COMMUNITY SERVICES WORKGROUP REPORT

for the

OREGON STATE HOSPITAL MASTER PLAN

March 13, 2007

Prepared for the Community Services Workgroup
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INTRODUCTION

The State Hospital Master Plan Phase II Report released in February 2006 recommended significant investment in community mental health services in Oregon. The report stated, "Without the enhanced community programming, demand for Oregon State Hospital (OSH) beds will substantially exceed projections of size and cost." To address in more detail the need for both "front end" and "back end" services, the Addictions and Mental Health Division (AMH) convened the Oregon State Hospital Master Plan Community Services Workgroup in September 2006. In support of the findings in the Phase II Report, the Workgroup agrees that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. The Workgroup received extensive input into the types of services needed, especially for "front end services" and issues this report to inform the AMH, the Department of Human Services (DHS), the Governor, and the Legislature on the continuum of services required to complement the replacement of the state hospital facilities and to assure the new hospitals' success. In addition, the report provides a narrative description of each type of "front end" service, systematic estimates of the need for and costs of these services, and a timeline for implementing the services.

The Governor's Recommended Budget includes the anticipated funds needed for the 2007-09 biennium's "back end" (or extended care and forensic community services) plus an initial investment of $14.3 million towards the "front end" services recommended in the Phase II report. Funding to expand eligibility of persons for Oregon Health Plan Standard is also included in the Governor's Recommended Budget, which will increase access to Medicaid covered mental health services. The recommendations in this report are intended to provide information about the services needed in an effective mental health system and the funds necessary over the next four biennia to

implement those services. The Workgroup acknowledges that the realities of available funding will influence the decisions made in response to this report. Also the Workgroup recognizes that there are not yet sufficient numbers of qualified mental health professionals and other trained staff to fully implement the recommendations in the immediate future. AMH's Behavioral Workforce Development Committee is a key component in the improvement and enhancement of the community mental health system.

VALUES

As has been articulated in many previous reports and recommendations, community mental health services must be developed with values that support individual recovery. The following statements, adapted from the Governor's Mental Health Task Force Report, summarize the values that drive the recommendations in this report.

- Recovery is the goal of all mental health services.
- Treatment and supports must be consumer-directed.
- Services provided by persons who are recovering from mental health problems serve a valuable role in supporting other people in recovery.
- Services must be available in communities where people live.
- Services must be evidenced-based.
- Safe and affordable housing is key to recovery.
- Services must be culturally and age specific.
- Services must recognize the effects of trauma and support recovery from trauma.
- Planning for services best occurs at the local level while the state provides the resources and accountability.
- An effective mental health system coordinates and collaborates with the broader system of community services.

RECOMMENDATIONS FOR COMMUNITY "FRONT END" SERVICES

Services needed in a comprehensive effective community mental health system are outlined in these recommendations. In addition to identifying new services, the expansion of current services to meet the unmet needs is outlined. The costs for this expansion are stated in terms of additional funds needed each biennium from 2007 - 2009 through 2013 - 2015.

General Assumptions

Well-established research into prevalence rates for mental health disorders project that 161,736[1] persons in Oregon currently experience a serious or severe mental illness. Some of these individuals are served in the public system while others receive services through the private sector. An Office of Health Policy and Research 2004[2] report on uninsured people in Oregon showed that 18.5 percent of adults were uninsured. This would indicate that approximately 29,921 persons with a mental illness are currently uninsured. Of the people now served in the adult outpatient mental health system, 10,699[3] people were non-Medicaid eligible. Therefore, there are approximately 19,222 uninsured persons with a serious mental illness that are not being served. This report will use this estimate as the unmet need. These recommendations also assume a three percent population growth per biennium. All funding for services described in this report are General Fund dollars and the funding identified for each biennium is additional funding.

Early Intervention and Prevention Services

The experience of psychosis is remarkably common and frequently devastating. From age 15 to 30 the brain is in its final stages of maturation, with

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[1] See 2007 Oregon Mental Health Federal Block Grant Application Prevalence Table as Appendix A

[2] *Profile of Oregon's Uninsured, 2004,* Oregon Health Policy and Research

[3] Addictions and Mental Health Division Client Process Monitoring System

development focusing on the frontal cortex. During this process three out of 100 people will develop a psychosis. More than one in 100 will develop ongoing symptoms of psychosis, which need to be managed.

Early treatment of psychosis with evidence-based practices provides the best opportunity for ensuring long-term recovery. These services focus on early identification, support and treatment for the individual and the individual's family. Educating the person about their illness and assisting them in developing skills to manage their symptoms of the illness are key components of the services. Expanding specialized treatment of this kind will reduce hospitalizations, homelessness, and involvement with the criminal justice system. It will also increase educational achievement and stable, productive employment. Based on epidemiological research and five years of experience with the Mid-Willamette Valley's Early Assessment and Support Team (EAST) project, the statewide need for services is estimated to be 360 new clients and their families per year. About 270 persons per year would require services funded by General Fund monies. The average length of stay in treatment would be 18 months, with 6 months of aftercare or transition. This would mean a General Fund-supported caseload of about 540 persons in the second year of the 2007 – 2009 biennium. The $5,000 per person per year cost reflected in these recommendations includes psychiatry, case management with moderate outreach, full family support and preliminary community education. This level of funding would produce significantly positive results for the majority of the persons served with EAST services. To include supported education/employment, occupational therapy, highly persistent outreach, nursing and comprehensive community education would raise the cost to $9,000 to $10,000 per person per year.

Recommendations for:

<u>2007 – 2009</u>

- Expand EAST services statewide to serve 270 persons the first year and 540 persons in the second year.
    - Cost: $4.3 million
    - Assumption:
        - $5,000 per person, per year

- Length of EAST services is two years
- Costs this biennium include contracted technical assistance, project evaluation, statewide project coordination position

2009 – 2011

- Increase funding of EAST services to serve 540 people for the full biennium
    - Cost: $1.3 million
    - Assumptions:
        - Biennial 3.1% Cost of Living Adjustment (COLA)

2011 – 2013

- Increase funding of EAST services to serve 570 people for the entire biennium
    - Cost: $160,000
    - Assumptions:
        - Biennial 3.1% COLA
        - Growth of 30 persons to be served

2013 – 2015

- Increase funding of EAST services to serve 600 people for the entire biennium
    - Cost: $160,000
    - Assumptions:
        - Biennial 3.1% COLA
        - Growth of 30 persons to be served

Crisis Services

Crisis services respond to mental health crises in the community. The services are accessed directly by an individual or indirectly through a community first responder. Communities already have crisis lines that provide at least a minimum crisis response especially for persons whose behaviors have already begun to be dangerous to themselves or others. However, an effective crisis

system includes the ability of a mental health professional to respond much earlier to crises in the field. Mobile crisis interventions, for example, are delivered quickly on site and ensure that a person receives needed services promptly. Most communities have limited ability to provide mobile crisis services, forcing first responders to rely on hospitals or incarceration. This results in persons being served in inappropriately high levels of care or unsuitable settings while they wait for more appropriate and efficient services.

Recommendations for:

2007 – 2009

- Increase crisis funding to Community Mental Health Programs (CMHPs) to serve 25% of the unmet need
  - Cost: $2.6 million
  - Assumptions:
    - 25% (or 4,806 people) of the unmet population will require crisis services[4]
    - Average of 1.5 episodes per person[5]
    - $735 per episode[6]
    - Fund 25% of the gap this biennium

2009 – 2011

- Increase crisis funding to CMHPs to serve 50% of the unmet need
  - Cost: $3 million
  - Assumptions:
    - Biennial 3.1% COLA
    - Growth of 180 people in total unmet need based on population growth

2011 – 2013

- Increase crisis funding to CMHPs to serve 75% of the unmet need
  - Cost: $3.4 million

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[4] *Report to the Governor from the Mental Health Alignment Workgroup,* January 2001

[5] Ibid

[6] Ibid

- Assumptions:
  - Biennial 3.1% COLA
  - Growth of 180 people in total unmet need based on population growth

2013 – 2015

- Increase crisis funding to CMHPs to serve 100% of the unmet need
  - Cost: $3.8 million
  - Assumptions:
    - Biennial 3.1% COLA
    - Growth in 180 people in total unmet need based on population growth

Acute Care Service

Acute care services are medically managed mental health services are typically provided in a hospital setting. Currently Oregon has approximately 278 acute care beds distributed among the 16 community hospitals with psychiatric units. Although some sub-acute mental health services can be provided in secure residential settings, Oregon currently has only 25 such beds. The average length of stay for persons in acute care is approximately 10 days.

Rural communities have particular difficulty accessing acute care mental health services due to the considerable distance from hospitals with psychiatric units. Some rural community hospitals are certified to provide emergency short-term care for persons experiencing a mental health crisis. The average length of stay for these hospital holds is two days.

Hospital-based acute mental health care capacity in Oregon has decreased 23 percent in the last eight years. The existence of significant administrative burdens, financial losses, and the shortage of state-owned psychiatric beds have contributed to the closure of hospital acute care beds. It is likely that if both the funding shortfall and the administrative problems are not addressed additional acute care beds will be close, leading to increasing pressure on the remaining

hospital based providers. This part of Oregon's mental health system is at a tipping point.

In addition to the challenges facing hospital-level acute care service, options need to be expanded to provide sub-acute care when appropriate. With only 25 sub-acute beds currently in the state, this opportunity provides less expensive care options for patients who do not need hospital level of care, as well as providing a "step down" for people leaving the hospital. AMH will soon announce a planning process to assess statewide need for both acute care hospital and non-hospital alternatives.

These alternatives include:

- Sub-acute services – acute care services delivered in a small (16 beds or fewer) residential treatment facility that are monitored by a licensed medical practitioner.

- Crisis respite – 24-hour, 7 days per week, mental health support services provided a person outside the home.

The funding recommended below would fund both acute care services and acute care alternatives. As communities develop acute care alternatives, funding can be reassessed so that high cost inpatient services are properly reimbursed and that community alternatives are available whenever they offer the safest and most efficient level of care needed.

Recommendations for:

<u>2007 – 2009</u>

- Increase funding to acute care regions to respond to the gap between acute care costs and acute care payments, develop sub-acute treatment and crisis respite alternatives. Meet 75% of the unmet need.
    - Cost: $8.37 million

- Assumptions:
  - 35,728 hospital days 2005-2006 fiscal year were for non-Medicaid eligible persons[7]
  - Approximately $1,200 per day based on Medicaid billed charges data from fiscal year 2005-2006
  - 10% for community alternatives to acute care
  - $27 million per biennium currently fund indigent acute care services

2009 - 2011

- Increase regional acute care funding to meet 100% of unmet need
  - Cost: $11.0 million
  - Assumptions:
    - Biennial 5% medical COLA
    - Growth of 810 patient days per biennium
    - Funding for 2009-2011 detox services subtracted from this funding

2011 – 2013

- Increase regional acute care funding to respond to growth
  - Cost: $3.6 million
  - Assumptions:
    - Biennial 5% medical COLA
    - Growth of 810 patient days per biennium
    - Funding for 2011-2013 detox services subtracted from this funding

2013 – 2015

- Increase regional acute care funding to respond to growth
  - Cost: $3.8 million
  - Assumptions:
    - Biennial 5% medical COLA
    - Growth of 810 patient days per biennium

[7] Addictions and Mental Health Division Oregon Patient Residential Care System

- Funding for 2013-2015 detox services subtracted from this funding

Case Management Services

Case management service is the core of an effective adult community mental health system. This service provides an individual with the ongoing support to continue recovery in the community and avoid higher levels of care. Case managers link individuals to treatment services, community services and naturally occurring supports. While some services might occur in a clinic setting, effective case management is delivered in settings outside the clinic in the community.

Not all persons receiving mental health services require the same intensity of service. Approximately 15 percent of persons with a serious mental illness require the intensive level of services of Assertive Community Treatment (ACT). ACT is an outpatient treatment model, adapted from traditional case management methods, for individuals with serious mental illnesses that have not benefited from traditional case management services. A multidisciplinary team with an average caseload size of 10 to 12 people provides the services. Key components of ACT include assertive outreach, team approach, crisis services provided by the team and close work with other community support services. Currently in Oregon, the availability of ACT is limited and caseload sizes vary considerable from one county to the next.

For many persons with a serious mental illness medications are essential to healthy living in the community. However, for persons without medical coverage, medications are too expensive to obtain. Community mental health programs need funding to cover the cost of medications for persons that have a gap in medical coverage and do not qualify for medication scholarship programs. Both medication funding and access to licensed medical professionals who can assess and prescribe medications are a necessity. Rural Oregon experiences considerable difficulty recruiting and retaining licensed medical professionals that can prescribe medications. These regions of the state need to develop networks of psychiatrists and nurse practitioners to meet this

need. Telepsychiatry is a technology that can help meet this need.

While case management and medication services are very important, some individuals need and respond well to counseling services. The funding included in the recommendations that follow is intended to cover counseling services when needed.

When evaluating the unmet need for case management services, the increase needed to meet that demand is immense. So significant is this increase that it is unlikely that the current mental health workforce is sufficient to meet the need. Therefore, the projections outlined in the recommendations for case management services project to meet only 50 percent of the estimated unmet demand for these services after four biennia. As previously noted, AMH's Behavioral Workforce Development Committee is addressing in more detail the future needs and resources to assure a qualified pool of behavioral health staff. As advancements in the growth in the workforce are realized, the projections in the case management recommendations can be adjusted.

Recommendations for:

2007 – 2009

- Develop the equivalent of three ACT Teams statewide to serve 300 adults
    - Cost: $8.4 million
    - Assumptions:
        - ACT
        - Full ACT teams serve 100 consumers and rural areas of the state would require smaller teams
        - Annual cost per person is $14,000
        - An estimated 3,000 non-Medicaid eligible persons with a serious mental illness would benefit from ACT
        - 500 people needing the intensive services of ACT would be served through jail diversion funding and 1,300 people would receive services provided through supported housing

- Increase funding to serve 12.5% of case management unmet need
    - Cost: $10.2 million
    - Assumptions:
        - 85% of the unmet need requires basic case management services
        - $2,500 per year for basic case management services with medication services

2009 - 2011

- Develop the equivalent of three additional ACT Teams statewide to serve an additional 300 adults
    - Cost: $11.6 million
    - Assumptions:
        - Same assumptions as 2007-2009 biennium
- Increase funding to serve 25% of case management unmet need.
    - Cost: $8.7 million
    - Assumptions:
        - Same assumptions as 2007-2009 biennium

2011 – 2013

- Develop the equivalent of 3 additional ACT Teams statewide to serve an additional 300 adults
    - Cost: $13.2 million
    - Assumptions:
        - Same assumptions as 2009-2011 biennium
- Increase funding to serve 37.5% of case management unmet need
    - Cost: $8.9 million
    - Assumptions:
        - Same assumptions as 2009-2011 biennium

2013 – 2015

- Develop the equivalent of three additional ACT Teams statewide to serve an additional 300 adults
    - Cost: $14.9 million
    - Assumptions:
        - Same assumptions as 2011-2013 biennium

- Increase funding to serve 50% of case management unmet need
    - Cost: $9.2 million
    - Assumptions:
        - Same assumptions as 2011-2013 biennium

Supported Employment and Supported Education

Part of recovery for a person with a mental illness is having a meaningful role in the community. Supported employment and supported education services provide the assistance that a person needs to successfully participate in the community. Supported employment is an evidence-based practice that not only has proven results in employment, but also greatly improves a person's quality of life. Supported education is a practice that is developing and research is underway to establish it as an evidence-based practice. Supported employment and supported education works with the individual and the employer or educator to support success in these environments.

Oregon is a leader in the development of supported employment. However, supported employment is only available in select counties. Studies estimate that 70 percent of persons with a serious mental illness express a desire to work. However, studies are not conclusive regarding the optimum length of supported employment services. For the purposes of this report, it is assumed that at any given time 25 percent of the unmet need should have supported employment services.

Recommendations for:

<u>2007 – 2009</u>

- Provide Supported Employment/Education to fund 25% need
    - Cost: $11.2 million
    - Assumption:
        - $3,000 per person, per year
        - Total of 1,870 people served each year

2009 – 2011

- Provide Supported Employment/Education to serve 50% of the need
    - Cost: $12.8 million
    - Assumption:
        - Biennial 3.1 % COLA
        - Total of 3,875 people served each year

2011 – 2013

- Provide Supported Employment/Education to serve 75% of the need
    - Cost: $14.4 million
    - Assumption:
        - Biennial 3.1 % COLA
        - Total of 6,015 people served each year

2013 – 2015

- Provide Supported Employment/Education to serve 100% of the need
    - Cost: $16.1 million
    - Assumptions:
        - Biennial 3.1 % COLA
        - Total of 8,290 people served each year

Jail Diversion and Jail Release Programs

As a result of inadequate resources for non-Medicaid eligible individuals, plus the continuing methamphetamine epidemic in Oregon, law enforcement has had to accept a far more central role in handling mental health crises in the community than it should have to assume. Many individuals end up in our criminal justice system that is ill-equipped to meet the mental health needs of these individuals. Jail diversion services need to be in place to divert people with a serious mental illness from the criminal justice system, and also provide immediate services when a person is released from a local jail. Mental health or treatment courts are emerging as an effective practice for persons with a mental

illness charged with a crime. Those jurisdictions that operate a mental health court rely on the community mental health system to provide the services that the court requires.

Some individuals with a mental illness will require more intensive services when being diverted from the jail or being released from jail. In 2005, the Addictions and Mental Health Division (AMH) in collaboration with the Oregon Jail Managers Association completed a survey regarding persons with a severe mental illness in the jail system[8]. The results from a 100 percent sample of county jails indicated that over 9 percent of the persons in the jail have a severe mental illness. The number of daily jail bookings in Oregon is 540, which means that about 50 people with a serious mental illness are booked every day. Assuming that some of these bookings are repeat offenders, and some individuals can be served in the traditional ACT programs, approximately 500 non-Medicaid eligible people per year will need forensic intensive case management services.

The 2005 Legislature passed SB 913 that allows Medicaid benefits to be suspended instead of terminated when a person with a serious mental illness is incarcerated. The statutory change needs to be fully implemented and advocacy needs to occur at the federal level to permit Medicaid benefits to continue when a person enters a local jail.

Recommendations for:

2007 – 2009

- Provide forensic intensive case management services to people being diverted from jail or upon release from jail. Provide 25% of the estimated need.
    - Cost: $6.25 million
    - Assumptions
        - Cost is $25,000 per person, per year
        - 500 people served is estimated need

[8] Oregon 2005 Jail Survey Results

2009 – 2011

- Provide forensic intensive case management services to people being diverted from jail or upon release from jail. Provide 50% of the estimated need.
    - Cost: $7 million
    - Assumptions
        - Biennial 3.1 % COLA
        - 515 people served is estimated need

2011 – 2013

- Provide forensic intensive case management services to people being diverted from jail or upon release from jail. Provide 75% of the estimated need.
    - Cost: $7.9 million
    - Assumptions
        - Biennial 3.1 % COLA
        - 530 people served is estimated need

2013 – 2015

- Provide forensic intensive case management services to people being diverted from jail or upon release from jail. Provide this to 100% of the estimated need.
    - Cost: $8.7 million
    - Assumptions
        - Biennial 3.1 % COLA
        - 545 people served is estimated need

Co-Occurring Disorder Consultation, Technical Assistance and Detoxification

Studies have have shown that approximately 70 percent of people with a mental illness have a substance use problem. Treatment for co-occurring disorders is most effective when the alcohol and drug services are integrated with mental health services. While outpatient services for co-occurring disorders are widespread, the fidelity for integrated co-occurring disorder services is low.

Residential services for co-occurring disorders are extremely limited and specific detox services for people with co-occurring disorders are essentially non-existent. Communities throughout Oregon have identified co-occurring disorder detox services as a high priority. Last fiscal year, there were 8,130 psychiatric acute care admissions[9] in the state and one county reported that approximately 45 percent of the persons admitted to inpatient psychiatric services in their county were positive for drugs or alcohol. This would lead to an estimate of 3,659 acute admissions statewide that had drug or alcohol involvement. This estimated need would be met with 100 detox beds.

Recommendations for:

2007 – 2009

- Provide technical assistance to 100 outpatient programs
- Provide specific funding to CMHPs to provide supervision and fidelity monitoring
- Provide indigent funding for 25 community residential co-occurring detox beds
    - Cost: $6.15 million
    - Assumption:
        - $1.5 million to be distributed in accordance with a prevalence formula for supervision and implementation
        - $500,000 for the technical assistance.
        - $4.15 million for co-occurring detox
            - $200 per day, per bed
            - $500,000 for development

2009 – 2011

- Provide indigent funding for an additional 25 community residential co-occurring detox beds
    - Cost: $4.28 million

[9] Addictions and Mental Health Division Oregon Patient Residential Care System

- Assumptions:
  - $200 per day, per bed
  - $500,000 for development

2011 – 2013

- Provide indigent funding for an additional 25 community co-occurring residential detox beds
  - Cost: $4.4 million
  - Assumptions:
    - Biennial 3.1% COLA

2013 – 2015

- Provide indigent funding for an additional 25 community residential co-occurring detox beds
  - Cost: $4.6 million
  - Assumptions:
    - Biennial 3.1% COLA

Housing

A 2005 Housing Survey conducted by AMH reports that approximately 5,270 persons receiving mental health services are in immediate need of affordable housing and 1,940 are in need of supportive housing[10]. Resources to develop affordable housing come from a variety of sources and AMH is central to assisting communities connecting with the potential funding. AMH administers the Community Mental Health Housing Fund that supports new development and provides funding for necessary modifications of existing housing. AMH will continue to use designated funds to develop new housing. Numerous people receiving mental health services need housing subsidies to obtain clean, safe housing in the community. The AMH Housing Survey will be conducted again in 2010. This information would measure the progress related to the housing recommendations listed below.

[10] Results of the 2005 OMHAS Housing Survey

Supportive housing for people with serious mental illness has been shown to be effective in promoting residential stability and reducing incidence of hospitalization, homelessness and incarceration. AMH currently has a grant from the Centers for Medicare and Medicaid Services to support work on refining service financing mechanisms to better support people in independent community housing settings. The grant provides funding for technical assistance and development of a resource manual to promote supportive housing services. There is growing evidence in support of the "housing first" model. "Housing first" refers to programs that provide flexible supports and help mental health consumers acquire affordable housing of their choice without having to progress through interim structured housing.

Recommendations for:

2007 – 2009

- Provide monthly housing subsidy to 25% of the need identified in 2005 Housing Survey
    - Cost: $15.81 million
    - Assumptions:
        - $500 per month subsidy
- Provide Supported Housing services to 25% of the need identified in 2005 Housing Survey
    - Cost: $9.36 million General Fund
    - Assumptions:
        - $1,875 per month for services and rend subsidy
        - 80% Medicaid eligible

2009 – 2011

- Provide monthly housing subsidy to 50% of the need identified in 2005 Housing Survey
    - Cost: $17.71 million
    - Assumptions:
        - Biennial 3.1 % COLA
        - Growth of 150 people in the identified need group
- Provide Supported Housing services to 50% of the need identified in 2005 Housing Survey

- Cost: $10.54 million General Fund
- Assumptions:
  - Biennial 3.1% COLA
  - Growth of 60 people in the identified need group
  - 80% Medicaid eligible

2011 – 2013

- Provide monthly housing subsidy to 75% of the need identified in 2005 Housing Survey
  - Cost: $19.75 million
  - Assumption:
    - Biennial 3.1 % COLA
    - Growth of 150 people
- Provide Supported Housing services to 75% of the need identified in 2005 Housing Survey
  - Cost: $11.8 million GF
  - Assumptions:
    - Biennial 3.1% COLA
    - Growth of 60 people in the identified need group
    - 80% Medicaid eligible

2013 – 2015

- Provide monthly housing subsidy to 100% of the need identified in 2005 Housing Survey
  - Cost: $21.94 million
  - Assumption:
    - Biennial 3.1 % COLA
    - Growth of 150 people in the identified need group
- Provide Supported Housing services to 100% of the need identified in 2005 Housing Survey
  - Cost: $13.14 million GF
  - Assumptions:
    - Biennial 3.1% COLA
    - Growth of 60 people in the identified need group
    - 80% Medicaid eligible

Special Populations

Two special populations require specific attention in the development of mental health resources. The needs of transitional age youth, ages 16 to 24, with a mental illness have long been ignored. These youth are expected to move from the child mental health system to the adult mental health system with nothing more than a referral and without acknowledging their developmental needs. Services delivered at this crucial stage in a person's life are essential to recovery. The goals are to have Transitional Age Youth Coordinators in every Community Mental Health Program (CMHP) to assure the proper transition from child mental health services to adult mental health services when necessary.

Older adults are another special population needing increased attention. Mental health problems among older adults pose a continuing challenge to Oregon's healthcare and social services systems. Addressing this need is critical because of the projected rapid increase in the percentage of older adults in the population. Older adults form 13 percent of Oregon's population now, but the percentage may reach 24 percent over the next 30 years. Although the size of the problem is growing, Oregon has limited specialized outpatient mental health programs that address the specific treatment access, engagement, and retention needs of the older adult population. Geriatric Mental Health Specialists should be placed in each community mental health program.

The mental health services outlined in the previous sections include these populations in the projections. In addition to the recommendation to place age specific specialists in each CMHP, the counties should be directed to include services targeted to these special populations as they develop the array of services.

Transitional Age Youth Recommendations for:

<u>2007 – 2009</u>

- Establish Transitional Age Youth Coordinators in every CMHP
    - Cost: $6.1 million

- Assumption:
  - 33 Qualified Mental Health Specialists at $92,226 each for the biennium

2009 – 2015

- No additional funding

Older Adult Recommendations for:

2007 – 2009

- Establish Geriatric Specialists in every CMHP
  - Cost: $6.1 million
  - Assumption:
    - 33 Qualified Mental Health Specialists at $92,226 each for the biennium

2009 – 2015

- No additional funding

Peer Delivered Services

Research is mounting that demonstrates the effectiveness of peer delivered services and people receiving mental health services voice the positive effect of services provided by people that have had similar experiences. Peer delivered services can and should be included in all the categories described above. For example, ACT services are enhanced when the team includes a peer counselor or case manager, and peers can provide support as a person experiences a crisis that might include acute care services. As the mental health services are funded and directed to the CMHPs, peer-delivered services should be incorporated into the development of services. Peer Service Specialists in each CMHP would ensure that peer-delivered services are incorporated into the services array.

An excellent example of peer-supported services is the establishment of Dual Diagnosis Anonymous (DDA) in Oregon. DDA conducts meetings throughout Oregon that are based on the 12 Steps of Alcoholics Anonymous plus 5 steps

that focus on dual disorders of substance abuse and mental illness. In less than 2 years, DDA has grown to over 600 people attending meetings. Further modest financial support would continue the expansion of these valuable meetings.

Recommendations for:

2007 – 2009

- Establish Peer Services Coordinators in every CMHP
  - Cost: $6.1 million
  - Assumption:
    - 33 Peer Specialists at $92,226 each for the biennium
    - $100,000 investment in Dual Diagnosis Anonymous

2009 – 2015

- No additional funding

Local Administration

The community mental health system in Oregon relies on a strong partnership between AMH and the local CMHPs. Nearly all of the community mental health services are contracted through the CMHPs. Frequently when mental health service funding is enhanced, the CMHPs are expected to implement additional services without consideration of the costs associated with the administration of those services. Proper administration ensures that the planning, development, and delivery of mental health services occur with regulatory assurance and quality. Therefore, the following recommendation addresses this often-overlooked aspect of effective mental health system.

Recommendations for:

2007 – 2009

- Fund Local Administration of added mental health services
  - Cost: $1.6 million
  - Assumption:
    - 4% of the cost of added services

2009 – 2011

- Fund Local Administration of added mental health services
  - Cost: $4.0 million
  - Assumption:
    - 4% of the cost of added services

2011 – 2013

- Fund Local Administration of added mental health services
  - Cost: $3.52 million
  - Assumption:
    - 4% of the cost of added services

2013 – 2015

- Fund Local Administration of added mental health services
  - Cost: $3.5 million
  - Assumption:
    - 4% of the cost of added services

COMMUNITY "BACK END" SERVICES

Community residential programs are often referred to as "back end" services because these are the services that most directly facilitate people leaving the state hospital. The State Hospital Master Plan Phase II Report also emphasizes the importance of a strong residential system as part of an effective mental health system. The report states, "...availability and access to these programs (*community residential)* are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community."[11] The table below, based on projections in the Phase II Report, demonstrates the needed residential services by region between 2005 and 2030.

[11] State Hospital Master Plan Phase II Report

Community Residential Bed Need by Region[12]

Region	2005[a]		2011[b]		2030[b]	
	Civil	Forensic	Civil	Forensic	Civil	Forensic
North Willamette Valley	749	118	865	233	996	365
South Willamette/Central Coast	356	27	380	51	430	101
North Coast	22	8	38	24	41	28
Southern Oregon	281	11	292	25	318	52
Central Oregon	29	7	67	45	87	66
Eastern Oregon	116	5	119	9	129	20
TOTAL	1,553	176	1,761	387	2,001	632

[a] Actual distribution of beds in 2005
[b] Assumes 50% civil and 50% forensic development

AMH is projecting the development of 300 community placements in the 2005-2007 biennium and the 2007-2009 Governor's Recommended Budget includes funding for 150 additional civil commitment residential beds and 131 additional forensic residential beds. AMH has determined that the community residential need can be met with funding in the Governor's Recommended Budget and future biennia caseload growth funding. AMH will plan future development to address current disparities in residential bed distribution. Special attention will need to be paid to the Central Oregon region, as it is the region that is most in need for residential development.

FURTHER CONSIDERATIONS

Additional issues were identified that do not have specific recommendations for services and funding that need to be highlighted. The following warrant consideration as "front end" services are implemented:

[12] Ibid

Transportation

Mental health services not only need to be of high quality, but they also need to be accessible. While the large portion of the population is located in areas with a public transportation system, many counties and municipalities have minimal or non-existent public transportation. Also, distances to mental health services are significant in the rural areas. Transportation to available services needs to be addressed as communities plan mental health services.

Rural Costs

Another concern for rural communities is delivering mental health services on a much smaller scale. This often increases the cost of those services. CMHPs would need to work closely with AMH to assure the cost of rural services is considered as new funding is allocated.

Improved Information System Infrastructure

Effective planning for mental health services and effective monitoring of outcomes require information systems that can produce timely meaningful data. Electronic medical records would improve the coordination of individuals care across the system. Funding for the replacement state hospital facilities includes some funding for the Behavioral Health Improvement Project (B-HIP) to replace the archaic data systems upon which the mental health system relies.

Funding Disparities

It is critical that each community or regional system of care in our State have enough resources to fund a set of core services and supports. The Oregon State Hospital Master Plan will <u>not</u> be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate if every region is not funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area.

Our current system has great disparity in the level and type of state investment in our regions and communities. Historical precedent, insufficient funding of behavioral health care, significant cuts in indigent and OHP funds in recent years, extraordinary population growth in a handful of counties and an inability to fully address disparity all contribute to the current dilemma. AMH should work with the CMHPs as plans for the allocation of new funds are determined.

AMH and the CMHPs have agreed that the use of the Kessler Prevalence Formula would guide future allocations of new funds.

EASTERN AND CENTRAL OREGON PSYCHIATRIC INPATIENT AND RESIDENTIAL NEEDS WORKGROUP

The Eastern and Central Oregon Psychiatric Inpatient and Residential Needs Workgroup has been meeting since August 2006 to focus on the special mental health system needs of those regions. It was from this Workgroup that the Central Oregon region initiated a local comprehensive community mental health planning process. Central Oregon has developed a detailed report that outlines their particular needs and that draft report informed the Eastern and Central Oregon Workgroup as well as this Community Services Workgroup. While the Eastern and Central Oregon Workgroup was directed to focus on residential and inpatient needs, the Workgroup also reviewed the broader mental health system needs and the Central Oregon Regional Plan is attached as Appendix B.

IMPLEMENTATION OF COMMUNITY "FRONT END" SERVICES

As stated above, the Central Oregon Region initiated an indepth planning initiative to develop a plan for regional community mental health services. The comprehensive Central Oregon Regional plan was presented to this Workgroup in December 2006. The value of local planning was highlighted in that presentation. The state needs to provide the overall direction of a statewide system of mental health services and the local communities need the opportunity to plan the implementation of those services to meet the particular needs of the citizens of that community. Clear guidelines for local planning of community mental health service enhancements should be provided to the counties or regions by the state. The values delineated in the beginning of this report need to guide the local planning process. Performance indicators related

to the values and service enhancements need to be identified for the local community and statewide.

In each of the service funding areas, there are discrepancies in the distribution of funding across the counties. Any additional funding should address these disparities while meeting the statewide mental health system needs. The Kessler Prevalence formula should be used to determine the allocations to counties and regions.

Recommendations for Implementation:

- AMH should require local plans for each of the service area associated with service enhancement funding.

- Statewide Performance Indicators associated with each service area should be developed by AMH.
- AMH should monitor the implementation of the local plans.

CONCLUSION

The Oregon State Hospital Master Plan Phase II Report focuses on the replacement of hospital facilities. However, the recommendations in the report are predicated on the significant enhancement of the community mental health system. Without the investment in these "front end" services, the demand for state hospital beds will exceed the number of beds included in the new state hospital facilities. This report informs the Governor, the Legislature and DHS what services are needed to support the new state hospital.

Community Services Workgroup Report
Services and Additional Funding by Biennium
Summary Table – Amounts in Millions

SERVICE	07/09 Biennium	09/11 Biennium	11/13 Biennium	13/15 Biennium
EAST	$4.3	$1.39	$.16	$.16
Crisis	$2.65	$3.0	$3.4	$3.8
Acute	$8.37	$11.0	$3.6	$3.8
Case Management (50%)[a]	$18.6 *($28.8)*	$20.3 *($32.0)*	$22.1 *($35.3)*	$24.1 *($38.9)*
Supported Employment/Education	$11.2	$12.8	$14.4	$16.1
Jail Diversion/Re-Entry	$6.25	$7.0	$7.9	$8.7
Housing	$25.17	$28.25	$31.55	$35.08
Co-Occurring	$6.15	$4.28	$4.4	$4.6
Transition Age	$6.1	$0	$0	$0
Older Adult	$6.1	$0	$0	$0
Peer Specialist	$6.2	$0	$0	$0
Local Administration	$4.0	$3.52	$3.5	$3.85
AMH Administration				
TOTAL	$105.09	$91.54	$91.01	$100.19

[a]These funds will only provide outpatient services to 50 percent of the unmet need by 2015. These funding projections were reduced due to concern that the behavioral workforce would not be sufficient to deliver the services at the fully funded level. The funds needed to fully meet all case management needs are in parentheses.

APPENDICES

A - 2007 Oregon Mental Health Federal Block Grant Application Prevalence Table

B - Central Oregon Regional Plan

C - List of Needs and Barriers

D - Acronym Guide

APPENDIX A

2007 Oregon Mental Health Federal Block Grant
Prevalence Table

2007 Oregon Mental Health Federal Block Grant
Prevalence Table

APPENDIX A

Oregon Population and Special Population Estimates

	State Fiscal Year												
	1993-94	1994-95	1995-96*	1996-97*	1997-98*	1998-99*	1999-2000*	2000-2001*	2001-2002*	2002-2003*	2003-2004*	2004-2005*	2005-2006*
Adults													
Population	2,225,278	2,285,317	2,323,637	2,362,617	2,393,047	2,481,340	2,520,805	2,574,873	2,615,068	2,670,114	2,665,710	2,698,507	2,732,030
Prevalence (SMI)	133,819	135,550	137,641	139,897	141,668	146,895	149,232	152,432	154,812	158,071	157,810	159,752	161,736
Prevalence (SPMI)	63,148	63,989	65,062	66,153	66,981	70,470	71,591	73,126	74,268	75,831	75,706	76,638	77,590
Medicaid Eligibles	200,573	317,169	332,299	288,336	289,978	310,733	308,341	327,843	367,892	371,095	332,090	309,448	265,625
Percent	8.9%	13.9%	14.3%	12.2%	12.1%	12.5%	12.2%	12.7%	14.1%	13.9%	12.5%	11.5%	9.7%
Enrolled in OHP managed care	76,815	209,137	267,137	273,721	259,361	271,616	267,572	276,111	301,462	301,248	278,792	220,396	210,643
Percent of eligibles	38%	66%	80%	95%	89%	87%	87%	84%	82%	81%	84%	71%	79%
Adults served in MH system	37,773	43,096	45,213	48,137	52,769	56,259	59,692	67,712	71,135	69,918	61,178	72,043	71,820
Percent of demand	28%	32%	33%	34%	37%	38%	40%	44%	46%	44%	39%	45%	44%
Children													
Population	782,722	796,683	808,363	818,383	823,953	866,330	881,479	846,526	857,798	869,886	875,790	884,008	899,302
Prevalence (Moderate)	93,927	95,602	97,004	98,206	98,874	103,960	105,777	101,583	102,936	104,386	105,095	106,081	107,916
Prevalence (Severe & Persistent)	6,575	6,692	6,790	6,874	6,920	7,277	7,404	7,111	7,206	7,307	7,357	7,426	7,554
Medicaid Eligibles	207,806	245,166	255,941	239,513	221,112	248,246	252,633	274,154	279,132	281,131	314,139	282,706	289,053
Percent	26.5%	30.8%	31.7%	29.3%	26.8%	28.7%	28.7%	32.4%	32.5%	32.3%	35.9%	32.0%	32.1%
Enrolled in OHP managed care	79,585	161,659	205,753	210,823	196,271	223,880	231,300	238,379	249,049	248,889	268,732	262,974	264,427
Percent of eligibles	38%	66%	80%	88%	89%	90%	92%	87%	89%	89%	86%	93%	91%
Children served in MH system	23,815	25,498	26,750	28,192	23,932	24,451	27,938	28,875	29,024	28,356	29,199	33,220	37,467
Percent of demand	25%	27%	28%	29%	24%	24%	26%	28%	28%	27%	28%	31%	35%

*Note: To minimize duplication of effort, CPMS reporting requirements for Oregon Health Plan providers are less stringent than for non-OHP providers. Managed care encounter data has not yet been fully integrated with existing mental health information systems. Beginning with fiscal year 1995-96, counts of clients understate the actual number served for community outpatient and crisis programs, particularly for children. Projection methodology was altered during this time period to account for signifigant changes in Medicaid eligibilty. Further, due to welfare reform, actual numbers of people eligible for Medicaid declined significantly. This decline in total eligibles resulted in fewer people accessing the publicly-funded mental health system. As Oregon's economy has declined over the last year, the number of Medicaid eligibles increased.

Data Sources:

Population- 1992-93 through 2002-03: Center for Population Research and Census, Portland State University, 2002-2003: US Census Bureau

2002-2003: Department of Administrative Services, Office of Economic Analysis

All other data Produced by the Program, Analysis and Evaluation Unit, Office of Mental Health and Addiction Services

APPENDIX B

Central Oregon Regional Plan

A Regional System to Support the Oregon State Hospital Master Plan

Critical Community Service Needs & Plans For Central Oregon 2007-2013

Serving and supporting the recovery of people with mental illness
In Crook, Deschutes and Jefferson Counties

December 2006

Adopted by:

- Cascade Healthcare Community Board of Directors
- Crook County Court
- Crook County Mental Health Board
- Deschutes County Board of Commissioners
- Deschutes County Mental Health, Alcohol & Drug Advisory Board
- Housing Works
- Jefferson County Mental Health Advisory Board
- NAMI of Central Oregon

"The need for investment in community residential and other settings is pivotal to Oregon State Hospital (OSH) projections. Without community residential investment ... the beds needed at OSH could exceed those projected, increasing the size and cost of replacement facilities. This increase in hospital beds would occur largely because of unnecessary admissions and longer lengths of stay, both caused by lack of enhanced community resources"
- Oregon State Hospital Master Plan Phase II Report

Thank You

Special thanks to the following people and organization that supported this work.

77 Respondents to the Central Oregon Needs Survey – A wide range of perspectives including consumers, family members, public safety officials, elected officials, practitioners and advocates

Susan Battles, Intake/Referral Coordinator, Psychiatric Emergency Services, St. Charles Medical Center, **Seth Bernstein**, Accountable Behavioral Health Alliance, **Bree Burch**, Case Manager, Sage View at St. Charles Medical Center **Karen Bird**, Deschutes County Support Staff, **Linda Boyce**, Crook County Consumer and Advocate, **Cindy Cook**, Housing Works, **Heather Crow-Martinez**, BestCare / Jefferson County Mental Health Services, **Jim Denman**, Deschutes County Community Support Services, **Kathy Drew**, Deschutes County Senior and Developmental Disabilities Services, **Jeff Emrick**, Accountable Behavioral Health & Deschutes County Chemical Dependency Org., **Sarah Haefele**, Deschutes County Support Services and Housing, **Robin Henderson**, Director, Behavioral Health Services, Cascade Healthcare Community, **Lori Hill**, Deschutes County Adult Mental Health Services, **Cathy Howes-Yates**, Community Outreach Worker, BestCare, Consumer and Advocate, **Scott Johnson**, Deschutes County Mental Health, **Toni Kelleher**, BestCare Jefferson County Consumer and Advocate, **Angela Kimball**, Association of Oregon County Mental Health Programs, **Alison Lowe**, Deschutes County Advisory Board Member, Consumer and Advocate, **Tim Malone**, Deschutes County Senior Services, **Mike Morris**, Addictions & Mental Health Division, **Judy Odil**, Crook County Consumer and Advocate, **Kristin Powers**, Manager, St. Charles Medical Center, Psychiatric Emergency Services, **Beth Quinn**, Deschutes County Advisory Board, ABHA, Consumer and Advocate, **Roger Olsen**, NAMI of Central Oregon President and Family Member, **Terry Schroeder**, Deschutes County Crisis Assessment Team, **Nick Sundstrom**, Case Manager, Sage View at St. Charles Medical Center, **Rick Treleaven**, BestCare Treatment Services (County Mental Health Provider, Jefferson County), **Nancy Tyler**, Lutheran Community Services NW (County Mental Health Provider, Crook County), **Olivia Wilson**, Deschutes County Consumer and Advocate, **Eugene Zinzer**, Crook County Consumer and Advocate.

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Overview

In recent years, there has been growing recognition among State Officials, mental health advocates, consumers, family members, hospitals, County mental health programs and other local providers that the condition of the current Oregon State Hospital system has reached crisis proportions and cannot be improved without a complete overhaul. It is recognized that this effort must begin immediately. It will require extraordinary effort, investment and innovation, both at the State level and within Oregon communities.

This past summer, Governor Kulongoski, Senate President Peter Courtney and House Speaker Karen Minnis jointly agreed to move forward in implementing the Oregon State Hospital Master Plan Phase II Report by KMD Architects dated February 28, 2006. A Site Selection Committee and process has begun.

Of equal importance, the Report recognizes that the new hospital services must be used wisely, that some people can benefit from more appropriate and less costly treatment alternatives at the local level and that people ready for discharge from the State Hospital must have community options. Furthermore, the Report states clearly that projections and goals of the Report, including bed need, length of stay estimates and critical occupancy rates cannot be realized without significant investment at the community level.

Purposes of this Report

1. To reach consensus within Central Oregon among our key stakeholders about how to best strengthen and improve our local mental health systems for adults with significant mental health needs to complement development of the new Oregon State Hospital System.
2. To inform elected officials, locally and statewide, as well as the Governor's Office and the State Department of Human Services.
3. To describe critical investments in this new system, both at the State and local level, to assure maximum benefit for residents of Central Oregon and the entire State of Oregon.
4. To strengthen local services and supports for adults with mental illness and addictions consistent with the State Hospital Master Plan and decisions of the 2007 Oregon Legislature.

The Oregon State Hospital Plans - Our Goals for Central Oregon

Goal One: Create a true system of care, with continuity of services between Central Oregon communities and the Oregon State Hospital that supports collaboration between County mental health, community hospitals, and the State Hospital staff.

Goal Two: Increase access to preventative care, outpatient and case management services while limiting more costly acute and State hospital levels to times of urgent need.

Other Considerations

- This report represents our best thinking in December 2006 at the start of a dynamic legislative session. We anticipate a dialogue about the future of the mental health system in Oregon. We will represent our region in this process, adjust these recommendations as warranted and advocate for improvements we believe most benefit residents of our region and our State.
- We have other responsibilities as well and will continue to balance these interests with our efforts to help children with mental health challenges, people with addictions and people with developmental disabilities.
- Final decisions on investments will depend on funding levels, state expectations, the most critical needs identified after the 2007 Legislative session and future assessments of need and capacity.

A Local System to Support the Oregon State Hospital Master Plan
Critical Community Service Needs & Plans in Central Oregon 2007-2013

Executive Summary

Overview

This report recognizes that the 2007 Oregon Legislature and the Governor's Office are expected to proceed with the development of a new and improved State Hospital System for adult Oregonians with significant mental health issues. Given the likelihood that a key source document for this effort will be State Hospital Master Plan Phase II (KMD Architects, February 28, 2006), we have crafted a report endorsed by key groups in Central Oregon, that details essential community investments that must occur for this project to be successful. We urge the State to invest in communities and to provide the best possible care, as close as possible to each person's community, families and friends. These recommendations have been developed by a Coalition including Jefferson, Crook and Deschutes counties, areas hospitals, consumers, family members and mental health advocates.

A foundation for our work:

- Recovery oriented practices.
- Integration of services and routine collaboration between County mental health programs, the hospital system, primary care physicians, jails / law enforcement.
- An integrated electronic medical records system (long term).
- Most effective level of care for all populations served to support recovery.

All regions of our State, including Central Oregon have unique needs

Central Oregon (Crook, Deschutes and Jefferson counties) has 200,000 residents and is the fastest growing region in Oregon. The strengths of our mental health system include the cooperation between our County Mental Health Programs and area hospitals, a shared affiliation with a single Mental Health Organization to help members of the Oregon Health Plan, acute care services that include five psychiatric emergency services hold rooms and a 15-bed secure residential facility (Sage View—that will soon be licensed as acute care) and an engaged housing authority, Housing Works.

Our challenges include State funding levels that lag significantly behind other regions in Oregon, a decline in Oregon Health Plan funding, an inability to fully meet the mental health and alcohol/drug treatment and support needs of uninsured residents of our region, the projected erosion of current service levels in the next biennium and the limited residential programs and affordable, supported housing options for people in needs of such services.

Oregon State Hospital Community Services Recommendations

The Master Plan reaches 25 years into the future and also calls for significant improvements in the community system in six regions in our State, including Central Oregon. Our full report details a number of recommendations that build on our current assets and help correct our current limitations.

Our most urgent and essential recommendations contained in the Report are:

1. **SUSTAIN AND ENHANCE CORE SERVICES, ADJUST FOR GROWTH** – Fund critical mental health needs in Oregon's fastest growing region at levels, computed annually, that are comparable to other state regions. Services will decline as growth continues and costs increase without State aid, reducing the likelihood the State Hospital Plan will work in our region. To meet the added challenge of the State Hospital Master Plan we will need to significantly enhance these core services.

2. **INCREASE RESIDENTIAL AND HOUSING OPTIONS** - Expand residential programs, affordable housing options and supported housing (staff support). Assure appropriate level of care, prevent unneeded hospitalizations; help transition and support people returning to our community from State hospital or community acute care placements. Provide resources for development and operations of more than 100 new beds.

3. **DEVELOP RESPITE OPTION(S) TO COMPLEMENT PSYCHIATRIC EMERGENCY SERVICES (PES) AND SAGE VIEW** – Reestablish one or more respite options to support people in crisis that do not need a secure hospital setting. In addition, provide a step-down option for people who can be discharged from a higher level of care to respite setting supported by mental health professionals. Provide resources for the development and operations of new respite beds in two development stages.

4. **IMPROVE OUR CRISIS RESPONSE** – Improve the responsiveness, consistency and capacity of the region's mental health crisis system by establishing a mobile crisis team modeled after Project Respond in Multnomah County and other similar models.

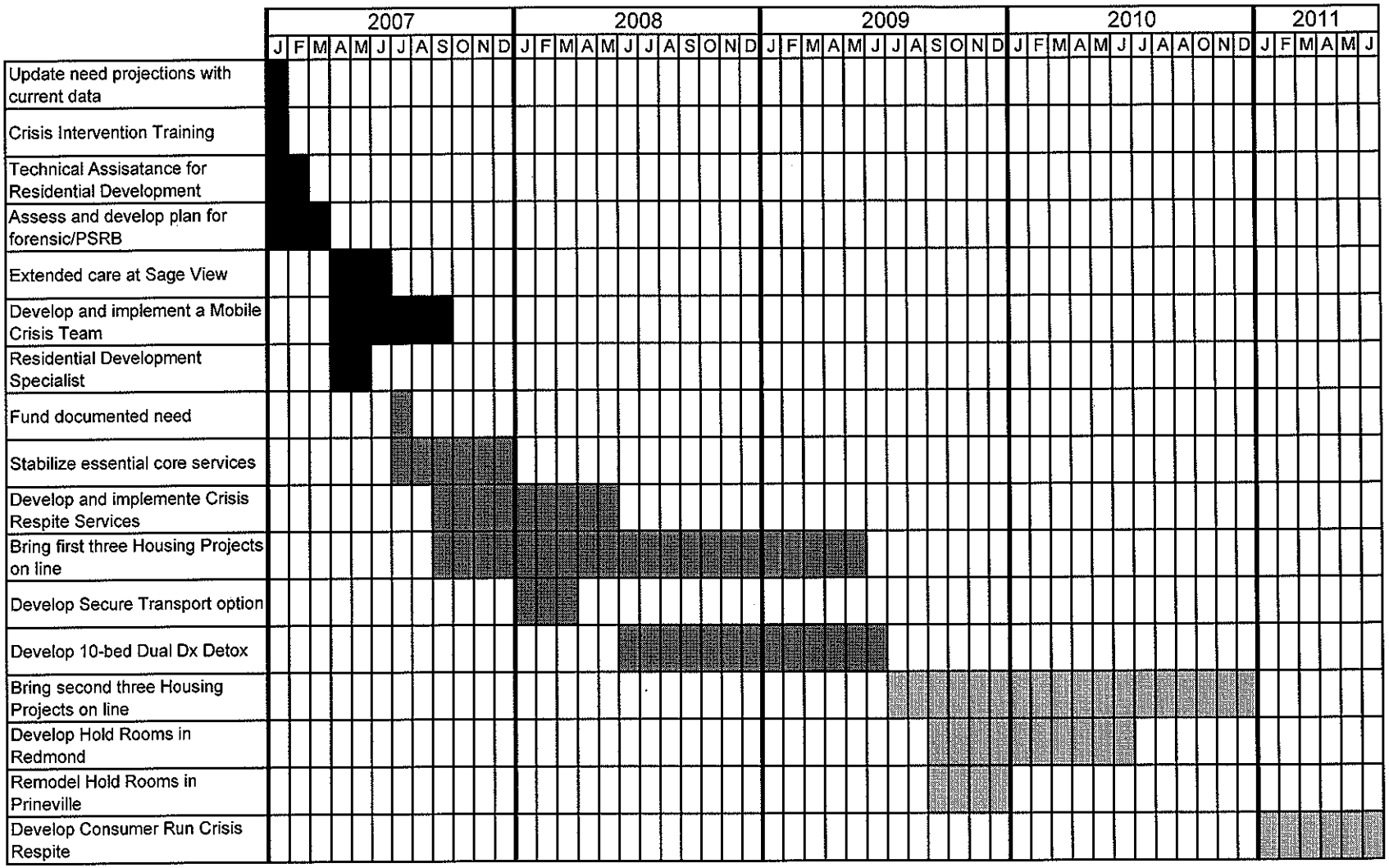
5. **CREATE A ROBUST ADDICTION TREATMENT SYSTEM** – Expand and strengthen dual disorder detox capacity, and enhance community addiction treatment capacity to serve dually diagnosed individuals.

We ask for the opportunity to participate in this planning and development process and for inclusion of this report and its recommendations in the State plans.

For more information, contact:

- **Crook County Mental Health:** Nancy Tyler, Director, Lutheran Community Services NW Phone: 541-447-771 or ntyler@lcsnw.org
- **Deschutes County Mental Health:** Scott Johnson, Director, Deschutes County Mental Health Phone: 541-322-7502 or scott_johnson@co.deschutes.or.us
- **Jefferson County Mental Health:** Rick Treleaven, Director, BestCare Treatment Services Phone: 541-504-9577 or rickt@bestcaretreatment.org
- **Acute Care / Hospital System:** Robin Henderson, Director of Behavioral Health Services Cascade Healthcare Community, Phone: 541-322-2791 or rhenderson@scmc.org

Central Oregon Plan Timeline



Findings

1. **The State Master Plan recommendations are seriously flawed without community investment over the next six years.** The Phase II Master Plan includes an expectation that State funding for community program development will significantly increase prior to 2011. At this time, the Community Mental Health system in Central Oregon is not robust enough to provide significant diversion options from the State Hospital system. Without significant community investment, including investment in Central Oregon, the State Master Plan will fail.

2. **A regional approach is essential to complement State Hospital development.** The Master Plan call for a focus on six regions, including Central Oregon. This framework is well reasoned and beneficial as we share numerous regional organizations and projects. [1] It is not as practical or cost effective to undertake a significant amount of this work on a county or city basis. It is also not practical to consider a state wide approach to complement development due to the vast regional differences in our State.

3. **Current County systems are fragile; limited services make access difficult.** We face an increasing gap between the needs of our community and access to publicly supported mental health and addiction services. In particular, low income people with mental illness and addiction issues and without health insurance are at risk. Without investment, services will decline even further.

4. **Our plans must include improvements in communities throughout Central Oregon.** Each County's mental health program must be strengthened in this process. The hospital system must operate in a complementary fashion. Most importantly, adult consumers in each community, from Madras to LaPine, Sisters to Prineville must have better access to needed help.

5. **Growth in Central Oregon is extraordinary, dramatically increasing the need.** This decade, the population in Central Oregon will rise by 57,000 people, up 37%. Between 2004 and 2005, the population in Crook County rose 10% and the population in Deschutes County rose 6%. In 2006, Crook County became Oregon's fastest growing county, up almost 8%, with Deschutes not far behind at 6.4%. Deschutes grew by the second largest number of people overall in Oregon. Based on current projections, 335,000 people are expected to live in this region by 2030.

6. **The disparity in need-based funding is striking and particularly problematic in Central Oregon.**[2] This gap in the funding of need will jeopardize the Oregon State Hospital assumptions about local capacity and responsibility and could give rise to higher levels of referrals to OSH in the future as well as greater difficulty in transitioning people (ready for discharge) to the community.

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[1] Regional use of 5 psychiatric emergency services hold rooms at St. Charles Medical Center, Housing Works (regional housing authority), a Regional Mental Health Acute Care Council, Sage View (secure 16-bed residential treatment facility), NAMI of Central Oregon and regional planning for the Children's System of Care Initiative.

[2] The listed examples are based on 2005 population figures and will likely be more pronounced based on 2006 actual data and estimates for 2007, 2008 and 2009. Examples of other Counties which may be affected include Washington County and Jackson County.

- **State indigent acute care funding lags behind most Oregon Counties**
  State high $9.48 per capita, State average $8.32 per capita; $6.18 in Central Oregon. [3]

- **State addictions treatment funding lags behind most Oregon Counties, Deschutes 35th**
  State high $17.28 per capita, State average $8.30
  Deschutes ranks 35th of 36 $2.87, Crook 27th $6.00, Jefferson 24th $7.00 [4]

- **State crisis services funding, adult mental health treatment funding and children's mental health funding lags behind the State average based on need and population.**

- **Residential housing resources in Central Oregon are significantly lacking. The Phase II Master Plan indicates the region should have 95 more residential beds by 2007-09, a 300% increase from current levels.**

An additional $8.4 million in state funds would be needed in 2007-2009 simply to bring the Central Oregon region up to the average of needs based funding to Oregon counties to fulfill their responsibilities under Oregon Statutes and Administrative Rules.

Central Oregon Plan Costs 2007-2009

Equity to sustain current operations:	$ 1,148,795
Additional Funding for Residential Beds:	3, 658,168*
Residential Development Costs:	903,450+
Recommended system improvements:	1,300,000
Dual Diagnosis Detox (capital & operations):	1,100,000
Hold Rooms in Redmond & Prineville (capital & operations):	350,000
TOTAL 2007-2009	**$ 8,460,413**

* adjusted percentage based on OSH Master Plan estimates
\+ figure taken directly from the OSH Master Plan estimates

7. **State investments need adjusted at least annually to address areas of greatest need.** The DHS Addictions and Mental Health Division lacks a method to use the most current demographic information and the Kessler formula and fund community mental health needs.

8. **The mental health regions in our State are as diverse as Oregon itself.** Services, needs and resources vary. It is impossible to develop community systems to complement the new State Hospital with a one-size-fits-all approach. Local stakeholders, including consumers, family members, governments, hospitals and health systems must develop responsive local systems.

Note: it is recommended that the equity analysis be calculated in December of each year with state grants adjusted the following to account for changes in need and demographics.

[3] Source: Oregon DHS Addictions and Mental Health Div. Only Lane County is lower at $5.72 per capita.
[4] Source: Oregon DHS Addictions and Mental Health Division.

Recommendations (in priority order)

Caution: this list of projects are in priority order based on a current assessment of needs that most closely relate to the Oregon State Hospital Phase II Master Plan and the associated needs at a community and regional level. Priorities may vary over time. These priorities should be reassessed on an annual basis, and may need adjustment. There are other critical community needs that also need to be addressed over this six year period including services to children and families, help for people with developmental disabilities, addiction treatment and other human service needs and conditions that affect Central Oregon and its citizens and that are normally the responsibility of local governments, hospitals and community groups.

Immediate Priorities – January thru June 2007

1. **Update need projections based on most current data.** The timing of this report required us to use outdated population data. Projections should be updated based on the December 2006 population data as certified by the Population Research Center at Portland State University as well as the certified data for Deschutes County. The funding and need gap in any applicable region of the State, including Central Oregon, should be documented as part of that exercise [5] Once competed, these financial needs should be reported to all constituents.
2. **Provide Central Oregon technical assistance to aggressively launch residential development.** We are asking the DHS Addictions and Mental Health Division to offer a workshop in Central Oregon to a) inform us about residential options, their characteristics and advantages, b) assist us in matching these options to our local needs, and c) help us understand related development, licensing and oversight requirements at the local and State level. We ask that this workshop include local practitioners who can describe how these models were developed. Data from the State suggests we need to add 76 beds at a development cost of $903,450 and with operating expenses (for total beds) totaling $5,900,263.
3. **Allow for Extended Care at Sage View.** Gain the maximum service benefit of Sage View including the availability of Post Acute Intermediate Treatment Services (PAITS-extended care).
4. **Develop a Mobile Crisis Team and hire team members. Pursue a new model for crisis response.** Strengthen the region's acute care psychiatric response with dedicated specialists in lieu the current "on call" arrangement in each County. The team would consist of three master's level clinicians to respond to psychiatric events within the tri-county area. Extensive cross training would occur with first responders in each County. Estimated cost: $280,780, partially offset by current on call budget. Long term, a reduction of 1.5 admissions to St. Charles Psychiatric Emergency Services Unit or Sage View would cover these costs. Evaluate the Project Respond model in Multnomah County and the program in Missoula County Montana.
5. **Offer Crisis Intervention Training** through collaboration with law enforcement, the hospital(s), the counties, consumers and family members. Critical need to provide for the proper management of crisis situations in the community as well as law enforcement officer safety.

[5] We are asking that this calculation and needs analysis include Service Elements 20 (adult services), 22 (children's services), 24 (indigent acute care services, 25 (crisis services) and 66 (indigent addiction treatment services).

6. **Seek commitment of State funds for a Residential Development Specialist.** The State Hospital Master Plan identifies Central Oregon as the region that most seriously lacking in residential programming and housing supports, a region that needs as much as 76 additional residential beds over the next four years. State investment in a local development specialist, effective July 1, 2007, will help us aggressively pursue these State targets.
7. **Assess and develop a plan for forensic/PSRB needs** through collaboration with law enforcement, the hospital(s), counties, consumers and family members. The first step of this process is to convene all local interests in these issues with representatives from the PSRB to develop a better understanding of the processes, resources and development potentials that may not currently be understood or utilized in Central Oregon. The second step is to assess what our current forensic capacity is, what it is projected to be, and to develop a comprehensive plan for this population to be added as a recommendation to this report.

Intermediate Term Priorities July 2007 – June 2009

1. **Fund documented need (similar to other regions) and account for growth.** Receive assurances from the State that need will be assessed and resources adjusted at least annually. Set population forecasts prospectively with projections for the next biennium used in each Kessler formula.
2. **Stabilize essential core services first.** Sustain key components of the Central Oregon mental health system including outpatient treatment for indigent residents, 24/7 crisis services and intensive case management, supported employment particularly for people who are seriously mentally ill. Review the results of the community survey and consider those priorities in any investment plan.
3. **Develop and contract for a Crisis Respite Model serving adults in Central Oregon.** The lack of viable, short term respite options for people in crisis can result in the use of more costly alternatives and extended lengths of stay, occupying precious acute care resources. This project will fill a gap between community outpatient treatment / case management and acute or sub-acute care such as Sage View. The region will seek a residential provider to develop this option in a 5-bed foster home type setting or other alternative. Average length of stay is expected to be 1-9 days. The region will contract for room and board, supervision and medication management while providing mental health support through a County Mental Health Program. Early cost estimates: provider ($120,000), mental health staff ($85,000) per year.
4. **Bring at least three Housing Projects on line including at least one in each County.** Implement the results of the January 2007 workshop; collaborate with a private residential provider, expanding residential options with at least one additional project in each County during the 24 month period. Hire a residential development specialist to work full time on the development of these projects. Assure adequate, additional staff capacity to support additional residential programs and housing options. Goal: Bring on line 64 beds during the 2007-2009 biennium; the State Plan calls for 76 additional beds (Phase II Plan). The balance will be brought on line in 2009-2011.
5. **Develop a consistent Secure Transport option.** Consult with local law enforcement and consider contracting with one or more transport companies. Contractual options include an hourly rate or an annual rate with assurances of unlimited transports throughout the tri-county area. Procurement process to include an open bid process for qualified providers.

6. **Expand current 4-bed Detox capacity (4-bed) in Redmond, to a 10-bed enhanced Dual Diagnosis Program.** The proposed facility would be a 10-bed capacity on the "Visions of Hope" campus in Redmond. The facility would house 5 beds for men and 5 beds for women. Expected stays would be between 5 and 14 days. Clinical goals for this program would be behavioral stabilization, medically monitored detox, starting and/or adjusting of psychiatric meds (if appropriate), co-occurring assessment, brief motivational intervention, and engagement in co-occurring outpatient services.

   The outcomes would be diversion of co-occurring clients from emergency services, diversion of co-occurring clients in jail, and greater client engagement in outpatient treatment. Cost estimates: capital ($400,000) and operations ($354,000). Note: modeled after the Bridgeway Detox program in Salem, Oregon.

Preliminary Residential Development Plan
Subject to further work at January 2007 Workshop – *will be modified to include recommendations for forensic/PSRB populations*

Current capacity within Central Oregon

- Adult foster home – 3 homes, 15 total beds (includes PSRB and ECMU all located in Deschutes)
- Supported housing – Emma's Place with 11 beds (Bend), Prairie House with 8 beds in Prineville.
- Transitional housing – Horizon House with 14 total beds

Type	2007-09	2009-11
PAITS (complete b/w Jan-June 06)	3	
Short term crisis / respite	5	5 consumer run
Long term residential housing		
Residential tx home secure/PSRB/ECMU/GEROPSYCH	5	5
Residential tx home non-secure/PSRB/ECMU/GEROPSYCH	5	5
Foster care	10 5 Crk; 5 Jeff	10
Slots for high need mental health clients in SPD licensed homes (non ECMU)	15	15
Slots for individual apartments for supported housing (if apts AND vouchers are available)	5	
Supported housing		
Redmond	8	
Jefferson	8	
Bend		8
Prineville		8
Short term transitional/emergent housing (90 day)		
Jail / hospital priority		14
SUBTOTAL RESIDENTIAL	**64**	**70**
Affordable Housing thru Housing Works*	*	*

* Housing Works is unable to determine any specific number of units due to funding limitations.

Staff Needs:

- Regional residential development staff (1.0 fte)
- Supported housing case management staff (1.0 fte 2007-2009; 2.0 total fte 2009-2011)
  Residential treatment housing support staff (determine provider and county duties) 1.0 fte

Foster care one staff person per County (offset through open card revenue)

- PSRB one staff person for treatment and .5 fte for coordinator 2007-2009; 2.5 total fte 2009-11
- On site staff for transitional housing project (hours from 5:00pm-8:00 am) –2009-2011
  AFFORDABLE HOUSING
  Affordable housing is a major issue across the region. The regional Housing Authority is dependent on the availability of funds to build such housing. Currently there is no specific funding available in the next biennium for additional affordable housing. There are two projects that will be completed in that timeframe- one in Bend and one in Madras. In addition, it is unknown when there will be additional vouchers available. Both these issues present serious barriers to Central Oregon's ability to adequately house individuals with mental illness. Success in the future for projects such as our proposed transitional housing project, are dependent on the availability of housing resources for individuals to transition to. In addition, in order for more individuals to successfully access the limited affordable housing that is available, a program such as "Fresh Start" is also needed. This program can help assist individuals in reducing barriers to housing such as bad credit history, criminal history, etc.

Long Term Priorities July 2009 – June 2011

1. **Bring at least 3 Housing Project(s) on line including at least one in each County.** Continue residential development as outlined in the previous table, including bring on an estimated seventy (70) additional beds.

2. **Develop Hold Rooms in Redmond.** The St. Charles Medical Center Redmond Hospital (SCMC-R) is centrally located for Madras and Prineville and has room to grow. It also has the ability to have an exempt psychiatric unit. It could also be an excellent location for mobile crisis team and is also located near the detox facility for support. Two-three rooms could be built off the emergency room at SCMC-R in the redesign. Staffing would consist of 4.2 FTE RNs to staff and use an existing ER tech to supplement. Psychiatric support could be through tele-medicine. County mental health would also provide support. Cost involved in development could run $25,000 per room. Costs for staffing $275,000 per year. SE-24 monies may be available for indigent care. SCMC-R is also an ideal location for a gero/medical psychiatric unit with 8-10 beds. This can be scoped into the 7-10 year plan. Cost to develop would be approximately $1.0 – 1.5 million.

3. **Remodel Hold Room in Prineville.** Pioneer Memorial Hospital closed its hold room almost two years ago. Significant remodeling is needed for the room to open safely, along with funding of telepsychiatry to support patients who are there. Costs for remodel and additional staff support and training would be $100,000.

Supporting Material #1

Association of County Mental Health Programs – Essential Elements

The Central Oregon plan is consistent with the AOCMHP Oregon State Hospital Masterplan recommendations. These essential services are as follows:

- A range of housing from specialized residential care to affordable and supportive independent housing.
- 24/7 mobile crisis services and acute, sub-acute, and / or crisis respite care
- Assertive community treatment (ACT) teams that provide intensive "wraparound" services
- Care coordination and effective client-driven treatment services
- Supported employment
- Supported education
- Early intervention programs like EAST
- Integrated treatment for co-occurring disorders
- Illness self-management and recovery programs
- Effective, affordable medications and medication management (including access to psychiatrists)
- Family and community education
- Suicide prevention programs
- Peer-delivered supports and services
- "Gatekeeper" programs and mobile outreach services for older adults, the homeless, and other at-risk individuals
- Diversion and re-entry from criminal justice systems, such as through Mental Health and Treatment Courts and jail diversion and re-entry programs
- Mental health and substance use expertise and collaborative care in school-based clinics, federally qualified health clinics, and other primary care locations
- Transportation to services
- Dual diagnosis detox facility and services

Supporting Material #2

Request for assistance
from the DHS Addictions and Mental Health Division

1. **At least biennially, provide comparative data on financial need in each region of Oregon as well as comparative data with other systems throughout the United States.**

   Data is needed on the level of State investment in the mental health system in all regions of the State using the Kessler Formula. To begin, we are requesting AMHD calculation of funding levels based on December 2006 certified data from the Portland State University Population Center and an estimate of need (i.e. funding at the State average) based on 2007-09 population projections.

2. **Early in 2007, provide a workshop(s) and technical assistance for residential development.**

   AMHD sponsorship of a workshop in Central Oregon would a) inform us about residential options, their characteristics and advantages, b) assist us in matching these options to our local needs, and c) help us understand related development, licensing and oversight requirements at the local and State level. This workshop should be organized based on projected resources for our region as outlined in the State Hospital Master Plan.

3. **Early in 2007, convene a summit to discuss, plan and implement needed changes to the handling of the PSRB clients and those who potentially could be involved in PSRB in the future, with recommendations for facility and service development.**

   Convening a summit of mental health, law enforcement, judicial and state interests to investigate this issue is essential to the success of this plan. There are significant opportunities for handling this population more effectively with training and program development. This summit provides an opportunity to understand the problem from a variety of perspectives, gain insight and information into solutions and integrate these recommendations into the overall plan.

4. **Work with the Governor and the Legislature to craft legislation detailing plans and accountability measures for the State Hospital and necessary community services over the next 6 years.**

   Considerable work is needed at the community level to develop and strengthen local and regional systems. This work cannot be accomplished entirely during one biennium nor can the necessary financial investment be made in that time period. It will require sustained effort, cooperation between the State of Oregon, local communities and key coalitions, and a commitment to financial investment and significant improvements in local services and our capacity to help.

5. **Invest significantly in community services in all six regions of the State, beginning in July 2007.**

   Target investment in community services in all regions to help assure that the bed, occupancy rate, length of stay and transition to community assumptions contained in the OSH Master Plan can be achieved. Use new resources to balance this invest so all regions have sufficient and comparable resources to meet the need in their area. Include use of population projections, the Kessler Formula, housing / residential capacities and need and expectations for individuals under the jurisdiction of the Psychiatric Security Review Board.

Supporting Material #3

Our Population – The Impact of Growth on Need

Population Projections for Central Oregon [6]

County	2000	2005	2010	2015	2020	2025	2030	% Change 30 years
Crook	19,300	21,035	23,051	25,249	27,590	30,125	32,796	70%
Deschutes	116,600	143,053	166,572	189,572	214,145	240,811	270,797	132%
Jefferson	19,150	20,491	22,168	24,079	26,065	28,298	30,831	71%
Central Oregon	**155,050**	**184,579**	**211,791**	**238,900**	**267,800**	**299,234**	**334,424**	**116%**

Special note: The Deschutes County population projections, adopted in September of 2005 are markedly higher than the data published by the office of Economic Analysis in April of 2004.

[6] Deschutes County projections are based on Deschutes County's adopted coordinated population forecast as adopted by the Board of Commissioners in September 2005. The 2030 estimate is based on the % increase from 2020 to 2025; no 2030 figure is included in the forecast itself. Crook County and Jefferson County projections are based on data reported by the Office of Economic Analysis in a Report released in April 2004.

Supporting Material #4

Portland State University Comparative Population Data by County

Area	April 1, 2000 Census Count	July 1, 2003 Certified Estimates	July 1, 2004 Certified Estimates	July 1, 2005 Certified Estimates	% change 2004 to 2005	July 1, 2006 Certified Estimates	% change 2005 to 2006
Oregon	**3,421,399**	**3,541,500**	**3,582,600**	**3,631,440**	**1.4%**	**3,690,160**	**1.6%**
BAKER	16,741	16,500	16,550	16,500	-0.3%	16,470	-0.2%
BENTON	78,153	80,500	81,750	82,835	1.3%	84,125	1.6%
CLACKAMAS	338,391	353,450	356,250	361,300	1.4%	367,040	1.6%
CLATSOP	35,630	36,300	36,400	36,640	0.7%	37,045	1.1%
COLUMBIA	43,560	45,000	45,650	46,220	1.2%	46,965	1.6%
COOS	62,779	63,000	62,700	62,695	0.0%	62,905	0.3%
CROOK	**19,184**	**20,300**	**20,650**	**22,775**	**10.3%**	**24,525**	**7.7%**
CURRY	21,137	21,100	21,150	21,190	0.2%	21,365	0.8%
DESCHUTES	**115,367**	**130,500**	**135,450**	**143,490**	**5.9%**	**152,615**	**6.4%**
DOUGLAS	100,399	101,800	102,350	102,905	0.5%	103,815	0.9%
GILLIAM	1,915	1,900	1,900	1,890	-0.5%	1,885	-0.3%
GRANT	7,935	7,650	7,750	7,685	-0.8%	7,630	-0.7%
HARNEY	7,609	7,300	7,650	7,660	0.1%	7,670	0.1%
HOOD RIVER	20,411	20,500	21,050	21,180	0.6%	21,335	0.7%
JACKSON	181,269	189,100	191,200	194,515	1.7%	198,615	2.1%
JEFFERSON	**19,009**	**19,900**	**20,250**	**20,600**	**1.7%**	**21,065**	**2.3%**
JOSEPHINE	75,726	78,350	78,600	79,645	1.3%	81,125	1.9%
KLAMATH	63,775	64,600	64,800	65,055	0.4%	65,455	0.6%
LAKE	7,422	7,400	7,500	7,505	0.1%	7,540	0.5%
LANE	322,963	329,400	333,350	336,085	0.8%	339,740	1.1%
LINCOLN	44,479	45,000	44,400	44,405	0.0%	44,520	0.3%
LINN	103,069	104,900	106,350	107,150	0.8%	108,250	1.0%
MALHEUR	31,615	32,000	31,850	31,800	-0.2%	31,725	-0.2%
MARION	284,838	295,900	298,450	302,135	1.2%	306,665	1.5%
MORROW	10,995	11,750	11,750	11,945	1.7%	12,125	1.5%
MULTNOMAH	660,486	677,850	685,950	692,825	1.0%	701,545	1.3%
POLK	62,380	64,000	64,950	65,670	1.1%	66,670	1.5%
SHERMAN	1,934	1,900	1,900	1,880	-1.1%	1,865	-0.8%
TILLAMOOK	24,262	24,900	24,950	25,205	1.0%	25,530	1.3%
UMATILLA	70,548	71,100	72,250	72,395	0.2%	72,190	-0.3%
UNION	24,530	24,650	24,850	24,950	0.4%	25,110	0.6%
WALLOWA	7,226	7,150	7,150	7,130	-0.3%	7,140	0.1%
WASCO	23,791	23,550	23,900	23,935	0.1%	24,070	0.6%
WASHINGTON	445,342	472,600	480,200	489,785	2.0%	500,585	2.2%
WHEELER	1,547	1,550	1,550	1,550	0.0%	1,565	1.0%
YAMHILL	84,992	88,150	89,200	90,310	1.2%	91,675	1.5%
Bend	52,029	62,900	65,210				
Madras	5,078	5,370	5,430				
Prineville	7,358	8,500	8,640				
Redmond	13,481	17,450	18,100				

Supporting Material #5

Oregon State Hospital Central Oregon Bed Needs

Projected Bed Needs @ 85% occupancy [7]

Note: The data in this table comes directly from the Oregon State Hospital Framework Master Plan Phase II Report as prepared by KMD Architects, February 28, 2006. Central Oregon has made no attempt to test this data or offer alternative estimates. We are concerned that KMD may have underestimated the population growth in our region and, as a result, the geriatric and forensic needs. If that is in fact the case, the actual need, without a significant State investment in community services, could be higher.

	2011			2021			2030		
	Adult	Neuro-pscych	Forensic	Adult	Neuro-Psych	Forensic	Adult	Neuro-psych	Forensic
Central Oregon	**4**	**4**	**14**	**3**	**6**	**17**	**3**	**9**	**19**
Rest of Oregon	126	113	604	125	159	659	122	206	701
Totals @ 85%	130	117	618	128	165	676	125	215	720

Projected increase in total bed need (derived from Table No. 1)

	2011	2021	2030	% Change 2011-2030
Central Oregon	**22**	**26**	**31**	**41%**
Rest of Oregon	843	943	1,060	26%

[7] Page 9 Oregon State Hospital Framework Master Plan Phase II

Supporting Material #6

Residential Needs Greatest in Central Oregon

Note: The data in these tables comes directly from the Oregon State Hospital Framework Master Plan Phase II Report as prepared by KMD Architects, February 28, 2006 and data provided to the Central & Eastern Oregon Community Services Work Group. Central Oregon has made no attempt to test this data or offer alternative estimates. We are concerned that KMD may have underestimated the population growth in our region and, as a result, the geriatric and forensic needs. If that is in fact the case, the actual need, without a significant State investment in community services, could be higher.

In addition, we are particularly concerned with the acute need for affordable housing options in several communities in Central Oregon. Those costs may compromise our ability to move at the accelerated pace suggested by the data below. At the same time, **we are in complete agreement that affordable housing options, residential facilities and supported housing are urgently needed in our region.**

	2005-07	2009-11	2011-13	2030	% Change 2005-2030
Central Oregon	**36**	**104**	**112**	**153**	**325%**
Rest of Oregon	1,693	1,952	1,995	2,480	46%

State reported estimated OPERATING COSTS of community beds by region

	2005	2007-2009		2009-2011		2011-13	
	Beds	Bed Need	Cost	Bed Need	Cost	Bed Need	Cost
Central Oregon	**36**	**95**	**$5,900,263**	**104**	**$6,753,083**	**112**	**$7,167,681**
Total Beds	1,729	1,959	$130,480.035	2,056	$136,922,004	2,147	$142,537,842

State reported DEVELOPMENT COSTS for new beds by region

	2007-2009	2009-2011	2011-2013
Central Oregon	**$903,450**	**$190,100**	**$172,500**
Rest of Oregon	$9,520,400	$1,901,550	$1,673,850

Supporting Material #7

Need / Funding Shortfall in Central Oregon

Source: Oregon DHS Addictions and Mental Health Division

Indigent acute care funds (Service Element 24) are used to help provide access to emergency and short term psychiatric services and support for uninsured residents of Central Oregon who have an acute need for mental health services. Current and recent investments include Psychiatric Emergency Services at St. Charles Medical Center, secure residential psychiatric services at Sage View (Bend), secure transports, intensive case management to divert (where appropriate) people from more restrictive and costly care and to help people transition back to more appropriate community options upon discharge.

The Central Oregon Regional Acute Care Council projects that current services are NOT sustainable and that funding for current services, at current levels, will run out in 2008-2009.

Oregon State Grant No.	Formula Amount IF equity	Actual State Grant 2005-2007	Deficit / Surplus
Crook County (Lutheran Community Services NW)			
SE 20	143,549	146,248	(2,699)
SE 22	73,319	64,869	8,450
SE 25	112,444	103,819	8,625
Sub total	329,312	314,936	**14,376**
Deschutes County Mental Health			
SE 20	988,723	881,942	106,781
SE 22	380,842	362,448	18,394
SE 25	693,377	593,639	99,738
Sub total	2,062,942	1,838,029	**224,913**
Jefferson County (BestCare Treatment Services)			
SE 20	133,653	143,557	(9,904)
SE 22	82,396	78,264	4,132
SE 25	113,923	89,187	24,736
Sub total	329,972	311,008	**18,964**
CO SE 24	1,649,066	1,166,630	**482,436**
Grand Total	**4,371,292**	**3,630,603**	**740,689**
1 year amt.	2,185,646	1,815,302	370,344

Key for grants

SE 20 = Adult Services
SE 22 = Children's Svcs.
SE 24 = Acute Care
SE 25 = Crisis Services

Central Oregon population increase '05 to '06	6.1%
Oregon population increase 2005 to 2006	1.6%

2007-2008 need to sustain access and quality	2,318,970
2008-2009 need to sustain access and quality	2,460,427

Biennial amount needed in 2007-2009	**$ 4,779,398**	(current services)
Increase above current amt. to reach state avg	$ 1,148,795	

Does NOT include funds for new services to support new State Hospital Master Plan

Notes:

* Other mental health / addiction grants: other grants of importance that are NOT included in this analysis include a) Service Element 35 - seniors mental health services, Service Element 66 - addiction treatment for low income, c) Service Element 60 (addiction special projects).

** COLA - Figures do NOT include any cost of living increase in 2007-2009.

Supporting Material #8

Indigent Acute Care Funding per capita by Region

Source: Oregon DHS Addictions and Mental Health Division

Indigent acute care funds (Service Element 24) are used to help provide access to emergency and short term psychiatric services and support for uninsured residents of Central Oregon who have an acute need for mental health services. Current and recent investments include Psychiatric Emergency Services at St. Charles Medical Center, secure residential psychiatric services at Sage View (Bend), secure transports, intensive case management to divert (where appropriate) people from more restrictive and costly care and to help people transition back to more appropriate community options upon discharge.

The Central Oregon Regional Acute Care Council projects that current services are NOT sustainable and that funding for current services, at current levels, will run out in 2008-2009.

Region	Funding Per Person
Portland Metropolitan Area	$9.48
Southern Oregon	$8.90
Statewide Average	**$8.32**
Mid-Valley Communities	$7.57
Central Oregon [8]	**$6.68**
Lane County	$5.72

[8] Central Oregon includes Crook County, Deschutes County and Jefferson County.

Supporting Material #9

Addictions Treatment Funding by County

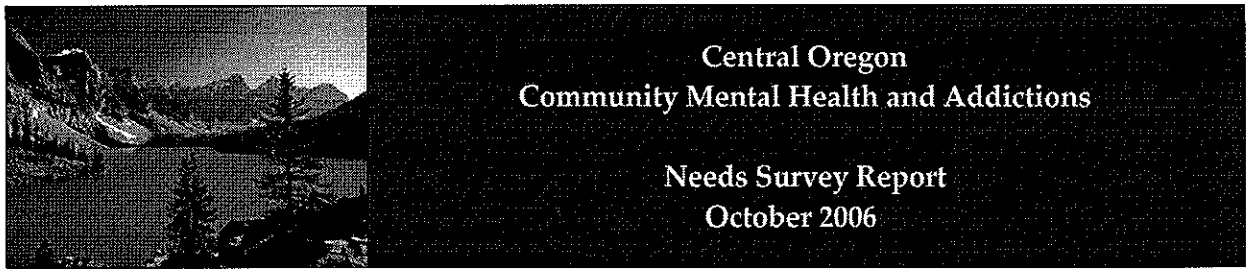
Source: Oregon DHS Addictions and Mental Health Division
Continuum of care services for people who are indigent

County	A & D $ Per Cap	July 2006 Pop	% of Pop.	% Tx. $	State Grant AD66	State Grant AD60	Total
Josephine	$16.96	81,125	2.20%	4.57%	$709,609	666,538	$1,376,147
Morrow/Wheeler	$16.69	13,690	0.37%	0.76%	$228,514	-	$228,514
Columbia	$16.21	46,965	1.27%	2.53%	$171,060	590,130	$761,190
Wallowa	$15.54	7,140	0.19%	0.37%	$110,962	-	$110,962
Harney	$14.87	7,670	0.21%	0.38%	$114,090	-	$114,090
Grant	$14.76	7,630	0.21%	0.37%	$112,630	-	$112,630
Lake	$14.44	7,540	0.20%	0.36%	$108,874	-	$108,874
Mid-Columbia**	$12.79	49,155	1.33%	2.09%	$471,384	157,426	$628,810
Multnomah	$12.75	701,545	19.01%	29.68%	$7,627,622	1,315,618	$8,943,240
Malheur	$12.41	31,725	0.86%	1.31%	$393,602	-	$393,602
Klamath	$12.07	65,455	1.77%	2.62%	$504,008	286,320	$790,328
Baker	$11.23	16,470	0.45%	0.61%	$184,950	-	$184,950
Douglas	$11.18	103,815	2.81%	3.85%	$722,950	437,776	$1,160,726
Umatilla	$11.08	72,190	1.96%	2.65%	$477,568	322,080	$799,648
Curry	$10.04	21,365	0.58%	0.71%	$214,438	-	$214,438
Lincoln	$9.26	44,520	1.21%	1.37%	$329,490	82,790	$412,280
Jackson	$8.52	198,615	5.38%	5.62%	$898,856	793,332	$1,692,188
Benton	$8.46	84,125	2.28%	2.36%	$439,472	272,240	$711,712
Yamhill	$8.26	91,675	2.48%	2.51%	$465,574	291,986	$757,560
State average	**$8.16**						
Counties in high need / below per capita state average							
Marion	**$7.42**	306,665	8.31%	7.55%	$1,974,856	300,000	$2,274,856
Jefferson 25th	**$6.84**	21,065	0.57%	0.48%	$144,132	-	$144,132
Lane	**$6.05**	339,740	9.21%	6.83%	$1,761,276	295,276	$2,056,552
Linn	**$5.66**	108,250	2.93%	2.03%	$387,852	224,821	$612,673
Crook 28th	**$5.57**	24,525	0.66%	0.45%	$136,620	-	$136,620
Clatsop	**$5.52**	37,045	1.00%	0.68%	$204,358	-	$204,358
Washington	**$5.34**	500,585	13.57%	8.87%	$1,553,346	1,118,544	$2,671,890
Tillamook	**$5.26**	25,530	0.69%	0.45%	$134,220	-	$134,220
Union	**$4.81**	25,110	0.68%	0.40%	$120,764	-	$120,764
Clackamas	**$3.97**	367,040	9.95%	4.83%	$978,268	477,710	$1,455,978
Coos	**$3.77**	62,905	1.70%	0.79%	$188,730	48,114	$236,844
Deschutes 35th	**$2.70**	152,615	4.14%	1.37%	$411,692	-	$411,692
Polk	**$2.48**	66,670	1.81%	0.55%	$165,118	-	$165,118
Total	**$8.16**	**3,690,160**	**100%**	**100%**	**$22,446,885**	**7,680,701**	**$30,127,586**

* Based on 7/1/2005 certified estimates from Population Research Center - PSU

** Mid-Columbia includes Wasco, Sherman, Hood River and Gilliam Counties

Supporting Material #10



Executive Summary

An Oregon State Hospital Master Plan, commissioned by the Oregon Legislature, recognizes the need for a wide range of community-based mental health services and supports to complement new state hospital facilities. To plan for these needed community services, Oregon's Department of Human Services has convened a Community Services Workgroup. Central Oregon representatives on the Workgroup, charged with identifying regional needs, consulted community stakeholders in Crook, Deschutes, and Jefferson counties through both a survey and community forum. The Association of Oregon Community Mental Health Programs helped with this process by producing a needs survey, facilitating a forum, and reporting results that will help frame Central Oregon priorities for community development.

The survey results, as well as key issues from the forum, represent a strong consensus regarding the need for development of a wide range of treatment and support options that create a continuum of care for Central Oregonians with mental illness. Key needs identified in this work include crisis respite options, transportation, access to medications, urgent treatment services, and an array of stable, affordable housing options with various levels of support services to assist persons in maintaining their housing and living successfully in the community.

In addition to the above needs, strong voices emerged for specific expertise for a growing population of older adults with mental health needs, for children, for justice-involved juveniles and adults, and for detox and co-occurring disorder treatment. Also of importance to many is the need for rapid access to benefits for people in need of help, opportunities for meaningful community inclusion, and education for the community, family members, and persons with mental health or co-occurring disorders.

In summary, the Central Oregon needs survey and subsequent community forum illustrated a strong desire amongst three counties to address growing unmet needs for persons with serious mental health or co-occurring disorders. It became clear, from both survey responses and discussion during the forum, that helping persons with serious mental health or co-occurring disorders live successfully in Central Oregon will require not only an array of appropriate and integrated treatment and supports, but will also require cooperation and collaborative planning and development at the local level between multiple systems that play important and inter-related roles, such as hospitals, community mental health programs, public safety systems, housing programs, schools, public assistance programs, and community coalitions and businesses, among others.

Background

The Central Oregon needs survey was developed with thirty questions grouped into four broad areas of care: Urgent/acute care needs, treatment service needs, residential/housing needs, and recovery support

needs for persons with serious and persistent mental health or co-occurring disorders who are at risk of or have experienced hospitalization, incarceration, long-term care or homelessness. Respondents had five possible response check boxes to these questions: strongly disagree, disagree, agree, strongly agree, or don't know. A question regarding priorities followed each grouping. The final portion of the survey posed two open-ended questions intended to give respondents an opportunity to make more specific remarks on community strengths and needs. (To view a copy of the Central Oregon Community Mental Health and Addictions Needs Survey, please see appendix A.)

The needs survey was finalized on September 12th, 2006, and was distributed and collected over a period of ten days, from Wednesday, September 13th through Friday, September 22nd, with tabulated results presented at a community forum on Monday, September 25th. During this time, 77 completed surveys were collected from a wide range of individuals in the three participating counties.

While approximately 38% of surveys were from a range of mental health or addictions professionals, nearly 30% of respondents were persons with a mental health or co-occurring disorder or a family member. In addition, 11% of respondents were primary or specialty medical care professionals, 7% were legal/judiciary or public safety/first responder professionals, another 7% were from advisory or quality assurance councils, 4% from the state Department of Human Services (child welfare, self-sufficiency, etc.), and 4% identified as local government officials or staff. The high response rate in a short turnaround time is notable, and may reflect the sense of urgency a wide range of professions and individuals feel about the need to serve persons with mental health or co-occurring disorders in Central Oregon. (For tabulated survey results, please see appendix B.)

Key Findings

Urgent/Acute Care Needs

"Crook County is so rural, really the issue is what we have vs. what we lack...
.Finding detox services seems impossible, as detox/acute care/crisis placements are all out-of-county."

"We need mental health crisis responders available to assist law enforcement on scene or at the hospital."

In answering a question about community urgent/acute care capacity, 65% of respondents felt that their county did not adequately meet urgent or acute care needs. Of the following seven questions around specific urgent or acute care services, the four most strongly stated responses are as follows:

- 65% strongly agreed with need for detox capacity
- 58% strongly agreed with need for urgent access to psychiatrists
- 58% strongly agreed with need for longer-term, 30-90 day facility-based assessment and treatment
- 53% strongly agreed with need for crisis respite/crisis stabilization services.

In reviewing written comments on priorities, the need for detox, crisis respite, and urgent access to psychiatrists were noted often, consistent with the high percentages in the survey result. Significantly, Crisis Intervention Training (CIT) for first responders and public safety officials was a priority for nearly as many respondents. Following CIT training, mobile crisis services and inpatient psychiatric hospitalization were the next most mentioned priorities.

In the September 25th community forum at St. Charles Medical Center following the survey distribution, much of the urgent/acute care discussion centered on the need for facilities that provide step-down care for those who are being discharged from Sage View (psychiatric inpatient care) and the need for mobile crisis services and crisis respite options for those who might not require or want psychiatric inpatient hospitalization.

Treatment Service Needs

"We currently have so many cracks in the system where individuals who don't have the right amount of money, insurance or mental health diagnosis are falling right through. Providing more options for these folks has the potential of not only improving the individuals' lives, but the community as a whole."

"We need to work on the connection between law enforcement and mental health."

"Let us not forget the mental health needs of our seniors in the community."

In general, 72% of survey respondents remarked that community treatment needs for persons with serious mental health or co-occurring disorders are not adequately met in Central Oregon. From a list of ten questions around specific treatment services, the four service needs that generated the highest percentage of "strongly agree" answers are as follows:

- 70% strongly agreed we need free or affordable psychiatric medications
- 48% strongly agreed we need treatment and case management for persons transitioning from incarceration to the community
- 48% strongly agreed we need additional psychiatrist or psychiatric nurse practitioner availability
- 46% strongly agreed we need integrated treatment for co-occurring mental health / substance use disorders.

Written priorities ranged from an emphasis on geriatric services to children's mental health services, but with an overwhelming number focused on the need for access to psychiatric medications—likely reflecting discussion at the community forum regarding the large number of clients who are not eligible for the Oregon Health Plan and its prescription coverage. In addition, a significant number of respondents stated intensive case management as a priority, as well as the need for a range of criminal justice-related services, including sentencing alternatives, services for juvenile departments, mental health assessment and treatment in jails, and services for those transitioning from incarceration to the community.

Residential and Housing Needs

"More facilities like Horizon House [are needed] that are safe, affordable and allow for controlled independent living."

"I think the community of Bend could use more education to not be scared of the mentally ill and that housing the mentally ill is less expensive than having them homeless."

An overwhelming 90% of respondents disagreed or strongly disagreed that Central Oregon has enough safe, decent and affordable housing for persons with serious mental health or co-occurring disorders.

Over 50% of respondents replied "strongly agree" to both a following question about the need for additional specialized/structured residential facilities (more intensive care and supervision) and a question about the need for additional supportive independent or transitional housing (more minimal support for living). In a region where housing and land prices are at a premium, the supply of housing for those clients who have limited or no incomes is a matter of great concern.

In both written comments and at the community forum, no single type of housing (adult foster homes, residential treatment facilities, secure facilities, supportive independent housing, long-term housing, etc.) emerged as a priority. Rather, there was a strong consensus that a range of housing types is necessary to meet widely varying needs, including options that may prevent hospitalization and options that are designed to help an individual transition to life in the community.

Recovery Support Needs

"Transportation!! This is a HUGE barrier."

"Access to benefits and transportation."

"What's working well? The Clubhouse provides a social support network, peer supported counseling and job training opportunities."

As with urgent/acute care services, 65% of survey respondents did not feel community recovery support needs are adequately met. Out of a wide range of supportive services, the following priorities emerged:

- 60% strongly agreed we need transportation for persons receiving services
- 55% strongly agreed we need opportunities for meaningful community inclusion
- 44% strongly agreed we need easy, rapid access to benefits (e.g. medical assistance, food stamps)

In reviewing written priorities, transportation again received overwhelming support. Notably, though, support groups and education for clients and their families were consistently listed as a priority, along with access to benefits.

In discussion at the community forum, the need for transportation was a topic of intensive dialogue. In contrast to many urban areas in the I-5 corridor, housing appears to be more affordable in rural areas of the region, whereas services and employment are more concentrated in urban areas like Bend. With no public transportation system in the region, access to treatment and other support services is problematic.

Conclusion

The Central Oregon Needs Survey addressed four major components of a continuum of community-based care: Urgent/acute care needs, treatment service needs, residential/housing needs, and recovery support needs. While strong needs were voiced in all areas and across all service and support types, the following seven issues received 50% or more responses of "strongly agree:"

Free or affordable psychiatric medications (70% strongly agree)
Transportation for persons receiving services (60% strongly agree)
Longer term (30-90 day) facility based assessment and treatment (58% strongly agree)

Urgent access to psychiatrists (58% strongly agree)
Opportunities for meaningful community inclusion (55% strongly agree)
Supportive independent, transitional, or minimally structured housing with daily to weekly staff assistance (53% strongly agree)
Crisis respite/crisis stabilization services (53% strongly agree)

It should be noted that while the above seven items may merit special attention in planning, discussion during the community forum indicated that a broad and stable continuum of services is necessary to provide an effective foundation of support for a new state hospital. More specifically, the desire for a 24/7 mobile crisis team trained to provide in-home crisis intervention and to work in collaboration with police/fire/sheriff departments was noted—with an often-corresponding need expressed for additional detox capacity and "user friendly," home-like respite care as an alternative to hospitalization.

Community forum participants emphasized that a large percentage of Central Oregon residents do not meet narrow Oregon Health Plan eligibility requirements, yet have significant mental health needs. As a result, access to medications is a considerable problem, along with access to benefits and other treatment and support needs. Housing and transportation emerged as persistent barriers to successful recovery for persons with serious mental health or co-occurring disorders. Acknowledging the breadth of issues and the need to develop solutions specific to Central Oregon needs, three sub-committees were formed to meet and compile specific recommendations for phased development. In summary, the Central Oregon needs survey and community forum indicate wide-spread support for development of a cohesive and more comprehensive array of services and support options to meet growing regional needs.

Central Oregon / Oregon State Hospital Community Services Survey

77 Responses from Central Oregon Stakeholders

Section 1: Urgent/Acute Care Needs (for persons with serious and persistent mental health or co-occurring disorders)					
	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
1. Overall, my community adequately meets urgent or acute care needs.	7	43	19	6	2
2. My community needs (additional) acute inpatient psychiatric hospitalization capacity.	1	4	35	32	5
3. My community needs (additional) detox capacity.	2		10	50	15
4. My community needs (additional) capacity for longer term facility-based treatment and assessment (30-90 days).		1	29	45	2
5. My community needs (additional) capacity for crisis respite/crisis stabilization services (1-14 days).		7	24	41	5
6. My community needs (additional) 24/7 mobile crisis response services that go to the individual or family in need.	1	7	26	34	9
7. My community needs (additional) Crisis Intervention Training (CIT) for first responders and public safety officials.		2	27	39	9
8. My community needs (additional) urgent access to psychiatrists.	2	2	22	45	6
What urgent or acute care service would you prioritize for your community? 3,4,5,6,7,8_____					

Section 2: Treatment Service Needs (for persons with serious and persistent mental health or co-occurring disorders)					
9. Overall, my community adequately meets treatment needs for persons with serious mental health or co-occurring disorders.	9	46	16	3	3
10. My community needs (additional) intensive early intervention services for young adult's first experiencing psychosis.	1	4	30	34	8
11. My community needs (additional) intensive community treatment teams that provide 24/7 "wraparound" care (e.g. Assertive Community Treatment "ACT" teams).	1	4	35	29	8
12. My community needs (additional) outpatient intensive case management/care coordination.	1	3	34	33	6
13. My community needs (additional) integrated treatment for co-occurring mental health and substance use disorders. 14.		1	33	35	8
14. My community needs greater access to free or affordable psychiatric medications.		2	18	54	3
15. My community needs (additional) bilingual/bicultural mental health and addictions providers.		6	37	21	13
16. My community needs (additional) psychiatrists and/or psychiatric nurse practitioner availability.		4	32	37	4
17. My community needs (additional) mental health and addictions screening and assessment capacity in jails.		2	30	32	13
18. My community needs (additional) sentencing alternatives (e.g. Mental Health/Treatment Courts or day reporting)		7	35	22	13
19. My community needs (additional) case management and treatment for persons transitioning from incarceration to the community (re-entry services).	3	4	26	37	7
What treatment services would you prioritize for your community? _____					

Section 3: Residential/Housing Needs (for persons with serious mental health or co-occurring disorders)					
20. Overall, my community has enough safe, decent and affordable housing to meet needs.	43	26	5	1	2
21. My community needs (additional) specialized/structured residential facilities that provide 24 hour supervision (e.g. residential treatment facilities/homes, adult foster homes, secure facilities, and enhanced care services programs).	3		29	40	5
22. My community needs (additional) supportive independent, transitional, or minimally structured housing with daily to weekly staff assistance.	2	5	25	41	4
What kind of residential facility or housing for persons with serious mental health or co-occurring disorders would you prioritize for your community? _____					

Section 4: Recovery Support Needs (for persons with serious mental health or co-occurring disorders)					
23. Overall, my community meets recovery support needs.	12	38	14	3	10
24. My community needs (additional) competitive supported employment opportunities.	1	3	40	25	8
25. My community needs (additional) consumer peer supports and/or peer-delivered services.		8	29	25	15
26. My community needs easy and rapid access to benefits (e.g. medical assistance, food stamps, etc.)		5	32	34	6
27. My community needs (additional) opportunities for meaningful community inclusion/socialization.		6	20	42	9
28. My community needs access to transportation for persons receiving services.	2	4	17	46	8
29. My community needs child care assistance for persons receiving services.	2	2	25	32	16
30. My community needs (additional) supports/education for family members of persons receiving services.	2	1	29	32	13
What recovery support needs would you prioritize for your community? 26, 28, 29, 30_____					

Contacts

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Acute Care / Hospital System
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Cascade Healthcare Community
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APPENDIX C

Issues and Barriers List

DHS/Addictions and Mental Health Division
Oregon State Hospital Master Plan – Community Services Workgroup

Issues and Barriers List

November 20, 2006

- Workforce development
  - Recruitment
  - Retention

- Acute care
  - Retention of current resources
  - Projected Need

- Persons with a mental illness in the criminal justice system

- Benefit gaps
  - Social Security
  - Medicare/Medicaid
  - Housing Subsidies

- Working cross-systems
  - Criminal justice

- Outreach services

- Care involves relationships
  - Continuity
  - Quality/recovery focus
  - Physicians
  - Acute care

- Ready access to services

- Local (cities/counties) commitment to statewide system
  - Planning according to need vs. planning to the resources

- Working on siting residential programs
  - Community collaboration

- Develop strategy that encourages doing the right thing

- Data for planning

- Public operated programs
    - Ongoing commitment

- Issues related to:
    - Small vs. large counties
    - Rural vs. urban counties

- Public/private partnerships

- Issues related to psychiatric hold rooms
    - Telepsychiatry as alternative

- Uninsured

- Other systems that impact mental health system (i.e. A&D Services)

- Look at the "what to do" and "the how to do"

- Services for transition age youth

- Access to medications

- Emergency room pressures

- Crisis centers

- Housing
    - Safe
    - Affordable
    - Supports

- Consumer-based independent advocacy

- Mental health services to seniors

- Mental health services to persons that are developmentally disabled

- Supported employment and supported education

APPENDIX D

Acronym Guide

APPENDIX D

Community Services Report
Acronym Guide

ACT	Assertive Community Treatment
AMH	Addictions and Mental Health Division
B-HIP	Behavioral Health Improvement Project
CMHP	Community Mental Health Program(s)
COLA	Cost of Living Adjustment
DHS	Department of Human Services
DDA	Dual Diagnosis Anonymous
EAST	Early Assessment and Support Team
OMHAS	Office of Mental Health & Addictions Services (now known as AMH)
OSH	Oregon State Hospital
SB	Senate Bill