Introduction

For federal fiscal year beginning in October, 2003, Oregon's Community Mental Health Services Performance Partnership Block Grant Application is organized according to the Voluntary Application Format provided by the Center for Mental Health Services. Oregon is using the five consolidated criteria established to meet the requirements of the Community Mental Health Block Grant, Public Service Act, and are submitting a one year plan. For this submission, updates include a revised Executive Summary; a section dealing with funding agreements; certificates; a brief narrative report on prior year grant activities, including those funded by recent Block Grant supplemental awards; and a revised context section. The report for fiscal year 2003 is not included with this application but will be submitted by December 1, 2003 as permitted in the application instructions.

Appendices are included to present technical information and statistics in greater detail. Annual statistics for population, prevalence and demand estimates, persons served, and funding expended for the last ten years have been included for reference.

The State Plan, including the performance goals and indicators, is provided separately for adults and children. All other sections of the application combine children and adults.

In federal fiscal year 2004, Oregon will continue to supplement the federal Community Mental Health Block Grant funds with Oregon State General Funds to support MHS 20 and MHS 22 community outpatient services. These funds are distributed to all counties in the state for outpatient services for individuals, including children and adults who are in need of mental health services but are unable to pay and are uninsured.

Executive Summary

The 2003-2004 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 fiscal year. The objectives reflect Oregon's continued commitment to provide persons with mental illness the greatest opportunity to pursue independent and meaningful lives. These objectives also guided the selection of additional goals and performance indicators that resulted from the funds awarded in May 2003.

On July 1, 1997, 100% of all individuals eligible for Medicaid became eligible for mental health services under a state Medicaid 1115 demonstration waiver (the Oregon Health Plan). Currently 84% of Medicaid-eligible persons are enrolled with a capitated Managed Care Mental Health Organization (MHO). The Office of Mental Health and Addiction Services (OMHAS) continues its outreach efforts to maximize enrollment and to insure that all enrollees receive timely and medically appropriate services. Referral to non-capitated services and supports is available when needed.

Major issues facing the Oregon Office of Mental Health and Addiction Services include:

- improving the quality of the services provided to adults and children through the increased use of Evidenced-Based Treatment;
- developing a more integrated and comprehensive system of intensive community-based services for children;
- 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; and
- achieving system improvement and higher quality of treatment in an era of economic downturn in Oregon.
- increasing access to and providing appropriate mental health services for older Oregonians.

Additional funding provided during the federal fiscal year 2003 from the Community Mental Health Services Block Grant will allow OMHAS to continue to address these issues. The recent increase in the federal Block Grant of $123,644 will be allocated to

trainings in Evidence-Based Practices and the Oregon Healthy Teens Survey. As it has been projected that Oregon will have a reduction of approximately $155,514 in the 2004 allocation, we have chosen to commit the 2003 increase to "one time" efforts. The economic environment in Oregon has worsened over the past two years. After five special legislative sessions, community-based programs have experienced dramatic cuts in services in both Medicaid and State General Fund supported programs. To further promote the utilization of Evidence-Based Practices at a direct service level, Oregon will be providing free regional trainings to county and provider staff.

The 2001 Oregon Legislative Session reserved $7.5 million in the Emergency Fund to be utilized in the second year of the biennium to enhance the community-based system of care. Up to $1 million of this money had been reserved to fund comprehensive, locally driven planning efforts at the county or regional mental health program level. By the time the fifth special legislative session drew to a close, however, the funds for planning had been reduced to $750,000 and the remaining $6.5 million was no longer available. The 2003 Legislative Session continues to grapple with a substantial deficit in revenues.

CONTEXT: DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

HISTORY

Oregon's mental health system has been in existence for more than 150 years. In 1844, territorial lawmakers appropriated two hundred dollars to defray the expense of caring for persons with mental illnesses. The first hospital for persons with mental illness was opened in 1861 and the State maintained a contract with the private facility until the Oregon State Hospital was completed in 1883. Part of that state hospital facility is still in use today.

The state hospital population peaked in the 1950s at over 5,000. By 1962, Oregon State Hospital in Salem, Eastern Oregon Hospital in Pendleton, and Dammasch State Hospital in Wilsonville, were in use. There was little community care for adults.

In 1961, the Mental Health Division was established. During the 1960s Oregon began contracting with Community Mental Health Programs.

In 1973, the state's Comprehensive Community Mental Health Program Act was passed. The Act integrated the three state hospitals with community programs into a regional system. In an effort to encourage counties to expand basic mental health services and to develop alternatives to hospitalization, the Act also granted one-to-one matching state funds to cover the cost for most services, with up to 100% state funding for defined alternatives to state hospital care.

In 2001, two pieces of legislation initiated other changes to Oregon's mental health service system. HB 2294 mandated a reorganization of the Department of Human Services; the state's umbrella social services agency. The Office of Mental Health Services and the Office of Alcohol and Drug Abuse Programs, were merged to form the Office of Mental Health and Addiction Services within the Health Services group which also includes the Medicaid office and public health services. Services incorporated into the new office include prevention, mental health, alcohol and drug treatment, and gambling addiction prevention and treatment. This change provides the structure for an integrated and supportive approach to prevention, planning and treatment for behavioral health services.

House Bill 3024, now codified as Oregon Revised Statute 430.630, also passed in the 2001 session, initiating a community-based, comprehensive local planning process that engages a broad array of stakeholders. All community mental health programs in Oregon undertook a local needs assessment, identified critical gaps in services and developed plans to redesign their service delivery system. A single statewide plan has been written based on the local plans and which moves Oregon's mental health system toward increased effectiveness and fiscal accountability.

Funding for 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 the majority 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 July 1, 2003, 84% of persons who are Medicaid-eligible received their Medicaid mental health benefit through an at-risk managed care Mental Health Organization (MHO).

Unfortunately, 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. 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.

Oregon is currently experiencing a severe economic crisis with an unprecedented budget shortfall. While the ultimate effect of reductions in funding is yet unknown, it is very likely that fewer Oregonians with mental health disorders will be able to receive care, and that the infrastructure at state and local levels needed to provide effective and appropriate care will be significantly reduced for those who continue to qualify for services. The following State General Fund reductions were implemented over a five month period beginning in February 2003:

- 100% of State General Funds for crisis services ($3,419,854) was eliminated, resulting in a potential loss of service to 9,275 children and adults.
- Adult Residential Services were reduced by 6% ($426,277), requiring a restructuring of these services, resulting in a net loss of 16 beds to the overall system.

- Non-Residential Adult Services were reduced by 49% ($2,128,200), affecting 10,450 adults.
- Supported Employment Services were eliminated ($510,568).
- Children's Psychiatric Day Treatment was reduced by 43% ($2,128,200), affecting 262 children and adolescents.
- A child and adolescent treatment package was eliminated ($5,466,631), resulting in a potential loss of service to 545 families
- Caseload Growth funds targeted to aid in the placement of individuals ready to transition from an institutional setting to community based placements were eliminated for the remainder of the 2001-2003 biennium ($745,056), resulting in 30 fewer placements.
- Elimination of the Oregon Health Plan (Medicaid) mental health benefit for the OHP-Standard population resulting in the loss of services to more than 118,000 adults.
- Contracts with hospitals and private psychiatric units for long-term care were terminated, affecting 17 community hospitals ($1,108,106).

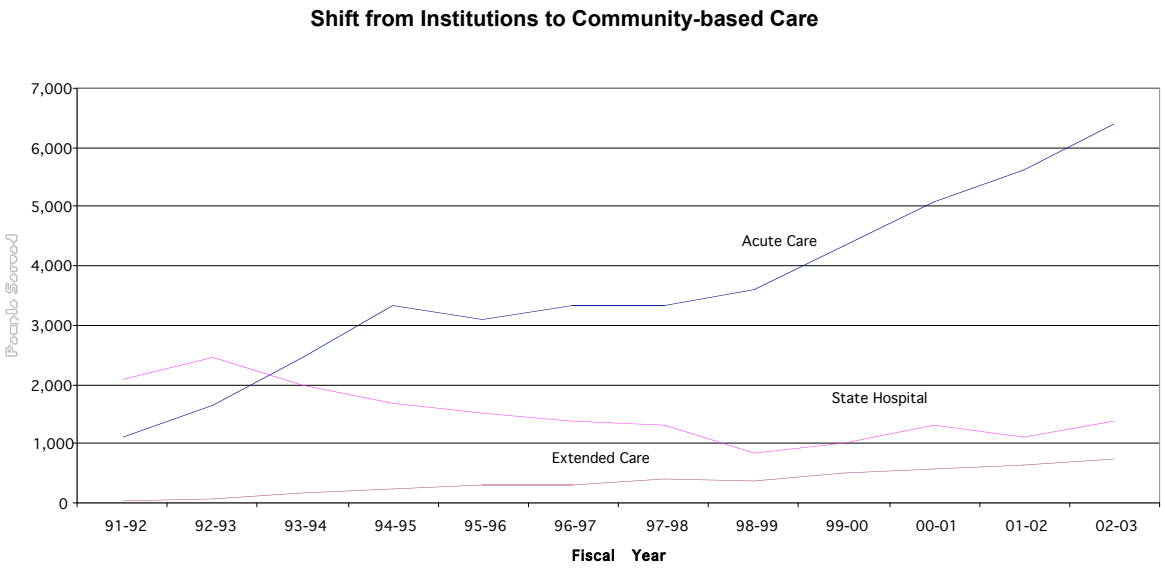
An additional result of these reductions and program elimination has been the lay off of nearly 2000 mental health and substance abuse workers statewide, employed by counties or subcontract providers. This has substantially strained local programs and threatens to significantly damage the local mental health system infrastructure and delivery system.

Continuing Deinstitutionalization

The shift from state hospitals toward a continuum of intensive community placements, short-term acute psychiatric care, and state hospital services when necessary continues with nine new residential programs developed during fiscal year 2003. The Extended Care Management Unit (ECMU) maintains responsibility for individual placement approvals and for conducting utilization reviews of adults in all 81 extended and enhanced care projects. From July 2002 through June 2003, 898 former long-term state hospital patients were served in nearly 600 program placements designed for extended and enhanced care. During this one-year period, 127 state hospital patients were discharged into extended care programs. Of the 326 people who moved out of the extended care programs during the same period, 215 were transferred to equivalent or lower level programs and 43 people moved to independent living or out of the system. Only 18 of the 326 returned for treatment at the state hospital.

During the same period of time, 23 additional patients from the state hospital made the transition to Enhanced Care facilities throughout the state. Of these, a total of 20 were discharged to equal or lower levels of care and only 3 needed to return to the state hospital for more intensive treatment.

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 was 75% in State fiscal year 2001-02, compared to 70% in 1995-96 and 65% in state fiscal year 1994-95. The following graph further demonstrates the shift from institutions to community-based care.



System of care for children. Oregon uses the Federal SED definition 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 Diagnostic and Statistical Manual of Mental Disorders.

Oregon has continued to modify service delivery and add new components to the system over the years. Children's mental health services are currently provided in a range of settings including homes, schools, and other community settings. Prevention and early intervention is an area of increasing focus in policy and program development. The children's mental health system is built on the system of care philosophy, being child and family focused, with the needs of the child and family dictating the types and mix of services provided. Critical to the philosophy is the full inclusion of the child and family, integrated flexible community-based service plans, and funding mechanisms that can match the evolving treatment needs of the child and family.

In October 1998 responsibility and funding for outpatient and acute psychiatric hospitalization for Medicaid-eligible children was fully transferred to the Oregon Health Plan and managed through Mental Health Organizations. OMHAS continues direct contracts with private non-profit agencies for intensive treatment services, such

as psychiatric day treatment and psychiatric residential treatment. For children needing intensive mental health treatment services, a system of residential and community-based programs has been developed and jointly managed between DHS, OMHAS, Children Adults and Families, Community Human Services, and with allied agencies Oregon Youth Authority, and the Oregon Department of Education.

In February 1999, OMHAS released a Request for Information to integrate children's Intensive Treatment Service programs into the Oregon Health Plan (OHP) managed mental health service delivery system. Participation in the Intensive Treatment Services (ITS) Pilot Project provides an opportunity for the ITS providers in collaboration with Mental Health Organizations (MHO) to improve the availability of services for children and their families. Through this ITS Pilot Project, providers are able to deliver levels of care and types of services based on the immediate needs of the child. The traditional system is limited to providing narrowly defined services that are based on a filled slot or bed. OMHAS expects these pilots to be more flexible in the utilization of funds, that a greater number of children and adolescents requiring ITS will be served, that the quality of care will be either maintained or improved, and that alternative treatment delivery methods will be developed.

As of August 1, 2003 the ITS Pilot Project includes 109 children, seven MHOs, 21 counties, seven providers, and three distinct levels of care. A formal evaluation has been completed. Data suggest several positive child and system outcomes. These include a higher percentage of children served through Pilot Projects with improved clinical outcomes; children are transitioned to other levels of service more quickly and more frequently discharged directly to parents' homes, when compared to traditional residential services.

OMHAS continues to develop systemic alternatives to state hospitalization for children. As part of this change and development, the Secure Children's Inpatient Program (SCIP) opened in January 2002. SCIP replaced the children's unit within the Child and Adolescent Treatment Services located on the Oregon State Hospital grounds. The new program provides services to children under age 13 who previously would have received services at the Oregon State Hospital. The services are now 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. Average length of stay has been reduced from 258 days at the Oregon State Hospital to 126 days at SCIP.

THE CURRENT MENTAL HEALTH SYSTEM

A. VISION FOR THE FUTURE

From February 2000 to January 2001, then Governor John Kitzhaber's Mental Health Alignment Workgroup developed a new vision for the mental health system. This vision positioned Oregon to develop a long-range plan for a more coordinated, comprehensive, locally controlled system of mental health treatment for children and adolescents and their families and for adults with mental health disorders. The planning process emphasized community-based medical and social supports for individuals with mental health needs regardless of place of residence, age or income.

Complementing and building on the first priority recommendation of the Governor's Mental Health Alignment Workgroup, House Bill 3024 from the 2001 Legislative Session initiated a comprehensive planning process for statewide mental health services derived from an extensive, locally driven planning process. As directed by this legislation, consumers, family members and allied agency providers were convened at the local level to develop a mental health plan that addresses the needs of their community or geographic locale. Such stakeholders as representative of law enforcement, community corrections, education, vocational rehabilitation, juvenile justice, local public safety coordinating councils, local mental health and alcohol and drug planning committees were engaged in this process. A statewide mental health plan derived from these local community-based plans has been delivered to the Governor and the 2003 Legislature.

As this plan was being developed, the State's revenue picture worsened and funding has become a critical issue for the State's human service programs. General fund revenue, the basic source of human services funding, has fallen dramatically and future revenue forecasts are not optimistic. For the past two years, Oregon has had the highest unemployment rate in the nation.

OMHAS will continue, as available funds allow, to provide essential mental health services to individuals who are not Medicaid-eligible, unable to pay for needed services and underinsured or uninsured.

GUIDING PRINCIPLES

As an active participant in the Governor's Mental Health Alignment Workgroup, OMHAS contributed to the development of a new set of guiding principles for the delivery of mental health services throughout this state. The Workgroup, a statewide effort led and coordinated through the Governor's office, recommended 18 areas of

change which, when enacted will align existing programs, policies and resources into a statewide mental health system for children and adults. Critical to the delivery of best practice mental health services are the following guiding principles developed by this Workgroup:

- Individuals with mental health disorders should be served by caring and empathetic individuals- with services and supports designed to stabilize their disorder and to maximize independence, dignity, self-worth and recovery.
- Individuals with mental health disorders, their families, and other support persons should be full participants in policy setting, planning, delivery and evaluation of services.
- Mental health needs should be identified at the earliest point possible and at the youngest age possible in order to increase the likelihood of positive outcomes.
- The entire mental health system should reflect a caring, comprehensive approach that provides services in an appropriate, least restrictive setting.
- Successful client outcomes should drive the services in an appropriate, least restrictive setting.
- The mental health system should safeguard human dignity, minimize coercion and maximize self-determination of individuals with mental health disorders.

Oregon's primary focus in evolving the current system of care is to prevent or reduce the impact of mental illness for all persons affected. Programs work to empower persons with severe mental illness and their families so that they may achieve the most meaningful lives in the least restrictive settings possible. OMHAS continues to expand community-based programs that promote self-determination and assure collaboration and continuity across multiple systems and settings. Consumers and family members are invaluable sources of insight and direction. Their involvement is essential at every stage of decision-making from individual treatment planning to system development and quality improvement.

B. Areas Needing Attention and Significant Achievements

Areas Needing Attention:

- Oregon tax revenues have plummeted over the last 18 to 24 months, creating a severe budget shortfall that in turn has resulted in unprecedented reductions in mental health services to children and adults statewide. These reductions resulted in the lay off of nearly 2000 mental health and substance abuse staff in county programs and nonprofit providers. Programs have changed treatment models in an effort to maintain services for the most vulnerable adults. While the Legislature is still in session and hasn't passed a human services budget, there are hopes for some restorations to the mental health budget.

- 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. OMHAS 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. Additionally, OMHAS's research and data analysis unit will break out the 65+ population on performance indicators to sharpen the focus on this population.

- OMHAS 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 Department has established a Consumer Task Force to advise the Real Choice System Planning Grant. OMHAS reconvened a consumer group in July 2003, to meet with the new Administrator to discuss concerns and improved consumer roles with the state. This will create increased opportunity for consumer input and advice in planning, system design, implementation and monitoring of mental health service delivery.

- Better coordination and collaboration for the delivery of dual diagnosis services has resulted through the passage of HB 3024 and HB 2294 in the 2001 Legislative Session. HB 3024 required a community-based plan that takes into consideration the needs of people with co-occurring mental health and substance abuse disorders. The reorganization of the Department of Human Services (HB 2294) merged the Offices of Mental Health Services and Alcohol and Drug Abuse Services to form the Office of Mental Health and Addiction Services. This has strengthened state attention to the issues of services to individuals with co-occurring disorders. Attention is specifically brought to issues of access to services, integration and coordination of care and cost effective service delivery.

- Local acute care resources continue to be a critical gap in service delivery, mainly because Oregon has continued to have a daily monitored "wait list" of individuals approved for long-term care awaiting a bed in state institutions. State hospital capacity issues for adult treatment services and forensics continue to be an issue.

- A new service entitled Post Acute Intermediate Treatment Services (PAITS) has been created to divert persons from the waiting list into short term, community-

based service offerings thus relieving some, but not all of the pressure for admission to state institutions.

- Currently, criminal justice representation on the PAMAC is provided by the Oregon Youth Authority, however, this representation is presently limited to youth. The OMHAS has requested a representative from the Oregon Department of Corrections (DOC) for the Council. OMHAS works closely with DOC efforts to improve access to mental health and addiction services for the community corrections population.

- While Oregon has strengthened its working relationship and collaboration with the Oregon Department of Education, there is 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 serves on 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. Some Oregon community mental health programs either provide mental health services within local schools or have created mutually supportive relationships to serve children and families experiencing serious emotional disturbances.

- The Children's Mental Health system will continue to develop a more integrated community-based system of care for children and their families. OMHAS supported by a budget note, will work with system stakeholders in 2003-05 to increase the availability and quality of individualized, intensive home and community-based services to serve children in the most natural environment possible and to minimize the use of institutional care.

- Homelessness among mental health service recipients is a significant issue. A total of 2,522 adults and 929 children and adolescents were estimated to be "currently homeless". About two-thirds of the adults served are estimated to have experienced homelessness in the past five years and about two-thirds are estimated to be at immediate risk of becoming homeless. While homelessness has traditionally been regarded as an urban problem and continues to be most prevalent in urban areas, it is clear from the survey results that persons with mental illness in rural areas also experience homelessness. The poverty of persons with mental health disorders and scarcity of affordable housing contribute to the extent of homelessness.

Significant Achievements of the last fiscal year include the following:

- OMHAS continues to promote the coordination of care between physical and mental health providers and organizations. Three examples are:
    1. Establishing the OHP Integration Workgroup, a collaboration of OHP contractors which seeks to define the responsibilities and improve the coordination of care between historically separate systems of care: medical, mental health, and chemical dependency. The group produced a document that outlines a process to further improve the coordination of care between mental health and physical health care systems for inpatient hospital admissions. In 2002, the group produced written recommendations for the sharing of information, practitioner to practitioner, and between organizations.

    2. OMHAS, in collaboration with the Office of Medical Assistance Programs (OMAP), developed three Targeted Case Management projects. The projects were collaborations between Fully Capitated Health Plans and Mental Health Organizations. Each of the three projects took a slightly different approach to increase the oversight, improve care and lower costs for individuals who were enrolled in both types of managed care plan and being prescribed anti-depressant or anti-psychotic medications. OMHAS and OMAP are developing a state-wide mental health pharmacy management plan using information learned from these one year projects.

    3. OMHAS in collaboration with OMAP and Seniors and People with Disabilities (SPD) developed two locally managed "Depression Projects". The goal of the projects was to improve the care of people with depression using methods developed through local collaborative strategies. Each project involved the Community Mental Health Program, Fully Capitated Health Plan and Department of Human Services regional office. One project focused on outreach to underserved populations and the other
    project developed more clearly defined pathways to care.

- In spite of budget shortfalls, the state is promoting Evidenced-Based supported employment practices. A significant portion of the most recent increase in our Block Grant has been allocated to programs to create or enhance these services using Evidence-Based Practices.

- Between 1990 and 2002, the number of adults served in acute care units and intensive community and residential programs has increased at an annual rate in excess of 35%. This has assured stabilization of consumers nearer to their homes with less disruption in their lives.

- During the 2001-2003 biennium, eight awards totaling $240,000 have been made to assist in the development of housing for people with severe and persistent

mental illness in seven counties that accommodated 199 residents. Renovation funds are expected to address pressing health and safety improvements at 12

housing sites, preserving housing accommodations for an estimated additional 150 residents.

- Over a ten-year period ending June of 2002, $3.2 million (predominantly State General Funds) has been awarded to housing projects in twenty-five counties to create and preserve housing for over 1,500 people with severe and persistent mental illness.

- OMHAS provided housing support services through the Rural Oregon Leasing Plus Support Grant persons with mental illness that reside in rural areas.

- OMHAS implemented several new projects such as the Pre-adjudicated Youth Project to support Evidence-Based Practices targeting known delinquency risk factors consistent with the Governor's Juvenile Crime Prevention Plan and Jail Transition projects to support successful transition for adult offenders with mental illness leaving institutions/jails. In addition, the following projects were implemented: a Consumer Technical Assistance project, Evidence-Based Practices in employment supports, and two projects for transition-age youth whose mental health disorders require supports as they become young adults.

- Improvements are seen in the increasing number of children receiving a more diverse range of services. For example, in fiscal year 2002 –03, 7,934 children received clinical services coordination or case management, as compared to 1,080 in 2001-02. OMHAS continues to develop systemic alternatives to state hospitalization for children. As part of this change and development, the Secure Children's Inpatient Program (SCIP) opened in January 2002. This program serves children age 13 and younger. SCIP replaced the children's unit within the Child and Adolescent Treatment Services Unit located on the Oregon State Hospital grounds. The services are now provided on a campus and within a program specifically designed for children. Average length of stay has been reduced from 258 days at the Oregon State Hospital to 126 days at SCIP.

- Considerable efforts have been made by community mental health programs to address housing issues. CMHPs reported that 83 housing projects for persons with mental illness have been developed over the past five years and 25 are currently under development. Most CMHPs report that they work successfully with private landlords, public housing authorities and other nonprofit housing providers.

- 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.

- Increased coordination of access to mental health and alcohol/drug treatment through the Department of Corrections Transition Project for people being released from prison.

- An adult Evidence Based Practices stakeholders planning group has been formed to develop a strategic, multi-level approach to implementing EBPs in all community based mental health and addiction services. All CMHPs have been introduced to EBP toolkits and fidelity scales, and have a basic understanding of implementation procedures.

- OMHAS received a three-year $2,000,996 Real Choice Systems Change Grant from the federal Center for Medicare and Medicaid Services (CMS) to improve Oregon's services for persons with disabilities. The grant supports several initiatives, with a primary focus on strengthening services for persons with psychiatric disabilities. Initiatives include:
  - A program of advocacy and rights training for regionally-based consumer advocates;
  - Pilot projects in Person Centered Planning in four Oregon County Mental Health Programs;
  - Housing Mini-grants, coordinated by County Mental Health Programs, that provide direct assistance to individuals with disabilities in obtaining more independent housing;
  - A Pilot Mental Health Brokerage operated by a consumer-directed organization in Multnomah County;
  - Small grants to strengthen at least twenty-five consumer Drop-in Centers;
  - Funding for state and regional conferences in the areas of Housing Services, Best Practices in Services for Persons with Psychiatric Disabilities, and Coordinated Services for Children and Families;
  - A matching grant program aimed at promoting improved transportation services for persons with disabilities living in rural areas of Oregon; and
  - A Consumer Task Force meets quarterly as the advisory group for Oregon's Systems Change Project.

- OMHAS continues to be part of 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 in cooperation with the Dartmouth/New Hampshire Psychiatric Research Center. OMHAS is observing

success in implementing the toolkits in all the community mental health settings, and is understanding the process of implementing change.

- OMHAS established two facilities to provide post acute treatment services to adults who have been approved for long-term psychiatric treatment, as an alternative to state hospital admission. Services are Medicaid-reimbursed and provided in an intensively staffed 24 hour non-hospital facility approved as a secure residential treatment facility.

- OMHAS expanded Intensive Treatment Services (ITS) Pilot Projects to serve 109 children, in three levels of care, at seven MHOs, at seven ITS providers, and in 21 counties. Service delivery to these children allows funding to follow the child to the most appropriate treatment setting. Child-based outcomes demonstrate the improved effectiveness of this more flexible community-based service approach.

- OMHAS developed an estimated 40 placements to serve approximately 134 children in less restrictive community-based settings.

- OMHAS conducted 81 community-based mental health training events, attended by 6,307 providers, consumers, and family members. Topic areas focused on Evidence-Based practices, community treatment and assessment systems, quality assurance, consumer self-determination, cultural competency, children's mental health, early detection and intervention in psychotic disorders, co-occurring disorders, and housing and homelessness.

- OMHAS staff worked internally as well as collaboratively with the PAMAC to develop a proposed model to measure outcomes for mental health treatment. OMHAS, Community Mental Health Program directors, and Mental Health Organization staff produce quarterly Mental Health Treatment Outcome Improvement Reports that reflect multiple treatment outcome measures.

- OMHAS implemented a Senior Gatekeeping Program to ensure that older adults are able to live as independently and safely as possible in the community. The program identifies those older adults most in need of services, especially those who are isolated, living alone, unable or unwilling to self-refer, and require some assistance to maintain their independence.

The program trains employees of businesses which, though their normal business activities, come into contact with at-risk older adults. Employees in the Gatekeeper program are taught to recognize signs and symptoms which may indicate an older adult is in need of assistance and start the process to refer that person to Mental Health, Senior Services, a physician, or a combination of the above, depending on the person's needs.

C. New Developments Affecting Mental Health Service Delivery

Oregon's economic environment worsened resulting in major shortfalls in tax revenue. The state is required to have a balanced budget and the Legislature, meeting in Special Sessions, accomplished that through reductions following the failure of a revenue-generating referendum. This required large cuts in funding in mental health treatment, health care, and social supports. The state protected children, to some extent, and the greatest impact has been on poor adults. (Refer to page four of this document under Funding for Mental Health Services for a listing of fund and program reductions in mental health.)

The Office of Mental Health Services merged with the Office of Alcohol and Drug Abuse Programs to form the Office of Mental Health and Addiction Services within the Health Cluster of the Department of Human Services. The objective of this change is to promote the integration of all state-funded human services. For mental health services, this means a streamlined structure intended to further the initiatives already underway with the inclusion of Medicaid-funded mental health services under the Oregon Health Plan.

OMHAS plays a key role in the development of mental health and substance abuse services for the Oregon Children's Plan (OCP). This 2001 legislative initiative mandated the development and implementation of a statewide, comprehensive, coordinated early childhood system of services and supports for children aged 0-8 and their families. Although the State's budget shortfall led to the eventual elimination of funding for mental health and addiction services through OCP, coordination of early childhood services and community-based training was achieved. A total of 1,084 young children and their families received services funded through OCP.

OMHAS has also developed a statewide trauma policy to guide the improvement of services specific to persons who have trauma backgrounds as well as the sensitization of the entire public mental health system to the effects of trauma and re-traumatization.

Finally, OMHAS has initiated two other system projects at the end of the 2001-03 biennium. The first is the State Hospital System Review Group, which studied the interface between treatment in the state hospital and services in the community for

discharged patients. The group provided a series of consensus recommendations which are now being formulated into a series of goals for improving the state hospital and community systems. An expert committee was appointed in August to do a more in-depth review of medical/psychiatric services and supervision. Secondly, OMHAS working in conjunction with the Medicaid office, has designed an approach to psychiatric pharmaceutical cost containment that relies on quality review and

consultation for prescribers in the community rather than prior authorization or restricted formularies. The Medical Director of OMHAS has taken a lead role in designing this approach consistent with Evidence-Based Practices in medication management.

D. LEGISLATIVE INITIATIVES

The Office of Mental Health and Addiction Services continues to work with the Governor's Office and Legislative Leadership to achieve restoration of funds eliminated by the state's revenue crisis mentioned previously in this document. The Oregon Legislature, while grappling with how to maintain or restore human service programs eliminated or reduced by the state's revenue shortfall has set records for the number of special sessions following the 2001 Legislative Session and the length of its current 2003 Legislative Session.

Several issues related to mental health are currently under consideration by the 2003 Oregon Legislative Assembly. They include behavioral health parity (Senate Bill 1), support and planning related to the implementation of evidence-based practices (Senate Bill 267), increased funding for behavioral health services through an increase in taxes on malt beverages (House Bill 2804), and the consolidation, reconfiguring, and moving to the level of a Governor's Council of the State Mental Health Planning and Management Advisory Council (Senate Bill 146A).

Senate Bill 1 prohibits health insurers from imposing treatment limitations on coverage for mental health and chemical dependency conditions unless similar limitations are imposed on coverage of other medical conditions. Senate Bill 267 requires the Oregon Office of Mental Health and Addiction Services to conduct an assessment of programs it funds to determine the percentage of federal and state resources that are allocated to evidence-based, cost effective programming. Once such an assessment is completed, the Department is required to submit biennial reports to the Legislature and ensure that by 2009, at least 75% of state resources allocated for intervention and treatment are used to purchase services from programs determined to be evidence-based.

Oregon is currently facing dramatic revenue shortfalls. State funded mental health services have been reduced to non-Medicaid individuals in need of mental health or addiction services. House Bill 2804 raises state general fund revenue through an increase in taxation on malt beverages. The revenue generated would be allocated to prevention, mental health and addiction services, providing increased stability to behavioral health services.

Finally, Senate Bill 146A creates a Governor appointed Mental Health Council and allows the Department to terminate two existing mental health advisory groups. Elevating the appointment of Council members to a gubernatorial level will increase the visibility and public awareness of the importance of services to children and adults with mental illness.

E. DESCRIPTION OF SERVICES

Population Served

Traditionally adults have been prioritized for publicly-funded mental health services based on risk of hospitalization and/or posing a danger to the health and safety of themselves or others. Oregon, like other states, had been required under Federal law to provide Medicaid-covered services to eligible children assessed with a condition by an Early and Periodic Screening, Diagnosis and Treatment. Prioritization for non-Medicaid resources to serve children is based on risk of hospitalization, risk of being removed from their home due to a mental disorder and risk of harming self or others.

Oregon's Medicaid-managed care demonstration, the Oregon Health Plan, authorized through a Federal waiver of part 1115 of Title XIX of the Social Security Act, has changed how this client population is determined. Whereas eligibility for Medicaid has traditionally been restricted to people who met eligibility for welfare or disability programs and then only for a subset with average family incomes around 58% of Federal Poverty Level, the Oregon Health Plan established expanded criteria for Medicaid eligibility, beyond the requirement for categorical eligibility.

For the Medicaid population, eligibility for mental health services is not determined by risk factors. The Oregon Health Plan Medicaid benefit package integrates health services for dental, chemical dependency, mental and physical conditions. Assessments needed to diagnose a condition are always covered. Coverage for treatment is based on a prioritized list of integrated condition/treatment pairs. The state Legislative Assembly makes recommendations regarding how many lines on the prioritized list will be

funded. The federal Center for Medicare and Medicaid Services has final approval authority of changes to the funding line on the Prioritized List. An individual with a condition above the funded line can receive Medically Appropriate mental health treatment, including educational and preventative programs, before the condition deteriorates to a critical stage.

Not all individuals requiring public mental health services will meet Medicaid eligibility criteria. Services continue to be made available to persons not eligible for the Oregon Health Plan according to statutorily defined risk criteria noted earlier. In addition, various federal grants, local funds, and private insurance payments provide additional sources of revenue for Community Mental Health Programs to serve people who have mental illness but are not eligible for Medicaid or other third party payments.

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.

Intensive services for adults. In addition to the services outlined above, a comprehensive system of intensive community-based, residential, and inpatient programs is maintained. As of June 2003, 442 extended care placements located in secure residential, foster care, and supported-living programs were available for adults. An additional 138 placements were maintained in nursing homes or other facilities funded jointly with the State Office of Services to Persons with Disabilities for clients requiring nursing and psychiatric care. In these 580 placements, 898 individuals were served during the 2003 fiscal year. In addition to extended care placements, OMHAS funded over 1000 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, virtually all in community general hospitals, provides over 200 beds for short-term inpatient psychiatric services. For adults in need of long-term secure treatment, 193 state hospital beds are also available in two state psychiatric hospitals.

Supported Employment and Supported Education. The OMHAS has for many years recognized the value of employment to individuals experiencing severe mental illness. With the additional Block Grant funds awarded over the past years, new demonstration projects have been developed and operating. Currently 300 individuals receive supported employment services from two sites funded by the Block Grant, all of which

are using the Evidence-Based Practice model of supported employment. Additionally, with a recent Dartmouth-New Hampshire/Johnson and Johnson supported employment grant, the OMHAS procured three new Evidence-Based Practice sites, each to serve 110 consumers next year. At all five sites, an average of 50% of consumers enrolled obtain competitive employment in community-based jobs.

With Block Grant funds and private funding from Johnson and Johnson, Oregon will serve 410 consumers in supported employment, and more than 200 of those consumers are expected to gain and retain competitive employment. Additionally, 27 consumers will be placed in supported education in one of the project sites.

Transitional services for older adolescents. There are two Block Grant funded projects with particular emphasis on ensuring a seamless transition to adult services for youth ages 16-25 with severe emotional disorders. All youth served in the projects receive a comprehensive array of integrated and coordinated services to address emotional, social, educational, recreational, vocational, housing and physical health needs of each participant. The services are: 1) tailored to each individual's unique set of strengths and needs, 2) appropriately matched to the individual's cultural and gender needs, 3) skill and goal oriented, and 4) delivered in the least restrictive and clinically normalized setting. Services also encourage the involvement of family members to support the youth into adulthood.

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. Qualified mental health professionals and psychiatrists provide intensive treatment services. Intensive treatment services, except for psychiatric day treatment, are provided in residential or hospital settings. Children's intensive treatment services include a range of service components: Adolescent Treatment Services at the Oregon State Hospital, Secure Children's Inpatient Program, Psychiatric Residential Treatment Services,

Psychiatric Day Treatment Services, Psychiatric Assessment and Evaluation Services, and Therapeutic Foster Care.

Access to non-emergency inpatient services for those under the age of 21 at the Oregon State Hospital and nationally accredited psychiatric residential treatment service programs requires certification of the need for services by an independent psychiatrist. Admissions are thus 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.

Children living in Oregon can access an array of services available throughout the state. Psychiatric Day Treatment Programs, located in 16 different counties, have a daily service capacity for 223 children who cannot attend regular school programs due to an emotional disorder. Because of budget cuts in 2003 these programs had to reduce the number of children they served from 387 to 223. Therapeutic Foster Care services are provided to 52 children as a community-based alternative to psychiatric residential and hospital levels of care. Psychiatric Residential Treatment Programs have a daily service capacity for 168 children in a more restrictive and intensive level of residential treatment. The Intensive Treatment Service Pilot Project (ITS), which integrates two children's, services - psychiatric day treatment and psychiatric residential treatment - into the Oregon Health Plan serves 109 children daily. The ITS Pilot Project gives providers the financial flexibility to provide children with the services that best meet their needs, without the restrictions imposed by the traditional "slot" funding system. Assessment and Evaluation services provided in nationally accredited treatment facilities are designed to provide intensive evaluation services and brief treatment for 45 children on an emergency basis. The Adolescent Treatment Program at the Oregon State Hospital provides long term psychiatric inpatient services for as many as 40 adolescents ages 14 to 17. The Secure Children's Inpatient Program provides a similar level of care for up to 12 children 13 years of age and younger. In total 649 children per day are receiving intensive mental health treatment services throughout the state.

The Psychiatric Security Review Board (PSRB). The PSRB maintains jurisdiction for individuals adjudicated "Guilty Except for Insanity". There are approximately 620 individuals under the jurisdiction of the PSRB in the State of Oregon. Approximately _ of the entire PSRB population resides at the state hospital in Salem (OSH). The rest of the PSRB population reside in the community observing the conditions outlined in their individual release plans and through 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. OMHAS, 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.

Access to Services

The comprehensive nature of the benefit package available to Oregon Health Plan (OHP) enrollees continues to improve access to mental health treatment for a significant proportion of Oregonians afflicted with mental illness. Unfortunately Oregon is facing unprecedented revenue shortfalls for the 2003-05 biennium which may necessitate dramatic reductions in expenditures for the OHP. Oregon continues to utilize the flexibility provided through an 1115 waiver amendment approved on October 15, 2002.

As of March 1, 2003 there are two benefit packages under OHP:

1. OHP Plus benefit package. This benefit package covers Medicaid categorically eligible clients – old age, blind and disabled, pregnant women, poor children, and children in foster care and includes mandatory Medicaid services, outpatient mental health and chemical dependency treatment services. Clients not enrolled in managed care, or receiving services not under managed care will have some co-payment requirements.

2. Standard benefit package. This benefit package covers adults and couples without children who qualify primarily based on income. This benefit package requires premium payments. For clients who are not enrolled in managed care or for services under managed care, clients will have some co-payments. As of March 1, 2003, the benefit package does not include outpatient mental health and chemical dependency treatment services, but does have limited inpatient hospital and physician services.

The 2003 Oregon Legislature is reviewing OHP benefit packages and the categories of persons to receive those services. Final decisions will depend on raising sufficient revenue to cover some or all of the groups who have been covered

Oregon's Federal Title XXI State Children's Health Insurance Program (SCHIP) assures health coverage for low-income, age appropriate children who are not otherwise eligible for Medicaid services in Oregon. Children eligible for the SCHIP program will receive the OHP Plus benefit package. The SCHIP program is not an entitlement program and has limited funding with enrollment subject to available funds.

Access for persons residing in remote regions. As **Table 1 in Appendix B** illustrates, access to mental health services in rural areas of the state 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 they may travel many miles to these services.

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 mental health demonstration. 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.

Treatment Foster Care. In an effort to better serve rural children, Treatment Foster Care was developed in 1992-93. It is jointly funded 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 provided by trained foster parents, employed and supervised by the local Community Mental Health Program, is a particularly viable treatment option for children in rural counties.

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

Access for persons who are homeless. Homelessness among persons with serious mental illness is a significant problem in Oregon. Enrollment of homeless persons with mental illness into community mental health services has been encouraged. One of the goals in Oregon's Block Grant plan is to "increase the number of homeless adults with severe mental illness receiving publicly funded mental health services". An analysis of enrollment data over the past five years indicates that the enrollment of persons who are homeless has increased by about 50% while enrollments overall increased by about 27%. The following table illustrates this.

Fiscal Year	CPMS Enrollment Data-Adult MH Clients		
	Homeless Served	% of Homeless Total Served	Total Served
1997-98	2,022	4.2%	48,035
1998-99	2,052	4.0%	51,333
1999-00	2,308	4.2%	55,602
2000-01	2,510	4.3%	58,511
2001-02	3,026	5.0%	61,173
Increase 97-98 to 01-02	49.7%		27.4%

Some of the specific strategies employed by OMHAS include the following: (1) Community mental health program (CMHP) staff are encouraged to participate in their local HUD Continuum of Care planning process. (2) CMHPs must address housing needs in their local mental health planning process. (3) OMHAS provides data and technical assistance. (4) OMHAS facilitates partnerships between mental health service providers, homeless service providers and housing providers at the state and local level by arranging meetings and training.

Some recent outcomes achieved in addressing homelessness include the following: (1) OMHAS staff worked collaboratively with the City of Portland/Multnomah County in their successful attempt to apply for $625,000 in Robert Wood Johnson Foundation funds from the Corporation for Supportive Housing's Taking Health Care Home Initiative. (2) OMHAS worked collaboratively with Oregon Housing and Community Services to obtain two $500,000 HUD Homeless Assistance grants to provide leasing subsidies and wrap-around support services to homeless people with mental illness in nine rural counties. (3) OMHAS provided grants to support development of housing projects in six counties that will accommodate 105 persons with mental illness, many of whom were formerly homeless. (4) OMHAS is using its increase in federal PATH dollars to expand outreach services for homeless persons with mental illness in Lane County and provide statewide training on best practices to address homelessness.

Access for minorities. Leadership at the OMHAS recently initiated an ad hoc group to review and recommend improvements and access to, and quality care for, persons from Oregon's increasingly diverse racial and ethnic population. OMHAS has worked to promote access to culturally appropriate and responsive services through statewide trainings. The two-day event demonstrated the State's commitment to culturally competent and responsive services. Local, regional, and national experts shared practical ways to improve services, increase access, decrease barriers, and modify assessments and treatment models to fit clients, rather than clients fitting into a "one-size fits all" system.

Administrative rules require that cultural factors be included as one of the domains of comprehensive clinical assessments for all persons enrolled in state-funded mental health treatment services. Further, Mental Health Organizations and other Medicaid providers are required to provide appropriate translation services for adults, children, and families who require them. 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.**

F. Coordination of Mental Health Services Across the Broader System

Mental health services are most effective when delivered in concert with other social supports, including housing and income assistance, health care, and vocational and educational programs. The OMHAS is committed to developing the linkages necessary to give persons with mental illness the opportunity for independent and meaningful lives.

House Bill 3024 from the 2001 Legislative Session changed Oregon Revised Statute 430.630 by mandating a locally driven, comprehensive community-based planning process. This process requires participation by a broad range of providers, allied agencies, consumers, family members and community members. The initial planning process has been completed and forms the basis for a State Mental Health Plan that has been submitted to the Oregon Legislature. Local Mental Health Authorities are to report on the progress achieved with respect to their plans, every two years, which subsequently provides a basis for biennial report to the Legislature.

Plans include a broad continuum of services ranging from prevention to long term care and hospitalization. Ancillary services such as transportation and housing or residential placements are included as well.
Given the dramatically reduced state revenues, the planning process has had a bifurcated focus. Initially LMHAs were asked to provide a needs assessment, estimate gaps in service and propose system change that would address service gaps. As the economic picture grew worse, plans were directed to project the impact of such cuts in funding and how they might reconfigure remaining services to mitigate the impact of these reductions.

Mental Health Administration

Public mental health services are administered within Oregon's Department of Human Services (DHS) by the OMHAS. Two state-operated psychiatric institutions, Oregon State Hospital and Eastern Oregon Psychiatric Center report directly to the Administrator of the Office of Mental Health and Addiction Services. Capitated services for persons who are Medicaid-eligible are administered through contracts between DHS and Managed Care Organizations. All other non-capitated services are administered through contracts to the counties and direct contracts with service providers for children's intensive mental health treatment services, 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 each county to assure the provision of community mental health

services. State funds are allocated to counties using a "block grant" approach. This method of allocation provides the greatest flexibility for counties in managing resources to best meet the needs of consumers.

The Oregon Health Plan. Oregon Health Plan Mental Health Organization contractors are required to establish linkages with non-OHP funded support services, contracted through Community Mental Health Programs. Thus, enrollment in an Oregon Health Plan managed care organization provides coordination between Medically Appropriate treatment services available to persons eligible for Medicaid and many of the social supports necessary for successful community living for adults with severe and persistent mental illness and children/adolescents with severe emotional disorders.

Housing issues. The lack of affordable housing and community residential settings for people with severe and persistent mental illness is a serious problem in Oregon and results in too many individuals becoming homeless or incarcerated. A Fall 2000 housing survey assessed the housing needs of children and adults receiving publicly funded mental health services. Results from this survey included the following findings: (1) Of about 35,000 adults served at the time of the survey, 1,365 were in various "group home" settings; 2,515 were in supportive housing; and 4,275 were estimated to be living in affordable housing. (2) Based on waiting lists and other indicators, an estimated 12,146 adults were in immediate need of affordable housing, 1,852 were in need of supportive housing, and 715 were in need of structured "group home" settings. (3) Current residential resources operate at full capacity with vacancy rates estimated at 1.7% in group home settings and 0.6% in supportive housing. (4) It was estimated that 2,522 adults and 929 children are homeless at any point in time and two-thirds of adults served are at risk of homelessness. (5) Community mental health programs reported that 83 housing projects for persons with mental illness were developed over the past five years and 25 additional projects were under development.

OMHAS housing staff assess housing needs, plan for resource development and provide technical assistance to increase affordable housing resources for persons with serious mental illness. Since 1989, OMHAS has awarded over $3.2 million to develop and preserve integrated community housing in local communities; these efforts will be expanded as a new Community Mental Health Housing Fund is established from proceeds of the sale of a former state hospital property. As a result of Oregon's Olmstead planning process, efforts to develop community housing for people ready for discharge from state psychiatric hospitals has resulted in the establishment of 104 new community placements. With funds from a Center for Medicaid and Medicare Services *Real Choice System Change Grant*, OMHAS has been able to increase its housing and homeless services staff and establish a "Real Choice Housing Fund" to assist an estimated 500 individuals to eliminating financial barriers to acquiring more integrated community housing.

Children in child welfare services. Children in the care, custody and supervision of the Department of Human Services comprise more than half of all children receiving mental health treatment services. OMHAS works closely 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) in a residential setting for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services in these programs are delivered through the Oregon Health Plan.

Children in the juvenile justice system. In 2000, the 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. The Integrated Treatment Court model was developed and pilot projects established in seven Oregon counties: Clackamas, Coos, Crook, Douglas, Jackson, Josephine, and Marion. To date, approximately 200 youth and families have participated in the project. 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.

State Hospital and Community Mental Health Program Linkage. OMHAS requires and maintains linkage agreements to assure the effective transition and case management of individuals treated in and discharged from state institutions. Similar agreements are in effect between regional acute care units and Community Mental Health Programs. These agreements require active involvement in screening, admission, treatment, discharge planning and aftercare on the part of Community Mental Health Programs. House Bill 3024 from the 2001 Legislative Session strengthened and more clearly delineated the relationship and respective roles of the community mental health programs and state institutions. In addition, as part of Oregon's Olmstead plan, a process was articulated (*appendices*) which assigns roles and responsibilities of all providers who participate in the transition of individuals with severe and persistent mental illness or serious emotional disorder from institution-based care to lower levels of care and successful community placement.

Persons in correctional facilities. OMHAS is represented on the Department of Corrections Transition Project Steering Committee. OMHAS staff members have played a leadership role and participated in a variety of Transition Project workgroups and continue to be actively involved on the Transition Project Steering Committee. The purpose of the Transition Project Steering Committee is to oversee the implementation of a number of key recommendations that were developed during the project's Design Phase related to promoting safe and successful inmate transition from incarceration to the community. OMHAS role on the Steering Committee is to provide policy direction and programmatic consultation with regard to behavioral health services for inmates transitioning from institutions back to their communities. Inmates with mental health and substance use disorders require specialized services in the institutions including transition services uniquely designed to address behavioral health, physical health, housing, and other needs. The Department of Corrections, in collaboration with OMHAS, has developed gender specific treatment services for inmates with co-occurring mental health and substance use disorders. These programs range in intensity from day treatment to residential therapeutic community models and are located in two state correctional institutions.

Utilizing the federal Block Grant increase this year Oregon selected three counties to receive funds to enhance their services to individuals in local jails and community corrections. These projects focus their efforts upon persons with co-occurring substance abuse and mental illness and allow providers to more thoroughly assess and provide treatment not only within community correctional facilities but also upon discharge to and follow up in the local community corrections system. Projects report numbers served, average stay in treatment, efforts to enroll consumers in the Oregon Health Plan (Medicaid) where appropriate, housing gained where needed, efforts at employment and probation revocations or re-arrests.

Stakeholder Participation in Policy-Making and Oversight

Dual Diagnosis Task Force. The Department of Human Services convened a statewide task force on co-occurring disorders, which issued a final report in 2000 identifying nine recommendations for improving Oregon's service system. A number of the recommendations have already been implemented:

- The Office of Mental Health Services (OMHS) and the Office of Alcohol and Drug Abuse Programs (OADAP) jointly developed an action plan, assigning staff and stakeholders to develop a strategy for each of the recommendations.
- Both agencies built links to the Dual Diagnosis Task Force web site on their web sites.

- The Steering Committee revised and adopted a nationally supported conceptual framework of service delivery/coordination by severity of disorder.
- Administrative rules were amended to reduce barriers for integrated dual diagnosis treatment services.
- Existing initiatives that addressed individuals with co-occurring disorders were catalogued and several dual diagnosis/integration projects were funded.
- The Offices sent out a letter to providers indicating support for using one integrated clinical record.
- OADAP and OMHAS participated in each Office's onsite program reviews for licensing and/or certification, and conducted some joint reviews.
- Both offices cooperated with county-level organizations to deliver a series of regional trainings with Dr. Kenneth Minkoff, a nationally recognized co-occurring disorder expert.
- The newly unified Office of Mental Health and Addiction Services delivered a major statewide conference focusing on the needs of youth and families with co-occurring disorders in September 2002.
- OMHAS partnered with the State Court Administrator's Office to develop integrated Family Treatment Courts.
- OMHAS reviewed Toolkits for implementing Evidence Based Practices (EBP) for Serious and Persistently Mentally Ill (SPMI) adults with co-occurring disorders.
- OMHAS formed a work group with the Community Mental Health Directors to promote Evidence Based Practices.
- OMHAS assisted in supporting the May 2003 conference, "Co-occurring Disorders: Implementing Evidence-Based Practices", with over 500 in attendance.

The Steering Committee prioritized the remaining issues as follows:

1) Reimbursement systems for integrated services.
2) Combining data collection systems.
3) Standards for “dual diagnosis capable” and “dual diagnosis enhanced/integrated” programs.

To assist in further implementation, Oregon has applied for two SAMHSA grant initiatives: State Training and Evaluation of Evidence-Based Practices and the State Incentive Grant for Treatment of Persons with Co-occurring Substance Related and Mental Disorders.

Governor’s Mental Health Alignment Workgroup. OMHAS actively participated in the Governor’s Mental Health Alignment Workgroup from February 2000 until the publication and release of the Report to the Governor in January 2001. The Workgroup, a statewide effort led and coordinated through the Governor’s office, recommended 18 areas of change. Since that time, the 2001 Oregon Legislature passed House Bill 3024. Now codified as Oregon Revised Statute (ORS) 430.630 and ORS

430.640, the law mandates a community based, comprehensive, coordinated planning process at a local level. A two phase planning process was initiated wherein each local mental health authority (LMHA) convened a planning process that involved a wide array of stakeholders, ranging from consumer and family advocates to allied agencies and such advisory groups as local alcohol and drug planning committees and local public safety coordinating councils. As directed by ORS 430.640, these planning efforts were reviewed and formed the basis of a statewide mental health plan. This plan has been presented to the 2003 Oregon Legislative Assembly. It includes a focus on accountability for client outcomes and efficient use of resources; the use of state dollars to ensure basic levels of support are available to all Oregonians of similar risk; addresses systemic problems before requesting additional resources; and emphasizes utilization of accurate data in support of decision making and system management.

Mental Health Planning and Management Advisory Council (State Mental Health Planning Council). OMHAS provides administrative resources and staff to the Mental Health Planning and Management Advisory Council (PAMAC). The Council consists of representatives from consumers, family advocacy organizations, citizen advocates, state hospitals, state agencies, Community Mental Health Programs, and provider organizations and serves as a forum for stakeholders to make recommendations on major policy changes and initiatives. Equal representation is maintained for both adults and children. This past year, the Council has played an instrumental role in the development of guidelines and the review of the State Mental Health Plan required by ORS 430.630. Council members spent many hours reviewing the plans submitted and working with department staff to summarize input on each of the plans submitted.

Regional Planning Councils. Oregon has established six regional acute care planning councils to address system of care issues and the legal and regulatory framework for services to adults who require inpatient psychiatric care. Representatives from OMHAS, inpatient psychiatric acute care programs, community mental health programs and their contractors, advocacy organizations, and other stakeholders attend the regional council meetings. The regional acute care planning councils provide input and direction to inpatient acute care facilities and community service providers related to service integration and maintaining a system of care. The role of the local acute care facilities in relation to other components of the community service delivery system is a primary focus of the planning councils. Councils provide recommendations for policy development and to facilitate implementation of services within the existing service delivery system. OMHAS attends the regional planning councils to provide clarification of state policy and to facilitate the coordination of care at local and regional levels.

NAMI Oregon. OMHAS has continued to work with NAMI Oregon to enhance the resources they offer. In recent years NAMI had recruited and trained 24 family-to-family education teachers; and provided this service to over 900 participants in Oregon. Additionally, they have enhanced cultural competency of this training with at least one regional training program for persons working with Latino communities, and they provide an information help line that provides a service of at least 20 hours per week. OMHAS is currently in the process of renewing the contract with NAMI to continue to expand services and supports to families statewide.

Oregon Family Support Network (OFSN). OMHAS works with Oregon Family Support Network (OFSN) to produce a statewide program focused on supporting, educating, as well as, assisting caregivers of children with severe emotional disorders. OFSN is a non-profit organization of families throughout Oregon supporting other families that have children and adolescents with emotional, behavioral, mental and related disorders. OFSN is affiliated with the Federation of Families for Children Mental Health and Adolescent Network.

State Target Planning and Consultation Committee. OMHAS participates as a member of the DHS, Children, Adults and Families Target Planning and Consultation Committee. This committee approves and funds individualized service plans for children in state custody for whom there are no funded resource or service that is appropriate and/or available.

Oregon Health Plan. Oregon Health Plan managed care organizations are required to maintain consumer, advocate, and family member involvement in monitoring and quality assurance processes for Medicaid managed mental health services.

QUALITY OF SERVICES

Training. The Office of Mental Health and Addiction Services' (OMHAS) mission for training and community education is to give our clients/customers information, technical assistance, and skills training to implement current, evidence-based, and culturally competent prevention and treatment services. OMHAS training promotes practices fostering quality of life, facilitating self-determination, and building on individual, family, and community strengths. OMHAS supports services to persons with mental illness, substance abuse, and gambling addictions.

During the 2001-2003 biennium the State of Oregon Department of Human Services (DHS) implemented major organizational and structural changes to provide better services to clients, simplify access to services, consolidate programs, and reduce the multiple layers and steps clients have to take to obtain the help they need. This

approach has helped to reduce administrative expenses and strengthen the network among DHS employees. By working together as teams, some of the mysteries of specific agency program and culture have melted into a united way of thinking about and responding to client needs. The OMHAS Training Unit demonstrates a team approach in providing multi-disciplinary education services.

On November 29, 1999, prior to formal reorganization and integration of DHS agencies, the Mental Health Training Plan for 2001-2003 was approved. While the 2003-2005 OMHAS Training Plan will reflect total integration and collaboration of training projects for mental health, substance abuse, prevention, and problem gambling, the following summary only reflects training on mental health topics:

> Between July 2001 and July 2003, 6,307 providers, mental health consumers/advocates, and family members attended 81 training events on a variety of topics, sponsored or co-sponsored by OMHAS.

The 2003-2005 OMHAS Training Plan is attached as Appendix C.

Quality Assurance. The OMHAS Quality Assurance 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, treatment and nationally accredited psychiatric residential 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 Assurance staff conducts 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.

Mental Health Organizations (MHOs) under contract with OMHAS are required to submit annual quality assurance plans and work plans that are reviewed and approved by the Quality Assurance Section. OMHAS also analyzes data from utilization reports, periodic reports from MHOs, and other outcome measures for use in quality improvement and monitoring activities. The Quality Assurance section conducts site reviews of contracted MHOs to assess quality of services and compliance with contract expectation. The contract requires each MHO to have quality assurance and advisory committees that include representation from community stakeholders, consumer and family members, and practitioners. These groups provide important information to

OMHAS during the review process. Information is used to monitor performance standards relating to access to services; quality of care; prevention, education, and outreach efforts; and integration and coordination with other community services.

Other responsibilities of the Quality Assurance unit include coordination with the DHS Office of Investigation and Training for protective service investigations; coordination with the DHS Criminal Records Unit for provider employee criminal background checks; development of Oregon Administrative Rules; technical assistance and training to mental health providers; contracting for external quality reviews of MHOs; and other related activities.

***Abuse and Critical Incident Reporting*.** Under Oregon Statute and associated Administrative Rules, private or public officials must report actual and suspected instances of abuse of any adult with mental illness enrolled in publicly funded services. The Office of Investigations and Training assumed primary responsibility for receiving reports of abuse, monitoring the progress of investigations and when necessary, conducting investigations and writing reports. An annual report for fiscal year July 1, 2001 – June 30, 2002 is attached as **Appendix G.**

G. THE ROLE OF THE MENTAL HEALTH PLANNING COUNCIL

In Oregon the Mental Health Planning Council is known as the Mental Health Services Planning and Management Advisory Council (PAMAC). The Council meets six times a year. The membership of the council and By-laws are included in **Section One** of this document.

The council has been active in the selection and writing of the Goals & Performance Indicators found in the original and current application. Two teams of Advisory Council members worked on this proposal, one addressing adult issues and the other children's issues. The Council will continue to play a significant role in the improvement of services within the state. The OMHAS relies on the council for advice on issues related to public mental health.

As part of the community based, comprehensive local planning process required by ORS 430.630 (2001 Legislative Session House Bill 3024), a subcommittee of the council and additional stakeholders was formed to establish guidelines and expectations for the local plans written by the local mental health authorities/counties. Once these guidelines were refined, they were distributed to the counties. The planning process was divided into two phases with separate due dates. Phase One, due June 2002 was reviewed by the subcommittee and a report summarizing strengths and weaknesses of each plan was submitted to the Administrator of OMHAS. Phase Two, due December

of 2002 was also reviewed by a subcommittee of the Planning and Management Advisory Council and other system stakeholders and a similar summary report provided to the leadership of the office. Based on the two sets of county plans and in keeping with the perspective provided by substantial State revenue shortfalls and cuts to services, a report, entitled the "House Bill 3024 Statewide Mental Health Plan" was issued in June 2003.

Current legislation under consideration by the 2003 Legislative Assembly proposes to replace the Mental Health Planning and Management Advisory Council with a smaller council to be appointed by the Governor. Crafting a Governor appointed council and including two legislative members appointed by the Speaker of the House and Senate President will provide increased visibility and prominence for mental health issues.

H. Critical Gaps and Unmet Needs

As mentioned previously, Oregon's public mental health system experienced major funding reductions in the last five months of the fiscal year which ended June 30, 2003. The reductions were required by the Legislature as a result of a tax revenue shortfall. Some programs have been completely eliminated while others have been reduced anywhere from 43 to 76 percent. These reductions have directly impacted children and adults in need of mental health services, have resulted in a loss of nearly 2000 mental health and substance abuse professionals statewide and have altered Oregon's mental health service delivery system infrastructure. Coupled with reductions in substance abuse treatment and other human services, there has been a negative effect on Oregonians with mental disorders. The Office of Mental Health and Addiction Services continues to work to lessen the effect of these reductions and to work within the Legislative process to restore services and rebuild programs.

An overriding issue for Oregon's mental health system continues to be ensuring access to local acute care services for adults and children. Oregon continues its historic efforts to implement the intent of the Supreme Court's Olmstead decision. Given limited resources, the system has labored to establish sufficient alternatives to long-term hospitalization. The mental health system has been challenged in its effort to create community-based alternatives to institutional care by individuals requiring long-term care who are presently awaiting admission to a state institution. Many of these individuals occupy much needed acute care resources until a long term care bed opens. Funding that could be utilized to establish lesser levels of care in the community for individuals awaiting placement from state hospitals is potentially eroded by these acute care costs.

The Children's Mental Health system continues to be challenged provide intensive home and community-based services. Historically, around the country and in Oregon, intensive treatment services for children with severe emotional disorders have been almost exclusively located either in the office of a mental health professional or in an institution. However, the evolution of the system of care approach to service delivery changed the delivery system in important ways. These changes include; shifting the location of service to the community and family based settings, adapting service delivery from office-based practices to community treatment and supports, and elevating the role of families in treatment to create a strength-based approach that constructs a partnership between families and professionals. This work will require policy and regulatory reform, focus on work force training and technical assistance, and system collaboration. OMHAS will work with system stakeholders to develop an implementation plan to increase the availability and quality of individualized, intensive 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 timely discharge from state hospitals has continued to be an area of work for the Office of Mental Health and Addiction Services. Data collection and research is used to assess the development of additional residential and clinical resources required to resolve unmet needs. The Olmstead workgroup has met regularly to advise the Office in its efforts to address the needs of persons residing in state institutions who are ready for discharge placement. In addition, the workgroup played a key role in the development and review of recommendations contained in the Olmstead Plan.

Extended Care Management Unit staff meets weekly with System Planning staff to assess services and accommodations required to assist in the placement of these individuals in community-based settings. In addition, these two units have formed what is termed the "Exceptional Barriers Review" team which meets bi-weekly to review cases of individuals who are deemed to have exceptional barriers to placement, including, trauma survivors, low intellectual functioning sexual offenders, traumatic brain injury, significant medical issues and/or some combination of these issues or others that present particular challenges to community placement.

I. MANAGEMENT INFORMATION SYSTEM

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

1. 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 Health Plan also provides coverage to an "expansion population" of poverty-level adults who do not qualify for traditional Medicaid, and a "medically needy" population who have extraordinary health care costs.

   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.

   Currently, this data is downloaded and stored in a Sybase data warehouse. The warehouse is undergoing a number of upgrades and improvements to make it more user friendly and, under the new system, data will be integrated with other Medicaid information into a decision support system known as DSSURS.

2. 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 OMHAS 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.

3. 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.

   The State Hospital and the acute care units submit OP/RCS data at admission and discharge. This data are stored in a mainframe. The DHS Office of Information Services is responsible for data processing and storage.

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

OMHAS staff has also worked to match client data to the Department of Human Services (DHS) Integrated Client Database (ICDb). The ICDb contains episodic service records for more than 40 DHS services including: alcohol/drug, child welfare, developmental disability, health insurance, nutrition, self sufficiency, seniors and people with physical disability, and vocational rehabilitation. The ICDb also contains criminal arrest/history and vital statistics death records.

SECTION III
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATORS

This section represents the collaborative work of the Oregon State Office of Mental Health and Addiction Services and the Mental Health Planning and Management Advisory Council (PAMAC). Two sub-committees were formed to write these performance indicators. One group represented members of the advisory council with a special interest in adult issues and another group focused on child and adolescent issues. Both were staffed by the Office of Mental Health and Addiction Services.

These performance indicators were selected because they represented issues that are of the utmost importance to both the Office of Mental Health and Addiction Services and the Council.

Both the Council and the Office of Mental Health and Addiction Services will address many more issues in the coming year but these 27 indicators give both focus and direction. In addition, future data will be sorted by children, adults and seniors (65+) in order to direct services specifically to the senior population and measure effectiveness.

Adult Criterion Narrative

The performance indicators identified in this proposal reflect the State's objectives, vision and guiding principles identified under Section II. The following narrative describes the ways in which services under each indicator are organized, financed and delivered within the community mental health system.

Oregon has created and manages a Comprehensive Community-Based System of care for individuals diagnosed with mental illness and substance abuse. These services are funded through a combination of Federal, State, and local funds and grants from various charitable foundations. In addition, the 2001 State Legislative Assembly passed House Bill 3024, now codified as Oregon Revised Statute 430.630, requiring comprehensive, local planning at a community level, ultimately culminating in a statewide plan derived from these local efforts. House Bill 3024 requires that the Local Mental Health Authority (LMHA) engage community partners, consumers and advocates in a planning effort to pursue systemic changes in service delivery. LMHAs must engage such community partners as health and physical medicine, criminal justice, vocational rehabilitation, local housing, local alcohol and drug planning committees, local public safety planning councils, education and others in this process.

Mental health services for **adults** in the State of Oregon currently include the following:

(1) Services for persons with chronic mental illness. Service coordination is made available to each person who does not have access to services outside the public sector, who has a chronic mental illness, and who has been a patient in a State-operated or contracted psychiatric inpatient service during the preceding 36 months or who has been committed to the Department pursuant to ORS 426.005 to 426.495 for a severe mental disorder other than substance abuse. Such service coordination services include:

(a) Participation with State psychiatric hospital staff in the preparation of a discharge plan for each person. The discharge plan must specify the basic and special needs of the person upon release from the hospital;

(b) Assistance in applying for financial aid to which the person is entitled;

(c) Coordination of services including at least housing, employment, and case planning with other agencies and resources;

(d) Emotional support and counseling;

(e) Provision of information about the 24 hours-per-day services available through the CMHP, and training in their use;

(f) Direct provision or arrangement for medication monitoring.

(2) Services for all persons served in the Adult Mental Health Program. Subject to the County's biennial mental health plan, as approved by the Department, the following services are made available to meet the assessed individual needs of enrolled consumers:

(a) Crisis intervention services available 24 hours per day, seven days per week;

(b) Rehabilitation and social services;

(c) Continuity of care to link the consumer to housing and available health and social services;

(d) Medication monitoring; and

(e) Individual, family, and group therapy.

Stat. Auth.: ORS 426 & ORS 430

Criterion 1: Comprehensive Community-Based Mental Health Systems

The reorganization of the Department of Human Services coupled with the locally based planning processes required by ORS 430.630 brings together consumers, families and allied agencies to ensure the inclusion of the following services and allow for input and feedback from:

- Health, Dental and physical medicine
- Rehabilitation and Employment services through the Department of Vocational Rehabilitation Services as well as IPS projects funded through the Block Grant and recent Block Grant increases
- Housing resources through both the Department's efforts and liaison with the State Department of Housing and Community Services
- Educational services
- Local Alcohol and other Drug Planning Committees
- Local public safety coordinating councils including community corrections, local law enforcement agencies, courts, district attorneys, public defenders and county commissioners.

In addition, the Department has emphasized initiatives to reduce inpatient services and divert persons with mental illness to community-based alternatives.

Following are the Performance Indicators for **Criterion 1** with description of how services are organized, financed and delivered.

1) **Increase the percentage of persons who receive follow-up mental health services within 7 days of discharge from an Acute Care Service.**
   - All community mental health programs have direct relationships with local acute care facilities.
   - Six regional acute care councils have been formed over the last 4 years and function to monitor acute care stays and follow-up as well as trouble shoot particularly difficult cases and proactively pursue alternatives to hospital based care.
   - Services are financed through a combination of Medicaid funds, federal Block Grant funds, State general funds and local funds.
   - Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the State Office of Mental Health and Addiction Services (OMHAS).

2) **Increase the number of adults with severe mental illness receiving publicly funded Supported Employment Services.**
   - Supported employment continues to be addressed via plans required of community mental health programs on a biennial basis.
   - Supported employment services are presently funded through a combination of OHP, private funding though Johnson and Johnson, Block Grant funds, and local funding.
   - Delivery occurs via three pilot programs established with recent Block Grant increases that are blended with local funds as well as OMHAS funded supported employment slots that are contracted to various providers across the State.

3) **To increase affirmative responses to the following Adult Mental Health Services Survey items: "I was involved in the development of my treatment plan." and "My treatment plan fits what I want."**
   - As part of a 2002 survey funded through the OMHAS, consumers are polled with respect to the above items. In addition, site reviews undertaken by the Office include interaction with consumers to ascertain their level of involvement in treatment and treatment planning.
   - Information is provided to community mental health programs to promote and enhance the role of consumers in their treatment.
   - OMHAS provides regional training to assist providers in their efforts to involve consumers in treatment planning. Additionally the OMHAS is organizing a statewide provider conference on evidence-based practices that involve consumers as partners in determination of relevant and preferred services.

4) **To increase an affirmative response to the following item on the Adult Mental Health Services Survey: "If I had other choices, I would still get services from this program."**
   - As part of an annual survey funded through the OMHAS, consumers are polled with respect to the above item. In addition, site reviews undertaken by the Office include interaction with consumers to assess their level of satisfaction with services provided.
   - Information is provided to community mental health programs to enhance the "consumer friendly" nature of services delivered and to empower consumers toward a more active level of participation in the receipt of services.

5) **Maintain the number of funds designated to assist in the creation of new housing or upgrading of existing housing serving adults with mental illness.**
   - Recognizing that stable housing is a key element in the continued tenure of placement in the community for those with mental illness, the OMHAS has allocated significant staff resources to the procurement and development of housing resources.
   - The Office completed an extensive survey of available and needed housing resources in late 2000. Information derived from that process will be used to plan further housing endeavors.
   - The OMHAS budget for 2002 includes $150,000 to be allocated to the creation of new housing and upgrading of existing housing.

6) **To identify, assess, coordinate and provide treatment services for adults with co-occurring substance abuse and mental illness who are incarcerated in local jails and involved in community corrections systems.**
   - Utilizing a recent Block Grant increase, the OMHAS has selected three mental health programs to pilot intensive services for the consumers dually diagnosed with mental illness and substance abuse involved with community criminal justice. Delivery of these services occurs onsite within local jails and will follow discharged individuals to community placements. Efforts will be made to engage family members and other significant individuals within the discharged individual's social support system.

7) **Increase the number of affirmative responses by minority respondents to the following Adult Mental Health Services Survey item: "My therapist or case manager is sensitive to my cultural or ethnic background."**
   - All MHO and community mental health program site reviews include assessment/evaluation with respect to the cultural sensitivity of services provided.
   - Biennial implementation plans required of community mental health programs specifically address the availability of culturally competent services.
   - The OMHAS is sponsoring a statewide conference addressing the provision of culturally sensitive mental health and addiction services.

8) **Increase the number of adults with severe mental illness receiving publicly funded supported education services.**
   - Utilizing CPMS and Supported Employment Survey data we intend to establish a baseline for supported education services.

- The three Block Grant funded supported employment pilot projects utilize supported education as an avenue toward future employment and recovery for those consumers who express the need and interest in these services.

9) Development and implementation of consumer directed services for adults with SMI.

- The Office funded a survey of Consumer Drop-In Centers in early 2002, conducted by the Center on Self Determination of Oregon Health and Science University, which focused on the activities, support needs and level of consumer self-governance in the Drop-In Centers. An OMHAS Committee, composed primarily of consumers, developed an application process for awarding Block Grant funds to strengthen the operation of Consumer Drop-in Centers and promote an increased consumer role in decision-making within the Drop-in Centers.
- A pilot Mental Health Brokerage will be funded by the office to one, independent, consumer-directed organization to provide brokered self-directed services within one Oregon County for at least two years, beginning in the Fall of 2002.
- The Office contracts with Oregon Technical Assistance Corporation, Inc. to provide information, training and technical assistance regarding Person Centered Planning to consumers, family representatives and providers. Person Centered Planning pilot projects are currently being conducted in four counties; Tillamook, Josephine, Yamhill, and Benton. Informational forums were held in all four counties in 2003 with trainings that followed to which providers and consumers were invited to participate.

Criterion 2: Mental Health System Data Epidemiology

The Office of Mental Health and Addiction Services (OMHAS) and the Office of Medical Assistance Programs (OMAP) both track client demographic information - including racial/ethnic affiliation, age, gender and place of residence - through the Client Process and Monitoring System (CPMS) and the Medicaid Management Information System (MMIS). The successful pursuit of a Data Infrastructure Grant through SAMHSA will allow us to provide detailed analysis of service by demographic groups in our next application.

Following are the Performance Indicators for **Criterion 2** with description of how services are organized, financed and delivered.

10) **Increase the number of Hispanic adults who receive publicly funded mental health services to match the proportion of the State's adult Hispanic population.**
   - Data to support this effort is derived via the Client Process Monitoring System (CPMS).
   - Biennial plans required of community mental health programs specifically provide information with respect to bilingual staffing.
   - Information provided to potential consumers, family members and allied agencies is available in multi-lingual format.
   - Financing for service supporting this outreach is derived from a combination of federal, State and local funding.
   - Training has been and continues to be provided to educate service providers in the provision of culturally sensitive and relevant care.

11) **Increase the percentage of adults with severe mental illness who are served in the publicly funded mental health system in relation to the prevalence data.**
   - The State of Oregon uses a nationally accepted prevalence-estimating tool that was especially formulated for rural western States. The Client Process Monitoring System and the Oregon Patient/Resident Care System are used to track client utilization.
   - Services are financed through a combination of Medicaid funds, federal Block Grant funds, State general funds and local funds.
   - Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the State.
   - The serious revenue shortage at the State as well as departmental level has severely eroded funds available for adults with mental illness. Deep cuts were made in funds intended to serve adults with severe mental illness. It is more than likely the State will not be able to increase the percentage served, let alone maintain previous levels of service provision.

12) **Increase the percentage of adults with severe mental illness who are 65 years of age or older who receive publicly funded mental health services.**
   - Data to assess the level of service is derived from the Client Process Monitoring System.
   - Community-based geropsychiatric services are provided through a combination of federal, State and local funds as well as innovative partnering with senior service agencies at a local level.
   - The Governor's Commission on Senior Services is represented on the Planning and Management Advisory Council as well as having its own mental health committee.

- Information gathered through these efforts enhances our knowledge base as well as identifies areas of improvement with respect to access and relevance to seniors.

Criterion 4: Targeted Services to Homeless and Rural Populations

Services to rural and homeless populations continue to be an important area of focus in Oregon. In the past year OMHAS conducted an extensive survey of community mental health programs with respect to housing needs. That information will be vital as we plan future development.

Following are the Performance Indicators for **Criterion 4** with description of how services are organized, financed and delivered.

13) Increase in the number of homeless adults with severe mental illness receiving publicly funded mental health services.

- The Client Process Monitoring System defines place of residence or lack thereof for all clients.
- The OMHAS continues to pursue additional housing resources through liaison with the Department of Housing and Community Services and local HUD agencies.
- A survey conducted by residential staff within the OMHAS queried community mental health program staff at a local level with respect to housing resources and needs and has enhanced the knowledge base to assist in future development.

14) Increase affirmative response by rural consumers to the Adult Mental Health Services Survey item: "Mental health services are available at times that are good for me."

- Data provided via survey is collected and reviewed to determine both satisfaction with available times/access and to support improvement in access to services where appropriate.
- Gathered survey information is fed-back to provider agencies so that they may adjust services to better meet the needs of those they serve.

Criterion 5: Management Systems

The Community Mental Health Services Block Grant supports vital services for individuals who cannot access treatment through other means. Oregon utilizes it to fund basic "safety net" services as well as to promote the development of innovations in treatment service delivery, prevention and to enhance vital linkages with allied agencies. Oregon used funds to pilot services to pre-adjudicated youth,

persons with mental illness in community jails, increased supported employment services, and psychiatric consultation for children served in rural areas, as well as gatekeeper programs for seniors and support of existing and new consumer run programs.

The OMHAS offers an extensive array of technical assistance, training and educational opportunities. Recent and future offerings include:

Improving mental health services to ethnically diverse populations and communities
Seminars on service delivery to individuals with co-occurring disorders
Supported Employment
Trauma-Informed service delivery systems and planning
Evidence-based case management practices
Working with clients with acquired brain injury
Quality Assurance
Pre-commitment and civil commitment trainings
Extended Care Management forums (quarterly)
Early Childhood Mental Health
Advanced Geriatric Mental Health Services
Geriatric Education Summer Institute (co-sponsored with Oregon Health Sciences University)

Following is the Performance Indicator for **Criterion 5** with description of how services are organized, financed and delivered.

15) Working through a statewide family education and support organization, develop and implement projects for education, support, technical assistance and information and referral for adults and families living with severe mental illness.

- OMHAS has established a contract with NAMI Oregon that shall distribute the family education materials to all 33 Community Mental Health Programs (CMHP) throughout Oregon. Additionally, the family education materials shall be made readily available, by the Contractor, to interested Oregon family members, Department of Human Services (DHS) related agencies, and the general public as appropriate.
- Contractor shall provide NAMI Family to Family Programs in all 36 Oregon counties. The NAMI Family-to-Family Education Program is a free 12-week course for family caregivers of individuals with severe

brain disorders (mental illnesses). The course shall be taught by Contractor trained family members. Contractor agrees that all instruction and course materials shall be provided free to all class participants.

- Contractor shall provide and maintain a manned telephone information/helpline, for at least a minimum of 20 hours per week during the term of this Contract.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 1: Increase the percentage of persons who are in follow-up mental health services within 7 days of discharge from an Acute Care Service.

Objective: Increase the percentage of persons who are in follow-up mental health services from 37% to 50% within 7 days of discharge.

Population: Adults discharged from an acute-care mental health hospital stay who are tracked by the Oregon Client Process Monitoring System (CPMS) or MMIS.

Criterion: 1. Comprehensive Community-based Mental Health Systems
A. Access

Brief Name: Follow-up mental health services for adults discharged from Acute Care

Indicator: Percentage of adults who receive follow-up services within 7 days of discharge from an acute care hospital.

Measure: Numerator: Number of adults who receive follow-up services within 7 days of discharge from an acute care hospital.
Denominator: Number of adults discharged from an acute care hospital.

Sources of Information: The Oregon Patient/Resident Care System (OP/RCS), the Oregon Client Process Monitoring System (CPMS), and MMIS

Special Issues: This measure will look at all individuals (SMI and non SMI) who were admitted to a Mental Health acute care service and whose funding requires that the hospital and out-patient provider enter the client information in the State data systems (OP/RCS, CPMS, & MMIS).

Significance: It is our expectation that outpatient follow-up after an acute hospitalization is essential to community stabilization and tenure.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 2: Maintain the number of adults with severe mental illness receiving publicly funded Supported Employment Services.

Objective: Maintain the number of adults with severe mental illness receiving publicly funded Supported Employment Services at 410.

Population: Adults diagnosed with a severe mental illness

Criterion: 1. Comprehensive, Community-based Mental Health Services System
A. Access To Services

Brief Name: Supported Employment Services

Indicator: Number of adults with severe mental illness receiving supported employment services.

Measure: The number of adults with severe mental illness receiving publicly funded Supported Employment Services therefore gaining competitive employment in a job that anyone can apply for and that pays at least minimum wage during the fiscal year.

Source of Information: Client Process Monitoring System (CPMS), Supported Employment Surveys, Office of Mental Health and Addiction Services funded demonstration project's quarterly and annual reports defining these measures.

Special Issues: Supported Employment provides support to adults with serious mental illness to enable them to obtain and maintain employment in integrated settings. It is for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent as a result of a severe disability.

Supported employment services include but are not limited to: supervision and job training with the consumer, on-the-job visits, consultation with employer, job coaching with the consumer, counseling, skills training, and transportation.

Significance: Employment is an important factor in enhancing the quality of life for persons with serious mental illness. Evidence based practice supported employment services are considered to be a significant treatment approach in assisting individuals through their recovery process.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 3: To increase the percentage of affirmative responses to the following Adult Mental Health Services survey items: "I was involved in the development of my treatment plan" and "my treatment plan fits what I want".

Objective: To increase the percentage of affirmative responses to the above two items on the Adult Mental Health Services Survey to 90%.

Population: Adults receiving outpatient mental health services who responded to the following Adult Mental Health Services Survey.

Criterion: 1. Comprehensive Community-based Mental Health Systems
B. Appropriateness/Quality

Brief Name: Involvement of Consumers in Treatment Planning

Indicator: Percentage of adult client surveys reviewed indicating consumers were involved in treatment planning and believe their plan to reflect what they want.

Measure: Numerator: Number of surveys reviewed indicating consumers were involved in treatment planning and believe their plan to reflect what they want during a fiscal year.
Denominator: Number of all responses to the above questions on the survey.

Source of Information: Adult Mental Health Services Survey**.**

Special Issues: The State of Oregon Office of Mental Health and Addiction Services distributes an annual Adult Mental Health Services Survey. Though this survey reflects only the opinions of those who choose to fill out and return the survey, historically the return has been adequate to represent a valid sample.

Significance: Assuring involvement by a consumer in his/her treatment plan and their belief that their treatment plan reflects what they want increases the likelihood that consumers will be engaged and invested in working with their provider in partnership. These indicators reflect that services received will be relevant and specific to the consumers stated needs and desires. Promoting consumer self-determination is a primary goal of Oregon's mental health system.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 4: To increase the percentage of an affirmative response to the following item on the Adult Mental Health Services Survey: "If I had other choices, I would still get services from this program".

Objective: To increase the percentage of adult consumers responding affirmatively to the above survey item to 88%.

Population: Adults receiving publicly funded mental health services

Criterion: 1. Comprehensive Community-based Mental Health Systems
B. Appropriateness/Quality

Brief Name: Adult Client Satisfaction

Indicator: Percentage of consumers who would choose their provider of mental health services even if given an alternative source of services.

Measure: Numerator: Number of affirmative responses to this Adult Mental Health Services Survey item.
Denominator: Number of responses to this question on the Adult Mental Health Services Survey.

Source of Information: Adult Mental Health Services Survey

Special Issues: The State of Oregon Office of Mental Health and Addiction Services distributes an annual Adult Mental Health Services Survey. Though this survey reflects only the opinions of those who choose to fill out and return the survey, historically the return has been adequate to represent a significant sample.

Significance: The decision to stay with one's existing provider is an indicator of the satisfaction that the consumer has with his/her provider.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 5: Maintain the number of funds designated to assist in the creation of new housing or upgrading of existing housing serving adults with mental illness.

Objective: Maintain $150,000 per year in the budget to be allocated to the creation of new housing and upgrading of existing housing.

Population: Adults with severe mental illness

Criterion: 1. Comprehensive, Community-based Mental Health Systems
C. OUTCOMES

Brief Name: Housing Development

Indicator: The annual amount of funding available in the Oregon Office of Mental Health and Addiction Services Housing Development Fund.

Measure: The allocation for this item in the Oregon Office of Mental Health and Addiction Services fiscal budget.

Source of Information: The State Department of Human Service's Budget.

Special Issues: The Oregon Office of Mental Health and Addiction Services Mental Health Housing Development Fund is State general fund designated to assist in the creation of new housing or the upgrading of existing housing serving adults with severe mental illness. These funds are combined with other sources of public and private dollars to maximize their impact.

Significance: Affordable, clean and safe housing for adults with severe mental illness is a high priority issue for the Oregon Office of Mental Health and Addiction Services. Housing is one of the most important factors in community stabilization for adults with severe mental illness.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 6: To identify, assess, coordinate and provide treatment services for adults with co-occurring substance abuse and mental illness who are incarcerated in local jails and involved in community corrections systems.

Objective: To identify, assess, coordinate and provide treatment services for at least 120 of the individuals identified above.

Population: Adults with co-occurring substance abuse and mental illness who are incarcerated in local jails and involved in community corrections systems.

Criterion: 1. Comprehensive, Community-based Mental Health Services System
A. Access to Services

Brief Name: Criminal Justice Intervention Project

Indicator: Development and implementation of two or more programs at the local community mental health level that will identify, assess, coordinate and provide treatment services for adults with co-occurring substance abuse and mental illness.

Measure: Number of identified Adults with co-occurring substance abuse and mental illness who are incarcerated in local jails and involved in community corrections systems who are assessed, and provided coordinated treatment services.

Source of Information: Office of Mental Health and Addiction Services funded demonstration project's quarterly and annual reports defining these measures.

Special Issues: An increasing number of adults with mental illness are being lodged in local jails and becoming part of local corrections systems. They now represent approximately 16% of county jail inmates. The majority of these individuals also have substance abuse issues. Often one or the other, but not both, of these problems has been addressed. Also, the person may receive some type of treatment while in custody but no provision for treatment is made upon release.

Significance: These programs will address a need that is currently unmet in many Oregon counties. For the participants in the programs, it may reduce the likelihood of future contact with the criminal justice system by providing services that addressing their specific needs in all life domains.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 7: Maintain the number of affirmative responses by minority respondents to the following Adult Mental Health Services Survey item: "My therapist or case manager is sensitive to my cultural or ethnic background."

Objective: Maintain the number of affirmative responses to the above item at 85%.

Population: Adults receiving outpatient mental health services.

Criterion: 1. Comprehensive Community-based Mental Health Systems
B. Appropriateness/Quality

Brief Name: Culturally sensitive services

Indicator: Percentage of adult client surveys reviewed indicating consumers' beliefs that their cultural and ethnic background is considered and respected.

Measure: Numerator: Number of affirmative responses to the above stated item by minority respondents as reflective of cultural/ethnic demographics in Oregon.
Denominator: Number of total responses to the survey by minority respondents as reflective of cultural/ethnic demographics in Oregon.

Source of Information: Adult Mental Health Services Survey

Special Issues: The State of Oregon Office of Mental Health and Addiction Services distributes an annual Adult Mental Health Services Survey. Though this survey reflects only the opinions of those who choose to fill out and return the survey, historically the return has been adequate to represent a significant sample.

Significance: Recognition of the importance and significance of a client's cultural and ethnic orientation and identity is imperative to the provision of relevant and appropriate services within the cultural/ethnic demographics of Oregon, thereby increasing the effectiveness of the therapeutic relationship and client outcomes.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 8: Increase the number of adults with severe mental illness receiving publicly funded supported education services.

Objective: Maintain a baseline of 30, which is, the number of adults with severe mental illness receiving publicly funded supported education services thereby encouraging access and independence.

Population: Adults diagnosed with a severe mental illness.

Criterion: 1. Comprehensive, Community-based Mental Health Services System
A. Access To Services

Brief Name: Supported Education Services

Indicator: Number of adults with severe mental illness receiving publicly funded supported education services.

Measure: The number of adults with severe mental illness receiving publicly funded Supported Education Services during the fiscal year.

Source of Information: Client Process Monitoring System (CPMS) and Supported Employment Survey

Special Issues: Supported Education provides support and services to adults with serious mental illness so they may have access to post-secondary educational institutions for the purpose of participating in and completing training programs or higher education degree programs. It is for individuals with the most severe disabilities for whom continuing education has not traditionally occurred or for whom continuing education has been interrupted or intermittent as a result of a severe disability. Individual education assessments will reflect each individual's path of interest.

Significance: Research has demonstrated that people with psychiatric disabilities who participate in supported education programs complete 90% of their classes with a grade point average of 3.14. Supported education decreases hospitalization rates, increases work opportunities, improves job/education fit and is the single best indicator for successful employment outcomes.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 9: Development and implementation of consumer directed services for adults with SMI.

Objective: A. Monitor level of consumer self-governance at the Mental Health Consumer Run Drop-In Centers.
B. Establish a baseline number of individuals who have completed a Person Centered Plan.

Population: Adults with SMI.

Criterion: 1. Comprehensive Community-based Mental Health Service Systems
B. Appropriateness/Quality

Brief Name: Consumer Directed services

Indicator: The number of consumers who have completed a Person Centered Plan.

Measure: The number of consumers who have completed a Person Centered Plan.

Sources of Information: Quarterly contract performance reports.

Special Issues: Technical assistance on these projects will be provided by staff from the Center on Self Determination of the Oregon Health and Science University. All projects will promote the employment of consumers as project participants.

Significance: There is broad consumer interest in strengthening consumer self-determination through Oregon's Mental Health Services system. Successful implementation of these projects will invite replication elsewhere in Oregon's system and further promotion of consumer self-determination vales and efforts.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 10: Increase the number of Hispanic adults who receive publicly funded mental health services to match the proportion of the State's adult Hispanic population.

Objective: Increase the number of Hispanic adults who receive publicly funded mental health services from 1.8% to 2.0%.

Population: Hispanic adults receiving mental health services who are tracked by the Oregon Client Process Monitoring System (CPMS) and the Oregon Patient/Resident Care System (OP/RCS).

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Access to mental health services for Hispanic adults.

Indicator: Number of Hispanic adults who receive publicly funded mental health services.

Measure: Numerator: Number of Hispanic adults who receive publicly funded mental health services.
Denominator: Number of Hispanic adults in Oregon.

Sources of Information: The Oregon Patient/Resident Care System (OP/RCS) and the Oregon Client Process Monitoring System (CPMS)

Special Issues: The Hispanic community in the State of Oregon is the fastest growing minority population. It is the belief of the OMHAS that this population needs more focused attention.

Significance: It is important to know the number of Hispanic adults accessing the mental health system and to identify needs and barriers to those in need not currently accessing services. This information is essential to the development of culturally sensitive community stabilization services.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 11: Maintain the percentage of adults with severe mental illness who are served in the publicly funded mental health system in relation to the prevalence data.

Objective: Maintain the percentage of adults with severe mental illness served in publicly funded mental health system at 92% served out of the total estimate of public services demand.

Population: Adults in the public mental health system with severe mental illness.

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Percentage of adults with severe mental illness served

Indicator: Percentage of adults with severe mental illness receiving publicly funded mental health services during the fiscal year.

Measure: Numerator: The number of adults with severe mental illness receiving publicly funded mental health services**.**
Denominator: The number of adults with severe mental illness in need of publicly funded mental health services.

Sources of Information: The State of Oregon uses a nationally accepted prevalence estimating tool that was especially formulated for rural western states along with the Client Process Monitoring System (CPMS) and the Oregon Patient/ Resident Care System (OP/RCS) to track client utilization.

Special Issues: If recent budget cut changes in the Oregon Health Plan benefit package continue, it is estimated that 15,000 to 20,000 adults that need mental health services will no longer receive services. So, while the goal is to maintain the state's current level of service, the percentage will probably fall by 15 to 20%.

Significance: Individuals identified with a severe mental illness benefit from community mental health services that are specific to their needs and desires. These services can assist in promoting greater community tenure in least restrictive settings and promote a path to recovery.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 12: Increase the percentage of adults with severe mental illness who are 65 years of age or older who receive publicly funded mental health services.

Objective: Maintain the use of publicly funded mental health services by adults with severe mental illness aged 65 and older at 46%.

Population: Adults with severe mental illness who are 65 years of age or older

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Older adults receiving publicly funded mental health services.

Indicator: Percentage of 65 years of age or older adults with severe mental illness receiving publicly funded mental health services in the fiscal year.

Measure: Numerator: Number of adults with severe mental illness aged 65 and older receiving publicly funded mental health services.
Denominator: Number of adults with severe mental illness aged 65 and older in need of publicly funded mental health services.

Sources of Information: The State of Oregon uses a nationally accepted prevalence estimating tool that was especially formulated for rural western states along with the Client Process Monitoring System (CPMS) and the Oregon Patient/Resident Care System (OP/RCS) to track client utilization.

Special Issues: The State of Oregon requires all providers of publicly funded mental health services to enter the services provided in either the CPMS which tracks out-patient services or the OP/RCS which tracks in-patient utilization. Publicly funded mental health services include any services provided using City, County, State or Federal funds (including Medicare and Medicaid).

Significance: The special needs of this population require collaborative interagency, cross-systems and interdisciplinary planning that consider the specific developmental and health issues that face older adults with severe mental illness.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 13: Increase in the number of homeless adults with severe mental illness receiving publicly funded mental health services.

Objective: Increase the number of homeless adults with severe mental illness receiving publicly funded mental health services from 3,343 to 3,510.

Population: Homeless adults with severe mental illness

Criterion: 4. Targeted Services to Homeless and Rural Populations.

Brief Name: Homeless adults with severe mental illness and mental health services.

Indicator: The number of homeless adults with severe mental illness receiving publicly funded mental health services.

Measure: The number of homeless adults with severe mental illness receiving publicly funded mental health services.

Sources of Information: The Oregon Patient/Resident Care System (OP/RCS) and the Client Process Monitoring System (CPMS).

Special Issues: This data is the best information we currently have on the number of homeless individuals that are receiving mental health services. This data is collected at the first encounter the provider has with the client and may be only partially reliable.

Significance: An increase in the number of individuals with severe mental illness who identify themselves as homeless at their first encounter for services is an indication that Oregon is serving more homeless adults with severe mental illness.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 14: Increase affirmative response by rural consumers to the Adult Mental Health Services Survey item: "Mental health services are available at times that are good for me."

Objective: Increase affirmative response by rural consumers to the above question from 76% to 90%.

Population: Rural adult public mental health consumers

Criterion: 4. Targeted Services to Homeless and Rural Populations.

Brief Name: Timely and convenient rural access

Indicator: Percentage of rural consumers who responded affirmatively to the above survey item.

Measure: Numerator: Number of rural consumers who responded affirmatively to the above item.
Denominator: Number of rural consumer who responded to this survey question.

Source of Information: Adult Mental Health Services Survey

Special Issues: The State of Oregon Office of Mental Health and Addiction Services distributes an annual Adult Mental Health Services Survey. Though this survey reflects only the opinions of those who choose to fill out and return the survey, historically the return has been adequate to represent a significant sample.

Significance: Timely and convenient access is essential to successful mental health care. The consumer's view on this matter is the most significant.

ADULT SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 15: Working through a Statewide family education and support organization, develop and implement projects for education, support, technical assistance and information and referral for adults and families living with severe mental illness.

Objective: Increase education and support to family members and providers regarding mental illness and improve upon the inclusion of family member involvement in treatment and treatment planning.

Population: Adults with SMI and families of adults with SMI.

Criterion: 5. Management Systems

Brief Name: Family education and support

Indicator: Number of participants in family education programs

Measure: Development and implementation of an adult and family support, education, technical assistance, information and referral project.

Source of Information: Contract performance via National Alliance for the Mentally Ill (NAMI)

Special Issues: None.

Significance: Increased awareness of the role of family members on the part of both providers and family members will increase the effectiveness of treatment and treatment planning and will likely increase the community tenure of individuals discharged to less restrictive settings.

ADULT SERVICES

STATE PLANNING & MONITORING

MENTAL HEALTH PERFORMANCE INDICATOR

Goal 16: Provide regional trainings to emergency health service providers on identifying or providing services to persons with mental illness

Objective: Provide trainings on recognizing signs and symptoms of mental illness to community mental health program staff, community providers and providers of emergency health services.

Criterion: 5. Management Systems

Brief Name: Emergency Health Services Provider Training

Indicator: Number of mental health and emergency health providers trained.

Sources of Information: Registration for regional trainings and CEU's awarded

Special Issues: Given the severe economic environment, trainings will be provided in a least cost manner to inform, educate and promote system change and collaboration between emergency health service providers and local providers of mental health services.

ADULT SERVICES

STATE PLANNING & MONITORING

MENTAL HEALTH PERFORMANCE INDICATOR

Goal 17: Provide regional trainings to mental health providers on Evidence-Based Practices

Objective: Provide 7 topical trainings on a variety of Evidence Based Practices to community mental health program staff and community providers.

Criterion: 5. Management Systems

Brief name: Evidence Based Practices Trainings

Indicator: Number of mental health providers trained.

Sources of Information: Registration for regional trainings and CEU's awarded

Children's Criterion Narrative

The performance indicators identified in this proposal reflect the State's objectives, visions and guiding principles identified under Section II. The following narrative describes the ways in which services under each indicator are organized, financed and delivered within the community mental health system.

Oregon manages a Comprehensive Community-based System of care for children with severe emotional disorders. 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 of care is child and family-centered 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 medically appropriate to sustain the child in treatment in the community. These services are funded through a combination of Federal, State, and local funds and grants from various charitable foundations.

In addition, the 2001 State Legislative Assembly passed HB 3024, now codified as Oregon Revised Statute (ORS) 430.630 and 430.640, requires comprehensive, local planning at a community level and a statewide plan based on the local 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.

Following are the Performance Indicators for **Criterion 1: Comprehensive Community-Based Mental Health Systems** with description of how services are organized, financed and delivered.

1) Maintain or increase the percentage of parents or guardians whose children receive services through the Oregon Health Plan and respond to the Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey for Families. The percent of parents who responded identified that they agree or strongly agree that the location of services was convenient and services were available at convenient time.

- All community mental health programs accept referrals from a variety of sources including, parents, schools, medical and dental providers, and substance abuse providers.
- Access to services has been one of the primary quality improvement domains for Oregon Health Plan contractors and providers.
- Services are financed through a combination of Medicaid funds, federal Block Grant funds, State general funds and local funds.
- Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the State Office of Mental Health and Addiction Services (OMHAS).

2) Develop a Statewide baseline for the Mental Health Statistics Improvement Program (MHSIP) youth and family survey questions that measure appropriateness and quality for children receiving psychiatric residential treatment services.

- Psychiatric residential treatment service agencies are working with OMHAS in a collaborative evaluation and analysis of this level of care.
- Psychiatric residential treatment services are presently funded through a combination of Medicaid funds, State general funds through Mental Health, Child Welfare, Juvenile Justice, and Education.
- The MHSIP youth and family surveys will be administered by the provider agency upon discharge. The aggregated data will be used to establish a baseline expectation of appropriateness and quality in Oregon. This baseline data will be used in ongoing system evaluation and for nation wide data comparison.

3) Maintain or increase the percentage of parents or guardians whose children receive services through the Oregon Health Plan and respond on the MHSIP Youth Services Survey For Families questions indicated as measuring Appropriateness of services.

- As part of an annual survey funded through the OMHAS, parents or guardians are polled with respect to the above item. In addition, site reviews undertaken by OMHAS include interviews with parents and guardians to ascertain their perceived level of appropriateness of services
- Information obtained in this process is provided to community mental health programs to promote and enhance the appropriateness of services and the role of parents and guardians in treatment.

4) **To select and implement a methodology for demonstrating children's functional improvement while receiving intensive treatment services.**
   - As part of the ongoing evaluation of the intensive services in Oregon's system of care for children OMHAS will work with service providers to develop a systemic methodology for evaluating the effectiveness of intensive treatment services
   - Intensive mental health treatment services are presently funded through a combination of Medicaid funds, State general funds through Mental Health, Child Welfare, Juvenile Justice, and Education.
   - Information garnered in this process is provided to children's intensive mental health treatment service programs to enhance the assurance of functional outcomes. The data is also used for policy development and quality management.

5) **A. 86% of children receiving Psychiatric Residential Treatment will decrease overall Childhood Acuity of Psychiatric Illness (CAPI) scores by at least 10%.**
B. 98% of children receiving treatment at the Oregon State Hospital and Secure Children's Inpatient Program will decrease overall Childhood Acuity of Psychiatric Illness (CAPI) scores by at least 10%.
   - The Children's program at the Oregon State Hospital and the Psychiatric Residential Treatment Service providers represent the most restrictive, most intensive, and some of the most expensive levels of care in the public mental health system.
   - The OMHAS contracts with the Oregon Medical Professional Review Organization to administer the CAPI upon admission, every ninety days and upon discharge for each child in these levels of care.
   - A quarterly report is disseminated to OMHAS and each provider. The CAPI data is an objective measurement tool regularly used for policy development and quality management.

6) **50% of the adolescents and young adults, aged 16-25 with severe emotional behavioral and/or mental disorders receiving services through the demonstration projects will be placed in educational or vocational settings.**
   - Utilizing the Block Grant increase recently granted to Oregon, the OMHAS has selected two counties/community mental health programs to pilot an intensive effort at providing specialized services to older adolescents and young adults.

- One community mental health program has designed a program specifically for older adolescents who are dually diagnosed with severe emotional disorders and substance abuse. The other community mental health program has designed service delivery for those older adolescents and young adults who are transitioning from the Oregon State Hospital or psychiatric residential treatment services to less restrictive settings.
- OMHAS is committed to the promotion of Youth Development services. This model of service delivery goes beyond treating the problems and high-risk behaviors of youth, but rather provides them with opportunities and supports to build competencies to contribute to their own growth and that of their communities and families. Vocational, educational, and housing programs are fundamental to the transition from adolescence to adulthood.

Following are the Performance Indicators for **Criterion 2: Mental Health System Data Epidemiology** with description of how services are organized, financed and delivered.

7) Maintain or increase the percentage of children receiving publicly funded mental health services in relation to the estimated demand rate.

- The State of Oregon uses a nationally accepted prevalence-estimating methodology for children and adolescents. The Client Process Monitoring System and the Oregon Patient/Resident Care System are used to track client utilization.
- Services are financed through a combination of Medicaid funds, federal Block Grant funds, State general funds and local funds.
- Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the State OMHAS.
- Due to significant budget reductions system wide, it is anticipated that the number of children receiving services will be adversely impacted.

8) The proportion of children receiving publicly funded mental health services who are Hispanic will match or exceed the proportion of the State's children's Hispanic population. The proportion of children receiving publicly funded mental health services from Native American, Hispanic, African American, and Asian ethnic backgrounds will match

or exceed the proportion of the State's children's ethnic background population.

- Data to support this effort is derived via the Client Process Monitoring System (CPMS)
- Information provided to potential consumers, family members and allied agencies are available in multi-lingual format.
- Financing for service supporting this outreach is derived from a combination of federal, State and local funding.
- Training has been and continues to be provided to educate service providers in the provision of culturally sensitive and relevant care.

Following are the Performance Indicators for **Criterion 3: Children's Services** with description of how services are organized, financed and delivered.

9) Develop the data system capacity between the Office of Mental Health and Addiction Services, County Juvenile Departments, and the Oregon Youth Authority.

- The OMHAS and the juvenile justice agencies analyze data independent of each other. This initiative will lead to a system that allows for analysis of services provided to the estimated 22% of the youth receiving juvenile justice service having a diagnosable mental disorder. Services are financed through a combination of Medicaid funds, federal Block Grant funds, State general funds and local funds.
- Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the OMHAS.
- Information resulting from the collaborative arrangement will be shared with community mental health programs, county juvenile departments, and the Oregon Youth Authority to assist in program and policy development.

Following are the Performance Indicators for **Criterion 4: Targeted Services to Homeless and Rural Populations** with description of how services are organized, financed and delivered.

10) 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.

- The Client Process Monitoring System defines county of residence for all clients.
- Oregon has selected to use definitions of "urban" and "rural" based on county population density. Twenty-seven counties with a population of under 96,000 are considered rural and contain approximately 25% of the State's population.
- Service delivery is provided either directly by the community mental health program or a contract entity under approval of the community mental health program and the State Office of Mental Health and Addiction Services (OMHAS).

11) Increase the provision of publicly funded mental health services to children with severe emotional disorders who are homeless.

- The Client Process Monitoring System defines place of residence or lack thereof for all clients.
- The OMHAS continues to pursue additional housing resources through liaison with the Department of Housing and Community Services and local HUD agencies.
- The extent of the provision of mental health services to homeless children is difficult to quantify. However, OMHAS 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 program for homeless youth.

Following is the Performance Indicator for **Criterion 5: Management Systems** with description of how services are organized, financed and delivered.

12) To increase the participation of family members of children with severe emotional disorders on advisory councils, quality management committees, and other mental health delivery system decision-making bodies.

- Oregon Administrative Rules and contractual language require family members of children with SED to participate on advisory councils, quality management committees, and other mental health delivery system decision-making bodies.
- Utilizing the Block Grant increase recently granted to Oregon, the OMHAS has funded a family member and provider training program through the Oregon Family Support Network.

- This educational curriculum will enhance family member 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.

13) To provide current, quantifiable county-level data to counties and other to be used in planning of service to Oregon Teens.

- Utilizing Block Grant funding OMHAS is collaborating on the Oregon Healthy Teens Survey that assesses 8th and 11th grade students from a representative sample of Oregon schools.
- The Survey assesses teen depression, suicide attempts and victimization in addition to individual/peer, family, school and community factors that either place youth at risk of developing problems or those that protect youth from future problems. The risk and protective factors are associated with a number of teen problems, including mental health problems, juvenile delinquency, school dropout, teen pregnancy and alcohol and drug abuse.
- The Survey offers Oregon mental health advocates the opportunity to assess the need for mental health services at a local level. It also provides an opportunity to explore the risk and protective factors associated with severe emotional disorders. The data can then assist local planners to develop programs that address the risk and build on the protective factors currently in the community.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 1: To provide mental health services in a timely manner.

Objective: Maintain or increase the percentage of parents or guardians whose children receive services through the Oregon Health Plan and respond to the Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey for Families. The percent of parents who responded identified that they agree or strongly agree that the location of services was convenient and services were available at convenient time.

Population: Children and their families

Criterion: 1. Comprehensive, Community-based Mental Health System
A. Access to Services

Brief Name: Access to Services

Indicator: The percentage of parents or guardians who answered, "Agree or Strongly Agree" to the MHSIP Youth Services Survey For Families questions indicated as measuring Access.

Measure: Numerator: Number of parents who agree or strongly agree that the location of services was convenient and services were available at a convenient time.
Denominator: Number of completed surveys reviewed.

Sources of Information: MHSIP Youth Services Survey for Families

Special Issue: The State of Oregon Office of Mental Health and Addiction Services distributes the Youth Services Survey for Families annually. Though this survey reflects only the opinions of those who choose to complete and mail the survey, historically the return rate has been adequate to represent a significant sample.

Significance: The Office of Mental Health and Addiction Services is committed to improving access to care for children and their families. In 2002, Office of Mental Health and Addiction Services established a baseline for the MHSIP Youth Services Survey for Families. Access to services has been one of the primary quality improvement domains for Oregon Health Plan contractors and providers. Timely and convenient access is essential to successful mental health care.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 2: To provide effective treatment for children receiving psychiatric residential treatment services.

Objective: Develop a Statewide baseline for the MHSIP Youth and Family Services Survey that measure appropriateness and quality for children receiving Psychiatric Residential Treatment Services (PRTS)**.**

Population: Children with SED receiving PRTS and their parents/guardians.

Criterion: 1. Comprehensive, Community-based Mental Health System
B. Appropriateness/Quality

Brief Name: Effective intensive treatment services.

Indicator: The percentage of parents or guardians who answered, "Agree or Strongly Agree" to the MHSIP Youth Services Survey For Families questions indicated as measuring appropriateness and quality of treatment services.

Measure: Numerator: Number of parents who answered, "Agree or Strongly Agree" to questions indicated as measuring appropriateness and quality of treatment services.
Denominator: Number of completed surveys reviewed.

Source of Information: MHSIP Youth Services Survey For Families

Special Issues: The Office of Mental Health and Addiction Services finished collaborative evaluation of the Intensive Treatment Services Pilot Project and Psychiatric Residential Treatment Services using the MHSIP Youth Services Survey . The service providers agree to use the MHSIP Youth Services Survey and Youth Services Survey for Families, upon discharge for all the children and guardians that have received psychiatric residential treatment services.

Significance: The aggregated data will be used to establish a baseline expectation of appropriateness and quality in Oregon. This baseline will be used in ongoing system evaluation and for nation wide data comparison. To date there has been insufficient data to create a baseline. OMHAS will continue to work with providers of PRTS to collect and analyze enough survey data to create a statistically valid baseline measurement.

CHILDREN SERVICES

STATE PLANNING & MONITORING

MENTAL HEALTH PERFORMANCE INDICATOR

Goal 3: To provide effective publicly funded mental health treatment services to children and their families.

Objective: Maintain or increase the percentage of parents or guardians whose children receive services through the Oregon Health Plan and respond on the MHSIP Youth Services Survey For Families questions indicated as measuring Appropriateness of services.

Population: Children receiving services through the Oregon Health Plan and their parents.

Criterion: 1. Comprehensive, Community-based Mental Health System
B. Appropriateness

Brief Name: Effective OHP children and family services

Indicator: Percentage of parents or guardians who answered that they strongly agree or agree to the Appropriateness of Services questions on the MHSIP Youth Services Survey for Families.

Measure: Numerator: The number of parents who answered they "agree" or "strongly agree" to the appropriateness of treatment questions.
Denominator: The total number of responses to the question.

Source of Information: MHSIP Youth Services Survey For Families

Special Issues: The State of Oregon Office of Mental Health and Addiction Services distributes 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, historically the return has been adequate to represent a significant sample.

Significance: Assuring that children and their parents or guardians who receive OHP services rate the appropriateness and quality of services as effective is critical to Oregon's system of care.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 4: To provide intensive mental health treatment services that lead to functional improvement in the children who receive services.

Objective: To select and implement a methodology for demonstrating children's functional improvement while receiving intensive treatment services.

Population: Children receiving intensive treatment services

Criterion: 1.Comprehensive, Community-based Mental Health System
C. Outcomes

Brief Name: Functional and system improvement development and planning.

Indicator: Creation of a group a stakeholders including service providers, other state agencies, family members, and state mental health staff to develop a plan to efficiently and effectively collect functional and system level outcome information for children receiving intensive treatment services.

Measure: Develop and implement outcome measurement plan.

Source of Information: Stakeholder Workgroup report.

Special Issues: Objective measurement of services is critical to system accountability to assure the provision of treatment services that produce functional outcomes.

Significance: The Office of Mental Health and Addiction Services established a benchmarked data system utilizing Child and Adolescent Functional Assessment Scale (CAFAS), which ended in January 2003. The goal for FY03 will be to collaborate with ITS Providers, Family members and OMHAS and develop a process for gathering and using appropriate outcomes for children enrolled in intensive treatment services.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 5: To provide intensive treatment services that reduces the acuity and severity of psychiatric symptoms.

Objective: A. 86% of children receiving Psychiatric Residential Treatment will decrease overall Childhood Acuity of Psychiatric Illness (CAPI) scores by at least 10%.
B. 98% of children receiving treatment at the Oregon State Hospital and Secure Children's Inpatient Program will decrease overall Childhood Acuity of Psychiatric Illness (CAPI) scores by at least 10%.

Population: Children receiving treatment services in Psychiatric Residential Treatment Service programs, Secure Children's Inpatient Program and the Oregon State Hospital.

Criterion: 1. Comprehensive, Community-based Mental Health System
C. Outcomes

Brief Name: Improvement in CAPI scores

Indicator: The percentage of children with a 10% decrease in CAPI scores from admission to discharge.

Measure: Numerator: Number of children with a 10% in CAPI scores from admission to discharge.
Denominator: Total number of children discharged.

Source of Information: Oregon Medical Professional Review Organization quarterly report.

Special Issues: During the time period of 1/01/02 to 12/31/02 86% of children receiving treatment services in Psychiatric Residential Treatment Service programs and the Oregon State Hospital had a 10% decrease in CAPI scores.

Significance: The Childhood Acuity of Psychiatric Illness (CAPI) is an assessment tool used to assist in the determination of admission, continued stay, and discharge for children in Psychiatric Residential Treatment Programs, Secure Children's Inpatient Program and the Oregon State Hospital. CAPI information is submitted on a quarterly basis to the Office of Mental Health and Addiction Services and each service provider. Sub scale and overall score benchmarks have been established system wide as well as on an individual provider basis. These benchmarked reports have provided valuable information to objectively review outcomes associated with this level of care. This reporting mechanism is widely used in system planning discussions and individual provider technical assistance.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 6: To increase service coordination and delivery for older adolescents and young adults aged 16-25 with severe emotional, behavioral and/or mental disorders transitioning into the adult community mental health service system.

Objective: 50% of the adolescents and young adults, aged 16-25 with severe emotional, behavioral and/or mental disorders receiving services through the demonstration projects will be placed in educational or vocational settings.

Population: Older adolescents and young adults with severe emotional, behavioral and/or mental disorders transitioning into the adult community mental health service system.

Criterion: 1. Comprehensive, Community-based Mental Health Services System
A. Outcome indicator

Brief Name: Transition Services for Older Adolescents and Young Adults

Indicator: Two programs were implemented in Clackamas and Josephine Counties to improve systematic coordination and service. Implementation of these two programs at the local level identified, assessed, and treated this specified population.

Measure: Percentage of older adolescents and young adults served who were placed in educational or vocational settings.

Source of Information: OMHAS funded demonstration project's quarterly and annual reports tracking these measures.

Special Issues: There is continued need to develop coordination across youth service and adult service systems to assist older adolescents and young adults in making a smooth transition. This population has many special needs related to their stage of development. Youth development services go beyond treating high-risk behaviors by providing opportunities and supports to build competencies to contribute to one's own growth and that of their communities. Vocational and educational programs are fundamental to the transition from adolescents to adulthood.

Significance: These programs are addressing a need that is currently unmet in many Oregon counties. For the participants in the programs, it will likely reduce their encounters with the acute care and criminal justice systems while increasing community tenure, vocational and educational outcomes and life satisfaction.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 7: Increase access to mental health services for all children who need to access publicly funded mental health services.

Objective: Maintain or increase the percentage of children receiving publicly funded mental health services in relation to the estimated demand rate.

Population: Children needed publicly funded mental health services

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Access to publicly funded mental health services

Indicator: Percentage of children receiving publicly funded mental health services in relation to the estimated demand rate.

Measure: Numerator: Number of children receiving services.
Denominator: Estimated demand rate.

Source of Information: Client Process Monitoring System (CPMS), Oregon Patient/Resident Care System, and Medicaid Management Information System.

Special Issues: The State of Oregon requires all providers of publicly funded mental health services to report the services provided on the CPMS form. Publicly funded mental health services include any services provided using State or Federal funds.

Significance: Children with mental health disorders have shown to benefit from the utilization of mental health services. However, due to significant budget reductions system wide, it is anticipated that the number of children receiving services will be adversely impacted.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 8: To provide mental health services to children from Native American, Hispanic, African American, and Asian ethnic background.

Objective: The proportion of children receiving publicly funded mental health services from Native American, Hispanic, African American, and Asian ethnic backgrounds will match or exceed the proportion of the State's children's ethnic background population.

Population: Children from Native American, Hispanic, African American, and Asian ethnic backgrounds.

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Access to mental health services for children

Indicator: The proportion of children receiving mental health services from each ethnic background such as: Native American, Hispanic, African American, and Asian, compared to the proportion of children with the same ethnic background in the State's population.

Measure: Numerator 1: The number of children ethnic background who are identified as: Native American, Hispanic, African American, and Asian, receive publicly funded mental health services.
Denominator 1: The number of children ethnic background who is identified as: Native American, Hispanic, African American, and Asian, who receive publicly funded mental health services.
Numerator 2: The number of Children ethnic background who is identified as: Native American, Hispanic, African American, and Asian, in the State population.
Denominator 2: The number of children in the State population

Sources of Information: State population data, Client Process Monitoring System, Oregon Patient/Resident Care System, and Medicaid Management Information System.

Special Issues: In 2002, the proportion of children receiving mental health services from the following ethnic backgrounds: Native American, Hispanic, African American, and Asian, compared to the proportion of children with the same ethnic background in the State's population was the same or higher.

Significance: The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs children with diverse ethnic backgrounds.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 9: To analyze the recidivism rate of youth coming in contact with the juvenile justice system who receive mental health services.

Objective: Develop the data system capacity between the Office of Mental Health and Addiction Services, County Juvenile Departments, and the Oregon Youth Authority.

Population: Children with SED who come in contact with the Juvenile Justice System

Criterion: 3. Children's Services

Brief Name: Recidivism of youth with SED

Indicator: The juvenile justice recidivism rate of youth who receive mental health services compared to the recidivism rate for all youth.

Measure: The number of youth who receive mental health and recidivate compared to the recidivism rate for all youth.

Sources of Information: Juvenile Justice Information System, Client Process Monitoring System, Oregon Patient/Resident Care System, and Medicaid Management Information System.

Special Issues: The Office of Mental Health and Addiction Services 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. Through a collaborative data sharing and analysis relationship Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 10: To provide a proportionate number of services to children in rural areas.

Objective: 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 Homeless and Rural Populations

Brief Name: Mental Health services in rural areas

Indicator: The proportion of all children receiving mental health services who live in rural areas compared to the proportion of children in the State's population who live in rural areas.

Measure: Numerator 1: The number of rural children who receive publicly funded mental health services.
Denominator 1: The number of children who receive publicly funded mental health services.
Numerator 2: The number of rural children in the State population.
Denominator 2: The number of children in the State population.

Source of Information: Client Process Monitoring System, Oregon Patient/Resident Care System, and Medicaid Management Information System.

Special Issues: Rural and frontier areas of Oregon have a unique set of circumstances in the provision of mental health services.

Significance: Because of the small population density of 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 and planning, outreach, and unique service delivery mechanisms to ensure the mental health needs of children and their families are identified and addressed.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 11: Increase the provision of publicly funded mental health services to children with severe emotional disorders who are homeless.

Objective: Increase the provision of publicly funded mental health services to children with severe emotional disorders who are homeless.

Population: Children who are homeless

Criterion: 4. Target services to homeless and rural populations

Brief Name: Mental health services for children who are homeless

Indicator: The number of children who are homeless that receive publicly funded mental health services

Measure: The number of children who are homeless that receive publicly funded mental health services.

Source of Information: The Oregon Patient/Resident Care System (OP/RCS) and the Client Process Monitoring System (CPMS).

Special Issues: Children and families who are homeless receive public services through multiple delivery systems. The extent of the provision of mental health services to these children is difficult data to track. The data is collected at the first encounter the provider has with the child and may be only partially descriptive of the actual numbers of homeless children being served throughout the State.

Significance: Children and families who are homeless have multiple needs for public services. An increase in the number of children with severe emotional disorders who are identified as homeless at their first encounter for mental health services is an indication that Oregon is providing specialized services for these children.

CHILDREN SERVICES
STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 12: To promote family member participation in influencing the mental health delivery system.

Objective: To increase the participation of family members of children with severe emotional disorders on advisory councils, quality management committees and other mental health delivery system decision-making bodies.

Population: Family members of children who have serious emotional disorders.

Criterion: 5. Management Systems

Brief Name: Family member technical advisory skill training

Indicator: The number of family members involved in service provider organizations prior to attending training in relation to the number of family members involved in provider organizations six months after the training

Measure: The number of family members involved in provider organizations six months after training compared to number of family members who participated in the workshop.

Source of Information: Office of Mental Health and Addiction Services funded demonstration project's annual report tracking these measures.

Special Issues: Oregon Administrative Rules and contracts require the participation of family members in advisory councils, quality management committees, and other means of influencing the mental health delivery system.

Significance: Family members and mental health service providers need specialized training to ensure effective family member participation in councils and committees. Family member involvement in organizational decision making and analysis is critical to continuous quality improvement of service to children with SED and their families.

CHILDREN SERVICES

STATE PLANNING & MONITORING
MENTAL HEALTH PERFORMANCE INDICATOR

Goal 13: Collect and compile data resulting from the Healthy Teens Survey to aid planning and system development of community-based mental health services.

Objective: To provide current, quantifiable county-level data to counties and others to be used in planning of services to Oregon Teens.

Criterion: 2. Mental Health System Data Epidemiology

Brief Name: Oregon Healthy Teens Survey

Indicator: Number of 8th and 11th grade adolescents in need of Mental Health or Dual Diagnosis services.

Sources of Information: Results of the Oregon Healthy Teen Survey

Special Issues: The Oregon Healthy Teens Survey will assess 8th and 11th grade students from a representative sample of Oregon schools. The Survey assesses teen depression, suicide attempts and victimization in addition to individual/peer, family, school and community factors that either place youth at risk of developing problems or those that protect youth from future problems. The risk and protective factors are associated with a number of teen problems, including mental health problems, juvenile delinquency, school dropout, teen pregnancy and alcohol and drug abuse.

The Survey offers Oregon mental health advocates the opportunity to assess the need for mental health services at a local level. Beyond that, it provides an opportunity to explore the risk and protective factors associated with serious emotional disorders. The data can then assist local planners to develop programs that address the risk and build on the protective factors currently in the community.