FACE SHEET
FISCAL YEAR/S COVERED BY THE PLAN
___FY2008 ___ FY 2008-2009 _XX_ FY 2008-2010

STATE NAME: Oregon
DUNS #: 135749013

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Human Services, Health Services
ORGANIZATIONAL UNIT: Addictions and Mental Health Division
STREET ADDRESS: 500 Summer Street NE – E86
CITY: Salem STATE: Oregon ZIP: 97301-1118
TELEPHONE: 503-945-5763 FAX: 503-378-8467

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Robert E. Nikkel, MSW TITLE: Assistant Director
AGENCY: Addictions and Mental Health Division
ORGANIZATIONAL UNIT: Department of Human Services
STREET ADDRESS: 500 Summer Street NE – E86
CITY: Salem STATE: Oregon ZIP: 97301-1118
TELEPHONE: 503-945-5763 FAX: 503-378-8467

III. STATE FISCAL YEAR

FROM: 07/01/2007 TO: 06/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Michael Morris TITLE: Mental Health Policy Manager
AGENCY: Addictions and Mental Health Division
ORGANIZATIONAL UNIT: Mental Health and Addiction Services
STREET ADDRESS: 500 Summer Street NE – E86
CITY: Salem STATE: Oregon ZIP: 97301-1118
TELEPHONE: 503-947-5539 FAX: 503-378-8467
EMAIL: michael.n.morris@state.or.us

Executive Summary

The 2008 state plan for mental health services in Oregon contains measurable goals and performance indicators to guide and assess the development and implementation of a comprehensive system of mental health care during the next three years. The objectives reflect Oregon's continued commitment to provide persons with mental illness the greatest opportunity to pursue independent and meaningful lives.

Major issues facing the Oregon Addictions and Mental Health Division include:

- transforming to a mental health system that provides services that are person and family facilitated and directed;
- improving the quality of the services provided to adults and children through the increased use of Evidenced-Based Treatment;
- improving the timelines and rate of discharge from the state hospital for people who have achieved maximum benefit from that level of care by creating additional housing and community-based alternatives;
- increasing supported employment and education opportunities for adults;
- increasing transitional services for young people ages 16-25 who are leaving the children's mental health system and moving into the adult mental health system;
- developing enhanced services for persons with mental illness in local jails and community corrections systems;
- enhancing treatment efforts for persons with co-occurring mental illness and substance abuse disorders;
- increasing access to and providing appropriate mental health services for older Oregonians; and
- improving conditions for persons residing in the Oregon State Hospital.

Oregon is moving ahead with actions to transform the public mental health system. Some of these actions include:

- The Legislature has funded the initial phases of replacing state hospital facilities with new psychiatric treatment and recovery facilities.
- The 2007/2009 Legislatively Approved Budget includes $14.5 million additional funding for adult community mental health services, $3 million for children's mental health services and $4.3 million for early psychosis assessment and treatment services.
- AMH is monitoring the full implementation of the Children's System Change Initiative that integrates children's Intensive Treatment Services into a community-based system of care.
- The Governor, through an executive order, established the Children's Statewide Wraparound Initiative to develop an integrated statewide system of addictions and mental health care across state and local child serving agencies.
- Oregon is proceeding with the implementation of Evidence Based Practices to achieve the goal that by 2011 75% of mental health funds are spent to provide Evidence Based Practices as directed by the state Legislature.

TABLE of CONTENTS

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

I. Federal Funding Agreements, Certifications and Assurances

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that **OREGON** agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Robert E. Nikkel, MSW– For Governor Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabil-itation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction
was made or entered into. Submission of this certification is a prerequisite for making or entering into
this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification
shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Assistant Director
APPLICANT ORGANIZATION Oregon Department of Human Services	DATE SUBMITTED

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Assistant Director
APPLICANT ORGANIZATION Oregon Department of Human Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____ **Congressional Distric**t, *if known:* _____	**Congressional Distric**t, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Numbe**r, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Service**s *(including address if different from No. 10a.) (last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** Robert E. Nikkel, MSW **Title:** Assistant Director **Telephone No.:** 503-945-9704 **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

II. Set-aside for Children's Mental Health Services Report

Set-Aside for Children's Mental Health Services

Data Reported By **x** **State FY** **Federal FY** **Other**

State Expenditures for Children's Services

Line Item	FY 94 Base	Actual 2004-05	Actual 2005-06	Actual/Estimated 2006-07	Estimated 2007-08	Estimated 2008-09
Child and Adolescent Community Treatment Services	8,559,365	4,048,717	4,199,052	4,309,557	5,821,126	5,821,126
Child and Adolescent Community Treatment Services - Block Grant 1992	633,677	-	-	-	-	-
Additional 10% 0o 93 Block Grant Added to Base	282,497	-	-	-	-	-
Additional 10% 0o 94 Block Grant Added to Base	282,497	-	-	-	-	-
Oregon Health Plan Children's Services	-	36,310,696	38,009,805	33,426,610	31,853,692	31,988,549
Children's Crisis Services	-	1,452,990	1,448,569	1,494,660	1,888,754	1,888,754
Medicaid Authorization Specialists	289,475	-	-	-	-	-
Day and Residential Treatment Services/Psychiatric Day Treatment Services	5,559,692	3,858,850	-	-	-	-
JCAHO Certified Residential Care Facilities for Children and Adolescents	1,443,965	-	-	-	-	-
Robert Wood Johnson Foundation Grant	860,800	-	-	-	-	-
Total	**17,911,968**	**45,671,253**	**43,657,426**	**39,230,827**	**39,563,572**	**39,698,429**

Notes:
In 1999 JCAHO expenditures were reported as a separate service element. Beginning in 2000 these expenditures were reported in the Health Plan Expenditures.

II. Maintenance of Effort Report (MOE)

State of Oregon
2008 Community Mental Health Services Block Grant
Maintenance of Effort

Data Reported By **x** **State FY** **Federal FY** **Other**

	Line Item	Actual 2004-05	Actual 2005-06	Actual/Estimated 2006-07	Estimated 2007-08	Estimated 2008-09
20	Non-Residential Adult MHS	14,733,826	15,331,078	16,588,679	23,516,255	24,692,068
	Oregon Health Plan Adult Services	37,569,365	36,467,314	35,551,292	37,509,886	39,110,145
21	Psychiatric Day Treatment Services (PDTS)	3,858,850				
25	Adult Crisis Services	8,327,766	8,208,556	8,469,740	10,702,940	10,702,940
28	Adult Residential Care Facilities	6,106,802	15,931,891	20,346,640	32,964,638	34,612,870
30	PSRB	1,565,029	1,527,269	1,686,265	2,461,057	2,701,259
31	Enhanced Care Services	751,835		46,711	2,548,651	2,676,083
34	Adult Foster Care	(1,386,515)	157,705	265,013	4,913,650	5,159,333
35	Older and Disabled Adults	419,446	431,991	512,904	500,033	500,033
36	PASSAR Reviews	69,071	125,655	155,329	210,607	221,137
37/24	Special Project	4,232,981	16,763,399	19,147,544	24,415,662	25,636,445
38	Supported Employment	30,168	132,401	151,039	1,093,680	1,148,363
22	Child and Adolescent CTS	4,048,717	4,199,052	4,309,557	5,821,126	5,821,126
	Oregon Health Plan Childrens Services	36,310,696	38,009,805	33,426,610	31,853,692	31,988,549
25	Children's Crisis Services	1,452,990	1,448,569	1,494,660	1,888,754	1,888,754
	Medicaid Authorization Specialist	-				
128	JCAHO	-				
	Total	**118,091,026**	**138,734,685**	**142,151,983**	**180,400,630**	**186,859,105**

IV. State Mental Health Planning Council Requirements

1. Membership Requirements

DHS – Health Services
Office of Mental Health & Addiction Services

Mental Health Planning and Management Advisory Council
February 22, 2005
BYLAWS

ARTICLE 1. Purpose

The body shall be known as the Mental Health Planning and Management Advisory Council (PAMAC) of the Oregon Addiction and Mental Health Division (AMH). Its responsibilities include the following:

a. Advise the Office of Mental Health & Addiction Services on mental health policies and programs for children, adolescents, adults, and older adults;

b. Facilitate effective cooperative working relationships among the components of the mental health system;

c. Make recommendations regarding the identification, development and utilization of resources;

d. Identify problems and develop recommendations for resolution; and

e. Serve as the Planning Council for purposes of monitoring, reviewing and evaluating the federally mandated state plan for mental health services.

ARTICLE 2. Membership

a. The Mental Health Planning and Management Advisory Council shall be composed of members appointed by the Administrator of the Office of Mental Health & Addiction Services.

b. When appointing members, the Administrator shall give consideration to geographic, cultural and ethnic representation and seek members who represent the varied interests of adults, older adults, children, and adolescents. The membership shall be as described below.

1. Three (four) advocates for mental health services;

2. Five people who are or have been recipients of public mental health services;

3. Three family members of children/adolescents with serious emotional disorders;

4. Three family members of adults with mental illness;

5. Four representatives of mental health providers;

6. Three representatives of community mental health programs;

7. Eight representatives of state agencies serving persons with mental illness;

8. One representative of the Governor=s Commission on Senior Services to represent seniors with mental health service needs.

9. Five ex-officio members including the two superintendents of the state hospitals and three representatives of the Office of Mental Health & Addiction Services, one of whom shall represent the interests of children.

10. The AMH Administrator may appoint one at-large representative for the PAMAC and any committee established.

c. Members of the Council shall be responsible to communicate with constituents they represent regarding matters before the council.

d. Council members may serve up to three consecutive three-year terms. The Nominating Committee shall recommend nominees to the Administrator. The terms of the Council shall expire each December 31, and new council members shall begin new three-year terms each January 1.

e. If members are not able to attend a meeting, they are encouraged to send an alternate. A Designated Alternate may participate and vote. Notice of the alternate shall be given in advance to the AMH staff.

f. AMH will view three absences within a year's period, without alternate representation, as a resignation from the Council.

g. Proxy votes are not allowed.

ARTICLE 3. Meetings

a. Regular meetings of the Council will be held every other month. Committees of the Council will meet between regularly scheduled Council meetings.

b. Special meetings may be called by either of the co-chairpersons, or by agreement of a majority of the Council members.

c. One-third of the current Council membership shall constitute a quorum. Council decisions will be made by majority vote.

d. All meetings are public meetings.

ARTICLE 4. Officers

a. The officers of the Council shall consist of the co-chairpersons and vice co-chairpersons and shall be representative of the adult and children's mental health system, one of whom will be a consumer/survivor or family member

b. Officers shall be elected biennially at the meeting most closely following December 1.

c. Officers shall assume their official duties immediately following the meeting in which they are elected and shall serve for a term of two years and until the election of their successors.

d. A member shall not be eligible to serve more than two consecutive terms in the same office.

e. Vacancies in offices shall be filled by Council election for the unexpired portion of the term.

f. The co-chairpersons shall preside at all meetings of the Council; and shall represent the Council and conduct such business as the Council directs.

g. The vice co-chairpersons shall act as aides to the chairpersons and shall perform the duties of the co-chairpersons in the absence or inability of the officers to act.

h. Executive Committee. The officers of the PAMAC will serve as members of the Executive Committee. The Executive Committee will oversee the work of the Council in between meetings, plan agendas with the Administrator (or designee), and receive recommendations from committees for full Council review.

ARTICLE 5. Committees

There shall be two standing committees of the Council, the Children's Services Advisory Committee (CSAC) and the Adult Services Advisory Committee (ASAC).

a. There shall be two standing committees of the Council, the Children's Services Advisory Committee (CSAC) and the Adult Services Advisory Committee (ASAC).

b. Other committees shall be created by the Administrator or the chairpersons of the Council or by vote of the Council, as necessary to carry out the functions of the Council. Time limited committees shall be assigned a specific task to be accomplished in a limited period of time and then discontinued.

c. All committees will be staffed by a person from the Office of Mental Health & Addiction Services as assigned and approved by the Administrator for Mental Health & Addiction Services.

d. The AMH Administrator shall designate co-chairpersons for each committee created. One of whom will be a family member for CSAC or consumer/survivor for ASAC.

e. Committees may include non-council members.

f. The chairperson of each committee shall report to the Council at regularly scheduled meetings of the Council and submit a final report to the Council from the committee upon completion of the task assigned.

g. The co-chairpersons shall serve as the Nominating Committee to recommend Council nominees to the Administrator and to nominate officers.

h. A permanent sub-committee shall be established to focus on mental health systems for children and their family members. The sub-committee shall be known as the Children's System Advisory Committee (CSAC). The CSAC shall advise the Addiction and Mental Health Division through reports and recommendations to the PAMAC on issues affecting the children's mental health system.

These issues include:

1. System change and coordination, policy development, planning, evaluation, and fiscal development.
2. The committee will also address the specialized issues and services for transition age older adolescents and the young adults.

i. A permanent sub-committee shall be established to focus on resolving adult mental health system issues. The sub-committee shall be known as the Adult Services Advisory Committee, (ASAC). The ASAC shall advise the Addiction and Mental Health Division through recommendations and reports. Areas include:

1. Role of the State Hospitals in the system, management of census, and improved admission and discharge practices.

2. System change and coordination, policy development, planning, evaluation, and fiscal development.
3. The committee shall also address special issues such as:
   Consumer driven services, workforce cultural competence, forensic services, transition age services (in collaboration with the Children's Advisory Committee), extended care services, older adult services, etc.

j. A set of by-laws will be established to govern the operation of the standing Committees. Membership shall represent the geographic, cultural and ethnic population of the state, with 51% of the Committees being consumers, family members and advocates.

k. AMH shall provide reimbursement for members for travel expenses, which may include mileage, meals, lodging, child-care and certain other miscellaneous items. Reimbursement will be provided to persons without agency sponsorship for such expenditures.

ARTICLE 6. Policies

a. These bylaws may be amended or repealed at any regular or special meeting of the council provided notice of changes have been made to Council members 15 days prior to the meeting. A two-thirds majority of the membership in attendance is required to adopt amendments.

b. Robert's Rules of Order, newly revised, shall govern the conduct of members at all meetings of the Council.

c. Minutes shall be taken at all meetings and shall include action items and recommendations. Copies shall be emailed or mailed to all members. A staff person of the Office of Mental Health & Addiction Services shall perform the duties of secretary including preparation of minutes, agendas, correspondence and informational materials.

d. Records of the Council shall be maintained by the Office of Mental Health & Addiction Services.

2. State Mental Health Planning Council Membership List & Composition

Table 1. List of Planning Council Members

MENTAL HEALTH PLANNING AND MANAGEMENT ADVISORY COUNCIL

Department of Human Services
Health Services, Mental Health and Addiction Services

MENTAL HEALTH PLANNING AND MANAGEMENT ADVISORY COUNCIL

Department of Human Services
Addictions and Mental Health Division

Representation	Phone No./ Fax No./E-Mail	Term ending
STATE AGENCIES-8+2		
Sheriff Raul Ramirez Marion County Sheriff's Office P.O. Box 14500 Salem, OR 97309	Ph: 503-588-7971 rramirez@co.marion.or.us	2008
Denise Dion, MD Governor's Commission on Senior Services 1873 B Street Hood River, OR 97031	Ph: 541-298-2101 Denise_dion@class.oregonvos.net	2009
Megan Hornby Seniors and People with Disabilites 500 Summer Street NE, E02 Salem, OR 97301	Ph: 503-945-6415 Fax: 503-378-8966 **Megan.Hornby@state.or.us**	2009
Stephaine Parrish Taylor OVRS 500 Summer St. NE, E87 Salem, OR 97301-1120	Ph: 503-945-6201 Fax: 503-947-5010 stephaine.taylor@state.or.us	2010
Mary Claire Buckley Executive Director Psychiatric Security Review Board 620 SW Fifth, Suite 907 Portland, OR 97204	Ph: 503-229-5596 Fax: 503-229-5085 mcb@oregonvos.net	2005

Representation	Phone No./ Fax No./E-Mail	Term ending
Vacant Children, Adults & Families 500 Summer Street NE E83 Salem, OR 97310		2006
Dr. Arthur Tolan Department of Corrections 2575 Center St. NE Salem, OR 97301-4667	Ph: 503-378-8373 **Arthur.tolan@doc.state.or.us**	2007
Phil Cox Oregon Youth Authority 530 Center Street NE, Ste. 200 Salem, OR 97310-3740	Ph: 503-373-7531 Fax: 503-373-7622 Philip.Cox@state.or.us	2006
Vacant Housing and Community Services 775 Summer St. NE, Suite 200 Salem, OR 97301-1280	Ph:	2006
Robbi Perry Office of Special Education Department of Education 255 Capitol NE Salem, OR 97310	Ph: 503-378-3600 x2312 Robbi.Perry@state.or.us	2009
FAMILY MEMBERS ***YOUTH-3*** Vacant	Ph:	
Sandy Bumpus 8805 SE 17th Ave. #101 Portland, OR 97202	Ph: 503-287-9891 sbumpus@comcast.net	2007
OFSN c/o Lisa Moody 2411 Martin Luther King Jr Blvd, Ste 275 Eugene, OR 97401	Ph: 541-342-2876 Cell: 541-543-4008 carpadm05@yahoo.com	2008
FAMILY MEMBERS ***ADULT-3*** Vacant		

Representation	Phone No./ Fax No./E-Mail	Term ending
Phil Chadsey 2705 SW Summit Portland, OR 97201	Ph: 503-227-6155 chadsey6155@msn.com	2008
ADVOCATES-4		
Jan Stewart 2411 Ninth Street Tillamook, OR 97141	Ph: 503-842-1259 Fax: 503-842-8538 jstewart@oregoncoast.com	2010
Bob Joondeph Oregon Advocacy Center 620 SW Fifth Avenue, 5th Floor Portland, OR 97204-1428	Ph: 503-243-2081 Fax: 503-243-1738 bob@oradvocacy.org	2007
Jeanne Schulz Oregon Family Support Network 2411 Martin Luther King Blvd, 275 Eugene, OR 97401	Ph: 541-912-4009 Fax: 541-349-9226 jeanneschulz@yahoo.com	2010
Janet Arenz Oregon Alliance of Children's Programs 707 13th Street SE, Ste 290 Salem, OR 97301	Ph: 503-399-9076 Fax: 503-362-0419 janet@oregonalliance.org	2008
MENTAL HEALTH DIRECTORS-3		
Chris Johnson, Director Yamhill Co. Health & Human Svcs. 627 N. Evans McMinnville, OR 97128	Ph: 503-434-7523 Fax: 503-434-9846 johnsonc@co.yamhill.or.us	2007
Rod Calkins, Administrator Marion Co, Health Dept. 3180 Center St. NE Salem, OR 97301	Ph: 503-588-5357 Fax: 503-585-4908 rcalkins@co.marion.or.us	2009
Todd Jacobson, Interim Assistant Director Mid-Columbia Center for Living 1610 Woods Ct. Hood River, OR 97031	Ph: 541-386-2620 Fax: 541-386-6075 Todd_Jacobson@class.oregonvos.net	2009

Representation	Phone No./ Fax No./E-Mail	Term ending
PROVIDERS-4		
Bob Lieberman, Exec. Director Southern Oregon Adolescent Study & Treatment Center CHARPP 210 Tacoma Street Grants Pass, OR 97526	Ph: 541-476-3302 541-479-5901 A&E Fax: 541-476-2895 Fax: 541-479-6329 A&E rlieberman@soastc.org	2006
Bill Wellard, Director The Child Center OATC 3995 Marcola Road Springfield, OR 97477	Ph: 541-726-1465 Fax: 541-726-5085 Bwellard@Thechildcenter.org	2007
Vacant Oregon Psychiatric Association		
Jim Russell, Executive Manager Mid-Valley Behavioral Care Network 1660 Oak Street SE, Suite 203 Salem, OR 97301-6454	Ph: 503-585-4991 or 361-2647 Fax: 503-585-4989 jimr@mvbcn.org	2010
CONSUMERS-5		
Rollin Shelton PSU, Regional Research Institute 1600 SW 4th Avenue, Ste 900 P.O. Box 751 Portland, OR 97207-0751	Ph: 503-725-4040 sheltonr@pdx.edu	2007
Dave Romprey 1240 Chemeketa NE Salem OR 97301	Ph: (503) 365-3906 Cell: 503-930-5710 davidromprey@aol.com	2007
Beckie Child 333 NW 4th Ave. #227 Portland, OR 97209	Ph: 503-227-8496 Beckie.child@gmail.com	2006
Tracey Dumas, Ph.D. 2986 Oak St. Apt. 110 Eugene, OR 97405	Ph: 541-684-8195 Tcdumas2@juno.com	2008

Representation	Phone No./ Fax No./E-Mail	Term ending
Corbett Monica 5903 NE Rodney Ave. Portland, OR 97211	Ph: 503-247-7209 Corbettmonica@yahoo.com	2008
EX-OFFICIO MEMBERS-5		
Marvin Fickle, MD Oregon State Hospital 2600 Center Street NE Salem, OR 97310	Ph: 503-945-2850 Fax: 503-945-2867 Marvin.Fickle@state.or.us	
Bob Furlow Blue Mountain Recovery Center (EOPC) 2600 Westgate Pendleton, OR 97801	Ph: 541-276-0810 ext. 321 Fax: 541-276-1147	
Bill Bouska, MPA Childrens Treatment System Manager Addictions and Mental Health Division	Ph: 503- 945-9717 Fax: 503-373-7327 bill.bouska@state.or.us	
AMH Staff		
Bob Nikkel, MSW Assistant Director Addictions and Mental Health Division	Ph: 503-945-9704 Fax: 503-373-7327 Robert.E.Nikkel@state.or.us	
Madeline M. Olson Deputy Assistant Director Addictions and Mental Health Division	Ph: 503- 945-9718 Fax: 503- 373-7327 madeline.m.olson@state.or.us	
Mike Morris, MS Mental Health Policy Manager Addictions and Mental Health Division	Ph: 503-947-5538 **Michael.N.Morris@state.or.us**	
Jennifer Leseman Office Specialist Addictions and Mental Health Division	Ph: 503-947-5549 Jennifer.leseman@state.or.us	
Co-Chair for Adults	**Mary Claire Buckley**	
Vice Co-Chair for Adults	**Vacant**	
Co-Chair for Children	**Bill Wellard**	
Vice Co-Chair for Children	**Phil Cox**	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	**32**	
Consumers/Survivors/Ex-patients (C/S/X)	**5**	
Family Members of Children with SED	**3**	
Family Members of Adults with SMI	**2**	
Vacancies (C/S/X & family members)	**1**	
Others (not state employees or providers)	**6**	
TOTAL C/S/X, Family Members & Others	**17**	**53%**
State Employees	**8**	
Providers	**6**	
Vacancies	**1**	
TOTAL State Employees & Providers	**15**	**47%**

3. Planning Council Charge, Role and Transformation Activities

The Planning and Management Advisory Council PAMAC has two sub-committees, Adult Services Advisory Committee (ASAC), and the Children's Services Advisory Committee (CSAC). The sub-committees meet between meetings of PAMAC and route recommendations to PAMAC for consideration and action. This configuration has permitted PAMAC to address overall mental health system issues and to take action on the work conducted by the two sub-committees. The two sub-committees have been active by addressing the issues for their population group. They have also agreed to have the two groups meet twice a year to coordinate activities.

PAMAC arranged for National Association Mental Health Planning Councils (NAMPAC) to meet with PAMAC and AMH representatives for an all day planning and technical assistance meeting. NAMPAC was instrumental in educating those in attendance regarding the role of a planning council and assisting with identifying a focus for future planning.

In its second year of operations the Adult Services Advisory Committee (ASAC) has sharpened its focus on system transformation and aligned its attention to projects that are gaining momentum as Oregon's mental health system continues to develop. The ASAC spent significant amounts of time on the following projects:

- ASAC members further developed the Committee's direction and the cohesion of its membership to partner with CSAC and provide guidance on adult issues to PAMAC.
- Concepts to expand Peer Services were identified and presented to PAMAC for funding with Block Grant funds. Concepts included developing a peer delivered services curriculum, workforce development, technical assistance to provide peer delivered services across the state, and a warm line.
- ASAC framed a transition age youth/young adult (TAY/YA) project with proposed funding from the New Freedom Initiative/Olmstead grant. The project will provide peer mentors for a new five-bed TAY/YA residence, a stipend for the mentors and funds to support community integration for the residents of the new home.
- ASAC invited CSAC to participate in the development of the TAY/YA project.
- ASAC participated in the development and approval of adult service projects for Block Grant Funds.
- New member recruitment resulted in the addition of six new members to the ASAC.
- ASAC invited members of the local Mental Health Organization to provide information on the health conditions that dramatically decrease the lifespan of people with serious mental illness.
- ASAC continued its focus on promoting Supported Employment and Supported Education.
- ASAC provided guidance on the development of Block Grant Goals and Performance Indicators for adult services.

CSAC conducted the following activities during the last year:

- Standing agenda item of 'Youth Involvement' at the monthly CSAC meetings, increased the membership of youth from two to three members. CSAC facilitates active youth participation by using youth mentors.
- AMH developed an RFP for the Family Navigator Program to assist family members and youth access and receive services and supports in a timely manner.
- CSAC developed an annual work plan that established: transition age youth, co-occurring disorders, youth involvement, and system of care development as priorities.
- CSAC provided recommendations to AMH for Legislative policy & budget development.
- Based on CSAC recommendations, AMH is investing block grant funds in System Improvement Projects using the Change Book.
- CSAC is monitoring the CSCI and receives monthly data and outcome reports.
- CSAC recommended several new policy statements including an up-date on family-driven care for youth in foster care or who are homeless; nutritional care; and a suggestions, concerns and feedback form.

- Curriculum development: up-date and continued use of the *Family & Professionals as Policy Partners*, including a train-the-trainer model; *Youth & Professionals as Policy Partners*.
- Quarterly meetings of statewide *Family Leaders in Policy Options* to share developed trainings, networking and skill building activities.
- Monthly meetings with CSAC members to review and develop outcome indicators for the Annual Block Grant Application.

4. Public comment on the state plan

Oregon's State Plan is posted on the Department of Human Services website at the time the application is submitted to the Center for Mental Health Services. The plan is open for comment during the Legislative Session as part of the Agency's budget presentation to the Legislature. There is opportunity for public comment at that time. The feedback from the public comment will be incorporated into any modifications to the State Plan. AMH will notify the Center for Mental Health Services of any State Plan modifications made in response to public comment.

Part C: State Plan

SECTION I. DESCRIPTION OF STATE SERVICE PLAN

A. CURRENT STRUCTURE

1. Organizational Structure

The Oregon Addictions and Mental Health Division (AMH) is located within the Department of Human Services (DHS), which reports to the Governor. DHS is made up of the following program areas: Children, Adults and Families; Seniors and People with Disabilities; AMH, the Division of Medical Assistance Programs (State Medicaid Agency) and the Public Health Division.

Capitated mental health services for persons who are Medicaid-eligible are administered through contracts between AMH and Managed Care Organizations. All other non-capitated services are administered through contracts with the counties and direct contracts with service providers for community hospitals for acute psychiatric care and a small number of residential programs.

The State is required by Oregon Revised Statute 430.640 to establish a contractual relationship with every community mental health program in each county, or Native American Tribe on request by the Tribe, to assure the provision of community mental health services. State funds for nonresidential services are allocated to counties using a "block grant" approach. This method of allocation provides the greatest flexibility for counties or community mental health programs in managing resources to best meet the needs of consumers. AMH currently contracts with 31 counties or consortium of counties, one community mental health program and one tribe.

2. Funding Mental Health Services

Throughout the 1980s and early 1990s, an increasing amount of state General Fund was used to match federal Medicaid funds for community mental health services. Considerable expansion of the public physical and mental health care systems resulted. Escalating health care costs, however, required new strategies for cost effective and appropriate public health care. The Oregon Health Plan, developed in the late 1980s, provides a rational method for allocating public resources for health care. The Plan devotes resources to services that are most effective in treating covered conditions, provides incentives to intervene early, and extends coverage for some of low income Oregonians in need of mental health services.

Since 1989 the Health Services Commission has prioritized medical conditions and associated treatments. Condition and treatment pairs are ranked according to the state of medical technology, the effectiveness and cost of treatment, public values, and advice from medical specialists and ethicists. Since 1993, a prioritized list has served as the basis for the allocation of health, mental health, and chemical dependency services.

The Oregon Health Plan includes an expanded mental health benefit that covers all Oregon Health Plan eligibles. As of September 2006, 84% of persons who are Medicaid-eligible received their Medicaid mental health benefit through an at-risk managed care Mental Health Organization (MHO).

Not all individuals requiring public mental health services meet Medicaid eligibility criteria. Mental health services continue to be made available to persons ineligible for the Oregon Health Plan according to risk criteria defined in state law. However, with recent Legislative funding of Early Assessment and Support Teams, the state is beginning to prioritize early intervention and a more foresighted approach to longer-term risk management. State general funds, various federal grants (including this grant), local funds, and private insurance payments provide additional sources of revenue for Community Mental Health Programs to serve people who have mental health needs, but are not eligible for Medicaid or other third party payments.

B. AMH STATEWIDE LEADERSHIP

AMH provides leadership in the delivery of mental health services through the establishment of administrative rule and contracts, the provision of training and technical assistance, the development of Statewide Mental Health Services and the initiation of various workgroups. This section will briefly describe each of these areas of leadership.

Administrative rules and contracts establish standards for community mental health services. The AMH Quality Improvement and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Certificates of Approval are issued to community mental health programs and sub-contracted providers, children's psychiatric day treatment, and nationally accredited psychiatric residential treatment programs for children, inpatient psychiatric acute care programs, psychiatric hold rooms used for seclusion or restraint, and private outpatient mental health providers. Licenses are issued to Residential Treatment Facilities and Adult Foster Homes serving adults with mental illness. Quality Improvement staff conduct site reviews of these programs to ensure compliance with contract conditions and state regulations. This section also approves individuals in the state to conduct investigations and examinations for civil commitment proceedings and for individual clinicians to authorize the use of seclusion or restraint for children in approved facilities. The Mental Health Organizations that are contracted to manage the mental health benefit of the Oregon Health plan are also reviewed regularly for contract compliance.

The 2001 State Legislative Assembly passed HB 3024, now codified as Oregon Revised Statutes (ORS) 430.630 and 430.640, requires a statewide comprehensive plan based on local community-based plans. ORS 430.630 requires that the Local Mental Health Authority (LMHA) engage community partners, consumers, families, and advocates in a planning effort to pursue systemic changes in service delivery. LMHAs must engage such community partners as health and physical medicine, juvenile justice, child welfare, schools, local alcohol and drug planning

committees, local public safety planning councils, vocational rehabilitation, local housing and others in this process. AMH reviews these plans as the statewide plan is developed.

In 2003 Oregon passed legislation that directed AMH, among other agencies, to spend public funds on evidence-based practices (EBPs) By the end of the 2005 – 2007 biennium, AMH needs to demonstrate that 25% of the public mental health, alcohol and drug treatment and prevention funding is spent on EBPs. AMH has been engaged in a process with statewide community partners input to define, identify and implement EBPs. Currently there have been 171 EBPs identified that meet the state definition for EBPs. AMH has reworked many of the functions of the office to support the implementation of this statewide initiative. Workforce development efforts have shifted from stand-alone trainings to the provision of technical support to providers in the implementation of EBPS.

Each biennium AMH evaluates the mental health training needs in the state. The Workforce Development Unit develops a plan to provide the training necessary to equip the mental health workforce to deliver the services needed to carry out the statewide mental health initiatives. A report on the implementation of the training plan is included in this application.

AMH establishes task forces and workgroups to develop plans and build consensus for mental health initiatives. Some of the recent workgroups established include the State Hospital Master Plan Community Services Workgroup and Psychiatric Nurse Workforce Development Team.

C. REVIEW OF FY 2007 STATE PLAN

Needed Improvements

The areas of needed improvement identified in the previous plan were:

- Improved access to mental health services for older adults.
- Strengthening the role of consumers in the design, planning and implementation of mental health services at the state and local level.
- Individuals needing long-term care are without ready access to admission to a state hospital and thus wait in acute care facilities.
- The lack of affordable housing and community residential settings for people with severe and persistent mental illness in Oregon.
- Homelessness among mental health service recipients is a significant and increasingly common issue.
- There is a gap in services for the transitional aged youth (16-25) with emotional difficulties.
- Although the increase in residential development across the state has improved the rate of discharge for patients deemed “ready to place” at the state hospital, there is a small population of patients (approximately 10%) on the ready to place list that have exceptional barriers to discharge. These barriers include sexual offenses, compromised medical conditions, aggressive behaviors, and low cognitive functioning. AMH has created an exceptional barriers team that will include representatives from the state

hospital and AMH Extended Care Management Unit (ECMU) and development staff. The purpose of this team is to problem solve and eliminate barriers to discharge.

- While Oregon has strengthened its working relationship and collaboration with the Oregon Department of Education (ODE), there is still more to be done. This will continue to be an area of focus at the state and local level. A representative of the state Department of Education and local school systems serves on the Children's System Advisory Committee of the Mental Health Planning and Management Advisory Council and on the full Planning Council. At a community level, efforts are made to engage local school districts in mental health system planning and in system oversight.
- A conference was held in March 2006 that was co-sponsored by AMH and ODE on Positive Behavioral Support and System of Care philosophies. This conference provided an opportunity for educational personnel and mental health providers to collaborate on behavioral management in the classroom and to develop strategies for continued collaborative processes to occur on a regional basis.
- Mental health services for children are currently provided in settings that were not previously used or were under-utilized, including homes, schools, and other community settings. Communities within Oregon are working hard to expand these services, but more needs to be done.
- The range of mental health services provided in less traditional settings is expanded to include crisis, respite, in home supports, and therapeutic foster care. Communities are challenged to create services that will meet a variety of mental health needs within the community itself, and continue to find different ways to accomplish this task.
- AMH is working closely with family organizations to recruit and train family members who can become effective family advocates at all levels of the system. Implementation of the Family-Driven System policy is a high priority for AMH.
- Another important area of focus during the next several years will be the development of youth directed services and inclusion of youth voice in decision- making bodies throughout the system.
- With the implementation of the Children's System Change Initiative, AMH needs to improve the cultural competency of mental health services provided to children and their families. AMH hired a cultural competency consultant and a committee within AMH is reviewing the report for appropriate changes and modifications to ensure cultural competency. A representative from the children's mental health unit within AMH sits on this committee.
- Transitional services for young people ages 16-25 leaving the children's mental health system who need services from the adult mental health system or services for young people experiencing first indications of a major mental illness need to be improved and expanded. Efforts are underway to convene a statewide group of constituents to address this ongoing issue and make recommendations for systemic changes that will provide for a coordinated transition between the child and adult systems.
- More collaboration must occur between state and local Child Welfare and AMH to ensure children entering substitute care receive a comprehensive mental health assessment within 60 days to reduce placement disruption.

- AMH continues the process of developing and maintaining a coordinated system of care to meet the needs of children served by multiple child serving agencies. It is the goal of AMH to create a shared partnership along with other child serving agencies in the state to more effectively address the needs of children served in multiple systems. Efforts at workforce development, training and collaborative efforts are underway.
- Implementation of a statewide Trauma Policy, and the development of trauma informed care, are goals throughout the system.

Significant Achievements

Achievements identified in the 2007 plan were:

- Continuing Deinstitutionalization
- Investment in Addressing the Acute Care/Long-term Care Problems
- Continuing to Promote Affordable Housing
- Supported Employment Research Project
- Commitment to Train to Support Evidence-Based Practices
- Medication Administration Project.
- Early Assessment and Support Team (EAST).
- AMH is engaged in a broad scale planning and implementation process to provide a more integrated community-based system of care for children and their families, which began October 1, 2005.
- AMH has developed systemic alternatives to state hospitalization for adolescents.
- AMH established a policy of family-driven care.
- AMH is developing a new coordinated system of care to meet the needs of children served by multiple child serving agencies.
- AMH led a strategic planning process partnering with Children's Array of Psychiatric Programs (CHARPP) to develop alternatives to using seclusion and restraints.
- AMH received a 2003 Legislative appropriation of two million dollars to provide mental health and addiction services for children ages 0-8 and their families.
- AMH funding directed to evidence-based practices.
- AMH established an Outcomes Policy to guide child mental health data collection.

D. NEW DEVELOPMENTS

State Hospital Replacement

Oregon has been engaged in an intensive two year planning process to replace the current deteriorating state hospital facilities. A 2005 report outlined the problems with the current facilities with recommendations for replacement of the facilities. The 2006 report provided the Governor and Legislative Leadership with options for replacing the facilities. In May 2006 the Governor and Legislative Leadership chose the option to build two new state facilities with one 620 bed facility in the northern Willamette Valley region and a 360-bed facility in the Willamette Valley south of Albany. After an extensive siting solicitation and review the site of

the current state hospital site in Salem for the larger facility and a site in Junction City, just north of Eugene for the smaller state facility. The Legislature has approved funding to proceed with the initial phases of constructing the replacement facilities at the two recommended sites.

Settlement of Federal Lawsuit Harmon v. Fickle

AMH was sued in 2005 by the Oregon Advocacy Center (OAC) on behalf of a class of Oregon State Hospital (OSH) forensic patients. The suit focused on conditions for forensic patients due to crowding on the wards and lack of sufficient staff to provide optimal treatment. On June 7, 2006, AMH and OAC entered into a settlement agreement. As part of the agreement, AMH agreed to hire 30 new state hospital staff and develop 71 community-based placements in addition to those funded in the 2005-2007 budget. As of June 30, 2007, OSH had filled 29 of the 30 positions and is continuing a vigorous recruitment for the psychiatrist position. AMH completed a total of 109 community placements by the end of the state fiscal year. As of June 30, 2007, the staff-to-patient ratio had improved to 1:1.26 compared to the 1:1.09 ratio in the October to December 2005 quarter.

Civil Rights of Institutionalized Persons Act (CRIPA) Investigation

The Federal Department of Justice (DOJ) is investigating Oregon State Hospital under CRIPA. The investigation has include a site visit to OSH and extensive document review. While AMH awaits the report of the investigation, efforts continue to improve the living conditions and treatment of patients at OSH.

Governor's Statewide Wraparound Project Executive Order

The Governor's office issued an Executive Order in March 2007, calling for a Statewide Wraparound Project Steering Committee to insure the integration and blending of children's services and funding for children's services, statewide.

The Executive Order stated the time has come for Oregon to develop a statewide, integrated system of care for children at risk of developing, or who have already developed, significant emotional, behavioral or substance abuse related needs and their families. The Steering Committee has defined membership including; the Governor's Office, Legislators, family members, youth, State Agency Directors, Superintendent of Public Instruction, service providers, local education system, early childhood system, and system of care experts.

A contract has been awarded for the Project Manager, who began working with the steering committee in April 2007. The steering committee will develop a strategic plan for the implementation of a system of care approach to the delivery of behavioral health services and supports for children, youth and families with a priority on a financing plan. The system of care encompasses a continuum of services including health promotion, prevention, intervention and follow-up.

The steering committee has begun meeting and has formed subcommittees for local implementation, data and evaluation, cultural competency and financing. Recommendations will be made following the September 2007 conclusion of the committee's work.

E. LEGISLATIVE INITIATIVES

- SB 364 is a consumer self-determination bill that was passed with strong support. This bill requires AMH to develop a mental health consumer self determination policy, establish a mental health Consumer Advisory Council and assure that any public body, committee or task force on mental health have at least 20% of the membership be consumers of mental health services.
- The Legislature approved approximately $18 million to improve support for the community mental health services necessary to identify and treat adults in the community before their illness reaches a level requiring state hospital level of care. This will improve access to services for people without Medicaid when they are in a crisis, need acute hospital treatment, and will fund evidence-based services to divert people from jail, assist in employment, housing stability and case management.
- The Legislature approved $3.0 million funding to provide additional treatment for children and their families who are not eligible for Medicaid. These services will stabilize the children in the community, either avoiding or shortening treatment in residential settings and will provide support to families and local schools to keep these children at home and in school.
- Early in the Session, the Oregon State Hospital Site Recommendations report was accepted. This was a milestone in the process for replacing the current facilities with a modern facility designed to promote recovery, community reintegration and patient and staff safety. The Legislature financed the first phase of the Oregon State Hospital replacement project with the passage of HB 5005 and HB 5006. These bills together provide the bond financing for the selection of a project management firm, the architectural and engineering firm and the construction firm, and the state resources to manage the project. Work can proceed on the design and early phases of construction of a new facility and the program to be delivered to the patients.

SECTION II. IDENTIFICATION AND ANAYLSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIOTITIES;
AND
SECTION III. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICES SYSTEM

A. ADULT PLAN

1. Current Strengths and Accomplishments

- **AMH funding will be used on evidence-based practices.**

In June 2003, Oregon Legislature passed a law that requires the Office of Mental Health & Addiction Services to use state and federal funds for cost effective practices that are based on scientific evidence. AMH reported progress to the September 20, 2006 meeting of the interim Judiciary committee in meeting the goal that 25% of AMH funds are being used for evidence based practices for the 2005-07 biennium. In 2007-09, the percentage of funds to be spent on EBPs increases to 50% and in 2009-2011 to 75%. The following strategies will be used to further the implementation of EBPs:

- AMH has improved it operational framework by appointing a project manager who will serve as a change leader for AMH in EBP efforts.
- AMH will identify incentives for change in mental health practices to EBP that may include prioritizing funding for specific EBPs.
- AMH will identify administrative rule changes and contact actions necessary for EBP implementation.
- AMH will develop technical assistance resources that facilitate effective implementation of EBPs.
- AMH has developed an operational definition to evaluate EBPs level of evidence.
- AMH has asked providers to demonstrate how EBPs are being delivered with a degree of fidelity.
- AMH will use the DHS website http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml to promote information about EBP plans and activities.

The most commonly listed EBPs by providers are Cognitive Behavioral Therapy (118), Motivational Interviewing and MET (94), Drake's 5 without IDDT (91), ASAM (61) and Dialectical Behavioral Therapy (46).

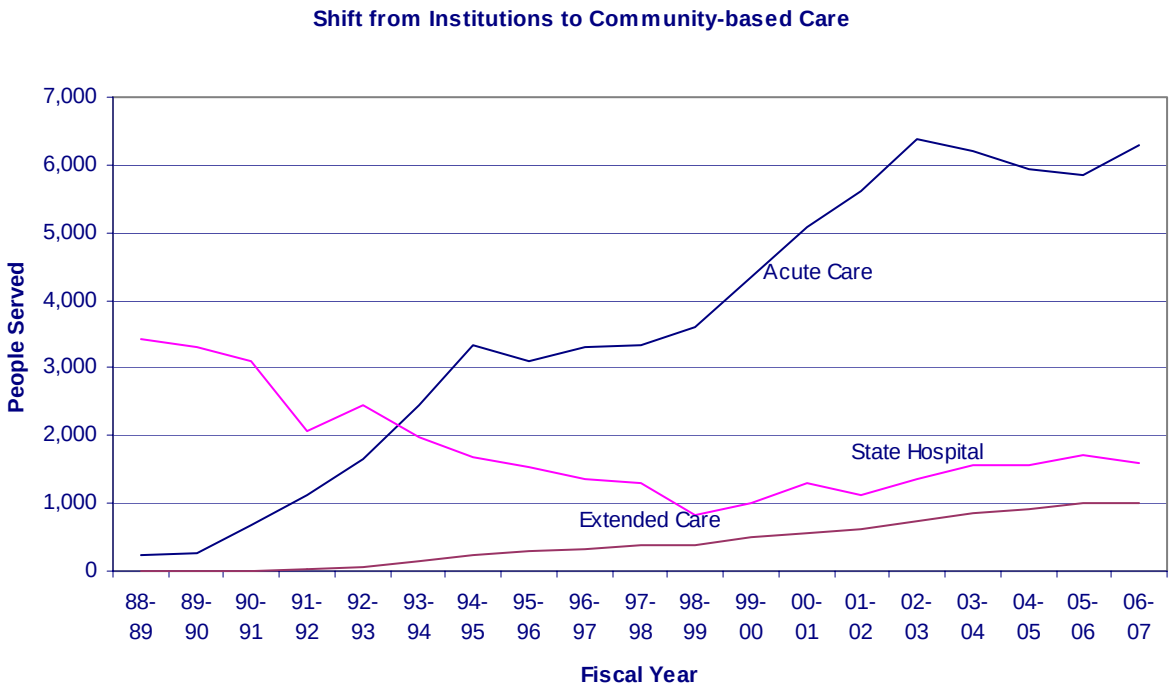
- **Continuing Deinstitutionalization**

Oregon (AMH) continues to transform the mental health system by moving from institution-based care to community based care. Since 2003, the Department of Human Services, Addiction and Mental Health Division, in partnership with local governments, has developed more than 500 new community-based placement options for adults with severe and persistent mental illness. The Legislatively Approved Budget includes funding to complete an additional 290 community placements during the 2007-09 biennium.

The Extended Care Management Unit (ECMU) maintains responsibility for individual placement approvals and for conducting utilization reviews of adults in all 822 extended and enhanced care placements. AMH added 144 new ECMU community placements in 2005 – 2007 biennium.

Deinstitutionalization has resulted in resources being shifted from state hospitals to community programs. The percentage of total dollars expended on adult and children's community mental

health services is 72% for the 2005-07 biennium compared to 65% in state fiscal year 1994-95. The following graph further demonstrates the shift from institutions to community-based care.



Co-Management Plan

AMH worked with the CMHPs to address the issue of state hospital utilization and continuity of care for civilly committed (though not forensic or criminally committed) county residents. The Financial Assistance Agreements (FAA) with the CMHPs was modified to share financial risk for those civilly committed patients that remain in the state hospital when they are ready to return to the community and the community resources and supports are available. This FAA modification is based on the Co-Management Plan which establishes county and regional targets for state hospital Average Daily Population and establishes a utilization review process for persons approved for state hospitalization. This and other efforts of the local CMHPs and AMH have lead to a reduction in the number of people waiting in local acute care hospitals to enter the state hospital. In 2004 the average number of people on the waitlist was 36 and thus far for 2007 the average number on the waitlist is 19.

- **Continuing to Promote Affordable Housing**

Since 1989 AMH has directly awarded modest grants to assist housing for persons with mental illness. As of July 2007, $8.6 million has been awarded to housing projects in 28 Oregon counties to create and preserve housing for more than 1,640 people with severe and persistent mental illness. During the 2005-2007 biennium, 25 awards totaling $3.7 million have been made

to assist with the development of housing in 15 counties accommodating 221 residents. As of July 2007 a total of $815,851 has been awarded to 104 housing operators for renovations to correct health, safety or accessibility problems. With these funds, housing has been improved for 1,213 persons, and in some cases, residential resources have been prevented from threatened closure. Renovation funds awarded during the 2005-2007 biennium assisted 32 projects for 320 residents in all counties. This housing development program has taken on increased importance as three of Oregon's metropolitan areas have been ranked among the 25 least affordable housing markets in the nation.

The Community Mental Health Housing Fund (CMHHF) was created by the 1999 Legislature from the sale of the former Dammasch State Hospital and is codified in ORS 426.502 through 426.508. The statute directs 70 percent of interest earned to community housing purposes and 30 percent to improve living conditions for state hospital patients. The Legislature statutorily reserved not more than10 acres for the development of housing for persons with serious mental illness at Villebois, the new community under development on the former state hospital grounds.

During the 2005-2007 biennium $841,979 was awarded to 12 sponsors to create 12 housing projects for persons with serious mental illness in 12 Oregon counties. DHS collaborates with Oregon Housing and Community Services to ensure the highest return and best value for community housing, through matching public and private money available from other development sources.

Of the statutorily reserved land in the Villebois development, AMH conveyed two sites to developers in 2005-2007. On the first, a group home for five residents opened in August 2006. On the second an apartment building with 20 rent-subsidized units, is currently under construction. In 2007-2009 five additional sites will be developed, providing additional affordable housing for persons who have serious mental illness.

- **Supported Employment Continues to Advance**

AMH has completed a three-year EBP demonstration project funded by Johnson and Johnson and Eli Lilly to implement supported employment in three typical community mental health settings and in cooperation with the Dartmouth/New Hampshire Psychiatric Research Center. Since the funding supporting this projected ended in 2004, AMH continues to receive technical assistance from Debbie Becker and Bob Drake and continues to provide training, support and fidelity reviews to 7 counties utilizing supported employment. AMH has strengthened the relationship with Vocational Rehabilitation to blend funding to continue supportive employment services. The result of this continued efforts, as of March 2007, 335 consumers were enrolled in supported employment programs with 169 consumers competitively employed.

- **Commitment to Train to Support Evidence-Based Practices**

The AMH Workforce Development efforts support the Department and Office mission to provide education, training and technical assistance on current Evidenced Based Practices to

families, stakeholders and policy makers. All efforts are designed to facilitate service delivery methods and systems that promote resilience and recovery for people of all ages who experience or are at risk for psychiatric and /or substance abuse disorders. Recovery is the anticipated outcome.

- **Early Assessment and Support Team (EAST).**

AMH continues to support the efforts of the Mid Valley Behavioral Care Network's (MHO covering five counties in Oregon) early intervention program supporting first episode schizophrenia and related disorders. MVBCN launched the Early Assessment and Support Team (EAST) in 2001. EAST offers early, effective care for schizophrenia and related disorders, through clinical teams in each county. The 2007 Legislature approved $4.3 million dollars to expand these services to other parts of the state.

EAST follows best practice guidelines from the foremost international experts, the Early Psychosis Prevention and Intervention Center in Australia. The project provides:

- Community education
- Rapid, flexible outreach, engagement and assessment
- Psychiatric treatment
- Illness education, therapy and help finding resources
- Family psychoeducation and support
- Support for independent living, school, work, and other goals
- Local teams include psychiatrists, social workers, psychologists and occupational therapists.

EAST is getting results. The program reports a decline in acute psychiatric admissions during the first quarter of treatment from 60% to 10%, increased referrals from the community and decreased referrals from psychiatric units and 65% of the clients are working or enrolled in an education program. EAST works with approximately 100 young people and their families. Each week, EAST engages at least one new young person with psychosis.

- **Transition Age Youth Residential Program**

AMH recognizes the need to develop and improve services to transition age youth. The current adult system is not equipped to respond to the developmental needs of youth "aging out" of the child mental health system. As a step to address this issue AMH contracted with ChristieCare, a child mental health provider, to develop and open a five bed residential treatment home to serve this population. At least one other project is under development to serve this age group.

2. Current Weaknesses and Areas of Needed Improvement

- The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for seniors is a critical area of improvement for Oregon's

mental health system. AMH has bolstered its collaboration and communication with Senior and People with Disabilities and has a representative of the Governor's Commission on Senior Services on the Mental Health Planning and Management Advisory Council.

- AMH will continue to strengthen the role of consumers in the design, planning and implementation of mental health services at the state and local level. The local planning requirements in Oregon Revised Statute 430.630 requires the involvement of consumers, family members and advocates in the community-based comprehensive planning process. The statute further emphasizes the role of consumers in their treatment and in system oversight. The Consumer Advisory Committee continues to meet with the Assistant Director of DHS and AMH. This increased opportunities for consumer input and advice in planning, system design, implementation and monitoring of mental health service delivery.

- There continues to be an issue of individuals needing long-term care without ready access to admission to a state hospital. Once approved for long term care at the state hospital, persons are waiting an average of 19 days in an acute care hospital prior to transfer to the State Hospital. While this is an improvement, more needs to be done to reduce or eliminate the wait list. The time a person spends in an acute care hospital waiting for a bed at the state hospital negatively impacts acute care access for those in need of that level of care.

- The lack of affordable housing and community residential settings for people with severe and persistent mental illness continues to present a serious challenge in Oregon and results in too many individuals becoming homeless or incarcerated. Without a housing subsidy, an individual with a SSI income cannot find affordable housing anywhere in Oregon through the private housing market. A 2005 AMH housing survey assessed the housing needs of children and adults receiving publicly funded mental health services. Results from this survey included an estimate that a total of 2,972 adults with mental illness are homeless at any point in time. The survey also estimated that 12,861 adults were in immediate need of affordable housing, 1,940 were in need of supportive housing, and 577 were in need of structured "group home" settings. On the positive side, community mental health programs reported that 92 housing projects for persons with mental illness were developed in the previous five years and 24 additional projects were under development. These recent and current projects have the capacity to house 1,142 persons.

- There continues to be a gap in services for the transitional aged youth (16-25) with emotional difficulties. There are limited resources available in Oregon that provide adequate developmentally appropriate mental health services to this population. A brief meta-analysis of this population found that this population is two times more likely to drop out of high school then their peers. There is an increased risk of poverty and homeless. 58% of this population has been arrested at least one time and of those that

dropped out of school 73% have been arrested. They are also two times as likely to be living in a treatment facility. To address this AMH has collaborated with evidenced based transitional youth services already established to improve treatment needs.

- Although the increase in residential development across the state has improved the rate of discharge for patients deemed "ready to place" at the state hospital, there is a small population of patients (approximately 10%) on the ready to place list that have exceptional barriers to discharge. These barriers include sexual offenses, compromised medical conditions, aggressive behaviors, and low cognitive functioning. AMH has created an exceptional barriers team that includes representatives from the state hospital and AMH ECMU and development staff. The purpose of this team is to problem solve and eliminate barriers to discharge.

3. Priorities for the Adult Mental Health System

1. Increase the involvement of consumers in system planning and receiving and providing support services.
2. Improved mental health services for persons 65 and older.
3. Increase the availability of Evidence-based Practices.
4. Decrease the rate of readmission of adults to the State Psychiatric Hospitals within 30 days and 180 days.
5. Increase the access to publicly funded mental health services.
6. Increase the availability of appropriate housing for adults with severe mental illness.
7. Improve access to housing and mental health services for persons with severe mental illness being diverted and released from jail or prison.
8. Promote recovery oriented case management services.
9. Reduce the effects of trauma for adults with severe mental illness.
10. Improve coordination with the children's mental health system to better serve those transitioning to an adult mental health system.
11. Decrease waiting period for patients in the state hospital with exceptional barriers to discharge.

4. Future Vision For Adult Mental Health

- Mental Illness is treatable, often at a low direct cost.
- Recovery is possible and is the goal of all mental health services.
- Services are driven by the strengths and needs of consumers and their families, rather than by funding silos or the organization of service agencies.
- Services are culturally, age and gender specific.
- Services are available in the communities where people live.
- Services are preventative and offered as early as possible.
- Services reflect evidence-based practices with fidelity.
- Services are holistic and respond to a person's universe of strengths and needs.

- Services are based on conditions and outcomes, not diagnosis.
- Services are available without regard to ability to pay.
- For individuals who are dangerous to themselves or others, services must reflect public safety concerns.
- Recovery from mental illness also requires recovery from substance abuse and physical illness, if present. Thus, coordination and integration of services is essential.
- Outcomes can be measured, both in terms of individual recovery and improved population health. In public health terms the most important outcome is that substantial numbers of individuals achieve recovery and function effectively as productive members of society.

5. Criteria

a. Criterion 1: Comprehensive Community-Based Mental Health Systems

i. Description of Current Adult Mental Health System

Outpatient Services

Clients are provided with an array of outpatient services, including assessment and evaluation, individual and group therapy, medication management, case management, and daily support and skills training. Services for clients experiencing acute psychiatric conditions include 24-hour crisis assistance, community-based respite care, sub-acute psychiatric care, and inpatient services. A promising feature of the Oregon Health Plan is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments and alternative services suggested by contractors, allowing for less costly, more effective service delivery when appropriate. These services, coupled with residential placements, where needed and other supportive services such as supported employment aid individuals with mental illness in maintaining their tenure and stability in the community.

Case Management and Rehabilitation Services

Case Management and rehabilitative services in the State of Oregon have been part of the care available to adults with severe and persistent mental illness. In the past services have relied on the traditional models of care. Research literature suggests that the traditional models have limited success in moving people to recovery and increased independence. In recent years, Oregon has promoted the recovery model and Evidence Based Practices (EBP) as a more effective method of service delivery that results in improved progress for consumers and greater system accountability and performance. As a result of this, we are working with providers to deliver assertive community case management to meet individual consumer needs and to engage consumers in work with supports rather than months and years of day treatment in preparation for sheltered work.

Just as rehabilitation services are being influenced by EBP and recovery modalities, case management services throughout the State of Oregon continue to be influenced as well. Local Mental Health authority received an additional $2 million for case management resources to provide services to persons at risk of state hospitalization or transitioning from the state hospital. There are many aspects to the case management process, as outlined in the administrative rules that have as its focus client participation and agreement as means to attain goals leading to recovery. Case Managers assist clients in:

- Resource Acquisition (Social Security, food stamps, housing assistance, personal care services).
- Symptom management and recovery.
- Supported Employment and Vocational Rehabilitation.
- Development of personal crisis plans and Declaration for Mental Health Treatment.
- Active discharge planning in the event of a hospitalization.
- Constant monitoring of health and safety needs relative to their housing environment.

Intensive Treatment Services

In addition to the services outlined above, a comprehensive system of intensive community-based, residential, and inpatient programs is maintained. As of August 2007, 616 extended care placements located in secure residential, foster care, and supported-living programs were available for adults. An additional 206 placements were maintained in nursing homes or other settings funded jointly with the State Office of Services to Persons with Disabilities for clients requiring nursing and psychiatric care. In addition to extended care placements, AMH funded over 720 beds in foster care, residential treatment facilities and other supported housing models for adults with severe mental illness. A statewide system of regional acute care units provides over 200 beds for short-term inpatient psychiatric services. For adults who are civilly committed and in need of long-term secure treatment, 187 state hospital beds are also available in two state psychiatric hospitals. In addition to residential development, the Local Mental Health Authorities and AMH have agreed on a co-management plan to link the community service system with the State Hospital.

Supported Employment and Supported Education

AMH has completed a three-year EBP demonstration project funded by Johnson and Johnson and Eli Lilly to implement supported employment in three typical community mental health settings and in cooperation with the Dartmouth/New Hampshire Psychiatric Research Center. Since the funding supporting this projected ended in 2004, AMH continues to receive technical assistance from Debbie Becker and Bob Drake and continues to provide training, support and fidelity reviews to 7 counties utilizing supported employment. AMH has strengthened the relationship with Vocational Rehabilitation to blend funding to continue supportive employment services. The result of this continued efforts, as of March 2007, 335 consumers were enrolled in supported employment programs with 169 consumers competitively employed.

Oregon is using Mental Health Block Grant funds to implement a three-site supported education

project to advance the development and spread of supported education services throughout Oregon. The projects are schedule to begin August 2007.

Adult Services For Co-Occurring Mental Health And Substance Use Disorders

The state of Oregon has current initiatives to enhance and expand COD services to adults. Initiatives are progressing in both mental health and substance use treatment programs. Services vary from capable to enhanced service provision. Screening to identify COD is reported by most programs. Integrated comprehensive assessments are being developed and many programs have already implemented such assessments. Approximately 56 programs report providing some level of integrated treatment that ranges from assessment and referral to fully integrated evidence-based practices.

The Psychiatric Security Review Board (PSRB).

The PSRB maintains jurisdiction for individuals adjudicated "Guilty Except for Insanity". As of July 1, 2007 there were 750 individuals under the jurisdiction of the PSRB in the State of Oregon. Approximately 49% of the entire PSRB population resides at the state hospital in Salem (OSH). The majority of the rest of the PSRB population resides in the community observing the conditions outlined in their individual release plans and through supervision and supports offered by local Community Mental Health Programs. The PSRB reports to the Governor and uses a variety of resources to manage people successfully under its jurisdiction. AMH, in close coordination with the PSRB, provides mental health services to such individuals. The state also provides assessment of persons for the PSRB and the court to determine if treatment in the community is appropriate. Determination of the supervision requirements of each placement, and treatment for persons conditionally released into the community is also provided. Individualized community placements include evaluation, supervision, case management, psychotherapy, supported employment services, alcohol and drug treatment, and medication management. The passage of two Senate Bills should improve providers' ability to improve services to PSRB clients. SB 913 passed in 2005 which allows persons with a serious mental illness to have Medicaid benefits suspended rather than terminated when incarcerated and SB 39 also passed in 2005 which requires a mental health evaluation in Guilty Except for Insanity proceedings. AMH also continues to work with Chief Justices to educate the court system regarding mental health issues.

Recognizing that almost half of the PSRB population resides at the state hospital, AMH continues its commitment to develop new residential placements that will provide the necessary supports for this population to transition to community. An additional 109 community placements were opened last biennium.

Other Health Services

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and chemical dependency

treatment providers. Thus, enrollment in a MHO provides coordination between medically appropriate treatment services for adults eligible for Medicaid and many of the social supports necessary so adults with serious mental illness can remain in their community. The OHP benefit package includes a full array of services such as:

- Preventive services
- Diagnostic services
- Medical and surgical care
- Dental services and
- Outpatient chemical dependency services.

ii. Goals, Objectives, and Performance Indicators

Goal 1. Increase the involvement of consumers in system planning.

Population	Adults with severe mental illness participating in county, mental health organization, and state mental health advisory groups.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Determine the number of mental health advisory boards (state/county/MHO) with consumers from rural counties.
Measure	The number of consumers from rural counties participating mental health advisory boards (state/county/MHO).
Numerator	The number of consumers from rural counties participating mental health advisory boards (state/county/MHO).
Denominator	Not applicable.
Sources of Information	A survey will be conducted to collect information from the MHOs and counties, while archive data will be used for state advisory groups.
Special Issues	None.
Significance	It is essential that there be broad participation in mental health system planning from all areas of the state. There is concern participation is more difficult for individuals from rural areas of the state where communication and transportation networks are less developed. The information derived from this measure will help the Planning and Management Advisory Council to gain a truer understanding of the current level of rural consumer participation in advisory groups. The Planning and Management Advisory Council can then advise the Division on the need and course for further direction regarding this issue.
Action Plan	AMH will work with the new Peer Support Specialist with the Association of Community Mental Health Programs to provide technical assistance and support to consumers serving on advisory boards. AMH will focus on the new requirements for mental health consumers on advisory boards when conducting reviews of programs.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The number of consumers from rural counties participating mental health advisory boards	N/A	N/A	Baseline	20% above baseline	25% above baseline	30% above baseline

Goal 2. Increase the involvement of consumers receiving and providing support services.

Population	Adults with severe mental illness participating in the provision of mental health services.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Establish the baseline number regarding the availability of peer-operated services throughout Oregon.
Measure	The number of peer-operated services offered throughout Oregon.
Numerator	The number of peer-operated services offered throughout Oregon.
Denominator	Not applicable.
Sources of Information	Surveys of CMHPs regarding peer delivered services.
Special Issues	Due to a State budget deficit in 2002-2003, and the prioritization of funding reductions, the Addiction and Mental Health Division's budget no longer provides state funding for a consumer technical assistance provider.
Significance	A survey was conducted in 2007 to better assess the availability, type, and distribution of peer-operated services throughout Oregon. This information will be used to plan for the development of this service.
Action Plan	AMH, with stakeholders, will review the survey and survey results to determine actions to increase peer delivered services. AMH will work with stakeholders to improve to accuracy and reliability of future surveys. AMH will monitor activities and outcomes of peer delivered services projects funded with Mental Health Block Grant Funds.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The number of peer-operated services offered throughout Oregon	N/A	N/A	Baseline	10% over baseline	20% over baseline	30% over baseline

Goal 3.

a. Increase the number of adults with severe mental illness in Oregon receiving evidence-based practices.

b. Increase the number of evidence-based practices provided in Oregon. (NOM)

Population	Adults with severe mental illness receiving evidence-based practices.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	a. The reported percentage of adults with severe mental illness receiving evidence-based practices. b. The number of evidence-based practices provided.
Measure	a. The percentage of adults with severe mental illness receiving evidence-based practices. b. The number of evidence-based practices provided.
Numerator	a. The number of adults with severe mental illness receiving evidence-based practices. b. N/A
Denominator	a. The number of adults with severe mental illness receiving services. b. N/A
Sources of Information	Administrative data and reports available from county mental health programs.
Special Issues	A law enacted by the 2003 Oregon Legislature required that the Addictions and Mental Health Division progressively increase the percentage of its treatment funds that support evidence-based practices to 75% by the 2009-2011 biennium.
Significance	In Oregon, as well as nationally, funding agencies are being required to demonstrate that funds are being used cost-effectively. Increasing the spending on services that have been shown to be effective demonstrates better stewardship of public funds. AMH is specifically interested in making sure these services are available across all age groups.
Action Plan	AMH will continue efforts to promote the proliferation of evidence based practices throughout the State.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
a. The percentage of adults receiving evidence-based practices.	N/A	N/A	Baseline	An increase of 10% over baseline	An increase of 15% over baseline	An increase of 20% over baseline
b. The number of evidence based practices offered throughout Oregon.		N/A	Baseline	An increase of 10% over baseline	An increase of 15% over baseline	An increase of 20% over baseline

Goal 4. Increase the percentage of adults with severe mental illness reporting positively on outcomes. (NOM)

Population	Adults who received Medicaid mental health services within the past year.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The outcome performance domain of the MHSIP Adult Outpatient Consumer Survey.
Measure	Percentage of adults reporting positive perception of outcomes.
Numerator	The number of adults reporting positive perception of outcomes.
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Outpatient Consumer Survey.
Special Issues	This will be the fourth time the MHSIP Adult Survey will have been used; because of this, the MHSIP data will provide administrators and stakeholders with meaningful, consistent information on trends in consumers' perceptions of outcomes over the past three years.
Significance	Consumers' perception of outcomes is one of the most basic performance measures the Division can use to track the success of services. This measure has historically been low, leaving much room for improvement.
Action Plan	AMH will work with the Consumer Advisory Council (CAC) and the Adult Services Advisory Committee (ASAC) to monitor the results of this survey as an indicator of system transformation.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of adults reporting positive perception of outcomes.	61%	N/A	Available Dec. 2007	61%	63%	65%

Goal 5. Increase reported Social Connectedness. (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The social connectedness domain of the MHSIP survey.
Measure	Percentage of adults with positive response to the Social Connectedness questions on the MHSIP
Numerator	Number of adults with positive response to the Social Connectedness questions on the MHSIP
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	This is a new domain on the Adult MHSP survey.
Significance	Recovery means that individuals have a place in the community. People need to feel that they have meaningful relationships and have a place in the community.
Action Plan	ASAC and CAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of adults with positive response to the Social Connectedness questions on the MHSIP.	N/A	N/A	Baseline	5% over baseline	10% over baseline

Goal 6. Improved Functioning. (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The functioning domain of the Adult MHSIP Survey.
Measure	Percentage of adults with positive response to the Functioning questions on the MHSIP
Numerator	Number of adults with positive response to the Functioning questions on the MHSIP
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	This is a new domain on the Adult MHSP survey.
Significance	Recovery is more than just feeling better. Persons in recovery are able to do more and do better those activities that are meaningful.
Action Plan	ASAC and CAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of adults with positive response to the Functioning questions on the MHSIP	N/A	N/A	Baseline	5% over baseline	10% over baseline

Goal 7. Decrease the rate of readmission of adults to the state psychiatric hospitals within 30 days and 180 days. (NOM)

Population	Adults discharged from the Oregon state psychiatric hospitals.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	30 day and 180 day readmission rates into the state psychiatric hospitals.
Measure	Percentage of adults discharged from state psychiatric hospitals who return to the same hospital within 30 or 180 days
Numerator	The number of adults discharged from the state psychiatric hospitals who return within 30 or 180 days.
Denominator	The number of adults discharged from the state psychiatric hospitals
Sources of Information	Oregon Patient/Resident Care System (OP/RCS)
Special Issues	The Supreme Court's *Olmstead Decision* requires people to be treated at service levels that are appropriate to their needs. This measure is one indicator to judge the adequacy of discharge planning that occurred as people transition from institutional level care to community services.
Significance	AMH has placed special emphasis on integrating state hospital and community services. This is a key proxy measure to insure that communication between community providers and the state hospital is adequate to create successful discharges from the state hospitals.
Action Plan	Will continue the development of residential support services to move people out of the state hospital and into the community. In addition, AMH is investigating the New York Peer Bridges Program in Oregon to improve patients' return to the community.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
30 day readmission rate	4.6%	3.1%	Available Oct 2007	2.9%	2.8%	2.7%
180 day readmission rate	15.1%	10.6%	Available Oct 2007	14.3%	13.6%	12.9%

Goal 8. Decrease the rate of recidivism among clients with severe mental illness who have been released from state correctional facilities.

Population	Adults with severe mental illness discharged from state correctional facilities.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Recidivism into state correctional institutions.
Measure	The percentage of clients with severe mental illness who recidivate into state correctional facilities within 36 months.
Numerator	The number of adults with severe mental illness released from state correctional facilities who are convicted of a felony within 36 months.
Denominator	The number of adults with severe mental illness released from state correctional facilities.
Sources of Information	Oregon Department of Corrections Data system.
Special Issues	Oregon legislation passed in 2003 (SB 267) required the increased use of evidence-based practices. One goal of this legislation was to decrease recidivism into the criminal justice system. This measure will help us track progress for people with severe mental illness.
Significance	Roughly 13% of Oregon's inmates released suffer from severe mental illness. Persons with psychiatric disabilities and a history of corrections involvement are among the "hardest to house", increasing the likelihood that individuals emerging from corrections are likely to re-enter the institutional systems. The Olmstead Decision requires states to provide appropriate services for persons at-risk of institutionalization.
Action Plan	AMH will coordinate with the Governor's Re-Entry Council established in May 2007 to improve access to mental health services for prisoners being released from prison.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
DOC recidivism rate	N/A	*26.9% (released 2002)*	*24.4%*	23.5%	22.5%	21.5%

Goal 9. Decreased Criminal Justice Involvement (NOM)

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Criminal justice involvement questions of the Adult MHSIP Survey.
Measure	Percent of Consumers Arrested in Year 1 who were re-arrested in Year 2
Numerator	The number of adult respondents reporting no arrests for a year after starting treatment.
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	None
Significance	In Oregon as in other parts of the country police are often times the default mental health crisis system. This results in increasing numbers of people with a serious mental illness being incarcerated when mental health services may have been more appropriate. Effective treatment reduces a consumer's likelihood of being involved in the criminal justice system.
Action Plan	AMH will allocate legislatively approved new funding to CMHPs to provide services that assist people with a serious mental illness in transitioning out of jail and diverting people from jail. AMH will monitor the implementation and outcome of these services.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percent of Consumers Arrested in Year 1 who were not re-arrested in Year 2	N/A	N/A	Baseline	5% over baseline	10% over baseline

Goal 10. Increase the percentage of adults with severe mental illness who are served in the publicly funded mental health. (NOM)

Population	Adults with severe mental illness served in the public mental health system.
Criterion	2. Mental Health System Data Epidemiology
Indicators	Severely mentally ill adults' access to publicly funded services.
Measure	The percentage of adults with severe mental illness accessing publicly funded services.
Numerator	The number of adults with severe mental illness accessing publicly funded services.
Denominator	The number of adults with severe mental illness.
Sources of Information	CMHS adult severe mental illness prevalence information for adults. State mental health data systems.
Special Issues	Access to services for adults has diminished with recent restrictions to Medicaid benefits for Oregon's wavier population.
Significance	Individuals identified with a severe mental illness benefit from community mental health services that are specific to their needs and desires. These services assist individuals in avoiding institutionalization and promote a path to recovery.
Action Plan	AMH will be allocating new State General Funds for community mental health services to CMHPs with the expectation that more persons will receive appropriate mental health services.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
% of adults with severe mental illness receiving publicly funded services	45%	44%	Data available 10/07	45.5%	46%	46.5%

b. Criterion 2: Mental Health System Data Epidemiology

i. Description of Current Adult Mental Health System

Access for Minority Populations: The majority of the population in Oregon is Caucasian with the remaining population being African American, Hispanic, Native American, Asian, etc. A comparison of the ethnic composition of Oregon's population and persons receiving mental health services by age group is provided in Table 2 of Appendix B. Oregon Administrative Rules state that community mental health programs are to provide culturally competent services. AMH requires information be provided to potential consumers, family members and allied agencies regarding the availability in a multi-lingual format.

At the direction of the AMH management team, the AMH Cultural Competency Work Group (ACCWG) was created and has been meeting monthly to develop recommendations for the AMH Cultural Competency Plan (ACCP). At this point the guidelines to the ACCP have been developed and are awaiting stakeholder input. The ACCP is being developed in response to the DHS Standards and Guidelines for Cultural Competency and Gender Specific Services, which were approved by the DHS Cabinet in September of 2003.
The purpose of the plan is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from, or that are under contract with AMH, including county social services organizations and their vendors or contractors, managed care organizations and their provider networks, and community-based organizations. The intent is that this will serve as a planning document to assist AMH, county governments, and provider networks to develop and implement an individualized cultural competence plan as addressed in each county's biennial implementation plan, with its goal to enhance treatment outcomes for all patients.
The AMH Cultural Competence Plan identifies eight core sections that would need to be addressed to move cultural competence forward. These are:

1. Planning
2. Evaluation
3. Services to Clients
4. Retention, Recruitment & Promotion
5. Education & Training for AMH staff/providers
6. Collaborative Partnerships & Informing the Public
7. Data Collection & Operation
8. ADA Compliance

The issues of culture have been integrated with the implementation of EBPs. This work respects and values differences among consumers, shares responsibility for addressing these differences, and measures the success in addressing cultural differences. AMH will continue to strengthen communication and cooperation within racial and ethnic communities.

ii. Goals, Objectives, Performance Indicators

Goal 11. To maintain or increase the proportion of adults from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded culturally competent mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's adults within the same ethnic population.

Population	Adults with severe mental illness served in the public mental health system.
Criterion	2. Mental Health System Data Epidemiology
Indicators	Percentage share of adults within ethnic categories who are receiving mental health services compared to the percentage share of adults within ethnic categories for the general population.
Measure	Compare the percentage share among ethnic groups of adults receiving mental health service to the percentage share among ethnic groups in the general population.
Numerator	Not applicable.
Denominator	Not applicable.
Sources of Information	CPMS, MMIS, PSU Population Research Center.
Special Issues	In 2005, the proportion of adults receiving mental health services with a Hispanic ethnic background was low compared to the proportion of adults with the same ethnic background in the State's adult population. At the same time African Americans appear over represented in the mental health service population.
Significance	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of adults with diverse ethnic backgrounds.
Action Plan	The Legislature approved $1 million for mental health services to be provided by the Afro-Centric Mental Health Center. AMH will proceed with the implementation of the Cultural Competency Plan.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Maintain or increase the proportion of adults receiving mental health services from each ethnic background such as: Native American, Hispanic, African American, and Asian compared to adults with the same ethnic background in the State.	N/A	N/A	Percentage shares will be equal between mental health service population and general population	Percentage shares will be equal between mental health service population and general population	Percentage shares will be equal between mental health service population and general population

c. Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

i. Description of Current Adult Mental Health System

Rural Services

Oregon is comprised of 36 counties, 11 counties are considered urban. The other 25 counties are considered rural and approximately 23% of the State's population resides in these counties. In rural areas, distances and lack of transportation can become barriers for adults with severe mental illness to access mental health services. The MHOs and CMHPs provide a full continuum of services to e persons. The MHOs are required by contract to meet the medically-appropriate needs of their members. Regardless of the rural nature of the person's community, the intent of the MHO contract is that a full array of services is available to all members that need mental health services. Generally in Oregon, access to mental health services in rural areas is comparable to that in urban areas. In addition to local programs, all persons have access to appropriate statewide resources such as acute psychiatric hospitalization, state hospital programs and intensive community and residential programs, although persons may travel many miles to receive these services.

Individuals in rural areas continue to face barriers to receiving services such as psychiatric evaluation, extended care and acute care. Oregon has increasingly used teleconference technology for psychiatric evaluations. Additionally, a majority of Oregon's rural counties have received federal designation as mental health professional shortage areas to assist in recruiting psychiatrists for areas that lack coverage by physicians without regard to specialty.

Rural Eastern Oregon counties have developed an integrated community mental health service delivery system. A quasi-public benefit corporation, Greater Oregon Behavioral Healthcare, Inc. (GOBHI), purchases and manages mental health care in many rural Oregon counties under the Oregon Health Plan. Through the pooling of resources, the thirteen counties that comprise GOBHI are able to provide mental health services across an area that makes up more than half of the landmass of the state. GOHBI's base of coverage also includes some rural counties in northwestern Oregon.

Homelessness

Access for persons who are homeless. Homelessness among persons with serious mental illness continues to be a significant problem in Oregon. Enrollment of homeless persons with mental illness into community mental health services has been encouraged. Goal 9 in Oregon's Block Grant plan is to "increase transitional and long-term housing for adults with severe mental illness who are identified as homeless".

Table I shows trends in public mental health service enrollment of homeless adults and the total number served over a seven-year period. The post-September 11th recession resulted in mental health service reductions in 2002-03 and 2003-04. Since 2003-04, mental health service capacity has increased by 18.4% and enrollment of homeless people with serious mental illness increased

by 42.4%. These statistics illustrate the effort made by local service providers to serve homeless individuals with serious mental illness.

Table I: CPMS Data on Homelessness, FY's 1999-00 through 2005-06			
Fiscal Year	Enrollment Data, Adult Mental Health Clients		
	# Homeless Served	% of Total Served	Total # Served
1999-00	3,253	5.9%	55,115
2000-01	3,369	5.8%	57,992
2001-02	3,916	6.5%	60,065
2002-03	3,542	6.3%	55,979
2003-04	3,376	7.4%	45,771
2004-05	4,457	8.5%	52,204
2005-06	4,807	8.9%	54,205
Increase '03-04 to '05-06	*+42.4%*	--	*+18.4%*

Some of the specific strategies employed by AMH to address homelessness include the following:

1. Community mental health program (CMHP) staff is encouraged to participate in their local HUD Homeless Assistance Continuum of Care planning process.
2. CMHPs are required to address housing needs in their local mental health planning process.
3. AMH provides data, technical assistance and grants to support housing development.
4. AMH facilitates partnership between mental health service providers, homeless service providers and housing providers at the state and local level by arranging meetings and training.
5. The AMH housing and homeless services manager is a member of the Governor's Ending Homelessness Advisory Council.

Some recent outcomes achieved included the following:

1. AMH staff worked collaboratively with the City of Portland, Multnomah County and service providers to support a ten-year plan to end homelessness and provide permanent supportive housing. Since December 2004, 1,039 chronically homeless people have acquired housing.

2. AMH worked collaboratively with Oregon Housing and Community Services to sustain HUD Homeless Assistance grants that provide leasing subsidies and wrap-around support services to 43 homeless persons with mental illness in six rural Oregon counties.
3. AMH is using its federal PATH (Projects for Assistance in Transition from Homelessness) dollars, to provide support services for 625 persons with serious mental illness who are homeless or at imminent risk of homelessness in six Oregon counties.
4. AMH provided State General Fund grants to support development of eleven housing projects that will provide housing for 80 persons with serious mental illness in 8 counties.
5. Two additional funding competitions for the Community Mental Health Housing Fund resulted in twelve projects that will provide housing for 134 persons with serious mental illness.
6. Sites have been identified for the first five housing projects on acreage set aside at the site of a former state hospital; the first opened in August 2006, another is currently under construction.
7. In April 2006, the State's revised Housing Policy for People with Mental Health and Addiction Disorders was finalized. This policy has been widely distributed, promotes the availability of affordable housing, and notes that "homelessness is not an acceptable alternative."
8. In 2006, Oregon held 10 SOAR (SSI/SSDI Access, Outreach, and Recovery) workshops throughout the state. According to follow-up data, SSI/SSDI applications approvals increased from 19% to 66% and processing time has been reduced, on average, from 11 months to 3 months as a result of SOAR participation.
9. In March 2007, one-day workshops on "Community Living Options: Building Housing, Homes & Communities" were held in three Oregon counties.

Older Adult Services

Community older adult mental health services are delivered through Oregon's community mental health programs (CMHP). Every two years the community mental health programs are required to submit Biennial Implementation Plans that outline the delivery of mental health and addiction services. In 2006 the CMHPs were required to specifically address the plan to provide community mental health services for older adults. After a review of the Biennial Implementation Plans, the Governor's Commission on Senior Services was pleased to see the increased focus on mental health services for older adults.

AMH also has 206 Enhanced Care community placements for older adults or physically disabled persons with serious mental illness. This is a joint project between DHS Seniors and People with Disabilities (SPD) and AMH. The people in this program are eligible for structured residential services provided by SPD and AMH funds the mental health services for these individuals.

ii. Goals, Objectives, Performance Indicators

Goal 12. Increase transitional and long-term housing for adults with severe mental illness who are identified as homeless.

Population	Adults with severe mental illness who are identified as homeless.
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	The amount of newly developed housing for adults with severe mental illness who are identified as homeless.
Measure	New units of supportive housing in rural and urban areas provided for adults with severe mental illness through AMH and/or county programs.
Numerator	New units of supportive housing in rural and urban areas provided for adults with severe mental illness through AMH and/or county programs.
Denominator	Not applicable.
Sources of Information	Tracked by AMH Housing and Homeless Services Unit staff.
Special Issues	Findings from the Fall 2005 Mental Health Housing Survey indicate that as many as 2,972 adults with mental illness and 3,062 adults with substance use disorders were estimated to be "currently homeless" at the time the survey was completed.
Significance	It is difficult for people disabled by serious mental illness to benefit from mental health and addiction treatment when they do not have stable, safe housing. The Oregon Supportive Housing Evaluation Study demonstrated that supportive housing decreases homelessness and residential instability. While Oregon has several successful housing initiatives, this goal will target efforts toward creating supportive housing for people with serious mental illness who are experiencing or at imminent risk of homelessness.
Action Plan	AMH received an additional $1 million dollars for the next two years for Supportive Housing services. AMH will continue the ongoing funding of the development of new housing for persons with a serious mental illness.

Performance Indicator	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
New units of supportive housing in rural and urban areas provided for adults with severe mental illness.	N/A	N/A	N/A	*100*	**110**	**120**	**130**

Goal 13. Increased Housing Stability (NOM)

Population	Adults with severe mental illness.
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	The percent of respondents reporting that their housing situation has improved will increase.
Measure	Percent of respondents reporting that their housing situation has improved.
Numerator	The number of respondents that report improvement in their housing.
Denominator	The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.
Sources of Information	MHSIP Adult Survey
Special Issues	Stable housing is a primary factor for facilitating recovery for persons with a serious and persistent mental illness.
Significance	Oregon has clearly identified housing as a key factor for persons with a serious mental illness recovering.
Action Plan	AMH has received an additional $1 million for supportive housing services and will use these funds in conjunction with existing funding to expand housing resources to improve housing for persons with a mental illness.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percent of respondents reporting that their housing situation has improved.	N/A	N/A	Baseline	5% over baseline	10% over baseline

Goal 14. Increase the percentage of adults with severe mental illness living in rural counties who are employed in competitive employment (NOM)

Population	Adults with severe mental illness in rural counties
Criterion	4. Targeted Services to Homeless and Rural Populations
Indicators	Adults with severe mental illness and living in rural counties who are employed in competitive jobs
Measure	Percentage of adults with severe mental illness living in rural counties who are employed in competitive jobs
Numerator	The number of adults with severe mental illness living in rural counties who are employed in competitive jobs
Denominator	The number of adults with severe mental illness living in rural counties
Sources of Information	State mental health service data systems and the state Department of Employment records
Special Issues	Employment in rural areas presents many more barriers than in many urban areas.
Significance	Employment is an important factor in increasing self-determination and enhancing the quality of life for persons with severe mental illness. Efforts to decrease the use of adult day treatment services and increase the use of supported employment services is requiring a culture shift at the local level.
Acton Plan	AMH will insure that a portion of new supportive employment funding is awarded to rural programs.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
% of rural adults with severe mental illness competitively employed	Not available	Not available	18.5%	20%	23%	25%

d. Criterion 5: Management Systems

i. Description of Current Adult Mental Health System

Training

In 2003 Oregon passed legislation that directed AMH, among other agencies, to spend public funds on evidence-based practices (EBPs) defined as follows: *"Evidence-based program" means a program that: (a) Incorporates significant and relevant practices based on scientifically based research; and (b) Is cost effective."* AMH established an ongoing list of EBPs that currently consists of Mental Health (32), Substance Abuse (30), Co-occurring (6) and Prevention (103) practices. All workforce development efforts provide support for identification, implementation and sustainability of EBPs delivered in an age and gender appropriate, culturally competent, and trauma-informed manner.

The strategies used to support the delivery of EBPs include the following:

1. Immersion projects that provide ongoing training and technical assistance onsite by local and national experts, AMH staff and consumers. Projects include: Integrated Dual Diagnosis Treatment (IDDT), Supported Employment and Starting Early Starting Smart (SESS).
2. Service Improvement Projects that work with providers to use systems change models (Addiction Technology Transfer Centers - ATTCs) change book and the Network for the Improvement of Addiction Treatment (NIATX) to improve service delivery and select implement EBPs. Projects include increase in family participation in treatment and implementing the EBP "Seeking Safety." Consumer focus groups and feedback are included in the change and implementation process.
3. Program specific training deliveries, as identified by the program, including technical assistance via phone and e-mail. Projects include American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) and trauma-informed services.
4. Stand-alone trainings are seldom used but some of the following were delivered; Health Insurance Portability and Accountability Act (HIPAA) to over 170 people in 2005, and Outreach and Case-Management for Hard to House People with Co-Occurring mental health and substance abuse disorders to over 150 people.

AMH efforts to improve consumer and community outcomes, including the SAMHSA National Outcomes, include work with consumers, providers and institutions of higher education, to influence curriculum, pre-service preparation at both undergraduate and graduate levels, and continuing education standards. Initial gatherings, which include consumers in leadership roles, have reviewed the Annapolis Coalition Recommendations, have drafted competencies for identified services and have scheduled executive meetings. Next steps include continued work with Oregon's colleges, the Governor's Health Care Workforce Initiative and the Oregon Health Care Workforce Institute to improve the Behavioral Healthcare Workforce.

The AMH 2007-2009 Workforce Development Plan is attached as **Appendix C.**

First Responder Training

Over the past year, the Department of Human Services Addictions and Mental Health Division (AMH) has facilitated, supported, staffed, assisted and/or developed the following training of emergency first responders:

- Salem Police Officers Training – "The Crisis From the Consumer Perspective and Intro to Major Mental Illness"—"Symptoms and How a Person May Present in Crisis"—"How to Communicate with a Person Hearing Voices".

- Crisis Intervention Team (CIT) Training for Marion County Sheriff's Department – (2) 40-hour sessions, 80 Officers trained.

- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE, Marion County.

- "Addictions and Mental Health Basics" training to front-line case management staff of DHS-Child Welfare, TANF Program.

- Statewide STOPSTIGMA Campaign in response to negative outcomes and violence during first-responder intervention.

In addition, several other localities have initiated or expanded CIT training for law enforcement officers. Recently, the City of Portland committed to CIT training for all officers.

This Office has participated and/or developed community education programs as described above since 1999. The AMH Workforce Development Unit is currently developing an education plan for 2007-2009. It will include aspects of all of the above.

Management Information System
Data on persons with psychiatric and emotional disorders and the services they receive are collected and stored in three primary databases:

The Medicaid Management Information System (MMIS) provides information on persons who receive health insurance benefits under the Oregon Health Plan.

The Oregon Health Plan provides coverage to people who are categorically eligible for Medicaid. The plan also provides coverage to an "expansion population" of poverty-level adults who do not qualify for traditional Medicaid and are eligible by virtue of poverty, the OHP standard population. MMIS includes information on eligibility status, services rendered and fee-for-service actual or capitation payments. MMIS also includes information about chemical dependency, pharmacy, dental and physical health service expenditures. MMIS data is accessed via a decision support surveillance utilization review system known as DSSURS.

The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs. The CPMS also includes records of care in chemical dependency and developmental disability programs.

CPMS is submitted on various standardized forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode and monthly during an episode of service.

The Oregon Patient/Resident Care System (OP/RCS) includes records for all publicly funded psychiatric inpatient care delivered in the State Hospital and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment.

Each of these systems contains unique client level identifiers. The AMH Program Analysis and Evaluation Unit uploads data from each of the systems to a central SQL server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

Staffing

Four types of staff provide services and support to child and adult consumers of mental health services in Oregon through the Community Mental Health programs. These include programs that are integrated, blending services for mental health, alcohol and drug and gambling recovery. However, numbers represented here exclude staff solely funded by alcohol, drug and gambling recovery. Funding for Community Mental Health programs and services come from Medicaid, Medicare, State and County General Fund, Federal Block Grant, and private grants and insurances.

These staff are currently sufficient to provide access to medically appropriate mental health services, in particular, crisis services, case management, and emergency psychiatric hospitalizations.

Community Mental Health Program Staffing	**Number**
Licensed Medical Professionals (both employed and contracted	487
Qualified Mental Health Professional (both full and part time)	1376
Qualified Mental Health Associate (both full and part time)	1466
Paraprofessional (both full and part time)	270
Total	**3599**

ii. Goals, Objectives, Performance Indicators

Goal 15. Reduce the reliance on mandated treatment for adults with severe mental illness through civil commitment and aid and assist process.

Population	Adults with severe mental illness.
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	Civil commitment investigations started by community mental health programs.
Measure	a. The rate of civil commitment investigations per 100,000 population. b. The number of Aid and Assist admissions.
Numerator	a. The number of civil commitment investigations. b. The number of Aid and Assist admissions.
Denominator	a. Total adults living in Oregon ('population') divided by 100,000. b. N/A
Sources of Information	State mental health service data systems and state census information.
Special Issues	Resources associated with treatment in higher-level services such as the state hospitals have been over-utilized—beyond the means of the budget.
Significance	Reliance on the state hospital system for criminally committed persons has grown steadily in recent years and will continue to increase whether or not there are any changes to the statewide system of care simply because of population growth. With a focus on community-based resources to facilitate more efficient and effective use of state hospital and other residential services, the need for and use of civil commitment could decrease over time. Some preliminary data analysis suggests that while civil commitments may decrease, some court jurisdictions are directing persons with minor charges to the state hospital for aid and assist evaluations and treatment under criminal commitment code.
Action Plan	AMH is in the process of allocating new State General Funds for community mental health services with the expectation that more persons will receive appropriate mental health services. In addition, AMH will be awarding funding for special programming to address the aid and assist issue with community diversionary services.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
a. Rate of civil commitment investigations per 100,000 population	211.2	232.6	Available October 2007	220	218	216
b. Number of admissions to the state hospital for Aid and Assist evaluation and treatment.	295	315	Available October 2007	315	300	295

iii. Budget

Contractor	Funds
Baker County	$34,797.16
Benton County	$40,525.33
Clackamas County	$453,895.84
Clatsop County	$41,480.54
Columbia County	
Confederated Tribes Of Warm Springs	$23,159.62
Coos County	$15,826.17
Crook County	$12,075.54
Curry County	$16,040.06
Deschutes County	$37,100.64
Douglas County	$103,017.18
Grant County	$21,551.88
Harney County	$30,210.97
Jackson County	$82,384.78
Jefferson County	$15,916.10
Josephine County	$22,859.22
Klamath County	$2,741.24
Lake County	$11,091.57
Lane County	$234,856.68
Lifeways Umatilla	$118,974.96
Lincoln County	$7,888.02
Linn County	$62,073.53
Malheur County	$23,588.89
Marion County	$262,090.40
Morrow, Wheeler	$18,507.91
Multnomah County	$266,625.61
Polk County	$36,632.30
Tillamook County	$20,200.80
Union County	$19,114.61
Wallowa County	$13,331.77
Wasco, Hood River, Sherman, & Gilliam	$59,451.60
Washington County	$167,964.61
Wheeler	$2,056.43
Yamhill County	$76,591.01
NAMI-Oregon	$125,000.00
Projects	$139,534.80
Supported Education	$130,500.00
Peer Response Network	$23,000.00
Dual Diagnosis Anonymous	$60,000.00
Peer Delivered Services Projects	$216,221.20
Transitional Age Youth Project	$50,000.00
CMHP COLA	$58,934.20
Admin	$64,250.00
Total	$3,222,063.17

B. CHILDREN'S PLAN

1. Current Strengths and Accomplishments

AMH is engaged in a broad scale planning and implementation process to provide a more integrated community-based system of care for children and their families, which began October 1, 2005.

The Children's Mental Health System Change Initiative (CSCI) ensures that the management of resources, decision-making and delivery of services occur at the local level—through local or regional Mental Health Organizations and Community Mental Health Programs managing resources for intensive treatment services with single points of access, authority, and accountability. This system promotes early identification and proactive planning to identify children who may need mental health services so that the right kind of services can be provided in the right location for the right amount of time and intensity.

The CSCI system structure includes the use of child and family teams, care coordination at multiple levels, and system oversight. A statewide community-based level of need determination process has been established utilizing the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry, in concert with other clinical determinants. Oregon is also participating in the field-testing of the Early Childhood Service Intensity Instrument (ECSII), which will allow for level of need determination in the early childhood population, 0-6 years of age.

The CSCI requires the collaboration of state and county child-serving agencies and providers of services across the continuum of care from least restrictive and intensive (prevention/outpatient services) to most restrictive and intensive (acute hospitalization and psychiatric residential and day treatment services). The goal is to make every effort to serve the child and family in their community.

AMH is continuing to work with system stakeholders to increase the availability and quality of individualized, culturally competent, family-driven and youth guided intensive home and community-based services to serve children in the most natural environment possible and to minimize the use of institutional care. A Statewide Wraparound Project Steering Committee will submit recommendations for the enhancement of a system of care for Oregon's children in the Fall of 2007.

- The Governor's office issued an Executive Order in March 2007, calling for a Statewide Wraparound Project Steering Committee to insure the integration and blending of funding children's behavioral health services statewide.

The Executive Order stated the time has come for Oregon to develop a statewide, integrated system of care for children at risk of developing, or who have already developed, significant emotional, behavioral or substance abuse related needs and their families. The Steering Committee has defined membership including; the Governor's Office, Legislators, family members, youth, State Agency Directors, Superintendent of Public Education, service providers, local education system, early childhood system, and system of care experts.

A contract has been awarded for the Project Manager, who began working with the steering committee in April 2007. The steering committee will develop a strategic plan for the implementation of a system of care approach to the delivery of behavioral health services and supports for children, youth and families with a priority on a financing plan. The system of care encompasses a continuum of services including health promotion, prevention, intervention and follow-up.

The steering committee has begun meeting and has formed subcommittees for local implementation, data and evaluation, cultural competency and financing. Recommendations will be made following the September 2007 conclusion of the committee's work.

- New AMH Children's Mental Health Medical Director.

On July 1, 2007 a contract begun with Oregon Health Services University for the services of Dr. Nancy Winters. Dr. Winters will perform duties similar to a Children's Mental Health Medical Director. As a Child Psychiatrist Dr. Winters has many years of experience on System of Care, early childhood research and measurement. In her new role Dr. Winters will be directly involved in Children's Mental Health policy development, Statewide Wraparound Project, Evidence Based Practices and other strategies to improve treatment services to children, adolescents, transition age youth, and their families.

- Early Childhood Services Lead the Way to Development of a Statewide Children's System of Care.

Oregon Children's Plan (OCP) funds continue services for children ages 0-8 and their families who have, or are at high risk of developing, a mental health or addiction condition and have no other resources to pay for needed services. State general funds are allocated to develop and enhance early childhood behavioral health services to:

Support early identification of risks and problem behaviors in young children and their families Provide linkages to the behavioral health care and prevention systems of supports and services, and provide necessary treatment based on a family-centered approach.

Seven pilot sites implement an array of services focusing on outcomes related to the goals of the Early Childhood System. During the last year, the pilot sites have identified directly observable or standardized measures to determine outcomes for children and families. These measures include; parents completing substance abuse treatment, obtaining safe housing, obtaining safe childcare, having employment and completing parenting classes. 1030 parents and 1090 children, were served between July and December 2006.

The state Early Childhood Team (ECT), a subcommittee of the Partners for Children and Families, meets monthly to strengthen, integrate and sustain Oregon's early childhood system of services and supports in collaboration with State and local partners. This effort builds on coordinated comprehensive plans to meet the diverse needs of Oregon's young children ages 0-8 and their families.

- A number of steps have been taken to improve the early childhood system and to link early childhood services and supports with other child-serving systems. These include:

- Development of Oregon's Early Childhood Comprehensive Systems Plan through the Office of Family Health.
- Consolidation of the Early Childhood Team with the Early Childhood Steering Committee to form the Early Childhood Coordinating Committee. Implementation will occur in mid 2007. The Early Childhood Coordinating Committee will assume responsibility to implement strategies for the Oregon Early Childhood Comprehensive Systems Plan.
- Initiation of a public-private partnership with the purpose of developing the political will to fund efforts for the Early Childhood System.

AMH is developing a new coordinated system of care to meet the needs of children served by multiple child serving agencies.

AMH continues to work closely with Child Welfare, Education, Juvenile Justice, and Family Advocacy organizations to improve intersystem coordination.
Memoranda of understanding have been written between AMH and Child Welfare, and between AMH and Education.

Stakeholders from child welfare, education, juvenile justice, family advocacy organizations and youth/family members are integral participants in the Children's System Advisory Committee of the Planning and Management Advisory Council for AMH. Local advisory bodies are also inclusive of these child-serving agencies, family members and family advocates.

Efforts continue locally and statewide to be inclusive of representatives from adolescent alcohol and drug treatment agencies, developmental disabilities, and other child-serving agencies. Efforts to maintain a diverse and culturally competent representation on CSAC and local advisory bodies will be ongoing.

Results of the statewide Youth Services Survey-Families demonstrated an increase in the level of satisfaction with coordination of services between agencies. Respondents' satisfaction with coordination of services improved notably from survey years 2005 and 2006. Overall, 61 percent of respondents reported being satisfied with coordination of mental health services between different external programs, compared with 55 percent in the 2005 survey. The highest percentages of satisfaction were reported for coordination between the mental health system and education (71 percent) and child welfare (67 percent).

- AMH promotes family-driven and youth guided care in the process of implementing a coordinated system of care.

Youth advocates are beginning to participate in local advisory councils and CSAC. More youth are receiving training this year, and are being recruited for appointments to advisory councils at all levels. 14 youth are participating in local system advisory councils, and 2 are participating at the State level.

Formal agreements have been written between the Oregon Family Support Network and eleven Oregon counties. Nine Community Mental Health Programs, one Mental Health

Organization and one provider have hired family members as family partnership specialists. AMH has a family leader filling the position of Family Partnership Specialist, to provide effective family-driven technical assistance and policy leadership at the state level.

A policy on Meaningful Family Involvement written in 2004 was amended in 2006 to incorporate the Federation of Families for Children's Mental Health national organization's statement on family driven care. A policy brief on youth guided system involvement was introduced to CSAC in June 2007.

Local, regional and State Children's System Advisory Committees are operational formed with 51% membership of family members/advocates. 114 family members have been trained through the Family Partnership Training conducted by the Oregon Family Support Network (OFSN). (NFC Goal: Mental Health Care is Consumer and Family Driven).

- AMH is revising its Outcomes Policy and has refined the Integrated Service Array Outcome guide to direct data collection.

Specific data relevant to the CSCI are being tracked in accordance with the Outcomes Policy, including level of need determination data derived from CASII scores, process measures, family perception of outcomes (through the Youth Services Survey for Families [YSS-F]) and integrated service array outcomes. Oversight of data issues throughout the system is provided through the Quality Data Improvement Group (QDIG). QDIG has reviewed and revised the Integrated Service Array Outcome guide. QDIG is reviewing and amending the Outcomes Policy.

- AMH is partnering with Children's Array of Psychiatric Programs (CHARPP) to develop alternatives to using seclusion and restraints.

AMH is leading an initiative titled, "Best Environments Supporting Success in Treatment (BESST)", in collaboration with the Children's Array of Psychiatric Programs (CHARPP). The BESST initiative is developing alternatives to the use of seclusion and restraint.

AMH plans to focus on an expanded group membership inclusive of day treatment providers and MHO quality managers, and to continue to examine seclusion and restraint indicators and the relationship of those indicators to quality of care.

Changes in membership in this group as the system has undergone tremendous change have contributed to a reconfiguring of the group and its mission. (NFC Goal: Excellent Mental Health Care is Delivered and Research is Accelerated).

- AMH funding is directed to evidence-based practices.

The Oregon Legislature passed a law that requires the AMHD and four other state agencies to use state and federal funds for practices that are based on scientific evidence. AMH made a report to the meeting of the Joint Interim Judiciary Committee on the status of work to meet the

goal that 50% of mental health and addiction treatment and prevention funds will be used for evidence-based practices in the 2007-09 biennium.

Work continues throughout state agencies in partnership with AMH to implement the statute. Fidelity monitoring of 9 practices has begun in conjunction with system partners. 23 practices have been approved that pertain to the care and treatment of children and adolescents and their families with mental health treatment needs. 55 practices have been approved that pertain to the prevention of mental health and/or substance abuse disorders for children, adolescents and their families. (NFC Goal: Excellent Mental Health Care is Delivered and Research is Accelerated).

2. Current Weaknesses, Unmet Service Needs and Critical Gaps

- Mental health services for children are currently provided in settings that were not previously used or were under-utilized, including homes, schools, and other community settings. Communities within Oregon are working hard to expand these services, but more needs to be done.

The range of mental health services provided in less traditional settings is expanded to include crisis, respite, in home supports, and therapeutic foster care. Communities are challenged to create services that will meet a variety of mental health needs within the community itself, and continue to find different ways to accomplish this task. Oregon is experiencing a decrease in the number of admissions to psychiatric residential and day treatment programs and an increase in the number of children receiving other forms of intensive community-based services. (NFC Goal: Early Mental Health Screening, Assessment and Referral to Services Are Common Practice).

- AMH is working closely with family organizations to recruit and train family members and youth who can become effective family/youth advocates at all levels of the system.

Implementation of the Family-Driven System policy and the development of youth directed services and inclusion of youth voice in decision-making bodies throughout the system is a high priority for AMH. 14 youth have been brought into both local and state system advisory councils and more youth are being added. The Oregon Family Support Network through a contract with AMH has developed and conducted training for youth and professionals to increase policy making partnerships and system level involvement. (NFC Goal: Mental Health Care is Consumer and Family Driven).

- AMH is working to reduce stigma through participation in the SAMHSA/Ad Council Anti-Stigma campaign and other activities.

Recent activities include Mental Health Awareness month (May) and Children's Mental Health Awareness Day May 8 at the state capitol. Speakers including youth and family members as well as the Governor's Office and several legislators spoke providing their perspective on children's mental health. Fact sheets on children's mental health were distributed by several agencies, including DHS. Legislators, family members, state employees and public schoolchildren were among those in attendance. Several other areas of the state participated in Children's Mental Health Day with companion activities in their regions.

- With the implementation of the Children's System Change Initiative, AMH needs to improve the cultural competency of mental health services provided to children and their families.

AMH hired a cultural competency consultant in 2004. In 2006, a committee within AMH developed a draft cultural competency plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. The group inventoried eight core areas: planning, evaluation, services to clients, recruitment, retention and promotion, education and training for AMH staff/providers, collaborative partnerships and informing the public, data collection and operation, and ADA compliance.

The purpose of this committee is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from or are under contract with the Addictions and Mental Health Division: county social services organizations, their vendors and contractors, mental health organizations and their provider networks, and community-based organizations. The committee will engage stakeholders to provide feedback on the cultural competency plan prior to implementation of the plan. A representative from the children's mental health unit within AMH sits on this committee. Findings of the committee are being reviewed by CSAC. (NFC Goal: Disparities in Mental Health Services are Eliminated).

- Transitional services for young people ages 16-24 leaving the children's mental health system who need services from the adult mental health system or services for young people experiencing first indications of a major mental illness need to be improved and expanded.

AMH is working internally to address this ongoing issue and make recommendations for systemic changes that provide for a coordinated transition between the child and adult systems. New service delivery models are being developed to address the clinical and transitional needs of this age group.

Specifically designed service and supports for 15 individuals in three geographic locations are being established within a work plan addressing the needs of transition age youth and young adults in Oregon. This program is created for youth and young adults who may have spent many years in institutional settings, is specifically designed for the transition age group of 16-24 years of age, and will focus on community reintegration. Services such as supported employment, supported education, supported housing, life skills training, and community living form the core of this intensive model designed to assist young people with mental health challenges as they move into their adult years and the adult system.

The EAST (Early Assessment and Support Team) program is an early intervention program serving young people between age 15 and 30 who have had a first experience with psychosis within the past twelve months. Its primary purpose is to reduce the disability associated with psychosis.

Some of the services offered by EAST include rapid access to psychiatric and counseling services; education about causes, treatment, and management of psychosis; rights in

employment, school and housing, and resources; support and education groups; support for vocational, educational, and independent living goals; and mentor and volunteer opportunities. The program is operating in the mid-Willamette valley region. The Legislative Assembly recognized the benefit of and need for this service and allocated an additional $4.3 million to expand the program to 2-3 areas of the state. (NFC Goals: Disparities in Mental Health Services are Eliminated and Early Mental Health Screening, Assessment and Referral to Services Are Common Practice).

- AMH continues the process of developing and maintaining a coordinated system of care to meet the needs of children served by multiple child-serving agencies.

It is the goal of AMH to create a shared partnership along with other child serving agencies in the state to more effectively address the needs of children served in multiple systems. In March 2007, an executive order was issued by the Governor's office to create a Statewide Wraparound Project Steering Committee.

This committee will direct the process by which child-serving efforts are coordinated, and a system of care is formed in Oregon. The committee is inclusive of child-serving agency partners, family members, and other parties integrally involved in children's mental and physical health. The steering committee has begun to meet and has formed subcommittees for local implementation, data and evaluation, cultural competency and financing. Recommendations will be submitted to the Governor following the September 2007 conclusion of the committee's work. (NFC Goal: Mental Health Care is Consumer and Family Driven).

- Partnership with the Oregon Department of Education (ODE) continues to be an area of focus at the state and local level.

Oregon has strengthened its working relationship and collaboration with ODE. A representative of the state Department of Education and local school systems serves on the Children's System Advisory Committee of the Mental Health Planning and Management Advisory Council. At a community level, efforts are made to engage local school districts in mental health system planning and in system oversight. (NFC Goal: Mental Health Care is Consumer and Family Driven).

- A strategic plan for the implementation of a statewide Trauma Policy and the development of trauma informed care is being written.

The Trauma Policy Advisory Committee (TPAC) is completing its work on a Strategic Plan to guide efforts in implementation of the Trauma Policy, which includes an emphasis on trauma-informed and trauma-sensitive service delivery. Several nationally known consultants will be assisting AMH in this task. Action on the plan is expected to begin in the Fall of 2007. DHS has agreed to collaborate with AMH in the rollout of the Trauma Policy.
(NFC Goal: Excellent Mental Health Care is Delivered and Research is Accelerated).

3. Priorities and Plans to Address Unmet Needs for the Children's Mental Health System

AMH, based upon the Children's System Advisory Committee of the Planning and Management Advisory Council's work-plan for FY 2007-08, established the following priorities and plans for children's mental health:

- Advocacy for Policy Option Packages/ Budgetary Concerns
- Participation in legislative activities by CSAC members
- Support to expand the Family Partnership Specialist position within AMH to full time
- Information exchange and dissemination
- System of Care Development
- Participation by multiple CSAC members on the Statewide Wraparound Project Steering Committee
- Foster development of Memoranda of Understanding and other system integration tools
- Increase service coordination with child welfare, education, and juvenile justice at the state and local levels
- Develop youth-directed care within the mental health delivery system
- Statewide youth inclusion: Locate, identify and train youth to become youth advocates
- Development of training curriculum specific to youth that is similar to family member training for advisory positions
- Advocacy for school credit for participation in advisory committees
- Co-occurring Disorders
- Determine statewide availability of co-occurring disorder treatment services for youth and families, and level of need for services
- Presentation of information that enhances awareness to CSAC
- Entry assessment includes co-occurring disorder assessment (alcohol, drugs, or gambling and mental health disorder)
- Appoint alcohol and drug provider to CSAC
- Budget advocacy for services
- Transition Age Youth (ages 16-24)
- Increase service coordination and delivery for older adolescents and young adults
- Expand awareness and information base of CSAC by inviting experts from programs in the state to speak at committee meetings
- Participation by CSAC in advising AMH Task Force on transition age youth
- Pilot program for transition age youth: outcomes shared with CSAC and Adult System Advisory Committee (ASAC)
- Continue to expand community-based services at all levels.
- Provide more services to children with serious emotional disorders (SED) and their families in the community, especially in rural areas
- Increase the array and availability of community-based services for children with SED
- Workforce development for care coordination; expansion of care coordination capability

Recent Significant Achievements

- Children are being screened for and served within the Integrated Service Array according to a

standardized level of need determination protocol for their mental health service needs.

Every Community Mental Health Program (CMHP) and Mental Health Organization (MHO) is using a comprehensive, validated instrument (the Child and Adolescent Service Intensity Instrument, or CASII) to determine children's mental health service needs. This instrument is part of a protocol in every county using several sources of information to make the determination.

- Since the transition to a new system of services and supports for children, MHO enrollment of children has increased significantly.

In the first 9 months following initiation of the CSCI, MHO enrollment of children increased 4.4% (from 209,377 enrollees in the 3rd quarter of 2005, to 216,649 enrollees in the 2nd quarter of 2006).

- Since the transition to a new system of services and supports for children, the percentage of MHO enrolled children who are served has also increased significantly.

In the first 9 months following initiation of the CSCI, the number of enrolled children served increased from 9,198 (in the 3rd quarter of 2005) to 11,086 (in the 2nd quarter of 2006).

- As of the end of 2006, a significant number (over 500) of the children in the Integrated Service Array were being served in a community setting rather than in a psychiatric day treatment or residential treatment setting.

The types of services they receive in the community includ intensive outpatient, Wraparound, care coordination, skills training, respite care or crisis respite care.

- There are 114 family members trained to participate in advisory councils, planning groups and workgroups.

  Every MHO has a children's system advisory committee with 51% family member representation.

- 14 youth are involved in advisory committees at the local, regional and state levels.

- The State Incentive Grant for Early Childhood Prevention addressed gaps and resources by designing programs to serve migrant Hispanic/Latino and Native American families.

A workgroup planned and implemented activities to engage the population. They determined that many families were engaged through the provision of concrete services, and that effective navigation of the system could occur through the use of two "promotoras" who assisted them with enrollment in needed services, which included mental health services. Half of the families who received services from the promotoras were referred to and engaged in mental health services. The local mental health organization is now sustaining the work of this project by hiring the promotoras. This project provided substantial cross agency training, and implemented The Incredible Years, an evidence-based practice, in Spanish.

Another State Incentive Grant pilot site addressed culturally specific services for both Native American and Hispanic/Latino communities. The Klamath Tribal Health and Family Services established and built on screening programs for all children using the Ages and Stages Questionnaire, and provided referral and wraparound services for children and families with identified needs. Parenting classes were also provided. Tribal and Hispanic families now receive "mainstream" services within the county because of the collaboration through the Klamath Family Partnership and the support of "natural helpers".

4. Future Vision For Children's Mental Health

The future envisioned for children's mental health in Oregon is clearly described in the Children's Mental Health System Change Initiative. The findings of the Statewide Wraparound Project Steering Committee will further clarify and delineate future directions. The vision of the children's mental health system has been clearly articulated by family members that our hope is to have children "at home, in school, and out of trouble."

- Children's Mental Health System Change Initiative

The 2003 Legislative Assembly directed DHS through a Budget Note to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive, and culturally competent home and community based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized." The following actions were implemented October 1, 2005 and continue to be a focus:

- Integrate inpatient hospital, psychiatric residential, psychiatric day treatment and community care into the local or regional managed care environments.
- Ensure meaningful family/youth involvement at individual child, provider, local or regional managed care systems and policy levels and explore mechanisms to ensure family/youth involvement and control over some of the resources.
- Ensure continuous care coordination for children with serious mental and emotional disturbances.
- Require culturally competent, skills-based, staff training on family involvement and evidence-based practices through prioritizing training resources and aggressively pursuing additional resources for this purpose.
- Create clinical and fiscal incentives to provide culturally competent care in the least-restrictive and most normative setting in the child's home community.
- Ensure an effective system of care for children and families through a statewide system of quality improvement and use of pertinent outcome data.
- Ensure that funding intended and allocated by the legislature for children's mental health is used for that purpose.
- Encourage local or regional managed care organizations to create a flexible funding pool and to contract with one or more non-traditional providers who are positioned to provide culturally competent, flexible responses on a 24 hour, seven day a week basis, without requiring the children to enter a facility.

- Support the system of care approach through meaningful regulation and contract provisions.

AMH created a stakeholders' workgroup, which focused on the task of setting policy for the CSCI. This group developed six policy statements in the areas of level of service intensity determination, system structure and functions, meaningful family involvement, workforce development in cultural competency, outcomes, and financing. These policies culminated in guidance for the implementation of system changes in October 2005. The policies are currently undergoing revision.

Oregon is moving toward a system of care for its children, with full integration of financing, local implementation efforts, cultural competency and data and evaluation. The findings of the State Wraparound Project Steering Committee will set the vision and plan for this to occur.

5. Criteria

Performance Goals and Action Plans to Improve the Service System

a. Criterion 1: Comprehensive Community-Based Mental Health Systems

i. Description of Current Children's Mental Health System

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Describes mental health transformation efforts and activities in the State in Criterion 1, providing reference to specific goals of the NFC Report to which they relate.

Oregon manages a comprehensive community-based children's mental health system. The goal of these services is to maintain the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system is family driven, youth guided and community-based with the needs of the child and family determining the types and mix of services provided. These services may be as intensive, frequent and individualized as is necessary and appropriate to sustain the child in treatment in the community. (NFC Goal: Mental Health Care is Consumer and Family Driven).

The Legislature directed DHS through a Budget Note in 2005 to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive and culturally competent home and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized". (NFC Goal: Disparities in Mental Health Services are Eliminated).

AMH has developed systemic alternatives to state hospitalization for children. The Secure Children's Inpatient Program (SCIP) replaced the children's unit within the Child and Adolescent Treatment Services located at the Oregon State Hospital and opened in January 2002. The program provides highly specialized intensive services to children under age 13.

AMH consolidated two adolescent units at the Oregon State Hospital in 2003 and in 2005 the remaining twenty beds on the Adolescent Treatment Services unit at the Oregon State Hospital

were closed. AMH reinvested the resources from this closure to develop secure 24-hour medically monitored services in the community at the Secure Adolescent Inpatient Program (SAIP), as well as enhanced residential services, Stabilization and Transition Services (STS) that allow additional psychiatry time, or intensified staffing patterns to allow children to remain in a less restrictive level of care, or to step down from a higher level of care at an earlier time.

Additionally, distribution of funds to Community Mental Health Programs to support services for children who are not eligible for Medicaid occurred with the cost savings of the closure of the Adolescent Treatment Services unit at Oregon State Hospital.

To assist in implementing the Budget Note, Psychiatric Residential Treatment Services and Psychiatric Day Treatment Services funding has been transferred to the Oregon Health Plan and is managed through MHOs. AMH continues direct contracts with private non-profit agencies for Stabilization and Transition Services, SCIP and SAIP, with admissions being reviewed and approved by AMH children's mental health specialists.

Programs for children who are Medicaid eligible but not enrolled with a Mental Health Organization (fee for service), Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Services (PRTS) are co-managed with the Community Mental Health Programs. The Community Mental Health Programs conduct level of need determination and approve referrals to PDTS and PRTS programs. (NFC Goal: Mental Health Care is Consumer and Family Driven).

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and chemical dependency treatment providers. **(**NFC Goal: Americans Understand that Mental Health is Essential to Overall Health). Thus, enrollment in a MHO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary so children with severe emotional disorders can remain in their community. The OHP benefit package includes a full array of services such as:

- Preventive services
- Diagnostic services
- Medical and surgical care
- Dental services and
- Outpatient addictions treatment services

In addition, the State is required by ORS 430.640 to establish a contractual relationship with each county to assure the provision of community mental health services. State funds are allocated to counties using a "block grant" approach.

Outpatient Services

- Clients are provided with an array of outpatient services, including:
- Mental health assessments
- Co-occurring disorder assessments
- Individual and group therapy with flexible delivery location

- Medication management
- Parent training
- Case management and care coordination
- Crisis intervention, including crisis respite
- Consultation to schools and other agencies
- Flexible services
- Specialized support services to families, including respite
- Skills training

(NFC Goal: Early Mental Health Screening, Assessment and Referral to Services are Common Practice).

Services for children experiencing acute psychiatric conditions include 24-hour crisis assistance, community-based respite care, sub-acute psychiatric care and inpatient services. A promising feature of the Oregon Health Plan is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments and alternative services suggested by contractors, allowing for less costly and more effective service delivery when appropriate. (NFC Goal: Disparities in Mental Health Services are Eliminated).

Three youth suicide prevention coordinators are funded through the Garrett Lee Smith Memorial Act grant, and a number of Oregon counties are actively involved in training and community coalitions for suicide prevention. The Question, Persuade, Refer (QPR) training program is being used in a train the trainer model to disseminate QPR, a suicide intervention program in multiple areas of the state. Several regions are also conducting ASIST (Applied Suicide Intervention Skills Training), a two day training that teaches direct intervention skills to those most likely to come into contact with suicidal persons, such as school counselors, mental health professionals, and juvenile justice staff and law enforcement officers. (NFC Goal: Americans Understand that Mental Health Is Essential to Overall Health).

Care Coordination

Community based care and facility-based mental health providers are required to provide care coordination. Care Coordination services are provided for coordinating the access to and provision of services from multiple agencies, establishing services linkages, advocating for treatment needs and providing assistance in obtaining qualified entitlements. Oregon has 60.4 FTE care coordinators distributed amongst 36 counties. (NFC Goal: Disparities in Mental Health Services are Eliminated).

Rehabilitation Services

With the implementation of the Children's System Change Initiative, AMH continues to work with providers and partners to increase intensive community-based services for children with serious emotional disorders. Currently, MHOs use Medicaid funds to serve these children in the community until a child requires a Psychiatric Residential Treatment Program, Acute Hospitalization or STS, SCIP or SAIP. Funding has transferred to the MHOs for Psychiatric Day

Treatment, Psychiatric Residential Treatment, and Acute Hospitalization. (NFC Goal: Excellent Mental Health Care is Delivered and Research is Accelerated).

Treatment Foster Care

Treatment Foster Care is a collaborative effort with the Department of Human Services, Children, Adults and Families. Considered the least restrictive of residential treatment options for children in the care and custody of the state, Treatment Foster Care is provided by trained foster parents, supervised by the local Community Mental Health Program. It is a critical treatment option for children, especially in rural counties. (NFC Goal: Disparities in Mental Health Services are Eliminated.)

Intensive Treatment Services For Children

Intensive treatment services represent the most intensive and restrictive levels of care provided in Oregon's publicly funded children's mental health system. Intensive treatment services are designed to improve or stabilize the symptoms of a severe emotional disorder diagnosed on Axis I of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Qualified mental health professionals and psychiatrists provide Intensive Treatment Services.

Access to non-emergency inpatient services for those under the age of 21 at nationally accredited Psychiatric Residential Treatment Service programs requires certification of the need for services by an independent psychiatrist. Admissions are made according to the treatment needs of referred children and adolescents and when less restrictive levels of care have proven ineffective or are inappropriate to meet these needs. The Certificate of Need for Services process preserves high-level treatment options for those children who are in need of these services and prevents inappropriate placements for other children and adolescents who could be better served in the community.

Children living in Oregon can access an integrated service array available throughout the state, which includes:

- Psychiatric Day Treatment Services;
- Therapeutic Foster Care;
- Psychiatric Residential Treatment Services;
- Psychiatric Assessment and Evaluation Services;
- Sub-acute Services;
- Secure Children's Inpatient Program treatment services; Secure Adolescent Inpatient Program treatment services, and
- Acute care

All programs except Therapeutic Foster Care provide integrated education services for all children. They meet all the Individuals with Disabilities Education Act requirements and ensure each child has a free appropriate public education that is designed to meet their unique needs.

Therapeutic Foster Care services are provided to children as a community-based alternative to psychiatric residential and hospital levels of care.

Psychiatric Day Treatment Programs are located in 16 counties, geographically distributed through much of the state, and have a daily service capacity for over 300 children who cannot attend regular school programs due to a serious emotional disorder.

Psychiatric Residential Treatment Programs have a daily service capacity for 359 children in a more restrictive and intensive level of residential treatment. Services can be enhanced, when a child's condition requires a more intensive level of service, through the Stabilization and Transition Services (STS) program.

Assessment and evaluation services provided in psychiatric residential treatment facilities are designed to provide intensive evaluation services and brief treatment for children on an emergency basis. Sub-acute services are available in several psychiatric residential facilities to provide an alternative to acute hospitalization, and are primarily for short-term, crisis based services.

The Secure Adolescent Inpatient Program (SAIP) provides long-term psychiatric inpatient services for 17 adolescents ages 14 to 17. The Secure Children's Inpatient Program (SCIP) provides a similar level of care for children 13 years and younger and serves 12 children. (NFC Goal: Mental Health Care is Consumer and Family Driven).

Transitional Services for Older Adolescents

AMH has made moderate progress with serving this population over the past year. There are currently three new transition age youth and young adult projects being developed. Internally, AMH has begun the process of development and implementation of a statewide model of care for this population. Much of the work accomplished over the past year has involved improved channels of communication among systems of care and a streamlined process for new requests to the state for assistance.

In the past, care providers did not know who to contact or how to negotiate between the child and adult mental health systems. There is now an identified resource person at the state level who is able to triage the cases and follow up with weekly planning meetings. Information regarding these services is in the process of being posted to our web site. (NFC Goal: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice).

Educational Services provided by local school systems under the Individuals with Disabilities Act

The local school district is responsible for any educational service under an Individual Education Plan (IEP). Each School District uses a variety of assessment tools and strategies to gather relevant information about the child. The Oregon Department of Education funds the education services through the local Education Service District (ESD) or the School District, in Psychiatric Residential and Psychiatric Day Treatment programs.

Based on the evaluation results, the IEP team, which includes the family, decides which services

the child needs in order to benefit from a free and appropriate public education. This may include developmental, corrective or supportive services as required in assisting a child with a disability to benefit from special education. The IEP team then determines the least restrictive environment in which services can be provided to meet the educational needs of the child.

There are 44 School Based Health Centers in Oregon. 28 of them have mental health providers on staff. Of the total, 7 are in elementary schools of which 6 have mental health providers, 6 are in middle schools of which 2 have mental health providers, and 27 are in high schools of which 20 have mental health providers. One is in a K-12 program and one is in a combined elementary/middle school program. The most commonly seen categories of mental health problems addressed in school based health centers are: 1) social, interpersonal or family problems, 2) anxiety, stress or school phobia, and 3) mood disorders. (NFC Goal: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice).

Reduction of hospitalization of Children with Serious Emotional Disorders

Children with serious emotional disorders are provided individualized mental health services in their home and community to the extent possible. These services include support and training for parents in meeting their child's mental health needs as well as support and training for the child and parents in self-management. A child's needs are continuously evaluated and modified.

A child's individual plan of care addresses and anticipates crises and includes specific strategies and services that will be utilized. When responding to crises, providers access appropriate mental health services to help the child remain at home, minimize placement disruptions and avoid the inappropriate use of police and the juvenile justice system. The Community Mental Health Programs provide crisis response with 24-hour clinical accessibility. (NFC Goal: Mental Health Care is Consumer and Family Driven).

ii. Goals, Objectives, Performance Indicators

Goal 1: Increase the percentage of severely emotionally disordered (SED) children who receive mental health services while residing in a family-like setting.

Population:	Children and their families
Criterion	1. Comprehensive Community based mental health services
Indicator	Percentage of SED children receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 89%.
Measure	Number of children receiving outpatient mental health services while residing in a family-like setting.
Numerator	Number of children receiving outpatient mental health services while residing in a family-like setting.
Denominator	Number of SED children receiving public mental health services.
Sources of Information	Client Process Monitoring System (CPMS)
Special Issues	A number of counties have limited community based mental health services for children to enable children with severe emotional disorders to stay in their communities.
Significance	The Department of Human Services, Addictions and Mental Health Division is committed to serving children with severe emotional disorders in a family-like setting in the community. Providing mental health services to children who are at home or residing in a homelike environment is an essential component of community based services.
Action Plan	Continued implementation of the Children's System Change Initiative; Statewide Wraparound Project Steering Committee; Technical assistance to counties.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of SED children receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 89%.	89%	Baseline	90%	90%	90%

Goal 2: Increase the array of community-based mental health services available to and delivered to children with serious emotional disorders.

Population	Children and their families
Criterion	1. Comprehensive, Community-based Mental Health System
Indicator	The percentage of children with serious emotional disorders who receive three or more types of community-based mental health services over the course of a year will match or exceed baseline.
Measure	The percentage of children with serious emotional disorders who receive three or more types of community-based mental health services.
Numerator	Number of children with SED who receive three or more types of community-based mental health service
Denominator	Number of children with SED
Sources of Information	Client Process Monitoring System (CPMS) and Medicaid Management Information System (MMIS)
Special Issues	Some Oregon communities have a very limited array of services available to children with serious emotional disorders and their families.
Significance	The Department of Human Services, Addictions & Mental Health Division is committed to serving more children with serious emotional disorders with intensive community-based services. Increasing the array of intensive community-based services to children and their families remains crucial in implementing the children's system change. NOMS 1. Increased access to services.
Action Plan	Workforce development; technical assistance; Statewide Wraparound Project Steering Committee.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The percentage of children with serious emotional disorders who receive three or more types of community-based mental health services over the course of a year will match or exceed baseline.	N/A	Baseline	Match/ Exceed Baseline	Match/ Exceed Baseline	Match/ Exceed Baseline

Goal 3: Increase parents' or guardians' of children receiving public mental health services perception of care. NOM

Population	Children and their families
Criterion	1. Comprehensive, community-based mental health system
Indicators	Increase the percentage of parents or guardians of children receiving public mental health services who respond positively, overall, to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.
Measure	Percentage of parents or guardians of children receiving public mental health services who agree or strongly agree, as a whole, to the Youth Services Survey for Families questions measuring appropriateness of service: *1. I have been satisfied with the services my child receives. 4. The people helping my child stuck with us no matter what. 5. I felt my child had someone to talk to when s/he was troubled. 7. The services my child and/or family received were right for us. 10. My family got the help we wanted for my child. 11. My family got as much help as we needed for my child.*
Numerator	Number of parents / guardians who provide an overall response of "agree" or "strongly agree" to the questions measuring appropriateness of service on the Youth Services Survey for Families.
Denominator	Number of parents / guardians who provide valid responses to the items of the Youth Services Survey for Families pertaining to appropriateness of service.
Sources of Information	MHSIP Youth Services Survey for Families
Special Issues	The Department of Human Services, Addictions and Mental Health Division distributes the MHSIP Youth Services Survey For Families annually. Though this survey reflects only the opinions of those who choose to fill out and return the survey, the return has represented a statistically significant sample.
Significance	Assuring that children and their parents or guardians who receive public mental health services rate the appropriateness and quality of services as effective is critical to Oregon's system of care. NOMS 4. Client Perception of Care
Action Plan	System monitoring activities: local/regional advisory councils, Children's System Advisory Council, quality assurance activities

Performance Indicator	FY2006	FY2007	FY2008	FY2009	FY2010
Increase the percentage of parents or guardians of children receiving services through the Oregon Health Plan who respond positively to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.	61%	63%	65%	67%	69%

Goal 4: To increase service coordination and delivery for those persons aged 16-24 with a severe emotional, behavioral and/or mental disorders and who are transitioning into the adult community mental health service system.

Population	Transition age youth (16-24) and their families
Criterion	1. Comprehensive, Community-based Mental Health Services System
Indicators	a. A model for a statewide system of supports and services for transition age youth (TAY) will be developed. Barriers to care for youth accessing services, and educational needs of systems partners will be identified for future development. b. Establish and increase the number of TAY served in specific community placements.
Measure	a. Model developed. b. Number of TAY served in specific community placements.
Numerator	Number of TAY with severe emotional, behavioral and/or mental disorders who are transitioning into the adult service system and who are served in specific community placements.
Denominator	N/A
Sources of Information	Report from AMH Task Force on TAY; AMH funded specific community placements-annual reports.
Special Issues	Transition age youth services go beyond treating high-risk behaviors by providing opportunities and supports for youth to transition smoothly into adulthood and live productive, functional lives.
Significance	This model will address a service need that is currently not met in Oregon. For transition age youth, it will likely reduce their encounters with the acute care and criminal justice systems while improving educational, vocational and functional outcomes and life satisfaction. NOMS 1. Increased Access to Services.
Action Plan	Use of pilot community placements; technical assistance; task force of AMH child and adult mental health staff

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
a. A model for a statewide system of supports and services for transition age youth (TAY) will be developed. b. Establish and increase the number of TAY served in specific community placements.	N/A	Model develop-ment in process	a. Model developed b. 5	a. Model developed and in use b. 10	a. Model in use b. 20

Goal 5: To increase parents' / guardians' of children with serious emotional disorders who agree or strongly agree that mental health services have been family-driven.

Population	Children and their families
Criterion	1. Comprehensive, Community-based Mental Health System
Indicator	Increase the percentage of caregivers of children with serious emotional disorders who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven: *Please indicate the extent to which you agree or disagree with the following statement: The child's parent or caregiver directed the child's mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.*
Measure	The percentage of caregivers of children with serious emotional disorders who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven: *Please indicate the extent to which you agree or disagree with the following statement: The child's parent or caregiver directed the child's mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.*
Numerator	Number of parents / guardians who provide an overall response of "agree" or "strongly agree" to a survey item indicating that services were family-driven.
Denominator	Number of parents / guardians who provide a valid response to a survey item indicating that services were family-driven.
Sources of Information	YSS-F survey for families as amended by AMH for 2007; Family Involvement Survey
Special Issues	Family-driven services remain a primary goal of the Children's System Change. Meaningful family involvement means that families have a primary decision making role in the mental health care of their own children.
Significance	The Department of Human Services, Addictions and Mental Health Division is committed to increasing the breadth of services which are deemed family-driven at all levels of the children's mental health system. NOMS 4. Client Perception of Care
Action Plan	Family and caregiver input on YSS-F; Integrated Service Array Progress Review forms completed at Child and Family Teams

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The percentage of caregivers of children with SED responding to the YSS-F who respond agree or strongly agree to an item indicating that services were family-driven.	N/A	Baseline	14 %	16 %	20%

Goal 6: Increase reported Social Connectedness. (NOM)

Population	Children with a serious mental disorder
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The social connectedness domain of the YSS-F survey.
Measure	Percentage of caregivers of children with serious emotional disorders with positive response to the Social Connectedness questions on the YSS-F survey.
Numerator	Number of caregivers of children with serious emotional disorders with positive response to the Social Connectedness questions on the YSS-F survey
Denominator	The number of caregivers of children with serious emotional disorders responding to the YSS-F survey
Sources of Information	YSS-F survey
Special Issues	This is a new domain on the YSS-F survey.
Significance	Recovery means that individuals have a place in the community. People need to feel that they have meaningful relationships and have a place in the community.
Action Plan	CSAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of caregivers of children with serious emotional disorders with positive response to the Social Connectedness questions on the YSS-F survey.	N/A	N/A	Baseline	5% over baseline	10% over baseline

Goal 7: Improved Functioning. (NOM)

Population	Children with a serious mental disorder
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The functioning domain of the YSS-F survey.
Measure	Percentage of caregivers of children with serious emotional disorders with positive response to the Functioning questions on the YSS-F survey.
Numerator	Number of caregivers of children with serious emotional disorders with positive response to the Functioning questions on the YSS-F survey
Denominator	The number of adults responding to the YSS-F survey
Sources of Information	YSS-F survey
Special Issues	This is a new domain on the YSS-F survey.
Significance	Recovery is more than just feeling better. Persons in recovery are able to do more and do better those activities that are meaningful.
Action Plan	CSAC will review survey results and recommend appropriate response.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of caregivers of children with serious emotional disorders with positive response to the Functioning questions on the YSS-F survey.	N/A	N/A	Baseline	5% over baseline	10% over baseline

b. Criterion 2: Mental Health System Data Epidemiology

i. Description of Current Children's Mental Health System

Serious Emotional Disorder (SED)

The State of Oregon uses the Federal definition of Serious Emotional Disorder, which includes children and youth from birth to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within DSM-IV that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder alone does not constitute a serious emotional disorder although one or more of these two disorders may coexist with a serious emotional disorder. This definition is used in determining prevalence, need and access. The current estimate of the number of children with a serious emotional disorder living in Oregon is 107,916 children.

Access for Minorities

Access for Minority Populations: The majority of the population in Oregon is Caucasian with the remaining population being African American, Hispanic, Native American, Asian, etc. A comparison of the ethnic composition of Oregon's population and persons receiving mental health services by age group is provided in Table 2 of Appendix B. Oregon Administrative Rules state that community mental health programs are to provide culturally competent services. AMH requires information be provided to potential consumers, family members and allied agencies regarding the availability in a multi-lingual format.

At the direction of the AMH management team, the AMH Cultural Competency Work Group (ACCWG) was created and has been meeting monthly to develop recommendations for the AMH Cultural Competency Plan (ACCP). At this point the guidelines to the ACCP have been developed and are awaiting stakeholder input. The ACCP is being developed in response to the DHS Standards and Guidelines for Cultural Competency and Gender Specific Services, which were approved by the DHS Cabinet in September of 2003.
The purpose of the plan is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from, or that are under contract with AMH, including county social services organizations and their vendors or contractors, managed care organizations and their provider networks, and community-based organizations. The intent is that this will serve as a planning document to assist AMH, County Governments, and provider networks to develop and implement an individualized cultural competence plan as addressed in each County's biennial implementation plan, with its goal to enhance treatment outcomes for all patients.
The AMH Cultural Competence Plan identifies eight core sections that would need to be addressed to move cultural competence forward. These are:

1. Planning
2. Evaluation
3. Services to Clients

4. Retention, Recruitment & Promotion
5. Education & Training for OMHAS staff/providers
6. Collaborative Partnerships & Informing the Public
7. Data Collection & Operation
8. ADA Compliance

The issues of culture have been integrated with the implementation of EBPs. This work respects and values differences among consumers, shares responsibility for addressing these differences, and measures the success in addressing cultural differences. AMH will continue to strengthen communication and cooperation within racial and ethnic communities.

In the Children's Mental Health System Change Initiative directed by the 2003 Legislative Assembly two of the eight tasks focus on developing culturally competent services. They are: Requiring culturally competent skills-based staff training on evidence-based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.

Encourage local or regional managed care organizations to create a flexible funding pool to contract with one or more non-traditional providers who are positioned to provide culturally competent flexible response on a 24 hour, seven day per week basis without requiring the children to enter a facility to access the services.

The Governor's Statewide Wraparound Project Steering Committee has a specifically appointed subcommittee on Cultural Competency. A clearer focus on specific needs is expected as this group makes its recommendations in September 2007. (NFC Goal: Disparities in Mental Health Services are Eliminated).

Gender Specific Services

The Addictions & Mental Health Division participates in the Coalition of Advocates for Equal Access for Girls. The mission and activities of the Coalition aims to ensure that girls receive equal access to all of the appropriate gender specific support and services they need to help girls develop to their full potential. Coalition membership includes representatives from AMH, other state agencies, and private non-profit organizations. This coalition also has legislative support.

The Coalition meets at least 6 times a year and publishes *The Girls' Advocate*, a quarterly newsletter that aims to inform members and others regarding the activities that either support or threaten service access for girls.

AMH continues to revise and monitor administrative rules and contract provisions to enhance gender responsive services. (NFC Goal: Disparities in Mental Health Services are Eliminated).

- The current Oregon Administrative Rule standard for substance abuse outpatient and residential services contains requirements for gender-specific services [OAR 415-051-0100 (2) (e)].

- Regional Alcohol and Drug Specialists conduct quality assurance and licensing on-site reviews to ensure that adolescent residential and outpatient substance abuse programs adhere to gender-specific requirements [OAR 415-051-0100].
- The current Oregon Administrative Rules for Children's Intensive Mental Health Treatment Services, [OAR 309-032-1120 (16)] and Children's Intensive Community Based Treatment and Support Services Providers, [OAR 309-032-1250 (15)] include standards for gender responsiveness.

AMH contracts with Girls, Inc. of NW Oregon to implement an evidence-based prevention program: Friendly PEERsuasion. Friendly PEERsuasion is being utilized in three Oregon counties and is geared toward female adolescents. This effort is focused on reducing under age drinking rates for girls, especially middle school age youth.

Tribal Liaisons

AMH has identified two staff to serve as liaisons with the Tribes. When working with Tribes and tribal organizations, AMH staff solicits assistance and guidance from the liaisons to assure that cultural issues are identified and addressed. AMH tribal liaisons coordinate with the DHS tribal liaison.

The AMH tribal liaison is present at tribal functions in an effort to establish rapport. The tribal liaison answers questions and assists with diminishing system barriers for the Tribes. The CSCI referral and enrollment protocol has caused some barriers in service access, as the Tribes had previously been able to access treatment directly. They are learning to access the local CMHP or MHO for authorization for services. Some options are being considered regarding the requirement for the local mental health authority to make referrals for residential and day treatment services, and how that can be changed to better meet the cultural needs of our tribes in Oregon. (NFC Goal: Disparities in Mental Health Services are Eliminated).

ii. Goals, Objectives, Performance Indicators

Goal 8: To maintain or increase the proportion of children from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's children within the same ethnic population.

Population	Children
Criterion	2. Mental Health System data Epidemiology
Indicator	The percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children within ethnic categories for the general population.
Measure	MMIS
Numerator	Within each ethnic / racial group, the number of Medicaid-eligible children who receive publicly funded mental health services.
Denominator	Within each ethnic / racial group, the number of Medicaid-eligible children.
Sources of Information	CPMS, MMIS, Portland State University Population Research Center.
Special Issues	Whites, Asians and Hispanics are under represented in the service population, while African-Americans and Native Americans are over represented. Services must be modified to become culturally sensitive and culturally competent so that those seeking services will find services that address their cultural needs and needs for ethnic diversity.
Significance	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of children with diverse ethnic backgrounds. NOMS 1. Increased Access to Services.
Action Plan	Expansion of cultural competency workforce development and increased access to services for children who are ethnically or culturally diverse in their background.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children within ethnic categories for the general population.	Whites, Asians and Hispanics are under represented in the service population, while African-Americans and Native Americans are over represented.	To Be Reported December 2007	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.

c. Criterion 3: Children's Services

i. Description of Current Children's Mental Health System

Oregon uses the Federal definition for serious emotional disturbance (SED) to describe the population of children under age 18 who receive services. In this document the term, "children with severe emotional disorders" is synonymous with SED. The majority of the children served have diagnosed disorders on Axis I of the DSM-IV. The following describes the coordination of mental health services throughout the children's system.

System Alternatives to State Hospitalization

The former Oregon State Hospital child and adolescent treatment program units were closed in 2002 and 2005 respectively. AMH has developed the following systemic alternatives to state hospitalization for children:

1. The Secure Children's Inpatient Program (SCIP) opened in January 2002. SCIP provides services to 12 children under age 13. The services are provided on a campus and within a program specifically designed for children. SCIP utilizes a child and family focused, community-based model with integrated linkages to a continuum of care. This ensures that each child receives treatment in the most clinically appropriate and least restrictive setting possible.

2. The Secure Adolescent Inpatient Program (SAIP) provides services to up to 17 adolescents ages 14 through 17 on a campus and within a program specifically designed for adolescents. SAIP utilizes a child and family focused, community-based model with integrated linkages to a continuum of care.

AMH reinvested the resources saved in this closure to develop enhanced residential services. Stabilization and Transition Services (STS) are enhanced residential treatment resources developed by AMH: 1) to divert children/adolescents from SCIP/SAIP when clinically appropriate and to treat them in a less restrictive setting, or 2) to provide additional funding to assist with transition needs for children/adolescents who are ready for discharge from SCIP/SAIP but who might not be accepted into lower levels of care without additional funding incentives.

In 2006 AMH provided STS funding for 31 children/adolescents for a total of 1874 days. STS funding was used to allow children/adolescents the ability to receive higher levels of care in the least restrictive environment. STS funding was used to adequately treat youth in their current setting (sparing them a move to yet another treatment program) with additional funds to pay for enhanced services. This funding was also utilized to assist with transition services upon discharge from SAIP for some youth who were turning 18. It provided an avenue for continued care for transition age youth until adequate discharge plans could be put in place.

Children in Child Welfare Service

Children in the care, custody and supervision of the Department of Human Services comprise a majority of all children receiving mental health treatment services. AMH works with child welfare to co-finance and co-manage much of the out-of-home psychiatric treatment services provided to these children. The Department of Human Services, Children, Adults and Families contracts with public and private child caring agencies to provide Behavior Rehabilitation Services (BRS) for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

DHS/CAF Office of Safety & Permanency for Children has issued an RFP to increase statewide access to enhanced services in a BRS foster care setting for children in their custody. When fully implemented, the RFP will add 43 "slots" to the BRS foster care system. Intensive Community Care (ICC) targets a resource gap for children that qualify for the children's mental health Integrated Service Array (ISA) and have child welfare and mental health needs that can more effectively be met in a community-based setting. ICC will provide highly structured living environments with foster parents that are specially trained in behavioral support, in a placement that is conducive to the provision of in-home, intensive mental health services. (NFC Goal: Mental Health Care is Consumer and Family Driven).

AMH is partnering with Child Welfare District Managers to work on the requirements for their Federal Performance Improvement Plan (PIP). The primary requirement the two agencies are working on is that children entering substitute care will receive a mental health assessment/screening within 60 days. AMH staff meets on a monthly basis with this group and the Child Welfare Program Managers regarding the implementation of the Children's System Change Initiative. (NFC Goal: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice).

State Target Planning and Consultation Committee

AMH participates as a member of DHS, Children, Adults and Families Target Planning and Consultation Committee. This committee approves and funds individualized service plans for children in state custody up to age 21, for whom there are no appropriate and/or available funded resources or services. (NFC Goal: Mental Health Care is Consumer and Family Driven).

Children in the Juvenile Justice System

In 2000, the (then) Office of Mental Health and Addiction Services in collaboration with the Oregon Judicial Department (OJD) was awarded funds through the Juvenile Accountability Incentive Block Grant (JAIBG) to implement Integrated Treatment Courts for juveniles and their families. The statutory goal of this federal grant is to promote greater accountability in the juvenile justice system. The DHS – OJD partnership resulted in an innovative statewide pilot project designed to address a growing concern related to juvenile offenders with co-occurring substance use and mental health disorders**.** (NFC Goal: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice).

The Integrated Treatment Court model was developed and pilot projects established in seven Oregon counties: Clackamas, Coos, Crook, Douglas, Jackson, Josephine and Marion. Integrated Treatment Courts combine "juvenile drug court" concepts and service integration principles in order to increase accountability, promote service coordination across agencies and systems, promote the use of evidence-based practices and provide individualized behavioral health services for youth and families involved in the juvenile justice system.

In 2005, (then) OMHAS and Juvenile Justice agencies began sharing data information resulting from a collaborative arrangement. This information will be shared with community mental health programs, county juvenile departments and the Oregon Youth Authority to assist in program and policy development.

AMH representation has been added to the Oregon Youth Authority Advisory Council. This council is composed of state and local partners including judges and victims. The council provides oversight and advice to the Directors of the Oregon Youth Authority in the management and development of new services and programs to serve youth offenders move appropriately and increase the potential for reformation. AMH is also represented at the Juvenile Department Directors monthly meeting to provide information sharing and collaboration among the systems.

Individuals with Disabilities Education Act Partnership

In October 2002, DHS and the Oregon Department of Education (ODE) were awarded a seed grant from the National Association of State Directors of Special Education. ODE and DHS convened statewide forums that addressed children's education needs for a successful transition from residential treatment facilities back to their school within their community and an action plan was created to ensure successful transitions. AMH and ODE continue to use this action plan to coordinate children's mental health services and improve educational opportunities for children. (NFC Goal: Mental Health Care is Consumer and Family Driven).

AMH participates in the State Advisory Council for Special Education (SACSE). This Council reviews all aspects of the statewide program of special education, and also provides policy guidance with respect to special education and related services for children with disabilities. Each year SACSE provides recommendations to superintendents and the State Board of Education.

Interagency Care for Children

AMH is creating a coordinated system of care to meet the needs of children served by multiple child serving agencies. Mental health, education, child welfare, juvenile justice, family support organizations, and families continue to work together to establish meaningful service planning at the individual, local and state levels. The Governor issued an executive order in March 2007 to create a Statewide Wraparound Project Steering Committee to examine the issues, barriers and possible solutions to currently existing roadblocks impeding the development of a truly integrated system of care serving children and youth. The Committee's report is due in October 2007.

Memoranda of understanding have been written encompassing key tenets of the Children's System Change Initiative together with education and child welfare to assure a common understanding of the mental health system changes.

The Children's System Advisory Committee was established in 2005 as a permanent committee of the Planning and Management Advisory Council. This committee provides oversight of children's mental health system planning, coordination, policy development, fiscal development and evaluation of service delivery/functioning. The committee also addresses specialized issues and services for transition age older adolescents and young adults.

The Children's System Advisory Committee membership includes child welfare, juvenile justice, education, family members, youth, advocates, and providers, and this is replicated at the regional and local advisory councils. Workforce development activities have also been initiated with interagency input. (NFC Goal: Mental Health Care is Consumer and Family Driven).

Adolescent Services For Co-Occurring Mental Health And Substance Use Disorders

The state of Oregon provides fully integrated services for adolescents who present with both mental health and substance use issues in the alcohol and drug residential treatment programs. The state amended contract language and increased the daily rate to support the provision of competent programs capable of delivering adequate and appropriate services. The mental health providers screen for co-occurring substance use problems and make appropriate referrals for treatment to outpatient programs. Additionally, the Oregon Youth Authority is moving toward providing specific treatment for incarcerated youth who present with COD. They have hired qualified mental health professionals (QMHP) in all institutions to support this effort.

ii. Goals, Objectives, Performance Indicators

Goal 9: The population of children with serious emotional disturbance will show improved participation in school following mental health treatment. NOM

Population	Children with serious emotional disorders
Criterion:	1. Comprehensive Community-Based Mental Health Service Systems. 2. Children's Services—educational
Indicator	The number of parents / guardians who report that their child's school attendance improved following the initiation of mental health treatment will meet or exceed baseline increase.
Measure	The percentage of parents / guardians who report that their child's school attendance worsened following the initiation of mental health treatment.
Numerator	The number of parents / guardians who report that their child's school attendance improved following the initiation of mental health treatment.
Denominator	Number of parents / guardians who provide a valid response to a survey item indicating that services were family-driven.
Sources of Information	YSS-F item: "Since my child started to receive mental health services from this provider, the number of days my child has been in school is: ☐ a. Greater than before ☐ b. About the same as before ☐ c. Less than before ☐ d. Does not apply"
Special Issues	Many children who need mental health services are not willing or able to participate in school.
Significance	Oregon is committed to increasing access to educational services for children with serious emotional disorders. NOMS Indicator 5. Return to/stay in school.
Action Plan	Continue to support statewide provision of educational services and supports to children with serious emotional disorders.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The percentage of parents / guardians who report that their child's school attendance improved following the initiation of mental health treatment will meet or exceed baseline increase.	**N/A**	Establish baseline	Meet or exceed FY 2007 percentage	Meet or exceed FY 2007 percentage	Meet or exceed FY 2007 percentage

Goal 10: The population of children with serious emotional disturbance will experience a lower likelihood of arrest following initiation of mental health treatment. NOM

Population	Youth with serious emotional disorders who come in contact with the Juvenile Justice System.
Criterion	3. Children's Services
Indicator	The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2 will increase.
Measure	The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2.
Numerator	The number of children, as reported by parents or guardians, with no arrests for a year after starting treatment.
Denominator	The number of children, as reported by parents or guardians, who were arrested within a year prior to mental health treatment.
Sources of Information	YSS-F as amended by Oregon Department of Human Services Addiction and Mental Health Division.
Special Issues	The Oregon Department of Human Services Addictions and Mental Health Division and the Oregon Youth Authority are interested in the various factors affecting youth with mental health needs and their involvement in the juvenile justice system.
Significance	Youth who come in contact with the juvenile justice system have a high occurrence of mental health needs. Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system. Improved mental health services are expected to decrease criminal activity.
Action Plan	Evaluate whether treatment has an impact on likelihood of arrest. Evaluate other factors that may be contributing to the likelihood of arrest.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2 will increase.	----	Baseline	Maintain or increase baseline percentage	Maintain or increase baseline percentage	Maintain or increase baseline percentage

Goal 11: Children with a serious emotional disorder entering substitute care from the DHS Child Welfare will receive a mental health assessment.

Population	Children entering Substitute Care from the Child Welfare System.
Criterion	3. Children's Services
Indicator	Maintain or increase the percentage of children involved in the child welfare system who receive timely initial mental health assessments.
Measure	Percentage of children involved in the child welfare system who receive timely initial mental health assessments.
Numerator	Number of children with a serious emotional disorder entering substitute care from the DHS Child Welfare system who receive a mental health assessment within 60 days of entering care.
Denominator	Number of children with a serious emotional disorder entering substitute care from the DHS Child Welfare system.
Sources of Information	MMIS and administrative data maintained within the Division of Children, Adults and Families.
Special Issues	Child welfare has a federal requirement that a child must have a mental health assessment completed within 60 days of substitute care placement. Oregon has not met this measure and is working collaboratively to meet this goal.
Significance	Children in substitute care with DHS child welfare need to have a mental health assessment completed to determine the need for mental health services. NOMS 1. Increased access to services.
Action Plan	Determine method to increase number of completed mental health assessments.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Maintain or increase the percentage of children involved in the child welfare system who receive timely initial mental health assessments.	Baseline percent	Maintain or increase from baseline	Increase by 1% over prior year	Increase by 1 % over prior year	Increase by 1% over prior year

Goal 12: Increase the provision of evidence-based practices to children with serious emotional disorders. [TRANSFORMATION OUTCOME MEASURE] NOM

Population	Children and their families
Criterion	3. Children's Services
Indicator	Percentage of children with serious emotional disorders receiving evidence-based practices.
Measure	Percentage of children receiving evidence based practices.
Numerator	Number of children receiving evidence-based practices.
Denominator	Number of children receiving public mental health.
Sources of Information	List of treatment practices approved as evidence-based by AMH; expenditure and demographic reports on evidence-based practices submitted to AMH by Community Mental Health Programs.
Special Issues	A law enacted by the 2003 Oregon Legislature requires that, by 2009, at least 75% of the treatment funds expended by AMH be for evidence-based practices. AMH has created a statewide list of approved evidence-based practices. Implementation of evidence-based practices is occurring with 171 approved practices encompassing mental health, addictions, co-occurring disorders and prevention practices.
Significance	AMH is required to demonstrate that funds are being used cost-effectively for treatment services that are based upon empirical research demonstrating the effectiveness of the practices in treating people with psychiatric disabilities. NOMS 3. Use of Evidence-Based Practices.
Action Plan	Survey of publicly funded providers regarding numbers of clients served in evidence-based practice treatment and percentage of funds used in delivery of these practices.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Percentage of children with serious emotional disorders receiving evidence-based practices.	Methodology established	25%	50%	75%	75%

Goal 13. Increase the number of evidence-based practices provided to children and their families in Oregon. (NOM)

Population	Children and families
Criterion	1. Comprehensive Community-based Mental Health Systems
Indicators	The number of evidence-based practices provided.
Measure	The number of evidence-based practices provided.
Numerator	N/A
Denominator	N/A
Sources of Information	Administrative data and reports available from county mental health programs.
Special Issues	A law enacted by the 2003 Oregon Legislature required that the Addictions and Mental Health Division progressively increase the percentage of its treatment funds that support evidence-based practices to 75% by the 2009-2011 biennium.
Significance	In Oregon, as well as nationally, funding agencies are being required to demonstrate that funds are being used cost-effectively. Increasing the spending on services that have been shown to be effective demonstrates better stewardship of public funds. AMH is specifically interested in making sure these services are available across all age groups.
Action Plan	AMH will continue efforts to promote the proliferation of evidence based practices throughout the State.

Performance Indicator	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The number of evidence based practices offered to children and their families throughout Oregon.		N/A	Baseline	An increase of 10% over baseline	An increase of 15% over baseline	An increase of 20% over baseline

Goal 14: a. Reduce the rates of readmission within 30 days and within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP). (NOM)

b. Increase the number of days until the readmission of 5% of the youth discharged from the Secure Adolescent Inpatient Program (SAIP) or the Secure Children's Inpatient Program (SCIP) in the past fiscal year.

Population	Children with serious emotional disorders
Criterion	3. Children's Services
Indicators	a. Reduce the percentage of readmission within 30 days and (b.) within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP). c. Increase the number of days until the readmission of 5% of the youth discharged from the Secure Adolescent Inpatient Program (SAIP) or the Secure Children's Inpatient Program (SCIP) in the past fiscal year.
Measure	a. Percentage of children with serious emotional disorders who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year. b. Percentage of children with serious emotional disorders who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year. c. Number of days until the readmission of 5% of the youth discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) in the past fiscal year.
Numerator	a. Number of children with serious emotional disorders who are readmitted to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year. b. Number of children with serious emotional disorders who are readmitted to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year. c. Not Applicable
Denominator	a. Number of children with serious emotional disorders who are discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year. b. Number of children with serious emotional disorders who are discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year. c. Not Applicable
Sources of Information	MMIS and CPMS
Special Issues	Oregon is working with Community Mental Health Programs, Mental Health Organizations and Intensive Community Based Treatment Services (ICTS) providers to ensure children discharged from SCIP and SAIP have good transition plans to assure successful community tenure.

Significance	It is important that children with serious emotional disorders have effective transition planning upon discharge from the Secure Children's Inpatient Program or Secure Adolescent Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the child's mental health needs and strengths. NOMS 2. Reduced Utilization of Psychiatric Inpatient Beds.
Action Plan	Monitor discharge planning at SCIP/SAIP through technical assistance; continue to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
a. Decrease the fraction of children with SED who are readmitted to SCIP and SAIP within 30 days of their first discharge of the fiscal year.	2%		1%	<1%	<1%
b. Decrease the fraction of children with SED who are readmitted to SCIP and SAIP within 180 days of their first discharge of the fiscal year.	5%		4%	3%	<3%
c. Increase the number of days until the readmission of 5% of the youth discharged from SCIP or SAIP in the past fiscal year.	N/A	Establish baseline	Match or exceed baseline	Match or exceed baseline	Match or exceed baseline

d. Criterion 4: Targeted Services to Homeless Population

i. Description of Current Children's Mental Health System

Rural Services to Children

Oregon is comprised of 36 counties. Eleven counties have a population of over 96,000 citizens, and are considered urban. The other 25 counties are considered rural with 23% of the State's population residing in these counties. In rural areas, distances and lack of transportation are barriers for children with serious emotional disorders and their families to access mental health services.

The MHOs provide a full continuum of services to eligible children with serious emotional disorders. The MHOs are required by contract to meet the medically appropriate needs of these children. Regardless of the rural nature of a child's community, the intent of the contract is that a full array of services is available to all children and families who need mental health services. The MHOs provide mental health services directly through the Community Mental Health Program or a contract entity under approval of the Community Mental Health Program and AMH. (NFC Goal: Disparities in Mental Health Services are Eliminated).

Access to mental health services in rural areas is generally comparable in Oregon to that in urban areas. In addition to local programs, all children have access to appropriate statewide resources such as acute psychiatric hospitalization, inpatient psychiatric treatment programs, psychiatric residential and day treatment services, and intensive community based services, although children and families may travel many miles to receive these services.

Individuals in rural areas continue to face barriers to receiving services such as intensive community based services, child psychiatry services and acute care. Oregon has increasingly used teleconference technology for child psychiatric evaluations in rural parts of the state. In 2006 teleconference capacity for psychiatric evaluations of children and adolescents increased. Additionally, a majority of Oregon's rural counties have received federal designation as mental health professional shortage areas to assist in recruiting psychiatrists for areas that lack coverage by physicians without regard to specialty. (NFC Goal: Technology is Used to Access Mental Health Care and Information).

Homeless Youth and Children

Homeless children and adolescents are a diverse group facing many challenges. Often these children are in need of mental health and other health and social services. Some homeless children are members of homeless families, and some are children who have run away from home for an extended period and/or have been abandoned by their parents. Estimates of the number of homeless and runaway youth vary widely due to the difficulty in locating and quantifying this population.

Identifying the provision of mental health services to homeless children is also difficult to quantify. AMH uses the Client Process Monitoring System, which defines place of residence or lack thereof for all clients. AMH is involved in multiple planning and program development initiatives including Oregon's Homeless Policy Academy and Shelter Services Partnership for Youth. Many communities provide multi-agency based programs for homeless youth.

AMH continues to pursue additional housing resources through liaison with the Department of Housing and Community Services and local Housing and Urban Development (HUD) agencies. Many of the Community Mental Health Programs collaborate with the homeless and domestic violence shelters to serve these homeless youth.

AMH also distributes funds through Mental Health Services housing awards. Housing Funds were recently made available to assist with the acquisition, rehabilitation and/or construction of new housing for young adults with serious psychiatric disabilities transitioning to independent living and the adult mental health system. These funds are being made available in recognition that shelter is a basic need and current economic conditions make it very difficult for individuals served in local community mental health programs to acquire safe and adequate housing. (NFC Goal: Disparities in Mental Health Services are Eliminated).

ii. Goals, Objectives, Performance Indicators

Goal 15: The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State's population of children who live in rural areas.

Population	Children who live in rural areas receiving mental health services
Criterion	4. Targeted Services to Rural and Homeless Populations
Indicator	The proportion of the children receiving mental health services who live rural areas will match or exceed the proportion of the State's population of children who live in rural areas.
Measure	The proportion of children receiving mental health services who live in rural areas will match or exceed the proportion of the State's population of children who live in rural areas.
Numerator	a. *For the proportion of children receiving mental health services who are from rural areas:* The number of children receiving mental health services who live in rural areas. b. *For the proportion of children living in rural areas:* The number of children living in rural areas.
Denominator	a. *For the proportion of children receiving mental health services who are from rural areas:* The number of children receiving mental health services. b. *For the proportion of children living in rural areas:* The number of children living in Oregon.
Sources of Information	Client Process Monitoring System, Oregon Patient/Resident Care System, Medicaid Management Information System, and public sources of data on the number of children living in various areas across the State.
Special Issues	Rural areas of Oregon have unique issues in the provision of mental health services.
Significance	Because of the small population density in areas of rural Oregon, the assurance of comparable rates of service utilization between children in rural and urban areas is a key indicator. The geographic area requires collaborative interagency involvement, planning, outreach, and unique service delivery mechanisms to ensure that the mental health needs of children and their families are identified and addressed. NOMS 1. Increased Access to Services
Action Plan	Formation of regional oversight committees; telemedicine; videoconferencing for interagency collaboration

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
The proportion of children receiving mental health services who live in rural areas will match or exceed the proportion of the State's population of children who live in rural areas.	Proportion of rural children served exceeded proportion of child population that is rural by 3.4%	To be reported in December 2007	Proportion of rural children served will match or exceed proportion of child population that lives in rural areas	Proportion of rural children served will match or exceed proportion of child population that lives in rural areas	Proportion of rural children served will match or exceed proportion of child population that lives in rural areas

Goal 16: Decrease homelessness among children who receive into publicly funded outpatient mental health services.

Population	Children who are homeless.
Criterion	4. Target services to homeless and rural populations.
Indicator	Increase the proportion of children identified as homeless upon initiation of outpatient mental health services that is no longer homeless at the termination of services.
Measure	Proportion of children identified as homeless upon initiation of outpatient mental health services that is no longer homeless at the termination of services.
Numerator	Number of children completing an episode of outpatient mental health service who were identified as homeless upon initiation of that service episode and identified as no longer homeless upon termination of that service episode.
Denominator	Number of children completing an episode of outpatient mental health service who were identified as homeless upon initiation of that service episode.
Sources of Information	Client Process Monitoring System
Special Issues	For a variety of reasons, the impact of the provision of mental health services on homelessness is difficult to measure. Homeless children entering the outpatient mental health system may not be representative of the broader population of homeless children. Furthermore, children receiving mental health services are likely to receive services from other service delivery systems prior to, during, and/or following receipt of mental health services; the services provided through these other service delivery systems could also have an impact on homelessness. Finally, data on homelessness within the mental health service population are collected only at the beginning and at the end of an outpatient mental health service episode; changes in housing status within the service episode are not known.
Significance	An increase in the proportion of homeless SED children who are no longer homeless upon completion of mental health services would suggest that mental health services have the direct or indirect effect of reducing homelessness within at least a subset of the children living in Oregon.
Action Plan	Technical assistance to provider agencies; collaboration with Commission on Children and Families.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Identify/Increase the number of children who are no longer homeless at the termination of services out of the total number identified as homeless on initiation of service.	N/A	Baseline	5 % increase from baseline	10% increase from baseline	15% increase from baseline

e. Criterion 5: Management Systems
***i.* Description of Current Children's Mental Health System**
Training

AMH's mission for training and community education is to disseminate information, provide technical assistance, and make available skills training to implement current, evidence-based, and culturally competent prevention and treatment services. AMH training promotes practices fostering quality of life, facilitating self-determination, and building on individual, family, and community strengths.

Workforce Development efforts in Children's Mental Health continue to focus on system change and the implementation of evidence-based practices. The Children's Mental Health team and the Workforce Development team will provide training and technical assistance to providers via an individual "change" project called CSIP (Children's System Improvement Project). One agency is currently involved in the pilot and will serve as a model in efforts to expand and enhance technical assistance with an agency training and support network.

Other workforce development efforts include:

- Fidelity Reviews conducted by AMH staff (including Wraparound and Functional Family Therapy)
- Child/youth Behavioral Health Workforce Development committee and educational conference
- Statewide Children's System Change Initiative Implementation Conference

Additionally, training and technical assistance will be offered in the following areas that support the Children's System Change Initiative and implementation of evidence-based practices:

- ECSII (Early Childhood Service Intensity Instrument)
- Trauma Informed Services
- Family Involvement
- Transition-Age Youth
- Wraparound Implementation

First Responder Training

Over the past year, the Department of Human Services Addictions and Mental Health Division (AMH) has facilitated, supported, staffed, assisted and/or developed the following training of emergency first responders:

- Salem Police Officers Training – "The Crisis From the Consumer Perspective and Intro to Major Mental Illness"—"Symptoms and How a Person May Present in Crisis"—"How to Communicate with a Person Hearing Voices".

- Crisis Intervention Team (CIT) Training for Marion County Sheriff's Department – (2) 40-hour sessions, 80 Officers trained.

- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE, Marion County.

- "Addictions and Mental Health Basics" training to front-line case management staff of DHS-Child Welfare, TANF Program.

- Statewide STOPSTIGMA Campaign in response to negative outcomes and violence during first-responder intervention.

In addition, several other localities have initiated or expanded CIT training for law enforcement officers. Recently, the City of Portland committed to CIT training for all officers.

The 2007-2009 Workforce Development Plan details the logistics, delivery methods and budget proposed in each of these areas.
The 2007-2009 AMH Training Plan is attached as Appendix C.

Training Family Members

Oregon Administrative Rules and Mental Health Organization contractual language requires family members of children with serious emotional disorders to participate on advisory councils, quality management committees and other mental health delivery system decision-making bodies.

AMH funds the Oregon Family Support Network (OFSN) to train family members/caregivers/youth and professional mental health staff about effective partnering for policy-making. The educational curriculum provided by OFSN enhances family member/youth and provider ability to be engaged in collaborative organizational decision-making and analysis critical to continuous quality improvement of services to children with SED and their families. A train-the-trainer model is being used to increase the provision of this effective training.

OFSN collaborates with representatives from CMHPs, MHOs and integrated service array providers to increase family members/caregivers/youth membership on local or regional committees. OFSN recruits, mentors and supports family members/caregivers/youth with financial assistance for expenses including travel, childcare, and other expenses as family members/caregivers/youth participate on policy decision-making committees. (NFC Goal: Mental Health care is Consumer and Family Driven).

Transitional Services for Older Adolescents

AMH has made moderate progress with serving this population over the past year. There are currently three new transition age youth group homes being developed and the first will open in August 2007. Internally, AMH has begun the process of development and implementation of a statewide model of care for this population. Much of the work accomplished over the past year has involved improved channels of communication among systems of care and a streamlined process for requests to the state for assistance.

In the past, care providers did not know who to contact or how to negotiate between the child and adult mental health systems. There is now an identified resource person at the state level who is able to triage the cases and follow up with weekly planning meetings. Information regarding these services is in the process of being posted to our web site. (NFC Goal: Mental Health care is Consumer and Family Driven).

Quality Improvement

The AMH Quality Improvement and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Certificates of Approval are issued to Community Mental Health Programs and sub-contracted providers, children's Psychiatric Day Treatment, and Psychiatric Residential Treatment programs for children, inpatient psychiatric acute care programs, and private outpatient mental health providers. Quality Improvement and Certification staff conducts site reviews of these programs to ensure compliance with contract conditions and state regulations. This section also approves individual clinicians to authorize the use of seclusion or restraint for children in approved facilities.

Reportable incidents from PDTS and PRTS providers are reported and processed by the Quality Improvement and Certification unit. Seclusion and restraint data from the PRTS programs is reviewed and analyzed on a quarterly basis.

MHOs, under contract with AMH, are required to submit annual quality improvement work plans that are reviewed and approved by the Quality Improvement and Certification Unit. AMH also analyzes the annual quality improvement work plan reports, other periodic reports from the MHOs and data from utilization reports. These and other outcome measures are used in quality improvement and monitoring activities.

Currently, AMH contracts with an external quality review organization to conduct site reviews of the compliance with contract expectations and to assess quality of services, including performance improvement projects. Each MHO is required to have quality improvement and advisory committees that include representation from community stakeholders, consumer and family members and practitioners. Information is gathered and used to monitor performance standards relating to access to services, quality of care, prevention, education and outreach and integration and coordination with other community services.

Management Information System

Data on persons with psychiatric and emotional disorders and the services they receive are collected and stored in three primary databases:

The Medicaid Management Information System (MMIS) provides information on persons who receive health insurance benefits under the Oregon Health Plan.

The Oregon Health Plan provides coverage to people who are categorically eligible for Medicaid. The plan also provides coverage to an "expansion population" of poverty-level adults who do not qualify for traditional Medicaid and are eligible by virtue of poverty, the OHP standard population. MMIS includes information on eligibility status, services rendered and fee-for-service actual or capitation payments. MMIS also includes information about chemical dependency, pharmacy, dental and physical health service expenditures. MMIS data is accessed via a decision support surveillance utilization review system known as DSSURS.

The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs. The CPMS also includes records of care in chemical dependency and developmental disability programs.

CPMS is submitted on various standardized forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode and monthly during an episode of service.

The Oregon Patient/Resident Care System (OP/RCS) includes records for all publicly funded psychiatric inpatient care delivered in the State Hospital and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment.

Each of these systems contains unique client level identifiers. The AMH Program Analysis and Evaluation Unit uploads data from each of the systems to a central SQL server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

AMH collects other information. Specific data relevant to the CSCI is being tracked in accordance with the Outcomes Policy, and it includes level of need determination data, process measures, family perception of outcomes and integrated service array outcomes. Oversight of data issues throughout the system is provided through the Quality Data Improvement Group (QDIG). Family members, advocates, and other system stakeholders participate in QDIG.

Outcome and performance measure data are gathered through the Mental Health Statistics Improvement Project (MHSIP) Youth Services Survey for Families (YSS-F), which is administered annually. YSS-F results are used to: 1) provide feedback to those who are affected by AMH performance measures; 2) identify areas in need of improvement or attention; 3) track improvement in the well-being of children served with public funds; 4) recognize those programs which are doing well; and 5) communicate results to the Governor, the Legislature, Department contractors, and the public.

Staffing

Four types of staff provide services and support to child and adult consumers of mental health services in Oregon through the Community Mental Health programs. These include programs that are integrated, blending services for mental health, alcohol and drug and gambling recovery. However, numbers represented here exclude staff solely funded by alcohol, drug and gambling

recovery. Funding for Community Mental Health programs and services come from Medicaid, Medicare, State and County General Fund, Federal Block Grant, and private grants and insurances.

These staff are currently sufficient to provide access to medically appropriate mental health services, in particular, crisis services, case management, and emergency psychiatric hospitalizations. There is also an extensive network of psychiatric residential and psychiatric day treatment providers for children and adolescents and the staff in those facilities are not counted in the totals below.

Community Mental Health Program Staffing	**Number**
Licensed Medical Professionals (both employed and contracted	487
Qualified Mental Health Professional (both full and part time)	1376
Qualified Mental Health Associate (both full and part time)	1466
Paraprofessional (both full and part time)	270
Total	**3599**

ii. Goals, Objectives, and Performance Indicators

Goal 17: Increase the participation of children with a serious emotional disorder their family in mental health services planning and monitoring.

Population	Family members of children with serious emotional disorders, youth with serious emotional disorders
Criterion:	5. Management Systems
Indicators	a. Increase the participation of trained family members of children with serious emotional disorders on advisory councils, quality management committees, and other mental health delivery system decision-making bodies. b. Increase the participation of trained youth (ages 16-24) who have had or who are currently receiving mental health services with serious emotional disorders on advisory councils, quality management committees, and other mental health delivery system decision-making bodies.
Measure	a. Number of trained family members participating on policy-making committees. b. Number of trained youth participating on policy-making committees.
Numerator	a. Not Applicable. b. Not Applicable.
Denominator	a. Not Applicable. b. Not Applicable.
Sources of Data	Oregon Family Support Network Project Reports and training rosters, rosters of policy-making committees
Special Issues	Contracts require the participation of family members/youth in advisory councils. Family members/youth may also participate in quality management committees and other means of influencing the mental health delivery systems.
Significance	Family members/youth and mental health service providers together need training to ensure effective family member/youth participation on policy-making councils and advisory committees. Family member/youth involvement in organizational decision-making and analysis is critical to continuous quality improvement of services to children with SED and their families. The Children's System Change Initiative endorses meaningful family involvement. Participation on decision-making bodies is one means to achieving meaningful family/youth involvement. Youth directed services are increasingly being valued and implemented nationally.
Action Plan	Training of youth and family members; recruitment of youth for advisory councils

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Increase the number of family members on policy-making committees.	**25**	**28**	**30**	**35**	**40**
Increase the number of trained youth who are on policy-making councils or committees.	Establish baseline	**10**	**12**	**16**	**18**

Goal 18: Increase access to publicly funded mental health services by children and their families. NOM

Population	Children with serious emotional disorders
Criterion	5. Management Systems
Indicator	Increase the percentage of children with severe emotional disorders served in the publicly funded mental health system
Measure	Percentage of children with severe emotional disorders served in the publicly funded mental health system
Numerator	The number of children with severe emotional disorders receiving publicly funded mental health services.
Denominator	The estimated number of children with severe emotional disorders.
Sources of Information	Contracts, Medicaid encounters and claims (CPMS and MMIS data).
Special Issues	Many children enrolled in mental health organizations who may need mental health services are not accessing those services. A number of communities are lacking community-based services and supports to meet the needs of children with serious emotional disorders and their families.
Significance	Oregon is committed to both increasing access to mental health services and increasing the number of communities offering a wide array of community-based services. NOMS 1. Increased access to services.
Action Plan	Continue to support statewide expansion of community-based services and support MHOs in service provision to enrollees.

Performance Indicator	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Increase the percentage of children with severe emotional disorders served in the publicly funded mental health system	35%	36%	37%	38%	39%

iii. Budget

Contractor	Funds
Baker County	8,355.86
Benton County	20,472.08
Clackamas County	130,238.13
Clatsop County	23,453.90
Columbia County	13,074.13
Confederated Tribes Of Warm Springs Res.	13,147.24
Coos County	24,036.33
Crook County	7,918.74
Curry County	10,608.00
Deschutes County	69,099.82
Douglas County	20,415.92
Grant County	9,649.82
Harney County	9,162.93
Jackson County	26,231.33
Jefferson County	11,855.62
Josephine County	16,535.20
Klamath County	21,818.36
Lake County	3,474.20
Lane County	21,529.76
Lifeways Umatilla	46,835.88
Lincoln County	23,623.77
Linn County	21,891.34
Malheur County	9,797.13
Marion County	121,386.78
Morrow, Wheeler	4,294.75
Multnomah County	209,539.17
Polk County	25,749.10
Tillamook County	7,343.02
Union County	21,176.80
Wallowa County	949.57
Wasco, Hood River, Sherman, & Gilliam	22,604.90
Washington County	98,847.85
Wheeler	477.19
Yamhill County	24,300.61
Oregon Family Support Network	43,539.00
Admin	38,750.00
OHSUTelepsychiatry	10,000.00
Family Navigator	228,433.00
Systems Improvement Projects	116,426.80
Transitional Age Youth Project	50,000.00
CMHP COLA	31,733.80
Total	1,618,777.83

Appendix C: Training Plan

Addictions and Mental Health Division
Workforce Development Unit

07-09 Workforce Development Plan

The Workforce Development Unit will incorporate the following "core principles" into all training, workshop, conference and technical assistance projects coordinated and funded in the 2007-2009 biennium:

- DHS and AMH mission, goals and core values
- Cultural Competency
- Evidence-Based Practices
- Recovery-Oriented
- Trauma-Informed
- Children's Projects include Children 0-18

The under lying philosophy of each of these principles will be woven into all workforce development projects. Education on policies and other data supporting the principles will be offered as specific projects dictate.

Addictions and Mental Health Recovery

Goal 1: Significantly expand the role of individuals in recovery to provide care and supports to others.

Title and Code **100**	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**AMH project Lead**
Behavioral Health Recovery Management (Addiction) 101	"Building Recovery Oriented Systems of Care Using Peer Delivered Services." Three regional events with follow up Recovering panel; Mike Boyles	RAP/Oxford House/ ACCBO/IAS	10,000 SAPT	Karen Wheeler LuAnn Meulink
Peer to Peer Services (Focus: Mental Health) 102	Consensus Forum and Recommendations 1. Develop OAR definition of position and certification standards. 2.Work with Ralph's unit to make sure the services can be paid for and share that with providers 3. Develop competencies and curricula 4. Deliver trainings to meet above and 5. Create a Consumer Training Cadre	ASAC/PeerLinc Consumer Survival Council Healthcare Institute	15,000	Pat Davis-Salyer Rick Snook
Family Support Conference (Focus: Addiction) 103	Four regional one-day conferences focusing on the support of family members of consumers in recovery. (Need to get legislative approval to write CSAT conference grant)		10,000 We will match with CSAT grant 20,000	Children's and A/D Units LuAnn Meulink
Anti-Stigma Efforts 104	SAMHSA and ad council *Anti-Stigma Public Service Announcements and Oregon statewide campaign	Clear channel NAMI/AOCMHP C/S Council/CROs Oregon Stop Stigma Council	5,000	Pat Davis-Salyer
Recovery and Empowerment: Continuing Education 105	Two-day education event 1-Professionals 2-People in recovery	PSU/Dan Fisher	5,000	Pat
Total			45,000	

EBP: Implementation, Fidelity and Sustainability

Goal 2: Increase the relevance, effectiveness, and accessibility of training and education in providing EBPs

Title and Code **200**	*Description*	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Systems Change Projects **201**	Change Leader Institute and individual SIP projects with AMH and NFATTC technical assistance. (Training includes The Change Book and NIATx Process Improvement models.) Should include **children 0-18 and seniors**	NFATTC	20,000	EBP staff LuAnn Meulink
Fidelity Review and Monitoring project **202**	25 fidelity reviews with follow up and TA over two years. All approved practices with tools including prevention.	OPERA AOCMHP Peer reviewers	20,000	Greta Coe, Fidelity Committee
CSIP (Children's System Change Project) **203**	Current pilot for 20,000 includes a six-month change project with Lifeworks NW to implement components of the CSCI. Matt and LuAnn are coordinating and providing TA. **Includes services for children 0 to 18**		50,000 This is MHBG 07 not part of the training plan total	LuAnn Meulink, Matt Pearl
ISFP (Strengthening Families Program) **204**	Training of trainers model and support for childcare for parents of children age **6 to 10- exception to the standard as the practice is standardized for a specific age group**		60,000	Caroline Cruz Pat Davis-Salyer

Integrated Dual Diagnosis Treatment (IDDT) **204**	• 2 IDDT immersion projects • 1 project will be adolescent • 3 one-day trainings on using the COD checklist (Compass)		25,000 Immersion projects are 10,000 per 5,000 video 5,000 for 3 trainings SAPT	CJ Reid LuAnn Meulink
Illness Management and Recovery (IMR) **205**	• Immersion projects	PSU, CCC, MVBCN, OSH/Blue Mt.	10,000	Keith Breswick, Mike Hlebechuk Pat Davis-Salyer
Supported Employment • **Center of Excellence with PSU** • **Ongoing Immersion projects** **206**	Supported E. Project with Mike Moore and he will do RFP with OVRS PSU continuing education support	PSU and OVRD (matches 50,000)	60,000	Mike Moore Shawn Clark
MATRIX **207**	Technical Assistance following SIP	NFATTC	5,000 SAPT	Karen Wheeler Shawn Clark
Drug Courts **208**	Work on a plan with the Commission		5,000 SAPT	Shawn Clark Wheeler's staff
Motivational Interviewing **209**	MIA-STEP Training of Trainers Include adolescent providers	NFATTC	5,000 SAPT	Shawn Clark
Clinical Supervision **210**	2 Immersion projects(they pay half) and one will be adolescent/elderly 2 Clinical supervision courses 1Advance	NFATTC/OSH	10,000 SAPT	Shawn Clark
Medication Assisted Recovery **211**	Eastern/Central Delivery Ron Jackson 1. To primary care/criminal justice 2. Summers re: payment	ACCBO	5,000 SAPT	Wheeler's staff LuAnn Meulink

Impact: Geriatric **212**	Immersion and application (they pay half)	Primary Care Providers	10,000	Rebecca Curtis LuAnn Meulink
Dialectal Behavioral Therapy **213**	1. Teach ECMU program staff 2. ECMU staff train programs	ECMU contractors	5,000	ECMU Pat
Parent/Child Interaction Therapy **214**	Introductory training event between January-March 08 as Children's Plan "ends"	SIG team CCF CAF	Suggested 10,000	Pat Davis-Salyer
Total			$190,000	

Prevention
Goal 3: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

Title and Code 300	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Smoking Cessation **301**		OPERA and Richard Drandoff	5,000 SAPT	Karen Wheeler Rey Agullana
EAST	Implementation of new EAST projects		**POP 4.3 million**	Mike Moore Pat Davis-Salyer
Prevention Specialist Training/Summer Institute **302**	Two co-hort groups to gain information/CEUs to take CPS exam up to 40 hours. Application Outreach to those working with older adults.	PCC/Daystar/ ACCBO, Gambling unit	20,000 SAPT	Greta Coe Prevention staff
National Prevention Conference: scholarships **303**	20 full scholarships or up to 40 partial (350 for 3 days) Diverse and rural priority.	National Conference	7,000 SAPT	Prevention staff
Substance Abuse Prevention Specialist Training (SAPST): Tribal **304**	Co-hort model over time for entry-level information re: certification and ongoing for CEUs and culturally specific data sharing and test preparation.	WCAPT Tribes Gambling	10,000 SAPT	Caroline Cruz Shawn Clark
Bi-annual prevention summits (4) **See list of requests from survey for topics** ***Coordinator's survey** **305**	Four (150 people) summits in the valley for prevention specialists and community members Suggest this include training on older adult prevention.	OP Community Coalitions DHS prevention partners re: Teen Pregnancy, HIV	10,000 SAPT	Prevention unit Greta Coe Rebecca Curtis Jeanne Dalton

Ethics trainings for prevention specialists and those working in prevention 306	2 regional trainings or support for on-line course to meet required CEUs		2,500 SAPT	Greta Coe Contractors/exchange
Communities that Care training of trainers (TOT) **307**	1. Training of Trainers 2. TOTs train 3 communities 3. Follow up training with communities	WCAPT pays for trainers 1000 and rooms 9000 for per diem for Trainers	10,000 SAPT	Caroline Cruz Shawn Clark
Total			$64,500 All SAPT	

Behavioral Health Workforce Development
Goal 4: Increase relevance, effectiveness, and accessibility of training and education

Title and Code 400	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Surveys: To determine workforce need and recommend next steps **401**	Focus group survey to providers and consumers of MH services Community college survey of graduates and EBPs being taught Addiction survey distribution	Healthcare Workforce Institute NFATTC Colleges	1,000	David Goldberg/ Whitehead Shawn Clark
Portland State University **402**	Exec. team to be formed and agreements developed regarding curriculum.		5,000	Bob Nikkel Shawn Clark
Training of primary care providers: substance abuse screening, brief intervention and referral **403**		OHSU Dale Walker Dennis McCarty	5,000 SAPT	
Total			$11,000	

Trauma Policy Implementation

Goal 5: To prepare partners and providers to implement DHS trauma policy and deliver trauma informed and trauma competent services.

Title and Code 500	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Trauma Informed Services: Implementation Plan 501	Trauma Policy Advisory Board (TPAC) to develop the training plan	DHS partner Ann Jennings Sandra Bloom Providers to pay	20,000	Trauma Policy Team (D'Leah Cruz) Pat Davis-Salyer
DHS-wide training re: people with mental illness 502	Provide training on people with mental illness in ongoing DHS events.	DHS/Joe Hestings trainer per diem	2,000	Pat Davis Salyer
Seeking Safety **503**	Train the EBP regionally with the developer.	OYA (may match) Lisa Najavitis	5,000	Diane Lia Pat Davis-Salyer
Total			27,000	

Leadership
Goal 6: Actively foster leadership development among all segments of the workforce.

Title and Code 600	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Network for the Improvement of Addiction Treatment (NIATx) collection **601**	1. Data collection training 2. Learning sessions 3. Regional engagement offerings	AOCMHP OPERA 50 SA programs	Payment by feds. 50,000	Dagan Wright Shawn Clark
Change Leader Institute **602**	Co-hort model, training by feds. Mentors and ongoing support Recovery and cultural diversity the focus of application	NFATTC (They match by providing the trainers etc)	10,000 SAPT	LuAnn Meulink
Turning Point (07 summer and on-line) scholarships **603**	Training substance abuse educators and providers to teach to adults effectively.	NFATTC	2500 SAPT	LuAnn Meulink
Substance Abuse, Poverty and Plans for Recovery **A planning summit** **604**	Two part daylong trainings to teach DHS and provider leaders how they can modify programming/policy to impact barriers to recovery caused by "poverty". Local plans/strategies with DHS/providers to be developed.	Daystar DHS/SDA managers	5,000 SAPT	Karen's staff Shawn Clark
Total			17,500 all SAPT	

Children's System Change Initiative

Goal 7: To support the implementation of changes directed by the Children's initiative

Title and Code 700	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Early Childhood Systems **701**	Early childhood MH consultation in ECH care settings (2,000) Cross systems training (2,000) Positive behavior supports (4,000) **Includes information on Children 0-18**	CCF CAF Eileen Brennan (PSU) SIG leaders DOE	8000	Kathy Seubert Pat Davis-Salyer
Children's System Change Initiative Conference **702**	A two day conference held in early 08 **Includes information on Children 0-18**	State Partners DHS partners	20,000	Children's Unit LuAnn Meulink
ESCII **703**	Diagnostic Criteria :0-3 and clinical formulation **Includes information 0-18**		10,000	Children's Unit Pat Davis
Collaborative Problem Solving (Seclusion and Restraint) MH Award **Mental Health Program** **704**	Change process to implement the model (Immersion projects) SIP **Includes information on Children 0-18**	Emanuel Hospital	10,000	Rita McMillan Pat Davis
Collaborative Problem Solving (Seclusion and Restraint) MH Award **Substance Abuse Program** **705**	Change process to implement the model (Immersion projects) SIP **Includes information on Children 0-18**		10,000	Diane Lia LuAnn Meulink
Cultural Competency Project **706**	TBA **Includes information on Children 0-18**		10,000	LuAnn Meulink Children's Unit Pat Davis
Total			68,000	

Rules and Required Events

Goal 8: To increase compliance with Oregon/DHS and AMH policies and procedures designed to increase client outcomes.

Title and Code 800	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Psychiatric Review Board (PSRB) Conference **801**	Suggest PSRB should match and include money to contract out Should be one day and it was $6,000 for printing	PSRB staff and board	10,000	Len's Unit Cissie Bollinger
Youth "PSRB" **802**	Networking and rules/policy	Board	5,000	Nancy Allen
Extended Care Services (ECS) semi-annual mtgs. **803**	4 one day events to update ECS staff and providers on policies/rules and EBPs Include Utilization Review		5,000	D'Leah Cruz Pat Davis-Salyer
CPMS and MDS-Data Collection **804**	Ongoing training of how to complete data forms		2,000	Ben Kahn Jeff Ruscoe Support staff
Civil Commitment Training **805**	Recertification training and advanced Four regional trainings - contract	Contract and/or and new staff	10,000	Shawn Clark Acute Care committee
"Rules training" **806**	Note: if there is printing in any volume cost could increase two-fold		5,000	Mike Morris's Unit Support staff
First Responders **807**	This is required by the MH block grant and I assume that will fund it		5,000	Mike Morris Pat Davis-Salyer
OHP and Billing update **808**	Ralph's staff to train providers on how to bill and use codes etc. Five regional video conferences on billing regarding Dually Diagnosed clients		5,000	Ralph Summers CJ Reid Support staff
Gender Specific Tx for Children (Report in law) **809**		Patton	5000	Diane Lia Jeannine Beatrice Support staff
Total			52,000	

Co-sponsorships

Goal 9: To increase exposure of providers and partners to emerging practices and "creative" solutions.

Title and Code 900	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Northwest Institute of Addiction Studies 901	Suggest one or two AMH staff offer to serve on the board or the planning team	NWIAS	$10,000 (5,000 a year) SAPT	Shawn Clark
CHARRP Conference 902	Would like to support FASD training	Providers	2,000 (1,000 a year)	LuAnn Meulink
Violence Prevention Institute 903		DHS CCF DOE	2,000 (1,000 a year) SAPT	Caroline Cruz
Total			14,000-12,000 SAPT	

Information Dissemination

Goal 10: To provide information to staff, partners and providers regarding services/rules/practices and resources.

Title and Code 1000	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Resource Center, Web site, Listserv 1001		OP/DHS/OPERA/ NFATTC AOCMHP	5,000	AMH staff Greta Coe Sandi Lacher
Awareness Events **1002**	MH month Recovery Month –Sept. Alcohol Awareness month Various screening days and DHS and partner events		5000	AMH Units and staff as assigned
Total			10,000	

Goal 11: Problem Gambling

Title and Code PG 1-8	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Workforce Development System RFP PG1	▪ Orientation for new gambling counselors ▪ Classes for counselors who are currently trained/practicing in other addictions/mental health fields and who would like to become certified or work as gambling counselors ▪ Classes, accessible in various locations in the state, to help counselors meet the requirements for certification and/or the provisions of the DHS service elements on counselor competence ▪ Planning, coordination and logistics for 3 clinical conferences (1.5-2 days each) for problem gambling treatment providers (spring 08, fall 09, spring 09). ▪ One prevention conference. ▪ Scholarships/application process to fund participation at special training events or for special needs ▪ Workforce development special projects (depends on what gets proposed by bidders): clinical supervision for problem gambling counselors, identification of problem gambling specific competencies, recruitment programs/activities to help interest new providers in this field; leadership development training; prevention mentors/coaches, recovery mentors/coaches	TBA via RFP	$415,000	Wendy Hausotter

Advanced Clinical Consultation Project PG2	Provide gambling-specific clinical consultation to treatment providers	ACCBO	$60,000	Janese Olalde
EBP Pilot PG3	Support pilot implementation of EBP that have worked for A/D and MH with problem gambling clients	TBA by RFP	$200,000 via RFP	Wendy Hausotter
Post-PGS clinical trainings PG4	12 trainings in all on various topics following PGS meetings	ACCBO	$5,000	Wendy Hausotter
NWIAS conference PG5	Presentation/session for this conference each year	NWIAS	$5,000	Wendy Hausotter
Entry level counselor training PG 6	TBA (may work with RFP bidder)		TBA	Janese Olalde
Site review follow-up: agency based training projects PG7	Technical assistance and trainings provided to specific sites		$5,000	Janese Olalde
Prevention workshops PG8	Provide 4 prevention workshops/mtgs		$10,000	Wendy Hausotter
Total			**$700,000 Lottery Funds**	

Goal 12: Housing

Title and Code HS 1-4	**Description**	**Partners/Co-Sponsors**	**Estimated Budget**	**Project Lead**
Real Choice Supportive Housing Training **HS1**	Regional trainings across Oregon on supported housing resources as part of the 2004 Real Choice Grant: Integrating long-term supports with affordable housing; includes resource manuals distributed as part of training.		5,000 (2004 Real Choice Grant)	Terry Mastin Support staff
SSI/SSDI, Outreach, Access, & Recovery (SOAR) **HS2**	SOAR workshops deliver technical assistance to workers in the field on helping individuals successfully access the Social Security benefits they are eligible for.	Policy Research Associates Technical Assistance Initiative (PRA)/ PATH)	5,000 (PATH)	Vicki Skryha/ Terry Mastin Support staff
Oregon Coalition on Housing and Homelessness (OCHH) **HS3**	AMH sponsors 3-6 relevant sessions in the field of homelessness at OCHH's annual conference.	PATH	5,000 (PATH)	Vicki Skryha/ Housing Staff
AMH Housing Institute **HS4**	Forum to present workshops on housing development resources, landlord-tenant and fair housing laws, alcohol and drug-free housing, housing first models and other topics of general interest.	AMH/ PATH	7,000 (PATH)	Vicki Skryha/ Housing Staff
Total			**$22,000 PATH**	

Behavioral Health Hazard Training
Goal 13

Title	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
Behavioral Health Hazard Field Training	Five" Hazard" regional deliveries summer/fall 07 25 -50 in each session for .5 day Contract trainer Use v-con and print field guide	Public Health Emergency training team	3,000 Fed. Hazard funds Print costs	Bob Furlow Laurel Hill Bob Costa Pat Davis-Sayler
Total			**3,000 Federal Funds**	

Recruitment and Retention
Goal 14: Action plan for behavioral health workforce development. Implement systemic recruitment and retention strategies at the state and local level.

Title	***Description***	**Partners/ Co-Sponsors**	**Estimated Budget**	**Project Lead**
		CAAP ACCBO colleges professional groups NASW		
Total				

Appendix D Table 2: Budget / Expenditures for Mental Health Programs

	Fiscal Year								Est./Actual	Est.
Community	**1998-99**	**1999-2000**	**2000-01**	**2001-02**	**2002-03**	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**2007-08**
Adults										
Outpatient	14,833,886	15,632,274	20,658,793	15,359,376	16,639,323	-	-	-	-	30,631,412
Acute Care	12,136,331	12,690,393	13,648,662	12,592,739	13,642,133	-	-	-	-	15,975,264
Community Crisis	6,680,485	6,878,674	7,321,944	6,629,219	7,181,654	-	-	-	-	10,828,857
Residential Care	5,319,242	5,427,365	1,319,110	13,465,758	15,279,924	-	-	-	-	53,527,447
Enhanced Care	3,626,822	3,181,961	3,625,515	3,463,827	3,752,480	-	-	-	-	6,919,590
Adult Foster Care	4,179,355	4,935,458	10,650,630	5,371,717	5,819,361	-	-	-	-	12,251,938
PSRB	1,329,025	1,492,094	1,547,435	1,503,404	1,628,687	-	-	-	-	2,581,158
Other Programs	9,558,443	11,356,717	7,096,665	8,454,696	8,467,234	-	-	-	-	14,994,420
Total Adult	57,663,589	61,594,936	65,868,754	66,840,736	72,410,796	34,326,269	107,689,614	96,969,668	101,426,194	147,710,084
Children										
Outpatient	5,686,684	8,575,034	3,171,129	4,282,848	4,639,753	2,739,598	8,137,189	5,532,883	5,749,522	7,851,251
Community Crisis	1,166,863	1,256,875	1,292,108	1,169,862	1,267,351	1,085,236	1,841,491	1,351,998	1,395,016	1,762,837
Psychiatric Day Tx	11,081,552	4,209,370	11,257,318	11,443,873	8,827,202	8,349,932	10,302,717			
Psychiatric Residential	21,791,562	214,462	-	-	-	-	-	-	-	-
RES-MED	6,730,372	-	-	-	-	-	-	-	-	-
Other Programs	-		7,137,038	3,073,350	3,329,463	1,406,699	2,942,966			
Total Children	46,457,033	14,255,741	22,857,593	19,969,933	18,063,769	13,581,465	23,224,363	6,884,881	7,144,538	9,614,088
Total Community	104,120,622	76,759,285	88,726,347	86,810,669	90,474,565	47,907,734	130,913,977	103,854,548	108,570,732	157,324,172
State Hospitals										
Oregon State Hospital										
Adult Programs	64,387,491	63,382,484	75,121,740	77,739,379	76,465,207	77,603,650	88,218,570	98,445,079	111,253,669	117,491,285
CATP	5,623,375	5,535,602	6,525,107	5,271,031	4,482,096	2,723,907	1,734,800	-	-	-
EOPC	6,404,506	6,093,551	7,535,365	8,074,734	8,241,554	8,784,756	9,970,506	7,930,857	13,110,644	11,973,657
all but CATP	70,791,997	69,476,035	82,657,105	85,814,113	84,706,761	86,388,406	98,189,076	106,375,936	124,364,313	129,464,942
Total State Hospitals	76,415,372	75,011,637	89,182,212	91,085,144	89,188,857	89,112,313	99,923,877	106,375,936	124,364,313	129,464,942
Oregon Health Plan										
Estimated Adult Share	76,983,895	112,788,419	126,035,839	97,780,259	92,656,526	81,690,595	85,024,905	94,621,989	91,627,042	95,950,079
Estimated Children Share	36,227,716	60,732,226	54,227,036	93,767,976	97,595,240	88,921,395	95,273,434	69,202,442	72,953,035	67,605,627
Psychiatric Day Tx								25,528,964	12,337,293	12,992,174
Psychiatric Residential								3,892,894	860,730	890,283
Total OHP	113,211,611	173,520,645	180,262,875	191,548,235	190,251,765	170,611,990	180,298,340	193,246,289	177,778,100	177,438,163
All Adult Mental Health	205,439,481	244,767,998	274,561,698	250,435,108	249,774,083	202,405,270	290,903,596	297,967,593	317,417,549	373,125,105
All Children's Mental Health	88,308,124	80,523,569	83,609,736	119,008,940	120,141,105	105,226,767	120,232,597	105,509,181	93,295,596	91,102,172
Total Mental Health	293,747,605	325,291,567	358,171,434	369,444,048	369,915,188	307,632,037	411,136,193	403,476,773	410,713,145	464,227,277
% Adult Community	66%	72%	70%	66%	66%	57%	66%	64%	61%	65%
% Children Community	94%	93%	92%	96%	96%	97%	99%	100%	100%	100%
% Community Programs	74%	77%	75%	75%	76%	71%	76%	74%	70%	72%

Note: Oregon budget figures are prepared on a biennial basis. Fiscal year estimates are provided to allow for consistency with other Information found In this document.
Oregon Health Plan dollars are not budgeted separately for adults and children. Estimates of the adult share are provided for clarity.
Childrens Psychiatric Day treatment and Psychiatric Residential were moved out of the Community section and placed the Oregon Health Plan where they are budgeted.
Due to Accounting System Issues we are unable to provide detailed breakout of Community Adult services for The period between 2003 and 2007.

Appendix E: Legislatively Approved Budget

Oregon Community Mental Health Programs
By Funding Source within Service Element
Legislatively Approved Budget for 2005-2007 and 2007-2009 (as of June 2007)

	Biennial Period 2005-2007	Biennial Period 2007-2009
Non-Residential Adult Mental Health Services		
General Fund	30,334,637	32,697,548
General Fund - Medicaid Match for Rehab Services	9,604,094	15,502,157
Federal Title XIX Funds for Rehab Services	15,250,123	24,852,520
Other Funds	-	-
Federal CMHS Block Grant	5,566,679	5,392,049
Additional Federal Title XIX Limitation [2]		
subtotal	60,755,533	78,444,274
Community Mental Health Services for persons under the jurisdiction of the Psychiatric Security Review Board		
General Fund	4,722,368	5,162,315
Supported Employment Services		
General Fund	222,602	2,242,043
Other Fund		
Federal CMHS Block Grant	327,000	334,328
subtotal	549,602	2,576,371
Homeless Services		
General Fund	-	1,000,000
Federal PATH Grant (100%)	598,450	598,450
subtotal	598,450	1,598,450
Adult Crisis Services		
General Fund	18,572,788	21,909,548
Adult Residential Care Facilities		
General Fund	19,842,079	25,791,297
General Fund - Medicaid Match for Personal Care Services	27,593,729	41,786,211
Federal Title XIX Funds for Personal Care Services	43,973,583	60,330,790
Additional Federal Title XIX Limitation [2]		
subtotal	91,409,391	127,908,298
Adult Foster Care		
General Fund	1,870,095	1,984,138
General Fund - Medicaid Match for Personal Care Services	7,401,494	8,088,845
Federal Title XIX Funds for Personal Care Services	11,795,078	14,430,892

Additional Federal Title XIX Limitation [2]			
	subtotal	21,066,667	24,503,875
Local Acute Care Facilities			
General Fund		27,466,392	31,950,527
Pre-Admission Screening and Resident Reviews (PASRR)			
General Fund - Medicaid Match for PASRR		631,133	431,744
Federal Title XIX Funds for PASRR		1,005,779	1,266,910
	subtotal	1,636,912	1,698,654
Older and Disabled Adult Mental Health Services			
General Fund		963,717	1,000,066
Enhanced Care Services			
General Fund		1,159,725	988,092
General Fund - Medicaid Match for Rehab Services		3,744,008	4,236,642
Federal Title XIX Funds for Rehab Services		5,966,481	8,614,446
Additional Federal Title XIX Limitation [2]			
	subtotal	10,870,214	13,839,180
Local Administration			
General Fund		2,088,891	4,571,543
Federal Title XIX		2,088,891	1,937,404
	subtotal	4,177,782	6,508,947
Special Projects (includes Extended Care Projects, Regional Coordination, Client Travel, and Evaluation Projects)			
General Fund		5,373,140	15,304,628
General Fund - Medicaid Match for Rehab Services			
Other Funds		3,422,882	3,562,135
Federal Title XIX Funds for Rehab Services			
Federal Funds - Supportive Housing		-	-
Federal - Real Choice Systems Change Grant			
Federal CMHS Block Grant		48,431	48,431
	subtotal	8,844,453	18,915,194
Child and Adolescent Community Treatment Services			
General Fund		8,370,703	10,610,762
General Fund - Medicaid Match for Rehab Services		998,248	1,031,490
Other Funds - Medicaid Match		-	-
Federal Title XIX Funds for Rehab Services		1,583,205	1,807,942
Additional Federal Title XIX Limitation [2]			
Federal CMHS Block Grant		2,252,307	2,252,307
	subtotal	13,204,463	15,702,501

Children's Crisis Services			
General Fund (100%)		2,775,244	3,273,840
Psychiatric Day Treatment for Children and Adolescents			
General Fund		-	
General Fund - Medicaid Match for Rehab Services		7,726,771	336,671
County Funds - Medicaid Match for Rehab Services		231,759	372,750
Federal Title XIX Funds for Rehab Services		13,392,100	1,102,355
Additional Federal Title XIX Limitation [2]			
	subtotal	21,350,630	1,811,776
Certified Psychiatric Residential Care Facilities for Children and Adolescents			
General Fund - Medicaid Match for Psychiatric Inpatient Under 21 Services		28,108,573	10,352,808
Other Funds		292,998	
Federal Title XIX Funds for Psych Inpatient Under 21 Services		48,195,314	16,087,013
Additional Federal Title XIX Limitation [2]			
	subtotal	76,596,885	26,439,821
Oregon Health Plan			
General Fund - Medicaid Match for OHP Services		121,134,351	140,086,521
Other Funds - Medicaid Match for OHP Services		524,757	372,750
Federal Title XIX Section 1115 Waivered Funds		192,949,395	218,260,619
	subtotal OHP Budget	314,608,503	358,719,890
Less Children's Services included above:		97,947,515	28,251,597
	remaining OHP Budget	216,660,988	330,468,293
Total:		582,222,479	713,711,930
checkfigure:		-	-
Statewide Totals			
General Fund		123,762,381	158,486,347
General Fund - Medicaid Match for Rehab Services		22,073,121	21,106,960
General Fund - Medicaid Match for Personal Care Services		34,995,223	49,875,056
General Fund - Medicaid Match for Psychiatric Inpatient Under 21 Services		28,108,573	10,352,808
General Fund - Medicaid Match for OHP Services		85,299,007	129,397,042
General Fund - Medicaid Match for PASRR		631,133	431,744
County Funds - Medicaid Match for Rehab Services		231,759	372,750
Other Funds - Medicaid Match for OHP Services		-	-
Other Funds - Medicaid Match		-	-
Other Funds		3,715,880	3,562,135
Federal Title XIX Funds for Rehab Services		36,191,909	36,377,263
Federal Title XIX Funds for Personal Care Services		55,768,661	74,761,682
Federal Title XIX Funds for Psych Inpatient Under 21 Services		48,195,314	16,087,013
Federal Title XIX Section 1115 Waivered Funds		131,361,981	201,071,251

Federal Titile XIX		2,088,891	1,937,404
Federal Title XIX Funds for PASRR		1,005,779	1,266,910
Federal Funds - Supportive Housing		-	-
Federal - Real Choice Systems Change Grant		-	-
Federal CMHS Block Grant		8,194,417	8,027,115
Federal PATH Grant		598,450	598,450
Additional Federal Title XIX Limitation [2]			
	Total	**582,222,479**	**713,711,930**
General Fund		294,869,438	369,649,957
Other Funds		3,947,639	3,934,885
Federal Funds		283,405,402	340,127,088
	Total Funds	**582,222,479**	**713,711,930**