CCMH BIENNIAL IMPLEMENTATION PLAN 2014 – 2015

PART 1:

I: SYSTEM NARRATIVE:

A. Substance Abuse and Gambling services.

- Adolescent A&D Day Treatment

CCMH began providing "wraparound" day treatment services in St. Helens to adolescents from all over Columbia County in September of 2000. This program was initially developed by the adolescent task force in St. Helens which was recently renamed the Columbia County Youth Enhancement Advisory Council (CCYEAC). CCYEAC is comprised of community leaders from Columbia County including representatives from AFS, SCF, juvenile department, school districts, Commission on children and families, CAT, Mental Health Division, judges, OYA, and others. This council oversees the development of the day treatment program as well as other services to youth, children and families in Columbia County.

Due to school district budget cuts during the last three years, the school prevention and referral base has been affected. In addition, the program participants have been relocated to an alternative high school within the St. Helens school district. Our program continues to utilize therapeutic proctor homes as an alternative to residential treatment. Greater Oregon Behavioral Health, Inc. (GOBHI) certifies proctor homes and proctor parents are recruited, screened and trained to be active members of the treatment team. The day treatment program has diverted a number of teens from attending residential services outside of Columbia County and has been successful in treating youth and families in our own community.

Our treatment staff includes 3.5FTE certified A&D counselors and the clinical supervisor. The clinical curriculum includes cognitive behavioral therapy and stages of change theory as well as recreation and experiential groups. Our multifamily therapy group meets on Thursday nights. Counselors are responsible for regular communication between families, referral sources, schools and community resources to ensure continuity of care and aftercare treatment planning. Since many of our teens in day treatment require intensive

services and treatment planning, our staff participates in a weekly treatment-planning meeting with the clinical supervisor. Parents, proctor parents, and any other agency involved with the teen meet regularly in "level of care meetings" to update treatment plans and discuss progress. Teens involved in the legal system participate in "drug court" weekly and right after the court teens and their parents each have a separate process group to discuss progress and actions of the drug court.

- Adolescent Outpatient A&D Services

CCMH also continues to provide adolescent outpatient services for youth completing our Day Treatment Program and for youth that need a lower level of care. These services are provided in St. Helens as well as in Vernonia, Scappoose and Clatskanie. Our outpatient counselors provide treatment, outreach and prevention services to teens and their families.

Our Day treatment staff serves as outpatient therapists and support the continued needs of youth in the aftercare program. We will subsidize all or a portion of the outpatient treatment of our adolescents. Our policy is to treat the needs of adolescents whether they have funding resources or not. These youth may participate with the same counselors as they had while attending the Day Treatment Program.

Treatment Services for Targeted Minority Groups – serves approximately 69 clients/year

Columbia Community Mental Health continues to be committed to provide outreach and treatment services for our growing Hispanic population. We continue to contract with a Spanish interpreter in order to provide level one treatment services to Spanish speaking people. CCMH is active in networking with the local faith-based organizations that serve this population. We have educational materials, workbooks, brochures and assessment tools printed in Spanish. CCMH regularly provides cultural competence training for its staff and counselors.

- Adult Outpatient A&D Services

Outpatient services are designed to achieve progressive changes in an individual's thinking and alcohol or other drug using behavior in order to prevent further negative consequences. CCMH addresses the client's strengths, stage of change, emotional, physical and family issues which may help or inhibit the individual's ability to cope with major life tasks without the non-medical use of psychoactive substances.

Outpatient services are provided between one and five days per week and can be expanded to a day treatment level of care if necessary. Clients receive individual, group and family counseling during this level of treatment. Treatment curriculum includes anger management, dual diagnoses, seeking safety, methamphetamine matrix model, exploration and discovery, sobriety skills, pain management, 12step facilitation, thinking for a change, MRT and relapse prevention groups.

CCMH provides outpatient services at our offices in St. Helens, Vernonia, Scappoose and Clatskanie. At our main office in St. Helens we have implemented a walk in assessment clinic to minimize the wait to engage in services. Currently, we provide both evening and daytime treatment at all outpatient sites. In the Vernonia, Clatskanie and Scappoose offices we only offer a limited number of days per week for services as a result of prior funding cuts to our DUII indigent fund and the loss of OHP outpatient treatment benefit for many of our clients. Pregnant women and IV drug users continue to have top priority for treatment.

In addition, we are contracted to provide additional 66 service dollars to non-insured clients who are described as parents of children involved with DHS Child Welfare programs. This Intensive Treatment and Recovery Services, (ITRS) is managed by coordination with DHS for new referrals.

CCMH addictions program has implemented a Peer Recovery Mentor program that is training and certifying peer recovery mentors to work with outpatient client. These mentors help the client navigate through the system to help them be successful in their recovery and work toward resolving their DHS Child Welfare or probation issues.

- Residential A&D Services

Pathways adult residential treatment program continues to be a well utilized and much needed resource for our community and throughout the state. The residential program, which primarily serves Columbia, Tillamook and Clatsop counties, has also provided services for other counties in the state. Although nine of the beds at Pathways are state funded, we have developed a number of contracts with private insurance companies and other agencies to provide residential services to a wider range of our population. Unfortunately, the Pathways program regularly maintains a wait list of a month to 6 months for state funded beds.
Drug Free Transitional Housing

After successful completion in the Pathways program, a few clients who are homeless or have non-supportive living arrangements that would sabotage their recovery can be transitioned to one of two apartments located in the basement of Pathways. Tenants attend either day treatment or outpatient treatment while living in the transition apartments. A goal of the transitional housing is for clients to find employment and save enough money to enable them to find a stable living situation.

Although Pathways does not provide treatment for parents and children, children may be allowed to live with a parent or parents once they move to transitional housing. Women with children that is unable to make arrangements for care while in residential treatment can be referred to other agencies.

Clients are expected to remain chemically free and are subject to random drug screenings upon staff request. Clients who are non-compliant with transitional housing rules or regulations or even their treatment plan, may be requested to leave.

- Outpatient Problem Gambling Treatment

CCMH provides outpatient gambling treatment in Columbia County. A designated Oregon Certified Problem Gambling Counselor trained in treatment for problem gamblers will provide outreach and treatment services to problem gamblers and/or their families in individual and/or group sessions. The problem gambling counselor is an active participant in the GAT meetings for Gambling Programs.

Outpatient Wrap-around Services are added to treatment provided, which includes when indicated: Mediation Management for clients with co-occurring disorders, Case Management in order to assist with placement and Financial Counseling in order to relieve the stress experienced by clients in significant debt.

- Problem Gambling Treatment Enhancement

CCMH was a provider of a residential treatment bed for the "respite care" of any Oregon resident referred by any gambling outpatient treatment provider. That respite care was designed to last from 3 days to 14 days depending on the client's needs. Respite care included recovery literature, mental health consultations, medical care and transportation as needed. The expected outcomes were: emotional stabilization, exposure to Gamblers Anonymous meeting and literature, and successful transition from respite to residential or outpatient treatment following discharge. This respite care funding was discontinued in the last biennium due to Oregon PGS budget cuts.

B. MENTAL HEALTH SERVICES:

The Psychiatric Rehabilitation department provides services to individuals that have been diagnosed with a serious mental illness. The following recovery-based services are provided:

OUTPATIENT MH SERVICES for SMI population.

- Assertive Community Treatment
- Supported Employment (within the next few months)
- Case Management
- Individual and Group Therapy
- Individual and Group Skills Training
- Peer Support Services
- Wellness

- Respite Services
- Medication Distribution
- Medication Management
- Psychiatric Services

LICENSED RESIDENTIAL MH FACILITIES

- Cornerstone Residential Treatment Facility – Cornerstone is a 16 bed facility; 15 residential beds and 1 respite bed. Individuals residing at Cornerstone often come to the facility on trial visit from the civil commitment portion of the State Hospital. The facility is also used to house individuals within the County who need a higher level of care. Cornerstone accepts both in-county and out-of-county referrals.
- Alternatives Residential Treatment Facility – Alternatives is a 9 bed facility; 8 residential beds and 1 respite bed. Alternatives is a dual diagnosis facility that accepts referrals from the Psychiatric Security Review Board.
- Our House Adult Foster Care – Our House is a 5 bed facility. Services are provided in a home-like atmosphere.

SUPPORTED HOUSING APARTMENTS

- Cowlitz Street Apartments – The Cowlitz Street Apartments is a 4 apartment complex. Each unit has two bedrooms and one apartment is utilized for a house manager. The facility can house 6 individuals.
- 15th Street Apartments – The 15th Street Apartments consists of 2, two-bedroom duplexes. The facility can house 6 individuals and the house manager.
- 12th Street Apartments – The 12th Street Apartments consists of 1, 3-bedroom duplex that can house up to 4 individuals. There is no house manager at this site.

C. OUTPATIENT MH SERVICES FOR ADULTS AND CHILDREN AND THEIR FAMILIES.

- **Child Outpatient Services**

CCMH children's services have grown significantly over the past four years. The Intensive Community Treatment Services (ITCS) is a very active and proactive program offering collaboration between all of the community partners that involve children. The Family Care Coordinator (FCC) has developed positive relationships with the more intensive children's programs in other areas of the State.

CCMH offers a wrap around model that provides in-home skills training, medication management and child/family centered treatment. CCMH has also participated in the development of therapeutic foster homes in Columbia County. Treatment services for children at CCMH include, Collaborative Problem Solving, DBT for teen girls, Child/Parent Relationship Training (Filial therapy – a relationship building, interactive program between parent and child), child centered play therapy including expressive therapies such as sand tray, family therapy, parent skills training, treatment for sexual abuse and young offender treatment CCMH also provides a therapist in local schools under contract and psychiatric services by a child psychiatrist and child RN.

Outcomes: Psychiatric Residential and Day Treatment Program admissions have been reduced by 90%. Length of stay has been reduced from 360-720 +days to an average of 90 days or less. 100% of DHS Child Welfare Children receive mental health assessments that include CASII's within 60 days of being taken into custody. Child treatment services have increased 52% over the past 4 years from 321 open child clients in 2004 to 487 in 2008.

- Adult Outpatient Services

Adult outpatient services involve a wide array of treatment services. The model of greatest focus is Dialectical Behavioral Therapy (DBT) an EBP with thoroughly trained therapists that follow the Linnehan model. Other interventions include Cognitive Behavioral Therapy (CBT), Dual Diagnosis that includes motivational interviewing and Focus groups for men and women (anger management). CCMH also employs a therapist under contract with the Women's Resource Center for domestic violence issues and provides offender domestic violence assessments for the courts.

Outcomes: 60% of the clients participating in the DBT program complete a full year of the program. 50% of the clients who complete the program return for a second year. Adult treatment services have increased 28% over the past 4 years from 508 open adult clients in 2004 to 652 in 2008.

- EASA

The Early Assessment and Stabilization Alliance is a new CCMH program modeled after EAST (Early Assessment and Support Team.) The program focuses on early intervention of individuals around ages 15-25 with beginning psychotic symptoms. A team from CCMH is involved with screening, ongoing assessment, engaging and treatment of these individuals and families. Significant care is offered in the areas of medication, family groups, assertive case management and support.

Outcomes: 100% of referrals are screened for clinical appropriateness for program. Program follows established model 95% of the time.

- Crisis/Access Services

CCMH offers 24/7 crisis services. Walk-in crisis services are available Monday-Friday regardless of ability to pay. Phone crisis services are also available 24/7. After hours, CCMH contracts with Protocall services for first line intervention. After hour therapists are also available to assist Protocall with police requests and hospitalizations. CCMH crisis workers/investigators work closely with hospital systems outside of Columbia County to ensure clinically and fiscally appropriate care is being provided.

Outcomes: Clients are seen within 15 minutes of request to see a crisis worker 98% of the time. Crisis phone calls are answered by a live person 24/7, 100% of the time.

- Indigent Services

The outpatient department of CCMH provides crisis services and ongoing treatment to indigent adult and children clients when clinically necessary. As stated, crisis services are provided regardless of ability to pay. CCMH then asks that the client complete a fee reduction packet of information so that they can most appropriately be placed on our sliding scale. An additional service CCMH has been able to offer is 2nd year Masters level interns who are able to provide services to indigent clients with little to no ability to pay even on a sliding scale. The State and Greater Oregon Behavioral Health have allowed QMHP variances for interns who meet necessary criteria.

Outcomes: All individuals receive a no cost phone or walk-in screening 100% of the time. 75-80% of those screened receive a mental health assessment at a reduced fee based on their income.

- Law Enforcement

CCMH has developed a very positive working relationship with the varying Police and Sherriff departments in Columbia County. They readily call upon our expertise when needed as we call upon them when that level of authority is required.

Outcomes: Clinical opinion and community collaboration regarding the safety and welfare of community members is provided upon request to law enforcement 100% of the time.

D. PREVENTION:

- Substance Abuse Prevention

The High Level Outcomes (HLO) currently addressed through these services includes 2012 data over the last thirty day period: Three percent of sixth grade students have reported attempting suicide in the last thirty days; and nine percent of eighth graders reported attempting suicide in the thirty days. Twenty-nine percent of sixth graders reported any kind of gambling over the last 30 days; and thirty-three percent of eighth graders reported gambling over the last thirty days. One percent of sixth graders reported drinking in the last thirty days, less than one percent reported marijuana use in the last thirty days, and four percent reported using inhalants in the last thirty days. Twenty-three percent of eight graders reported drinking in the last thirty days; five percent reported using cigarettes in the last thirty days; nine percent reported using marijuana in the last thirty days; six percent reported using inhalants in the last thirty days; four percent reported using prescription drugs in the last thirty days; and two percent reported using steroids in the last thirty days.

Current funding does not support the prevention activities and needs within the county. The LADPC is being reinstated and is currently not functioning. Any prevention effort being done in the schools outside of school based curriculum is being done to the best of the county's ability with one prevention coordinator. This has impacted the advocacy and prevention efforts negatively within the county. Our local Community Coalitions address the risk of early child/adolescent problem behaviors yet all Levels of Prevention and HLO's are not implemented in a way that meets community needs.

There is a current recommendation that all schools have full time prevention specialists at their disposal to address the need for prevention and advocacy in the community's middle and high schools. However, we know with the current funding situation this is not a possibility. This is part of the reason we have seen an increase in the numbers of alcohol, tobacco, and other drug use, as well as gambling and suicidal ideation. Schools continue to request support for problem identification and referral information through school officials. These services are offered to the schools as resources permit.

Information Dissemination This includes education about the signs and symptoms of alcohol, tobacco, and other drug problems, gambling prevention, suicide prevention, as well as mental health issues. The information is available through a variety of brochures, education to community coalitions and faith/community leaders, newsletters, news articles, public speaking events, workshops and advertisements. Spanish-speaking families will continue to be offered education and information.

Education through Second Steps Curriculum, Project Alert, Safe Dates, OSSOM (Operation Safe Students on the Move), ASIST (Applied Suicide Intervention Skills Training), QPR, RESPONSE; these all take place to schools that want to advocate for prevention resources.

Problem Identification and Referral including student assistance programs and healthy activities which remains the largest request by the community as a whole.

Community Based Process involving our Prevention Coordinator who continues to support the community support networks used to strengthen ties and prevention strategies. The Prevention Coordinator works with the state designated county planning groups, as well as community groups in development. The prevention programs include providing technical assistance to community coalitions in Vernonia. Coalition development in Vernonia is an ongoing effort. Technical assistance is currently being provided to Vernonia Prevention Coalition. The Local Alcohol and Drug Planning Committee are currently being redesigned and will have county wide participation. Other coalitions will be developed as time and resources permit.

Environmental Community strategies are a key feature of out prevention process to establish ongoing links to various agencies and organizations in the community. We currently have student based health centers in Vernonia, Rainier, and St. Helens School Districts. We look for Scappoose and Clatskanie to be next in line in the coming year to have school based health centers. Local school districts will be encouraged to provide student assistance programs, develop healthy policies for students, and to support athletic policies that enforce existing alcohol and drug policies.

In addition, the Prevention Coordinator will participate in community planning efforts. Minimum Data Set for Prevention will be reported to OHA for each month as well as, interim report when required. Funding for continued and expanded programming and partnership will be sought through several sources. With appropriate funding, these and other strategies will continue to grow. All listed preventions services will continue to be provided on condition that resources are sufficient.

- Problem Gambling Prevention

Gambling Prevention services in Columbia County will be provided in collaboration with allied social service agencies, schools, and the media. We will disseminate written information regarding problem gambling to the general public using Public Service Announcements, brochures and other materials developed for DHS and OPGAW and on links to the CCMH Web Site. CCMH will also make targeted presentations to these contacts and will include information regarding the prevalence of gambling locally, referral information and how to identify problem gamblers.

E. MENTAL HEALTH PROMOTION.

CCMH has been able to promote mental health as well as CCMH services through a variety of avenues. CCMH staff have participated in the annual Kiwanis Children's Fair and been able to help educate families on mental health services.

The CCMH Developmental Disabilities (DD) Department was recently able to host several Community Resource Panels across the county. CCMH staff was able to present and discuss access and availability of mental health services to a number of local community members, families, and community partners.

CCMH's current EASA program utilized a broad range of promotion including speaking to community partners through formal presentations (Foster parent meetings, DHS meetings, School counselor meetings) and on a professional basis by working with local hospitals around discharge planning and resources.

In addition to this outreach, CCMH staff have been able to work with several committees and groups such as EICC (Early Intervention), Healthy Start, HUB (Parent education), Level of Care (with Juvenile Dept., DHS, and OYA), and Youth Service Teams (with local schools and community partners).

CCMH also coordinates parent education classes both with biological/relative families and foster families. One main goal is to reduce the stigma associated with attendance in parenting education and focus on learning and developing skills for caregivers.

CCMH participates in the NAMI walk, CCMH hosts the warm line, CCMH supports and embraces the peer program including peer employees, and even our current wellness program for all our departments encourages mental health promotion.

II: CCMH DOESN'T HAVE ANY SUBCONTRACTORS DELIVERING SERVICES.

CCMH provides all services included in the FAA, State and CCO contracts.

III: COLLABORATION WITH CCO.

CCMH had a leading role in the County in the development of a CCO. CCMH hosted and organized a county-wide team to discuss how a CCO should operate, what standards will be applied and which needs to be addressed. The team reviewed potential applicants and worked with GOBHI and CareOregon in particular.

CCMH is already working for over a year with a similar focus as a CCO should have, where the Triple Aim is the main focus. CCMH integrated physical health as part of their treatment with the severely mentally ill. We now have a special group that focuses on e.g. eating healthy, exercising to improve their diabetes type II. We have close collaboration with Primary Care and we started focusing on high utilizers.

The director of CCMH is the Chair of the Governing Board of the Columbia-Pacific CCO.

A successful CCO is success for all our clients and all citizens in the County.

IV: LADPC and MHAC.

CCMH has re-established an LADPC, and MHAB.

(Some history: 2 years ago the Commissioners (LMHA) decided not to continue these 2 advisory councils. We discussed this at length at our recent AMH site review. Since CCMH is so intensely involved with the CCO, we also could consider their Advisory Council replacing the need for MHAC. Columbia County has a tradition of having strong interagency relationships and strong consumer involvement. This replaced the need for a separate group, of which the participants meet each other regular in other settings anyways.)

PART 2: COMMUNITY NEEDS ASSESSMENT

CCMH organized their traditional bi-annual community meeting to discuss and address strength and areas of improvement in our behavioral health services. We traditionally advertise this county wide and approach people and agencies directly. We approach consumers and family also. The community appreciate these meetings very much, and actually want to have them more frequently. These meetings are well attended.

This year we had almost 30 attendees from all parts of the system. List of attendees attached.

To make the discussion more, we divide the discussion in 3 major areas and people can chose voluntarily where they want to contribute. The 3 subgroups are: Adult Mental Health, Kids and Families Mental Health and Addiction & Prevention Services. At the end we all come together again and discuss the findings, determine priorities and look for common denominators.

Since we wanted even more consumer and family feedback than from the community group, we went to NAMI and families and people in recovery to receive more and substantial feedback. These comments and priorities are added separately at each topic.

GROUP 1, ADULT MENTAL HEALTH

The top three were:

1. More community outreach and education for professionals, community partners and clients.

   Community felt there was not enough general outreach of services. They think people don't always know how to access services.

   There is a need to have mandatory advocates to educate students in school on how to speak out for their needs and teens about healthy relationships and boundaries. There is a need to do more mental health training for primary care providers, professionals that work with the mentally ill, people that have mental illness and other members of the community. This would include good de-escalating skills and teaching what are the signs of trauma.

   Many displaced seniors, lose belongs, home, pets and etc. are in need of grief counseling, the effects of depression and medical issues. So there is also a need for lectures and education at senior centers and adding family members to the education.

   Develop Mental Health Panels where three or so people are talking about experiences to others that have mental health illnesses.

2. Develop and maintain a multiple dimensional crisis/emergency response team that can respond many different situations and develop more options for respite care.

   Most traumas happen at night or when most mental health agencies are closed. This makes it important to have a good emergency response team that can do emergency interventions after hours. The team would need to know where they could go and what they should do. For sexual assault there is the Sexual Assault Response Team (SART) but not all officers call them or even know about them. With this team in place schools would need to know who to call and the called persons would need to respond appropriately. Often the crisis situation means a person may need a safe respite care facility, so there should be more availability for respite care.

3. Do more volunteer recruitment and develop more meaningful peer and family support.

   Developing more peer support and volunteers is important to day to day community needs for the mentally ill. Suggestions would be having trained volunteers to ride with the police or others that deal with specific populations. It would be beneficial if more faith based organizations became involved with CCMH and Mental Health Advisory Boards. With more peer support specialist there would be better community support for the persons with mental illnesses.

GROUP 2, KIDS AND FAMILY MENTAL HEALTH

Strengths

- Therapists are on-sight at school-based health centers

  1. This improves integration;
  2. Allows parents to access services more readily;
  3. Allows for early identification and intervention with issues;
  4. Increases access outside of St. Helens; and,
  5. Families are more likely to follow up with services at CCMH because the relationship with the therapist is already in place.

- Mental Health Contract with Head Start

  1. More seamless transition into services; and,
  2. Helps with barriers like transportation.

- Family Skills training with Seth.
- Dr. Sabin (Child Psychiatrist) does good evaluations.

Areas for Improvement

- Greater follow-up and communication when child is leaving hospital and returning to school. Sometimes the school has not been communicated to and the child may be spending 6 or more hours at school per day. It would be helpful to coordinate care more closely.
- Therapeutic Foster Care – It would be good to have more in-county options. Shelter evaluation programs in-county.
- Shorten wait time to see Dr. Sabin. More LMP time is needed.
- Educate emergency services about how to intervene – fire department, Police, Libraries. Possibly MH First Aid Training.
- Look at families as systems – Integrating approach with adults and children in the same family.
- Design programs with specific demographics and community cultures in mind.
- Greater variety than play therapy for abused children including a program like CARES @ Emmanuel.
- Wrap-around services for cross-over youth (kids involved in multiple programs in the county).
    1. Get CASA involved more with the program;
    2. Conversations to help support kids especially with school staff;
    3. Greater coordination for kids in therapeutic foster care with the schools; and,
    4. Getting releases so all can be involved.

- Kids moving from county to county: communication is limited and information often lags at the new placement.
- Need better access to classes for young parents, parents, and grandparents.

ADDITIONAL FEEDBACK FROM FAMILIES:

Additional Community Feedback for Children's Mental Health Services:

What is working?

- Service providers have been able to embrace clients with different diagnosis and co-morbid traits.
- The ability to contact counselors directly verses going through a switchboard has greatly improved communication.
- Counselors have been great about follow up with Parents, especially with the ability for secure emails/encryption.
- Transitions between CCMH providers and community providers has been supported and went smoothly.
- The clinical "pairing" of client to therapist is helpful in the therapeutic relationship and delivery of services.

What are the barriers?

- The waiting room in the CCMH lobby does not feel conducive for children due to adults and children being in them at the same time.
- Communication needs to be improved regarding service availability and projected length of time.
- Crisis services (Protocall) is not helpful when a child is in crisis. Need more client specific interventions for crisis after hours.
- More developmentally and age appropriate trainings need to occur regarding mental health and disabilities in children.
- More availability in satellite offices would be helpful. More availability of service providers (therapy, mentoring) due to schedules being full and more need being "out there".
- Parking at CCMH has been difficult and can interfere with appointment times.

What can we do?

- Improvements in therapist language could be beneficial. Due to the use of acronyms and therapeutic jargon, some parents are left out of the conversation. Language needs to focus on positive and age appropriate/developmentally appropriate terms and demeanor.
- Therapist need to continue to respect a foster parent's wishes and be careful of not contradicting them in front of children.
- Scheduling should be able to be consistent (same day/time) instead of wherever the therapist has an opening.

GROUP 3, ADDICTION SERVICES:

Community Feedback for Alcohol and Drug Services:

What is working?

- Improvements have been made with accessing services especially with regards to the time it takes to be seen.
- There have been marked improvements with the collaboration with community partners.
- Communication between providers, community partners, and clients has been improved.
- In the community it is reported people are talking more about treatment and seeking services through CCMH as a positive option.

What are the barriers?

- Lack of alternate acute care in Columbia County. All referrals and clients are referred to the Portland-Metro area.
- Parents and community partners still have a lack of education about drugs and effects as well as to what to look for. More education for community could be beneficial.
- There has been a lack of participation by parents and community members in trainings that do occur. This could be from timing or advertisement of trainings. This will need to improve to help educate the community.
- Exploring alternative ways of "billing" services is not conducive to "prevention". Services that can be beneficial are not usually done due to not being able to be billed for by a clinician. These can be preventative services to non-clients/students without a diagnosis.
- Due to the nature of substance abuse, the recidivism rate is high and clients are typically in services a number of times. Also there is a high rate of multi-family/ generational substance abuse which makes it harder to treat on an individual basis.
- Lack of community resources in terms of "drop in centers" and alternative pro-social drug free youth centers.

What can we do?

- Preventative services have been proven to be effective. More preventative services need to be utilized with younger children and applied in the schools.
- The use of volunteers in the county is low. Utilizing volunteers for preventative services such as mentoring, peer support, in-services, can be beneficial to the county especially with funding being decreased across the state. Development of a "Coordinator" position could assist in the use of volunteers.
- Although communication between service providers has increased, more consistent and efficient approaches for treatment updates/status reports need to be implemented. With multiple forms and reports, an educational piece will need to be used especially with diagnosis, treatment, UA levels and there definitions.

Needs Assessment from Addictions Clients and people in recovery in Columbia County.

1. <u>Better financial assistance for treatment services.</u>

   Clients think there are good treatment programs in Columbia County. They believe it could be better if the outlying towns had as much as St. Helens does. Clients think the biggest barrier to accessing treatment is the financial piece. The majority of clients are mandated to treatment but most have no financial means to pay for treatment and have no insurance. Many client are forced to participate in much less treatment than what is recommended as a result of only doing what they can afford or not doing treatment at all. This naturally creates a revolving door affect at the jail, probation and DHS.

2. <u>More available public transportation.</u>

   Clients in Columbia County are very dependent on public transportation. In St. Helens and Scappoose it is better than other area of Columbia County. Beside limited routes and times for the transportation there are no affordable public transportation options after 6 pm. This makes it very difficult for clients to do evening treatment groups because they have transportation to the group but have to walk home after the group. Besides missing evening treatment it also creates barriers to accessing other services in the County.

3. Affordable Clean and Sober Housing.

Homelessness is a large issue in Columbia County, especially for chemical dependent recovery population. When people are in treatment and getting into early recovery they are forced to cut ties with many of the people they used to spend time with or live with. Often people relapse just because they had no other place else to live than with substance abusing friends, relative, significant others and etc. This makes early recovery very hard. More clean and sober transitional and other housing is a big need in this county, especially for single women with children.

PART 3 –

Strengths and Areas for Improvement

3. Strengths and Areas for Improvement: **Based on the Community Needs Assessment, please indicate where there are strengths or areas for improvement in each of the areas below.**		
Review Criteria: • **Reflects Community Needs Assessment.** • **Identified strengths and areas for improvement match data and other information referenced in the community needs assessment.** • **Plans to maintain and develop strengths are addressed in each area.** • **Strategies to make improvements are described and match performance goal strategies where applicable.**		
Area	**Strength or Area for Improvement**	**Plan to Maintain Strength or Address Areas Needing Improvement**

a) Mental Health Promotion	CCMH has been able to promote mental health as well as CCMH services through a variety of avenues. CCMH staff have participated in the annual Kiwanis Children's Fair and been able to help educate families on mental health services. The CCMH Developmental Disabilities (DD) Department was recently able to host several Community Resource Panels across the county. CCMH staff were able to present and discuss access and availability of mental health services to a number of local community members, families, and community partners. CCMH'c current EASA program utilized a broad range of promotion including speaking to community partners through formal presentations (Foster parent meetings, DHS meetings, School counselor meetings) and on a professional basis by working with local hospitals around discharge planning and resources. In addition to this outreach, CCMH staff have been able to work with several committees and groups such as EICC (Early Intervention), Healthy Start, HUB (Parent education), Level of Care (with Juvenile Dept., DHS, and OYA), and Youth Service Teams (with local schools and community partners). CCMH also coordinates parent education classes both with biological/relative families and foster families. One main goal is to reduce the stigma associated with attendance in parenting education	By working more directly with Primary Care and become co-located we have an excellent opportunity to educate and advertise more and better. In addition, since we are an integral part of all 5 school districts in the county, we will provide more education on important (mental) health topics. We will do a better job with advertising and getting out information about our walk-in clinic and services. We plan to develop community wellness strategy where we host community events that promote wellness.

	and focus on learning and developing skills for caregivers.	
b) Mental Illness Prevention	EASA program is in place. The wellness strategy listed above makes for a healthier community as well. We are trained in suicide prevention and provide 24/7 support for crisis and urgent mental health issues. We do mental health first aid for our agency and the whole community	In collaboration with the CCO, we need to expand our EASA strategy to other domains too. We make mental health first aid training available to Police and all other community partners.
c) Substance Abuse Prevention	A lot of strength identified in Part 1. Prevention could do a better job about information dissemination. We could facilitate more curriculums within the schools and more outreach in the county as a whole. We are working toward restoring the Local Alcohol and Drug Planning Committee.	Expand our curricula at schools. Restoring LADPC. Maintain the strength that we have. We will use more volunteers, like peers support, in-services. Create a 'coordinator' position. Strategizing with other community partners to improve transportation to improve access. Assure participation in CCO advisory council.
d) Problem Gambling Prevention	A lot of strength identified in Part 1. Prevention needs to do more work with the media and getting information out to the county in regards to gambling prevention. We make gambling part of the conversation in trainings and when facilitating curriculum trainings.	A lot more advertising and getting the word out, through PSA's and other media, as well as focused presentations.
e) Suicide	CCMH provides continual support and education for clients in need. CCMH has excellent access and response time. 24/7 crisis support available. We have ASIST training and we do mental health first aid.	Advertising of services might assist in this area. Getting out information on suicide prevention lines. Holding ASIST Trainings quarterly, working with school districts to change policy and making RESPONSE Curriculum a part of

Prevention		suicide prevention in the classrooms. CCMH will increase outreach and education and will have a targeted focus on elderly.
f) Treatment: Mental Health Addictions Problem Gambling	Mental health treatment suggestions specific to Psych rehab – Continue to obtain permanent housing structures for the SMI population. Expand the Wellness program to include preventative treatment. Implement Supported Employment Program. The Addictions program offers adult and adolescent outpatient addictions treatment in 4 of the major communities in Columbia County. Except for St. Helens there are limited days and hours the satellite office run due to budget cuts. We have an excellent adolescent day treatment program but it is also only available in St. Helens. The adolescent program does utilize Proctor Homes, alternative school and treatment in combination to create an excellent alternative to residential treatment. CCMH has a 16 bed residential facility (Pathways) but it is much underfunded in that only 9 of the 16 beds have steady funding through a SAPT grant. The wait list to get in Pathways is usually months. We provide Problem Gambling treatment to the gambler and any family members in Columbia County. Due to funding cuts CCMH only has a .5 FTE counselor in the gambling program. This creates a barrier to people needing gambling services that live outside of St. Helens.	ACT reinstated. SEP is developed. Integration with Primary Care Focus on high utilizers. Improve services to inmates in jail and specifically immediately after release from jail. Housing and work should be priority. CCMH will participate in creating a community wide crisis/emergency response team. Improve and expand our already strong peer support system and family support with volunteers and trained consumers.

g) Maintenance/ Recovery Support (Include specifics pertaining to mental health, addictions and problem gambling treatment)	We have a strong peer support system in our program for severely mentally ill. We hired several peer support specialists on staff. CCMH supports the Jordan Center, a consumer run support center.	Specific to Psych Rehab – Provide ongoing supports, educational opportunities, and trainings to participants of the Jordan Center. Provide Financial Support to this group as well. Enhance utilization of peer supports within the department specific to the Wellness Program. Utilize paid alumni to help support new members. The Addictions program is in the infant stages of implementing peer/recovery mentors in the addictions and problem gambling treatment programs. This is a very cost effective way to provide recovery support but funding for this is minimal at this time.
h) The LMHA's Quality Improvement process and procedure	Our Quality Improvement Committee has worked on several projects related to tracking trends in services to children, tracking no-show rates, and identifying areas for improvement in collaboration with community partners and consumers. We have recently combined with the Developmental Disabilities Quality Assurance Committee to increase efficiency and improve collaboration across program areas. We have struggled, at times, with identifying measures that will capture system-level trends, such as transitioning to integrated care and increasing outcome tracking and prevention activities, given the sometimes evolving information, and while remaining within the scope of the committee's role in our agency. The	The Quality Improvement Committee will continue to work on increasing engagement with community members through outreach and quarterly meetings open to the public. The committee also plans to develop annual performance improvement plans that include measureable, manageable goals that can be accomplished by partnering with projects that are happening at the community level, such as working alongside community partners who are reaching out to underserved populations to provide service information in venues that are in existence, rather than duplicating efforts, giving the committee an opportunity to leverage additional resources.

	committee is more successful when the annual plan incorporates concrete goals and steps that can be accomplished in manageable steps.	
i) Service coordination and collaboration with corrections, social services, housing, education, employment and other community service agencies	The Addictions program has a good working relationship with adult and adolescent corrections and the justice system. We are involved with three drug courts, adolescent, adult and dependency. We work closely with Child Welfare and we have a full time staff that works on the ART team. Housing and employment is a large need for this county, where the unemployment and homeless rate is high.	
j) Behavioral health equity in service delivery	CCMH considers health equity as one of the most important goals. We implemented several things already: walk-in clinic, wellness program for clients and wellness program for staff and family. We participate with a community wide initiative to accomplish health equity for the community, facilitated by Public Health. Close collaboration with primary care. Decreasing Diabetes type II for our SMI population.	There are still a lot of areas we can improve on. Wellness is one of our quality improvement goals. We collaborate with OSU extension office. CCMH also needs to improve in cultural diversity and have more cultural divers staff. Although Columbia County is mainly a white population, we should improve our efforts to be open and accessible for every culture, language or other

		minority groups.
k) Meaningful peer and family involvement in service delivery and system development	When Peers want family involvement, the program could probably do a better job assuring family involvement in treatment planning. The Addictions program has just started training and using a Peer/Recovery Mentor for clients involved with Child Welfare issues.	CCMH will consider changing opening times to accommodate convenient times for families to come in. These mentors will be trained and certified through ACCBO. For improvement we would implement more mentors and involve family members in the support system. Consider better consumer representation on the Board of Directors
l) Trauma-informed service delivery	The Addictions program has made a point to send counselors to Trauma-Informed trainings as often as possible with the goal to have all counselors trained and implementing trauma-informed counseling techniques in all the services provided in this program. Several mental Health therapist are educated and practicing trauma-informed services	CCMH's goal is to educate ALL counselors and in all departments in trauma-informed service delivery.
m) Stigma reduction	CCMH is already doing a lot to reduce stigma: education, mental health first aid, MH promotion, school programs, prevention programs, advertising, hiring peers, EASA etc	CCMH is fully aware that we can always do a lot more to reduce the stigma for mental illness and addiction problems. WE are very aware how crucial this is. We are committed to maintain what we do and increase the efforts we already do. We are convinced that in the CCO world and the integration with Physical and Dental Health will reduce stigma too.
n) Peer-	CCMH is proud to have already strong commitment and outcomes in this area. We have peer-delivered services and paid peers support and a drop-in center (Jordan	An area of improvement could be to hire alumni of the Wellness program as peer supports for others in the program. CCMH will

delivered services, drop-in centers and paid peer support	Center).	provide greater supports to the Jordan center.
o) Crisis and Respite Services	Current respite services are in the RTF's. This creates a problem for the RTF in that it is difficult to build community in the facility with very symptomatic people coming in and out of the facility in respite. In addition, it drains resources.	CCMH is considering a regional, stand-alone respite center, in collaboration with our 4 county CCO.

PART 4: PERFORMANCE MEASURES

1) Current Data Available		
Performance Measure	**Data Currently Available**	**Current Measures (If available)**
a) Access/Number of individuals served	Mental Health people served: 203; 1329 services A&D people served 284; 3732 services Gambling people served 8, 33 services	**Not Available**
b) Initiation of treatment services – Timely follow up after assessments	Mental Health: **40%,** excluding med management since a lot have 90 day follow up Addictions: **67%** Gambling: **90%**	**Not Available**

c) Treatment service engagement – Minimum frequency of contact within 30 days of initiation	Mental Health: **36%** (excl med man.) Addictions: **70%** Gambling: **90%**	**Not Available**
d) Facility-based care follow up - % of individuals with follow up visit within 7 days after (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential	**Not Available**	**Not Available**
e) Readmission rates 30 and 180 day: (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential	**Not Available**	**Not Available**

f) Percent of participants in ITRS reunited with child in DHS custody	**47 %**	**Not Available**
a) Percent of individuals who report the same or better housing status than 1 year ago.	**Not Available**	**Not Available**
b) Percent of individuals who report the same or better employment status than 1 year ago.	**Not Available**	**Not Available**
c) Percent of individuals who report the same or better school performance status than 1 year ago.	**Not Available**	**Not Available**

d) Percent of individuals who report decrease in criminal justice involvement.	**Not Available**	**Not Available**
e) Stay at or below a target ADP of individuals for which the county is responsible in the state hospital psychiatric recovery program.	**100 %**	**Not Available**
f) Maintain an average length of stay on the OSH ready to transition list at or below a pre-determined target	**100 %**	**Not Available**
g) Each LMHA will complete a minimum of 80% of approved prevention goals	**Not Available**	**Not Available**

and objectives.		

2) Plans to Incorporate Performance Measures

a) Describe CCMH's plan to actively incorporate the performance measures into planning, development and administration of services and supports:

CCMH will use the performance data, collected by CCMH and/or the State, review quarterly and implement in our QI plan. We will coordinate this tracking and reviewing in coordination with the CCO performance and outcome measures. QI will make recommendations to management and will have input from the County Advisory Council and Professional Council. A lot of the measures are currently already relevant. CCMH has open access, is improving engagement, efficient and fast follow up after hospitalization etc.

We will put more emphasize on some functional outcomes, as we are implementing Supported Employment e.g. We also are in all 5 school districts to start tracking school performance more consistently. We are already on track with ADP and LOS in State Hospital.

Part III: Budget Information

Budget information includes planned use of all flexible funding included in the contract and planned use of beer and wine tax funds and funds specifically allocated for problem gambling services and prevention and substance abuse prevention.

1) General Budget Information
a) Planned expenditures for services subject to the contract: We will continue to spend the money in the same way as we did in the current biennium. We will make adjustments as we change our services with CCO plan and assure same quality and access as the Medicaid population will get. The indigent population will also benefit from integration efforts. Proposed improvement in this plan will made with same (flex) funding and funding we receive from donations, fund raising and contracts.

Review Criteria:

- **Allocation matches goals for increased performance in areas needing improvement.**
- **Allocation reflects community needs assessment.**

2) Special Funding Allocation

Area	Allocation/Comments	Review	
		Yes	**No**
a) Maintenance of Effort attestation for Beer and Wine Tax funding of addictions prevention and treatment services.	We will continue to use Beer and Wine tax funding for addiction and prevention services only.		
b) Use of lottery funds allocated for Problem Gambling prevention and treatment.	We will continue to use the lottery funds for Problem Gambling only.		

c) Use of funds allocated for alcohol and other drug use prevention.	We will continue to use all the allocated funds to alcohol and other drugs prevention for prevention services only!		

PART 4: BUDGET

CCMH

Biennial Implementation Plan (BIP)

Planned Expenditures 2014 - 2015 (Based on historical allocation)

Budget Period: **7/ 1, 2014 –6/30,201**

Date Submitted:

Category (as defined in the CFAA)	Sub-Category	Population	AMH Flex Funding*	Local Beer and Wine Tax	County GF	Other	Total	Carry-over Amo
Behavioral Health Promotion and Prevention								
	Mental Health							
		Adults	$0	$0	$0	$0	$0	
		Children	$0	$0	$0	$0	$0	
	Alcohol and Other Drug							
		Adults	$0	$0	$0	$0	$0	
		Children	$0	$7,500	$0	$0	$7,500	
	Problem Gambling		$90,000	$33,000	$0	$0	$123,000	

Outreach (Early Identification and Screening, Assessment and Diagnosis)							
	Mental Health						
		Adults	$0	$0	$0	$0	$0
		Children	$0	$0	$0	$0	$0
	Alcohol and Other Drug						
		Adults	$0	$0	$0	$0	$0
		Children	$0	$0	$0	$0	$0
	Problem Gambling		$0	$0	$0	$0	$0
Initiation and Engagement							
	Mental Health						
		Adults	$0	$0	$0	$0	$0
		Children	$0	$0	$0	$0	$0
	Alcohol and Other Drug						
		Adults	$0	$0	$0	$0	$0
		Children	$0	$0	$0	$0	$0
	Problem Gambling		$0	$0	$0	$0	$0

Therapeutic Interventions (Community-based Outpatient, Crisis, Pre-Commitment, Acute Care, PSRB and JPSRB)							
	Mental Health						
		Adults	$475,000	$0	$0	$0	$475,000
		Children	$95,000	$0	$0	$0	$95,000
	Alcohol and Other Drug						
		Adults	$180,000	$0	$0	$0	$180,000
		Children	$305,000	$0	$0	$0	$305,000
	Problem Gambling		$15,000	$0	$0	$0	$15,000
Continuity of Care and Recovery Management							
	Mental Health (housing)		$366,620	$0	$0	$0	$366,620
	Alcohol and Other Drug		$0	$0	$0	$0	$0
	Problem Gambling		$0	$0	$0	$0	$0
Peer-Delivered Services			$0	$0	$0	$0	$0
Administration			$900	$0	$0	$0	$900
Other (Include Description			$0	$0	$0	$0	$0
Total			$1,527,520	$40,500	$0	$0	$1,568,020

Addictions and Mental Health Division
January 21, 2014

Biennial Implementation Plan Amendment Template

CMHP: _____Columbia_____

Program: _____SH Program_____

Budget Item	**Jan. 1, 2014 – Jun. 30, 2014**	**July 1, 2014 – Jun. 30, 2015**
Personnel *(including FTEs, Classification of staff and associated costs)* *1 FTE Residential Specialist *1 FTE Peer Support Specialist Annual Cost per FTE Salary = $34,000 Taxes/Benefits = $20,400	54,400	108,800
Travel		
Equipment		
Supplies		
Consultants/Contracts		
Other Costs: (please list) *Rental Assistance *Administrative Fee *Move-in Assistance	 90,000 23,910 15,000	 180,000 47,820 30,000
Totals	**183,310**	**366,620**

Overall Project Cost		**549,930**
Revenue Identify expected revenues; i.e., Medicaid billing/encounters)	**unknown**	**unknown**
Number of individuals Intended to be Served	**A total of 30 individuals across three counties Tillamook, Clatsop, and Columbia for the life of the grant**	**A total of 30 individuals across three counties Tillamook, Clatsop, and Columbia for the life of the grant**

Budget Narrative:

- Please provide a description of the program and any unusual expenditures

  This permanent supported housing program spans Columbia, Clatsop, and Tillamook counties and is designed to house qualifying individuals in the community by providing participants with financial subsidies which allow them to pay only 30% of their income toward rent and utilities. The three CMHPs in each of the counties are partnering with their local Community Action programs to assist in qualifying participants with finding housing, and will provide those housed with supports to reduce barriers to successful community living. There are no unusual expenditures associated with the submitted budget.

- Please provide an implementation timeline for this program.

  Please see attached.

1-13-14	Award Letter	Not sure of completion date
1-22-14	Meet with fiscal manager to establish/review system issues.	1-22-14
1-22-14	CCMH to establish a list of potential participants.	1-22-14 and ongoing
1/28/14	Meet with Jim Tierney Columbia CAT to negotiate practices and plan implementation. Establish financial intake slot times for referral list.	1/28/14
1/28/14	Return award letter with required documentation.	1/28/14
1/29/14	Meet with Tillamook and Clatsop CAT teams for information/training on processes.	1/29/14
2/3/14	Meet with Columbia CAT direct provider staff and Peer Support Specialist from CCMH for training.	2/3/2014
2/4/14	Meet with Peer Support Specialist in Tillamook for training.	2/20/14
2/20/14	Meet with community Action Program in Tillamook for training	2/20/14
2/5/14	Tillamook to establish a list of potential participants.	ongoing
2/5/14	Meet with Peer Support Specialist in Clatsop for training.	3/5/14
2/6/14	Clatsop Community Action for training and to establish a list of potential participants.	3/14/14
2-6-14	The Consortium Peer Support staff to schedule appointments with their local CAT agencies for financial qualification of referred clients.	ongoing
2-10-14	Begin finding housing for participants who are programmatically and financially qualified.	ongoing
2-13-14	Attend CCMH Quality Assurance Meeting to establish QA compliance monitoring for SH program.	Completed 3-13-14
3-14	Offer Ready–to-Rent program to participants.	3 classes completed in Columbia County on 3-24-14 for 14 individuals. Other counties to schedule as needed.
3-14	Distribute outreach brochures to the various agencies and community organizations regarding program.	Brochure completed, translation occurring
3-14	Specific date to be determined – Meet with all Peer Support Specialist for any remaining training and to review program implementation.	Will occur in April
3-14	Specific date to be determined - Meet with CAT teams to review	Will occur

	implementation and to trouble shoot challenges.	in April
3-14	Contact Northwest Oregon Housing Authority to discuss the set aside matching slots – Establish timeline for transition Implementation.	Will occur in April
5-14	Attend QA Meeting and report on identified data sets	
5-14	Specific date to be determined – Meet with all Peer Support Specialist .	
5-14	Specific date to be determined - Meet with CAT teams to review implementation and to trouble shoot challenges	
8-14	Attend QA Meeting and report on identified data sets.	
8-14	Specific date to be determined – Meet with all Peer Support Specialist.	
8-14	Specific date to be determined - Meet with CAT teams to review implementation and to trouble shoot challenges.	
11-14	Attend QA Meeting and report on identified data sets.	
11-14	Specific date to be determined – Meet with all Peer Support Specialist.	
11-14	Specific date to be determined - Meet with CAT teams to review implementation and to trouble shoot challenges.	
2-15	Attend QA Meeting and report on identified data sets.	
2-15	Specific date to be determined – Meet with all Peer Support Specialist.	
2-15	Specific date to be determined - Meet with CAT teams to review implementation and to trouble shoot challenges.	
2-15	Data reporting to the State.	

Addictions and Mental Health Division
January 21, 2014

Biennial Implementation Plan Amendment Template

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