiatry, bringing on Dr. Craigan Usher MD, to consult with the psychiatrists attached to the EASA teams.

Sustainability and System Development

EASA CfE staff provides ongoing consultation to OHA, providing information on estimates of service costs and program specifications for new EASA programs, as well as the conceptual development of "hub models" which expand on EASA's core to serve a wider population of young adults in transition.

Health care reform is having a major impact on availability of insurance benefits. The expansion of health coverage has shifted assumptions of how much outside revenue may be needed to subsidize services. Ongoing discussions are occurring with OHA, Association of County Mental Health Programs and local sites to clarify plans for long-term sustainability. Currently, approximately 60% of EASA participants are on the Oregon Health Plan, 8% are uninsured and the remaining 38% have private insurance. EASA included information about enrollment under the Affordable Care Act in its state conference, as well was links through its website, and tracking success via the data system.

EASA's data system will interface with the Measures and Outcomes Tracking System (MOTS) and routine reports will be provided to local and state audiences. EASA CfE and site staff worked together to develop a consolidated format for data collection that will be used to gather client level outcome data once the university institutes its new HIPAA non-research compliance policies and procedures.

EASA extended the Career Information System license to all EASA sites during this period, and is offering ongoing training and consultation. EASA TA staff work closely with the Oregon Supported Employment Center for Excellence (OSECE) and joined OSECE in its site review of three EASA sites. EASA TA staff work with OSECE on shared written guidelines for the fidelity process, sharing reports, and ongoing co-training opportunities.

The EASA Center for Excellence is maintaining a centralized registry of credentialing status for all EASA clinicians through a databased established at PSU.

The emphasis of the current social marketing effort is integrating a social media presence, which includes the existing website, Tumblr, Facebook, Linked-In and Twitter. Participation in these online forums continues to grow and has become a central part of the EASA approach to working with young adults.

Young Adult Leadership

A very dynamic and engaged Young Adult Leadership Council has been established, made up of EASA graduates who want to help guide and support EASA's evolution. EASA's Young Adult Leadership Council continues to thrive, meeting monthly and establishing their goals and priorities. Their vision statement speaks to their focus and enthusiasm: "The vision of the Young Adult Leadership Council is to unite the voices and strengths of young adults and their allies to build a thriving community and a revolution of hope."

The Young Adult Leadership Council is venturing into policy areas including making housing support recommendations to the state, reviewing data about the engagement process, and discussing ways to change media portrayals of psychosis. Members are

volunteering to go to local EASA graduation ceremonies, Family Workshops, and to represent EASA in other forums. They have been key trainers in introductory training and have become involved in peer mentoring opportunities.

The council recently drafted a welcome letter for new individuals entering the program. The council has its focus on several projects and issues. The council has a goal of strengthening the process of young adults finding EASA, engaging with EASA and remaining with the program. The Young Adult Leadership Council is discussing how to develop a survey to collect and integrate routine feedback from participants and graduates. A Young Adult Participation Coordinator assists with this process.

Members of the leadership council are also participating on a design team as part of the Regional Research Institute's Pathways to Adulthood grant, creating web-based peer support modules.

Figure 3.

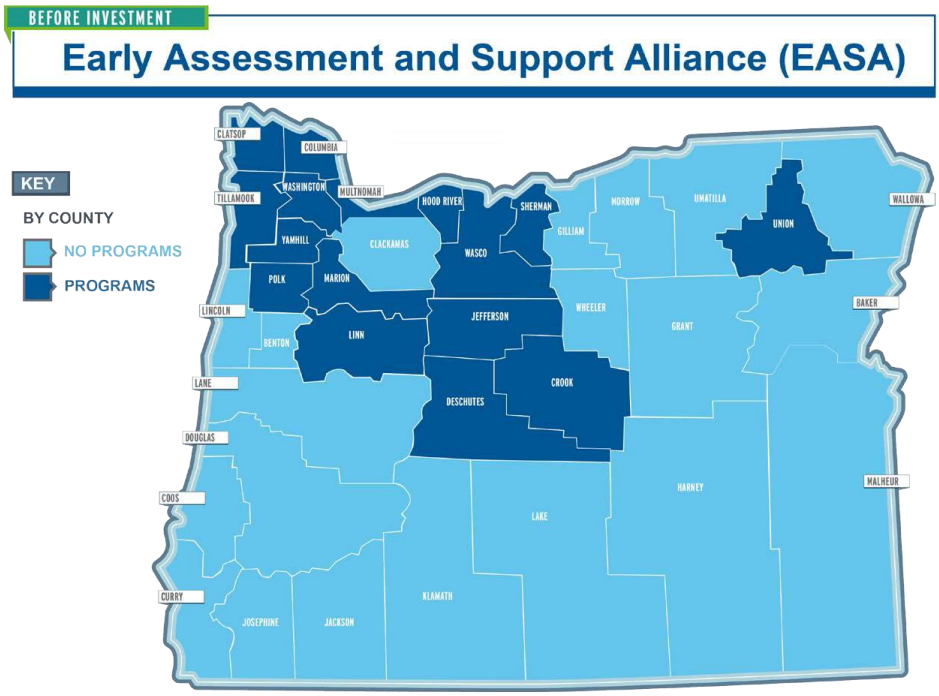
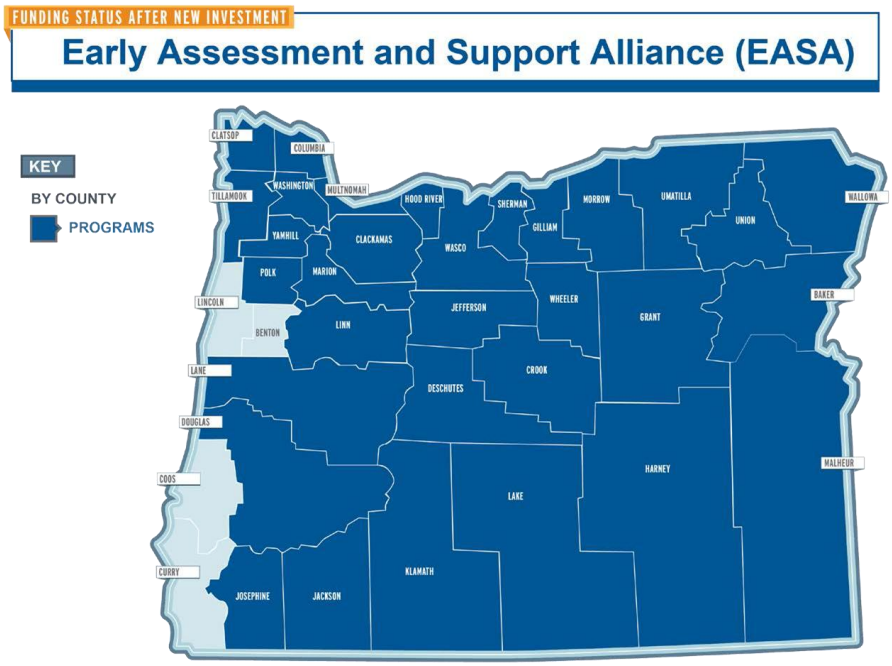


Figure 4.



Community Treatment

Adult Mental Health Services

Each CMHP provides or ensures the provision of a continuum of care for adults with serious mental illness, subject to the availability of funds. These services include, but are not limited to:

- Screening and evaluation to determine the individual's service needs;
- Individual, family, and group counseling and therapy;
- Medication monitoring;
- Residential services;
- Psychiatric care in state and community hospitals; and
- Crisis stabilization to meet the needs of people experiencing acute mental or emotional disorders, including the costs of investigations and prehearing detention in community hospitals or other facilities approved by OHA for people involved in involuntary commitment procedures.

Within the limits of available funds, CMHPs provide the above services to individuals in the following order of priority:

1. Individuals who, in accordance with the assessment of a mental health professional, are:
    a. At immediate risk of hospitalization for the treatment of mental or emotional disorders, or

b. Are in need of continuing services to avoid hospitalization, or
c. Pose a hazard to the health and safety of themselves, including the potential for suicide, or others
d. And those persons under 18 years of age who are at immediate risk of removal from their homes for treatment of mental or emotional disorders or exhibit behavior indicating high risk of developing disorders of a severe or persistent nature;

2. Individuals who, because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and
3. Individuals who are experiencing mental or emotional disorders but will not require hospitalization in the foreseeable future.

Individuals participating in mental health services assist their service providers to develop a comprehensive service plan, which specifies services and supports provided or coordinated for an individual and his or her family. The plan should be reflective of the assessment and the intended outcomes of service. The plan documents the specific services and supports to be provided, arranged or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes. At a minimum, each plan must include:

- Measurable or observable intended outcomes;
- Specific services and supports to be provided; and
- Applicable service and support delivery details.

Mental Health Services for Older Adults

Mental health services for older adults are provided through the CMHPs. Several CMHPs use multidisciplinary teams to address the gap in mental health services for older adults. Although the teams vary from county to county, sometimes including representatives from the CMHP, Aging and People with Disabilities (APD), Adult Protective Services, law enforcement, and private non-profit mental health service agencies, the primary focus is to link vulnerable older adults with necessary mental health and social services.

Many CMHPs or their subcontractors have developed and maintained age specific services, providing senior peer counseling services. For example, Age Wise, Age Well or other senior peer programs provide supportive individual, group and psycho-educational counseling by incorporating successful aging, physical health, spiritual and behavioral health approaches for older adults. One county contracts with a Psychiatric Mental Health Nurse Practitioner to provide behavioral health and psychiatric medication recommendations to older adults living in Department of Human Services

Aging and People with Disabilities (APD) long-term care and Home and Community Based Care Waivered Programs.

Pre-Admission Screening and Annual Resident Review

Pre-Admission Screening and Annual Resident Review (PASRR) is a federally mandated program that requires all states to develop a comprehensive process to pre-screen all individuals applying for admission to a Medicaid-certified nursing care facility. The mandate requires a personalized assessment and personalized care recommendations for any person who may have serious mental health conditions and a follow-up to determine whether those needs are being met within the nursing facility.

Oregon, as the State Mental Health Authority, maintains a PASRR Level II program that follows federal regulations. In most counties, CMHPs are contracted to provide PASSR-II services and are expected to link individuals with a serious mental illness with the appropriate outpatient mental health services.

Enhanced Care Facilities/Enhanced Care Outreach Services

The Enhanced Care Facilities/Enhanced Care Outreach Services (ECF/ECOS) program is a partnership between OHA and APD. It serves both older and disabled adults in APD-licensed nursing facilities, residential care, assisted living and adult foster care. The individualized mental health services provided include: assessment, treatment planning, counseling, skill building, community integration, psychiatric medication management, 24-hour crisis services, and provider consultation and training.

The older adult team within OHA works closely with OSH staff to coordinate discharge planning and diversion. The OHA Adult Mental Health unit also works with acute care hospitals in discharge planning to the appropriate level of care in collaboration with APD at both the state and local levels.

This year, the older adult program launched the senior behavioral health investment, which strengthens services for older adults and people with disabilities across Oregon. Twenty-five older adult behavioral health specialists will be hired to increase collaboration and coordination among agencies that serve older adults and to facilitate training for individuals who work with older adults. The outcome of this investment will be improved access to care, provision of coordinated high quality physical and behavioral health care and meeting Oregon’s Triple Aim of better health, better care and lower costs.

Synthetic Opioid Replacement Therapy

There are currently 15 opioid treatment programs (OTPs) in Oregon. Most programs are centrally located along the Interstate 5 corridor in the most populated areas of the state between Portland to Medford. Seven clinics are located in Multnomah County, which

includes the city of Portland; Marion and Lane Counties each have two; and Jackson, Washington, Deschutes and Clackamas Counties have one clinic each.
Programs are a mix of private for-profit and non-profit operated clinics, with one clinic administered by the Federal government. Approximately 8,000 individuals received methadone treatment services at OTPs in calendar year 2014. Methadone treatment is a mandated covered benefit through the Oregon Health Plan (OHP). Payments from OHP are made based on the services provided by the clinic. For self-pay patients, providers charge a monthly or daily rate for services. Self-pay fees range from $200.00 per month to as high as $350.00 per month.

Regulatory Requirements

OTP programs must comply with both federal and state regulations. A federally recognized accreditation body must approve all programs. In Oregon, the Commission on Accreditation of Rehabilitation Facilities accredits 13 OTP programs, and two programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Agencies are reviewed by their accreditation agencies at least once every three years. In addition, all programs must have their dispensary and dispensing process approved by the Drug Enforcement Agency (DEA). The DEA conducts random inspections of clinics to ensure compliance with medication dispensing regulations.

OHA approves OTPs in Oregon, with the exception of the federally run program. Each program is reviewed at least once every three years. In addition, current state statutes prohibit methadone programs from operating within 1,000 feet of a school, a licensed childcare facility, or a career school attended primarily by minors. Statutes also require OTPs to obtain approval from an individual's parole/probation officer, if applicable, upon admission.

Admission Requirements

The program's Medical Director approves all admissions. Individuals being considered for methadone treatment must have a one year history, immediately prior to admission, of a continuous physical dependence on narcotics or opiates as documented by medical records, records of arrests for possession of narcotics, or records from drug treatment programs. The program must have evidence of an individual's current physical dependence on narcotics or opiates as determined by the program physician or medical director. The agency may also admit individuals where there is documentation demonstrating that medically supervised withdrawal or medically supervised withdrawal with acupuncture and counseling has proven ineffective, that a physician licensed by the Oregon State Board of Medical Examiners has documented in the patient record a medical need to administer opioid agonist medications, or if the patient is currently pregnant and opioid dependent.

Daily Operations

Clinics in Oregon are required to be open Monday through Saturday, except for federal holidays. Clinics are open early morning through early afternoon and provide dosing, counseling and urinalysis testing. Upon admission, individuals are required to pick up their medication at the clinic six days a week. Over time and with documented progress, individuals are eligible for “take home” privileges that enable them to come to the clinic less frequently. The criteria and time frame for these privileges are described in federal and state regulations.

Individuals may be enrolled and participate in medication assisted treatment (MAT) for as long as they benefit and believe they need to be on medication to maintain the positive changes and stability they have achieved since enrollment in treatment. For patients taking methadone, an average length of stay is between one and three years. If both the individual and the clinic believe the person may be successfully titrated off methadone, a therapeutic detoxification can occur. Depending on an individual’s response, this detoxification period can be several months or longer.

OHA will continue to collaborate with partners, including the OHA Public Health Division, the Alcohol & Drug Policy Commission, the Prescription Drug Monitoring Program, the Governor’s Prescription Drug Abuse Task Force, LMHAs, and Oregon MAT providers to address issues related to prescription opioid poisoning. Technical assistance and training is used to increase awareness and promote implementation of MAT to treat opioid addiction. OHA works with CMHPs, counties, subcontractors and other providers to monitor and ensure that priority populations receive services required by the Substance Abuse Prevention and Treatment Block Grant by implementing the Oregon Web Infrastructure for Treatment Services (OWITS) Capacity Management System. Treatment outcome improvement measures continue to be refined as part of the outcome-based contracting process and are revised in response to any new measure or performance domains that may be included in the National Outcome Measures.

Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) assists health care providers and pharmacists to provide patients better care in managing their prescriptions. The PDMP was started in 2011 to help individuals collaborate with their health care providers and pharmacists to determine what medications are best for them. The system allows healthcare practitioners to be able to access a database, which makes them aware of the specific medications prescribed to their individual patient, in order to provide oversight in medication management, as well as protect the overall health and welfare of their patient. The patient data is secure, and can be only accessed by individuals using the proper authentication, for the purpose of treatment planning and the healthcare needs of their individual patients.

Pharmacies contribute data to the program on specific prescription drugs, Schedule II, III and IV controlled substances, dispensed to patients. These medications place patients at risk for overdose, side effects, and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP provides practitioners and pharmacists a means to identify and address these problems.

- More than 7,200 practitioners and pharmacists have PDMP accounts in Oregon;
- In 2013, more than 621,000 queries were made by practitioners and pharmacists;
- Approximately 7,000,000 prescription records are uploaded into the system annually.

Access to Recovery

Access to Recovery (ATR) is a three-year $2.3 million per year competitive grant that was secured by OHA in May 2015. This is part of a federal initiative supported by SAMHSA and the Center for Substance Abuse Treatment (CSAT) to develop person-centered, community-based services to those seeking recovery. ATR emphasizes participant choice by supporting the individual's decision about what services they believe will be helpful to their recovery, as well as where they would like to receive such services. ATR has bipartisan federal support and requires service linkages to include faith-based and community-based organizations that receive payment for services through an electronic voucher management system.

ATR is currently piloted in three counties: Multnomah, Clackamas, Lane and Washington. One additional county, Marion, is expected to be enrolling individuals by the end of 2015. Any individual 18 years or older who lives in the identified counties, has a serious substance use condition, and seeks supportive services to help them enter or maintain recovery is eligible for ATR services. Oregon is prioritizing active military or returning veterans, parents mandated to Child Welfare services, young adults in transition, individuals exiting a higher level of care, including withdrawal management or residential treatment, and individuals transitioning to communities from corrections institutions who have substance use disorders. The total number of unique individuals to be served over the project period of May 2015 to April 2018 is 3,723.

Driving Under the Influence of Intoxicants Treatment

Whether an individual enters into a diversion agreement or is convicted of driving under the influence of intoxicants (DUII), the court will order the individual to set and keep an appointment with an Alcohol and Drug Evaluation and Screening Specialist (ADES). The ADES has two roles in the DUII service system:

- Screen for an appropriate referral to a state approved DUII alcohol and drug treatment program; and

- Monitor and provide the court with evidence of individual alcohol and drug treatment compliance.

During screening, the ADES will determine if an individual should be referred to alcohol and drug treatment or to a DUII information program. Factors that the ADES reviews in making a referral include blood alcohol content at the time of the arrest, previous arrest history, and other factors, including the individual's alcohol and drug use history.

Individuals referred by the ADES for alcohol and drug treatment are assessed by the treatment provider who then develops an individualized treatment plan. While in treatment, individuals are required to demonstrate at least 90 days of abstinence from alcohol and other drugs. Individuals with a positive drug test will be required to restart the 90-day requirement. Levels of care, including the number of clinical treatment hours per week, are individualized per ASAM-PPC-2R criteria. Hours of treatment per week is between two to eight, but may be more depending on individual addiction severity level.

DUII Education Program

The requirements for DUII Education Programs are outlined in the Oregon Administrative Rules and include 12 to 20 hours of alcohol and drug education. The DUII Education programs are required to take place over a minimum of four sessions over four consecutive weeks. In addition to these drug and alcohol education requirements individuals are required to submit at least one random urine sample for testing within the first two weeks of enrollment. Individuals who produce a positive alcohol and drug test will be required to enter and successfully complete an alcohol and drug treatment program including the 90 days of abstinence as outlined above.

DUII Recovery Supports

As part of the continuum of care, recovery support services are encouraged for individuals who engage in addiction treatment following a DUII. Individuals who need treatment will continue to have access to community recovery supports such as twelve step groups and faith based programs.

Health Professionals' Services Programs

OHA has contracted with Reliant Behavioral Health to manage a monitoring program for health professional licensees with substance use disorder, a mental health disorder, or both types of disorders. The program supports public safety while helping licensed health professionals continue their careers.

Four health profession regulatory boards currently participate in HPSP: the Oregon Board of Dentistry, the Oregon Board of Nursing, the Oregon Board of Pharmacy, and the Oregon Medical Board. Other health professional regulatory boards are also welcome to participate in the HPSP and may choose to opt in at a later date. The Health

Professionals' Services Program operates under the authority of ORS 676.190 and OAR 415-065.

Referrals
A health profession regulatory board may refer a licensee to HPSP or a licensee may self-refer. When a board refers a licensee, HPSP will work with the board to ensure the licensee is monitored in accordance with his or her board agreement. When a licensee self-refers, HPSP will work with the licensee to develop an individualized monitoring agreement and will keep the licensee's enrollment confidential as long as the licensee is in compliance with his or her HPSP monitoring agreement.

Education and Information
HPSP provides information and education to employers, licensee associations and support networks, treatment programs and other stakeholders. Topics include an overview of HPSP and its services, the value of HPSP for self-referrals, signs and symptoms of substance abuse disorders, mental health disorders and relapse, and effective workplace supervision.

Adult Mental Health Initiative
In order to ensure individuals receive the appropriate level of care for the appropriate duration, the Adult Mental Health Initiative (AMHI) was implemented in September 2010. The initiative reallocated a portion of resources historically used to develop community based licensed residential care facilities. These resources were directed to non-traditional person-centered supports in care management, a broad range of treatment services, discharge planning, and community based supports such as rental assistance.

AMHI has improved local accountability for positive treatment outcomes through performance based contracting. Increased local control and accountability help OHA's community partners provide high quality care at the right time, for the right duration, and at lower cost.

Initially, AMHI targeted state hospital patients who had been deemed ready for discharge but who, in some cases, had been waiting several years for an appropriate community placement. After significantly reducing the average length of time waiting for discharge for these individuals, efforts have been directed toward ensuring individuals in the community are in the most integrated, independent settings possible.

AMHI collaborates with local partners to enhance client self-determination by developing an Individualized Recovery Plan (IRP) for each member served. This enhanced emphasis on recovery and self-determination is expected to help lessen transition times to more independent and integrated living environments.

Residential Mental Health

Adult Mental Health Residential Treatment Programs

Co-occurring behavioral disorders and serious, chronic medical conditions create the need for specialized treatment environments that provide the level of service intensity to support individuals striving toward independence. Wise use of these intense supports can improve treatment outcomes and facilitate more timely transitions to independent living. While Oregon has been implementing several important strategies to increase the availability of integrated, community-based supported housing during the last biennium, the state recognizes the continued need for licensed residential care environments that provide intense, specialized services and supports.

Individuals in licensed residential treatment participate in an individualized assessment of strengths and treatment needs to help determine the most appropriate level of care that allows the most independence. An individualized treatment plan and an Individualized Recovery Plan are developed from this assessment, outlining the services and supports to be provided in the residential setting.

Three settings of community-based residential treatment services are offered for adults with serious mental illness:

- Residential Treatment Homes (RTHs) provide services on a 24-hour basis for five or fewer residents;
- Residential Treatment Facilities (RTFs) provide services on a 24-hour basis for six to 16 residents; and
- Secure Residential Treatment Facilities (SRTFs) restrict a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. SRTFs provide services on a 24-hour basis for 16 or fewer residents.

Type of Housing	Capacity
Adult Foster Home	765
Residential Treatment Home	214
Residential Treatment Facility	209
Secure Residential Treatment Facility	157
TOTAL	1,345

Three new RTHs opened in May and June 2015, providing residential services for residents with intense behavioral needs.

Telecare Stults House

This RTH provides five beds for adults transitioning from the Oregon State Hospital (OSH) over age 18 with intense behavioral issues. This home serves individuals with intense psychiatric and behavioral support needs who require assistance in activities of

daily living (ADL), socialization and living skills training. The ability to meet the ADL needs of these individuals is consistent with the average RTH.

Behaviors addressed at this RTH include but are not limited to:

- Physical aggression;
- Property destruction;
- Self-injurious/parasuicidal behavior; and,
- Sexually inappropriate/disinhibited behavior.

Rockwood RTH

This RTH provides five beds for adults transitioning from OSH over the age of 18 with intense behavioral needs and complex medical issues. This home has the ability to serve individuals with intense psychiatric and behavioral issues who need assistance with ADLs, socialization and living skills training. These homes will also support individuals with chronic medical conditions such as diabetes, physical disabilities, and other needs requiring intensive medical support. The ability to meet the ADL needs of these individuals is consistent with the average RTH and Rockwood RTH provides enhanced nursing support.

Behavioral issues can include one or a combination of the following:

- Physical aggression;
- Property destruction;
- Self-injurious/parasuicidal behavior; and,
- Sexually inappropriate/disinhibited behavior.

Clear Vue RTH

This RTH provides five beds for adults under the jurisdiction of the Psychiatric Security Review Board (PSRB), recommended for conditional release from OSH, and for individuals transitioning from a Secure Residential Treatment Facility (SRTF). Clear Vue serves individuals who need residential services including: assistance with activities of daily living, household responsibilities, access to medical and social services, education or vocational supports and any other life skill area related to re-integration into the community.

New Residential Settings in Pendleton

OHA staff in the Residential Programs and Services Unit work closely with community-based residential treatment providers and OSH staff to identify system needs and gaps. The following two projects for adults were also developed in the 2013-2015 biennium, and opened in February 2014.

Pendleton Creek Crisis Respite Center (CRC)

Pendleton Creek CRC is a 24-hour voluntary crisis stabilization center setting for individuals in crisis with mental health related issues. This is an open program and all placements are voluntary. The CRC program serves the eastern region of the state. The CRC provides support to agencies that encounter people in a psychiatric crisis. Referrals to the CRC come mainly from law enforcement, community mental health programs, acute care hospital or statewide referrals.

Salmon Run RTH

This RTH provides beds for five or fewer adults who are under the jurisdiction of the PSRB and recommended for conditional release from OSH or adults transitioning to the next level of treatment from a Secure Residential Treatment Facility (SRTF). Salmon Run serves individuals who need residential services including: assistance with activities of daily living, household responsibilities, access to medical and social services, education or vocational supports and any other life skill area related to re-integration into the community.

Psychiatric Security Review Board

The Psychiatric Security Review Board (PSRB) is a Governor appointed, five member multi-disciplinary board made up of a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public. This panel reviews the progress of individuals who successfully pled Guilty Except for Insanity (GEI) through the court system. The Psychiatric Security Review Board's mission is to protect the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest and person centered care.

The State Hospital Review Panel (SHRP) is appointed by the Oregon Health Authority and consists of the same make-up of panel members and mission as the PSRB. This panel reviews the progress of individuals who are found GEI of crimes that are non-Ballot Measure 11[3] while placed at Oregon State Hospital (OSH). SHRP has the responsibility for determining when these patients are ready to leave the state hospital on conditional release. When patients leave the hospital, PSRB is responsible for their monitoring and supervision in the community.

The PSRB and SHRP maintain jurisdiction for individuals adjudicated as GEI. As of July 1, 2015, 535 individuals were under the jurisdiction of the PSRB and 80 individuals were under the jurisdiction of SHRP, totaling 615 individuals in Oregon’s forensic system. Of those under the jurisdiction of the PSRB, 146 were patients at OSH and 380 (61%) reside in the community-- observing the requirements outlined in their individual

[3] Ballot Measure 11 identified certain person-to-person crimes, which, upon conviction, result in mandatory-minimum sentences.

conditional release plans and through supervision and treatment supports offered by Community Mental Health Programs (CMHP).

The PSRB reports to the Governor and uses a hearings process and conditional release orders to supervise people under its jurisdiction. OHA is statutorily responsible for providing mental health services to these individuals. CMHPs provide evaluations for the PSRB, SHRP, or the court, to determine if treatment in the community is appropriate and to secure resources in the community. Determination of supervision requirements and treatment for persons conditionally released into the community is also provided by CMHPs. Residential services are provided in varying levels of care including: Secure Residential Treatment Facilities, Residential Treatment Facilities and Homes, Adult Foster Care, Supported Housing, Intensive Case Management and Independent Living. Individualized community placements include, but are not limited to, the following services:

- Community risk evaluation;
- Monitoring, security and supervision;
- Case management;
- Psychotherapy;
- Residential supports;
- Supported employment and education services;
- Substance use disorder treatment services; and
- Medication management

The PSRB, SHRP and OHA continue to work with OSH Treatment Teams and CMHPs to assure that individuals are placed in the appropriate level of care and receive the services needed to live as independently as possible. OHA continues its commitment to develop residential placements that provide the necessary supports for this population to transition to the community. Five community placements were opened during the 2011-2013 biennium, and development of an additional 10 placements were completed in the 2013-2015 biennium.

Residential - Substance Use Disorder
Adult Withdrawal Management Services

Withdrawal management services include an assessment to determine medical need and the level of care necessary to manage withdrawal symptoms and the need for substance use disorder treatment. Level of care is determined based on The American Society of Addiction Medicine (ASAM PPC 2R) assessment and placement: ASAM placement level 3-WM, Residential; level 3.2-WM: Clinically Managed Residential; and level 3.7-WM: Medically Monitored Inpatient would qualify for adult detoxification services. Treatment services include 24 hour support and/or medically supervised care, medications to help alleviate and manage withdrawal symptoms, and support and

observation for those who are intoxicated or experiencing withdrawal. Individuals diagnosed with a substance use disorder receive a referral to residential or outpatient substance use disorder services.

Adult Residential Addictions Services

As of July 1, 2013, Oregon's Medicaid funded addictions stabilization services, including residential (Figure 5.) and detoxification, transitioned to administration by Coordinated Care Organizations. OHA continues to provide regulatory oversight and policy implementation for residential and withdrawal management programs. Treatment services are in safe, permanent settings and adhere to policies and procedures approved by OHA. All programs are staffed twenty four hours a day and include a wide variety of services inclusive of adult women, women with children, men with children, and adult men.

Assertive Community Treatment (ACT)

OHA spent an additional $5.5 million to expand ACT services statewide. This investment increases capacity to provide case management and assertive community treatment to help people avoid hospitalization or shorten hospital stays. OHA has provided infrastructure grants to 10 CCOs to develop ACT services in their service delivery areas.

OHA continues to collaborate with the non-profit Oregon Center of Excellence for ACT (OCEACT), to provide training and technical assistance statewide. The work of OCEACT will be even more valuable as new ACT providers begin providing services to those who previously had no access to those services.

Figure 5.

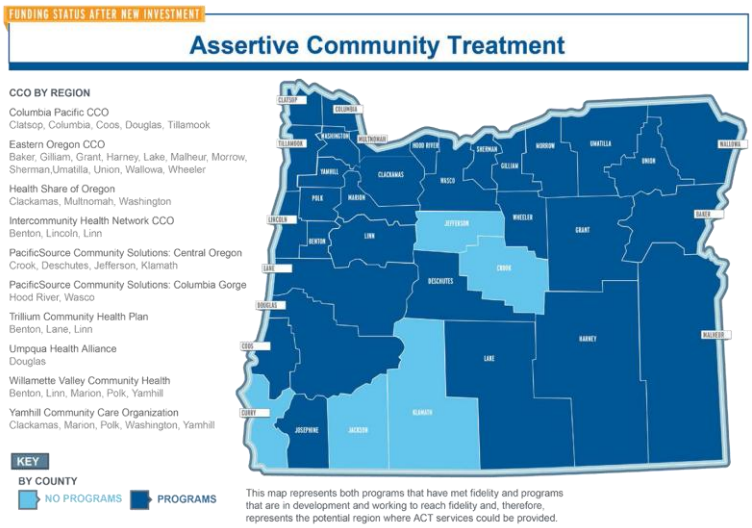
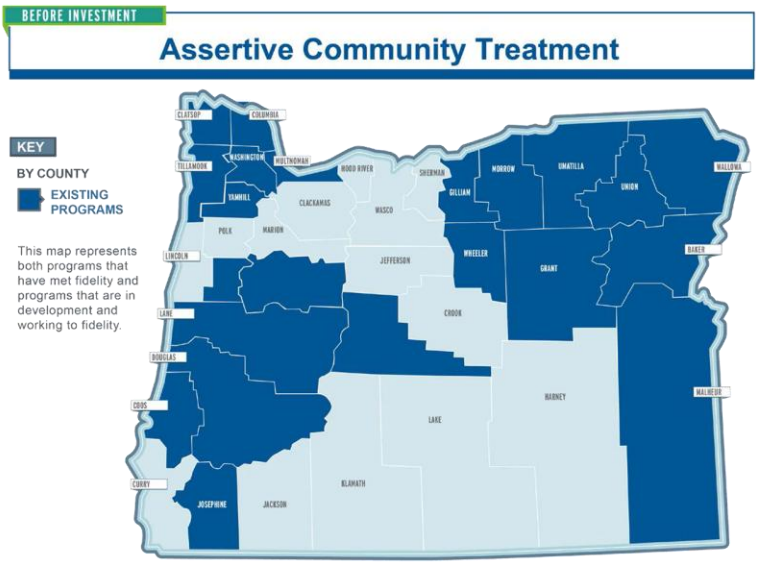


Figure 6.



Community Treatment for Children and Youth

Children ages zero through 17 are served under the children's mental health system in Oregon, with programs and services also available to young adults in transition between the ages of 14 and 25. Services are provided through the community mental health programs, and available throughout Oregon. A continuum of services exists from outpatient services to hospitalization, including long-term care in an alternative setting to the state hospital system, based in the community. Developmentally appropriate services are available to young adults in transition.

The System of Care Wraparound Initiative (SOCWI) implemented Wraparound, a research based practice model, for children with the highest levels of need and their families. The SOCWI intensive care coordination model engages a creative and collaborative process led by families and youth, to develop a flexible, coordinated and individualized plan of services and supports in a culturally responsive manner. These services and supports are geared to meeting each young person's needs and strengths. Wraparound moves away from the historically limited array of client services, and toward coordinating across systems including Child Welfare, Developmental Disabilities, education, juvenile justice, and others encompassing a variety of services and supports to best meet the youth's individual needs.

SOCWI was launched at three demonstration sites, comprising eight counties, in July 2010 and expanded in 2014 to an additional 12 sites comprising 30 counties. More than 863 children and young adults have been served since the inception of this project. In the coming biennium, the expansion is slated for completion statewide.

SOCWI has been successful and accomplished a transformation in children's mental health services. It uses an intensive care coordination model for cross-system planning of children's service and support needs. Data demonstrate that children in SOCWI have:

- Better health, as reflected by more children having access to a primary care physician, and improved monitoring of psychotropic medication being prescribed, in addition to having adequate effective care for emotional and behavioral challenges.
- Better care when children are able to move into long-term community-based family settings, either with their biological family, guardianship, or through adoption. Families experience better care, no longer need child welfare involvement in their lives, receive better supports and have a natural support network.
- Access to services provided at a lower cost through participation and collaboration of multiple systems. The intensive care coordination model reduces higher-cost services. This makes it possible to more children to be served at reduced cost.
- Increased levels of dignity and respect with which children, youth and families are treated with the Wraparound model as evident through anecdotes and family stories.

Guidelines for the local practice have been established through the Oregon Best Practice document, which provides a framework, tools, and strategies that align with the principles and values of Wraparound. To ensure that the quality and consistency of the model is evidenced statewide, fidelity to Wraparound is measured by two instruments: the Team Outcome Measure (TOM) and Wraparound Fidelity Index-EZ (WFI-EZ). The next phase in the System of Care approach using the Wraparound model is to continue to create a child-serving system where this is the way business is conducted in all Oregon communities, by expanding to the remaining three CCOs who are not currently participating in SOCWI. This initiative, to date, has shown that children receive better care, enjoy better health and are served at a lower cost under this System of Care.

Using this model, which supports many existing initiatives, all child-serving systems must be brought to the table for ongoing success. High-level decision makers from Oregon Health Authority, Oregon Youth Authority (OYA), Department of Human Services (DHS), developmental disabilities and Oregon Department of Education (ODE) must tackle shared governance and funding of this business model for continued sustainability.

School Access to Mental Health

School Access to Mental Health enhances the availability of mental health services to students by bringing mental health services into schools and increasing the array of mental health services available in the school building in a school-based infrastructure.

Locating services within the school setting increases accessibility for children, adolescents and their families to receive mental health services and targets youth who may not otherwise engage in traditional outpatient services. Mental health professionals in schools can also train and assist school staff in screening and early identification of mental health issues, provide consultation to support students, promote mental health and influence a positive school environment. Through partnership with Public Health, funding was allocated to School Based Health Centers (SBHCs) specifically for children's mental health, which allowed for SBHCs to increase their capacity to provide mental health services to their clients.

SBHCs were well positioned to receive this funding due to their robust partnerships, strong system of care, and prevention focus. As a result, greater numbers of Oregon SBHCs are now able to provide integrated care for physical and behavioral health in one location. SBHCs were awarded grants to add or expand mental health staffing capacity, and to support mental health projects, including implementation of:

- A mental health screening tool or framework (e.g. substance abuse or depression screening tool such as screening, brief intervention, and referral to treatment (SBIRT));
- A tele-mental health project, consisting of psychiatric assessments being done by videoconference (telehealth);
- A Youth Advisory / Action Council, which would complete a mental health research project;
- A data capturing system (e.g. Electronic Health Record); and/or
- Projects that supported equity and cultural competency.

There are now 57 SBHCs that have mental health providers on site, of which 12 did not provide mental health services prior to the 2013-14 school year.

The SBHCs work in conjunction with the local school districts to provide wellness services, care coordination, and referrals to specialized services. In the last biennium significant expansion of mental health services was funded resulting in nearly all SBHCs having at least one FTE providing behavioral health clinical services. Mental health funding will be expanded in the current biennium to cover all currently certified SBHCs. In addition, funding has been allocated to community mental health programs to provide school based behavioral health services in selected school districts that were identified as being at elevated concern with high-risk adolescent behaviors. Both funded programs required coordination, approval, and collaboration with the local school districts. In a joint effort between Public Health and OHA, a mental health liaison has

been hired to coordinate the expansion of behavioral health services in School Based Health Centers[4].

Adolescent Depression Screening

The Oregon Pediatric Society and community providers work with primary care clinics to integrate routine mental health screening within primary care to increase early detection of mental health issues in adolescents, and provide appropriate follow-up. Statewide consultation services and training are provided for primary care providers and clinics in use of an adolescent depression and substance use screening tool such as the Patient Health Questionnaire (PHQ-9) and SBIRT.

Routine screening allows primary care providers to identify youth who may need treatment but have not historically been identified. Early detection and follow up is vital for adolescent development. Untreated mental disorders can lead to harmful effects such as suicide and substance abuse. Training is provided to primary care providers with a focus on improving linkages to mental health providers and further expansion of evidence based treatment practices.

Oregon Psychiatric Access Line about Kids (OPAL-K)

OPAL-K was established and began operations in June 2014 in collaboration and partnership with Oregon Health and Sciences University, Oregon Pediatric Society, and the Oregon Council of Child and Adolescent Psychiatry. This telemedicine consultation service offers a link between pediatric or other primary care providers with providers of child psychiatric and mental health consultation, to improve integration and quality of children's mental health and physical health care. Based on proven programs used in other states, the OPAL-K model has been positively received and utilized and has already made notable impacts to treatment array across the state. At the end of the first year of operation, 954 providers were enrolled in OPAL-K and OPAL-K physicians had completed nearly 500 consultations. This initiative is fully supported in policy and funding by the Governor and Legislature.

OPAL-K provides a physician-to-physician consultation system, linking child psychiatry expertise with primary care providers (PCPs). Objectives include:

- Same day consultation through phone or videoconference;
- Referral information made available to PCPs to assist them with links within their community;
- Provision of continuous mental health education for PCPs; and
- Face-to-face or telehealth consultation for complex cases in remote communities without access to child psychiatry services.

[4] SBHC liaison: Stefanie Murray, Stefanie.l.murray@state.or.us

This service will improve mental health care delivery in primary care, improve access to timely mental health consultation and triage within primary care settings, and improve the cost effectiveness of mental health care for children and youth through early identification, consultation and access to mental health treatment. OPAL-K can prevent mental health disorders from developing and increasing in severity in children, and more effectively identify and treat children who experience mental health challenges. The majority of children and youth with mental health challenges and diagnosable illness are initially seen and identified by primary care clinicians, and not by mental health professionals.

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through six years who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and are consequently experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent or caregiver to restore the child's sense of safety, attachment, and appropriate affect and to improve the child's cognitive, behavioral, and social functioning. CPP is recognized by the National Child Traumatic Stress Network and the SAMHSA National Registry of Evidence-Based Programs and Practices as having adequate cross cultural application.

The goals of this project were to:

- Identify clinicians previously trained in CPP and provide updated training;
- Implement CPP with fidelity through provision of mental health promotion and intervention services to at-risk families;
- Utilize the CPP Fidelity Tools;
- Utilize two validated developmentally appropriate measures, such as the Parenting Stress Index, to evaluate effectiveness of the intervention; and,
- Develop ongoing consultation, supervision and networking between CPP-trained therapists to maintain fidelity to the model over time.

OHA identified 42 therapists trained in CPP through other funding sources and provided training in the updated protocols. The training took place in October 2014. An additional cohort of therapists never before trained in CPP began training at the same time.

Addressing the Needs of Commercially Sexually Exploited Children

The 2013 legislative session allocated $2.3 million to address the needs of Commercially Sexually Exploited Children (CSEC) in Oregon. This funding was awarded to Morrison Child and Family Services in Portland, through a competitive

proposal process. Morrison began operating a 12 bed residential treatment facility for females and transgender females ages 11 through 15 years of age in January 2015.

OHA has worked closely with community partners and the Oregon Department of Justice (DOJ) to devise a plan for creating a comprehensive statewide system to identify, respond to and treat child victims of sex trafficking.

Commercial Sexual Exploitation of Children occurs when individuals buy, trade, or sell sexual acts with a child. Sex trafficking is "the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act[5]," *Victims of Trafficking and Violence Protection Act of 2000* (TVPA, 2000).

Children who are involved in the commercial sex industry are viewed as victims of severe forms of trafficking in persons, which is sex trafficking "in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age," (TVPA, 2000). A commercial sex act is "any sex act on account of which anything of value is given to or received by any person," (TVPA, 2000).

DOJ Crime Victim's Services Division (CVSD) shall create an advisory committee that will address issues associated with the Commercial Sexual Exploitation of Children (CSEC) and provide recommendations on policy and procedure to DOJ, CVSD and OHA. This Agreement sets forth both agencies' expectations for the CSEC Advisory Committee.

The CSEC Advisory Committee will be modeled after the Child Abuse Multidisciplinary Intervention (CAMI) Advisory Committee and will collaborate with OHA. The CSEC Advisory Committee will make policy recommendations, provide system oversight and define funding priorities for money allocated to OHA for the purpose of addressing the commercial sexual exploitation of children. The Advisory Committee will also provide collaboration and recommendations on any CSEC grants administered by CVSD in the future.

In collaboration with DOJ CVSD and OHA, the CSEC Advisory Committee will provide the following:

1. Serve as a board of experts on the subject of CSEC and the Oregon system of care related to CSEC;
2. Establish statewide CSEC priorities;
3. Assist in advancing CSEC priorities on a local, state and federal level;

[5] Victims of Trafficking and Violence Protection Act of 2000 (TVPA) retrieved from: http://www.state.gov/j/tip/laws/61124.htm

4. Review how state funding is spent on CSEC within the Oregon Health Authority, and provide recommendations on how best to utilize current and future funding;
5. Review current systems addressing CSEC, identify strengths and weaknesses;
6. Provide recommendations for the use of future CSEC funds, both public and private;
7. Assist in identifying public and private partnerships;
8. Partner with OHA to assist in ensuring successful policy implementation;
9. Provide consultation and recommendations to Morrison Child and Family Services regarding the administration of the OHA funded CSEC shelter and development of programs for the CSEC population;
10. Secure ongoing funding for a state wide CSEC coordinator position past the June 30, 2015 expiration date of this agreement;
11. Participate on the CSEC advisory committee that reports to the CAMI board;
12. Work with state and local partners to establish a statewide, organized continuum of care and response for CSEC victims;
13. Develop protocol for CSEC victims grounded in System of Care values and principles; and,
14. Develop a State Plan with community partners and OHA staff, which address prevention, early intervention and services for potential and existing CSEC victims.

Work is being done in Multnomah County to significantly address issues faced by children and youth who have been commercially sexually exploited (CSEC). Multnomah County has hired a full-time coordinator to coordinate planning efforts and services for this population.

Statewide, there are three established committees working on training for general intervention, medical interventions, and housing for this population. The FBI, Senator Ron Wyden's office and the Multnomah County Commissioner's office participate in these committees.

In Multnomah County a group of professionals from multiple agencies have been trained to identify and serve this population. Multnomah County has a five-bed shelter program for children who have been commercially sexually exploited. Child Welfare in Multnomah County developed a CSEC specific unit that only assists cases of children who are or have been involved in trafficking.

Federal legislation HR 4980 requires DHS Child Welfare requires child welfare to have policies and procedures for protecting and identifying children and youth at risk of sex trafficking. OHA is collaborating with Oregon child welfare on the development of these Oregon Administrative rules, policies and procedures.

Intellectual/Developmental Disability/Mental Health Collaboration

The Portland Metro Tri-County area and Marion County have developed collaborative groups of Mental Health and Intellectual/Developmental Disability providers, Child Welfare representatives, state and county representatives, and providers to create a System of Care for children and youth who have co-occurring mental health and intellectual/developmental disability disorders. These county level collaboratives design and coordinate training for providers serving the co-occurring population, explore necessary policy change, and provide case consultation to providers.

This group will convene 150 professionals, stakeholders, families and consumers again for the third time in October 2015 to continue discussion on breaking down barriers between these two child serving systems with a greater focus on treatment application and evidence based practice.

Collaborative Problem Solving

Collaborative Problem Solving (CPS) is a communicational approach to working with children with social, emotional and behavioral challenges, which has two major tenets:

1. Social, emotional, and behavioral challenges in children are best understood as the by-product of lagging cognitive skills; and
2. These challenges are best addressed by resolving the precursors for challenging behavior in a collaborative manner.

OHA partners with Oregon Health & Sciences University (OHSU) for the OHSU/Think: Kids Alliance, which focuses on advancing practitioner and family member skill development in the application of the CPS model. The Alliance supports work in creating connectivity and coordination among systems and organizations utilizing CPS, and creates affordable CPS training opportunities for professionals and families throughout Oregon.

The OHSU/Think: Kids CPS Alliance[6] has strengthened and expanded its Oregon capacity significantly with 2013 legislatively authorized new investment funding, including:

- Trainings and Work group development, including CPS Certified Trainer Coalition, Foster Care Coalition, Parent Training Coalition, and planning for an Outpatient Provider Work Group;
- Supervision and support to individuals and agencies implementing the model, support for certification;
- Resource expansion: Full-time OHSU Co-Coordinator position, a lending library, public CPS discussion group at Legacy Emanuel Hospital, and proliferation of the model across community sectors statewide; and,

[6] Additional scope of work information and overview of CPS Alliance is available at:www.ohsu.edu/cps.

- Exposing new systems of care to the CPS Model including drug and alcohol programs and the Developmental Disabilities service array.

The increase in Certified Trainers across the state has expanded the availability of CPS to the public, moving service delivery to the community outside of OHSU. The Oregon CPS Alliance will effectively roll out parent group trainings and CPS support groups for families across the state, overlapping with other models such as Wraparound and practices supportive of trauma informed care.

Juvenile Fitness to Proceed

The Oregon State Legislature passed House Bill 2836 in 2013 to address Juvenile fitness to proceed throughout the state. Before this law, the state lacked a consistent standard for addressing juvenile competency. HB 2836 addresses the unique nature of juvenile fitness to proceed and establishes a standard for evaluating adjudicative competency in juvenile court and providing restorative services for juveniles who are found unfit to proceed. The bill named OHA as the certifying body for the administration of these evaluations.

Oregon Health Authority has expanded its statewide Forensic Evaluator Certification training to certify psychiatrists and psychologists who conduct forensic evaluations for juvenile defendants to include the intricacies of juvenile fitness to precede evaluations. Forensic evaluators who wish to be certified to conduct forensic evaluations on juvenile defendants must participate in this training and submit three sample reports for review by a panel convened by OHA in order to complete their certification.

HB 2836 stipulates that juveniles are not to be removed from their current placements for fitness to proceed evaluations or for restorative services unless absolutely necessary for the safety of the youth or the community. OHA has contracted with Trillium Family Services to provide outpatient restorative services throughout the state. Trillium Family Services has developed a restorative services psychoeducational curriculum that can be administered in any setting. Prior to the enactment of this statute, children were often placed unnecessarily in overly restrictive settings to receive restorative services. By assuring that these services can be provided in the community in which the juvenile resides, the beds in the most restrictive levels of care can be reserved for those most appropriate for these settings.

Partnership with DHS Child Welfare

Child Welfare and OHA share the contracted services of a child and adolescent psychiatrist to provide medical direction to behavioral health and child welfare. This collaborative approach has facilitated a shared understanding and a common approach to addressing the complex mental health needs of children in the child welfare system.

DHS policy and contracts require that children who are placed in substitute care through Child Welfare receive a mental health assessment. Child Welfare policy states that all children in substitute care will be referred for a mental health assessment within 21 days of placement. CCO contractual expectations include an outcome based incentive, which requires that comprehensive mental health assessments for children placed in substitute care by Child Welfare be provided no later than 60 days following the date of DHS custody. This measure has been incorporated into accountability measures for the CCOs. A service improvement goal has been identified to increase the percentage of children who receive timely mental health assessment to ninety percent.

Longer term goals include developing capacity for mental health assessment for children younger than age three, and that system changes extend beyond improving compliance with the assessment requirement and lead to increased capacity to provide appropriate treatment for traumatized children.

Coordinated Care Organizations are now contractually mandated to provide a Child and Adolescent Needs and Strengths (CANS) assessment to all children coming into child welfare custody within the first 60 days of care, in alignment with the mental health metric described above. Reimbursement for the CANS is now a Medicaid covered service. Some CCOs have set up a rate structure to incentivize combining the CANS with the mental health assessment in an effort to achieve best practice. In addition, through the statewide expansion of Wraparound, sites are being trained on and encouraged to incorporate CANS within the child and family team setting in order to achieve best practice in the Wraparound care planning process.

The goal for the next biennium is to contract with the Praed Foundation (author of the CANS) for the use of ECANS, a reporting and analytics service. This will allow further expansion of CANS use throughout the system. CCO's, state agencies and providers will have data to track outcomes of youth receiving mental health services, and Wraparound Care Coordinators and mental health professionals will be able to increase CANS use in care and treatment planning.

Child Welfare sponsors the Target Planning and Placement Committee to review complex cases of children in the custody of Child Welfare. Caseworkers prepare a packet of case materials for review and present the case to the committee to obtain assistance in planning and consultation. The committee includes representation from Child Welfare, OHA, Education, county mental health, Aging and People with Disabilities, Juvenile Justice and any other child serving system involved in the child's case. This committee identifies gaps and barriers to system access and services, and assists caseworkers in obtaining appropriate services for children and young adults.

OHA works with Child Welfare to co-finance and co-manage much of the out-of-home mental health treatment services provided to children served through Child Welfare. CW contracts with public and private child serving agencies to provide Behavioral Rehabilitation Services for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

Treatment Foster Care is a collaborative effort with Child Welfare. Treatment Foster Care is a combined service between DHS Child Welfare and OHA Oregon Health Authority administered at the local level through specific foster care providers who are supervised by the local community mental health program. It is considered the least restrictive of residential treatment options for children in the care and custody of the state; it is a critical treatment option for children, especially in rural counties.

Child Welfare Collaboration

Oregon works to assure that children in foster care receive appropriate psychotropic prescribing practices. A mental health assessment is obtained before more than one new psychotropic prescription or any antipsychotic medication is prescribed to a child in foster care. Annual reviews are conducted for psychotropic medications for children in foster care prescribed more than two psychotropic medications, or for any child in foster care under the age of six prescribed any psychotropic medication.

Oregon, through a technical assistance grant from the Center for Health Care Strategies, has recently concluded an in depth quality improvement effort as part of a multi-state collaborative, to design, pilot and evaluate effective practices to improve psychotropic medication use among children in foster care.

State goals for targeting improvement in psychotropic medication prescribing for children under the age of six in foster care are:

- Improve the effectiveness of the consent process for psychotropic medication use;
- Expand collaboration among key stakeholders including child welfare caseworkers and managers, physical and mental health care providers, CCOs, foster parents, and children in foster care who are being prescribed psychotropic medication;
- Improve safety and effectiveness of psychotropic medication use through utilization of best practices and indications for use;
- Reduce use of antipsychotic medications for unapproved indications by improving the understanding and availability of non- pharmacological treatment for sleep disorders and aggression; and
- Reduce the practice of poly-pharmacy with psychotropic medications.

Data points are being examined in the project to determine the percentages of children:

- In the custody of child welfare;
- In the custody of child welfare with developmental disabilities;
- With developmental disabilities; and
- All children in the Oregon Health Plan receiving:
    - More than two antipsychotic medications;
    - Multiple psychotropic medications;
    - Medication with lack of age appropriate indication for use
    - Antipsychotic medication without appropriate medical monitoring (e.g. glucose/lipid monitoring); or
    - Psychotropic medications with concurrent or recent mental health services.

Another focus in OHA work with Child Welfare is obtaining informed consent for psychotropic medication. The state has implemented changes in the administrative rules for this area of consent to reflect the identification of psychotropic medication prescribing as a special medical procedure. Resource guides for youth and caseworkers have been developed as a tool in increasing more effective collaboration and understanding of prescribing practices, rights, and options for effective treatment.

Early Learning Council

The Early Childhood and Family Investment Transition Report was presented to former Governor Kitzhaber early in 2011. The Report included recommendations to integrate state funded services, and to create agencies and structures to ensure that every child enters school ready and able to learn, enters first grade ready to read, and leaves first grade reading. The focus of change has been on early identification and support, shared measurement and accountability; and creation of an Early Childhood System Director position in the Governor's Office and an Early Learning Council (ELC) to consolidate multiple existing coordination efforts, funding streams and administrative structures. The Early Learning Council and Oregon Education Investment Board were established, and conversations in communities were sourced into planning, strategy, and communications. School districts, social service providers, community members, early intervention, childcare and early learning professionals, health care practitioners, educators and others convened to align collective assets towards the common goal of kindergarten readiness, using technology, best practice interventions and performance-based contracting[7]. These entities are referred to as **"**Community-based Coordinators of Early Learning Services" (hubs).

[4]Stanford Social Innovation Review, *Collective Impact*, John Kania & Mark Kramer. Winter 2011.

The hubs provide structure for achieving the goal that all children are ready to learn when they enter kindergarten. Children at the highest risk are the focus. Success will result from a determined concentration on outcomes and the integration of services at state and community levels. Individual, service and system measurements will be tracked with a willingness to change approaches that do not deliver success.

The overarching goals for the hubs are:

1. Children are ready for kindergarten when they arrive;
2. Children will be raised in stable and attached families; and,
3. Services are integrated and aligned into one early learning system design to achieve Goals one and two.

The Early Learning Council and the Youth Development Council have been brought into the Oregon Department of Education as the new Early Learning Division (ELD). The Early Learning Division will provide staff support and oversight of the Hubs.

Children and Youth Residential Mental Health Services
Intensive Psychiatric Treatment

The Secure Children's Inpatient Program (SCIP) provides 24-hour secure residential treatment (formerly delivered in the state hospital) designed to provide intensive psychiatric treatment for children age 14 or younger, including a therapeutic school program on the residential campus. SCIP is housed in a residential facility in the Portland metro area.

Children and youth are referred to this level of care by their Child and Family team. The referral is approved at the local level and sent to OHA for final authorization for admission. The level of care needed must be between acute care hospitalization and psychiatric residential treatment service levels.

The Secure Adolescent Inpatient Program (SAIP), located in Corvallis, Oregon, provides secure residential treatment for adolescents ages 14 to 17 years. The SAIP program also provides secure forensic mental health treatment for youth who are court mandated for restorative services, for Oregon Youth Authority crisis and petition admissions, and for the Juvenile Psychiatric Security Review Board (JPSRB) secure residential treatment.

Intensive psychiatric services are provided in coordination and with the collaboration of a Child and Family team. Services are delivered in an integrated and holistic approach in a safe and comfortable living environment that is as normalized as possible and matches the individual developmental level of the child. Both the SCIP and SAIP programs are transitioning to trauma informed practice under the Sanctuary Model. Therapies employed include:

- Collaborative Problem Solving;
- Dialectical Behavioral Therapy (SAIP);
- Cognitive Behavioral Therapy for multiple symptoms; and
- Dr. Bruce Perry's Neuro-sequential Model.

Both SCIP and SAIP programs are committed to delivering care to children and youth that:

- Deliver active psychiatric treatment in an individual plan of care developed by an interdisciplinary team under the direction of a psychiatrist who is board eligible or board certified in child psychiatry by the Oregon Board of Medical Examiners;
- Employs a multidisciplinary approach to care that includes CMHPS, CCOs, the child's school, family representatives and advocates, acute care psychiatric hospitals, juvenile justice, and children's intensive treatment service providers as indicated and appropriate for each child;
- Employs culturally relevant and competent treatment that is appropriate for the gender, age, culture, ethnicity, strengths, and individualized treatment needs of the child;
- Has a staffing model that allows for a child's frequent contact with a child psychiatrist, psychologist, psychiatric nurses, psychiatric social workers, rehabilitation therapists, and milieu staff with specialized training twenty four hours a day. Additionally, a psychologist and a psychiatrist with specialized training in forensic evaluation are available; and,
- Provides linkages with various levels of care and provides for care coordination with guardians, community partners, and continuing care providers to ensure the child's treatment is provided in the most appropriate and least restrictive setting.

Children's psychiatric residential treatment services (PRTS) and psychiatric day treatment services (PDTS) funding was transferred to the OHP in 2005 and is managed today through CCOs as part of their global budget. PDTS and PRTS programs for children who are Medicaid eligible but not enrolled with a CCO are co-managed with the CMHPs. The CMHPs conduct level of service intensity determination and approve referrals to PDTS and PRTS programs.

All CCOs are required to create linkages with community support systems including local and/or regional allied agencies. Integration of physical and behavioral health care is a requirement of their Transformation Plans. Enrollment in a CCO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary so children with severe emotional disorders can remain in their community.

PDTS and PRTS service providers are expected to collaborate with the local Child and Family Team to coordinate transitions back into the community with the goal of maintaining the child in the least restrictive setting.

Residential Services for Young Adults in Transition

Statewide residential programs and supported housing specifically designed to meet the needs of young adults continue to expand. Residential services for young adults in transition (YAT) programs serve young adults ages 17 through 25 who have mental health challenges and who may have a history of institutional care. Residential resources for young adults include five young adult Secure Residential Treatment Facilities (SRTF), an alternative to state hospital level of care; seven young adult residential treatment homes (RTHs), as well as capacity for 51 young adults in supportive housing (Table 1).

Cadenza YAT RTH is a new young adult residential treatment home that was developed and opened in the 2013-2015 biennium. Staff in the OHA Residential Programs and Services (RPS) Unit also worked closely with community-based residential treatment providers and local mental health service providers to develop a new residential treatment home for the YAT population located in Pendleton during 2013-2015 biennium. New Roads YAT RTH, operated by ColumbiaCare Services, Inc. serves young adults in the eastern Oregon region, providing housing as well as support services.

Table 1.

Name	Provider	Capacity	Residential Type
Linn County	Linn County Mental Health	5	Supportive Housing
Washington County	Washington County Mental Health	16	Supportive Housing
Multnomah Brokerage	Empowerment Initiatives	10	Supportive Housing
Community Support Services	Polk County Mental Health	3	Supportive Housing
EAST Place Apartments	Polk County Mental Health	5	Supportive Housing
Three Bridges	Kairos Northwest	12	Supportive Housing
Mosaic	Youth Villages	5	Residential Treatment Home
Sender House	Trillium	5	Residential Treatment Home
Momentum	Kairos Northwest	5	Residential Treatment Home
Firefly	Cascadia Behavioral Healthcare	5	Residential Treatment Home
Tempo	Kairos Northwest	5	Residential Treatment Home
Zora	Lifeworks NW	5	Residential Treatment Home
New Roads	ColumbiaCare Services, Inc.	5	Residential Treatment Home
Cadenza	Kairos Northwest	5	Residential Treatment

			Home
New Beginnings	Kairos Northwest	12	Secure Residential Treatment Facility
McKay Lodge	Looking Glass Youth and Family Services	14	Secure Residential Treatment Facility
Children's Farm Home School	Trillium Family Services	65	Secure Residential Treatment Facility
Parry Center	Trillium	50	Secure Residential Treatment Facility
Albertina Kerr (Crisis Psychiatric Care)	Albertina Kerr	24	Secure Residential Treatment Facility
Total Capacity		256	

YAT-specific programming is being implemented within the OSH system. OHA has developed specific programming at various levels of care to address the needs of young adults ages 17 through 25 that are transitioning from OSH to a community residential setting. These residential options are needed to address the dramatic shortfall in services that occur due to categorical eligibility when an individual turns 18. These housing projects support expanded options. Services delivered in these residential options are engaging and relevant to young adults, including feedback from the young adults whenever possible. Programs accommodate the critical role of peers, families and friends in service delivery.

Services delivered in these residential settings serving young adults include but are not limited to:

- Money and household management;
- Supervision of daily living activities such as skill development focused on nutrition, personal hygiene, clothing care and grooming, and communication skills for social, health care, and community resources interactions;
- Assuring the safety and well-being of individuals in the program;
- Administration, supervision and monitoring of prescribed and non-prescribed medications;
- Provision or arrangement for routine and emergency transportation;
- Developing skills to self-manage emotions;
- Management of physical or health issues such as diabetes and eating disorders;
- Access to mentoring and peer delivered services;
- Promoting the positive use of leisure time and recreational activities;
- Access to supported education and supported employment resources;
- Individual, group and family counseling;
- Social and independent Living Skills training;
- Appropriate access to crisis intervention to prevent or reduce acute emotional distress;
- Development of a service plan with a safety component to ensure that a developmental and trauma informed perspective is incorporated; and,

- Specific sections addressing services and supports unique to the developmental challenges of a transition-age young adult.

Adolescent Residential Substance Use Disorder Treatment

When youth need detoxification services, they are sent to a local or regional hospital facility licensed by OHA Public Health Division. OHA licenses facilities to provide residential services to youth who are assessed as needing ASAM Level III services. Level III programs offer organized treatment services featuring a planned regimen of care in a 24-hour residential setting. Treatment is delivered in accordance with defined policies, procedures and clinical protocols. Programs are housed in or affiliated with permanent facilities where youth can reside safely. The programs are designed for adolescents needing safe and stable living arrangements in order to develop their recovery skills.

There are three levels of services available to youth needing substance use disorder treatment services. Those levels are:

- **Level III.1** – Halfway house or group home with Level I and Level II.1 services.
- **Level III.5** – Services offered in a therapeutic group home, therapeutic community, or licensed facility.
- **Level III.7** – Services offered in an inpatient or medical model residential home.

Crisis Services

Emergency Department Crisis Workgroup

Hospitals in Oregon are experiencing increasing demand in serving young people who go to emergency departments (EDs) for behavioral health challenges. Youth are waiting in emergency departments or pediatric hospital rooms, sometimes for many days, due to a lack of options for safe, therapeutic services. Families, health care providers and insurers are concerned about this growing problem. Psychiatric boarding is unlikely to be therapeutic, is at times traumatic for young people, their families and hospital staff, and it creates logistic and financial problems for hospitals.

This problem is national as well as local. Data in Oregon suggest that there is an increase in the utilization of emergency departments for children experiencing a behavioral health crisis. Hospitals report increases both in children presenting for behavioral health care within emergency departments and also in the amount of time spent waiting in the emergency department for an appropriate resource.

OHA convened a two-session workgroup to evaluate data and solicit expert opinion on the contributing factors and possible solutions to this problem. The workgroup included representatives from emergency departments, psychiatric hospital units, pediatric hospital units, sub-acute psychiatric residential treatment programs, CMHPs, intensive

community-based treatment service providers, child welfare, private insurance, CCOs, family members, and young adults.

The children's mental health system must have capacity to mitigate crisis and to work with families to plan for ongoing services that will address the underlying issues. Each community's unique strengths and resources will define its strategies and solutions to creating a rapid yet therapeutic response to families faced with a behavioral health crisis. Strategies to improve local options must be developed at both state and local levels. One immediate action taken by OHA will be to track the length of time that clients stay in emergency departments waiting for resources. This will be one benchmark of the system.

OHA will pilot two to three diversion programs to evaluate how well they reduce use of emergency departments for mental health crisis needs. OHA has identified regions around the State with high utilization of children and young adults accessing the EDs.

OHA will work with the local mental health authority and the CCOs in each region to design a plan specific to assisting children and their families to access alternative services to acute care and ED usage. The response to EDs will not be based on insurance coverage. Alternatives may include:

- Crisis stabilization ED diversion teams;
- Foster care and in home crisis respite; and
- Flexible activities or items that directly decrease ED usage.

Crisis Services

In anticipation of the Affordable Care Act, Oregon expanded withdrawal management services. Community withdrawal management services provide immediate and short-term clinical support to people who are experiencing acute physical symptoms from alcohol and/or drug withdrawal and who are at an immediate health risk.

OHA provides financial support, in part, for crisis services in every community mental health program in Oregon. Some examples of crisis services include the following:

Assessment/Triage (Living Room Model) - There are currently three programs that are integrating portions of the Living Room Model into their available crisis services programs; Jackson County, Multnomah County, and Clackamas County.
Jackson County - A Living Room Model program is being designed to offer a safe, supportive, and welcoming environment and to provide a short-term, secure crisis program that allows up to ten hours of stay for five individuals. This program will add to the diversion options for individuals who may otherwise receive higher levels of care. Treatments include therapeutic crisis management; strengths based assessments; health screenings to determine health care needs; safety planning; and use of peer specialists. The January opening has been postponed to June 2015.

Multnomah County - Standing Stone Resource Room is a part of the Urgent Walk-In Clinic, as an optional support to individuals in crisis. Standing Stone is not a separate service, and is intended to function as a part of crisis stabilization and to support clients in connecting with community resources and engaging in their recovery process as they seek out or wait for ongoing treatment in the community. Consumers who are referred to Standing Stone by Urgent Walk-In Clinicians have access to the Standing Stone Resource Room for one week from the date of their referral.

Clackamas County - In 2015, Clackamas County plans to open a 23 hour receiving center, as an expansion of the existing crisis walk-in clinic, to provide a hybrid of a Living Room model and Psychiatric Emergency Department. The goal is a voluntary, low barrier setting where individuals in crisis can receive active treatment, peer support and case management and potentially avoid an emergency department visit or jail.

Crisis Residential/Respite - Oregon defines crisis respite as short-term crisis stabilization beds located in a licensed non-secure crisis respite facility. There are multiple counties in Oregon that provide crisis respite services. At the end of June 2014, 13 CMHPs reported having 39 crisis respite beds available to their communities.

Crisis Intervention Team/ Law Enforcement - During the 2013 legislative session, the Oregon Legislature allocated funds to enhance and expand jail diversion services. The legislature has allocated up to $600,000 to contract for the coordination and instruction of Crisis Intervention Team (CIT). A contract was awarded to Performance Leadership, Inc., to conduct a CIT needs assessment, facilitate relationships between law enforcement agencies and CMHPs, develop a curriculum for both 24 and 40 hours of crisis intervention training, and to hold three regional CIT events. The project will be completed by June 30, 2015.

Mobile Crisis Outreach - In 2014, 12 CMHPs serving 18 counties in Oregon were awarded over $6.2 million to expand their mobile crisis services. While some counties utilized the funding for traditional crisis response by partnering with local law enforcement to have a licensed mental health clinician available 24 hours a day, seven days a week to respond to mental health crises, other counties invested in mobile crisis outreach. An example of each approach can be found in Marion County's Mobile Crisis Response Team and Yamhill County's Community Outreach Services (COS) program:

- Marion County's crisis services are offered through their Psychiatric Crisis Center, which operates 24 hours a day, seven days a week. Marion County has collaborated with the Marion County Sheriff's Department and the Salem Police Department to staff a mental health clinician to respond to mental health crisis situations 24 hours a day, seven days a week.

- Yamhill County's crisis services include mobile crisis community outreach services (COS) that is available 24 hours a day, seven days a week. The mobile crisis team consists of licensed psychiatric medical professionals, registered nurses, Qualified Mental Health Professionals (QMHP) and Qualified Mental Health Associates (QMHA), Certified Alcohol and Drug Counselors (CADC), and peer/crisis associate specialists and supervisors. Yamhill County uses their COS program to provide outreach to clients who have been identified through their providers as experiencing life situations that could lead to crisis situations. COS provides services to the client in the community; at their home, school, or work environment.

Collaboration with Hospital Emergency Departments and Urgent Care Systems
The Emergency Department Information Exchange (EDIE) is a real-time information exchange that enables intra- and inter-emergency department communication and notifications. The technology alerts emergency department clinicians and case managers of high utilizer and complex needs patients, so that care can be better managed and patients directed to the right setting and level of care. In addition to sharing ED visit information, the EDIE Utility collects all hospital event data including inpatient admissions, discharges and transfers. This will further improve communication and coordination of care across care providers, health systems, health plans and CCOs serving Oregon's Medicaid population.

OHA and USDOJ have a shared interest in utilizing the health system transformation to improve health outcomes for individuals with SMI. OHA will collect data on specific metrics to better understand the system and to engage in discussions regarding services and outcomes. The matrix identifies the metrics to be collected and the data dictionary provides the definition and data collection methodology for each metric. One of the identified metrics is Crisis Respite, which is referred to as "Short-Term Crisis Stabilization Beds." The data dictionary defines it as beds located in a licensed non-secure crisis respite facility. This biannual metric identified 39 beds statewide in the last reporting period of January 1, 2015 - June 30, 2015. USDOJ also counts Community Crisis Beds and Sub-acute Beds.

Jail Diversion includes peer delivered services, community resources, and respite services, which are intended to reduce or eliminate jail time for people with mental illness charged with a crime. Oregon's jail diversion effort includes 13 programs in 15 counties, which have provided services to 1,305 individuals.

Recovery Support Services
OHA believes that recovery must be the common outcome of treatment and support services and an approach that promotes resiliency and develops and supports policies consistent with that outcome. This guiding principle follows the recovery model: "People

get better! People Recover!" Oregon's recovery support services include the key components of health, home, purpose and community; and recognize that recovery is a lifelong experience. In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. Health system transformation in Oregon has allowed resource investment in recovery support services throughout the behavioral health system, supporting an active consumer, family and youth voice in the planning of services throughout the system.

OHA has made significant investments in recovery support services. In 2014, the Office of Consumer Activities (OCA) was created to work in collaboration with OHA leadership to improve behavioral health services for the state. OCA is staffed by people who self-identify as having lived experience with a mental health or addictions condition.

OCA addresses issues important to individuals who receive behavioral health services and provides a designated, consumer voice.

A chief goal of the office is to be a cornerstone for systemic change in reshaping policies and service delivery toward a more recovery-oriented system of care. The office strives for services to be more welcoming and to more fully honor each individual's dignity. The primary initiatives of the OCA include:

- Building a statewide network of peer-run programs to facilitate the sharing of promising ideas, policies, practices and procedures;
- Providing technical assistance to peer-run programs;
- Helping OHA behavioral health increase peer involvement in evaluating the state's policies, planning, and programs;
- Increasing representation of consumers, survivors, and former patients-including ethnic and racial groups-in local and state mental health planning activities;
- Conducting a stigma and discrimination reduction initiative;
- Reducing racial and ethnic groups' barriers to mental health and addiction services by promoting culturally competent services for peers in these groups;
- Ensuring that peers have a strong voice in state mental health and substance use disorder treatment policy development, planning and practice; and,
- Coordinating an annual statewide peer conference.

Honoring the voice of consumers and survivors in mental health and addictions policy is what will give them equal footing in shaping the service delivery system. The long-term goal of OCA is to promote policies and services that:

- Support mental health and substance use disorder recovery;
- Respect individuals' choices and acknowledge their self-determination;
- Honor individuals' dignity and ability to experience recovery;
- Promote higher levels of community inclusion, employment and education; and

- Encourage traditional providers to partner with peers and adopt practices that help people heal and recover their lives to the fullest, as they define for themselves.

Peer Delivered Services

The Center for Medicaid and Medicare Services (CMS) recognizes Peer Delivered Services (PDS) as an evidence-based practice for supporting recovery from behavioral health disorders. Peer delivered services is an array of agency or community-based services provided by peers to individuals with similar lived experience. There are four types of peer delivered services:

- An adult who has either received mental health services or self-identifies as a person in recovery from a mental health condition may provide services to an adult who is receiving mental health services;
- An adult who has either received addictions services or self-identifies as a person in recovery from addictions may provide services to an adult who is receiving addictions services;
- A young adult with behavioral health concerns or challenges who has either received or self-identifies with behavioral health concerns may provide services to another young adult who has behavioral health concerns; and
- A family member who has parented a child or young adult with behavioral health concerns may provide services to another family member addressing children's behavioral health concerns.

The services are provided at all levels including health promotion, outreach, crisis intervention, recovery support, advocacy skills, and respite care. As a part of Oregon's health transformation efforts, Peer Support and Peer Wellness Specialists (PSSs/PWSs) are now under the broader term of Traditional Health Workers (THW). OHA supports the use of PDS and plans to continue to increase availability of PDS.

Peer Delivered Services in the Children's Behavioral Health System

Peer delivered services are effective in helping individuals build a foundation for recovery in the community. This connection provides lifelong support to sustain long-term recovery. Peer delivered services for families with children or young adults assists parents to expand their understanding of and engagement in behavioral health services. This increases their capacity to assure the protective factors for children and collaborative problem solving skills for the entire family. Specialized youth support services promote the transition of youth to become progressively independent with increased resiliency skills.

The children's mental health system has focused on workforce development to increase the availability of peers. The Peer Delivered Service (PDS) Foundation's curriculum for

young adults and family members is offered quarterly, with recent updates to include more information on strategies to meet national standards and state of the art research findings for parent to parent peer support in one-to-one settings and group modalities. The training also includes strength based assessment, use of lived experience, motivational interviewing, collaborative problem solving, parenting, self-care, use of natural supports and community resources, cultural and linguistic responsiveness, safety planning and goal setting. The curriculum also incorporates current research and information related to the education, health, and wellness needs of children, youth, and families.

As more trainings are offered, there are a growing number of trained young adult peer support providers and family peer support providers. Eighty-five families and eight young adults have been trained in the past three years. A future goal is to continue the development of combined online and traditional training with both distance and in person follow-up and supervision.

The Oregon Family Support Network (OFSN) developed a peer coach training curriculum that is now available for use in the communities where family support services have multiple staff. OHA contracts with OFSN and YouthMOVE Oregon (YMO) to provide PDS training and coordination to meet the need for continued development of peer delivered services both for young adults and family members of children with SED. Additionally, family leaders from across Oregon meet together with OHA staff on a quarterly basis for policy updates, to identify system issues, and to plan for advocacy and training needs. The Family Leadership Summit occurs quarterly and was attended by 93 family leaders in 2014.

YouthMOVE Oregon has drop-in centers located in Eugene, Salem, Albany, Medford and the Portland metropolitan area, which welcome youth daily and focus on helping at-risk youth who may experience substance use disorders, homelessness or mental health challenges. Trained young adult peer support specialists are available to provide support for drop-in center participants and also lead open discussions to provide general information and resources.

Peer delivered services in the adult mental health system

OHA believes recovery must be the common outcome of treatment and support services, and develops and supports policies consistent with that outcome. These values are evident in the array of peer delivered services and supports provided by independent, Peer-Run Recovery Organizations (PROs) throughout Oregon. There are 73 PROs in Oregon. Of these, 17 are chapters of Oxford House that qualify as Peer-Run Recovery Organizations. Twenty-eight of the Oregon PROs focus on mental health with the following focus:

- Ten are NAMI chapters;

- Three focus on co-occurring or both mental health and substance misuse; and
- Forty-two PROs focus on addictions related services.

In order to increase both the number and quality of PROs, OHA has supported several trainings to increase the skills of peer support and peer wellness specialists and the people who will be employing them. OHA Adult Mental Health Unit, in collaboration with the OHA Transformation Center hosted a series of Learning Sessions by webinar, to prepare CCOs to support behavioral health integration. The topics included Peer Delivered Services, Assertive Community Treatment and Supported Employment and Person Centered Planning.

Mental Health Block Grant funds supported the expansion of recovery support services in 2013-2015, including:

- Expansion of peer wellness specialists services in connection with supported education;
- Implementation of peer support specialists and dual diagnosis treatment in recovery support housing program;
- Expansion of Peer Wellness Specialist Services;
- Development of a PDS coalition in Mid-Willamette Valley;
- Implementation of PDS in an urban Native American outreach program;
- Research a Community Integration Specialists for Recovery Outcomes (CISRO) Model with Peers in Multnomah County; and
- Implementation of “Peer Paths to Wellness” in Marion and Yamhill Counties.

To support Mental Health client recovery and Person Centered Planning (IRP), HSD recently put forth an RFP for training on Person Centered/Directed Planning and Individualized Recovery Plan instruction for the Adult Mental Health Initiative Contractors. The IRP provides the framework by which services should be provided for the individuals that AMHI serves. It is a highly individualized process designed to respond to the expressed needs and desires of the individual.

OHA’s identifies peer delivered services as essential and includes initiatives to increase the availability of peer delivered services throughout the state, including underserved area of the states. A key component to success in health equity will be the development of a diverse workforce that includes the expanded use of traditional health workers in all health care settings. A measure of success in reducing stigma is increased percentage of people who receive peer-delivered services. Behavioral Health, along with Medical Assistance Programs (MAP) and other partners will develop plans for the expansion of PDS in Oregon.

Peer Delivered Services Steering Committee

OHA employs a Peer Delivered Services Coordinator to support development and implementation of PDS services in Oregon. The PDS Coordinator leads the Peer Delivered Services Steering Committee (PDS SC) which meets monthly to develop recommendations to increase access to quality peer delivered recovery support services. PDS SC membership is composed of OHA program staff representing substance abuse prevention and treatment, problem gambling prevention and treatment, children's mental health, adult mental health, older adult mental health, and the Oregon State Hospitals Director of Peer Recovery Supports, Medical Assistance Program (MAP) staff, Office of Consumer Activities (OCA) staff, and a representative from the Office of Equity and Inclusion (OEI). The Committee is addressing methods to increase use of Medicaid funding for PDS, increase the peer voice in the discussions, and decrease health inequity. As a result, OHA has completed the *Service Definition and Reimbursement Guide for Certified Peer Support Specialist Provider Type*, which will allow for the increase of PDS statewide.

Traditional Health Worker's Commission

Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS) are included in the new Oregon Administrative Rule (OAR) for Traditional Health Workers (THW). The rule outlines the criteria for OHA Office of Equity and Inclusion (OEI) to register and certify PSS and PWS in order for Medicaid to fund PDS services. The THW Certification and Registry through the OEI opened in the winter of 2014. The rule requires that PSS take an approved OEI training program of 40 hours for PSS and eighty hours for PWS and pass a criminal background check. Over two hundred fifty peers are registered/certified, with the expectation that the number will increase with continued workforce development.

Warmline

OHA has made additional investments in recovery support services, including increasing the operating hours of the David Romprey Warmline. Community Counseling Solutions began operating the David Romprey Warmline in Oregon in 2008. The Warmline is available to all Oregon residents and is operated by peers. Individuals seeking support may call and speak to a peer support specialist. The peer will listen and support the caller. The Warmline has demonstrated success in diverting individuals to more appropriate and lower cost levels of care.

Supported Education

Supported Education, as a component of Individual Placement and Supports (IPS), Supported Employment helps people with serious mental health illness meet their education and recovery goals to become gainfully employed through participation in an education program (i.e. Adult High School Diploma, GED program, or postsecondary education).

On July 1, 2015, a Supported Education modifier for the IPS Supported Employment Medicaid encounter code was activated in MMIS. The Supported Education modifier will allow OHA to better monitor the types of services that are being delivered within the IPS Supported Employment Program. There are currently several IPS Supported Employment Programs that provide Supported Education, however, there was no way to identify clients who were primarily receiving Supported Education services without viewing case notes in the Electronic Health Record (EHR).

The Oregon Supported Employment Center for Excellence (OSECE) is working with OHA and national Supported Education experts to develop guidance for providers on Supported Education best practices. It is anticipated that this guidance will be completed by the second quarter of State Fiscal Year 2016.

Supported Employment

Individual Placement and Support (IPS) supported employment is an evidence-based approach to supported employment for people who have a severe mental illness. IPS assists individuals in their efforts to achieve steady employment in mainstream competitive jobs, either part-time or full-time. Supported employment services include resume building and interviewing skills, assistance with job searches and transportation to interviews. Staff members also work with clients on-the-job or debrief them after work to ensure a good transition. People who obtain competitive employment through IPS supported employment have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Individuals receiving supported employment services have been shown to reduce their use of hospitals and visits to the emergency room.

Supported Housing

In 2014, the Addictions and Mental Health Division partnered with the National Alliance for Mental Illness and the Oregon Residential Provider Association to develop proposals and identify community providers who will build affordable housing.

As a result of this partnership, 168 new units of affordable housing will be built in Oregon with tobacco tax funds. OHA also has had a successful history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. Over the next five years, OHA will work with the National Alliance for Mental Illness, Oregon Family and Community Services, providers, and other public and private partners to add affordable housing units for individuals and families and for people who are disabled due to mental illness, substance use disorders and co-occurring disorders.

OHA outlines strategies to support, sustain and enhance the current recovery-oriented system of care and to increase and enhance those services. OHA aims to provide recovery support services, including those that are specifically responsive to diverse

cultural health beliefs and practices, preferred languages and literacy levels, to people who are transitioning out of substance use disorders treatment and gambling disorders treatment as part of their continuing care plan to support ongoing recovery. In addition, OHA strives to improve the existing recovery-oriented system of care for people transitioning from residential to outpatient treatment for substance use disorders.

Peer support is critical in assisting parents to address the fears and immobilization associated with the stigma of possible behavioral health concerns. In 2015, Peer Delivered Services will be extended to ensure 1:1 outreach and engagement for families prior to a child or youth receiving a mental health diagnosis. Peer support services will assist families in communicating with their health care provider about their child or youth's mental health needs. This applies especially to families with children under the age of six and for families who are new to the availability of health care and behavioral health care.

Ensuring Cultural Competence and Health Equity through Health System Transformation

Oregon Administrative Rules (OARs) require that community mental health and addictions programs provide culturally and linguistically competent services. Oregon has significant numbers of people at risk for experiencing health disparities due to cultural, language, economic and geographic barriers. Many Oregonians are unable to attain their highest level of health due to cultural, language, and other communication barriers. When the health care system is not responsive to the cultural and linguistic needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes.

Health equity is the attainment of the highest level of health for all people. Many Oregonians are unable to attain their highest level of health because of cultural, language, and other communication barriers. When the health care system is not responsive to the cultural needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes.

Cultural, linguistic and communication barriers can lead to increasing health disparities. Research demonstrates that language barriers between patient and provider create problems such as delay or denial of services, issues with medication management, underutilization of preventive services and increased use of emergency services. Racial and ethnic minorities have higher prevalence of chronic health conditions and higher mortality rates than the general population. Moreover, for all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. For racial and ethnic minorities, access to care and health status are worse than for the general population.

In order to create a responsive, inclusive and equitable system of care, OHA has collected feedback from providers through town hall meetings across the state to develop a three year behavioral health strategic plan. Within the strategic plan is a health equity goal with strategies to reduce health disparities and pursue health equity in the behavioral health care system.

Over the next five years, the OHA Office of Equity and Inclusion, Public Health, and Health Systems Division will partner with and existing and new community partners, and consumers, to seek opportunities to support the health care needs of an increasingly diverse population. A key component to success in this area will be the development of a diverse workforce, which includes encouraging strong, targeted programs at colleges and universities as well as the expanded use of traditional health workers in all health care settings.

To assist with the implementation of the health equity goal and to support success of health equity through health system transformation for populations, OHA created the Committee on Health Equity and Policy (CHEP). The CHEP's mission is to engage and align diverse community voices to assure the elimination of avoidable health gaps and promote optimal health in Oregon. This internal committee is made up of representation from various units within Health Systems Division. The strategies CHEP will use to increase awareness, skills and knowledge about how cultural and linguistic diversity affects the delivery of health and human services include:

- Policy development;
- Training and consultation;
- Community and organizational capacity building.

Specific efforts of CHEP to support culturally competent services and increase health equity over the past year are described below.

Tribal Behavioral Health Programs

Senate Bill 770, passed by the Oregon Legislature in 2001 enacted a Government-to-Government relationship between the State of Oregon and each of the nine tribal governments. OHA meets this statute by consulting with the nine tribes on a quarterly basis at the SB 770 Health Services Cluster, the Tribal Prevention Meetings, the Oregon Indian Council on Addictions, participating in tribal relations cultural trainings, and communicating with tribal staff on a regular basis.

OHA has a dedicated staff person that serves as a tribal liaison to the nine federally recognized tribes. The tribal liaison attends tribal functions to continue building understanding and rapport with Native American communities. The liaison listens for concerns, answers questions, assists in removing barriers, and looks for opportunities to provide improved or additional services to the tribes. OHA staff solicits assistance

and guidance from the liaison to ensure that cultural considerations and tribal voices are included in planning efforts around substance abuse and problem gambling prevention, addictions treatment, and mental health services.

Tribes develop biennial plans for substance abuse prevention and now also develop Mental Health Plans for the investment dollars that have been allocated by the Oregon Legislature. These plans are approved by the Tribal Council, the Tribal Health Department, or through an entity authorized by the Tribal Council.

Certified Alcohol and Drug Counselor Cohort

In 2011, tribes stated that their alcohol and drug programs had a lack of Certified Alcohol and Drug Counselors (CADC). OHA funded a training series designed to provide culturally relevant and specific addiction educational topics that would meet the addiction counselor certification training requirements in order to apply for certification examination. The goals of the training series were to increase the number of Native American certified addiction counselors in Oregon, and provide an opportunity for Native American treatment providers to shadow and co-train with professional trainers in the field of addictions with the goal of those shadowing to one day teaching the course. The initial cohort was completed in May 2014 and consisted of 15 tribal participants. At this time, of those participants, at least two have completed examination and received their CADCI, along with numerous participants applying to be Certified Recovery Mentors (CRM). A new cohort began in the fall of 2014 with 20 participants enrolled.

The Student Wellness Survey is conducted every two years and provides data for tribes and communities in the areas of school climate, positive youth development, mental and emotional health, problem gambling, substance use, drug free community core measures and risk/protective factors. Tribal prevention coordinators use the survey date to plan prevention programming and identify trends. In 2014 students were given the option to identify if they belonged to one of the nine federally recognized tribes in Oregon. This provides localized data for their tribal members along with data of Native Americans in their school district.

African American Population

In September 2014, the African American Treatment Summit 3 hosted 143 participants and 14 presenters with the charge of developing a list of recommendations for policy makers, stakeholders and funders necessary for developing a treatment and behavioral health system, which would be more responsive to the needs of the African American community. From the Summit, four main recommendations emerged:

1. Development of an African American Treatment Services Coalition;
2. A focus on African American Behavioral Health Prevention;

3. Implementation of African American treatment services that are administered by African Americans and based on proven practices from the African American community; and
4. Integration of the Traditional Health Workers into the Behavioral Health work force.

A planning committee is being formed to clarify the recommendations and next steps.

Hispanic and Latino Populations

The Hispanic/Latino population in Oregon grew by 64% in the years 2000 to 2010; Hispanic individuals/Latinos currently account for over 12% of Oregon's population. Studies show that patient satisfaction is higher when the patient and doctor are the same race or ethnicity. In Oregon, the ratio of Hispanic/Latino behavioral health providers to the Latino population served for behavioral health services is not close to being equivalent.

In August 2014, CHEP presented behavioral health data for Latinos in Oregon at the Instituto Latino, a conference designed specifically for Latino behavioral health providers. CHEP distributed a survey to obtain information from a sampling of providers serving the Oregon Hispanic/Latino community regarding behavioral health services and the needs and barriers to services identified by the Hispanic/Latino population. The survey results will inform and lead to the creation of recommendations regarding behavioral health in support of the Hispanic/Latino community in Oregon.

Culturally Specific Services

A Culturally Specific Program is defined in the Oregon Administrative Rule as a program designed to meet the unique service needs of a specific culture and one that provides services to a majority of individuals representing that culture. SAPT Block Grant dollars are used to enhance treatment services by providing culturally relevant treatment support, using African American mentors, artists, and storytellers. Additionally, SAPT Block Grant funding is used for culturally relevant field trips that provide youth with positive engagement activities within their community. There are few providers in Oregon who provide culturally specific services for adolescents. Central City Concern and Lifeworks Northwest in the Portland area are two such providers. Lifeworks Northwest contracts with their local CMHP to provide culturally specific addiction treatment services to underserved African American and Latino youth.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

---

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

STEP TWO

In 2014, the Oregon Health Authority hosted a series of events designed to solicit input from a wide range of behavioral health stakeholders. In six regional town hall meetings, stakeholders were asked to respond to four questions related to the challenges and strengths of the current behavioral health system, the role of the state in the delivery of behavioral health care, and the guiding principles and values underpinning services and supports. OHA also hosted a tribal consultation, a webinar and an OHA all-staff town hall meeting. OHA identified key themes emerging from all of the discussions to guide the development of strategic initiatives and their underlying goals.

OHA is also guided by three formal advisory groups: The Addictions and Mental Health Planning and Advisory Council (AMHPAC), the Oregon Consumer Advisory Council (OCAC), and the Children's System Advisory Committee (CSAC). In addition, the Oregon State Hospital has the Oregon State Hospital Advisory Board, whose members are appointed by the Governor.

During these discussions, common themes emerged. Stakeholders emphasized that OHA must ensure that all Oregonians get:

- The right care – Behavioral health care should be culturally appropriate, person-centered and trauma-informed;
- In the right place – People should have access to behavioral health services regardless of where they live, and they should receive services in their community whenever possible, keeping people out of emergency departments and the state hospital who do not need to be there.
- At the right time – In addition to making sure that appropriate services are available when people need them, we must strive to catch illnesses early and prevent behavioral conditions from developing in the first place, through promotion and early intervention, especially with children, youth and families.

Five priority areas will focus attention and resources in the areas of greatest need and opportunity in Oregon. These priority areas will guide behavioral health efforts, with the overarching goal of improving the lives of all Oregonians, as well as those in need of behavioral health services and their families. These priority areas are designed to promote healthy communities using cost-effective and timely interventions.

The priority areas are consistent with the triple aim of Oregon's health system transformation:

1. Better health – improve the lifelong health of all Oregonians;

2. Better care – increase the quality, reliability and availability of care for all Oregonians;
3. Lower cost – reduce or contain the cost of care so it is affordable for everyone.

Each priority area includes indicators based on the priority populations: adults with serious mental illnesses, children with serious emotional disorders, persons who are intravenous drug users (IDU), pregnant women with substance use disorders, parents with substance use disorders with dependent children, individuals with tuberculosis, persons living with HIV/AIDS, services for persons in need of primary substance abuse prevention. Indicators were developed to reflect the common themes that emerged as a result of the stakeholder meetings, data analysis, and block grant priorities.

- Health equity exists for all Oregonians within the state's behavioral health system.
- People in all regions of Oregon have access to a full continuum of behavioral health services.
- The behavioral health system promotes healthy communities and prevents chronic illness.
- The behavioral health system supports recovery and a life in the community.
- Only people who meet admission criteria are admitted to the Oregon State Hospital and for those who need it, admissions and discharges are performed in a timely manner.

Prevalence

Substance use disorders, gambling disorders and mental illness carry widespread physical, social and financial consequences for individuals, their families and communities. These problems result in billions of dollars each year spent on health care for preventable illnesses, and in the criminal justice and social welfare systems. There are both measurable costs, such as lost wages and homelessness, and the immeasurable human cost of lost potential and lost opportunity.

Behavioral health issues are a major public health concern nationally and in Oregon. It is estimated that in a one-year period between 2011 and 2012, 4.6 percent of Oregonians 18 and older coped with a severe and persistent mental illness and 21 percent of all adults suffered from any mental illness.[1] The estimated prevalence for children with serious emotional disorders is tied to the states' poverty rate; for Oregon, it

[1] Center for Behavioral Health Statistics and Quality. (2013). Behavioral Health, United States, 2012 (HHS Publication No. SMA 13-4797). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from www.sOHAsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf.

was estimated that 6–12 percent of all young people ages 9–17 would experience serious emotional disorders in 2013.[2]

OHA uses the Federal definition of Serious Emotional Disorder[3], which includes children and youth from birth to age 18 who currently, or at any time during the past year:

- Have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-4),
- That resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

A substance use disorder or developmental disorder alone does not constitute a serious emotional disorder although one or more of these disorders may coexist with a serious emotional disorder. This definition is used in determining prevalence, need and access.

In 2012, the estimated number of Oregon children with serious emotional disorders is103,861. The public mental health system serves approximately 30 percent of these children.

Prevalence of Serious Mental Illness

For adults, OHA uses prevalence rates from SAMHSA's National Survey on Drug Use and Health and apply these prevalence rates to population estimates by the Portland State University Population Research Center. Pursuant to section 1912(c) of the Public Health Services Act, adults with serious mental illness are defined as:

- Age 18 and over;
- Currently have, or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-4 or their ICD-9-CM equivalent; and
- That results in functional impairment, which substantially interferes with or limits one or more major life activities.

The definition is used in determining prevalence, need and access. The current estimate of adults (age 18 and older) with a serious mental illness living in Oregon is 156,962. Approximately 46 percent of those adults are served in the public mental health system.

[2] Prepared by NRI/SDICC for CMHS: September 17, 2012.
[3] Oregon family members have specifically requested that the term serious emotional disturbance NOT be used; the term serious emotional disorder is replacing it in this document

Prevalence of Youth and Adults with DSM-4 Disorder of Substance Abuse or Dependence

Substance use disorders remain a serious problem in Oregon. During any one-year period between 2008-2012, about 283,000 people aged 12 or older were dependent on or misused alcohol; 123,000 people aged 12 or older were dependent on or misused illicit drugs within the year prior to the survey.[4] Oregon has made significant progress in reducing unintentional and undetermined drug overdose deaths; the rate declined from 11.4 per 100,000 people in 2007 to 8.9 per 100,000 people in 2012. However, the death rate for overdose death in 2012 was four times higher than in 2000.[5]

Data Sources

OHA uses several administrative data systems to support monitoring of addictions and mental health services provided to residents of the State of Oregon. These data systems historically included the Client Process Monitoring System (CPMS), the Oregon Patient/Resident Care System (OP/RCS), and the Medicaid Management Information System (MMIS). Starting in 2014, OHA implemented a new data system called the Measures and Outcomes Tracking System (MOTS).

Block Grant and planning data derived from these systems are supplemented with data acquired through annual administration of modified versions of the Mental Health Statistics Improvement Project (MHSIP) Adult Services Survey, the MHSIP Youth Services Survey for Families and the MHSIP Youth Services Survey.

MOTS has replaced all data previously submitted to CPMS and is replacing OP/RCS as a data source. There is expected to be period of transition. All three administrative data sources (MOTS, OP/RCS, and MMIS) are needed to collect data on National Outcome Measures (NOMs) such as *Access/Capacity: Number of Persons Served with Demographic Characteristics.* Each data source used in the Block Grant planning is detailed below.

Measures and Outcome Tracking System (MOTS)

OHA has implemented a comprehensive behavioral health electronic data system to improve care, control cost and share information. The data system improvement project is called MOTS. This new system allows OHA to meet business needs and requirements and will provide data that more readily supports the ability to track:

- Performance outcomes associated with services;

[4] Substance Abuse and Mental Health Services Administration. (2013). Behavioral health barometer. Oregon, 2013. (HHS Publication No. SMA-13-4796 OR). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[5] Oregon Health Authority, Public Health Division. (2014). Retrieved from http://public.health.oregon.gov/PHD/ODPE/IPE/Pages/index.aspx.

- Access, utilization and duration of services; and
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

Electronic Data Capture
Currently, the majority of OHA data is collected and housed in MOTS and OP/RCS. The information housed in these two main systems is collected at admission and discharge. MOTS data is collected at admission and the system then allows for regular updates to the data . The data collected includes status and encounter data – status data provides information during the treatment cycle, and encounter data provides information on the services provided during the treatment episode.

Collection of these data will allow OHA to better assess the array of services provided and outcomes achieved. OHA will be able to provide better data and information to stakeholders, legislators and other requesters, in addition to providing better access and analysis of data for CMHPs and their subcontractors.

OHA has been accepting MOTS electronic data submission since November 2013. Providers and other required reporters have access to different methods for this data submission:

- Electronic Data Interchange/Transfer from existing EHRs; or
- A web-based Minimum Client Entry tool.

The Oregon Patient/Resident Care System (OP/RCS)
OP/RCS is the database for all publicly funded psychiatric inpatient care delivered in state hospitals and acute care units. OP/RCS has also functioned as the primary resource for tracking individuals who have been civilly or criminally committed for mental health treatment. State Hospitals and Psychiatric Acute Care Units of regional hospitals submit OP/RCS data about patients at admission and at discharge.
OP/RCS contains important data such as county of commitment, date of commitment, and type of commitment; the name of the facility where the patient has been committed; the dates that the patient was admitted and discharged; and patient demographics such as sex, date of birth, marital status, and living arrangement. Unfortunately, OP/RCS does not allow OHA to record the patient's Hispanic/non-Hispanic ethnicity separately from the patient's race.

OP/RCS is over 30 years old and is not meeting the current business needs of OHA. Continually upgrading the OP/RCS system to meet federal reporting requirements and state needs has become too costly and is impractical. The mental health system has evolved beyond the original needs that the data systems were designed to fill.

After consideration of the limitations of the OP/RCS system, OHA made the business decision to contract with Netsmart Technologies, Inc. to replace OP/RCS with the Avatar Electronic Health Record system. Avatar has been implemented within the state hospital system. This leaves OP/RCS as the current system of record for acute care hospital admission and discharges. Over the next two years OHA will be working to incorporate data collected from the state hospital and the acute care hospitals into MOTS.

The Medicaid Management Information System (MMIS)

MMIS provides information on services provided to persons who are enrolled in Medicaid. The information contained in MMIS includes eligibility, capitation payments, fee-for-service claims, and encounter data for persons receiving services via prepaid capitated managed care organizations. MMIS also includes all mental health, chemical dependency, pharmacy, dental, physical health services, and eligibility information for individuals enrolled in Medicaid.

Medicaid fee-for-service data and encounter data are submitted electronically and by fee-for-service billing. Managed mental health organizations and service providers have 180 days from the date of service to submit Medicaid data to the MMIS. Data from MMIS are downloaded and stored in a data warehouse for use by state analysts and actuaries responsible for rate setting.

Surveys

The Youth Services Survey for Families and the Adult Services Survey

OHA makes efforts to collect information about providers and service recipients from sources other than administrative data systems. Many of the outcome and performance measure data are collected and compiled from consumer responses to modified versions of the MHSIP Adult Services Survey, the MHSIP Youth Services Survey for Families (or YSS-F) and the MHSIP Youth Services Survey (YSS). The Adult Services Survey and YSS-F are mailed annually to stratified random samples of over 10,000 Medicaid-enrolled adults and over 10,000 parents or guardians of Medicaid-enrolled children; the consumers selected to receive these surveys are chosen on the basis of having received Medicaid-billable mental health services at some time during the last six months of the previous calendar year. In the interest of better understanding the service experiences and service needs of Hispanic individuals and people of color, OHA sends the Adult and Youth consumer surveys to *all* individuals who received services in the six-month window of interest and who are identified in OHA data systems as either Hispanic and/or of non-white race. Surveys are also available in Spanish.

Information obtained from the Adult and Youth Services surveys is used to:

- Provide feedback on OHA performance measures;
- Identify areas in need of improvement;
- Track improvement in the well-being of people served with public funds;
- Recognize those programs which are doing well; and
- Communicate results to the Governor, the Legislature, Department contractors, and the public.

OHA has worked carefully to modify the Adult and Youth Services surveys in ways that allow us to collect important information on several of the NOMs of Interest, including: employment status of adult consumers; school attendance among child consumers; and housing stability and criminal justice involvement among both adult and child consumers.

Minimum Data Set (MDS)

MDS is the database that is used for statewide collection of data for substance abuse prevention services. Each county and tribal program is responsible for entering prevention data into the system. These data are used for the Block Grant Application and by the Oregon State Legislature.

While the MDS has been effective in providing *output* data, it is unable to capture *outcome* data. Therefore, the state has transitioned to a new database system utilizing the Web Based Infrastructure for Treatment Services (WITS). This new system called the Oregon Prevention Data System (OPDS) has the capacity to capture outcome-level data. This new Prevention Data System is being implemented now.

Children's Mental Health Dashboard

OHA collects data relevant to the children's mental health system. Data being tracked includes level of service intensity determination data, outcomes for children served in the integrated service array and the Statewide Children's Wraparound Initiative demonstration projects. OHA also tracks process measures and youth/family perception of outcomes using the YSS and the YSS-F. An electronic web interface makes outcome data available in real time, improving the ability to use data for planning and decision-making. Oversight of data issues throughout the system is provided through the Children's System Advisory Committee and through periodic reporting to stakeholders. CCOs are required to meet benchmarks within their first year on several measures pertaining to children's behavioral health outcomes.

The Oregon Student Wellness Survey (SWS)

The Oregon Student Wellness survey is an anonymous and voluntary survey conducted in every even year in schools statewide and administered to 6th, 8th and 11th graders. Confidential data gathered from the survey and reports compiled from the survey data are provided to all participating schools and school districts while the state and county data and data reports are for public access. The reports are found on the Oregon Health Authority website at http://www.oregon.gov/oha/OHA/pages/student-wellness/reports.aspx. The survey is designed to access a wide range of topics that include: school climate, positive youth development, mental health, physical health, substance use, problem gambling, violence and other risky behaviors among Oregon youth.

The SWS results are used by schools, state and local agencies, organizations and communities to assess and monitor the health and well-being of Oregon youth and the environment in which they live. The survey data and report serve as a valuable tool for program planning, implementation, and evaluation. The data are essential information for communications with legislators and the public. Additionally, communities and local agencies can utilize the data to improve their ability to procure grant funding by providing baseline data.

In 2014, 63,104 Oregon students participated in the Oregon Student Wellness Survey. In total, 35 counties, 123 school districts and 458 schools were included in the survey. OHA anticipates an even higher participation rate in 2016. The survey is administered every even year and schools can choose to either use a pencil-and-paper version or an online version. The 6th and 8th grade survey is a subset of the 11th grade survey. The survey is very well received by county and Tribal prevention coordinators statewide, and their interest in utilizing the survey data is ever increasing. The survey data is consistently used by counties and school districts and the state for program planning, implementation, and evaluation, for communication with legislators, for the SPF-PFS grant, for Drug Free communities reporting, for Positive Community Norm campaign across the state and many other policy/decision making processes. Analyzing the data from the SWS not only gives OHA clear epidemiological information on substance use and behavioral health of Oregon youth, but also helps to understand correlations between various problem behaviors.

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for compiling information, analyzing, and reporting substance use and mental health incidence, prevalence, trend data and NOMs. These data are available for use in the development of the county Local Plans submitted to OHA. Data sources that are utilized by the

SEOW include the local State survey's, Student Survey: Student Wellness Survey (SWS), and Oregon Healthy Teens Survey (OHT), the Behavioral Risk Factor Surveillance System (BRFSS), National Survey on Drug Use and Health, Oregon State Medical Examiner, Oregon Vital Statistics Annual Report, Volume 1, Oregon Public Health Assessment Tool (OPHAT) / WISQARS, Oregon State Police Annual Uniform Crime Reports and the Oregon Department of Transportation (ODOT) DUII Data Book. The population for which data is collected by these various sources is birth to death and captures both our urban and rural areas.

In addition, data are used by OHA to assess, plan, and implement state prevention and promotion policy and programs. The SEOW tracks progress of population level data at the state and county level, but these data are not used for evaluation of activities.

The SEOW has the following key criteria for data indicator selection for each substance use and mental health measure:

1. The indicators should be an accurate reflection of change in public health.
2. Chosen indicators should be derived from peer-reviewed research.
3. The data should be reliable and valid and collected for at least three years.
4. There should be an infrastructure in place to ensure continued data collection.

The SEOW seeks to employ a number of strategies for tracking data and reporting significant changes:

1. Fifty state-level measures are tracked and reported on the internet. Each measure is updated as the data become available.
2. There are 36 counties in Oregon; a county report inclusive of 40 measures is generated for each county every other year. Single-page, double-sided fact sheets are produced on specific priority topics.
3. Reports are also updated on the SEOW's website for public access. The website is available at http://www.oregon.gov/oha/OHA/sew/Pages/index.aspx.

Planning

OHA utilizes data from the administrative data sources and the surveys to work with contractors and help guide them in the improvement and development of services. In addition to the treatment and survey data, OHA collects and summarizes a great deal of epidemiological data for substance abuse and mental health. OHA directs the county contractors to utilize this data to plan for services and requires counties to be accountable for services. This allows OHA to guide statewide services while allowing for specific community needs that counties and tribes may identify.

OHA is developing a behavioral health mapping tool, which will identify population data, community and statewide investments, behavioral health service data, outcome data, and gaps by county. This tool will inform key stakeholders and legislators as they discuss the future design of the behavioral health system in Oregon, as well as make strategic investments in communities.

LMHAs utilize these data sources to develop Local Plans. OHA consulted with key stakeholders to develop and implement new guidelines that assist LMHAs in the development of a community-focused plan for behavioral health services. As LMHAs receive more flexibility in the use of public behavioral health funding, it is important to establish a mechanism for LMHAs to inform OHA and the public about the plans to administer those funds. The new Local Plan process facilitates that accountability.

Additionally, the Local Plan is designed to keep LMHAs and OHA in compliance with statutes, Block Grant and other federal requirements. Information is required in three areas:

1. System Narrative;
2. Performance Measures; and
3. Budget Information.

To support success, OHA is providing further guidance and resources to help develop plans that will meet each community's needs. Changes in the Oregon statute require the local planning process be coordinated with the planning process of the coordinated care organization for the area.

The revision of the Local Plan format and process along with the implementation of MOTS will assist in the development of the State Plan included in the 2016-2017 (and subsequent) Combined Block Grant application.

OHA is developing a statewide needs, resource and outcome system that includes three major components summarized below.

1. Needs Assessment (current state) - Behavioral health needs defined by population groups (children, adolescents, adults, families) and demographic variables (population, prevalence, severity, socio-economics, diversity).
2. Needs Projection Model (dynamic) - A method projecting behavioral health service needs over time with contributing variables such as current funding picture, demographic factors and major related systems: juvenile/adult justice and educational systems.
3. System and Client Outcomes Measurement – A process for measuring community/system, provider and client outcomes that connects to the contracts

and resources supporting these services. This process needs to include a dynamic relationship between outcomes and funding.

Priority Areas

The five priority areas will focus attention and resources in the areas of greatest need and opportunity in Oregon. These priority areas will guide behavioral health efforts during the planning period. The overarching goal of these priority areas is to improve the lives of all Oregonians, as well as those in need of behavioral health services and their families, with emphasis on the priority populations. These initiatives are designed to promote healthy communities using cost effective and timely interventions.

Each priority area has identified strategies and measures for success. The strategies will guide policy and budget priorities, collaboration with partners and measuring outcomes.

Priority Area 1: Health equity exists for all Oregonians within the state's behavioral health system.

Health equity is the attainment of the highest level of health for all people. Many Oregonians are unable to attain their highest level of health because of cultural, language and other communication barriers. When the health care system is not responsive to the cultural needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes. In order to create a responsive, inclusive and equitable system of care, OHA will make investments in resources to reduce health disparities and pursue health equity in the behavioral health care system.

The need to eliminate racial and ethnic health disparities is imperative given the rapid increase in diversity in Oregon over the last twenty years. Between 2000 and 2010 alone, Oregon's saw a significant increase across all communities; however, populations of color increased more dramatically[6]. In 2010, at least 137 languages were spoken in Oregon. This makes Oregon one of the 15 most language-diverse states in the nation. The distribution of Oregon's population by race and ethnicity and percent change across all populations is provided in the table below:

Table 1: Oregon Population by Race and Percent Change 2000 – 2010

Percent of Population	Change: 2000 – 2010

[6] US Census Bureau. 2010. Available at the following website:http://www.census.gov/population/projections/state/

White alone 83.6% (n=3,899,353)	8.2% increase
Black or African American alone 1.8% (n=70,188)	24.3%
American Indian and Alaska Native alone 1.4% (n=54,591)	17.7%
Asian alone 3.7% (n=144,276)	39.4%
Native Hawaiian or other Pacific Islander alone 0.3% (n=11,698)	68.1%
Some other race alone 5.3% (n=206,666)	41.3%
Two or more races 3.8% (n=148,175)	38.2%
Hispanic or Latino ethnicity 11.7% (n=456,224)	63.5%
Not Hispanic or Latino ethnicity 88.3% (n=3,443,129)	7.5%

As the population diversity increases, the cultural and linguistic barriers can lead to problems such as delay or denial of services, issues with medication management, underutilization of preventive services and increased use of emergency services. Research demonstrates that language barriers between patient and provider greatly impact the quality of health care and consequently, increase health disparities for communities with language access barriers. Difficulty in communication also may limit clinicians' ability to understand patient symptoms and effectively provide treatment[7], even more critical today in the face of rapidly shifting Oregon demographics as mentioned above, and the rising number of people with limited English proficiency. According to 2011 American Community Survey, more than 541,345 residents speak a language other than English at home and 228,891 residents over 5 years speak English "less than very well" and may be considered Limited English Proficiency (LEP)[8]. African Americans and American Indians are disproportionately represented in their admissions into substance abuse treatment program than their overall demographic representation of 2% and 1.8% respectively in Oregon[9]. In 2012-2013, the African Americans and American Indians show lower rates of completion of addiction treatment. Over 30% of these two population groups do not complete treatment once they are engaged[10].

Cultural, linguistic and communication barriers can lead to increasing health disparities. Research demonstrates that language barriers between patient and provider create problems such as delay or denial of services, issues with medication management, underutilization of preventive services and increased use of emergency services. Racial and ethnic minorities have higher prevalence of chronic health conditions, higher mortality rates and less access to care than the general population.

[7] Green et al. 2005; Jacobs et al. 2006; Karliner et al 2007; Flores et al. 2008

[8] SELECTED CHARACTERISTICS OF THE NATIVE AND FOREIGN-BORN POPULATIONS. 2011 American Community Survey 1-Year Estimates. U.S. Census Bureau

[9] African American Summit on the State of African American Substance Abuse and Treatment in Oregon. (2012).

[10] OHA Addictions and Mental Health Division, Quarterly Addiction Treatment Outcomes Report. (2012 – 2013). http://www.oregon.gov/oha/amh/Pages/data.aspx

Strategies:
To increase access among racial and ethnic behavioral health populations, OHA will:

1. Gather feedback from communities and specific cultural populations to inform policy development to support health equity in the behavioral health care system;
2. Collaborate with the Office of Equity and Inclusion, Public Health, Medical Assistance Programs, and both existing and new community partners and consumers to seek opportunities to support the health care needs of an increasingly diverse population. A key component to success in this area will be the development of a diverse workforce, which includes encouraging strong, targeted programs at colleges and universities as well as the expanded use of traditional health workers in all health care settings.
3. Collaborate with tribes to revise the approval process for tribal behavioral health services to support them in providing culturally responsive services.

Priority Area 2: People in all regions of Oregon have access to a full continuum of behavioral health services.

Oregon has experienced a significant increase in access to health care coverage through the expansion of Medicaid under the Affordable Health Care Act. In addition, the 2013 Oregon Legislature made an unprecedented investment in the expansion of mental health services to provide increased availability of services for individuals without health care coverage and for services not covered by Medicaid. Both initiatives provide the opportunity for more Oregonians to access behavioral health services.

To take full advantage of these opportunities, a structure needs to be more clearly defined for the behavioral health care delivery system ensuring access throughout Oregon, with particular attention to rural and frontier regions. These regions of Oregon struggle to find the human resources and infrastructure to support a basic array of behavioral health services. While recent investments in mental health services have improved the availability of behavioral health services for many, further funding of the non-Medicaid behavioral health system is necessary to reach all Oregonians. In rural counties in state fiscal year (SFY) 2014, 4.98% of the Oregon Health Plan (OHP) population received at least one substance use disorder service whereas 5.72% of OHP population in urban counties received similar services. The service utilization rate per 1,000 members was 77.4 services in rural counties and 178.1 services in urban counties. For mental health services, 18.4% of persons in rural counties received services as compared to 19.2% in urban counties. Utilization shows similar disparities in

addiction services with 158.1 services per 1,000 members in rural counties compared to 213.8 services per 1,000 members in urban counties.

Several positive factors have contributed to the coordination of behavioral health services in Oregon communities. Coordinated care organizations and community partners have made strides in identifying community needs and coordinating services with a variety of partners from the counties, criminal justice system, judicial system, education and social services. The Oregon Legislature also made significant investments in behavioral health that have greatly increased capacity in many areas.

To increase access to behavioral health services in rural areas, OHA will:

1. Work with coordinated care organizations, the Transformation Center, community mental health programs, local mental health authorities and other partners to develop strategies to encourage and facilitate regionalization of behavioral health services in rural and frontier regions where useful;
2. Work with the Oregon Health & Science University OPAL-K program, the Transformation Center and others to identify strategies to develop the infrastructure and expand telehealth psychiatric services in rural and frontier regions of Oregon.

OHA will monitor the impact of the enhanced service array and use of services statewide. This will be accomplished through contractually required reporting by programs and monitoring the data dashboard developed to track utilization and costs of both Medicaid and non-Medicaid services. A similar data dashboard was developed for Medical Assistance Programs.

OHA will collaborate with internal and external partners to look for practical, long-term solutions to bring a set of basic services to all communities. Solutions are likely to include the use of traditional health workers, natural supports, telehealth, mobile units and schools. In all cases, engaging with both the private and public health systems will be imperative.

The increase in access to health care coverage and the Oregon Legislature's investment in mental health services provided opportunities to increase the availability of services for individuals without health care coverage and for services not covered by Medicaid. In SFY 2014, among Oregon Health Plan members, 39% initiated addictions treatment services and of those, only 21% engaged in services. For mental health services, 22% initiated treatment services and only 8% engaged in services. To increase utilization and engagement, OHA will collaborate with local mental health

authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.

To increase initiation and engagement in behavioral health treatment, OHA will employ the following strategy:

1. Collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.

Crisis Services

A responsive crisis system provides the necessary intervention and supports that reduce the likelihood of hospitalization or incarceration. Several of the recent investments in the behavioral health system are aimed at strengthening the crisis system. Recent investments in mobile crisis services and jail diversion programs provide timely behavioral health interventions in the community that decrease the need for hospitalization and avoid incarceration. The expansion of Assertive Community Treatment teams provides necessary supports for adults with serious mental illness, reducing the need for crisis interventions.

Adults, youth and children sometimes spend extended periods in an emergency department waiting for a psychiatric acute care bed to become available. For adult OHP members in SFY 2014, there were 2.73 emergency department visits for psychiatric services per 1,000 members. Baseline data are currently being collected for children and young adults. This misuse of emergency care appears to relate to a range of issues including access and coordination of care challenges. Improving access to timely routine care and intensive outpatient care may prevent the need for higher levels of care.

To decrease the number of youth and adults seen in emergency departments for psychiatric services, OHA will employ the following strategies:

1. Develop a taskforce of key providers and make recommendations designed to prevent the use of emergency departments from being the primary intervention in the absence of effective treatment services;
2. Increase behavioral health crisis funding to support new and existing promising practices; and
3. Develop a notification system so that coordinated care organizations know when their members are in emergency departments and pediatric units and are unable to return home due to safety concerns.

Reduction in Juvenile Justice Involvement

OHA, Health Services Division, the Department of Human Services (DHS) and Oregon Youth Authority (OYA) are all participating in designing behavior rehabilitation services. Four percent of children receiving Wraparound were involved in criminal justice at 12 months after entry into Wraparound planning process. OHA will continue to work closely with the coordinated care organizations, the Department of Human Services, Oregon Youth Authority and others to increase the number of children and youth who have access to Wraparound services.

To reduce criminal justice involvement for children engaged in the Wraparound planning process, OHA will work collaboratively with DHS and OYA to increase the number of community justice and OYA-involved youth participating in a fidelity-based Wraparound planning process.

Medication Assisted Treatment

Oregon ranks high among the states for the non-medical use of prescription opioid medications. Increasingly restrictive prescribing guidelines and increased access to heroin has resulted in a growing number of Oregonians becoming opioid dependent. Addiction carries a high societal and medical cost, including increased criminal justice and child welfare involvement, overdoses, hospitalization and death. There is also a greater risk of the spread of infectious diseases due to intravenous drug usage. Medication Assisted Treatment, combined with therapeutic services and psychosocial supports, is an evidence-based practice considered the most effective for the treatment of opioid dependence. In SFY 2014, 8,081 individuals accessed methadone treatment and 1,584 individuals accessed buprenorphine.

Opioid overdose impacts people of all ages in Oregon. OHA, along with Public Health, will focus on work that will immediately increase the availability of Medication Assisted Treatment and promote the wide dissemination of medication that saves lives following overdose. At the same time, OHA will join with Public Health, the OHA Transformation Center, providers, prevention specialists, and communities to develop long-term prevention and treatment strategies to address this statewide and national problem.

To increase the percentage of individuals with opioid dependence accessing medication assisted treatment services, OHA will employ the following strategies:

1. Work with the Transformation Center and Public Health to create an opioid task force composed of stakeholders;
2. Provide education and resources to coordinated care organizationrepresentatives, community groups, and health care providers on policies and best practices related to opioid dependence and treatment;

3. Engage residential treatment providers to improve medication assisted treatment usage rates in residential treatment; and
4. Collaborate with Public Health and Pharmacy to increase availability of overdose reversal medications.

Priority Area 3: The behavioral health system promotes healthy communities and prevents chronic illness.

Prevention

OHA provides prevention funding to all 36 counties and nine federally recognized tribes using Substance Abuse Prevention and Treatment block grant funds. Preventing youth initiation of alcohol and drug use, and early intervention in substance use disorders, must be priorities to curb the state's misuse and dependence rates across the lifespan. Past month alcohol use among 18 to 25 year olds in SFY 2014 was 61.96%. Oregon is reducing the costs of health care; investing in pre-treatment prevention and health promotion will achieve long-term reductions in misuse and dependence rates in the future.

To decrease alcohol use among young adults, OHA will:

1. Revise implementation plan guidelines to include strategy requirements and communicate the requirements to prevention coordinators; and
2. Develop the mORe campaign related to underage drinking.

Mental Health Promotion

New science is constantly emerging that reinforces the importance of early childhood development. According to the World Health Organization, early childhood is the most important time in overall development; brain and biological development during the first years of life is highly influenced by an infant's environment. Early experiences determine health, education and economic participation for the rest of life. Oregon is addressing early childhood trauma and trauma across the lifespan to improve both physical and behavioral health.

Mental health promotion includes universal preventive interventions such as parenting education, support for growing families and creation of healthy communities and environments for children. It is needed to provide upstream prevention to families, especially those with young children. Risk factors such as early trauma can be addressed before they become problematic and mitigate the need for early intervention or treatment.

During the first years of a child's life, there are opportunities across systems (primary care, hospitals, early learning and behavioral health) for screening and early

intervention. In SFY 2014, 1.8% of children ages zero to five received a mental health assessment followed by another mental health assessment in 60 days. In a coordinated system of care, at risk families with young children are routinely identified and served by the appropriate entity. An effective early childhood system of care identifies, coordinates, serves and reduces risk factors for families with young children.

Comprehensive developmental screening is a common goal within the Collective Impact Model, which is used in Oregon. Screening using the Ages and Stages Questionnaire (ASQ) has high sensitivity and specificity for identifying children at risk for developmental delays. The Early Learning Council as adopted the ASQ as the preferred tool for developmental screening. It is a component of the Quality Rating Improvement System (QRIS) child care and preschool ratings process. Health providers are required to use developmental screening tools that are validated and reliable, such as: Ages & Stages Questionnaire, 3rd Edition (ASQ-3) or the Parents' Evaluation of Developmental Status (PEDS). Developmental screening is an incentivized metric for Coordinated Care Organizations.

To increase the provision of mental health services to children age zero to five, OHA will:

1. Develop core competencies, including cultural competencies, for early childhood mental health service providers;
2. Create professional development opportunities to increase proficiency in providing trauma informed treatment services to families with young children; and,
3. Collaborate with MAP and DHS to disseminate and fund mental health best practices for young children.

In SFY 2014, 67% of children in DHS custody received a mental health assessment within 60 days. To increase that percentage for children, youth and families, DHS Child Welfare and OHA will participate in a state level steering committee to address regional barriers and to ensure that local systems of care can adequately plan for and serve children with significant and complex health care needs. For example, OHA is actively involved in developing the new Family System Navigators that will be part of the child welfare system.

Tuberculosis Screenings

All OHA licensed providers receive biannual site visits. During these visits, OHA staff will randomly sample clinical records to ensure that SAPT funded residential and medication assisted treatment programs have completed Tuberculosis (TB) screenings.

Strategy:
Tuberculosis screening is provided to all persons entering a SUDs residential and MAT program. Utilization of the BG checklist with each client is required of all SAPT funded providers.

Priority Area 4: The behavioral health system supports recovery and a life in the community.

Housing

Safe and affordable housing is essential for the recovery process, but is not always readily available. Individuals with severe and persistent mental illness often depend on income from Supplemental Social Security that is inadequate to cover rent and other living expenses.

Apartments with affordable rents are in short supply statewide. Individuals may have difficulty securing and maintaining housing if support services are not available. Landlords may be reluctant to rent to individuals despite fair housing laws. These factors can overwhelm people who end up cycling between jails, institutions and homelessness. The lack of a home and the stability it offers makes it difficult to address the dimensions that support life in recovery: health, home, purpose and community.

According to the Bazelon Center for Mental Health Law, studies have consistently shown that people with mental illness overwhelmingly prefer living in their own homes rather than in congregate settings with other people with mental illness. The benefits of supported housing include a reduction in the use of shelters for individuals who are homeless as well as reductions in hospital admissions and lengths of stay. According to the Center for Supportive Housing, a stable living situation improves a tenant's ability to participate in support services. Investments in housing and social services for individuals in recovery can result in significant reductions in the public cost for medical and criminal justice services.

OHA currently provides funding to aid the development of supported housing and rental assistance programs. Supported housing programs provide funding to develop affordable, community-based rental housing for individuals in recovery. These properties are funded with the stipulation that the units are integrated with non-disabled housing to assure an individual's right to reside in the least restrictive environment possible, consistent with the Americans with Disabilities Act (ADA) and the US Supreme Court's 1999 decision in Olmstead v L.C.

In SFY 2014, the number of people served in mental health rental assistance programs was 202 and the number serviced in substance use disorder rental assistance programs

was 314. Rental assistance programs serve individuals in recovery for both mental illness and substance use disorders and provide the opportunity to locate and lease a rental unit with all the rights and responsibilities of any other resident.

In 2014, OHA partnered with the National Alliance for Mental Illness and the Oregon Residential Provider Association to develop proposals and identify community providers who will build affordable housing. As a result of this partnership, 168 new units of affordable housing will be built in Oregon with tobacco tax funds. OHA also has had a long history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. OHA will continue to work with the National Alliance for Mental Illness, Oregon Family and Community Services, providers, and other public and private partners to add affordable housing units for individuals and families and for people who are disabled due to mental illness, substance use disorders and co-occurring disorders.

To increase the number of people in recovery who are enrolled in Supported Housing Rental Assistance and to increase the number of individuals in supported housing, OHA will employ the following strategies:

- Implement rental assistance programs for individuals with mental illness;
- Fund rental assistance programs for individuals in recovery from substance use disorders;
- Continue the current practice of allocating General Fund, Community Mental Health Housing Trust Fund and Alcohol and Drug-Free dollars to the development of supported housing for individuals in recovery;
- Expand partnerships with stakeholder groups

Employment

Research consistently affirms that most people with serious mental illness want to work and feel that it is an integral part of their recovery. Twenty percent of individuals in Oregon were employed during the time they received outpatient behavioral health services.

Individual Placement and Support (IPS) supported employment is an evidence-based approach to supported employment for people who have serious mental illness. Individual Placement and Support assists individuals in their efforts to achieve steady employment in mainstream competitive jobs, either part-time or full-time. Supported employment services include resume building and interviewing skills, assistance with job searches and transportation to interviews. Staff members also work with clients on-the-job or debrief them after work to ensure a good transition. People who obtain competitive employment through IPS supported employment have increased income,

improved self-esteem, improved quality of life, and reduced symptoms. Individuals receiving supported employment services have been shown to reduce their use of hospitals and visits to the emergency room. In SFY 2014, 1,025 individuals received services in Individual Placement and Support Supported Employment Services.

To increase the number of people receiving Supported Employment Services and to increase the percentage of individuals accessing behavioral health services who gain employment, OHA will use the following strategies:

- Ensure all community mental health programs have IPS supported employment programs;
- Increase staffing levels for Oregon Supported Employment Center of Excellence (OSECE) to provide more timely training and technical assistance to newly developing programs.

Recovery is a lifelong experience. In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. Resources have been allocated to supporting recovery-oriented systems of care that employ person-centered planning to identify and meet individual needs across all life domains. These needs can be met by accessing recovery support services and non-traditional interventions that are usually not reimbursable as medically necessary services. Examples of recovery support services are traditional health workers, education and job training, housing barrier removal, transportation, and access to flexible funding to pay for miscellaneous items such as identification cards, interview clothing and bus passes.

Peer delivered services

For SFY 2014, less than 2% of individuals enrolled in mental health services received peer delivered services and less than one percent for substance use disorder services. Health Systems Division (HSD) employs a Peer Delivered Services (PDS) Coordinator to support development and implementation of PDS services in Oregon. The PDS Coordinator staffs the Peer Delivered Services Core Team (PDS CT) which meets monthly to develop recommendations to increase access to quality peer delivered recovery support services. PDS CT membership is composed of HSD program staff representing substance abuse prevention and treatment, problem gambling prevention and treatment, children's mental health, adult mental health, older adult mental health, and Oregon Health Plan policy. It includes the Oregon State Hospital's Director of Peer Recovery, the Director and coordinator of the Office of Consumer Activities (OCA), and the manager for Traditional Health Workers from the Office of Equity and Inclusion (OEI). The sponsor for the team is the Operations Support Administrator in HSD.

The team is addressing methods to increase use of Medicaid funding for PDS, increase the peer voice in the discussions, and decrease health inequity. The PDS Core Team plan includes the following strategies:

- Identification and exploration of sustainable funding strategies for PDS, including increasing access to Medicaid funding;
- Identification of current workforce strengths, needs, gaps and a plan to build a quality PDS workforce including trainings for supervisors;
- Identify changes to administrative rules necessary to support the increase of people receiving peer delivered services;
- Identify current data evaluation activities and outcome measures,
- Using the data collected, develop a dashboard to track increases in PDS; and
- Develop and implement a communication plan to educate the health care system and service recipients about the use of and outcomes of PDS.

Pregnant women and adults with dependent children

In SFY 2014, 73.8% of pregnant women and adults with dependent children were retained in outpatient treatment for at least 90 days. Treatment providers have added and or expanded existing day treatment models with housing supports. This model allows for the individual to attend treatment all day with residential clients and return home to safe, sober and supported housing. In the fall of 2015, OHA will be posting for a competitive application for funding to develop Substance Use Disorder Day Treatment (Out Patient ASAM Level II.5) with Housing Support Services for Medicaid and Indigent populations. This shift, alongside a Child Welfare system change, can improve outpatient retention rates.

The Department of Human Services, Child Welfare Program has implemented a system change to redesign initial contact with families: Differential Response. Differential Response moves away from a one-size-fits-all approach to child protection by adding an alternate response track. Differential Response promotes partnering with parents, family, communities and neighborhoods to keep children safe.

This system change is expected to bring about significant changes that will potentially increase the outpatient retention rates of parents with dependent children, including:

- The community and Oregon DHS will work in partnership with a shared responsibility for keeping children safely at home and in their communities;
- Families will partner with Oregon DHS to realize their full potential and develop solutions for their challenges;
- Private agencies and community organizations will experience stronger partnerships with Oregon DHS on behalf of children and families.

OHA works closely with Child Welfare, including regular statewide staffings to assist in removing barriers and allowing for rapid access to assessments and treatment for priority populations. OHA facilitates a quarterly Women's SUD Treatment Provider Workgroup to access the statewide system of care, identify barriers and work to enhance and improve our system. Child Welfare participates in these workgroups. These strategies have improved cross communication and education between the SSA, treatment providers and Child Welfare, with all participants working to improve services and treatment outcomes for parents with dependent children.

Priority Area 5: Only people who meet admission criteria are admitted to the Oregon State Hospital and for those who need it, admissions and discharges are performed in a timely manner.

When someone is experiencing a mental health crisis, they may be taken to a nearby emergency department for evaluation. If they need admission to an inpatient psychiatric unit of a general hospital, they frequently wait under observation in emergency rooms; this is called "psychiatric boarding." Psychiatric boarding becomes problematic: the child, adolescent or adult being boarded is not receiving the level of care needed and is often not in an environment conducive to recovery. The emergency department where the individual is being boarded is unequipped to meet the needs of the psychiatric boarder.

People who are subsequently admitted to a psychiatric acute care service may be civilly committed and are then put on a waiting list for admission to the Oregon State Hospital. There are approximately 200 beds available at Oregon State Hospital for civilly committed adults and geriatric patients. One way to reduce psychiatric boarding in emergency departments is to reduce the wait time to be admitted to the Oregon State Hospital. When acute psychiatric beds are open, individuals can be transferred more quickly from emergency departments.

To decrease the average number of people on the waitlist, OHA will:

- Create a new process for determining that a person is appropriate for admission to Oregon State Hospital; and
- Engage acute care hospitals in finding solutions to "psychiatric boarding."

Decreasing readmission to SCIP, SAIP and the Oregon State Hospital requires the collaboration of law enforcement, community behavioral health staff, the courts and jails.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels). *

The Measures and Outcomes Tracking System (MOTS) is the key data collection and reporting system for all agencies and facilities in Oregon who are required to report behavioral health services. This includes mental health, addiction, mental health crisis, and involuntary services, that are provided in communities throughout Oregon and that are funded, in whole or in part, by public dollars.

MOTS gathers client level data. For some federal reporting, MOTS data is merged with Medicaid data for a more complete picture of publicly funded services.

Oregon's data collection is geared exclusively toward demographic data and treatment outcomes. The Oregon Health Authority (OHA) does not collect any client level prevention data.

Data is collected in MOTS via two methods: 1) providers use the Web Client Entry tool to enter their data; 2) providers send data electronically from their existing EHRs. Option two is used by a majority of our providers. The advantage to option two is that providers do not have to do duplicative data entry.

Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.). *

Oregon's current data collection and reporting system is specific to both mental health and substance abuse services. To fulfill some federal reporting requirements, analysts review Medicaid data as well.

MOTS's treatment outcome data is necessary in order to analyze what is working well and to identify areas for system improvement. The data elements collected are used to:

- Evaluate client demographics;
- Monitor and report client outcomes;
- Comply with federal and state funding and/or grant requirements to ensure adequate and appropriate funding for the behavioral health system;
- Assist with financial-related activities such as budget development and rate setting;
- Evaluate contract utilization;
- Support quality and utilization management activities;
- Analyze health system transformation measures for performance and outcomes; and
- Respond to requests for information.

Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)? *

Oregon is not currently able to collect and report on the majority of the draft measures. Oregon's MOTS collects employment and criminal behavior data while individuals are in treatment, but does not collect the other measures.

If not, what are the perceived or actual barriers to this? What changes or adjustments will the state need to make – or what technical assistance will the state need to receive - to be able to collect and report on these measures? *

Oregon has identified the following barriers to reporting on the draft measures:

- Oregon does not collect client level prevention data and does not have the infrastructure to begin collecting this information.
- MOTS has the capability to collect some of the measures; however, this would require major changes to MOTS, including the incorporation of new data fields and extensive changes to individual provider's Electronic Health Records (EHR).
- Physical disease indicators are not included in a client's EHR and are not collected in MOTS. Tracking physical health indicators, such as diabetes, would be a major undertaking for both OHA and over 200 behavioral health providers. Some of this data is available in the Medicaid system, but only for a subset of the population receiving behavioral health services.
- The MOTS reporting period is 90 days. Some draft measures would require reporting periods of 30 days, which would add significantly to the administrative burden of Oregon's providers.
- The proposed client-level measures are of limited utility based on the Oregon data collection system. Other than the Oregon State Hospital, OHA does not provide direct services, but contracts for services through County Mental Health Providers, Coordinated Care Organizations and other entities. Many of the proposed measures are of direct utility to the providers and would be of little use for state level performance monitoring.
- There are over 200 providers who use an EHR to submit the required data set to OHA. The providers would need to change their EHR at an average cost of $50,000 per EHR to comply with the draft measures. These actions will translate to increased operating costs and additional administrative work.
- All of these items would be costly for OHA to address.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Health equity exists for all Oregonians within the state's behavioral health system.

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, TB (LGBTQ, Rural, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

OHA will make investments in resources to reduce health disparities and pursue health equity in the behavioral health care system.

Objective:

OHA will increase access among racial and ethnic behavioral patient health populations and maintain the number of consumer and family members on advisory councils.

Strategies to attain the objective:

1. Gather feedback from communities and specific cultural populations to inform policy development to support health equity in the behavioral health care system;
2. Collaborate with the Office of Equity and Inclusion, Public Health, Medical Assistance Programs, and both existing and new community partners and consumers to seek opportunities to support the health care needs of an increasingly diverse population; and
3. Collaborate with the tribes to revise the approval process for tribal behavioral health services to support them in providing culturally responsive services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access among racial and ethnic behavioral health patient populations.

Baseline Measurement: Number of people identified in specified racial and ethnic populations who access mental health and addictions treatment in SFY 2014 was 120,343.

First-year target/outcome measurement: Number of people identified in racial and ethnic populations who access mental health and addictions treatment in SFY 2015 will be 122,749 (2% increase over baseline).

Second-year target/outcome measurement: Number of people identified in racial and ethnic populations who access mental health and addictions treatment in SFY 2016 will be 125,203 (2% increase over baseline).

Data Source:

The number of people identified in racial and ethnic populations who access mental health and addictions services is tracked in MOTS, DSSURS and OPRCS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

The targets are based on increasing access for the total population, and do not set targets for specific racial/ethnic groups due to the numerous uncontrollable factors preventing reliable goal setting. Setting a number for the population is feasible, given the efforts OHA is engaging in to increase equity and access for all Oregonians.

Indicator #: 2

Indicator: Maintain the number of consumer and family members' membership on the Addictions and Mental Health Planning and Advisory Council (AMHPAC), Oregon Consumer Advisory Council (OCAC) and Children System Advisory Committee (CSAC).

Baseline Measurement:	In SFY 2014, the percentage of consumers and family members on AMHPAC was 51%; 52% consumer, family member or advocate membership on CSAC; 100% consumer or family member membership on OCAC.
First-year target/outcome measurement:	Maintain consumer and family member membership on AMHPAC, CSAC and OCAC in SFY 2015.
Second-year target/outcome measurement:	Maintain consumer and family member membership on AMHPAC, CSAC and OCAC in SFY 2016.

Data Source:

Advisory council membership rosters.

Description of Data:

Each advisory council maintains a membership roster including the membership configuration.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #:	2
Priority Area:	People in all regions of Oregon have access to a full continuum of behavioral health services.
Priority Type:	SAP, SAT, MHS
Population(s):	SMI, SED, PWWDC, PP, IVDUs, TB (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

OHA will collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.

Objective:

Determine the rural counties where disparities of utilization of mental health and substance use disorder treatment exist and increase access and utilization; improvement in crisis services; reduction in reliance on emergency departments, increase availability of medication assisted treatment; reduce criminal justice involvement for young people who are involved in the Wraparound process.

Strategies to attain the objective:

1. Collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities;
2. Work with coordinated care organizations, the Transformation Center, community mental health programs, local mental health authorities and other partners to develop strategies to encourage and facilitate regionalization of behavioral health services in rural and frontier regions where useful; and
3. Work with the Oregon Health & Science University OPAL-K program, the Transformation Center and others to identify strategies to develop the infrastructure and expand telehealth psychiatric services in rural and frontier regions of Oregon.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Determine the rural counties where disparities of utilization of substance use disorder (SUD) treatment services exist; increase capacity and utilization in the identified counties.
Baseline Measurement:	In rural counties 4.98% of the OHP population received at least one SUD service; in urban settings 5.72% received SUD services in SFY 2014. The service utilization rate per 1,000 members was 77.4 services per 1,000 members in rural counties and 178.1 services per 1,000 members in urban counties.
First-year target/outcome measurement:	Increase the service utilization rate in urban counties to 81 services per 1,000 members (a 5% increase over baseline).
Second-year target/outcome measurement:	Increase the service utilization rate in urban counties to 85 services per 1,000 members (a 5% increase over the first year target).

Data Source:

Decision Support Surveillance and Utilization Review System (DSSURS).

Description of Data:

Counts of services for SUD treatment or SBIRT based on cleansed paid Medicaid claims in the State Fiscal Year. Members are based on the sum of the fractional membership period for the year.

Data issues/caveats that affect outcome measures::

Substance use disorder services covered by the Oregon Health Plan can change. Future comparisons will use the services covered in the benefit package for that Fiscal Year.

Indicator #:	2
Indicator:	Determine the rural counties where disparities of utilization of mental health services exist; increase capacity and utilization in the identified counties.
Baseline Measurement:	In SFY 2014, 18.4% of persons in rural counties received mental health (MH) services compared to 19.2% of persons in urban counties. Mental health service utilization was 158.1 services per 1,000 members in rural counties compared to 213.8 services per 1,000 in urban counties.
First-year target/outcome measurement:	Increase service utilization to 163 services per 1,000 members (a 3% increase over baseline).
Second-year target/outcome measurement:	Increase service utilization to 168 services per 1,000 members (a 3% increase over first year).

Data Source:

Decision Support Surveillance and Utilization Review System (DSSURS).

Description of Data:

Counts of persons with a claim for MH treatment or evaluation/management based on cleansed paid Medicaid claims in the state fiscal year. Members are based on the sum of the fractional membership period for the year.

Data issues/caveats that affect outcome measures::

Mental health services covered by the Oregon Health Plan can change, future comparisons will use the services covered in the benefit package for that fiscal year.

Indicator #:	3
Indicator:	Initiation and engagement in substance use disorder treatment among OHP members.
Baseline Measurement:	Percent of individuals who initiated treatment services in SFY 2014 was 39%; percent of individuals who engaged in treatment services in SFY 2014 was 21%.
First-year target/outcome measurement:	The percent of individuals who initiate treatment services in SFY 2015 will be 41%; the percent of individuals who engage in treatment services in SFY 2015 will be 23%.
Second-year target/outcome measurement:	The percent of individuals who initiate treatment services in SFY 2016 will be 43%; the percent of individuals who engage in treatment services in SFY 2016 will be 25%.

Data Source:

Percentage of individuals who initiate and engage in treatment services is tracked in MMIS/DSSURS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

This metric tends to change incrementally and is related to the number of individuals with Medicaid coverage, as well as the prevalence of individuals experiencing mental health issues. Unless state demographics change substantially, outcome goals of 2% are a reasonable expectation.

Indicator #:	4
Indicator:	Initiation and engagement in mental health treatment among OHP members.
Baseline Measurement:	Percent of individuals who initiated treatment services in SFY 2014 was 22%; percent of individuals who engaged in treatment services in SFY 2014 was 8%.
First-year target/outcome measurement:	Percent of individuals who initiate treatment services in SFY 2015 will be 23%; percent of individuals who engage in treatment services in SFY 2015 will be 10%.
Second-year target/outcome measurement:	Percent of individuals who initiate treatment services in SFY 2016 will be 25%; percent of individuals who engage in treatment services in SFY 2016 will be 12%.

Data Source:

Percentage of individuals who initiate and engage in treatment services is tracked in MMIS/DSSURS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

This metric tends to change incrementally and is related to number of individuals with Medicaid coverage, as well as the prevalence of individuals experiencing mental health issues. Unless state demographics change substantially, outcome goals of 2% are a reasonable expectation.

Indicator #:	5
Indicator:	Decreased numbers of youth aged 0-17 seen in emergency departments for psychiatric reasons.
Baseline Measurement:	Percent of youth seen in emergency rooms for psychiatric reasons (Medicaid only) in SFY 2014 was 0.5%.
First-year target/outcome measurement:	Percent of youth seen in emergency rooms for psychiatric reasons (Medicaid only) in SFY 2015 will be 0.49% (3% reduction in rate).
Second-year target/outcome measurement:	Percent of youth seen in emergency rooms for psychiatric reasons (Medicaid only) in SFY 2016 will be 0.47% (3% reduction in rate).

Data Source:

Decision Support Surveillance and Utilization Review System (DSSURS). Data request DRTS 3031.

Description of Data:

Counts of youth admitted to the emergency department are based on cleansed paid Medicaid claims in the state fiscal year. Members are based on the sum of the fractional membership period for the year.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #:	6
Indicator:	Reduced number of emergency department visits for psychiatric services for individuals who are enrolled in the Oregon Health Plan.
Baseline Measurement:	Number of emergency department visits for psychiatric services per 1,000 members SFY 2014 was 2.73.
First-year target/outcome measurement:	The number of emergency department visits for psychiatric services per 1,000 members for SFY 2015 will be 2.65 (3% reduction).
Second-year target/outcome measurement:	The number of emergency department visits for psychiatric services per 1,000 members for SFY 2016 will be 2.57 (3% reduction).

Data Source:

Number of emergency department visits for psychiatric services is tracked in MMIS/DSSURS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

This data represents all those covered by OHP and is not limited to individuals with serious mental illness. Community based measures designed to reduce emergency department use for psychiatric crises are likely to be most effective for individuals with serious mental illness, but should help reduce emergency department utilization for psychiatric issues for all members.

Indicator #:	7
Indicator:	Reduced criminal justice involvement for young people engaged in the Wraparound (to fidelity) planning process.
Baseline Measurement:	Percentage of young people receiving the Wraparound planning process involved in criminal justice at 12 months after entry into Wraparound planning process during SFY 2104 was 4.2%.
First-year target/outcome measurement:	The percentage of children receiving the Wraparound planning process who were involved in criminal justice at 12 months after entry into the Wraparound planning process during SFY 2015 will be 3.7%.
Second-year target/outcome measurement:	The percentage of children receiving the Wraparound planning process who were involved in criminal justice at 12 months after entry into the Wraparound planning process during SFY 2016 will be 3.2%.

Data Source:

Progress Review (PR) reports submitted via the Children's Progress Review System (CPRS), a data portal developed by OHA for tracking required reporting on the status and progress of youth participating in Wraparound.

Description of Data:

PR reports are submitted for each client at entry and every 90 days until exit. They include information provided by caregivers about the client's living arrangement, health care and medications, risk factors, and the Behavioral Emotional Rating Scale (BERS-2).

Clients are included in this measure if they (1) were age 0-17 years on date of initial PR and were served within a CCO/County that provides Wraparound planning process (to fidelity) administered by OHA; and (2) their first (Entry) PR occurred during CY 2013 and is marked as SCWI; and (3) at least one additional report was submitted in CPRS for a subsequent PR as SCWI, which occurred at least 12 but not more than 15 months after Entry.

This measure is based on results for Q20, "Child's history of / risk for delinquency," in the CPRS Progress Review. Clients with response values of 1 or 2 ("No history of delinquency" or "History of delinquency, but not in the past 30 days") are counted as not involved in criminal justice. Those with values of 3 or 4 ("Recent acts of delinquency in the past 30 days" or "In the past 30 days, severe acts of delinquency that place others at risk of significant loss or injury and place child at risk of adult sanctions") are counted as having been involved in criminal justice. Clients whose response to Q20 was 5 (deferred/unknown) or 6 (not reported) were not included in the measure.

Data issues/caveats that affect outcome measures::

The System of Care Wraparound Initiative expansion (SOCWI) was not fully implemented until after CY 2013. As a result, only participants in the Statewide Children's Wraparound Initiative demonstration (SCWI) sites are included in the baseline measure. Qualifying SOCWI clients will be included in the 2015 and 2016 measurements. If needed, we will evaluate the impact of this change by comparing SFY 2015 results for SCWI and SOCWI clients.

"Date Completed" on the PR is assumed to be the date on which the data was collected from the caregiver. Entry dates are based on "Date Completed" for PRs identified as Entry on the report or based on reporting history for that client.

PRs saved as drafts are not included in the measure.

Indicator #:	8
Indicator:	Mental health consumers in Oregon reporting improved functioning from treatment

	received in the public mental health system.
Baseline Measurement:	Percentage of individuals receiving mental health services who reported improved functioning in SFY 2014 was 51%.
First-year target/outcome measurement:	Percentage of individuals receiving mental health services who reported improved functioning in SFY 2015 will be 53%.
Second-year target/outcome measurement:	Percentage of individuals receiving mental health services who reported improved functioning in SFY 2016 will be 55%.

Data Source:

Mental Health Statistical Improvement Project (MHSIP) survey.

Description of Data:

The Mental Health Statistical Improvement Project (MHSIP) survey is a consumer satisfaction survey.

Data issues/caveats that affect outcome measures::

Since 2008, this metric has fluctuated within nine percentage points, and could be considered fairly static. The development of additional community resources during SFY 2014 is expected to assist more individuals to achieve improved functioning as a result of treatment and support services.

Indicator #:	9
Indicator:	Increased percentage of individuals with opioid dependence accessing medication assisted treatment (MAT) services.
Baseline Measurement:	The number of individuals accessing MAT in SFY 2014 was: Methadone = 8,081 (5,026 OHP clients) and Buprenorphine = 1,584.
First-year target/outcome measurement:	The number of individuals accessing MAT services for opioid dependence in Oregon in SFY 2015 will increase 5% from baseline.
Second-year target/outcome measurement:	The number of individuals accessing MAT services for opioid dependence in Oregon in SFY 2015 will increase 10% from baseline.

Data Source:

Number of individuals accessing MAT services is tracked in MMIS/DSSURS and MOTS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

Outside of methadone patients, not all patients who received MAT services for opioid dependence are required to be reported into the MOTS system; for individuals receiving buprenorphine for opioid dependence, only those receiving treatment through Medicaid coverage will be reported.

Priority #:	3
Priority Area:	The behavioral health system promotes healthy communities and prevents chronic illness.
Priority Type:	SAP, SAT, MHS
Population(s):	SMI, SED, PWWDC, PP, IVDUs, TB (Adolescents w/SA and/or MH, Students in College, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

OHA will reduce the costs of health care by investing in pre-treatment prevention and mental health promotion to achieve long-term reductions in misuse and dependence rates.

Objective:

Increase provision of mental health services to children ages 0-5; increase percentage of children in DHS custody who receive a mental health

assessment; decrease alcohol use among 18-25 year olds; increase TB screenings.

Strategies to attain the objective:

1. Revise implementation plan guidelines to include strategy requirements and communicate the requirements to prevention coordinators;
2. Develop the mORe campaign related to underage drinking;
3. Develop core competencies, including cultural competencies, for early childhood mental health service providers;
4. Create professional development opportunities to increase proficiency in providing treatment services to families with young children;
5. Collaborate with Medicaid Programs (MAP) and Child Welfare (DHS) to disseminate and fund mental health best practices for young children; and,
6. Utilize the Block Grant checklist during site visits to ensure compliance with Tuberculosis (TB) screenings.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased provision of mental health services to children aged 0-5.
Baseline Measurement:	The percentage of children ages 0-5 who received a mental health (MH) assessment that was followed by another MH service within 60 days during SFY 2014 was 1.8%.
First-year target/outcome measurement:	The percentage of children ages 0-5 who received a MH assessment that was followed by another MH service within 60 days during SFY 2015 will be 2.2%.
Second-year target/outcome measurement:	The percentage of children ages 0-5 who received a MH assessment that was followed by another MH service within 60 days during SFY 2016 will be 2.5 percent.

Data Source:

Medicaid enrollment and services are tracked in MMIS/DSSURS.

Description of Data:

The denominator for this measure is the total enrollment in member-years during SFY 2014 among children from birth to five years of age, inclusive. The numerator is the total number of children in this age group who received mental health assessment services (as defined in Indicator 3.2) during SFY 2014, followed within 60 days by any other type of mental health service.

Mental health services are defined as claims or encounters with both procedure code and detail diagnosis that are included in respective lists of mental health procedure codes and diagnoses. These lists are widely used for reporting of mental health services provided by Oregon Health Plan and other publicly funded mental health services in Oregon.

Data issues/caveats that affect outcome measures::

Claims and encounters for Medicaid services may be submitted up to six months after services are provided, which means that the time period covered by this measure must end at least eight months before the results are due.

Mental health services are defined by procedure code and detail diagnosis listed on each claim/encounter in MMIS/DSSURS. The list of qualifying codes used for this measure is the standard list used by OHA for reporting on mental health services.

CANS was implemented for children in foster care in July 2014. Every child entering foster care or substitute care receives both a CANS and a mental health assessment (MHA) within 60 days. The impact of full implementation of the CANS can be assessed by comparing the proportion of CANS versus other types of mental health assessments before and after that date.

During the 60-day window after MHA, all other types of mental health services are counted, including Evaluation and Management procedure codes.

Indicator #:	2
Indicator:	Children in the custody of Child Welfare receiving a mental health assessment within 60 days of entering substitute care.
Baseline Measurement:	Percentage of children in DHS custody who received a mental health assessment within 60 days in SFY 2014 was 67%.
First-year target/outcome measurement:	The percentage of children in DHS custody who receive a mental health assessment within 60 days in SFY 2015 will be 70%.
Second-year target/outcome measurement:	The percentage of children in DHS custody who receive a mental health assessment within 60 days in SFY 2016 will be 72%.

Data Source:

Medicaid enrollment, eligibility, and services are tracked in MMIS/DSSURS. Foster care entry and placements are extracted from OR-Kids.

Description of Data:

Children are included in the measure if they meet all three criteria:
• Ages 4-17 and identified between Jan. 1 and Oct. 31, 2014, as having entered foster care;
• Continuously enrolled in the same plan with CCOA or CCOB coverage for at least 60 days from CCO notification date; and
• Remained in foster care for at least 60 days from CCO notification date.

Mental health assessment services are defined as claims or encounters with procedure codes specified for the CCO Metric "Assessments within 60 Days for Children in DHS Custody" – 90791, 90792, 96101, 96102, H0031, H1011, and H2000 with TG modifier.

Children are counted as having received a mental health assessment (MHA) if the services are provided within 60 days after CCO notification of foster entry and covered by that CCO; or occurred during the 30 days preceding CCO notification, regardless of the plan provider.

Data issues/caveats that affect outcome measures::

This measure is the same as the CCO metric "Assessments within 60 Days for Children in DHS Custody." Technical specifications are posted online: http://www.oregon.gov/oha/analytics/CCOData/Assessments%20for%20Children%20in%20DHS%20Custody%20-%202015.pdf

CANS was implemented for children in foster care in July 2014. Every child entering foster care or substitute care receives both a CANS and a mental health assessment (MHA) within 60 days. The impact of full implementation of the CANS can be assessed by comparing the proportion of CANS versus other types of mental health assessments before and after that date.

Results in year one and two may also be affected by addition of assessments provided in conjunction with psychiatric residential, day treatment, and sub-acute services, beginning in SFY 2015.

Indicator #:	3
Indicator:	Past month alcohol use among young people ages 18-25 years.
Baseline Measurement:	The percent of young people ages 18-25 years who reported alcohol use in SFY 2013 was 61.96%.
First-year target/outcome measurement:	The percent of young people ages 18-25 years who report alcohol use in SFY 2015 will be 60.99%.
Second-year target/outcome measurement:	The percent of young people ages 18-25 years who report alcohol use in SFY 2016 will be 59.99%.

Data Source:

Percentage of 18-25 year olds who report alcohol use is tracked in NSDUH.

Description of Data:

National Survey of Drug Use and Health, administered annually by SAMHSA.

Data issues/caveats that affect outcome measures::

Latest data is not always available during the BG application process. The most recent state level reports available are from 2013.

Indicator #:	4
Indicator:	Random sample of clinical records (during the biannual site visit reviews) will show tuberculosis (TB) screening is being conducted in all SAPT funded residential and MAT programs.
Baseline Measurement:	SFY 2014 will establish the baseline of sampled clinical records in SAPT funded residential and MAT programs that are in compliance with the Block Grant checklist for TB screening.
First-year target/outcome measurement:	SFY 2015 will establish the baseline of sampled clinical records in SAPT funded residential and MAT programs that are in compliance with the Block Grant checklist for TB screening.

Second-year target/outcome measurement:	SFY 2016 will establish the baseline of sampled clinical records in SAPT funded residential and MAT programs that are in compliance with the Block Grant checklist for TB screening.

Data Source:

State of Oregon licensing/certification site visits and State of Oregon Block Grant checklist.

Description of Data:

All SAPT funded residential and MAT providers are monitored for TB/IVDU priority population BG requirements through the BG checklist during the biannual site visit reviews. The site visits would include a random pull and review of IVDU client's case files.

Data issues/caveats that affect outcome measures::

It will require three years to establish baseline results, because quality reviews of programs are conducted once in three years by the licensing/certification unit.

Indicator #:	5
Indicator:	Increase number of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for tuberculosis (TB) and c) adhering to the federally defined requirement of interim services for IVDU priority populations.
Baseline Measurement:	SFY 2014 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations.
First-year target/outcome measurement:	SFY 2015 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations.
Second-year target/outcome measurement:	SFY 2016 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations will increase by 1% in SFY 2016.

Data Source:

State of Oregon licensing/certification site visits and State of Oregon Block Grant checklist.

Description of Data:

All SAPT funded residential and MAT providers are monitored for TB/IVDU priority population BG requirements through the BG checklist during the site visit reviews, which occur once every three years. The site visits would include a random pull and review of IVDU client's case files.

Data issues/caveats that affect outcome measures::

It will require three years to establish baseline results, because quality reviews of programs are conducted biannually by the licensing/certification unit.

Priority #:	4
Priority Area:	The behavioral health system supports recovery and a life in the community.
Priority Type:	SAP, SAT, MHS
Population(s):	SMI, SED, PWWDC, IVDUs, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

OHA will support recovery-oriented systems of care that support person centered planning.

Objective:

OHA is committed to developing recovery support services to meet individual needs across all life domains that include safe and affordable housing, supported housing and rental assistance; supported employment, and support for pregnant women and adults with dependent children who need outpatient treatment.

Strategies to attain the objective:

1. Implement rental assistance programs for individuals with mental illness;
2. Fund rental assistance programs for individuals in recovery from substance use disorders;
3. Continue the current practice of allocating General Fund, Community Mental Health Housing Trust Fund and Alcohol and Drug-Free dollars to the development of supported housing for individuals in recovery;
4. Expand partnerships with stakeholder groups;
5. Ensure all community mental health programs have IPS supported employment programs;
6. Increase staffing levels for Oregon Supported Employment Center of Excellence (OSECE) to provide more timely training and technical assistance to newly developing programs;
7. Develop plans for the expansion of peer delivered services; and
8. Initiate, develop and maintain partnerships between OHA, DHS Child Welfare, and the community to uphold the shared responsibility of keeping children safely at home and in their communities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of individuals in recovery who are enrolled in Supported Housing Rental Assistance.
Baseline Measurement:	The number of people served in mental health rental assistance programs in SFY 2014 was 202; the number of people served in SUD rental assistance programs in SFY 2014 was 314.
First-year target/outcome measurement:	The number of people served in mental health rental assistance programs in SFY 2015 will be 359; the number of people serviced in SUD rental assistance programs in SFY 2015 will be 318.
Second-year target/outcome measurement:	The number of people served in mental health rental assistance programs in SFY 2016 will be 701; the number of people serviced in SUD rental assistance programs in SFY 2016 will be 319.

Data Source:

For the MH rental assistance programs, rental assistance quarterly reports are posted on the New Investments SharePoint site. Program staff conducts periodic survey updates to confirm. For the SUD rental assistance programs, seven community-based programs for individuals with substance abuse disorders under contract with OHA Health Systems Division (HSD) AD60 Housing Assistance Program and each program submits a quarterly report.

Description of Data:

The total number of housing slots filled by individuals receiving rental assistance at the end of each quarter. Number of individuals receiving rental assistance; baseline measurement data as reported in each program's quarterly report, targets/outcome measures as set forth in each program's contract with OHA HSD.

Data issues/caveats that affect outcome measures::

The data is dependent on the day the units are counted. To remedy this, the report will be revised to state "the number of units occupied on the last day of the reporting month." For mental health rental assistance, the 2015 legislature dedicated seven million in additional funding, which should result in a significant increase in the amount of rental assistance available.

Indicator #:	2
Indicator:	Increased access for individuals diagnosed with serious mental illness to Individual Placement and Support (IPS) Supported Employment Services.
Baseline Measurement:	The number of individuals receiving services in IPS Supported Employment programs in SFY2014 was 1,025.
First-year target/outcome measurement:	The number of individuals receiving services in IPS Supported Employment programs in SFY2015 will be 1,554.
Second-year target/outcome measurement:	The number of individuals receiving services in IPS Supported Employment programs in

SFY2016 will be 1,749.

Data Source:

Claims data in MMIS, encounter data entered into MOTS and caseload reports from the Oregon Supported Employment Center for Excellence (OSECE) are utilized to calculate the number of individuals receiving IPS Supported Employment services.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

Quarterly caseload information from OSECE is compared with data from pulled from MMIS and MOTS. The information from MOTS and MMIS may be incomplete, as there may be individuals receiving IPS Supported Employment services who are part of an Assertive Community Treatment (ACT) team. In these cases, the ACT code is utilized and IPS Supported Employment code is not.

Additionally, there could be individuals who receive ongoing IPS Supported Employment supports, but do not have any billable encounters in MMIS. These individuals are counted in the provider's caseload, but will not show up in claims information.

Indicator #:	3
Indicator:	Increased percentage of individuals accessing behavioral health services who gain employment.
Baseline Measurement:	Percent of individuals who are employed during the time they are receiving outpatient treatment for a behavioral health condition in SFY 2014 was 20.3%.
First-year target/outcome measurement:	Percent of individuals who are employed during the time they are receiving outpatient treatment for a behavioral health condition in SFY 2015 will be 24%.
Second-year target/outcome measurement:	Percent of individuals who are employed during the time they are receiving outpatient treatment for a behavioral health condition in SFY 2016 will be 27%.

Data Source:

Moving forward, individuals who are employed during the time they are receiving outpatient treatment for a behavioral health condition will be tracked in MOTS; current data was pulled from MMIS.

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

This data pertains to individuals enrolled in OHP, and service eligibility is dependent on income thresholds. Modest increases should be possible through available community based services.

Indicator #:	4
Indicator:	Increased percentage of individuals who receive peer delivered services.
Baseline Measurement:	Percent of individuals from birth and up who receive peer delivered services in SFY 2014 for mental health was 1.7% and for substance use disorder was 0.7%.
First-year target/outcome measurement:	Percent of individuals from birth and up who receive peer delivered services in SFY 2015 for mental health will be 1.8% and for substance use disorder will be 0.8% (based on a 5% improvement over baseline).
Second-year target/outcome measurement:	Percent of individuals from birth and up who receive peer delivered services in SFY 2016 for mental health will be 1.9% and for substance use disorder will be 0.9% (based on a 5% improvement over the first year target).

Data Source:

Medicaid data source is the Decision Support Surveillance and Utilization Review System (DSSURS); Non Medicaid data source is the Measures and Outcomes Tracking System (MOTS).

Description of Data:

Medicaid Data: Counts of persons receiving peer services are based on claims for procedure code H0038 (cleansed paid Medicaid claims) in the state fiscal year. Persons in treatment include persons with a claim for a mental health or substance use disorder treatment procedure code and diagnosis (for mental health that excludes persons that only have an evaluation/management code; for substance use disorders that excludes persons that only have an SBIRT code).

Non-Medicaid Data: Counts are also based on a mental health or substance use disorder treatment procedure code and primary diagnosis during the fiscal year (for mental health that excludes persons that only have an evaluation/management code; for substance use disorders that excludes persons that only have an SBIRT code).

Data issues/caveats that affect outcome measures::

Baseline was determined using Medicaid data only. First year results will be presented with Medicaid and Non-Medicaid separately so it will be clear if the target was met.

Indicator #:	5
Indicator:	Increased number of individuals with Serious Mental Illness (SMI) utilizing ACT services.
Baseline Measurement:	Number of people with SMI utilizing ACT services in SFY 2014 was 460.
First-year target/outcome measurement:	The number of individuals with SMI utilizing ACT services in SFY 2015 will be 853.
Second-year target/outcome measurement:	The number of individuals with SMI utilizing ACT services in SFY 2016 will be 1,500.

Data Source:

Individuals with SMI utilizing ACT services is tracked in/by MMIS/DSSURS, MOTS, OSEACT.

Description of Data:

MMIS/DSSURS and MOTS are described in step two. OHA contracts with the Oregon Center for Excellence for Assertive Community Treatment (OCEACT) to provide technical assistance to providers and to review ACT programs for their adherence to the Dartmouth ACT Fidelity Scale. OCEACT provides OHA with quarterly caseload reports from fidelity reviews that were conducted in previous reporting quarter. The caseload reports are reconciled with counts of individual identification numbers from billing records and encounter information in MOTS to validate the number of individuals enrolled in ACT services.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #:	6
Indicator:	Decreased arrests among individuals accessing behavioral health services who are referred by the criminal justice system.
Baseline Measurement:	Percent of individuals receiving behavioral health services who are not arrested in the 30 days prior to the latest treatment status update in SFY 14 was 77.7% for mental health and 85.9% for substance use disorders.
First-year target/outcome measurement:	80% for mental health treatment; 87.2% for substance use disorder treatment (3% improvement over baseline).
Second-year target/outcome measurement:	82.5% for mental health treatment; 89.8% for substance use disorder treatment (3% improvement over the first year target).

Data Source:

Measures and Outcome Tracking System (MOTS).

Description of Data:

See step two.

Data issues/caveats that affect outcome measures::

This calculation reports the percent of individuals who are not arrested in the 30 days before the last status update for persons that have information on arrests at both admission and status updates. Exclusions from the calculation include: individuals whose treatment status changed to death.

SFY 2014 baseline data for this measure is based on a relatively small amount of data available in MOTS.

The majority of the data for SFY 2014 was from Medicaid and there was a low rate of MOTS data submissions for these clients. It may be necessary to re-adjust targets once the first year data is available.

There were more than 120,000 OHP members, 12 or older, that received mental health treatment services in SFY 2014. Only 476 of them had a referral from the criminal justice system and values for arrests (in MOTS).

There were 38,798 OHP members, 12 or older, that received SUD treatment in SFY 2014. Only 1,064 of them had a referral from the criminal justice system and values for arrests (in MOTS). In comparison, MOTS had information about 660 persons that received Non Medicaid services in SFY 2014 and were referred by the criminal justice system. Only one was missing arrest information.

Once the first year data is available from MOTS it may be necessary to review and adjust targets.

Indicator #:	7
Indicator:	Maintain percent of pregnant women and adults with dependent children who successfully complete treatment or receive at least 90 days of treatment.
Baseline Measurement:	In SFY 2014, 80.2% of the pregnant women and adults with dependent children were retained in outpatient treatment for at least 90 days.
First-year target/outcome measurement:	The percent of pregnant women and adults with dependent children retained in outpatient treatment for at least 90 days in SFY 2015 will be 80.2%.
Second-year target/outcome measurement:	The percent of pregnant women and adults with dependent children retained in outpatient treatment for at least 90 days in SFY 2015 will be 80.2%.

Data Source:

Measures and Outcomes Tracking System (MOTS); Decision Support Surveillance and Utilization Review System (DSSURS).

Description of Data:

Persons receiving Non-Medicaid services will be identified through outpatient treatment procedure codes submitted in MOTS. Persons receiving Medicaid outpatient services will be identified through claims with an outpatient procedure code. The MOTS system provides information on retention, pregnancy and parent status.

Data issues/caveats that affect outcome measures::

SFY 2014 baseline data for this measure is based on a relatively small amount of data available in MOTS. The majority of the data for SFY 2014 was from Medicaid clients. Because MOTS data submissions came online in January 2014, the results are based on a relatively small number of clients. Once the first year data is available from MOTS it may be necessary to review and adjust targets.

Indicator #:	8
Indicator:	Increased number of people in independent living.
Baseline Measurement:	Number of OHA funded programs throughout the state providing supported drug-free housing was 163 in SFY 2014.
First-year target/outcome measurement:	The number of OHA funded programs throughout the state providing supported drug-free housing will be 171 in SFY 2015.
Second-year target/outcome measurement:	The number of OHA funded programs throughout the state proving supported drug-free housing will be 179 in SFY 2016.

Data Source:

The number of OHA funded programs providing supported drug-free housing and the number of beds available is tracked by Oxford House, Inc.

Description of Data:

Oxford House, Inc. provides OHA with a monthly status report for Oregon.

Data issues/caveats that affect outcome measures::

Oxford House is expanding in rural parts of Oregon, including the Oregon coast and Eastern Oregon. Oxford House hired a coordinator to serve Eastern Oregon. The focus in rural Oregon should result in a steady increase in drug-free housing.

Priority #: 5

Priority Area: Only people who meet admission criteria are admitted to the Oregon State Hospital and for those who need it, admissions and discharges are performed in a timely manner.

Priority Type: MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless)

Goal of the priority area:

Reduction in wait time for discharge from the Oregon State Hospital and decrease of readmission rates to SCIP, SAIP and the Oregon State Hospital.

Objective:

Processes for admission to OSH, working with community partners, including acute care, to find solutions for psychiatric boarding.

Strategies to attain the objective:

1. Create a new process for determining that a person is appropriate for admission to Oregon State Hospital; and
2. Engage acute care hospitals in finding solutions to “psychiatric boarding.”

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decrease non-forensic patients' readmission to SCIP at 180 days.

Baseline Measurement: Percentage of non-forensic patients readmitted to SCIP at 180 days SFY 2014 was 9.5%.

First-year target/outcome measurement: Percentage of non-forensic patients readmitted to SCIP at 180 days SFY 2015 will be 7%.

Second-year target/outcome measurement: Percentage of non-forensic patients readmitted to SCIP at 180 days SFY 2016 will be 4.8%.

Data Source:

MMIS/DSSURS claims and encounters; list of Forensic clients provided by Trillium.

Description of Data:

Treatment episodes based on dates of services for each client with procedure code H0017 and billing provider Medicaid ID for SCIP (312008). Clients with a treatment episode end date during SFY 2014 were included in the measure. Among those, clients with a subsequent episode beginning within 180 days after the previous end date were counted as having been readmitted within 180 days.

Data issues/caveats that affect outcome measures::

This measure relies on Medicaid service data to define treatment episode start and end dates. Previously we compared CPMS records with information provided by the program. CPMS has been replaced by MOTS, which is structured differently and requires a different approach. This change and the fact that MOTS is still in development led to the decision to use data from MMIS/DSSURS.

One of the two clients counted as readmitted within 180 days had a peculiar pattern of 12 one to two day episodes between two longer continuous episodes. Since they all occurred within the required window but were very close together, they were counted as one readmission instead of 12.

None of the SCIP clients were listed as having forensic episodes.

Indicator #: 2

Indicator: Decrease non-forensic patients' readmission to SAIP at 180 days.

Baseline Measurement: Percentage of non-forensic patients readmitted to SAIP at 180 days during SFY 2014 was 9.8%.

First-year target/outcome measurement: Percentage of non-forensic patients readmitted to SAIP at 180 days during SFY 2015 will be

	8.0%.
Second-year target/outcome measurement:	Percentage of non-forensic patients readmitted to SAIP at 180 days during SFY 2016 will be 4.8%.

Data Source:

MMIS/DSSURS claims and encounters; list of Forensic clients provided by Trillium.

Description of Data:

Treatment episodes based on dates of services for each client with procedure code H0017 and billing provider Medicaid ID for SAIP (312072), SITS (500620225), or STS (312089). Forensic clients were excluded if the dates of service on the list provided by Trillium corresponded with the dates of the treatment episode from MMIS/DSSURS. Clients with a non-forensic treatment episode end date during SFY 2014 were included in the measure. Those with a subsequent episode beginning within 180 days after the previous end date were counted as having been readmitted within 180 days.

Data issues/caveats that affect outcome measures::

This measure relies on Medicaid service data to define treatment episode start and end dates. Previously, OHA compared CPMS records with information provided by the program. CPMS has been replaced by MOTS, which is structured differently and requires a different approach. This and the fact that MOTS is still in development led to the decision to use data from MMIS/DSSURS.

SITS and STS services were included on the advice of the program analyst who works with these clients after it was noted that the number of SAIP clients was much lower than expected. We also found that all except one of the 23 clients with SAIP billing ID 312072 were also on the forensic list.

Indicator #:	3
Indicator:	Increase percent of non-forensic OSH patients discharged within 30 days of being determined ready.
Baseline Measurement:	Percentage of non-forensic OSH patients discharged within 30 days of being determined ready in SFY 2014 was 40%.
First-year target/outcome measurement:	Percentage of non-forensic OSH patients discharged within 30 days of being determined ready for transition in SFY 2015 will be 65%.
Second-year target/outcome measurement:	Percentage of non-forensic OSH patients discharged within 30 days of being determined ready for transition in SFY 2016 will be 75%.

Data Source:

RTT Report

Description of Data:

This report, generated by the state hospital, provides the list of patients identified as ready to transition and the number of days on that list.

Data issues/caveats that affect outcome measures::

None known.

Indicator #:	4
Indicator:	Decrease forensic patients' readmission to State psychiatric hospitals at 30 days.
Baseline Measurement:	The percentage of forensic patients' readmission to State psychiatric hospitals at 30 days in SFY 2014 was 2.54%.
First-year target/outcome measurement:	For SFY2015, the 30-day readmission rate will be no higher than 2%.
Second-year target/outcome measurement:	For SFY 2016 the 30-day readmission rate will be no higher than 1.95%.

Data Source:

OPRCS

Description of Data:

OPRCS collects data on all persons admitted/readmitted to OSH, regardless of legal status.

Data issues/caveats that affect outcome measures::

This metric was begun last year and the baseline for readmissions at 30 days was 6.79%. The targets are modest, as the population is small and even one readmission can profoundly affect outcomes.

Indicator #:	5
Indicator:	Decrease forensic patients' readmission to State psychiatric hospitals at 180 days.
Baseline Measurement:	The percentage of forensic patients' readmission to State psychiatric hospitals at 180 days in SFY 2014 was 6.09%.
First-year target/outcome measurement:	For SFY 2015, the 180-day readmission rate will be no higher than 5.5%.
Second-year target/outcome measurement:	For SFY 2016 the 180-day readmission rate will be no higher than 5%.

Data Source:

OPRCS

Description of Data:

OPRCS collects data on all persons admitted/readmitted to OSH, regardless of legal status.

Data issues/caveats that affect outcome measures::

This metric was begun last year and the baseline for readmissions at 180 days was 18.78%. The targets are modest, as the population is small and even one readmission can profoundly affect outcomes.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$29,036,821		$270,261,757	$5,987,360	$31,096,841	$0	$0
a. Pregnant Women and Women with Dependent Children*	$5,208,380		$0	$0	$0	$0	$0
b. All Other	$23,828,441		$270,261,757	$5,987,360	$31,096,841	$0	$0
2. Substance Abuse Primary Prevention	$9,009,819		$0	$0	$1,177,836	$0	$0
3. Tuberculosis Services	$0		$0	$0	$196,730	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$2,002,455		$100,000	$920,135	$5,856,741	$0	$0
13. Total	$40,049,095	$0	$270,361,757	$6,907,495	$38,328,148	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$60,900,000	$8,500,000	$424,328,000	$2,272,000	$0
6. Other 24 Hour Care		$0	$289,326,018	$0	$5,993,253	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$12,376,534	$1,686,884,721	$1,100,164	$319,990,289	$0	$0
8. Mental Health Primary Prevention**		$309,000	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$614,466	$0	$0	$7,859,104	$0	$0
10. Administration (Excluding Program and Provider Level)		$700,000	$68,294,271	$0	$9,459,439	$0	$0
13. Total	$0	$14,000,000	$2,105,405,010	$9,600,164	$767,630,085	$2,272,000	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$14,018,410
2 . Substance Abuse Primary Prevention	$5,004,909
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$1,001,227
6. Total	$20,024,546

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	$725,955
	Total	$725,955
Education	Universal	
	Selective	
	Indicated	
	Unspecified	$1,367,959
	Total	$1,367,959
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	$1,565,498
	Total	$1,565,498
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	$222,232
	Total	$222,232

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	$987,696
	Total	$987,696
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	$69,139
	Total	$69,139
Section 1926 Tobacco	Universal	
	Selective	$66,430
	Indicated	
	Unspecified	
	Total	$66,430
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		$5,004,909
Total SABG Award*		$20,024,546
Planned Primary Prevention Percentage		24.99 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$1,367,959	
Universal Indirect	$3,279,149	
Selective	$135,569	
Indicated	$222,232	
Column Total	$5,004,909	
Total SABG Award*	$20,024,546	
Planned Primary Prevention Percentage	24.99 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	€
Tobacco	€
Marijuana	€
Prescription Drugs	€
Cocaine	€
Heroin	€
Inhalants	€
Methamphetamine	€
Synthetic Drugs (i.e. Bath salts, Spice, K2)	€
Targeted Populations	
Students in College	€
Military Families	€
LGBT	€
American Indians/Alaska Natives	€
African American	€
Hispanic	€
Homeless	€
Native Hawaiian/Other Pacific Islanders	€
Asian	€
Rural	€
Underserved Racial and Ethnic Minorities	€

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$156,179	$190,889	$0	$347,068
2. Quality Assurance	$0	$47,545	$0	$47,545
3. Training (Post-Employment)	$17,988	$161,896	$0	$179,884
4. Education (Pre-Employment)	$19,015	$0	$0	$19,015
5. Program Development	$38,033	$0	$0	$38,033
6. Research and Evaluation	$0	$23,771	$0	$23,771
7. Information Systems	$0	$0	$0	
8. Total	$231,215	$424,101		$655,316

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$0

Comments on Data:

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

---

[26] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013;91:102–123

http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52–77

[27] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts,

http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[28] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

[29] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[30] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

http://www.cdc.gov/socialdeterminants/Index.html

[32] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5;Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[33] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[34] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

[36] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[37] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

[38] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[40] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

[42] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[43] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

[44] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[45] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[46] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[47] http://www.nrepp.samhsa.gov/

[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[49] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Health Disparities

Health Disparities

Oregon has significant numbers of people at risk for experiencing health disparities due to cultural, language, economic and geographic barriers. Many Oregonians are unable to attain their highest level of health because of cultural, language, and other communication barriers. When the health care system is not responsive to the cultural and linguistic needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes.

The need to eliminate racial and ethnic health disparities is imperative given the rapid increase in diversity in Oregon over the last twenty years. Between 2000 and 2010 alone, Oregon saw significant growth, and populations of color increased dramatically[1]. In 2010, at least 137 languages were spoken in Oregon. This makes Oregon one of the 15 most language-diverse states in the nation. The distribution of Oregon's population by race and ethnicity, and percent change across all populations, is provided in the table below:

Table 1: Oregon Population By Race and Percent Change Between 2000 – 2010

Percent of Population	Change: 2000 – 2010
White alone 83.6% (n=3,899,353)	8.2% increase
Black or African American alone 1.8% (n=70,188)	24.3%
American Indian and Alaska Native alone 1.4% (n=54,591)	17.7%
Asian alone 3.7% (n=144,276)	39.4%
Native Hawaiian or other Pacific Islander alone 0.3% (n=11,698)	68.1%
Some other race alone 5.3% (n=206,666)	41.3%
Two or more races 3.8% (n=148,175)	38.2%
Hispanic or Latino ethnicity 11.7% (n=456,224)	63.5%
Not Hispanic or Latino ethnicity 88.3% (n=3,443,129)	7.5%

As the population diversity increases, the cultural and linguistic barriers can lead to problems such as delay or denial of services, issues with medication management, underutilization of preventive services and increased use of emergency services. Research demonstrates that language barriers between patient and provider greatly impact the quality of health care and consequently, increase health disparities for communities with language access barriers. Difficulty in communication also may limit clinicians' ability to understand patient symptoms and effectively provide treatment[2],

[1] US Census Bureau. 2010. Available at the following website: http://www.census.gov/population/projections/state/

[2] Green et al. 2005; Jacobs et al. 2006; Karliner et al 2007; Flores et al. 2008

even more critical today in the face of rapidly shifting Oregon demographics as mentioned above, and the rising number of people with limited English proficiency. According to 2011 American Community Survey, more than 541,345 residents speak a language other than English at home and 228,891 residents over five years speak English "less than very well" and may be considered Limited English Proficiency (LEP)[3].

Oregon's minority communities face overwhelming and significant disparities across multiple systems levels and intersecting with every social determinant of health. Recent (2012-13) data show key differences between Oregon's whites and minority populations in education, income, level of poverty and rate of incarceration. Based on 2012-13 statewide graduation and dropout rates in Oregon high schools, the challenges experienced by students of color resulted in significantly lower graduation rates and higher dropout rates. The data shows that the high school graduation rate of American Indian/Alaskan Native, African American, and Limited English Proficient students has been at least 15% lower than their White peers (75%) and they also drop out of school at a much higher rate[4]. Additionally, when one compares the level of poverty, the per capita income and the rates of incarceration between the ethnic/racial minorities and the White population in Oregon, the inequities are quite transparent. The poverty rates for American Indians/Alaskan Natives (34%), African-Americans (41%) and the Hispanics (30%) are almost double or more than that of White population (16%), and all three population groups earn at least 10,000 dollars less[5]. African Americans represent 7% higher in the prison population than they do in Oregon's population[6].

Oregon statewide health data indicate that health outcomes for communities of color mirror challenges created by the social determinants of health. The rapid growth presents a major challenge and opportunity for the state's health and health care systems. Populations of color and other culturally and socially diverse populations currently experience health inequities. Racial and ethnic minorities have higher incidence of chronic conditions, higher mortality rates and less access to care than the general population.

- According to Oregon Vital Statistics and National Center for Health Statistics, among all adult Oregonians, African Americans have the highest prevalence of

[3] SELECTED CHARACTERISTICS OF THE NATIVE AND FOREIGN-BORN POPULATIONS. 2011 American Community Survey 1-Year Estimates. U.S. Census Bureau

[4] http://www.ode.state.or.us/search/page/?id=1 & http://www.ode.state.or.us/search/page/?id=2644

[5] American Community Survey – US Census Bureau. (2012). 1-Yr. Estimates. http://www.census.gov/acs/www/

[6] Oregon Department of Corrections. (May 2014). http://www.oregon.gov/DOC/RESRCH/docs/POPREP.pdf?ga=t
American Community Survey. Quick Facts Oregon. (2013). http://quickfacts.census.gov/qfd/states/41000.html

select chronic conditions such as asthma, diabetes, hypertension, and American Indians/Alaskan Natives have the highest rates of smoking[7];

- The age-adjusted African American prevalence of diabetes is three times higher than for Whites (Oregon Behavioral Risk Factor Surveillance System Oversample, 2010–2011);
- Thirty-five percent of minority women have no regular care provider compared to 18% of White women (State of Oregon, Oregon's Action Plan for Health, 2010);
- Latinos experience obesity at a higher rate than the general population (30.9% vs. 24.1% respectively) (State of Oregon, Public Health Division, 2012);
- Lesbians, gays and bisexuals are less likely to have medical insurance than heterosexual adults (State of Oregon, Public Health Division, 2012);
- Pacific Islanders experience the lowest 2-year-old immunization rates among Oregon's race and ethnicity groups (State of Oregon, Office of Equity and Inclusion, 2013);
- African American and Native American populations have a higher rate of potentially avoidable hospitalizations compared to the benchmark of non-Hispanic Whites (3,172 and 3,463 per 100,000 person years, respectively, compared to 2,789 per 100,000 per person years)[8].

Disparities in Addiction and Mental Health Outcomes

African American and American Indians are disproportionately represented in their admissions into a substance abuse treatment program than their overall demographic representation of 2% and 1.8% respectively in Oregon[9]. In 2012-2013, the African Americans and American Indians show much lower rates of completion of addiction treatment. Over 30% of these two population groups do not complete treatment once they are engaged[10]. Data also reveals that only 52% African American follow-up after mental health hospitalizations, which is significantly lower than the benchmark of 68%[11].

Addressing Health Disparities Investments in mental health services have improved the availability of behavioral health services for many. When the health care system is not responsive to the cultural and linguistic needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes. Oregon's is taking unprecedented measures to improve the quality of care and health outcomes, especially

[7] Oregon Vital Statistics and National Center for Health Statistics, 2009

[8] Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

[9] African American Summit on the State of African American Substance Abuse and Treatment in Oregon. (2012).

[10] OHA Addictions and Mental Health Division, Quarterly Addiction Treatment Outcomes Report. (2012 – 2013). http://www.oregon.gov/oha/amh/Pages/data.aspx

[11] OHA/DHS Decision Support Surveillance and Utilization Review System (DSSURS), Final 2013, Downloaded: May, 2014.

for those who historically have experienced behavioral health disparities, while at the same time curbing the rising cost of health care.

Partnerships

In order to have a meaningful impact on populations experiencing disparities, OHA's Office of Equity and Inclusion (OEI) is partnering with the former Addictions and Mental Health Division. The Office of Equity and Inclusion's mission is to engage and align diverse community voices and OHA to assure the elimination of avoidable health gaps and promote optimal health in Oregon. To this end, OEI partners with community members to create policy agendas and ensure that OEI's policy platforms are informed by lived experience and community wisdom. OEI is charged to integrate health equity in all aspects of OHA to achieve the triple aim (improved health outcomes, increased access to health care, and decreased or controlled health care costs). The office also identified and is implementing improvements in a number of agency-wide systems relating to diversity and inclusion, civil rights and affirmative action.

With the passage of Health System Transformation legislation in 2011 and 2012, OEI's role has shifted from introducing and explaining terms and values such as health equity and cultural competence to providing very specific and detailed technical assistance and training, policy development and community engagement to support health policy leaders, health care administrators and community organizations to ensure that health equity and diversity and inclusion concepts and strategies are integrated into all policies. OEI has also supported the advancement of health equity strategies in contractual agreements with Oregon's Coordinated Care Organizations, has led efforts to include community health workers, peer support providers, doulas, and health care interpreters; disaggregation of race, ethnicity and language data collection requirements; and meaningful engagement of communities of color and other underrepresented communities in Health System Transformation legislation and the subsequent administrative rule-making process. OEI staff provided specific guidance to behavioral health and public health systems about how to explicitly consider equity and cultural competence as part of the process.

OEI engages communities of color to help define and design approaches to advance health equity, cultural competence, and diversity and inclusion. OEI has established numerous committees comprised of subject-matter experts and researchers: Community Advisory Council, Health Equity Policy Committee, Cultural Competency Continuing Education Committee, and Health Equity Researchers of Oregon. At every step of the way, through these committees, drawing on the wisdom and partnership of these stakeholders, OEI has focused much more on providing health equity, cultural competency and diversity training and technical assistance to our stakeholders. With

the National Partnership for Action to End Health Disparities as the foundation, OEI has been sharing concepts, planning and action steps to apply principles of health equity, diversity, inclusion and cultural competence within OHA's fundamental values, goals, programs and processes.

The Regional Health Equity Coalitions (RHECs)
Since July 2011, the Oregon Health Authority (OHA) through its Office of Equity and Inclusion, has acquired funding and established six Regional Health Equity Coalition (RHEC) program to support local, community-driven, culturally-specific activities to reduce disparities and address social determinants of health. The RHECs are cross-sectorial coalitions consisting of community-based nonprofits, health care providers, local public health departments, local policymakers and researchers, and non-traditional partners such as businesses, economic development leaders, private funders, and faith-based organizations. The RHECs are organized to address issues that create inequities in health and social well-being, identify system and program changes, craft and implement strategies and policies that promote equity and address the social determinants of health. Through the efforts of the Regional Health Equity Coalitions, communities are working toward reducing disparities through a variety of activities aimed at specific health or health access issues. Some examples include establishing policies around smoke free housing, increasing workforce diversity, and enhancing cultural competency among health, education and other service providers.

Equity and Inclusion lens
OEI created an equity and inclusion lens, which specifically focus on Health Program and Service Provision Improvements and Diversity:

Health Program and Service Provision Improvements for Equity and Inclusion:
Programs and services utilizing culturally and linguistically appropriate services (including the incorporation of non-Western approaches to health and health care); programs and services making health literacy assessments of their clients/patients and print materials; strengthening the application of Title VI of the Civil Rights Act; incorporation of language access provisions (e.g., provide timely interpretation, translation, alternate formats); use of only qualified/certified health care interpreters and/or ASL certified interpreters in clinical/medical settings; bilingual/multilingual program staff and contracted interpreters meeting the bilingual proficiency standards if using their language skills in program delivery; timely translation of documents necessary to maintain and protect the health of all communities; cultural competency training for health and service providers; use of Traditional Health Workers in health care service delivery; incentivizing participation to engage under-represented groups (e.g., stipends for advisory bodies) and incorporation of health equity policies/practices; integration of the provision of services in "non-traditional" settings to increase access; require programs to tie health improvement policies and strategies to social

determinants of health and collaborate with other state and local cross-sector entities to address those determinants of health.

Diversity Increased efforts for workforce diversity (recruitment and interviewing processes, retention strategies such as employee resource groups, professional development opportunities targeted to under-represented staff); data collection, reporting and establishment of metrics related to employment of under-represented populations; incentivizing or requiring cultural competency training for staff; increased contracting or procurement opportunities for minority, women and emerging small businesses.

Community Engagement

Community engagement is important for increasing the overall performance and accountability of health systems (World Health Organization, 2013). The quality and inclusivity of engagement between institutions and the communities they serve largely determine whether policies and programs reflect the interests of all residents. Solutions for achieving health equity are not limited to professional “experts” and individuals with formal education, training or extensive work or research experience in a particular subject. Wisdom from communities with lived experience of health inequities will lead to more effective and sustainable solutions. These communities have intimate knowledge of their strengths and what works best to support their health. Institutions can earn and keep the community’s trust and partnership through continually engaging and following through with meaningful actions to achieve health equity for all Oregonians.

Data Collection/Analysis

Standardized, meaningful data collection is critical for assuring consequential health equity implementation. It is necessary for behavioral health system to collect more granular data by race, ethnicity, language, and disability data. This type of granular data create better understanding of the community served and better matching of workforce to community served. In the long run, the data will enable us to effectively address the community needs for culturally and linguistically appropriate services, to improve the access and quality of care, and ultimately, closing the gap between different groups.

The 2013 Oregon House Bill 2134 (OAR 943-070), mandates Oregon Health Authority and Oregon Department of Human Services to implement uniform standards and practices for collection of data on race, ethnicity, preferred spoken or signed and preferred written language, and disability status. The standardized methodology will allow us to demonstrate progress towards reductions in disparities by increasing transparency in reporting indicators by race, ethnicity, language and disability. Hence, this type of data collection standard is necessary to measure the health equity outcomes of the Block grant in order to enable AMH and the stakeholders to promote

policies that address disparities among racial and ethnic minority and other disadvantaged groups.

Culturally Competent Behavioral Health Workforce

One vital resource for health disparity reduction is comprehensive training for staff, providers and clients. Training opportunities may include:

- Training on granular data collection to demonstrate how to collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of Culturally and Linguistically Appropriate Service standards (CLAS) on health equity and outcomes and to inform service deliver
- Training on how to offer language assistance to individuals who have limited English proficiency and/or other communication needs
- Training on the utilization of and payment structure for Traditional Health Workers (i.e. Peer Support Specialists and Peer Wellness Specialists)
- Health literacy training that demonstrates how to provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area
- Effective community engagement (i.e. partnering with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness)
- Staff training on strategies to increase racial and ethnic representation on AMH councils and committees
- Leadership training that promotes health equity through policy, practices, and allocated resources
- Client civil rights training

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

---

[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

---

[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Evidence-Based Practices for Early Intervention

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

   The Early Assessment and Support Alliance (EASA) is a systematic effort within Oregon to prevent early trauma and disability caused by schizophrenia-related conditions. The program was originally based on the Australian Practice Guidelines for Early Psychosis (McGorry, et al., 1998, 2010) and has since been updated. The 2013 practice guidelines are a culmination of international research, revisions in the Australian and international directives, feedback from EASA clinicians and participants, and current and emerging research from experts in the field of early psychosis. Oregon will use the set-aside funds to support the existing Early Assessment and Support Alliance (EASA) First Episode Psychosis (FEP) program, which provides FEP treatment in 32 of the state's 36 counties.

2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

   During the 2013-2015 biennium, Oregon expanded EASA services to 32 of 36 counties. State general fund and a modest amount of Block Grant funds were invested to establish an EASA Center for Excellence within the Portland State University Regional Research Institute for Human Services. In 2015-2016, the state will expand EASA into the four remaining unserved counties. In addition to the complete expansion to all counties, the set-aside funds will be used to enhance sustainability of EASA programs under expanded healthcare coverage due to the Affordable Care Act. Oregon will also support the existing EASA Center for Excellence, which provides technical assistance and program and outcome evaluation for county EASA programs statewide. The Center for Excellence has also been instrumental in advising other states in the development of their FEP programs, including Kentucky, Alabama, and Washington, among others.

3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

Year	Priorities	Goals and Objectives	Implementation	Performance Measures/Benchmarks
2016	Expansion	Bring 4 remaining counties online	Site visits to remaining counties Discovery of barriers and incentives Timeline and Benchmarks for start-ups	For each site: Hiring Training Screening and Services Begun

	Fidelity and Practice Review	Metrics for services TA Model Updated Psychiatric Interface Defined Role of Peers in Model Updated	Get input from programs about TA experience, including psychiatry Define use of peer support across programs and determine ideal application of peer support	Fidelity Elements in Practice Alignment of elements with data and reporting
2017	Integration into Permanent MH System Sustainability Model	Assess optimal use of EASA as it relates to age of onset, duration of program, and subsequent treatment or support, i.e. long term Identify funding model that allows FEP model to sustain itself	Develop longitudinal data and follow up process Look at trajectory of treatment and transitions for EASA participants Model for sustained funding created	Maintenance of outcomes at 1 and 2 years following transition from program Model used across 36 counties

1. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

2015-2017 EASA Budget (Oregon First Episode Set Aside)

EASA Services in 32 Counties

MHBG Set Aside (13-15)	$ 507,374
State General Funds	$ 7,232,176
Total-Direct Services	**$ 7,739,550**

2015-2017 EASA Training, TA, and Clinical Support-Center for Excellence

MHBG Set Aside (13-15)	$ 73,780
State General Funds	$ 640,000
Total for FEP Training & TA	**$ 713,780**

2. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Data for the EASA program is collected in two ways:

1. Through the Oregon Health Authority state-wide data collection system, Measures and Outcomes Tracking System (MOTS), providers update client information quarterly and all individuals served through the state health systems programs have a record in MOTS.
2. Through the EASA Center for Excellence reporting process each service participant has referral, intake, and outcome data recorded. Some of the outcomes are tied to the Oregon Health Authority metrics (emergency

department utilization, access to care, satisfaction with care, and follow-up after hospitalization for mental illness) and others reflect early psychosis risk avoidance and mitigation, such as decreased hospitalization and use of crisis services, decreased involvement with law enforcement, increased connectivity with school and community, and a more positive outlook, among others.

Please indicate area of technical assistance needed related to this section.

Many states, and SAMHSA, are looking to Oregon and its EASA program for technical assistance. Oregon would welcome technical assistance related to sustainable funding models, long-term outcome antecedents, and a Medicaid service system model that incorporates and supports the outcomes from team-based client centered services.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

---

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Primary Prevention for Substance Abuse

Substance Abuse Prevention

OHA is active in the area of prevention. More than 369,000 Oregonians participated in community prevention services in the last biennium from July 2013 through June 2015. In addition, prevention professionals serve Oregon youth, ages 10 to 25, prior to the onset of any disorder. Prevention professionals work with community partners to limit youth access to gambling, alcohol and other drugs throughout the state, and to foster community environments, which support behavioral health and the ability of individuals to withstand challenges.

The six Center for Substance Abuse Prevention (CSAP) Strategies: Alternatives, Community-based Processes, Education, Environmental, Information Dissemination and Problem Identification and Referral are used to categorize prevention planning. Prevention Providers utilize data to select risk, protective and causal factors to target specific problem behaviors. Oregon provides services in each of the Institute of Medicine defined Universal (direct and indirect), Selective, and Indicated populations, and OHA encourages the use of evidence-based and tribal best practices. OHA continues to provide dedicated prevention funding for all 31 CMHPs and nine federally-recognized Native American Tribes. While specific primary prevention programs are not mandated for use in the CSAP strategies, a comprehensive local prevention program is encouraged. Counties and Tribes each receive a portion of the 20% set-aside, and are required to provide OHA with a plan to spend the funds allocated. Evidence-based and tribal best practices are encouraged for all programs, policies and practices implemented, which are based on local needs assessments.

Oregon’s prevention efforts are guided by the Strategic Prevention Framework (SPF). The SPF has been integrated into the Local Plan that is required by all funded counties and tribes. Oregon most recently was awarded a Partnership For Success (PFS)-SPF grant that will focus on underage drinking and high risk drinking for 12 to 25 year olds and prescription drug misuse and abuse among persons aged 12 to 25.

In order to catalyze change in the entire prevention system and assess the possible impact on different populations, the PFS allocation model will continue to allow SPF to reach high priority need areas in all corners of the state. Details of this model will be identified by the revitalized SPF Advisory Council and the State Epidemiological Workgroup. The funding model will be designed to utilize data from various student and community surveys to ensure that areas of high consumption and consequences are addressed

The State Epidemiological Outcomes Workgroup (SEOW) is responsible for compiling information, analyzing, and reporting substance use and mental health incidence, prevalence, trend data and NOMs. These data are available for use in the development of the county Local Plans submitted to OHA. Data sources that are utilized by the SEOW include the local State survey's, Student Survey: Student Wellness Survey (SWS), and Oregon Healthy Teens Survey (OHT), the Behavioral Risk Factor Surveillance System (BRFSS), National Survey on Drug Use and Health, Oregon State Medical Examiner, Oregon Vital Statistics Annual Report, Volume 1, Oregon Public Health Assessment Tool (OPHAT) / WISQARS, Oregon State Police Annual Uniform Crime Reports and the Oregon Department of Transportation (ODOT) DUII Data Book. The population for which data is collected by these various sources is birth to death and captures both our urban and rural areas.

In addition, data are used by OHA to assess, plan, and implement state prevention policy and programs. The SEOW tracks progress of population level data at the state and county level, but these data are not used for evaluation of activities.

The SEOW has the following key criteria for data indicator selection for each substance use and mental health measure:

1. The indicators should be an accurate reflection of change in public health.
2. Chosen indicators should be derived from peer-reviewed research.
3. The data should be reliable and valid and collected for at least three years.
4. There should be an infrastructure in place to ensure continued data collection.

The SEOW seeks to employ a number of strategies for tracking data and reporting significant changes:

1. Fifty state-level measures are tracked and reported on the internet. Each measure is updated as the data become available.
2. There are 36 counties in Oregon; a county report inclusive of 40 measures is generated for each county every other year. Single-page, double-sided fact sheets are produced on specific priority topics.
3. Reports are also updated on the SEOW's website for public access. The website is available at http://www.oregon.gov/oha/OHA/sew/Pages/index.aspx.

Oregon Administrative Rules (OARs) require that all prevention workforce members who work at least .5 FTE (full-time equivalence), utilizing prevention funds from OHA, be certified by the Addiction Counselor Certification Board of Oregon (ACCBO). This helps to ensure that the prevention workforce is highly trained and current with the latest prevention science.

To further ensure a highly trained workforce, OHA is committed to ongoing education of the prevention workforce. Annual prevention training cohorts of up to 30 prevention workers across the state have been brought together for ongoing training for the past three years. Training includes both face-to-face trainings for two to three days during a month as well as a variety of online webinars. The intent of the prevention training cohort series is to provide the required training hours for and to prepare candidates to sit for the International Certification and Reciprocity Consortium (IC&RC) Certified Prevention Specialist (CPS) exam.

In addition, all prevention coordinators and local prevention coalition leaders are invited twice each year to Semi-Annual Prevention Summits. Held in the fall and spring, the Prevention Summits provide opportunities for the prevention workforce to obtain advanced training in the latest prevention science, as well as to network with colleagues from around the state.

OHA does not currently have a strategic plan in place for prevention services. Historically, prevention set-aside funds have been allocated to counties and tribes who administer local assessments and provide OHA with a prevention plan based on that assessment and prioritization of needs. However, OHA intends to implement a statewide prevention work plan over the next year. This will be accomplished by conducting a series of town-hall type discussions with prevention professionals across the state and gathering input from local authorities regarding prevention needs and gaps. In addition, data will be utilized to drive the discussions and provide additional evidence of need based on consumption patterns and consequence data. It is anticipated that the statewide prevention work plan will help guide local prevention efforts in order to reduce risk factors and increase protective factors.

Oregon has both an Evidence-Based Practices Workgroup and a Tribal Best Practices Workgroup. While currently idle, the Evidence-Based Practices Workgroup is available to review any new prevention programs, policies or practices (P^3) as that need arises. The Tribal Best Practices Workgroup meets on a regular basis to discus and review various tribal programs and practices. A formal process to approve both evidence-based and tribal best practices is in place for both groups, ensuring that all approved programs, policies and practices have ample data to support their effectiveness.

OHA is in the process of implementing a new Oregon Prevention Data System (OPDS) to collect data from providers regarding implemented strategies. This new system primarily collects the required SAPT Block Grant data requirements and will allow easy access to all provider data throughout the year. This new system replaces the Minimum Data Set for Prevention (MDS) database that OHA has utilized since 1997. OPDS will

allow both the local prevention contractor and the state to more closely track the local prevention plan to the outputs and outcomes of implemented strategies. Data collected with the OPDS will include total numbers served, gender and racial/ethnic breakdowns of each participant receiving services, CSAP strategy information and IOM categories for each prevention service and costs associated with prevention services.

In addition, the Oregon Student Wellness Survey (SWS) is administered in each even numbered year to capture a variety of youth data. This includes all required GPRA measures as well as those questions required by SAMHSA for the Drug Free Communities Support Program grants.

mORe Project

The Oregon Health Authority (OHA) is partnering with the Center for Health and Safety Culture at Montana State University in multi-year project to transform attitudes related to underage drinking. Training on the Positive Community Norms (PCN) framework has been provided to cities, counties and tribes across the state and OHA has had inquiries from neighboring states as well. The process has involved the development and implementation of baseline surveys to measure existing positive norms, perceived norms, and critical gaps regarding underage drinking across the social ecology, and has developed multiple communications campaigns to guide conversations about the issue.

The mORe Project communicates to Oregon communities that most underage young people don't drink. The campaign endeavors to guide conversations about underage drinking and correct misperceptions. The mORe Project is designed to: confront the seriousness of underage drinking and to build hope that communities can work together to reduce risk and create positive change.

Toolkits to support the long-term media campaign have been developed specific to:

- Community Building
- Adults
- Students
- Parents

Additional toolkits in development include:

- Law Enforcement (Summer 2015)
- School (Summer 2015)
- Alcohol Retailers (Fall 2015)
- State and Local Organizations (Fall 2015)
- Health Care Providers (2015/16)

For more information visit www.oregonmore.org

Problem Gambling Prevention

The prevention system in Oregon includes a focus on problem gambling prevention to address emerging and risky behaviors among Oregon youth, and to increase community awareness that problem gambling is a significant public health concern. Problem gambling prevention efforts use the same framework as the CSAP's six core prevention strategies. Because "best practices" in problem gambling prevention are still being developed, Oregon relies on principles of alcohol and drug abuse prevention programs, whose efficacy is well documented, as research indicates that many risk and protective factors are shared between generalized problem behaviors and problem gambling. The Oregon Student Wellness Survey and Oregon Healthy Teens Survey data consistently show that over 30 percent of 6^{th}-11^{th} graders gamble and that those who do are much more likely (in some cohorts, twice as likely) to use alcohol, binge drink, skip school, get in fights, or engage in other risky behaviors. The Oregon Administrative Rules governing prevention now include problem gambling and substance abuse prevention.

Providers develop and implement locally specific prevention plans that include measurable goals and objectives aimed at prevention of problem gambling throughout the lifespan. Local prevention activities include infusing problem gambling prevention into existing substance abuse prevention efforts, working with schools on gambling prevention education, incorporating gambling prevention into activities aimed at other youth risk factors and working with groups of older adults on gambling education.

Tobacco Prevention & Education and the Synar Amendment

Oregon began Synar inspections in 1994-95. The initial Retail Violation Rate (RVR) was 38.9%. During 1997-98, Synar non-compliance rates jumped to 28.7%, over the maximum allowable and negotiated rate and Oregon was found in non-compliance with the Synar Amendment. As a result, Oregon infused nearly $1 million into merchant education and additional retail tobacco inspections. From 2000-2004, all known tobacco retail outlets were inspected at least once, and those found non-compliant were inspected a second time. By 2005-06, the RVR reached 11% - the lowest rate since the beginning of the inspections.

In 2009, the Oregon State Police (OSP) notified OHA that they were no longer able to provide Synar Inspections. OHA hired inspectors as temporary employees with no citation authority, and non-compliance rates jumped to 19.3% in 2009 and as high as 22.5% by 2012.

In January 2015, OHA hired a full-time, dedicated staff person for the Synar Program. The Synar Coordinator is currently developing updated merchant educational materials

(toolkit) to be distributed to every retailer in the state that sells tobacco products. In addition, OHA has submitted a proposal to the Food and Drug Administration (FDA) to obtain a direct contract to conduct Tobacco Retailer Compliance Inspections for the state of Oregon. If awarded, this contract would increase tobacco inspections in Oregon by 100%.

OHA is also exploring a comprehensive database tool that will allow all inspection data (Synar, Enforcement and FDA) to be combined in order to run more comprehensive reports and map retail locations. The database tool would also allow inspections to be completed on digital devices instead of using paper forms.

The Synar Coordinator is working in collaboration with the Oregon Liquor Control Commission (OLCC) to conduct a pilot training program for retailers focusing on selling age restricted products (tobacco, alcohol and lottery tickets). In addition, OHA has continued to improve communication with county prevention coordinators and tobacco coordinators to inform local communities in a timely manner regarding inspection results and to work together to address issues.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step two.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

---

75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Trauma

Oregon has had a trauma policy in place since 2006. The Children's System Advisory Committee recommended a revision of this policy, which was finalized in July 2014. The policy applies to all contracted providers of mental health and addictions services by OHA, and is scheduled for full implementation on July 1, 2015. The revised policy directs those who administer public mental health and addiction services to be informed about the effects of psychological trauma, assess for the presence of symptoms and problems related to that trauma, and develop and offer services that facilitate recovery. It is accompanied by an approved Trauma Procedure[1] to guide OHA partners and contractors.

Early in 2014, OHA developed a partnership with the Regional Research Institute at Portland State University to create Trauma Informed Oregon (TIO). Trauma Informed Oregon is a statewide resource for information on trauma prevention, identification, screening and treatment; notification of trainings, research on trauma informed care and best practices, and the convener of a statewide collaborative to advise on regional and local approaches being used in trauma prevention, screening and treatment. Additionally, the Division has been working across systems and agencies to address trauma approaches systemically, including use of The Adverse Childhood Experiences Study research in guiding a trauma-informed health care system, and working within the Children's Health Care Policy Team of the Oregon Health Authority to move trauma informed services and supports to the forefront of health care innovation under health system transformation.

The Oregon Consumer Advisory Coalition (OCAC) submitted a set of recommendations to OHA in October 2014. The OCAC requested that OHA address trauma utilizing a trauma informed approach and promotion of trauma treatment and healing across the lifespan.

OHA identifies increasing trauma informed care as a priority area, including the development of trauma informed services that are available across the lifespan: Specifically, "strengthen the prevention, screening and treatment of the psychological, physical and social impacts of early childhood and lifespan trauma."

Strategies to increase trauma informed care include:

1. Create professional development opportunities to increase proficiency in providing treatment services to families with children ages 0–5.
2. Contract with Portland State University, in partnership with Oregon Health & Science University and the Department of Human Services, to form a collaborative called Trauma-Informed Oregon.

[1] http://www.oregon.gov/oha/amh/trauma-policy/Trauma%20Policy.pdf

3. Work with Public Health and coordinated care organizations to develop a screening and treatment protocol for mothers of young children within primary care settings.
4. Disseminate the trauma-informed care Policy to all CMHPs and their service contractors.
5. Increase provision of trauma-informed care trainings to health care, behavioral health care and other helping professionals.

OHA has designated a portion of staff time from the adult mental health team, the children's mental health team and the addictions unit to coordinate implementation of trauma informed care. The three staff collaborate to advise and support the work of Trauma Informed Oregon, and to assist with implementation of trauma informed services across the lifespan for behavioral health services.

The Youth Services Survey for Families and the Adult Consumer (MHSIP) Survey inquire of consumers/families as to whether or not they/their child were screened for trauma, and if there had been trauma, whether it was adequately addressed in treatment.

OHA is also focused on addressing and responding to the needs of the Commercial Sexual Exploitation of Children (CSEC) population. Oregon has a significant problem with trafficking of minors. CSEC survivors are known to have complex trauma due to sexual abuse and experience other traumatic experiences related to the commercial aspect of their abuse. The 2013 legislature allocated $2.3 million for increased targeted services. OHA, through a request for proposal process, contracted for a 12 bed, secure shelter and treatment program to house and support the needs of youth females and transgender females ages 8 to 15. Morrison Child and Family Services, who operates the program, has adopted Sandra Bloom's Sanctuary Model agency wide and specifically within their SAGE –CSEC program. OHA will be tracking outcomes and outputs of the program quarterly including the rates of acute care hospitalization, runaway frequency, days in school, and number of healthy natural supports.

Oregon is also focusing extensively on pediatric psychotropic medication prescribing practices for children in child welfare foster care and developmental disabilities populations to hone in on excessive, inappropriate prescribing, lack of appropriate monitoring and lack of mental health services in conjunction with psychotropic medication prescriptions. These vulnerable populations are also likely to have experienced trauma and will benefit from mental health services and more appropriate attention to prescribing and monitoring practices. Child Welfare and Aging and People with Disabilities divisions of the Department of Human Services are involved with Trauma Informed Oregon in reviewing and updating practices to be consistent with a trauma informed approach.

OHA has included in the revised trauma policy a list of OHA approved evidence based practices, including Trauma Focused Cognitive Behavioral Therapy, Seeking Safety, Child Parent Psychotherapy, Cognitive Behavioral Interventions for Trauma in Schools, Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavioral

Therapy (DBT). Trauma Informed Oregon provides resources, technical assistance and trainings.

In the next biennium, OHA will be looking more closely at data across systems to determine regions and areas of the state where risk factors are higher for trauma, in an effort to promote resilience and assist clients with high risk factors and/or lived experience of trauma.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Medication Assisted Treatment

Synthetic Opioid Replacement Therapy

There are currently 15 opioid treatment programs (OTPs) in Oregon. Most programs are along the Interstate 5 corridor from Portland to Medford. Seven clinics are located in Multnomah County, Marion and Lane counties each have two, and Jackson, Washington, Deschutes and Clackamas counties have one clinic each.
Programs are a mix of private for-profit and non-profit organization-operated clinics, with one clinic administered by the Federal government. Approximately 8,000 individuals received methadone treatment services at OTPs in calendar year 2014. Methadone treatment is a mandated covered benefit through the Oregon Health Plan (OHP). Payments from OHP are made based on the services provided by the clinic. For self-pay patients, providers charge a monthly or daily rate for services. Self-pay fees range from $200.00 per month to as high as $350.00 per month.

Regulatory Requirements

Programs must comply with both Federal and state regulations. Nationally, all programs must be approved by a federally recognized accreditation body. In Oregon 13 of the programs are accredited by the Commission on Accreditation of Rehabilitation Facilities, and two programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Agencies are reviewed by their accreditation agencies at least once every three years. In addition, all programs must have their dispensary and dispensing process approved by the Drug Enforcement Agency (DEA). The DEA conducts random inspections of clinics to ensure compliance with medication dispensing regulations.

OHA approves OTPs in Oregon, with the exception of the program run by the Federal government. Each program is reviewed at least once every three years. In addition, current state statutes prohibit methadone programs from operating within 1,000 feet of a school, a licensed child care facility, or a career school attended primarily by minors. Statutes also require OTPs to obtain approval from an individual's parole/probation officer, if applicable, upon admission.

Admission Requirements

All admissions are approved by the Medical Director for the program. Individuals being considered for methadone treatment must have a one year history, immediately prior to admission, of a continuous physical dependence on narcotics or opiates as documented by medical records, records of arrests for possession of narcotics, or records from drug treatment programs. The program must have evidence of an individual's current physical dependence on narcotics or opiates as determined by the program physician or medical director. The agency may also admit individuals where there is documentation demonstrating that medically supervised withdrawal or medically supervised withdrawal with acupuncture and counseling has proven ineffective, that a physician licensed by the Oregon State Board of Medical Examiners has documented in the patient record a medical need to administer opioid agonist medications, or if the patient is currently pregnant and opioid dependent.

Daily Operations
Clinics in Oregon are required to be open Monday through Saturday, except for Federal holidays. Clinics are open early morning through early afternoon and provide dosing, counseling and urinalysis testing. Upon admission individuals are required to pick up their medication at the clinic six days a week. Over time and documentation of progress, individuals are eligible for “take home” privileges that enable them to come to the clinic less frequently. The criteria and time frame for these privileges are described in Federal and state regulations.

Individuals may be enrolled and participate in medication assisted treatment (MAT) for as long as they benefit and believe they need to be on medication to maintain the positive changes and stability they have achieved since enrollment in treatment. For patients taking methadone, an average length of stay is between one and three years. If both the individual and the clinic believe the person may be able to be successfully titrated off methadone, a therapeutic detox can occur. Depending on an individual’s response, this detox period can be several months or longer.
OHA will continue to collaborate with partners including OHA Public Health Division, the Alcohol & Drug Policy Commission, the Prescription Drug Monitoring Program, the Governor’s Prescription Drug Abuse Task Force, and Oregon MAT providers to address issues related to prescription opioid poisoning. Technical assistance and training is used to increase awareness and promote implementation of MAT to treat opioid addiction. AMH works with CMHPs, counties, subcontractors and other providers to monitor and ensure that priority populations receive services required by the SAPTBG by implementing the Oregon Web Infrastructure for Treatment Services (OWITS) Capacity Management System. Treatment outcome improvement measures continue to be refined as part of the outcome-based contracting process and are refined in response to any new measure or performance domains that may be included in the National Outcome Measures.

Medication Assisted Treatment (MAT) and Strategic Planning
OHA is committed to expanding access and increasing awareness around MAT. The State Opioid Treatment Authority (SOTA) takes a key role in helping to educate community groups, Coordinated Care Organizations (CCOs) and other payers regarding the efficacy of MAT as the “gold standard” evidenced based treatment for opioid dependence. This involves regular trainings and community summits involving groups such as the NW Addiction Technology Transfer Center, as well as regular contact with groups such as the state Pharmacy and Therapeutic Board, to insure that opioid agonists as well as antagonists are fully available and covered for the Medicaid population. Outreach regarding the need to provide services to pregnant women who are opioid dependent occurs with primary care providers, as well as healthcare organizations, including hospitals, to educate providers on appropriate interventions as well as informing individuals regarding neo-natal abstinence syndrome. The SOTA works with several providers who have developed or are developing specific programming to provide appropriate neo-natal care for this population.

SAPT BG funds can also be used to facilitate providing Naloxone to community groups as well as treatment providers and the general public, in order to continue to decrease

mortality associated with opioid overdose. The SOTA works closely with other Federal agencies, including the Drug Enforcement Administration, to monitor diversion of medications used for opioid treatment, including buprenorphine. Additionally, the SOTA acts in a regulatory capability to insure that appropriate psychosocial therapies are integrated with the administration of opioid treatment medications, to improve treatment outcomes. OHA will train payers and providers to increase the number of physicians available to prescribe buprenorphine.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Community Living and the Implementation of Olmstead

Community Living and the Implementation of Olmstead

OHA currently provides funding to aid the development of supported housing and rental assistance programs. Supported housing programs provide funding to develop affordable, community-based rental housing for individuals in recovery. These properties are funded with the stipulation that the units are integrated with non-disabled housing to assure an individual's right to reside in the least restrictive environment possible, consistent with the Americans with Disabilities Act (ADA) and the US Supreme Court's 1999 decision in Olmstead v L.C. Rental assistance programs serve individuals in recovery for both mental illness and substance use disorders and provide the opportunity to locate and lease a rental unit with all the rights and responsibilities of any other resident.

Oregon's Olmstead plan was last updated in 2011, utilizing input from various stakeholders, including consumers, providers, and Community Mental Health Programs. The plan is currently being revised to improve access to integrated, community based treatment.

Oregon has made a significant investment in community living. During the 2013 and 2014 Legislative Sessions, OHA received over $8 million dollars in State General Fund and Tobacco Tax Funds to develop rental assistance programs for people with mental illness. Program funds provide rental assistance and funds to help cover move in costs, such as security deposits and past due utility bills. The programs also fund Residential Specialists and Peer Support Specialists to work with participants to locate and maintain housing. Programs are operated by Community Mental Health Programs and private providers.

In 2014, OHA partnered with the National Alliance for Mental Illness (NAMI) and the Oregon Residential Provider Association (ORPA) to develop proposals and identify community providers to develop supported housing opportunities.

As a result of this partnership, 168 new units of supported housing will be developed in Oregon. OHA also has had a long history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. OHA will continue to work with the National Alliance for Mental Illness, Oregon Housing and Community Services, providers, and other public and private partners to add affordable housing units for people with mental illness, substance use disorders and co-occurring disorders.

The 2015 legislative session saw continued new investments in behavioral health services in Oregon, including $7 million for rental assistance and peer delivered

services and $20 million in bond sales for the development of housing for people with mental illness and substance use disorders. The bond funding was awarded to Oregon Housing and Community Services (OHCS), creating a partnership of collaboration between the two entities. A condition of funding requires OHA to work with NAMI, and ORPA to make recommendations to OHCS regarding funding priorities.

In addition to the partnership created with the $20 million housing award, OHCS and OHA are partnering on the recent HUD Section 811 PRA Supportive Housing for Persons with Disabilities program award. Oregon Housing and Community Services (OHCS) in partnership with DHS and OHA received a $2.3 million award for a new HUD 811 Project Rental Assistance (PRA) program. The purpose of this new program is to provide affordable housing for extremely low-income people with disabilities to keep them “from being institutionalized or possibly falling into homelessness.” The funding will provide 76 units of supportive housing.

In addition to increases in rental assistance and supported housing development, OHA is re-structuring the adult mental health residential system in accordance with recent direction from Centers for Medicare and Medicaid Services (CMS), regarding new requirements for providing Home and Community Based Services. This restructuring will improve client choice and self-direction, community integration, and help de-emphasize the reliance on congregate care.

Recovery Support Services

In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. With the implementation of the Affordable Care Act, OHA had reallocated resources to promote recovery-oriented systems of care that employ person-centered planning to identify and meet individual needs across all life domains. These needs can be met by accessing recovery support services and non-traditional interventions that are usually not reimbursable as medically necessary services. Examples of recovery support services are peer delivered services and supported employment.

OHA supplied an additional $1.5 million to expand supported employment services statewide through contract amendments with Community Mental Health Programs (CMHPs). OHA distributed funds in three tiers, based on program readiness. Technical assistance is provided by Oregon Supported Employment Center for Excellence (OSECE). In the next biennium, OHA will increase staffing levels for OSECE to provide more timely training and technical assistance to newly developing programs.

The Center for Medicaid and Medicare Services (CMS) recognizes Peer Delivered Services (PDS) as an evidence-based practice for supporting recovery from behavioral health disorders. Peer delivered services is an array of agency or community-based

services provided by peers to individuals with similar lived experience. Peers are self-identified as a person who currently or has formerly received behavioral health services or a family member of a person who is receiving or has received behavioral health services. The services are provided at all levels including health promotion, outreach, crisis intervention, recovery support, advocacy skills, and respite care. OHA supports the use of PDS and plans to continue to increase the availability of PDS to every Oregonian.

Ready to Transition

The Adult Mental Health Initiative known as AMHI ("Aim-High") is designed to ensure that the right types of services are delivered at the right time to adults with mental illness. Instituted in 2010, AMHI garnered initial success with regard to decreasing hospital length of stay after a patient is deemed ready for discharge. The focus of this initiative is expanding to increase opportunities for truly integrated, community based services and supports for individuals with serious mental illness once they are discharged from OSH. The next phase of AMHI will promote increased utilization of the 1915i state plan option to increase in-home services and supports, expanding ACT services, and increasing rent subsidies and housing supports.

Currently, local mental health partners are involved in an individual's discharge plan as soon as they are admitted to OSH. Once designated Ready to Transition (RTT) by the hospital Interdisciplinary Team, representatives of the patient's local mental health partners become primarily responsible for transition planning and management. This includes developing community based services and supports such as Assertive Community Treatment (ACT) as well as making referrals to a licensed residential program or locating supported housing. OHA staff provides technical assistance and consultation to these local partners to expedite discharges.

USDOJ

Oregon is currently in the third year of a voluntary agreement with USDOJ regarding the State's community mental health system. The first two years focused on assessing Oregon's overall mental health system and developing metrics to gauge improvement. The current work involves setting performance targets in key areas such as ACT services and supported housing.

Community Partners

OHA works closely with Oregon Housing and Community Services regarding issues of housing and community integration. A similar relationship exists with the Department of Human Services to improve community integration and self-determination for individuals served by Aging and People with Disabilities and the Office of Developmental Disabilities Services. In addition, a multi-agency work group consisting of representatives from the above agencies, as well as Bureau of Labor and Industries,

Department of Vocational Rehabilitation, the Oregon State Hospital, and a private entity, The Oregon Center of Excellence for ACT and Supported Employment. This work group provides education and technical assistance to providers and other local partners with regard to community integration, civil rights, and consumer self-direction. The group also works to leverage mutual strategies to improve integration, treatment, and housing opportunities for individuals with SMI.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

---

[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one and two.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Pregnant Women and Women with Dependent Children

Pregnant Women and Women with Dependent Children

All women specialized programs, both outpatient and residential, provide gender specific services and are required to provide care for specific issues, such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems. Specialized treatment programs must follow the Oregon Administrative Rules (OAR) to provide or coordinate services that meet the access needs of this population, such as childcare, mental health services, transportation and interim services[1] if treatment is not readily available.

Treatment programs are expected to use the American Society of Addiction Medicine Patient Placement Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition in making level of care determinations. All residential programs provide transition services so that women and children can smoothly move from residential to community- based outpatient and continuing care services.

Contracts and administrative rules for the 2015-2017 biennium require prioritizing pregnant women and individuals with dependent children, referral for prenatal health care services, and providing or referring out for childcare.

Oregon Health Authority (OHA) Regional Alcohol and Drug Specialists complete regular site reviews to ensure that programs meet requirements as described in the administrative standards, including those corresponding to women's treatment services. OHA revised the addiction and mental health administrative rules governing these services. The rule requirements for women's treatment services were developed by an advisory committee comprised of clients, partners from various regions of the state, and policy analysts. The rules are based on best practice guidelines that aim to address the holistic recovery needs of women and their families within an integrated and trauma-informed framework. The administrative rules strive to promote family-centered treatment through the endorsement of collaborative care principles and culturally competent practices.

[1] FEDERAL DEFINITION: Interim Services or Interim Substance Abuse Services means services that are provided until an individual is admitted to a substance abuse treatment program. The purposes of the services are to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about HIV and tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Contracts between OHA and the counties, tribes, and direct contractors require that pregnant women and women with children must be prioritized.

Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every three years. The reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems and prenatal care. Programs are reviewed to evaluate compliance with administrative rule requirements to provide or coordinate services that meet special access needs such as childcare, mental health services, and transportation.

Providers are required to submit Monitoring of Treatment Services (MOTS) enrollment and status update data on all clients served in publicly funded treatment programs licensed by OHA. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, and arrest history) the MOTS system collects whether or not the client is pregnant at admission and the number of dependent children in the household.

OHA amended the reporting criteria of the capacity management report in September of 2013. Changes to the capacity management report included additional details regarding indigent and Medicaid populations; this was in an effort to better monitor priority population’s access to care and to de-duplicate the waitlist count, a change that would help us better understand what the actual capacity needs were for our specialized programs. After the report was amended and vetted, webinars were conducted to train the providers responsible for submitting the capacity report; ongoing technical assistance was offered as well. The collection of capacity management list data began again in January 2014.

After preliminary findings from the Core Tech Review in April 2014, amendments were made to the capacity management report to better capture interim services. The amended report was launched in July 2014. Due to amendments and staff turnover, there has been the need for additional technical assistance to address provider reporting errors, and to increase compliance with accurate and complete report submission. OHA is actively working on resolving all issues surrounding the capacity management report including an action plan to address provider non-compliance with report submission. The Women’s Services Coordinator monitors compliance.

The state of Oregon has 38 outpatient programs approved to provide women's services and 15 residential facilities approved for both women's services and women with children services. Currently, only two residential treatment providers offer the option of

participating in medication assisted treatment (MAT) programs while in their care: OnTrack located in Medford, and Willamette Family in Eugene. Both of these providers work closely with local opiate treatment programs (OTP) to coordinate care, including arranging for dispensing of both methadone and buprenorphine medication for the treatment of opioid dependence. OHA continues to work with residential providers to increase the usage of evidenced based MAT practices within this priority population.

There are multiple areas of the State where access to MAT for pregnant women could be improved; including Eastern Oregon, Coastal Oregon, and parts of Central Oregon. Central Oregon does have a new OTP in Bend, which will help to relieve some of the need in this area; however, there remains a shortage of physicians waivered to offer other partial agonist treatments for opioid dependence. OHA continues to work towards expanding access to MAT through strategic planning and coordination with our CCO partners and stakeholders.

RESIDENTIAL FACILITY: A/D WOM + WOM/CHLD	Capacity	Provider Name	Provider City
Recovery Village (W&C)	30	New Directions Northwest Inc.	Baker City
Women's Residential	15	Family Recovery Nonprofit Inc.	Corvallis
Willamette Family Inc. Women's Program	57	Willamette Family Inc.	Eugene
ONTRACK Inc. - Home Program	45	ONTRACK Inc.	Medford
ONTRACK Inc.	10	ONTRACK Inc.	Medford
Lifeways Inc. - Recovery Center	60	Lifeways Inc.	Ontario
Eastern Oregon Alcoholism Foundation	36	Eastern Oregon Alcoholism Foundation	Pendleton
DePaul Adult Treatment Program	95	DePaul Adult Treatment Program	Portland
Central City Concern- Letty Owings Center	56	Central City Concern	Portland
Project Network	34	LifeWorks NW	Portland
Mountaindale Recovery Center	10	LifeWorks NW	Portland
Native American Rehabilitation Assoc. of the NW	70	Native American Rehabilitation Association	Portland
VOA- Women's Residential Center	43	Volunteers of America	Portland
ADAPT - The Crossroads	32	ADAPT	Roseburg
Bridgeway Recovery Services Inc.	27	Bridgeway Recovery Services	Salem

PROVIDER: WOMEN'S SERVICES	OUTPATIENT PROGRAM NAME	City
Linn County Alcohol & Drug Treatment - 4th Ave	Linn County Alcohol & Drug Treatment - 4th Ave	Albany
Family Recovery Nonprofit, Inc.	Women's Residential	Corvallis
Polk County Alcohol & Drug Treatment Program – Academy	Polk County Alcohol & Drug Treatment Program - Academy	Dallas
Center for Family Development - 12th Ave	Center for Family Development - 12th Ave	Eugene
Center for Family Development - High	Center for Family Development - High	Eugene
Willamette Family, Inc. - Cheshire	Willamette Family, Inc. - Cheshire	Eugene
ADAPT - Grants Pass	ADAPT - Grants Pass	Grants Pass
Choices Counseling Center - Manzanita	Choices Counseling Center - Manzanita	Grants

		Pass
OnTrack, Inc. - Grants Pass	OnTrack, Inc. - Grants Pass	Grants Pass
Linn County Alcohol & Drug Treatment - Main St	Linn County Alcohol & Drug Treatment - Main St	Lebanon
Yamhill County Chemical Dependency Program	Yamhill County Chemical Dependency Program-Adult	McMinnville
Yamhill County Chemical Dependency Program	Yamhill County Chemical Dependency Program - Newby	McMinnville
Yamhill County Chemical Dependency Program - Reflections - Galloway	Yamhill County Chemical Dependency Program - Reflections - Galloway	McMinnville
ONTRACK Inc.	ONTRACK Inc. - Main Office	Medford
ONTRACK Inc. - Home Program	ONTRACK Inc. - Home Program	Medford
Reconnections Alcohol/Drug Treatment, Inc. - Coast Hwy	Reconnections Alcohol/Drug Treatment, Inc. - Coast Hwy	Newport
Clackamas County Behavioral Health	Clackamas County Behavioral Health	Oregon City
Clackamas County Mental Health - Library	Clackamas County Mental Health - Library	Oregon City
Clackamas County Mental Health - Library Ct	Clackamas County Mental Health - Library Ct	Oregon City
Confederated Tribes of the Umatilla Indian Reservation	Confederated Tribes of the Umatilla Indian Reservation - Yellowhawk	Pendleton
Cascadia Behavioral HealthCare, Inc. - Woodland Park	Cascadia Behavioral HealthCare, Inc. - Woodland Park	Portland
Central City Concern	Central City Concern - Eastside Concern	Portland
CODA -Gresham Recovery Center	CODA - Gresham Recovery Center	Portland
CRC Health Group	CRC Health Oregon Inc. dba Allied Health Services East	Portland
CRC Health Group, Inc. dba Allied Health Services – Alder	CRC Health Oregon, Inc. dba Allied Health Services Portland - Alder	Portland
CRC Health Group, Inc. dba Allied Health Services – East	CRC Health Oregon, Inc. dba Allied Health Services Portland - Burnside	Portland
DePaul Adult Treatment Program	DePaul Adult Treatment Program	Portland
LifeWorks NW	LifeWorks NW - Conquest Center	Portland
LifeWorks NW	LifeWorks NW- Umoja Center	Portland
LifeWorks NW	LifeWorks NW - Project for Community Recovery	Portland
Native American Rehabilitation Association of the Northwest, Inc. -Columbia	NARA of the NW, Inc. - Columbia	Portland
VOA - InAct – Washington	VOA - InAct - Washington	Portland
ADAPT - Main Office	ADAPT - Main Office	Roseburg
Marion County Health Department - Her Place	Marion County Health Department - Her Place	Salem
Clackamas County Mental Health - Proctor	Clackamas County Mental Health - Proctor	Sandy
Linn County Alcohol & Drug Treatment - Long	Linn County Alcohol & Drug Treatment - Long	Sweet Home
Reconnections Alcohol/Drug Treatment, Inc. - 2nd St	Reconnections Alcohol/Drug Treatment, Inc. - 2nd St	Toledo

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Suicide Prevention

Suicide Prevention

Oregon's suicide prevention efforts in the past decade have focused primarily on children, youth and young adults. Through Garrett Lee Smith Memorial Act grants, the Public Health division of OHA have led efforts to reduce Oregon's suicide rate among youth ages 10-24. The current plan, *A Call to Action: The Oregon Plan for Youth Suicide Prevention*[1], (Attachment 1) was adopted in 2000 and has guided state and local activities since that time.

Recognizing the need for updated goals and strategies, the Oregon Legislature in 2014 created a Suicide Prevention and Intervention Coordinator position in OHA. The Coordinator was hired in November 2014 and is charged with preparing an updated youth suicide prevention plan for submission to the Legislature. The Coordinator will be responsible for providing ongoing technical assistance to groups and communities toward implementation of the youth suicide prevention plan. The Coordinator is also responsible for preparing annual reports to the Legislature to include data trends and progress on implementation of the plan.

A collaborative process for preparing the plan is underway, following the framework created by the 2012 National Strategy for Suicide Prevention and recent direction for involvement of individuals with lived experience. Youth, young adults and families are heavily involved in preparing the plan in addition to other stakeholders, such as juvenile justice, foster care, the National Suicide Prevention Lifeline's accredited hotline in Oregon, and behavioral health providers, as well as primary care and health systems. Based on initial recommendations from stakeholders to date, it is expected that the plan will include formation of a statewide public-private alliance to guide suicide prevention in the future. Stakeholders also are addressing crisis response, emergency department follow up with warm handoffs to outpatient care, and improved continuity across behavioral and physical healthcare systems. In addition, stakeholders are interested in ensuring peer and family supports for those who have experienced suicidal ideation and attempts.

National data show higher suicide rates in the adult population and in sub-groups such as: LGBTQI2-S, Veterans/Military, Older Adults, Attempt/Bereavement Survivors, people with Behavioral Health Disorders, and Native Americans/Alaska Natives. In preparing the youth plan, OHA has created work groups to address LGBTQI-2S concerns; those of young military members, veterans and their families; and needs among Alaska Native/American Indians. Youth and young adults with SED/SMI are embedded in all activities. OHA is planning to coordinate with the Public Health division

[1] http://www.oregon.gov/oha/amh/datareports/Attachment%206.pdf

and with stakeholders in 2016 to expand the focus in the new plan across the lifespan to address the needs of special populations of adults, including the needs of higher risk middle aged and older adults.

A Call to Action

THE OREGON PLAN FOR

YOUTH SUICIDE PREVENTION

PREPARED BY:

INJURY PREVENTION AND EPIDEMIOLOGY SECTION,

Ron Bloodworth: Principle Editor

THE EDITORS:

Melvin Kohn, MD - Lisa Millet - Janice Alexander, PhD - June Bancroft

MANY PEOPLE REVIEWED AND OTHERWISE CONTRIBUTED TO THIS REPORT INCLUDING:

Health Division: Donalda Dodson, Tom Engle, Adrienne Greene, Grant Higginson, MD, David Hopkins, Bob Nystrom, Council of Local Health Officials

Diane Ponder, Bill Bouska: Office of Mental Health Services

Ramona Foley, Michael Serice: State Office of Services to Children and Families

Barbara Cimaglio: Office of Alcohol and Drug Abuse Programs

John Lenssen, Ginny Ehrlich: Department of Education

Gary McConahay, PhD: Josephine County Mental Health

OREGON DEPARTMENT OF HUMAN SERVICES

HEALTH DIVISION

INJURY PREVENTION AND EPIDEMIOLOGY PROGRAM

800 NE Oregon Street, Suite 772
Portland, Oregon 97232
Phone: 503-731-4025 — Fax: 503-731-4157

Gary Weeks, Director, Department of Human Services
Martin Wasserman, MD, JD, Administrator, Health Division
Melvin Kohn, MD, State Epidemiologist
Lisa Millet, Manager, Injury Prevention & Epidemiology

For more information, contact: Ron Bloodworth, Youth Suicide Prevention Coordinator
E-mail: Ronald.Bloodworth@state.or.us

This document is available on the web: www.ohd.hr.state.or.us/cdpe/yspinfo.htm

Available in an alternate format upon request. Call 503-731-4025

ACKNOWLEDGMENTS

We wish to acknowledge the work of the following people who served on the Statewide Planning Team for Youth Suicide Prevention. Many others served on Governor John Kitzhaber's Task Force on Youth Suicide Prevention in 1996.

STATEWIDE YOUTH SUICIDE PREVENTION PLANNING TEAM

Janice Alexander, PhD, Oregon Health Division

June Bancroft, Oregon Health Division

Adele Billingsley, Ontario High School, Ontario

Ron Bloodworth, Oregon Health Division

Bill Bouska, Office of Mental Health Services

Renee Coker, Oregon Health Division

Caroline Cruz, Office of Alcohol & Drug Abuse Programs

Julie Dotson, Child and Family Mental Health Program, Bend

Adrienne Greene, Oregon Health Division

Charlotte Herkshan, Warm Springs Tribe, Warm Springs

Peggy Holstedt, Oregon Department of Education

Jerry Hupp, Oregon Health Division

Nancy Johnson, American Foundation for Suicide Prevention, Portland

Zip Krummel, Chenowith Middle School, The Dalles

Gary Lasater, Northwest Human Services, Salem

Curt Lorenz, Neahkahnie High School, Tillamook

Gary McConahay, PhD, Josephine County Mental Health, Grants Pass

Kay Mills, Coos County Mental Health, Coos Bay

Lisa Millet, Oregon Health Division

Margaret Moore, Office of Mental Health Services

Mary Lu Pierce, LaGrande Middle School, La Grande

Russ Sharpiro, Klamath County Mental Health, Klamath Falls

Wendy Ray, Oregon Health Division

State Representative Vicki Walker, Eugene

Susan Weiner, Oregon Health Division

Pat Westling, Oregon Health Division

Kirk Wolfe, MD, Northwest Resource Group, Portland

"The one really unhealthy habit of mine is wanting to die. My friends know about it but not my teachers or parents."
– 11th grade girl

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Approximately 75 Oregon youths die by suicide each year, making it the second leading cause of death among those aged 10 to 24. In 1998, the suicide rate among Oregonians in that age group was 10.6 per 100,000. From 1995 to 1997, this state's teen suicide rate was 29% higher than the national average.

Even greater numbers of youth are treated in Oregon's emergency rooms for attempts they survive. Over 750 suicide attempts are reported each year. In the 1999 Oregon Youth Risk Behavior Survey, 16% of the state's youth - an estimated 26,000 individuals - reported seriously considering suicide.

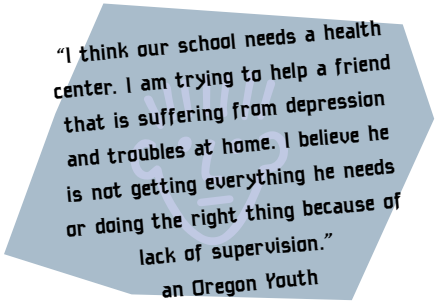
These data provide a shocking wake-up call to communities that have not yet recognized youth suicide as one of Oregon's silent epidemics. The Department of Human Services, as part of its mission to help people become independent, healthy, and safe, seeks to end that silence with a call to action.

This plan outlines an initiative through which Oregonians can help break through denial and cultural taboos about death, help end the shame associated with suicide, help foster the conviction that not even one youth has to die by suicide, and help take responsibility by openly and honestly joining with other Oregonians to reduce suicide among our youth.

The 15 strategies for state and community-based action require a commitment to partnership and shared responsibility among state agencies, between state and local governments, and between public and private sectors. Implementation of the strategies will require coordinated and comprehensive planning that fosters integration of services.

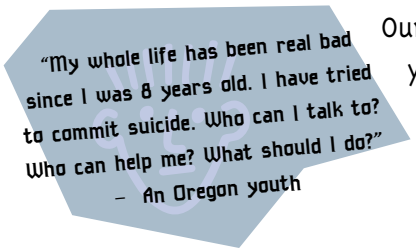
THE 15 STRATEGIES

1. **Develop and implement public education campaigns** to increase knowledge about symptoms of depression and suicide, response skills, and resources; increase help-seeking behavior; and decrease stigma associated with treatment for behavioral health problems.
2. **Promote efforts to reduce access to lethal means of self-harm**
3. **Educate youth and young adults about suicide prevention**
4. **Reduce harassment in schools and communities**
5. **Provide media education to reduce suicide contagion**
6. **Provide education for professionals** in health care, education, and human services
7. **Provide gatekeeper training** to create a network of people trained to recognize and respond to youth in crisis
8. **Implement screening and referral services**
9. **Increase effectiveness of crisis hot lines**
10. **Enhance crisis services**
11. **Establish and maintain crisis response teams**
12. **Improve access to affordable behavioral health care**



13. **Provide skill-building support groups** to increase protective factors and involve families
14. **Support suicide survivors** by fostering the development of bereavement support groups
15. **Improve follow-up services for suicide attempters**

The plan emphasizes three key prevention approaches: (1) community education, (2) integration of systems serving high risk youth, and (3) access to a full range of health care that includes mental health and alcohol and drug treatment services.



Our challenge and responsibility are to create communities where our youth won't choose to end their lives as a solution to a temporary problem, and communities where adults believe that suicide is preventable and that not even one child should die by suicide.

"I feel we should have someone come and talk about suicide here. It's very important."
- an Oregon Youth

THE NEED FOR A CALL TO ACTION

The United States Surgeon General, Dr. David Satcher, has declared suicide a serious public health concern and has issued a call to action for each state to implement suicide prevention strategies.[1]

Although Oregonians in every age group die by suicide, the upward trend in rates over the past few decades has been driven principally by suicide among adolescents and young adults (OHD, 1998). The grim facts speak for themselves:

- Suicide is the second leading cause of death among Oregonians aged 10 to 24
- Oregon's 1997 suicide rate among youth aged 10 to 24 was 17th highest in the nation
- Oregon's suicide rate among youth aged 15 to 19 increased from 2.8 per 100,000 during 1959-1961 to 13.4 per 100,000 during 1995-1997
- In 1998, the emergency room suicide attempt registry reported 761 attempts among youth under 18
- In 1998, 373 Oregonians aged 10 to 24 were hospitalized for suicide attempts
- In 1999, 16% of Oregon youth surveyed reported seriously considering suicide.[2] (See Appendix A for an epidemiologic profile of suicide among Oregon youth.)

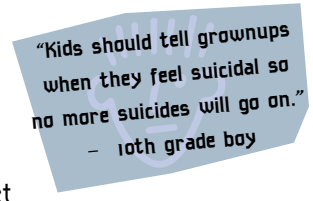
Suicide prevention is a statewide responsibility that affects the community as a whole. The purpose of The Oregon Plan for Youth Suicide Prevention: A Call To Action is to prevent suicide among Oregon youth by providing a multidisciplinary framework that calls for:

- communities to select, implement, and monitor youth suicide prevention strategies
- state agencies to integrate the coordination of technical assistance and resources
- collaboration between community-based organizations, state and local agencies, advocacy groups, professional associations, businesses, educational institutions, and foundations to implement prevention strategies

The strategies outlined in this call to action have built upon efforts that began in 1997 with recommendations from the Governor's Task Force on Youth Suicide. The 1997 Oregon Legislature established a Youth Suicide Prevention Coordinator position at the Health Division. The task primary of that coordinator is to facilitate the development of a statewide strategic plan addressing youth suicide. More than 500 Oregonians participated in the community assessment and planning process that resulted in this plan.

Efforts to reduce suicide rates show the most promise when multiple strategies are implemented simultaneously. There are many paths to suicidal behavior. Risk and protective factors and their interactions form the scientific base for suicide prevention. Risk factors are associated with a greater potential for suicide and suicidal behavior, while protective factors are associated with reduced potential.[3, 4, 5] The presence of multiple risk factors in adolescents is linked to a dramatic increase in the probability of having made a suicide attempt.[6] Significant reductions in Oregon's youth suicide rate will require integrated efforts to

produce long-term, system-wide changes. This plan outlines how to achieve that effort at the state and local levels.



COMMUNITY ASSESSMENT, PLANNING, AND MOBILIZATION

This plan contains tools to help communities assess their needs, plan to meet them, and mobilize for action. Because every Oregon community is unique, the implementation of suicide prevention strategies is best determined by community members who know local needs, resources, and possibilities. Community mobilization for youth suicide prevention requires that each community:

- identify an existing group or form a community team of stakeholders in youth suicide prevention
- assess the community's needs, resources, gaps in service, and readiness for addressing youth suicide
- determine strategies to be implemented and develop an implementation plan
- coordinate strategy implementation with local, state, and national partners and resources
- implement and monitor strategy implementation
- evaluate the effectiveness of strategy implementation

Because youths have a unique perspective and role to play in prevention, communities are encouraged to involve them when appropriate to advise adults on the planning, implementation, and evaluation of local youth suicide prevention strategies. Communities should also recruit and invite members of minority populations to join planning processes. This will help to assure that activities are culturally appropriate.

BUILDING STATE AND LOCAL CAPACITY THROUGH A MULTI-AGENCY TEAM

State agencies have expertise and resources that can support community activities by:

- providing technical assistance to communities in planning, implementing, and evaluating youth suicide prevention strategies.
- coordinating statewide efforts and resources in establishing youth suicide prevention and intervention strategies.
- monitoring the implementation of the statewide plan for youth suicide prevention.

This role can be accomplished through the formation of a multi-agency State Team for Youth Suicide Prevention. The core state agencies will include: Divisions and Offices of the Department of Human Services (the Health and Mental Health Divisions, Office of Drug and Alcohol Abuse Programs, State Office of Services to Children and Families, Adult and Family Services), the Commission on Children and Families, the Department of Education, and the Oregon Youth Authority.

Other organizations, and special interest groups should be identified as partners of the state team. These may include such entities as the Indian Health Board, Tribal Health Services, the American Foundation of Suicide Prevention Northwest Chapter, the Oregon Family Support Network, and the National Alliance for the Mentally Ill.

SECTION 2: YOUTH SUICIDE PREVENTION STRATEGIES

ABOUT THE 15 STRATEGIES

The prevention strategies presented below are derived from evidence-based research, public input on draft strategies, and recommendations from the Governor's Task Force on Youth Suicide Prevention.[7]

STRATEGY 1: DEVELOP AND IMPLEMENT PUBLIC EDUCATION CAMPAIGNS

OBJECTIVE

Develop and implement public education campaigns that will:

- increase knowledge about symptoms of depression, suicide risk and protective factors, indicators of possible suicidal behavior, skills for responding to a suicidal individual, and community resources
- increase help-seeking behavior by decreasing the stigma associated with behavioral health care

AUDIENCE

General public.

"Many teenagers hide their true feelings. they need to know what to do and where to go." - an Oregon Youth

RATIONALE AND EFFICACY

Many adolescents report that embarrassment, stigma, and fear are the main reasons they do not seek help for their problems. Studies show also that most adolescents do not seek help for suicidal ideation even when it is identified as the most pressing problem they are experiencing.[8]

Recognizing and responding appropriately to such troubled youth can prevent suicides. In addition, wider public understanding of the science of the brain and behavior can reduce the stigma associated with seeking help for behavioral health problems, and consequently may contribute to reducing the risk of suicidal behavior.

Knowing the signs of depression and suicide, and what to do can save lives.

A community-wide public education campaign can be an effective way to provide useful information on these subjects to all citizens. Evaluation of such a campaign recently conducted in Washington state indicates that it increased: (1) awareness of information about youth suicide prevention, (2) recognition of indicators of suicidal behavior, and (3) willingness to use suicide intervention skills in helping distressed youth.[9]

IMPLEMENTATION CONSIDERATIONS

Greater public awareness and knowledge about youth suicide prevention may expand the need for mental health and crisis intervention services. Providers should anticipate this possibility with contingency plans for managing the increased demand.

Public education campaigns about suicide prevention must be sustained efforts in order to maintain a necessary level of awareness.

SAMPLE IMPLEMENTATION ACTIVITIES

- Secure agreements from television broadcast stations to air public service announcements.
- Work with local print media to publish feature articles on adolescent depression and youth suicide prevention.
- Create, produce, and disseminate information through a variety of sources, including: grocery bags, book marks, slides at movie theaters, milk cartons, and local public access televised media.
- Disseminate informational flyers, brochures, and other materials to identified groups.
- Organize a community-wide Youth Suicide Prevention Week.
- Create, produce, and post informational posters in youth centers, health centers, employee assistance offices, and other places with high visibility to the general public.
- Create and distribute wallet cards to youth in and out of school, parents, and the general public that contain information about warning signs, how to help, and local /state/national resources.
- Create a speaker's bureau of professionals, survivors, youth, etc., for community presentations.

STRATEGY 2: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS OF SELF-HARM

OBJECTIVE

Energize Oregonians to restrict youth access to means of suicide by educating them about such vital issues as:

- the link between lethal means in the home and completed suicide
- safe firearm storage (locked and stored separately from ammunition)
- the importance of removing lethal means (firearms, poisons, medications, alcohol, etc.) from homes with a youth at high risk of suicidal behavior

Removing or restricting access to lethal means of self harm is an effective suicide prevention strategy that can decrease suicide.

AUDIENCE

All Oregonians, particularly parents/ guardians, firearm owners, community gatekeepers (Strategy 7), young people - especially those aged 10 to 24, behavioral health care providers, teachers, school administrators, law enforcement, clergy, juvenile justice workers, physicians, public health practitioners, and legislators.

RATIONALE AND EFFICACY

Increased public awareness of the role of firearms in youth suicides and knowledge about safe firearm storage can save young lives. Here are some pertinent facts: Firearms are used in fully two-thirds of youth suicides in Oregon.[10] During the last three and one-half decades, the rate of suicide by firearm increased 4.3 times faster than did the rate of suicide by other methods. An estimated 16% of Oregon households with children under 18 have firearms that are loaded and unlocked.[11] During 1994-1997, 71% of firearm suicides among Oregon youth aged 10 to 24 occurred at home. The American Academy of Pediatrics advises that parents of depressed or suicidal adolescents remove firearms and ammunition from the home.[12]

Education on the restriction of access to lethal means is seen as one of the most promising and economical strategies for preventing youth suicide.[13] Removing or restricting access is an effective suicide prevention strategy that can decrease suicide.[14, 15] Among parents whose children visited an emergency department for a mental health assessment or treatment, those who received injury prevention education from hospital staff are significantly more likely to limit access to lethal means of self-harm than are families who did not receive such education.[13]

"No one loves me. I don't want to go on." 10th grade boy

IMPLEMENTATION CONSIDERATIONS

The safety of Oregon's young people is a serious concern both of gun owners and of those who do not own guns. Messages on restricting access to means of suicide should be crafted collaboratively by both groups to achieve community-wide support. Public education campaigns aimed at preventing youth suicide should incorporate messages on reducing access to lethal means of self harm as well (see Strategy 1).

SAMPLE IMPLEMENTATION ACTIVITIES

- Select and/or create media to educate the public about the role of firearms in youth suicide, safe storage, and firearm disposal.
- Conduct a public information campaign(s) designed to reduce the accessibility of lethal means of self harm (including firearms) in the home.
- Solicit help from community gun owners and sellers to support campaigns for safe storage.
- Conduct public forums for parents, guardians, and media on strategies for securing weapons (gun boxes, trigger locks, etc.) and medications, particularly prescription drugs and those stored in large quantities.
- Train professionals and other adults who provide services to youth at risk for suicide about firearm access issues.
- Increase the proportion of primary care and other health care providers who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate patients about actions to reduce risks.
- Conduct a local community assessment to determine the extent to which firearms and other lethal means are stored safely in homes with children and adolescents.

STRATEGY 3: EDUCATE YOUTH AND YOUNG ADULTS ABOUT SUICIDE PREVENTION

OBJECTIVE

Increase suicide prevention awareness, knowledge, and skills of youth and young adults. The underlying benefit is the creation of school communities in which all members accept responsibility for each other's safety and can provide a competent initial response to those at risk.

All youth and young adults need to be able to help suicidal peers seek professional care.

AUDIENCE

Middle and high school-age youth in school and vocational training settings. Youth and young adults in higher education, job corps centers, youth shelters, military installations, detention facilities, and other community settings. Staff responsible for supervising youth in school and community settings.

RATIONALE AND EFFICACY

About one-half of adolescent females and about one-third of males report having talked to someone who was definitely or potentially suicidal, and yet only about 25% told an adult about their suicidal peers.[17] It is important that all youth and young adults have the knowledge, attitudes, and skills to help suicidal peers get professional help.

Evaluation studies indicate that suicide prevention education programs increase the knowledge of students about suicide warning signs and about sources for help and referral.[18] Students who participated in such programs were found to be more likely to refer other students to hotlines and crisis centers than students who did not participate.[19] Students who participated in a school-based suicide prevention campaign in Washington state demonstrated increased awareness of information about youth suicide prevention, increased ability to recognize indicators of potential suicidal behavior, and a greater likelihood of offering advice to others about how to get help.[9]

IMPLEMENTATION CONSIDERATIONS

There is no evidence that school-based prevention programs increase the likelihood of suicidal behavior.[16] Nevertheless, care should be taken in selecting, designing, and presenting the information to avoid sensationalizing, normalizing, or inadvertently offering how-to instructions for committing suicide.[20] As with any sensitive classroom topic, teachers of suicide prevention education should anticipate and plan for the possibility of negative reactions, particularly on the part of students who have had some personal experience with suicide.

Some of the highest risk youth are not in conventional schools. Efforts to reach these youth are especially important to consider.

Classroom curricula should focus on basic knowledge, attitudes, and skills that help students become more confident and competent in helping troubled peers. The curricula should be implemented as part of a comprehensive school program that also includes administrative policies and procedures for dealing with suicide situations; training for all school personnel; three to five classroom lessons for students in health

and/or family life studies; presentations to parents; and possibly such other components as school crisis teams, training of community gatekeepers, and or/media campaigns.[21]

Strategies 7 (Gatekeeper Training), 8 (Screening and Referral), and 13 (Skill-Building Support Groups) are appropriate complements to suicide prevention education programs and consideration of simultaneous implementation is encouraged.1

"I think school would be better if it had a teen group for lonely students."- an Oregon Student

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify existing suicide prevention education activities and venues within communities where youth aged 10 to 24 receive suicide prevention awareness, information, and skills. Document gaps in services.
- Select safe, age-appropriate suicide prevention curricula, materials, and programs for use in schools and other community settings.
- Conduct suicide prevention education and outreach in community venues that serve out-of-school, street, and homeless youth and young adults.
- Work with school boards, educators, and parents to get suicide prevention education taught to students, supported with training for school staff and parents.

STRATEGY 4: REDUCE HARASSMENT IN SCHOOLS AND COMMUNITIES

OBJECTIVE

Reduce harassment in schools and communities through the creation and implementation of inclusive anti-harassment school policies, staff training, and school curricula.

AUDIENCE

All staff and students in schools.

RATIONALE AND EFFICACY

Students must feel safe in school and other learning environments if they are to achieve their maximum potential. Lack of physical and emotional safety can result in negative educational outcomes linked to risk behaviors.

Students may be marginalized for a wide variety of reasons, including physical characteristics, disability, medical conditions, religion, gender, race, ethnic/cultural identity, sexual orientation, and gender identity.

Studies have established a link between victimization at school with an elevated risk of suicidal ideation and behavior in adolescents.[22, 23, 24] Nearly one-third of Oregon high school students responding to the 1997 Youth Risk Behavior Survey (YRBS) reported being harassed at school during the previous 30 days. These students were three times more likely to report a prior suicide attempt. At greatest increassed risk were victims of sexual harassment and those who were perceived to be gay, lesbian, or bisexual.[25]

IMPLEMENTATION CONSIDERATIONS

Communities differ in the extent to which they accept individual and group differences and schools tend to reflect the attitudes of the community. It is important to work with all aspects of the community in finding agreement about what constitutes safe and supportive learning environments for all youth and young adults.

Staff training should clearly define inappropriate student behavior and empower staff to intervene effectively.

There is a strong link between victimization at school and an elevated risk of suicidal ideation and behavior.

Teaching students tolerance is best done within the context of other risk and protective factors that affect student health and safety.

SAMPLE IMPLEMENTATION ACTIVITIES

- Assess school district policy with regard to non-discrimination, student protection from harassment and violence, user-friendly grievance procedures, and the existence of clearly stated consequences that are consistently enforced.
- Work with school boards and school districts to identify gaps and address needs in school policy language and enforcement to increase safety in school learning environments.
- Utilize local YRBS data or other student survey information to assess needs and implement action plans to address needs.
- Train school staff to identify harassing behavior and effectively intervene.
- Train school staff to teach tolerance.
- Implement tolerance education in classroom curricula.

STRATEGY 5: PROVIDE MEDIA EDUCATION AND GUIDELINES

OBJECTIVE

Reduce suicide contagion through communications media by providing editors with guidelines for reporting youth suicide and suicide prevention resource information.

AUDIENCE

Editors in all communications media, including newspapers, radio, and television.

RATIONALE AND EFFICACY

There is persuasive evidence that outbreaks of suicide - i.e., "suicide contagion" - occurs, and adolescents and young adults are particularly vulnerable.[26] Studies show that mass media coverage of the suicide of a youth can influence others to engage in suicidal behavior.[27, 28] The more networks carry a story about suicide, the greater the increase in suicides thereafter.[27]

The manner of reporting a suicide may increase or decrease the possibility of contagion. Media guidelines recommend that excessive reporting of suicide, how-to descriptions, glorification of persons who commit

suicide, and simplistic explanations be avoided.[29] When suicide is reported, prevention information and community resources should also be provided.

IMPLEMENTATION CONSIDERATIONS

On an issue as sensitive as youth suicide, it is important that communities work with the media to achieve a balance between the mission of the news media and the need for responsible coverage.

Media guidelines should be regularly updated, repeated, and reinforced to reflect new developments in suicide reporting and to ensure that both new and experienced editors stay informed.

Media approaches to reporting suicide can increase or decrease the possibility of additional suicidal behavior in a community.

SAMPLE IMPLEMENTATION ACTIVITIES

- Collaborate with media representatives in developing youth suicide reporting guidelines using the media guidelines recommended by the Centers for Disease Control as a model.[29]
- Provide guidelines to local media personnel in a position to report youth suicide.
- Provide the guidelines to key partners in youth suicide prevention, such as mental health professionals, community leaders, survivors, and gatekeepers.
- Present/distribute guidelines at media association meetings.
- Identify someone to collect and analyze local news articles, television/radio news coverage, and other media on how youth suicide is reported and whether reports include crisis lines and other local/ state/ national resources for help.

STRATEGY 6: PROVIDE EDUCATION FOR PROFESSIONALS

OBJECTIVE

Increase training and education specific to health care professionals, educators, and human service providers who work with youth and families.

Many professionals are inadequately prepared to address suicide issues with youth and families.

AUDIENCE

Professionals and those in professional training programs who work with children, youth, young adults, and families. This audience includes but is not limited to: physicians, nurses, mental health providers, juvenile justice personnel, counselors, teachers, school administrators, crisis response providers, psychologists, social workers, alcohol and drug treatment providers, volunteers with organizations serving youth, and religious/spiritual leaders.

RATIONALE AND EFFICACY

Health care professionals, educators, and human service providers are in key positions to identify, assess, intervene, and refer youth and young adults who are at risk of suicidal behavior. Unfortunately, a number of studies indicate that many professionals are inadequately prepared in these areas.

A survey of pediatric residency programs in the United States found that topics least often cited as adequately covered included psychological testing and violence prevention.[30] Another study found that continued education for adolescent medicine physicians was associated with increased competence in addressing suicide.[31] A survey of graduate schools in psychology found that only 40% had some training on suicide.[32] In a survey of high school health teachers, only 9% believe they would recognize a student at risk for suicide. Suicide prevention education programs for teachers increase their ability to recognize warning signs for suicide, their knowledge of treatment resources and willingness to make a treatment referral.[33] Teachers who attended an in-service program on adolescent suicide, or who have experience teaching about youth suicide, or who work on a school-based crisis intervention team reported a higher level of confidence in being able to recognize a student at risk for suicide.[34]

IMPLEMENTATION CONSIDERATIONS

Training for professional groups should be tailored to reflect the focus and service delivery model of each profession. Champions in each discipline should be recruited to work within their field to promote interest in and support for youth suicide prevention education.

Educational strategies for professionals and service providers will require sustained implementation to keep pace with new developments in the field of suicide prevention and to adjust for the attrition of personnel.

SAMPLE IMPLEMENTATION ACTIVITIES

- Assess what is currently being taught about youth suicide prevention within identified course work, in-service training, and continuing education for professionals.
- Identify audiences and training opportunities.
- Recruit and train individuals to conduct youth suicide prevention education for specific professional groups.
- Conduct and evaluate in-service training for professionals.
- Advocate for the inclusion of youth suicide prevention education in relevant graduate/undergraduate programs as a requirement for certification/licensure and for certification/licensure renewal.

> "Just because you haven't attempted suicide doesn't mean you're not depressed. I think the way students feel about things is just as important as what they do."
> - an Oregon Student

STRATEGY 7: PROVIDE GATEKEEPER TRAINING

OBJECTIVE

Establish a network of adults and youth in every community who can recognize and respond to youth exhibiting signs of suicide risk and can assist them in getting professional help.

AUDIENCE

Gatekeeper training should be provided to adults who have regular contact with youth and their families. This includes but is not limited to: health care professionals, mental health providers, substance abuse counselors, law enforcement officers, juvenile corrections workers, protective service workers, family planning staff, school personnel (nurses, social workers, psychologists, counselors, teachers),

tribal leaders, clergy, peer helpers, crisis line workers, emergency room personnel, and others who have significant contact with youth between 10 and 24.

RATIONALE AND EFFICACY

Gatekeeper training for adults who work with youth builds their competence and confidence to:

- recognize risk factors associated with youth suicide
- identify at risk youth
- communicate with youth at risk for suicide
- make referrals to connect at-risk youth with skill-building and/or crisis intervention services
- implement policies to guide interventions with at-risk youth (e.g., never leave a suicidal youth alone)
- facilitate a 30- to 45-minute awareness program on the topic of youth suicide
- serve on a school/community prevention team and/or crisis response team

Gatekeeper training for youth builds their competence and confidence to:

- recognize the risk factors associated with youth suicide
- increase positive communication with youth at risk for suicide
- tell an adult of their concerns about a peer
- connect a peer at risk with an adult capable of helping

Adults and youth can be trained to identify youth at risk, show they care and connect youth with services.

Adults who are community gatekeepers interact with youth in a variety of school and community settings. Once trained, they're in a position to recognize youth at high risk of suicide and to intervene with them.[16]

Youth are more likely to talk with peers than with adults about suicidal feelings, ideation, plans, and behaviors.[21] Gatekeeper training for youth offers more in-depth training than general suicide awareness education and provides a cadre of youth with a high level of awareness and skill in intervening with and referring high-risk peers to professional help.

Results from Washington state gatekeeper training programs indicate that trained adults and youth are significantly more likely than the general public to: (1) believe they would act to prevent youth suicide, (2) demonstrate greater confidence in suicide assessment and intervention knowledge, and (3) report higher levels of comfort, competence, and confidence in helping at-risk youth. Youth who participated in a 2-day gatekeeper training were significantly more likely to know warning signs for suicide and more likely to respond with effective suicide prevention steps than non-participating peers.[9] Gatekeeper training programs in Colorado and New Jersey have shown similar results.[35]

IMPLEMENTATION CONSIDERATIONS

A public education campaign (Strategy 1) is adequate for the majority of parents.

Gatekeeper training is not generally designed for parents of youth identified as high-risk for suicide. Those parents should be contacted and referred to professional help.

A number of gatekeeper training methodologies are commercially available. Two train-the-trainer models currently in use in the Pacific Northwest are LivingWorks and Question Persuade and Respond (QPR) for Suicide Prevention.[36, 37]

Adult gatekeeper training should take place before youth training to ensure that the trained youth gatekeeper will have adult support and follow-up when reaching out for help for themselves or friends.

Gatekeepers - especially youth gatekeepers - should receive ongoing supervision, debriefing, and training to help ensure that suicide intervention activities do not increase the risk of suicidal behavior by gatekeepers themselves.

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify community members who are already trained gatekeepers.
- Assess the need for additional gatekeepers.
- Utilize trained gatekeepers to provide youth suicide awareness education and serve on local prevention/crisis response teams (Strategy 11).
- Conduct a training to increase the number of gatekeepers.
- Provide support and ongoing training for current gatekeepers and for those seeking to become gatekeepers.

STRATEGY 8: IMPLEMENT SCREENING AND REFERRAL SERVICES

OBJECTIVE

Screen youth and young adults for suicide risk and refer identified individuals for further evaluation and intervention.

AUDIENCE

Screening can identify which youth need assessment and care.

Screening and referral is appropriate for youth in any setting but may be particularly warranted for those in subgroups known to be at higher risk for suicide. These include: incarcerated youth, youth with history of juvenile justice and/or protective service involvement; American Indians; white males; depressed youth; substance abusers; high-striving, perfectionist youth; potential dropouts; runaways; gay and lesbian youth; victims of assault and/or abuse; and pregnant teens.[38]

RATIONALE AND EFFICACY

Screening can identify youth with symptoms of depression, suicidal ideation, and behavior, thus providing a means to determine which of them are in need of further assessment and care.

Screening using a three step process that reduces the number of false positives has been shown to be efficient and cost effective when used with both individual youth and large populations.[39]

IMPLEMENTATION CONSIDERATIONS

Screening programs can be characterized as **focused or broad.** Focused screening would select youth known to be at increased risk who present in settings such as juvenile corrections, foster care, alcohol and drug treatment, mental health, youth shelters, and family planning programs. Broad screening programs screen every youth in a population.

One focused approach is to screen high risk youth in settings where they appear for protective services, detention, or health care. Screening can be accomplished by trained paraprofessionals at service delivery sites administered by state and local agencies and community-based organizations.

Suicide-risk screening instruments are still in the developmental stage, with evaluation a priority research area. Some promising screening instruments that have been used include: Suicide Ideation Questionnaire; Evaluation of Imminent Danger of Suicide; Emergency First Aid; Measure of Adolescent Potential for Suicide; Columbia Teen Screen; and the National Institute of Mental Health Diagnostic Interview Schedule for Children.[40, 41, 42, 43, 44, 45]

Settings in which screening should occur include: juvenile corrections centers, homeless shelters, crisis centers, family planning clinics, mental health centers, alternative schools, recreation centers, homeless shelters, crisis centers, employee assistance offices, and alcohol and drug treatment programs.

Periodic screening of high-risk youth should be conducted, since an individual's risk for suicide may change over time.

> "I think that teachers and staff members need to pay more attention to kids who are depressed. When they get in these depressions, many become violent and may harm others or attempt suicide." - an Oregon Student

SAMPLE IMPLEMENTATION ACTIVITIES

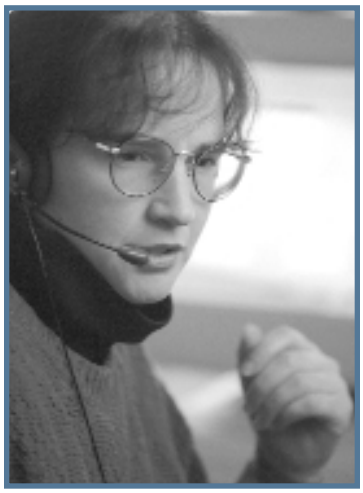
- Assess current efforts and gaps in screening youth and young adults for suicide risk in school and community settings.
- Identify screening approach, either focused or broad.
- Identify environments where high-risk groups appear and where screening should occur.
- Identify screening instrument.
- Train staff to administer screening process.
- Ensure that clinicians are available to assess and treat referred youth.

- Conduct screening and document implementation processes.
- Refer youth at high risk to clinicians for further assessment and intervention.
- Assist youth at imminent danger of attempting suicide with immediate crisis intervention.

STRATEGY 9: INCREASE EFFECTIVENESS OF CRISIS HOTLINES

OBJECTIVE

Improve the effectiveness of 24-hour local, state, and national crisis hotlines by helping youths to increase their knowledge about how, when, and why to use them.



AUDIENCE

The primary audience is youth and young adults aged 10 to 24, especially those at high risk for suicide. A secondary audience includes community members who are especially concerned with youth suicide and for whom hotlines can be a helpful, readily available resource. These include family members, peers, and trained community gatekeepers (Strategy 7).

RATIONALE AND EFFICACY

There is evidence that hotlines: (1) are preferred by youth over mental health centers, especially if they are known to cater to youth and provide peer counselors; (2) provide a service for individuals troubled by suicidal ideation; (3) succeed in attracting populations they are designed to help; (4) are associated with decreases in suicide rates among white females under 25, the most frequent users of hotline services; and (5) reach otherwise underserved populations in the community.[16]

On the other hand, Shaffer notes that research on the effectiveness of crisis hotlines suggests that they have little impact on suicide rates in a community.[39] He concludes, however, that their impact may be improved if enhanced by appropriate advertising and if hotline personnel are trained in how to respond more specifically to callers regardless of the caller's problems.

IMPLEMENTATION CONSIDERATIONS

Providing youth-friendly hotline response and outreach is important in facilitating the use of hotlines by young people.

Immediate help is as close as a telephone.

Implementation efforts should include plans for anticipating and dealing with an increase in crisis hotline use. Without such preparation, hotline workers and other care providers may be overwhelmed by public response.

Hotline workers should receive regular supervision from a mental health clinician.

Hotline workers should receive training in crisis response and management.

Hotline workers should have latest information to assist in linking to emergency resources.

A system for tracking the frequency and type of calls is an important tool for documenting and monitoring changes in crisis line use.

Publicity should include national youth hotlines for youth who may, for a variety of reasons, choose not to contact a local crisis line.

Some communities may find it more efficient and cost effective to implement this strategy as part of a regional collaboration with surrounding communities or counties.

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify the number of crisis hotlines, number of calls received from youth aged 10 to 24, the nature of hotline calls, and gaps and coordination issues in the local service area.
- Develop a plan to track calls to collect data as an aid to monitoring effectiveness.
- Develop and implement strategies for making crisis hotlines more user friendly to youth.
- Use a variety of media to publicize availability of crisis lines and crisis services to community members, families, and youth, especially youth at high suicide risk.
- Monitor, evaluate and improve standards for crisis line services.

STRATEGY 10: ENHANCE CRISIS SERVICES

OBJECTIVE

Enhance existing community-based crisis services to accommodate the growth in demand for these services resulting from successful implementation of youth suicide prevention strategies.

Effective community response after a suicide crisis depends on the education of responders and coordination specific to suicide built into a community's crisis response plans and protocols.

AUDIENCE

Crisis hotline staff and other crisis service providers.

RATIONALE AND EFFICACY

Implementation of the youth suicide prevention strategies in this plan is likely to increase the demand for crisis services; crisis service staff should anticipate and plan for this increased workload.

When an action plan for enhancing crisis services was implemented in Washington state in 1996, crisis services staff reported increases in awareness of suicide prevention, visibility of crisis services, interest from school counselors and others, and helpful resources for improving crisis service staff competencies and for conducting community presentations.[9]

IMPLEMENTATION CONSIDERATIONS

Standards for certifying crisis workers and crisis agencies have been established by the American Association of Suicidology http://www.suicidology.org www.suicidology.org.

SAMPLE IMPLEMENTATION ACTIVITIES

- Document the frequency, type, and nature of crisis events involving youth and young adults and the crisis service provided in order to monitor delivery of services and provide a data base for continuous improvement.
- Ensure that crisis hotline staff have adequate training to respond to at-risk youth callers.
- Identify barriers to the delivery of crisis services to at-risk youth and make recommendations for ways of improving those services.
- Involve crisis service providers in the selection, implementation, and evaluation of community youth suicide prevention strategies.
- Survey crisis service providers about their needs.

STRATEGY 11: ESTABLISH AND MAINTAIN CRISIS RESPONSE TEAMS

OBJECTIVE

Establish and maintain trained, responsive, school and community crisis response teams (CRT) to help minimize the likelihood of suicide contagion in schools.

Quick and appropriate response from crisis workers can minimize the negative impact of a suicide in a community.

AUDIENCE

The primary audience is current and prospective school and community CRT members. A secondary focus is other community members who play an important role in facilitating the work of a school CRT. These include: school administrators, school counselors, teachers, social workers, psychologists, mental health providers, religious/ spiritual leaders, bereavement counselors, hospital representatives, trained gate-keepers, parent groups, survivor groups, media representatives, crisis service providers, treatment providers, law enforcement, and emergency medical personnel.

RATIONALE AND EFFICACY

Exposure to the suicides of family members, friends, or others may increase the risk for youth and young adults already at high risk of self-destructive behavior. Suicide clusters (groups of suicides occurring closer in space and time than would normally be expected) and copycat suicides are rare events, but adolescents and young adults seem particularly vulnerable to such contagion. Estimates indicate that the percentage of adolescent suicides identified as cluster-related may range from less than 1% to 13%.[46] Schools and communities should be prepared to respond quickly to minimize the likelihood of suicide contagion following one or more youth suicides.

The advisability of a crisis response plan to manage the risk of multiple youth suicides is widely accepted by experts. In the absence of a crisis, it is difficult to evaluate the adequacy of response plan interventions.

Unfortunately, no evaluations exist on the effectiveness of crisis response team interventions on youth suicide behavior.[16]

IMPLEMENTATION CONSIDERATIONS

No matter how well developed a CRT plan might be, it will not work effectively if community stakeholders are not aware of the content of the plan or supportive of it. To ensure a coordinated, cooperative response in the event of a tragedy, school staff and community members should be educated about the role of crisis response teams in suicide prevention.[16]

CRT plans should specify a process for helping team members reduce stress resulting from interventions that prevent a suicide. Team members report significant benefits from participating in these critical incident debriefings.[47]

In addition to school-based and school/community-based CRTs in many communities, Oregon counties have access to National Office of Victim's Rights (NOVA) teams to respond to crises. An informal survey by the Oregon Department of Education in the fall of 1998 showed that most Oregon school districts have a crisis response plan that includes post-suicide intervention. However, many of the plans had not been updated within two years, and only about 25% of school districts had provided any kind of annual staff training in crisis response and crisis response planning. These two types of training were identified as the areas of greatest need.[48]

Suicidal behavior among high-risk youth may also be precipitated by accidental death or homicide or by other significant losses in schools and communities. The use of CRTs after these events should therefore be considered.

> "We need to open our eyes and face reality. We have problems here and need to look at them."
> - an Oregon Student

SAMPLE IMPLEMENTATION ACTIVITIES

- Establish CRTs in areas without existing teams.
- Incorporate CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters into new and existing CRT plans.[49]
- Involve local CRT members in community youth-suicide prevention efforts.
- Educate community stakeholders about the role of a CRT in the aftermath of youth suicide and solicit their support and utilization of a CRT when appropriate.
- Coordinate crisis response activities with existing community resources.

STRATEGY 12: IMPROVE ACCESS TO AFFORDABLE BEHAVIORAL HEALTH CARE

OBJECTIVE

Improve access to affordable behavioral health care for youth and young adults by:

- taking information and services (education, screening, treatment, consultation) to youth in places where they gather (schools, youth centers, events, youth-serving agencies, churches, athletics, shopping malls, etc)

- increasing the number of school-based health centers that provide behavioral health services
- improving linkages and collaborative relationships between schools and community providers of behavioral health services
- advocating for low-cost or no-cost services and more behavioral health treatment insurance coverage

AUDIENCE

The key audience consists of administrators of institutions that serve youth and young adults, insurance providers, and legislators. An important secondary audience includes public and private entities that provide behavioral health services, school-based health centers, parents, youth, business leaders, suicide survivors, and professional organizations and associations affiliated with health, mental health, and substance abuse issues.

RATIONALE AND EFFICACY

Mood disorders and alcohol abuse and other drug abuse are strongly linked to suicidal behavior.

Barriers to obtaining treatment for behavioral health conditions in adolescents include availability, transportation, and cost - as well as the social stigma often associated with behavioral health problems (Strategy 1).[50] Oregon youth cite ease of access as the single most important reason why they use a school- based health center.[51] Access to treatment can be increased by providing affordable and confidential services in schools, youth centers, shopping malls, churches, and other places in the community frequented by youth. In addition, access may be facilitated by increasing parental knowledge of mental health services (Strategy 1) and assisting adolescents to initiate contact with a service provider.[52]

There is ample evidence that many youth suffer from a mental, emotional, or behavioral disorder, and many of them do not receive the care they need.[53, 54, 55] Teens who abuse alcohol or drugs are more likely to progress from suicidal ideation to suicide attempts.[56] Mood disorders, conduct disorder, and/or substance abuse are the conditions commonly linked to suicidal behaviors among teenagers.[57, 54] Various therapies and medications have been shown to be effective in the treatment of depression in children and adolescents.[53] Increasing access to effective treatment provides more opportunities for addressing the unmet behavioral health needs of children, adolescents, and young adults.

IMPLEMENTATION CONSIDERATIONS

Implementation of other strategies in this plan, such as screening and referral (Strategy 8) and gatekeeper training (Strategy 7), are likely to increase the need for community behavioral health treatment resources. It is important to anticipate this possibility so individuals with identified treatment needs can access existing resources in a timely manner.

School and community providers should collaborate to coordinate delivery of behavioral health care to youth and families.

The Health Division Center for Child and Family Health has published state and community based strategies for improving adolescent access, availability, and utilization of behavioral health services which can be found at: www.ohd.hr.state.or.us/ccfh/cfhna.htm

SAMPLE IMPLEMENTATION ACTIVITIES

- Involve youth and families in planning improvements in access to care.
- Inform adolescents of their right to health care access and confidential health services
- Perform outreach to enroll adolescents eligible for Children's Health Insurance Program or the Oregon Health Plan.
- Identify ways to decrease barriers and increase access to services and treatment.
- Create an outreach action plan for the delivery of behavioral health information and services in places where young people gather.
- Conduct focus groups with youth and young adults to identify barriers to utilizing local behavioral health services.
- Increase the number of school-based health centers providing behavioral health services that match needs and are planned to supplement local community resources.
- Advocate for affordable behavioral health treatment that achieves parity with medical insurance coverage on local, state, and national levels.

STRATEGY 13: PROVIDE SKILL-BUILDING SUPPORT GROUPS FOR YOUTH

OBJECTIVE

Provide skill-building support groups for identified at-risk youth in school and community settings that work to reduce the impact of multiple-risk factors, enhance protective factors, and involve families in supporting youth involvement and success.

AUDIENCE

Skill building that includes learning to set goals, make decisions, reduce anger, solve problems, and abstain from alcohol and other drugs is a promising approach to reduce suicidal behavior.

The primary audience is young people who have multiple risk factors linked to suicidal behavior. The strategy should concentrate on school and community locations where at-risk young people are found. These include, but are not limited to, high schools, teen health clinics, college counseling/ health centers, youth activity centers, community health centers, juvenile detention facilities, youth shelters, and Job Corps centers.

RATIONALE AND EFFICACY

Skill-based support groups offer an opportunity to intervene with troubled youth and young adults short of the clinical intervention necessary for those at high risk of suicidal behavior. One feature that often characterizes at-risk youth is the challenge of facing multiple problems at the same time. Risk factors such as emotional distress, family strain, school strain, drug involvement, poor school performance, and low levels of personal and social support may overwhelm a young person's coping abilities. Conducting skill-based support groups for identified at-risk youth can be an effective prevention strategy.[58]

Studies show that youth with suicidal thoughts and behaviors are more likely to use emotion-based coping strategies and less likely to use problem-solving strategies than non-suicidal youth.[59, 60] Deficiencies in such functions as goal setting, decision-making, anger management, problem-solving, and drug use control compound a youth's sense of hopelessness. Social and family support combined with skill development in these areas shows promise in reducing youth suicidal behaviors.[61, 62, 63] Cognitive and behavioral experiences that increase feelings of competency and mastery will increase protective factors that offset risk factors of hopelessness and poor self esteem.

Talking with at-risk youth about their suicidal thoughts, combined with the support of caring adults in the youth's social network, appears to significantly reduce critical risk factors linked to suicidal behavior.[62] Several programs have shown to be effective for depressed youth and youth at risk for suicidal behavior, including the Coping with Depression Course, Group Problem-Solving/Support Interventions, and Reconnecting Youth.[64, 65, 61] Each of these programs has developed curricular materials for program planning and implementation.

IMPLEMENTATION CONSIDERATIONS

Young people in need of mental health services beyond the scope of skill-building support groups should be referred to mental health providers. Adults working with youth identified to be at high suicide risk should contact parents immediately and refer the family to a behavioral health care provider.

Lack of parental or family support is associated with youth suicidal behaviors.[66] The family component of skill-building groups focuses on parent involvement and linking youth and their families to sources of support. Collaboration between each youth, the program manager, and a parent/guardian (or adult friend or family member for a young adult) is important for involving at least one caring adult in a young person's life.[58]

It is important to select an evidence-based model that offers a multi-component prevention approach. It is also important to assess existing groups according to the model followed and to what extent they are skill based, they provide a family support component concurrent with the youth's group involvement, and they are effective in reducing depression and suicidal ideation/behavior.

Youth with multiple risk factors have a dramatically higher probability of having attempted suicide than youth with few risk factors.[54] Assessing youth who may benefit from participation in skill-based support groups depends on identifying those with risk factors linked to suicide or youth populations with an elevated suicide risk (Appendix A). Care should be taken to avoid including youth who do not need the group intervention and to assure that high suicide-risk youth receive more intensive clinical services.

The presence of risk factors or a combination of risk factors can be indicative of risk behaviors other than suicide.

A good question to ask would be: "When you felt depressed, did you have access to items which could have ended your life?" - an Oregon Youth

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify support/skill-building groups for youth and young adults that already exist in school and community settings, and identify gaps in services.
- Identify locations where high-risk youth are likely to be found as possible places to conduct groups.
- Train professionals to conduct skill-building groups for high-risk youth.
- Conduct group programs in coordination with screening programs and referral systems.
- Develop a plan for ongoing facilitator training, consultation and supervision services, and program evaluation.

STRATEGY 14: SUPPORT SUICIDE SURVIVORS

OBJECTIVE

Foster the development of bereavement support groups for youth and adult survivors of suicide (those who have lost someone by suicide).

AUDIENCE

Suicide survivors, including parents, other family members, and young people who have lost a friend.

RATIONALE AND EFFICACY

In 1998, 569 Oregonians died by suicide.[67] It has been estimated that six to eight people are directly affected by each suicide death, suggesting that at least 3,000 Oregonians each year face the emotional pain of losing a loved one or friend to suicide.[68] A survivor's own risk of suicide can increase as a result of cultural taboos and stigmatization, leading to criticism or condemnation of the survivor, social isolation, and loss of social support.[69] Young people who have lost a friend or acquaintance to suicide may be at increased risk of depression, post-traumatic stress disorder, and suicidal ideation and behavior. Social support should be provided for these potentially bereaved and depressed youth.[72]

Research on the effectiveness of supportive intervention with suicide survivors is limited. One study concluded that group interventions are initially worthwhile in helping adolescents cope with peer suicide, but that supportive intervention may be needed to offset a decrease over time in self-worth and academics.[71] Another study of bereavement support group outcomes for adult survivors produced significant reductions in overall depression, distress, and despair.[7]

Many survivors find that involvement with suicide prevention promotes healing, reduces stigma, and helps them cope with the grief of losing a loved one or friend.

Suicide survivors are at increased risk for suicide.

IMPLEMENTATION CONSIDERATIONS

The stigma often associated with suicide inhibits some survivors from risking public visibility; care should be taken in outreach efforts to protect their privacy. Collaboration with established survivor networks and/or local survivor leadership is recommended.

Bereaved youth and their families may need crisis intervention services, individual counseling, or participation in a peer support group or community-based bereavement support group. Parents of and adults working with bereaved youth should be knowledgeable about local services and should assist youth in getting the support they need.

SAMPLE IMPLEMENTATION ACTIVITIES

Annually, 3000 Oregonians loose a loved one or friend to suicide.

- Conduct outreach to suicide survivors and invite them to participate in implementing suicide prevention strategies.
- Assist survivors in organizing local bereavement support networks.
- Assist survivors in connecting with state, regional, and national organizations working to support survivor advocacy in preventing suicide.
- Support efforts to create community and regional events that increase survivor networking and involvement in suicide prevention activities.

STRATEGY 15: IMPROVE FOLLOW-UP SERVICES FOR SUICIDE ATTEMPTERS

OBJECTIVE

Improve emergency room and after-care services for youth suicide attempters and their families by:

- training emergency room staff in the use of a protocol to increase treatment adherence
- providing follow-up after-care for youth and their families

AUDIENCE

Emergency room personnel and after-care service providers.

A prior suicide attempt is the strongest predictor of a future attempt

RATIONALE AND EFFICACY

One of the strongest predictors of a future suicide attempt is a past attempt.[73] Follow-up studies have found that 31% to 50% of youth whose suicide attempts are serious enough to warrant medical care will make another attempt. As many as 11% will eventually take their own lives.[74, 75] Studies show that psychiatric intervention can have a positive effect in reducing subsequent attempts.[76] Yet, approximately half of all adolescents seen for suicidal behavior receive no mental health intervention after their emergency room visit, and of those who do receive follow-up, as many as 75% do not adhere to the recommended treatment.[75] Appropriate medical care and after-care for suicide attempters is important for preventing future attempts in this highly vulnerable population.

A specialized emergency room program for adolescent attempters has demonstrated increased adherence to treatment after-care.[77] In addition, a brief family therapy model has shown promise in reducing overall symptom levels in youth suicide attempters, but research following them over time is needed to evaluate the effectiveness of the model.[77, 78]

IMPLEMENTATION CONSIDERATIONS

Involvement of medical personnel, especially emergency room and critical care providers, is vital to the implementation of this strategy.

Model programs may need to be adapted for specific emergency room/critical care settings and staffing patterns to work in ways that do not compromise the program's demonstrated effectiveness.

SAMPLE IMPLEMENTATION ACTIVITIES

- Involve hospital personnel and critical care providers in community efforts to prevent youth suicide.
- Assess the number and frequency of youth in the community receiving medical care for suicide attempts.
- Assess emergency room and critical care provider protocols in responding to suicidal youth and the extent and nature of after-care provided to youth suicide attempters and their families.
- Work with medical providers in selecting appropriate emergency care protocols and after-care interventions.
- Facilitate the provision of training to emergency care and after-care service providers.

SECTION 3: MEASURING PROGRESS

Heightened community awareness about suicide can lead to a sense of urgency and a will to act. Tragic stories can win votes, can help get money appropriated to the cause, and can inspire volunteers to pour their heart and soul into prevention activities. But all that vigorous and heartfelt activity will be wasted unless it is harnessed to a program that works.

Plans for program evaluation should be part of any plan for the implementation of a suicide prevention program. The evaluation can help provide proof that the program is successful, and this is often important when looking to obtain financial or political support for the program. In addition, detecting the unintended effects of a program can lead to efforts to refine that program. Finally, documentation of how a program was implemented can also be useful to others if they choose to replicate a successful program.

In designing an evaluation plan it is often useful to explicitly and concretely specify the activities involved in the program, and the short-and long-term goals of the program. Once the activities and goals have been specified, at least two kinds of evaluation should be considered:

- Process evaluation: measuring the extent to which activities are implemented as planned
- Outcome evaluation: measuring the effectiveness of the program in achieving the program's stated outcomes.

The appendices to this plan contain information and tools that may be useful as you plan prevention activities and evaluation of those activities.

REFERENCES

[1] U.S. Public Health Service. The Surgeon General's Call to Action to Prevent Suicide. 1999. Washington, DC.

[2] Center for Health Statistics. Youth Suicide. Results from the 1999 YRBS. Oregon Health Trends, Number 57. Health Division, Oregon Department of Human Services. 2000. Portland, Oregon.

[3] Blumenthal S. Suicide: a guide to risk factors, assessment, and treatment of suicidal patients. Med Clin North Am 1988;72:937-71.

[4] Jenkins R. Principles of prevention. In: Paykel E, Jenkins R, eds. Prevention in Psychiatry. London: Gaskell,1994:11-24.

[5] Silverman, M, Felner R. Suicide prevention programs: issues of design, implementation, feasibility, and developmental appropriateness. Suicide Life Threat Behav 1995;25:92-103.

[6] Lewinsohn P, Rohde P, Seeley J. Psychosocial characteristics of adolescents with a history of suicide attempts. J Am Acad Child Adolesc Psychiatry. 1993;32(1):60-8.

[7] Governor's Task Force on Youth Suicide Prevention. Recommendations and Narrative Report. 1997. Salem, Oregon.

[8] COMPAS, Inc. Canadian Youth Mental Health & Illness Survey: Survey Overview, Interview Schedule and Demographic Crosstabulations. A COMPAS Survey Conducted for the Canadian Psychiatric Association. 1993. Ottawa, Ontario.

[9] University of Washington, School of Nursing. Washington State Youth Suicide Prevention Program. Report of Activities 1997-1999. 1999. Seattle, Washington.

[10] Center for Health Statistics. Oregon Vital Statistics Annual Report, 1997. Health Division, Oregon Department of Human Services. Portland, Oregon. 2000.

[11] Center for Health Statistics. Weapons, Schools, and Kids; What is the Risk? Oregon Health Trends, Number 54. Health Division. Oregon Department of Human Resources. 1999. Portland, Oregon.

[12] American Academy of Pediatrics. http://aap.org/policy/re9928.html http://aap.org/policy/ re9928.html

[13] Kruesi M, Grossman J, Pennington, J, et al. Suicide and violence prevention: parent education in the emergency department. J Am Acad Child Adolesc Psychiatry. 1999; 38:250-256.

[14] Berman A, Jobes D. Adolescent Suicide Assessment and Intervention. American Psychological Association. 1991. Washington, DC.

[15] Sloan J, Rivara F, Reay D, et al. Firearm regulations and rates of suicide-A comparison of two metropolitan areas. New England Journal of Medicine. 1990;322:369-373.

[16] Centers for Disease Control. Youth Suicide Prevention Program: A Resource Guide. 1992. Atlanta.

[17] Kalafat J, Elias M. Adolescents' experience with and response to suicidal peers. Suicide Life Threat Behav 1992 Fall;22(3):315-21.

[18] Spirito A, Overholser J, Ashworth S, et al. Evaluation of a suicide awareness curriculum for high school students. J Am Acad Child Adolesc Psychiatry 1988, Nov;27(6):705-11.

[19] Nelson F. Evaluation of youth suicide prevention program. Adolescence, 1987;20:813-825.

[20] Underwood M, Dunne-Maxim K. Managing Sudden Traumatic Loss in the Schools. New Jersey Adolescent Suicide Prevention Project. New Jersey State Department of Education, New Jersey State Department of Human Services, New Jersey State Department of Health & Senior Services, & UMDNJ - University Behavioral HealthCare. 1997. Piscataway, New Jersey.

[21] Kalafat J, Elias M. Suicide prevention in an educational context: broad and narrow foci. Suicide Life Threat Behav. 1995. Spring;25(1):123-33.

[22] Savin-Williams R. Verbal and physical abuse as stressors in the lives lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. Journal of Consulting and Clinical Psychology. 1994. 62(2):261-269.

[23] Garofalo R, Wolf C, Wissow L, et al. Sexual Orientation and Risk of Suicide Attempts Among a Representative Sample of Youth. Arch Pediatr Adolesc Med. 1999;153:487-493.

[24] Rigby K. Effects of peer victimization in schools and perceived social support on adolescent well being. J Adolesc, 2000 Feb;23(1):57-68.

[25] Center for Health Statistics. Suicidal Behavior. A Survey of Oregon High School Students, 1997. Health Division. Oregon Department of Human Services. 1998. Portland, Oregon.

[26] Gould M, Wallenstein S, Kleinman MH, et al. Suicide clusters: An examination of age-specific effects. American Journal of Public Health 1990;80:211-212.

[27] Phillips D, Carstensen L. Clustering of teenage suicides after television news stories about suicide. New England Journal of Medicine 1986;315:685-689.

[28] Schmidtke A, Hafner H. The Werther effect after television films: New evidence for an old hypothesis. Psychological Medicine, 1988;18:665-676.

[29] O'Carroll P, Potter L. Suicide contagion and the reporting of suicide: recommendations from a national workshop. MMWR. 1994. 43(RR-6):9-18.

[30] Emans S, Bravender T, Knight J, et al. Adolescent medicine training in pediatric residency programs: are we doing a good job? Pediatrics. 1988 Sep;102(3):588-95.

[31] Key J, Marsh L, Darden P. Adolescent medicine in pediatric practice: a survey of practice and training. Am J Med Sci. 1995 Geb;309(2):83-7.

[32] Bongar B, Harmatz M. Clinical psychology graduate education in the study of suicide: availability, resources, and importance. Suicide Life Threat Behav. 1991 Fall;21(3):231-44.

[33] Shaffer D, Garland A, Whittle R. An Evaluation of Three Youth Suicide Prevention Programs in New Jersey. New Jersey Adolescent Suicide Prevention Project: Final Project Report. New Jersey Department of Human Services: Governor's Advisory Council on Youth Suicide Prevention. 1988. Trenton, New Jersey.

[34] King K, Price J, Telljohann S, Wahl J. High school health teachers' perceived self-efficacy in identifying students at risk for suicide. J Sch Health. 1999 May;69(5):202-7.

[35] Barrett T. Youth in Crisis: Seeking Solutions to Self-Destructive Behavior. Longmont, Co. Sopris West, 1985.

[36] Ramsay R, Tanney B, Lang W. Suicide Intervention Handbook, Third Edition 1999. LivingWorks Education Inc. Calgary, AB, Canada.

[37] Quinnet P. QPR for Suicide Prevention. QPR Institute. 1995. Spokane, Washington.

[38] Alcohol, Drug Abuse and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide. 1989. Publication No.ADM 89-1621 US Government Printing Office. Washington, DC.

[39] Shaffer D, Craft L. Methods of Adolescent Suicide Prevention. J Clin Psychiatry. 1999;60(suppl2):70-74.

[40] Reynolds W. Suicide Ideation Questionnaire: A Professional Manual. 1988. Psychological Assessment Resources, Inc. Odessa, Florida.

[41] Bradley J, Rotheram-Borus M. Evaluation of Imminent Danger for Suicide: A Training Manual. 1990. National Resource Center for Youth Services. Tulsa, Oklahoma.

[42] Ramsay R, Tanney B, Tierney R, Lang W. Suicide intervention handbook. Living Works Education Inc. 1994. Calgary, AB, Canada.

[43] Eggert L, Thompson E, Herting J. A measure of adolescent potential for suicide (MAPS): Development and preliminary findings. Suicide & Life-threatening Behavior. 1994;24:359-381.

[44] Shaffer D, Wilcox H, Lucas C, et al. The development of screening instrument for teens at risk for suicide. Poster presented at the 1996 meeting of the Academy of Child and Adolescent Psychiatry. 1996. New York, NY.

[45] Shaffer D, Fisher P, Lucas C, et al. NIMH diagnostic interview schedule for children, version IV (NIMH DISC- IV). J Am Acad Child Adolesc Psychiatry. In Press.

[46] Gould M, Wallenstein S, Kleinman M, et al. Suicide clusters: An examination of age-specific effects. American Journal of Public Health. 1990;80:211-212.

[47] Neely K, Spitzer W. A model for a statewide critical incident stress debriefing program for emergency services personnel. Prehospital Disaster Med. 1997;Apr-Jun;12(2):114-9.

[48] Lenssen J. Personal Communication. Oregon Department of Education. 1998.

[49] Centers for Disease Control. CDC recommendations for a community plan for the prevention and containment of suicide clusters. MMWR. 1988;37(S-6):1-12.

[50] Ford C, Bearman P, Moody J. Foregone health care among adolescents. JAMA. 1999;282:2227-2234.

[51] Center for Child and Family Health. School-Based Health Centers in Oregon: Adolescents Report Their Needs, Use, Behaviors & Attitudes. Health Division. Oregon Department of Human Services. 1996. Portland, Oregon.

[52] Flisher A, Kramer R, Grosser R, et al. Correlates of unmet need for mental health services by children and adolescents. Psychol Med. 1997. Sep;27(5):1145-54.

[53] US Public Health Service. Mental Health: A Report of the Surgeon General. 2000. Washington, DC.

[54] Lewinsohn, P, Hops H, Roberts R, et al. Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in high school students. Journal of Abnormal Psychology. 1993;102(1):133-144.

[55] Zimmer-Gembeck M, Alexander T, Nystrom R. Adolescents report their need for and use of health care services. Journal of Adolescent Health. 1997;21:388-399.

[56] Gould M, King R, Greenwald S, et al. Psychopathology associated with suicidal ideation and attempts among children and adolescents. J Am Acad Child Adolesc Psychiatry. 1998;37(9):915-23.

[57] Shaffer D, Gould M, Fisher P, et al. Psychiatric diagnosis in child and adolescent suicide. Arch Gen Psychiatry. 1996;53(4):339-48.

[58] Washington State Department of Health. Washington State Injury Prevention Program. Youth Suicide Prevention Plan for Washington State. 1995. Olympia, Washington.

[59] Puskar K, Hoover C, Miewald C. Suicidal and non suicidal coping methods of adolescents. Perspectives in Psychiatric Care. 1992;28(2):15-20.

[60] Sadowski C, Kelley M. Social problem solving in suicidal adolescents. J Consult Clin Psychol. 1993. 61(1)121-7.

[61] Eggert L, Thompson, E, Herting J, Nicholas, L. Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. Suicide and Life-Threatening Behavior. 1995;25:276-296.

[62] Brent D, Perper J, Moritz G, et al. Stressful life events and adolescent suicide: A case control study. Suicide & Life-Threatening Behavior. 1993;23(3):179-189.

[63] Shaffer D, Philips I, Garland A, Bacon K. Prevention issues in youth suicide. In D Shaffer, I Philips & N Enzer. eds. Prevention of Mental Disorders, Alcohol and Other Drug Use in Children and Adolescents. pp. 373-412. OSAP Prevention Monograph-2, US Dept of Health and Human Services. Washington, DC. US Government Printing Office.

[64] Lewinsohn P, Clarke G, Hops H, Andrews J. Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy. 1990;21(4):385-401.

[65] Clum G, Priester M, Weaver T, et al. Group decision-making and group support treatments for chronic suicide ideation. Paper presented at the meeting of the American Association of Suicidology Conference. 1993 San Francisco, California.

[66] Pfeffer C. Family characteristics and support systems as risk factors for youth suicidal behavior. In L Davidson & M Linnoila, eds. Risk Factors for Youth Suicide (pp.55-71). New York, NY: Hemisphere.

[67] Center for Health Statistics. Oregon Vital Statistics County Data 1998. Health Division. Oregon Department of Human Services. 2000. Portland, Oregon.

[68] American Foundation for Suicide Prevention. Survivor's of Suicide Information Guide. 1999. New York, NY.

[69] Suicide Information & Education Centre. SIEC Alert. 1999;38. http://www.siec.ca http://www.siec.ca Calgary, Alberta.

[70] Brent D, Perper J, Mortiz G, et al. Psychiatric sequelae to the loss of an adolescent peer to suicide. J Am Acad Child Adolesc Psychiatry. 1993;32(3):509-17.

[71] Sandor M, Walker L, Sands D. Competence-building in adolescents, Part II: Community intervention for survivors of peer suicide. Issues Compr Pediatr Nurs. 1994;17(4):197-209.

[72] Constantino R, Bricker P. Nursing postvention for spousal survivors of suicide. Issues Ment Health Nurs. 1996;17(2):131-52.

[73] Lewinsohn P, Rohde P, Seeley J. Psychosocial risk factors for future adolescent suicide attempts. J Consult Clin Psychol. 1994;62(2):297-305.

[74] Shaffer D, Piacentini J. Suicide and attempted suicide. In: Rutter M, Taylor E, eds. Child Psychiatry-Modern Approaches. 3rd ed. Oxford: Blackwell Scientific, 1993, in press.

[75] Spirito A, Brown L, Overholser J, Fritz G. Attempted suicide in adolescence: a review and critique of the literature. Clin Psych Rev. 1989;9:335-63.

[76] Shaffer D, Piacentini J. Suicide and attempted suicide. In: Rutter M, Taylor E, eds. Child Psychiatry-Modern Approaches. 3rd ed. Oxford: Blackwell Scientific. 1993.

[77] Rotheram-Borus M, Piacentini J, Van Rossem R, et al. Enhancing treatment adherence with a specialized emergency room program for adolescent suicide attempters. J Am Acad Child Adolesc Psychiatry. 1996;35:5.

[78] Piacentini J, Rotheram-Borus M, Cantwell C. Brief cognitive-behavioral family therapy for suicidal adolescents. In L VandeCreek, S Knapp & T Jackson, eds. Innovations in Clinical Practice: A Sourcebook. Vol 14, pp 151-168. Professional Resource Press. 1995. Sarasota, Florida.

APPENDIX A: THE EPIDEMIOLOGY OF YOUTH SUICIDE IN OREGON

In order to develop and focus prevention strategies, it is essential to understand who is at risk, and when and where suicide occurs. This is a summary of what is known about the epidemiology of suicide and suicide attempts among Oregon youth aged 10 to 24.

SUICIDE DEATHS

Data Source and Limitations

This section summarizes information gathered from death certificates. In order to classify a death as a suicide, medical examiners must be aware of specific evidence that the decedent attempted to kill himself or herself. Such evidence might include a suicide note, a recent period of depression, or a prior suicide attempt or threat. Because of this requirement, the number of deaths classified as suicides on death certificates is almost certainly an underestimate.

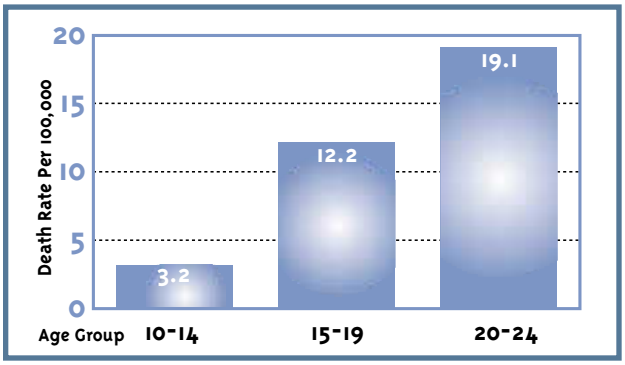
Overall Rates

Approximately 75 Oregon youth aged 10 to 24 commit suicide each year, making it the second leading cause of death for Oregonians in that age group. Oregon's 1997 suicide rate of 9.81 per 100,000 among youth aged 10 to 24 ranked 17th among states.

Age

The highest rate of suicide among youth occurs in those aged 20 to 24 (Figure1). Although the rate among youth aged 10 to 14 is low, national statistics show that from 1980 to 1992, this rate increased 120% from 0.8 to 1.7 per 100,000.[1]

Figure 1: Suicide Death Rates Among Youth Aged 10-24 Oregon, 1994-1998



Source: Oregon Death Certificates

Race

White youth account for the largest number of youth suicides in Oregon: 62 suicide deaths in 1998, representing 94% of total suicide deaths, at 9.1 deaths per 100,000 white population. Since the majority of Oregon's population is white, it is necessary to look at multiple years of data to make comparisons by race. From 1994 to 1998, suicide rates were highest among American Indian youth, and almost three times higher than for white youth: 15 deaths from 1994 to 1998, 4% of total suicide deaths, 24.5 deaths per 100,000 American Indian population. During this same time period, the figures for African American youth were: 10 suicide deaths, 3% of total youth suicide deaths, 12.3 deaths per 100,000 African American population. Asian youth manifested a significantly lower risk for suicide:[6] suicide deaths, 1% of total suicide deaths, 4.7 deaths per 100,000 Asian population.

Gender

In 1998, male youth were seven times more likely to commit suicide than female youth (11.0 per 100,000 vs. 1.6 per 100,000).

Method of Suicide

Firearms are the leading method of suicide. From 1994 to 1998, firearms were used in 64% of Oregon youth suicides. Self-hanging was the second most common method (21%).

SUICIDE ATTEMPTS

Data Sources and Their Limitations

The information in this section is based on data from Oregon's Adolescent Suicide Attempt Registry, Youth Risk Behavior Survey, and Hospital Discharge Index.

Emergency room personnel are required by law to report suicide attempts by adolescents to the Oregon Health Division, and these reports are compiled into the Adolescent Suicide Attempt Registry. Note, however, that the registry records only attempts by youth aged 0 to 17, and does not include any attempts that do not result in a visit to an emergency room..

Additional data on youth suicide attempts is available from the Youth Risk Behavior Survey (YRBS), which is administered each year to a sample of Oregon middle and high school students. A strength of this survey is that it collects information by self-report of students, so it includes all suicide attempts whether or not they resulted in a visit to a health care provider. However, as with suicides included in the Adolescent Suicide Attempt Registry, these data also are limited to middle school and high school students.

The Hospital Discharge Index is a compilation of billing records from Oregon inpatient and psychiatric hospitals. This data source includes suicide attempts by patients of all ages, and attempts that do not result in a hospitalization are not included.

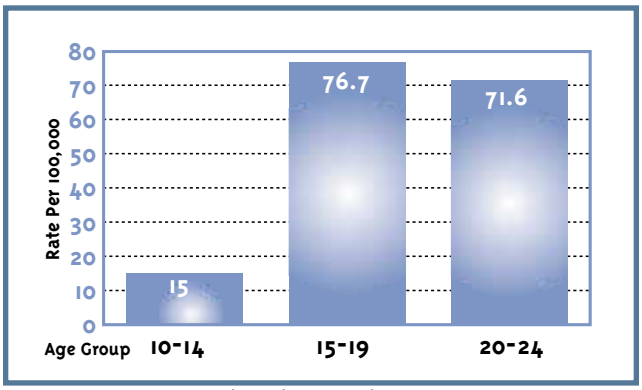
Overall Rates of Suicide Attempts

In 1998, a total of 761 suicide attempts were reported to the ER attempt registry. Among Oregon youth under age 18, approximately 44 attempts were reported to the registry for every death. Also in 1998, 366 youth aged 10 to 24 were hospitalized for suicide attempts.

Age

The highest rate of hospitalization for a youth suicide attempt occurred among those aged 15 to 19 (76.7 per 100,000) (see Figure 2).

Figure 2: Youth Suicide Attempts by Age Group Oregon, 1998

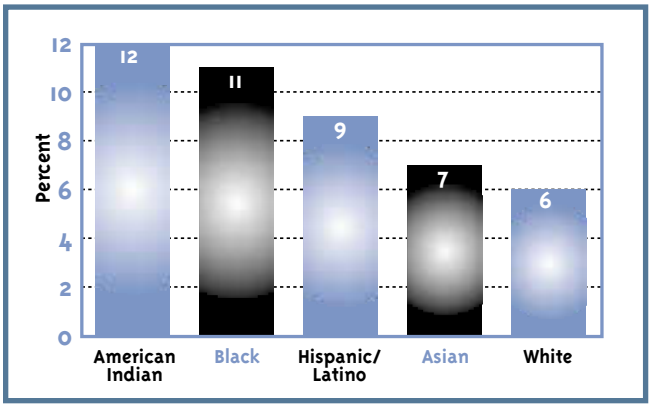


Source: Oregon Hospital Discharge Index

Race

Race information on suicide attempters is obtained from the adolescent suicide attempt registry (attempters under 18) and the YRBS. The 1998 registry reported the highest rate for American Indian youth under 18, at 103.2 per 100,000, followed by white youth at 100.6 per 100,000 and African American youth at 75.4 per 100,000. Asian youth had a lower rate of suicide attempts at 43.0 per 100,000. The YRBS also reported the highest prevalence of suicide attempts in American Indian students (Figure 3).

Figure 3: Percentage of Students Who Reported a Suicide Attempt in Previous year by Race/Ethnicity, Oregon, 1999



Source: Youth Risk Behavior Survey

Gender

Among adolescents (i.e., under 18) whose attempts led to an emergency room visit, females were 3.2 times more likely to attempt suicide than males (142.7 attempts per 100,000 females vs. 45.0 attempts per 100,000 males). This is a dramatic contrast to the predominance of males in deaths due to suicide.

Method of Suicide

Among youth whose attempt led to hospitalization, the most common was ingestion of drugs (94%). This is a dramatic contrast to the predominance of firearm use in completed suicides. Cutting or piercing injuries (3%), suffocation/strangulation (1%), and firearms (0.5%) were the next most common methods for this age group.

Risk Factors

In order to target prevention efforts, it is essential to understand what populations are most at risk and the characteristics of high-risk groups. Research data indicate that there are factors common to those who commit suicide and those who attempt suicide. The following table outlines some of the risk factors associated with youth suicide. The magnitude of the increased risk and the estimated prevalence of a particular risk factor vary from study to study; the elevated risk and the number of individuals with the factors might therefore be presented as a range. Through the identification of high-risk groups and the estimated size of a group with the particular characteristic, interventions can be more efficiently focused.

TABLE 1: RISK FACTORS FOR SUICIDAL BEHAVIOR

Risk Factor	Relative Risk	Estimated Population with Risk Factor in Oregon
Prior Attempt[2]	1.5-14.0	13,500-68,000
Past Depression[3]	3.4	30,500-34,000[4]
Major Depression[2]	11.9	20,000
Poly-Substance Abuse[3]	2.8-5.3	81,000[5]
Alcoholism[3]	5.3	210,000[6]
Drug Abuse[2]	14.8	156,000[6]
Family Hx of Suicide[7]	3.9-7.0	30,500[3]
Incarceration[8]	4.8	2,800[9]
Access to firearm[10]	4.8	40,000[11]
Homelessness[12]	2.8	34,000[13]

Suicidal Ideation and Previous Suicide Attempts

Sixteen percent of high school students surveyed in the 1999 Oregon YRBS reported "seriously considering suicide," 6% reported an attempt in the last 12 months, and 2% reported an attempt in the last six months that resulted in an injury requiring medical attention. Suicidal ideation appears to be a common experience among adolescents. Some risk factors may differentiate those who only contemplate suicide from those who proceed to actually attempting suicide. It is estimated that between 7% and 16% of adolescents and young adults (aged 10 to 24) have attempted suicide.[2] A previous suicide attempt has been identified as the most strongly associated risk factor for completing a suicide.[2] In 1998, one out of every three Oregon youth suicide attempters requiring an ER visit, (youth under 18) had made a prior attempt in the last 5 years. These facts support the need for appropriate follow-up care after a suicide attempt.

Major Depression and Other Mental Health Issues

A history of depression, mood disorder, or other mental health diagnosis is common in individuals who commit suicide. In fact, studies estimate that 90% of youth who commit suicide have at least one major psychiatric disorder.[2,4]

Substance Abuse

Substance abuse increases the risk both for suicide and attempts in youth. Studies indicate that approximately one-third of youth who commit suicide were under the influence at the time of their death.[7] Cross sectional studies using the Youth Risk Behavior Survey have observed that suicidal behavior often coexists with substance abuse.

History of Physical or Sexual Abuse

Thirteen percent of all Oregon high school students who took the 1999 YRBS said they had been purposely hit, kicked, or slapped by an adult family member in the last year. Six percent reported forced sexual intercourse, and 18% reported unwanted sexual touching. These youth were several times more likely to have made a suicide attempt than those students who did not report being abused.[14]

Incarceration

Suicide is the leading cause of death in jails and lock-up facilities. In Oregon juvenile detention facilities, 32% of the incarcerated youth reported a prior suicide attempt, compared to 9% of Oregon high school students.[9] In 1997-1998, there was a cluster of three suicides in an Oregon juvenile correction facility.

Homelessness

Researchers have noted that homeless youth are at much greater risk of suicide than their domiciled peers. Studies of homeless youth in large urban areas found that 41% of their samples had considered suicide, and more than 25% had attempted suicide.[15] Greenblat found that almost half of homeless youth aged 13 to 17 had attempted suicide.[16] Ringwalt studied "throwaway" youth who were specifically told to leave home and found this sub-population to be at higher risk for suicidal behavior than homeless youth who were not told to leave home.[13]

Sexual Orientation

In an analysis of five studies involving representative samples of U.S. high school students Remafedi found higher rates of attempted suicide among homosexual youths compared to their heterosexual peers.[17] This higher risk has been shown to be significant, with homosexual youth ranging from 3.4 to 13.9 times more likely than heterosexual youth to engage in suicide attempts.[18,19] Safren and Heimberg found that gay, lesbian, and bisexual adolescents reported greater depression, hopelessness, and past and present suicide ideation than did heterosexual adolescents.[20] When accounting for other predictor variables, they concluded that environmental factors play a major role in predicting distress in this population.

Accessible Firearms

Firearms in the home, whether locked up or not, whether loaded or not, is associated with a higher risk for adolescent suicide, even after controlling for other psychological risk factors.[21] According to the 1999 Oregon YRBS, students who reported a suicide attempt in the last year were twice as likely to report carrying firearms.[22]

Multiple Risk Factors and Protective Factors

Research shows that the probability of adolescents having made a suicide attempt increases dramatically as a function of the number of risk factors they possess.[23] Nevertheless, it is the accumulation of risk factors and the absence of protective factors in a young person's life, rather than membership in or identification with a particular high-risk group, that increases the risk for suicidal behavior.[12] Results of the 1999 Oregon Youth Risk Behavior Survey indicate that as the number of environmental and behavioral risk factors increase, individuals are more likely to report a suicide attempt.[14]

DATA COLLECTION NEEDS

Death Scene Investigations and Manner of Death

Death by suicide is underreported, especially among youth, and the true prevalence of suicide attempts is unknown at this time. Law enforcement and medical examiner investigations of youth suicide often involve only immediate family members. However, relatives, friends, and adults who knew the deceased often have information that is not known to immediate family members. Improved investigations of youth suicide can improve the ability of local communities to evaluate how their systems of care respond to youth and families in crisis, and can assist them in developing community suicide prevention plans. Improved investigations would include an effort to correctly identify not just the mechanism of death (e.g., a firearm or ligature), but to determine a precipitating event, known factors that contributed to the death, and the underlying risk factor or reason the suicide occurred.

An additional benefit of n in depth investigation is the connection of bereaved families and friends to support services. Research indicates that those who have lost a loved one to suicide are at increased risk for suicide themselves. Complicated grief can also lead to depression that may need clinical care.

Suicide Attempt Registry

Little is known about the difference between attempters and suicide completers. Research into post-treatment follow-up care in emergency rooms is needed to better understand the differences between successful interventions and those that fail.

Accurate, comprehensive data are critical to the development, implementation, and evaluation of effective prevention strategies. In order to evaluate if prevention efforts begun at age 16 carry through into adulthood, it will be necessary to track health data across time. Such data are needed for tracking the rate of attempts in each age group as time passes. Expanding the age range for data collection to all attempters would assist in defining the magnitude of the problem and in evaluating activities to prevent suicide. Without expanded attempt data on young adults and adults as they age, it will not be possible to evaluate if efforts begun in adolescence continue to bring results later on.

Survey Work on Risk Behaviors

School participation in the risk behavior survey is necessary to accomplish the goal of creating a representative sample of Oregon youth in high school and middle school. Accurate, comprehensive data are critical to the development, implementation, and evaluation of effective prevention strategies. Data from this survey can provide communities with a rich source of information to use in community planning efforts to best determine use of resources.

REFERENCES

[1] Centers for Disease Control. Injury Mortality Statistics.

http://webapp.cdc.gov/sasweb/ncipc/mortrate.html. National Center for Injury Prevention and Control.

[2] Brent D. Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, Family environmental factors and life stress. Suicide and Life Threatening Behavior. 1995;25;Supp: 52-63.

[3] Brent D, Perper J, Moritz G, Liotus L, et al. Familial risk factors for adolescent suicide: a case-control study. Acta Pyschiatr Scand. 1994;89:52-58.

[4] Lewinsohn P, Hops H, Roberts R, Seely J, Andrews, J. Adolescent psychopathology: 1.prevalence and incidence of depression and other DSM-III-R Disorders in high school students. J of Abnormal Psychology. 1993;102(1):133-144.

[5] 1998 Oregon Public School Drug Use Survey. Office of Drug and Alcohol Abuse Programs. Oregon Department of Education. Salem, Oregon.

[6] Center for Health Statistics. Oregon Youth Risk Behavior Survey, 1997. Health Division. Oregon Department of Human Services. 1998. Portland, Oregon.

[7] Garland A, Zigler E. Adolescent suicide prevention; Current research and social policy implications. American Psychologist. 1993;48(2):169-182.

[8] Memory J. Juvenile suicides in secure detention facilities: Correction of published rates. Death Studies. 1998;13:455-463.

[9] Oregon juvenial inmate population, 1996. Oregon Criminal Justice DIvision

[10] Kellerman A, et al. Suicide in the home in relation to gun ownership. N Eng J Med. 1992;327: 467-472.

[11] Center for Health Statistics. Oregon Behavioral Risk Factor Surveillance System, 1997. Health Division, Oregon Department of Human Resources.

[12] Yoder K. Comparing suicide attempters, suicide ideators, and nonsuicidal homeless and runaway adolescents. Suicide and Life-Threatening Behavior. 1999, 29(1): 25-36.

[13] Ringwalt C, Greene J, Robertson M, McPheeters M. The prevalence of homelessness among adolescents in the United States. Am J Public Health. 1998;88(9):1325-9.

[14] Center for Health Statistics. Youth Suicide. Results from the 1999 YRBS. Oregon Health Trends, Number 57. Health Division. Oregon Department of Human Services. 2000. Portland, Oregon.

[15] Feitel B, Margetson N, Chamas J, Lipman C. Psychosocial background and behavioral and emotional disorders of homeless and runaway youth. Hosp Community Psychiatry. 1992; Feb;43(2):155-9.

[16] Greenblat M, Robertson M. Life styles, adaptive strategies, and sexual behaviors of homeless adolescents. Hosp Community Psychiatry. 1993; 44(12): 1177-80.

[17] Remafedi G. Sexual orientation and youth suicide. JAMA. 1999;282(13):1291-2.

[18] Garofalo R, Wolf R, Kessel S, et al. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. Pediatrics 1998;101(5):895-902.

[19] Bagley C, Tremblay P. Suicidal behaviors in homosexual and bisexual males. Crisis. 1997; 18(1), 24-34.

[20] Safren S, Heimberg R. Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. J Consult Clin Psychol. 1999;67(6):859-66.

[21] Bell C, Clark D. Adolescent suicide. Pedia Clinic Nor Amer. 1998;45(2):365-380.

[22] Center for Health Statistics. A Potential for Violent Injury. Oregon Health Trends, Number 56. Health Division. Oregon Department of Human Services. June 2000. Portland, Oregon.

[23] Lewinsohn P, Rohde P, Seeley J. Psychosocial characteristics of adolescents with a history of suicide attempt. J Am Acad Child Adolesc Psychiatry. 1993;32(1):60-8.

APPENDIX B: STATE AND LOCAL COMMUNITY DATA SOURCES ON RISK/PROTECTIVE FACTORS

Data can assist in the selection and implementation of local suicide prevention activities and assessment of their impact on local youth. Community-wide issues that impact the quality of life, such as poverty, crime, discrimination, limited access to services, and isolation, are also important considerations in planning for local suicide prevention efforts. The following data sources provide information on morbidity, mortality, and risk and protective factors among Oregon youth.

The Youth Risk Behavior Survey. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1997.

Suicidal Behavior, A Survey of Oregon High School Students, 1997. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1998.

Youth Suicide, Results from the 1999 YRBS. Center for Health Statistics, Health Division, Oregon Department of Human Services. 2000.

Weapons and Oregon Teens: What is the Risk? Center for Health Statistics, Health Division, Oregon Department of Human Services. 1999.

Oregon Child Fatality Review Team First Annual Report. Center for Child and Family Health, Health Division, Oregon Department of Human Services. 1998.

Child Death in Oregon, 1998; Oregon Child Fatality Review Report. Center for Disease Prevention and Epidemiology, Health Division, Oregon Department of Human Services. 1999.

Oregon Vital Statistics County Data Report, 1998. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1999.

Multi cultural Health: Mortality Patterns by Race and Ethnicity, Oregon, 1986-1994. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1997.

Suicide and Suicidal Thoughts by Oregonians. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1997.

Oregon Vital Statistics Annual Report, Volume 2. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1997.

County Profile of Risk/Protective Factors, Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Services. 1997.

The Status of Children in Oregon's Child Protection System. State Office for Services to Children and Families, Oregon Department of Human Services. 1999.

The Oregon Public School Drug Use Survey. Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Services.

Status of Oregon's Children, 1999 County Data Book. Children First for Oregon. 1999.

Websites

Health Division reports: www.ohd.hr.state.or.us/cgi/publish.cgi
Office of Alcohol and Drug Abuse County Data Books: www.oadap.hr.state.or.us/2000db.html
Office of Services to Children and Families reports: www.scf.hr.state.or.us/abusereports.htm
Office of Mental Health Services reports: www.omhs.mhd.hr.state.or.us/dataonline/reports.cfm
Oregon Department of Education: www.ode.state.or.us/stats/

APPENDIX C: COMMUNITY ASSESSMENT

Communities are in the best position to assess local needs and resources, identify gaps, and make decisions about suicide prevention activities. The following questions can be used to identify local resources and to assess the gaps in services that should be addressed.

What **public education** has occurred in the community to increase awareness of youth suicide warning signs, intervention approaches, and local resources for help?

Do youth and young adults in and out of school receive any **suicide prevention education** in school and community settings? If so, when, where, what?

What percentage of community members understand **the role of firearms** in youth suicide? What percentage of community members own firearms? What percentage of community members store them safely?

Have all schools and school districts in the community created and implemented a **safe schools plan** that protects students from harassment and violence through the establishment and enforcement of school norms of tolerance and mutual respect?

Have the local **media** been educated about the appropriate reporting of suicide? If so, who, by whom, when, what education?

Is training on suicide awareness, prevention, and intervention provided to **educate professionals** who work with youth and families? If so, who, what, when?

How many community members are trained in youth suicide intervention skills **(gatekeeper training)** and prepared to intervene with youth at high risk for suicidal behavior?

Is there any kind of identification, **screening,** and referral of high-risk youth for suicidal ideation or behavior? Where is this done? Who does the screening? What screening tools are used? Where are the youth referred? What is the community's capacity for serving referred youth (hospitals, schools, mental health centers, private mental health practitioners, doctors, etc.)?

How do youth and young adults get information about access to the community 24-hour **crisis line?** How is the crisis line accessed? What is the response time? hours of operation? gaps in service?

Are **crisis service providers** in the community trained in suicide prevention? Are they integrated into community-wide suicide prevention efforts? Do crisis services meet American Association of Suicidology certification?

Does your community have a **crisis response team** with school and community professionals that coordinates the utilization of local resources in response to youth suicide? If so, what is the membership of this team?

Are individuals or groups working to increase **access to behavioral health care** services in your community? If so, who are they? If not, who may be interested? Are schools amd providers linked?

Are there any **skill building support groups** available to identified high-risk youth in school and community settings? If so, where, when, who supports?

Is there an organized network of **survivors of suicide** that provides support to those who lose a loved one or friend to suicide? Who are the network representatives and how are they contacted?

Is your community aware of the **sources of data** on youth risk behaviors, suicide attempts, and completions? Are these data used to understand and plan for reducing youth risk behaviors and increasing protective factors?

How do local **emergency rooms** respond to youth suicide attempts? Are referrals made, and what kind of follow-up is provided? Are ERs reporting attempts to Health Division?

APPENDIX D: PROJECT MANAGEMENT TOOL

Goal Statement: Reduce morbidity and mortality due to suicide among youth in Curry County, Oregon.

Strategy	Audience	Activities	Indicators	Monitoring Methods	Lead Person	Complete Date
#1 Public Education Campaign	All residents of Curry County	Secure PSAs to use in television, radio, & print media	Copies of PSAs obtained locally	Review Materials & document	Jane	February oo
		Secure agreements to broadcast & print media	Agreements with local editors & run dates & times	Announcement of agreements	Mark	March oo
		Work with print media to develop feature articles on adolescent depression & suicide	Draft copies of articles	Collect copies of feature articles published	June	April oo

Goal Statement: Reduce morbidity and mortality due to suicide among youth in _____Oregon.

Strategy	Audience	Activities	Indicators	Monitoring Methods	Lead Person	Complete Date

APPENDIX E: THE INTERVENTION DECISION MATRIX

Intervention	**Option 1**	**Option 2**	**Option 3**
Provide youth with crisis line number	Develop, print & distribute 2000 wallet cards	Develop, print & post posters	Develop, print & distribute brochures
Effectiveness	High...kids will carry small card in wallets but should laminate with plastic	Moderate, they won't have number with them	Low, kids won't read and carry
Feasibility	High	Moderate as design costs are high	High
Affordability	Moderate with plastic cost	High	Moderate
Sustainability	Moderate with changes in number	Moderate	Moderate with changes in number
Political Acceptability	High	High	Low
Unintended Consequences	Not sure	Not sure	Not sure
Final Priority (high, medium, low)	High to Moderate	Moderate to High	Moderate to Low

THE INTERVENTION DECISION MATRIX

Intervention	**Option 1**	**Option 2**	**Option 3**
Effectiveness			
Feasibility			
Affordability			
Sustainability			
Political Acceptability			
Unintended Consequences			
Final Priority (high, medium, low)			

Compare options ranking each cell as "high, medium or low" priority. Which option is strongest? Is there a cell that sinks the idea?

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

See step one and two.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

---

[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

State Behavioral Health Planning/Advisory Council

State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

The Addictions and Mental Health Planning and Advisory Council (AMHPAC) was developed in January 2013 and is a fully integrated advisory council. AMHPAC has specific duties as required by the Mental Health Services Block Grant. These duties are:

1. Provide input on the State Plan for Behavioral Health Services (Block Grant application) by monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state.
2. Advocate for children, youth, young adults, adults and older adults experiencing behavioral health disorders
3. Assess the adequacy and allocation of behavioral health services at least annually.

AMHPAC brings together a wide array of stakeholders to create a cross-system advisory council – the first of its kind in Oregon. AMHPAC consist of 45 members, each of whom serves on one of the subcommittees[1]. AMHPAC consists of the following seats:

- One representative of the OHA Division of Medical Assistance Programs
- One representative of the OHA Public Health Division
- One representative of the Department of Human Services (DHS) Child Welfare
- One representative of DHS Aging and People with Disabilities
- One representative of DHS Vocational Rehabilitation
- One representative of the Psychiatric Security Review Board
- One representative of the Department of Corrections
- One representative of the Oregon Youth Authority
- One representative of the Oregon Department of Education
- One representative of Oregon Housing and Community Services
- One representative of a Federally Recognized Tribe
- One representative of the Children's System Advisory Committee
- One representative of the Oregon Consumer Advisory Council
- Two Coordinated Care Organizations[2] (one rural, one urban)
- Two mental health service providers (one rural, one urban)
- Two substance use disorder treatment service providers (one rural, one urban)

[1] Subcommittees may have additional members who do not serve on AMHPAC.

[2] cco.health.oregon.gov

- Two substance use prevention services providers (one rural, one urban)
- One problem gambling treatment service provider
- One problem gambling prevention services provider
- Four advocates
- Two adults who have experienced serious mental illness
- Two adults in recovery from a substance use disorder
- Two adults in recovery from problem gambling
- One military representative
- One consumer veteran representative
- Two young adults in transition who have experienced a behavioral health disorder
- Four family members of children who experience serious emotional disorders
- Two family members of youth with a substance use disorder
- Two family members of adults with a behavioral health disorder

AMHPAC has representation not only across stakeholder groups, but also geographically. AMHPAC is committed to ensuring diversity on the Council, and actively recruits members of diverse racial, ethnic, and cultural groups including LGBTQ and young adults in transition. AMHPAC's membership represents the continuum of care for community-based behavioral health services, across the lifespan, and across the state. The membership of each subcommittee mirrors that of the full Council in that it represents the spectrum of behavioral health services (mental health, substance abuse prevention and treatment, and problem gambling services) across the lifespan. Additionally, AMHPAC's membership consists of 42 percent state agency or service provider representatives; well below the federal maximum[3] of 49 percent.

With such a large and diverse membership, the work of the Council will be done through its subcommittees with the Full Council developing priority areas for each subcommittee to focus on. The subcommittees are able to identify additional areas to address within their respective scopes. For more information on AMHPAC and its subcommittees, please visit http://www.oregon.gov/oha/amh/Pages/amhpac.aspx.

AMHPAC has been provided with regular updates on the progress of the Block Grant application. Draft content specific to AMHPAC subcommittees was sent to subcommittees for review and comment in May 2105. These specific content areas included Recovery Support Services, Community Living and Olmstead, Trauma, Suicide Prevention and Medication Assisted Treatment. Comments received at that time were reviewed by Block Grant writing staff and incorporated into the Block Grant application.

[3] Per Mental Health Block Grant federal regulations

On August 10, 2015, a webinar was held to review the Block Grant requirements and AMHPAC Public Comment period. Comments received during that Public Comment period will be reviewed by the Block Grant writing team and incorporated in to the application as appropriate.

AMHPAC was awarded Strategic Planning Technical Assistance in 2015. One of the priorities identified for the strategic plan includes establishing a dashboard, which will be developed using the Block Grant indicators included in this application. OHA staff will work with AMHPAC to identify which indicators will be included in the dashboard. Health Analytics staff will create and distribute the dashboard to AMHPAC Full council on a quarterly basis. The dashboard will better prepare AMHPAC members to provide input on the Block Grant application and annual report and assist in review and evaluation of allocation of services.

Type of Membership	Number	Percentage of Total Membership
Total Membership	45	100%
Individuals in Recovery	7	16%
Family Members of Individuals in Recovery	5	11%
Parents of children with SED	2	4%
Vacancies (individual & family members)	6	13%
Others (Advocates who are not State employees or providers)	3	7%
Total Individuals in Recovery, Family Members and Others	23	51%
State Employees	8	18%
Providers	12	27%
Vacancies	2	4%
TOTAL State Employees & Providers	22	49%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	7	16%
Providers from Diverse Racial, Ethnic and LGBT Populations	2	4%
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	8	18%
Persons in recovery from or providing treatment for or advocating for substance abuse services	6	13%
Federally Recognized Tribal Representatives	1	2%
Youth/adolescent representative (or member from an organization serving young people)	6	13%

FABRICK Jackie

From: Debby Jones <debbyj@co.wasco.or.us>
Sent: Tuesday, August 18, 2015 10:41 AM
To: FABRICK Jackie
Subject: block grant

Jackie, thank you so much for your time on the phone today. It was very helpful and encouraging!

I have just a couple suggestions/questions on the block grant. Here you go and thank you so much for all the time and effort you have put into this!

- page 2 under Medicaid/Oregon Health Plan - 4th sentence - "health care" do CCO's provide health care or just coverage
-
- page 12 under Mental Health First Aid - add that Youth Mental Health First Aid has also been a priority (there is a youth and an adult curriculum)
- page 37 under Adolescent Depression Screening - what is the substance use screening tool that is mentioned at the end of the first paragraph under this section
-
- page 73 second paragraph - is it appropriate to add promotion to the sentence ... "In addition, data are used by OHA to assess, plan, and implement state prevention and **promotion** policy and programs"
-
- page 74, second paragraph - may be there and just overlooked it ... LMHA's has that been listed out as to definition
-
- page 80, second paragraph under Medication Assisted Treatment, is there an opportunity to include Certified Prevention Specialist's or at least the prevention division by name as an identified partner
-
- page 82, adding possible wording of the great work Oregon is doing around ASQ and ASQ-SE screening
-
- page 100, second to last paragraph - has CANS been given a definition

Hope it's helpful. Thanks again!

Debby

Debby Jones,
Certified Prevention Specialist
YouthThink / Wasco County
541-506-2673

2016-2017 Combined Block Grant Application Feedback

Thank you for taking the time to review the Oregon Health Authority Addiction and Mental Health Division's draft policy topic areas for the Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

SAMHSA requests that any recommendations for modifications to the application or comments that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations.

This form provides an overview of each section and space for feedback. It is not necessary to submit written feedback and you may submit feedback anonymously; however, written comment is very helpful to the Block Grant writing team and providing your name and contact information allows the writing team to clarify any questions that may arise regarding feedback.

Please submit your written feedback, electronically to Jackie.Fabrick@state.or.us by close of business on May 29th.

Housing and Olmstead:

SAMHSA has identified the following areas that they consider critical to successful health care integration. SAMHSA has provided the following questions as a guide - it is not necessary to answer every question. Please review SAMHSA questions for considerations.

Community Living and the Implementation of Olmstead

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?
5. Is the state involved in a partnership with other state agencies to address community integration?

Please indicate areas of technical assistance needed related to this section.

Housing and Olmstead Feedback Form

1. Did the draft provide an overview of the specific content area?
   Yes.

2. Did the draft answer the majority of questions?
   Yes.

3. Any additional comments or feedback?
   Would add something regarding the new HUD Section 811 PRA Supprotive Housing for Persons with Disabilities program.
   Oregon Housing and Community Services (OHCS) in partnership with the Department of Human Services (DHS) and the Oregon Health Authority (OHA), submitted a grant application and successfully received a $2.3 million award for a new HUD 811 Project Rental Assistance (PRA) program.
   The purpose of this new program is to provide affordable housing for extremely low-income people with disabilities to keep them "from being institutionalized or possibly falling into homelessness". With this successful award, approximately 76 units of supportive housing will be able to serve individuals and households within which there is a member who has a severe and persistent mental illness, intellectual, and/or developmental disability with low incomes.
   May also be worthwhile to add a list of contractors of service (or at least state how many) under the Community Partners section. Currently have primarily the interdepartmental partners.

Your name:_____Robert Lee_____

Email: _____robert.lee@oregon.gov_____

Combined Block Grant Application Feedback 2016-2017

Thank you for taking the time to review the Oregon Health Authority Addiction and Mental Health Division's draft policy topic areas for the Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

SAMHSA requests that any recommendations for modifications to the application or comments that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations.

This form provides an overview of each section and space for feedback. It is not necessary to submit written feedback and you may submit feedback anonymously; however, written comment is very helpful to the Block Grant writing team and providing your name and contact information allows the writing team to clarify any questions that may arise regarding feedback.

Please submit your written feedback, electronically to Jackie.Fabrick@state.or.us by close of business on May 29th.

Recovery:

SAMHSA has identified the following areas that they consider critical to successful health care integration. SAMHSA has provided the following questions as a guide - it is not necessary to answer every question. Please review SAMHSA questions for considerations.

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative

and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Recovery Support Services Feedback Form

Recovery:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
   I don't see the definition of recovery included. SAMHSA has a definition and the RSS Subcommittee also created a definition based on SAMHSA's but modified a bit to meet the needs of the communities here in Oregon. There is evidence of hiring people in recovery in leadership roles and strategies are in place to use person-centered planning and recovery supports, etc. However, I don't see how the RFP for training on person-centered planning fits in with peer services. This is generally a strategy used by clinicians, care coordinators, etc.
2. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
   Yes to both. The Traditional Health Worker Commission meets the requirement for an accreditation/certification program.
3. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
   There isn't anything in the block grant section I received that indicates any empirical research has been done.
4. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
   This is indicated in the application; however, it's all very small scale and promotes fragmentation of peer delivered services. These efforts need to be taken to scale to have a substantial impact. There is far more support from the children's mental health system team within AMH for these type of activities than in AMH's team that addresses the adult mental health system. The children's mental health team seems to be far more organized around issues facing children and youth/young adults and working to actively address them.
5. Describe how the state is supporting the employment and educational needs of individuals served.

Supported Employment is discussed. There isn't any mention of supported education which is a critical component for transition age youth and also is a contributing factor to reduced recidivism for dually diagnosed adults re-entering the community from the corrections system.

Your name:____Ally Linfoot_____

Email: _____alinfoot@clackamas.us_____

2016-2017 Combined Block Grant Application Feedback

Overview:

Thank you for taking the time to review the Oregon Health Authority Addiction and Mental Health Division's draft policy topic areas for the Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

SAMHSA requests that any recommendations for modifications to the application or comments that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations.

This form provides an overview of each section and space for feedback. It is not necessary to submit written feedback and you may submit feedback anonymously; however, written comment is very helpful to the Block Grant writing team and providing your name and contact information allows the writing team to clarify any questions that may arise regarding feedback.

Please submit your written feedback, electronically to Jackie.Fabrick@state.or.us by close of business on May 29th.

Treatment:

SAMHSA has identified the following areas that they consider critical to successful health care integration. SAMHSA has provided the following questions as a guide - it is not necessary to answer every question. Please review SAMHSA questions for considerations

Trauma:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma- specific interventions?

Medication Assisted Treatment (MAT):

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Pregnant women and women with dependent children:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
3. How many programs serve pregnant women and their infants and/or dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

** Please indicate areas of technical assistance needed related to this section.*

Treatment Subcommittee Feedback- Fillable Form

Trauma:

1. Did the draft provide an overview of the specific content area?
   yes
2. Did the draft answer the majority of questions?
   Click here to enter text.
3. Any additional comments or feedback?
   The state needs to take leadership in the development of a culturally sensitive and aware workforce. Oregon used to have a process whereby 30-40 trainees participated in a "fast track" process toward certification. It would take little to reawaken this process. With a growing workforce of young, white, master's level, females, not in recovery…..we will end up facilitating the end of the people we need to help! This is ludicrous. Oregon's vulnerable should have ready access to services as well as a culturally responsive workforce. That's trauma informed care.
   I would volunteer my time to aid in this venture.

MAT:

1. Did the draft provide an overview of the specific content area?
   Click here to enter text.
2. Did the draft answer the majority of questions?
   Click here to enter text.
3. Any additional comments or feedback?
   Click here to enter text.

Pregnant women and women with dependent children:

1. Did the draft provide an overview of the specific content area?
   Click here to enter text.
2. Did the draft answer the majority of questions?
   Click here to enter text.
3. Any additional comments or feedback?
   Click here to enter text.

Your name:_____

Email: _____

OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority
500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

August 31, 2015

Kana Enomoto, Administrator
Substance Abuse and Mental
Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

RE: 2016/2017 Combined Block Grant Application

Dear Ms. Enomoto:

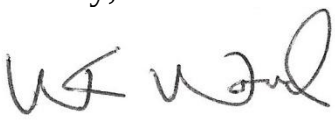
In accordance with the Block Grant federal regulations, the Addictions and Mental Health Planning and Advisory Council (AMHPAC), has reviewed both the block grant and the additional submitted comments. The AMHPAC council was provided with regular updates on the progress of the Block Grant application and implementation reporting federal revisions. Specific content regarding AMHPAC subcommittees was sent to the four council subcommittees for review and comment in May of this year. All comments received during the review period were reviewed by Block Grant writing staff and incorporated as needed into the Block Grant application. A webinar was also held to review the Block Grant requirements and to assist in gathering additional comments from the council and its associated subcommittees.

The AMHPAC council, established to address the newly combined federal block grant, since inception has met regularly every other month over the course of the last two plus years. In conjunction with the council meetings, the associated AMHPAC subcommittees have met every month or more often as needed. The council executive committee as well meets monthly with the subcommittee chairs and state support staff, also allotting additional time as needed. At the aforementioned meetings the fiscal block grant and state behavioral health needs

are discussed at length, leading to a robust and well-rounded consensus on the majority of issues affecting the state.

The executive committee chairs (current, past and incoming) commend the work of all the State of Oregon staff involved with the Block Grant, for working tirelessly and collaboratively with the council and subcommittees. This has not been the easiest of tasks with the ongoing changes within the state over the past two plus years and with the recent restructuring of the Oregon Health Authority (OHA). In closing this letter is to confirm that the AMHPAC council, executive committee and subcommittees fully support the current combined block grant application.

Sincerely,



Wes Wood (Incoming Chair)
Rodney Cook (Current chair)
Matthew Holland (Past Chair)

MH/mm

CC: Jackie Fabrick, OHA
File

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Robert E. Lee	State Employees	Oregon Housing and Community Services	725 Summer St NE, Suite B Salem, OR 97301 PH: 503-986-0983 FAX: 503-986-2020	robert.lee@state.or.us
Caroline Cruz	Federally Recognized Tribe Representatives	Confederated Tribes of Warm Springs	PO Box C Warm Springs, OR 97761 PH: 541-553-0497	caroline.cruz@wstribes.org
Jeremy Wells	State Employees	Oregon Department of Education	255 Capital St NE Salem, OR 97310-0203 PH: 503-947-5634	jeremy.wells@state.or.us
Chris Bouneff	Others (Not State employees or providers)	NAMI Oregon	4701 SE 24th Avenue, Suite E Portland, OR 97202 PH: 503-230-8009	chris@namior.org
Colin Dumont	Providers	Eastern Oregon Alcoholism Foundation	216 SW Hailey Pendleton, OR 97801 PH: 541-276-3518	cdumont@eoaf.org
Debby Jones	Providers	YOUTH:Think	4575 Basalt Street The Dalles, OR 97058 PH: 541-506-2673	debbyj@co.wasco.or.us
Helen Lara	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2421 Lancaster Dr NE Salem, OR 97305 PH: 503-566-2991	hlara@co.marion.or.us
Hilary Harrison	Parents of children with SED	Oregon Family Support Network	c/o ACIST Team, PO Box 579 Corvallis, OR 97339-0579 PH: 541-740-6306	hilary.ofsn@gmail.com
Jammie Farish	Parents of children with SED		9385 SE Hamilton Lane Happy Valley, OR 97086 PH: 503-855-4664	jammie.farish@gmail.com
Jay Wurscher	State Employees	Department of Human Services - Child Welfare	500 Summer Street NE Salem, OR 97301 PH: 503-945-6634	jay.m.wurscher@state.or.us
Kathryn Nunley	State Employees	Department of Human Services - Aging and People with Disabilities	500 Summer Street NE Salem, OR 97301 PH: 503-947-2309	kathryn.m.nunley@state.or.us
Lara Carranza	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	YouthMOVE Oregon	13039 Miller Rd NE Gervais, OR 97026 PH: 971-400-0889	lara@youthmoveoregon.com
Juliet Britton	State Employees	Psychiatric Security Review Board	620 SW 5th Avenue, Suite 907 Portland, OR 97204 PH: 503-229-5596	juliet.britton@psrb.org

Matthew Holland	Others (Not State employees or providers)	YouthMOVE Oregon	1356 Pressler Court S Salem, OR 97306 PH: 541-971-1657	mholland@co.linn.or.us
Paula Bauer	State Employees	Oregon Youth Authority	530 Center St NE Salem , OR 97301-3765 PH: 503-373-7528 FAX: 503-373-1511	paula.bauer@state.or.us
Ray Brown	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1720 W 25th Avenue Eugene, OR 97405 PH: 541-343-9706	raybr@reliefnursery.org
Rebecca Eichhorn	Family Members of Individuals in Recovery (to include family members of adults with SMI)		8515 Highway 47 Carlton, OR 97111 PH: 503-852-0056	eichhorn4@hotmail.com
Rodney Cook	Providers	Clackamas County Health, Housing and Human Services	Public Services Building, CYF, 2051 Kaen Road Oregon City, OR 97045 PH: 503-650-5677	rodc@co.clackamas.or.us
Ron Sipress	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 368 Medford, OR 97501 PH: 541-774-3636	ronsipress@gmail.com
Ruth Riskedahl	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		29500 SW Montebello Dr Wilsonville, OR 97070 PH: 503-505-3953	ruthriskedahl@yahoo.com
Joe Miller	State Employees	Department of Human Services - Vocational Rehabilitation	500 Summer Street NE, E-87 Salem, OR 97301 PH: 503-945-6375 FAX: 503-947-5010	JOSEPH.W.MILLER@state.or.us
Tim Murphy	Providers	Bridgeway Recovery Services	PO Box 17818 Salem, OR 97305 PH: 503-363-2021	tmurphy@bridgewayrecovery.com
Wes Wood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Voices of Problem Gambling Recovery	10128 SE Clatsop St Portland, OR 97266 PH: 503-481-9197	wcwbrn2bld@aol.com
Etta Assuman	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kendra Duby	Providers		1002 Library Court Oregon City , OR 97045 PH: 503-655-8264	kduby@co.clackamas.or.us
Cody Elder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Michael Fernandez	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Rory Gerard	Providers		1581 Niagara Avenue Astoria, OR 97103 PH: 503-515-2545	rorygilgerard@gmail.com
James Goleman	Others (Not State employees or providers)			
Heather Hartman	Providers	ALLCare		
Marisha Johnson	Others (Not State employees or providers)			

Ally Linfoot	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Tanya Pritt	Others (Not State employees or providers)			
Dawnell Meyer	State Employees	Oregon Department of Corrections	2575 Center Street NE Salem, OR 97301 PH: 503-378-5524	dawnell.l.meyer@state.or.us
Lynn Smith-Stott	Providers	Central City Concern	33 NW Broadway Portland, OR 97209 PH: 503-228-7134	lynn.smith-stott@ccconcern.org
Scott Tiffany	Providers	Mid-Valley Behavioral Health Care Network	2965 Ryan Dr. SE Salem, OR 97301 PH: 503-585-4991	scott@mvbcn.org
Michele Vowell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Steve Comella	Others (Not State employees or providers)			

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	45	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	24	53.33%
State Employees	8	
Providers	9	
Federally Recognized Tribe Representatives	1	
Vacancies	3	
Total State Employees & Providers	21	46.67%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	7	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	15	
Persons in recovery from or providing treatment for or advocating for substance abuse services	6	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

AMHPAC has been provided with regular updates on the progress of the Block Grant application. Draft content specific to AMHPAC subcommittees was sent to subcommittees for review and comment in May 2105. These specific content areas included Recovery Support Services, Community Living and Olmstead, Trauma, Suicide Prevention and Medication Assisted Treatment. Comments received at that time were reviewed by Block Grant writing staff and incorporated into the Block Grant application.
On August 10, 2015, a webinar was held to review the Block Grant requirements and AMHPAC Public Comment period. Comments received were reviewed and incorporated, as appropriate, in the application.

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Dr. Pamela A. Martin
Oregon Health Authority Addictions
and Mental Health Division
500 Summer Street NE, E-86
Salem, OR 97321

Dear Dr. Martin:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

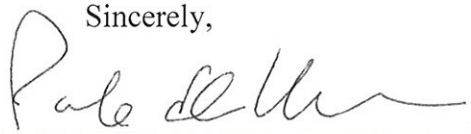
Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,



Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Jackie Fabrick
Rodney Cook

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory