



Oregon Guide

to

Community Mental Health, Addictions &
Developmental Disabilities Programs 2009



Association of Oregon
Community Mental Health Programs

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Association of Oregon Community Mental Health Programs



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Our Mission

The Association of Oregon Community Mental Health Programs assures that state policy and funding recognize and support local authorities that are responsible for the development and management of publicly funded systems of care for people affected by mental illness, addictions, and developmental disabilities.

Our Vision

AOCMHP is the state unified voice of local governments that are accountable for the well being of people with mental illness, addictions and developmental disabilities.

Principles

AOCMHP Members believe that:

- 1) The best decisions are made locally in collaboration with people who use our services and with families.
- 2) State policy fully supports the diversity of local solutions.
- 3) Local county and tribal governments are full partners with state and federal decision-makers in policy and funding decisions affecting mental health, addictions, and developmental disabilities.
- 4) Addressing the overall wellness of people who use our services and their families demands collaboration with multiple agencies as well as service and resource providers.

Values

- 1) Excellence in service delivery, including services based on principles of recovery, empowerment and self determination.
- 2) The use of management best practices to ensure efficiency and effectiveness, as well as timely and appropriate access in service delivery.
- 3) Transparency and accountability at all levels through the use of measurable outcomes.

Our Association

AOCMHP is a non-profit membership organization comprised of the directors of county and tribal mental health authorities* with the responsibility for planning and delivery of community mental health, developmental disabilities and addictions services. These services are funded by a partnership of counties and tribes, the State of Oregon and the federal government.

AOCMHP is a member of the National Association of County Behavioral Health Directors (NACBHD), the National Council for Community Behavioral Health Care (NCCBH), and the Human Services Coalition of Oregon (HSCO). AOCMHP is also an affiliate member of the Association of Oregon Counties (AOC).

Our Goals

Advocacy and Policy Analysis: AOCMHP maintains strong, active ties with Oregon state policy makers and addresses the issues of critical concern to county, tribal and regional mental health authorities. We advocate for the county, tribal and regional positions and share information with the Community Mental Health Program Directors in a timely, efficient manner.

Creating Alliances: AOCMHP partners with key consumer groups, advocates, local and state elected officials, and state government administrators and staff to ensure our seat at the table. We will continue to develop effective partnerships to strengthen the credibility and visibility of county, tribal and regional mental health authorities.

Statewide Forum: AOCMHP will continue to encourage the exchange of information and ideas among community mental health, developmental disabilities and addictions professionals, which enhances leadership and service delivery and promotes an informed, articulate voice.

AOCMHP is committed to the well-being of our customers and their families in every community, the care and protection of our most vulnerable populations and to strengthening the local human services safety net.

* "Local Mental Health Authority" is defined in Oregon statute as a board of county commissioners, a tribal council, or a regional authority made up of two or more boards of county commissioners, which is responsible for the planning and management of local mental health, addictions, and developmental disabilities programs. ORS 430.630.10

COMMUNITY MENTAL HEALTH & ADDICTIONS SERVICES



Association of Oregon
Community Mental Health Programs

legislative quick card

- **The State & Local Government partnership on behalf of citizens with mental illness goes back 150 years to the territorial government and early statehood.**
- **Local Mental Health Authorities (LMHAs) were established to:**
 - (1) Help the State control the size of state hospitals
 - (2) Assure public accountability
 - (3) Treat people in their home community
- **Oregon's system is a national leader in progressive community care.** (According to the National Council on Behavioral Healthcare (NCCBH))
- **Counties in Action: Oregon's Community-Based Systems of Care**
 - 1970s Community Support Services - early adopter of assertive community treatment (an evidence-based practice)
 - 1980s National Institute of Mental Health (NIMH), Dual Diagnosis - early leader (one of thirteen sites)
 - 1990s Developed community programs to close Dammasch & coordinate acute care
 - 2000s - Evidence Based Practices (EBPs): an increasing proportion of community services are evidence-based
 - Children's System Change Initiative: local agencies together ensure service coordination and efficiency
 - Peer supports & services: building a new, cost-effective workforce of peer-delivered services
 - At risk for state hospital: shared financial risk motivates local solutions and local contribution of resources
 - TODAY - Integrated health care (over 80 current projects in Counties)
 - Wellness projects
 - Regionalization projects
 - Early Psychosis Intervention (EAST programs)
 - Coordination with child welfare & criminal justice
- **Funding has not kept pace with inflation or need.**
 - Counties receive about 2% administration for mental health, 0% for addictions administration - a real bargain.
 - Counties contribute over \$82 million per biennium in county general fund, plus in-kind contributions of land, facilities & services.
- **Counties stand ready to move forward through thick & thin. Just like in the past.**

THE NEED

- 1) Implement State Hospital Master Plan Phase II. See *Community Services Workgroup Report, 2009*.
- 2) Current addictions prevention, treatment, & recovery needs. See *Oregon Speaks: Community Addictions Services Investment Strategy (2008)*.
- 3) Children's intensive mental health services. See *Children's Mental Health System Change Initiative Implementation Evaluation*.

THE REQUEST

We understand that the economy and current budget climate necessitate budget adjustments and/or raised revenues.

- 1) **Start with the Essential Budget Level (EBL): \$4.5 billion for all of human services.**
- 2) **Pass a beer tax** that will fund all of the need in addictions prevention, treatment, and recovery and alleviate pressure on the general fund.
- 3) **Fund the Community Services Workgroup Report** to protect the state's investment in the State Hospital and to manage the state's risk of an Olmstead lawsuit.
- 4) **Fund the Children's Mental Health System** at a sustainable rate to pay providers.
- 5) **Support the Children's Wraparound and the Healthy Kids Initiative.**

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The Legacy

- 1843 The Constitutional Convention at Champoege considers not only statehood but also what to do with the mentally ill. It is decided that counties will be the custodians of last resort when families' resources are exhausted.
- 1855 Territorial government approves county funding request for county mental health care for the first time; a year later the funding is revoked.
- 1862 Governor Curry signs first state contract for state-level mental health care, beginning Oregon's transition from community-based mental health care to massive state institutions.
- 1883 Oregon State Hospital in Salem opens its doors.
- 1950s The Oregon State Hospital population, in all its locations, hits its peak with more than 5,000 people in care.
- 1963-65 Community mental health centers become national policy under President Kennedy and Oregon follows suit with county programs geared to serve people with less severe mental health needs.
- 1975 Counties receive funding from beer and wine tax for addictions prevention and treatment (eight-tenths of one cent per 12 ounce drink).
- 1987 The effort begins in earnest to move people out of Oregon's huge institutions and back into their communities but very little of the funding follows them to the local service infrastructure.
- 1988 Governor Goldschmidt's Commission on Psychiatric Inpatient Services recommends the development of community-based regional inpatient service capacity. The Legislature approves funding for a gradual roll-out. Select counties plan and implement regional acute care projects beginning in 1990 with varying degrees of state support; Lane County passes a local levy to help support the effort. However, the state does not follow through on its plan to fund the effort and development of statewide regional acute care capacity is never completed.
- 1990s Community treatment continues to be state policy but funding for community infrastructure diminishes while demand increases.
- 1994 Closure of Dammasch State Hospital in Wilsonville means more people will need community-based acute care and extended care. The funding needed to serve this population in the community does not follow them there. In spite of this, in the ensuing years counties will go on to develop more than 800 new beds in communities across the state.
- 2001 Governor Kitzhaber's Mental Health Alignment Work Group issues its final report in January. The work group was charged with analyzing gaps and redundancies in existing mental health treatment and services in Oregon.
- 2002 Economic downturn leads to major cuts to mental health and addictions programs; 1,000 community mental health workers and 1,000 addictions staff are laid off. Funding for non-Medicaid clients diminishes as does funding for residential addictions treatment. Oregon Health Plan funding for mental health and addictions is also cut, though a fraction

is restored later. Oregon community hospitals receive increased funding during this period. Community programs can now serve only the most severely ill. The rolls in child foster care and jails begin to climb.

- 2004 Governor Kulongoski's Mental Health Taskforce Report finds that the public mental health system is significantly underfunded.
- 2005 SB 267 is passed. Requires the Department of Corrections, the Oregon Youth Authority, the State Commission on Children and Families, the Addictions & Mental Health Division and the Oregon Criminal Justice Commission to spend increasing proportions of state moneys on evidence-based programs. The Children's System Change Initiative is implemented at the direction of a 2003 Legislative Budget Note; Mental Health Organizations take on a central role in regional financial and quality management of services to children.
- 2006-2007
- PSU study finds early evidence that the Children's System Change Initiative is meeting its primary goals: 1) children's mental health services are provided in a way that keeps kids at home and in school and 2) funds directed to children's mental health services are actually spent for that purpose.
 - Plans for two new, smaller state hospitals are developed on the premise of increased state funding for community-based services and infrastructure. Counties assist the state in determining the necessary community programming to support the recommendations of KMD's Hospital Master Plan. The Legislature invests a fraction of what is recommended in the Community Services Workgroup Report. Oregon State Hospital is under review by the Federal Justice Department.
 - The Kids Wraparound Report recommends a variety of measures to strengthen the state-county partnership and local cooperation between agencies to ensure coordination of services to children and greater accountability for outcomes across agencies.
- 2008
- Governor's Recommended Budget devastates mental health funding for the non-Medicaid population, crisis services and almost all funding for addictions services for 2009-2011. Legislative opposition emerges strongly. County sheriffs make restoring community treatment services a priority to prevent the continual influx of people with mental illness into their high cost jail beds. PCG report is commissioned by the Legislature to analyze gaps and redundancies in existing mental health treatment and services in Oregon.
 - Dale Jarvis' "Study of the Costs in Oregon Children's Mental Health System" finds the current rates for services do not cover the cost of providing them, that salaries for service staff are 26% below market, employee benefits are below national and Oregon government averages, and administrative and overhead expenses are significantly lower than other states.
- 2009 **Focus on Recovery & Wellness** The goal of community-based treatment in 2009 is to stabilize and equip people with mental health and addictions needs to live meaningful lives in the community of their choice. People in recovery from mental illness and addictions are now a growing and cost-effective workforce of professional peer support. Investment in peer services, along with the complete continuum of community-based supports and services championed for many years by community-based systems of care, is the model of the future that will make Oregon's new investment in smaller state hospital facilities an enduring success.

STATE-COUNTY SHARED SERVICES

Counties are agents of the state for many public services like public safety, natural resources management, transportation and roads, elections, and health and human services. Shared mental health, addictions and developmental disabilities services support a variety of other shared services such as child welfare, seniors and veterans services, law enforcement, courts, and corrections.

State of Oregon Seniors & People with Disabilities Division (SPD)

SPD is responsible for

- State-Operated Community Programs (group homes)
- Oversight & planning: statewide accounting, ensuring adherence to state law and administrative rule, writing administrative rule, managing contracts with brokerages, children's group homes and children's intensive home services, managing state-county partnership agreements

State & federal funds,
technical support & training

Data & local program evaluation,
biennial implementation plan

Local Mental Health Authorities (County Commissions & Tribal Councils)

Counties and tribes are responsible for

- Local oversight & planning. They identify capacity needs within the local community and facilitate the development of group homes, foster homes, etc. Counties oversee local contract management, foster care licensing, quality assurance and protective services
- Service coordination, including crisis services, eligibility determination (gatekeeping), referrals, person-centered planning, and information and training of providers, families & community partners
- Contract services: counties contract with local providers for group homes, foster homes, supported living, comprehensive in-home support, vocational services and transportation services

State of Oregon Addictions & Mental Health Division (AMH)

AMH is responsible for statewide data collection and analysis, system planning and budgeting, the creation and enforcement of Administrative Rules in response to changes in the Oregon Revised Statutes, distribution of state and federal funds to counties for community-based services, and administration of Oregon State Hospital (Portland and Salem) and Blue Mountain Recovery Center.

Statewide planning,
state & federal funds,
training & technical support

Data & local program evaluation,
biennial implementation plan

Local Mental Health Authorities (County Commissions & Tribal Councils)

Counties and tribes are responsible for planning and overseeing the Community Mental Health & Addictions Program in their county or region. Some counties operate this program directly with county employees, through contract(s) with local non-profit organization(s), or a combination of county-operated and contracted services.

As agents of the state, counties are responsible for local administrative functions, including:

- Abuse reporting and follow-up
- Quality assurance and quality improvement
- Gatekeeping (ensuring lawful & appropriate access of public services)
- Planning and development, including workforce development and training and development of local facilities and service capacity
- Civil rights & public safety: clinical supervision and discharge planning for children and adults on safety holds or in civil commitment
- Contracting, contract monitoring, and site reviews of local services providers
- Data reporting, management, and documentation of public services
- Jail liaison & release planning
- Prevention and outreach to schools and the community
- Disaster planning
- Residential services
- Regular and systematic coordination with local and state agencies and commissions, including Oregon State Hospital, child welfare, jails and courts, and local community service organizations.

Local Partnerships

put the community in
Community Mental Health Programs
(CMHPs)

Public Health
CMHPs coordinate with local public health to coordinate outreach and disaster response

Local DHS Child Welfare
CMHPs screen children entering the child welfare system and provide care and referrals as needed

Local Mental Health and Alcohol & Drug Advisory Committee(s)
Local advisory committees ensure that the public, including mental health customers, have a voice in local planning and services

Physical Health Care Providers
CMHPs coordinate services with local federally qualified health centers, rural health centers, school-based clinics and extended care facilities

Community Hospitals
CMHPs respond to local emergency rooms for mental health evaluations

Housing, voc rehab, and employment agencies
CMHPs work with these local agencies to develop and maintain local capacity and to coordinate services

Private mental health and substance abuse providers
CMHPs act as the local coordinating and oversight body for quality assurance and ensure the most efficient and effective use of local public mental health and addictions dollars

Schools
CMHPs train school counselors to identify mental health crisis and are available on-call for crisis intervention on site

Community Mental Health & Addictions Program

The Community Mental Health Program is the array of coordinated public services available at the local or regional level.

Subject to the availability of funding, the Local Mental Health Authority is responsible for ensuring that a complete continuum of services exists for county residents and that those services are coordinated and responsive to the needs of the community and community partners.

These local partners are colleagues in protecting public health and safety.

Peer and Family Supports
AA, Dual-Diagnosis Anonymous, Oregon Family Support Network, etc.

County Courts/Judges
CMHPs are responsible for civil commitment investigations, reporting to the court, clinical supervision & discharge planning for people on involuntary public safety holds. They also coordinate with adult and juvenile drug, mental health, and family dependency courts.

Jails, Community Corrections, and Juvenile Justice
CMHPs provide services inside local correctional facilities and help people transition from incarceration back to the community

Sheriff and City Police
CMHPs coordinate with law enforcement on crisis response and often divert people in crisis from arrest to mental health crisis services

Local Commission on Children and Families

Public Safety Planning Committee
CMHPs are involved in the planning processes of other local public safety and human services agencies to ensure coordination of services and financial efficiency

Local employers and landlords
CMHPs nurture relationships with local businesses and landlords and act as trustworthy matchmakers between mental health customers and local employment and housing

Who are the mentally ill?

Mental illness is quite common; about one quarter of any population will suffer from a mental illness at any given time;¹ about ten percent of Oregonians are in need of drug or alcohol abuse treatment.²

People with less severe illness and those who have a strong support system or means to pay for treatment will never come in contact with community mental health programs. It is people with the most severe mental illness and people without a natural support system or the ability to pay for treatment and medication who use community mental health programs.

Who is served?

Oregon's public mental health system today serves two important roles: public safety and recovery from illness. Community Mental Health Programs are responsible for investigation and reporting to courts for involuntary civil commitment proceedings of persons whose mental state might pose a danger to themselves or others. Community programs also offer early intervention and recovery services for those children and adults who, without such public support, are likely to fall into costly cycles of homelessness, crime and incarceration, and repeated or long-term hospitalization.

Community Mental Health & Addictions Programs serve (as funds permit):

- Oregon Health Plan members
- People without insurance or other resources
- People who are civilly committed
- People under the jurisdiction of the Psychiatric Security Review Board
- Private pay customers (in some rural counties, the Community Mental Health Program is the only provider)

Who pays?

- The federal government through Medicaid matching funds and block grants
- State General Fund, some lottery and other funds
- County General Fund and in-kind contributions of county lands, facilities and human resources (varies by county)
- Philanthropic organizations including foundations and homeless shelters
- Uninsured individuals pay out of pocket on a sliding fee scale

The greatest cost actually accrues to our economy, businesses and families from *untreated* mental illness and addiction. An ECONorthwest study released in January 2008 estimated the cost of untreated addiction in Oregon in 2006 at \$5.93 billion.³ Depression alone, according to the World Health Organization, is the number one disease burden (loss of total years and loss of healthy years of life) in the Americas, trumping violence, heart and vascular diseases, alcohol-use disorders, traffic accidents, and brain and respiratory diseases.⁴

1 Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

2 AMH & DMAP. Outpatient Addiction Treatment Services Utilization Quarterly Report, November 2008. www.oregon.gov/DHS/mental_health/data/main.shtml

3 Whelan Robert, et al. "The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006, January 14, 2008". www.econw.com

4 http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_part4.pdf



The Supported Employment program at Options for Southern Oregon in Josephine County helped Jeff obtain the commission to create this mural on the outside of ROC, a local food bank. This led to more employment opportunities for Jeff when local businesses began to call for murals on their buildings. He also now displays his art work for sale at community art shows.

Supported Employment is an evidence-based practice which helps people with mental illness find and keep competitive employment within their communities.

How is community mental health different from traditional medical care?

Oregon’s community mental health system was born from a new state policy enacted in the mid 1960s to serve people at home in their communities instead of housing them for the rest of their lives in giant state institutions. The primary goal of the community system has been from the start to reach the people who fall through the cracks of traditional medical systems of care and keep this vulnerable population living safely in the community, out of state and private hospitals and out of jails and prisons.

This task requires local authority for budgeting and for establishing strategic alliances between federal, state, county and other local agencies, organizations and providers. It requires the flexibility to tailor clinical and business practices to subsets of people with unique needs. Community mental health program staff are much more mobile than other healthcare providers. For a variety of reasons, the people they serve will not always come to the mental health clinic for care, so programs have adapted over time to make home visits, meet people in parks, coffee shops, schools, jails, or wherever they have to in order to serve them in the most effective and most cost-efficient way.

Community Mental Health Programs are also responsible in statute for developing a local continuum of care; providing the right service at the right time is both clinically and financially sound.

Transparency, public accountability & outcomes

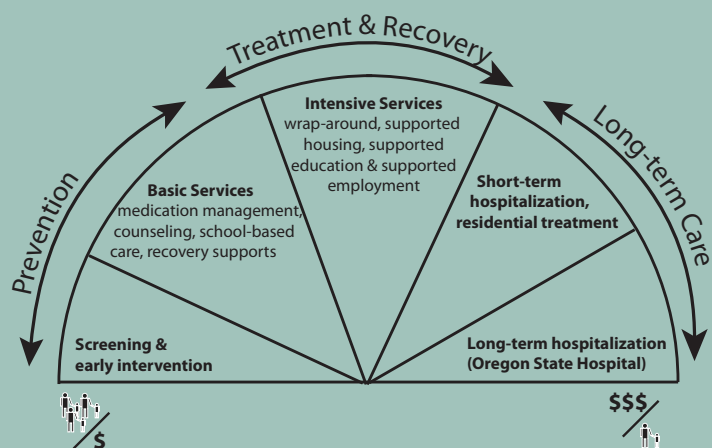
Community Mental Health Programs are highly accountable for the use of public funds. They are accountable to the state through state-county biennial contracts and implementation plans, monthly data reports on services provided, periodic site reviews by DHS, state certification and licensing requirements, and oversight by the Office of Investigations and Training.

Community Mental Health Programs are accountable to the elected county board of commissioners who are the Local Mental Health Authority and to local advisory committees. Their budgets are public record.

Information on service delivery is collected by the state data system and reported monthly and quarterly on the DHS website.¹ Community programs collect and analyze more detailed data on individual programs that are accountable to foundation and federal grantors.

¹ <http://www.oregon.gov/DHS/mentalhealth/data/main.shtml>

“Continuum of care”: the right service at the right time



As people stabilize and enter the recovery phase, they graduate to lower levels of care.

When they experience a set back, immediate access to more intensive services can quickly get them back on track. Counties from east to west work with their MHOs, with neighboring counties, cities, local providers and with business people to develop local capacity for a complete continuum of care.