MULTNOMAH COUNTY

Department of County Human Services
Mental Health and Addiction Services Division

Strategic Plan
2010 to 2013

April 5, 2010

MHASD MISSION: *To enhance and maintain high-quality, accessible, and culturally appropriate systems of care for children, youth and adults with mental illnesses and emotional and addictive disorders.*

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I. Purpose of this Strategic Plan

The Multnomah County Mental Health and Addiction Services Division (MHASD) is committed to providing evidence-based services that endorse a recovery philosophy and are integrated within a system of care. Our core values include consumer choice, prevention and early intervention, and responsibly managing a full system of care for vulnerable citizens of Multnomah County.

In this plan we identify our primary goals for strengthening the system over the next three years and the specific strategies we will use to achieve those goals.

Consumers, providers, advocates, community partners, and other stakeholders have contributed to this plan in the past few years. These groups include: the Children's Mental Health System Advisory Committee (CMHSAC), the Adult Mental Health and Substance Abuse Advisory Council (AMHSAAC), the Local Public Safety Coordinating Council for Multnomah County (LPSCC), the Multnomah County Commission on Children, Families and Community (CCFC), and our many provider organizations, including culturally specific providers.

While this plan identifies multiple long-term goals, we are prioritizing three projects initially:

- **Wraparound Services for Children, Youth and Families** – We will actively support the transition of this program to administration by the Department of County Human Services.

- **Crisis Assessment and Treatment Center** – We will develop a Crisis Assessment and Treatment Center (CATC) as an alternative to hospitalization for adults experiencing a mental health crisis who don't require medical services.

- **Integration of Physical Health and Mental Health and Addictions Services** – We will work with fully capitated health plans to deliver integrated health care and services throughout the County.

We welcome feedback from the community and partners on this plan, as well as ideas for future planning efforts. Together we can use this Strategic Plan to guide us as we make decisions about system improvements both immediately and over the next few years.

II. Need for Services: Individual, Family, Community

Mental illness affects individuals and families in every community. Data from the World Health Organization's *Global Burden of Disease* study indicates that mental illness is the second leading cause of disability worldwide after heart disease, outranking even cancer.[1] Mental illnesses were found to account for over 15 percent of all disabilities in major industrialized countries. In addition, the study indicated that suicide was a leading cause of violent deaths worldwide, and the 11th leading cause of death among Americans in 2000[2].

Nationally, one of four adults suffers from a diagnosable mental illness in any given year.[3]

According to National Institute of Mental Health, one in ten children[4] has a mental health condition. The President's New Freedom Commission Report states that 7% to 9% of young children have emotional needs serious enough to require clinical intervention.[5] In reviewing a sample of 95 public and private juvenile facilities, researchers found that 73% of the youth in these facilities reported mental health problems, as cited by Mental Health in America.[6]

Nationwide, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) notes that one in every thirteen adults (7%) have alcohol abuse or dependence problems.[7] The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reported in their 2007 *National Survey on Drug Use and Health* that, of people age twelve or older, 8% used illicit drugs[8] and 9% needed treatment for their drug or alcohol use problem. Of those in need, 89% did not receive treatment in the prior year.[9]

Many people in our community would benefit from prevention, or mental health or addiction services, but do not have health insurance. State and County general funds are insufficient to pay for treatment for everyone who is low income and needs services but is not eligible for the Oregon Health Plan.

III. Challenges: Funding and Coverage

Mental health and addiction services for Oregonians who are uninsured are not well funded. This can result in high personal impacts for people with a serious mental illness or addiction, as well as increased costs to the public in other systems, such as jails or foster care. Four factors contribute to this current situation.

1) **Insufficient funding is dedicated to prevention programs.** As a result, too many people develop serious mental health and addictions problems. Prevention and early intervention can avoid a lifetime of misery resulting from an untreated addiction or mental illness. Public costs due to repeated crises or incarceration can be avoided, and individuals and families can be helped to maintain healthy and productive lives.[10]

   Proven addiction prevention programs reach only 9% of at-risk children and youth in Multnomah County.[11] The County's Early Assessment and Support Alliance (EASA) reaches people under age 25 who are experiencing a first episode of psychosis, when treatment can be most effective. Such early treatment is more successful and can prevent a severe mental illness; however, EASA is only funded to serve 85 young people a year.. With additional general funds from the State, this program could be expanded to reach more young people.[12]

2) Too few people have health insurance coverage, including a mental health benefit. The national debate on health care has highlighted the fact that a large number of people nationwide people have no insurance coverage for their health or mental health needs.

Many people with a mental illness were forced out of the Oregon Health Plan (OHP) in 2003 due to funding cuts. Also in 2003, Oregon eliminated its General Assistance (GA) program, which provided cash assistance of $314 a month plus OHP enrollment to 1,090 low-income County residents with disabilities, while waiting for determination of their Supplemental Security Income or Social Security Disability claims. At the same time, the State's Medically Needy program was eliminated, which provided medical coverage for 1,955 County residents who were slightly over OHP income levels, but had high medical costs.[13]

In 2008, when the State reopened the OHP Standard program, over 83,000 people signed onto the waiting list for 8,000 available slots.[14]

Multnomah County now provides mental health services to 33% fewer adults than in 2002, largely due to these cuts. Children have been continuously eligible for OHP, so the number of children served has remained about the same. Nevertheless, the need for health coverage is currently very high.[15] Uncovered individuals lack not only health care, but the mental health or addictions treatment, medications and case management they may need as well.[16]

Multnomah County Verity Enrollment and Mental Health Services: 2002-2008[17]

People enrolled and people served by Verity MHO	2002	2007*	change from 2002	2008*	change from 2002
Unduplicated adults enrolled	*68,539*	*40,900*		*42,441*	
Unduplicated adults served	9,975	6,983	-30%	6,488	-33%
Unduplicated children enrolled	*48,845*	*52,733*		*52,747*	
Unduplicated children served	4,187	4,096	-2%	4,164	-1%
Total unduplicated served	**14,162**	**11,079**	**-22%**	**10,656**	**-25%**

* Part of the drop in Verity enrollment is due to enrollment in another MHO or state program.

Despite a nationwide economic downturn, the 2009 Oregon Legislature voted to expand OHP coverage with a plan to cover 95% of the state's needy children through the Healthy Kids program,[18] and fund an additional 35,000 adults in the OHP Standard program. Lotteries will be held to fill these new slots. However with about 141,000 uninsured adults living in poverty statewide, this plan will address only a quarter of the need.[19]

3) The State plan to deinstitutionalize more people from the State Hospital system and into the community is underfunded. The State's Community Services Workgroup estimated that statewide costs for community services necessary to support the State Hospital Replacement Plan would be $91 to $105 million per biennium.[20] Multnomah County (with 20% of the state's mental health need) would require $9.1 to $10.5 million more per year.

State funding for community mental health and addiction services was maintained by the 2009 legislature at about the level of the prior biennium, with only a few cuts, such as in

addiction prevention. This was possible due to Federal stimulus funding, which increased the federal match for Medicaid services as long as the state maintained service levels. However, there is a risk of budget reductions when Federal stimulus funding ends.Also, the State budget included no cost of living increases or service expansion funds.

4) State and County funding cannot support the demand for non-Medicaid services. Almost all State funds for mental health and addiction services are for specific populations or purposes, or are committed to matching the federal Medicaid program, which covers only medically necessary services. Oregon Health Plan (Medicaid) funds are restricted to pay Medicaid providers serving Medicaid enrollees.

Yet the community has a need for programs like sobering, peer-delivered services and culturally specific treatment that are not typically reimbursable by Medicaid/Oregon Health Plan, or that uninsured people can access.

IV. MHASD Overview: System for Services

The Mental Health and Addiction Services Division (MHASD) operates within Multnomah County's Department of County Human Services (DCHS).

> ***MISSION:*** *To enhance and maintain high-quality, accessible, and culturally appropriate systems of care for children, youth and adults with mental illnesses and emotional and addictive disorders.*

MHASD manages the public system of care for children, youth and adults with mental illnesses, or emotional or addictive disorders. In partnership with the community, MHASD makes ongoing improvements to the availability, accessibility, and quality of prevention and treatment services.

Most of the MHASD business is contracted to mental health and addiction treatment agencies. Some specialized services, like school based mental health and involuntary commitment investigation, are not contracted out and instead are performed by County staff.

Therefore a large part MHASD's role is provider network management. Assessing the needs of our County, advocating at the local, state and federal levels, purchasing services from provider agencies, contract management, fiscal monitoring, technical assistance, provider relations and communication, developing performance measures, monitoring outcomes, and other quality and regulatory functions are a significant part of the work performed by MHASD staff.

The County has increased its focus on prevention and early intervention programs including early childhood mental health, school-based mental health, care coordination for high-need children and youth, and the Early Assessment and Support Alliance (EASA) early psychosis intervention program for teens and young adults.

Although crisis programs are available to the entire community, there are several variables that determine whether MHASD is able to provide ongoing care to an individual. First, the majority of mental health services are for individuals enrolled in the Oregon Health Plan. Eligibility for enrollment is based on several factors, including income. Second, some County or State general

funded programs are only budgeted to serve uninsured, low-income individuals diagnosed with a severe mental illness, in addition to qualifying risk factors. Addictions programs are accessible to uninsured or underinsured in the community. Finally, some of the more intensive levels of care, such as residential addiction treatment, can have waiting lists and may not be able to immediately accept the individual into treatment.

The programs within the MHASD system of care vary in intensity, frequency of services, and duration. The crisis system of care built by MHASD is available to any resident of the County. However, emergency intervention is, by its nature, brief and is generally limited to one or two contacts. For a more comprehensive course of care, a client seeking mental health treatment must be eligible for one of the following: Oregon Health Plan, Multnomah Treatment Fund, or one of several small specialized categorical programs (see the Appendix: Eligibility Categories). Someone who needs addiction treatment and is uninsured can go to any of the providers under contract with MHASD. These programs are funded primarily by State and local funding, and capacity is subject to the availability of that funding.

The Mental Health and Addiction Services Division serves more than 4,300 of the County's most vulnerable residents every month, either directly or through one of its provider agencies. This results in service to 24,000 adults and children each year in all programs, including prevention – about 3.5% of the County population. Though many get the help they need, others do not seek help because they are unaware that a mental illness or addiction can be effectively treated, or because they do not have insurance coverage or the money to pay for services out of their own income.

V. Progress Report: Developing a Comprehensive System of Care

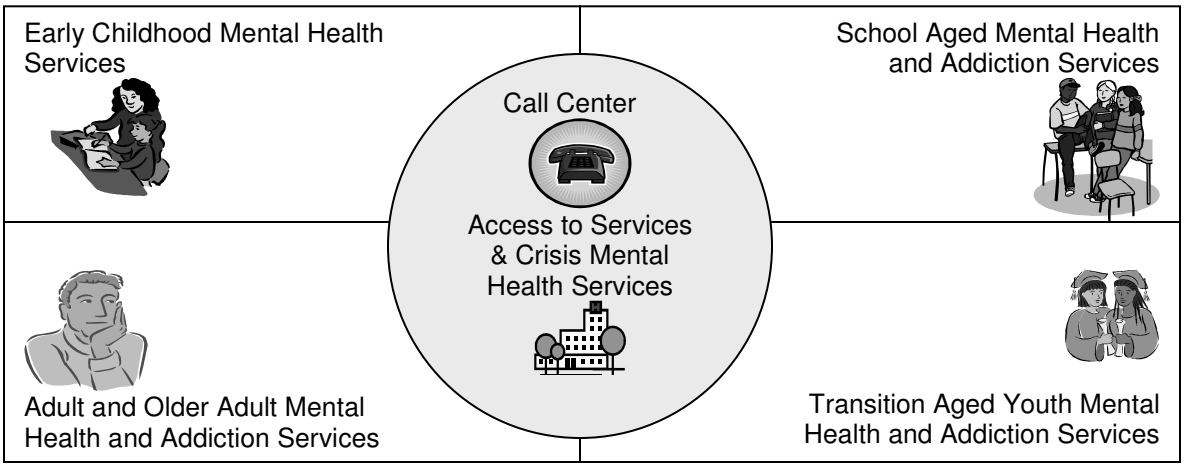
At the end of 2001 MHASD published a Mental Health Redesign Plan, which identified the changes necessary to implement a consumer-focused system of care, based on developmental and recovery models. The majority of those changes have been implemented.

The Plan identified seven key elements as necessary to exist within the system of care: easy and timely access, prevention and early intervention, care coordination, treatment services, support services, acute care, and protective services. The plan set out strategies to develop each element.

Most of the Redesign Plan's goals have been achieved. Over the past six years, MHASD has made the following major system improvements:

- **Call Center** – the 24/7 hub of the mental health system, including access to information about mental health and addiction services, and crisis system response coordination.
- **Crisis Response Teams** – 24/7 mobile mental health outreach teams that partner with the Call Center and an Urgent Walk-In Clinic to provide on-site crisis services.
- **System of Care** – an effective approach for delivering coordinated, culturally competent mental health and addiction services so that children, youth, adults and elders receive evidence-based care in a manner appropriate to their needs and circumstances. Our goal is to ensure that services are evidenced-based, integrated from both a management and clinical perspective, and able to work together effectively for children, families and adults.

Multnomah County Mental Health and Addiction System of Care



- **System of Care for Children and Families** – In 2005, MHASD implemented the State's **Children's System Change Initiative**. The goal of the initiative was to better address the needs of children and youth placed, or at risk of placement, in psychiatric residential treatment services. As a result of that initiative, many more children are now served in community-based programs such as Intensive Community Treatment Supports (ICTS). MHASD and community partners have continued collaborations to improve high-intensity services for children and youth in the community, including Wraparound services for children school aged and younger.
- **Cultural Competency** – MHASD expects all providers to deliver culturally competent services. To reach underserved populations, County general funds are used to contract with culturally specific agencies. The County has identified the underserved populations as follows: African American, Latino, Eastern European, Native American, and Asian.
- **Mental Health Organization (MHO)** – The County created a Mental Health Organization to contract with the Oregon Health Plan (OHP) in Multnomah County, and manage the mental health insurance benefit for OHP members enrolled in Verity, our MHO. As part of this we implemented a business methodology to ensure that service data is accurately captured, and to manage costs in the State's capitated (per person) payment model. Our business model for reimbursement of our contracted providers is a fee for service payment system.

VI. Strategic Goals: 2010 to 2013

MHASD strives to develop and maintain a person-centered system of care for individuals with a mental health or addiction disorder. This system of care incorporates evidence-based practices and endorses a recovery philosophy. Our goals and key strategies to accomplish them are below.

System Goal: To develop and maintain a system of care that meets the treatment needs of children, families and adults facing a mental health or addiction issue.

Strategic Goals:

I. Involve consumers and families in planning and delivery of services.
II. Enhance the system of care to better meet the needs of consumers.
III. Integrate physical health care with mental health and addiction services.
IV. Strengthen financial and system accountability.

Note: Strategies that appear in *italics* on the following pages require funding that is not currently available.

Goal I. Involve consumers and families in planning and delivery of services.

Community based services must give consumers and families meaningful involvement in planning and delivery of services, as well as choices about their own treatment. Effective services improve one's ability to meet challenges and move toward recovery, leading to the reduction or remission of symptoms and a more productive life. The consumer movement has raised awareness that practical services and peer supports are critical to building resilience and improving functioning. When resources such as housing, treatment, supported education, employment opportunities and peer supports are available and well-funded, individuals with serious mental illness can live successfully in the community.

Key Strategies:

1. Improve public awareness of MHASD programs.
2. Support implementation of the new Family Navigators programs.
3. Enhance peer-to-peer support services.
4. *Create a consumer advocate position in MHASD.*

Goal II. Enhance the system of care to better meet the needs of consumers.

MHASD is responsible for maintaining systems of care appropriate for each level of treatment needs. A complete system of care can meet individual needs better than a "one-size-fits-all" system that treats all illnesses with the same level of intensity. The system of care could be improved in the following areas to better meet the needs of our community.

Key Strategies:

1. Target all at-risk youth with an effective addiction prevention message.
2. Transition the operation of Wraparound services for children, youth and families to a sustainable Administrative Services Organization (ASO) under the Department of County Human Services.

Priority Project: Wraparound Services for Children, Youth and Families

Children and youth with complex emotional or mental health needs often receive costly, fragmented care, leaving families frustrated. "Wraparound" is a model that creates child and family teams for high need children. A team creates and manages one plan of care across multiple agencies and resources.

The community chose DCHS to be the Administrative Services Organization (ASO) responsible for managing funds and the overall Wraparound project. Multnomah County plans to transition to a sustainable model, with funding based on Medicaid reimbursement and blended funds from state and local partners.

Work is underway to transition the school-age program by July 2010, and the early childhood program two years later. The Wraparound program will be planned and overseen by a Collaborative Partnership Council.

3. *Expand access to mental health treatment for individuals with no insurance.*
4. Expand evidence-based peer clubhouses that incorporate supported employment.
5. *Develop a Crisis Assessment and Treatment (sub-acute) Center for adults.*

> **Priority Project: Crisis Assessment and Treatment Center for adults.**
>
> Crisis assessment and treatment for adults is not currently available outside a hospital in our system. The Crisis Assessment and Treatment Center will treat individuals in our community who are experiencing a mental health crisis, but who do not need medical services and are not appropriate for inpatient hospitalization or incarceration. Since persons will remain linked to the community, length-of-stay will be minimized and the individual will be more likely to return to their existing services and housing.
>
> Admissions to a 16-bed secure facility would last a week on average, including assessment, initial treatment, and development of a stable medication regimen. Treatment periods may be shorter, allowing more people to be served.

6. Advocate for adequate funding for:
    - State general funded mental health, residential, and addiction services;
    - Oregon Health Plan (OHP); and
    - increased community-based mental health services, including a supported housing gatekeeper for people transferring from State Hospital, as a part of the State Hospital Redesign plan.

Goal III. Integrate physical health care and mental health and addiction services.

The Surgeon General's 2000 report cites that mental disorders occur along with physical disorders in 20-80% of primary care patients.[21] The Oregon Health Fund Board recently found that chronic behavioral health conditions account for significant negative health outcomes and a large portion of health care spending in Oregon.[22] Studies show that adults with medical disorders have high rates of depression and anxiety, which if untreated can become debilitating, limiting an individual's ability to participate in family, work and community activities.[23] Depression can negatively effect self-care and reduce adherence to treatment for chronic medical illnesses, leading to medical complications.[24]

Recent data from several states have found that people with serious mental illness served by our public mental health systems die, on average, 25 years earlier that the general population. [25]

Delivery of care that includes both mental and physical components can prevent the development of more serious conditions, improve the quality of life for a great number of individuals and produce better treatment outcomes. Mental health and addictions services and physical health care are inextricably linked, and both systems of care should be provided and coordinated within an integrated delivery system.[26]

Key Strategies:

1. Work with fully capitated health plans to develop integrated health care and mental health and addiction services throughout the County.

Priority Project: Integrate physical health care and mental health and addictions services.

As the system is currently arranged, physical health care, addictions treatment and mental health treatment are delivered in separate settings. By delivering integrated care in a single setting, individuals have better access to care and improved overall health.

MHASD will develop a workgroup with representatives from the physical health care delivery system to explore areas where service can be integrated or funding could be blended. This effort will incorporate results from the State Health Services Fund Board. MHASD will also work with the State on the Integrated Health Care Initiative.

2. Improve access to integrated care at current service locations.

Goal IV. Strengthen financial and system accountability.

Multnomah County MHASD and its contracted providers share the responsibility for the fiscal and clinical health of the systems of care. As the Local Mental Health Authority, MHASD retains responsibility for planning, developing and maintaining the overall system of care; managing the funding; and ensuring that quality services are available for the community.

Providers are required to use a level of care assessment tool and submit payment claims for the services they deliver. This allows us to monitor whether the amount and type of treatment matches the level of care at which the client was initially assessed. The provider uses evidence-based or best practices to deliver treatment services, manage its budget, and coordinate with other agencies on behalf of the person or family in its care.

In recent years the provider network has expanded to include new agencies. This not only keeps the system more resilient but gives consumers more choice when considering treatment. MHASD will continue these expansion efforts which will reflect the needs of the community.

We have also been working with providers to improve services. Over the past few years, when a new concept or best practice has been identified that would be beneficial for our system, we have brought in national experts to provide training for our providers. Pay-for-performance incentives are now being used to strengthen and support changes to the system. Pay-for-Performance also takes into account the expenses those providers may incur as the changes are being implemented.

In addition to audits performed by the quality management staff within MHASD, we regularly review providers' spending to assure that agencies are staying within their outpatient budgets. If a provider is projected to be over budget at their current spending levels, they are requested to develop a plan to resolve that, and MHASD closely monitors the providers' progress towards the changes in their plan. In addition, we meet monthly with the largest providers to review financial reports and productivity levels.. The Department of County Management also performs fiscal and management reviews of County contractors.

Consumers and family members are involved in individual treatment planning for themselves and their families, and in developing the overall system of care. We have been using advisory committees and consumer group meetings to gather input and discuss ways to strengthen and

improve specific services and the system of care. MHASD is increasing our efforts to share information transparently with consumers and families, and to provide meaningful roles in shaping the service system.

Key Strategies:

1. Develop and implement financial incentives for providers to deliver services based on defined service priorities.
2. Increase technical assistance, improve methods of monitoring the financial health of providers, and continue monitoring of adherence to contractual requirements.
3. Use pay-for-performance to strategically enhance and incentivize providers to improve and/or change their services.
4. Expand the use of data when making decisions about the system of care.

VII. Information and Feedback

Management from MHASD is available to present on this plan and listen to your comments and suggestions for the future. Feedback from consumers, family members, advocacy groups, providers, citizens of the County and other stakeholders is welcome at any time and will be sought during periodic plan updates.

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MHASD System of Care – Strategic Plan Framework

Strategic Goals:	**I. Involve consumers and families in planning and delivery of services.** **II. Enhance the system of care to better meet the needs of consumers.** **III. Integrate physical health care and mental health and addictions services.** **VI. Strengthen financial and system accountability.**

Prevention	Access/Crisis Intervention	Care Coordination	Treatment Services	Recovery Support	Acute Care
Overview of Existing Mental Health and Addiction System of Care:					
• Addiction prevention and education for youth • EASA (Early Assessment & Support Alliance)	• 24/7 Call Center • 24/7 Mobile Crisis Outreach • Urgent Walk-In Clinic • Respite • Sobering • Detox • Family Navigators	• Verity Member Services/Care Coordination • Acute Care Coordination • Residential & Commitment Coordination • Case Management	• Medications • Individual and Group Therapy • Community based treatment • Residential treatment	• Supported Housing •Alcohol/Drug Free Housing • Supported Employment • Peer Services • Multi-Family Groups • Vocational/ Occupational Therapy	• Hospital • Sub-acute care (children)
Goal I. Involve consumers and families in planning and delivery of services:					
• Improve public awareness of MHASD programs.	• Support implementation of new Family Navigators programs.			• Enhance peer-to-peer support services.	
Systemwide: • *Create a consumer advocate position in MHASD.*					
Goal II. Enhance the system of care to better meet the needs of consumers:					
• *Target all at-risk youth with an effective addiction prevention message.*	• *Maintain sobering program.*	• **Support transition of Wraparound services to County DCHS administration** • *Expand access to MH treatment for those with no insurance.*	• *Add intensive supported addiction treatment.* • *Add flexible family support funding.*	• *Expand evidence-based peer clubhouse w/ supported employment.* • *Expand transitional housing*	• **Develop a Crisis Assessment and Treatment Center for adults.**
Advocate for: • Adequate funding for mental health and addiction services, and the Oregon Health Plan. • Adequate mental health consultation at state-funded Head Start programs. • A supported housing gatekeeper for people transferring from State Hospital • Increased community-based care funding within the State Hospital Redesign plan.					
Goal III. Integrate physical health care with mental health and addictions services:					
Systemwide: • **Work with fully capitated health plans to develop integrated health care and mental health and addiction services.** • Improve access to integrated care at current service locations.					
Goal IV. Strengthen financial and system accountability.					
Systemwide: • Develop financial incentives for providers to deliver services based on service priorities. • Increase technical assistance and monitoring of financial health of providers. • Use pay-for-performance incentives to enhance and update the service system. • Expand the use of data when making decisions about the system of care. • Provide technical assistance and monitoring to improve access to culturally competent care. • Provide technical assistance and training to improve provider clinical skills.					

Note: *Items in italics require additional funding.* **Bold items are priority goals.**

Appendix 1: Strategic Goals with Detailed Strategies

Notes: Layout follows the Strategic Plan Framework (see prior page).
Italicized items require additional funding to implement.

System Goal: To develop and maintain a system of care that meets the treatment needs of children, families and adults facing a mental health or addiction issue.

Strategic Goals:
I. Involve consumers and families in planning and delivery of services.
II. Enhance the system of care to better meet the needs of consumers.
III. Integrate physical health care with mental health and addiction services.
IV. Strengthen financial and system accountability.

Goal I: Involve consumers and families in planning and delivery of services.

PREVENTION

1. **Improve public awareness of MHASD programs.**

   a. Issue: Many people are not aware of current or new MHASD programs or how to access them.

   Strategy: Work with department and County liaisons to implement a media schedule for the year. Emphasize aspects of MHASD of special interest to the community, service partners, legislators and other decision-makers.

   b. Issue: Readily available information about services could improve access, but the current website is difficult for consumers to use.

   Strategy: Redesign website to be more user-friendly with up-to-date information.

   c. Issue: Many consumers lack web access; partners could circulate a print newsletter.

   Strategy: Create a printed newsletter for consumers and partners.

ACCESS/CRISIS INTERVENTION

2. **Support implementation of new Family System Navigators programs.**

   Issue: Families with children with high needs may not have experience in utilizing the mental health system or advocating for themselves and their children.

   Strategy: Provide technical assistance and support for the new Family System Navigator contracts with NAMI and OFSN, which help increase parent/family involvement in determining care plans for their children.

RECOVERY SUPPORT

3. **Increase the amount of peer supports and peer-delivered services in the system of care.**

   Issue: Peer supports and peer delivered services are an important part of an effective recovery program but are not available throughout the system.
   Strategy: Encourage providers to increase use of peer supports. Continue to support providers who deliver evidence-based supported employment programs.

SYSTEM-WIDE

4. ***Add a consumer advocate position to MHASD staff.***

   Issue: There is no existing MHASD staff position to represent the consumer viewpoint in planning and delivering services.
   Strategy: Create a consumer advocate position within MHASD to provide informal assistance, facilitate access to services and incorporate a consumer perspective. Increase the availability of existing NAMI and OFSN advocates.

Goal II. Enhance the system of care to better meet the needs of consumers.

PREVENTION

1. ***Reach all at-risk youth with an effective addiction prevention message.***

   Issue: The existing prevention program has been shown to cut youth alcohol, drug, and tobacco use in half, and to improve family bonding and adult parenting skills, as well as school success and youth life skills throughout middle and high school.
   Strategy: Using proven curricula, coordinate with community programs, such as Oregon Partnership and Strengthening Families, to deliver 8-10 week classes for all at risk 5th graders.

ACCESS/CRISIS INTERVENTION

1. ***Maintain Sobering program at current levels.***

   Issue: The Sobering Station provides a safe place for intoxicated individuals to sober up, serves a critical public safety function, and is a motivator for detoxification and treatment.

   Strategy: Advocate for continued use of County General Funds to support the Sobering Station, which has an average of 11,000 admissions annually.

2. **Transition the operation of Wraparound services for children and families to an Administrative Services Organization (ASO) under the Department of County Human Services.**

   Issue: Wraparound programs have proven to be effective for children with higher needs and their families by improving service coordination and strengthening family voice in treatment decisions. A Governor's Order allows for local administration of Wraparound programs using existing funds for flexible services.

   Strategy: Transition the Wraparound School-Age program operations to a County ASO by July 2010. Work with the State to develop necessary legal and funding strategies. Manage the pool of funds contributed by Wraparound partners. Issue an RFP for Wraparound care management.

3. ***Expand access to mental health treatment for non-covered individuals.***

   Issue: A large number of people who need treatment for a mental illness or addiction are uninsured. Many no-income or low-income county residents are currently not eligible for the Oregon Health Plan. Multnomah County now serves fewer people on OHP than in 2002, largely due to eligibility restrictions.
   Strategy: Advocate for expanding OHP eligibility to cover more individuals.

TREATMENT SERVICES

1. ***Provide flexible funding for family support.***

   Issue: Low-income families can encounter barriers to participating in their child's treatment. These barriers can include not having money for childcare or transportation. State and federal funding is restricted to direct care and can't be used for these supports.
   Strategy: Eliminate the barrier by developing an integrated or blended funding stream to pay for family support needs, the invisible costs of treatment.

RECOVERY SUPPORT

1. ***Expand the availability of evidence-based peer clubhouses with supported employment.***

   Issue: Supported employment has been shown to be the most effective means for returning an individual to productive work. Evidence-based clubhouse participants achieve high employment rates (60%), and earn higher wages for more weeks than other models. Yet there is no evidence-based clubhouse with a supported employment component in the County's system of care.
   Strategy: Work with NAMI to develop a supported employment component at Northstar House, a consumer-run clubhouse for individuals living with the effects of chronic mental illness. Participants will have opportunities to rejoin the worlds of friendships, family, employment and education.

2. ***Expand residential care in transitional housing settings.***

   Issue: People leaving a hospital setting need a transitional setting to bridge the gap to community care. Currently over 300 people per year are referred to residential services in the County, with 110 served by transitional residential care, and 65 moved to permanent housing.

   Strategy: With increased funding for transitional care, individuals would have housing support services while living in single-room transitional housing settings (housing paid separately), with on-site mental health treatment, as well as outreach and case management.

ACUTE CARE

1. ***Develop a Crisis Assessment and Treatment Center for adult crisis stabilization.***

   Issue: An alternative to hospitalization is a missing part of the existing system of care. Such a "sub-acute" alternative is appropriate when an individual's symptoms escalate beyond those manageable in an outpatient setting. Since persons remain linked to the community, length of stay is minimized and the individual is less likely to lose housing.
   Strategy: Admissions to a 16-bed secure facility would last a week on average, including assessment, initial treatment, and development of a stable medication regimen. Cost is projected at approximately $700 per day, compared to $850 to $925 in a hospital. Treatment periods may be shorter, allowing more people to be served.

SYSTEMWIDE

1. **Provide technical assistance and monitoring to improve access to culturally competent care.**

   Issue: People from many different cultural backgrounds live in Multnomah County. Services are most effective when they work with an individual's cultural identity and needs.

Strategy: Provide training and technical support to providers on best practices in culturally competent care. Monitor outcomes for new culturally specific providers and all service delivery providers, based on requirements in their contracts.

2. **Provide technical assistance and clinical training to providers.**

   a. Issue: Assessment tools support accurate delivery of the right kind and amount of services to meet individual needs. Due to personnel turnover, annual training is needed to maintain and improve clinical skills.

   Strategy: Conduct LOCUS training on adult assessment and CASII training on children's assessment annually.

   b. Issue: Clinical providers need a high level of skill in management of care decisions to achieve the best outcomes for their clients.

   Strategy: Provide training and technical support to the provider system to incorporate evidence-based practices and outcome measures to improve clinical skills.

ADVOCACY

1. **Advocate for adequate funding for State general funded mental health, residential, and addiction services from the Oregon Legislature.**

   Issue: State general fund levels directly affect the availability of services.
   Strategy: Identify issues for the 2010 legislative agenda, work with elected officials and advocates to achieve the best outcomes possible from funding decisions.

2. **Advocate for adequate funding of the Oregon Health Plan (OHP).**

   Issue: If the State budget is reduced there is a risk that program cuts will result in a loss of federal match money. The current federal match rate will likely drop to normal levels with the end of the stimulus package.
   Strategy: Identify issues for the 2010 legislative agenda, work with elected officials and advocates to achieve the best outcomes possible from funding decisions.

3. **Advocate for a supported housing gatekeeper for people transferring from the State Hospital.**

   Issue: Adult residential treatment facilities and supported housing are in short supply statewide. It requires staff to facilitate the initial placement and then monitor a person discharging from the State Hospital.
   Strategy: Advocate for funding to create a supported housing gatekeeper position for individuals transitioning from the State Hospital.

4. **Advocate for funding of community-based services as part of the State Hospital Redesign plan.**

   Issue: There is insufficient community housing and service capacity to meet the needs of clients moving into the community as a result of the State Hospital downsizing.
   Strategy: Advocate for increased housing and service funding through State sponsored workgroups planning the redesign of the State Hospital.

Goal III. Integrate physical health care and mental health and addiction services.

SYSTEM-WIDE

1. **Work with fully capitated health plans to develop integrated health care and mental health and addiction services throughout the County.**

   Issue: Physical health care and mental health and addictions services are currently delivered in separate settings. Health professionals in the individual systems may not have the expertise to identify a problem that requires treatment from another system.
   Strategy: Convene a workgroup comprised of MHASD and representatives from physical health to explore opportunities for service integration, how to blend funding, and define integration action steps. Implement the recommendations made by the State's Health Services Fund Board.

2. **Improve access to integrated care at current service locations.**

   Issue: Individuals seeking help for mental illness or an addiction can benefit from on-site health care.

   Strategy: Complete protocols for Integration Pilot Project through Multnomah County Health Department Medical Clinics. Evaluate effectiveness of pilots that place an RN in a MH clinic.

Goal IV. Strengthen financial and system accountability.

SYSTEM-WIDE

1. **Update provider rates to better match clinical priorities.**

   Issue: Rates paid for services should be based on sound, updated assumptions about reasonable productivity levels and costs, and provide an incentive to deliver services aligned with best practices and preferred settings.

   Strategy: Update rates for use in new provider procurements. Increase focus on rewarding use of best practices and delivery of services in preferred community-based settings.

2. **Increase technical assistance, improve methods of monitoring the financial health of providers, and continue monitoring contractual requirements.**

   Issue: Existing monitoring systems have not adequately measured a provider's financial health to assure stability of client services.

   Strategy: Strengthen MHASD monitoring of providers' financial situation, including through review of key financial reports, to assess financial stability and accountability.

3. **Use pay-for-performance incentives to enhance and update the service system.**

   Issue: When changes or improvements to services or the system are needed, it can be hard for providers to make these changes due to the additional work or expense involved. Incentives can to help achieve desired outcomes, while taking into account the providers' expenses.
   Strategy: Use pay-for-performance to strategically enhance and incentivize providers to improve and/or change their services.

4. **Increase the use of data when making decisions about the systems of care.**

   Issue: MHASD would benefit from a uniform way to measure outcomes across the system. Numerous funding streams with different reporting requirements have resulted in variation in how performance and outcomes are measured.

   Strategy: Improve outcome management by centralizing analysis of provider data. Continue to implement outcome instruments such as ACORN and CANS. Establish a system for utilizing the data in the decision-making process at the most effective time.

#

Appendix 2: Need for Services Requiring Additional Funds

1. PREVENTION

Prevention programs reach youth and families with information about alcohol and drugs, and support positive activities. Prevention can be targeted to universal, selective (at-risk), or indicated (high-risk) populations. Some prevention and early intervention programs have been proven to be highly cost effective in reducing later problems.[27] Early treatment for an addiction or mental illness works in reducing the devastation that can result throughout a person's life.[28]

State Addiction and Mental Health (AMH) states that all of the County's 153,000 youth who are age 0-17 would benefit from universal prevention services; 61% are at above average risk for addiction or mental health disorders.[29] Currently, proven alcohol and drug prevention programs reach only 8,050 (9%) of at-risk youth in our County.[30] In a 2007 comprehensive review of County addiction prevention, the main programmatic recommendation was for a system-wide early prevention program that involves parents.[31]

2. ACCESS/CRISIS INTERVENTION

When an individual or family recognizes the need for mental health or addiction services, quick and effective access to services is essential. The County offers that easy access through the Call Center, which also serves as the hub for the crisis system.

However, the system of care can be difficult to navigate sometimes. It can be helpful to have assistance or advocacy in getting one's needs met. The County contracts for Family Navigators to help consumers and their families get to the right part of the system for their needs.

3. CARE COORDINATION

Case managers help consumers access supports, such as stable housing and physical health care, that are necessary to be successful in mental health or addictions treatment. However, many people have no way to cover these expenses, are too disabled to work, and face a several-year process to apply and be approved for federal SSI or SSD benefits. Since elimination of the General Assistance program, there is no source of income while awaiting a federal decision.

When certain risk criteria are met, the County's Multnomah Treatment Fund pays for time-limited mental health services for people with severe mental illness who have not yet been approved for disability benefits or Medicaid. In 2008, 822 people were served in the Multnomah Treatment Fund.

4. TREATMENT

The community outpatient treatment system for mental illness and addictions uses evidence-based practices, augmented with proper use of medications, to help people manage and recover from the effects of their condition. Treatment has been shown to be highly effective:[32]

- 50 to 80% of people with mental illness improve significantly and experience reduced symptoms with appropriate medications.[33]
- 78% of children receiving school-based mental health services in Multnomah County showed improved school behaviors, and 75% had improved attendance.[34]
- Washington State Institute for Public Policy found that evidence-based mental health and addiction treatment works, achieving a 15 to 22% reduction in incidence or severity, and $3.77 in benefits per dollar of treatment cost.[35]
- A 24-state analysis showed that alcohol and drug addiction treatment was effective under virtually all conditions, regardless of which indicator and measure was used, regardless of setting, modality, or target population.[36]
- In Oregon, residential addiction treatment achieves almost 60% recovery. Even for those who do not finish treatment, substance abuse and use of health care services is reduced.[37]
- In Oregon, for every dollar invested in addiction treatment, $5.60 is saved.[38]

Unfortunately, too few people have insurance coverage to help pay for services, and thus lack access to the service they need.

5. RECOVERY SUPPORT

To be successful in their recovery, people need more than treatment. Housing is essential.[39] Employment is the factor most highly linked with improved individual outcomes.[40] Many benefit from peer support, which helps integrate new behaviors into long term recovery.[41]

6. ALTERNATIVE TO HOSPITALIZATION

Multnomah County does not currently have “sub-acute” services as an alternative to hospitalization for adults. Yet an alternative program, located in a secure non-institutional location where assessment and stabilization can occur, is a key component of a system of care for individuals experiencing a mental health crisis. Law enforcement is currently forced to choose between hospital admission and incarceration – both more restrictive and often more expensive than necessary to meet a person’s needs – when they encounter a person with a mental illness who would be more appropriately served in a sub-acute facility.

Appendix 3: MHASD Eligibility Categories

MHASD programs provide care that varies in frequency and duration. Everyone, regardless of age, income, or insurance can get care in a crisis. However, emergency intervention is by its nature brief and is generally limited to one or two contacts. For a more comprehensive course of care, a client must be appropriate for one of the following:

◆ The **Oregon Health Plan (OHP)** provides treatment utilizing federal Medicaid funding. Because the Oregon Health Plan is an entitlement program, the County must fund services for every individual who meets its eligibility requirements. OHP's mental health care service operates locally through a Mental Health Organization (MHO). The MHO functions like a private insurance company by coordinating and paying for treatment, and bearing the financial risk for the total cost of an individual's care. Multnomah County's Mental Health Organization is Verity Integrated Behavioral Health Systems (Verity), a part of MHASD.

◆ **Multnomah Treatment Fund** (formerly Verity Plus) is a safety net program for children and adults with a serious mental illness who are not eligible for (or not able to be enrolled in) the Oregon Health Plan and who cannot afford private mental health insurance. County General Funds and the State of Oregon pay for Multnomah Treatment Fund coverage.

To be eligible for the Multnomah Treatment Fund, the individual's mental health diagnosis must meet Priority 1 clinical criteria. The individual must be at immediate risk of hospitalization for treatment of a mental illness, require continuing services to avoid hospitalization, or pose a hazard to the health and safety of others.

Priority 1 also encompasses children and families with a serious mental illness. Individuals under the age of 18 who are at risk of removal from home due to mental illness meet its criteria. Parents also meet this criteria when their mental illness poses an imminent risk of removal of children, or of homelessness, incarceration, hospitalization, or dangerousness.

◆ **Local Mental Health Authority/Community Mental Health Program.** Historically, the State and County have developed and funded these programs to address unmet needs in the global system of care. This group of programs includes addiction prevention and treatment, commitment services, and coordinated hospital and jail diversion programs.

Eligibility for these programs varies widely based upon income, insurance, and need. Reimbursement to treatment agencies ranges from fee-for-service to calendar payments.

Appendix 4: Progress Report on the 2001 Mental Health Redesign Plan

Primary Goals from 2001	Results during 2002-2009
Create Access/Crisis System	
Implement central call center	Opened September 2001
Develop Walk-in Clinics	Opened September 2001
Develop Mobile Crisis Teams	Mobile Crisis extended to eastside September 2001
Develop a secure evaluation facility	Not completed - plan updated 2008.
Expand sub-acute overnight alternatives	Children's sub-acute expanded October 2005 Adult sub-acute in planning stage for 2010
Expand acute care coordination team	Completed
Implement Clinical Accountability	
Transition to a primary provider model of care	Initiated July 2001 and in use until April 2006
Clinical accountability contract model	Began April 2006
Reduce/focus specialized provider contracts	Completed 2002
Implement new MHO business model	Primary Provider Model July 2001- March 2006 Fee for Service Model April 2006 - present
Complete new information system (Raintree)	Completed January 2002
Outcome measurement/performance monitoring	Performance monitoring implemented July 2004. Outcomes measurement tool implemented for children's providers 2006. ACORN tool implementation pilot in adult system of care November 2009.
Implement Fully Integrated Seamless System	
Promote a recovery approach to services	Began 2002
Implement cultural competency plan	Implemented 2002
Implement children's system of care initiative	Implemented October 2005
Integrate addictions and mental health services	Completed
Reduce hospitalization utilization	Maintained reduced utilization through 2009

Appendix 5: MHASD Members and Individuals Served

Source: Verity Membership Data

Verity Annual Membership Data
FY02 through FY08

Category	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY08	Difference 02 to 08
Total Member Months	869,015	825,441	683,312	799,866	799,430	789,251	824,788	-5%
Total Unduplicated Members	117,384	115,510	84,615	97,158	94,012	95,188	93,633	-20%
Unduplicated Adults and Children Served	14,162	13,539	9,871	11,144	10,741	10,878	11,079	-22%
Total Adult Member Months	500,799	443,508	300,078	395,199	379,557	364,280	369,969	-26%
Total Unduplicated Adult Members	68,539	65,346	35,523	47,754	43,209	42,441	40,900	-40%
Unduplicated Adults Served	9,975	9,061	5,526	6,604	6,488	6,714	6,983	-30%
Total Child Member Months	368,216	381,933	383,234	404,667	419,873	424,971	454,819	24%
Total Unduplicated Child Members	48,845	50,164	49,092	49,404	50,803	52,747	52,733	8%
Unduplicated Children Served	4,187	4,478	4,345	4,540	4,253	4,164	4,096	-2%

Verity enrollee data compared to Oregon Health Plan members not enrolled in Verity
Month of December FY02 – FY08

Category	Dec. 2002	Dec. 2003	Dec. 2004	Dec. 2005	Dec. 2006	Dec. 2007	Dec. 2008	Difference FY02 to FY08
Total Verity Member Months	73,770	54,851	66,244	65,883	64,963	63,700	64,712	-9,058
Non-Verity* Member Months	12,570	7,384	8,772	7,788	7,166	21,900	21,900	9,330
Total Medical Assistance Program Member Months	86,340	62,235	75,016	73,671	72,129	85,600	83,738	-2,602

**May be a combination of OHP members belonging to another MHO, or in other State medical assistance programs.*

Appendix 6: Summary of Input to MHASD Strategic Plan

April 5, 2010

MHASD Director Karl Brimner met with nine advisory and community groups between January 6 and March 2 to review the MHASD Draft Strategic Plan Summary, answer questions, and receive comments and suggestions. The groups were:

- Adult Mental Health and Substance Abuse Advisory Council (AMHSAAC), Multnomah County
- Children's Mental Health System Advisory Council (CMHSAC), Multnomah County
- Commission on Children, Families & Community, Multnomah County
- DHS Child Welfare Advisory Committee
- Local Public Safety Coordinating Council, Multnomah County
- Mental Health Providers
- National Alliance on Mental Illness (NAMI), local chapter
- Oregon Family Support Network (OFSN)
- Wraparound Oregon:Early Childhood, Steering Committee
- Department of Human Services Leadership Team

Following is a summary of comments and suggestions, organized in the order of the Plan's goals and strategies. Themes have been identified and suggestions edited for brevity.

Goal I: Involve consumers and families in planning and delivery of services.

Improve public awareness of MHASD programs.

- Public awareness should include communicating about new services to families and youth, and about how to integrate services with natural community supports.

Increase the amount of peer supports and peer-delivered services in the system of care.

- Ensure a robust plan for family partners and a full service array of peer-delivered services in the service delivery model.

Add a consumer advocate position to MHASD staff.

- In addition to the consumer advocate, add a family advocate position. In the early childhood arena, families are the consumers, and both consumers and families need advocate support.

OTHER COMMENTS:

FAMILY AND YOUTH VOICE AND INCLUSION

- Include families and youth at all levels of planning, implementation, service delivery, oversight and policy, to further develop family-driven care and improve clinical practices about how to best design services for diverse families.
- Adopt Oregon Family Support Network (OFSN) as the community partner and equal stakeholder to help guide Multnomah County in ever more progressive family inclusion.
- Accommodate childcare, parking, transportation, and other barriers to family participation. Assure meetings are handicapped and mass transit accessible, and at a time when youth and families may attend without consequence.

FAMILY AND YOUTH TRAINING AND LEADERSHIP

- Teach family members how to care-coordinate and advocate for themselves and form one's own Wrap team. It is a lifelong job, even if they shift to a support role as the child gets older.
- Prepare families to teach their children about their own leadership, a skill set they will need.
- Train educators and service providers on the complex physical, mental, and social needs of families.
- Provide on-going training, support, and supervision to Wraparound facilitators to assure reduction in service model drift (i.e. variance from fidenlity with the practice).
- Develop a cross-systems training and workforce development plan for continued advancement of a System of Care.

GRIEVANCE PROCESS

- Adopt a responsive grievance process, written in a common language and readily understood by all parties, that includes a neutral family member to advocate for families.
- Also adopt a more informal process for communication of a problem to a neutral party.

Goal II. Enhance the system of care to better meet the needs of consumers.

Reach all at-risk youth with an effective addiction prevention message.

- Address the need for mental health prevention for school age, and for early childhood as well. Use outreach and education on decreasing stigma, suicide prevention, via classroom curricula and parenting groups.
- Many evidence-based practices for prevention help develop protective factors.
- Community outreach to culturally specific programs through paraprofessionals or promotores is a culturally specific prevention practice.

Maintain Sobering program at current levels.

- No Comments.

Transition the operation of Wraparound services for children and families to an Administrative Services Organization (ASO) under the Dept. of County Human Services.

- Embed Wraparound principles and values in the model and at all levels to ensure good outcomes for children, youth and families.
- Adopt criteria for eligibility for Wraparound services to assure that, once a family enters services, they would not be rejected – even if they move to another county.
- Create a way for Wraparound to be available for those with private insurance.
- Implement Wraparound for children in the DHS system as a 2-position practice model comprised of a Family Partner and Facilitator (Care Coordinator). The skills of the Family Partner help engage family members in a team planning process in a unique way.
- In Wraparound, continue use of a centralized Intake Committee, consisting of a quorum of stakeholders, community providers and family members.

Expand access to mental health treatment for non-covered individuals.

- Avoid making any reductions to the already small Multnomah Treatment Fund.
- Help DHS Child Welfare involved parents who lose OHP when their children are removed keep their own coverage for mental health services.

Provide flexible funding for family support.

- Assure Flexible Funding for Child and Family Teams, to allow teams to generate individualized plans and support nontraditional, culturally relevant, or unfunded approaches for alleviating the challenges for children with mental health needs.

Expand the availability of evidence-based peer clubhouses with supported employment.

- Coordinate efforts to meet specific developmental needs of transition-aged youth to help promote mental well being and help individuals achieve important adult milestones.

Expand residential care in transitional housing settings.

- Expand our supply of supported housing.
- Consider using PSRB beds regionally when there are vacancies.

Develop a Crisis Assessment and Treatment Center for adult crisis stabilization.

- Work with private insurance to be sure Crisis Assessment and Treatment services are available to people with private insurance.
- Consider how crisis services will be provided to transition-age youth.
- Design specific policies/practices to meet the developmental needs of adults being served by the Crisis Center (regardless of age), and involve clients in a model of decision-making that reflects strengths-based, individualized characteristics.

Provide technical assistance and monitoring to improve access to culturally competent care.

- Address cultural competency on the basis of all parameters of cultural diversity, not just race. Include the culture of poverty (issue of class and poverty versus race and color) in the definition of cultural competency.
- Include values and principles for cultural and linguistic competencies and hiring practices that reflect the cultural and linguistic community being served in RFP/RFI requests.
- Provide cultural brokers and translation and interpretation services.
- Develop a method to control quality and assure accountability regarding the expectation of providers for culturally competent services.
- Develop an advisory board of ethnically and culturally under-represented community members (consumers, professionals) to help guide effective services to these communities.

Provide technical assistance and clinical training to providers.

- No Comments.

Advocate for: adequate funding for State general funded mental health, residential, and addiction services from the Oregon Legislature; adequate funding of the Oregon Health Plan (OHP); a supported housing gatekeeper for people transferring from the State Hospital; funding of community-based services as part of the State Hospital Redesign plan.

- No Comments.

OTHER COMMENTS:

- Establish successful discharge criteria at the systems level.
- Conduct case planning in a strengths based manner.
- Conduct crisis and safety planning for families in a manner specific to the family, so that there is a regularly updated and specific 24/7 plan.
- Work to locate family members who have been separated from their children/youth, to reunite children successfully with strong and safe family members.
- Adopt transparency as a practice value at the practice level, as a key element to effective Child and Family Teams.
- Reference in the plan those clients re-entering society from jails and prisons.

Goal III. Integrate physical health care and mental health and addiction services.

Work with fully capitated health plans to develop integrated health care and mental health and addiction services throughout the County.

- Plan for integration of physical and mental health for children and youth, as well as adults.
- Children's integration should include quality communication between health care and mental health, and increased access to consultation with a psychiatrist, which is needed regarding medications, especially for children in foster care.
- There are concerns about health and lifespan, especially regarding the medications that children will be taking over many years.
- Explore options for 3-way integration of health, mental health and education to help keep kids out of foster care, increase parenting knowledge, etc.
- Funding for health care integration should go toward school based health clinics, which have successfully delivered integrated care in co-located school settings.
- Health and Mental Health integration should be focused on the private sector, as well as public pay/OHP recipients.
- Integration should address the needs of the uninsured.
- Small community providers need funding for infrastructure to allow for the shared records that would make improved outcomes from integration possible.

Improve access to integrated care at current service locations.

- No Comments.

Goal IV. Strengthen financial and system accountability.

Update provider rates to better match clinical priorities.

Increase technical assistance, improve methods of monitoring the financial health of providers, and continue monitoring contractual requirements.

Use pay-for-performance incentives to enhance and update the service system.

Increase the use of data when making decisions about the systems of care.

- No Comments.

OTHER COMMENTS:

PLANNING PROCESS

- The strategic plan should align with other parallel systems in the community dealing with the same population, such as corrections, child welfare, etc.
- The feedback process should allow people time to process and consider this information.
- Include how the County plans to respond to the State's discussion of organizing services on a regional basis.
- Describe the overall budget status, as going up or down, and availability of funding.

PROCUREMENT

- Share whether MHASD plans to continue contracting out most services.
- Require family inclusion in the Wraparound RFI, and include families in proposal review.

STAFFING

- Consider Family Partners as equals to Family Group Facilitators, as it is critical to have both on each family team.
- When hiring family members as County employees, have family members oversee job descriptions and the hiring process, so that employees reflect the needs of the community.
- Hold team member and staff turnover at a minimum as a critical part the of outcome based process. Utilize focused hiring practices, wage adjustments and training, as well as peer to peer and professional support for job stress.

ACCOUNTABILITY

- Spell out the criteria providers will be held to and the monitoring and review process in the full strategic plan.
- Continue the Wraparound program's robust evaluation plan regarding the outcomes for children and families, as well as effects on the system of care. Include families in evaluation planning. Provide a continuous feedback loop between practice, provider, and systems levels.
- Establish some sort of regular reporting on the progress toward these goals.

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Appendix 7: Endnotes

[1] *The World Health Report, Mental Health: New Understanding, New Hope,* World Health Organization, 2001. http://www.who.int/whr/2001/en/index.html

- "Mental and behavioural disorders are common, affecting more than 25% of all people at some time during their lives...Mental and behavioural disorders are present at any point in time in about 10% of the adult population."
- "Around 20% of all patients seen by primary health care professionals have one or more mental disorders."
- "One in four families is likely to have at least one member with a behavioural or mental disorder."
- "Mental and neurological conditions account for 30.8% of all years lived with disability."
- "Depression causes the largest amount of disability, accounting for almost 12% of all disability."

Report of a Surgeon General's working meeting on the integration of mental health services and primary health care; 2000 Nov 30–Dec 1; Atlanta, Georgia. Rockville, MD: U.S. Department of Health and Human Services. 2001. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.2907

- "Mental disorders frequently co-occur with other mental or somatic (physical) disorders. Estimates of this "comorbidity" range from about 20 to 80 percent of primary care patients (Sherbourne et al., 1996; Olfson et al., 1997). Comorbidity adds to disability and contributes to morbidity and mortality."
- "Clearly, the mental and physical health of an individual are connected. Studies show that adults with medical disorders have high rates of depression and anxiety. Depression can impair self-care and adherence to treatment for chronic medical illnesses, leading to medical complications. Without treatment, depression and anxiety can become significantly debilitating, limiting an individual's ability to participate in family, work and community activities. Further, individuals with serious mental health challenges face numerous medical conditions that create additional barriers to functioning. Health care that includes both mental and physical components can prevent the development of more serious mental health or medical conditions, improve the quality of life, produce better treatment outcomes and is, thus, more cost effective."
- "Mental disorders are highly disabling, ranking second only to cardiovascular conditions as a leading cause of worldwide disability by the World Health Organization (Murray & Lopez, 1996). Moreover, these disorders impose substantial cost burden to patients, their families, and communities at large. That burden is reflected in lost productivity and premature death and in the amount of medical and community resources expended."

[2] *President's New Freedom Commission on Mental Health: Report to the President,* 2003. http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html

[3] *The Numbers Count: Mental Disorders in America*, National Institute of Mental Health (NIMH), 2006. http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml

- "Mental disorders are common in the United States and internationally. An estimated 26.2% of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year." Kessler R, et al. *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
- "Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 — who suffer from a serious mental illness," ibid.
- "Many people suffer from more than one mental disorder at a given time. Nearly half (45%) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity," ibid.
- "In addition, mental disorders are the leading cause of disability in the U.S. and Canada for ages 15-44." *The World Health Report 2004: Changing History*, Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002. Geneva: The World Health Organization, 2004.

Results from the 2007 National Survey on Drug Use and Health: National Findings, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007. http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf

- "In 2007, 29.4 million adults (13.2 percent of the population 18 years or older) received mental health services during the past 12 months (Figure 8.6). This was similar to the rate in 2006 (12.9 percent)."
- "In 2007, the type of mental health services most often received by adults aged 18 or older was prescription medication (11.1 percent), followed by outpatient services (6.9 percent). Rates of prescription medication and outpatient service use in 2007 were similar to the rates in 2006 (10.9 and 6.7 percent, respectively). Respondents could report receiving more than one type of mental health care."
- "About 2.1 million adults (1.0 percent of the population aged 18 years or older) received inpatient care for mental health problems during the past year. This estimate was the same as the rate reported in 2005 after a significant decline in inpatient care noted in 2006 (0.7 percent or 1.6 million adults)."

[4] *Treatment of Children with Mental Disorders: A booklet with answers to frequently asked questions about the treatment of mental disorders in children*, National Institute of Mental Health, 2004. http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-disorders/summary.shtml

- "An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment. Fewer than one in five of these ill children receives treatment."

Results from the 2007 National Survey on Drug Use and Health: National Findings, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007.

http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf

- "In 2007, 3.1 million youths aged 12 to 17 (12.5 percent) received treatment or counseling for problems with behavior or emotions in the specialty mental health setting (inpatient or outpatient care). Additionally, 11.5 percent of youths received services in the education setting, and 2.8 percent received mental health services from the general medical setting in the past 12 months. Mental health services were received from both the specialty setting and either the education or general medical settings ... by 5.1 percent of youths."

[5] *Report to the Governor and Legislature: A Blueprint for Action*," Governor's Mental Health Task Force, 2004. http://www.oregon.gov/DHS/mentalhealth/govmhtaskforce/gmhtf-report.pdf

- "The President's New Freedom Commission reports that, in any given year, 5% to 7% of adults have a serious mental illness. A somewhat larger percentage of children - 7% to 9% - have a serious emotional disturbance. This means that in Oregon, in any given year, more than 175,000 adults 18 and older and more than 75,000 children under age 18 need some kind of mental health services. Some fraction of these individuals receive services from the private system. Others receive services from the public system. But in Oregon, many individuals receive no services at all, and in recent years, the number of people who do not receive needed services has increased, rather than decreased."

[6] *Factsheet: Prevalence of Mental Disorders among Children in the Juvenile Justice System,* Mental Health in America. http://www1.nmha.org/children/justjuv/prevalence.cfm

- "Based on data obtained from site visits to a nationally representative sample of 95 public and private juvenile facilities, researchers found that 73% of the children in these facilities reported mental health problems during screening (Abt Associates, 1994). In addition, 57% of youth reported that they have previously received treatment for mental health problems."

[7] *NIH News.* National Institute on Alcohol Abuse and Alcoholism (NIAAA), March 17, 1995. http://www.niaaa.nih.gov/NewsEvents/NewsReleases/nlaes.htm

- "The National Institute on Alcohol Abuse and Alcoholism today released the first report from its National Longitudinal Alcohol Epidemiologic Survey (NLAES), including the most precise estimates to date of alcohol abuse and dependence among U.S. adults....According to the report, 13,760,000 U.S. adults (7.41 percent of persons aged 18 years and older) met standard diagnostic criteria for alcohol abuse or alcohol dependence during 1992. Although more were classified with alcohol dependence (4.38 percent) than alcohol abuse (3.03 percent), most persons with alcohol dependence also met alcohol abuse criteria."

[8] *Multnomah County Prevention Gaps Analysis*, Community Planning Workshop, Department of Planning, Public Policy and Management at the University of Oregon, Jan. 2007.

- "Youth drug and alcohol use and abuse are of particular concern in Multnomah County. Recent reports suggest that almost one in three eight graders in Multnomah County have used alcohol in the past month, 50% over the national average (ODHS, 2006). Moreover, these statistics identified an 8.2% increase in alcohol use among eighth-grade girls between 2001 and 2005. Multnomah County youth are also above the national average for marijuana use, with 12% of eighth-graders using marijuana regularly, almost twice the national average (6.4%)."

[9] *Results from the 2007 National Survey on Drug Use and Health: National Findings*, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007. http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf

- "In 2007, an estimated 19.9 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.0 percent of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically."
- "Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2007, 23.2 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.4 % of persons aged 12 or older). Of these, 2.4 million (1.0 % of persons aged 12 or older and 10.4 %t of those who needed treatment) received treatment at a specialty facility. Thus, 20.8 million persons (8.4 % of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year."
- "Based on 2004-2007 combined data, five of the most often reported reasons for not receiving illicit drug or alcohol use treatment among persons who needed but did not receive treatment at a specialty facility and perceived a need for treatment included (a) not ready to stop using (38.7 %), (b) no health coverage and could not afford cost (31.1%), (c) possible negative effect on job (11.6 %), (d) not knowing where to go for treatment (11.6 %), and (e) concern that receiving treatment might cause neighbors/ community to have negative opinion (11.1 %). "
- "Based on 2004-2007 combined data, among persons who needed but did not receive illicit drug or alcohol use treatment, made an effort to receive treatment, and felt a need for treatment, some of the most often reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (35.9 %), (b) not ready to stop using (26.6 %), (c) able to handle the problem without treatment (12.5 %), (d) no transportation/ inconvenient (10.5 % (e) might cause neighbors/community to have negative opinion (8.9 %), (f) no program having type of treatment (8.1%), (g) might have negative effect on job (7.0 %), and (h) did not know where to go for treatment (6.9 %)."

[10] *Multnomah County Prevention Gaps Analysis*, Community Planning Workshop, Department of Planning, Public Policy and Management at the University of Oregon, Jan. 2007.

- "The literature shows that preventing high-risk behavior is far more cost-effective and successful than treating and/or rehabilitating youth that have already become engaged in these behaviors. The literature also shows that many prevention efforts lack the funding, coordination, and public awareness efforts that are devoted to traditional, less-economically-efficient treatment, criminal justice, and other remedial services. "

[11] MHASD Website, 2008. http://www.co.multnomah.or.us/dchs/mhas/alcohol.shtml (see note 21), and 2002 Multnomah County Data Book, Oregon Department of Human Services, Office of Mental Health and Addiction Services; http://www.oregon.gov/DHS/addiction/data/databooks/2002/multnomah.pdf.

- Number youth receiving prevention services (8,050) divided by 93,997 youth 0-17 needing selective (at-risk) prevention, is 8.56%.

[12] Multnomah County Program Offer #25064 – Early Psychosis Program.

[13] *Historical Report of Impact of ballot Measure 28 Cuts*, Multnomah Count y Aging and Disability Services; and Oregon DHS Reporter Tools, http://www.oregon.gov/DHS/news/tools/programs.shtml

- "General Assistance program provided cash assistance of $314 a month to low-income people with disabilities waiting for determination of their Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) claim. These are individuals who are expected to be disabled for at least a year. Funding for this program was eliminated in 2003 to balance the state budget."
- "Medically Needy program provided prescription-drug coverage, mental health services and transportation to obtain these services to more than 8,500 low-income Oregonians. It also paid Medicare Part B premiums, co-insurance and deductibles for eligible individuals and a full range of Medicaid benefits for children. The program was eliminated in 2003 to balance the state's budget, although specific drugs for about 425 HIV and organ-transplant patients were restored through June 30, 2003."

[14] *State to send out 3,000 Oregon Health Plan applications*, Helen Jung, The Oregonian July 07, 2008 09:26AM http://blog.oregonlive.com/breakingnews/2008/07/state_to_send_out_3000_oregon.html

- "The state is sending out 3,000 applications to low-income residents on a waiting list to apply for Oregon Health Plan insurance coverage. The recipients were randomly selected from those who submitted their names earlier this year to request coverage under the Oregon Health Plan's Standard benefit plan. That plan is available to uninsured, low-income individuals who don't qualify for traditional Medicaid. While the state can add several thousand more people before it reaches its limit, there are many more potential applicants than available slots. Some 76,000 people are still on the list just to receive an invitation to apply for coverage... About 20,000 people are currently covered under the Standard program, and another 1,100 applications are pending further documentation, according to the state Department of Human Services, which administers the plan. "

[15] *Odds Steeper in Health Care Lottery*, Bill Graves, The Oregonian, October 21, 2009.

- "Last year, the State gave people six weeks to sign up for more than 8,000 slots that had opened up through attrition, and more than 83,000 people signed up."

[16] *Fewer of Oregon's Poor Eligible for MH Benefits*, Kate Mulligan, Psychiatric News, July 16, 2004, Volume 39 Number 14, American Psychiatric Association, p. 10. http://pn.psychiatryonline.org/cgi/content/full/39/14/10

- "During the period from January to October 2003, however, the number of OHP Standard beneficiaries dropped from about 100,000 to about 51,000. Seventy-two percent of those who lost coverage became uninsured... State officials can cap enrollment in OHP Standard, which they planned to do as of July 1. Enrollees who lose their coverage after that date cannot re-enroll... In April 2003, the first month that OHP Standard enrollees were disenrolled for nonpayment of premiums, about 16,000 people lost coverage for that reason. Between May and October 2003, about 31,000 more people lost coverage for nonpayment. "
- "Seventy-eight percent of the beneficiaries who had lost coverage reported unmet mental health care need, compared with 53 percent with continuous coverage who reported such a need. "

[17] MHASD and AMH Databases.

[18] Oregon Health Plan 2, Section 1115 Quarterly Report Federal Fiscal Quarter: 3/2009 (4/09 - 6/09), http://www.oregon.gov/DHS/healthplan/data_pubs/quarterly/q2009/2q09.pdf

[19] *Odds Steeper in Health Care Lottery,* op cit.

[20] Community Services Workgroup Report, for the Oregon State Hospital Master Plan, March 13, 2007, page 34. http://www.oregon.gov/DHS/mentalhealth/osh/comm-srvcs-report.pdf

[21] *Report of a Surgeon General's working meeting on the integration of mental health services and primary health care*; 2000 Nov 30–Dec 1; Atlanta, Georgia. Rockville, MD: U.S. Department of Health and Human Services. 2001. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.2907

- "Mental disorders frequently co-occur with other mental or somatic (physical) disorders. Estimates of this 'comorbidity' range from about 20 to 80 percent of primary care patients (Sherbourne et al., 1996; Olfson et al., 1997). Comorbidity adds to disability and contributes to morbidity and mortality."

[22] *Aim High: Building a Healthy Oregon,* Oregon Health Fund Board, Draft for Public Review & Comment, September 3, 2008. http://www.oregon.gov/OHPPR/HFB/docs/9_3_Draft_Report_for_Public_Comment.pdf

- "Chronic behavioral health conditions account for a significant amount of morbidity and mortality and a large portion of health care spending in Oregon. In 2006, the economic costs of substance abuse in this state were nearly $6 billion.23 Other health, social, and indirect costs associated with inadequately treated or untreated

behavioral health conditions are also substantial, in part because many persons with significant behavioral health conditions have co-morbid physical health conditions."

- "Integration of mental health and addiction services with physical health care and within primary care is an essential goal of a reformed delivery system. Such integration can and should occur in a progressive fashion over a reasonable period of time."

[23] President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America,* 2001, http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport-02.htm

- "Research demonstrates that mental health is key to overall physical health. Therefore, improving services for individuals with mental illnesses requires paying close attention to how mental health care and general medical care interact. While mental health and physical health are clearly connected, a chasm exists between the mental health care and general health care systems in financing and practice. Primary care providers may lack the necessary time, training, or resources to provide appropriate treatment for mental health problems."

[24] Ibid.

- "Mental disorders frequently co-exist with other medical disorders. For example, a number of studies have shown that adults with common medical disorders have high rates of depression and anxiety. Depression is also common in people with coronary heart disease and other cardiac illnesses. This situation is especially dangerous because depression increases the risk of dying from heart disease by as much as three-fold. Depression impairs self-care and adherence to treatments for chronic medical illnesses."

[25] National Association of State Mental Health Program Directors, Medical Directors Council, July 2006

[26] Colton CW, Manderscheid RW. Prev of Chronic Disease, 2006 Apr. www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

- "Using age-adjusted death rates, standardized mortality ratios, and years of potential life lost, we compared the mortality of public mental health clients in eight states with the mortality of their state general populations. The data used in our study were submitted by public mental health agencies in eight states (Arizona, Missouri, Oklahoma, Rhode Island, Texas, Utah, Vermont, and Virginia) for 1997 through 2000 during the Sixteen-State Study on Mental Health Performance Measures, a multistate study federally funded by the Center for Mental Health Services in collaboration with the National Association of State Mental Health Program Directors."
- "In all eight states, we found that public mental health clients had a higher relative risk of death than the general populations of their states. Deceased public mental health clients had died at much younger ages and lost decades of potential life when compared with their living cohorts nationwide. Clients with major mental illness diagnoses died at younger ages and lost more years of life than people with non-major mental illness diagnoses. Most mental health clients died of natural causes similar to the leading causes of death found nationwide, including heart disease, cancer, and cerebrovascular, respiratory, and lung diseases."
- "Mental health and physical health are intertwined; both types of care should be provided and linked together within health care delivery systems. Research to track mortality and primary care should be increased to provide information for additional action, treatment modification, diagnosis-specific risk, and evidence-based practices."

[27] Washington State Institute on Public Policy, Benefits and Costs of Prevention and Early Intervention Programs for Youth, 2004. http://www.wsipp.wa.gov/pub.asp?docid=04-07-3901

- "Our principal conclusion is that, as of September 2004, some prevention and early intervention programs for youth can give taxpayers a good return on their dollar... some youth development programs provide very attractive returns on investment. While their net benefits are relatively low, many substance use prevention programs for youth are cost effective, because the programs are relatively inexpensive....Youth development programs such as Guiding Good Choices and Strengthening Families received positive cost-benefit analyses in the $6000 range."

[28] Mental Health America, *Early Identification of Mental Health Issues in Young People, 2005*. http://www.nmha.org/go/position-statements/41

- "Research shows that early intervention can prevent significant mental health problems from developing. Epidemiological research confirms the relationship between mental health issues and suicide or self-mutilation, substance abuse, suspension, dropping out, expulsion and involvement with the juvenile justice system. The research also shows that effective treatment can reduce the risk of such consequences. [citations provided]"

[29] *2002 Multnomah County Data Book*, Oregon Department of Human Services, Office of Mental Health and Addiction Services; http://www.oregon.gov/DHS/addiction/data/databooks/2002/multnomah.pdf

- "Universal prevention is directed at the entire population regardless of level of risk. Selective prevention is directed at groups of people who are at above average risk for addiction or mental health disorders. Indicated prevention is directed at individuals who show early, detectable signs of addiction or mental illness, but do not have a diagnosis.
- Estimated Need for Prevention Services in Multnomah County: Universal: 100%, 153,089 youth; Selected: 61.4%, 93,997 youth; Indicated: 14.5%, 22,235 youth."

[30] See note number 9.

[31] *Multnomah County Prevention Gaps Analysis*, Community Planning Workshop, Department of Planning, Public Policy and Management at the University of Oregon, Jan. 2007.

- "Our research has also resulted in two recommendations for how County efforts could have the most impact at the programmatic level: Focusing on early prevention, particularly emphasizing programs that support and involve parents; Implementing a system-wide school prevention program."

[32] *Overcoming Barriers to Community Integration for People with Mental Illness*, SAMHSA, Center for Mental Health Services, 2001.

- "Serious mental illness can be treated. Today most mental disorders are considered to be as treatable as general medical conditions."

Testimony before the House Committee on Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources, United States House of Representatives, Nora D. Volkow, M.D. Director, National Institute on Drug Abuse National Institutes of Health Department of Health and Human Services, March 30, 2004:

- "We have found treatments that are delivered by qualified professionals using empirically validated medications and behavioral therapies and applied for adequate durations, followed by monitoring and after-care, have successful outcomes. In fact, recovery from addiction is an established reality, achieved through a variety of treatment modalities when they are matched for the needs of individual patients. Numerous studies have shown that addiction treatments are comparable in effectiveness to treatments for other chronic illnesses."

[33] *At Issue: Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations*, Lehman & Steinwachs, Schizophrenia Bulletin, Vol. 24, No. 1, 1998.

- "Over 100 randomized double-blind studies consistently support the efficacy of antipsychotic medications relative to placebo in the reduction of the acute positive symptoms (hallucinations, delusions, thought disorganization, bizarre behavior) of schizophrenia. Approximately 50 to 80 percent of persons will improve significantly with this treatment compared with about 5 to 45 percent on placebo."
- "Randomized trials have demonstrated consistently the effectiveness of these programs [ACT and ACM] in reducing inpatient use among such high-risk patients."

[34] Multnomah County Program Offer 25076 – School Based Mental Health Services, 2008.

- Of children receiving school-based mental health services in Multnomah County, 78% showed improved school behaviors and 75% had improved attendance. For culturally specific school-based services, behavior improved 95% and attendance 89%.

[35] Washington State Institute on Public Policy, *Evidence-Based Treatment of Alcohol, Drug, and Mental Health Disorders: Potential benefits, costs, and fiscal impacts for Washington State*, 2006. http://www.wsipp.wa.gov/pub.asp?docid=06-06-3901

- "Evidence-based treatment works. We found that the average evidence-based treatment can achieve roughly a 15 to 22 percent reduction in the incidence or severity of these disorders—at least in the short term. The economics look attractive. We found that evidenced-based treatment of these disorders can achieve about $3.77 in benefits per dollar of treatment cost."

Treatment Works For Youth In The Juvenile Justice System, National Mental Health Association website, 2008

- "Treatment works to change the life course of young people and deter them from juvenile justice involvement. Numerous research studies point to the effectiveness of certain types of treatment and services for youth involved in the juvenile justice system. Generally speaking, regardless of type of program or youth, recidivism rates among those who received treatment are as much as 25% lower than those among untreated, control groups. The best, research-based treatment programs can reduce recidivism from 25 to 80%."

[36] Alcohol and Other Drug Treatment Effectiveness: A Review of State Outcome Studies, National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD). www.nasadad.org/index.php?doc_id=91 - 23k

- "In general, it was found that alcohol and drug use decreased, employment increased, and criminal justice involvement decreased at various points after treatment... Also, it was found that physical health, mental health, and family/social functioning improved considerably after treatment."

[37] *50 Reasons to pass the Malt Beverage Cost Recovery Fee*. http://www.oregondec.org/legislation/HB2535-50reasons.pdf

- "Oregon Addiction Treatment is very effective compared to the national average. Nationwide 51% of treatment admissions successfully complete treatment. In Oregon 59.5% of treatment admissions successfully complete treatment. (TEDS, 2003; OMHAS, 2003)"

[38] Finigan, 1996, 1999.

[39] *Overcoming Barriers to Community Integration for People with Mental Illness*, SAMHSA, 2001.

- "Housing is perhaps the first line of treatment for people with psychiatric disabilities. Yet with limited income, many people with serious mental illness are forced to live in over-crowded and often substandard living environments that place them at risk of physical and emotional risk."

[40] Ibid

- "People with serious mental illness want to work, and with appropriate support, many are quite successful on the job."

Mental Illness and the Workplace , http://www.reintegration.com/reint/employment/workplace.asp

- "Experts increasingly acknowledge that work is a key factor in supporting mental wellness and warding off its reverse -- mental illness. Employment provides five factors that promote mental well-being: Time structure, Social contact and affiliation, Collective effort and purpose, Social and personal identity, Regular activity. So for those who have suffered from such illnesses, meaningful employment is an essential part of the recovery process."

[41] *Overcoming Barriers to Community Integration for People with Mental Illness*, SAMHSA, 2001.

- "Participants in self-help groups report greater self-esteem, fewer hospitalizations and better community adjustment. Consumer operated programs ... provide meaningful work for consumers who serve as positive role models for their peers."

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