STEP ONE

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.

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 95% of Oregonians enrolled in the Oregon Health Plan (Medicaid) by the end of CY2016. 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

In 2013, Oregon established 16 Coordinated Care Organizations (CCOs) through a health system transformation process. The CCOs manage the physical, dental, and behavioral health benefits for individuals who have Medicaid. As a result, Oregonians are experiencing improved and more integrated care. However, behavioral health has not been as integrated within this framework as possible. The statewide behavioral health structure also relies on community mental health programs(CMHPs). CMHPs, at a minimum, maintain the mental health safety net system, manage children and adults at risk of entering or transitioning from Oregon State Hospital, manage the mental health crisis system, and community based specialty services, and require care coordination of residential services. The CCOs are currently entering a new contract phase: CCO 2.0

In 2015, Senator Sara Gelser, D-Corvallis, and Oregon Health Authority Director Lynne Saxton traveled round Oregon to meet with consumers and family members in a series of Town Halls and aimed to address the concerns heard during these meetings. In the Summer of 2016, Oregon Health Authority (OHA) convened the BHC to develop a set of recommendations to chart a new course for the behavioral health in Oregon. Director Saxton asked the BHC to make recommendations defining policy, financing, and

infrastructure needs to modernize and integrate Oregon's Health System with Behavioral Health (Mental Health and Substance Use Services) for people who receive services and their families. The BHC was comprised of nearly 50 members throughout the state that represent every part of the behavioral health system. The BHC worked for over six months to develop a set of recommendations that will transform Oregon's BH system. Stakeholders defined the problems, identified solutions and created a vision for excellence and sustainability in Oregon's BH system.
The Oregon Health Authority serves as the Single State Authority (SSA) and State Mental Health Authority (SMHA) for Oregon. Oregon's plan is to integrate care and treat mental health, substance use and other health services equitably in local communities. Mental health and substance use must be integrated clinically, operationally and financially into larger, system wide reform efforts to achieve BHC's goal.

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 manage 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.

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 HSD biennial budget of $15,963,729,519.00 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 people and has a biennial budget of $995,681,956.00. The Health Services Division (HSD) manages the remaining federal

and state funds. 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 BH policy team is 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.

Certified Community Behavioral Health Clinics (CCBHC)

In 2016, Oregon was awarded the CCBHC Planning Grant by SAMHSA. Twenty-five million dollars in planning grants were available to states to develop applications to participate in a two-year CCBHC demonstration program. Only states awarded a planning grant are eligible to apply for the demonstration program grant. Oregon applied for, and was awarded a planning grant, as the program aligns with the state's broader health care transformation efforts, enabling Oregon to further advance behavioral health care for Oregonians. The Oregon Health Authority subsequently submitted an

application to SAMSHA to be considered for participation in the 2017-2019 CCBHC Demonstration Program. In December 2016, Oregon was selected as one of eight demonstration states. Currently Oregon has 12 CCBHC organization, with 21 sites across the state.

The 2017-2019 Demonstration Program Advisory Group, comprised of diverse stakeholders from across Oregon, representing providers, consumers, policy makers, health plans and professional associations, meets quarterly to advise the Oregon Health Authority on a variety of programmatic issues throughout the demonstration period.

CCBHCs are supposed to report on asset of measures as per SAMHSA standards to demonstrate integration of behavioral health with physical health, especially among population with Serious Persistent Mental Illness and Substance Use Disorder. In addition, Oregon has introduced 12 more standards for CCBHCs to meet in order to stay certified, which are in alignment with Oregon's Patient centered Primary Care Home standards.

Patient-Centered Primary Care Home Program

Oregon's Patient-Centered Primary Care Home (PCPCH) program was established in 2009 as part of the state's broader transformation efforts to achieve better health, better care, and lower costs within the health system. The intent was to improve Oregon's primary care system by developing a set of standards for primary care practices. After the legislation was passed, a volunteer advisory committee was convened to develop the PCPCH standards. The committee has reconvened several times over the years to refine the standards.

The PCPCH recognition criteria is defined by six core attributes, each with specific standards under each attribute, and measures that indicate the extent to which a clinic is meeting that standard. Behavioral Health Services is standard 3.C in the PCPCH model. There are three measures for the behavioral health services standard; one is required and two are optional.

- 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (required)
- 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers.

- 3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.

More than 600 primary care clinics are recognized as PCPCHs in Oregon - about 2/3 of all primary care clinics in the state. There are recognized PCPCHs in 35 out of 36 counties in Oregon and approximately ¾ of all Oregonians get their care at a PCPCH.

PCPCH recognition is attestation based, so the program conducts on-site visits to a select number of PCPCHs each year. The PCPCH program has conducted more than 320 site visits to date, over 1/3 of those in last 18 months. Each clinic will receive a site visit at least once every five years, per Oregon Administrative Rule.

Behavioral Health Home (BHH) program

In 2015 Senate Bill 832 mandated the Oregon Health Authority (OHA) establish behavioral health homes (BHH). OHA, through the Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee, developed BHH criteria and standards, but there was no provision or funding to identify organizations meeting standards. In 2019 the Oregon legislature passed Senate Bill 22 which provides funding to OHA to establish a program. This work will begin in 2020 by convening a multi-stakeholder advisory committee to further develop and update the BHH standards developed in 2015 to incorporate learnings and best practices over the last four years. BHH standards will provide a blueprint for care delivery and quality improvement in behavioral health organizations. After the BHH standards have been finalized, OHA will develop a process to identify organizations that meet the standards.

Opioid State Targeted Response Grant and State Opioid Response Grant

In May 2017, Oregon was offered the Opioid STR grant by SAMHSA, for a total award amount of $6.5 million. The OR-Opioid STR aims to 1)enhance state and community-level efforts to advance public health interventions that reduce PDO and problematic prescribing of controlled substances, 2)increase the number of DATA-waived providers in Oregon who are actively prescribing FDA approved medication for OUD, 3) enhance and expand the provision of peer support services design to improve treatment access and retention and support long-term recovery, 4) provide treatment transition and coverage for patients reentering the community from the criminal justice system,5)implement access to FDA approved medication for MAT in combination with social interventions, 6)establish statewide public education campaign on opioid and 7)

establish a more robust network of recovery resources in places most affected by opioid epidemic in Oregon. This grant will supplement the existing CDC and SAMHSA grant that Oregon has and expand those efforts across the state. A continuous need assessment will be part of the grant activities. The Oregon Dept. of Corrections and Oregon Health and Human Sciences University will be two of the sub-grantees. More partnering organization will be identified with grant progress.

The project will overall aim to increase access MAT across the state. In addition a special focus would be on Oregon's Tribal communities. This is because currently the Oregon Tribes do not have a robust system of needs assessment even though opioid use disorder is a major burden in the Native American population (according to Medicaid data). The project will also keep a focus on rural and frontier counties, since in Oregon, opioid use disorder is mostly a rural issue. Despite of this high need in rural areas there is significant low access to MAT provider sin these regions. A significant proportion of this population also turns to heroin once opioid becomes too expensive to afford, among individuals living with chronic pain. This is true in certain urban areas as well, such as the Portland Metro area since heroin is easily available.

In Oregon, Opioid Use disorder is primarily an access, training, and education issue. For example, only 30% of the DATA waived providers actually prescribe MAT medication. The STR grant project will drive the efforts of training providers on CDC's prescribing guideline, and community engagement and outreach. In addition, the Oregon Prescription Drug Monitoring Program will also be enhanced to get at least 95% of the high prescribing providers This will allow for more accurate and targeted needs assessments in moving forward.

The project will be done in collaboration with Department of Public Health, county health departments, criminal justice system, and regional Medicaid providers. Several of the infrastructure, such as ongoing evaluation, technical support, policy model, and sustainability plans, are already in place.

Public Health Division

Within OHA’s PHD, the HPCDP section leads initiatives for alcohol, tobacco and marijuana prevention efforts and the Injury and Violence Prevention Program (IVPP) leads opioid prevention priorities. Maternal and Child Health, Adolescent and School Health and the HIV Program all coordinate and implement respective programs and initiatives that aim to prevent substance use and promote physical and behavioral health along the continuum of care. PHD’s collective substance use prevention team

and portfolio is organized under the Center for Health Promotion's administrator and a newly created Alcohol and Other Drug Prevention Manager. This work coordinates closely with OHA's Behavioral Health Addiction, Recovery and Prevention Unit as well as other Behavioral Health program areas.

Health Promotion and Chronic Disease Prevention (HPCDP)

OHA-PHD HPCDP provides leadership for prevention and health promotion initiatives for tobacco, asthma, nutrition, diabetes, arthritis, heart disease, physical activity, stroke and cancer, and substance use prevention in its portfolio. HPCDP takes an integrated approach to reducing premature death and chronic diseases by focusing on the common risk factors of tobacco use, excessive drinking, physical inactivity and poor nutrition across all Oregon communities.

- **Alcohol and Other Drug Prevention and Education Program (ADPEP)**
  HPCDP continues to build a comprehensive Alcohol and other Drug Prevention and Education Program (ADPEP). HPCDP provides administration and management, data and evaluation, health communications, support for state-level interventions and community funding to plan and implement strategies that prevent alcohol, tobacco and other drug use through community mobilization efforts. This includes 36 counties, culturally specific organizations, nine federally recognized Native American tribes, and six Regional Health Equity Coalitions (RHECs).

  Alcohol use is the third-leading cause of preventable deaths among people in Oregon. Excessive alcohol use—which includes binge drinking, heavy drinking, and alcohol use by people under 21 or pregnant women—can cause or exacerbate heart disease, diabetes, cancer, motor vehicle accidents, and violence. ADPEP's comprehensive program prioritizes:

    - State and community interventions: Creating environments that reduce exposure to alcohol and other drug availability, marketing and promotions to discourage excessive drinking as well as raising the price of alcohol.
    - Mass-reach health communications: Researching and developing mass-reach health communications, and education that support alcohol and other drug prevention initiatives.
    - Data and evaluation: Continuous monitoring of alcohol and other drug trends and program effects to identify population needs and inform future areas of focus.
    - Infrastructure, administration and management: Ensuring leadership, accountability and oversight for all program strategy and expenditures.

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 strategies. Oregon implements strategies 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.

Oregon is ending a five-year federal Partnership For Success (PFS) Strategic Prevention Framework (SPF) grant to address underage drinking and binge drinking among young adults and prescription drug misuse and abuse among youth and young adults. SPF-PFS provided funding for administration and management, health communications assessment, data collection and analysis, and contracts to five federally recognized tribes and nine Counties to address these priority areas and strengthen their capacity to plan and implement prevention strategies The PFS allocation model was guided by a previous SPF Advisory Council and the State Epidemiological Outcomes Workgroup (SEOW). The SPF Advisory Council and SEOW were requirements and mechanisms to guide PFS-SPF sub-recipient funding to reach high priority areas within the state.

- **Tobacco Prevention and Education Program (TPEP)**

  The Oregon Tobacco Prevention and Education Program (TPEP) is a comprehensive program that supports tobacco prevention and helps people quit statewide. The program has been in place for more than 20 years, ever since Oregon voters passed Measure 44, which raised the price of tobacco and dedicated funding to tobacco prevention and education.

  TPEP partners with local public health authorities, tribes and regional health equity coalitions to prevent and reduce tobacco-related deaths in every Oregon community. More than 60 percent of Oregon's TPEP funding flows directly into communities.

  TPEP's strategic goals are to:
  - Increase the price of tobacco products
  - Promote smoke-free environments
  - Protect youth from exposure to tobacco industry marketing
  - Reduce access to tobacco products, and
  - Decrease tobacco-related disparities.

  TPEP drives science-based interventions in each of the following areas to achieve its goals:

- State and community interventions: Creating environments where a tobacco-free life is the easy option, and youth are less likely to start using tobacco.
- Mass-reach health communications: Developing media campaigns and education that support tobacco prevention initiatives and help people quit.
- Supports to help people quit: Ensuring counseling and FDA-approved medication are available through quit lines and health care systems.
- Data and evaluation: Continuous monitoring of tobacco use trends and program effects to identify population needs and inform future areas of focus.
- Infrastructure, administration and management: Ensuring leadership, accountability and oversight for all program strategy and expenditures.

Synar Amendment

Since 2012, OHA has taken several measures to effectively enforce the minimum legal sales age. These measures include:

1. Increasing the minimum legal sales age to 21;
2. Expanding the types of products requested during compliance checks (cigarettes, little cigars, e-cigarettes);
3. Renegotiating an agreement with the Oregon State Police to conduct inspections;
4. Instituting a reinspection process for retailers that violate the law;
5. Funding local public health authorities to work on tobacco control policies; and,
6. Implementing a comprehensive database to combine Synar, state enforcement and FDA inspections and allow for mapping of retail locations.

OHA coordinates regularly with other state enforcement agencies (Departments of Revenue and Justice, the Oregon Liquor Control Commission and the Oregon State Police) to improve and strengthen statewide enforcement efforts for tobacco.

In addition, in 2016, OHA began publicly posting results from both the Synar and the state enforcement inspections. These results include individual retailers' inspection results. As a result of these efforts, Oregon's RVR dropped from 22.5% in 2012 to 11.1% in 2018.

Adolescent and School Health Unit

Adolescent and School Health (A&SH) unit collaborates with HPCDP's prevention work around substance abuse prevention issues as capacity allows. The Adolescent Health Snapshot presents health and behavioral outcomes from a policy framework. This information is shared with internal and external partners so that programs and policies can be most reflective of what adolescents experience. Information includes mental health and substance abuse issues. A&SH oversees the Oregon School-Based Health Center (SBHCs) Program. There are 78 State-Certified SBHCs in Oregon. SBHCs receive grants for mental health capacity and/or youth-focused mental health projects. The majority of grant funds are used to support additional mental health providers in SBHCs. Grant funds are also used to support Youth Advisory Councils and Youth Participatory Action Research Projects.

- Providing Mental Health Services at SBHCs allows for timely mental health care, a strong system of care, a focus on prevention and a commitment to serving adolescents regardless of their ability to pay.
- SBHC mental health providers held behavioral health, psycho-education, support, and wellness groups for anxiety, depression, grief, and healthy relationships. These groups enabled providers to treat and work with more adolescents, do prevention work, and strengthen partnerships with school and community providers.
- SBHC mental health providers helped schools respond to mental health crisis situations by providing immediate intervention, as well as longer term grief and bereavement supports.
- Youth Advisory Councils assure clinics are welcoming to youth and help advertise clinic services to their peers.
- Youth Participatory Action Research topics included: mental health stigma, teen substance use, suicide prevention, sleep, effects of public displays of affection on school climate, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care.
- Each certified SBHC is required to report on two Core Key Performance Measures (KPMs), as well as one of five Optional KPMs. Substance Abuse Screening and Depression Screening are optional KPMs. The Core KPMs are the Adolescent Well-Visit and a Comprehensive Health Assessment. Both include mental health and substance abuse screening, prevention messaging and anticipatory guidance.

Adolescent and School Health partners with the Health Systems Division, Oregon Department of Education, Trauma-Informed Oregon, Suicide Prevention Initiatives, Youth-Serving Organizations and several community-based organizations to address mental health and substance abuse issues. Adolescent and School Health emphasizes

that when youth are given accurate information, skill building opportunities and access to youth-friendly care they more like to be mentally well and less like to abuse substances.

Maternal and Child Health

Oregon's Maternal and Child Health (MCH) Section of the OHA Public Health Division has a long history of collaborating both within the Public Health Division and across the OHA to effectively reach pregnant and post-partum women, as well as other parents with mental health and substance abuse issues. The goal of the MCH Section is that every mother, child and family has the best opportunity to reach their greatest potential life-long health and well-being. The work addresses both universal and targeted approaches that promote protective factors and resilience in the early years for life-long health. Working across systems and in communities, MCH fosters safe, supportive environments for children, mothers and families; builds resilient and connected communities and families; promotes nutrition and healthy development; and improves oral health. MCH implements evidence-based policies, programs and strategies across the lifespan to address the social determinants of health, improve health equity, and build strong social, emotional and physical health for the next generations of Oregonians.

The Health Systems Division, Children and Family Behavioral Health Unit and MCH work together on issues around substance abuse and families. MCH also partners with all local public health departments and five Tribes to address root causes of mental health and substance abuse through maternal and child health work that includes home visiting for pregnant women and families with young children, Oregon MothersCare, and policy and programs that address toxic stress/trauma/adverse childhood experiences, smoking, well woman care, and breastfeeding. MCH provides funding to 211info, a non-profit organization that empowers Oregon communities by helping people identify, navigate and connect with the local resources they need, to support maternal and child health information and referral services statewide that includes mental health/substance abuse and other resources. MCH also leads policy development related to pregnancy and opioid use with internal and external partners.

In collaboration with partners including local health departments and tribes, the MCH section supports home visiting programs. **Home visiting** is a proven strategy for strengthening families and improving the health status of women and children. Programs are voluntary and serve families with a variety of risk factors including mental health and substance abuse issues. Funding for programs comes from a variety of sources including federal, state, county, local and private funding. Home visiting is one strategy in the larger Early Learning system being developed for Oregon. The Oregon Legislature recently passed legislation making Oregon the first state in the nation to

provide universally offered home visiting to all families of newborns regardless of insurance coverage and insurance status through the Family Connects model. This service will roll out statewide over the next 3 biennia. The MCH section works to support healthy pregnancy through the **Oregon Mothers Care** (OMC) program which assists pregnant women to access a variety of prenatal services including mental health and substance abuse services as needed.. OMC screens and provides referrals for both behavioral health and alcohol and other drug issues.

The MCH section has convened a **Pregnancy and Opioids Workgroup**. With a focus on primary and secondary prevention, the workgroup developed statewide clinical guidelines on opioid prescribing among women of childbearing age, during pregnancy, identification and treatment of opioid use disorder during pregnancy and care and treatment of prenatally exposed infants. The guidelines are intended to help health care providers incorporate best practices when caring for women and their substance-exposed infants and encourage local efforts to provide coordinated care for families.

Oregon PRAMS, the Pregnancy Risk Assessment Monitoring System, is a project of the MCH section with support from the national Centers for Disease Control and Prevention (CDC). PRAMS collects data monthly on maternal attitudes and experiences prior to, during, and immediately after pregnancy from a representative sample of Oregon women. The survey also asks women about their mental health and substance use during this period of their life. The sample data are analyzed in a way that allows findings to be applied to all Oregon women who have recently had a baby. The Oregon PRAMS-2 survey interviews respondents when their child is 2 years old. Both the PRAMS and PRAMS-2 survey include questions to assess mental health and substance abuse issues. Additionally, the MCH section funds the Adverse Childhood Experiences (ACEs) module of the BRFSS, to collect data regarding adverse childhood experiences of adults, which can then be analyzed for its association with adult mental and behavioral health issues. Both PRAMS and BRFSS ACEs data are used to inform public health policy and program efforts.

Maternal and Child Health is primarily funded through HRSA's Title V Block Grant Program. Title V requirements address specific priorities, of **which Toxic Stress/Trauma** are included. Seven counties have an MCH focus on Toxic Stress/Trauma that include promotion of family friendly policies, outreach and education, ACE's and trauma assessment and surveillance, and trauma-informed workforce and workplace development. Title V's work to address parenting supports, as well as the MIECHV-funded home visiting programs have evolved to include a focus on ACEs and toxic stress prevention, building resilience, and developing trauma-informed systems of care in Oregon. Title V and other partners' work on this priority strengthens the foundation of safe and nurturing relationships and stable attached families in

Oregon – a critical factor for preventing and mitigating substance abuse and mental/behavioral health problems in Oregon children and families.

Oregon's 211Info Resource and Referral line is partially funded by the MCH Title V Block Grant. As part of that grant, two **MCH Specialists** provide resources to pregnant women and families, including mental health and alcohol and other drug treatment referrals. During the first 6 months of 2019, MCH Specialists received 491 calls from pregnant women and women with children requesting mental health/AOD referrals.

The MCH Section has a history of partnering with community organizations (Baby Blues Connection and Postpartum Support International) around **Perinatal Mood Disorders.** The Section hosts a Maternal Mental Health website (http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALTH/Pages/index.aspx) that provides information for pregnant women, new mothers, family members and providers around Perinatal Depression and Anxiety. Community strategies, policy, legislation and data are also addressed.

With guidance from **Oregon's Retail Marijuana Scientific Advisory Committee** and focus groups with pregnant and breastfeeding women, the MCH section worked with partners to develop educational materials about marijuana use while pregnant, breastfeeding or caring for children. Materials have been shared with WIC sites, home visiting programs and other partners.

HIV Care and Treatment Program

The HIV Care and Treatment Program of the HIV/STD/TB (HST) Section of the Public Health Division provides information, referral and access to treatment for persons with mental health and substance use disorders. Under the Ryan White funded AIDS Drugs Assistance Program (locally known as CAREAssist), almost all persons living with HIV are eligible for financial assistance for insurance premiums and deductibles and copayments for services and medications used in the treatment of mental health and substance use disorders. Within the Part B, Ryan White funded case management program, the SBIRT is used annually to identify persons interested in accessing treatment. Ryan White supportive services are also available to provide financial assistance.

Persons with HIV, mental health and substance use issues are disproportionately impacted by the current housing crisis. Within the HOPWA funded housing programs administered by the Public Health Division, one program specifically meets the needs of persons who have experienced housing related barriers as a result of mental health and substance use. Furthermore, a direct referral system is in place to ensure access to care and case management for persons transitioning out of the Oregon Department of Corrections, many of whom have a mental health and/or substance use disorder.

Starting in 2019 the HST Section has also obligated $10 million over five years to support low barrier housing and in-home intensive wrap around support services for people living with significant behavioral health barriers to housing and healthcare. All Part B Case Managers and Housing Coordinators have received training in motivational interviewing, harm reduction principles, and use of a trauma informed approach. An online “HIV Prevention Essentials” course, which is required of individuals providing publicly funded HIV testing and other prevention services, also includes principles related to harm reduction and a trauma informed approach. HIV Care and Treatment works closely with HIV and STI Prevention programs to ensure streamlined and coordinated services across the HIV continuum.

HIV and other sexually transmitted infections, such as syphilis and gonorrhea, are reportable diseases. Oregon’s 34 local county health departments are responsible for case follow-up and elicitation of sex and needle sharing partners, a process referred to as HIV/STI Partner Services. A key component of HIV/STI Partner Services is referrals to services such as mental health, substance use treatment, and harm reduction (e.g. syringe access) programs. Additionally, as part of the interview that takes place with individuals diagnosed with HIV or an STI, questions are posed concerning substance use which allows epidemiologists at the state and local level to track data regarding use of illicit substances as a risk factor for HIV/STIs. Given nearly all HIV positive persons in Oregon are insured or are insurable with the assistance of CAREAssist, most financial barriers to mental health and substance use treatment are removable. The bigger barriers related to access are systematic in nature, for example provider shortages and access to culturally competent providers, particularly in rural areas of the state. HST has prioritized several projects that focus on ameliorating health disparities between Latinx and non-Latinx folks in Oregon. These projects include health education and risk reduction for primary prevention, as well as outreach testing and an increase harm reduction services in Latinx communities.

The HIV Prevention Program uses state general funds, federal funds, or a combination of both to support syringe access activities in 14 counties and two community-based HIV/AIDS service organizations in Oregon. This support takes the form of funds for purchases of syringes, staff time, waste disposal services, sharps containers, and other supplies. The HIV Prevention Program also provides technical support and the opportunity to apply for supplemental start-up funds to entities across the state interested in implementation of syringe access programs in their area. Syringe access programs in Oregon primarily fall into three categories: fixed location (e.g. location at a health department or community-based organization office), delivery system, or through use of a van which visits multiple locations at fixed days/times each week.

Injury and Violence Prevention Program

Prescription Drug Overdose Prevention: The Oregon Health Authority (OHA) Internal Opioid Initiative was launched in January 2016 to coordinate and align agency-wide activities and policy work to advance the Oregon Opioid Initiative, with leadership from the Health Systems Division, Health Policy and Analytics, and the Public Health Division. The Oregon Opioid Initiative's overarching Aim is to reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, while expanding use of non-opioid pain care.

The primary goals of the Oregon Opioid Initiative are:

- Reduce risks to patients by making pain treatment safer and more effective, emphasizing non-opioid and non-pharmacological treatment.
- Reduce harms to people taking opioids and support recovery from substance use disorders by making naloxone rescue and medication-assisted treatment (MAT) more accessible and affordable.
- Protect the community by reducing the number of pills in circulation through implementation of safe opioid prescribing, storage, and disposal practices.
- Optimize outcomes by making state and local data available for informing, monitoring, and evaluating policies and targeted interventions.

Oregon is the only state that manages the Prescription Drug Monitoring Program (PDMP) within its Injury and Violence Prevention Program (IVPP). This allows direct access to data and the ability to link with death, hospitalization, emergency department, emergency medical services, and Medicaid client enrollment data. IVPP also maintains an interactive online dashboard of state and county data on controlled substance prescribing and drug overdose hospitalizations and deaths, and local health departments are trained to access and use these data to monitor progress and make data-driven decisions. The Oregon Opioid Prescribing Guidelines Task Force adopted the *CDC Guideline* as the foundation for opioid prescribing for Oregon. An Implementation Work group developed statewide goals, objectives, quality metrics, a framework to guide opioid-related work in Oregon, and a clinician toolkit and trainings. Using the *Six Building Blocks of Opioid Prescribing* self-assessment tool, a small interdisciplinary Pain Management Improvement Team (PMIT) of clinical experts provides academic detailing and practice coaching to health systems in six high burden regions to assist with guideline implementation and improved pain management practices. These two- to three-county regions are funded to hire a PDO Coordinator to coordinate prevention work and monitor outcomes, boost PDMP enrollment, host regional pain/opioid summits, post online resources, and increase public awareness. In addition to the regional summits, an annual pain symposium hosted by Oregon Pain

Guidance (OPG) has educated the medical community and others throughout the state about evidence-based pain management since 2011. IVPP sponsors an annual policy and practice academy for local health officers and administrators, launched in 2017, which will coordinate with HPCDP to include alcohol and other drugs in 2018. The Opioids in Pregnancy Work Group, led by MCH and with internal and external partners, is developing recommendations for health care providers to address pregnant women who use opioids.

Suicide Prevention: The OHA PHD administers the Oregon Caring Connections Youth Suicide Prevention Initiative with funding through SAMHSA Garrett Lee Smith Memorial Act (GLS). Oregon currently has funding for five years (2014-2019) to implement activities that align with the National Strategy for Suicide Prevention. The Oregon Caring Connections Initiative focuses on youth aged 10-24 years with a focus on at-risk youth primarily in five Oregon counties provided funds to support suicide prevention efforts. Goals of the initiative are:

- Increasing gatekeeper training to individuals serving youth to identify and refer youth at risk of suicide and increasing suicide prevention education to students, educators, and school staff.
- Providing clinical training to increase health, mental health and substance abuse clinicians trained to assess, manage and treat youth at risk for suicide.
- Improve continuity of care for youth discharged from emergency departments and inpatient psychiatric units; and for veterans and military families receiving care in the community; and improved county crisis response plans for wrap around services.
- Promote, engage and provide technical assistance to Oregon healthcare organizations around the Zero Suicide Initiative approach to provide suicide safer care.

IVPP maintains an interactive online dashboard of state and county data on suicide deaths suicide death by mechanism and factors associated with suicide, and local health departments have access and use these data to monitor progress and make data-driven decisions. Through GLS funding, IVPP works with five Oregon counties (Deschutes, Jackson, Josephine, Umatilla, and Washington) on the above stated grant goals. Each of these counties (or designated community mental health provider) has a dedicated Suicide Prevention Coordinator. IVPP also works with Oregon healthcare organizations and Oregon schools outside of these five counties on suicide prevention/intervention/postvention work.

Impaired driving: This project is in the planning and assessment phase. IVPP staff participates in a Public Health Division / Oregon Department of Transportation

partnership workgroup, and is re-establishing partnerships that will contribute to the future direction of policy development around motor vehicle interlock law in Oregon.

Intimate Partner Violence: This project is in the planning/assessment phase. Coordinated multiple projects with PHD Maternal and Child Health (MCH); Adolescent, Genetic and Reproductive Health; and Health Promotion & Chronic Disease Prevention sections and the Oregon Department of Education for prevention of sexual violence and intimate partner violence.

IVPP uses a collective impact approach for all PDO and suicide prevention projects, with the Public Health Division as the backbone organization, using established statewide metrics and performance measures.

IVDUs: The state naloxone work group and funded local public health authorities collaborate with syringe exchange programs, social service agencies, corrections, behavioral health partners and law enforcement/first responders to expand access to naloxone rescue for people experiencing overdose. Acute and Communicable Disease Program (ACDP) has a new grant to align opioid, Hepatitis C and HIV work in rural areas, and IVPP collaborates closely with ACDP on this project.

The PDO project targets specific populations based on outcomes data: people living with chronic pain, rural communities, tribal communities, and people using opioids. IVPP sponsors regional opioid summits and is planning a tribal opioid summit for 2018.

The IVPP suicide prevention efforts align with the OHA Youth Suicide Intervention and Prevention Plan (2016-2020). Implementation and evaluation of the plan is led by Health Systems Division. IVPP and Health Systems Division work together to meet the plan's activities and goals.

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 14,900 practitioners and pharmacists have PDMP accounts in Oregon

Behavioral Health Promotion

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. Emotional health promotion is one of the keys to maintaining physical and mental wellness by increasing the individual's ability to cope with normal stresses of life and their positive connectivity with family and community. Emotional 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 and the impact of trauma and stigma.

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 postvention and Prevention Programs, Culturally-Specific Services and Mental Health Promotion Activities. Four projects focus specifically focus on children 3-8 to increase their skills of establishing positive peer relationships and increasing emotional self-regulation. In addition, one project continues to create and promote social marketing messages to reduce stigma and promote public awareness of mental health issues.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

OHA supports a continuum of care based on the Institutes of Medicine model[1], 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.

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 has created 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 on trauma and Adverse Childhood Experiences. Trauma Informed Oregon is also training nurses to incorporate Trauma Informed Care into their workforce training and culture as a standard in Oregon.

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[1] 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.

Parent-Child Interaction Therapy (PCIT)
PCIT is an empirically supported treatment for young children with emotional and behavioral disorders. 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. An adaptation of PCIT for toddlers (ages 12-24 months) teaches parents to become more attuned and responsive to their young child while helping toddlers develop emotional and behavioral self-regulation. National research indicates PCIT can also be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum, 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. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during treatment.

In 2008, four Oregon agencies began to implement PCIT with funding support from OHA to provide PCIT to Medicaid eligible families. As of January 2019, there were high-fidelity PCIT programs serving Medicaid eligible families at 45 locations, in 19 Oregon counties. In July 2019, PCIT was expanded to 11 additional agencies with sites in 6 counties, which previously did not have PCIT programs. Currently there are approximately 130 trained staff on PCIT treatment teams, including certified Masters Level PCIT Trained therapists, Bachelor's level skills trainers, PCIT Level I Trainers authorized to train within their own agency, and Level 2 Trainers authorized by PCIT International, Inc. to train regionally across Oregon. Two universities have PCIT programs without funding from OHA and are preparing graduate students to become certified in PCIT after they graduate. There are 36 additional Masters Level therapists who started their training in July 2019 as part of the latest expansion of PCIT. Training to meet PCIT certification requirements takes a year or more to complete. All OHA funded PCIT sites receive on-going consultation, training and fidelity monitoring by OHA contracted certified Regional PCIT trainers.

PCIT demonstrates large effect sizes in reducing child problem behavior despite high treatment attrition rates in community-based clinics. A recently published study done by the Department of Psychology at West Virginal University, in cooperation with OHA was published in Dove Press journal: Psychology Research and Behavior Management, Reconceptualizing attrition in Parent–Child Interaction Therapy: | PRBM
This study employed one of the largest PCIT community research samples ever conducted (2,787 children and their families across the state of Oregon, 1,318 with usable data) to determine how PCIT impacts both who complete treatment and those

who leave treatment early. The purpose of this study was to examine the impact of PCIT on child behavior problems for families who received at least a small dose of PCIT but not enough to meet the strict mastery criteria required for PCIT treatment graduation. While families who graduated from PCIT demonstrated a very large effect size in problem behavior intensity improvements (d=1.65), families who terminated treatment early, but after attending at least four treatment sessions, still showed significant improvements in behavior problems with a medium-to-large effect size (d=0.70).

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, or 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.

OHA has been providing funding since 2014 for CPP training annually, including 18 months of reflective supervision/consultation. To date, 133 clinicians have started CPP training and approximately 27 clinicians have dropped out of the training and on-going supervision before completing training.

The current goals of this project are to:

- Implement CPP with fidelity through provision of mental health promotion and intervention services, behavioral health clinics, and Oregon Relief Nurseries to at-risk families;
- Utilize the CPP Fidelity Tools;
- Utilize the Devereaux Infant Toddler Assessment to measure outcomes starting in September 2019,
- Continue ongoing consultation, supervision and networking between CPP-trained therapists to maintain fidelity to the model over time.

Mental Health First Aid

The Association of Oregon Community Mental Health Programs provides statewide trainings to train Mental Health First Aid (MHFA) instructors. To date 2,098 Oregon Mental Health First Aid responders have completed the training. 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.

The major barrier to training teachers in schools on MHFA is lack of staff resources. In the past, the total hours of training for MHFA has been reduced to address some of this barrier but it still significantly hinders school districts from successfully adopting the MHFA training as a standard.

Early Identification and Intervention

Screening, Brief Intervention and Referral to Treatment (SBIRT) 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.

Young Adult Mental Health Hub Program

A 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.

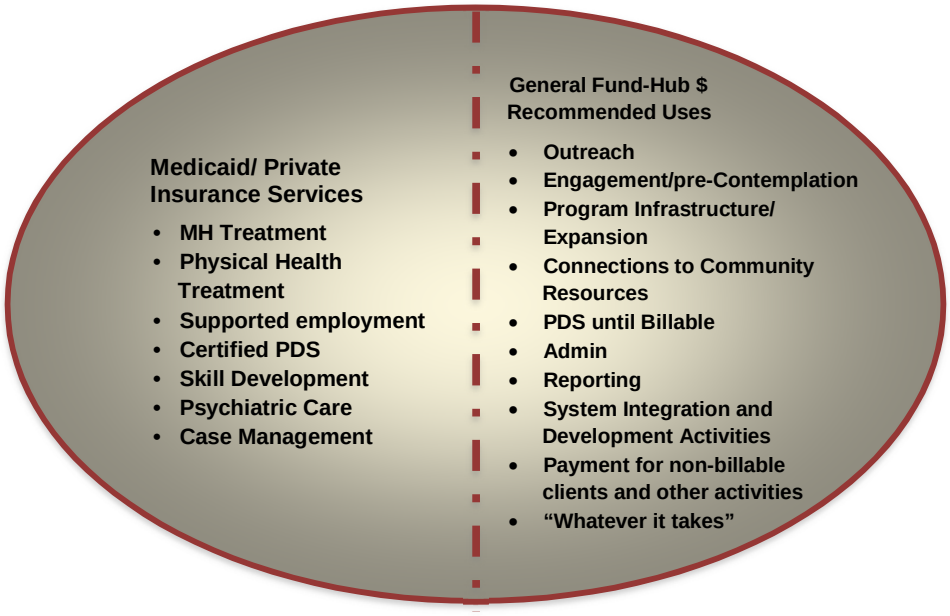
The Family Search & Engagement program works to locate life-long connections for youth served by the hubs and fosters engagement with supportive family members and natural supports. Family Search & Engagement services are available for youth in Multnomah, Clackamas, Washington, Marion, and Lane County.

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. HUB staff are 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 addressed by 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.

Survey data has indicated that the hubs are reaching the populations they are intended to serve and conducting activities consistent with the outcome areas listed above.

Early Assessment and Support Alliance (EASA)

EASA serves young adults 12-25 and their families, using an intensive multidisciplinary approach during what is known as the "critical period," where intervention is most effective and may prevent the long-term negative life consequences 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 a robust and efficient model of care while mirroring many public health strategies through 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.

Impact and Data

Since its first investment in 2007, EASA has provided services to 1800 young adults and their families. With the addition of federal dollars, all 36 Oregon counties are funded to provide EASA and are developing teams, and 96% of Oregonians have access to an established team. In calendar year 2016, EASA received 957 referrals and served 715. The ongoing current caseload is 400 individuals and families throughout the state of Oregon.

In EASA, young people maintain or enter school or work (44% at intake, 55% at discharge) and decrease substance abuse (15% with severe substance abuse at intake, 9% at discharge). At discharge 59% of EASA youth are not on public disability and do not plan to apply.

Hospitalizations in the three months prior to entry have dropped from 58% in 2008 to 38%. Once in EASA, hospitalizations each quarter averaged 6%. Some programs are achieving hospitalization rates at or near zero, and community education, outreach and quality improvement effort focus on further improving these figures.

Each EASA team conducts extensive and on-going community education. In 2016 alone, EASA reached over 46,000 individuals through 350 presentations and media stories.

EASA Center for Excellence

Oregon is the first state in the U.S. to commit to universal access to early psychosis intervention, and is an established national leader. EASA has a Center for Excellence (CfE) housed at OHSU's (Oregon Health and Science University) School of Public Health.

The EASA CfE maintains collaborative partnerships with Portland State University and OHSU Child Psychiatry, and is 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.

During this time period, EASA Center for Excellence staff presented to state conferences such as conferences focused on CCOs, supported employment, counselors, physicians and NAMI. In addition, EASA CfE staff presented to the National Early Psychosis Association, NAMI National, the annual Child and Adolescent Research Conference in Tampa, and the National Association of State Health Programs. EASA CfE edited the 2016 edition of Focal Point Magazine (issued through Portland State University to an audience of over 20,000), with a focus on early psychosis intervention. Articles were contributed by international and national experts as well as EASA clinicians, the Young Adult Leadership Council and EASA family members. EC4E staff also participated in advising the national evaluation of federal block grant funding to early psychosis programs, and the development by NAMI national of a policy on proactive engagement of individuals with mental illness.

EASA's website added a toolkit section which includes a wide variety of materials from multiple sources. In addition, EASA is linking its efforts to Partners4Strong Minds and other entities with strong media presence.

The Center for Excellence maintains a partnership with OHSU School of Child Psychiatry, employing both the expertise of Dr. Craigan Usher MD, as a psychiatric consultant to EASA teams and Julie Magers, a family engagement and partnership expert.

Technical assistance and training staff at the EASA Center for Excellence provided weekly consultation and quarterly trainings throughout this period, training approximately 200 new staff during this time period:

Quarter	Intro	MFG	Diff Dx./SIPS	Other	Total
3rd 2015	21	29	0	0	50
4th 2015	45	0	0	combined w/clinical skills	45
1st 2016	0	0	30	0	30

2nd 2016	54	35	102	0	191
3rd 2016	0	25	63	0	88
4th 2016	50	25	0	Conference 300	375
1st 2017	17	49	22	39	127
Total	187	163	217	339	906

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. The council meets monthly and 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 EASA Young Adult Leadership Council is actively involved in advising and developing programming for EASA and national audiences. Leadership Council members have presented at Peerpocalypse and numerous conferences including NAMI national and a research conference in Florida. The Leadership Council developed a national policy statement and an article for Focal Point magazine, and met with Paolo Del Vecchio, the director of the Center for Mental Health Services. The Young Adult Leadership Council has taken the lead on working through a social media strategy for reaching young adults. Ongoing outreach to high schools and colleges continues to occur.

EASA developed shared decision making materials in collaboration with members of the Young Adult Leadership Council. In addition, a young adult design team funded through Pathways and the Young Adult Leadership Council developed a comprehensive website, videos and written handouts which are written from the perspective of individuals who have graduated from EASA.
Statewide Training

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 provided to older adults through the CMHP and their contractor are limited. This is primarily due to the fact that the majority of older adults are only on Medicare . Several CMHP use multidisciplinary teams (MDT) to address the gap in mental health services. These teams vary from county to county and not all counties have a MDT. These teams often have representatives from Aging and People with Disabilities, law- enforcement, adult protective services with the primary focus to link vulnerable older adults with necessary mental health and social services in a seamless manner. Some CMHP use their indigent funds underinsurance for Medicare recipients with serious mental illness.

Some CMHP or their subcontractors have developed and maintained age specific services. In our most populous county one subcontractor has developed a substance use disorder program specifically for older adults called Young at Heart using the SAMHSA curriculum called Substance Abuse and Relapse Prevention for Older Adults.. Some counties have older adult peer delivered services.

OHA has convened an Older Adult & People with Disabilities Advisory Council.

Pre-Admission Screening and Resident Review (PASRR)

PASRR is a federally mandated, statutory program that requires all states to develop a comprehensive process to prescreen for serious mental illness all individuals applying for admission to a Medicaid certified nursing facility. The mandate requires a personalized assessment and recommendations for the mental health services and a determination that nursing home level of care is appropriate for the person.

Oregon Health Authority, as the State Mental Health Authority, maintains a PASRR Level II program that follows federal regulations. In the majority of counties, CMHP are contracted to provide PASRR level 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 (ECF & ECOS)

These programs are a collaborative partnership between OHA Health Systems Division and DHS Aging and People with Disabilities (APD). Services are designed to support individuals with complex mental health and complex physical health needs that necessitate a higher level of support than typically provided in a standard care setting.

Programs emphasize person-centered rehabilitative mental health treatment while continuing to work towards transitioning individuals into the most integrated community setting possible. OHA is responsible for collaborating with APD on managing program referrals, and for working with local providers regarding program administration and strengthening coordination between systems. There are 9 Enhanced Care Facilities that are either APD licensed residential care facilities or units within intermediate care facilities dedicated to serving individuals who qualify for this service. These programs have higher staffing ratios than traditional APD licensed settings, and mental health staff on-site 7 days a week. Mental health staff work closely with APD in developing strategies to support individuals in meeting their goals. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings. Services, for the most part, are delivered in the community in an outreach model. Treatment services for both ECF and ECOS programs are delivered by designated local mental health providers who have a knowledge base in working with the aging population and have an understanding of the interplay between physical and mental health.

Complex Case Consultation and Care Transitions

The older adult team within OHA works closely with Oregon State Hospital staff and Aging and People with Disabilities to discharge and or divert complex BH clients to the most appropriate level of care in the community.

Older Adult Behavioral Health Initiative (OABHI)

The OABHI was launched in June 2015 and is currently entering its third year. This investment seeks to strengthen and improve the behavioral health infrastructure for older adults and people with disabilities. OHA has hired 24 older adult BH specialists across Oregon . Their core job functions promote collaboration and coordination between multiple sectors and coalition building, complex case consultation and promotion of best practices, workforce development/capacity building through training and building age friendly and resilient communities through elevating aging in our community and civic discourse and raising awareness. Between July 2016 and June 2017 there were over 1600 complex case consultations; 273 training and community events reaching 7,000 participants. This Initiative has also highlighted Statewide challenges such has Medicare as a barrier (restricted providers and reimbursement rates for BH), transportation, outreach models for treatment, lack of a geriatric competent workforce to name a few. This Initiative is incubating a few innovative programs to mitigate these challenges – development of a senior peer warm-line/friendship line in rural Oregon to mitigate social isolation and risk of depression and

suicide, training ADRC (Aging Disability Resource Connection) staff in mental health screening and local services, providing mental health first aid (MHFA)along with the older adult module to an array of providers, a telehealth MDT for complex cases in rural Oregon , exploring enhancing our current peer delivered services certification with an add on for older adult BH using COAPS (certified older adult peer specialists), a joint OHA/APD Project ECHO Geriatric Behavioral Health Clinic for nursing homes based on the model from University of Rochester which was approved by CMS, adoption of WISE (Wellness Initiative for Senior Education) as a health promotion program in come counties, and the identification of hoarding as a problem and development of hoarding task forces.

PCIT

Opioids: Access to Services and Treatment

Oregon currently has 20 opioid treatment programs (OTP) within the state; these facilities are comprehensive treatment facilities which offer counseling and other psychosocial supports, including wraparound service referrals to assist patients with mental health needs and other services. These facilities all dispense full agonist (methadone) and partial agonist (buprenorphine) medications, for the treatment of opioid use disorder (OUD). For over 60 years, this modality of treatment has been considered the “gold standard” of OUD treatment, due to its empirically proven ability to reduce harms associated with OUD, including infectious disease, illicit drug usage, overdose, and death; in addition, patients engaged in treatment through the OTP system generally show improved quality of life and reduced involvement in the criminal justice system compared to those with OUD in other care settings. Oregon has a total of 20 OTPs, and 19 of these 20 have certifications with OHA to provide “outpatient synthetic opioid replacement therapy”. All have certifications from the US Drug Enforcement Administration (DEA) and SAMHSA/CSAT Division of Pharmacologic Therapies (DPT) to dispense narcotic medication for the treatment of OUD as well as provide comprehensive therapeutic services to their clients. In Oregon, these programs are regulated by the State Opioid Treatment Authority (SOTA), who approves these programs to operate on behalf of SAMHSA DPT, and serves as a liaison between the State and federal governments in terms of their management and operation, as well as the OHA HSD Licensing and Certification unit, who is responsible for issuing a State certification to operate an outpatient OTP. While a majority of Oregon’s OTPs are located in the Willamette Valley and “I-5” corridor (home to approximately 80% of Oregon’s population) several new facilities have opened in underserved rural and frontier areas of Oregon, including the Oregon Coast, and Eastern and Central Oregon. Several of these newer facilities have been supported through expansion efforts funded by Federal opioid related grant dollars. Demographically, Oregon’s OTPs have differing patient populations; while several located in Portland have significant populations of

people of color, the majority of the OTPs in the state mirror's Oregon's overall demographic landscape, with a vast majority of the patients self-identifying as "white".

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. 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 14,900 practitioners and pharmacists have PDMP accounts in Oregon;

- In 2016, more than 1.2 million queries were made by practitioners and pharmacists;
- Approximately 7 million prescription records are uploaded into the system annually.

Access to Recovery

Access to Recovery (ATR) was a three-year $2.3 million per year competitive grant that was secured by the Oregon Health Authority in May 2015. ATR operated in five counties: Multnomah, Clackamas, Washington, Marion, and Lane from May 2015 through April 2019, which included a no-cost extension. Through ATR 4 grant funding, OHA expanded and promoted a community-based Recovery Oriented Systems of Care (ROSC), serving 4,507 individuals. By increasing the number of providers, especially community and faith-based organizations who are trained and qualified to offer recovery services, OHA increased recovering individual's access to a wide variety of recovery support services. Oregon ATR 4 utilized SPARS data as well at the WITS voucher management system to analyze each program and the state as a whole. SPARS GPRA data shows that ATR services had a positive impact on every measure in the GPRA. Most notably was the rate of change ,135.4%, in permanent housing, which is defined as "had a permanent place to live in the community." Another significant rate of change, 105.8%, was in Employment/Education, which is defined as "currently employed or attending school." The following data table demonstrates the success of the ATR grant, the potential gaps in funding, and the importance of continuing funding of community-based recovery support services following the conclusion of the ATR grant.

Measures	# Valid Cases	Percent at Intake	Percent at 6-Month Follow-Up	Rate of Change
Abstinence (did not use alcohol or illegal drugs)	3,061	83.4%	84.5%	1.4%
Crime (had no past 30-day arrests)	3,063	96.0%	94.4%	-1.7%
Employment/Education (currently employed or attending school)	3,064	29.1%	59.9%	105.8%
Health/Behavioral (experienced no alcohol or illegal drug related health, behavioral, or social consequences)	3,062	88.1%	89.5%	1.6%

Social Connectedness (were socially connected)	3,064	98.8%	97.7%	-1.2%
Stability in Housing (had a permanent place to live in the community)	3,063	15.0%	35.4%	135.4%
Injection Drug Use (injected illegal drugs)	3,059	4.7%	3.8%	-20.7%
Had Unprotected Sexual Contact	370	71.6%	71.4%	-0.4%
Had Unprotected Sexual Contact with an Individual who is or was HIV Positive or has AIDS	214	0%	0%	N/A
Had Unprotected Sexual Contact with Injection Drug User	214	29.0%	30.4%	4.8%
Had Unprotected Sexual Contact with an Individual High on a Substance	214	12.6%	11.7%	-7.4%

Driving Under the Influence of Intoxicants (DUII) Treatment

Whether an individual enters into a diversion agreement or is convicted of 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.

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.

Choice Model Services

Choice Model Services, previously known as Adult Mental Health Initiative, is designed to promote more effective utilization of current capacity in facility-based treatment

settings, increase care coordination and increase accountability at a local and state level. Choice Model will promote the availability and quality of individualized community-based services and supports so that adults with mental illness are served in the most independent environment possible and use of long-term institutional care is minimized. The initiative re-allocated 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.

The target population is individuals who, because of mental illness: (a) Currently reside at an institution listed in ORS 179.321 and includes patients residing within a Neuro/Gero ward at OSH in Salem, Oregon; or (b) Currently reside in a licensed community based setting listed in ORS 443.400 and includes licensed programs designated specifically for young adults in transition; or (c) Are under a civil commitment pursuant to ORS 426; or (d) Were under a civil commitment that expired in the past 12 calendar months; or (e) Would deteriorate to meeting one of the above criteria without treatment and community supports; and (f) Does not include individuals who are under the jurisdiction of the Psychiatric Security Review Board (PSRB).

Choice 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. Providers are required to stay involved with their members throughout the full service continuum, and work with the individual to develop a care plan that meets the individual's needs and choices.

Choice 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. For individuals experiencing mental illness, residential treatment helps promote and enhance skills needed to lead independent healthy lives. Many coordinated care organization (CCO) members receive this kind of treatment on a temporary basis, outside their home community. After many thoughtful discussions with CCO and behavioral health stakeholders, the Oregon Health Authority updated CCO enrollment rules to support keeping individuals in their "home" CCO when in out-of-area treatment. (The "home" CCO is the CCO the individual had prior to being placed in temporary residential treatment.)

Residential Mental Health
Adult Mental Health Residential Treatment Programs

Adult Mental Health Residential Treatment is defined as a 24-hour level of care that provides a range of rehabilitative and habilitative services which cannot be provided in an outpatient setting. Placement in residential treatment is appropriate if the member is not in need of a higher level of physical security and frequency of psychiatric or nursing intervention that is available on an inpatient unit. The overall goal is to provide a therapeutic environment that is both safe and least restrictive to the individual.
Adult Residential Treatment includes Residential Treatment Facility (RTF); Residential Treatment Home (RTH); Secure Residential Treatment Facility (SRTF); Adult Foster Home (AFH). Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day. The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents. Most placements into these residential programs come from state hospitals and acute care facilities. An assessment and determination for admission is usually conducted by a local Community Mental Health Provider (CMHP).
HSD monitors and consults with licensed and contracted community providers to ensure appropriate services are being delivered to individuals in the least restrictive environment. Facilities are required to be licensed or accredited for the level and type of care provided and is practicing within the scope of its license.
Three levels 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	590
Residential Treatment Home	290
Residential Treatment Facility	498
Secure Residential Treatment Facility	539
TOTAL	1,917

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[1] 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 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;

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

- 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
Adult Mental Health Residential Treatment is defined as a 24-hour level of care that provides a range of rehabilitative and habilitative services which cannot be provided in an outpatient setting. Placement in residential treatment is appropriate if the member is not in need of a higher level of physical security and frequency of psychiatric or nursing intervention that is available on an inpatient unit. The overall goal is to provide a therapeutic environment that is both safe and least restrictive to the individual.
Adult Residential Treatment includes Residential Treatment Facility (RTF); Residential Treatment Home (RTH); Secure Residential Treatment Facility (SRTF); Adult Foster Home (AFH). Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed

24 hours a day. The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents. Most placements into these residential programs come from state hospitals and acute care facilities. An assessment and determination for admission is usually conducted by a local Community Mental Health Provider (CMHP).
HSD monitors and consults with licensed and contracted community providers to ensure appropriate services are being delivered to individuals in the least restrictive environment. Facilities are required to be licensed or accredited for the level and type of care provided and is practicing within the scope of its license.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is an Evidence-Based Practice (EBP) designed to provide comprehensive treatment and support services to individuals who are diagnosed with serious mental illness. ACT services are provided by a multidisciplinary team and are designed to be provided in the most integrated setting possible to maximize independence and community integration. The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) was created to promote and implement Assertive Community Treatment (ACT) as an evidence-based practice (EBP) throughout Oregon.

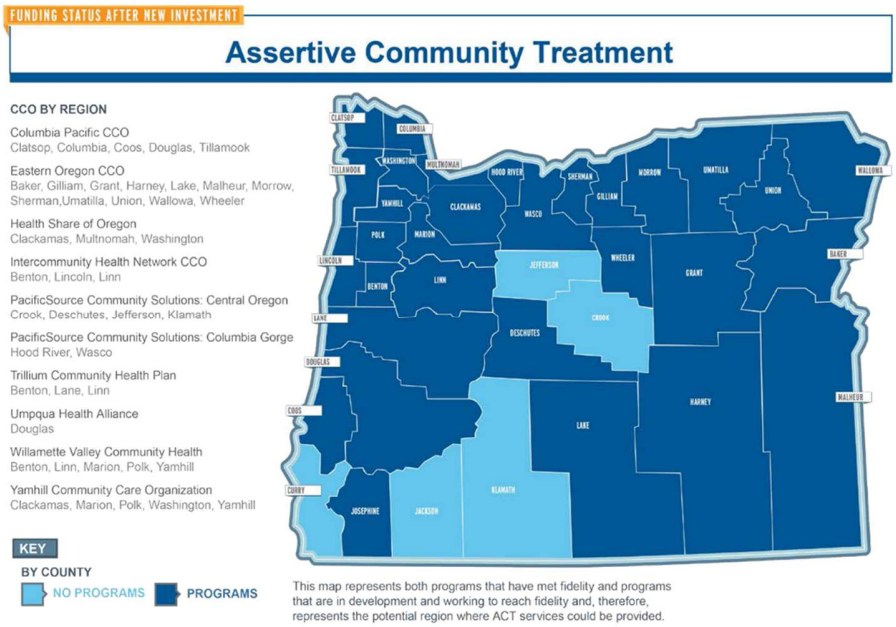
The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) is funded through a contract with the Oregon Health Systems Division (HSD) and is operated in partnership with the Oregon Supported Employment Center for Excellence(OSECE) and Options for Southern Oregon, which administers the contract.

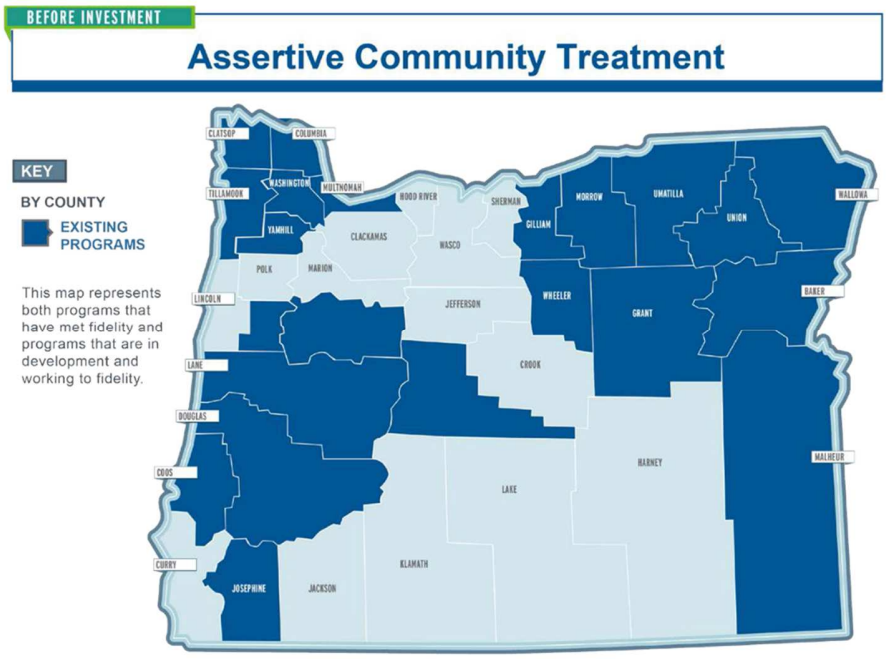
The primary goals of OCEACT are to:

- Provide training and technical assistance. OCEACT provides training and technical assistance to educate mental health service providers about the Assertive Community Treatment model. OCEACT statewide trainers provide expert consultation to established and developing ACT teams.
- Help programs achieve high fidelity to the ACT model and improve quality. The OCEACT staff conducts annual fidelity reviews of ACT programs statewide. OCEACT is a resource for current and future ACT teams interested in learning more about the ACT model and improving adherence to ACT principles.
- Organize an annual ACT conference. OCEACT sponsors an annual statewide conference on ACT and other relevant evidence based practices in mental health treatment.
- Measure and report statewide ACT program outcomes on a quarterly basis. High fidelity ACT programs have been shown to reduce psychiatric hospitalization and utilization of acute care, improve housing stability, and improve quality of life for

participants. ACT programs report on a core set of participant outcomes to measure the impact of the ACT program across Oregon.

- Educate and advise state and local policy makers. OCEACT staff meet regularly with representatives from the Oregon Health Authority and other stakeholders to share success stories, discuss implementation issues, program outcomes, and ways to best support high fidelity ACT model service delivery.





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) has implemented Wraparound, a research based practice model, for communities' children with the highest levels of need and their families. The SOCWI intensive care coordination model engages a creative and collaborative process 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, etc., 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. 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, Department of Human Services, developmental disabilities and Oregon Department of Education must tackle shared governance and funding of this business model for continued sustainability.

School Access to Mental Health/ School Based Health Centers
Adolescent and School health unit with HPCDP's prevention work around substance abuse prevention issues as capacity allows. Recent work includes: preparing and distributing the publications *Preventing Underage Marijuana Use: Parents' Guide to Talking with Your Kids* and *Preventing Youth from Using Marijuana: Educators' Guide*. Created an annual Adolescent Health Snapshot of health and behavioral data and presented outcomes from a policy framework. This information is shared with internal and external partners so that programs and policies can be most reflective of what adolescents experience. Information includes mental health and substance abuse issues. Oversees the Oregon School-Based Health Center (SBHCs) Program. There are 78 State-Certified SBHCs in Oregon. SBHCs receive grants for mental health capacity and/or youth-focused mental health projects. The majority of grant funds are used to support additional mental health providers in SBHCs. Grant funds are also used to support Youth Advisory Councils and Youth Participatory Action Research Projects.

- Providing Mental Health Services at SBHCs allows for timely mental health care, a strong system of care, a focus on prevention and a commitment to serving adolescents regardless of their ability to pay.

- SBHC mental health providers held behavioral health, psycho-education, support, and wellness groups for anxiety, depression, grief, and healthy relationships. These groups enabled providers to treat and work with more adolescents, do prevention work, and strengthen partnerships with school and community providers.
- SBHC mental health providers helped schools respond to mental health crisis situations by providing immediate intervention, as well as longer term grief and bereavement supports.
- Youth Action Councils assure clinic are welcoming to youth and help advertise clinic services to their peers.
- Youth Participatory Action Research topics included: mental health stigma, teen substance use, suicide prevention, sleep, effects of public displays of affection on school climate, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care.
- Each certified SBHC is required to report on two Core Key Performance Measures (KPMs), as well as one of five Optional KPMs. Substance Abuse Screening and Depression Screening are optional KPMs. The Core KPMs are the Adolescent Well-Visit and a Comprehensive Health Assessment. Both include mental health and substance abuse screening, prevention messaging and anticipatory guidance.

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.

There are now 77 SBHCs and 95% of them have mental health providers on site. There are also 9 counties, with about 24 schools, being served outside of the SBHC program, where CMHP therapists are out stationed in schools and serving kids, from elementary through high school.

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.

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. 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.

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 (CSEC)
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[2],” *Victims of Trafficking and Violence Protection Act of 2000* (TVPA, 2000).

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

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) created 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 collaborates 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 provides the following:

1. Serves 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. Assists in advancing CSEC priorities on a local, state and federal level;
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. Reviews current systems addressing CSEC, identify strengths and weaknesses;
6. Provide recommendations for the use of future CSEC funds, both public and private;
7. Assists in identifying public and private partnerships;
8. Partners with OHA to assist in ensuring successful policy implementation;
9. Participates on the CSEC advisory committee that reports to the CAMI board;
10. Works with state and local partners to establish a statewide, organized continuum of care and response for CSEC victims;
11. Develops protocol for CSEC victims grounded in System of Care values and principles; and,

12. Develops a State Plan with community partners and OHA staff, which address prevention, early intervention and services for potential and existing CSEC victims.

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.

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[3] has strengthened and expanded its Oregon capacity significantly 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,

[3] 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. 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 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.

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 (CW) Collaboration

The reformation of Oregon Intensive Treatment Services is a noteworthy collaborative effort between the Oregon Health Authority (OHA) and the Department of Human Services (DHS) effort to improve the mental health outcomes for children and their families. Currently, Oregon's lack of intensive service capacity (PRTS/Subacute) is resulting in youth being placed in inappropriate settings such as hotels, emergency departments, detention centers and homes without adequate mental health supports.

Efforts to address the intensive services capacity decline over the past 18 months have not been successful. Oregon's largest provider of PRTS/Subacute care, Trillium Family Services, reported on March 1, 2017 that there were 95 children and youth referred to PRTS/Subacute programs with no current openings. Out of those 95 referrals, 60 were for younger children. All other programs were also at capacity with a backlog of referrals. (There is additional information at http://www.oregon.gov/oha/bhp/Pages/Behavioral-Health-Collaborative.aspx)
Gaps remain in the system in the following areas:

- Increase in numbers of youth with intensive needs relative to treatment options.
- Utilization Management (UM) criteria and processes are inconsistent among CCOs causing confusion among state agencies with custody of youth needing care and PRTS/Subacute providers.
- Not enough providers to meet demand.
- Long wait times between acceptance and admission.
- Lengthy appeals/hearings process within OHA.
- Alternative services are limited by what is available in the community.
- Discharge options are limited by what is available in the community and state wide step down options.
- Gaps in service availability impact the Guardian's (DHS) ability to provide safe and appropriate residential placement to meet the needs of the youth.
- Use of General Funds to cover intensive mental health services for individuals who have private health insurance. This is related to the fact that some private insurance providers do not cover certain intensive mental health services.

The short-term plan includes the following steps:

- Immediately assess residential homes on hospital campuses in Salem and Junction City through partnership with DHS, to provide temporary shelter for youth and utilize if needed
- Increase the fee for service reimbursement rates
- Continue to track capacity, scrutinize outcomes and monitor current needs of the system
- Make CCO contract changes to ensure quality care of the youth with the highest intensity service needs and allow for a more centralized system of care for those youth.
- Enhance Technical assistance to CCOs and partner agencies to ensure quality care coordination and avoid children's unmet behavioral health needs causing a youth to enter into an inappropriate placement and reduce trauma

The longer term plan contains the following key objectives:

- Implement detailed capacity management system to track current capacity, trends and movement between intensive levels of care.
- Conduct regular rate analyses annually to ensure providers have a sufficient reimbursement rate to continue to provide this critical service.
- Work with CCOs and partners regarding incorporating the children's mental health residential services under the capitated rates.
- Complete System of Care governance structure implementation at the state level to include CCOs, Providers, Family, Youth and Agency Partners to discuss and manage capacity issues with Intensive Treatment Services and within the entire System of Care.
- Incentivize development of community based intensive outpatient services and supports which are data driven and have demonstrated outcomes connected to higher rates of school attendance, college entrance and workforce contribution later in life and lower likelihood of truancy, delinquency and incarceration.
- Increase the quality of high fidelity Wraparound, which hinges on holding CCOs accountable for Best Practices, further investment, by CCOs into behavioral health services, the use of data from the recommended metrics to incentivize the development of intensive outpatient services including intensive in home models, and thoughtful and thorough discharge planning during transitions out of intensive behavioral health covered services with adequate notice given to the guardian or other residential care provider.

Early Learning Council (ELC)

The Early Learning Council and Oregon Education Investment Board were established in 2011, 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[4]. These entities are referred to as **"**Community-based Coordinators of Early Learning Services" (hubs).

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.

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.

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

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 have transitioned 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 ½ through 25 who have mental health challenges and who may have a history of institutional care. Residential resources for young adults include seven young adult residential treatment homes (RTHs), as well as capacity for 51 young adults in supportive housing (Table 1).

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 is to track the length of time that clients stay in emergency departments waiting for resources. This will be one benchmark of the system.

OHA is working 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.

Community Withdrawal Management 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.

Crisis Intervention Team/ Law Enforcement - During the 2013 legislative session, the Oregon Legislature allocated funds to enhance and expand jail diversion services. 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 was completed in June, 2015.

Needs to be updated. 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 of care.

OHA and USDOJ have a shared interest in utilizing the Health System Transformation to improve health outcomes for individuals with SMI. OHA and USDOJ have agreed to have OHA 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. (Metric and data dictionary reference: 1.d.) 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 promotes the belief 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 supports through 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 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:

- Build 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;
- Help OHA behavioral health increase peer involvement in evaluating the state's policies, planning, and programs;
- Increase representation of consumers, survivors, and former patients-including ethnic and racial groups-in local and state mental health planning activities;
- Conduct a stigma and discrimination reduction initiative;
- Reduce racial and ethnic groups' barriers to mental health and addiction services by promoting culturally competent services for peers in these groups;
- Ensure that peers have a strong voice in state mental health and substance use disorder treatment policy development, planning and practice; and,
- Coordinate 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 service delivery. 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;
- More fully 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 and addictions 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, recovering or recovered from a mental health condition may provide services to an adult who is receiving mental health services;

- An adult who has either received additions services or self-identifies as a person in recovery, recovering or recovered 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 of mental health service delivery including: health promotion, outreach, crisis intervention, recovery support, advocacy skills, supported housing, SRT, SRTF, acute, and respite care. As a part of Oregon's health transformation efforts, Peer Support and Peer Wellness Specialists (PSS/PWS) are now organized under the as Traditional Health Workers (THW). OHA supports the use of PDS and plans to continue to increase the availability of PDS statewide.

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 the availability of PDS.

Peer Delivered Services in the Children's Behavioral Health System

Peer delivered services are effective in helping individuals build a foundation in the recovery 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 who are certified to deliver peer services. The Peer Delivered Service (PDS) Foundation's curriculum for young adults and family members is offered at least quarterly, includes content necessary for state certification, and provides 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 modality.

- The PDS curriculum also includes strength based assessment, use of lived experience, motivational interviewing, collaborative problem solving, holistic self-care, use of natural supports and community resources, cultural and linguistic responsiveness, suicide and interpersonal violence safety planning, relapse prevention, and trauma informed goal setting. The curriculum 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 206 certified Family Support Specialists and Youth Support Specialists on the Oregon Traditional Health Worker registry. Each new class trains 18-25 individuals. They are absorbed into the workforce as soon as they complete the training. A goal is to continue the development of combined online and traditional training with both distance and in person follow-up and supervision. A peer support coach training cohort began in 2017. These coaches will provide regional supervision in rural areas as well as local supervision in more urban settings. The Oregon Administrative Rule 309 requires supervision of PDS staff by a clinician and a PDS staff person certified in that specialty (adult mental health, adult addiction, family, or youth peer support). In 2018, the plan is to develop specialized PDS trainings on emergency services and suicide prevention and postvention safety planning.

- 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 Youth MOVE 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 Support Specialists from all disciplines (mental health, addiction, intellectual/developmental disability, special education, and complex health care needs) across Oregon meet together with OHA staff on a monthly basis for policy updates, to identify system issues, and to plan for advocacy

and training needs. The Family Workforce Association meets in person quarterly and was attended by 112 PDS family providers in 2016.

- There is a need to create a Center for Excellence for Peer Delivered Services, a collaboration of PDS staff and academicians in health outcomes, setting competency based standards for training, certification, and measurable services outcomes for the PDS. The model consists of subject matter experts of certified peer delivered services staff by discipline (adult to adult, parent to parent, and youth to youth) working with individuals at the University level who can provide research analysis. The joint effort would provide Oregon Health Authority with competency-based testing and certification for all types of peer support. It would also provide the guidance for the collection and analysis of outcomes data on the use of PDS. This body of knowledge would further modify the training and supervision/coaching mechanisms for effective PDS.

Access to Peer Support Services

Oregon Administrative Rule (OAR 309) now requires behavioral health services clinical providers to ensure access to PDS for families with children and youth. This makes it possible for Family Support Specialists (FSS) to be members of emergency department follow-up teams. It is anticipated that Family Support Specialists will also be added to outpatient teams, including CCBHC, , FQHC, and School-Based Health Center. There is a more acute need to offer Family Support Specialist services to families before they have access to regular behavioral health. When PDS were offered in one community with three FSS, in the community, all 93 families were able to maintain without having to utilize crisis teams and hospital emergency departments until they could access outpatient services in 3-6 weeks after the initial contact with the FSS.

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.

Mental Health Block Grant funds supported the expansion of recovery support services in 2015-2017, 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), AMH 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 Workgroup

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 Workgroup which meets regularly to develop recommendations to increase access to quality peer delivered recovery support services. PDS Workgroup 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, a representative from the Office of Equity and Inclusion (OEI), and representative form Traditional Health Worker's Commission. The Committee is addressing methods to increase use of Medicaid funding for PDS, increase the peer voice in the discussions, setting standards and competencies for the PDS providers, increasing ad retaining PDS workforce, and decrease health inequity.

Traditional Health Worker's Commission

Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS) are included in the 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 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. Recently, the Warmline contract has been amended to include out-of-state phone numbers instead of screening them out, to ensure individuals who are residents of Oregon but have out-of-state phone numbers are not missed.

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.

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, AMH 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. 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 was extended to ensure 1:1 outreach and engagement for families

prior to a child or youth receiving a mental health diagnosis. Peer support services 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, OHA will partner with the OHA 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.

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 meeting with the nine tribes on a monthly 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 Tribal Affairs Director (TAD) who serves as a tribal liaison to the nine federally recognized tribes. The Tribal Affairs Director attends tribal functions to continue building understanding and rapport with Native American communities. The TAD 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 TAD to ensure that cultural considerations and tribal voices are included in planning efforts to work with Tribes across Oregon.

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.

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. A second cohort started with left-over funding from the first cohort.

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. Students are 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 2016, 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 was 12.8% in 2016, according to the Census Report. 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(a) behavioral health providers to the Latino(a) population served for behavioral health services is not close to being equivalent.

In August 2014, CHEP presented behavioral health data for Latino(a)s 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(a) community regarding behavioral health services and the needs and barriers to services identified by the Hispanic/Latino(a) population. The survey results have lead to the creation of recommendations regarding behavioral health in support of the Hispanic/Latino(a) 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. OHP covers youth who are not covered by their parents' insurance. 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 (a) youth.

Problem Gambling Services

Oregon has a long history of addressing the risks associated with gambling through research, prevention and education, responsible gambling guidelines, treatment, strong partnerships and collaborations. Oregon uses the public health approach that combines prevention, harm reduction and multiple levels of treatment focusing on quality of life issues for individuals with problems with gambling, their families and communities.

In Oregon, it is estimated 2.6 percent of the adult population experience moderate or serious problems with gambling. For each person with a serious problem, many others are affected (e.g., spouse, children). One percent of Oregon Lottery revenues fund problem gambling services. The Oregon Health Authority administers the funds that provides approximately $7.5 million annually for prevention and treatment programs and services within each county.

Oregon is a national leader in preventing and treating gambling related problems, promoting informed and balanced attitudes and protecting vulnerable groups. These goals are accomplished by promoting healthy public policy, developing collaborative relationships among various stakeholder groups and providing local governments with funds to develop strategies like those used in other behavioral health systems.

Oregon provides prevention, outreach, early intervention, treatment and recovery services across the continuum of care at NO COST to the individual with a problem with gambling, and family members or significant persons impacted by the gambling. The following is a list of the type of services OHA funds provide:

- Prevention and outreach efforts, stand alone and infused into other prevention efforts such as suicide, alcohol, tobacco and other drug. Oregon's prevention efforts are guided by the Center for Substance Abuse Prevention's (CSAP) six core prevention strategies and the Social Ecological Model;
- 24- hour Helpline staffed by professional certified problem gambling specialists;
- A minimal intervention program involving phone counseling with a workbook;
- Outpatient treatment services in every county;
- 2 centers providing Crisis Respite care;
- 1 Residential treatment center; and
- Culturally specific and prison-based treatment programs

In fiscal year 2017-8, 947 individuals received problem gambling treatment services, along with 117 family members or those impacted by the negative consequences of gambling. Fifty-five individuals were enrolled in residential service. 1021 calls for assistance or information were made to the Helpline, along with 314 web chats and 124 text messages. Data collected from our treatment evaluation system informed that at six-month follow-up from those that successfully completed treatment, 51.1 percent reported no gambling; 37.8 percent reports much less gambling. Additionally, at 12-month follow-up, individuals served provided a very strong endorsement of willingness to recommend the program to others.

Strengths of Program:

- Guaranteeing that problem gambling prevention and treatment funding is provided in each county.
- Supporting the development and implementation of the PGS five-year strategic system improvement plan that guides projects, outputs, outcomes and future planning and decision-making.

- Ensuring culturally relevant treatment services for Latinos, African Americans, Native Americans and Asian Americans.
- Ensuring treatment or psycho-education for incarcerated persons and other high-risk populations.
- Implementing a program evaluation system that allows the program to gather demographic data on the individuals served, along with feedback on the services, as both help to inform decisions.
- Monitoring risk of gambling in Oregon through completion of an Oregon Adult Gambling Behavior Study (2015) and an Oregon Adolescent and Parent Gambling Behavior Study (2016).
- Ensuring prevention providers conduct community readiness assessments to obtain metrics to guide future planning.
- Implementing the Positive Cultural Framework model within our system to increase awareness of problem gambling though enhanced communication and messaging.
- Providing, in partnership with Oregon Lottery, access to information, help and hope through the Oregon Problem Gambling Resource web page. This web page directs visitors to our helpline through options of calling, texting, motivational texting or online chatting and is also available in Spanish.
- Strengthening our connections to and partnership with the emerging problem gambling recovering community.
- Sustaining partnerships and meeting regularly the Oregon Council on Problem Gambling, which is a consortium of various key players interested in this issue.

Gaps/Need for the Future:

- Need for funding availability from the Federal level and provided to states to support problem gambling services.
- Need for designation of Federal level entity to direct national level efforts and assisting with increasing awareness that gambling carries risk through media campaigns and other efforts.
- Need for increase in multicultural and special population treatment and prevention services in Oregon and across the nation.
- Need to support a minimum of .5 FTE for prevention program in each county of Oregon.
- Need for resources to support housing availability and opportunities for individuals with gambling problems.
- Need for resources to expand and support recovery services; development of telephone peer support services.
- Need for resources to expand and support additional problem gambling treatment residential services in Oregon and nationally.

- Need for resources to include gaming disorder among the problem gambling service systems to raise awareness and train workforce to best address this emerging issue.