

Summary of Areas Previously Identified by the State as Needing Improvement – Adult

1. Improved Access to Mental Health Services for Older Adults

According to the Substance Abuse and Mental Health Administration (SAMHSA), the numbers of older adults in need of treatment for substance abuse and/or mental illness will more than double by 2020, in large part fueled by the aging baby boomer population.¹ The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. The recent restructuring of the Addictions and Mental Health Division's (AMH) Adult Policy and Planning Unit to include older adults will facilitate momentum to meet the increased need for older adult services within the division's current budgetary confines.

During the past year, AMH has continued to strengthen its collaborative working relationship with Seniors and People with Disabilities. This partnership is the result of The New Person-centered Alternatives to Hospitalization (NewPATH) Initiative. The goal of this initiative is to develop a plan for community-based care and stabilization/treatment programs that promote policies of self direction and person-centered care, as well as access to necessary medical, nursing and licensed specialists, peer support and care coordination in a community setting for people who need both long term care due to disabilities of aging or brain injuries and mental health care. The NewPATH Core Team completed the project and issued a final report. The report recommends community-based services and programs that will:

- meet the needs of individuals with complex medical and behavioral health issues in the community, rather than admit them to the Oregon State Hospital (diversion); and
- discharge those individuals more rapidly who have reached maximum benefit from treatment at OSH Geropsychiatric Treatment Services (GTS) units, but have not been able to return to or stay in the community because of a lack of suitable community services and supports.

The four project objectives have been met: (1) Analyze the current census of OSH GTS to identify the NewPATH population; (2) Complete a community assessment to identify gaps in available services and supports necessary to provide for the community stabilization and community-based long-term care needs for individuals with geropsychiatric/behavioral issues and complex medical conditions; (3) Identify possible internal discharge barriers that hinder or prevent timely discharge of stabilized GTS patients; and (4) Review relevant literature related to geropsychiatric services for the population, in particular the reports and studies of workgroups convened in Oregon in the past two decades to address the needs of this population.

As Oregon faces a major shift in the way health care is provided in the state², this work will help to inform the work of other committees now charged with integrating all health care, including mental health and long-term care, to ensure that older adults can remain in their homes while receiving the care they need.

¹ www.samhsa.gov/OlderAdultsTAC/.

² Discussed further in *Most Significant Events* section.

2. Gap in Planning and Age Appropriate Services for Young Adults in Transition (formerly called Transition Age Youth)

The Young Adults in Transition Initiative focused on young adults ages 14 to 25. The goals of the initiative were to:

- Promote access to a system of services and supports that are young adult-directed and developmentally appropriate
- Implement strategies that promote a Young Adult system through the elimination of barriers to access and through the creation of developmentally appropriate and effective services and supports
- Effectively bridge adolescent and adult systems thereby providing young adults with opportunities to realize their full potential and have healthy, productive lives.

This project was successfully completed on June 30, 2011. AMH has now developed specific programming at various levels of care targeting young adults in transition.

In addition to the development of residential programs and supported housing specifically designed to meet this group's needs, the initiative also identified the need for developmentally appropriate services to be offered within the State Hospital system.

A new project has targeted a standardized transition process that will include the cross training of hospital and provider staff, the development of on site programming, and the development of a young adult transitional house on the hospital grounds. The functioning of the house will be tailored to meet the specific needs of this population.

3. Improved rate of discharge for people ready to leave the state hospital, who are deemed "ready to place"

AMH has focused on transitioning individuals to more appropriate levels of care that meet their specific service and treatment needs. In the initiative, AMH has adopted a standardized level of care assessment tool that is now being used within the state hospitals, the residential system. The tool selected is the Level of Care Utilization of Services 10th edition (LOCUS). LOCUS is used to assist individuals when they transition to community services and supports. AMH has also developed and adopted standardized "ready-to-place" criteria for Oregon State Hospital (OSH). The state and county programs have agreed to a standardized method to hold counties accountable for the timely discharge of their residents from OSH. These changes are expected to reduce the time that people who are ready for transition from the hospital must wait for admission to community-based treatment. These changes may also reduce the wait time for admission to the state hospital.

In addition, the Adult Mental Health Initiative (AMHI) became effective on September 1, 2010. On this date AMH transferred responsibility for managing access to and from facility-based residential services to the Mental Health Organizations (MHOs). The AMHI initiative is a multi-phase project designed to restructure the adult mental health system, by infusing person-centered planning, improving utilization of restrictive settings and standardizing criteria across all levels of care. Statewide data shows that individuals

remain in highly controlled licensed settings such as residential treatment facilities for a longer time than needed.

A core goal of AMHI is to help individuals be successful and as independent as possible. AMHI will ensure that individuals can leave residential services when they are ready and that expensive resources are utilized by those who need them. AMHI uses performance-based contracting to provide incentives and drive better outcomes for individuals. AMH has provided the MHOs with flexible funding to provide community-based services such as supported housing, rental assistance, Individual Placement and Supports Supported Employment, Assertive Community Treatment and peer-delivered supports.

4. Lack of affordable housing and residential options for people with Mental Health Disorders

Stable housing is a primary factor for facilitating recovery for people with mental health disorders. “Having a place to call home is necessary for adequate psychological health. It is very difficult for people with psychiatric disabilities to stabilize their psychiatric condition or begin to move towards recovery without having a place to call home. A home is a universal human need”³. Oregon has clearly identified housing as a key factor in recovery. Oregon’s historical focus has been on developing structured housing; however, more resources are being utilized to develop scattered site supported housing and independent living opportunities statewide.

In the 2009-2011 biennium AMH provided \$4.37 million in funding for 188 units of housing for persons with serious mental illness, substance use disorders and co-occurring disorders. Of these, 44 units were developed in counties meeting the U.S. Department of Housing and Urban Development’s definition of a rural county. Despite continued housing development, stable affordable housing continues to be a significant need in Oregon.

5. Decreased waiting periods for people in acute care hospitals waiting to transfer to Oregon State Hospital

The length of waiting periods for people in acute care hospitals waiting to transfer to OSH is inversely proportionate to the length of stay (LOS) at OSH. To reduce the LOS at OSH, AMH is working closely with consumers of mental health services and supports, OSH staff, community mental health programs, providers of mental health services and supports, stakeholders and advocates to identify past practice, current barriers and future solutions to timelier discharges that would contribute to a reduced LOS at OSH.

OSH, AMH and community mental health partners currently have several initiatives underway which will address barriers to diversion, deinstitutionalization and community integration. Communities in Oregon have developed a series of crisis facilities and crisis/respice beds across the state; these are seen as some of the building blocks necessary to provide a solid foundation for successful community living while helping to decrease readmissions to the state hospital system.

³ Permanent Supportive Housing Toolkit, SAMHSA, 2010

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The Quality Improvement and Certification Unit at AMH reports that there are crisis resolution centers in four counties of western Oregon and crisis/respite beds available in eight other counties across the state. The purpose of these crisis centers and crisis/respite beds is to promote community-based treatment for people experiencing mental health difficulties while diverting them from a state hospital admission when successful treatment can be provided in the community.

Staff from OSH and AMH, consumers of mental health services and supports, community mental health program representatives and providers of mental health services and supports worked together and identified several barriers that resulted in people staying too long at OSH. These barriers and accompanying solutions are the basis for AMH's initiative for transitioning people to the community. The main goal is to assure that people are discharged from OSH more quickly using both a standardized set of readiness discharge criteria and a standardized level of care tool. AMH implemented training on the LOCUS using a "train the trainer methodology" to train a core group of individuals from OSH, AMH, the community mental health programs, providers of mental health services and supports as well as consumers of mental health services and supports how to apply the tool as part of both the OSH discharge process and to determine the level of care, supports and services an individual needs to be successful in the community. The initial training resulted in 45 LOCUS trainers. Each trainer is then required to provide a minimum of two "train the trainer" training events. The Adult Mental Health Services Unit of AMH estimates that over 1,000 individuals throughout Oregon have been trained in using LOCUS. Oregon believes that this current transformation initiative will be successful in decreasing the LOS at OSH by providing standardization to both the discharge criteria and standardization in the use of an assessment tool used statewide. Those standardization components, increased statewide training capacity to those who administer and provide the services and supports, plus improving the entire discharge process from OSH to the community will prove successful for Oregonians in obtaining "a key to their own door."

An initiative specific to decreasing the LOS for people currently residing in the OSH Geropsychiatric Treatment Services (GTS) units, the Fast Track Initiative, began in March 2011. This was a collaborative effort including staff from OSH, AMH and Seniors and People with Disabilities. The Fast Track Initiative had two specific goals. The first goal was to develop and implement a plan to discharge individuals residing in the OSH GTS units who are deemed "ready-to-place". The work of this group resulted in the opening of Oceanside House in Lincoln City, Oregon. Oceanside House, with a capacity of up to four individuals, was developed to meet the needs of specialty populations from OSH GTS, such as individuals with traumatic brain injury or severe dementia. The second goal was to establish funds in seven counties to assist individuals transitioning from OSH for whom lack of guardianship is the primary barrier. The Oregon counties that have agreed to participate are currently part of the AMH Enhanced Care System and received funding based on a limited amount of slots for guardianship. This project began July 1, 2011, and is being utilized as envisioned.

Summary of Areas Previously Identified by the State as Needing Improvement – Children

1. Gap in Planning and Age Appropriate Services for Young Adults in Transition

AMH engaged in a cross division initiative in the 09-11 biennium to better serve Young Adults in Transition (YAT) ages 14 to 25. AMH implemented strategies that promote a Young Adult system through eliminating barriers to access and through the creation of developmentally appropriate and effective services and supports. The initiative promoted access to a system of services and supports that are both young adult-directed and developmentally appropriate. This initiative worked to effectively bridge adolescent and adult systems and thereby provide young adults with opportunities to realize their full potential and lead healthy, productive lives.

AMH has developed funding priorities that establish an array of treatment services and supports needed by this developmental age group, and created sequential steps to the development of expanded residential options. This led to the first YAT specific program that has gone beyond traditional residential services, offering a more secure developmentally appropriate alternative to the state psychiatric hospital in a setting more conducive to therapeutic and skill oriented care. The *Three Bridges* level one residential program in Grants Pass opened in March 2010. In May 2011, *Kairos* opened, offering a treatment environment in which young adults can develop skills necessary for independent adult living including high school completion and initiation of college coursework, acquisition of skills necessary to obtain employment, budgeting, shopping and money management, use of public transportation, and skills needed in accessing community services. Two other programs specific to the needs of young adults in transition were developed earlier and continue to serve young adults, providing similar services.

A request for proposals has been developed with two pathways to improve integration of services for young adults age 18 and older at the Oregon State Hospital: 1) through the development of three Residential Treatment Homes that will be serving hospital clients as their primary purpose and 2) creating a standardized transition process that will include cross training of hospital and provider staff and development of on site programming; and, development of a Young Adult cottage on the hospital grounds that has been tailored to meet specific needs of this population.

AMH is working together with Oregon State Hospital staff and the Pathways Research and Training Center (RTC) for Young Adults at Portland State University to improve service delivery and the knowledge base about needs of the young adult population age 18 and older utilizing state hospital level services. RTC staff will assist with: conducting focus groups or interviews to obtain input from young adults and their providers; sharing knowledge of curricula and trainings appropriate for young adults and providing a developmental framework to better understand the needs of young adults with mental health challenges. Pathways RTC will research and produce a white paper on best practices and national efforts related to developmentally appropriate programming for young adults in state hospital settings.

2. Development of Peer Delivered Services for Youth and Family Navigators/ Expansion of Peer Delivered Services for Family Members and Young Adults in Transition

Peer-delivered services are promising practices that exemplify hope, recovery, and independence. AMH recognizes the development, funding, and support of peer-related services that connects multiple stakeholders and promotes recovery. Programs are run by persons with addictions or mental health treatment experiences, which contributes to the growth of young adults and family members.

Addictions and Mental Health Division, Peer Delivered Curriculum Committee started approving submitted curricula early 2009. Oregon Family Support Network, Oregon's statewide family-run organization, began developing Peer Delivered Services in 2009 in the form of the Family Navigator Program. Oregon YouthMOVE, the statewide young adult-run organization, developed their Young Adult Navigator Program in early 2010.

The core of all approved curricula include the following components: crisis plans, listening skills, problem solving, relationship building, recovery/ resiliency tools, boundaries, personal support, civil rights, fair housing, confidentiality, mandatory reporting, individual education planning (children/families), social service support systems, advocacy systems, and tobacco cessation resources. A curriculum must also be: culturally appropriate, grounded in informed choice, respectful of partnerships, person-centered, strengths-based and trauma informed.

Peer Delivered Services (PDS) Foundations curriculum for young adults and family members was offered quarterly and 38 family members and 24 young adults were trained during FFY 2011. Core elements of the Foundations training will be featured at the national conference of the Federation for Families with Children's Mental Health in November 2011. The director of training for OFSN has also participated in several meetings nationally on the certification of family members as Peer Support Specialists.

Future goals include: continued development of the *Online Training Center* and expansion of the PDS Foundations into a webinar format. The updated version of the PDS Foundations and support group training are being merged with the Advanced Family Navigator training.

3. Adolescent Co-occurring Disorder Treatment Services

Best practices support prevention and intervention services for children and youth with substance use and mental health disorders. When services are not available or utilized children and youth are much more likely to experience increased mental health and substance use disorders, homelessness, unemployment, and incarceration. When prevention and intervention services are available at all levels of mental health or addictions treatment, the risk of co-occurring disorders developing or worsening is reduced. When a mental health and substance use assessment is conducted with the whole family while the young person is in treatment, positive treatment outcomes occur and co-occurring disorders are reduced.

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The Children's System Advisory Committee (subcommittee of the Mental Health Planning and Management Advisory Council) created these recommendations in an Issue Brief in April 2011:

- AMH supports training, education and peer delivered services that encourage the use of evidence-based programs with young adults as co-trainers supporting harm reduction.
- AMH utilize existing A & D and mental health professionals and peers who have been trained in prevention curricula to disseminate accurate information and to train others (where individuals are approved trainers) within their communities. This will increase early identification and intervention, as well as increase capacity for referrals by schools and other community partners.
- AMH requires community mental health and addictions programs to provide information, tools, and training for prevention and early assessment of A&D concerns as applicable to children and youth, for their community primary care provider partners.
- AMH establish and disseminate (on website) a set of core competencies necessary to deliver co-occurring treatment.
- AMH utilize LEAN processes to consolidate and improve efficiencies within their administrative infrastructure, particularly with respect to treating co-occurring A&D and mental health disorders.
- AMH initiates and continues ongoing collaboration to support the above recommendations with system partners, beginning with other Oregon Health Authority Divisions.

4. Additional Intensive Community-based Mental Health Services

In the most current fiscal year, AMH has seen the development within multiple communities of family finding programs (through a grant in child welfare through the Casey Foundation), development of mentoring capacity in several counties, two new day treatment programs in underserved rural areas, a new psychiatric residential treatment program for children and youth, and the development of a crisis respite program.

5. Development of Blended Funding Pools between Child-serving State Agencies

Please review the *significant events that impacted the children's mental health system* section for information on bringing agencies together to work toward children's behavioral health. Development of blended, or minimally braided funding remains a goal statewide, and efforts are increasing at the community level to make this a reality.

6. Increased Numbers of Care Coordinators and Adequate Training and Supervision for Care Coordinators

An outgrowth of the Statewide Children's Wraparound Initiative (SCWI) has been improved workforce development for communities not participating in the demonstration aspect of the initiative, especially for skills related to care coordination. A workshop was held in June 2011 using a train the trainer model, conducted by David Barkan on facilitation skills. Work through the SCWI has also resulted in the formation of a supervisory group support and sharing that has improved supervisory capacity.

7. Increase the Use of an Integrated Neurobiological Perspective / Skills for Behavior Support in Psychiatric Residential and Day Treatment Facilities

Fifty-eight individuals in multidisciplinary teams from eight sites around Oregon completed phase I of training in the Neurosequential Model of Therapeutics (NMT) or the Neurosequential Approach to Caregiving (NAC) by Dr. Bruce Perry and the ChildTrauma Academy.

This year long training included multimedia presentations on understanding traumatized and maltreated children, six core strengths of healthy child development and related articles in addition to forty on-line case staffings. Fifteen of these individuals continue training to become trainers in NMT. Two of these trainers provide services for children in Integrated Service Array (intensive community-based treatment).

8. Services that Reflect the Cultural and Linguistic Characteristics of Clients in Non-dominant Groups

Work done to date through the Statewide Children's Wraparound Initiative has improved awareness and ability to meet the needs of clients in non-dominant groups. Using the SCWI to drive changes in the rest of the children's mental health system is a current focus. The Children's Outcomes Workgroup has selected two questions to gather data on whether families are feeling that their cultural needs are being met in services and supports they are receiving. Families receiving intensive services and/or services through the SCWI will have the opportunity to answer these two questions in a quarterly review of progress.

9. Eliminate Barriers to Access to Programs for Young Adults in Transition in Rural Areas

Early Assessment and Support Alliance (EASA) currently serves 60% of the state's population of young adults and a conscious decision was made during the selection process to include rural counties. In four of the EASA sites, the following counties have a population density of: Clatsop with 43 people per square mile; Deschutes with 38 people per square mile; Union with 12 people per square mile and Jefferson with 11 people per square mile. AMH continues to tailor these services and supports to meet the needs of Young Adults in rural communities through regional variations based upon geography and available resources.

10. Improved Integration between Physical and Mental Health

A joint committee of the Oregon Pediatric Society and Oregon Council of Child and Adolescent Psychiatry, the Oregon Children's Mental Health Task Force, recently issued a set of recommendations to the Oregon Health Authority. This document outlines the components of a functional system that can promote and deliver integrated physical and mental health care services. Important principles outlined in the document follow:

- Health system transformation should promote the array of activities that build health, healthy development and resilience in the child within the context of family.
- Integration of mental emotional and behavioral (MEB) treatment strategies requires strengthening of the capacity of the medical home to identify and treat these conditions. One important example is OPAL-K (Oregon Psychiatric Access

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Line for Kids) which provides available, immediate and expert psychiatric consultation to the medical home. This availability is a key factor to the quality, success and emerging competency of the medical home to support children and families with mental health disorders and crises.

- Integration of MEB treatment strategies into the medical home requires coordination of service with Oregon's broad mental health, chemical dependency, developmental health, social and educational service array.

The vision of the Task Force is: An integrated children's health system in Oregon that monitors social-emotional development, identifies risk and challenge, and provides effective and appropriate treatment to assure that all children, adolescents and their families achieve optimum health and development.

11. Discrepancy between Children's and Parents' Oregon Health Plan (Medicaid) eligibility Impacting on Service Delivery

Several key programs developed through the AMH Division of the OHA address the discrepancy in children's and adult's eligibility for Medicaid services.

- Parent Child Interaction Therapy in four counties is an evidence-based practice that helps reduce the likelihood of child abuse and strengthens the relationship and parenting between young children and their parents.
- The Intensive Treatment and Recovery Services program for parents in addiction treatment and their children affords opportunities for clean and sober housing as well as the opportunity for parents and children to not be separated when parents need residential treatment.
- The Early Assessment and Support Alliance is a program addressing the needs of families with a young adult with an initial, early diagnosis of psychosis. Family therapy groups are a part of this program that may also assist parents of the young adult.
- It is anticipated that the availability of the Health Insurance Exchange in 2013 will help ameliorate some of this discrepancy.

12. Creating Family-centered and Child-focused Respite and Crisis Respite

This continues to be an area needing improvement. In the prior fiscal year, a new crisis respite program was developed in one county. The impact of the state budgetary stressors has impeded development in this area.

13. Holistic Approach to Service Planning for Families

Please see the narrative in the *significant events that impacted the children's mental health system* section for a description of the expansion of system of care and wraparound services and supports. Wraparound is being used in more communities within Oregon as the preferred service planning process, and is built on principles that are holistic.

Most Significant Events that Impacted the State Mental Health System in the Previous Fiscal Year – Adults

1. Creation of the Oregon Health Authority

House Bill 2009, which passed in the 2009 Oregon Legislative Session, created the new Oregon Health Authority (OHA) to make quality health care more accessible and affordable for everyone, and to improve the health of all Oregonians. Most existing health-related state programs were combined into one organization to create OHA, including three program divisions from the Oregon Department of Human Services (DHS). OHA reports directly to the Governor and is composed of the following program areas:

- Addictions and Mental Health Division;
- Division of Medical Assistance Programs (state Medicaid agency);
- Public Health Division;
- Office of Private Health Partnerships;
- Office for Oregon Health Policy and Research;
- Oregon Educators Benefit Board;
- Public Employees Benefit Board;
- Oregon Medical Insurance Pool (high risk pool);
- Family Health Insurance Assistance Program; and
- Oregon Prescription Drug Program.

The transition was completed and became effective July 1, 2011. The change was made without any new funding from the State Legislature.

2. Health System Transformation

In June 2011, with the leadership of Governor Kitzhaber, the legislature passed House Bill 3650 that will create a statewide system of Coordinated Care Organizations (CCOs). This health reform effort will have a dramatic impact on the delivery of behavioral health services for Oregonians. CCOs will manage all of the health care for Oregon Health Plan members in their communities. These organizations will combine the work currently being done by the Fully Capitated Health Plans and the Mental Health Organizations and expand upon it. The CCOs will be used to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care. These new organizations will provide Medicaid recipients with physical, behavioral and dental health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities.

The key elements of CCOs include:

- Local control,
- Coordination,
- Health equity,
- Global budgets and shared savings,
- Metrics/performance measures, and

- Primary care health homes

OHA has begun implementation of House Bill 3650. The Health Policy Board oversees the work of the Oregon Health Authority and Governor Kitzhaber appointed work groups to develop a plan to improve the health delivery system for Oregon Health Plan Medicaid-eligible clients and clients who are dually eligible for Medicare and Medicaid. The groups are charged with presenting a draft operations plan to the February 2012 legislative session. OHA anticipates the legislatively approved plan to be implemented beginning July 1, 2012.

3. Addictions and Mental Health System Change

In addition to the work being done through HB 3650, AMH has undertaken a parallel but separate system change effort with Oregon's county governments to restructure the publicly funded addiction and mental health system for people who are not eligible for the Oregon Health Plan. The goals for this system change work are similar to those of HB 3650 and include:

- Emphasizing early intervention to promote independence, resilience, recovery and health and to avoid long-term costs including loss of employment, damage to family stability, increased health care costs, and criminal justice involvement.
- Providing financial and program flexibility to local communities to enable them to better serve people with addictions and mental health needs and achieve critical outcomes.
- Improving accountability in the community-based addictions and mental health system by managing to contracted outcomes.
- Ensuring consumer and family involvement in both the planning and ongoing governance of the system.
- Reducing reliance on high-cost institutional care.
- Over the long term, increasing the availability of high quality community-based addictions services and mental health care.

These improvements will be driven by the flexibility afforded by global budgeting, allowing counties the discretion to put resources where they are most needed to serve people in their communities. The budgeting flexibility will be balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served.

The work will move forward, with a target for establishing the framework for global budgeting and outcomes-based management for services not covered by the Oregon Health Plan by July of 2012.

4. Health Insurance Exchange

Senate Bill 99 was passed by the Legislature and signed by Governor Kitzhaber in June 2011. The legislation establishes an independent public corporation to operate the Oregon Health Insurance Exchange, a single central marketplace for individuals, families and small businesses to have access to affordable, quality health care. Under the law, people

will be able to sign up for the exchange in October 2013, for coverage to start in 2014. The law explicitly states that the exchange must be accountable to the public and work for the benefit of the people and businesses that obtain health insurance coverage through the exchange. Also through the exchange, working Oregonians who cannot afford the high cost of premiums will have access to tax credits that will lower those costs.

The Health Insurance Exchange will be run by a nine-member Board of Directors to be appointed by the Governor and confirmed by the Senate. Oregon's legislation is one of the first in the nation to pass with strong bipartisan support in both chambers; 24 of 30 Senators and 48 of 60 Representatives voted in favor of the bill. Oregon's goal is to create a Health Insurance Exchange that is compliant with the Affordable Care Act and that furthers the state's health reform goals of improved access, quality and affordability.

5. Transformation at Oregon State Hospital

The construction of the first new psychiatric treatment and recovery facility in more than 50 years was funded in the 2009-11 budget. This budget funded additional staff, equipment and supports needed to operate the new hospital and allow progress toward meeting the federally mandated minimum of 20 hours of active psychiatric treatment per person per week. These resources will help patients recover and gain the skills needed for successful community living. The new hospital is designed with patients' needs foremost in mind, including healthy food, access to education, assistance in reaching personal goals, and access to open outdoor space and fresh air in a secure, nurturing environment. The first 90 patients moved into Harbors, the admission and intense treatment program for forensic patients in January 2011. In August 2011, 175 patients in psychosocial rehabilitation services moved into Trails with six housing units, treatment mall, and exercise and relaxation spaces. Construction of the new facility is expected to be complete by the end of the year, with the remainder of the patients moving into new housing units shortly thereafter.

OSH has implemented central intensive treatment malls at the Salem and Portland campuses. The use of treatment malls is based on a philosophy of active patient-driven treatment with the goal of preparing patients for successful discharge. It employs a community design of centralized care in which the patients' living areas are connected to a "neighborhood" mall that connects to a larger "downtown" mall so that patients can access services provided in the facility and have more opportunities for healthy socialization. In the past, all of a patient's meals, care and treatment have been provided on the ward. Activities were limited and patients spent a lot of time sleeping and watching television. While patients will live on a unit, they will receive treatment, eat meals, attend classes and participate in activities in the mall areas. There is growing evidence that this centralized model can provide lasting benefits, including a decrease in hospital readmission rates, increase skills in symptom management and improved quality of life.

Traditionally, OSH has not had the technological infrastructure to track patient progress across treatment domains. The implementation of the Behavioral Health Integration Project (BHIP) provides modern technology for hospital management. BHIP is a hospital

information technology system that supports patient treatment and recovery outcomes through a master treatment care plan. The successful vendor for the new electronic medical record system was Netsmart. The work to adapt the Avatar medical records system with new laboratory and pharmacy systems was successful. The first roll out was November 1, 2011.

In December 2010 AMH contracted with the consulting firm Kaufman Global to spur culture change and improvements at OSH. After seven months of work with OSH, the final report from Kaufman Global, “documented the many achievements and efforts of individuals and work teams to implement purposeful change and drive the organization forward on a day-to-day basis. The result has been a significant advance toward the ultimate...goal of hospital excellence.”⁴

6. Adult Mental Health Initiative

Since the beginning of 2010, AMH has been working with a diverse group of stakeholders to implement the Adult Mental Health Initiative (AMHI). AMHI is designed to promote more effective utilization of current capacity in facility-based treatment settings, increase care coordination and increase accountability at the local and state level. It is also designed to promote the availability and quality of individualized community-based services and supports so that adults with mental illness are served in the most integrated community setting possible and the use of long-term institutional care is minimized.

To accomplish these goals, on September 1, 2010 AMH transferred many of the responsibilities regarding utilization of licensed facility-based treatment settings to regional MHOs. MHOs are the entity responsible for assisting individuals in transitioning between living settings, including individuals transitioning from the state hospitals. Under AMHI, MHOs will be able to provide:

- Supported Housing, including limited rental assistance;
- Supported Employment;
- Assertive Community Treatment; and
- Increased Outpatient Services.

Initially, AMH had projected that 331 individuals would be transitioned to more appropriate levels of care in the first 10 months. The MHOs were able to transition more than 464 individuals in the first 10 months.

In addition to the initiatives described above, two bills were passed in Oregon’s 2011 Legislative Session that significantly impact the adult mental health system – House Bill 3100 effects when and how some individuals are admitted to OSH and Senate Bill 420 effects when and how some individuals are discharged from OSH.

⁴ Oregon State Hospital Excellence Project, Kaufman Global (2011)

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1. House Bill 3100

Entry points to the mental health system do not allow the community mental health system or AMH the ability to determine: (1) if someone needs the level of services provided by the state hospital, (2) if the person could be appropriately served in other settings or (3) if the person does not need mental health services at all. The state mental health system is not a direct participant in any of the processes that lead to individuals being criminally committed to the state hospital. House Bill 3100 will help in standardization and ensuring that appropriate levels of care are provided.

House Bill 3100 creates a certification process for forensic evaluators; provides for admission to the state hospital for persons unfit to proceed only when there is dangerousness or a lack of community resources; removes misdemeanants from Psychiatric Security Review Board (PSRB) jurisdiction while continuing to permit state hospital admission when warranted; and requires an evaluation for potential court-conditional release for low level offenders under the jurisdiction of the PSRB.

A rule advisory committee has been developing rules to implement the certification and training process required, as well as developing a standardized evaluation addressing specific issues of competency and criminal responsibility. This rule also addresses the peer review panel required to evaluate the standardization and quality of the evaluations received by the courts. Implementation for this bill is required by January 1, 2012.

2. Senate Bill 420

Senate Bill 420 places a person found guilty except for insanity of a non Measure 11 crime under the jurisdiction of the Oregon Health Authority (OHA) rather than the Psychiatric Security Review Board (PSRB). Measure 11 crimes require mandatory minimum sentences and are more serious. Individuals who are guilty except for insanity of a Measure 11 crime will remain under the jurisdiction of the PSRB. For those under the jurisdiction of OHA, OHA will decide when a person can be released back into the community and whether the person should be recommitted; however, the PSRB will supervise the person when released into the community. Requires that person under the jurisdiction of OHA who is convicted of a crime and sentenced to incarceration be conditionally released in order to serve that sentence and upon completion of the sentence be placed back under the jurisdiction of OHA.

The Oregon State Hospital is responsible for rule writing and implementation of SB 420. OSH has a new legal affairs department which will be responsible for issues including risk review and placement of individuals who have been found guilty except for insanity of non Measure 11 crimes occurring after January 1, 2012, and individuals revoked after January 1, 2012. OSH is currently working on processes to accomplish this within the timeframes identified. New responsibilities will include a hearings process that addresses, initial hearings, revocation hearings, two year hearings, Treatment Team and patient requested hearings. At the hearings, OHA will be determining the status of the individual either continued jurisdiction or discharge due to no longer having a mental disease or defect or no longer a danger to self or others. If determined to need continued jurisdiction a determination of appropriate placement is required; either continued stay at OSH or

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conditional release. Notification will need to be made to all interested parties about the hearing schedule. When making these determinations OHA must have as their primary concern the protection of society.

Most Significant Events that Impacted the State Mental Health System in the Previous Fiscal Year – Children

1. Creation of the Oregon Health Authority

House Bill 2009, which passed in the 2009 Oregon Legislative Session, created the new Oregon Health Authority (OHA) to make quality health care more accessible and affordable for everyone, and to improve the health of all Oregonians. Most existing health-related state programs were combined into one organization to create OHA, including three program divisions from the Oregon Department of Human Services (DHS). OHA reports directly to the Governor and is composed of the following program areas:

- Addictions and Mental Health Division;
- Division of Medical Assistance Programs (state Medicaid agency);
- Public Health Division;
- Office of Private Health Partnerships;
- Office for Oregon Health Policy and Research;
- Oregon Educators Benefit Board;
- Public Employees Benefit Board;
- Oregon Medical Insurance Pool (high risk pool);
- Family Health Insurance Assistance Program; and
- Oregon Prescription Drug Program.

The transition was completed and became effective July 1, 2011. The change was made without any new funding from the State Legislature.

2. Health System Transformation

In June 2011, with the leadership of Governor Kitzhaber, the legislature passed House Bill 3650 that will create a statewide system of Coordinated Care Organizations (CCOs). This health reform effort will have a dramatic impact on the delivery of behavioral health services for Oregonians. CCOs will manage all of the health care for Oregon Health Plan members in their communities. These organizations will combine the work currently being done by the Fully Capitated Health Plans and the Mental Health Organizations and expand upon it. The CCOs will be used to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care. These new organizations will provide Medicaid recipients with physical, behavioral and dental health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities.

The key elements of CCOs include:

- Local control,
- Coordination,
- Health equity,
- Global budgets and shared savings,
- Metrics/performance measures, and

- Primary care health homes

OHA has begun implementation of House Bill 3650. The Health Policy Board oversees the work of the Oregon Health Authority and Governor Kitzhaber appointed work groups to develop a plan to improve the health delivery system for Oregon Health Plan Medicaid-eligible clients and clients who are dually eligible for Medicare and Medicaid. The groups are charged with presenting a draft operations plan to the February 2012 legislative session. OHA anticipates the legislatively approved plan to be implemented beginning July 1, 2012.

3. Patient Centered Primary Care Homes

Primary care health homes are the center of an individual's coordinated care, but aren't a physical location. A primary care health home is a team of people working on one goal: keeping the individual healthy. In most places the team includes a doctor, a nurse or nurse practitioner, a mental health or behavioral specialist, a community health worker, and others. This team-based approach reduces inefficiencies and removes barriers to care for individuals. It also puts a stronger emphasis on preventive care and helping individuals manage chronic health conditions. By having a primary care home, individuals are able to stay healthier and get their needs met by their provider, so they can reduce the likelihood of needing emergent and costly services.

Primary care health homes are integral to the development of Coordinated Care Organizations in Oregon. It's expected that many providers that are part of CCO networks will become primary care homes so they can work in coordination with other providers to provide the best care to members. It is being designed to be implemented statewide, and based on the needs of specific populations, such as the child and youth population.

4. Health Insurance Exchange

Senate Bill 99 was passed by the Legislature and signed by the Governor in June 2011. The legislation establishes an independent public corporation to operate the Oregon Health Insurance Exchange, a single central marketplace for individuals, families and small businesses to have access to affordable, health insurance. Under the law, people will be able to sign up for the exchange in October 2013, for coverage to start in 2014. The law is also explicit in that the exchange must be accountable to the public and work for the benefit of the people and businesses that obtain health insurance coverage through it for them, their families and their employees. Also through the exchange, working Oregonians who cannot afford the high cost of premiums will have access to tax credits that will lower those costs. It is anticipated that the availability of insurance for adults will improve their ability to care for their children in a stable home.

The Exchange will be overseen by a nine-member Board of Directors to be appointed by the Governor and confirmed by the Senate. Oregon's legislation is one of the first in the nation to pass with strong bipartisan support in both chambers; 24 of 30 senators and 48 of 60 representatives voted in favor of the bill. Oregon's goal is to create an Exchange

that is compliant with the Affordable Care Act and furthers the state's health reform goals of improved access, quality and affordability.

5. Addictions and Mental Health System Change

In addition to the work being done through HB 3650, AMH has undertaken a parallel but separate system change effort with Oregon's county governments to restructure the publicly funded addiction and mental health system for people who are not eligible for the Oregon Health Plan. The goals for this system change work are similar to those of HB 3650 and include:

- a. Emphasizing early intervention to promote independence, resilience, recovery and health and to avoid long-term costs including loss of employment, damage to family stability, increased health care costs, and criminal justice involvement.
- b. Providing flexibility to local communities to enable them to better serve people with addictions and mental health needs
- c. Improving accountability in the community-based addictions and mental health system.
- d. Ensuring consumer and family involvement in both the planning and ongoing governance of the system.
- e. Reducing reliance on high-cost institutional care.
- f. Over the long term, increasing the availability of high quality community-based mental health and addictions services and supports.

These improvements will be driven by the flexibility afforded by global budgeting, allowing counties the discretion to put resources where they are most needed to serve people in their communities. The budgeting flexibility will be balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served.

The work will move forward rapidly, with a target for establishing the framework for global budgeting and outcomes-based management for services not covered by the Oregon Health Plan by July of 2012.

6. Economic Impact of State Budget Reductions

The impact of slow economic rebound, continued high unemployment and overall decrease in state budget has affected all systems interfacing with the children's mental health and addictions system. In many state agencies, vacant positions are being held open as one more strategy to keep expenditures lower. Reductions have been taken that are significant in several state agencies, most notably in child welfare, education and juvenile justice.

7. Continued System of Care Development utilizing Wraparound Initiative to move into Statewide Expansion

In Oregon, we are working steadily to create a system of care based on acknowledgement of the following:

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- Children are dependent upon their care-takers for their current and future health.
- As the number of family risk and trauma factors increase, (i.e. poverty, family drug use, parental depression, domestic violence) so does the child's risk for chronic disease, educational and social-emotional/mental health issues.
- Most behavioral health conditions emerge from forces in early childhood. However, we expend resources in the management of these chronic conditions in adulthood rather than identifying and intervening earlier.
- An emphasis on chronic disease strategies to intervene, manage and contain the impact of the adverse childhood experiences downstream results in massive expenditures in health care and incarceration. This emphasis further aggravates the perpetuation of poverty, violence, chronic disease, lost opportunity, lost productivity and human suffering.

The Statewide Children's Wraparound Initiative (SCWI) will continue to institutionalize interdependence between the healthcare and human service delivery systems and assure alignment with other transformative efforts in health care and education. The Statewide Children's Wraparound Initiative began in 2010 following passage of a state law mandating the development of a system of care foundation for services and supports in Oregon in 2009.

Workforce development has been a foundation of the Statewide Children's Wraparound Initiative. Portland State University, partnered with the SCWI, has trained people at all levels and across child-serving systems since the Initiative launched in July 2010, with over 867 attendees in training sessions (this number does include repeating trainees building a skill base). Technical assistance has been provided to the three demonstration sites and regular, ongoing consultation with experts in systems of care development to address both individual level and systemic issues and barriers.

AMH has developed a web-based data reporting format to monitor progress and outcomes of children being served in the SCWI. This system provides data in real time to each demonstration site as well as to system administrators. Key indicators are monitored including harm to self and others, school performance, juvenile justice involvement, substance abuse concerns, and placement moves, in addition to basic demographic information. The format also provides data regarding children being prescribed psychotropic medication, availability of caregiver supports, and tracks who is in attendance at the child and family team meetings. This outcome-based data collection tool will be used for children receiving intensive community-based treatment services and supports.

The SCWI has been a driving force in the demonstration communities for increased breadth and depth of family member and youth participation in system level advisory groups, and in hiring of youth and family partners to provide peer delivered services. During this reporting period, over 400 children have been served through the Initiative, which uses a high fidelity model of Wraparound. Oregon is steadily working toward creating a fully functioning System of Care for all children being served.

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2011 Mental Health Block Grant Expenditure Report – Adult

Administration	\$248,699
Grant Manager (salary and benefits)	\$43,932
Program Support (salary and benefits)	\$5,433
Administrative Support (salary and benefits)	\$3,095
Oregon Supported Employment Center for Excellence	\$196,239
Services	\$2,353,928
Community Mental Health Program Allocations:	
Non-residential mental health services for adults (SE 20)	\$2,353,928
Other Services:	\$626,252
Suicide Hotline	\$52,275
AOCMHP Peer-Operated Warmline	\$173,763
Peer-Delivered Services	\$103,680
Supported Education	\$52,500
Supported Employment	\$244,034
Set-aside for FY 2012	\$196,240
Total Adult Expenditures	\$3,425,119

Five percent of Oregon’s Block Grant budget is allocated towards administrative expenses: Staff salary and benefits and a contract with Oregon Supported Employment Center for Excellence which provides training and fidelity monitoring for evidence-based Supported Employment programs throughout the state. A summary of services provided is attached.

The majority of funds are allocated to the Community Mental Health Programs and the Warm Springs Tribe under Service Element 20 (Non-residential mental health services for adults). A description of the Service Element is attached.

The remaining Block Grant funds provide for recovery support services and pilot projects for promising practices. Approximately \$196,000 has been set-aside to support programs in the 2012 fiscal year. Descriptions of the activities funded by the adult MHBG funds in fiscal year 2011 are attached.

2011 Mental Health Block Grant Expenditure Report – Children

Services

Community Mental Health Program Allocations:	\$1,105,983
Child and Adolescent Mental Health Services (SE 22)	\$1,105,983
Other Services:	\$442,882
Oregon Family Support Network – Young Adults	\$2,832
Pathways Research and Training Center	\$50,000
Family Navigators	\$108,572
Young Adults in Transition	\$91,326
Set Aside for 2012	\$190,152
Total Children’s Expenditures	\$1,548,865

Five percent of Oregon’s Block Grant budget is allocated towards administrative expenses: Staff salary and benefits and a contract with Oregon Supported Employment Center for Excellence which provides training and fidelity monitoring for evidence-based Supported Employment programs throughout the state. A summary of services provided is attached.

The majority of funds are allocated to the Community Mental Health Programs and the Warm Springs Tribe under Service Element 22 (child and adolescent mental health services). A description of the Service Element is attached.

The remaining Block Grant funds provide for recovery support services and projects for promising practices. Approximately \$190,000 has been set-aside to support programs in the 2012 fiscal year. Descriptions of the activities funded by the children’s MHBG funds are included in the *Summary of Areas Previously Identified by the State as Needing Improvement (Children)* section.

Performance Indicators - Adult

1. Increased Access to Services (NOM)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	47%	47%	50%	46%	92%
Numerator	73,071	N/A	--	72,392	--
Denominator	156,962	N/A	--	158,649	--

Goal: Increase the percentage of adults with SMI who are served in the publicly funded mental health system.

Target: Adults with SMI served in the public mental health system

Population: Adults with SMI served in the public mental health system

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Access of adults with SMI to publicly funded mental health services

Measure: The percentage of adults with SMI accessing publicly funded mental health services

Source of Information: CMHS adult with SMI prevalence information. State mental health data systems

Special Issues: Oregon’s economy has not recovered at the speed anticipated by policy makers and agencies were forced to make programmatic cuts as the result of the 2011 Legislative Session.

Significance: Individuals identified with serious mental illness benefit from community mental health services that are specific to their needs and strengths. These services assist individuals in avoiding institutionalization and promote a path to recovery.

Activities and strategies/changes/innovative or exemplary model: With movement toward Coordinated Care Organizations and AMH System Change, it is anticipated that more adults with serious mental illness will have access to services.

Target achieved or not achieved – If not, explain why: Target not achieved. The capacity of Oregon’s community mental health programs has been adversely impacted by the state’s economic circumstances which may have an impact on access to services.

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2. Decrease rate of re-admission of adults to the state psychiatric hospitals within 30 days: NOM (percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2.3%	1.1%	2.6%	0.4%	650%
Numerator	8	3	--	1	--
Denominator	351	282	--	265	--

Goal: Decrease the rate of readmission of adults to the state psychiatric hospitals within 30 days of discharge

Target: Adults discharged from the Oregon state psychiatric hospitals

Population: Adults discharged from the Oregon state psychiatric hospitals

Criterion: 1. Comprehensive community-based mental health service systems

Indicator: 30 day readmission rates into the state psychiatric hospitals

Measure: Percentage of adults discharged from state psychiatric hospitals who return to the state hospital within 30 days

Source of Information: Oregon Patient Resident Care System (OPRCS)

Special Issues: The Supreme Court’s Olmstead decision requires people to be treated at service levels appropriate to their needs in the most integrated setting possible. This measure is one indicator to judge the adequacy of discharge planning that has occurred as people transition from institutional level of care to community-based services.

Significance: AMH has placed special emphasis on integrating state hospital and community-based services. This is a key proxy measure to ensure that communication between community providers and the state hospital is adequate to create successful discharges from the state hospital.

Activities and strategies/changes/innovative or exemplary model: As part of AMHI, the LOCUS assessment tools is being used in discharge planning efforts and MHOs have been trained in the use of this tool.

Target achieved or not achieved – If not, explain why: Target achieved.

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3. Decrease the rate of readmission of adults to the state psychiatric hospitals within 180 days: NOM (percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	9.4%	10.28	9.2%	9.1%	101%
Numerator	33	29	--	24	--
Denominator	351	282	--	265	--

Goal: Decrease the rate of readmission of adults to the state psychiatric hospitals within 180 days of discharge

Target: Adults discharged from the Oregon state psychiatric hospitals

Population: Adults discharged from the Oregon state psychiatric hospitals

Criterion: 1. Comprehensive community-based mental health service systems

Indicator: 180 day readmission rates into the state psychiatric hospitals

Measure: Percentage of adults discharged from state psychiatric hospitals who return to the state hospital within 180 days

Source of Information: Oregon Patient Resident Care System (OPRCS)

Special Issues: The Supreme Court’s Olmstead decision requires people to be treated at service levels appropriate to their needs in the most integrated setting possible. This measure is one indicator to judge the adequacy of discharge planning that has occurred as people transition from institutional level of care to community services.

Significance: AMH has placed special emphasis on integrating state hospital and community services. This is a key proxy measure to ensure that communication between community providers and the state hospital is adequate to create successful discharges from the state hospital.

Activities and strategies/changes/innovative or exemplary model: As part of AMHI, the LOCUS assessment tools is being used in discharge planning efforts and MHOs have been trained in the use of this tool.

Target achieved or not achieved – If not, explain why: Target achieved.

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4. Increase the number of programs offering Evidence-Based Practices (EBP): NOM

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	None	Data not available	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

Goal: Increase the number of EBPs in Oregon

Target: Increase the number of EBPs in Oregon

Population: Adults with severe mental illness receiving EBPs

Criterion: 1. Comprehensive community-based mental health services

Indicator: The number of EBPs provided

Measure: The number of EBPs provided

Source of Information: Administrative data reports available from county mental health programs

Special Issues: A law enacted by the 2003 Oregon Legislature requires several state agencies (including AMH) to progressively increase the amount of public funding spent on EBPs to 75% by the end of the 2009-2011 biennium.

Significance: Oregon offers seven EBPs: supported housing, supported employment, assertive community treatment, medication management, illness self management, integrated dual diagnosis and family psycho-education.

Activities and strategies/changes/innovative or exemplary model: Due to Oregon’s economic climate only the populations referenced in the state statute will be surveyed for EBPs: individuals with substance use disorders referred by the criminal justice system, individuals who have been court committed for treatment due to mental illness, and children and adolescents with serious emotional disorders receiving intensive, integrated services.

Target achieved or not achieved – If not, explain why: Target not achieved. AMH is in the process of updating its data system. The data system will be used in the future is Oregon Web Infrastructure for Treatment Services (OWITS). It will supply a data-rich environment and will allow for ad hoc reporting. OWITS will also allow AMH to access real time data in order to drive policy.

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5. Client Perception of Care: NOM (Percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	56%	57%	58%	55%	95%
Numerator	1,473	1,695	--	1,695	--
Denominator	2,630	2,961	--	3,111	--

Goal: Increase the percentage of adults with SMI reporting positively on outcomes on MHSIP survey.

Target: Adults who received Medicaid mental health services within the past year.

Population: Adults who received Medicaid mental health services within the past year.

Criterion: 1: Comprehensive community-based mental health services.

Indicator: The outcome performance domain of the MHSIP Adult Outpatient Consumer Survey.

Measure: Percentage of adults reporting positive perception of outcomes.

Sources of Information: MHSIP Adult Outpatient Consumer Survey.

Special Issues: Oregon’s economic situation has not improved significantly since the application was written and the target for this measure was set.

Significance: Consumers’ perception of outcomes is one of the most basic performance measures the division can use to track success of services.

Activities and strategies/changes/innovative or exemplary model: In June 2011, with the leadership of Governor Kitzhaber, the legislature passed House Bill 3650 that will create a statewide system of Coordinated Care Organizations (CCOs). This health reform effort will have a dramatic impact on the delivery of behavioral health services for Oregonians. These new organizations will provide Medicaid recipients with physical, behavioral and dental health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities.

Target achieved or not achieved – If not, explain why: Target not achieved. Due to Oregon’s economy, the capacity of community mental health programs has been adversely affected. This has led to longer waiting periods before being enrolled in services and a decrease in the types of services offered.

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6. Decreased Criminal Justice Involvement: NOM (Percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	54%	68.8%	54%	71%	131%
Numerator	140	170	--	197	--
Denominator	261	247	--	277	--

Goal: Decreased criminal justice involvement

Target: Adults with SMI

Population: Adults with SMI

Criterion: 1: Comprehensive Community-based mental health service systems

Indicator: Criminal justice involvement questions in the Adult MHSIP survey

Measure: Reduction in arrest rate in the year prior to initiation of treatment to the year following initiation of treatment, expressed as a percentage of the arrest rate in the year prior to initiation of treatment.

Sources of Information: MHSIP Adult Survey

Special Issues: AMH continues to work with law enforcement, criminal justice system partners and CMHPs to develop preventive strategies and appropriate interventions.

Significance: It is critical that people with mental illness receive treatment early in the course of the illness in order to minimize contact with law enforcement that is a result of untreated mental illness. Jail is not the appropriate place for people with mental illness, they are costly to the criminal justice system, vulnerable to harm from other inmates and belong in a treatment environment.

Activities and strategies/changes/innovative or exemplary model: Continued development of community-based recovery support services, including peer support services, will assist in further decreasing criminal justice involvement for adults with serious mental illness.

Target achieved or not achieved – If not, explain why: Target achieved.

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7. Increased Housing Stability (NOM)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	54%	54%	55.5%	46%	83%
Numerator	508	488	--	502	--
Denominator	939	964	--	1088	--

Goal: Increased housing stability

Target: Adults with SMI

Population: Adults with SMI

Criterion: 4: Targeted services to homeless and rural populations

Indicator: The percent of respondents reporting that their housing situation has improved will increase.

Measure: Percent of respondents reporting that their housing situation has improved

Sources of Information: MHSIP Adult Survey

Special Issues: Stable housing is a primary factor for facilitating recovery for people with mental health challenges.

Significance: Stable housing is a primary factor for facilitating recovery for people with mental health disorders. “Having a place to call home is necessary for adequate psychological health. It is very difficult for people with psychiatric disabilities to stabilize their psychiatric condition or begin to move towards recovery without having a place to call home. A home is a universal human need”⁵. Oregon has clearly identified housing as a key factor in recovery.

Activities and strategies/changes/innovative or exemplary model: AMH currently has 749 supportive housing units⁶, of which 120 (16%) are scattered sites. AMH continues to invest in supportive housing units. However, rather than continuing to develop residential programs, AMH is providing resources to support individuals in their own homes. These resources include access to services such as Assertive Case Management and Intensive Case Management as well as rental assistance and rental subsidies.

Target achieved or not achieved – If not, explain why: Target not achieved. Due to Oregon’s slow economic recovery and high foreclosure rates, the state’s overall homelessness rate is on the rise. Affordable housing is limited and more people than ever are seeking rental and mortgage assistance.

⁵ Permanent Supportive Housing Toolkit, SAMHSA, 2010

⁶ AMH housing appraisal as of June 30, 2011

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8. Increased Social Supports/Social Connectedness: NOM (percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	59%	60%	59.5%	58.5%	98%
Numerator	1,611	1,845	--	1,887	--
Denominator	2,745	3,069	--	3,225	--

Goal: Increase reported social connectedness

Target: Adults with SMI

Population: Adults with SMI

Criterion: 1: Comprehensive community-based mental health service systems

Indicator: The social connectedness domain of the MHSIP survey

Measure: Percentage of adults with positive response to the MHSIP survey

Source of Information: MHSIP Adult Outpatient Consumer Survey

Special Issues: Feeling supported in recovery is key to remaining vital and healthy. Support delivered by peers who have experienced the mental health system can be a powerful tool in a person’s recovery. Use of peer services promotes mentoring, self-confidence and hope.

Significance: Recovery means that individuals have a place in the community. People feel empowered to make choices and feel hope for the future. People have meaningful relationships and feel connected to their community.

Activities and strategies/changes/innovative or exemplary model: Increasing community-based recovery support services, including peer support services, will help to increase individuals’ feeling of social support and connectedness.

Target achieved or not achieved – If not, explain why: Target not achieved. The Peer Delivered Services (PDS) Coordinator at AMH is working with counties and community-based consumer-run organizations to increase the utilization of peer support services throughout Oregon. In addition, House Bill 3650, the Health System Transformation Bill, statutorily requires that consumers have access to Peer Wellness Coaches through the Coordinated Care Organizations. These peer support services are expected to increase consumers’ social supports and connectedness.

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9. Improved Functioning: NOM (Percentage)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	55%	57%	55.5%	56%	101%
Numerator	1,489	1,737	--	1,784	--
Denominator	2,704	3,046	--	3,187	--

Goal: Improved functioning

Target: Adults with SMI

Population: Adults with SMI

Criterion: 1: Comprehensive community-based mental health service systems

Indicator: The functioning domain of the adult MHSIP survey

Measure: Percentage of adults with positive response to the functioning questions on the adult MHSIP survey

Sources of Information: MHSIP survey

Special Issues: MHSIP data will provide administrators, policy makers and stakeholders with meaningful and consistent information on trends in consumers' perceptions of meaningful outcomes.

Significance: Improved functioning can be measured in a number of ways depending on a person's goals and strengths. Oregon's array of services assists consumers in meeting their recovery goals and building on their strengths by allowing consumer choice and individualized service plans.

Activities and strategies/changes/innovative or exemplary model: Access to an array of services, including evidence-based practices, will continue to provide consumers with the services and supports necessary to meet their recovery goals.

Target achieved or not achieved – If not, explain why: Target achieved.

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10. Increase the number of consumer and family members participating on mental health advisory groups, particularly in rural areas.

Fiscal Year	2009 Actual	2010 Target	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

Goal: Increase the number of advisory groups with consumer and family member participation, particularly in rural areas.

Target: Adults (age 18+) with SMI and family members participating in county or regional mental health advisory boards per 20% statutory requirements (ORS 430.075).

Population: Adults with SMI and family members of children, youth or adults with SMI.

Criterion: 1: Comprehensive community-based mental health service system

Indicator: Determine consumer participation in rural Oregon counties (as defined by OMB 25/36 counties).

Measure: Number of county or regional mental health advisory committees with statutorily required 20% consumer and family member participation.

Source of Information: Licensing Site Reviews

Special Issues: ORS 430.075 requires 20% consumer participation on all mental health and addictions public task forces, commissions, advisory groups and committees.

Significance: It is essential that there be broad participation in mental health system planning in all areas of the state. There is concern that participation is more difficult for individuals in rural areas of the state where communication and transportation networks are less developed.

Activities and strategies/changes/innovative or exemplary model: AMH licensing staff verify statutory requirements during site reviews conducted at least once every three years.

Target achieved or not achieved – If not, explain why: Target not achieved. AMH does not currently have a data system that allows for annual collection and monitoring of this goal.

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11. Increase the percentage of adults with SMI living in rural areas who are employed in competitive employment (NOM)

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	22%	20%	20%	20%	100%
Numerator	1,936	1,851	--	1,880	--
Denominator	8,808	9,165	--	9,612	--

Goal: Increase the percentage of adults with SMI living in rural counties who are employed in competitive employment.

Target: Adults with SMI in rural counties

Population: Adults with SMI in rural counties

Criterion: 4: Targeted services to rural and homeless populations

Indicator: Adults with SMI living in rural counties who are employed in competitive jobs

Measure: Percentage of adults with SMI living in rural counties who are employed in competitive jobs

Source of Information: State mental health service data systems and the state Department of Employment records.

Special Issues: Oregon has not recovered from the magnitude of the national recession, and Oregon’s unemployment rate, 9.6 percent, remains higher than the national average⁷. The Legislatively Adopted Budget for 2009-2011 included \$1.0 million fewer funds for Supported Employment services.

Significance: Employment is an important factor in increasing self-determination and enhancing the quality of life.

Activities and strategies/changes/innovative or exemplary model: A portion of MHBG funding is allocated to the Oregon Supported Employment Center for Excellence, which provides technical assistance to evidence-based supported employment programs in Oregon. There are several rural Oregon counties with supported employment programs that receive assistance.

Target achieved or not achieved – If not, explain why: Target achieved.

⁷ <http://www.qualityinfo.org/olmisj/AllRates>

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12. Reduce the reliance on mandated treatment for adults with SMI through the civil commitment process

Fiscal Year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Measure	241	243	195	204	96%
Numerator	N/A	8,326	--	7,889	--
Denominator	N/A	34.21	--	38.2	--

Goal: Reduce the reliance on mandated treatment for adults with SMI through the civil commitment process

Target: Adults with SMI

Population: Adults with SMI

Criterion: 1: Comprehensive community-based mental health services

Indicator: Civil commitment investigations started by community mental health programs

Measure: The rate of civil commitment investigations per 100,000 population

Source of Information: State mental health data systems and state census information

Special Issues: It is important to recognize increasing symptoms of mental illness and engage people in effective treatment and support before the acuity reaches the point that people reject treatment and become a danger to themselves or others.

Significance: With a focus on community-based resources to facilitate more efficient and effective engagement in community-based services, the need for and use of civil commitment could decrease over time. At the same time more people would be served early in the course of their illness.

Activities and strategies/changes/innovative or exemplary model: With its focus on community-based integrated service delivery, AMHI may impact this performance measure.

Target achieved or not achieved – If not, explain why: Target not achieved. AMH believes that this was an overly ambitious goal. Despite not meeting the goal set in the 2011 application, AMH is pleased in the significant decrease in civil commitments during the 2011 fiscal year. The early intervention programs, services for youth experiencing their first psychotic break, and use of diversion services prior to civil commitment proceedings have all helped to positively impact this performance indicator.

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13. Reduce the Reliance on mandated treatment for adults with SMI through the aid and assist process

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	303	302	291	298	98%
Numerator	303	302	--	298	--
Denominator	1	1	--	1	--

Goal: Reduce the reliance on mandated treatment for adults with SMI through the aid and assist process

Target: Adults with SMI

Population: Adults with SMI

Criterion: 1: Comprehensive community-based mental health services

Indicator: Aid and assist investigations started by community mental health programs

Measure: Number of aid and assist admissions

Source of Information: State mental health service data systems

Special Issues: With a focus on community-based resources to facilitate more efficient and effective engagement in community-based services, the need for and use of mandated treatment for adults through the aid and assist process could decrease over time. At the same time more people would be served early in the course of their illness.

Significance: Oregon Revised Statute (ORS) 161.370 states, “The court may release the defendant on supervision if it determines that care other than commitment for incapacity to stand trial would better serve the defendant in the community.”

Activities and strategies/changes/innovative or exemplary model: AMH has pilot projects in four Oregon counties which support diversion from the state hospital. AMH is working with judges, defense attorneys and public defenders to divert people from being committed to the state hospital. Additionally, House Bill 3100 provides for admission to the state hospital for persons unfit to proceed only when there is dangerousness or a lack of community resources. This important change will allow consumers to receive the services and supports they need within their community.

Target achieved or not achieved – If not, explain why: Target not achieved. As stated above, House Bill 3100 is expected to positively impact this goal beginning January 1, 2012.

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14. Adults with SMI receiving Supported Housing

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Goal:

Target:

Population:

Criterion: 1: Comprehensive community-based mental health services

Indicator:

Measure:

Numerator:

Denominator:

Source of Information:

Special Issues:

Significance:

Activities and strategies/changes/innovative or exemplary model:

Target achieved or not achieved – If not, explain why: N/A. AMH is unable to collect this data with current information systems. It is anticipated that OWITS will allow for tracking of this performance indicator.

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15. Adults with SMI receiving Supported Employment.

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	22%	N/A	N/A	831	100%
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Goal: Increase the percentage of adults with SMI receiving Supported Employment.

Target: Adults with SMI

Population: Adults with SMI receiving Supported Employment

Criterion: 1: Comprehensive community-based mental health services

Indicator: The number of adults receiving Supported Employment

Measure: The number of adults receiving Supported Employment

Source of Information: MMIS

Special Issues: A law enacted by the 2003 Oregon Legislature required that AMH progressively increase the percentage of its treatment funds that support evidence-based practices to 75% by the 2009-2011 biennium.

Significance: Evidence-based Supported Employment is based on the premise (which is supported by research) that working in a regular job in everyday work environments, rather than sheltered employment, enhances people’s lives, promotes wellness and reduces stigma. Supported Employment has been shown to decrease hospitalizations, decrease psychiatric symptoms, decrease substance use, and increase medication adherence. Supported Employment also increases social connectedness, self-esteem and self-management for Supported Employment participants.

Activities and strategies/changes/innovative or exemplary model: Oregon has high-fidelity Supported Employment programs in 16 of its 36 counties. Four additional counties are expected to have high-fidelity programs by the end of 2012.

Target achieved or not achieved – If not, explain why: N/A – no target set for 2011

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16. Adults with SMI receiving Assertive Community Treatment (ACT)

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	541	100%
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Goal: Increase the percentage of adults with SMI receiving ACT.

Target: Adults with SMI

Population: Adults with SMI receiving ACT

Criterion: 1: Comprehensive community-based mental health services

Indicator: The number of adults receiving ACT

Measure: The number of adults receiving ACT

Source of Information: MMIS

Special Issues: A law enacted by the 2003 Oregon Legislature required that AMH progressively increase the percentage of its treatment funds that support evidence-based practices to 75% by the 2009-2011 biennium.

Significance: ACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness, to meet basic needs and enhance quality of life, to improve functioning in adult social and employment roles, to enhance an individual's ability to live independently in his or her own community, and to lessen the family's burden of providing care by providing comprehensive, locally-based treatment to people with serious mental illness.

Activities and strategies/changes/innovative or exemplary model: Oregon has fidelity-based ACT programs in 11 of its 36 counties.

Target achieved or not achieved – If not, explain why: N/A – no target set for 2011.

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17. Adults with SMI receiving Family Psychoeducation

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Goal:

Target:

Population:

Criterion: 1: Comprehensive community-based mental health services

Indicator:

Measure:

Source of Information:

Special Issues:

Significance:

Activities and strategies/changes/innovative or exemplary model:

Target achieved or not achieved – If not, explain why: N/A. AMH is unable to collect this data with current information systems. It is anticipated that OWITS will allow for tracking of this performance indicator.

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18. Adults with SMI receiving Integrated Treatment of Co-Occurring Disorders

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Goal:

Target:

Population:

Criterion: 1: Comprehensive community-based mental health services

Indicator:

Measure:

Source of Information:

Special Issues:

Significance:

Activities and strategies/changes/innovative or exemplary model:

Target achieved or not achieved – If not, explain why: N/A. AMH is unable to collect this data with current information systems. It is anticipated that OWITS will allow for tracking of this performance indicator.

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19. Adults with SMI receiving Illness Self-Management

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Goal:

Target:

Population:

Criterion: 1: Comprehensive community-based mental health services

Indicator:

Measure:

Source of Information:

Special Issues:

Significance:

Activities and strategies/changes/innovative or exemplary model:

Target achieved or not achieved – If not, explain why: N/A. AMH is unable to collect this data with current information systems. It is anticipated that OWITS will allow for tracking of this performance indicator.

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20. Adults with SMI receiving Medication Management

Fiscal year	2009 Actual	2010 Actual	2011 Target	2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Goal:

Target:

Population:

Criterion: 1: Comprehensive community-based mental health services

Indicator:

Measure:

Source of Information:

Special Issues:

Significance:

Activities and strategies/changes/innovative or exemplary model:

Target achieved or not achieved – If not, explain why: N/A. AMH is unable to collect this data with current information systems. It is anticipated that OWITS will allow for tracking of this performance indicator.

Performance Indicators – Children

1. Increase access to publicly-funded mental health services by children and their families.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	33%	33%	35%	34%	97%
Numerator	34617	34713	--	36161	--
Denominator	105706	106124	--	106089	--

Target: Increase access to publicly-funded mental health services by children and their families. 35% of publicly funded children and their families will have access.

Population: Children with serious emotional disorders (SED)

Criterion: 5. Management Systems

Measure: Percentage of children with SED served in the publicly funded mental health system

Sources of Information: Contracts, Medicaid encounters and claims (CPMS and MMIS data).

Special Issues: Health care transformation and the increased enrollment in Medicaid through Oregon’s Healthy Kids program are two systemic developments that are designed to improve access. Many children enrolled in mental health organizations who may need mental health services are not accessing those services.

Significance: Oregon is committed to both increasing access to mental health services and increasing the number of communities offering a wide array of community-based services. NOM 1. Increased access to services.

Activities and strategies/changes/innovative or exemplary model: Monitor enrollment increases from expansion of Medicaid program to children (Oregon Healthy Kids). Continue to support statewide expansion of community-based services and support MHOs in service provision to enrollees. Utilize wraparound demonstration sites to further develop the array of community based services. Increase linkages with other child-serving systems and referral sources. Healthcare transformation efforts, including the patient centered primary care home, and linkages between primary care physicians and psychiatrists are expected to improve access.

Target Achieved or Not Achieved: This target was **not achieved**. While the mental health system did increase access it did not reach the target. This is in part due to Oregon Healthy Kids enrollment of over 90,000 children during 2010 and 2011.

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2. Reduce the rates of readmission within 30 days for children with Serious Emotional Disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).

Performance Indicator	FY2009 Actual	FY 2010 Actual	FY2011 Target	FY 2011 Actual	FY 2011 % Attained
a. Decrease the fraction of children with SED who are readmitted to SCIP and SAIP within 30 days of their first discharge of the fiscal year.	8.8%	SCIP 0% SAIP 3.5% (2/57)	5%	SCIP 0% SAIP 5.5% (3/55)	100 % 90%

Goal: Reduce the rates of readmission within 30 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).

Target: Reduce the rates of readmission to 5% or less within 30 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP). NOM #2 Reduced Utilization of Psychiatric Inpatient Beds.

Population: Children with serious emotional disorders (SED)

Criterion: 3. Children's Services

Indicators: The percentage of readmission within 30 days for children with SED to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).

Measure: Percentage of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year.

Sources of Information: MMIS and CPMS

Special Issues: Oregon is working with Community Mental Health Programs, Mental Health Organizations and Intensive Community Based Treatment Services (ICTS) providers to ensure children discharged from SCIP and SAIP have transition plans that assure successful community tenure.

Significance: It is important that children with SED have effective transition planning upon discharge from the Secure Children's Inpatient Program or Secure Adolescent Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the child's mental health needs and strengths.

Activities and strategies/changes/innovative or exemplary model: Monitor discharge planning at SCIP/SAIP through technical assistance; continue to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP. Changes in administrative monitoring were implemented in July 2010, requiring Mental Health Organizations to take responsibility for approving admissions and coordinating services available after discharge. AMH has also taken action by creating a separate secure program for youth who need the highest level of mental health (not forensic) care within a residential program.

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Target Achieved or Not Achieved: This goal was **achieved** for the children in SCIP. It was **not achieved** for the children served in SAIP. Children served in SAIP are typically children with extremely complex and longstanding mental health disorders in addition to other severe stressors such as a high number of multiple placements, contact with the juvenile justice system, developmental disability, or absence of parental and other family connections. Maintaining community support for children with this level of need is extremely challenging and requires tight monitoring and follow-up.

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3. Reduce the rates of readmission within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).

Performance Indicator	FY2009 Actual	FY 2010 Actual	FY2011 Target	FY 2011 Actual	FY 2011 % Attained
Decrease the fraction of children with SED who are readmitted to SCIP and SAIP within 180 days of their first discharge of the fiscal year.	27.9%	SCIP 0%	5%	SCIP 3.7% (1/26)	166 %
		SAIP 10.5% (6/57)	15%	SAIP 18.2% (10/55)	82%

Goal: Reduce the rates of readmission within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP). NOM 2. Reduced Utilization of Psychiatric Inpatient Beds

Target: Reduce the percentage of readmission to 5% within 180 days for children with SED to the Secure Children's Inpatient Program (SCIP) and to 15% for the Secure Adolescent Inpatient Program (SAIP).

Population: Children with serious emotional disorders (SED)

Criterion: 3. Children's Services

Measure: Percentage of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year.

Sources of Information: MMIS and CPMS

Special Issues: Oregon is working with Community Mental Health Programs, Mental Health Organizations and Intensive Community Based Treatment Services (ICTS) providers to ensure children discharged from SCIP and SAIP have transition plans that assure successful community tenure.

Significance: It is important that children with SED have effective transition planning upon discharge from the Secure Children's Inpatient Program or Secure Adolescent Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the child's mental health needs and strengths.

Activities and strategies/changes/innovative or exemplary model: Monitor discharge planning at SCIP/SAIP through technical assistance; continue to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP. Admission processes were changed 7/1/11 to create administrative responsibility through Mental Health Organizations for admissions, discharge planning and to facilitate community linkages during and after participation in the program.

Target Achieved or Not Achieved: This goal is **achieved** for SCIP, **improved but not achieved**, for SAIP. Many of the children being served in SAIP have complex, longstanding psychiatric histories resulting from trauma, repeated placements within various child-serving

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systems, and have a difficult time reintegrating into community where they have lost connections. AMH continues to work with the SAIP program, Mental Health Organizations and Community Mental Health Programs to find more effective ways to successfully transition these youth to their communities.

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4. Increase the number of evidence-based practices provided to children and their families in Oregon.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	No report*	No report	Phase out goal	No report	-----

* A change in focus regarding priority of evidence-based practice monitoring, as well as the practical issues involved in accurately determining which practices are being implemented in different localities has led AMH to conclude that this indicator should be eliminated in this cycle. Therefore, a report is not being made on this indicator.

Goal: Increase the number of evidence-based practices provided to children and their families in Oregon.

Target: The number of evidence-based practices provided.

Population: Children and families with serious emotional disorders (SED)

Criterion: 1. Comprehensive Community-based Mental Health Systems

Measure: The number of evidence-based practices provided.

Sources of Information: Administrative data and reports available from county mental health programs.

Special Issues: A law enacted by the 2003 Oregon Legislature required that the Addictions and Mental Health Division progressively increase the percentage of its treatment funds that support evidence-based practices to 75% by the 2009-2011 biennium.

Significance: In Oregon, as well as nationally, funding agencies are being required to demonstrate that funds are being used cost-effectively. Increasing the spending on services that have been shown to be effective demonstrates better stewardship of public funds. AMH is specifically interested in making sure these services are available across all age groups.

Activities and strategies/changes/innovative or exemplary model: AMH will continue efforts to promote the adoption and ongoing implementation of evidence based practices throughout the State.

Target Achieved or Not Achieved: We are unable to report on this indicator at this time. AMH is currently not able, within staffing reductions and budget impact, to monitor and survey programs about evidence-based practice usage.

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5. The number of children who receive therapeutic foster care services is maintained.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	69	79	85 (modified)	76	89%
Numerator	---	---	---		
Denominator	---	---	---		

Goal: The number of children who receive therapeutic foster care services is maintained. NOM #3

Target: The number of children receiving therapeutic foster care services remains stable.

Population: Children and their families

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

Measure: The number of children receiving therapeutic foster care services.

Sources of Information: Medicaid Management Information System (MMIS)

Special Issues: Therapeutic Foster Care is an evidence-based practice that must be reported.

Significance: The Department of Human Services, Addictions & Mental Health Division is committed to serving more children with serious emotional disorders with intensive community-based services. Therapeutic Foster Care is an evidence-based practice that is community-based.

Activities and strategies/changes/innovative or exemplary model: Continue to work with Children, Adults & Families (child welfare) to implement therapeutic foster care services. Oregon is creating and implementing many forms of bringing treatment to children in foster care. The mental health and child welfare systems are working to create memoranda of understanding at both state and community levels that will identify systemic means of linking the family foster care, treatment foster care and mental health systems so that when specialized care is needed for a child it can be provided as close to the community as possible.

Target Achieved or Not Achieved: This goal is nearly achieved, only slightly lower than prior report.

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6. Increase parents’ or guardians’ positive perception of appropriateness of services for children receiving public mental health services.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	68%	68.1%	70%	69.5%	99%
Numerator	1088	1465		1853	
Denominator	1599	2151		2667	

Goal: Increase parents’ or guardians’ positive perception of appropriateness of services for children receiving public mental health services. NOM #4

Target: Increase the percentage of parents or guardians of children receiving public mental health services who respond positively, overall, to the questions measuring appropriateness of service on the MHSIP Youth Services Survey for Families.

Population: Children and their families

Criterion: 1. Comprehensive, community-based mental health system

Measure: Percentage of parents or guardians of children receiving public mental health services who agree or strongly agree, as a whole, to the Youth Services Survey for Families questions measuring appropriateness of service: *1. I have been satisfied with the services my child receives. 4. The people helping my child stuck with us no matter what. 5. I felt my child had someone to talk to when s/he was troubled. 7. The services my child and/or family received were right for us. 10. My family got the help we wanted for my child. 11. My family got as much help as we needed for my child.*

Sources of Information: MHSIP Youth Services Survey for Families

Special Issues: The Oregon Health Authority, Addictions and Mental Health Division distributes the MHSIP Youth Services Survey for Families annually. Though this survey reflects only the opinions of those who choose to fill out and return the survey, the return has represented a statistically significant sample.

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

Activities and strategies/changes/innovative or exemplary model: System monitoring activities: local/regional advisory councils, Children’s System Advisory Council, quality assurance activities.

Target Achieved or Not Achieved: This goal is **achieved**.

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7. The population of children with serious emotional disorders (SED) will experience a lower likelihood of arrest following initiation of mental health treatment.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY2011 Target	FY2011 Actual	FY2011 % Attained
Performance Indicator	56.1%	52.2%	60%	43.7%	73%
Numerator	46	48		38	
Denominator	82	92		87	

Goal: Children with serious emotional disorders will experience a lower likelihood of arrest following initiation of mental health treatment. NOM #6

Target: The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2, will increase.

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

Criterion: 3. Children’s Services

Measure: The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2.

Sources of Information: YSS-F as amended by Oregon Department of Human Services Addiction and Mental Health Division.

Special Issues: The Oregon Department of Human Services Addictions and Mental Health Division and the Oregon Youth Authority are interested in the various factors affecting youth with mental health needs and their involvement in the juvenile justice system.

Significance: Youth who come in contact with the juvenile justice system have a high occurrence of mental health needs. Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system. Improved mental health services are expected to decrease criminal activity.

Activities and strategies/changes/innovative or exemplary model: AMH is continuing to work with juvenile justice to improved integration of services. Evaluate whether treatment has an impact on likelihood of arrest. Evaluate other factors that may be contributing to the likelihood of arrest. Work more closely with juvenile justice system representatives to increase options for youth actively engaged and progressing in treatment.

Target Achieved or Not Achieved: This target was **not achieved**. It has been challenging to engage youth who are at risk for arrest in sustained treatment. Oregon continues to struggle at the system level with appropriate collaboration between juvenile justice, Oregon Youth Authority and mental health service delivery. More concerted work in this area is needed and being planned.

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8. Decrease homelessness among children who receive publicly funded outpatient mental health services.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY2011 Actual	FY2011 % Attained
Performance Indicator	60.4%	58%	>60 %	63%	105%
Numerator	32	29		34	
Denominator	53	50		54	

Goal: Decrease homelessness among children who receive publicly funded outpatient mental health services.

Target: Increase the number of children who are no longer homeless at the termination of services out of the total number identified as homeless at the initiation of service.

Population: Children with serious emotional disorders (SED) who are homeless.

Criterion: 4. Target services to homeless and rural populations.

Measure: Proportion of children identified as homeless upon initiation of outpatient mental health services that are no longer homeless at the termination of services.

Sources of Information: Client Process Monitoring System

Special Issues: For a variety of reasons, the impact of the provision of mental health services on homelessness is difficult to measure. Homeless children entering the outpatient mental health system may not be representative of the broader population of homeless children. Children receiving mental health services are likely to receive services from other service delivery systems prior to, during, and/or following receipt of mental health services; the services provided through these other service delivery systems could also have an impact on homelessness. Data on homelessness within the mental health service population are collected only at the beginning and at the end of an outpatient mental health service episode; changes in housing status within the service episode are not known.

Significance: An increase in the proportion of homeless SED children who are no longer homeless upon completion of mental health services would suggest that mental health services have the direct or indirect effect of reducing homelessness within a subset of the children living in Oregon.

Activities and strategies/changes/innovative or exemplary model: Offer technical assistance to provider agencies; collaboration with Oregon Commission on Children and Families and other agencies addressing the needs of homeless children.

Target Achieved or Not Achieved: This goal was **achieved**.

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9. Caregivers of children with SED report an increase in Social Connectedness.

Fiscal Year	FY 2009 Actual	FY2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	84.5%	85.4%	91.8%	85.2%	93%
Numerator	1339	1809		2238	
Denominator	1584	2118		2626	

Goal: Caregivers of children with SED report a positive response to questions about Social Connectedness. NOM #8

Target: Caregivers of children with SED report a positive response to questions about Social Connectedness that is 91.8%.

Population: Children with a serious emotional disorder (SED)

Criterion: 1. Comprehensive Community-based Mental Health Systems

Measure: Percentage of caregivers of children with SED with positive response to the Social Connectedness questions on the YSS-F survey.

Sources of Information: YSS-F survey

Special Issues: This is a newer domain on the YSS-F survey.

Significance: People need to feel that they have meaningful relationships and have a place in the community, and this plays a significant part in recovery. Families of children with SED are in need of a supportive community. Stigma remains a significant barrier to increased feelings of social connectedness among families with SED.

Activities and strategies/changes/innovative or exemplary model: Continue to work at all levels of the system on reduction of stigma, through community events such as Children’s Mental Health Awareness Day. Promote support through Oregon Family Support Network and Oregon YouthMOVE. Continue with activities that assist in joining families for mutual support and peer-delivered services.

Target Achieved or Not Achieved: This goal was **not (but nearly) achieved**, substantially similar to prior report. Oregon needs to continue to work in assisting families in improving their sense of social connectedness.

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10. Parents/guardians of children with SED will report improved functioning of their children.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	59.5%	63.2%	68.5%	59.2%	86%
Numerator	938	1361		1564	
Denominator	1577	2152		2641	

Goal: Parents/guardians of children with SED will report improved functioning of their children.

Target: 68.5% of Parents/guardians of children with SED report a positive response to the Functioning question on the YSS-F survey (above a 2008 baseline of 56.5%).

Population: Children with a serious emotional disorder (SED)

Criterion: 1. Comprehensive Community-based Mental Health Systems

Measure: Percentage of caregivers of children with SED with positive response to the Functioning questions on the YSS-F survey.

Sources of Information: YSS-F survey

Special Issues: This is a newer domain on the YSS-F survey.

Significance: When children are not functioning, they cannot move forward in their development and it impacts their entire family. Many children with SED struggle with functioning on either a continual or episodic basis. Treatment should be designed to assist children and their families with an improvement in a child's ability to function. NOM #9

Activities and strategies/changes/innovative or exemplary model: CSAC will review survey results and recommend appropriate response. Inquiry of family members as to specific issues impeding functioning and evaluating whether treatment modalities are addressing this would be helpful. Utilization of evidence based practices that assist with improving functioning shall continue to be stressed throughout the system.

Target Achieved or Not Achieved: This target was **not achieved**. AMH will need to delve deeper into the reasons why parental perception has dropped so significantly in the past survey year. Generally in Oregon family members are becoming better informed and may have increased expectations over prior years of the survey.

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11. The population of children with SED will show improved participation in school following mental health treatment.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	30.2%	27.4%	35% (modified)	37.5%	107%
Numerator	306	436		543	
Denominator	1013	1594		1447	

Goal: The population of children with SED will show improved participation in school following mental health treatment. NOM #5 Return to/stay in school.

Target: 35% of parents / guardians report that their child’s school attendance improved following the initiation of mental health treatment.

Population: Children with serious emotional disorders (SED)

Criterion: 1. Comprehensive Community-Based Mental Health Service Systems. 3. Children’s Services—educational

Measure: The percentage of parents / guardians who report that their child’s school attendance improved following the initiation of mental health treatment.

Sources of Information: YSS-F item:

“Since my child started to receive mental health services from this provider, the number of days my child has been in school is:

- a. Greater than before
- b. About the same as before
- c. Less than before
- d. Does not apply”

Special Issues: Many children who need mental health services are not willing or able to participate in school.

Significance: Oregon is committed to increasing access to educational services for children with serious emotional disorders.

Activities and strategies/changes/innovative or exemplary model: Continue to support statewide provision of educational services and supports to children with SED. Work with educational system to create services/programs that meet the needs of children with SED effectively. Continue stigma reduction efforts.

Target Achieved or Not Achieved: This goal was **achieved**.

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12. Increase the percentage of children with severe emotional disorders who receive mental health services while residing in a family-like setting.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	89.6%	95.5%	92%	94.4%	103%
Numerator	19117	20545		27053	
Denominator	22214	21515		28667	

Goal: Increase the percentage of children with severe emotional disorders who receive mental health services while residing in a family-like setting.

Target: Percentage of children with SED receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 92% (2008 baseline=89%).

Population: Children with SED and their families

Criterion: 1. Comprehensive Community-based mental health services

Measure: Number of children receiving outpatient mental health services while residing in a family-like setting.

Sources of Information: Client Process Monitoring System (CPMS)

Special Issues: A number of counties have limited community-based mental health services for children to enable children with severe emotional disorders to stay in their communities.

Significance: The Oregon Health Authority, Addictions and Mental Health Division is committed to serving children with severe emotional disorders in a family-like setting in the community. Providing mental health services to children who are at home or residing in a homelike environment is an essential component of community-based services.

Activities and strategies/changes/innovative or exemplary model: Continued implementation of the Children’s System Change Initiative and the Statewide Children’s Wraparound Initiative; Technical assistance to counties. Work together with child welfare to promote use of family and relative foster care whenever children cannot live with their natural parents, promote permanent adoption whenever feasible. Create linkages between child welfare and mental health systems at both the state and local levels, to ensure that the mental health needs of these children are met in family-like settings.

Target Achieved or Not Achieved: This goal was **achieved** and has been steadily increasing.

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

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	3.9%	3.9%	Percentage shares of a specific child ethnic population will match or exceed the percentage shares of children within the same ethnic population in the state.	3.7%	Children who are White or Asian are underrepresented in the population served, relative to percentage of total population. Children identified as Native American, Black or Hispanic are over-represented in the service population relative to their percentage of the total population of children in Oregon.
Numerator				See chart below	
Denominator				See chart below	

Children	White	Native American	Hispanic	Black	Asian	Total
Child Population	765,859	13,265	64,559	14,150	26,531	884,364
Percent of Total	86.6%	1.5%	7.3%	1.6%	3.0%	
Number Receiving Mental Health Services	24,919	1,263	4,520	1,714	465	32,881
Percent of Total	74.3%	3.6%	14.6%	6.2%	1.4%	
Percent of Ethnic Group Receiving Mental Health Services	3.3%	9.5%	7.0%	12.1%	1.8%	3.7%

Produced by the Program, Analysis and Evaluation Unit, Addictions and Mental Health Division

*Estimates of distribution of served based on CPMS distribution applied to entire service population

**Overall population distribution based on historic patterns

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Goal: To maintain/increase the proportion of children from ethnic populations receiving publicly funded MH services so the proportion of the population receiving services will match/exceed the proportion of the State's children of the same ethnic population.

Target: The proportion of children within ethnic categories who are receiving mental health services compared to children within ethnic categories for the general population.

Population: Children receiving publicly funded mental health services

Criterion: 2. Mental Health System data Epidemiology

Measure: Percentage share of children within an ethnic / racial group who are receiving publicly funded mental health services compared to the percentage share of children within ethnic categories for the general population.

Sources of Information: CPMS, MMIS, Portland State University Population Research Center.

Special Issues: Whites, Asians and Hispanics are under represented in the service population, while African-Americans and Native Americans are over represented. Services must be modified to become culturally sensitive and culturally competent so that those seeking services will find services that address their cultural needs and needs for ethnic diversity. Extraction of this data within our current system is becoming increasingly challenging.

Significance: The provision of culturally sensitive and culturally competent mental health services is critical to meeting the needs of children with diverse ethnic backgrounds. NOM 1. Increased Access to Services

Activities and strategies/changes/innovative or exemplary model: AMH continues to work in this area. Expansion of culturally competent workforce development and increased access to services for children who are ethnically or culturally diverse in their background will likely improve this target.

Target Achieved or Not Achieved: The goal was **achieved**.

2011 Mental Health Block Grant Implementation Report

14. Children in Child Welfare with SED will receive a mental health assessment upon entry into substitute care.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	51.1%	39.6%	90%	50.7%	56%
Numerator	345	300		400	
Denominator	675	757		789	

Goal: Children in Child Welfare with SED will receive a mental health assessment upon entry into substitute care.

Target: Increase the percentage of children entering the child welfare system who receive timely initial mental health assessments to 90%.

Population: Children with serious emotional disorders (SED) entering Substitute Care from the Child Welfare system.

Criterion: 3. Children’s Services

Measure: Percentage of children entering the child welfare system who receive timely initial mental health assessments.

Sources of Information: MMIS and administrative data maintained within the Division of Children, Adults and Families (CAF).

Special Issues: Child welfare has a federal requirement that a child must have a mental health assessment completed within 60 days of substitute care placement. Oregon has not met this measure and is working collaboratively to meet this goal.

Significance: Children in substitute care with DHS child welfare need to have a mental health assessment completed to determine the need for mental health services. NOM #1

Activities and strategies/changes/innovative or exemplary model: Determine method to increase number of completed mental health assessments. Utilize CAF-AMH workgroup monitoring of system and child level data monitoring. Communicate with all child welfare caseworkers about importance of this measure. Promote use of memoranda of understanding to develop local solutions to ensure that the assessments are completed. Facilitate collaboration between mental health programs and child welfare system.

Target Achieved or Not Achieved: The goal was not **achieved**. Further work with partners in child welfare will be needed to improve this goal.

2011 Mental Health Block Grant Implementation Report

15. Increase the provision of evidence-based practices to children served in the public mental health system.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY2010 % Attained
Performance Indicator	No report *	No report*		No report*	
Numerator					
Denominator					

*AMH has not completed a recent survey to access the number of children who have received an evidence-based practice.

Goal: Increase the provision of evidence-based practices to children served in the public mental health system. NOM #3 Use of Evidence-Based Practices.

Indicator: Percentage of children with SED receiving evidence-based practices.

Population: Children with SED

Criterion: 3. Children’s Services

Measure: Percentage of children receiving evidence based practices.

Sources of Information: List of treatment practices approved as evidence-based by AMH; expenditure and demographic reports on evidence-based practices submitted to AMH by Community Mental Health Programs.

Special Issues: A law enacted by the 2003 Oregon Legislature requires that, by 2009, at least 75% of the treatment funds expended by AMH be for evidence-based practices. AMH has created a statewide list of approved evidence-based practices. Implementation of evidence-based practices is occurring with 167 approved practices encompassing mental health, addictions, co-occurring disorders and prevention practices.

Significance: AMH is required to demonstrate that funds are being used cost-effectively for treatment services that are based upon empirical research demonstrating the effectiveness of the practices in treating people with psychiatric disabilities. NOM #3 Use of Evidence-Based Practices.

Activities and strategies/changes/innovative or exemplary model: Continue to make information available to stakeholders about evidence based practice research and implementation strategies.

Target Achieved or Not Achieved: There is no report on this indicator. AMH does not have the resources at present to acquire this information.

2011 Mental Health Block Grant Implementation Report

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

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator: <i>Proportion of rural children served exceeded proportion of child population that lives in rural areas by:</i>	4.5%	4.9%	Meet or exceed	3.0%	100%
Numerator	---	---		---	
Denominator	---	---		---	

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

Target: The proportion of the children receiving mental health services who live rural areas will match or exceed the proportion of the State’s population of children who live in rural areas.

Population: Children who live in rural areas receiving mental health services

Criterion: 4. Targeted Services to Rural and Homeless Populations

Measure: The proportion of children receiving mental health services who live in rural areas will match or exceed the proportion of the State’s population of children who live in rural areas.

Sources of Information: Client Process Monitoring System, Oregon Patient/Resident Care System, Medicaid Management Information System, Portland State University Population Research Center data on the number of children living in various areas across the State.

Special Issues: Rural areas of Oregon have unique issues in the provision of mental health services.

Significance: Because of the small population density in areas of rural Oregon, the assurance of comparable rates of service utilization between children in rural and urban areas is a key indicator. The geographic area requires collaborative interagency involvement, planning, outreach, and unique service delivery mechanisms to ensure that the mental health needs of children and their families are identified and addressed. NOM 1. Increased Access to Services

Activities and strategies/changes/innovative or exemplary model: Formation of regional oversight committees; telemedicine; videoconferencing for interagency collaboration.

Target Achieved or Not Achieved: This target was **achieved**.

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17. Increase the training of youth with SED and their families in mental health services planning and monitoring.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Number of trained family members	43	32	40	54	135%
Number of trained youth	21	9	18	32	177%

Goal: Increase the training of youth with SED and their families in mental health services planning and monitoring

Target: a. Increase the number of trained family members of children with SED. b. Increase the number of trained youth (ages 14-25) with SED who have had or who are currently receiving mental health services.

Population: Youth with SED

Criterion: 5. Management Systems

Measure: a. Number of trained family members. b. Number of trained youth.

Sources of Data: Oregon Family Support Network Project Reports and training rosters

Special Issues: Contracts require the participation of family members/youth in advisory councils. Family members/youth may also participate in quality management committees and other means of influencing the mental health delivery systems. Training facilitates effective participation.

Significance: Family members/youth and mental health service providers together need training to ensure effective family member/youth participation on policy-making councils and advisory committees. Family member/youth involvement in organizational decision-making and analysis is critical to continuous quality improvement of services to children with SED and their families. The children’s mental health system endorses meaningful family involvement. Participation on decision-making bodies is one means to achieve meaningful family/youth involvement. Youth directed services are increasingly valued and being implemented nationally.

Activities and strategies/changes/innovative or exemplary model: Training of youth and family members; Family Navigator training; Youth Navigator curriculum development; recruitment of youth and family members for advisory councils; technical assistance by family partnership specialist within AMH.

Target Achieved or Not Achieved: This goal was **well achieved**.

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18. Increase the array of community-based mental health services available to and delivered to children with serious emotional disorders.

Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY2011 Actual	FY 2011 % Attained
Performance Indicator	58.7%	64.2%	75%	58.2%	77%
Numerator	13048	18846		19826	
Denominator	22214	29357		34068	

Goal: Increase the array of community-based mental health services available to and delivered to children with serious emotional disorders. NOM #1 Increased access to services

Target: The percentage of children with SED who receive three or more types of community-based mental health services over the course of a year will match or exceed 75% (2008 baseline =38%).

Population: Children with SED

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

Measure: The percentage of children with SED who receive three or more types of community-based mental health services.

Sources of Information: Client Process Monitoring System (CPMS) and Medicaid Management Information System (MMIS)

Special Issues: Children with serious emotional disorders need a broad array of community-based mental health services readily available for access.

Significance: The Oregon Health Authority, Addictions & Mental Health Division is committed to serving more children with serious emotional disorders with intensive community-based services. Increasing the array of intensive community-based services to children and their families remains crucial in implementing the children’s system change.

Activities and strategies/changes/innovative or exemplary model: Workforce development; technical assistance; Statewide Wraparound Project Steering Committee. AMH will continue to offer technical assistance to communities seeking assistance in broadening community-based services.

Target Achieved or Not Achieved: This goal was **not achieved**. The population needing services is increasing at a faster rate than services can be diversified and broadened. Budgetary impact may affect ongoing provision of newer (“non-traditional”) services in some communities.

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Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2011 Target	FY 2011 % Attained
Performance Indicator	18*	22	42	25	168%

19. To increase service coordination and delivery for persons aged 14-25 with serious emotional disorders who are transitioning into the adult community mental health service system.

* Numbers may reflect same client in two different FY

Goal: To increase service coordination and delivery for persons aged 14-25 with serious emotional disorders who are transitioning into the adult community mental health service system. NOM #1 Increased Access to Services

Target: Increase the number of young adults in transition (YAT) served in specific community treatment environments.

Population: Young adults in transition (14-25) and their families

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

Measure: Number of YAT served in specific community treatment environments.

Sources of Information: Annual reporting by AMH funded specific community treatment environments

Special Issues: Young adults in transition services provide opportunities and supports for youth to transition smoothly into adulthood and live productive, functional lives.

Significance: This goal addresses a service need that previously was not met in Oregon. It will likely reduce the encounters of young adults in transition with the acute care and criminal justice systems while improving their educational, vocational and functional outcomes and life satisfaction.

Activities and strategies/changes/innovative or exemplary model: Expansion of community treatment/housing options; technical assistance; AMH workgroup; youth system involvement.

Target Achieved or Not Achieved: This goal was **achieved**.

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20. To increase the number of parents / guardians of children with SED who agree or strongly agree that mental health services have been family-driven.

Fiscal Year	FY2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 % Attained
Performance Indicator	74.5%	85.4%	85%	75.2 %	88%
Numerator	1171	1809		1976	
Denominator	1582	2118		2628	

Goal: To increase the number of parents / guardians of children with SED who agree or strongly agree that mental health services have been family-driven.

Target: Increase the percentage to 85% of caregivers of children with SED who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven: *Please indicate the extent to which you agree or disagree with the following statement: The child’s parent or caregiver directed the child’s mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.*

Population: Children and their families

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

Measure: The percentage of caregivers of children with SED who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven: *Please indicate the extent to which you agree or disagree with the following statement: The child’s parent or caregiver directed the child’s mental health treatment, and made most of the treatment decisions, including decisions about treatment goals and which services and supports were needed.*

Sources of Information: YSS-F survey for families as amended by AMH for 2008

Special Issues: Family-driven services remain a primary goal of the Children’s System Change. Meaningful family involvement means that families have a primary decision making role in the mental health care of their own children.

Significance: The Oregon Health Authority, Addictions and Mental Health Division is committed to increasing the breadth of services which are deemed family-driven at all levels of the children’s mental health system. NOM #4 Client Perception of Care

Activities and strategies/changes/innovative or exemplary model: Ongoing support for meaningful family involvement; technical assistance regarding roles of family members in the child and family team, training of care coordinators and family partners. CSAC will review survey results and recommend appropriate response. Inquiry of family members as to specific issues impeding family-driven services and supports and evaluating systemic changes needed to improve provision of family-driven services and supports.

Target Achieved or Not Achieved: This goal was **not achieved**. AMH will need to explore contributing factors to the significant drop in parental perception of whether services and supports are family driven. The system, in some communities may not have sufficient flexibility to meet family’s needs. Community mental health programs need to continue to improve efforts at insuring family voice and choice. Resources available relative to need for children to remain in care continues to be a stressor in this area. Due to these various constraints,

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the system may not be shifting as quickly as family members' perception of the need for this to occur.

Attachments

**Oregon Supported Employment Center for Excellence
July 1, 2010 through June 30, 2011**

Highlights

- 2,698 people received Supported Employment
- Supported Employment is available to individuals with or without Medicaid
- Evidence-based Supported Employment available in 16 of Oregon’s 36 counties
- Four more counties are expected to be providing evidence-based Supported Employment by the mid-2012.
- The average employment rate across sites was 39 percent despite Oregon’s high unemployment rate.
- The first evidence-based Supported Employment program specifically for young adults in transition (ages 14-25) came online in June 2011.
- 1,191 hours of consultation provided to evidence-based Supported Employment programs.
- 20 fidelity reviews conducted.
- Two commercials were produced using employers and Supported Employment participants in Coos Bay and Hood River.

Statewide Evidence-Based Supported Employment Outcome Summary

Quarter	Number Served	Number Working	New Jobs	New Referrals	Employed at Discharge	State Unemployment Rate⁸
1	685	278 (41%)	82	131	28	11.0%
2	671	257 (38%)	71	118	40	10.6%
3	674	251 (37%)	86	153	39	10.0%
4	668	264 (40%)	95	142	26	9.4%
Totals	2,698		334	544	133	

⁸ <http://www.qualityinfo.org/olmisj/OlmisZine?zineid=00000011>

Suicide Hotline
July 1, 2010 through June 31, 2011

AMH provides Block Grant funds to support Oregon Partnership’s Suicide Crisis Hotline. The hotline is staffed 24 hours per day, seven days per week by trained suicide crisis line workers. Crisis line workers are required to be trained in Applied Suicide Intervention Skills (ASIST), an international evidence-based protocol used by suicide crisis line workers to competently handle calls from individuals with suicidal ideation or intent.

The suicide hotline provides services to both youth and adults, and provides the following services:

- Screening
- Assessment
- Informal on-line counseling
- Referrals to community mental health, local law enforcement, or other appropriate resources

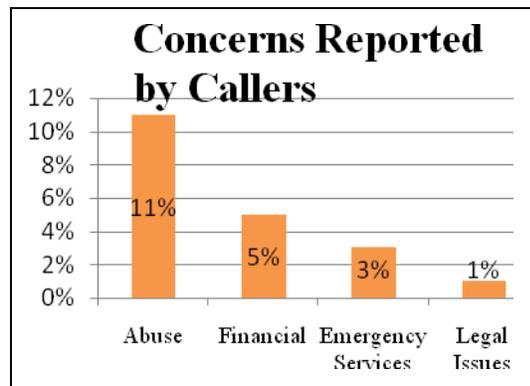
Oregon Partnership maintains a list of referral resources from each county and population center in Oregon so that suicide crisis line workers have the latest information on referral resources which they update at least once per year.

Highlights

- Oregon Partnership moved their office to a new location which enabled them to create a larger Call Center.
- The Crisis Line staff trained the Portland Police Hostage Negotiation Team in ASIST (Applied Suicide Intervention Skills Training) in exchange for the team members volunteering on the suicide line
- The Crisis Line staff facilitated a suicide prevention presentation for an Oregon National Guard unit that had a team member attempt suicide
- Two Crisis Line staff members were trained in Mental Health First Aid

Call Information⁹

Gender	% of Calls
Female	59%
Male	41%
Unknown	1%



⁹ Per Oregon Partnership’s annual report to AMH.

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Call Information Continued:

<u>Age Range</u>	<u>% of Calls</u>
Unknown	16%
>55	12%
46-55	19%
36-45	14%
26-35	21%
19-25	12%
13-18	6%
<13	1%

<u>Calling About</u>	<u>% of Calls</u>
Self	83%
Friend	6%
Child	4%
Other	3%
Spouse	1%
Sibling	1%
Client	<1%
Parent	<1%
Other Family Member	<1%
Grandchild	<1%

<u>County</u>	<u>% of Calls</u>
(unspecified)	2%
Baker	< 1%
Benton	2%
Clackamas	2.8%
Clatsop	< 1%
Columbia	< 1%
Coos	1%
Crook	< 1%
Curry	< 1%
Deschutes	2.5%
Douglas	4.5%
Gilliam	< 1%
Grant	< 1%
Harney	< 1%
Hood River	< 1%
Jackson	3%
Jefferson	< 1%
Josephine	1.6%
Klamath	< 1%
Lake	< 1%
Lane	8.8%
Lincoln	< 1%
Linn	7.2%
Malheur	< 1%
Marion	6.5%
Morrow	< 1%
Multnomah	27%
Polk	1%
Sherman	< 1%
Tillamook	< 1%
Umatilla	< 1%
Union	< 1%
Wallowa	< 1%
Wasco	< 1%
Washington	13%
Wheeler	0
Yamhill	3.5%

**The David Romprey Oregon Warmline (Warmline)
July 1, 2010 through June 30, 2011**

The Warmline was designed and is provided by persons who have or had challenges in mental health and are able to support peers who are struggling with a variety of mental health issues. The Warmline is grounded in the following principles: personal responsibility, mutuality, reciprocity, respecting others thoughts and beliefs as valid and important, growth beyond stigma, shame, and limits placed upon those living with mental illness.

Per the Warmline's website,

The Warmline's confidential and non-judgmental peer support starts with the premise that people have learned to make meaning of their experiences and relationships out of everything they have learned in their lives. This has lead many people to feel undeserving, distrusting, and inherently flawed. Without understanding how we, as individuals, have come to know what we know about being in relationships and the world around us, we are likely to have trouble, not only with emotional distress, but also with a continuous struggle when there is tension in relationships or in one's community.

Warmline staff also believe that by developing better relationships people feel valued, become empowered, and move toward a better quality of life and recovery from mental health issues. *Any Oregonian needing support* may call the David Romprey Oregon Warmline to speak to a trained peer. The trained peers do not give advice or attempt to 'get' any one to do anything. Warmline staff are there to listen and validate the caller's feelings and experiences. Together staff and callers have a conversation in which they both become more self aware while learning and growing together. They share experience and knowledge in order to discover ways in which they both learn new ways of managing feelings and discover healthier ways of being in relationships with others. Once where an individual had to "cope" with an issue, they may learn to challenge their beliefs regarding that issue, have a different experience of the situation and no longer have to "cope" because the issue no longer exists.

The use of this David Romprey Oregon Warmline may help people decrease the need for frequent doctor's visits, emergency room treatment, involvement with law enforcement, and the need for more intensive care such a psychiatric hospitalization.

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**David Romprey Oregon Warmline
July 1, 2010 through June 30, 2011**

<u>County</u>	<u># of Calls</u>
Baker	484
Benton	91
Clackamas	837
Clatsop	59
Columbia	21
Coos	817
Crook	4
Curry	23
Deschutes	65
Douglas	62
Gilliam	2
Grant	1
Harney	3
Hood River	1
Jackson	136
Jefferson	20
Josephine	113
Klamath	49
Lake	1
Lane	222
Lincoln	540
Linn	34
Malheur	28
Marion	36
Morrow	10
Multnomah	828
Polk	0
Sherman	0
Tillamook	0
Umatilla	14
Union	10
Wallowa	1
Wasco	1
Washington	270
Wheeler	0
Yamhill	9
Unknown	5,496

<u>Reason for Calling</u>	<u># of Calls</u>
Anxious, Scared/Afraid, Happy/Mad	704
Depression	333
Domestic Violence	15
Drug/Alcohol Related Challenges	65
Family Changes (Immediate or Extended)	36
Feeling Suicidal	53
Grief/Loss	67
Hang Up	81
Hearing/Seeing Things	40
Just to Talk	1,461
Lonely/Isolated/Shut-in	466
Relationship Challenges	156
Seeing Resources	92
Thank the Warmline	30
Other	315

****Please note that this data is based on the number of calls received rather than individuals served. These numbers may include more than one call per person.****

**Peer-Delivered Services Funded by the MHBG
July 1, 2010 through June 30, 2011**

Oregon is home to a wide array of peer-delivered programs; some operate within the mental health and addictions systems, and others provide alternative services. Most are community-based and all are delivered by people with mental health and/or substance use disorders or family members of adults or children with serious emotional disorders.

Peer-delivered and peer-run services are essential in reducing the significant health disparity of those living with behavioral health concerns. PDS will be instrumental in reforming the health care system to support recovery and wellness. The following programs are supported with Block Grant funds.

Benton County

The Peer Wellness Program is a service available through the Public Health Department using trained Peer Wellness Specialists. The Peer Wellness curriculum has been submitted and approved by AMH. The Peer Wellness Program operates Warmline services, and is actively networked within national and statewide consumer programs.

Josephine County

The Union Drop-In Center is a multi-use peer-run drop-in center with educational services and peer supports. The center operates several Warmline sites, including a crisis support line for the county. The center hosts nutritional groups and opportunities for exercise and other self-care activities.

Lane County

The LILA Support Club is a multi-use peer-run drop-in center with job readiness services, peer support and stabilization activities. LILA has extensive opportunities for peer support training and hosts groups at the drop-in center.

Malheur County

The Silver Sage Drop-In Center is a leader in southeastern Oregon consumer organizing via the Frontier Leadership Network. They partner with other peer-run programs and contribute time to the Warmline. Services include educational services at the community college, art, fitness, and Dual Diagnosis Anonymous meetings.

**Supported Education (SEd)
July 1, 2010 through June 30, 2011**

Oregon’s Supported Education project was developed to assist people with serious mental illness in meeting their educational goals and to encourage their recovery process. Oregon provides Block Grant funds to support three Supported Education programs:

- Cascadia Behavioral Healthcare serving Multnomah County
- LifeWorks NW serving Washington County
- Options for Southern Oregon serving Josephine County

AMH continues to investigate funding sources to assist with development of Supported Education programs in other counties around the state.

The following data is gathered from quarterly reports submitted by the Supported Education sites:

	Cascadia	LifeWorks NW	Options for Southern Oregon
Unduplicated Number Served	111	51	75
Average Age	42.4	38.4	36.5
Male	45%	65%	27%
Female	55%	35%	73%
Overall Percentage Enrolled in an Educational Program	37.3%	34.7%	39.8%

Percentage of statewide Sed consumers enrolled in a General Equivalency Diploma (GED) Program = 11.2%

Percentage of statewide Sed consumers enrolled in an Adult Basic Education Program = 12.6%

Percentage of statewide Sed consumers enrolled in an Adult High School Completion Program = 0.9%

Percentage of statewide Sed consumers enrolled in a Post-Secondary Education Program = 74.4%

**Multnomah County Supported Employment
July 1, 2010 through June 30, 2011**

Evidence-Based Supported Employment helps consumers find and maintain meaningful jobs in the community. The focus is on community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs. Employment specialists help consumers understand how benefits such as Social Security or Medicaid are affected by working. Most people are able to work and continue to receive some benefits.

There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences and individualized supports to maintain employment continue as long as consumers want the assistance. Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Oregon currently has evidence-based Supported Employment programs in 16 of its 36 counties. A portion of the Mental Health Block Grant Adult Discretionary Funds supports services to individuals without Oregon Health Plan (Medicaid) at three Supported Employment programs in Multnomah County – Cascadia, Central City Concern and LifeWorks NW.

Cascadia provides Supported Employment services to individuals under the supervision of the Psychiatric Security Review Board in Multnomah County. Cascadia provides these services not only to individuals receiving services in their programs, but also accepts referrals from other mental health services providers in the county. For fiscal year 2011, Cascadia provided Supported Employment services for 37 individuals, 81 percent of whom were male and 19 percent were female. Nine individuals worked in competitive employment for an average employment rate of 34.3 percent.

Central City Concern specializes in providing Supported Employment services for individuals with serious mental illness who are also experiencing homelessness. While being homeless is not required to receive Supported Employment services at Central City Concern, many of the participants are or have recently been homeless. For fiscal year 2011, Central City Concern provided Supported Employment services to 13 individuals; 57.5 percent were male and 42.5 percent were female. The average employment rate was 38.6 percent.

LifeWorks NW has been a leader in Oregon's effort to increase evidence-based Supported Employment services throughout the state. In addition to providing Supported Employment Services in Multnomah County, LifeWorks NW also has Supported Employment programs in Washington and Clackamas counties and has recently begun a Supported Employment program specifically for young adults in transition at their Clackamas County office. In Multnomah County LifeWorks NW provided Supported Employment services for 22 individuals in the 2011 fiscal year. Approximately 53 percent of Supported Employment participants were male and 47 percent were female. LifeWorks NW had an average employment rate of 31.3 percent.