FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

___FY 2005-2007 __XX_ FY 2005-2006 ___ FY 2005

STATE NAME: _Oregon_____

DUNS #: __135749013_____

I. AGENCY TO RECEIVE GRANT

AGENCY: ___Department of Human Services, Health Services _____

ORGANIZATIONAL UNIT: ___Office of Mental Health and Addiction Services_____

STREET ADDRESS: ____500 Summer Street NE – E86_____

CITY: ___Salem_____STATE: ___Oregon_____ ZIP: _____97301-1118_____

TELEPHONE: __503-945-5763_____ FAX: __503-378-8467_____

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

NAME: __Robert E. Nikkel_____ TITLE: ___Administrator_____

AGENCY: ___Department of Human Services, Health Services _____

ORGANIZATIONAL UNIT: ___Office of Mental Health and Addiction Services_____

STREET ADDRESS: ____500 Summer Street NE – E86_____

CITY: ___Salem_____STATE: ___Oregon_____ ZIP: _____97301-1118_____

TELEPHONE: __503-945-5704_____ FAX: __503-378-8467_____

III. STATE FISCAL YEAR

FROM: ____July____ ___2004_____ TO: ___June_____ ____2005_____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:____Madeline M. Olson_____ TITLE:__Assistant Administrator_____

AGENCY: ___Department of Human Services, Health Services _____

ORGANIZATIONAL UNIT: ___Office of Mental Health and Addiction Services_____

STREET ADDRESS: ____500 Summer Street NE – E86_____

CITY: ___Salem_____STATE: ___Oregon_____ ZIP: _____97301-1118_____

TELEPHONE: _503-945-9718__ FAX: _503-378-8467__

EMAIL: madeline.m.olson@state.or.us

Executive Summary

The 2005 State Plan for mental health services in Oregon contains measurable goals and performance indicators to guide and assess the development and implementation of a comprehensive system of mental health care during the next fiscal year. The objectives reflect Oregon's continued commitment to provide persons with mental illness the greatest opportunity to pursue independent and meaningful lives.

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

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

While Oregon has seen some restoration of funding for community mental health services during the last year, the restorations have not been complete. One of the most significant reductions was the elimination of the mental health benefit for individuals eligible for Medicaid based on poverty in March 2003. In August 2004 the mental health benefit was restored however the population eligible has been dramatically reduced. Therefore, Oregon continues to struggle with funding for community mental health services.

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

- The Executive Order establishing the Governor's Mental Health Task Force was issued, the task force completed a comprehensive review of the mental health system and is nearing completion of the report to the Governor.

- The 2003 legislature directed OMHAS through a Budget Note to integrate children's Intensive Treatment Services into a community-based system of care.
- The 2003 legislature passed SB 267 that establishes percentages of funds that must be directed towards evidence-based practices.

Oregon's State Plan reflects the realities of the struggle while pushing ahead with improvements in the public mental health system.

TABLE OF CONTENTS

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

I. Federal Funding Agreements, Certifications and Assurances

1. Funding Agreements

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2005

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

Section 1911:

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

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

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

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

Section 1912

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

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

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

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

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

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

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

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

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

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

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

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

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

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

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

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

Section 1915:

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

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

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

Section 1916:

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

(1) to provide inpatient services;

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

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

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

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

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

Section 1941:

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

Section 1942:

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

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

(2) the recipients of amounts provided in the grant.

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

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

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

_____ _____

Governor Designee **Date**

2. Certifications

3. Assurances

4. Disclosure of Lobbying Activities

5. Public comment on the state plan

Oregon's State Plan is posted on the Department of Human Services website at the time the application is submitted to the Center for Mental Health Services. The plan is open for comment during the Legislative Session as part of the Agency's budget presentation to the Legislature. There is opportunity for public comment at that time. The feedback from the public comment will be incorporated into any modifications to the State Plan. The next Legislative Session will convene in January 2005. OMHAS will notify the Center for Mental Health Services of any State Plan modifications made in response to public comment.

II. Set-aside for Children's Mental Health Services Report
III. Maintenance of Effort Report (MOE)

State of Oregon
2005 Community Mental Health Services Block Grant
Maintenance of Effort

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

Line Item	Actual 2002-03	Actual/Estimated 2003-04	Estimated 2004-05
Non-Residential Adult MHS	9,799,028	16,433,794	16,765,789
Oregon Health Plan Adult Services	31,202,001	25,117,572	25,624,998
Psychiatric Day Treatment Services (PDTS)	4,726,599	3,051,276	3,112,918
Adult Crisis Services	4,128,264	7,011,196	7,152,837
Adult Residential Care Facilities	1,082,263	10,275,763	10,483,354
PSRB	1,702,111	3,184,324	3,248,654
Enhanced Care Services	2,835,945	3,073,676	3,135,771
Adult Foster Care	9,561,851	4,750,940	4,846,918
Older and Disabled Adults	368,086	788,179	804,102
PASSAR Reviews	160,447	170,536	173,982
Special Project / Local Acute Care	1,294,381	3,417,541	3,486,583
Supported Employment	716,653	245,336	250,292
Child and Adolescent CTS	1,706,670	3,425,994	3,495,207
Oregon Health Plan Childrens Services	30,988,573	28,835,731	29,418,271
Children's Crisis Services	672,043	1,141,358	1,164,415
Total	**100,944,914**	**110,923,217**	**113,164,090**

Set-Aside for Children's Mental Health Services

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

State Expenditures for Children's Services

Line Item	FY 94 Base	Actual 2002-03	Actual/Estimated 2003-04	Estimated 2004-05
Child and Adolescent Community Treatment Services	8,559,365	1,706,670	3,425,994	3,495,207
Child and Adolescent Community Treatment Services - Block Grant 1992	633,677	-	-	-
Additional 10% 0o 93 Block Grant Added to Base	282,497	-	-	-
Additional 10% 0o 94 Block Grant Added to Base	282,497	-	-	-
Oregon Health Plan Children's Services	-	30,988,573	28,835,731	29,418,271
Children's Crisis Services	-	672,043	1,141,358	1,164,415
Medicaid Authorization Specialists	289,475	-	-	-
Day and Residential Treatment Services/Psychiatric Day Treatment Services	5,559,692	4,726,599	3,051,276	3,112,918
JCAHO Certified Residential Care Facilities for Children and Adolescents	1,443,965	-	-	-
Robert Wood Johnson Foundation Grant	860,800	-	-	-
Total	**17,911,968**	**38,093,885**	**36,454,359**	**37,190,811**

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

IV. State Mental Health Planning Council Requirements

1. Membership Requirements

Mental Health Planning and Management Advisory Council

BYLAWS

ARTICLE 1. Purpose

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

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

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

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

d. To identify problems and develop recommendations for resolution; and

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

ARTICLE 2. Membership

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

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

1. Three advocates for mental health services;
2. Four consumers of mental health services;
3. Three family members of children/adolescents with serious emotional disorders;
4. Three family members of adults with mental illness;
5. Four representatives of mental health providers;
6. Four representatives of community mental health programs;
7. Eight representatives of state agencies serving persons with mental illness;

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

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

c. Members of the Council shall be responsible to disseminate information from council meetings to the constituents they represent.

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

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

f. Proxy votes are not allowed.

ARTICLE 3. Meetings

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

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

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

d. All meetings are public meetings.

ARTICLE 4. Officers

a. The officers of the Council shall consist of the co-chairpersons and vice co-chairpersons.

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

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

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

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

f. The co-chairpersons shall preside at all meetings of the Council; shall be ex-officio members on all committees; shall represent the Council and conduct such business as the Council directs.

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

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

ARTICLE 5. Committees

a. All committees shall be created by the chairpersons of the Council or by vote of the Council, as necessary to carry out the functions of the Council. Committees shall be assigned a specific task to be accomplished in a limited period of time and then discontinued. All committees will be staffed by a person from the Office of Mental Health & Addiction Services as assigned and approved by the Administrator for Mental Health & Addiction Services.

b. The chairpersons of the Council shall designate a chairperson for each committee created.

c. Committees may include non-council members.

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

e. The co-chairpersons shall appoint a Nominating Committee as necessary to recommend Council nominees to the Administrator and to nominate officers.

ARTICLE 6. Policies

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

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

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

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

2. State Mental Health Planning Council Membership List & Composition

Table 1. List of Planning Council Members

Co-Chair for Adults Mary Claire Buckley
Vice Co-Chair for Adults Bob Furlow
Co-Chair for Children Bill Wellard
Vice Co-Chair for Children Phil Cox

Name	Type of Membership	Agency Or Organization Represented	Address, Phone &Fax
Lynda G. Crandall	State Employee	Seniors and People with Disabilities	500 Summer Street NE Salem, OR 97310 Ph: 503-945-5918 ext 2569 Fax: 503-378-8966
Stephaine Parrish Taylor	State Employee	Office of Vocational Rehabilitation Services	500 Summer Street NE E87 Salem, OR 97301-1120 Ph: 503-945-6201 Fax: 503-947-5010
Mary Claire Buckley	State Employee	Psychiatric Security Review Board	620 SW Fifth, Suite 907 Portland, OR 97204 Ph: 503-229-5596 Fax: 503-229-5085
Paula Bauer	State Employee	Children, Adults & Families	500 Summer Street NE E83 Salem, OR 97310 Ph: 503-945-6690 Fax: 503-947-5084
Dr. Arthur Tolan	State Employee	Department of Corrections	2575 Center Street NE Salem OR 97301-4667 Ph: 503-378-8373 Fax: 503-378-5118
Phil Cox	State Employee	Oregon Youth Authority	530 Center Street NE, Ste. 200 Salem, OR 97310-3740 Ph: 503-373-7531 Fax: 503-373-7622
Bob Repine	State Employee	Oregon Housing and Community Services	725 Summer Street NE P O Box 14508 Salem, OR 97309-0409
VACANT	State Employee		
VACANT	State Employee		
Kathleen Ris	Family Member Youth SED		2080 SE Kelly Gresham, OR 97080 Ph: 503-667-2072 or 503-539-7267

Callie Schlippert	Family Member Youth SED		18030 S. Skyland Circle Lake Oswego, OR 97034 Ph: 503-697-1808 Fax: 503-735-7046
VACANT	Family Member Youth SED		
Angela Kimball Family Involvement Coordinator	Family Member Youth SED	Behavioral Health Division	421 SW 6th Avenue Portland OR 97204 Ph: 503-279-0256
Stan Davis, M.D.	Family Member Adult SMI		1973 Manor View Lane Salem, OR 97304 Ph: 503- 363-1581
VACANT	Family Member Adult SMI		
Doris Cameron-Minard	Family Member Adult SMI		P.O. Box 989 Wilsonville, OR 97070 Ph: 503-625-3288 Fax: 503-625-5038
Judy Wilson	Family Member Adult SMI	NAMI-Oregon	1905 Waverly SE, #54 Albany, OR 97321 Ph: 541-928-7036 Fax: 541-928-7036
VACANT	At Large		
VACANT	At Large		
VACANT	Advocates		
Jan Stewart	Advocates		2411 Ninth Street Tillamook, OR 97141 Ph: 503-842-1259 Fax: 503-842-8538
Bob Joondeph	Advocates	Oregon Advocacy Center	620 SW Fifth Avenue, 5th Floor Portland, OR 97204-1428 Ph: 503-243-2081 Fax: 503-243-1738
Jeanne Schulz	Advocates	Oregon Family Support Network	1041 Sanborn Avenue Eugene, OR 97404 Ph: 541-912-4009 Fax: 541-656-5442
Rollin Shelton,	Advocates	OCTA Center for Self Determination	3608 SE Powell Blvd. Portland, OR 97202 Ph: 503-232-9154 x153
VACANT	Advocates		

Mariana Bornholdt	Advocates	Governor's Commission on Senior Services	4730 NE Auburn Rd., Sp. 95 Salem, OR 97301-4943 Ph: 503-362-3230
Bob Furlow	Providers	Douglas County Health and Social Services Dept.	621 West Madrone Street Roseburg, OR 97470Ph: 541-440-3661 Fax: 541-440-3508
Chris Johnson, Director	Providers	Yamhill Co. Health & Human Svcs.	627 N. Evans McMinnville, OR 97128Ph: 503-434-7523 Fax: 503-434-9846
Mitch Anderson	Providers	Benton Co. Mental Health Benton Co. Mental Health Dept.	530 Northwest 27th Street Corvallis OR 97330Ph: 541-766-6844 Fax: 541-766-6642 Fax
Jan Kaplan	Providers	Lincoln Co. Mental Health Program	51 SW Lee Street Newport, OR 97365Ph: 541-265-4179 Fax: 541- 265-4194
VACANT	Providers		
Bob Lieberman	Providers	Southern Oregon Adolescent Study & Treatment Center/CHARPP	210 Tacoma Street Grants Pass, OR 97526 Ph: 541-476-3302 Fax: 541-476-2895
Bill Wellard	Providers	The Child Center OATC	3995 Marcola Road Springfield, OR 97477 Ph: 541-726-1465 Fax: 541-726-5085
Maggie Bennington-Davis, M.D.	Providers	Salem Hospital/ Oregon Psychiatric Association	1127 Oak Street SE Salem, OR 97301-5014 Ph: 503- 561-5791, ext 5255 Fax: 503-375-4787
Jim Russell	Providers	Mid-Valley Behavioral Care Network	1660 Oak Street SE, Suite 203 Salem, OR 97301-6454 Ph: 503-585-4991 Fax: 503-585-4989
Janet Arenz	Providers	Oregon Alliance of Children's Programs	707 13th Street SE, St. 290 Salem, OR 97301 Ph: 503- 399-9076 Fax: 503- 362-0149
VACANT	Consumers		

Dave Romprey	Consumers	Center for Self Determination	3608 SE Powell Blvd. Portland, OR 97202 Ph: (503) 232-9154 ext. 127
Beckie Child	Consumers		1218 SW Washington #319 Portland, OR 97205 Ph: 503-227-8496
Pat Risser	Consumers		1530 10th Street West Linn, OR 97068-4633 Ph: 503-655-2530
Kevin Fitts	Consumers	Oregon Mental Health Consumers Association	2514 SE Ankeny, Suite 600 Portland, OR 97214 Ph: 503-231-7324

TABLE 2. Planning Council Composition by Type of Member

3. Planning Council Charge, Role and Activities

The Planning and Management Advisory Committee has been actively engaged with OMHAS regarding the planning and oversight of the public mental health system in Oregon. The Governor of Oregon established a Mental Health Task Force to review the

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	44	
Consumers/Survivors/Ex-patients (C/S/X)	4	
Family Members of Children with SED	3	
Family Members of Adults with SMI	3	
Vacancies (C/S/X & family members)	7	
Others (not state employees or providers)	5	
TOTAL C/S/X, Family Members & Others	22	54%
State Employees	7	
Providers	9	
Vacancies	3	
TOTAL State Employees & Providers	19	46%

present mental health system and to make specific recommendations for changes. The PAMAC has been involved in the work of the Governor's Mental Health Taskforce. Two members of the Council are on the 21 member Task Force. PAMAC has reviewed the work of the task force at each of the regularly scheduled Council meetings. The leadership of PAMAC and the task force met in one work session to collaborate on the direction of the task force. At the August 5, 2004 meeting PAMAC reviewed a draft of the Task Force Report to the Governor and provided written feedback. This process of collaboration has been important since PAMAC will have a responsibility to monitor the implementation of the recommendations from the task force. In a similar way, PAMAC has been actively involved in the ongoing review of the Children's System of Care Change Initiative.

PAMAC has also provided direction for the development of the 2005-07 Agency Request. In April 2004 PAMAC provided OMHAS with input in the development of policy packages for the 2005/2007 budget. When new funds were made available through the PATH grant, PAMAC provided direction to OMHAS regarding the manner in which those funds would be distributed.

PAMAC has played a key role in the development of the Performance Indicators for the State Plan required by the Federal Mental Health Block Grant. Two subgroups for adults and children worked closely with OMHAS staff to write Performance Indicators that challenge the system to improve services. PAMAC has also monitored the implementation of the present State Plan and will be even more involved in the monitoring of the proposed State Plan.

In an effort to improve the monitoring function of PAMAC, the Council has actively worked on revisions to the By-Laws. The revised By-Laws will be reviewed and considered for approval at the next meeting of the Council. These changes are designed to strengthen membership and establish functions that are efficient and active in the monitoring of the public mental health system. There is an emphasis on strengthening membership for consumers and family members.

4. State Mental Health Planning Council Comments & Recommendations

Introduction

For federal fiscal year beginning October 2004, Oregon's Community Mental Health Services Block Grant Application is organized according to the Voluntary Application Format provided by the Center for Mental Health Services. Oregon is using the five consolidated criteria established to meet the requirements of the Community Mental Health Block Grant, Public Health Service Act, and is submitting a two year plan. The Executive Summary has been updated for this application. Part B of the application contains the required assurances, certificates and reports as outlined in the Block Grant Application Guidance and Instructions.

The State Plan starts with a broad description of Oregon's mental health service system as outlined in the Part C., Section I requirements in the Block Grant Application Guidance and Instructions. Oregon has elected to combine Sections II and III of Block Grant Application Guidance and Instructions to provide separate sections to detail separately the adult and child mental health plans with the respective performance indicators.

Oregon included membership of the State Mental Health Management and Planning Advisory Council in the development of the performance indicators. This was done by two work groups. One focused on performance indicators for the children's system and the other on those for the adult system. All performance indicators were scrutinized to determine if they were federally required and determine if they provide guidance to improve the mental health system. Therefore many of the performance indicators from previous years have been changed or replaced. This has resulted in establishing baselines in the first year for many of the indicators. More precise indicator targets will be established for the second year for those indicators.

The report for fiscal year 2004 is not included with this application but will be submitted by December 1, 2004 as permitted in the application instructions.

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

In federal fiscal years 2005 and 2006, Oregon will continue to supplement the federal Community Mental Health Block Grant funds with Oregon State General Funds to support MHS 20 and MHS 22 community outpatient services. These funds are distributed to all counties in the state for outpatient services for individuals, including children and adults who are in need of mental health services but are unable to pay and are uninsured.

PART C. STATE PLAN

SECTION I. DESCRIPTION OF THE STATE SERVICE SYSTEM

A. CURRENT STRUCTURE

1. Organizational Structure

The Oregon Office of Mental Health and Addiction Services (OMHAS) is located within the Department of Human Services (DHS) which reports to the Governor. DHS is made up of three program areas: Health Services; Children, Adults and Families; and Seniors and People with Disabilities. OMHAS is within the Health Services program area along with the Office of Medical Assistance Programs and Public Health related offices.

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

The State is required by Oregon Revised Statute 430.640 to establish a contractual relationship with each county, or Native American Tribe on request by the Tribe, to assure the provision of community mental health services. State funds are allocated to counties using a "block grant" approach. This method of allocation provides the greatest flexibility for counties in managing resources to best meet the needs of consumers. Currently, the State contracts with 32 counties or consortium of counties and one tribe.

2. Funding Mental Health Services

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

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

Unfortunately, not all individuals requiring public mental health services meet Medicaid eligibility criteria. Mental health services continue to be made available to persons ineligible for the Oregon Health Plan according to risk criteria defined in state law. State general funds, various federal grants (including this grant), local funds, and private insurance payments provide additional sources of revenue for Community Mental Health Programs to serve people who have mental health needs, but are not eligible for Medicaid or other third party payments.

B. OMHAS STATEWIDE LEADERSHIP

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

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

The 2001 State Legislative Assembly passed HB 3024, now codified as Oregon Revised Statute (ORS) 430.630 and 430.640, which requires a statewide comprehensive plan based on local planning at a community level. ORS 430.630 requires that the Local Mental Health Authority (LMHA) engage community partners, consumers, families, and advocates in a planning effort to pursue systemic changes in service delivery. LMHAs must engage such community partners as health and physical medicine, juvenile justice, child welfare, schools, local alcohol and drug planning committees, local public safety planning councils, vocational rehabilitation, local housing and others in this process. OMHAS reviews these plans as the statewide plan is developed.

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

OMHAS establishes task forces and workgroups to develop plans and build consensus for mental health initiatives. Some of the recent workgroups established include the Children's Mental Health System of Care Initiative Stakeholders Work Group and various workgroups regarding the implementation of the Evidence-Based Practices legislation. Workgroups focused on specific initiatives are described under the Stakeholder Participation section.

C. REVIEW OF FY 2004 STATE PLAN

Priorities

The areas identified in the previous plan were:

- Oregon tax revenues plummeted creating a severe budget shortfall that in turn resulted in unprecedented reductions in mental health services to children and adults statewide.
- The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for seniors is a critical area of improvement for Oregon's mental health system
- OMHAS needed to continue to strengthen the role of consumers, family members and advocates in planning, system design, implementation and monitoring of mental health service delivery.
- OMHAS needed to better coordinate and collaborate for the delivery of dual diagnosis services.
- State hospital capacity issues for adult treatment services and forensics continued to be an issue.
- Needed to add a representative from the Department of Corrections to the Mental Health Planning and Management Advisory Council.
- Oregon's OMHAS needed to build on the progress made to strengthen its working relationship and collaboration with the Oregon Department of Education,
- The Children's Mental Health system needed to continue to develop a more integrated community-based system of care for children and their families.

- Homelessness among mental health service recipients was identified as a significant issue.

Significant Achievements

Achievements identified in the previous State Plan included the following:

- OMHAS continues to promote the coordination of care between physical and mental health providers and organizations.
- The State has promoted Evidenced-Based supported employment practices.
- During the 2001-2003 biennium, eight awards totaling $240,000 had been made to assist in the development of housing for people with severe and persistent mental illness in seven counties that accommodated 199 residents. Renovation funds were expected to address pressing health and safety improvements at 12 housing sites, preserving housing accommodations for an estimated additional 150 residents.
- Over a ten-year period ending June of 2002, $3.2 million (predominantly State General Funds) had been awarded to housing projects in twenty-five counties to create and preserve housing for over 1,500 people with severe and persistent mental illness.
- OMHAS provided housing support services through the Rural Oregon Leasing Plus Support Grant for persons with mental illness who reside in rural areas.
- Considerable efforts were made by community mental health programs to address housing issues. CMHPs reported that 83 housing projects for persons with mental illness were developed over the previous five years and 25 are currently under development.
- OMHAS implemented several new projects such as the Pre-adjudicated Youth Project to support Evidence-Based Practices targeting known delinquency risk factors consistent with the Governor's Juvenile Crime Prevention Plan and Jail Transition projects to support successful transition for adult offenders with mental illness leaving institutions/jails.
- The following projects were implemented: a Consumer Technical Assistance project, Evidence-Based Practices in employment supports, and two projects for transition-age youth whose mental health disorders require supports as they become young adults.
- Improvements are seen in the increasing number of children receiving a more diverse range of services.

- Mental health services for children were provided in settings that were not previously used or were under-utilized, including homes, schools, and other community settings.
- Increased coordination of access to mental health and alcohol/drug treatment through the Department of Corrections Transition Project for people being released from prison.
- An adult Evidence Based Practices stakeholders planning group was formed to develop a strategic, multi-level approach to implementing EBPs in all community based mental health and addiction services.
- OMHAS received a three-year $2,000,996 Real Choice Systems Change Grant from the federal Center for Medicare and Medicaid Services (CMS) to improve Oregon's services for persons with disabilities. The grant supports several initiatives, with a primary focus on strengthening services for persons with psychiatric disabilities.
- OMHAS continued to be part of a three year EBP demonstration project funded by Johnson and Johnson and Eli Lilly to implement supported employment in three typical community mental health settings in cooperation with the Dartmouth/New Hampshire Psychiatric Research Center.
- OMHAS established two facilities to provide post acute treatment services to adults who have been approved for long-term psychiatric treatment, as an alternative to state hospital admission
- OMHAS expanded Intensive Treatment Services (ITS) Pilot Projects to serve 109 children, in three levels of care, at seven MHOs, at seven ITS providers, and in 21 counties.
- OMHAS developed an estimated 40 placements to serve approximately 134 children in less restrictive community-based settings.
- OMHAS conducted 81 community-based mental health training events, attended by 6,307 providers, consumers, and family members.
- OMHAS staff worked internally as well as collaboratively with the PAMAC to develop a proposed model to measure outcomes for mental health treatment. OMHAS, Community Mental Health Program directors, and Mental Health Organization staff produce quarterly Mental Health Treatment Outcome Improvement Reports that reflect multiple treatment outcome measures.
- OMHAS implemented a Senior Gatekeeping Program to ensure that older adults are able to live as independently and safely as possible in the community.

D. NEW DEVELOPMENTS

1. State Economy and Budget Reductions

As described in last year's application, the State of Oregon has experienced unprecedented budget reductions due to dramatic reductions in revenue. The 2003 Legislature made major restorations in mental health services; restoring the children's outpatient services completely. Mental health crisis and indigent adult outpatient state General Funds have been restored. The child and adolescent day treatment services were partially restored for Medicaid-eligible youth. While the Oregon's economy has shown some signs of improvement, there will be major funding issues for the 2005 Legislature to resolve.

2. Oregon Health Plan

In March 2003, those enrolled in the Oregon Health Plan based on poverty only (known as OHP Standard) lost all outpatient mental health benefits. Oregon just received approval for a waiver from the Center for Medicaid and Medicare Services. This waiver allows Oregon to use Managed Care Organization provider taxes to restore a revised Standard OHP benefit. While a mental health outpatient benefit has been restored to OHP Standard, the enrollment will be reduced to approximately 25,000 members by June 30, 2005 through an attrition plan.

3. Governor's Mental Health Task Force

This year Governor Ted Kulongoski convened the Governor's Mental Health Task Force by Executive Order dated October 8, 2003. The Task Force plans to have a report to the Governor prior to October 2004. The Task Force is building on work done and values developed by the Mental Health Alignment Work Group (MHAWG) which completed its work in 2000. The Task Force is incorporating the values and principles set out in the June 2003 report of the *The President's New Freedom Commission on Mental Health*.

4. Miranda B. vs. Kitzhaber Settlement Agreement

A class action suit was filed against the State of Oregon in regards to an Olmstead complaint. The class members in this suit were patients at the State Hospital who were deemed ready for discharge but, were not discharged in a timely manner. The court approved a settlement agreement in March 2004. The agreement assures that OMHAS will work to discharge all 69 class members. Processes have been developed that will formalize procedures to review and plan for all individuals ready for placement in the community. The Settlement Agreement states that OMHAS must discharge thirty-one class members and develop 75 community placements by June 30, 2005. As of July 30, 2004, 28 class members have been discharged and 39 community placements have been developed.

E. LEGISLATIVE INITIATIVES

1. Evidence-Based Practices

The 2003 Legislature passed Senate Bill 267 which directs the Oregon Office of Mental Health and Addiction Services to increase the percentage of state and federal funds used to provide evidenced-based practices. OMHAS is required to submit biennial reports to the Legislature and ensure that by 2009, at least 75% of state and federal resources allocated for intervention and treatment are used to purchase services from programs determined to be evidence-based. OMHAS has convened several stakeholder forums to discuss the implementation of this new law. Three sub-committees are currently being organized to develop plans for the implementation of various aspects of the law.

2. New Children's Mental Health System of Care Initiative

In June 2003, Legislature directed DHS through a Budget Note to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive and culturally competent home- and community- based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized". To assist in implementing the Budget Note: Psychiatric Residential Treatment Services, Psychiatric Day Treatment Services and Oregon State Hospital funding will be transferred to the Oregon Health Plan and managed through MHOs. The MHOs will be responsible and accountable to deliver levels of care and types of services based on the immediate needs of the child and his or her family.

3. Oregon Children's Plan

The Department of Human Services, OMHAS received a legislative appropriation of two million dollars to provide mental health and addiction services to young children. The funding is intended to serve children ages 0 to 8 who are high risk due to mental or emotional disorders or parental addiction disorders and/or mental illness. Services are to be provided to children and their families when there are no other resources to pay for needed services.

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

A. ADULT PLAN

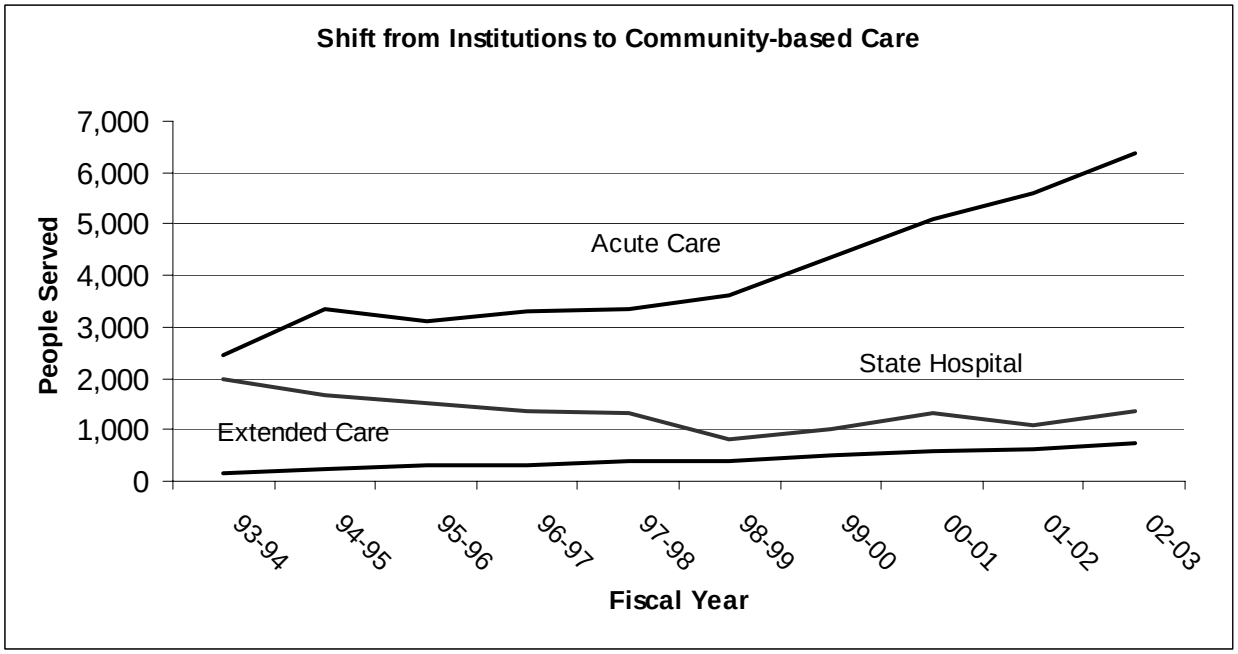
1. Current Strengths and Accomplishments

- **OMHAS funding will be used on evidence-based practices.** In June 2003, Oregon Legislature passed a law that requires OMHAS to use state and federal funds for cost effective practices that are based on scientific evidence. An initial report is due to the September 2004 Joint Interim Judiciary Committee which will decide the OMHAS implementation of evidenced-based practices and the plan to meet the 25% goal of OMHAS funds be used for evidence-based practices for the 2005-07 biennium.

- **Continuing Deinstitutionalization.** The shift from state hospitals toward a continuum of intensive community placements, short-term acute psychiatric care, and state hospital services when necessary continues with nine new residential programs developed during fiscal year 2004. The Extended Care Management Unit (ECMU) maintains responsibility for individual placement approvals and for conducting utilization reviews of adults in all 93 extended and enhanced care projects. From July 2003 through June 2004, 1090 former long-term state hospital patients were served in 641 program placements designed for extended and enhanced care. During this one-year period, 124 state hospital patients were discharged into extended care programs. Of the 302 people who moved out of the extended care programs during the same period, 183 were transferred to equivalent or lower level programs and 27 people moved to independent living or out of the system. Only 13 of the 302 returned for treatment at the state hospital.

  During the same period of time, 10 additional patients from the state hospital made the transition to Enhanced Care facilities throughout the state. Of these, a total of 5 were discharged to equal or lower levels of care and 5 needed to return to the state hospital for more intensive treatment.

  Deinstitutionalization has resulted in resources being shifted from state hospitals to community programs. The percentage of total dollars expended on adult and children's community mental health services is 74.37% for the 2003-05 biennium compared to 75% in state fiscal year 2001-02, 70% in 1995-96 and 65% in state fiscal year 1994-95. The following graph further demonstrates the shift from institutions to community-based care.



- **Investment in Addressing the Acute Care/Long-term Care Problems.** The 2003-05 Legislative Approved Budget for mental health includes $17.2 million to fund acute care services, alternatives to long-term care and case management services. These funds are to be directed at solutions to the problem of persons needing long-term care waiting unnecessarily in acute care hospitals. The wait list results in limited access to acute care services when emergent services are required.

- **Continuing to Promote Affordable Housing.** OMHAS housing staff assess housing needs, plan for resource development and provide technical assistance to increase affordable housing resources for persons with serious mental illness. Since 1989, OMHAS has awarded over $3.4 million to develop and preserve integrated community housing in local communities; these efforts will be expanded as the new Community Mental Health Housing Fund is implemented. As a result of Oregon's Olmstead planning process, efforts to develop community housing for people ready for discharge from state psychiatric hospitals has resulted in the establishment of over 200 new community placements. With funds from a Center for Medicaid and Medicare Services *Real Choice System Change Grant*, OMHAS has been able to increase its housing and homeless services staff and is implementing a "Real Choice Housing Fund" to assist about 500 individuals in eliminating financial barriers to acquiring more integrated community housing.

- **Supported Employment Research Project.** OMHAS is in the final year of a three-year EBP demonstration project funded by Johnson and Johnson and Eli Lilly to implement supported employment in three typical community mental health settings in cooperation with the Dartmouth/New Hampshire Psychiatric

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

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

- **Medication Administration Project.** The Oregon Office of Mental Health and Addiction Services (OMHAS) and Office of Medical Assistance Programs (OMAP) have launched a psychiatric medication initiative to improve patient care, allow patients access to all appropriate medications, and decrease overall Medicaid health costs.

  One component of The Partnership for Psychiatric Medication Access (PPMA) is the Behavioral Pharmacy Management System. This is an educational program that evaluates mental health prescription activity with the primary goal of ensuring that Medicaid recipients receive appropriate care based on evidence-based clinical guidelines. A secondary goal is to reduce inefficient use of Medicaid pharmacy resources. The project will review Medicaid pharmacy data to identify prescribing trends for psychiatric medications and compare these trends to evidence-based best practices. A small group of providers will be identified as having prescribing practices that fall outside of guidelines. These providers will receive educational material and consultation supporting the best practices and will be encouraged to make improvements in their prescribing practices and improve patient care.

  PPMA will also run two other initiatives to improve psychiatric prescribing practices and quality of care. One will develop algorithm-based practice guidelines for the use of certain psychiatric medications, especially for major psychiatric illnesses, such as schizophrenia, bipolar disorder, and severe depression. The second will focus more specifically on opportunities to save money by splitting pills or consolidating multiple doses into single daily doses, when such interventions are appropriate drug therapy and agreeable to patients and their doctors.

2. Current Weaknesses and Areas of Needed Improvement

- As previously stated in this plan, Oregon has experienced significant economic

downturn in the past several years that have resulted in significant cuts for mental health services for adults. While some funds have been restored, not all the previous cuts have been reinstated.

- The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for seniors is a critical area of improvement for Oregon's mental health system. OMHAS has bolstered its collaboration and communication with Senior and People with Disabilities and has a representative of the Governor's Commission on Senior Services on the Mental Health Planning and Management Advisory Council. Additionally, OMHAS's research and data analysis unit will break out the 65+ population on performance indicators to sharpen the focus on this population.

- OMHAS will continue to strengthen the role of consumers in the design, planning and implementation of mental health services at the state and local level. The local planning requirements in Oregon Revised Statute 430.630 requires the involvement of consumers, family members and advocates in the community-based comprehensive planning process. The statute further emphasizes the role of consumers in their treatment and in system oversight. The Department has established a Consumer Task Force to advise the Real Choice System Planning Grant. OMHAS reconvened a consumer group in July 2003, to meet with the new Administrator to discuss concerns and improved consumer roles with the state. This has created increased opportunity for consumer input and advice in planning, system design, implementation and monitoring of mental health service delivery.

- There continues to be an issue of individuals needing long-term care without ready access to admission to a state hospital. Once approved for long-term care at the state hospital, persons are waiting an average of twenty days in an acute care hospital prior to transfer to the State Hospital. This has resulted in limited access to acute care beds for emergent treatment.

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

- The lack of affordable housing and community residential settings for people with severe and persistent mental illness continues to present a serious challenge in

Oregon and results in too many individuals becoming homeless or incarcerated. Without a housing subsidy, an individual with a SSI income cannot find affordable housing anywhere in Oregon through the private housing market. A Fall 2000 housing survey assessed the housing needs of children and adults receiving publicly funded mental health services. Results from this survey included an estimate that 2,522 adults and 929 children are homeless at any point in time and two-thirds of adults served are at risk of homelessness. The survey also estimated that 12,146 adults were in immediate need of affordable housing, 1,852 were in need of supportive housing, and 715 were in need of structured "group home" settings. On the positive side, community mental health programs reported that 83 housing projects for persons with mental illness were developed in the previous five years and 25 additional projects were under development.

3. Priorities For The Adult Mental Health System

1. Increase the involvement of consumers in system planning and in providing and receiving support services.
2. Improved mental health services for persons 65 and older.
3. Increase the availability of Evidence-based Practices.
4. Decrease the rate of readmission of adults to the State Psychiatric Hospitals within 30 days and180 days.
5. Increase the access to publicly funded mental health services.
6. Increase the availability of appropriate housing for adults with severe mental illness.
7. Improve access to housing and mental health services for persons with severe mental illness being diverted and released from jail or prison.
8. Promote recovery oriented case management services.
9. Reduce the effects of trauma for adults with severe mental illness.

4. Future Vision For Adult Mental Health

The Governor's Mental Health Task Force has identified the following as elements of a responsible Oregon mental health system.

- Mental illness is treatable, often at low direct cost.
- Recovery is possible and is the goal of all mental health services.
- Services are driven by the strengths and needs of consumers and their families, rather than by funding silos or the organization of service agencies.
- Services are culturally and age-specific.
- Services are available in the communities where people live.
- Services are preventative and offered as early as possible.
- Services reflect evidence-based practices.
- Services are holistic and respond to a person's universe of strengths and needs.
- Services are based on conditions and outcomes, not diagnosis.
- Services are available without regard to ability to pay.

- For individuals who are dangerous to themselves or others, services must reflect public safety concerns.
- Recovery from mental illness requires also recovery from substance abuse and physical illness, if present. Thus, coordination and integration of services is essential.
- Outcomes can be measured, both in terms of individual recovery and improved population health. In public health terms, the most important outcome is that a substantial number of individuals achieve recovery and function effectively as productive members of society.

The Governor's Mental Health Task Force is in the final stages of publishing a report to the Governor that will identify key problem areas with specific recommendations. This report will be included in the Block Grant Implementation Report due in December 2004.

5. Criteria

Criterion 1: Comprehensive Community-Based Mental Health Systems

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

- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
    - Health, mental health, and rehabilitation services;
    - Employment services;
    - Housing services;
    - Educational services;
    - Substance abuse services;
    - Medical and dental services;
    - Support services;
    - Services provided by local school systems under the Individuals with Disabilities Education Act;
    - Case management services;
    - Services for persons with co-occurring (substance abuse/mental health) disorders; and
    - Other activities leading to reduction of hospitalization.

i. Description of Current Adult Mental Health System

Outpatient Services. Clients are provided with an array of outpatient services, including assessment and evaluation, individual and group therapy, medication management, case management, and daily support and skills training. Services for clients experiencing acute psychiatric conditions include 24-hour crisis assistance,

community-based respite care, sub-acute psychiatric care, and inpatient services. A promising feature of the Oregon Health Plan is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments and alternative services suggested by contractors, allowing for less costly, more effective service delivery when appropriate. These services, coupled with residential placements, where needed and other supportive services such as supported employment aid individuals with mental illness in maintaining their tenure and stability in the community.

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

The first phase of this process began when OMHAS issued new administrative rules and standards on recovery oriented adult mental health services. EBP is reflected within these standards and has impacted the services now delivered to consumers. Additionally, statewide training and a series of consensus building activities began on EBP and recovery oriented services. The training plan for 2003-05, included in Appendix C, details specific trainings for providers, consumers and families.

Just as rehabilitation services are being influenced by EBP and recovery modalities, case management services throughout the State of Oregon continue to be influenced as well. There are many aspects of the case management process, as outlined in the administrative rules that have as its focus client participation and buy-in as means to attain goals leading to recovery. Case managers assist clients in:

- Securing benefits. (Social Security, food stamps, housing assistance)
- Symptom Recognition and Management.
- Vocational Rehabilitation and maintaining employment in community based jobs.
- Development of a Personal Crisis Plan and Declaration for Mental Health treatment.
- Active discharge planning in the event of a hospitalization.
- Constant monitoring of health and safety needs relative to their housing environment.

Jail Bridge Program. Block Grant funds have been used to address the issue of persons with mental illness in the jail. Many of these persons have a co-occurring substance abuse problem. Oregon has three pilot programs that assist individuals with co-occurring disorders in jail to link up with integrated treatment in the community. The three projects started between January and June of 2002. As of March of 2003, a total of 316 persons had been served in the projects. OMHAS is in the process assessing the effectiveness of the pilot projects.

Family-to-Family Program Expansion. OMHAS provides some Block Grant funds to National Alliance for the Mentally Ill – Oregon to expand the family-to-family program. This is a nationally recognized program that provides education and support to families that have a family member with a serious mental illness.

Intensive Treatment Services. In addition to the services outlined above, a comprehensive system of intensive community-based, residential, and inpatient programs is maintained. As of June 2004, 464 extended care placements located in secure residential, foster care, and supported-living programs were available for adults. An additional 177 placements were maintained in nursing homes or other facilities funded jointly with the State Office of Services to Persons with Disabilities for clients requiring nursing and psychiatric care. In these 741 placements, 898 individuals were served during the 2003 fiscal year. In addition to extended care placements, OMHAS funded over 1000 beds in foster care, residential treatment facilities and other supported housing models for adults with severe mental illness. A statewide system of regional acute care units, virtually all in community general hospitals, provides over 200 beds for short-term inpatient psychiatric services. For adults in need of long-term secure treatment, 193 state hospital beds are also available in two state psychiatric hospitals.

Supported Employment and Supported Education. OMHAS has for many years recognized the value of employment to individuals experiencing severe mental illness. With the additional Block Grant funds awarded over the past years, new demonstration projects have been developed and operating. Currently 300 individuals receive supported employment services from two sites funded by the Block Grant, all of which are using the Evidence-Based Practice model of supported employment. Additionally, with a recent Dartmouth-New Hampshire/Johnson and Johnson supported employment grant, the OMHAS procured three new Evidence-Based Practice sites, each to serve 110 consumers next year. At all five sites, an average of 50% of consumers enrolled obtain competitive employment in community-based jobs.

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

The Psychiatric Security Review Board (PSRB). The PSRB maintains jurisdiction for individuals adjudicated "Guilty Except for Insanity". There are approximately 620

individuals under the jurisdiction of the PSRB in the State of Oregon. Approximately ¾ of the entire PSRB population resides at the state hospital in Salem (OSH). The rest of the PSRB population reside in the community observing the conditions outlined in their individual release plans and through supports offered by local Community Mental Health Programs. The PSRB reports to the Governor and uses a variety of resources to manage people successfully under its jurisdiction. OMHAS, in close coordination with the PSRB, provides mental health services to such individuals. The state also provides assessment of persons for the PSRB and the court to determine if treatment in the community is appropriate. Determination of the supervision requirements of each placement, and treatment for persons conditionally released into the community is also provided. Individualized community placements include evaluation, supervision, case management, psychotherapy, supported employment services, alcohol and drug treatment, and medication management.

ii. Goals, Objectives, and Performance Indicators

Goal 1. Increase the involvement of consumers in system planning and receiving and providing support services.

Population:	Adults with severe mental illness participating with community mental health programs, consumer drop-in centers, consumer-provided services and other consumer organizations.
Criterion:	1. Comprehensive Community-Based Mental Health System
Brief Name:	Consumer Communication Network
Indicators:	A. Establish a communication network of consumers and consumer organizations, with representation at the Administrator's Consumer Council, by June 30, 2005. B. Provide training and technical assistance to Drop-in Centers, Consumer-Directed Services and other consumer organizations in meeting OMHAS criteria for Evidence-Based Practices by 6/30/06.
Measure:	A. At least 85% of Drop-in centers and other community organizations will achieve a consumer communication network (June/ 05). B. Amount of training / technical assistance provided to consumer organizations regarding the criteria to be identified as an Evidence-Based Practice.
Numerator	A. The number of Drop-in Centers, Consumer-Directed Services and other consumer organizations connected to the Consumer Communication Network B. Not applicable
Denominator	A. Current number of Drop-in Centers, Consumer-Directed Services and other consumer organizations in the State. B. Not applicable.
Sources of Information	Survey of Oregon's Drop-in Centers and Consumer-Directed programs.
Special Issues:	Due to a State budget deficit in 2002-2003, and the prioritization of funding reductions, the Office of Mental Health and Addiction Services budget no longer provides state funding for a consumer technical assistance provider.
Significance:	Consumer-operated programs provide services from a peer-to-peer perspective. The Office of Mental Health and Addiction Services is in the process of certifying specific practices as evidence-based. Consumer-operated programming is one practice that will be considered for certification.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Establish a consumer network by 06/30/05.	N/A	N/A	N/A	85%	
B. Provide EBP training by 06/30/06.	N/A	N/A	N/A		Number of Trainings completed

Goal 2. **Increase community-based services for adults with severe mental illness, ages 65 and older, who are living in the community, nursing homes, state hospitals, or homeless shelters.**

Population:	Older adults with severe mental illness living in state hospitals, nursing homes, homeless shelters and community-based settings who are recommended by their treatment teams to move to more appropriate community settings.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Community-Based Services for Older Adults.
Indicators:	A. By 6/30/05, develop a baseline population of adults with severe mental illness, ages 65 and older that are living in the community, nursing homes, state hospitals, or homeless shelters and are recommended by their treatment teams for more appropriate community-based settings. B. Provide new community-based services for at least 40 persons from the baseline population by 6/30/06.
Measure:	A. Use surveys and administrative data to establish baseline population. B. Track the number of adults from baseline population placed in new community-based services.
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	Oregon Patient / Resident Care System (OP/RCS), Client Process Monitoring System (CPMS), and surveys of Nursing Homes and Homeless Shelters.
Special Issues:	The Oregon Legislature, through a Budget Note at the end of the 2003 Legislative Session, instructed OMHAS to provide recommendations to the Legislature by January 2005, on those persons with psychiatric disabilities in institutions and at risk of institutionalization.
Significance:	The Supreme Court's *Olmstead Decision* requires the states to provide services to those persons covered by the Americans with Disabilities Act in the most integrated setting appropriate. This mandate focuses upon covered persons in institutions and at risk of institutionalization.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop baseline for older adults for community-based settings by 06/30/05.	N/A	N/A	N/A	Number of people in baseline population	
B. Provide 40 new community-based settings by 06/30/06.	N/A	N/A	N/A		40 new community-based settings established

Goal 3. Determine the number of adults with severe mental illness in Oregon receiving evidence-based practices.

Population:	Number of adults with serious mental illness receiving Evidence-Based Practices
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Evidence-Based Practices
Indicators:	A. Establish methodology to count the number of Adults with a serious mental illness receiving Evidence-Based Practices by 6/30/05. B. Report the percentage of adults with a serious mental illness who are receiving Evidence-Based Practices by 6/30/06.
Measure:	A. The establishment of a methodology for counting the number of adults with a serious mental illness receiving Evidence-Based Practices. B. Use methodology established in "A" to describe percentage of adults with a serious mental illness receiving Evidence-Based Practices.
Numerator	A. Not applicable. B. Number of adults with a serious mental illness receiving Evidence-Based Practices.
Denominator	A. Not applicable. B. Total number of adults with a serious mental illness receiving services.
Sources of Information	List of treatment practices approved as evidence-based by OMHAS; expenditure and demographic reports on evidence-based practices submitted to OMHAS by County Mental Health Programs.
Special Issues:	A law enacted by the 2003 Oregon Legislature requires that, by 2005, at least 25% of the treatment funds expended by OMHAS be for evidence-based practices. This requirement increases to 50% in 2007 and 75% in 2009. OMHAS has defined the criteria for a practice to be considered evidence-based and has established three stakeholder workgroups which will develop the procedures for reviewing specific practices against the criteria, further promoting evidence-based practices and evaluating the effectiveness, and cost-effectiveness, of the practices.
Significance:	In Oregon, as well as nationally, funding agencies are being required to demonstrate that funds are being used cost-effectively for treatment services that are based upon empirical research demonstrating the effectiveness of the practices in treating people with psychiatric disabilities.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Establish method to count adults with a serious mental illness receiving.	N/A	N/A	N/A	Evidence of methodology established	
B. Percentage of adults with a serious mental illness receiving Evidenced-based Practices.	N/A	N/A	N/A		Establish baseline.

Goal 4: To increase the percentage of adults with severe mental illness reporting positively on outcomes.

Population:	Adults who received Medicaid Mental Health Services within the past year.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Client Perception of Care
Indicators:	A. Establish a baseline using the Mental Health Statistic Improvement Program (MHSIP) Adult Outpatient Consumer Survey by 6/30/05. B. Increase the percentage of adults with severe mental illness reporting positive outcomes by 5% over the established baseline by 6/30/06.
Measure:	A sample of adult with SMI who are receiving services will be surveyed using the MHSIP Adult Outpatient Survey
Numerator	Number of persons who respond with positive perceptions of improved outcomes.
Denominator	Number of persons who were surveyed.
Sources of Information	MHSIP Adult Outpatient Consumer Survey.
Special Issues:	Oregon is adopting the national MHSIP survey. Use of the MHSIP will provide on-going data to measure Oregon's effectiveness at strengthening meaningful consumer participation in, and satisfaction with meaningful outcomes. Use of MHSIP will permit cross-state comparisons in measuring progress. Oregon will seek to demonstrate gains in both the ratings of consumers responding to the survey and the percentage of consumers responding to the survey.
Significance:	Self-determination is one of the principle elements of recovery for persons with severe mental illness. As part of the treatment collaboration, a person-centered planning approach is essential, so that consumers are active participants, rather than passive objects, in setting goals and treatment objectives.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop baseline using MHSIP survey by 06/30/05.	N/A	N/A	N/A	Baseline percentage	
B. Increase 5% above baseline positive reporting by 06/30/06.	N/A	N/A	N/A		5% improvement over baseline

Goal 5: Decrease the rate of readmission of adults to the State Psychiatric Hospitals within 30 days and180 days.

Population:	Adults admitted to the Oregon State Psychiatric Hospitals.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Reduced Utilization of Psychiatric Inpatient
Indicators:	A. Reduce the rate of readmission of adults to the Oregon State Psychiatric Hospitals within 30 days from 2.3% to 2.0% by 6/30/05. B. Reduce the rate of readmission of adults to the Oregon State Psychiatric Hospitals within 180 days from 10.7% to 10% by 6/30/05. C. Reduce the rate of readmission of adults to the Oregon State Psychiatric Hospitals within 30 days from 2.0% to 1.9% by 6/30/06. D. Reduce the rate of readmission of adults to the Oregon State Psychiatric Hospitals within 180 days from 10% to 9.8% by 6/30/06.
Measure:	Percentage of adults readmitted to the hospital within 30 and 180 days.
Numerator	Number of adults readmitted within 30 and 180 days.
Denominator	Number of discharges within the previous 12 months.
Sources of Information	Oregon Patient/Resident Care System (OP/RCS)
Special Issues:	The Supreme Court's *Olmstead Decision* requires that State Hospital patients, who are determined appropriate for discharge, be transitioned to community-based settings at a reasonable pace. The 30 day and 180 day readmission indicators provide a measure of the adequacy of placement planning and the comprehensiveness of the community service system in preventing unnecessary institutionalization.
Significance:	Data will be gathered on Adult and Geriatric civilly committed clients and Adult Forensic clients. Oregon's mental health system is primarily based upon a community-based system of care, with institutions utilized as a last-resort, short-term alternative. The goal is to assist consumers to remain in the community or, if institutionalized, to return to the community as promptly as possible – and to avoid reinstitutionalization. The data gathered as part of this effort will provide important feedback on re-institutionalization of individuals, reflective of the adequacy of discharge planning and the effectiveness of community-based services.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Reduce readmission 30 days by 06/30/05.	N/A	N/A	N/A	2%	
B. Reduce readmission 180 days by 06/30/05.	N/A	N/A	N/A	10%	
C. Reduce readmission 30 days by 06/30/06.	N/A	N/A	N/A		1.9%
D. Reduce readmission 180 days by 06/30/06.	N/A	N/A	N/A		9.8%

Goal 6: Provide appropriate community-based mental health services and housing for adults with psychiatric disabilities who are diverted from entering, or released from Oregon jails or prisons.

Population:	Adults with severe mental illness who are at-risk for incarceration or who are incarcerated in Oregon jails and prisons.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Mental Health – Corrections Collaboration
Indicators:	A. By 6/30/05, develop specific recommendations, through a convened Mental Health-Corrections Workgroup, for collaborative work aimed at providing new community residential placements and treatment services for adults with psychiatric disabilities diverted from entering, or released from, Oregon jails or prisons B. In collaboration with Oregon Corrections agencies, develop at least 20 new community residential placements and treatment services for adults with psychiatric disabilities who are diverted from entering, or released from, Oregon jails or prisons during the period 10/1/05 through 6/30/06.
Measure:	A. Recommendations developed by a specially-convened Mental Health-Corrections workgroup. B. Number of new residential placements developed for persons with severe mental illness exiting the corrections system or at risk of entering it.
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	Workgroup minutes and recommendations; OMHAS Contracts; Caseload Growth Data
Special Issues:	Legislation passed by the Oregon Legislature in 2003 (SB 267) requires new and intensified efforts by state agencies to increase the effective-ness of services to consumers. The Governor's Task Force on Mental Illness has identified this as a priority area for increased collaboration between state and local agencies
Significance:	Twenty-two percent of Oregon's 12,200 inmates suffer from serious mental illness according to Oregon's Department of Corrections. Persons with psychiatric disabilities and a history of corrections involvement are among the "hardest to house", increasing the likelihood that – without stable, safe, affordable housing – individuals emerging from corrections are likely to re-enter the institutional systems. The Olmstead Decision requires States to provide appropriate services for persons at-risk of institutionalization, as well as in institutions.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop recommend-ations by 06/30/05.	N/A	N/A	N/A	Evidence of recommendations	
B. Develop 20 new residential placements and services by 06/30/06.	N/A	N/A	N/A		20 new placements developed.

Goal 7: Increase the number of adults with severe mental illness receiving publicly funded, Evidence-Based Supported Employment Services.

Population:	Adults diagnosed with severe mental illness.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Supported Employment Services
Indicators:	A. Increase the number of adults with severe mental illness receiving publicly funded Evidence-Based Supported Employment Services from 425 to 500 by 6/30/05. B. Increase the number of adults with severe mental illness receiving publicly funded Evidence-Based Supported Employment Services from 500 to 600 by 6/30/06.
Measure:	With data establish through Goal 3, which allow OMHAS to count the number of people receiving given evidence-based practices.
Numerator	Number of adults with severe mental illness receiving publicly funded supported employment services.
Denominator	Not applicable
Sources of Information	The established methodology for counting the number of Adults with a serious mental illness receiving Evidence-Based Practices.
Special Issues:	Due to a severe budget crisis, funding for supported employment provided to 600 persons with severe mental illness was cut from the 2003-2005 biennial budget. At the same time Oregon has participated in the National Evidence Based Practice Project by implementing supported employment in three typical community mental health settings by use of technical assistance and training through the use of toolkits. Also, the past year, Oregon developed Medicaid codes that facilitate billing of supported employment, so increasing supported employment will be possible through the Oregon Health Plan by procuring projects by using BG funding.
Significance:	Employment is an important factor in increasing self-determination and enhancing the quality of life for persons with serious mental illness. Efforts to decrease the use of day treatment and increase the use of supported employment will requires a culture shift change at the local level. Anticipated recognition in Oregon of supported employment as an evidence-based practice will help facilitate this change.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase EBP supported employment.	587	410	Will be reported 12/2004.	500	600

Goal 8: Increase the number of adults with severe mental illness receiving publicly funded, Evidence-Based Supported Education Services.

Population:	Adults diagnosed with a severe mental illness.
Criterion:	1. Comprehensive Community-Based Mental Health Service System
Brief Name:	Supported Education Services
Indicators:	A. Increase the number of adults with severe mental illness receiving publicly funded Evidence-Based Supported Education Services from 30 to 60 by 6/30/05. B. Increase the number of adults with severe mental illness receiving publicly funded Evidence-Based Supported Education Services from 60 to 100 by 6/30/06.
Measure:	With data establish through Goal 3, which allow OMHAS to count the number of people receiving given evidence-based practices.
Numerator	Number of adults with severe mental illness receiving publicly funded supported education services.
Denominator	Not applicable.
Sources of Information	The established methodology for counting the number of Adults with a serious mental illness receiving Evidence-Based Practices.
Special Issues:	Supported education is an important component of recovery for many persons with mental illness. The mental health system, however, is in the early stages of recognizing the importance of supported education. No available toolkit exists and the evidence-based foundation of supported education has yet to be determined. The state has previously lacked training infrastructure for promoting this practice.
Significance:	Supported education provides support and assistance with accessing GED programs and post-secondary educational institutions to persons with disabilities for whom continuing education has been interrupted or intermittent. Receiving support in resuming one's education provides a foundation for further education, self-determination and improved employment.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase EBP Supported Education services.	10	40	Will be reported 12/2004.	60	100

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

i. Description of Current Adult Mental Health System

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

The Department of Human Services has developed a department-wide policy for providing culturally competent services. OMHAS has two representatives on the committee that developed the policy. The policy has a list of eight standards and strategies to guide the work towards cultural competence. OMHAS is working to employ these standards and strategies to the unique mental health services and settings.

Tribal Liaisons. OMHAS has identified two staff to serve as liaisons between OMHAS and the Tribes. When working with Tribes and tribal organizations, OMHAS staff will solicit assistance and guidance to assure that cultural issues are identified and addressed. OMHAS tribal liaisons coordinate with the DHS tribal liaison.

ii. Goals, Objectives, and Performance Indicators

Goal 9: Increase the effectiveness of recommended evidence-based practices in suicide prevention services to older adults with severe mental illness.

Population:	Older adults with severe mental illness.
Criterion:	2. Mental Health System Data Epidemiology
Brief Name:	Reduction of suicides in older adults with severe mental illness.
Indicators:	A. Establish the baseline number of suicides in the population of older adults (ages 65 and older) with serious mental illness by 6/30/05. B. Reduce the number of suicides of older adults with serious mental illness by at least 5% from baseline by 6/30/06, through implementation of the 'Oregon Plan for Reducing Suicides in Older Adults'.
Measure:	The percentage of older adults with SMI receiving service that commit suicide
Numerator	Number of older adults with severe mental illness who are receiving mental health service whom commit suicide.
Denominator	Number of older adults with severe mental illness receiving mental health service.
Sources of Information	Client Process Monitoring System, MMIS, and Vital Statistics
Special Issues:	"The Oregon Plan for Reducing Suicides in Older Adults" will be published and distributed by the Department of Human Services Public Health Unit on September 22, 2004. The document will provide a statewide older adult suicide prevention plan. Though causative factors for suicide have previously been identified, no studies have yet been done upon older populations in Oregon.
Significance:	A recent study published by the 2004 Archives of Internal Medicine, shows many common illnesses may be linked to an increased risk of suicide in elderly people. Most of the patients in the study who committed suicide visited a physician in the month before death. About half of them saw a doctor the week before. In the study of 1,329 seniors who committed suicide, researchers found the largest increases in suicide risk were linked to depression, bipolar disorder, and severe pain.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop baseline for suicide in older adults by 06/30/05.	N/A	N/A	N/A	Baseline percentage	
B. Reduce 5% from baseline of older adult suicide by 06/30/06.	N/A	N/A	N/A		Reduction of 5% from baseline.

Goal 10: Increase the percentage of adults with severe mental illness who are served in the publicly funded mental health system in relation to the prevalence data.

Population:	Adults with severe mental illness served in the public mental health system.
Criterion:	2. Mental Health System Data Epidemiology
Brief Name:	Increased Access to Services
Indicators:	A. Increase the percentage of adults with severe mental illness served in the publicly funded mental health system from 30% to 31% served out of the total estimate of public services demand by 6/30/05. B. Increase the percentage of adults with severe mental illness served in the publicly funded mental health system 32% served out of the total estimate of public services demand by 6/30/06.
Measure:	Percentage of adults with severe mental illness receiving publicly funded mental health services during the fiscal year.
Numerator	The number of adults with severe mental illness receiving publicly funded mental health services.
Denominator	The number of adults with severe mental illness in need of publicly funded mental health services.
Sources of Information	The State of Oregon uses a nationally accepted prevalence estimating tool that was especially formulated for rural western states along with the Client Process Monitoring System (CPMS) and the Oregon Patient / Resident Care System (OP/RCS) to track utilization.
Special Issues:	Budget cuts implemented in 2003 in Oregon reduced services to adults with severe mental illness. Since then, some services have been restored and maximum efforts are being made to provide mental health services to those needing them.
Significance:	Individuals identified with a severe mental illness benefit from community mental health services that are specific to their needs and desires. These services assist individuals in avoiding institutionalization and promote a path to recovery.

Performance Indicator	FY2002	FY2003	FY2004 (projected)	FY 2005 Objective	FY 2006 Objective
Increase the percentage of adults with a severe mental illness receiving publicly funded services	46%	40%	30%	32%	34%

Goal 11: Increase the percentage of adults with severe mental illness who are 65 years of age or older who receive publicly funded mental health services.

Population:	Adults with severe mental illness who are 65 years of age or older.
Criterion:	2. Mental Health System Data Epidemiology
Brief Name:	Older adults receiving publicly funded mental health services
Indicators:	A. Increase the percentage of adults with severe mental illness who are 65 years of age or older who receive publicly funded mental health services from 20% to 22% by 6/30/05. B. Increase the percentage of adults with severe mental illness who are 65 years of age or older who receive publicly funded mental health services from 22% to 25% by 6/30/06.
Measure:	Percentage of adults with severe mental illness who are 65 years of age or older receiving publicly funded mental health services in the fiscal year.
Numerator	Number of adults with severe mental illness aged 65 or older receiving publicly funded mental health services.
Denominator	Number of adults with severe mental illness aged 65 or older in need of publicly funded mental health services
Sources of Information	The State of Oregon uses a nationally accepted prevalence estimating tool that was especially formulated for rural western states along with the Client Process Monitoring System (CPMS) and the Oregon Patient/Resident Care System (OP/RCS) to track client utilization.
Special Issues:	The State of Oregon requires all providers of publicly funded mental health services to enter the services provided in either the CPMS which tracks out-patient services or the OPRCS which tracks in-patient utilization. Publicly funded mental health services include any services provided using City, County, state or federal funds (including Medicare and Medicaid).
Significance:	The special needs of this population require collaborative interagency, cross-systems and interdisciplinary planning that considers the specific developmental and health issues that face older adults with severe mental illness.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase older adult publicly funded mental health services.	N/A	19%	To be reported 12/2004	22%	25%

Goal 12. To maintain or increase the proportion of adults from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded culturally competent mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's adults within the same ethnic population.

Population:	Adults
Criterion:	2. Mental Health System data Epidemiology
Brief Name:	Access to mental health services for adults
Indicators:	Percentage share of adults within ethnic categories who are receiving mental health services compared to the percentage share of adults within ethnic categories for the general population.
Measure:	Compare the percentage share among ethnic groups of adults receiving mental health service to the percentage share among ethnic groups in the general population.
Numerator	Not applicable.
Denominator	Not applicable.
Sources of Information	CPMS, MMIS, PSU Population Research Center.
Special Issues:	In 2003, the proportion of adults receiving mental health services with a Hispanic ethnic background was low compared to the proportion of adults with the same ethnic background in the State's adult population. At the same time African Americans appear over represented in the mental health service population.
Significance:	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of adults with diverse ethnic backgrounds.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
To maintain or increase the proportion of adults receiving mental health services from each ethnic background such as: Native American, Hispanic, African American, and Asian compared to adults with the same ethnic background in the State.	N/A	N/A	Will be reported in 04 implementation report	Percentage shares will be equal between mental health service population and general population	Percentage shares will be equal between mental health service population and general population

Criterion 4: Targeted Services to Homeless Population

- Describes State's outreach to and services for individuals who are homeless; and
- Describes how community-based services will be provided to individuals in rural areas.

i. Description of Current Adult Mental Health System

Rural Services. Oregon is comprised of 36 counties, 10 counties have a population of over 96,000, and are considered urban. The other 26 counties are considered rural and 25% of the State's population resides in these counties. In rural areas, distances and lack of transportation can become barriers to access mental health services. The MHOs provide a full continuum of services to eligible persons. The MHOs are required by contract to meet the medically appropriate needs of their members. Regardless of the rural nature of the person's community, the intent of the contract is that a full array of services are available to all members that need mental health services. Generally in Oregon, access to mental health services in rural areas is comparable to that in urban areas. In addition to local programs, all persons have access to appropriate statewide resources such as acute psychiatric hospitalization, state hospital programs and intensive community and residential programs, although persons may travel many miles to receive these services. The MHOs provide mental health services directly through the community mental health program or a contract entity under approval of the community mental health program and OMHAS.

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

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

Access for persons who are homeless. Homelessness among persons with serious mental illness continues to be a significant problem in Oregon. Enrollment of homeless persons with mental illness into community mental health services has been encouraged. One of the goals in Oregon's Block Grant plan has been to "increase the number of homeless adults with severe mental illness receiving publicly funded mental health services". An analysis of enrollment data over the past five years illustrates trends. The following table shows homelessness among people at time of enrollment in any mental

health service and the homelessness among all served at the end of the year. These data indicate that service availability tends to decrease homelessness. It also indicates that the enrollment of persons who are homeless has been increasing, both in terms of number and percentage of total served. These increases are likely the result of increased access to mental health services under the Oregon Health Plan.

Fiscal Year	CPMS Enrollment Data-Adult MH Clients				
	Homeless at Enrollment		Homeless at Year End		
	Number	% of Total Served	Number	% of Total Served	Total Served
1998-99	2,940	5.7%	2,052	4.0%	51,333
1999-00	3,253	5.9%	2,308	4.2%	55,602
2000-01	3,369	5.8%	2,510	4.3%	58,511
2001-02	3,916	6.4%	3,026	5.0%	61,173
2002-03	3,542	6.3%	2,793	4.9%	56,574

Some of the specific strategies employed by OMHAS include the following: (1) Community mental health program (CMHP) staff are encouraged to participate in their local HUD Continuum of Care planning process. (2) CMHPs must address housing needs in their local mental health planning process. (3) OMHAS provides data and technical assistance. (4) OMHAS facilitates partnerships between mental health service providers, homeless service providers and housing providers at the state and local level by arranging meetings and training. (5) OMHAS staff participated in inter-agency planning to address homelessness as a result of participation in a federal homeless policy academy.

Some recent outcomes achieved in addressing homelessness include the following: (1) OMHAS staff worked collaboratively with the City of Portland/Multnomah County in their successful attempt to apply for a Robert Wood Johnson Foundation *Taking Health Care Home* system change grant and two inter-agency "collaborative initiative" federal grants to address chronic homelessness. (2) OMHAS worked collaboratively with Oregon Housing and Community Services to obtain two $500,000 HUD Homeless Assistance grants to provide leasing subsidies and wrap-around support services to homeless people with mental illness in nine rural counties. (3) OMHAS provided grants to support development of seven housing projects in six counties that will accommodate 73 persons with mental illness, many of whom have experienced homelessness. (4) OMHAS is using its increase in federal PATH dollars to expand outreach services for homeless persons with mental illness to two additional counties (Washington and Lane) and to sponsor seven statewide training events on best practices for serving hard-to-house persons with mental health and addiction disorders. (5) In July 2004, the new Community Mental Health Housing Fund was established with funds from the sale of the former Dammasch State Hospital property; this fund will expand OMHAS housing development capacity and help to prevent and decrease homelessness.

ii. Goals, Objectives, and Performance Indicators

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

Population:	Homeless Adults with Severe Mental Illness Living in Rural and Urban Areas
Criterion:	4. Targeted Services to Homeless and Rural Populations
Brief Name:	Housing services to Homeless and Rural Populations
Indicators:	A. Provide 30 new units of Supportive Housing, by 6/30/05 for persons with severe mental illness who are homeless. B. Provide 50 new units of Supportive Housing, by 6/30/06 for persons with severe mental illness who are homeless.
Measure:	New units of Supportive Housing in rural and urban areas provided for adults with severe mental illness provided through OMHAS and/or County Programs.
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	OMHAS Contracts
Special Issues:	One of the most significant findings of a Fall 2000 Mental Health Housing Survey were the 2,522 adults with mental illness estimated to be "currently homeless" and the two-thirds of adult service recipients who were estimated to be at immediate risk of homelessness. In FY 2002-03, 3,542 unduplicated homeless adults were enrolled in community mental health services and comprised a little over 6% of all adults served. Homelessness places individuals with mental illness at increased risk of incarceration. The Oregon Department of Corrections estimates that approximately 14% of its 12,500 inmates have severe mental health problems. Oregon participated in a November 2003 Policy Academy on increasing mainstream resources for persons experiencing chronic homelessness, many of whom have a serious mental illness or co-occurring substance use disorder. More needs to be done to create supportive housing for these individuals.
Significance:	It is difficult for people disabled by serious mental illness to benefit from mental health and addiction treatment when they do not have stable, safe housing. The Oregon Supportive Housing Evaluation Study demonstrated that supportive housing decreases homelessness and residential instability. While Oregon has several successful housing development initiatives, this goal will target efforts toward creating supportive housing for people with serious mental illness who are experiencing or at imminent risk of homelessness, and is consistent with the Oregon Homeless Policy Team draft action plan. The unique opportunity presented by the sale of a former state hospital property, and deposit of sale proceeds into a new "Community Mental Health Housing Fund", will assist this effort.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Add new units of Supportive Housing.	N/A	N/A	N/A	30 new units	50 new units

Goal 13: Reduce transportation barriers for adults with severe mental illness living in rural Oregon communities.

Population:	Adults with Severe Mental Illness Living in Rural Urban Areas
Criterion:	4. Targeted Services to Homeless and Rural Populations.
Brief Name:	Reducing Transportation Barriers
Indicators:	A. In collaboration with the Oregon Department of Transportation, Mental Health Organizations and County Mental Health programs, develop at least two new transportation services in two or more rural counties by 6/30/05. B. In collaboration with Mental Health Organizations, County Mental Health Organizations and consumer organizations, provide information and materials regarding alternative models of transportation services in rural areas to all rural Regions of Oregon by 6/30/06.
Measure:	A. Establishment of contracts B. Evidence of distribution of information
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	Mental health contracts, transportation carrier schedules, and ODOT data.
Special Issues:	Most of Oregon's 26 rural counties have no publicly-funded local bus or train services. Moreover, inter-city bus lines (e.g., Greyhound) recently have discontinued stops to more than 35 destinations in Oregon.
Significance:	Adults with severe mental illness are often persons with low-incomes, without personal automobiles or employment. They are particularly dependent upon low-cost transportation, which is severely lacking in most rural areas.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop at least two new transportation services by 06/30/05.	N/A	N/A	N/A	Two contracts in two or more counties	
B. Provide information regarding alternative models of transportation in rural areas by 6/30/06.	N/A	N/A	N/A		Evidence of distribution of material

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

i. Description of Current Adult Mental Health System

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

During the 2001-2003 biennium the State of Oregon Department of Human Services (DHS) implemented major organizational and structural changes to provide better services to clients, simplify access to services, consolidate programs, and reduce the multiple layers and steps clients have to take to obtain the help they need. This approach has helped to reduce administrative expenses and strengthen the network among DHS employees. By working together as teams, some of the mysteries of specific agency program and culture have melted into a united way of thinking about and responding to client needs. The OMHAS Training Unit demonstrates a team approach in providing multi-disciplinary education services.

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

> Between Jan - Dec. 2003, 4,572 providers, mental health consumers/advocates, and family members attended 68 training events on a variety of topics, sponsored or co-sponsored by OMHAS.

During the past year the following trainings were held:

- OMHAS co-sponsored a conference with the Child and Adolescent Residential Psychiatric Programs (CHARPP) about Evidence Based Practices for Children and Families.
- Co-Occurring Disorders Conference "The Changing Landscape"

- OMHAS help sponsor a conference on the provision of Evidence-Based Practice community-based services.
- A Latina Prenatal Summit focused on serving young Latino mothers with culturally appropriate services to prevent mental health and substance abuse issues in later years.
- OMHAS sponsored training about Fetal Alcohol Syndrome (FAS) and improved services to meet the needs of children with FAS.
- OMHAS co-sponsored a training with CHARPP on reducing the use of Seclusion and Restraint.

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

Mental Health Block Grant Funding Innovative Services

All-Hazards Response for Behavioral Health Treatment Providers. OMHAS will sponsor a two-day training designed for behavioral health care providers to address the topics of assessment, triage and referral, psychological first aid and acute-care subsequent to large-scale emergencies. It will be targeted to mental health and addiction service providers, especially crisis and outreach clinicians, who would be designated as part of the immediate and post-disaster response cadre. The training will include clinical assessment and treatment information and logistical orientation for the entire group. It will also provide specific guidance for working with special populations (as defined by age, cultural/ethnicity, high-risk factors, or geographic variables). The program will train 20 people who will then train regional staff.

Mental Health Training for Emergency First Responders. OMHAS is sponsoring a three-day training entitled "Practical Front Line Assistance and Support for Healing after Terrorism and other Disasters". While this training is intended for mental health providers, the plan is to have participants to then provide training for local emergency first responders. The dates of the training are August 23, 2004 through August 25, 2004.

Jail Bridge Program. Block Grant funds have been used to address the issue of persons with mental illness in the jail. Many of these persons have a co-occurring substance abuse problem. Oregon has three pilot programs that assist individuals with co-occurring disorders in jail to link up with integrated treatment in the community. The three projects started between January and June of 2002. As of March of 2003, a total of 316 persons had been served in the projects. OMHAS is in the process assessing the effectiveness of the pilot projects.

Family-to-Family Program Expansion. OMHAS provides some Block Grant funds to National Alliance for the Mentally Ill – Oregon to expand the family-to-family program. This is a nationally recognized program that provides education and support to families that have a family member with a serious mental illness.

Supported Employment. As described in the Criterion 1 of the Adult plan, Block Grant funds are contracted to two programs to provide Supportive Employment services. These programs serve 300 individuals. An average of 50% of consumers enrolled obtain competitive employment in community-based jobs.

OMHAS in consultation with the with the State Mental Health Planning and Management Council will evaluate each of the funded pilot programs and decide which of the pilots are ready to transition to other sources of funding. This will allow the funding of other projects.

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

1. The Medicaid Management Information System (MMIS) provides information on persons who are Medicaid-eligible including those who are on the Oregon Health Plan (OHP). The information contained in MMIS includes eligibility, capitation payments, fee-for-service claims, and encounter data for persons receiving services via prepaid capitation programs. Further, MMIS includes all mental health, chemical dependency, pharmacy, dental, and physical health service and eligibility information for all Medicaid-eligible persons.

   Medicaid fee-for-service data and encounter data is submitted electronically and by fee-for-service billing. Managed MHOs and service providers have 180 days to submit Medicaid data from the time of service. Data from MMIS is downloaded and stored in a Sybase data warehouse for use by state analysts and actuaries responsible for rate setting.

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

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

3. The Oregon Patient/Resident Care System (OP/RCS) is the database for all publicly funded psychiatric inpatient care delivered in state hospitals and acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed for mental health treatment.

   State Hospitals and Acute Care Units of regional hospitals submit OP/RCS data at admission and discharge. This data is also stored in a mainframe. DHS's Office of Information Services is responsible for all DHS client data processing and storage.

Each system contains client level identifiers unique within the system. DHS's Office of

Information Services maintains inter-system references that allow analysts to track and summarize service utilization and population demographics at the client level, regardless of the type of service received.

OMHAS collects other information. For example, outcome and performance measure data are gathered through consumer and family surveys. These surveys are translated to appropriate language as indicated through service data. This information is used to: 1) provide feedback to those who are affected by OMHAS performance measures; 2) identify areas in need of improvement or attention; 3) track improvement in the well-being of people served with public funds; 4) recognize those programs which are doing well; and 5) communicate results to the Governor, the Legislature, Department contractors, and the public. OMHAS maintains a staff of research analysts and information systems analysts who coordinate survey efforts, as well as summarizing and disseminating information gathered through the MMIS, CPMS, and OP/RCS data systems.

OMHAS also has access to detailed population estimates through Portland State University. This information is used to derive estimates of prevalence for adults with severe mental illness and children with severe emotional disorders.

Several other State agencies that serve many of the same clients maintain central databases to track services within their area of responsibility. Unfortunately, unique identifiers are not the same across many of the agencies. Currently there are plans to explore methodologies to compare datasets across different state agencies. OMHAS has developed a research facilitation plan that will allow us to gather data from CPMS, OP/RCS, MMIS and other State agencies and store it in a data-mart. OMHAS hopes to develop standard reports on the web that link to those data. This will facilitate data driven decision-making.

ii. Goals, Objectives, and Performance Indicators

Goal 14: Reduce the waiting list of Oregon State Hospital patients approved for discharge and waiting placement.

Population:	Adults with severe mental illness awaiting discharge from Oregon's State Hospitals.
Criterion:	5. Management Systems
Brief Name:	State Hospital Discharges to Community-Based settings
Indicators:	A. Develop at least 50 new community-based residential placements for adult patients awaiting discharge from the State Hospital by 6/30/05. B. Reduce the number of Miranda B. Settlement civilly committed patients awaiting placement to 20 or fewer by 6/30/06.
Measure:	A. Number of New licensed residential beds or supported housing beds developed between October 1, 2004 and June 30, 2005. B. Number of Miranda B. Settlement civilly committed patients awaiting placement
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	OMHAS contracts; Caseload Growth data; Miranda B. Settlement data
Special Issues:	The Oregon Legislature appropriated more than $7 million in new Caseload Growth funds in 2003 to increase the numbers of community-based settings available for State Hospital patients awaiting discharge to the community. In 2004, Oregon reached settlement on the *Miranda v. Kitzhaber* lawsuit, with agreement, in part, to develop appropriate community placements for 69 specific patients in the State hospital.
Significance:	The Supreme Court's *Olmstead Decision* requires the states to provide services to those persons covered by the Americans with Disabilities Act in the most integrated setting appropriate. This mandate focuses upon covered persons in institutions and at risk of institutionalization.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop 50 new placements from OSH by 06/30/05.	N/A	N/A	N/A	50 new placements established	
B. Reduce waitlist from Miranda B. settlement to 20 or less by 06/30/06.	N/A	N/A	N/A		Waitlist reduced to 20 or less

Goal 15: Provide on-going recovery-oriented training to Case Managers of adults with severe mental illness to promote consumer independence, health, safety, and recovery.

Population:	Case managers serving adults with severe mental illness.
Criterion:	5. Management Systems
Brief Name:	Case Manager Training
Indicators:	A. Develop a core curriculum of training for case managers by 6/30/05 through a work group of case managers, consumers, Community Mental Health Program and Mental Health Organization representatives, and other stakeholders. B. Provide quarterly training opportunities for case managers that emphasize a Recovery Model and assure case manager competencies in areas such as applications for disability benefits, housing vouchers, the Americans with Disabilities Act and the Olmstead decision by 6/30/06.
Measure:	A. A core curriculum of training has been developed. B. Quarterly trainings have been provided.
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	OMHAS Annual Training Plan and calendar
Special Issues:	Recovery oriented service delivery has been demonstrated to promote positive outcomes; housing resources are diminishing statewide; and many clients are not living in the most integrated community setting that their personal situation will allow.
Significance:	The President's New Freedom Commission on Mental Health report states that mental health service delivery that is recovery-oriented leads to improved client outcomes. It is important that existing housing resources be fully used by case managers in order to provide clients with the best housing options possible. Case managers and clients who are enlightened to the provisions of the Olmstead Decision and the Americans with Disabilities Act tend to promote positive outcomes more than those who are not so enlightened.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. A core curriculum of training has been developed by 06/30/05.	N/A	N/A	N/A	Core Curriculum	
B. Quarterly trainings have been provided by 06/30/06.	N/A	N/A	N/A		Evidence of trainings.

Goal 16: Reduce the effects of trauma for adults with severe mental illness.

Population:	Adults with severe mental illness who receive publicly funded mental health services.
Criterion:	5. Management Systems
Brief Name:	Trauma identification through screening.
Indicators:	A. OMHAS will adopt a statewide Trauma Screening Tool for use with adults with serious mental illness by 6/30/05. B. Provide training, in collaboration with trauma survivors, on trauma-informed care and the adopted Trauma Screening Tool to all Community Mental Health Programs and all Mental Health Organizations by 6/30/06.
Measure:	A. The establishment of an accepted Trauma Screening Tool. B. The percentage of CMHPs and MHOs trained.
Numerator	A. Not applicable B. The number of CMHPs and MHOs trained to use screening tool
Numerator	A. Not applicable B. Total number of CMHPs and MHOs.
Sources of Information	OMHAS.
Special Issues:	Persons with severe mental illness often have a significant history of trauma that increases the severity of their illness. By identifying those who have a significant trauma history, treatment can be tailored to address their trauma needs, resulting in improved outcomes. Follow-up outcome surveys will be developed after staff training has been initiated to determine the effectiveness of this approach.
Significance:	Utilization of a Trauma Screen Tool may promote positive practices through the more accurate identification of population needs, allowing the provision of evidence-based practices tailored to those needs.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Adopt a statewide Trauma Screening Tool by 06/30/05.	N/A	N/A	N/A	Acceptance of a tool	
B. Provide training on Trauma Screening Tool by 06/30/06.	N/A	N/A	N/A		100%

iii. Budget for Adult 2004-05

2004-2005 Fiscal Year

Contractor	Adult Services
Baker County	33,981.60
Benton County	39,575.52
Clackamas County	423,726.40
Clatsop County	41,480.55
Columbia County	-
Coos County	15,455.25
Crook County	11,792.52
Curry County	15,664.13
Deschutes County	96,231.09
Douglas County	100,602.72
Grant County	21,046.76
Harney County	29,502.90
Jackson County	80,453.89
Jefferson County	15,543.07
Josephine County	152,323.46
Klamath County	2,676.98
Lake County	10,831.61
Lane County	229,352.22
Lincoln County	67,703.15
Linn County	60,618.68
Malheur County	23,036.02
Marion County	255,947.65
Morrow/Wheeler County	20,082.37
Multnomah County	260,376.57
Polk County	35,773.73
Tillamook County	19,727.35
Umatilla County	118,974.90
Union County	18,666.61
Wallowa County	13,019.31
Washington County	421,027.95
Yamhill County	74,795.90
Mid-Columbia County	78,058.20
Confederated Tribe of Warm Springs	22,616.82
NAMI: Adult/Family Support and Education	50,000.00
OHSU: Child Psychiatrist	-
Total	**2,860,665.88**

B. CHILDREN'S PLAN

1. Current Strengths and Accomplishments

- **OMHAS is engaged in a broad scale planning and implementation process to provide a more integrated community-based system of care for children and their families beginning January 1, 2005**.
  As directed by a 2003 Legislative Budget Note, OMHAS is working with system stakeholders to increase the availability and quality of individualized, culturally competent, intensive home and community-based services to serve children in the most natural environment possible and to minimize the use of institutional care.

- **OMHAS is developing a new coordinated system of care to meet the needs of children served by multiple child serving agencies.**
  OMHAS is working closely with Child Welfare, Education, Juvenile Justice, and Family Advocacy organizations to improve intersystem coordination.

- **OMHAS led a strategic planning process partnering with Child and Adolescent Residential Psychiatric Programs (CHARPP) to develop alternatives to using seclusion and restraints.**
  OMHAS is leading an initiative tilted, "Best Environments Supporting Success in Treatment (BESST).in collaboration with the Child and Adolescent Residential Psychiatric Programs (CHARPP). The BESST initiative is developing alternatives to the using of seclusion and restraint.

- **OMHAS received a 2003 Legislative appropriation of two million dollars to provide mental health and addiction services for children ages 0-8 and their families.**
  Services are to be provided to children and their families when there are no other resources to pay for needed services. The funding is intended to serve children ages 0 to 8 who are high risk due to mental or emotional disorders or parental addiction disorders and/or mental illness. Services are to be provided to children and their families when there are no other resources to pay for needed services.

- **OMHAS funding will be used on evidence-based practices.**
  In June 2003, the Oregon Legislature passed a law that requires the Office of Mental Health and Addiction Services to use state and federal funds for cost effective practices that are based on scientific evidence. All affected agencies will report to the meeting of the Joint Interim Judiciary Committee on the status of work to meet the goal that 25% of mental health and addiction treatment and prevention funds will be used for evidence-based practices in the 2005-07 biennium.

- **OMHAS is implementing Integrated Treatment Courts for Juveniles and Their Families**

In 2000, the Office of Mental Health and Addiction Services, in collaboration with the Oregon Judicial Department (OJD), was awarded funds through the Juvenile Accountability Incentive Block Grant (JAIBG) to implement. DHS – OJD partnership resulted in an innovative statewide pilot project designed to address a growing concern related to juvenile offenders with co-occurring substance use and mental health disorders.

- **OMHAS continues to develop systemic alternatives to state hospitalization for adolescents.**
  OMHAS consolidated two adolescent units at the Oregon State Hospital in November 2003. OSH has the capacity to serve 20 adolescents instead of 40. The monies saved have been directed to develop individualized alternatives to institutional care.

- **Mental health services for children are currently provided in settings that were not previously used or were under-utilized, including homes, schools, and other community settings.**

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

- **Intensive Treatment Services (ITS) Pilot Projects served 109 children in three levels of care at seven MHOs, seven ITS providers and in 21 counties from 2002-2004.**
  Service delivery to these children allows funding to follow the child to the most appropriate treatment setting. Child-based outcomes demonstrate the improved effectiveness of this more flexible community-based service approach such as: a higher percentage of children in pilot programs showed improved clinical outcomes and had shorter lengths-of-stay in "high end" (residential and acute) services, and were more likely to be discharge to their families or relatives' homes.

2. Current Weaknesses and Areas of Needed Improvement

- As previously stated in this plan, Oregon has experienced significant economic downturn in the past several years that resulted in cuts for mental health services for children. While all of the community-outpatient treatment funds for indigent children have been restored, the cuts in psychiatric day treatment were partially restored leaving that service component available only for Medicaid-eligible children.

- While Oregon has strengthened its working relationship and collaboration with the Oregon Department of Education, there is still more to be done. This will continue to be an area of focus at the state and local level. A representative of the state Department of Education serves on the Mental Health Planning and

Management Advisory Council and the Children's System of Care Initiative. At a community level, efforts are made to engage local school districts in mental health system planning and in system oversight.

- Although Oregon is working closely with family organizations to have more meaningful family involvement in the children's system of care, there is more work to be done. OMHAS is working closely with the family organizations to develop strategies to ensure meaningful family involvement in all areas of children's mental health.
- With the implementation of the Children's System of Care Initiative, OMHAS needs to improve the cultural competency of mental health services provided to children and their families. A committee is providing technical assistance to OMHAS.
- Transitional services for young people ages 16-25 leaving the children's mental health system and moving into the adult mental health system or services for youth experiencing first indications of a major mental illness need to be improved and expanded.
- The coordination of mental health services for children ages 0-8 with Head Start needs to improve as it does with early intervention programs, childcare centers, physicians and public schools.
- More collaboration must occur between state and local Child Welfare and OMHAS to ensure children entering substitute care receive a mental health assessment within 60 days.
- OMHAS continues the process of developing and maintaining a coordinated system of care to meet the needs of children served by multiple child serving agencies. Increasing the availability of flexible funding for individualized service planning, along with incorporating family/parental involvement in the planning and evaluation of implementing activities are major components in the development of a coordinated system of care for children and their families.

3. Priorities For The Children's Mental Health System

The OMHAS, based upon Planning and Management Advisory Council recommendations, established the following priorities for children's mental health:

1. <u>Expand community-based services at all levels.</u>
    - Provide more services to children with Serious Emotional Disorders (SED) in the community.
    - Increase the array and availability of community-based services for children with SED.
    - Increase expenditures on community-based services.

2. Improve transition and enhance integration of mental health services with other agencies.
    - Increase service coordination and delivery for older adolescents and young adults ages 16-25.
    - Increase service coordination with child welfare and juvenile justice at the state and local level.

3. Increase access of mental health services in rural areas of the state.
    - Increase the use of teleconference technology for psychiatric evaluations in rural areas.

4. Increase family member influence within the mental health delivery system.
    - Increase the number of family members participating on policy committees.
5. Increase the number of evidence-based practices offered to children.
    - The Oregon Legislature passed Senate Bill 267 requiring that mental health funds be used for Evidence-Based Practices in increasing amounts beginning with the 2005-07 Budget.

6. Decrease readmission rates of children into the Oregon State Hospital (OSH) and Secure Children's Inpatient Center (SCIP).
    - Oregon is developing alternatives to the Oregon State Hospital and Secure Children's Inpatient Center (SCIP), as well as, increasing care coordination for children with SED.

4. Future Vision For Children's Mental Health

The future envisioned for children's mental health in Oregon is clearly described in the Children's Mental Health System of Care Initiative and the Oregon Children's Plan.

- Children's Mental Health System of Care Initiative

The Legislative Assembly directed DHS through a Budget Note to " substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive, and culturally competent home and community based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized." The following actions are required by June 30, 2005.

- Integrate inpatient hospital, psychiatric residential, psychiatric day treatment and community care in the local or regional managed care environments.
- Ensure meaningful family involvement at policy local or regional managed care systems, providers and explore mechanisms to ensure family involvement and control over some of the resources.

- Require culturally competent, skills-based, staff training on evidence-based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.
- Ensure continuous care coordination for children with serious mental and emotional disturbances.
- Create clinical and fiscal incentives to provide culturally competent care in the least-restrictive and most normative setting in the child's home community.
- Ensure an effective system of care for children and families through a statewide system of quality improvement and use of pertinent outcome data (e.g., reducing the amount of time children spend in institutional care and increasing the proportion of children and families who receive flexible, community-based services).
- Ensure that funding intended and allocated by the legislature for children's mental health is used for that purpose.
- Encourage local or regional managed care organizations to create a flexible funding pool and to contract with one or more non-traditional providers who are positioned to provide culturally competent, flexible responses on a 24 hour, seven day a week basis, without requiring the children to enter a facility.
- Support the system of care approach through meaningful regulation and contract provisions.

OMHAS created a Children's Mental Health System of Care Initiative Stakeholders Workgroup to respond to this legislatively directed Budget Note. The workgroup includes balanced representation of key stakeholder groups and is task focused. This group has developed recommended action steps that OMHAS will consider to implement the Children's Mental Health System of Care Initiative Budget Note.

The Department of Human Services, OMHAS received a legislative appropriation of two million dollars to provide mental health and addiction services to young children. The funding is intended to serve children ages 0 to 8 who are high risk due to mental or emotional disorders or parental addiction disorders and/or mental illness. Services are to be provided to children and their families when there are no other resources to pay for needed services. In funding services for this population, the Department will further the goals of the Oregon Children's Plan.

The goals of the Early Childhood System developed through the Oregon Children's Plan are:

- Prevent child abuse and neglect.
- Improve the health and development of young children.
- Promote bonding and attachment in the early years of a child's life.
- Support parents in providing the optimum environment for their young children.
- Link and integrate services and supports in the voluntary statewide early childhood system.

- Ensure that children are entering school ready to learn.
- Ensure that children receive quality service delivery.

5. Criteria

Criterion 1: Comprehensive Community-Based Mental Health Systems

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services;
  - Housing services;
  - Educational services;
  - Substance abuse services;
  - Medical and dental services;
  - Support services;
  - Services provided by local school systems under the Individuals with Disabilities Education Act;
  - Case management services;
  - Services for persons with co-occurring (substance abuse/mental health) disorders; and
  - Other activities leading to reduction of hospitalization.

i. Description of Current Children's Mental Health System

Oregon manages a comprehensive community-based system of care for children with severe emotional disorders. The goal of these services is to maintain the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system of care is child and family-centered and community-based with the needs of the child and family determining the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically appropriate to sustain the child in treatment in the community.

OMHAS currently operates a pilot project to integrate Children's Intensive Treatment Service programs into the Oregon Health Plan (OHP) managed mental health service delivery system. Through this ITS Pilot Project, providers are able to deliver levels of care and types of services based on the immediate needs of the child. The traditional system is limited to providing narrowly defined services that are based on a filled slot or bed. Currently the ITS Pilot Project using seven MHOs in 21 counties with seven providers serves 109 children in three distinct levels of care. The ITS Pilot Project will end on December 31, 2004 with the implementation of the new children's system of care initiative.

OMHAS continues to develop systemic alternatives to state hospitalization for children. As part of this change and development, the Secure Children's Inpatient Program (SCIP) opened in January 2002. SCIP replaced the children's unit within the Child and Adolescent Treatment Services located on the Oregon State Hospital grounds. The new program provides services to children under age 13 who previously would have received services at the Oregon State Hospital. In November 2003, two adolescent units were consolidated into one unit serving 20 adolescents reducing the number from 40 adolescents at the Oregon State hospital. The monies saved have been directed to develop individualized alternatives to institutional care.

Also in June 2003, Legislature directed DHS through a Budget Note to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive and culturally competent home and community based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized" to assist in implementing the Budget Note: Psychiatric Residential Treatment Services, Psychiatric Day Treatment Services and Oregon State Hospital funding will be transferred to the Oregon Health Plan and managed through MHOs. Currently OMHAS continues direct contracts with private non-profit agencies for intensive treatment services, such as Psychiatric Day Treatment and Psychiatric Residential Treatment.

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

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

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

Outpatient Services. Clients are provided with an array of outpatient services, including:

- Mental health assessments
- Co-occurring disorder assessments
- Individual and group therapy

- Medication management
- Parent training
- Case management
- Crisis intervention
- Consultation to schools and other agencies
- Flexible services
- Specialized support services to families
- Skills training

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

Rehabilitation Services/Wraparound Services. With the implementation of the new Children's System of Care Initiative, OMHAS is working with providers and partners to increase intensive community-based services for children with SED. Currently, MHOs use Medicaid funds to serve these children in the community until a child requires a Psychiatric Residential Treatment Program, Acute Hospitalization and Oregon State Hospital. After January 1, 2005, funding will transfer to MHOs for Psychiatric Day Treatment, Psychiatric Residential Treatment, Acute Hospitalization and Oregon State Hospital/Secure Children Inpatient Program.

Care Coordination. Community based care and facility-based mental health providers are required to provide care coordination. Care Coordination services are provided for coordinating the access to and provision of services from multiple agencies, establishing services linkages, advocating for treatment needs and providing assistance in obtaining qualified entitlements.

Treatment Foster Care. In an effort to better serve rural children, Treatment Foster Care was developed in 1992-93. It is jointly funded with the Department of Human Services, Children, Adults and Families. Considered the least restrictive of residential treatment options for children in the care and custody of the state, Treatment Foster Care provided by trained foster parents, employed and supervised by the local Community Mental Health Program, is a critical treatment option for children in rural counties.

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

Qualified mental health professionals and psychiatrists provide Intensive Treatment Services.

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

Children living in Oregon can access an array of Intensive Treatment Services available throughout the state such as:

- Psychiatric Day Treatment Services;
- Therapeutic Foster Care;
- Psychiatric Residential Treatment Services;
- Psychiatric Assessment and Evaluation Services;
- Adolescent Treatment Services at the Oregon State Hospital; and
- Secure Children's Inpatient Program treatment services.

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

Psychiatric Day Treatment Programs are located in 16 counties, have a daily service capacity for 292 children who cannot attend regular school programs due to a serious emotional disorder. Because of budget cuts in February 2003, these programs reduced the number of children they served from 399 to 223. The 2003 Legislature partially restored the Psychiatric Day Treatment services effective October 2003. Currently 292 children receive services. Therapeutic Foster Care services are provided to 52 children as a community-based alternative to psychiatric residential and hospital levels of care. Psychiatric Residential Treatment Programs have a daily service capacity for 168 children in a more restrictive and intensive level of residential treatment. The ITS Pilot Project, which integrates two children's services - psychiatric day treatment and psychiatric residential treatment - into the Oregon Health Plan, serves 109 children daily. The ITS Pilot Project gives providers the financial flexibility to provide children with the services that best meet their needs without the restrictions imposed by the traditional "slot" funding system. Assessment and evaluation services provided in nationally accredited treatment facilities are designed to provide intensive evaluation services and brief treatment for 45 children on an emergency basis.

The Adolescent Treatment Program at the Oregon State Hospital provides long-term psychiatric inpatient services for 20 adolescents ages 14 to 17. SCIP provides a similar

level of care for children 13 years and younger and serves 12 children. An average of 653 children per day are receiving intensive mental health treatment services throughout the state.

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

Educational Services provided by local school systems under the Individuals with Disabilities Act. The local school district is responsible for any educational service under an Individual Education Plan (IEP). Each School District uses a variety of assessment tools and strategies to gather relevant information about the child. Based on the evaluation results, the IEP team, which includes the family, decides which services the child's needs in order to benefit from a free and appropriate public education. This may include developmental, corrective or supportive services as required in assisting a child with a disability to benefit from special education. The IEP team then determines the least restrictive environment in which services can be provided to meet the educational needs of the child. If the IEP team determines that the child cannot be educated in the community either within the school district or a contracted private school then a residential special education placement is necessary.

Reduction of hospitalization of SED children. Children with SED are provided with mental health services in their home and community to the extent possible. These services include support and training for parents in meeting their child's mental health needs as well as support and training for the child and parents in self-management. A child's needs are continuously evaluated and modified. A child's individual plan of care should address and anticipate crises and include specific strategies and services that will be utilized. When responding to crises, providers access appropriate mental health services to help the child remain at home, minimize placement disruptions and avoid the inappropriate use of police and the juvenile justice system. The Community Mental Health Programs provides crisis response with 24-hour clinical accessibility.

ii. Goals, Objectives, and Performance Indicators

Goal 1. **Increase the number of children with severe emotional disorders (SED) who reside in a family like environment and receive mental health services.**

Population:	Children and their families
Criterion:	Comprehensive Community based mental health services
Brief Name:	Family Like Environment
Indicators:	A. Develop a baseline percentage of children with SED who reside in a family-like environment and receive mental health services by June 30, 2005. B. By June 30, 2006 increase the percentage of children with SED who reside in a family-like environment and receive mental health services by 5%.
Measure:	Percentage of children receiving services who live in a private residence or in foster care
Numerator	Number of children with SED receiving mental health services that identify themselves as living in a private residence or foster care home.
Denominator	Total number of children with SED receiving mental health services.
Sources of Information	Client Process Monitoring System (CPMS)
Special Issues:	A number of counties have limited community based mental health services for children to enable children with SED to stay in their community.
Significance:	The State of Oregon Office of Mental Health and Addiction Services is committed to serving more children with SED in the community. One way of keeping a child in the community is to provide mental health services to them at home or homelike environment.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop baseline % of children who reside in a family like environment and receive mental health services by June 30, 2005.	N/A	N/A	N/A	Baseline percentage	
B. Increase the baseline % by 5% by 06/30/06.	N/A	N/A	N/A		5% increase over baseline percentage

Goal 2. To increase the delivery of family driven array of services and the availability of community based services for children with SED. These services will include assessment, case management, therapeutic foster care, crisis response, outpatient treatment, family support services, and respite.

Population:	Children and their families
Criterion:	Comprehensive, Community-based Mental Health System
Brief Name:	Array of community based services
Indicators:	A. Develop a baseline by June 30, 2005 of the number of children with SED receiving services from an array of family-driven community-based services. These services will include case management, therapeutic foster care, crisis response, family support services, respite, behavioral skills and community-based wraparound services. B. Increase the number of children with SED who receive family-driven community-based services for children with SED by 5% on June 30, 2006.
Measure:	A. Establish the number of children receiving an array of family-driven community-based services. B. Compare number of children receiving an array of family-driven community-based services to previous year.
Numerator	A. Not applicable. B. Difference between those receiving defined service this year compared to last year
Denominator	A. Not applicable. B. The number of children receiving defined services the previous year.
Sources of Information	Client Process Monitoring System (CPMS) and Medicaid Management Information System (MMIS)
Special Issues:	Some of the communities have very limited array of services available to children with SED.
Significance:	The State of Oregon Office of Mental Health and Addiction Services is committed to serving more children with SED with further community based services. Increasing the array of services to children will be essential in implementing the new children's system of care initiative.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop baseline on the availability of family-driven services by 06/30/05.	N/A	N/A	N/A	Baseline number	
B. Increase baseline % by 5% by 06/30/06.	N/A	N/A	N/A		Increase of 5% over baseline.

Goal 3. Maintain or increase the percentage of parents or guardians whose children receive services through the Oregon Health Plan and respond positively to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.

Population:	Children and their families
Criterion:	1. Comprehensive, community-based mental health system
Brief Name:	Effective OHP children and family services.
Indicators:	A. 63% of parents or guardians whose children receive services through the Oregon Health Plan and respond positively to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families by June 30, 2005. B. That 65% of parents or guardians whose children receive services through the Oregon Health Plan and respond positively to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families by June 30, 2006.
Measure:	Survey of parent and caregivers of children who have received mental health services.
Numerator	The number of parents or guardians who answered they "agree or "strongly agree" to the appropriateness of treatment questions.
Denominator	The total number of responses to the questions.
Sources of Information	MHSIP Youth Services Survey
Special Issues:	The State of Oregon Office of Mental Health and Addiction Services distribute MHSIP Youth Survey For Families annually. Though this survey reflects only the opinions of those who choose to fill out and return the survey, historically the return has been adequate to represent a significant sample.
Significance:	Assuring that children and their parents or guardians who receive OHP services rate the appropriateness and quality of services as effective is critical to Oregon's system of care.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. 63% of parents/guardians respond positively to the appropriateness of service on the MHSIP Survey by 06/30/06.	66%	63%	Will be reported in 12/2004	63%	
B. Increase percentage from 63% to 65% by 06/30/06.	66%	63%	Will be reported in 12/2004		65%

Goal 4. To increase service coordination and delivery for older adolescents and young adults aged 16-25 with severe emotional, behavioral and/or mental disorders transitioning into the adult community mental health service system.

Population:	Children and their families
Criterion:	Comprehensive, Community-based Mental Health Services System
Brief Name:	Transition Services for Older Adolescents and Young Adults
Indicators:	A. To identify, assess, coordinate and provide treatment services for 40 older adolescents and young adults, aged 16-25 with severe emotional, behavioral and/or mental disorders transitioning into the adult community mental health service system by June 30, 2005. B. To identify, assess, coordinate and provide treatment services for 45 older adolescents and young adults, aged 16-25 with severe emotional, behavioral and/or mental disorders transitioning into the adult community mental health service system by June 30, 2006.
Measure:	The number of defined children receiving service.
Numerator	Not applicable
Denominator	Not applicable
Sources of Information	OMHAS funded demonstration projects quarterly and annual reports tracking these measures.
Special Issues:	There is a continued need to develop coordination across youth service and adult service systems to assist older adolescents and young adults in making a smooth transition. Youth development services go beyond treating high-risk behaviors by providing opportunities and supports to build competencies to contribute to one's own growth and that of their communities. Vocational and educational programs are fundamental to the transition from adolescents to adulthood.
Significance:	These programs are addressing a need that is currently not met in many Oregon counties. For the participants in the programs, it will likely reduce their encounters with the acute care and criminal justice systems while increasing community tenure, vocational and educational outcomes and life satisfactions.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Provide transition services to 40 adolescents/young adults by 06/30/05.	63 clients	52 clients	Will be reported in 12/2004	40	
B. Increase to 45 adolescents/ young adults by 06/30/06.	63 clients	52 clients	Will be reported in 12/2004		45

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

i. Description of Current Children's Mental Health System

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

Access for Minorities. The majority of the population in Oregon is Caucasian with the remaining population being African American, Hispanic, Native American, Asian, etc. Oregon Administrative Rules state that community mental health programs are to provide culturally competent services. OMHAS requires information be provided to potential consumers, family members and allied agencies regarding the availability in a multi-lingual format.

Planning for mental health services must more fully address access to culturally competent services for Oregon's minority populations. In the Children's Mental Health System Initiative directed by the 2003 Legislative Assembly two of the eight tasks focus on developing culturally competent services, and they are:

- Requiring culturally competent skills-based staff training on evidence based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.
- Encourage local or regional managed care organizations to create a flexible funding pool to contract with one or more non-traditional providers who are positioned to provide culturally competent flexible response on a 24 hour, seven day per week basis without requiring the children to enter a facility to access the services.

Oregon is currently working on a technical assistance plan to implement cultural competency into the new children's system of care initiative. The Department of Human Services has developed a department-wide policy for providing culturally competent services. OMHAS has two representatives on the committee that developed the policy. The policy has a list of eight standards and strategies to guide the work towards cultural competence. OMHAS is working to employ these standards and strategies to the unique mental health services and settings.

Gender Specific Services. The Office of Mental Health and Addiction Services participates in the Coalition of Advocates for Equal Access for Girls. The mission and activities of the Coalition aims to ensure that girls receive equal access to all of the appropriate gender specific support and services they need to help girls develop to their full potential. Coalition membership includes representatives from OMHAS, other state agencies, and private non-profit organizations. This coalition also has legislative support. The Coalition meets at least 6 times a year and publishes *The Girls' Advocate*, a quarterly newsletter that aims to inform members and others regarding the activities that either support or threaten service access for girls.

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

ii. Goals, Objectives, and Performance Indicators

Goal 5. Expand access to publicly funded mental health services for all children who need publicly funded mental health services.

Population:	Children and Families
Criterion:	2. Mental Health System Data Epidemiology
Brief Name:	Access to publicly funded mental health services
Indicators:	A. Increase the percentage of children with severe emotional disorders served in the publicly funded mental health system from 28% to 29% served out of the prevalence estimates by 6/30/05. B. Increase the percentage of children with severe emotional disorders served in the publicly funded mental health system to 30% served out of the total estimate of prevalence by 6/30/06.
Measure:	Percentage of children with severe emotional disorders receiving publicly funded mental health services during the fiscal year.
Numerator	The number of children with severe emotional disorders receiving publicly funded mental health services.
Denominator	The estimated number of children with severe emotional disorders .
Sources of Information	Client Process Monitoring System (CPMS), Oregon Patient/Resident Care System, and Medicaid Management Information System
Special Issues:	The State of Oregon requires all providers of publicly funded mental health services to report the services provided through CPMS. Publicly funded mental health services include any services provided using State or Federal funds.
Significance:	Children with mental health disorders have shown to benefit from the utilization of mental health services.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase the percentage of children with severe emotional disorders served in the publicly funded mental health system.	27%	28%	Will be reported in 12/2004	29%	30%

Goal 6. To maintain or increase the proportion of children from Native American, Hispanic, African American, or Asian ethnic backgrounds receiving publicly funded culturally competent mental health services, so that the proportion of the population receiving services will match or exceed the proportion of the State's children within the same ethnic population.

Population:	Children
Criterion:	2. Mental Health System data Epidemiology
Brief Name:	Access to mental health services for children
Indicators:	Percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children with ethnic categories for the general population.
Measure:	Compare the percentage share among ethnic groups of children receiving mental health service to the percentage share among ethnic groups in the general population.
Numerator	Not applicable.
Denominator	Not applicable.
Sources of Information	CPMS, MMIS, PSU Population Research Center.
Special Issues:	In 2003, the proportion of children receiving mental health services from Native American, Hispanic and African American ethnic backgrounds compared to the proportion of children with the same ethnic background in the States or Medicaid eligible children was higher. However, children from an Asian ethnic background receiving mental health services were lower.
Significance:	The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of children with diverse ethnic backgrounds.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children with ethnic categories for the general population.	N/A	N/A	Will be reported in 12/2004	Percentage shares will be equal between mental health service population and general population	Percentage shares will be equal between mental health service population and general population

Criterion 3: Children's Services

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
    - Social services;
    - Educational services, including services provided under the Individuals with Disabilities Education Act;
    - Juvenile justice services;
    - Substance abuse services; and
    - Health and mental health services.
- Establishes defined geographic area for the provision of the services of such system.

i. Description of Current Children's Mental Health System

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

System Alternatives for State Hospitalization. OMHAS continues to develop systemic alternatives to state hospitalization for children. As part of this change and development, the Secure Children's Inpatient Program (SCIP) opened in January 2002. SCIP replaced the children's unit at the Child and Adolescent Treatment Program located at the Oregon State Hospital. The new program provides services to children under age 13 who previously would have received services at the Oregon State Hospital. The services are now provided on a campus and within a program specifically designed for children. SCIP utilizes a child and family focused, community-based model with integrated linkages to a continuum of care. This ensures that each child receives treatment in the most clinically appropriate and least restrictive setting possible. Average length of stay has been reduced from 258 days at the Oregon State Hospital to 126 days at SCIP. In the past year the Oregon State Hospital consolidated two adolescent units into one unit, reducing the capacity to serve adolescents from 40 beds to 20 beds. The average length of stay was reduced from 258 days to 139 days.

Children in Child Welfare Service. Children in the care, custody and supervision of the Department of Human Services comprise more than half of all children receiving mental health treatment services. OMHAS works closely with child welfare to co-finance and co-manage much of the out-of-home psychiatric treatment services provided to these children. The Department of Human Services, Children, Adults and Families contracts with public and private child caring agencies to provide Behavior Rehabilitation Services (BRS) in a residential setting for children whose primary need for out-of-home placement

is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

Also, OMHAS is partnering with Child Welfare Service Delivery Area Managers to work on the requirements for their Federal Performance Improvement Plan (PIP). The primary requirement the two agencies are working on is that children entering substitute care will receive a mental health assessment/screening within 60 days. A strategy is being developed.

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

Children in the Juvenile Justice System. In 2000, the Office of Mental Health and Addiction Services in collaboration with the Oregon Judicial Department (OJD) was awarded funds through the Juvenile Accountability Incentive Block Grant (JAIBG) to implement Integrated Treatment Courts for juveniles and their families. The statutory goal of this federal grant is to promote greater accountability in the juvenile justice system. The DHS – OJD partnership resulted in an innovative statewide pilot project designed to address a growing concern related to juvenile offenders with co-occurring substance use and mental health disorders. The Integrated Treatment Court model was developed and pilot projects established in seven Oregon counties: Clackamas, Coos, Crook, Douglas, Jackson, Josephine and Marion. Over 200 youth and families have participated in the project. Integrated Treatment Courts combine "juvenile drug court" concepts and service integration principles in order to increase accountability, promote service coordination across agencies and systems, promote the use of evidence-based practices and provide individualized behavioral health services for youth and families involved in the juvenile justice system.

OMHAS and the juvenile justice agencies analyzed data independent of each other and found that an estimated 22% of the youth receiving juvenile justice service have a diagnosable mental disorder. In 2004, OMHAS and Juvenile Justice agencies will be sharing data information resulting from a collaborative arrangement. This information will be shared with community mental health programs, county juvenile departments and the Oregon Youth Authority to assist in program and policy development.

Individuals with Disabilities Education Act Partnership. In October 2002, DHS and the Oregon Department of Education (ODE) were awarded a seed grant from the National Association of State Directors of Special Education. ODE and DHS convened statewide forums that addressed children's education needs as they transition from residential treatment facilities back to their school within their community. The forums brought together stakeholders such as parents, advocates, legal representatives and

professionals from the mental heath field, juvenile justices, educational services and child welfare.

These forums resulted in an action plan to assist DHS and ODE in developing strategies to ensure a child has a successful transition back to their community school. OMHAS and ODE continue to use this action plan to coordinate children's mental health services and improve educational opportunities for children.

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

Interagency Care for Children. OMHAS is in the process of developing a new coordinated system of care to meet the needs of children served by multiple child serving agencies. Increasing the availability of flex funding and Community Care Coordination Committees for individualized service planning, along with incorporating family/parental involvement in the planning and evaluation of implementing activities are major components in the development of a coordinated system of care for children and their families.

ii. Goals, Objectives, and Performance Indicators

Goal 7. Develop the data system capacity between the Office of Mental Health and Addiction Services, County Juvenile Departments and the Oregon Youth Authority.

Population:	Children with SED who come in contact with the Juvenile Justice System.
Criterion:	3. Children's Services
Brief Name:	Juvenile Justice Recidivism Rate of youth with SED
Indicators:	A. Develop the data system capacity between the Office of Mental Health and Addiction Services, County Juvenile Departments and the Oregon Youth Authority by June 30, 2005. B. Develop a baseline between the Office of Mental Health and Addiction Services, County Juvenile Departments and the Oregon Youth Authority by June 30, 2006.
Measure:	A. Establish a methodology to match children in the juvenile justice information system and the mental health data system. B. Compare recidivism rate for children with SED to the recidivism rate for the general juvenile justice population.
Numerator	A. Not applicable. B. The recidivism rate of youth who receive mental health services and are also in the Juvenile Justice System.
Denominator	A. Not applicable. B. The recidivism rate of youth who are in the Juvenile Justice System.
Sources of Information	MMIS, CPMS, and the Juvenile Justice System Data Warehouse
Special Issues:	The Office of Mental Health and Addiction Services and the Oregon Youth Authority are interested in the various factors affecting youth with mental health needs and their involvement in the juvenile justice system.
Significance:	Youth who come in contact with the juvenile justice system have a high occurrence of mental health needs. Through a collaborative data sharing and analysis relationship, Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Develop the data system capacity by 06/30/05.	N/A	N/A	N/A	Evidence of data system linkages	
B. Develop a baseline by 06/30/06.	N/A	N/A	N/A		Baseline established.

Goal 8. **Create a baseline on the percentage of children with SED who enter substitute care from the DHS Child Welfare system and Oregon Youth Authority System who receive an initial mental health assessment.**

Population:	Children entering Substitute Care from the Child Welfare or Oregon Youth Authority System.
Criterion:	3. Children's Services
Brief Name:	Children from DHS child welfare system and Oregon Youth Authority receiving mental health assessments
Indicators:	A. Create a baseline percentage of children who are involved in the child welfare system and/or juvenile justice substitute care system and receive a mental health assessment by June 30, 2005. B. Increase the percentage of children who are involved in the child welfare system and/or juvenile justice substitute care system that receives mental health assessments 3% by June 30, 2006.
Measure:	The percentage of children in the child welfare system and/or juvenile justice substitute care system who receive a mental health assessment
Numerator	The number of children who are living in substitute care with the DHS child welfare or Juvenile Justice system receiving a mental health assessment.
Denominator	The total number of children living in substitute care with the DHS child welfare and juvenile justice system.
Sources of Information	MMIS
Special Issues:	Child Welfare has a federal requirement where a child must have a mental health assessment completed within 60 days of substitute care placement. Oregon has not met this measure and is working on meeting this goal.
Significance:	Children in substitute care with DHS child welfare and Juvenile Justice need to have a mental health assessment completed to determine the need for mental health services.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Create a baseline % of children in child welfare and juvenile justice substitute care systems by 06/30/05.	N/A	N/A	N/A	Baseline percent	
B. Increase the baseline % by 3% by 06/30/06.	N/A	N/A	N/A		Increase of 3% over baseline percent

Goal 9. Increase the number children with SED receiving evidence-based services.

Population:	Children and their families
Criterion:	3. Children's Services
Brief Name:	Children receiving Evidence-Based Practices
Indicators:	A. Establish methodology to count the number of children with SED receiving Evidence-Based Practices by 6/30/05. B. Report the percentage of children with SED who are receiving Evidence-Based Practices by 6/30/06.
Measure:	A. The establishment of a methodology for counting the number of children with SED receiving Evidence-Based Practices. B. Use methodology established in "A" to describe percentage of children with SED receiving Evidence-Based Practices.
Numerator	A. Not applicable. B. Number of children with SED receiving Evidence-Based Practices
Denominator	A. Not Applicable B. Number of children with SED receiving MH services
Sources of Information	List of treatment practices approved as evidence-based by OMHAS; expenditure and demographic reports on evidence-based practices submitted to OMHAS by County Mental Health Programs.
Special Issues:	A law enacted by the 2003 Oregon Legislature requires that, by 2005, at least 25% of the treatment funds expended by OMHAS be for evidence-based practices. This requirement increases to 50% in 2007 and 75% in 2009. OMHAS has defined the criteria for a practice to be considered evidence-based and has established three stakeholder workgroups which will develop the procedures for reviewing specific practices against the criteria, further promoting evidence-based practices and evaluating the effectiveness, and cost-effectiveness, of the practices.
Significance:	In Oregon, as well as nationally, funding agencies are being required to demonstrate that funds are being used cost-effectively for treatment services that are based upon empirical research demonstrating the effectiveness of the practices in treating people with psychiatric disabilities.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Establish method to count children with SED receiving EBP by 06/30/05.	N/A	N/A	N/A	Methodology established	
B. Percentage of children with SED receiving Evidenced-based Practices by 06/30/06.	N/A	N/A	N/A		Baseline percentage generated.

Goal 10. **Decrease the rate of readmission of children with SED to the Oregon State Hospital (OSH) and Secure Children's Inpatient Center (SCIP) within 30 days and 180 days of their original discharge.**

Population:	Children with SED
Criterion:	3. Children Services
Brief Name:	Readmission rates for SCIP and OSH
Indicators:	A. Establish the baseline rate of readmission within 30 days for children with SED to the Oregon State Psychiatric Hospitals and SCIP by 6/30/05. B. Establish the baseline rate of readmission within 180 days for children with SED to the Oregon State Psychiatric Hospitals and SCIP by 6/30/05. C. Reduce the rate from baseline of readmission within 30 days for children with SED to the Oregon State Psychiatric Hospitals and SCIP by 6/30/06. D. Reduce the rate from baseline of readmission within 180 days for children with SED to the Oregon State Psychiatric Hospitals and SCIP by 6/30/06.
Measure:	Percentage of children readmitted to the hospital within 30 and 180 days.
Numerator	Number of children readmitted within 30 and 180 days to OSH and ACIP.
Denominator	Number of discharges within the previous 12 months from OSH and SCIP.
Sources of Information	Oregon Patient/Resident Care System (OP/RCS) & CPMS
Special Issues:	Oregon is working with community mental health programs, Mental Health Organization and Intensive Treatment Services (ITS) providers to ensure children discharged from SCIP and OSH have good transition plans to assure successful community tenure..
Significance:	It is important that children with SED have effective treatment planning upon discharge from the Oregon State Hospital or Secure Children's Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment according to the child's mental health needs.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Develop baselines for 30-day and 180-day readmission rate.	N/A	N/A	N/A	Establish baseline	
Reduce readmission within 30 days and 180 days by 3%.	N/A	N/A	N/A		Reduce percentage from baseline

Criterion 4: Targeted Services to Homeless Population

- Describes State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas

i. Description of Current Children's Mental Health System

Rural Services to Children. Oregon is comprised of 36 counties, 10 counties have a population of over 96,000 citizens, and are considered urban. The other 26 counties are considered rural and 25% of the State's population resides in these counties. In rural areas, distances and lack of transportation can become barriers for children with SED to access mental health services. The MHOs provide a full continuum of services to eligible SED children. The MHOs are required by contract to meet the medically appropriate needs of the children. Regardless of the rural nature of the child's community, the intent of the contract is that a full array of services is available to all children and families that need mental health services. Generally in Oregon, access to mental health services in rural areas is comparable to that in urban areas. In addition to local programs, all persons have access to appropriate statewide resources such as acute psychiatric hospitalization, state hospital programs and intensive community and residential programs, although children and families may travel many miles to receive these services. The MHOs provide mental health services directly through the community mental health program or a contract entity under approval of the community mental health program and OMHAS.

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

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

Homeless Youth and Children. Homeless children and adolescents are a diverse group facing many challenges. These children have no shelter and may be in need of mental health and other services. Some of the children may be members of homeless families or may be children who have run away from home for an extended period and/or have been abandoned by their parents. Estimates of the number of homeless and runaway youth vary widely due to the difficulty in locating this population. Identifying the provision of

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

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

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

ii. Goals, Objectives, and Performance Indicators

Goal 11. The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State's population of children who live in rural areas

Population:	Children who live in rural areas receiving mental health services
Criterion:	4. Targeted Services to Rural and Homeless Populations
Brief Name:	Mental Health Services in Rural areas
Indicators:	A. The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State's population of children who live in rural areas by June 30, 2005. B. The proportion of children receiving mental health services in rural areas will continue to match or exceed the proportion of the State's population of children who live in rural areas by June 30, 2006.
Measure:	Compare the percentage share between urban and rural areas of children receiving mental health service to the percentage share between urban and rural areas in the general population.
Numerator	Not applicable
Denominator	Not applicable.
Sources of Information	Client Process Monitoring System, Oregon Patient/Resident Care System and Medicaid Management Information System.
Special Issues:	Rural areas of Oregon have a unique set of circumstances in the provision of mental health services.
Significance:	Because of the small population density of areas of rural Oregon the assurance of comparable rates of service utilization between children in rural and urban areas is a key indicator. The geographic area requires collaborative interagency involvement, planning outreach and unique service delivery mechanisms to ensure the mental health needs of children and their families are identified and addressed.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State's population of children who live in rural areas by June 30, 2005.	Attained	Attained	Will be reported in 12/2004	Percentages at least equal	Percentages at least equal

Goal 12. Increase the provision of the publicly funded mental health services to children with severe emotional disorders who are homeless.

Population:	Children who are homeless.
Criterion:	4. Target services to homeless and rural populations.
Brief Name:	Mental Health services for children who are homeless.
Indicators:	A. Increase the number of children with severe emotional disorders who are homeless who receive publicly funded mental health services to 180 by June 30, 2005. B. Increase the number of children with severe emotional disorders who are homeless who receive publicly funded mental health services to 185 by June 30, 2006.
Measure:	The number of children who are homeless that receive publicly funded mental health services.
Numerator	The number of children who are homeless that receive publicly funded mental health services.
Denominator	The total number of children who receive publicly funded mental health services.
Sources of Information	Client Process Monitoring System, Oregon Patient/Resident Care System and Medicaid Management Information System.
Special Issues:	Children and families who are homeless receive public services through multiple delivery systems. The extent of the provision of mental health services to these children is difficult data to track. The data is collected at the first encounter the provider has with the child and may be only partially descriptive of the actual numbers of homeless children being service throughout the State.
Significance:	Children and families who are homeless have multiple needs for public services. An increase in the number of children with severe emotional disorders who are identified as homeless at their first encounter for mental health services is an indication that Oregon is providing specialized services for these children.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase the number of children who are homeless that receive publicly funded mental health services.	N/A	175 baseline	Will be reported in 12/2004	180	185

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

i. Description of Current Children's Mental Health System

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

During the 2001-2003 biennium the State of Oregon Department of Human Services (DHS) implemented major organizational and structural changes to provide better services to clients, simplify access to services, consolidate programs, and reduce the multiple layers and steps clients have to take to obtain the help they need. This approach has helped to reduce administrative expenses and strengthen the network among DHS employees. By working together as teams, some of the mysteries of specific agency program and culture have melted into a united way of thinking about and responding to client needs. The OMHAS Training Unit demonstrates a team approach in providing multi-disciplinary education services.

The 2003-2005 OMHAS Training Plan reflects total integration and collaboration of training projects for mental health, substance abuse, prevention, and problem gambling, the following summary only reflects training on mental health topics:

> Between Jan - Dec. 2003, 4,572 providers, mental health consumers/advocates, and family members attended 68 training events on a variety of topics, sponsored or co-sponsored by OMHAS.

During the past year the following trainings were held:

- OMHAS co-sponsored a conference with the Child and Adolescent Residential Psychiatric Programs (CHARPP) about Evidence Based Practices for Children and Families.
- Co-Occurring Disorders Conference "The Changing Landscape"
- OMHAS help sponsor a conference on the provision of Evidence-Based Practice community-based services.
- A Latina Prenatal Summit focused on serving young Latino mothers with culturally appropriate services to prevent mental health and substance abuse issues in later years.

- OMHAS sponsored training about Fetal Alcohol Syndrome (FAS) and improved services to meet the needs of children with FAS.
- OMHAS co-sponsored a training with CHARPP on reducing the use of Seclusion and Restraint.

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

Mental Health Block Grant Funding Innovative Services

Training Family Members. Oregon Administrative Rules and Mental Health contractual language requires family members of children with SED to participate on advisory councils, quality management committees and other mental health delivery system decision-making bodies. This year OMHAS has funded a family member and provider-training program. Oregon Family Support Network (OFSN) is partnering with the National Alliance for the Mentally Ill (NAMI) to pilot a program where they will be using a national curriculum training family members/caregivers and professional mental health staff about effective partnering for policy-making. They will collaborate with representatives from CMHPs, MHOs and ITS Providers to increase family members/caregivers membership on local or regional committees. The family organizations will recruit, mentor and support family members/caregivers with financial assistance, childcare, travel expenses, etc, as family members/caregivers participate on policy decision making committees. An evaluation will be done to identify the effectiveness of the project. This educational curriculum will enhance family member and provider ability to be engaged in collaborative organizational decision-making and analysis critical to continuous quality improvement of services to children with SED and their families.

All-Hazards Response for Behavioral Health Treatment Providers. OMHAS will sponsor a two-day training designed for behavioral health care providers to address the topics of assessment, triage and referral, psychological first aid and acute-care subsequent to large-scale emergencies. It will be targeted to mental health and addiction service providers, especially crisis and outreach clinicians, who would be designated as part of the immediate and post-disaster response cadre. The training will include clinical assessment and treatment information and logistical orientation for the entire group. It will also provide specific guidance for working with special populations (as defined by age, cultural/ethnicity, high-risk factors, or geographic variables). The program will train 20 people who will then train regional staff.

Transitional Services for Older Adolescents. There are two Block Grant funded projects with particular emphasis on ensuring a seamless transition to adult services for youth ages 16-25 with severe emotional disorders. All youth served in the projects receive a comprehensive array of integrated and coordinated services to address emotional, social, educational, recreational, vocational, housing and physical health needs of each participant. The services are tailored to each individual's unique set of strengths and needs, appropriately matched to the individual's cultural and gender needs, skill and goal

oriented and delivered in the least restrictive and clinically normalized setting. Services also encourage the involvement of family members to support youth into adulthood.

Quality Assurance. The OMHAS Quality Assurance and Certification Unit is responsible for certification and licensure of provider organizations that are deemed to be in compliance with Oregon Administrative Rules and state laws. Certificates of Approval are issued to community mental health programs and sub-contracted providers, children's psychiatric day treatment, and nationally accredited psychiatric residential treatment programs for children, inpatient psychiatric acute care programs, psychiatric hold rooms used for seclusion or restraint and private outpatient mental health providers. Quality Assurance staff conducts site reviews of these programs to ensure compliance with contract conditions and state regulations. This section also approves individuals in the state to conduct investigations and examinations for civil commitment proceedings and for individual clinicians to authorize the use of seclusion or restraint for children in approved facilities.

MHOs, under contract with OMHAS, are required to submit annual quality assurance plans and work plans that are reviewed and approved by the Quality Assurance Section. OMHAS also analyzes data from utilization reports, periodic reports from MHOs and other outcome measures for use in quality improvement and monitoring activities. The Quality Assurance section conducts site reviews of contracted MHOs to assess quality of services and compliance with contract expectations. The contract requires each MHO to have quality assurance and advisory committees that include representation from community stakeholders, consumer and family members and practitioners. These groups provide important information to OMHAS during the review process. Information is used to monitor performance standards relating to access to services, quality of care, prevention, education, and outreach efforts, and integration and coordination with other community services.

Management Information System

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

1. The Medicaid Management Information System (MMIS) provides information on persons who are Medicaid-eligible including those who are on the Oregon Health Plan (OHP). The information contained in MMIS includes eligibility, capitation payments, fee-for-service claims, and encounter data for persons receiving services via prepaid capitation programs. Further, MMIS includes all mental health, chemical dependency, pharmacy, dental, and physical health service and eligibility information for all Medicaid-eligible persons.

   Medicaid fee-for-service data and encounter data is submitted electronically and by fee-for-service billing. Managed MHOs and service providers have 180 days to submit Medicaid data from the time of service. Data from MMIS is downloaded and

stored in a Sybase data warehouse for use by state analysts and actuaries responsible for rate setting.

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

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

3. The Oregon Patient/Resident Care System (OP/RCS) is the database for all publicly funded psychiatric inpatient care delivered in state hospitals and acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed for mental health treatment.

State Hospitals and Acute Care Units of regional hospitals submit OP/RCS data at admission and discharge. This data is also stored in a mainframe. DHS's Office of Information Services is responsible for all DHS client data processing and storage.

Each system contains client level identifiers unique within the system. DHS's Office of Information Services maintains inter-system references that allow analysts to track and summarize service utilization and population demographics at the client level, regardless of the type of service received.

OMHAS collects other information. For example, outcome and performance measure data are gathered through consumer and family surveys. These surveys are translated to appropriate language as indicated through service data. This information is used to: 1) provide feedback to those who are affected by OMHAS performance measures; 2) identify areas in need of improvement or attention; 3) track improvement in the well-being of people served with public funds; 4) recognize those programs which are doing well; and 5) communicate results to the Governor, the Legislature, Department contractors, and the public. OMHAS maintains a staff of research analysts and information systems analysts who coordinate survey efforts, as well as summarizing and disseminating information gathered through the MMIS, CPMS, and OP/RCS data systems.

OMHAS also has access to detailed population estimates through Portland State University. This information is used to derive estimates of prevalence for adults with severe mental illness and children with severe emotional disorders.

Several other State agencies that serve many of the same clients maintain central databases to track services within their area of responsibility. Unfortunately, unique identifiers are not the same across many of the agencies. Currently there are plans to explore methodologies to compare datasets across different state agencies. OMHAS has

developed a research facilitation plan that will allow us to gather data from CPMS, OP/RCS, MMIS and other State agencies and store it in a data-mart. OMHAS hopes to develop standard reports on the web that link to those data. This will facilitate data driven decision-making.

ii. Goals, Objectives, and Performance Indicators

Goal 13. To increase the participation of family members of children with severe emotional disorders on advisory councils, quality management committees, and other mental health delivery system decision-making bodies.

Population:	Family members of children who have serious emotional disorders.
Criterion:	5. Management Systems
Brief Name:	Family members technical advisory skill training
Indicators:	A. Increase the number of family members on policy-making committees six months after attending the training to 8 by June 30, 2005. B. Increase the number of family members on policy-making committees six months after attending the training to 16 by June 30, 2006.
Measure:	Based on roster of policy making committees
Numerator	Not Applicable
Denominator	Not Applicable
Sources of Information	Office of Mental Health and Addiction Services funded demonstration projects annual report tracking this measure.
Special Issues:	Oregon Administrative Rules and contracts require the participation of family members in advisory councils, quality management committees and other means of influencing the mental health delivery systems.
Significance:	Family members and mental health service providers need specialized training to ensure effective family member participation in councils and committees. Family member involvement in organizational decision-making and analysis is critical to continuous quality improvement of service to children with SED and their families**.** The new children system of care initiative requires having meaningful family involvement and this is one method that can ensure this occurs.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
Increase the # of family members on policy-making committees.	0	0	Will be report in the 2004 implementation report	8	16

Goal 14. Increase expenditures on community-based services for children and families.

Population:	Children with SED
Criterion:	5. Management Systems
Brief Name:	Expenditures on community based services for children with SED
Indicators:	A. Create a baseline of ratio of dollars spent on community-based services such as Psychiatric Day Treatment, assessment, case management, therapeutic foster care, crisis response, outpatient treatment, family support services and respite care compared to the proportion of dollars spent on acute hospital, Psychiatric Residential Treatment Services, Oregon State hospital and Secure Inpatient Program by June 30, 2005. B. Increase the ratio of dollars spent on community-based services by 10% such as Psychiatric Day Treatment, assessment, case management, therapeutic foster care, crisis response, outpatient treatment, family support services and respite care compared to the proportion of dollars spent on acute hospital, Psychiatric Residential Treatment Services, Oregon State hospital and Secure Inpatient Program by June 30, 2006.
Measure:	Comparison of dollars spent on community based services to dollars spent on institution based services.
Numerator	The expenditures spent on community based services such as: Psychiatric Day Treatment, assessment, case management, therapeutic foster care, crisis response, outpatient treatment, family support services and respite care.
Denominator	The expenditures spent on acute hospital, Psychiatric Residential Treatment Services, Oregon State hospital and Secure Inpatient Program
Sources of Information	Contracts, Medicaid encounters and claims.
Special Issues:	A number of communities are lacking the wrap around services to serve high needs children with SED.
Significance:	Oregon is committed to having more expenditure spent on community based services rather than institutional care.

Performance Indicator	FY2002	FY2003	FY2004	FY 2005 Objective	FY 2006 Objective
A. Create a baseline of dollars spent on community based services.	N/A	N/A	N/A	Baseline	
B. Increase the proportion of dollars spent on community based services by 10%.	N/A	N/A	N/A		Increase of 10% over baseline.

iii. Budget for Children 2004-05

2004-2005 Fiscal Year

Contractor	Children Services
Baker County	8,160.03
Benton County	19,992.26
Clackamas County	299,160.68
Clatsop County	23,453.90
Columbia County	12,767.71
Coos County	23,472.98
Crook County	7,733.14
Curry County	10,359.37
Deschutes County	67,480.29
Douglas County	45,937.43
Grant County	9,423.65
Harney County	8,948.17
Jackson County	25,616.53
Jefferson County	11,577.76
Josephine County	159,172.65
Klamath County	21,306.99
Lake County	3,392.77
Lane County	21,025.16
Lincoln County	23,070.09
Linn County	21,378.26
Malheur County	9,567.50
Marion County	118,541.78
Morrow/Wheeler County	4,660.11
Multnomah County	204,628.09
Polk County	25,145.61
Tillamook County	7,170.92
Umatilla County	45,738.13
Union County	20,680.47
Wallowa County	927.32
Washington County	96,531.11
Yamhill County	23,731.06
Mid-Columbia County	22,075.10
Confederated Tribe of Warm Springs	12,839.10
NAMI: Adult/Family Support and Education	-
OHSU: Child Psychiatrist	45,515.00
Total	**1,461,181.12**

Appendix A-Attached

Appendix B: Table 1-Attached

Appendix B: Table 2-Attached

Appendix C

Office of Mental Health and Addiction Services
2003-2005 Training Plan

Regulatory Requirements

Alcohol, Tobacco & Other Drugs:

Title/Description	Dates/Length/#	Delivery Method	Partners/ Co-Sponsors	Estimated Budget	Funding Source	Revenue
ASAM: Patient Placement Criteria (ASAM PPC-2R) Facilitates OAR compliance. RADS will co-train. One will be targeted to methadone providers. **Shawn #1**	`03-`04 fall 5 regional 1-day 50 participants at each, 250 total	Onsite	Alcohol & Drug Abuse Program Association of Oregon (ADAPAO)	$8,000 Cost: $6,000 Staff: $2,000	Direct costs billed to Block Grant	$5,000 in fees
ASAM Patient Placement Criteria Facilitates OAR compliance. Contractor and OMHAS to train. **Shawn #1**	`03-`05 3, 8-week courses per year 25 @ each, 75 5total	Ongoing Web-Based	NFATTC DHS Communications	$8,000	Direct costs billed to Block Grant	No charge for first delivery $5,000 in fees @ $100 each
Motivational Interviewing (MI) Facilitates OAR compliance. Evidence-based practice. OMHAS staff will co-train. **Shawn #1**	`03-`05 fall 5, regional 1-day 50 participants	Onsite	ADAPAO	$8,000 Cost: $6,000 Staff: $2,000	Direct costs billed to Block Grant	$5,000 in fees
Increasing treatment outcomes: 1. Treatment Outcome Improvement Report: What's it telling you? 2. Stages of change 3. ASAM: Placement 4. Motivational Interviewing 5. Engagement 6. Retention 7. Treatment Planning	`03-`05 ongoing Series of 7, 3-hour sessions, 20 at each pilot. Facilitates contract compliance. Delivered by OMHAS staff in Salem.	Ongoing Netcast 1/week of 1 x every other week or 5 regional deliveries.	DHS sites (LCD should be dedicated)	$5,000 Cost: $1,000 Staff: $4,000 Note: DHS may choose to pro-rate Netcast service	Direct costs billed to Block Grant	No charge

Spear, B. Miller, Grams #1						
Alcohol & Drug Abuse Provider Association of Oregon (ADAPAO) TOT for ASAM PPC-2R & MI The teams would co-train regional delivery of ASAM/MI `03-`04. Shawn Clark **#2**	Fall '03 – '04 1, 3 day training 15 participants (5 regional teams) 250 total attendees	Onsite 5 regional	ADAPAO (Agreement signed to meet obligations.)	$10,000 Cost: $9,000 Staff: $1,000 (staff per diem paid for co-trainers)	Direct costs billed to Block Grant	No charge
ADAPAO: ASAM/Motivational Interviewing. Facilitates rule compliance. (above) Shawn Clark **#2**	`04-`05 10 ASAM; 10 MI, 1-day trgs, 25 @ each 300-500 total	Regional on-site delivery. Each team trains minimum 4 days	ATOD Providers	$6,000	Direct costs billed to Block Grant	No charge
Data Base Prevention Planning Needed to meet contract requirements as well as education for certification and CEUs. 1. Assessment 2. IOM Model as a Planning Tool 3. Outcomes 4. Evaluation **B. Cimaglio #1**	`03-`05 4, 1-day trainings (following required meeting) 120 attendees total	Salem-onsite	CAPT ODE CCF OMHAS PAE Trainers	$3,000 Contract Trainer	Direct costs billed to Block Grant	No charge
Minimum Data Set: Required by CSAP Block Grant Jeff Ruscoe to train. **J. Ruscoe #1**	'03-05 8-10 sessions x 20 at each, 160 total attending	Regional onsite, (Need computer lab)	DHS Netcast CCC or other teleconference site originator	$8,000 Cost: $4,000 Staff: $4,000 (subtotal 56,000 A/D)	Direct costs billed to Block Grant	No charge

Mental Health:						
PASRR Regional TA Contact: Sandra Moreland **#1**	Fall '03 &'04 1 day, 250	On-site TA Regional	SPD, OSH	$3,000	GF & Medicaid Match	No charge
PASRR Level II TA Contact: Sandra Moreland **#1**	Oct. '03 & '04 1 day, 60	On-site TA Salem		$1,000	GF & Medicaid	No charge
Pre-Commitment Investigator/Examiner Contact: Jerry Williams **#1**	5x per year 1 day, 250 attendees	On-site TA County	County MH Programs when possible	$2,000 (mostly printing)	GF	No charge
Advanced AFH/RTF Training **Contact: B. Sauer**	TBA 200-250 attendees	On-site TA Netcast/VC		$2,000	GF & Medicaid	No charge
Rule Training – Adult Foster Rule, ITS Rule Refresher, and New Child MH Rule Contact: QI Staff/MacLeod **#1**	Spring or Summer '04 4-8 hrs each 30 per SDA 480 total	Each City or 6 Regional TA	Providers	$2,500 (printing costs high)	GF & Medicaid Match	No charge
PSRB Conference Contact: Tony Guillen **#1**	Spring or Summer '04 1 day, 150 attend	On-site TA Portland	PSRB Board	$6,000	GF & PSRB match	$7,000 fees
Mental Health Training for Emergency Medical Personnel/1st Responders Contact: Frank Moore, Mike Morris, Dr. Pollack **#1-2**	Before Sept. '04 1-day TOT for 15, (10) 1-day trgs for 25 ea, total 250	On-site Regional or VC	Providers Red Cross, Adele Richey-McMurry, may be possible contact	$10,000	Federal Block Grant '04	No charge

subtotal 26,500 MH & 56,000 ATOD

Evidence-based Practices/Promising Practices

Adult Mental Health:

Evidence-Based Practices in the Adult & Geriatric Mental Health System – **Supported Employement & Dual Dx.** Contact: Mike Moore & Sandra Moreland **#1**	Sept. '03-Sept. '04	On-site TA Portland and various counties/SDAs as identified	CMHPs, MHOs	$10,000	Federal Block Grant '04	$10,000 fees (Program income Grant PCA)
Trauma Informed Services Contact: David Pollack Trauma Policy Advisory **#2**	On-going – followup to Dr. Blackshaw's work.	Regional followup	DHS	$2,000	GF	May charge
ECMU Forum Contact: Kathy Bales **#2**	Spring '04 or '05 8 hours, 75	On-site	Passage Providers	$500	GF & Medicaid	
Enhanced Care Services Quarterly Contact: Janet Langbecker **#2**	Nov. '03 & '04 1 day, 70	On-site Salem	ECS Partners	$500	GF & Medicaid	No charge
QI Conference Adoption, Dissemination, and Implementation of Practice Guidelines Contact: Darcie Johnson **#2**	Fall 2004 1 day, 200-400	On-site Regional or Statewide (need ok)	Lane Care Other MHOs?	$3-5,000 (facility, printing, speakers)	GF & Medicaid	$7,000

$18,000 MH EBP Adult

Alcohol, Tobacco & Other Drugs:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Internship Program Support Facilitates counselors meeting CADCI requirements (OARs) **NOTE**: Update at request of **ADAPAO** to broaden this to educational projects as identified by ADAPAO, including internships. Shawn Clark/K. Brown **#2**	Ongoing length and numbers vary	Training and supervision at treatment site Requesting OMHAS' support as follows: 1. Manuals 2. TIPS/TAPS 3. Video use 4. Staff trg/TA	ACES ADAPT New Directions NW Serenity Lane Project Network Progama Libertad y Recuperacion Others as RADS refer/request Dept of Labor & Employment Dept	$10,000 Cost: $7,000 Staff: $3,000	Direct costs billed to Block Grant	No charge

		5. Certificate				
Institute of Addiction Studies (IAS) Supports statewide conference and networking: focus on OMHAS has always funded. OMHAS staff co-train and staff. Shawn Clark **#3**	`04-`05 2 conferences, 3-4 days each	Onsite Statewide	IAS Board	$10,000	Direct costs billed to Block Grant	NA
Association of Alcohol and Drug Abuse Counselors of Oregon (AADACO) #3 Requesting one keynote with opportunity for both advanced study and CEUs to meet CADC I requirements. OMHAS staff trains and we support national speaker fee.	`03-`05 2-4, 1-day regional trainings	Onsite	AADACO to provide $2,000 ($500 and/or $1,000) each training	$4,000 (If we provide staff support, no need to contribute dollars.)	Direct costs billed to Block Grant	AADACO to provide site and charge fees
Best Practice in Addiction Treatment I & II and/or Implementing Evidence-Based Practice Exposure to evidence-based treatment models. NFATTC/OHSU staff and ATOD providers train. Steve Gallon, Shawn Clark **#1**	`03-`05 2-4, 1-day trainings 100 participants at each. 400 attendees total	Regional onsite delivery (not metro area)	NFATTC/OHSU Governor's Council?	$12,000 Cost: $10,000 Staff: 2,000	Direct costs billed to Block Grant	$7,500 in fees
Governor's Council Summit B. Cimaglio **#1**	'03-'04 1- 1 to 2 day training 150 participants	Regional onsite delivery	Governor's Council	$8,000	Direct costs billed to Block Grant	
Clinical Supervision and/or Leadership Series for Directors with WA and ID. Supports implementation of OARs/contract compliance. Shawn Clark **#2**	`03-`05 2-4, 3-day trainings 15 participants each, 60 total	Regional onsite delivery	NFATTC Frank Munson co-trainer	$5,000 Cost: $4,000 Staff: $1,000	Direct costs billed to Block Grant	$3,000 in fees
Methamphetamine: Pilot-manual-based Matrix treatment model (or other as	'03-'05 Drug Court Site to be selected. Staff	On selected site with same staff and selected	NFATTC/ATTC OMHAS PAE ATOD provider:	$10,000 $20,000	Direct costs billed to Block Grant	

determined by OMHAS staff.) Facilitate implementation of evidence-based practice. Contractor to train staff on site with on going TA re fidelity and implementation. Karen Wheeler **#2**	trained to deliver manualized methamphetamine treatment to randomly assigned clients	"client cadre" Training done by contractor with ongoing TA on site/distance	selected Drug Court Project			
Methamphetamine: Case Management Strategies Facilitate implementation of system-wide best practice with case management. Target Audience to include DHS partners and Criminal justice staff (adult and youth) OMHAS staff to co train/Wheeler/Munson Shawn Clark **#1**	6-10, 1-day sessions for 20-40 participants Ongoing and/or series of 3, 3-hour netcast sessions, 250 total	Onsite and/or Netcast	CAF (pay trainers) DHS-LLC	$5,000 Cost: $3,000 Staff: $2,000	Direct costs billed to Block Grant	$3,000 in fees, no charge if netcast
Marijuana: Adolescent Focus – CSAT Manualized Treatment Model /Approach Facilitate implementation of evidence-based practice **Note:** CPMS data shows that this is most abused drug by adolescents(after alcohol) B. Cimaglio, K. Spear **#2**	6, two day sessions for 25 participants Total =150	Onsite – Regional deliveries	CSAT provided research and the treatment manuals	$10,000 Cost includes 5 days of development as this course does not yet exist	Direct costs billed to Block Grant	
ATOD: **Screening**, **Intervention & Referral** Includes ATOD information as requested by Service Delivery Areas/DHS clusters & Learning **Leadership Council.** Frank Munson **#2**	`03-`05 Series of 1-day trainings (3 days a month) 25-35 participants each. 1,500-2,000 total	Onsite DHS sites	SDA Managers LLC	$20,000	Direct costs billed to Block Grant	No charge In past had contracts w/ DHS partners.
ATOD: Specific topics requested	`03-`05	Netcast	DHS Training staff	$5,000	Direct costs	No charge

by stakeholders. Examples: Methamphetamine, Stages of Change, Inhalants, Seniors & Addiction, etc. Frank Munson **#2**	(3) 6-hour trgs, 3 x/month, 15-20 participants at each. 1,200-1,500 total	Online registration			billed to Block Grant	

Subtotal $109,000 ATOD

Child/Adolescent Mental Health:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Implementing EBP and TX Guidelines for Severe Emotionally Disturbed Children Ellen Pimental **#1**	TBD 3-4 One day session during biennium, 200 attendees total	Regional	CMHPs, MHOs, NAMI, OFSN, Families & Consumers	$4,000	RCSC Grant	No charge
Strength-Based Practices in Child/Adolescent Treatment Environments:						No charge
(1) Seclusion and Restraint Reduction Training for Residential & Acute Hospital Tx Providers increasing stregths approaches and reducing secondary trauma.	Summer 2003 2, One day 100-120 attendees	Regional at provider site	CMHPs, MHOs,	$1,000	GF	
(2) Professional Assault Response Training for C/A Tx Facilities "PART" – methods of de-escalation and alternatives to S & R.	Fall '03 & '04 3-5 day 16-32 attendees	On-site Regional	C/A residential treatment facilities	$16,000 (contract trainer)	GF	

Contact: Bill Bnouska, Michael Taylor, Ellen Pimental **#1**						
EBP in Prevention of Attachment Disorders and Mental Health Issues in Early Childhood (Age 0-8) Contact: Ellen Pimental & Kathy Seubert **#1**	TBD 1 day each 3-4/biennium Approx. 400	Regional On-site or VC	CMHPs, MHOs, Families & Consumers	$5,000	Federal Block Grant '04	Providers will share expenses. May charge.
Support for Infant Attachment for Young Children in Foster Care Contact: Kathy Seubert **#3**	TBA 2004 or '05 150-180	On-site Regional	CAF/Child Welfare Partnership	$4,000	GF	$2,500 fees
ASSIST/Suicide Prevention Train Trainer or Suicide Prevention co-sponsorship at Prevention Conference Contact: Ron Bloodworth **#3**	Fall '03 & '04	Southern Oregon TOT	Josephine County MH or DHS/HS	$3,000 (1,500 per year)	GF OMHAS has co-sponsored for 3 years.	No charge
CHARPP Fall Conference – EBP in Services for Children and Families #1	Sept. 8-9, '03	Regional 2-day	CHARPP	$5,000	Federal Block Grant '04	Charpp to provide site and charge fee

$38,000 C/A EBP MH

Housing – Mental Health & ATOD:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Oregon Recovery Homes Goal to increase # of homes and reduce turnover of residents Contact Vicki Skryha **#1**	'03-'04 1- 2 day summit 75 participants 40 hours of TA 1- 1 day summit review 75 participants	Onsite in Valley for both summit and review TA – not on site	EMO Oxford House Coordinator RAP and recovering community	$10,000	CSAT TA request sent July/01/03	
Financing the Support in Supportive Housing Contact: Vicki Skryha **#1**	Sept. 2003 1-2 days, 200	On-site Portland	Seeking partners	$5-7,000	PATH or RCSC Grant	$7,000 fees
Housing/Homelessness	4-6 one-day sessions	Various	CMHPs help with	$1,800	GF	No charge

Quarterly Workshops Contact: Vicki Skryha **#2**	100 @ each, approx 500 total	County or Regional	facility	(printing & facility)		

Subtotals: $10,000 A/D and $8,800 MH

Medications – Mental Health & ATOD:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Physician-based Services Delivered in Medical Office Settings Addressing new federal regs allowing Drs. To dispense medications to tx addictions. **#3**	TBD Contact: D. Pollack	On-site Regional	CSAT, NFATTC May provide staffing or planning assistance.	-0-	N/A	
Public Psychiatry Conference: "Trick or Treat – Rational Prescriptions or Formularies, Take Your Pick" - Dr. Steven Stahl Contact David Pollack, MD **#1**	Oct. 22, 03 1 day, 150 total	On-site Salem	Salem Hospital CME sponsor & Psychiatry Dept. Grand Rounds	$3,000 (CME & printing)	GF May request Unrestricted Education Grant	No charge
Medication Management Training Video Belinda Sauer/MacLeod **#1**	Completed Fall '03 Approx. 300	Video Tape	Payless, SPD, DHS Distance Learning, Marion Cty HD	$5,000	Federal Block Grant '04	No charge

$8,000 MH

Prevention – Alcohol, Tobacco & Other Drugs:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Oregon SAPST **#3** Follow up training for those that have taken SAPST training on-	`03-`05 2, 1-day (or a series of 2, 4 hour	1 onsite Netcast: 1 series	CAPT	$3,000 Cost: $1,500	Direct costs billed to Block Grant	No charge

have taken SAPST training on-line through CAPT. OMHAS staff and partners train.	of 2, 4 hour sessions) 20 participants total	Following on-line course delivery		Staff: $1,500	Block Grant	
Ethics for Prevention Specialist Meets new certification requirements. **#2** OMHAS staff contractor train.	`03-`05 2, 6-hour sessions 100 total	Teleconference (5 sites) or (4) 1-day regional	CAPT CSAP	$4,000 Cost: $2,000 Staff: $2,000	Direct costs billed to Block Grant	No charge
"**Prevention 101**" Facilitates certification requirements. Training Staff K. Brown, W. Hausotter Prevention Staff **#1**	(1) 4 or 5-day training, 25 at each, 100 total trained.	On-site metro Support for providers traveling long distances.	ODE CAPT Dept of Labor	$8,000 Cost: $7,000 Staff: $1,000	Direct costs billed to Block Grant	$2,500 in fees
Prevention "Conference" This would be a collaborative effort with CCF, DHS (in particular HS) and other partners with focus on Children/Adolescents **#3**	'04-'05 1- 1or 2 day "conference" 400 participants	On Site Regional or Central	Partners of Children and Families, CCF, OYA , DHS, HS ODE , HMO's etc.	$8000 Cost: $7,000 Staff: $1,000	Direct costs billed to Block Grant	Would be determined by partners And need

$23,000 ATOD Prevention

Problem Gambling: (Proposed that all gambling training be RFP'd.)

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Problem Gambling: Prevention, Intervention, Treatment, and Recovery Jeff Marotta **#1**	12-16 days ranging from 1-3 day events, 50-100 participants each, 1,200 total	On-site Regional	G.A.T.	$48,000 Cost: 45,000 Staff: 3,000	Lottery funds through DAS/DHS	$20,000 in fees
Problem Gambling: Series of presentations as identified by Gambling Manager & G.A.T. Jeff Marotta **#1**	12 – 4 hr. sessions, 50 gambling professionals @ each. Total 600	On-site Metro	G.A.T.	$6,000	"	No charge
Problem Gambling: Variety of presentations on models, **techniques, and tools.**	10 – 4-6 hour sessions, 15-25 at each,	On-site Regional	G.A.T.	$5,000	"	No charge

Jeff Marotta **#2**	Total 150-250					
Problem Gambling: Information for allied service providers. **Jef**f Marotta **#2**	Series of 2-7 hour sessions with 100 at each. Total 200	On-site Regional	ATOD & MH Prof., Partners, MHOs, G.A.T., Consumers	$10,000 Cost: 9,000 Staff: 1,000	"	$0-25/day per person

subtotal $69,000

Seniors – Mental Health:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Geriatric Mental Health Assessment: Basics and Advanced Neuro-psychiatric Assessment Contact: Sandra Moreland **#2-3**	3 one-day sessions as identified by Partners (30-50 attendees)	Regional On-site or VC	MHOs	$5,000	GF	$750 fees (will request partner match)
Older Adult Depression and Suicide Contact: Sandra Moreland **#1**	4-6 one day sessions as identified by Partners	VC or satellite	MHOs	$5,000	Federal Block Grant '04	No charge (will request partner match
Working with Individuals with Dementia: Diagnosis, TX and Behavioral Intervention Contact: Sandra Moreland **#2**	3 one-day sessions as identified by Partners (30-50 attendees)	On-site Regional	MHOs	$3,000 (sites) $1,000 (materials)	GF	$750 fees (will request partner match)
Person-Centered Planning for Older Adults Contact: Sandra Moreland & Mike Hlebechuk **#2**	3 one-day sessions as identified by Partners (30-50 attendees)	On-site Regional	MHOs	$2,000	GF or RCSC Grant	$750 fees (will request partner match)

$15,000 MH Seniors

Co-Occurring – Mental Health & ATOD:

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Co-Occurring: Implementation	'03-Sept. '04	All types:	➢ HMOs	$20,000	$10,000	Partner co-

of Evidence-Based Practice Areas of focus and targeted audience will vary. Example: NAMI and consumer presentations, medication information for SA counselors, ASAM: focus on co-morbidity, family involvement, integrating criminal justice services. Grants have been and are being written to improve services. Shawn, Pat, OMHAS Advisory Committee. **#1**	ongoing series of one-half to 1-day sessions 25-125 participants	regional and local onsite Video conferencing Netcast Scholarship w/ co-sponsor Statewide trainings	(childhood conference example) ➢ NATA ➢ County MH Directors ➢ ATOD Programs ➢ DHS partners ➢ NFATTC		from Federal Block Grant '04	sponsorship Fees optional depending on method of delivery.

Subtotal $20,000 Joint

Consumer & NAMI & Family Requests

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Best Practice Models in Community Based Services – Consumer/Provider Conference Hlebechuk/Moore/Herzberg **#3**	Summer '04 1 day Total 250-280	On-site Regional	Consumer Groups, NAMI, OHSU Self-Determination Ctr.	$10,000	'04 Block Grant	$5,000 fees
"Visions for Tomorrow" Contact: Alice Wood or Loaiza, NAMI. Staff: Herzberg **#1**	Fall '03 start Ongoing	Small group face-to-face	NAMI Sponsored, we provide TA & CEU support	$120 (CEU app. fee))	GF	No charge
Contract RN/Personal Care Attendant Training in Consumer Issues Contact: Michael Hlebechuk **#1**	By 12/03 8 hrs, 10 25-50 CRN/PCAs	On-site Regional		$3,000	RCSC Grant	No charge
Enhancing Consumer Employment Contact: Michael Hlebechuk **#1**	Various '03-Jan. '04 4 hrs, 3-10 each	County or Regional		TBD	RCSC Grant	No charge

Family/Agency Training Contact: Michael Hlebechuk **#2**	March '04 start date, various 8 hours each for 50	Regional		$10,000	RCSC Grant	No charge
Person Centered Planning (Writing care plans in conjunction with pilot projects) Contact: Mike Hlebechuk **#1**	July '03-July '04 4 hours each x 4 regional 20 @ each	Regional		TBD	RCSC Grant	No charge
Self-Recovery, Self-Determination Local Training Contact: Mike Hlebechuk **#1**	June '03-Jan '04 2-3 hours each 5-40 each	Regional		$8,100	RCSC Grant	No charge
Fall Institute Self-Determination Train the Trainer – Year Two **Contact: Mike Hlebechuk** #1	2004-2005 4 Regional advance sessions for up to 40 attendees at each	Regional	MHO	$12,000	RCSC Grant	No charge
Fall Institute Follow-up Workshops on Advocacy, Self-Determination, and Recovery **Contact: Mike Hlebechuk** #1	2003-2004 8 Regional One-day sessions for up to 40 at each.	Regional	MHO	$12,000	RCSC Grant	No charge

$55,220 MH Consumer

Cultural/Gender Specific Mental Health & ATOD

Title/Description	Dates/Length/#	Delivery Method	Partners/ Co-Sponsors	Estimated Budget	Funding Source	Revenue
Cultural Competency Multi-populations and various areas. Examples: 1-day onsite training ATOD and People w/ Disabilities, Pam Patton's training on best practices with girls/boys, series of cultural competence (Beyond Sensitivity conference speakers). Trainers: mostly Oregon experts (include TOT from PCF Fall '03	'03-'05 series of one-half to 1-day regional trainings 25-150 participants	All methods On-site, VC, Netcast	CCF and PCF Providers ATOD Native American AHEC DHS diversity Committee and conference	$10,000 – 15,000	Direct costs billed to Block Grant	Partner co-sponsorship, fees optional

training). Staff: Ponder, Stickler, Cruz + Advisory Committee **Suggest stakeholder/staff needs assessment. #1**						
Ethnic Minority Substance Abuse Counselor Mentoring Program Contact: Shawn Clark **#3**	'04-'05 10 days of training for 21 participants (70 CEUs)	Regional trainings and 6 local onsite trainings	ATOD providers (per diem + time off) HMOs/grant, Dept of Labor, AHEC, Community colleges	$15,000	Direct costs billed to Block Grant	$2,000 in fees Possible program support
African American Wellness Village Contact: Pat Herzberg **#2**	Oct. 18, 2003 9am-4pm 1,500 approx.	On-site Exhibit	Sponsored by African American Health Collation	$300	GF	No charge

$30,300 Jt. Culture/Gender

Others

Title/Description	**Dates/Length/#**	**Delivery Method**	**Partners/ Co-Sponsors**	**Estimated Budget**	**Funding Source**	**Revenue**
Addiction Counselor Certification Board of Oregon (ACCBO) Newsletter/training calendar for 3,000 counselors. **#3**	3-4/year 6-8 sessions (Could be done on Web)	statewide mail & website distribution	ACCBO, NFATTC AADACO, Southern Oregon Consortium	$5,000	GF	No charge
LCD Projector: OMHAS Training Unit has 1 working LCD with dedicated laptop. **#1**				$3,000	GF	NA
Laptop (dedicated for use with LCD) **#1**				$2,500	GF	NA
Multimedia Training Resources (videos & interactive CDs) **#1**				$2,000	GF	NA
Materials that support approved training plan could include binders, CEU fees. **#1**				$2,000	**GF**	**NA**

Subtotal $14.500 Other (A/D & MH)

Appendix D: Table 1-Attached

Appendix D: Table 2-Attached

Appendix E: Attached

Appendix F: Attached