Governor's Behavioral Health Advisory Council Recommendations

HEALTH SYSTEMS DIVISION
Office of Behavioral Health

October 2020

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Message from the Co-Chairs

We would like to thank Governor Brown for the opportunity to bring together a highly qualified group of experts on Oregon's behavioral health delivery system. The group represented behavioral health systems, consumers with lived experience, and clinicians who were brought together to jointly guide the development of recommendations to improve people's access to effective behavioral health services. We have been honored to work with this remarkable and dedicated group of individuals and proud to submit this report which reflects the Council's work.

The Council focused on fundamentals that will help strengthen the foundation for better care in Oregon, such as housing, behavioral health workforce, and gaps in the service delivery system. Oregon has one of the highest rates of people who are homeless in the country and most people who are homeless have a mental illness, addiction or both. None of our existing or future investment in treatment services will fully pay off if we don't also invest in housing and supports. People won't get or stay better when they don't have safe and supportive places to live.

The Council also acknowledges we have not sufficiently invested in our behavioral health workforce and we won't improve access to needed services until we do. We need more people to enter and stay in the field at all levels of care and in all areas of the state. We need a workforce that reflects Oregon's rich diversity and helps ensure the care being provided is responsive to who people are, along with what they need. And, to help make our investments in recruitment and retention pay off with effective care, we need to strengthen worker training, not just in models of care but also in trauma, engagement and equity. These are the kinds of worker preparations that will improve service quality and outcomes.

We think it's time to face the historic wage disparity in behavioral health. We won't be successful in strengthening our behavioral health systems of care without strengthening our workforce and we won't be successful in strengthening our workforce until we begin paying and incentivizing people appropriately to continue performing this critically important and challenging work. There is no defensible reason to pay behavioral health workers less than similarly qualified workers in the rest of healthcare and right now, we do.

Given these considerations, the Council's recommendations focus on a balanced set of high-leverage opportunities, including programs developed and driven by communities of color and tribal communities. Examples include investments in Tribal Based Practice and culturally based practice. The recommendations are designed to impact both rural and urban areas, like the workforce incentive fund for people of color, and people from tribal and rural communities. The recommendations promote and build on existing best practices like Early Assessment and Support Alliance (EASA), as well as promising practice like Peer Run Respite Centers. The recommendations provide for community-based supports for people across the spectrum of need, from flexible housing support to secure residential treatment and community restoration. Finally, the recommendations take modest but important steps to begin systems level change – including streamlining documentation requirements for behavioral health providers and supporting the development of a statewide crisis and behavioral health support tool.

The Council's work was shaped by the remarkable year in which it was convened and completed its work. During the past year, the COVID-19 pandemic swept through the world and significantly disrupted our everyday lives in Oregon and exacerbated and highlighted long-standing health disparities among our communities of

color. We in Oregon have also just experienced the worst fire season in a generation with mass devastation of communities across the state. The pandemic and fire season combined to have a deep emotional impact on people in Oregon as the Council developed its recommendations, highlighting the shortcomings of our existing systems and the urgent need for improvements.

In this context, we want to acknowledge that the Council's members and volunteers who participated in this process are, themselves, healthcare heroes. They have been working long hours under often difficult circumstances to either provide services directly or ensure services could be delivered while they also attended to their families and communities.

While a few participants felt discouraged that the end-product did not go far enough to transform the system, most saw the fruit of the Council's labor as important progress in the longer-term effort needed to create a behavioral health system that is simpler for people to access, more responsive to their needs, and that leads to meaningful improvements in their lives. We congratulate the Council in developing a roadmap of investments, centered on health equity, that will strengthen community-based services that benefit all Oregonians.

Steve Allen, Co-chair
Behavioral Health Director
Oregon Health Authority

Rachel Solotaroff, Co-chair
President & CEO
Central City Concern

Executive summary

This document provides the prioritized recommendations of the Governor's Behavioral Health Advisory Council (GBHAC). These recommendations represent general agreement and support by a strong majority of GBHAC members and persons with lived experience who participated in the recommendations' development. The Council now sends these recommendations to the Governor's Office, the Racial Justice Council, the Governor's System of Care Advisory Council, and other advisory councils for further consideration and alignment.

The GBHAC was established by Executive Order on October 18, 2019, and was charged with "the development of recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transition-aged youth with serious mental illness or co-occurring mental illness and substance use disorders." The GBHAC was charged with recommending to the Governor specific actions and investments necessary to improve access to behavioral health care that is responsive to people's individual needs and characteristics, and improves health outcomes. Guiding the Council's work were a number of principles and values:

- Health equity is advanced within the state's behavioral health system.
- Mental health and substance use disorders are detected early and treated effectively.
- Youth and adults with serious mental illness have timely access to the full continuum of behavioral health care.
- Youth and adults with serious mental illness can receive treatment that is responsive to their individual needs and leads to meaningful improvements in their lives.
- People with serious mental illness have access to affordable housing that offers independence and is close to providers, community resources, and public transportation.
- People have ready access to a broad-range of behavioral health workers who are well-trained to effectively engage them and provide care that is responsive to their needs and individual characteristics.

The Council organized their work into three areas of investments: *Programs and Services, Workforce* and *Housing*. Each Affinity Group developed and prioritized recommendations reflecting the charge above and the Council's foundational principles

The Council faced many obstacles including interruption due to the COVID-19 pandemic and a dramatic change in the budget outlook. During the course of the Council's work, the disproportionate impacts of the pandemic on our communities of color and tribal communities deepened discussion of health equity and the urgency for action and system reforms, in addition to recommended investments.

Members expressed disappointment that in the COVID-abbreviated schedule, the Council was not able to undertake a second set of planned activities related to improving the functioning of Oregon's behavioral health system as a whole. Planned topics included data collection and outcome measures, system accountability and outcome-based financing strategies.

Recognizing the depth and urgency of current needs in Oregon, the broader systemic changes that must be addressed to improve outcomes for people, and the critical work needed to bring about health equity and racial justice, these recommendations represent a starting point in a longer-term transformation effort. The Council appreciate the opportunity to present the following recommendations and look forward to working with the Governor toward progress.

The Council recommends the following investments in **behavioral health programs and services**:

1. Program changes that are directly responsive to and driven by communities of color, tribal communities and people with lived experience:
    a. Funds to support Medicaid reimbursement of Tribal Based Practices
    b. A state-funded pilot to create three non-clinical peer-run respite centers, including a culturally and/or linguistically specific program designed to provide services and supports to people of color.
    c. Expansion for the Early Assessment and Support Alliance (EASA) program from a two-year program to a three-year program
    d. Funding to double the program size of Young Adult Hubs, which are modeled after a Transition to Independence Process and provide mental health services, case management and support for disconnected youth.
2. Funding for continued operations and study of existing Certified Community Behavioral Health Clinic (CCBHC) demonstration sites.
3. Increased support for community restoration and an additional 16-bed secure residential treatment facility for defendants who do not have fitness to proceed in a criminal matter ("aid and assist" defendants).
4. Design of a statewide crisis system through OHA's ongoing development of a statewide crisis and behavioral health support tool called Oregon Behavioral Health Access System.

The Council recommends the following investments in **behavioral health workforce**:

1. Creation of a behavioral health incentive fund for recruitment and retention of the workforce to increase the number of people of color, people from tribal communities, and rurally based people in the behavioral health workforce.
2. Implementation and sustainability of culturally based practices, including promising practice and practices outside of the conventional medical model.
3. Support for training of the behavioral health workforce.
    a. All behavioral health workforce should be trained in the following: trauma-informed care and workplaces, culturally and linguistically specific/responsive care, anti-racism, equity, interdisciplinary care (including working with peers), leadership and management development, and co-occurring disorders
    b. Develop an outcomes-based system to demonstrate anti-racism and equity training.
4. 309 rule revision to reduce provider administrative burden.

The Council recommends the following investments in **housing and housing supports:**

1. Address housing and independent, community-based living needs by:
    a. Increase OHA funding for Rental Assistance with barrier busting funds and wraparound support.
    b. Create a flexible housing and independent, community-based living fund to fill gaps in the housing continuum for people of color, including recovery housing.
2. Development of additional Residential Treatment Facility and Secure Residential Treatment Facility capacity.
3. A state-funded pilot to create three non-clinical peer-run respite centers, including a culturally specific program designed to provide services and supports to people of color.
4. Transfer of the Housing for Mental Health Fund (ORS 458.380) to the Oregon Health Authority from Oregon Housing and Community Services.
5. Coordinated care organization (CCO) requirements for housing navigation and Social Determinants of Health through care coordination.

For all recommendations requiring investment, OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set-aside for funding opportunities specific for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt funding/programming to meet the need of tribal communities.

Membership

See formal membership document at the formation of the Council here.

GBHAC Member Name	Organization	Ex-Officio/Agency Member	Organization2
Sen. Denyc Boles	Senate District 10	Steve Allen, Co-Chair*	Oregon Health Authority
Sen. Arnie Roblan	Senate District 5	Joe Bugher	Oregon Department of Corrections
Rep. Cedric Hayden	House District 7	Tina Edlund	Office of Governor Kate Brown
Rep. Sheri Schouten	House District 27	Jackie Yerby	Office of Governor Kate Brown
Jill Archer	CareOregon	Kelly Fitzpatrick	Oregon Department of Veterans' Affairs
Wil Berry, MD	Deschutes County Behavioral Health	Kenny LaPoint	Oregon Housing & Community Services
Chris Bouneff	National Alliance on Mental Illness Oregon	Jeff Rhoades, JD	Office of Governor Kate Brown
Greg Brigham, PHD	Adapt Oregon	Reginald Richardson, MD	Alcohol and Drug Policy Commission
Judge Audrey Broyles	Marion County Circuit Court	Tashia Sizemore	Department of Consumer & Business Services
Ebony Clarke	Multnomah County	Shannon Singleton	Office of Governor Kate Brown
Melissa Eckstein	Unity Center for Behavioral Health	Lillian Shirley, BSN, MPH, MPA	Oregon Health Authority
Jeffrey Eisen, MD, MBA	Cascadia Behavioral Healthcare	Peter Sprengelmeyer	Oregon Youth Authority
Kevin Fitts	Oregon Mental Health Consumers Association	Don Erickson	Oregon Department of Human Services
Mike Franz, MD, DFAACAP, FAPA	PacificSource Community Solutions	**Persons of Lived Experience, Young Adults, Advocates**	
Robin Henderson, PsyD	Providence Health & Services	Sandy Bumpus	
Dwight Holton	Lines for Life	Danielle Grondin	
Dolores Jimerson, MSW, LCSW	Yellowhawk Tribal Health Center	Jacek Haciak, PsyD	
Chair Cheryle Kennedy	Confederated Tribes of Grand Ronde	Elliott Hinkle	
Kimberly Lindsey	Morrow, Grant, Gilliam, and Wheeler Counties	Ann Kasper, MA	
Sandra McDonough	Oregon Business and Industries	Janie Marsh, MPA	
Comm. Sharon Meieran, MD, JD	Multnomah County Commissioner, District 1	Emily Morrisey	
Jackie Mercer	Native American Rehabilitation Association of the Northwest (NARA)	Shannon Olive	
Mary Monnat	Lifeworks Northwest	Caroline Owczarzak	
Monique Jones, MD	OHSU Avel Gordly Center for Healing	Michelle Owens	
Jason Myers	Oregon State Sheriff's Association	Shane Roberts	
Tammi Paul	Oregon Family Support Network	Laura Rose	
Olivia Quiroz	Oregon Latino Health Coalition	Steve Sanden	
Sarah Radcliffe	Disability Rights Oregon	Samantha Skinner	
Mary Rumbaugh	Clackamas County	Joseph Stepanenko	
Michelle Shaw, MD, FACEP	Oregon College of Emergency Physicians	**Consultant**	**Organization**
Diane Solomon, PhD, PMHNP	Nurse Practitioners of Oregon, Oregon Nurses Association	Diana Bianco	Artemis Consulting
Rachel Solotaroff, Co-Chair*	Central City Concern		
Toc Soneoulay-Gillespie	Oregon Commission on Asian and Pacific Islander Affairs		
Paul Stewart	Sky Lakes Medical Center		
Karen Wheeler	Greater Oregon Behavioral Health, Inc.		

GBHAC process

Shared-learning and Affinity Group process

The GBHAC began its process in October 2019 through shared learning activities and reviewing recommendations from other workgroups and commissions from the last 10 years (Appendix A). Throughout the process, staff sought alignment with concurrent plans, including the Tribal Behavioral Health Strategic Plan, the Alcohol and Drug Policy Commission Strategic Plan, and the State Health Improvement Plan. The Council reviewed information to ensure that:

1. Council participants had a shared understanding of the behavioral health landscape, system changes and investment efforts that had taken place up until that point.
2. The GBHAC could build on and avoid duplication of past recommendations.
3. Participants could look to fund or complement recommendations that align with the GBHAC charge and principles.

At the end of 2019, the group adopted Oregon Health Authority's (OHA) Health Equity Definition as an equity framework to guide their work:

> Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address: the equitable distribution and redistribution of resources and power; and recognizing, reconciling, and rectifying historical and contemporary injustices.

The Council also established three principles to ground their recommendations:

1. *Simple:* Recommendations should improve simplicity of access to needed services and reduce barriers to receiving care. People should be able to gain timely access to services regardless of their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities, identities or other socially determined circumstances.
2. *Responsive:* Recommendations should be responsive to people's unique individual needs and characteristics including cultural and language access needs. The current system is cumbersome and can alienate people with a "one size fits all" approach. There is opportunity to optimize and elevate models that are working well and improve continuity of care.
3. *Meaningful*: Recommendations should result in meaningful improvements in people's lives, as defined by the person participating in services.

Based on the shared learning activities, principles and presentations on key issues like the behavioral health budget, housing and health equity, the group developed a policy package framework and a work plan that would lead to policy recommendations by October 2020. The framework established six areas of focus for development of policy recommendations:

Phase One	Phase Two[1]
Areas where the state needs to improve availability of supports and services	Areas where the state needs to improve system effectiveness
1. Programs and Services	4. Data/Outcomes
2. Workforce	5. Accountability
3. Housing and Housing Related Supports	6. Funding/Incentives

The Council's work plan created Affinity Groups to further develop each area – members self-selected an Affinity Group based on their own interest or expertise. Affinity Groups were tasked with formulating policy recommendations and bringing them to the full Council for further refinement and approval. The Phase One Affinity Groups included programs and services, workforce and housing. This first set of Affinity Groups initially met from January to March 2020 and then continued their work in July, following a break for COVID-19.

Consumer Engagement

During the Affinity Group deliberations in early 2020, the Council engaged with consumers, peers and other persons with lived experience in the development of Affinity Group recommendations. The Director of the Office of Consumer Activities (OHA-OCA) played an important role in the leadership and support of the Council, bringing her own lived experience to the group, representing the needs and concerns of consumers, and advising on how to support and further strengthen consumer participation throughout the process. OHA-OCA worked with the Oregon Consumer Advisory Council (OCAC) and three consumer members of the GBHAC to identify people with lived experience to participate in the Council deliberations. Eleven people with lived experience joined the council as consumer participants in January, participating in Affinity Groups and helping to craft recommendations. Several others joined the work when the GBHAC reconvened in June to help shape the group's final recommendations.

OHA-OCA provided ongoing support to consumer participants, including hosting meetings for consumers to prepare for Council meetings and discuss recommendations and feedback in depth. They also provided regular updates on the Council's work to the OCAC, Addictions and Mental Health Planning Advisory Council (AMHPAC), and Children's Systems Advisory Council (CSAC). They held two community dialogue meetings, one in Klamath Falls and one in Corvallis, to share information about the Council, collect feedback, and recruit consumer participants. More were planned but unable to be completed due to COVID-19.

[1] The Council was not able to begin work on these topics due to the shortened timeline caused by the COVID-19 pandemic.

Finally, OHA-OCA and other OHA staff worked with the Healthy Transitions Project, Oregon Health & Science University Early Assessment and Support Alliance (EASA) Center for Excellence, and Youth ERA to engage youth and young adults to provide input on the work of the GBHAC. Five young adults with lived experience regularly participated in the deliberations. These groups also organized a survey and Youth Advisory Council statewide summit to provide input.

The quality of the engagement, deliberations and guidance from the people with lived experience who joined the Council during the project was extraordinary. Participants who joined throughout the process greatly improved the Council's deliberations and the quality of its recommendations. Based on feedback from these participants and other community members, a process improvement would be to engage the broader consumer community from the very beginning of deliberations (October) and to provide a larger presence in the formal membership of the Council. COVID-19 prevented further state listening sessions with the larger consumer community. OHA and the Governor's Office sought to rectify that by providing consumer and peer participants with as many opportunities as possible to provide input and weigh in on the recommendations as they were drafted. Going forward, the agency and consumer participants recommend broader consumer engagement and formalized input and review by OHA's existing behavioral health advisory bodies for future councils related to behavioral health. Additional consumer feedback on this point is discussed below.

COVID-19 impact on the Council's work

By the end of March, Oregon was fully immersed in the COVID-19 pandemic. As a result of limited capacity by state employees tasked with responding to COVID-19 and by Council participants, the Council paused and canceled meetings in April and May. Unfortunately, the Council missed months when they would have deliberated on the second phase of policy topics – metrics/outcomes, payment/incentives, and accountability.

Social isolation, financial instability and anxiety caused by the pandemic all contributed to growing need for behavioral health services. As this need was increasing, physical distancing requirements and lower provider capacity affected accessibility of behavioral health services. COVID-19 and the response actions needed to moderate the health impacts of the virus have resulted in an economic downturn, negatively impacting the state's budget and creating uncertainty about the state's ability to invest in new behavioral health programs.

To help ensure progress during the Council's pause, OHA staff took ideas generated from the Affinity Groups in March and worked to include them in OHA's Agency Request Budget (ARB). These actions were designed to help ensure the Council's recommendations would have a pathway for inclusion in the Governor's budget.

When the Council reconvened in June and July, the agency presented the Council's recommendations as captured in the ARB as a potential vehicle for consideration. The Council requested additional time to review and refine the proposals. The Council reconvened the Affinity Groups to affirm and refine their work and to prioritize their recommendations given COVID-19 and the new budget landscape. Reconvening also allowed the Affinity Groups to ensure recommendations included an intentional focus on racial equity (*See Council shared-learning on equity*).

Final Deliberations and Council Support

In August and September, the Council met as a full body to refine and prioritize the Affinity Group recommendations. The Council held three full meetings in August and September to maximize opportunities for Council members and consumer participants to weigh in and shape the final recommendations. During the Council's final meeting on September 14, the co-chairs asked Council participants for their support on the recommendations (those who were unable to attend were asked to comment via survey or email). Support was defined as being generally supportive of the concepts within the recommendations and pledging not to actively work against the recommendations moving forward.

Forty of 50 council members and participants with lived experience support the recommendations (Appendix B).[2] No member stated direct opposition to the recommendations. A minority of Council members remained neutral on the recommendations or took no stance.[3]

Two primary process themes emerged in the Council's final deliberations, reflecting sentiments of some supporters and those who took a neutral stance:

- *Consumer voice:* Participants stated that voices of people with lived experience (including youth and family voice), should be involved at all levels, from the very beginning of each group or process. Participants felt that having that voice from the beginning would have improved the groups' relational learning and established a stronger dialogue between members and participants with lived experience. Participants also noted that the Council's formal roster did not have enough representation of persons with lived experience. While the statute may not apply to this Council directly, participants cited the spirit of ORS 430.075 as important guidance for member selection: "at least 20 percent of the membership of all task forces, commissions, advisory groups and committees established by a public body, as defined in ORS 174.109 ("public body" defined), shall be consumers, with representation balanced by age."
- *Innovation:* Some participants voiced concern that the Council did not put forward innovative, intersectional policy reform or get to larger transformational issues that would have likely been discussed during the second phase of policy topics. Some participants cited the need to look at the behavioral health system as a whole and push for urgent, large-scale systems improvement and innovation. One criticism was that participants were often provided with questions or meeting objectives that did not allow for greater dialogue and innovative thinking. Consumer participants felt that GBHAC missed an opportunity to expand options outside of typical offerings, which are focused on medical model and dominant culture values. One participant felt that greater dialogue could lead to focus on interconnections between mental health and addictions and social injustice, racism, poverty, and other forms of oppression. Likewise, other participants felt that by not convening the second phase of Affinity Groups, the group missed an opportunity to discuss building up health information and accountability. Participants expressed hope that these conversations would continue in the future.

Other participants such as NAMI Oregon and Oregon Business and Industry offered different reasons for remaining neutral on the Council 's recommendations. NAMI Oregon stated support for the housing recommendations as they are consistent with its advocacy priorities in recent past. For the other recommendations, it remained neutral as they may cite other investments as being of higher priority in their future advocacy. Overall, NAMI Oregon finds the other recommendations reasonable and would not oppose a budget proposal reflecting the recommendations. Oregon Business and Industry remained neutral due the budget impact of the package in the current fiscal environment. However, it found that all of the recommendations address the right priorities.

[2] 40 participants support, 0 against, 6 neutral, 2 took no stance, and 2 members supported some recommendations but wanted to remain neutral on others.

[3] Two members "took no stance" because were unavailable during the final deliberations.

While some felt discouraged by the end-product, many saw progress. Members acknowledged that the Council put together a concrete, valuable set of investments that would benefit Oregonians. Some participants felt the package represents a first step in repairing and reshaping a broken behavioral health system, and that a number of the recommendations include innovative practice (CCBHC, Peer Run Respite, and flexible housing assistance). The agency committed to working with participants in ongoing transformation efforts and to harness the ideas and voice of the participants. Members and participants with lived experience showed desire to maintain momentum of effort and engagement and continue conversations with OHA.

The Council now sends these recommendations to the Governor's Office and the Racial Justice Council for further consideration and alignment. The Council has submitted its recommendations to the System of Care Advisory Council for alignment and support due to the overlapping nature of the charges of these two bodies. OHA will seek consultation with the Oregon Tribes and confer with the Urban Indian Health Program as the recommendations become legislative concepts. Finally, the Council will also send these recommendations to other behavioral health advisory councils and statutory advisory bodies for further input as the recommendations move through the budgetary and legislative process.

Council's shared learning on equity

As mentioned above, the GBHAC adopted OHA's Health Equity Definition[4] as part of its foundational principles. The Council also heard a presentation from OHA's Equity and Inclusion Division on health equity and the upstream drivers of behavioral health, including historical and structural racism and the resulting intergenerational trauma and toxic stress for communities of color and tribal communities. While the equity principles and learnings were present in early deliberations and discussed as a lens by which to evaluate policy, it took time, shared learning, and reckoning as individuals and as a group to center equity as a framework for the recommendations. The GBHAC's members of color and members of tribal communities often led and provided important guidance and perspective in helping the group become more intentional in shaping policy to address equity. The shared insights, dedication and courage of said members was inspiring and had profound impacts on the Council's work and the members, themselves.

In the shared learning exercise and the Affinity Group deliberations in early 2020, health equity was used as a lens through which to evaluate policy ideas. However, as the Council reconvened from its COVID-19 pause in June 2020, a new centering and intentionality on race emerged in response to what was happening around Oregon and the rest of the country. Specifically, the murder of George Floyd by a Minneapolis police officer on May 25 and the resulting large-scale protests for racial justice increased member dialogue and shared learning about structural and systematic racism. Moreover, the group discussed the disparate impact of COVID-19 on Oregon's communities of color and tribal communities caused by the inequitable distribution of power and health care resources throughout the state. Social determinants of health deepened disparities, such as the disproportionate share of persons of color in essential, low-wage jobs without health insurance. COVID-19's impact also highlighted the lack of race-specific data on community needs and investment in services responsive to those needs.

In response, the Governor's Office, OHA and Council membership all took steps to redouble efforts to center racial equity in the group's deliberations. First, the Council met in June to have a conversation about race in the behavioral health system and how the structures and programs in the behavioral health system perpetuate racism. Second, the Council heard from persons of color with lived experience on ways the behavioral health system can be more responsive to communities of color and be more inclusive and representative of consumers of color in behavioral health policy decisions. Thirdly, the Governor established the Governor's Racial Justice Council and directed the GBHAC to prioritize their recommendations based on equity and submit their recommendations to Racial Justice Council subcommittees for further review and refinement.

Based on the additional shared learning, guidance and dialogue, the Council refined and reprioritized their recommendations on those that explicitly focused on equity and those that redistribute resources to programs

[4] Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address: the equitable distribution and redistribution of resources and power; and recognizing, reconciling, and rectifying historical and contemporary injustices.

and services designed and delivered by communities of color and tribal communities. Some Affinity Groups deliberated on priority populations and whether to lead with race in the goal of promoting health equity. For example, the recommendations for flexible housing assistance and workforce funds prioritize the following populations in addition to communities of color and tribal communities: immigrant and refugee communities, LGBTQIA+/LGBTQIA+ youth, people with disabilities (including those with physical, intellectual and developmental disabilities), veterans, people with a history of criminal justice involvement, and non-English speaking communities. Consumer participants also highlighted the marginalization experienced by individuals who live with mental health or addictions, the shared culture that has developed from their common experiences, and the need for services and supports that recognize and support these factors. Finally, based on discussions with members from tribal communities, specificity was added to recommendations to ensure that for every funded program, there is consultation and specific funding provisions/opportunities for the tribes and the Urban Indian Health Program.

Members expressed a desire to provide consistent definitions to capture the Council's intent with respect to terminology used in its recommendations.[5] OHA has worked to capture those definitions here:

a. Culturally and linguistically responsive services: the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.[6]
b. Culturally and linguistically specific services: provision of culturally and linguistically responsive services (see above) designed for a specific population by a provider who shares the culture, language, and/or identity with the person seeking services.
c. Anti-Racist programming/training: programming and training that actively works against policy, practice and structures that perpetuate racism and racial inequality.

Participants noted that increasing access to culturally and linguistically responsive and specific services will take time, planning and ongoing investment. Participants noted that, in the long term, changes to the workforce and delivery system are needed to make those services effective and truly responsive.

[5] These terms were never explicitly defined by the council as a whole and do not reflect the official OHA use of the term. These definitions attempt to capture intent and how the terms were commonly used in deliberations.
[6] The council's usage of the term mirrored how "Culturally and Linguistically Appropriate" is defined in the Coordinated Care Organization 2020 Contract Exhibit A. Page 24. https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf

Programs and Services recommendations

Budgetary Priority	Recommendation
1	The Council recommends the following program changes that are directly responsive to and driven by communities of color, tribal communities and people of lived experience: • Funds to support Medicaid reimbursement of Tribal Based Practices. • A state-funded pilot to create three non-clinical peer-run respite centers, including a culturally and/or linguistically specific program designed to provide services and supports to people of color. • Expansion for the Early Assessment and Support Alliance (EASA) program from a two-year program to a three-year program. • Funds to double the program size of Young Adult Hubs, which are modeled after a Transition to Independence Process and provide mental health services, case management, and support for disconnected youth.
2	The Council recommends funding for continued operations and study of existing Certified Community Behavioral Health Clinic (CCBHC) demonstration sites.
3	The Council recommends increased support for community restoration and an additional 16-bed secure residential treatment facility for defendants who do not have fitness to proceed in a criminal matter ("aid and assist" defendants).
Budget Neutral	The Council supports the design of a statewide crisis system through OHA's ongoing development of a statewide crisis and behavioral health support tool called Oregon Behavioral Health Access System.

General Discussion

The Programs and Services recommendations were developed using four overarching policy goals:

- Increase early intervention and services for youth,
- Provide better access to treatment,
- Integrate behavioral and physical health care, and
- Bolster community supports to avoid referrals to acute care/higher levels of care.

These policy goals helped to narrow the scope of the recommendations from a large list of policy ideas to a more concentrated group of investments. Based on the need to center equity, the Programs and Services Affinity Group quickly prioritized policy recommendations that explicitly drive toward health equity and that were developed and are driven by communities of color, tribal communities and persons with lived experience.

Alignment with selected state strategic plans: All the Programs and Services recommendations were developed to align with the *ADPC Strategic Plan* objectives of increasing ability to expand treatment access to underserved persons and communities, as well as those at higher clinical risk; and the overall goal of decreasing barriers to treatment services. As substance use treatment services are required in CCBHC standards, CCBHCs help to meet the ADPC objective of increasing ability to maximize and expand existing effective treatment capacity. Furthermore, the integrated nature of CCBHC will help to better identify persons at

risk of or experiencing health, social or legal consequences from alcohol and other drug use and provide them with appropriate access to needed treatment services. The statewide crisis systems would increase same-day access to appropriate levels of treatment. Peer Run Respite and Tribal Based Practice aligns with objective of increase the system's ability to reduce health disparities. The recommended funding to increase access to Tribal Based Practices aligns with a Strategic Pillar of the *Tribal Behavioral Health Strategic Plan*. Moreover, the recommendations carry forward initiatives of the Behavioral Health Strategic Plan 2015-2018, especially goals 2.1 and 2.2 of increasing equitable access to culturally and linguistically appropriate prevention, treatment and recovery services and support and increasing access to crisis services. CCBHC also aligns with goal 3.2 of increasing the availability of physical health care professionals in behavioral health care settings.

General deliberations: The Council voiced support for program evaluation and quality assurance across all the recommendations. Evaluation and quality assurance are implicit to many of the recommendations. However, some programs and services, like Certified Community Behavioral Health Clinic Program, have explicit evaluation and quality assurance measurement built into the program design. The Council showed general interest in OHA instituting measures of accountability to ensure that programs have quality assurance metrics and outcomes. Council participants suggested OHA strengthen program evaluation as part of its transformational efforts.

Council participants also noted the need to alleviate policy driven administrative burden, particularly for new and smaller organizations. Participants asked OHA to follow up and strategize on how to help organizations serving communities of color and tribal communities (particularly peer-run organizations) navigate funding opportunities.

Programs and Services: Priority #1 Recommendation

The Council's primary priority for programs and services is programs that are directly responsive to and driven by communities of color, tribal communities, and people with lived experience. These programs are peer and community driven and provide culturally and linguistically specific services. The Council recommends:

- **Funds to support Medicaid reimbursement of Tribal Based Practices, which would increase capacity for billing through Medicaid and increase support for culturally responsive care in tribal communities**. The recommendation provides funding for a strategy within the Tribal Behavioral Health Strategic Plan of 2019 and for the implementation of Senate Bill 134 (2019). The estimated cost is $0.5 million general fund ($1.4 million total funds with federal match).
- **A state-funded pilot to create three non-clinical peer-run respite centers, including a culturally and/or linguistically specific program designed to provide services and supports to people of color.** Peer-run respite centers provide culturally informed, voluntary, short-term support in a home-like setting to adults who are experiencing acute mental health or emotional distress. While the intent is that one program will be culturally and/or linguistically specific, all pilot sites will be expected to provide culturally and linguistically responsive services to people of color seeking services. The recommendation has an estimated cost of $2.4 million for the three pilot sites based on estimates for HB 2831 (2019), which originated with and was brought forward by consumer advocates.
- **Expansion for the Early Assessment and Support Alliance (EASA) program from a two-year program to a three-year program.** EASA currently provides support to young people experiencing symptoms of psychosis for the first time. The addition of a third year will be based on a step-down framework and would provide adolescents and young adults (14-25) continued transition services, access to a strengthened peer-support component, and enhanced life and self-care elements. The

recommendation has a cost of $9.1 million general fund and will serve approximately 250 additional youth annually.

- **Double the program size of Young Adult Hubs**, which are modeled after a Transition to Independence Process and provide mental health services, case management, and support for disconnected youth. The recommendation costs $3.2 million and will serve about 1,100 additional young people annually.

For EASA and Young Adult Hubs, OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set aside for this funding opportunity specific for provision to the tribes and Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt funded services/opportunities to meet the need of tribal communities. Tribes would be eligible to apply for the Peer-Run Respite Pilot.

Deliberations: One member did have questions about the evidence base for peer-run respite. His perspective was rooted in being based in a rural area without residential treatment capacity. He did not find sufficient evidence to support the recommendation of three peer-run respite centers and felt that communities should have foundational elements of the treatment continuum in place (i.e., residential treatment capacity), then pilot innovations as resources are available.

Programs and Services: Priority #2 Recommendation

The Council recommends funding for continued operations and study of existing Certified Community Behavioral Health Clinic (CCBHC) demonstration sites. The Council recommends that the demonstration fund nine existing CCBHC sites and that OHA work with those programs as well as advocates and CCOs to develop a sustainable financing model. The Council recommends that the demonstration further develop the service array, culturally and linguistically responsive service delivery approaches, and outcome measurement (based on successful sites) to reinforce comprehensive outpatient services. The estimated cost would depend on the new payment model (but is estimated to be less than the $33 million in general fund currently in the OHA Agency Request Budget).

For background, the Certified Community Behavioral Health Clinic Demonstration[7] is a federal pilot program that pays community behavioral health clinics an enhanced rate to provide comprehensive behavioral health services, integrated physical health screenings, care coordination, and targeted outreach/culturally and linguistically responsive services to populations disconnected from care, regardless of one's ability to pay. Oregon is one of eight federal demonstration sites. CCBHCs do not currently receive state support and face an uncertain financial future. The state legislature did not allocate needed state funding for the program due to the early adjournment of the 2020 Legislative Session.

[7] https://www.oregon.gov/oha/HSD/BHP/Pages/Community-BH-Clinics.aspx

The CCBHC program recommendation was to only fund existing sites. However, should the pilot expand, OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set-aside for this funding opportunity specific for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt the pilot to meet the need of tribal communities.

Deliberations: Council participants broadly acknowledged the benefits of the broad service array delivered by CCBHCs. However, some participants expressed concern that funding for CCBHCs may be misplaced in the GBHAC recommendations. Some participants viewed the CCBHCs as essential programs that should be funded through other vehicles in the system – such as county behavioral health funding or through CCOs. Ultimately, the Programs and Services Affinity Group viewed the CCBHCs as an important and innovative program and included them as a secondary priority with the goal that they would have a sustainable funding:

- The Affinity Group did not advocate for permanent funding for CCBHC nor expansion beyond existing sites. The group recommends continuing CCBHC to study effectiveness and draw federal financial support for critical programming that has been chronically underfunded. There are promising results at individual sites, so further study is warranted.
- CCBHCs offer innovative approaches at the community level (especially with respect to service integration with primary care and addiction services as well as coordination of care).
- The pilot/demonstration sites have already extended capacity in counties, and discontinuing these programs, especially in the face of increased need and a lack of clear alternatives, was concerning to participants. Participants commented that including recommendations to sustain the CCBHC in the GBHAC recommendations might not be the best place for CCBHC, but participants didn't see any better option. If not recommended here – it may be considered a sign of lack of support for this promising approach to integrated service delivery.
- Affinity Group members agree that CCOs should play a bigger role in the program; the recommendation includes language that directs OHA to work with CCOs and others to develop a sustainable funding model.
- CCBHC's leverage significant federal financial participation, extending the impact of the state's general fund expenditures for services.

At the conclusion of the discussion, no Council participants suggested cutting the recommendation or revising the language.

Programs and Services: Priority #3 Recommendation

The Council recommends increased support for community restoration and an additional 16-bed secure residential treatment facility for defendants who do not have fitness to proceed in a criminal matter ("Aid and Assist" defendants).

- Current Aid and Assist funding is distributed to Community Mental Health Programs based on an outdated formula that does not provide sufficient funding statewide. OHA worked with CMHPs before the 2020 short session to develop a case rate for case consultation and community restoration to ensure that funding is tied to the number of individuals served and their needs. The recommendation has a cost estimate of $3.1 million. The funding proposed would allow all CMHPs a baseline amount of funding to serve this population and sufficient funds to increase community restoration services to approximately 400 clients.
- In addition to community restoration funding, the Council recommends funding for one secure residential treatment facility (SRTF) for community-based residential support. One 16-bed SRTF costs

approximately $4.8 million (including one-time costs) and will serve approximately 31-39 people per year once operational. The proposed funding includes construction and startup costs to be allocated by OHA and funds to cover the cost of providing restoration services that are not Medicaid reimbursable (i.e., legal skills training). This recommendation represents a scaled-down version of the three SRTFs proposed in the OHA Agency Request Budget.

OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set-aside for community restoration funding specific for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt community restoration services to meet the need of tribal communities.

Deliberations: Several participants raised the importance of community restoration and residential services for the Aid and Assist population included in the Affinity Group's recommendations. A couple of participants suggested the possibility of treating the recommendation as budget neutral, given that community restoration/residential may lower utilization of more expensive stays at the state hospital. There were also suggestions to shift resources from state hospital facilities to community-based programing. Finally, there was a suggestion that the state could save money by providing options for more efficient forensic assessments and tools to determine level of fitness to proceed. Practically, the demand for this level of services and the variability of community-based services across the state would prevent the state from seeing immediate savings from investment in community-based services. The existing demand for state hospital beds greatly exceeds availability. What's more, any increase in community restoration utilization would have to reduce state hospital bed demand to the point a unit could be closed before general fund savings could be realized. While no specific language changes were suggested, there was general sentiment from participants that the state should prioritize community-based programs to reduce the need of hospitalizations.

Furthermore, during general deliberation, participants brought up the importance of behavioral health services for justice-involved populations. GBHAC members expressed support for OHA to increase programs and services offered in Department of Correction (DOC) facilities, particularly due to the large number of incarcerated individuals who experience underlying behavioral health issues. Consumer participants called out the need for mental health services in particular, as they are not as commonly available as substance use programs for this population. Members suggested that OHA should continue to work with DOC on strengthening access to substance use disorder treatment services and look to the work of the Governor's Opioid Taskforce Report on services in DOC facilities.

Programs and Services: Budget Neutral Recommendation

The Council recommends a statewide crisis system and supports OHA's ongoing development of a statewide crisis and behavioral health support tool called Oregon Behavioral Health Access System through CARES Act coronavirus relief funding. The system will include an all-inclusive webpage that connects individuals to all types of behavioral health services, including crisis, outpatient, inpatient, and community-based. The system is designed to consolidate, enhance and expand existing crisis lines to streamline access to crisis services for all Oregonians. The system will also offer no-barrier, brief, emotional support service regardless of language spoken or insurance status for a limited duration of service. Finally, the system will offer a centralized provider search engine and a bed registry.

While this system does not need immediate financial support, the Council endorses future state support for the program. The Council also recommends that the program coordinate with existing local, city, tribal, and county crisis systems.

Workforce recommendations

Budgetary Priority	Recommendation
1	The Council recommends creation of a behavioral health incentive fund for recruitment and retention of the workforce to increase the number of people of color, people from tribal communities, and rurally based people in the behavioral health workforce.
2	The Council recommends that OHA implement and sustain culturally based practices, including promising practice and practices outside of the conventional medical model.
3	The Council recommends support for training of the behavioral health workforce. • All behavioral health workforce should be trained in the following: trauma-informed care and workplaces, culturally and linguistically specific/responsive care, anti-racism, equity, interdisciplinary care (including working with peers), leadership and management development, and co-occurring disorders. • Develop an outcomes-based system to demonstrate anti-racism and equity training.
Budget Neutral	The Council recommends 309 rule revision to reduce provider administrative burden.

General Discussion

The Workforce recommendations were developed using policy goals from the 2019 workforce report from the Farley Health Policy Center[8] at the University of Colorado. The Affinity Group chose to focus on:

- Workforce composition;
- Workforce competency; and
- Workforce capacity.

These policy goals helped to narrow the scope of the recommendations from a large list of policy ideas to a more concentrated group of investments. Based on the need to center equity, the Workforce Affinity Group further prioritized culturally and linguistically specific workforce, culturally and linguistically responsive practice, and the roles of peer and family supports.

[8] https://www.oregon.gov/oha/HPA/HP-HCW/Documents/Recruitment-Retention-Recs-%20Oregon-BH%20Workforce-April-2019.pdf

Alignment with other plans: The recommendations are in alignment with the *Farley Health Policy Center Report* recommendations to build workforce composition (incentive fund for culturally and linguistic specific providers), competency (training and culturally based practice), and capacity (recruitment and retention through capacity fund). The Council recommendations center on building capacity and ensuring that workforce is not a barrier to treatment – aligning with many of the goals and objectives of the *ADPC Strategic Plan*. Specifically, the workforce incentive funding and training aligns with the ADPC plan's objectives of increasing system capacity to solve substance use problems and implement needed changes to operations. The incentive fund increases system ability to recruit, develop, and retain a highly effective workforce – including building a culturally responsive workforce and developing a compensation structure that is competitive and commensurate with responsibilities. The Workforce Affinity Group recommended funding for development of the tribal behavioral health workforce through the incentive fund. The support for tribal-based workforce, along with the OHA Agency Request Budget recommendations, aligns with the Workforce Training and Credentialing Strategic Pillar of the *Tribal Behavioral Health Strategic Plan*. Finally, the Workforce recommendations carry forward initiatives of the Behavioral Health Strategic Plan 2015-2018, especially goal 2.1 of increasing equitable access to culturally and linguistically appropriate prevention and treatment.

Workforce: Priority #1 Recommendation

The Council recommends creation of a behavioral health incentive fund for recruitment and retention of the workforce to increase the number of people of color, people from tribal communities, and rurally based people in the behavioral health workforce.

- Increase capacity for rural and under-resourced populations through bachelor's and master's level education and retention bonuses for culturally and linguistically specific workforce to serve communities with workforce shortages. These communities include, but are not limited to tribal communities, communities of color, immigrant and refugee communities, LGBTQIA+/LGBTQIA+ youth, people with disabilities (including physical and intellectual/developmental disabilities), veterans, people with a history of criminal justice involvement, and non-English speaking communities.
- Expand funding for/incentivize culturally and linguistically specific Peer Support and Peer Wellness Specialists (including family support), traditional health workers, licensed / certified providers, and licensed prescribers.
- Incentivize for all levels of workforce: loan forgiveness; housing assistance/tax credits; sign on bonuses; part time/flex time; retention bonuses; professional development; childcare; subsidized dual certification (with specific focus on rural and vulnerable populations; pay equity). The incentive fund would also be used to support access to tuition assistance and other incentive programs.
- Incentives for leadership and management training and support.
- Increasing support for the Tribal Workforce (in alignment with OHA Agency Request Budget). In addition, OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set aside for the incentive fund for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt workforce funding to meet the need of tribal communities.

The Council did not recommend a set level of funding for the recommendation but requested that the Governor invest significantly more than the $10.2 million dedicated to Behavioral Health workforce incentives in the OHA Agency Request Budget.

Deliberations: The Workforce Affinity Group and the full Council discussed the need to develop a plan to bring behavioral health workforce to pay parity with the rest of the healthcare workforce. Several participants called for establishment of living and professional wages for behavioral health workers. Wages

should rise with professional experience and Peer Support and Peer Wellness Specialists (inclusive of family support specialists) should be included in professional wage structures. There were comments that people performing the most challenging work are often not paid a living wage, and that wages vary drastically depending on where one serves on the continuum of care. Participants agreed that base wages need to go up for everyone, and that may take a change in service reimbursement rates.

There were some suggestions from participants to elevate the role and expand presence of Peer Support and Peer Wellness Specialists (including family support) with the fund.

Workforce: Priority 2 Recommendation

The Council recommends that OHA implement and sustain culturally based practices, including promising practices and practices outside of the conventional medical model. The Council recommends that OHA prioritize implementation and support for culturally based and traditional practices, including promising practices, and that these services be reimbursed equitably with other behavioral health services.

- Expand interventions to include culturally based practices (promising/practices outside of conventional medical model).
- Expand approved evidence-based practices to include promising or culturally based practices for coverage by Medicaid.

The Council did not recommend a set level of funding for the recommendation. It should be noted that these services are for culturally based practice outside of and in addition to Tribal Based Practice (see Tribal Based Practice recommendation).

Deliberations: There was discussion about the second priority to implement and sustain culturally based practices, including promising practices. These questions/comments related to the role of those practices in treatment, how to address the current lack of evaluation of many culturally based practices by the dominant culture as it relates to healthcare payers, and the need to study programs to create an evidence base.

- Participants strongly agreed that is important to identify practices (whether in treatment, engagement, or connection) that are fully inclusive and responsive to cultural need. For communities of color and tribal communities, participants acknowledged that it is often important to bundle together different practices (evidence-based and culturally based) that, when integrated, lead to healing during the course of treatment. One member commented that the group does not need to choose between evidence-based and cultural practice – the state should support both and these approaches should work in tandem.
- Participants acknowledged that evidence base and scientific practice can be based in systemic racism and white dominant culture and therefore, too often exclude study of culturally based practice. Treatment supported by the existing evidence base can be ineffective in communities of color, and cultural practices with promising outcomes are understudied or not studied through a community/cultural lens. Participants commented that there is not a lot of evidence base for cultural practice because evidence base requires investment. Investing in these programs in a systematic fashion, along with community-driven evaluation practices (moving away from white-dominant research practices), will lead to a more diverse base of practices and interventions that have been studied. One member commented that cultural-based practice must be elevated for the powerful impacts that they have demonstrated, while the evidence that we have become accustomed to must be interrogated for its own bias.

- One member pointed out that people who are undiagnosed are often going to a trusted community member for help because the behavioral health system is unknown or intimidating. For those reasons, the system needs to provide those trusted people with the tools and access to services needed to support the person seeking care.
- Some participants supported the culturally specific practice recommendation as anti-racist. Participants noted that evidence base to support practice can include expert opinion, and in terms of culturally based practice, communities of color and tribal communities are the experts. Supporting those practices through funding redistributes resources, allows people to see themselves and their culture in their care and brings recognition of historical trauma and racism to the forefront.
- There was additional commentary from two members on the need to ensure the recommended culturally based services eventually build a strong evidence base and complement/integrate with existing evidence-based practice. Members provided a monograph from the World Health Organization that provides a rubric for evaluating culturally based practices that have little existing evidence base under the dominant cultural construct to help guide this endeavor.[9] Consistent with that rubric, one of those members recommended that all clinical treatment services being considered for Medicaid funding, including those that are culturally specific, nontraditional and/or promising, be reviewed by the Health Evidence Review Commission (HERC) for consideration of placement on the Oregon Health Plan prioritized list. In the HERC's evaluation of the efficacy and cost-effectiveness of culturally specific services, intention must be given to ensuring that dominant-culture does not bias the analysis and evidence of effective practice. Evaluation should include qualitative data and direct input from communities of color and tribal communities.

Workforce: Priority 3 Recommendation

The Council recommends support for training of the behavioral health workforce. This recommendation consolidates prior Affinity Group recommendations including those that were included in the Agency Request Budget (funding for training for co-occurring disorders).

- All behavioral health workforce should be trained in the following: trauma-informed care and workplaces, culturally and linguistically specific/responsive care, anti-racism, equity, interdisciplinary care (including working with peers), leadership and management development, and co-occurring disorders (mental health and substance use diagnoses, a behavioral health and a physical diagnosis or disability, or behavioral health diagnosis and an intellectual/developmental disability).

[9] WHO Traditional Health Strategy: https://apps.who.int/iris/bitstream/handle/10665/92455/9789241506090_eng.pdf;jsessionid=35259158C6732128AEB57BBDC9827F74?sequence=1

- Develop an outcomes-based system to demonstrate anti-racism and equity training.

The Council did not recommend a set level of funding for the recommendation. If funding is provided, OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set-aside for workforce training funding for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt trainings to meet the need of tribal communities.

Deliberations: Consumer participants recommended more training for behavioral health specialists to provide trauma-specific services, given the great need for trauma-specific services and supports. Consumer participants also recommended more education about peer-delivered services (PDS), the role of a PDS provider and what they offer.

Workforce: Budget Neutral Recommendation

The Council recommends 309 rule revision to reduce provider administrative burden. The Council supports revising the 309 rules to reduce administrative burden for documentation, particularly around assessment and treatment planning, MOTS data system and other reporting for certificate of approval (COA) providers to be consistent with the 410 rules that apply to behavioral health staff operating in primary care and other settings. This recommendation does not need financial support but will require OHA staff to complete this work.

Housing recommendations

Budgetary Priority	Recommendation
1	The Council recommends addressing housing and independent, community-based living needs by: • Increasing OHA funding for Rental Assistance with barrier busting funds and wraparound support. • Create a flexible housing and independent, community-based living fund to fill gaps in the housing continuum for people of color, including recovery housing.
2	The Council recommends developing additional Residential Treatment Facility and Secure Residential Treatment Facility capacity.
3	The Council recommends a state-funded pilot to create three non-clinical peer-run respite centers, including a culturally specific program designed to provide services and supports to people of color
Budget Neutral	The Council recommends the transfer the Housing for Mental Health Fund (ORS 458.380) to the Oregon Health Authority from Oregon Housing and Community Services.
Budget Neutral	The Council recommends OHA create CCO requirements for housing navigation and Social Determinants of Health through care coordination.

General Discussion

The Housing recommendations were developed using three overarching policy goals:

- Increase housing and residential options;
- Reducing barriers, and
- Stabilize housing placements

These policy goals helped to narrow the scope of the recommendations from a large list of policy ideas to a more concentrated group of investments. Based on the need to center equity, the Housing Affinity Group further prioritized and refined to prioritize flexibility in housing funding and strategies to fill gaps in continuum of independent, community-based living offerings for priority populations.

Alignment with other plans: Increasing housing supports through the housing recommendations align with *ADPC Strategic Plan's* goals and objectives related to decreasing barriers to access to treatment and recovery. The ADPC's goals and objectives call out the need for the state to ensure persons in treatment and recovery have arrays of supports, such as housing, employment, childcare and transportation. The housing recommendations also carry forward initiatives of the Behavioral Health Strategic Plan 2015-2018, especially goal 4.1 of increasing affordable housing options for people in recovery.

General deliberations: Like with Programs and Services, Council members and participants voiced support for evaluation and quality assurance measures across all of the recommendations. For many recommendations, evaluation and quality assurance are implicit to the recommendation. Some programs have explicit evaluation

and quality assurance measurement built into the program design. The Council showed general interest in OHA instituting measures of accountability to ensure that programs have quality assurance metrics and outcomes. Members suggested that OHA should continue this work as part of its transformational efforts.

Housing: Priority #1 Recommendation

The Council recommends addressing housing and independent, community-based living needs by:

- **Increasing OHA funding for Rental Assistance with barrier busting funds and wraparound support.** The Council proposes this recommendation utilize existing programs and provide immediate support to people with SPMI to access permanent housing in the community. The increased funding will allow OHA to contract with more providers and community organizations to provide:
    a. Tenant-based Rental Assistance with maximum flexibility to be used in a variety of scenarios and placements ranging from traditional scattered site supported housing to less traditional low-barrier housing models.
    b. Wraparound services that pair with rental assistance to provide crisis stabilization, housing and benefit stabilization, and connections to more intensive services when necessary, and which follow clients, even in events where tenancy status changes.
    c. Robust barrier busting funds, which can be used to address a variety of financial concerns that might compromise housing stability. Funds would include landlord repair insurance funds to ensure private landlords are incentivized to rent to tenants who might be considered higher risk. Funds would also include tenant barrier busting fund to address move in costs, past bills and documentation needs required to obtain and maintain housing as well as barriers generally associated with justice involved individuals such as criminal record clearing activities. Hospitals may qualify for this funding, with a financial matching requirement.
- **Create a flexible independent, community-based living fund to fill gaps in the housing continuum for people of color, including recovery housing, to meet the following needs**:
    a. Opportunity for short-term stability to continue in an episode of care.
    b. Opportunity for long-term stability/housing.
    c. To aid transitions during critical moments (ER, inpatient, jail, etc.) and includes individuals with a need for residential supports who don't meet Assertive Community Treatment criteria.

    The target outcomes are:
    a. No extended stays in emergency rooms or hospitals because of a lack of community placement.
    b. No discharges to homelessness.
    c. Reduced contacts with the criminal justice system.

    Funding will be offered by Request for Proposals (RFP). Proposals must address community or regional need and include:
    a. Peer support, including youth and culturally and linguistically appropriate peer delivered service providers
    b. Coordination with other systems of care
    c. Connections to voluntary social and other supports to remove barriers to long term housing (criminal record clearing, credit repair, financial literacy, life skills, rights, evictions, Rent Well program, and other trainings).

OHA will prioritize these funds for communities of color, tribal communities, immigrant and refugee communities, LGBTQIA+, people with disabilities (including physical, intellectual, and developmental disabilities), veterans, people with a history of criminal justice involvement, and non-English speaking communities. In consultation with the tribes and conference with the Urban Indian Health Program, OHA will create a set-aside for the fund similar to the IMPACTS grant program. Based on data and outcomes produced by the program, OHA may dictate further specificity and prioritization. The recommendation should be reviewed by the Racial Justice Council for prioritization.

The Council did not recommend a set level of funding for the recommendation to address housing and community-based living needs, though it did set it as its priority housing recommendation.

Deliberations: Council participants voiced support for the flexibility of the funding in the recommendation to address housing and independent, community-based living. There were some questions about the mechanics of operationalizing this policy, which OHA will need to provide through rule and in program implementation. Some participants noted advantages in having these funds flow through organizations that provide support in different ways (peer support, case management, etc.) or offer holistic, more flexible support than traditional rental assistance programs.

Housing: Priority #2 Recommendation

The Council recommends developing additional Residential Treatment Facility and Secure Residential Treatment Facility capacity. OHA will expand residential capacity, as well as study the need for residential options. Specifically, the Council recommends:

- Expansion of the Young Adult in Transition Residential System with four additional five-bed Residential Treatment Homes (RTH) and a 10-bed Secure Residential Treatment Facility (SRTF) specializing in the young adult population (age 17.5 – 25). This expansion increases residential bed capacity by 30 beds, (90 to 100 young adults once fully operational, but depends on when those beds come online) and cost an estimated $9.1 million.
- Support for the Programs and Services recommendation and the OHA Agency Request Budget to fund three SRTFs to increase the number of facilities to serve the aid and assist population. The Programs and Services recommendation represents a scaled down version of this recommendation (one SRTF vs. three SRTFs). Three 16-bed SRTFs would increase residential bed capacity by 48 beds (approximately 95-116 people per year once operational) and cost $14.4 million.

OHA will consult with the tribes and confer with the Urban Indian Health Program to create a set-aside for residential funding specific for provision to the tribes and the Urban Indian Health Program. OHA will consult individually with each Oregon Tribe to provide flexibility to adapt residential funding to meet the need of tribal communities.

Housing: Priority #3 Recommendations

As a Housing recommendation, the Council reiterates support for the Programs and Services recommendation of a state-funded pilot to create three non-clinical peer-run respite centers, including a culturally and/or linguistically specific program designed to provide services and supports to people of color. See Programs and Services Recommendation #1.

Deliberations: Council participants voiced support for alignment of Peer-Run Respite across Affinity Groups and for the peer-driven programs that transcend all the Affinity Groups' work.

Housing: Budget Neutral Recommendations

The Council recommends the transfer the Housing for Mental Health Fund (ORS 458.380) to the Oregon Health Authority from Oregon Housing and Community Services. This increases the Fund's flexibility to provide incentive funding for the capital development of new housing ranging from licensed levels of care to short-term respite to independent and integrated housing. Recommend that the Legislature "deposit" funds during 2021 session, either one-time general fund allocation or flexible lottery bond proceeds.

The Council recommends OHA create CCO requirements for housing navigation and Social Determinants of Health through care coordination. CCOs are already required to coordinate care for their members as part of their contractual obligations, including Intensive Care Coordination for prioritized populations. However, while health related social needs may be a driver in health status, specific requirements for SDOH screening and referral have not been set or enforced.

The Council recommends that OHA create clearer expectations around screening, referral and facilitation of service navigation for housing and other health related social needs for populations with behavioral health needs. Recognizing this effort has specific data needs and requires alignment of information across multiple sectors, the Council further recommends that the collection of this information be a priority, as well as the alignment of data points across HMIS and other pertinent data systems within our social support networks to ensure alignment and to minimize unnecessary trauma around rescreening.

Appendix A: Behavioral health recommendations and reports

2014-2019

Report	Recommendations
OHA 2016-2018 Behavioral Health Strategic Plan, 2014	• Health equity exists for all Oregonians within the state BH system • People in all regions of Oregon have access to a full continuum behavioral health services • The BH system promotes healthy communities and prevents chronic illness • The BH system supports recovery and life in the community • Only people who meet admission criteria are admitted to OSH and admissions and discharges are performed in a timely manner • AMH operations support the strategic plan
Behavioral Health Town Hall Report, 2015	Town Halls throughout the state with the following themes: • Systemic challenges: access, lack of coordination among providers and partners, administrative complexity • Holistic supports needed: housing, employment transportation
Oregon's Prescription Drug Overdose, Misuse, and Dependency Prevention Plan, 2015	The plan provides strategies as part of a framework to reduce prescription opioid overdose, misuse, and dependency: • Reduce problematic prescribing practices • Improve safe drug storage and unused medication disposal • Increase and improve infrastructure for naloxone rescue, and naloxone co-prescribing • Provide medication assisted treatment (MAT) for opioid use disorder • Implement routine collection, analysis, and reporting of opioid overdose, misuse, and dependency data. • Provide education and training of the public, providers, health systems, policy-makers on the issues related to opioid overdose, misuse, and dependency • Collaborate with federal and state entities to support the work of the initiative.
Oregon's Five Year Youth Suicide Intervention and Prevention Plan 2016	Plan to prevent suicide among youth ages 10-24 with 4Strategic directions, each with goals and objectives: 1. Healthy and empowered families, individuals and communities 2. Clinical and community preventative services 3. Treatment and support services 4. Surveillance, research and evaluation
Oregon Chief Justice Task Force on Juvenile Justice and Mental Health 2016	Task force recommendations on structural and legal changes to child serving systems, including: • Child serving systems should agree to common principles • Three branches of government should create a Children's Cabinet • Develop legal framework for information sharing

	• Make efforts to identify and treat children before they reach the juvenile justice system • Screen and connect youth to services when they are referred to juvenile justice • Juvenile departments, CCOs and providers should work together to ensure positive outcomes • Place youth in least restrictive settings possible • Juvenile departments and OYA should ensure that youth have adequate mental health services in the community and CCOs should be mandated to schedule appointments with youth prior to their release from custody
Oregon Performance Plan 2016	Oregon Health Authority Plan to improve mental health services for adults with serious and persistent mental illness. The Plan was issued after lengthy discussions with the Civil Rights Division of the United States Department of Justice (USDOJ). In the Plan, the Authority commits to several performance outcome measures and to further data gathering and study of certain issues. Oregon also commits to quality and performance improvement measures, and to data reporting. These measures cover a broad array of subjects, including: • Assertive Community Treatment Services; • Crisis services; • Supported housing; • Peer-delivered services; • Oregon State Hospital discharges and linkages to services; • Acute psychiatric care discharges and linkages to services; • Emergency department services; • Supported employment services; • Secure Residential Treatment Facility discharges; • Criminal Justice diversion; • Quality and performance improvement; and • Data reporting.
Behavioral Health Collaborative	• Governance and Finance – single source of shared accountability through Regional Behavioral Health Collaborative • Develop standards of care and competencies for behavioral health workforce • Complete an Analysis of Oregon's BH Workforce and develop a Recruitment Retention Recommendations for Oregon BH Workforce • Strengthen use of information technology
Oregon Rural and Frontier Health Facility Listening Tour 2017	Overview of Oregon's BH system, types of outpatient and residential BH programs, county overview, access to BH providers.
Core Strategies to Improve Outcomes for Youth and Families in Oregon In a Trauma Informed System 2017	Recommendations address funding, coordination, workforce development, continuum of care, timeliness of care, and use of information technology.

Mental Health Service Disparities of Latino Oregonians 2017	• Integrate physical and behavioral health • Integrate mental health into existing centers in the community settings • Provide services in schools, legal services and churches • Culturally specific services • Increase mental health awareness and education • Increase funding • Community driven solutions and greater collaboration
Multnomah County MH System Analysis, 2018	• Engage in ongoing dialogue with service users and their families and other stakeholders to ensure a shared and actionable vision for the mental health system • Establish a director-level lived experience leadership position • Integrate and analyze data on funding and services to support system improvements
OCAC Recommendation for State Support to Establish Peer Run Programs 2018	• Ensure peer services are included in services with dedicated funds • Create a peer-delivered service coordinator for each CCO and county • OHA to facilitate provision of technical assistance and work collaboratively with OCAC to establish and advance peer-run respites
Oregon Recovers Framework	Recommendations to the Commissioners of the Alcohol & Drug Policy Commission (ADPC) for the content of a framework for developing a comprehensive addiction recovery strategic plan.
ADPC Scope Framework Preliminary Recommendations 2018	The framework is a guide for a competitive process to select a consultant to develop the APDC strategic plan. Examples in the framework will not necessarily be included in the strategic plan. The objective of the strategic plan is to reduce the significant prevalence of SUDs in Oregon's by preventing new substance abuse disorders and increasing the number of Oregonians in recovery.
House Bill 4143 Report	Oregon insurance commissioner report on access to medication-assisted treatment for substance use disorder. Extensive list of recommendations include recognizing substance use disorders as a chronic condition and integration with primary care.
Governor's Addictions Whitepaper 2018	• Reduce substance use disorder for 75,000 Oregonians in five years through completion and implementation of a statewide survey and strategic plan • Improve standards of care and access to treatment • Fix treatment structures and certification standards • Make key investments in services that support individuals in recovery • Continue to lead in the fight against the opioid epidemic

Areas of Unmet Health Care Needs Report 2019	The report includes nine variables that measure access to primary physical, mental and oral health care. Published annually.
Recruitment Retention Recommendations for Oregon BH Workforce 2019	Comprehensive workforce retention and recruitment strategies are necessary to increase access to high-quality behavioral health providers across the state and address challenges of insufficiency. Proposed recruitment and retention strategies are presented thematically to support solution-based planning efforts that address: Improve equitable geographic distribution of the behavioral health workforce across the state • Allocate workforce across different practice settings to meet population needs (i.e., distribute workforce to match presenting need in school-based, primary care, and specialty community settings) • Increase number of licensed and unlicensed behavioral health workforce providing direct services • Develop and support a behavioral health workforce that aligns provider and patient characteristics and needs.
Analysis of Oregon's BH Workforce 2019	Data on BH licensed and unlicensed workforce; includes ratio of providers to population and prevalence data.
Analysis of Oregon's Publicly Funded Substance Abuse Treatment System 2019	Senate Bill 1041. Oregon Criminal Justice Commission to study and report on the total public funds spent on substance abuse treatment, the outcomes received for that expenditure by type of treatment, and the effect of treatment outcomes on the criminal justice system. Recommendations include: • Fix or replace MOTS • Collaborate with private insurers/providers • Track public expenditures and outcomes • Optimize treatment outcomes • Study effectiveness of treatment • Utilize digital therapeutics
Oregon Veterans' Behavioral Health Services Improvement Study 2019	Recommendations to create measurable and achievable improvements in behavioral health care for Oregon veterans within one to five years: • Establish statewide veterans behavioral health commission • Fund innovative, cross-sector projects to address treatment gaps • Additional recommendations address coordinated access, outreach and quality of care
Statewide Housing Plan	Priorities for the Oregon Housing and Community Services (OHCS): • Equity and racial justice • Homelessness • Permanent supportive housing • Affordable rental housing • Homeownership • Rural communities

2019 Joint Plan to Develop In-State Capacity and Minimize Out-of-state Placements of Children	Senate Bill 171. Department of Human Services and the Oregon Health Authority to submit a joint report summarizing the department's plan to develop appropriate in-state placements for Oregon children and wards and to minimize out of-state placements.
Tribal Behavioral Health Strategic Plan – 2019 to 2024	The Oregon Native American Behavioral Health Collaborative developed recommendations and strategies in the following key areas: • Training and credentialing • Tribal-based practices • Efficient data systems • Tribal consultation • Governance and finance

Appendix B: Support table

GBHAC Member Name	Stance	GBHAC Member Name	Stance
Sen. Denyc Boles	Neutral*	Olivia Quiroz	Supportive*
Sen. Arnie Roblan	Supportive	Sarah Radcliffe	Supportive
Rep. Cedric Hayden	No Stance Taken	Mary Rumbaugh	Supportive
Rep. Sheri Schouten	Supportive	Michelle Shaw, MD, FACEP	Supportive
Jill Archer	Supportive	Diane Solomon, PhD, PMHNP	Supportive
Wil Berry, MD	Supportive*	Rachel Solotaroff, Co-Chair*	Supportive
Chris Bouneff	Supportive of Housing Recs, Neutral on others	Toc Soneoulay-Gillespie	Supportive
Greg Brigham, PHD	Supportive	Paul Stewart	Supportive of Prog. & Services and Housing Recs, Neutral on Workforce*
Judge Audrey Broyles	Supportive	Karen Wheeler	Supportive*
Ebony Clarke	Supportive	**Persons of Lived Experience, Young Adults, Advocates**	**Stance**
Melissa Eckstein	Supportive	Sandy Bumpus	Supportive*
Jeffrey Eisen, MD, MBA	Supportive	Danielle Grondin	Supportive
Kevin Fitts	Neutral	Jacek Haciak, PsyD	Supportive
Mike Franz, MD, DFAACAP, FAPA	Supportive	Elliott Hinkle	Supportive
Robin Henderson, PsyD	Supportive	Ann Kasper, MA	Neutral
Dwight Holton	Supportive	Janie Marsh, MPA	Neutral
Dolores Jimerson, MSW, LCSW	Supportive	Emily Morrisey	Supportive*
Chair Cheryle Kennedy	Supportive*	Shannon Olive	Supportive
Kimberly Lindsey	Supportive	Caroline Owczarzak	Supportive
Sandra McDonough	Neutral*	Michelle Owens	Supportive
Comm. Sharon Meieran, MD, JS	Supportive	Shane Roberts	Neutral
Jackie Mercer	Supportive*	Laura Rose	Supportive
Mary Monnat	Supportive	Steve Sanden	Supportive*
Monique Jones, MD	No Stance Taken	Samantha Skinner	Supportive
Jason Myers	Supportive*	Joseph Stepanenko	Supportive
Tammi Paul	Supportive*		

*Indicates person communicated stance through survey or direct communication with staff/co-chairs. All other members communicated stance in September 14 meeting.

Note: Members with "No Stance Taken" took no stance because they were unavailable during the final deliberations.

Appendix C: Recommendations table

	B	C	D	E
1	**GBHAC Recommendations**	**Description/Association to OHA Agency Request Budget (ARB) if Applicable**	**In ARB?**	**$ Amount Requested**
2	**PROGRAMS AND SERVICES**			
3	Funds to support Medicaid reimbursement of Tribal Based Practices	Funds to support Medicaid reimbursement of Tribal Based Practice as recommended in the Tribal Behavioral Health Strategic Plan. Language fully reflected in ARB.	Yes	$0.5 Million
4	A state-funded pilot to create three non-clinical peer-run respite centers	Funds 3 non-clinical peer-run respite centers, including a culturally specific program designed to provide services and supports to individuals who are of communities of color or tribal communities. Language fully reflected in ARB.	Yes	$2.4 Million
5	Increase funding for EASA and Youth HUBs	Expand Early Assessment and Support Alliance (EASA) program from 2 to 3 years to provide a step-down framework and transition services. Also provides additional funding to double the program size of Young Adult Hubs, which provide mental health services, case management, and support for disconnected youth. Language fully reflected in ARB.	Yes	$9.2 Million for EASA, $3.2 Million for HUBS
6	Fund continued operations and study of existing Certified Community Behavioral Health Clinic (CCBHC) demonstration sites.	The recommendation funds continuance of the CCBC demonstration for existing number of sites (currently 9) and work with existing CCBHCs, advocates, and CCOs to develop a model of sustainable payment. The demonstration would further develop service array, culturally and linguistically responsive service delivery, and outcome measurement (based on successful sites) to reinforce comprehensive outpatient services that are simple, meaningful, and responsive. This is different from the ARB which funds 12 sites for the biennium using the current payment model.	Yes	Amount less than ARB ($33 million) determined on payment structure and number of sites
7	Increase support for community restoration and an additional 16-bed secured residential treatment facility for defendants who do not have fitness to proceed in a criminal matter (“aid and assist” defendants).	Funding for one SRTF and CMHP funding for increased community restoration cases and consultation. The requested funding for SRTFs could include provider start-up costs, as well as provider capital investments. This is a scaled down request from the ARB -- fewer SRTF units (16 vs 48), and no funding for intensive services unit.	Yes	$3.1 million for community restoration; $4.8 million for 1 SRTF
8	Support design of a statewide crisis system through OHA’s ongoing development of a statewide crisis and behavioral health support tool: Oregon Behavioral Health Access System.	The Oregon Behavioral Health Access System is in development, leveraging CARES Act and FEMA funds.	No	Budget Neutral (CARES ACT covers $6 million start up)
9	Design and promote Treat First approach in Oregon	OHA is implementing a Rapid Engagement Model, adapted from New Mexico's Treat First model.	No	$25,000 covers start-up through 12/31/20
10	Funding for a Center for Youth and Young Adult Programs	Establish a Center for Training and Technical Assistance for Youth and Young Adult Behavioral Health that would develop fidelity models and best practice, outcome measures, and technical assistance for youth and young adult serving programs. This is reflected in the ARB.	Yes	$1 million
11	Study and provide funding for residential capacity	OHA included $0.2 mil in the ARB for a study of the need for residential options for individuals with SPMI (included under Housing recommendations).	Yes	$0.2 million
12	**WORKFORCE**	**Description/Association to OHA Agency Request Budget (ARB) if Applicable**	**In ARB?**	**$ Amount Requested**
13				
14				
16	Create behavioral health incentive fund for recruitment and retention of the workforce	Council recommends creation of a behavioral health incentive fund for recruitment and retention of the workforce to increase the number of people of color, people from tribal communities, and rurally based people in the behavioral health workforce. The group is asking for a greater investment than the ARB.	Yes	The group would like to invest more than the $10.2 million in the ARB
17	Implement and sustain culturally based practices, including promising practice and practices outside of the conventional medical model.	Implement and sustain culturally based practices, including promising practice and practices outside of the conventional medical model. The council recommends that OHA prioritize implementation and support for culturally based and traditional practices, including promising practices, and that these services be reimbursed equitably with other behavioral health services.	No	Unknown
18	Increase and support training for the Behavioral Health Workforce	This recommendation consolidates prior recommendations including those that were included in the Agency Request Budget (funding for training for Co-Occurring Disorders). All behavioral health workforce should be trained in the following: trauma informed care and workplaces, culturally and linguistically specific/responsive care, anti-racism, equity, interdisciplinary care (including working with peers), leadership and management development, and co-occurring disorders. Develop an outcomes-based system to demonstrate anti-racism and equity training.	Partially	$10.1 million for co-occurring disorders, unknown for remainder
19	Revise the 309 rules to reduce administrative burden	The recommendation revises the 309 rules to reduce administrative burden for documentation, particularly around assessment and treatment planning, MOTS data system and other reporting for certificate of approval (COA) providers to be consistent with the 410 rules that apply to behavioral health staff operating in primary care and other settings.	No	N/A
20	Provide funding for development of tribal BH workforce across full continuum of care	See Priority #1. In addition, the ARB provides $0.2 million to fund a position to assist in the development of a new health worker program.	Yes	$0.2 million

	B	C	D	E
21	**HOUSING**	**Description/Association to OHA Agency Request Budget (ARB) if Applicable**	**In ARB?**	**$ Amount Requested**
22	Increase OHA funding for Rental Assistance with barrier busting funds and wraparound support.	This recommendation utilizes existing programs and provides immediate support to people with SPMI to access permanent housing in the community. The increased funding will allow OHA to contract with more providers and community organizations to provide. Tenant based Rental Assistance with maximum flexibility to be used in a variety of scenarios and placements ranging from traditional scattered site supported housing to less traditional low barrier housing models. Wrap around services that pair with rental assistance to provide crisis stabilization, housing and benefit stabilization, and connections to more intensive services when necessary, and which follow clients, even in events where tenancy status changes. Robust barrier busting funds, which can be used to address a variety of financial concerns that might compromise housing stability. Funding in the ARB supports long term rental assistance, mobile PSH services, barrier removal funding for 300 people and could be used to support this effort.	Partially	ARB Amounts: $5.7 million for rental assistance, $2.7 for mobile PSH, $0.9 million for barrier busting. Additional Amount: Unknown.
23	Create a flexible housing and independent, community-based living fund to fill gaps in the housing continuum for people of color, including recovery housing.	Create a flexible housing and independent, community-based living fund to fill gaps in the housing continuum for people of color and tribal communities, including recovery housing, to meet the following needs: Opportunity for short-term stability to continue in an episode of care; Opportunity for long-term stability/housing; To aid transitions during critical moments (ER, inpatient, jail, etc.) and includes individuals with a need for residential supports who don't meet ACT criteria. Funding will be offered by RFP. Proposals must address community or regional need and include: 1. Peer support, including youth and culturally and linguistically appropriate peers; 2. Coordination with other systems of care; 3. Connections to voluntary social and other supports to remove barriers to long term housing.	No	Unknown
24	Develop additional Residential Treatment Facility and Secured Residential Treatment Facility capacity.	Expand Young Adult in Transition Residential System with four additional five-bed Residential Treatment Homes (RTH) and a 10-bed Secure Residential Treatment Facility (SRTF) specializing in the young adult population (age 17.5 – 25). Support for the Programs and Services recommendation and the OHA Agency Request Budget to fund three SRTFs to increase the number of facilities to serve the aid and assist population. The Programs and Services recommendation represents a scaled down version of this recommendation (one SRTF vs. three SRTFs). Language fully reflected in ARB.	Yes	$9.1 Million for YAT $14.4 Million for Aid and Assist
25	A state-funded pilot to create three non-clinical peer-run respite centers	Funds 3 non-clinical peer-run respite centers, including a culturally specific program designed to provide services and supports to individuals who are of communities of color or tribal communities. Language fully reflected in ARB.	Yes	$2.4 Million