PUBLIC COMMENTS
SUBMITTED VIA E-MAIL
May 1-7, 2008

COMMENTS ARE ORGANIZED BY BUDGET THEME.
Comments that addressed more than one theme were placed under the theme that seemed most closely related. Comments are listed in the order they were received.

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1. Vulnerable Oregonians have access to health care.

None.

2. Oregonians have access in their communities to the mental health care and addictions treatment they need.

Institutional psychiatry is a big failure. Why are you spending $500,000,000 more for THAT?

Psychiatry as practiced by those under the stunning $$$$ influence of BigPharma is cruel and debilitating, resulting in deaths 25 YEARS earlier than people not in the mental health system.

How about some funding for people who have been in the mental health system to speak up and be in communication with the government that is supposedly serving them?

I am writing to express alarm over Governor Kulongoski's recent decision, apparently supported by your department, to spend $500 million in our next budget to build more and larger psychiatric hospitals in Oregon. Why is there no budget for safe, supportive and affordable housing and other humane and community alternatives for psychiatric survivors ("mental health clients") in Oregon? As you may be aware, psychiatric hospitals are

essentially counterproductive, extremely costly and inhumane. Several have been permanently closed in other states, as well as in Ontario and other provinces across Canada. Psychiatric hospitals, which I prefer to label psychoprisons, are places where people in crisis are warehoused, physically restrained, forcibly treated with brain-damaging drugs and electroshock, and dehumanized. The vast majority of citizens locked up in psychiatric hospitals are some of the most vulnerable in society-- poor, exploited, marginalized and stigmatized.

I urge Governor Kulongoski, your officials and staff to spend the $500 million in your "mental health" budget on psychiatric survivors and their humane alternatives including safe, supportive and affordable housing -- not on locked wards and other dehumanizing psychiatric facilities.

I am writing to express my concern about the lack of state funding to ensure that users and ex-users of Oregon’s mental health services have a visible, organized presence, and that their input is reflected in systems planning. Policy should not be formulated without hearing from people who have direct experience of the service system and who are the ones most directly affected by it. But mental health clients are often impoverished, marginalized and silenced; their voices are muted by institutional walls, psychotropic drugs and societal prejudice. Counteracting this requires affirmative outreach, recognition and funding. Not only does this help raise the profile of recovery, it provides official recognition of the value of peer advocacy and self-help. Such efforts are also likely to improve the quality of care, since mental health professionals and agencies cannot be relied on to acknowledge their own deficiencies -- any more than state bureaucrats can be relied on to acknowledge systemic failures. If the mental health system is to effectively serve its clients, their voices -- including their criticisms -- should be actively sought. Please reconsider your budget.

As I was the one suggesting some training around trauma for all service providers, I wanted to add to that comment, which was posted within the health/mental health/addictions subgroup.

From my experience with 19 years at Salem Hospital Psychiatry in inpatient and acute care, the impact of traumatization cannot be understated. This is true both in the short-term and long-term realms. Short-term, you have people in an intensive fight/flight/fright mode of existence. Felitti's ACE study (http://www.cdc.gov/nccdphp/ACE/outcomes.htm) clearly indicates some of the elements to consider, not only for children, but adults as well.

Dr. Sandra Bloom (http://www.sanctuaryweb.com/) also delineates the close parallel processes that occur not only with individuals who have been traumatized, but also with entire systems that have experienced trauma. (Go no farther than your local emergency department for clarification on that.)

The trauma piece is significant and covers multiple arenas. Being diagnosed with a mental illness is traumatic, being treated (poorly?) in an emergency department for a mental illness (or addiction) can be very traumatic, having to negotiate the mental health/addictions systems can be traumatic, how a person is treated by law enforcement can be traumatic (and deadly), and there are many more societal and personal pivot points that can (and usually are) traumatic. The impact on support systems, families, etc., is huge, with resultant deterioration of the individual and the system.

The same trauma issues apply to addictions as we vividly heard testimonials from people with gambling addictions who were very close to suicide.

To add to this issue, any person with mental illness or addictions issues also has a higher vulnerability to be traumatized and victimized.

The impact of trauma can be partially mitigated through education, skills acquisition and application and various therapy modalities.

The other piece I suggested in the subgroup was around the state utilizing a minimally tapped resource of mentors and peer advocates. It is conceivable that a continuum of mentors/advocates/peer support across all illness elements would have some consistent underpinnings. Whether all of this might fit under the OHP Ombudsman process or would need to be even more diverse is worth considering. I also believe in the power of the mentor/peer.

A person who has walked in similar shoes, even at its darkest, and comes out the other side has at least three positives on board:

1) They know what they are talking about and that can be respected.
2) If the mentor's individual experience is validated and accepted by the new consumer, that in itself can 'bring hope' to someone who might not have had much hope.
3) There is a phenomenal degree of, and rewarding reciprocity (and perhaps moral obligation/imperative) on the part of the mentor to 'give back.' That investment and that commitment are invaluable, and I do not believe that resource has been used as an effective tool with the current models of practice. As a person, to be able to bring hope, to give back, to see someone have the opportunity to heal, what a gift!

It is absolutely DISGUSTING to learn that Oregon's Governor has budgeted ZERO for its mental health clients. MILLIONS of Americans take some sort of psychiatric medication on a daily basis. Does Oregon's Governor think these people are unworthy of care?

As an individual with a physical disability I have often been perceived as having a mental disability. As such, I have experienced discrimination. I am appalled that you support the building of psychiatric buildings to lock up individuals, yet no input of survivors of psychiatric abuse or advocacy groups was sought.

Based on some of the discussions in the small groups, I would like to suggest one more consideration for DHS regarding fully integrating child/family/adult mental health and addiction services. There are 'best practices' out there conducting such services and it would make sense, for consistency/continuum of services and of course financially, to do everything possible to integrate services for families. We know, systemically, that the issue with the child is not an isolated issue, that it involves all the family and support services (McFarland-multi-family group work with early psychosis is an excellent example), and we know that the easier and more immediate the access the more likelihood of engagement in services (again, the EAST work, and EPPIC by McGorry).

From most of the parties represented in the small group discussion around health, there is a great need for a consistent/continuum which is lacking not only in Oregon, but nationally. If Oregon can develop ‘the standard’ that is effective and efficient, we might go a long way in the breaking down of the multitude of silos – mental health, addictions, adult, child, older adult, corrections, etc. (Yes, this is a tall order, but worth considering from my taxpayer/healthcare provider perspective.)

The other suggestion I would like to make for DHS’s consideration is around our veterans. In talking with a couple of our clients who are war veterans, they have found some of the approaches that have been used at Bridgeway to be very effective in helping them manage PTSD issues. One of the vets, from Vietnam, had literally and figuratively, been carrying some of the trauma around for close to 40 years and felt he had some degree now of containment (probably not closure ever). Some of the approaches we have implemented have been around the “Seeking Safety” model, which has evidence-based work, particularly for gender-specific issues. There is less evidence for the male population, but we do see application.

When we inquired about other services vets could access, their perception was that the services offered through the VA and other agencies were almost exclusively case management and had little to no therapy elements. The other component that has not been implemented yet is the mentor/peer support aspect. (This is a variation on a previous suggestion for consideration regarding a unified network of mentor/peer support.)

We have a significant veteran population and network that we might tap into as a resource. As you can imagine, there is a high level of dedication and moral obligation within the veteran organizations and a program for veterans with vets actively involved could incorporate those values and that service. I would like to recommend that DHS consider this as a pilot program. With estimates of 20-40 percent of the immediate war zone soldiers being susceptible to PTSD symptoms or illness, this will carry over for many years to come. Perhaps a joint venture with some kind of support from the VA would be viable.

Building huge psychiatric institutions without giving their clientele a voice is an open invitation to abuse. While I am an ardent disability advocate, I do believe that the abolishment of ALL psychiatric institutions is a course for disaster. However, you MUST give these people a way to tell the world about abuses and problems in the institutions. There is a small segment that needs to be institutionalized, either for their own protection or for the protection of the public, but that does not mean they never have legitimate complaints or concerns, or that they should not be afforded a means to let their issues be known.

3. SENIORS AND PEOPLE WITH DISABILITIES LIVE SAFELY AND INDEPENDENTLY IN THEIR COMMUNITIES.

None.

4. CHILDREN ARE SAFE AND HEALTHY.

I'd like to thank DHS for supporting the Healthy Kids Learn Better (HKLB) program in light of the embarrassing disinvestment by the Oregon Department of Education. It's unfortunate that DHS has had to carry the torch of school health alone, but thank you for continuing to demonstrate the important link between health and learning through Healthy Kids Learn Better as well as school-based health centers. I ask that DHS not give up in trying to partner with ODE and continue in whatever ways possible to educate and involve ODE staff in HKLB and other school health programs such as school-based health centers.

I just wanted to provide some input on the support that DHS/Adolescent Health's group has provided to the Healthy Kids Learn Better Partnership. I know that funding has ceased from a federal level and I appreciate that DHS has stepped up and funded positions that continue the amazing work of healthy schools. Without healthy schools, kids will not learn and achieve to their fullest potential.

5. FAMILIES ARE SAFE AND STABLE.

I'm writing now to express my strong support for placing local domestic violence victim advocates at child welfare offices. In pilot projects, caseworkers who worked closely with domestic violence victim advocates have reported that their clients had better access to services, were more likely to get appropriate help for dealing effectively with their experience of violence, and were better able to create safety plans for their children. Caseworkers reported that they were better able to keep children with their non-offending parent instead of placing them in foster care. (Lane County pilot project, 2005 – 2006.)

I'm writing from the perspective of a pediatrician engaged in working with other volunteers and with non-profit organizations to end domestic violence by preventing its occurrence, its re-occurrence and its transmission across generations. We know that domestic violence and other intimate partner violence occurs when people choose, mindfully or not, to act in accordance with a worldview that mandates the exercise of power and control over others through the use or threat of force – physical, sexual, psychological, emotional, social, spiritual or economic – rather than a worldview that mandates compassion, mutual respect, shared power and joint decision-making. We know that witnessing domestic violence is the most commonly occurring major traumatic event in the lives of American children. We know that domestic violence devastates the lives of involved adults and children, and creates significant economic burdens for employers. We know that criminal domestic violence occurs far less often than domestic violence that does not reach the level of criminality, and that only a small proportion of occurrences of criminal domestic violence is reported to authorities; and yet, although only a minority of instances are ever recognized outside the home, domestic violence creates enormous costs for providers of law enforcement, criminal justice, shelter, child welfare, medical and mental health, emergency food, and housing services.

Even if we are only partially successful in preventing all occurrences of domestic violence in our violent society, we can structure our delivery of human services so that we become more effective in preventing its re-occurrence and in helping its victims become independent, healthy and safe. Allocating resources for placing local domestic violence victim advocates at child welfare offices has been shown to contribute to this outcome.

Let’s continue working together.

6. DHS PROMOTES PREVENTION, PROTECTION AND PUBLIC HEALTH.

I think there needs to be more monitoring of population control, especially among moms who continue to have more and more children, and fathers also. I don't think it’s fair among taxpayers to continue to keep paying for these expenses. I only have one daughter and most of the working class can only afford one or two children now days. Why are we continually being burdened with more taxes for individuals who are irresponsible and not taking accountability for their actions? It puts a huge strain on our pocketbooks as taxpayers with overburdening medical expenses, housing, food, etc.

I am a concerned, registered voter who would like to see a program placed within Oregon’s budget to help with birth defects of babies. We should be able to see what the other 46 states have implemented in order to get this program up and running. There are two babies in my family alone who were born with circumstances and our family did not have a clue of what was happening until a they reached a certain age and we found that they are dealing with issues that should or could have been caught if we had the proper surveillance to catch these problems. Please hear my voice and the voices of other concerned families here in Oregon.

PLEASE PLAN FOR A Birth Defects Surveillance in Oregon in 2009! Currently, Oregon does not have a birth defects surveillance system and simply collects data from birth certificates, and has no mechanism for systematic confirmation and follow-up. Oregon is one of only four states that have no birth defects surveillance system in place. Oregon needs to:

- Identify the incidence and clusters of birth defects,
- Obtain information to determine whether environmental hazards are associated with birth defects and poor reproductive outcomes in communities in Oregon,
- Establish a database to contribute to the improved health status of infants and children,

- Expand access and linkages to existing programs and services for children with special health care needs,
- Increase prevention activities related to these special conditions, and
- Assist in the development of public health programs to enhance community prevention initiatives

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Oregon needs to have this (a birth defects surveillance system) in place.

Birth defects are the #1 cause of infant mortality in the United States and account for almost 20 percent of all infant deaths each year. One in 28 U.S. babies has a birth defect; the causes of as many as 80 percent of defects are unknown.

Approximately 46,000 babies were born in Oregon in 2002, yet Oregon is one of only four states that does not keep track of birth defects. A birth defects surveillance system would provide data about the frequency and location of specific birth defects and could be used to identify anomalies, track trends and make links to possible causes. A similar type of disease registry for cancer was established by a unanimous vote of the Legislature in 1995. The Oregon State Cancer Registry (OSCaR) has been collecting information on all cancers diagnosed in Oregon since January 1996.

Surveillance is necessary to track the incidence of birth defects and identify communities and populations at higher risk. State-based surveillance systems help health officials evaluate needs, deliver services, and implement and evaluate prevention programs. Research into the cause of birth defects is a critical step in developing cost-effective strategies to prevent them.

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- Expand access and linkages to existing programs and services for children with special health care needs,
- Increase prevention activities related to these special conditions, and
- Assist in the development of public health programs to enhance community prevention initiatives.

Oregon Environmental Council urges the support and complete funding of a birth defects surveillance system in Oregon. A birth defects surveillance system would provide invaluable data in the future about the link between environmental pollution and birth defects, allowing Oregon to ensure the best health for its most precious resource – our children.

I am a labor and delivery nurse in Pendleton Oregon. I have recently been made aware that Oregon does not monitor birth defects. I feel strongly that we should monitor this important information. We live next one of the largest chemical storage facilities in the country. The facility is now destroying these stored weapons by incineration. Please consider including this in our state's budget. These are important issues to monitor. I have been told that we are one of the few states in the country that do not have birth defects monitored. I hope you can join me in the cause and place this in the Governor's budget for the next year.

I am the Executive Director of Oregon Toxics Alliance and I had the opportunity to attend the DHS Community Forum at Lane Community College April 23. Due to the many attendees and the lack of time to hear all the good suggestions, I was asked to submit my comments in writing. Thank you for this opportunity to provide public input on the development of budget priorities for the upcoming biennium. We appreciate that you have taken this discussion "on the road" to listen to the concerns of all Oregonians.

Oregon Toxics Alliance (OTA) is a full-time, statewide organization whose mission is to protect and enhance community and environmental health by promoting solutions to the root causes of toxic pollution. We build grassroots leadership opportunities and provide organizational support to communities all over Oregon who are working to prevent or respond to local

public health threats. OTA acts upon our belief that Oregonians must prioritize a child's health as the standard by which public health decisions are made.

Oregon Toxics Alliance recommends three priorities be given precedence in your budget:

1. DHS should conduct environmental and public health tracking and assessments, and link these to public health outcomes and goals. When I checked your 2007 report, I found no public health tracking/assessment of asthma, autism, childhood cancer, etc., linked to environmental conditions. California currently tracks environmental disease; Oregon should also implement this important public health improvement tool.

2. DHS should become the home agency for a new Pesticide and Environmental Health Division, and should coordinate the PARC program under this organizational umbrella. In this new structure, DHS must prioritize funding to respond to pesticide exposure complaints, collect health data on pesticide exposures, work directly with agricultural and timber workers to reduce pesticide exposures, and work with medical professionals to provide them information about pesticide poisoning symptoms and how to track pesticide poisonings.

3. DHS should base public health decisions on a precautionary approach that replaces the current regulatory system (that uses risk assessment and places the burden of proof of harm on those who are suffering) with a system that takes anticipatory action to prevent harm.

Following is a discussion of these three recommendations in more detail:

1. DHS should conduct environmental and public health tracking and assessments, and link these to public health outcomes and goals.

Fact: There is growing scientific evidence that environmental factors (such as toxic air pollutants) are strongly linked to many chronic diseases (such as asthma, heart disease and cancers). Exposure to environmental hazards accounts for a significant proportion of many chronic diseases that take an economic and physical toll on Oregonians' well-being.

Problem: Currently, Oregon lacks a comprehensive system to track many of the exposures and health conditions that may be related to environmental hazards. Environmental health hazards and related chronic diseases are not tracked at all. A search on the 2007 DHS Annual Performance Progress Report revealed that there are no tracking systems in place for asthma, autism, neurological diseases and other conditions that that may have their basis in exposures to environmental hazards. Lack of an on-going, comprehensive tracking system contributes to the critical gap in knowledge about the possible links between environmental hazards and chronic diseases.

Solutions: DHS must prioritize the collection of environmental health data through community health databases, registries and environmental monitoring systems. Data collection should be coordinated with environmental hazard data collected by other agencies. Public health officials need information about the population's health and environmental risks. Some of this information can be obtained inexpensively through citizens' epidemiological surveys; standardized citizen surveys can provide important data to point DHS in the direction of environmental health problems. Tracking environmental hazards will serve to guide exposure-prevention efforts.

Example: A Community Cancer Risk Assessment for the Trainsong Neighborhood in Eugene performed by DHS in 2006 did not utilize actual environmental health data from the community (despite their repeated requests for "on-the-ground" data collection). Instead, the DHS assessment relied on statistical modeling and data provided by the consultant hired by the polluter.

2. DHS should become the home agency for the Pesticide and Environmental Health Division, should prioritize funding to respond to pesticide exposure complaints, and should work with medical professionals to provide them information about pesticide poisoning symptoms and track pesticide poisonings.

Fact: Preventing harm from pesticide exposure is carried out by the same agencies that work directly with pesticide users to issue the permits that allow pesticide use.

Problem: The current system is broken – only industrial users of pesticides are considered "stakeholders" in policy decisions about toxic pesticide uses. Additionally, agricultural and timber businesses provide the fees that fund monitoring, complaints and compliance. This compromises the objectivity of their response to complaints about pesticide drift, label violations and harm to environmental health. Dozens of Oregon residents have criticized ODA and ODF for a lack of response to their pesticide drift and illegal usage complaints. Compare Oregon's pesticide program with California's Division of Pesticide Regulation, whose goal, in part, is that: "Anyone whose health or environment may be affected by pesticides holds a stake in DPR's decisions . . . to ensure that all have an opportunity to participate in the regulatory process."

One case serves to illustrate the problem:

> A horse breeder complained to ODA that pesticide drift from a nearby orchard caused the illness of an employee and the death of a foal. A veterinarian took blood and tissue samples from the foal and determined that pesticide exposure contributed to the death. The clothes of the worker were bagged and submitted. These samples were submitted to ODA to determine if the orchard owner was in violation of pesticide labeling instructions. ODA then claimed the samples were "lost" and did not pursue the matter.

Solutions: Protecting Oregonians, particularly children, from pesticide exposure, should be under the aegis of DHS, and not the industrial regulatory agencies such as ODA and ODF. We urge the Governor to reallocate resources so that pesticide policy, pesticide use reporting, pesticide response and analysis, pesticide complaint hotline and a pesticide poisoning tracking program are overseen by DHS.

The reason this is important is that some herbicides authorized for use by ODF, ODA and ODOT are designated by EPA as carcinogens. Others are known to cause adverse respiratory effects and adverse neurological effects, even more with children and fetuses than adults. Exposing virtually all Oregon citizens to these chemicals must be a concern of DHS, even if it entails more strain the budget.

Human rights are rights of individuals (i.e., they apply to each single person, not just to communities or majorities). Further, they are basic ethical minimums. A human right is a moral floor below which governments should

not go. The right not to be tortured by one's government, for example, is not a high, virtuous ideal, but is a basic minimum ethical floor. So too is the right of citizens not to be poisoned by their government

3. Base public health decisions on a precautionary approach that replaces the current regulatory system (that uses risk assessment and places the burden of proof of harm on those who are suffering) with a system that takes anticipatory action to prevent harm.

Fact: Our current regulatory system bases decisions on the risk assessment model that asks the question, how much public health and environmental harm is acceptable (under the current economic paradigm)?

Problem: As more science data become available about the human and environmental health impacts of exposure to toxic chemicals, we are learning that our regulatory guidelines are inadequate to protect health.

Solutions: The precautionary principle is a framework and guide for public health policy decision-making under conditions where there is a preponderance of evidence pointing to cause-and-effect, despite some scientific uncertainty. Inherent in the precautionary principle policy is the belief that a public health risk that is unnecessary, and not freely chosen, is not acceptable. Thus, it follows that DHS must initiate actions that immediately reduce health risks. One way to take precautionary action is to categorize chemicals into levels of concern, and eliminate the ones known to be carcinogens, neurotoxins and endocrine disruptors. A chemical categorization system will identify safer chemicals, chemicals to avoid, and chemicals that lack adequate safety data. DHS should lead this charge. Public health decisions must be transparent, participatory and informed by the best available information.

In closing, Oregon Toxics Alliance, along with other key environmental groups and representatives of state agencies, met with Mike Carrier, the Governor's natural resources advisor, on two occasions to vet policy options that will move Oregon in a direction that promotes environmental health, safer alternatives to toxics and a significant reduction in toxic chemical use. In light of the Governor's attention to the matter of reducing toxic chemicals, including reducing pesticide exposures for children, we urge DHS to use their resources to 1) prioritize risk reduction efforts on chemicals of greatest concern, 2) promote the use of safer alternatives, and

3) use full-cost accounting to determine the long-term impacts of delaying action to reduce toxic chemicals.

7. SERVICES ARE SAFE AND AVAILABLE IN COMMUNITIES WHEN THEY ARE NEEDED.

I serve as Executive Director of 211info in Portland. Last week in Eugene my colleague shared some facts with you about 211 service across the country and in Oregon. As she mentioned, 211 is a telephone number through which people in need can access human services information and referrals. Multilingual 211 service is now available, at least to a limited degree, to 40 percent of Oregonians.

Here's how 211 made a difference in the life of a Portland family: A man who had received an eviction notice called 211 and was connected with a local agency that helped him find permanent housing and utility assistance, and enrolled his family in its early childhood education program. He received support to exit the criminal justice system and is now successfully recovering from meth addiction. "I had a great experience with 211," he said. "I was facing homelessness with my five children. I called 211 to see what resources there were for me. They referred me to Portland Impact, where I got into transitional housing. I was able to go to school, and now I am working. My kids have also been really successful because of the stability that was provided. This all happened because I called 211. Without this help, I don't know where my family and I would be today." Last February he was one of only three people to speak at a national press conference led by members of Congress in Washington, D.C., about expanding 211 across the country.

Efficiencies can be and are already being achieved through a strong, statewide 211 system. The Oregon Department of Human Services Public Health Division turned to Portland's 211 in 2004 to host its well-established statewide specialized helpline, 1-800-SAFENET. This federally mandated helpline initially focused on maternal and child health, but over the years has taken on other services such as a food stamp outreach project that refers callers to the nearest self-sufficiency office and teaches them how to advocate for themselves when they get there. Currently people still dial 1-800-SAFENET, since 211 isn't available statewide, but the same trained staff answer both lines and refer from the same database.

Many people now go to the Internet to look for resources. Our database is on-line and fully searchable, and we publish print directories each year. Our goal is to provide information by whatever method the person needs it.

8. DHS HAS THE CAPACITY TO MEET CLIENTS' NEEDS.

DHS needs to make all forms available online to fill out to help reduce paper costs and make things more environmentally safe (i.e., make the system available online for people who need help filling out applications for food stamps, child care and other resources all online). This would cut down the cost of paper in the office and cut down on the cost of employees through time. And it would reduce the time to get things completed and allow counselors to set up review meetings, reducing the amount of people sitting in the waiting rooms of the offices. This would reduce the risk factors for the people who are waiting to be helped. Just a thought.

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