Multnomah County

Mental Health and Addiction Services Division

2009-2011 Biennial Implementation Plan

Treatment and Prevention Services

for

Mental Health, Addiction and Problem Gambling

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Addiction and Mental Health Division

Multnomah County Mental Health and Addiction Services Division

2009-2011 Biennial Implementation Plan

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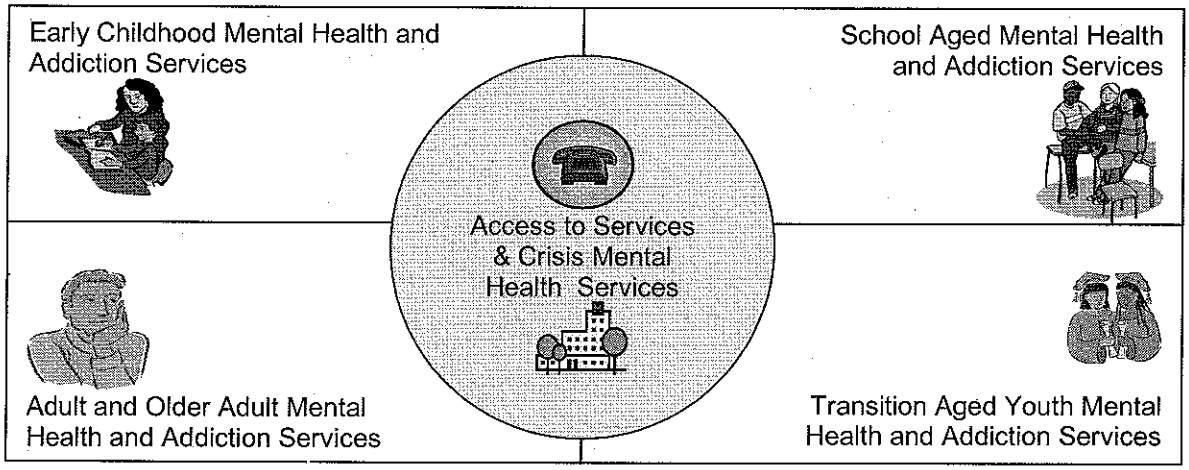
I. Introduction

The Multnomah County Mental Health and Addiction Services Division (MHASD) is committed to providing services that are evidence-based, backed by a recovery philosophy and integrated into a larger "System of Care." System of care values prescribe a full spectrum of care, balancing consumer choice, prevention, early intervention, and a continuum of care from community-based to acute services.

Systems of Care are an effective approach for delivering coordinated, culturally competent mental health and addiction services so that children, youth, adults and elders will have their service needs met appropriate to their individual, family and cultural needs and circumstances.

> "A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. A system of care helps children, youth and families function better at home, in school, in the community and throughout life."
>
> Federal Substance Abuse and Mental Health Services Administration (SAMHSA)

Multnomah County Mental Health and Addiction System of Care



A major redesign of Multnomah County's Mental Health System has been underway since 2001 to implement this approach. Key goals have been 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.

In 2005, MHASD released the first Requests for Programmatic Qualifications (RFPQ) to implement this comprehensive system of care for adults, and for school-age children and families. For the early childhood system of care, an RFPQ was released in December with responses due this February, completing the components envisioned in the system of care redesign.

This plan describes programs funded by the State Addiction and Mental Health (AMH) Division, and how these fit into a seamless system of care for residents of Multnomah County who need support for mental health or addiction issues.

II. Description of the Planning Process

System of Care Redesign

Prior to the 2005-2007 biennium, numerous public meetings were held to obtain provider and consumer feedback on plans for a new system of care serving children and families, and a system of care for adults. These meetings involved a wide variety of County residents, providers, stakeholders, consumers, and MHASD advisory council members in providing input. Utilization information, data on underserved populations, and input from these meetings were used to design an adult system of care and a system of care for children and families, which led to the release in 2005 and 2007 of Requests for Programmatic Qualifications (RFPQ) to procure services.

The 2009-2011 Biennial Implementation Plan continues to implement this System of Care redesign plan, with ongoing input from citizens, consumers, providers and partners.

Input from Consumers and Stakeholders

The **Children's Mental Health System Advisory Council (CMHSAC)** updated their bylaws in 2006 to require that at a minimum, 51% of membership will be consumers (including youth), family members, or child and family advocates, with half also being Oregon Health Plan (OHP) members. In 2007, CMHSAC adopted a statement of vision, mission and guiding principles for Family-Driven Care. The Council took a significant role in providing input to MHASD's redesign of the System of Care for Children and Families, and on the content of the Early Childhood RFPQ released in December 2007 for procurement of early childhood providers.

The **Adult Mental Health and Substance Abuse Advisory Council (AMHSA)** participated significantly in planning the system redesign in the prior biennium, and provided input to the 2005 RFPQ for Adult System of Care services. During the 2007-09 Biennium, the Council has focused on strengthening its internal functioning. Membership has been expanded, with a focus on increasing consumer representation.

Cultural and Ethnic Community members are involved in providing input to MHASD in part through representation on CMHSAC and AMHSA, as well as through culturally specific providers and programs. Currently, MHASD is investigating the needs of five priority underfunded ethnic populations: African American, Latino, Asian, Eastern European immigrants, and Native American. Using County funds, a consultant is conducting focus groups with each population on needs and preferences for service delivery. Findings from this effort, anticipated in spring of 2008, will inform decisions on funding for 2009-11 service contracts.

Input from County Partners and Community Initiatives

Comprehensive, Coordinated Plan (SB555 Plan): The update of this 6-Year Community Plan was led by the Multnomah County Commission on Children, Families and Community (CCFC). MHASD managers actively participated on the Steering Committee for this plan, which was approved by the Board of County Commissioners and submitted to the State in January 2007.

The planning process included a meta-analysis of 36 local planning documents and needs assessments, and collected input from the Steering Committee, the CCFC Board, and other community groups, engaging over 200 individuals directly. The top 18 pressing issues identified

by Steering Committee members were ranked by the number of reports that raised this issue; those where Multnomah County is below State benchmarks are marked with an asterisk (*)

Issues Identified by Steering Committee Members

Access to Comprehensive Health Care* 22	Poverty* 19	Affordable Housing* & Home Ownership 15	Adult Substance Abuse* 14	Child Care Availability* 14	Child Maltreatment* 13
High School Drop Out Rate 12	Unemployment Rate* 12	Domestic Violence 11	Per Capita Income* 11	Labor Force Skill Training 9	Food Security 9
Readiness to Learn 8	Homelessness* 8	Student Alcohol Use* 7	Community Engagement 6	Prenatal Care* 6	3rd Grade Reading 6

Other critical community issues that were identified included: student tobacco use, 8th grade reading, environmental sustainability, juvenile arrests, student drug use, juvenile recidivism, youth aging out of foster care, and youth suicide. Although it was believed that these issues all need attention, strong community partners were seen as leading the work effort in these areas.

After careful deliberation, the CCFC Board decided that the 6-Year Community Plan will focus on two broad goals:

1) Improve academic success and the high school completion rate, and increase student access to medical care; and

2) Decrease poverty rates for families with children, particularly for low-wage earners.

MHASD will consider these goals as it moves forward with system of care improvements, seeking to provide services that support children, youth and adults to lead healthy, successful lives unhampered by mental health or addiction barriers.

The CCFC has also developed three "frameworks" to guide community social services: the Early Childhood Framework, the School-Aged Services Policy Framework, and the Poverty Elimination Framework. These frameworks are supported by needs assessments, resource inventories, focus groups, community input, and comments from a network of providers and advisory councils on draft documents. An update to the Early Childhood Framework was adopted by the Board of County Commissioners in January 2008. The frameworks are used by MHASD to help plan and support application for County funds.

Aging and Disability Services Division (ADS) takes the lead in Multnomah County in planning for the needs of older adults and people with physical disabilities. MHASD partners with ADS in planning and contracting for mental health services to address the unique needs of these populations.

The **Local Public Safety Coordinating Council for Multnomah County (LPSCC)** provides an active forum and committee structure for collaboration on issues shared among health, human service and public safety agencies. The Director of MHASD sits on the LPSCC Executive Committee, as does the Director of the Department of County Human Services. This past biennium, MHASD staff have been active on the LPSCC committee that is working to implement recommendations from the 2005 LPSCC report, *A Study of People with Mental*

Illness in the Criminal Justice System. Through this work, MHASD is building closer working relationships across County departments, and making improvements in MHASD programs to address the cyclical problems of homelessness, mental illness, substance use and jail.

Oregon's **Children's Mental Health System Change Initiative** has a goal of improving mental health services to children by involving parents more in decisions about services, delivering more children's mental health services in the community, improving inter-agency cooperation, and acknowledging the child's language and cultural heritage. MHASD has incorporated this State Initiative into its redesigned System of Care for Children and Families.

Statewide Children's Wraparound Initiative follows the work done locally over the past several years through the Wraparound Oregon projects, both the initial School Age project, and the SAMHSA grant for Early Childhood. MHASD managers have been active in planning for both local Wraparound programs, and for statewide implementation and ongoing sustainability of wraparound services for children with significant emotional, behavioral or substance abuse problems.

III. Priority Needs

At the beginning of the mental health redesign process, the following list of priority need areas was developed. In 2008, AMH requested that counties indicate their priorities for additional funds; MHASD priorities are reflected in the bulleted items below each priority need section.

This, however, is not a comprehensive list of needs. The most critical need across all populations is for universal health coverage or an expansion of the Oregon Health Plan, so that all people needing mental health or addiction treatment receive timely and appropriate services.

1. Increase Access to Stable, Affordable and Decent Housing

In 2006, Portland's Bureau of Housing and Community Development estimated that 18,000 to 19,000 people in Portland were homeless over the course of the year, with 1,600 being chronically homeless. These figures include youth, adults and families.

Mental health and addiction are a major issue for these homeless populations, often serving as a barrier to housing. Locally, major health care providers for the homeless reported that 8.6% of homeless encounters were for mental health issues. For homeless individuals seen at the Westside Health Clinic, 46% needed mental health services or were chronically mentally ill.

The Housing First model, premised on evidence that homeless individuals and families are more responsive to interventions and treatment after they are in their own housing, rather than while living in temporary facilities, is therefore integral to adult system of care programs. MHASD has completed a full inventory of licensed, structured, 24/7 housing, is in the process of an RFP and re-location process for The Bridgeview transitional housing, and is completing a provider housing survey to facilitate a full inventory of supported permanent and independent housing. This will allow the County to determine where housing gaps exist and contribute to current efforts to prioritize types of housing, as well as housing populations.

However, lack of housing remains a critical issue. Priority needs include:

- Housing with integrated services to enable individuals appearing before the Mental Health Court to be successfully diverted from jail to the community. This will require State funding for the uninsured, as this population is often not enrolled and unable to enroll in the Oregon Health Plan, even though most would be eligible.
- Alcohol and Drug Free housing, using vouchers and other approaches, and housing assistance services.
- Expansion of mental health permanent supportive housing, including interim rent subsidies, mental health wraparound services and supported housing services.
- Creation of a homeless prevention and housing entry fund (similar to the Real Choice Housing fund that was piloted with a federal grant).
- Indigent and homeless case management and benefits assistance, including assistance with SSI, Food Stamp and OHP applications.

2. Improve the Mental Health of Multnomah County Residents

MHASD currently provides mental health service to approximately 28,000 Multnomah County residents, including both Oregon Health Plan (OHP) members and others through the use of State and County General Funds. This represents about 4% of all County residents (estimated at 701,505 in 2006). About 20,000 adults over age 18 were served, 3.7% of the County adult population (545,727 in 2006).

Using the federal Kessler formula, 14,189 adults (2.6%) would be estimated to have a severe and persistent mental illness in any given year, while 29,469 (5.4%) would have a mental, behavioral or emotional disorder that substantially interferes with or limits major life activities. Within the last twelve months, 23.9% of adults would have experienced some mental disorder.

As an urban area, Multnomah County serves both a large population base and a large proportion of chronically and severely ill residents, including a higher proportion of individuals with schizophrenia and other psychotic disorders (21% of mental health services) than the State average (17%). Multnomah County also serves a disproportionately large number of adult individuals whose mental illness is severe enough to require residential care in the County's 45 residential treatment homes and licensed facilities, totaling 390 beds.

Housing and employment are integral to long term recovery. However, Multnomah County has experienced an unemployment rate that is higher than the national rate. Supported employment is therefore an evidence-based practice used within the Adult System of Care. Assertive Community Treatment (ACT) providers are required to have a vocational specialist on the team to assist the most severely ill in finding and keeping jobs in the community.

Priority needs include:

- A sub-acute facility in Multnomah County, to complete the continuum of care for adults. The *Multnomah County Public Safety Planning Report* from the Crime and Justice Institute, January 2008, highlighted the need for a Secure Mental Health Sub-Acute Facility and triage capacity as a short term, urgent priority.
- Expansion of the ACT (Assertive Community Treatment) program to help people with mental illness and/or an addiction successfully live in the community.
- Peer delivered support, and other peer support approaches, to achieve and sustain stability and mental health improvements.
- Suicide prevention programs across the lifespan, developed cooperatively with Public Health.

3. Provide Services to Children, Youth and Families

Of the 28,000 individuals served by MHASD, approximately 8,000 are children and youth under age 18, representing 5.1% of the County's children (an estimated 155,778 in 2006)

The Surgeon General's 2002 Report on Children's Mental Health found that approximately 20% of children and adolescents experience a mental disorder and 10% experience a mental illness severe enough to cause impairment at home, in school or in the community. The State DHS Funding Formula provides estimates of severe emotional disorders for children, linked to poverty rates. Based on the percent of county residents living below the poverty level (14.2% for

Multnomah County compared to 12.9% for Oregon as a whole, and 12.7% for the nation), 11% of our children are likely to have a severe emotional disorder.

These children and youth have unique mental health and addiction needs, including that services be delivered within the context of their families. Priority needs include:

- Increased mental health consultation in early childhood and school-based sites.
- Children's Wraparound Services delivered as a sustainable part of the service continuum, rather than as grant-funded projects.
- Expanded funding for Children's Intensive Treatment Services (ITS), for children with need for a high level of care and coordination of services (described at length in the State's care study recommendations).
- Additional residential addiction treatment beds for youth.
- Flexible funds for services critical to positive outcomes for children and families, but not reimbursable by Medicaid.

4. Provide Services to Transition Age and Homeless Youth

MHASD serves approximately 2,900 transition-age youth and adults, ages 18 to 25.

The median age for onset of an initial episode of psychosis is under 25, and young people between the ages of 15 and 30 are most likely to suffer longer-term consequences if not provided early intervention.

Mental disorders and substance abuse are major issues for youth involved with Multnomah County Juvenile Justice. For the 957 youth on the Juvenile Justice caseload in 2004, 23% had one or more mental health indicators (8% had two or more indicators), and 40% had a substance use or abuse issue. Of 80 youth in Juvenile Detention in December 2004, 32.5% had a serious mental health diagnosis, and 20% were on suicide watch.

Homeless youth as well face mental health issues. Outside In, a major provider of services for homeless youth, estimates that 200 youth are homeless in Portland. Of youth served by Outside In, 90% report violence in their homes, 36% of girls report a history of childhood sexual abuse, and 30% are sexual minorities. Of youth who go through the Outside In transitional housing program, which includes treatment, care coordination, and linkage to other social services, 80% never return to the streets. Priority needs include:

- Early Psychosis and Transition Age youth services for Multnomah County.
- Expansion of Early Psychosis programs statewide to serve youth in their own communities.
- Suicide prevention for youth, developed cooperatively with Public Health.
- Services for youth transitioning to adult level of care, to support a stable transition through help with paperwork, transition beds, and other supports.

5. Provide Alcohol and Drug Prevention Services

In 2000-01, 11,500 people attended County-sponsored prevention events or prevention education, of which 70% were 17 years and younger. The 2000 Multnomah County DataBook estimated that over 150,000 youth and 399,000 adults needed prevention services, 85% of the County population.

Since 2001, however, state prevention funds have been reduced. Now only 1.6% of subcontracted A&D funds (less than $500,000 of $31,800,000) is available for prevention. To overcome this enormous imbalance, every effort is being made to foster prevention during system design, leverage resources, focus the prevention specialist position's efforts, and obtain additional resources.

There is consensus that substance abuse programs stand on three legs – prevention, treatment, and law enforcement – and that the prevention leg is inadequate. For example, best-practice prevention and comprehensive health curricula, shown to be extremely effective over several decades of research and implementation, have not been implemented comprehensively throughout Multnomah County school districts, and are not routinely provided with good fidelity. Priority needs include:

- Increase A&D Prevention services, ideally from a stable dedicated funding source, to foster prevention and upstream public health as a major component of the system.

6. Provide Alcohol and Drug Treatment

In 2006, MHASD provided A&D outpatient and/or residential treatment to 11,400 people (including some duplications), a number greater than the entire population of many Oregon counties. In addition, about 14,000 admissions to sobering and detoxification services are recorded each year.

An estimated 92,000 persons are in need of alcohol and drug treatment in Multnomah County annually. The reduction last year in methadone slots has increased the pressure on that system. The recent Crime & Justice Institute *Multnomah County Public Safety Planning Report* cited that, "Conservatively, on any day more than 500 Multnomah County residents are on waiting lists to enter publicly-funded, drug/alcohol residential treatment." Wait lists for general outpatient treatment are also growing, a recent development in Multnomah County. A reasonable estimate of need indicates that at least another 8,000 to 10,000 treatment episodes per year must be added to minimally meet our residents' needs. Priority needs include:

- Increase Alcohol and Drug Treatment Services, including outpatient and residential treatment.
- Increase Alcohol and Drug Free Housing (ADF), and Housing Assistance Services.

7. Enhance Partnerships to Improve Service Outcomes

Co-occurring disorders for an individual can be a barrier to effective treatment. The number of arrestees who test positive for drugs in Multnomah County is very high: 82.2% of all females and 74.7% of adult males.

Of people booked into jail, 13.8 % were identified as having a mental illness, with up to 5% having a serious mental illness. MHASD has fostered partnerships to improve outcomes for

individuals with co-occurring disorders, and requires that both mental health and addiction services providers offer or coordinate integrated assessment and treatment services, and engage in partnerships with the Department of Community Justice (DCJ), jails, health care, and other community partners.

MHASD believes that creating partnerships with business, law enforcement and health care agencies can provide better outcomes than a single agency working alone, and requires providers to work strategically with other community partners to expand services.

Workforce development is critical to support the capacity of all partners to provide effective treatment. Priority needs include:

- System of care development to create a full continuum of services, from community to acute care, for the full range of ages from early childhood to seniors, with professional education for treatment providers to implement evidence-based practices in a culturally appropriate and individual/family appropriate manner.
- Establish competency standards and associated training for co-occurring mental health and substance abuse disorder treatment.
- Mental health and addictions workforce development to help implement evidence-based practices in prevention & treatment.

Accurate data to plan and manage services is also needed across MHASD programs.

- Improved MHASD information technology and data tracking systems, to increase capacity for data-based management decisions.

IV. Access and Linkages

A. Access to the System of Care

One of the first steps in Multnomah County's Mental Health System Redesign was to improve access to care. In 2001, access and service coordination were improved by expanding services to include a call center, mobile outreach and walk-in clinics. Success of the system of care depends upon maintaining these critical system components.

The **Mental Health Call Center** is available 24 hours a day, 7 days per week to any Multnomah County resident. It serves as an information and referral hub, linking callers to community providers and other County departments, and is often the first point of contact for new services. It is also the access point for OHP clients inquiring about their Verity benefits. (Verity is the County's Mental Health Organization under contract with the State of Oregon to manage the mental health benefit for approximately 67,000 OHP members in Multnomah County.)

To reach the Mental Health Call Center, phone: 503-988-4888

The Call Center is largely funded by Medicaid, with State funds incorporated to assure that all County residents can obtain help in assessing their need and options for mental health services.

Over the past biennium, the Mental Health Call Center has increased collaboration with public safety, especially the Department of Community Justice and Corrections Health, to reduce inappropriate jail use for mental health emergencies. The Call Center now has a dedicated line for police, and a line for community corrections, so that when police or probation/parole officers interact with a mentally ill person, the Call Center can help avoid potential incarceration when treatment is more appropriate.

Over the next biennium, MHASD plans to continue to expand the family focus of the Call Center as a front door to an integrated system of care for children and families, as well as adults. More child and family specialists will be hired, and there will be more emphasis on accessing the entire continuum of care, and on addressing system navigation issues.

Mobile Crisis Teams are accessed through the Mental Health Call Center, which dispatches teams 24/7 to go on-site and support police and other emergency providers, assuring that individuals in crisis are appropriately triaged and referred to mental health services. Police also have direct access to the Mobile Crisis Teams. One team is specifically trained to link with hospital emergency departments. As part of the Waitlist Reduction Project, teams are currently contracted through Cascadia's Project Respond.

Cascadia's Urgent Walk-In Clinic is open 7 days a week from 7:00 a.m. until 10:30 p.m., providing no-appointment necessary assessment and treatment. Located in close-in SE Portland and on a frequent-service bus line, this clinic provides convenient access to licensed practitioners and crisis intervention.

B. Functional Linkages with State Hospital & Inpatient Providers

MHASD maintains functional linkages with local acute care hospitals, inpatient mental health providers and the State Hospital through the Mental Health Call Center, Pre/Post Commitment Services, and relationships maintained at the administrative level.

The **Mental Health Call Center** is the clinical resource hub for the county crisis network, providing a first point of contact for local acute care facilities and emergency departments. The Mental Health Call Center is consulted before admission of any Verity (OHP) member, to consider the medical necessity for acute care services, and to assess clinically appropriate diversion alternatives. After the first day of inpatient admission, pre-authorization for acute care services is required by Verity for the purpose of community coordination, utilization management and payment.

For all acute care admissions, the Call Center identifies whether the person has a treatment provider in the mental health system, and if so, notifies this provider of the admission and engages them in care coordination and discharge planning. If there is no provider, the Call Center coordinates referral for a provider who will begin to offer outpatient mental health services, usually prior to discharge from acute care.

MHASD presents regularly to acute and crisis providers to foster relationships with the community emergency services and crisis network. These meetings solidify the Mental Health Call Center's lead role in the mental health crisis system, and serve as a forum for discussing resources and strategies for keeping consumers in the least restrictive setting.

Pre- and Post-Commitment Services at MHASD are another primary point of linkage with local acute care hospitals and the State Hospital.

The Pre-Commitment/Involuntary Commitment Program (ICP) is responsible for investigating all Notices of Mental Illness filed in Multnomah County to determine whether persons held involuntarily for mental health treatment should be referred for civil commitment. Through daily contact with staff and patients of all local acute care hospitals, the ICP investigates these Notices, explores less restrictive treatment options and strengthens linkages between inpatient and outpatient providers.

For all persons who are civilly committed, the MHASD Post-Commitment Monitors connect individuals upon their discharge with community mental health treatment providers. Post-Commitment Monitors have daily contact with each local acute care hospital to link to community resources, monitor referrals to the State Hospital, and oversee discharge planning.

Within Post-Commitment Services, MHASD has designated a position to follow each Multnomah County resident committed to the State Hospital, and to participate in discharge planning with State Hospital social workers. Post-Commitment Services is designing an electronic tracking system for all Multnomah County residents placed in other counties upon discharge from the State Hospital, to facilitate eventual return to Multnomah County.

Over the next biennium, a new evidence-based program called Critical Time Intervention (CTI) will be implemented to interface with hospitals to address the needs of individuals with high utilization of inpatient care, psychiatric care or involuntary commitment. CTI will provide

intensive case management for individuals transitioning from hospitals, jail or from the front door as diversions, for up to 90 days. CTI case managers will exit once there is a solid link to a provider, and connections to natural supports that help achieve the best level of recovery, thus reducing recidivism.

Administrative Coordination: MHASD maintains administrative relationships with local acute care hospitals through participation in the monthly Metro Acute Care Advisory Council (MACAC), which is comprised of representatives of all local acute care hospitals that provide psychiatric care, as well as metro-area county mental health agencies, and outpatient mental health providers. The MACAC addresses system issues related to acute mental health care.

MHASD also participates in monthly Regional Emergency Department meetings, as hospital emergency departments are often the point of entry to inpatient mental health treatment.

In partnership with the medical staff of contracted outpatient providers, MHASD initiated a bi-monthly meeting involving inpatient and outpatient physicians and clinical administrators to facilitate consistent, functional communication between inpatient and outpatient treatment providers.

The manager of MHASD Adult Safety Net Services participates in monthly meetings of the State Governing Board to maximize effectiveness and efficiency related to the movement of consumers from the State Hospital to the community.

V. Program Plans

MHASD serves about 28,000 unduplicated individuals annually. Plans for each age group in the system of care, and for alcohol and drug prevention and treatment, are described below.

With the diverse needs of the many populations served, the complexity of operating the MHASD system of care has increased greatly. In addition to program improvements, MHASD will add a data analyst and improve information technology and data tracking systems, to increase the capacity for data-based management decisions for the system of care.

A. Child, Youth and Family Service Plan

System of Care for Children and Families

MHASD serves approximately 8,000 children and youth, 5.1% of the population under age 18, through a continuum of system of care services.

The **Children's System Change Initiative (CSCI)** was officially implemented October 1, 2005. The initial focus was assessing children and youth placed in, or at risk of, psychiatric residential treatment services, and developing a service coordination plan with the family that met the needs of the child and family in the community, at home and in school.

The following providers and services were added to the provider pool:

- Catholic Community Services of Southwest Washington, for intensive in-home services using a "whatever it takes" philosophy to help families.
- Options Counseling Services, utilizing Multi-Systemic Therapy, an evidence-based practice that has demonstrated results for clients with diagnoses of conduct disorder and oppositional defiant disorder.
- Morrison Family Services, Albertina Kerr, and LifeWorks Northwest, providing individually tailored mental health services, an intensive service model incorporating skills trainers, therapists, psychiatric services, respite and after-hours crisis response.
- Respite services, through ChristieCare, Morrison, Trillium Family Services, Boys and Girls Aid Society, and Catholic Community Services of Southwest Washington.
- Treatment foster care, through Trillium Family Services, using the Multi-dimensional Therapy Model.
- Family Care Coordination Team (FCCT) at Multnomah County, which facilitates Child and Family Teams for clients who are determined eligible using the CASII (Child Adolescent Service Intensity Instrument).
- Transition Age Youth Services provided by Cascadia, targeting youth with the developmental challenge of entering adulthood with a severe mental health disorder.

Last biennium's statewide and Multnomah County data indicate the number of admissions and total bed days for psychiatric residential services (PRTS) has dropped dramatically. Average length of stay in Multnomah County for the first half of 2007 was 49 days; prior to the implementation of CSCI, the length of stay in PRTS could be 1 to 2 years. The monthly cost to

Verity (OHP) for PRTS services in October 2005 was $147,680; in September 2007, the monthly cost had dropped to $62,028.

Using new state funds (MHS 22) to fund services for the non-Medicaid population, the CSCI covers services for early childhood, school-age children and youth, and transition age youth, with a goal of providing age-appropriate mental health services for each group. This continuum of care for children and families includes outpatient services, intensive community-based treatment services, and intensive treatment including residential placement and hospitalization where needed. Transition Age Services are intensive outpatient services designed to prevent youth from falling through the cracks as they move from the children's system of care to the adult system.

Through **Intensive Community-based Treatment Services** (Service Element 22), MHASD is serving up to 30 children who are in or at high risk for psychiatric residential placement, but are not Medicaid eligible for services prior to or following placement. The goal is to prevent higher levels of out of home placement. Services will be coordinated by the Family Care Coordination Team or provider care coordinators, and will include family preservation, evidence-based treatment strategies, collaborative problem solving and respite.

Child and Family Teams are a key feature of CSCI, and are charged with developing a service coordination plan to meet the needs of the child and family at home, in the community and at school. Teams are composed of the family, the child if age-appropriate, as well as a school representative, mental health provider, child welfare case worker if applicable, juvenile court counselor if applicable, and other natural support persons that the family has identified. Natural supports may be neighbors, extended family, or perhaps the pastor from their church.

Statewide data indicates increased billings for respite, skills trainers and case management, demonstrating that Intensive Community-based Treatment Services are being utilized by our families. The number of clients served by Verity (OHP) utilizing Intensive Community-based Treatment Services has risen from 84 in November 2006 to 156 in November 2007. This means these children and families are receiving their mental services at home, in the community and at school.

Evidence-Based Practices

The following evidence-based practices have been implemented or supported among children's services providers: Multi-systemic Therapy, Multi Dimensional Treatment Foster Care, Transition Age Youth Services based on Assertive Community Treatment model, Cognitive Behavioral Therapy, and Incredible Years.

A training on the Collaborative Problem Solving model for youth with assaultive or aggressive behavior, led by Legacy Emanuel Children's Psychiatric Unit and promoted by MHASD, resulted in families advocating for adoption and availability of this evidence-based practice. State AMH facilitated a statewide video conference with developer Stuart Ablon, leading to a 2-day training event in October 2007 attended by over 250 people representing child serving agencies and families from Multnomah County and across the state.

Coordination of Care

The Community Care Coordination Committee (C-4) is charged with identifying and resolving system barriers. This committee surveyed families, providers and partners for training needs, from which MHASD subsequently co-sponsored needed trainings with Wraparound Oregon, Legacy Emanuel Children's Psychiatric Unit, and State AMH. C-4 developed recommendations for strategies for assaultive and aggressive youth and chronic runaways. The committee is currently developing goals and objectives to deepen the cultural competency of the children's system of care and to address the crisis in community-based placements for children who cannot live at home.

The Children's Mental Health System Advisory Committee (CMHSAC) regularly advises MHASD on services for children, youth and families. Recently CMHSAC recommended adoption and implementation of a mental health screening tool which can be administered in a school setting. It has also recommended that MHASD Quality Management develop a plan to sample and review clinical charts for family involvement in treatment planning.

The School MOU (Memorandum of Understanding) group developed a Transition Protocol to integrate students back into school after discharging from PRTS, psychiatric day treatment, and juvenile detention. DHS Child Welfare is in the process of adapting these protocols for use with children who are discharging from Behavioral Rehabilitation Services. Schools have proved to be willing and flexible partners in providing for the individual education needs of children with mental health issues.

Family and Youth Participation in Planning & Service Development

CMHSAC has adopted a 51% requirement for youth and family membership, strengthening the level of consumer participation in MHASD planning. MHASD also seeks feedback from our partners through the C-4 committee, the School MOU group, monthly co-management meetings with DHS Child Welfare, NAMI, OFSN, and regular meetings with our providers

The **Oregon Family Support Network** (OFSN) has been participating in CMHSAC to increase family voice. One to two OFSN members have participated over the past year, and have been influential as system advocates. OFSN will receive a contract this year to help develop a meaningful youth voice for consumers under age 21.

A family member participates on MHASD's Quality Management committee. The agency's Youth Satisfaction Survey is a key strategy for evaluating the effectiveness of MHASD services for children and families. Staff also monitor the utilization of services.

Cultural Competence & Respect for Diversity

The MHASD Family Care Coordination Team (FCCT) strives to match the cultural needs of children, youth and families by hiring a diverse team. This includes a Spanish-speaking bi-cultural care coordinator, and an African American care coordinator on the team. Providers are required to be culturally competent, and recently the expectation has been increased to require a Spanish-speaking qualified mental health professional (QMHP) to qualify for a contract for early childhood outpatient mental health services. This requirement for multi-language capacity will be expanded as new RFPQs are issued.

Care coordination by the Family Care Coordination Team and providers has given families a voice in planning services for their child. They are no longer left to merely listen to the experts tell them what they should do. They are the experts on their child and participate in identifying the strengths and needs of their family. Their strengths are tools to assist them in meeting their own needs and the needs of their children. Identifying strengths honors the healthy and positive qualities of these families. Natural supports are incorporated into the planning and increased over time as the family identifies additional resources in their family and their community.

Our plan is to listen to our families about how we may better serve them and their children, to further deepen our cultural competency, to evaluate promising evidence-based practices, and to collaborate with our community partners to incorporate and implement these practices in our mental health service array and child serving agencies.

Improvements in Service Array

Decisions to improve the array of services are based on service utilization, management reviews, and feedback from a network of advisory and community groups including: the Children's Mental Health System Advisory Council (CMHSAC), Wraparound School Age and Early Childhood Councils, Community Care Coordination Committee (C-4), the Complex Case Consultation (C-3) group, and providers.

Service improvements that started in the past biennium, or are being implemented now, include:

Family System Navigators: An RFPQ this year resulted in an award to NAMI to work with families on accessing mental health services. Family System Navigators will be advocates who are knowledgeable about the mental health system. They will attend family team meetings, work with the Family Care Coordinators, help youth and families access other services and benefits, and support a better overall experience for families.

Sub-acute Services: An RFPQ for sub-acute services this year resulted in contracts with Albertina Kerr and Trillium as providers. These sub-acute services are for youth ages 11 to 18 who can be diverted from a higher level of care placement, or who need short-term (5 to 9 days) step-down placement from hospital acute care. Both providers can accommodate 24/7 admissions.

Intensive Outreach: Using new state funds, this Intensive Outreach program is being started in cooperation with DHS Child Welfare to reduce child placement in foster care and support family preservation. Outreach specialists placed in the Courts will be available to help families access and complete Court-mandated treatment, resulting in the opportunity to regain custody of their children and preserve the family.

Early Psychosis Program: Research indicates that the median age for onset of an initial episode of psychosis is under 25, and that young people between the ages of 15 and 30 are the group most likely to suffer longer-term undesirable consequences if not provided early intervention. MHASD is therefore implementing a new Early Psychosis Program (EPP), based on a successful model developed by Dr. Patrick McGorry and demonstrated over the past 6 years by the Mid-Valley Behavioral Care Network through their Early Assessment and Support Team (EAST).

MHASD's Early Psychosis Program will replicate the EAST program, providing outreach and active engagement; assessment and treatment with a team of professionals including psychiatry, social work, occupational therapy, nurse, and vocational training; multi-family psychological and social education; cognitive behavioral therapies and interventions; vocational and educational support; medication management using low dose protocols; support for individuals in home, community, school, and work settings; and other services required to meet the needs of the individual and maintain program fidelity.

Wraparound Oregon (School-Age): Multnomah County has partnered with Portland State University (as researcher) and Albertina Kerr (as fiscal agent) to test the efficacy of the Wraparound Milwaukee Model of providing treatment services to school-age children and youth ages 6-18 in Multnomah County. It is a parallel process to CSCI. The pilot project has served over 25 clients since January 2006. The emphasis is on family-driven decision making with one care coordinator, one plan of care for each child or youth, a crisis emergency plan, a provider network of formal and informal supports, coordinated services, shared funding using existing service dollars, web-based information management, cross-system training, and outcome and process evaluation.

Wraparound Oregon: Early Childhood uses the Wraparound Milwaukee Model to provide early intervention services to children ages birth to 8 years old who have a diagnosed or emerging mental health condition. Children may be eligible for early intervention and may be at risk or already in an out of home placement. The early childhood project is federally funded through a $9 million dollar 6-year grant from SAMHSA and has served about 43 clients to date.

MHASD is actively participating in the collaborative planning efforts to implement the Governor's **Statewide Children's Wraparound Initiative** within Multnomah County.

Collaboration for Comprehensive and Coordinated Supports

MHASD fosters collaboration with other child-serving agencies. The Children's Mental Health System Advisory Council (CMHSAC) includes provider agency representatives, as well as 51% youth and family representation. The multi-agency Community Care Coordination Committee (C-4) meets monthly. The Complex Case Consultation (C-3) group provides weekly consultation and case review for real time collaboration and coordination with other child serving agencies.

MHASD managers also participate in community-based coordination groups. MHASD serves on steering committees for Wraparound Oregon (School Age), operated through Albertina Kerr, and for Wraparound: Early Childhood, operated through the Multnomah Education Services District. The Early Childhood manager participates on the Early Childhood Mental Health Committee of the Commission on Children, Families and Community, where a wide array of child serving agencies, including child care and Head Start providers, work toward system improvements.

B. Adult Service Plan

MHASD provides mental health service to approximately 20,000 adults over age 18, about 3.7% of the County adult population. Approximately 2,900 of these individuals are transition-age youth and adults, ages 18 to 25.

Adult services are primarily funded by the Oregon Health Plan (OHP) through MHASD's Verity Mental Health Organization (MHO). While this plan focuses on State General Fund money administered through the State AMH, major changes in the adult system of care as well as in AMH-funded services are described below.

Changes in the Adult System of Care

Adult services are built on a recovery model, allowing people to enter treatment when they are ill and move to a lower level of care or exit treatment when their needs lessen.

Many people in adult services face multiple health, mental health and addiction issues, where integration of services provide the best outcomes. Integration of mental health and addiction services has been strengthened by the MHASD requirement that providers in both systems provide integrated services for individuals with co-occurring disorders. Integration of services with criminal justice agencies is being developed through staff outreach assignments and by continuing joint procurement for addiction services with the Department of Community Justice.

The newest area for integration is between mental health and primary care. Over the past biennium, three providers have added medical staff to mental health clinics to address co-occurring medical disorders. A pilot project, using County and Verity funds, is being conducted in a collaboration between Central City Concern and Care Oregon. In addition, Cascadia has arranged with Kaiser Health Care to place a Kaiser RN in one clinic, and LifeWorks Northwest has hired an RN to augment mental health services in one of their clinics.

In recognition of the County's growing ethnic diversity, all MHASD contracts require that culturally specific needs are met through provision of culturally and linguistically appropriate treatment.

MHASD is responsible for ensuring that there is a spectrum of services available to meet individual needs, and that providers are in compliance with state and federal regulations. Workforce development is a key strategy toward this goal, and MHASD provides evidence-based practice training in specific clinical modalities so that providers have the resources to implement the best clinical practices. Training is also offered on compliance with regulatory mandates, and billing in a fee for service environment. MHASD is hiring staff for technical assistance and consultation to providers, and Child and Family and Adult System of Care Coordinators will provide technical assistance for providers.

Diverse consumer needs have prompted a goal of diversifying the provider network, incorporating providers of unique services such as supported employment, supported education and designated outreach, to expand system capacity and options for consumer choice.

Transitional and permanent housing are also pressing needs. MHASD is actively engaged in the City of Portland's 10 Year Plan to End Homelessness, and in advocating for transitional low-

barrier housing to remain a priority to assure immediate access for individuals with mental health and addiction needs.

Another critical priority is meeting the needs of those most at risk. Evidence-based practices such as Assertive Community Treatment (ACT), Dialectical Behavior Therapy (DBT) and the Early Psychosis Program are important for individuals at high risk of needing acute care services who have not done well in traditional outpatient programs. An increased focus on Transition Age Youth will begin with designing a program to best meet the needs of youth just coming into the adult system of care, preserving their family relationships and supports.

A key unmet need is a sub-acute crisis assessment and treatment facility to serve as an alternative to placement in the hospital or jail, for adults and transition-aged youth (age 18 to 25) experiencing a mental health crises. This need was highlighted as a short term priority in the recent *Multnomah County Public Safety Planning Report* (Crime and Justice Institute, January 2008). MHASD will continue to work with the County Chair and Board to develop a feasible plan for sub-acute services.

Changes in AMH-funded Adult Services

Critical Time Intervention (CTI) Project: Using AMH crisis funding, MHASD plans to implement a CTI project to address the needs of indigent transition-age youth and adults who are being discharged from institutional care (psychiatric hospitals or hospital emergency departments), but need assertive short-term intervention to reduce risk of readmission. CTI strengthens the consumer's long term connection to treatment services, family and friends, and provides emotional and practical support during a critical transition period. MHASD will hire a CTI team for a modified-fidelity program providing services over 3 to 4 months, versus the 9 months in the original model, with transition to stable community-based care and housing.

High Utilization Diversion (HU Diversion): Additional AMH case management funding will be used to concentrate efforts on mentally ill individuals who are habitual users of high intensity, high cost services, including State hospitals, local hospitals and the jail. The new HU Diversion staff of two mental health professionals will maintain or connect a person with housing, Medicaid eligibility and services. Drawing on the expertise of the Call Center, Emergency Department Liaisons and Jail Outreach staff, the HU Diversion team will provide "combined diversion," encompassing diversion at the point of admission, as well as reducing the length of stay in jail or hospital after an admission.

Supported Employment (SE) Initiative: This new AMH funded project is an approach to helping people recovering from a mental illness, based on evidence that people with mental illness are more likely to find jobs if helped by supported employment than any other type of program. MHASD has contracted with local agencies with demonstrated success delivering mental health or substance abuse services. LifeWorks Northwest will implement this program at their King site where twenty percent of consumers are African American, and Central City Concern will serve from a downtown location, targeting those with dual diagnoses, criminal justice involvement or homelessness. Services will help people find and keep employment and self-employment, using best-practice models based on consumer choice.

Jail Diversion Funded Services

Mental Health Court Pilot Project: With new dollars from AMH, MHASD is collaborating with the Judicial and Criminal Justice Systems to implement an expansion of the Community Court Project. With a goal of successfully diverting mental health consumers from the Criminal Justice System, MHASD will hire three qualified mental health staff to work primarily in the field, assisting individuals diverted from jail, and reporting to the Court on their status. Staff will link individuals to benefits, housing, medical and social services, and outpatient mental health services. Maintaining contact for up to 45 days will allow time to assess consumer level of engagement with community providers.

370 Project: With new dollars from AMH, MHASD is participating in a 3-county pilot project for consumers charged with misdemeanor crimes and ordered to undergo an "Aid and Assist/Treat until Fit" evaluation, with the intent of diverting them from the criminal justice system to the mental health system. This project will provide: evaluation of mental status, options and recommendations for stabilization, evaluation of basic needs, and coordination of service with criminal justice and mental health systems. MHASD is hiring 2 qualified mental health professional case managers to facilitate increased engagement with the Criminal Justice, County Mental Health and State Hospital systems. Staff will function as connectors to benefits, housing, medical and social services, and mental health outpatient services.

Waitlist Reduction Project (WLRP): With on-going AMH funding, MHASD is implementing changes in this program. The WLRP position dedicated to providing engagement, transition planning and community support services to Multnomah County residents in the State Hospital was initially sited with a community mental health provider. With the advent of co-management, MHASD has changed this to a County position in order to increase facilitation of discharges of Multnomah County residents from the State Hospital. The staff begins engagement with State Hospital patients soon after admittance, and continues providing discharge-planning services up to the point of a successful placement in the community.

C. Older Adult Service Plan

Older Adult Needs

MHASD serves about 810 people who are age 65 and over, approximately 1.1% of the older adult population.

Older adults often have unique needs and circumstances. Elders, as well as their families and providers, often fail to recognize treatable mental disorders. According to SAMHSA, "mental disorders are not a normal part of aging, yet a significant number of older adults have these serious but treatable diseases." (*Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities*, SAMHSA, 2004)

Suicide prevention is also a major concern. Oregon has the fourth highest suicide rate in the nation for older adults, especially for older males, who have nine times the suicide rate of older females in the state. Older adult suicide rates are the highest of any age group. (*Oregon Older Adult Suicide Prevention Plan, DHS Office of Disease Prevention and Epidemiology*, 2006.)

People older than 60 make up more than 14% of the county population

General Multnomah County Population (2000 Census):

▪ Total County Population	660,486	100.0 %
▪ Persons Age 60+	94,567	14.3% of County
▪ Persons Age 65+	73,607	11.1% of County

Multnomah County anticipates growth over the next decades in the number of older adults with mental disorders, largely due to the aging of adults who already have serious mental health and addiction issues. The number of older adults in Oregon is expected to double over the next thirty years, largely due to the maturation of the "baby boomer" cohort, who will begin to reach age 65 in 2011. Greater longevity resulting from improved health care and other social factors adds to this projection.

In 2001, the Governor and Oregon State Legislature recognized these special needs and created SB781, to support county mental health and developmental disability programs to include preventive mental health services and early identification of problems for older adults.

Current Service Capacity

MHASD is developing both provider capacity and outreach to address the mental health needs of older adults who may not able to access care because they are isolated, lack the knowledge of what is available, lack resources to pay for services, have significant medical issues, perceive a stigma in seeking help, or lack ability to navigate the system.

Outreach Services

Oregon's 2006 Suicide Prevention Plan lists clinical outreach programs to older adults as a key strategy in reducing suicide for this age group. Outreach is also critical in locating elders with treatable mental disorders. Because reaching older adults requires unique strategies, MHASD has partnered with Multnomah County Aging and Disability Services Division (ADS) to develop a collaborative outreach system and educate MHASD staff about general senior services and issues related to aging.

Mental Health Call Center staff have been trained to interface with the ADS 24-hour hotline to coordinate mental health crises that may be called in to either system. The Call Center may be contacted by hospital emergency departments, the Health Department, or primary care providers who identify an older adult needing mental health services. Older adults needing services may also be located through contact with 24-hour mobile outreach, or the urgent walk-in clinic.

The **Multi-disciplinary Team (MDT)** is a collaboration between MHASD and ADS. ADS staff developed the model and oversee the program within their Adult Protective Services (APS) program, while MHASD manages contracting and payment. The contract for MDT services was recently awarded to Lutheran Community Services as the lead agency, based on their work with immigrants and culturally specific populations, which will enable the MDT team to address the needs of Multnomah County's diverse seniors and people with disabilities. The focus is on emergent and acute needs, usually where mental health and APS intersect. The MDT provides outreach, assessment, short-term counseling and stabilization, and linkage to appropriate follow-up mental health treatment.

Treatment Services

Services for all ages of consumers 18 and older are provided through MHASD's outpatient provider agencies, including services for older adults.

New this year, specialized outpatient services in long term care are being provided by Cascadia to older adults in nursing homes, adult foster homes and residential care facilities, as a component of Verity services. Rather than focusing on outreach and assessment as had been the case previously, this Cascadia service now focuses on on-site delivery of enhanced services to older adults identified by their facilities or the MDT.

Service Gaps and Unmet Needs

Older adults too often do not access traditional mental health services because of unfamiliarity or stigma. Their unique needs require the use of service modalities, such as co-location with other aging services or consistent engagement, to normalize mental health treatment.

There is a lack of residential housing options for older adults with mental health issues. There is also a lack of targeted addiction treatment for older adults, who often face this issue.

Mental health and addiction issues alone do not usually cause an impairment that would meet the state's service priority levels, and qualify a senior for ADS services. This can result in difficulty determining which program has the capacity to provide case management (MHASD or ADS), or crisis services (Project Respond or Adult Protective Services). Where medical and mental health issues are both present, it may require specific testing to determine the best treatment approach.

Workforce Development Efforts Needed

- Increase capacity to address older adult behavior issues through training for provider staff that includes such topics as: understanding the differences between dementia, Alzheimer's, depression, and other types of mental disorders, and how to normalize mental health treatment.
- Increase the supply of geriatric mental health specialists, and encourage adequate compensation to improve retention among providers. Encourage a model where a geriatric specialist is available to consult with any provider who is serving an older adult.

D. Alcohol and Drug Prevention Plan

Prevention Planning

Comprehensive Prevention Study: A study on the status of prevention in Multnomah County was undertaken by the University of Oregon in fall 2005 through June 2007. The study summarized existing research findings about key characteristics and critical intervention points of a comprehensive prevention program for Multnomah County, and conducted a scan to determine which characteristics and intervention points are currently implemented. The report concluded that there is a need for a comprehensive prevention system in Multnomah County. As a result, the Commission on Children Families and Community conducted additional study to determine next steps. Part of the current efforts by the A&D Prevention Coordinator and other

County personnel is to create a shared definition of prevention, and an inventory of County prevention programs.

Community Action to Reduce Substance Abuse (CARSA) is continuing their planning and visioning work. CARSA recently developed a vision for a Portland Drug Strategy, which will be presented to the Portland City Council in the near future. Collaboration regarding problems with methamphetamine use culminated in implementation of Oregon precursor laws that have virtually eliminated local meth labs and fostered planning that resulted in several large treatment and law enforcement systems grants. The CARSA coalition produced the second edition of the Portland Profile, which tracks substance abuse indicators and identifies key areas of concern, which is taken into consideration in MHASD prevention planning.

Availability of Prevention Funding: Only one service element, A&D 70, is specifically focused on prevention. A&D 80 includes both prevention and early identification. Due to severe funding limitations for other service elements, less than $500,000 out of $31,800,000 – or 1.6% of subcontracted funds – are being devoted to prevention. To overcome this enormous imbalance, every effort will be made to foster prevention during system design, to leverage resources, and to obtain additional resources.

Prevention Goals: The following goals have been developed for the A&D Prevention Program.

- Stabilize and/or strengthen existing prevention initiatives and collaborations, and continue intersystem collaboration and integration efforts.
- Incorporate best-practice approaches, including family-strengthening strategies and services across the continuum of prevention and treatment services.
- Increase access to services for very high risk and/or under-served populations.
- Support academic success and high school completion.

Major Program Areas

Consistent with the Federal Center for Substance Abuse Prevention (CSAP) strategies, MHASD will deliver A&D Prevention services in the following areas:

CSAP Strategy	MHASD A&D Prevention Program (A&D 70)
Information dissemination on substance use, abuse & addiction and their effects on individuals, families and communities.	MHASD Prevention Coordinator
Education and interaction between an educator/ facilitator and participants to affect critical life & social skills, including decision-making, refusal skills, critical analysis and judgment abilities.	Housing Authority of Portland
Alternatives through participation of target populations in activities that exclude substance use.	Housing Authority of Portland Latino Network Asian Family Center
Problem identification and referral for those who have indulged in illegal/age-inappropriate use of tobacco or alcohol, to assess if their behavior can be reversed through education.	Housing Authority of Portland
Community-based process to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders.	Latino Network Asian Family Center MHASD Prevention Coordinator

CSAP Strategy	MHASD A&D Prevention Program (A&D 70)
Environmental strategy to establish or change written/unwritten community standards, codes and attitudes, influencing incidence and prevalence of substance abuse in the general population.	[Underage Drinking, funded by AMH in the past, emphasized an environmental strategy]

Fund Allocation

The Multnomah County Mental Health and Addiction Services Division recommends supporting the following A&D 70 prevention program elements:

- Maintain a full-time (1.0 FTE) A&D Prevention Coordinator, plus $500 in travel funding.
- Maintain the A&D Prevention contracts spending level for minority services by continuing support for the Housing Authority of Portland youth services program, a long-term collaborative prevention initiative which serves a high proportion of people of color in public housing communities, and two culturally specific community-based organizations.
- Maintain technical assistance support for existing and new prevention community coalitions.

A&D Prevention Coordinator: Due to union-mandated salary and benefit increases for the position, the A&D 70 base funding remaining for contracted prevention activities is reduced approximately 5% in the upcoming biennium. In order to foster system stability, only one large and two small ongoing long-term programs will be funded using A&D 70 base funding.

A&D Prevention Contracts

The **Housing Authority of Portland (HAP)** will receive the largest funding commitment in the A&D 70 prevention plan. This collaborative effort, managed by HAP, involves multiple funders and planning processes, including the City of Portland's Children's Investment Fund (CHIF). A competitive procurement was held by HAP during 2007 for the A&D 70 funded portion of the program, which provides after-school clubs and core services to youth and their families, including school liaison services, individual tutoring and mentoring, and home visits. It also offers a Reading Together program and monthly alumni group based on the best practice Families and Schools Together (FAST) program, adapted to focus on an identified need of improving reading readiness. HAP regularly updates and revises details of the program; for example, staff assigned to New Columbia have been re-assigned to Gateway Park due to the increase in other services available to New Columbia residents.

The **Latino Youth Network** will provide project coordination and outreach to engage youth in a youth soccer team, which will participate in the Oregon Youth Soccer Association's league.

The **Asian Family Center's TUNE** (Teens Uniting for a New Era) program will develop youth leadership by involving youth in planning and implementing projects and community events.

Additional State Funding:

Additional funding from competitive grant awards will double contracted prevention funding, from approximately $400,000 to $800,000.

Safe and Drug-Free Schools (S&DFS) funds were recently redirected to a new cascading service learning and mentoring program which focuses directly on the goal of fostering school success. In this student peer support project, college students will work with high school

students, building teams to work with grammar school students to help promote the younger children's academic success, while involving the older students in service learning.

The **Strengthening Families (SFP 10-14)** grant provides startup funding to begin implementing this highly effective program county-wide, starting this year. Staffed by LifeWorks Northwest in HAP locations, this program involves sixth graders and their parents in a weekly evening event for 7 weeks. Over dinner, a family issue is introduced, after which parents and youth separate for an initial discussion on the topic, then get back together for a second hour and share in a joint discussion. LifeWorks staff will recruit faith-based organizations to provide volunteers who will learn to lead the program for their congregations, and help expand the program in schools.

During 2007-09, state competitive funding is making it possible to offer the Strengthening Families evidence-based family training program to HAP families at one HAP location, six associated SUN schools, and an additional middle school. This funding is also training faith community volunteer groups to provide additional low-cost trainings throughout the county. Additional County funds are being sought to expand this program and recruit additional faith community volunteer groups to further leverage resources, making SFP 10-14 the county's largest A&D prevention program.

Strategies to Address Underage Drinking

AMH previously provided specific funding for reducing underage drinking. This funding has since been eliminated. Without access to dedicated funding, MHASD has allocated $10,000 to this effort from other funds, less than a quarter of previous funding. Current efforts focus on convening partners to redesign the Minor in Possession system, exploring increased consequences for youth in possession of alcohol. However, implementation of a new system, including public education and addressing access to alcohol products, will be difficult without additional dedicated funding.

Comprehensive, Coordinated Plan Priorities (SB555 Plan)

MHASD actively participated in the Commission on Children, Families and Community-led planning process for this 2008-2014 community-wide plan. After careful deliberation, the CCFC and County Board decided that this 6-Year Community Plan will focus on two broad goals:

1) Improve academic success and high school completion rate, and increase student access to medical care; and

2) Decrease poverty rates for families with children, particularly for low-wager earners.

All activities in the proposed A&D 70 category support the top goal: academic success and high school completion. Federal funds, flowing through AMH for Safe and Drug Free Schools, will be spent on programs specifically focused on school success.

Support for Ongoing Development of Community Coalitions

The Multnomah County Prevention Coordinator will continue to be a participant in the activities of the substance abuse prevention coalition, CARSA.

Multnomah County staff participated in the development of the second edition of the Portland Profile, published by CARSA, a publication that gives data on substance abuse problems. Staff will continue work on updating and improving the quality and utilization of this product.

Cultural and Gender Specific Programs

A&D 70 funding will continue to support culturally specific coalitions and community-based organizations at approximately the current level. These are the Latino Youth Network and TUNE (Teens Uniting for a New Era), a project through Asian Family Center.

Professional Development Training for Prevention Staff & Providers

A priority for the Prevention Coordinator will be participating in and providing technical assistance to CARSA, a substance abuse prevention coalition was formed as part of the ONDCP (Office of National Drug Control Policy) Major Cities Initiative. This coalition is implementing a Drug-Free Communities grant, adding new partners, and writing a Portland Drug Strategy.

Specific Prevention Strategies

A&D prevention programs, outputs, and outcomes are listed in Attachment 10. Subcontract information is provided in Attachment 1.

E. Addiction Service Plan

Current Services

In 2006, MHASD provided A&D outpatient and/or residential treatment to 11,400 people (including some duplications), a number greater than the entire population of many Oregon counties. In addition, about 14,000 admissions to sobering and detoxification services are recorded each year.

MHASD provides an array of Addiction Treatment services, including case management, transitional housing, and relapse prevention designed to assist clients in their struggle to achieve and maintain their sobriety. Services include:

- Addiction Services – Detoxification, Residential, Outpatient, Methadone Treatment, Supported Housing, and Support and Education.
- Mentorship programs for clients with substance abuse problems to support them in recovery group participation as well as other services.
- Culturally and linguistically appropriate treatment to high-risk clients with a substance abuse disorder.

The majority of these treatment services were procured in 2004 in a joint procurement by MHASD and the Department of Community Justice (DCJ). Procurement planning included a series of community meetings attended by clients, family members, community members, and treatment provider staff held in 2003.

The Alcohol and Drug Assessment and Referral program designs treatment programs for 5,100 individuals annually including individuals charged with driving under the influence of intoxicants. MHASD provides over 1,100 outpatient treatment slots per year, and spends over $450,000 per month on residential treatment. However, this is estimated to meet only 50% to 60% of demand.

Unmet need is the largest single factor currently influencing addiction planning in Multnomah County. Over 300 people are on the wait list for residential treatment. The reduction last year in

methadone slots has increased the pressure on that system. Wait lists for general outpatient treatment are growing, a recent development in Multnomah County.

Increasingly, high priority clients must compete for the same limited resources. These high risk groups include people needing addiction treatment who are: being discharged from jail; frequent offenders at Community Court; homeless individuals needing to access drug free housing; IV drug users; and women seeking residential treatment as part of DHS agreements to have their children returned. Many other low income county residents have equally urgent needs to obtain addiction treatment for themselves or family members.

Coordination with Residential and Detox Providers

The four A&D residential providers all have outpatient programs, streamlining coordination from one phase of treatment to the next. These providers (CODA, DePaul, LifeWorks Northwest, and the Letty Owens program of Central City Concerns), along with Central City Concern's Hooper Detoxification Center, (including the CHIERS outreach van, a sobering program and a sub-acute program), have longstanding relationships and are knowledgeable about each other's services.

Contract changes are planned over the coming year so that all outpatient and residential treatment providers will set aside a proportion of treatment slots to facilitate movement of individuals out of detox and into residential and treatment, at the level appropriate for their needs.

Coordinating with Criminal Justice

In 2003 and 2004, MHASD planned and implemented a joint procurement process with the Department of Community Justice (DCJ) for alcohol and drug (A&D) treatment services. Resulting from this is an integrated system, in which DCJ manages their own treatment slots and purchases services from A&D providers.

The allocation of State AMH and County General Funds to providers and services selected through the RFPQ was done to maximize resources and provide as broad an array of A&D services as possible. This allocation is evaluated annually based on the criteria in the RFPQ, but primarily on the resources available. MHASD and DCJ co-chair a monthly meeting with these shared providers and jointly manage the treatment system.

DCJ recently compared individuals involved with probation or parole with those receiving A&D services and found a 32% overlap of mostly lower level offenders. This figure highlights the need for continued coordination.

The Addiction program, in conjunction with DCJ, is currently planning a new joint 5-year procurement which will be released in 2009. In conjunction with DCJ, our citizen's councils, the provider network, and others, the Addiction program is developing initiatives to: strengthen the connections between service levels, particularly between detox and residential; increase the availability of transitional housing; increase the focus on employment services; and develop practices to increase our rate of successful completions in treatment. Allocations from this process will be effective July 2009, and may be different from the current system.

In Multnomah County, drug court referrals and prioritization are handled by DCJ. Clients are referred to agencies that have contracts with the drug courts.

Use of Evidence-Based Practices

MHASD's Alcohol and Drug program is working with providers to ensure progress toward satisfying SB 267 requirements for the incremental implementation of evidence-based practices. At this stage, this effort is ahead of schedule. As A&D makes funding changes or adds new providers, providers are asked to specify which evidence-based practices they are using, and this is added to their contracts. Common practices being that are currently being used include: Cognitive Behavior Therapy, Motivational Interviewing, Seeking Safety, and the Matrix Model.

F. Problem Gambling Service Plan

Annually the County's treatment providers serve approximately 540 gamblers and 102 family members, for a total of 646 individuals.

Multnomah County has the highest lottery sales statewide. 71% of lottery sales are from video poker, and 78% of gamblers in treatment report video poker as their primary game of choice.

Problem gambling services are guided by a public health approach that takes into consideration biological, behavioral, economic, cultural and policy determinants influencing gambling and health. The programs incorporate prevention, harm reduction and multiple levels of treatment, by placing emphasis on quality of life issues for the gambler, their family and the community. Services include outreach, prevention and treatment.

Gambling addiction treatment uses evidence-based practices in an outpatient setting for individuals diagnosed with problem or pathological gambling. The average successful completion rate in the county is 39%. Countywide data shows that problem gamblers seeking treatment can access services in less than five days.

Problem gambling treatment services are closely aligned to Multnomah County's Basic Living Needs funding priority, in that these programs promote healthy behaviors. The treatment focus is on relieving initial client stress and crisis, supporting the client and family members in treatment, and assisting the family to return to a level of healthy functioning. Problem gambling treatment assists the gambler and family in managing their finances, rebuilding trust within the family, learning gambling prevention techniques, and maintaining recovery.

Last year, MHASD completed a successful Request for Provider Qualifications (RFPQ) process for the five-year period from July 1, 2007 through June 30, 2012. This process resulted in the selection of four qualified prevention and treatment providers, continuing the work of Cascadia, LifeWorks Northwest, and Oregon Health Sciences University's Behavioral Health Clinic, and adding Volunteers of America/ InAct as a new provider.

In addition to these treatment providers, two outreach and engagement providers were selected. LifeWorks Northwest received a contract for specialized outreach to African Americans and Cascadia received a contract for countywide outreach and public information.

No significant changes to the current service delivery system are foreseen for the near future.

VI. Allocation and Use of AMH Funding

A. Allocation Chart

Funding from the State Addiction and Mental Health Division is allocated Multnomah County MHASD programs as follows:

Allocation and Use of State AMH Resources

Service Element	Service Provision
LA01	Mental Health and Addiction Services Division Administrative Expenses.
MHS 20	Adult CMI case management/care coordination, trial visit monitoring, abuse investigation, residential case management, and other services designed to prevent hospitalization.
MHS 22	Children and adolescent mental health services including early childhood, school aged, intensive in-home treatment, treatment foster care, and care coordination.
MHS 24	Acute mental health services including inpatient hospitalization.
MHS 25	Adult and Child non-OHP community crisis services including crisis walk-in clinic, mobile outreach, and crisis line.
MHS 28	Mental health residential services.
MHS 30	PSRB
MHS 35	Older adult mental health services, including the multi-disciplinary team.
MHS 38	Residential
MHS 39	Transitional housing
A&D 60	Special projects including the housing conference, family involvement team and services to Latino youth.
A&D 61	Residential alcohol and drug treatment, including services to pregnant African American women.
A&D 62	Housing for dependent children whose parents are in alcohol and drug residential treatment.
A&D 66	Outpatient alcohol and drug treatment
A&D 70	Prevention/Early intervention services
A&D 71	Youth alcohol and drug residential treatment
A&D 80	Gambling prevention services
A&D 81	Gambling treatment services
A&D 83	Gambling treatment enhancement including brochures and gambling awareness week.

B. Use of Evidence-Based Practices

MHASD requires in its contracts that all adult mental health providers follow the State statute regarding evidence-based practices (EBP). For 2007-09, the statute required that at least 50% of state funds used to treat people with mental illness who use or have a propensity to use emergency mental health services be delivered with evidence-based practices, and 50% of state funds used to treat people with substance abuse problems who have a propensity to commit crimes be used for the provision of evidence-based practices. In 2000-11, this increases to 75%.

MHASD is ahead of requirements for implementation of evidence-based practices. Evidence-based practices among MHASD staff and sub-contracted providers are actively promoted through training on specific clinical practices, specific contractual requirements for new and amended contracts, monitoring of fidelity of practice implementation, and provider technical assistance.

Children's System of Care Evidence-Based Practices

Contracts for Intensive Community-based Treatment Services, School-Age Children and Early Childhood require providers to use at least the following evidence-based practices:

- Multi-Systemic Therapy
- Multi Dimensional Treatment Foster Care, Oregon Social Learning Center
- Transition Age Youth Services based on Assertive Community Treatment model
- Cognitive Behavioral Therapy
- Incredible Years
- Wraparound Services

MHASD is also in the process of integrating an evidence-based family readiness assessment tool into the outpatient intake process, the Family Check Up (FCU) model.

Adult System of Care Evidence-Based Practices

A minimum of six fidelity models have been implemented in the adult mental health system:

- Supported Employment
- Co-Occurring Disorders: Integrated Dual Diagnosis Treatment
- Illness Management and Recovery
- Family Psychoeducation
- Assertive Community Treatment
- Medication Management Approach in Psychiatry

Addiction Services Evidence-Based Practices

An inventory of the evidence-based practices implemented by each provider has been developed, which has been compared to the National and State OMHAS lists of evidence-based practices. Common evidence-based practices used by providers include:

- Cognitive Behavior Therapy
- Motivational Interviewing
- Seeking Safety
- The Matrix Model

C. Rationale for Changes to Allocations

Provider allocations are largely based on the major RFPQs released by MHASD since 2004:

1. 2004: MHASD and DCJ joint RFPQ for Alcohol and Drug Service providers
2. 2005: System of Care for Children and Families, Children's Intensive Mental Health Treatment
3. 2005: System of Care for Children and Families: Services for School-Aged Children
4. 2005: Adult System of Care RFPQ
5. 2007: Problem Gambling Services RFPQ
6. 2008: Early Childhood System of Care RFPQ

Each RFPQ is designed to move the County's mental health and addiction system to the next level of competency and gain greater control over the quality and cost of services.

In addition to program improvements described below, MHASD will add a data analyst and improve information technology to increase capacity for **data-based management decisions**.

The changes listed below are explained in greater detail in each program plan (section V).

1. Access to the System of Care

Continuing "front door" services include:

- **Mental Health Call Center**, available to all County residents 24 hours a day, 7 days a week, including dedicated lines for immediate access by police and corrections.
- **Mobile Crisis Teams**, available 24/7, to support police, emergency providers and hospitals to triage and link people in a crisis with mental health services.
- **Urgent Walk-In Clinic**, open 7 days a week from 7:00 a.m. until 10:30 p.m., providing no-appointment necessary assessment and treatment.

Improvements include:

- **Expand the family focus** of the Call Center, with more child and family specialists, and emphasis on navigation support and access to the entire continuum of care.

2. Links with State Hospital & Inpatient Providers

Current links will be maintained, including:

- **Mental Health Call Center** as a first point of contact for local acute facilities and emergency departments, to consider the medical necessity for acute care services, and to assess diversion alternatives. The Call Center also notifies the individual's treatment provider of an admission. If there is no provider, the Call Center links to a provider to offer outpatient mental health services, usually prior to discharge.
- **Pre-Commitment/Involuntary Commitment Program** investigates all "Notices of Mental Illness" to determine whether persons held for mental health treatment should be referred for civil commitment, and helps explore less restrictive treatment options.

- **Post-Commitment Monitors** connect individuals upon discharge with community mental health treatment providers. They also follow each Multnomah County resident committed to the State Hospital, and participate in discharge planning.

Improvements include:

- Post-Commitment Services is designing an **electronic tracking system** for residents placed in other counties upon discharge from the State Hospital, to facilitate eventual return to Multnomah County.
- The new **Critical Time Intervention** (CTI) program will provide intensive case management for individuals with high utilization of inpatient care, psychiatric care or involuntary commitment, for up to 90 days. CTI case managers will exit once there is a solid link to a provider and natural supports.

3. Child, Youth and Family Services

This plan continues:

- The **Children's System Change Initiative (CSCI)**, using state funds to serve non-Medicaid children and youth in, or at risk of, psychiatric residential treatment services. Coordinators form a child and family team to develop a service coordination plan, to met needs of the child and family in the community, at home and in school.
- **Intensive Community-based Treatment Services** are provided where needed to prevent higher levels of out of home placement.

Improvements include:

- Engagement of the **Oregon Family Support Network (OFSN)** to help develop a meaningful youth voice for consumers under age 21.
- Implementation of the **Early Childhood System of Care**. An RFPQ is currently being processed to determine which providers are qualified to deliver these services.
- **Family System Navigators:** An RFPQ this year will result in support by advocates knowledgeable about the system to help families access mental health services.
- **Sub-acute Services:** An RFPQ for sub-acute services this year resulted in services for youth ages 11 to 18 who can be diverted from a higher level of care placement, or who need short-term (5 to 9 days) step-down placement from hospital acute care.
- **Intensive Outreach:** Using new state funds, this cooperative program with DHS Child Welfare will help families access and complete Court-mandated treatment, resulting in the opportunity to regain child custody and preserve the family.
- A new **Early Psychosis Program** will be implemented to reach youth at the initial episodes of psychosis (usually under age 25), and provide early intervention to improve outcomes and maintain family ties.

4. Adult Services

We will continue to emphasize the following:

- **Integration of mental health and addiction** treatment for those with co-occurring disorders, and a smooth continuum of services between mental health, addiction, housing and criminal justice services.
- Strategies to help those impaired by a **cycle of mental illness, substance abuse and homelessness**, and often involvement with the criminal justice system as well, move into **stable living situations** and receive effective treatment.
- Assure that all providers deliver **culturally and linguistically appropriate** treatment.
- Emphasize **consumer-centered and peer-delivered support networks**, and engagement of **families and natural supports**.

Improvements to the system of care include:

- A new focus on **integration between mental health and primary care**, encouraging placement of RNs in mental health clinics to address co-occurring medical disorders.
- **Expand training** for providers on effective practices, and increase **technical assistance** and consultation.
- **Diversifying the provider network**, incorporating providers of unique services such as supported employment, supported education and designated outreach, to expand system capacity and options for consumer choice.
- Continue to **promote transitional and permanent housing**, including low-barrier housing for immediate access for individuals with mental health and addiction needs.
- Increase our focus on **transition age youth**, by exploring what is needed to best meet the needs of youth just coming into the adult system of care, preserving their family relationships and supports.

Improvements funded by AMH include:

- **Critical Time Intervention (CTI):** Using AMH crisis funding, this project (also see above) will address the needs of those being discharged from institutional care, who need assertive short-term intervention to reduce risk of readmission.
- **High Utilization Diversion (HU Diversion):** Additional AMH case management funding will focus on mentally ill individuals who are habitual users of high intensity, high cost services: State and local hospitals, and jail. Diversion staff will connect a person with housing, benefits and services to divert at the point of admission, or reduce the length of stay in jail or hospital after an admission
- **Supported Employment (SE) Initiative:** New AMH funding will help people with mental illness find jobs. Contracted providers will work in NE Portland to include African American consumers, and in a downtown location, targeting those with dual diagnoses, criminal justice involvement or homelessness. Services will help people

find and keep employment and self-employment, using best-practice models based on consumer choice.

Improvements funded by Jail Diversion Funds include:

- **Mental Health Court Pilot Project:** With new dollars from AMH, this collaboration with the Criminal Justice System and Courts will help divert mental health consumers by connecting individuals diverted from jail with benefits, housing, medical and social services, and outpatient mental health services.
- **370 Project**: With new dollars from AMH, this 3-county pilot project will work with consumers charged with misdemeanor crimes and ordered to undergo an "Aid and Assist/Treat until Fit" evaluation. This project will evaluate mental status, options and recommendations for stabilization, and connect people to benefits, housing, medical and social services, and mental health outpatient services.
- **Waitlist Reduction Project (WLRP):** With on-going AMH funding, the care coordination for this program will become a County position to facilitate discharges of Multnomah County residents from the State Hospital.

5. Older Adult Services Service

We will continue to provide:

- A **Multi-disciplinary Team,** in collaboration with Aging and Disability Services and their Adult Protective Services unit, through a subcontract to provide assessment, short-term counseling, stabilization, and linkage to follow-up mental health treatment.

Improvements in older adult services include:

- New this year, **specialized outpatient services** are being provided to older adults in nursing homes, adult foster homes and residential care facilities.

6. Alcohol and Drug Prevention

We will continue current state-funded prevention programs, including

- **Housing Authority of Portland** (HAP) youth services program, which serves a high proportion of people of color in public housing communities. In collaboration with the City of Portland's Children's Investment Fund (CHIF), this includes an after school program, a Reading Together program, and Families and School Together.
- **Latino Youth Network** for outreach to engage youth in a youth soccer team, which will participate in the Oregon Youth Soccer Association's league.
- **Asian Youth Network's TUNE** (Teens Uniting for a New Era), for youth leadership by involving youth in planning and implementing projects and community events.

Improvements from new competitive State grant awards will add two programs:

- **Safe and Drug-Free Schools** focus directly on the goal of fostering school success. In this student peer support project, college students will work with high school

students, building teams to work with elementary students to help promote younger children's academic success, while involving older students in service learning.

- **Strengthening Families** has been offered to HAP families at one HAP location, six associated Schools Uniting Neighborhoods (SUN) schools, and an additional middle school. Faith-community volunteers will be trained to lead the program for their congregations, and help expand the program in schools. Additional County funds are being sought to expand this program.

7. Addiction Treatment Services

We will continue to provide an array of Addiction Treatment services, including:

- **Addiction Services** – Detoxification, Residential, Outpatient, Methadone Treatment, Supported Housing, and Support and Education.
- **Mentorship** programs for clients with substance abuse problems to support them in recovery group participation as well as other services.
- **Culturally and linguistically appropriate treatment** to high-risk clients with a substance abuse disorder.

Improvements include initiatives to:

- **Strengthen connections** between service levels, particularly detox and residential.
- Increase the availability of **transitional housing**.
- Increase the focus on **employment services**.
- Develop practices to **increase our rate of successful completions** in treatment.

The collaboration with DCJ will be continued, by planning our second joint procurement process for alcohol and drug treatment services, for services beginning July 2009.

8. Problem Gambling Services

These services will continue to provide treatment services to assist the client and family to return to a level of healthy functioning. Treatment assists the gambler and family in managing their finances, rebuilding trust, learning gambling prevention techniques, and maintaining recovery.

Improvements include:

- An **expanded array of providers**, from three to four.
- Providers for **outreach and engagement** have been added, for specialized outreach to African Americans, as well as for countywide outreach and public information.

#

Required Attachments

Addiction and Mental Health Division

County Contact Information Form

1. County Contact Information

County: Multnomah

Address: 421 SW Oak Street, Suite 520

City, State, Zip: Portland, Oregon 97204

Name and title of person(s) authorized to represent the county in any negotiations and sign any agreement:

Name Karl Brimner Title Director, Mental Health and Addiction Services Division

Name N/A Title N/A

2. Addiction Treatment Services Contact Information

Name Ray Hudson

Agency Multnomah County

Address 421 SW Oak Street, Suite 520

City, State, Zip Portland, Oregon 97204

Phone Number 503-988-5018 Fax 503-988-5870

E-mail Ray.Hudson@co.multnomah.or.us

3. Prevention Services Contact Information

Name Larry Langdon

Agency Multnomah County

Address 421 SW Oak Street, Suite 520

City, State, Zip Portland, Oregon 97204

Phone Number 503-988-5464 ext. 26524 Fax 503-988-5870

E-mail Larry.Langdon@co.multnomah.or.us

4. Mental Health Services Contact Information

Name David Hidalgo

Agency Multnomah County

Address 421 SW Oak Street, Suite 520

City, State, Zip Portland, Oregon 97204

Phone Number 503-988-3076 Fax 503-988-5870

E-mail David.A.Hidalgo@co.multnomah.or.us

5. Problem Gambling Treatment Prevention Services Contact Information

Name John Pearson

Agency Multnomah County

Address 421 SW Oak Street, Suite 520

City, State, Zip Portland, Oregon 97204

Phone Number 503-988-5464 ext. 22612 Fax 503-988-5870

E-mail John.F.Pearson@co.multnomah.or.us

6. State Hospital/Community Co-Management Plan Contact Information

Name Sandy Haffey

Agency Multnomah County

Address 421 SW Oak Street, Suite 520

City, State, Zip Portland, Oregon, 97204

Phone Number 503-988-5464 ext. 26659 Fax 503-988-5870

E-mail Sandy.J.Haffey@co.multnomah.or.us

List of Subcontracted Services for Multnomah County – Attachment 1

After each service element, list all of your treatment provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/ License ID #	Service Element	AMH Funds in Subcontract	Specialty Service
Cascadia Behavioral Healthcare	97-0770054	A-D 60	91,066	Women
Central City Concern	93-0728816	A-D 60	91,066	Women
Central City Concern	93-0728816	A-D 60	360,458	NA
Central City Concern	93-0728816	A-D 60	244,032	Latino Youth
Comprehensive Options for Drug Abusers	93-0716860	A-D 60	116,568	Women
LifeWorks	93-0502822	A-D 60	116,568	Women
Volunteers of America	93-0395591	A-D 60	119,882	Women
Multnomah County Department of County Human Services *	93-0712083	A-D 60	143,484	NA
009-11 Biennial Total A-D 60			**$ 1,283,124**	
Central City Concern	93-0728816	A-D 61	1,222,750	Women
Central City Concern	93-0728816	A-D 61	183,413	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 61	2,017,538	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 61	427,963	Women
DePaul Treatment Centers	93-0706892	A-D 61	978,200	Minority
DePaul Treatment Centers	93-0706892	A-D 61	2,139,813	NA
LifeWorks	93-0502822	A-D 61	1,406,163	Women/Minority
LifeWorks	93-0502822	A-D 61	122,275	NA
To Be Determined	NA	A-D 61	312,078	Women
2009-11 Biennial Total A-D 61			**$ 8,810,190**	
Central City Concern	93-0728816	A-D 62	353,904	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 62	110,596	NA
LifeWorks	93-0502822	A-D 62	22,118	NA
To Be Determined	NA	A-D 62	111,690	NA
2009-11 Biennial Total A-D 62			**$ 598,308**	

Provider Name	Approval/ License ID #	Service Element	AMH Funds in Subcontract	Specialty Service
Cascadia Behavioral Healthcare	97-0770054	A-D 66	801,780	NA
Cascadia Behavioral Healthcare	97-0770054	A-D 66	191,002	Women
Central City Concern	93-0728816	A-D 66	306,244	Women
Central City Concern	93-0728816	A-D 66	2,897,156	NA
ChangePoint	93-1229222	A-D 66	391,230	NA
ChangePoint	93-1229222	A-D 66	205,626	Minority
ChangePoint	93-1229222	A-D 66	55,686	Youth
Comprehensive Options for Drug Abusers	93-0716860	A-D 66	777,764	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 66	191,002	Women
CRC Health Oregon	20-4966951	A-D 66	334,004	NA
DePaul Treatment Centers	93-0706892	A-D 66	38,640	NA
DePaul Treatment Centers	93-0706892	A-D 66	74,514	Youth
DePaul Treatment Centers	93-0706892	A-D 66	72,450	Minority
LifeWorks	93-0502822	A-D 66	241,500	Minority
LifeWorks	93-0502822	A-D 66	1,065,654	Youth
LifeWorks	93-0502822	A-D 66	191,002	Women
LifeWorks	93-0502822	A-D 66	169,050	NA
Morrison Center	93-0354176	A-D 66	244,736	Women
NARA	23-7098400	A-D 66	191,002	Women
OHSU	93-1176109	A-D 66	120,750	NA
Multnomah County Department of County Human Services	93-0712083	A-D 66	14,814	NA
Multnomah County Department of Community Justice	93-0706892	A-D 66	437,410	NA
Volunteers of America	93-0395591	A-D 66	28,980	NA
Volunteers of America	93-0395591	A-D 66	247,374	Women
To Be Determined	NA	A-D 66	30,924	NA
2009-11 Biennial Total A-D 66			**$ 9,320,294**	
Central City Concern	93-0728816	A-D 67	292,000	Women
Central City Concern	93-0728816	A-D 67	43,800	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 67	481,800	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 67	102,200	Women
DePaul Treatment Centers	93-0706892	A-D 67	233,600	Minority
DePaul Treatment Centers	93-0706892	A-D 67	511,000	NA
LifeWorks	93-0502822	A-D 67	335,800	Women/Minority
LifeWorks	93-0502822	A-D 67	29,200	NA
LifeWorks	93-0502822	A-D 67	109,500	Youth
To Be Determined	NA	A-D 67	73,000	Women
2009-11 Biennial Total A-D 67			**2,211,900**	

Provider Name	Approval/ License ID #	Service Element	AMH Funds in Subcontract	Specialty Service
Housing Authority of Portland	93-6001547	A-D 70	347,798	Youth
IRCO-Asian Family Center	93-0806295	A-D 70	20,360	Youth
Latino Network	73-1675402	A-D 70	20,360	Youth
To Be Determined	NA	A-D 70	40,000	Youth
Multnomah County Department of County Human Services *	93-0712083	A-D 70	171,482	NA
2009-11 Biennial Total A-D 70			**$ 600,000**	
LifeWorks	93-0502822	A-D 71	483,990	Youth
2009-11 Biennial Total A-D 71			**$ 483,990**	
Cascadia Behavioral Healthcare	97-0770054	A-D 80	100,000	NA
LifeWorks	93-0502822	A-D 80	100,000	NA
2009-11 Biennial Total A-D 80			**$ 200,000**	
Cascadia Behavioral Healthcare	97-0770054	A-D 81	1,120,000	NA
LifeWorks	93-0502822	A-D 81	100,000	NA
Oregon Health Sciences University Behavioral Health Clinic	93-1176109	A-D 81	190,000	NA
Volunteers of America	93-0395591	A-D 81	160,000	NA
To Be Determined	NA	A-D 81	30,000	NA
Multnomah County Department of County Human Services *	93-0712083	A-D 81	80,000	NA
2009-11 Biennial Total A-D 81			**$ 1,680,000**	
Cascadia Behavioral Healthcare	97-0770054	A-D 83	74,652	NA
LifeWorks	93-0502822		6,606	NA
Oregon Health Sciences University Behavioral Health Clinic	93-1176109	A-D 83	12,552	NA
Volunteers of America	93-0395591	A-D 83	10,570	NA
2009-11 Biennial Total A-D 83			**$ 104,380**	
Total 2009-2011 Biennial Funding Request			**$25,292,186**	

Breakout of Subcontracted Funds and Administration

State Mental Health Subcontract Funding		Administration Funding	
A&D 60 Special Projects	1,139,640	A&D 60	143,484
A&D 61 Adult Residential	8,810,190	A&D 61	0
A&D 62 Housing for Dependent Children	598,308	A&D 62	0
A&D 66 Continuum of Care	9,320,294	A&D 66	0
A&D 67 A&D Residential Capacity	2,211,900	A&D 67	0
A&D 70 Prevention	428,518	A&D 70	171,482
A&D 71 Youth Residential	483,990	A&D 71	0
A&D 80 Problem Gambling Prevention	200,000	A&D 80	0
A&D 81 Outpatient Problem Gambling Treatment	1,600,000	A&D 81	80,000
A&D 83 Problem Gambling Treatment Enhancement	104,380	A&D 83	0
Grand Total	**$24,897,220**	**Grand Total**	**$394,966**

Addictions and Mental Health Division – Attachment 7

PLANNED EXPENDITURES OF MATCHING FUNDS (ORS 430.380) AND CARRYOVER FUNDS

County: Multnomah

Contact Person: Keith Mitchell

Matching Funds

Source of Funds	Amounts	Program Area
Federal Grant	$ 2,002.802	Prevention & Treatment
County General Fund	$ 6,106,584	Prevention & Treatment
2145 Tax	$ 362,166	Prevention & Treatment

Source of Funds	Amounts	Program Area
County General Fund	$ 3,750,376	Sobering & Detox
2145 Tax	$ 837,834	Sobering & Detox
County General Fund	$ 1,114,708	DUII
Fees	$ 1,000,000	DUII

Carryover Funds

AMH Mental Health Funds Carryover Amount from 2007-2009	Planned Expenditure	Service Element
We have no plan to carry over 2007-2009 funds to 2009-2011		

AMH Alcohol & Drug Funds Carryover Amount from 2007-2009	Planned Expenditure	Service Element
We have no plan to carry over 2007-2009 funds to 2009-2011		

Reviews and Approvals

DHS Addiction and Mental Health Division – Attachment 2

BOARD OF COUNTY COMMISSIONERS

REVIEW AND APPROVAL

County: Multnomah

In accordance with ORS 430.258 and 430.630, the Multnomah Board of County Commissioners has reviewed and approved the mental health and addiction services County Biennial Implementation Plan for 2007-2009. Any comments are attached.

Name of Chair: Ted Wheeler

Address: 501 SE Hawthorne Blvd

Portland, OR 97214-3587

Telephone: 503-988-3308

Signature: _____

DHS Addiction and Mental Health Division – Attachment 3

LOCAL ALCOHOL AND DRUG PLANNING COMMITTEE

REVIEW AND COMMENTS

County: Multnomah: Adult Mental Health and Substance Abuse Advisory Council (AMHSA)

Type in or attach list of committee members including addresses and telephone numbers. Use an asterisk (*) next to the name to designate members who are minorities (ethnics of color according to the U S. Bureau of Census).

The Multnomah County LADPC recommends the state funding of alcohol and drug treatment services as described in the 2007-2009 County Implementation Plan. Further LADPC comments and recommendations are attached.

Name of Chair: Patricia Backlar and Sue Waite, Co-Chairs

Address: c/o 520 SW Oak Stree, Suite 520

Portland, OR 97204

Telephone: 503-988-4055 (c/o MHASD, Irene Lee)

Signature: _____

DHS Addiction and Mental Health Division – Attachment 3

LOCAL ALCOHOL AND DRUG PLANNING COMMITTEE

REVIEW AND COMMENTS

County: Multnomah: Adult Mental Health and Substance Abuse Advisory Council (AMHSA)

Type in or attach list of committee members including addresses and telephone numbers. Use an asterisk (*) next to the name to designate members who are minorities (ethnics of color according to the U.S. Bureau of Census).

The Multnomah County LADPC recommends the state funding of alcohol and drug treatment services as described in the 2007-2009 County Implementation Plan. Further LADPC comments and recommendations are attached.

Name of Chair: Patricia Backlar and Sue Waite, Co-Chairs

Address: c/o 520 SW Oak Stree, Suite 520

Portland, OR 97204

Telephone: 503-988-4055 (c/o MHASD, Irene Lee)

Signature: Patricia Backlar Co-Chair AMHSAC
Sue Waite co-chair

DHS Addiction and Mental Health Division – Attachment 4a

LOCAL MENTAL HEALTH ADVISORY COMMITTEE

FOR ADULTS

REVIEW AND COMMENTS

County: Multnomah: Adult Mental Health and Substance Abuse Advisory Council (AMHSA)

Type in or attach list of committee members including addresses and telephone numbers. Use an asterisk (*) next to the name to designate members who are minorities (ethnics of color according to the U.S. Bureau of Census)

The Multnomah County Local Mental Health Advisory Committee, established in accordance with ORS 430.630(7), recommends acceptance of the 2007-2009 Biennial County Implementation Plan. Further comments and recommendations of the Committee are attached.

Name of Chair: Patricia Backlar and Sue Waite, Co-Chairs

Address: c/o 520 SW Oak Stree, Suite 520

Portland, OR 97204

Telephone: 503-988-4055 (c/o MHASD, Irene Lee)

Signature: Patricia Backlar (co-chair AMHSAC
Sue Waite Co-Chair

AMHSA Membership Roster
October 2007

Members (Office)	Position Number - MH or A&D, Cate-gory, Term Exp. Date	Email Address	Mailing Address	Phone (503 unless noted)
ANDERSON, ELISE	D.6. – MH Housing Authority of Portland 11-2006	elisea@hapdx.org	Portland Housing Authority 135 SW Ash St. Portland, OR 97204	802-8574
BACKLAR, TRISH (Chair)	B.1. – MH Parent/Advocate 11-2006	backlarp@pdx.edu	PSU-Philosophy Dept. POB 751 Portland, OR 97207	725-3499
BORDERS, GREG (Amy Hutson)	D.3. – MH Crisis Response System 10-2007	gregb@cascadiabhc.org	Cascadia Behavioral HealthCare 2130 SW 5th Avenue, #210 Portland, OR 97201	238-0769
BOWERS, KEVIN	D.8 Community Corrections ongoing			
BOYER, TERRY	A.5 – MH Consumer	tboyer@folktime.org	Folk Time 4837 NE couch Portland, OR 97213	238-6428
BURROW, GAYLE	D.7. – MH/A&D Corrections Health ongoing	gayle.f.burrow@co.multnomah.or.us	Corrections Health 1120 SW 3rd Ave Portland, OR 97204-2828	988-3720
CONNOLLY, JOHN	A.4. – MH Consumer 03-2008		2730 SE 92nd #407 Portland, OR 97266	788-3644
DORSEY, TED (Executive Committee At-Large)	D.5. – MH/A&D Sheriff's Office ongoing	ted.dorsey@mcso.us	Mult Co Sheriff Office 1120 SW 3rd Ave. Portland OR 997204 (119/3/1307)	988-4571
DRAKE, MARIAN	A.10	postcards@hevanet.com	5800 NE Ctr Commons Wy Apt 213 Portland OR	236-1736
ENGLANDER, BETH	C.2. – MH Parents/Advocates 08-2008	benglander@oradvocacy.org	Oregon Advocacy Center 620 SW 5th Ave. Portland OR 97204	243-2081
FORD, LESLIE	D.1. - MH Outpatient ServiceAgency 12-2006	leslie@cascadiabhc.org	Cascadia Behavioral HealthCare 2130 SW 5th Avenue, #210 Portland, OR 97201	238-0769 x12

GERRITSEN, LIESBETH	D.4 – MH/A&D Portland Police Bureau 11-2008	lgerritsen@portlandpolice.org	CIT Coordinator Portland Police Bureau 1111 SW 2nd Ave. #1552 Portland OR 97204	823-0183
HAMIT, RYAN	A.11 11-2009			
HOLMES, JOHN	B.3. – MH Parents/Advocates 11-2006	jholmes@nami.org	NAMI 524 NE 52nd Ave. Portland OR 97213	228-5692
HURLBERT, JENNIFER	A.7. – MH Consumer 10-2007	hurlbert@coho.net	17376 NE Couch #102 Portland OR 97230	254-6287
KASPER, ANN	A.3. - MH Consumer 11-2008	pretcoregon@yahoo.com	628 NE Sacramento Portland OR 97212	287-4124
KRUEGER, CLAUDIA (Executive Committee At-Large)	D.2. – A&D Outpatient Service Agency (PAADMA) 11-2006	ckrueger@centralcityconcern.org	Central City Concern 523 NW Everett Portland, OR 97209	525-8483 x219
LEEB, ROBERT	C.3. – n/a Citizen 08-2007	robert@leebarc.com	**Leeb Architects** LLC 71 SW Oak Street Portland, Or 97204	228-2840 (w) 246-1798 (h)
MARIE, SUSAN (Godschalx)	D.9 – MH/A&D Health Department (ongoing term)	susan.marie@co.multnomah.or.us	Health Dept. 426 SW Stark St 8th fl. Portland, OR 97204-2347	988-3663 x22661
MEADE, LINEA	A.8. - MH Consumer 01-2009	feierdude@hotmail.com	335 NW 19th #103 Portland OR 97209	802-8384 msg #
MORPHIS, ESSIE (Executive Committee At-Large - Alternate)	A.1. – MH Consumer 12-2007	faithmor7@aol.com	5025 NE 8th Ave. #23 Portland OR 97211	282-0823
ROBERTSON, JEANNE (Executive Committee At-Large)	B.2. – MH Parent/Advocate 05-2007	jliz711@hotmail.com	3914 NE Laurelhurst Portland OR 97232	232-3441
SHATOKIN, JO ANNE V. (Executive Committee At-Large)	A.6. – MH Consumer 04-2008		6423 SE 73rd Portland OR 97206	771-5480
TRAN, TAN AM	B.4. – Parent/ Advocate 10-2007	taman_kinh@yahoo.com	7339 N. Willamette Blvd. Portland OR 97203	866-7974

WAITE, SUE (Vice-Chair)	A.2. – ADSD Aging and Disabil-ities Services Div. ongoing	suewaite@juno.com	7205 SE 68TH Ave. Portland OR 97206	774-6260
WALKER, TERRI				

Former Members Members (Office)	Position Number - MH or A&D, Cate-gory, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
BRENTON, ASHLEIGH (Secretary)	A.8. – MH Consumer 12-2008	ashleighpb@aol.com moved	920 NW Kearney #336 Portland OR 97209	810-1582
BROOKS, MALIK	A.7. – MH Consumer 10-2007	putitinyamouth69@yahoo.com	2415 SE 43rd Ave. Portland OR 97206	232-8503
BUCKLEY, MARY CLAIRE	E.4. - MH PSRB 11-2006	mcb@oregonvos.net	PSRB 620 SW 5th, #907 Portland, OR 97204	229-5596
CHILD, BECKIE	A.8. - MH Consumer 10-2007	beckie.child@gmail.com	333 NW 4th Ave. #227 Portland OR 97209	227-8496
COSGROVE, PAT	C.5. – MH/A&D Acute Care Service Agency 02-2006	cosgropi@ah.org	10123 SE Market St. Portland, OR 97204	251-6266 x4109
DIAMATA, DONITA	A.11. – MH Consumer 11-2007	donita@cascadiabhc.org		238-0769
GREEN, DAVID	A.9. – MH Consumer 10-2007		5110 SW 76th Ave. #8 Portland OR 97206	771-5535
MERCER, JACKIE	C.8. – A&D Structured Residential Services 11-2006	narajam@aol.com	NARA NW 1776 SW Madison Portland OR 97205	224-1044 x227
POTTER, PAUL	C.4. – A&D Outpatient Service Agency (PAADMA) 04-2005	paul@cascadiabhc.org	Cascadia Behavioral HealthCare PO Box 8459 Portland, OR 97207	238-0769 x132 963-7756 (direct)

SHATOKIN, JOHN (Executive Committee At-Large - Alternate)	A.13. – MH Consumer 01-2008		6423 SE 73rd Portland OR 97206	771-5480
STRONG, JACKIE	C.2. – Outpatient Service Agency (MH) 11-2006	jackies@lifeworksnw.org	LifeWorks 14600 NW Cornell Rd. Portland OR 97229	617-3826
SURFACE, REX (delegate: Patrice Botsford)	G.1. - DDSD Developmental Disabilities Services Division (ongoing term)	rex.b.surface@co.multnomah.or.us	Senior Manager Multnomah County Developmental Disabilities 421 SW Oak., Ste. 600 Portland OR 97204	988-3272 x26353
TREB, KATHLEEN (Executive Committee At-Large)	E.6. – A&D Community Justice (ongoing term)	kathleen.a.treb@co.multnomah.or.us	Multnomah County Dept. of Community Justice 2nd Floor 501 SE Hawthorne Portland, OR 97214-7214	988-6131
WARE, PAUL	E.1. – MH/A&D Portland Police Bureau 11-2006	cit@police.ci.portland.or.us	CIT Coordinator Portland Police Bureau 1111 SW 2nd Ave. #1552 Portland OR 97204	823-0183
YOUNG, ADRIENNE	A.1. – MH Consumer 05-2007	adrienne_elizabeth_young@yahoo.com	4370 NE Halsey #223 Portland OR 97213	249-1413
YOUNG, CAROL	A.12. – MH Consumer 10-2007	cyoung2005@msn.com appointed Terry Boyer	4175 SW Crestwood Drive Portland OR 97045	297-5234

DHS Addiction and Mental Health Division – Attachment 4b

LOCAL MENTAL HEALTH ADVISORY COMMITTEE
FOR CHILDREN, YOUTH AND FAMILIES

REVIEW AND COMMENTS

County: Multnomah: Children's Mental Health System Advisory Council (CMHSAC)

Type in or attach a list of committee members, including addresses and telephone numbers.

The Multnomah County Local Mental Health Advisory Committee, established in accordance with ORS 430.630(7), recommends acceptance of the 2007-2009 Biennial County Implementation Plan. Further comments and recommendations of the Committee are attached.

Name of Chair: Stephanie Boyer and Diane Wells, Co-Chairs

Address: c/o 520 SW Oak Stree, Suite 520

Portland, OR 97204

Telephone: 503-988-3999 x 24045 (c/o MHASD, Karen Mayfield)

Signature: Stephanie Boyer

Children's Mental Health System Advisory Council
(CMHSAC)
Member Roster
February 2008

Name	Representing	Address	Phone Number	Email Address
Ackerman, Traci	Families	737 SE 187TH Ave. #8 Portland OR 97233	503-328-9641	niceangel56@yahoo.com
Boring, Kathy	Families	6612 SE 89th Ave. Portland OR 97266	503-771-7872	katbportland@netzero.net
Boyer, Stephanie	Families	6522 SE 66th Ave. Portland, OR 97206	503-777-2421	sboyer@orclinic.com redparrot525@msn.com
Brown, Leslie (shared with Monica Ford)	Early Childhood	Children's Relief Nursery 8425 N. Lombard Portland OR 97203		lesliebrown@crn4kids.org
Bumpus, Sandy	Families	PO Box 13126 Portland, OR 97213	503-287-9891 503-351-7780	sbumpus@comcast.net
Church, Kitty	Provider Agency:	Cascadia 131 NE 102nd Ave. Portland, OR 97220		kitty@cascadiabhc.org
Fookson, Maxine				
Ford, Monica (shared with Leslie Brown)	Early Childhood	Morrison Child and Family Svs 11456 NE Knott Portland 97220	503-256-3040	Monica.Ford@morrisonkids.org

Name	Representing	Address	Phone Number	Email Address
Scott, Wayne	Juvenile Justice	1401 NE 68th Ave Portland, OR 97213	503-988-6904 x86904	wayne.scott@co.multnomah.or.us
Toomey, Bill	Developmental Disabilities	Multnomah County Developmental Disabilities Division 421 SW Oak St., Ste. 610 Portland OR 97204	503-988-3658 x86142	bill.f.toomeyE@co.multnomah.or.us
Vieira, William	Families	10009 NE 47th Ave. #11 Portland OR 97213	503-235-0530	afrobro@tmail.com
Wallick, Elaine	State Department of Human Services	2446 SE Ladd Ave. Portland OR 97214	503-872-5588	elaine.e.wallick@state.or.us
Walters, Eric	Families	737 SE 187TH Ave. #8 Portland OR 97233	503-328-9641	niceangel56@yahoo.com
Wells, Diane *	Families	570 NW Birdsdale Ave. Gresham OR 97030	503-665-2197	ladydy331@hotmail.com
Williams, Joan *	PPS	BESC Special Education Dept. 501 N. Dixon Portland OR 97227	503-916-2000	jwilliams@pps.k12.or.us
Wolfe, Kirk MD	Child and Adolescent Psychiatry	Morrison Center 1818 S.E. Division Portland, OR 97202		kdwolfe@prodigy.net

Name	Representing	Address	Phone Number	Email Address
Guillen, Anna *	Families	NAMI 524 NE 52nd Ave. Portland OR 97213	503-228-5692	aguillen@nami.org
Hansen, Debbie	Oregon Youth Authority	123 NE 3rd Suite 105 Portland OR 97232	503-731-4971 x233	debbie.hansen@oya.state.or.us
Hill, Cris and Robert *	Families	12224 SE Carlton St. Portland OR 97236	503-760-1889	robyoo2000@comcast.net
Hobbs, Milele *	Families	NAMI 524 NE 52nd Ave. Portland OR 97213	503-228-5692	mhobbs@nami.org
Holmes, John	National Alliance on Mental Illness-Multnomah County	NAMI 524 NE 52nd Ave. Portland OR 97213	503-228-5692	jholmes@nami.org
Johnson, Joan	Families	14818 Heather Glen Dr. Oregon City OR 97045		
Johnson, Mary Lou	East County School Districts	Centennial School Dist. 18135 SE Brooklyn Portland OR 97236	503-760-7990	marylou_johnson@centennial.k12.or.us
Lacy, Jan	Families	4840 SW Dosch Rd. Portland OR 97239	503-528-6239 (cell)	janlacy.1@juno.com
Lewinsohn, Mark	Provider Agency: LifeWorks NW	8770 SW Scoffins Rd Tigard,OR 97223	503-684-1424 x226	markl@lifeworksnw.org
McKechnie, Mark	Juvenile Rights Project	123 NE 3rd Ste. 310 Portland, OR 97232	503-232-2540	mark@jrplaw.org

CMHSAC

Children's Mental Health System Advisory Council

February 19, 2008
Multnomah Building – 501 SE Hawthorne, Room B14– Basement

Agenda

1.	a. Welcome/Introductions/Appoint Timekeeper & Acronym Monitor b. Review and Revise/Approve Agenda c. Receive Minutes from January 15 Meeting (approval tabled until March to allow time for review)	Stephanie Boyer and Diane Wells (Co-Chairs)	5:00
2.	Member Concerns	All	5:05
3.	Membership	Stephanie Boyer	5:10
4.	FY 09-11 Biennial Plan Review and Approval	Guest: Kamala Bremer, Consultant	5:15
5.	Department and Division Update	Management/Staff	5:45
6.	• Child and Adolescent Quality Management Workplan • Enrollment/Services by Zip Code and Agency	Joan Rice	5:50
7.	Meaningful Family Involvement: Next Steps	Jan Lacy	6:10
8.	Old Business • CBAC Report	Mark Lewinsohn	6:15
9.	CMHSAC "Tag Line" Decision - "Child and Family Driven Services without Barriers" or (insert your idea here!)	Stephanie Boyer	6:20
10.	Outcome Measures: Trillium Family Services	Guest: Sandy Boyle	6:25
11.	Announcements	All	6:55
12.	Adjourn	Stephanie Boyer and Diane Wells	7:00

Item	Handout
1. b.	Agenda
1. c.	January 15 minutes
4.	Biennial Plan Summary
6.	• Draft Workplan (January – December 2008) • Verity Enrollees (maps) • Agency Staffing Patterns (list)
7.	• Policy Two – System Structure and Functions • Policy Three – Meaningful Family Involvement

Next meeting: March 18, 2008
Next Family Team Conference Call: to be determined

CMHSAC Web Site: http://www.co.multnomah.or.us/dchs/mhas/mh_cmhsac.shtml

DHS Addiction and Mental Health Division - Attachment 5

COMMISSION ON CHILDREN & FAMILIES

REVIEW & COMMENTS

County: Multnomah: Commission on Children, Families and Community

The Multnomah County Commission on Children & Families has reviewed the alcohol and drug abuse prevention and treatment portions of the county's Biennial Implementation Plan for 2007-2009. Any comments are attached.

Name of Chair: Carla Piluso

Address: c/o 421 SW Oak St. Suite 200

Portland 97204

Telephone: 503-988-4500 (c/o the CCFC)

Signature:

DHS Addiction and Mental Health Division – Attachment 6

COUNTY FUNDS MAINTENANCE OF EFFORT ASSURANCE

County: Multnomah

As required by ORS 430.359(4), I certify that the amount of county funds allocated to alcohol and drug treatment and rehabilitation programs for 2009-2011 is not lower than the amount of county funds expended during 2007-2009.

Karl Brimner, M.Ed., Director
Name of County Mental Health Program Director

Karl R Brimner
Signature

March 17, 2008
Date

DHS Addiction and Mental Health Division – Attachment 8

LOCAL SERVICE DELIVERY
AREA MANAGER FOR THE DEPARTMENT OF HUMAN SERVICES

REVIEW AND COMMENTS

County: Multnomah

As Service Delivery Area Manager for the Department of Human Services, I have reviewed the 2007-2009 Biennial County Implementation Plan and have recorded my recommendations and comments below or on at attached document.

Name of SDA Manager: Jerry Burns, District 2
2446 SE Ladd Ave, Portland

Signature: _____

Date: _____

DHS Addiction and Mental Health Division – Attachment 9

LOCAL PUBLIC SAFETY COORDINATING COUNCIL

REVIEW AND COMMENTS

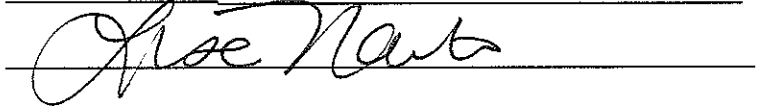
County: Multnomah

The Local Public Safety Coordinating Council has reviewed the 2007-2009 Biennial County Implementation Plan. Comments and recommendations are recorded below or are provided on an attached document.

Name of Chair: Commissioner Lisa Naito

Address: 501 SE Hawthorne Blvd., Suite 600
Portland, OR 97214

Telephone: 503-888-5217

Signature: 

Prevention Strategy Sheet

County: Multnomah County **Prevention Coordinator: Larry Langdon**

Programs for which AMH funding is requested, with measurable Program Outcomes (process objectives) and Intermediate Outcomes (educational, attitudinal & behavioral objectives).

Proposed Programs	Proposed Outputs	Proposed Outcomes
County Prevention Plan Oversight (1.0 FTE Prevention Coordinator)	•Provide technical assistance on prevention work plan development, grant opportunities, Minimum Data Set training and reporting, and provider annual reports.	• (Process only) Prevention work plans, County prevention annual report completed. MDS reports and annual report submitted to AMH. •Proposal(s) submitted to AMH for Statewide competitive prevention grant.
Community Mobilization/ Coalition Support (1.0 FTE Prevention Coordinator)	•Provide technical assistance to A&D prevention coalition (CARSA) and Drug-Free Communities Grant implementation. •Provide A&D prevention technical assistance to other community coalitions. •Process objectives: TA provided (at meetings).	# Community partners' grants received # Prevention materials produced # Prevention programs sponsored by community partners
County Prevention Program Planning & Development (1.0 FTE Prevention Coordinator)	•Prevention procurement planning. •Prevention implementation planning. •Monitor and report as required on Prevention High Level Outcomes; revise and report on County SB 555 prevention logic models as needed.	•Procure contract prevention programs. •Develop and update 2011-13 Prevention Implementation Plan as required by AMH. •Report outcomes, revise prevention portion of County Coordinated Plan as required by SB 555 timelines.
Latino Youth Network To provide project coordination and outreach to a youth soccer team that will participate in the Oregon Youth Soccer Association's DRL league. (Outputs are per year)	•15 Latino youth registered to play in league games •Outreach to 15 parents •2 community projects •2 practices per week •10 league games	•12 youth attend all practices* •12 youth attend all games* •12 youth participate in planning, organizing, and implementing team projects •8 parents participate in team activities * Up to 2 excused absences allowed for unavoidable problems.

Proposed Programs	Proposed Outputs	Proposed Outcomes
TUNE Asian Youth Program (Outputs are per year)	•Recruit on-going participation of 12 youth. •Hold at least 6 meetings throughout calendar year. •Implement at least two projects as determined by prior annual retreat. •Participate in at least 3 additional community events. •Hold a planning event to develop an activity plan for the next year.	•Leaders do under 75% of event coordination effort in year 1, under 50% in year 2. •80% of youth feel they have increased their leadership skills and feel more empowered.
Prevention Services to Public Housing Communities (Outputs are per year for entire program, funded by A&D-70, Children's Investment Fund, and Housing Authority of Portland.)	•Serve 400 unduplicated youth. Provide 500 After School Club sessions. •Identify & engage 60 youth & their families in core group services, including school liaison, individual tutoring and mentoring, as identified through individual family goals. •Provide 225 home visits with core group. •Provide six 6-session Reading Together groups.	•75% of Core Group show increased academic achievement and 75% demonstrate decreased behavioral problems. •50% of middle school children in after school clubs participate in community service projects. •75% of families will report reading together regularly 6 months after Reading Together program completion.