W.10.C.1.

AGENDA COVER MEMO

AGENDA DATE: March 17, 2004

TO: Board of County Commissioners

DEPARTMENT: Health & Human Services

PRESENTED BY: Rob Rockstroh

AGENDA TITLE: In the Matter of Approving the Submission of the Lane County Mental Health and Addictions Implementation Plan for the 2005-2007 Biennium to the State of Oregon, Department of Human Services, Office of Mental Health and Addiction Services.

I. MOTION

TO APPROVE THE SUBMISSION OF THE LANE COUNTY MENTAL HEALTH AND ADDICTIONS IMPLEMENTATION PLAN FOR THE 2005-2007 BIENNIUM TO THE STATE OF OREGON, DEPARTMENT OF HUMAN SERVICES, OFFICE OF MENTAL HEALTH AND ADDICTION SERVICES.

II. ISSUE OR PROBLEM

Under ORS 430.630 and ORS 430.640, the Office of Mental Health and Addiction Services (OMHAS) has the responsibility for reviewing and approving the county biennial plan for the establishment and operation of the County Community Mental Health program. OMHAS has required that the updated 2005-2007 biennial plan, due April 1, 2004, encompass treatment and prevention services for mental health, addiction and problem gambling in one comprehensive plan, instead of separate plans as previously submitted. This implementation plan will provide information for the development of the 2005-2007 biennium OMHAS budget request.

III. DISCUSSION

A. Background / Analysis

For the 2003-2005 biennium, the Office of Mental Health and Addiction Services requested submission of an implementation plan to provide alcohol and drug abuse prevention and treatment services and problem gambling prevention and treatment enhancement services. Board Order No. 03-1-6-1 accepted this implementation plan to be submitted to OMHAS.

In addition, for the 2003-2005 biennium, House Bill 3204 required that "each local mental health authority that provides mental health services shall determine the need for local mental health services and adopt a comprehensive local plan for the delivery of mental health services". This plan was completed in two phases. Board Order No. 02-5-8-20 approved the submission of phase one of this plan and Board Order No. 03-1-6-4 approved the submission of phase two.

For the 2005-2007 biennium, the Office of Mental Health and Addiction Services requires that the alcohol and drug and mental health plans be combined into one comprehensive mental health and addiction implementation services plan. Additionally, this updated implementation plan is required to identify changes in service needs, resources or other circumstances that might require changes in the service delivery system.

The updated plan must also address any system change priorities for adults/seniors and children/adolescents and describe evidence-based practices to be used in 2005-2007 biennium for treating children/adolescents and adults/seniors. The implementation plan is to provide a clear framework for allocating resources for the 2005-2007 biennium.

In order to gain community input to update the implementation plans, the following activities occurred:

- Alcohol & Drug Treatment Provider Forum was held on December 18, 2003.
- Prevention Focus Groups were conducted on January 8, 2004.
- Family Advisory Council members were interviewed on January 20, 2004.
- A Community Forum was convened on January 28, 2004.
- Gambling Focus Group was conducted on January 29, 2004.
- Regularly scheduled meetings with the Mental Health Advisory Committee occurred.
- The plan was reviewed by the local Department of Human Services Delivery Area (SDA) managers and staff.

Attached is the completed Mental Health and Addiction Implementation Plan for the 2005-2007 biennium. As required, the plan was reviewed and approved by the Mental Health Advisory Committee, the Local Alcohol and Drug Planning Committee and the Commission on Children and Families.

B. Alternatives / Options

1. To approve the submission of the Lane County Mental Health and Addiction Implementation Plan for the 2005-2007 biennium to the State of Oregon, Department of Human Services, Office of Mental Health and Addiction Services.

2. Not to approve number one above. If the Board of Commissioners does not approve the submission of the Lane County Mental Health and Addiction Implementation Plan for the 2005-2007 biennium to the State of Oregon, Department of Human Services, Office of Mental Health and Addiction Services, mental health and addiction services funding for planning and services for the next biennium may be affected.

C. Recommendation

To approve number one above and approve the submission of the Lane County Mental Health and Addictions Implementation Plan for the 2005-2007 biennium.

IV. IMPLEMENTATION / TIMING

Upon Board action, the Department of Health & Human Services will forward the Plan to the State of Oregon, Department of Human Services, Office of Mental Health and Addiction Services, to meet the April 1, 2004 deadline.

V. ATTACHMENTS

Board Order
Lane County Mental Health and Addiction Implementation Plan

THE BOARD OF COUNTY COMMISSIONERS, LANE COUNTY, OREGON

RESOLUTION AND ORDER:	)	IN THE MATTER OF APPROVING THE SUBMISSION OF THE LANE COUNTY MENTAL HEALTH AND ADDICTIONS IMPLEMENTATION PLAN FOR THE 2005-2007 BIENNIUM TO THE STATE OF OREGON, DEPARTMENT OF HUMAN SERVICES, OFFICE OF MENTAL HEALTH AND ADDICTION SERVICES.

WHEREAS, State of Oregon, Department of Human Services, Office of Mental Health and Addiction Services requires that a combined Mental Health and Addiction Implementation Plan be submitted for the 2005-2007 biennium; and

WHEREAS, Lane County Health & Human Services is the local Mental Health authority for Lane County; and

WHEREAS, the implementation plan has been reviewed as required by the Mental Health Advisory Committee, the Local Alcohol and Drug Planning Committee and the Commission on Children and Families.

NOW THEREFORE, IT IS HEREBY ORDERED that the Board of County Commissioners approve the submission of the Lane County Mental Health and Addictions Implementation Plan for the 2005-2007 biennium.

DATED this _____ day of March 2004.

Bobby Green Sr., Chair
Lane County Board of Commissioners

APPROVED AS TO FORM
Date 3/9/04 lane county
OFFICE OF LEGAL COUNSEL

Lane County
Mental Health and Addictions Implementation Plan
2005-2007

Lane County Health & Human Services
March 2004

Table of Contents

I. Planning Process
   A. Co-Occurring Disorder Treatment Program
   B. Inadequate Funding/Children's Mental Health
   C. The Loss of Oregon Health Plan (OHP) Coverage
   D. The Impact of Measures 28 and 30's Failure and Other Budget Cuts
   E. The Importance of Advocacy and Legislative Work
   F. Inconsistent Guidelines and Inadequate Time to Conduct High-Quality Planning
   G. The Importance of Developing a Comprehensive, Unified Behavioral Health Plan

II. Functional Linkages to the State Hospital System

III. Prevention Plan Narrative

IV. Gambling Prevention and Treatment Enhancements Narrative

V. Resource Allocation
   A. Alcohol and Drug
   B. Gambling
   C. Mental Health

VI. Alcohol and Drug Minority Services

VII. Attachments
   A. Attachment 1: Subcontractors and Service Elements
   B. Attachment 2: Board of County Commissioners
   C. Attachment 3: Local Alcohol & Drug Planning/Mental Health Advisory Committee
   D. Attachment 4: Commission on Children & Families
   E. Attachment 5: County Funds Maintenance of Effort Assurance
   F. Attachment 6: Service Delivery Area Manager
   G. Attachment 7: Integrated Program Area Grid
   H. Attachment 8: Workplans
      - Mental Health Plan
      - Alcohol & Other Drug Abuse Plan
      - 2005-2007 Prevention Plan
      - Problem Gambling Prevention Plan
      - Problem Gambling Treatment Enhancement Plan
   I. Attachment 9: Oregon Children's Plan Special Projects Proposal
   J. Attachment 10: Concept Paper for Developmental Disabilities/Mental Health Dual Diagnosis Service Enhancement Pilot Project
   K. Attachment 11: Notes from Community Forum and Focus Groups
   L. Attachment 12: County Contact Information
   M. Licensure/Approval

I. PLANNING PROCESS

Working with the Lane County Mental Health Advisory/Local Alcohol and Drug Planning Committee (MHAC/LADPC) Lane County Health and Human Services (H&HS) proceeded with a planning process respectful of existing resources and plans. H&HS formed a planning team comprised of H&HS staff dedicated to the program areas identified for this plan as well as the planner for Lane County Commission on Children and Families. This team met regularly to develop and coordinate timelines, planning tasks and responsibilities, all of which was reviewed by the MHAC/LADPC. From December 18, 2003 and concluding January 28, 2004, H&HS convened five forums specific to gathering information and feedback from community partners, consumers, family members, providers, and other stakeholders. The focus areas/groups included alcohol and drug treatment providers, alcohol and drug prevention practitioners, family advisory council, gambling advisory board and a community forum which included mental health providers, consumers and community advocates. Each meeting/forum included a review of existing plans and guidelines for the 2005-2007 biennial plan. Suggestions and feedback received from each meeting were considered and included in the development of this plan and notes from all the meetings are included in the attachment section of this document. The MHAC/LADPC convened a special meeting specifically to review the draft plan and make necessary revisions. Once the plan was revised/updated, it was presented to the local Human Services Service Delivery Area, SDA 5, the local Commission on Children and Families and back to the MHAC/LADPC for final approval before sending it to the Board of County Commissioners for review.

Key issues and areas of concern emerged from the forums/meetings that have been identified in previous planning processes and demanded attention during the development of this plan. These issues and concerns are:

- The need to develop a co-occurring disorder treatment program
- Coordination and inadequate funding for all services with particular concern about the apparent inequity of youth mental health funding for Lane County
- The loss of Oregon Health Plan (OHP) coverage for youth and adults when they are incarcerated
- The impact of Measures 28 & 30 failure and budget cuts
- The importance of advocacy and legislative work
- Inadequate time to conduct coordinated, multi-systemic, high-quality planning
- The importance of developing a comprehensive, unified behavioral health plan

A. Co-Occurring Disorder Treatment Program

Lane County H&HS has long recognized the need for a co-occurring disorder treatment program and began movement toward this goal in 2003. In early 2003, Lane County proposed the idea of a 'pilot project' to the state Office of Mental Health & Addiction Services. The 'pilot project' proposal included the ability to manage all state funds currently going to Lane County for mental health, alcohol and drug and gambling

services. Managing these funds locally would provide more flexibility across systems and could accommodate the desired goal of developing a co-occurring treatment program. Although the Lane County pilot project has not yet been realized, the commitment toward a co-occurring program remains strong. Indeed, providers in mental health and alcohol and drug, family members, consumers, and MHAC/LADPC members continued to identify this as a goal throughout the planning process. Responding to the consistent request and need, Lane County will a) allocate funds from both mental health and alcohol and drug funding and b) issue a request for proposal during the next biennium for a 'pilot' co-occurring treatment program. Funds used for this pilot will not come from state general funds but will come from local beer and wine tax and LaneCare, Lane County's mental health organization.

B. Coordination of Children's Mental Health and Inadequate Funding

Coordination. System coordination is critical for children and families who are served by multiple service providers. Mental health, child welfare, juvenile justice, and school systems often serve youth and families. Collaboration between providers generates coordinated service plans and often leads to better outcomes at a lower cost.

A legislative budget note passed in 2003 requires state funds currently paying for the psychiatric hospital, residential treatment and day treatment, be contracted to local managed care entities. Local planning groups will help assure that these intensive treatment services are well coordinated with system partners.

Inadequate funding. During the past year, different ends of the continuum of care, juvenile justice and prevention, identified the need for increased child/youth mental health services. The Department of Youth Services (DYS) and the local Commission on Children and Families (CCF) helped highlight this need through different processes.

Lane County's Department of Youth Services provides closed-custody beds and on-site non-residential intervention services and programs to hundreds of high risk juvenile offenders each year. Lane County Youth Services responds to more than 4,700 service requests a year, processing more than 2,500 youth; conservatively, more than 75 percent of them have mental health issues or substance abuse issues or both. Those with a dual diagnosis, (mental health and substance abuse), are the most expensive to process, house, treat and stabilize. Those with acute mental health issues represent a subset of this; an estimated number is in the hundreds. Cost per day in county detention is $189; for acute mental health clients, the cost is greater due to transportation, additional medical costs, and other costs.

In Lane County, there are currently no acute or sub-acute mental health programs to serve these youth or their families; they are referred to resources outside Lane County, which means a 7-8 month wait for placement/treatment. Additionally, these youth are sent to another county, making family treatment all but impossible. Youth services clients without acute mental health issues stay in detention, on average, 8 days. Of all

the offenders, those with serious or acute mental health issues, such as bi-polar schizophrenia, constitute the most serious challenge to manage and accommodate. Their effective supervision stretches limited community corrections resources to the limit, often requiring intense and prolonged one-on-one staff contact to maintain stability, order and protocol. Many of these juveniles contribute to a variety of public safety issues in Lane County. They are typically at low risk of committing serious offenses, but are highly likely to commit more offenses if not treated. Without intervention, they will continue to place an increasing burden on youth services programs and facilities that are designed to primarily serve offenders who can demonstrate some reasonable level of emotional and mental stability.
The local CCF focused on children's mental health needs in our community through a process of information gathering and offering subsequent recommendations to Lane County for system improvements. These included as top priorities:

- Forming multi-agency teams to review reports that local parents have to relinquish custody of their children in order to access inpatient mental health services out of our area. This issue requires a multi-agency focus in order to untangle what is happening, why and how to make improvements.

- Bring attention to the lack of respite care for parents of children with mental illness. CCF is facilitating a "Day of Respite" with community partners in order to bring attention to this issue and provide a much-needed afternoon "off" for parents

- The financial burden on rural schools that have a disproportionately large number of foster children with special needs (mental, emotional, behavioral, as well as physical).

A significant area of concern highlighted in both processes is the extremely low allocation toward child mental health that Lane County receives. Lane County receives approximately $48,740/biennium to serve all youth requiring mental health services. Marion County is comparable in size (in fact the population of Marion is approximately 40,000 less than Lane), and receives $258,904/biennium. Clackamas County, whose population is only approximately 16,000 more than Lane, receives $298,826, biennium. This inequity in funding is difficult to understand and accept, and results in a serious inability to meet the mental health needs of children and youth in Lane County.

C. The Loss of Oregon Health Plan (OHP) Coverage Due to Incarceration

Ensuring adequate and effective behavioral health treatment services requires consistency in care. Consistency of care becomes problematic when people, both youth and adults, commit crimes and become incarcerated. Upon incarceration, people previously eligible for and enrolled in the OHP become ineligible therefore, impacting the ability to provide behavioral health treatment services. This creates a 'catch 22' in two ways. If a person is receiving treatment, which is paid for through OHP, and commits a crime requiring incarceration, the ability to pay for that treatment

is stopped. Interruption of treatment can result in a variety of unhealthy and unwanted consequences. Also, if a person has not been diagnosed with a mental illness or addiction issue, and becomes incarcerated, a behavioral health assessment and evaluation may be performed. If the incarcerated person is assessed as needing behavioral health treatment services and does not have an ability to pay for treatment, the need goes unmet. Both of these scenarios are real and happen routinely. Both are unacceptable, and contrary to what we know works as evidence-based practices.

D. The Impact of Measures 28 & 30's Failure and Other Budget Cuts

The FY 02/04 State budget problems and the defeat of Measures 28 and 30, resulted in considerable losses to the Lane County behavioral health system. The Lane County Department of Health and Human Services alone had an overall budget reduction of $10 million and a reduction of 40 FTE.

Further system reductions were experienced in both alcohol and drug and mental health services. The local alcohol and drug service system losses were significant in the past year due to state revenue reductions, loss of OHP standard's chemical dependency benefit, and termination of a three-year federal treatment enhancement grant. Together, these losses resulted in a reduction of approximately $2.6 million and loss of services to over 2900 individuals.

The local mental health system also experienced devastating losses as a result of state revenue reductions and loss of the OHP standard mental health benefit, as well as delays in eligibility. Lane County Mental Health alone experienced a 30 percent reduction in FTE, including case managers, nurse practitioners and psychiatry. In addition, Lane County was forced to terminate its highly valued crisis triage service operating at Sacred Heart Emergency Department in order to maintain a viable staffing level at its outpatient clinic. LaneCare, Lane County's mental health organization, experienced a capitation reduction from $16 million to under $12 million. Approximately 10,000 Lane County residents with OHP coverage lost their behavioral health benefit and will lose their entire benefit in August, thereby swelling the numbers of indigent individuals needing access to services that are already under funded.

Perhaps the most clear negative outcome of the defeat of Measure 28 is the planned closure of Lane County Psychiatric Hospital after over 16 years of operation on March 31, 2004. LCPH was the first of the Regional Acute Facilities in Oregon, and served as a model for the provision of quality psychiatric inpatient care for the State. This closure is a direct result of the loss of the OHP standard mental health benefit, delayed eligibility for OHP for individuals admitted into the hospital, and the State's decision to abandon its statutory responsibility for paying for committed patients approved for the State Hospital but placed at Lane County Psychiatric Hospital awaiting a bed at the State Hospital. This decision resulted in a loss of revenue for LCPH of over $140,000 in the previous fiscal year and has already totaled over $130,000 in the current fiscal year. It is our understanding that the Hospital Association has filed notice of intent to sue the State for these lost revenues, and Lane County may consider this.

E. The Importance of Advocacy and Legislative Work

The local MHAC/LADPC has become increasingly concerned about the various issues facing the mental health and addictions service system. Lane County began convening community forums in 2002 as a process to gain consumer, family and community input on these areas. These forums have been invaluable as a mechanism for the MHAC/LADPC members to hear first hand about the needs, concerns and ideas for improved services from the very people who receive services. In addition to the community forums, the harsh budget cuts and resulting service cuts and changes, have provided MHAC/LADPC members ample motivation for concern. While the MHAC/LADPC have always been strong advocates, they have acknowledged the need for stronger advocacy and are committed to being a vociferous advocacy body.

F. Inconsistent Guidelines and Inadequate Time to Conduct High-Quality Planning

Developing an integrated behavioral health plan makes sense. However, it is challenging to complete given inconsistent instructions for each program area designated in the plan. Integration of three program areas important and has merit, the challenge comes not from examining ways in which integration could occur, but rather, from the directions in the guidelines. Alcohol and drug prevention requirements are lengthy and detailed, mental health has four bullets of instruction, while gambling prevention and treatment enhancement have two full pages of instructions. Different formats and different degrees of information required all contributed toward a confusing set of overall instructions. Integrating program areas is a complicated process, yet valuable. Complicated, confusing and inconsistent guidelines for each program area contribute toward this problematic challenge. Instructions need to be integrated if the planning and final document is to be integrated. Perhaps future-planning guidelines will provide all program areas the same instructions.

Additional challenges occurred due to the timeline of the plan. Although counties were ultimately given an additional month to complete the planning process, the five months allotted did not provide an adequate amount of time to conduct as thorough a plan as hoped. The *draft* guidelines were received in the end of October and the *final* guidelines were never received. Nevertheless, planning proceeded during the next two months, which are difficult to schedule due to holidays and vacations. Given all the requirements for various advisory bodies to review, the plan needs to be completed a full month before it is due to the state. Therefore, with the additional month, we had essentially two months to complete this comprehensive plan for the biennium that is one and one-half years away.

G. The Importance of Developing a Comprehensive, Unified Behavioral Health Plan

As previously mentioned, Lane County H&HS has been interested in developing a behavioral health system for quite some time. This is no easy task and requires careful

and thoughtful planning. Lane County recognizes the importance of this plan and is committed to using the work plan to help guide the services as well as the MHAC/LADPC as we proceed in the next biennium.

In an effort to integrate program areas, Lane County developed a grid, which summarizes shared priorities and strategies. This grid will be used as only a reference tool with more specific information included in each program area. See attachment 7.

II. FUNCTIONAL LINKAGES TO THE STATE HOSPITAL SYSTEM

Lane County provides functional linkages to the State Hospital system by having our Residential Team serve as primary liaison to State Hospital staff for the purposes of discharge planning, placement, and service access. We also have a monthly meeting with the Extended Care Management Unit (ECMU) at OMHAS, which is responsible for clinical assessment for the SPMI (Serious and Persistent Mental Illness) population who need long-term care, and various Lane County providers and County staff to oversee movement of ECMU clients placed in Lane County community placements. Functional linkages with local acute care include a weekly Bed Utilization Review meeting to review with both acute care providers and outpatient providers which clients are in inpatient care, develop appropriate discharge plans and assure appropriate aftercare service provision. Lane County Mental Health has been the primary aftercare option for most "public" clients coming out of both local inpatient units. With the closure of LCPH on March 31, 2004, a Discharge and Transition Team will be developed to provide an intensive array of community based wraparound services and supports to individuals being discharged from acute care. This team will be working with inpatient social work staff from the day of admission to develop appropriate service plans to allow for briefer inpatient lengths of stay.

III. PREVENTION PLAN NARRATIVE

Lane County has a rich history of supporting substance abuse prevention with a commitment toward implementing evidence-based practices. Working with key local prevention partners, the local Commission on Children and Families, DHS Service Delivery Area, education, community coalitions, and treatment providers, H&HS convened a focus group in January 2004 to respond to prevention requirements in the 2005-2007 guidelines. This group responded to questions designed to address the 2005-2007 biennial plan guidelines specific to substance abuse prevention. The two key areas addressed were ways to best support local/community based prevention efforts and what, if any, strategies need to change from 2003-05 plan to reduce 8th grade drug use. The group was clear that some of the most important strategies during this time of budget reductions are to utilize and collaborate with existing resources. The noteworthy responses to the two categories are as follows with more detail in the work plan found in the attached notes from the focus group.

Community Coalitions

- Staff Support
- Collaboration
- Public Relations
- Training
- Funding

Decrease 8th Grade Drug Use

- Existing Resources
- Positive Youth Development/Support
- Technical Assistance
- Advocacy & Funding

It should be noted that the focus group was convened prior to information received about the possibility of reduced prevention allocation to the county. A proposed 25 percent reduction in prevention funds will be addressed in late February at a statewide prevention stakeholders meeting. If the reduction becomes permanent, the local resource allocation will be limited to supporting the required components for prevention. The required components include a designated coordinator responsible for the prevention plan, ongoing support and development of community coalitions, and coordination with the Comprehensive Plan (SB555). The prevention coordinator will continue work cross systems to enhance collaborations and improve implementation of evidence based prevention practices. In addition to system-wide prevention coordination, community–based prevention is a cornerstone of prevention and therefore must be supported. Staff support to community coalitions is an essential component for ensuring success. Therefore, resource allocations will be used to continue staffing for a countywide prevention coordinator and staff support to mobilize and provide technical assistance to community coalitions. Funding allocation from the state above the base allocation will be used to support evidence-based practices, utilizing the six Center for Substance Abuse Prevention (CSAP) strategies, within the community and across systems.

IV. GAMBLING PREVENTION AND TREATMENT ENHANCEMENTS NARRATIVE

Problem gambling is a relatively new field in behavioral services. Yet while the majority of people gamble with few or no consequences, greater access to gambling in our state has certainly contributed to an increase in problem gambling. This growing public health issue affects problem gamblers themselves, their families and communities, and causes enormous social, economic, and psychological costs. Lane County is working to address the continuum of care in problem gambling through its comprehensive gambling prevention program and award-winning gambling treatment program.

Lane County's gambling prevention program has reached thousands of Lane County citizens through presentations, educational materials, media efforts, and collaboration with local prevention and treatment partners. Over 700 Lane County youth were served

since last year through the program's gambling prevention workshops. The County's gambling treatment program, ACES, served 229 problem gamblers and family members last year. ACES also houses the statewide problem gambling Help Line, which responded to over 4,407 calls last year.

V. RESOURCE ALLOCATION

Allocations for the 2005-2007 are a challenge to predict given the instability of the state budget, changes in allocations from the state, and loss of local revenue. Nonetheless, given the task to develop a budget based on 'what we know today', few resource allocation changes have been made in all service areas. All changes reflect identified needs expressed during the various community processes, changes in services due to budget deficits/cuts and as a commitment toward evidence-based practices.

Guiding Lane County in the process of resource allocation were three overriding values consistently expressed by community members, providers and key leaders:

- **ensure services for the most vulnerable,**
- **continue to implement community-based services and**
- **provide ongoing methods for contributions by consumers/survivors and family members**.

Allocation changes in each program area are presented below.

A. Alcohol & Drug

Prevention: According to current predictions, prevention funds will be reduced by 25 percent for the 2005-2007 biennium. Although the decision has not yet been finalized, Lane County will proceed as if they will be reduced by that amount. In addition to prevention funds being reduced by 25 percent it is also being proposed that allocations to counties will be divided in two methods: base allocation and competitive process. Given this proposed allocation change, coupled with the guidelines for prevention, the base allocation would be dedicated to supporting the county prevention coordinator and the ongoing support and development of community-based coalitions. All other strategies, including support for families, children of alcoholics/addicts, minority families, and school-based prevention efforts, will be addressed in a competitive proposal to the state if additional funds are made available through that process.

Treatment: The allocation for treatment services will change slightly to accommodate the commitment toward developing a 'pilot' co-occurring program. Although no state funds will be used to create this pilot program, local beer and wine tax funds will be used and therefore, a shift in overall funds to support alcohol and drug treatment services will occur. Local beer and wine tax revenue is currently allocated to support outpatient services for both adults and youth, outpatient services for minorities, methadone, and 20 percent for prevention services. Lane County will reduce the allocation to outpatient services in the amount of $50,000.00, which will be combined with an equal amount from mental health to create the 'pilot' program. Of course, this dual diagnosis program will serve people addicted to alcohol and other drugs.

B. Gambling

During the 2003-2005 biennium, gambling prevention funds were reduced statewide by 25 percent. Allocations for gambling prevention services in the 2005-2007 biennium are expected to continue at this reduced rate. Gambling treatment enhancement funds were not received by Lane County during the 2003-2005 biennium due to state funding reductions, however the rates are expected to resume similar to funds initially available in the 2003-2005 biennium.

C. Mental Health

There will no significant changes in state resource allocation at this time. Although no funding resources will be reallocated, Lane County is currently developing a hospital transition team to mitigate the impact of closure of the Lane County Psychiatric Hospital. Lane County may also explore other crisis services as an alternative to hospitalization. Given the current unpredictability of funding for mental health services, no new projects will be started and no reallocation of state funds will be made pending final state budget development.

Although no state funds will be allocated differently, LaneCare, Lane County's mental health organization, will allocate $50,000 toward the development of the co-occurring 'pilot' program. These funds will be matched by local beer and wine tax funds to create this 'pilot' program.

VI. MINORITY SERVICES

Lane County has a growing minority population, particularly within the Latino community. Lane County will maintain funding to support prevention and treatment services targeting the Latino community. Dedicated outpatient alcohol and drug treatment funding will continue with the current level of funding. Additionally, the gambling prevention program has specific strategies implementing an information, education, outreach and referral program directed toward the Latino community.

Office of Mental Health and Addiction Services
2005-2007 County Implementation Plan Guidelines
Attachment I

For each service element, please 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, (M, W, Y). ***Please note that each of providers listed below are contractors for the 2003-2005 biennium. A competitive process will be conducted to determine the contractors for 2005-2007 biennium.***

Provider Name	Approval/License ID Number	Service Element	2003-2005 OMHAS Funds in Subcontract	Specialty Service (M, W, Y)
ShelterCare—Heeran	#466	20	$160,518	
ShelterCare—Garden	#532	20	$52,536	
ShelterCare—Heeran	#466	20	$160,518	
ShelterCare—Garden	#532	20	$52,536	
ShelterCare—Crisis	#500	25	$93,317	
WhiteBird		25	$49,426	
PeaceHealth Counseling		25	$13,836	
Willamette Family Tx		60	$107,639	
White Bird		60	$39,999	
Willamette Family Tx	93-0569684	61	$1,555,200	
Willamette Family Tx		62	$54,900	
ACES	93-0798074	66	$217,945	
Centro Latino Americano	93-0638731	66	$23,916	M
Looking Glass	93-0605174	66	$69,655	Y
Center for Family Development	93-1071248	66	$23,729	Y
White Bird	93-0585814	66	$61,460	
Willamette Family Tx	93-0569684	66	$314,320	Y

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service (M, W, Y)
Lane County	93-6002303	66	$47,937	
Community Coalition Support		70	$32,847	Y
Centro Latino Americano	93-0638731	70	$9,463	M
Lane Education Service District		70	$63, 233	Y
Lane County	93-6002303	70	$66,674	
Lane County	93-6002303	80	$43,582	
ACES.	93-0798074	81	$223,371	
Lane County	93-6002303	81	$11,756	

Attachment 2

BOARD OF COUNTY COMMISSIONERS

County: Lane

The Lane County Board of County Commissioners has reviewed and approved the mental health and addictions services County Biennial Implementation Plan for 2005-2007. Any comments are attached.

Name of chair: Bobby Green

Address: Lane County; 125 E. 8th Ave., Eugene, OR 97401

Telephone: (541) 682-4203

Signature: _____

Attachment 3

LOCAL ALCOHOL AND DRUG PLANNING/MENTAL HEALTH ADVISORY COMMITTEE REVIEW AND COMMENTS

County: Lane

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 (person of color according to the U.S. Bureau of Census).

LADPC/MHAC COMMITTEE MEMBERS
2004

Name	Address	Phone	e-Mail
Tevina Benedict (term exp. 5/31/06)	2457 Oak St. Eugene, OR 97405	484-4396	tevinab@efn.org
Lois Day (term exp. 5/51/07)	3745 Hilyard Eugene, OR 97405	343-1771	lois.day@state.or.us fairdays@aol.com
Debra Depew (term exp. 5/31/07)	4588 Liberty St. Eugene, OR 97402	607-6980	dkdepew@msn.com
Carmen Frojen (term exp. 5/31/04)	2735 Malibu Way Eugene, OR 97405	485-0560	carfro@earthlink.net
Arnold Gottlieb (term exp. 5/31/06)	1721 N. Pacific Hwy. #14 Cottage Grove, OR 97424	942-2645	cgarnie@msn.com
Ruthie Manley (term exp. 5/31/04)	1133 Olive St., #412 Eugene, OR 97401	431-4668	cassiem@efn.org
David Piercy (term exp. 5/31/06)	1371 W. 4th Ave. Eugene, OR 97402	484-9720	dpiercy@teleport.com
Nancy Terry (term exp. 5/31/05)	790 E. 32nd Ave Eugene, OR 97405	345-1656	nancyfromeugene@webtv.net
Shannon Thienes (term exp. 5/31/06)	P.O. Box 25 Walterville, OR 97489	747-5595	shan878@aol.com
Phillip Zoller (term exp. 5/31/07)	2130 Willow Street Florence, OR 97439	902-7732	ptzoller@hotmail.com

admin/mental health advisory committee.doc
Updated 10/06/2003

The Lane County LADPC/MHAC recommends the state funding of alcohol and drug prevention and treatment and mental health treatment services as described in the 2005-2007 County Implementation Plan. Further LADPC/MHAC comments and recommendations are attached.

Name of Chair: Shannon Thienes

Address: P.O. Box 25
Walterville, OR 97478
Telephone: (541) 747-5595

Signature: _____

Attachment 4

COMMISSION ON CHILDREN & FAMILIES

County: Lane

The Lane County Commission on Children & Families has reviewed the mental health and addictions services County Biennial Implementation Plan for 2005-2007. Any comments are attached.

Name of Chair: Kitty Piercy

Address: c/o Lane County Dept. of Children & Families
125 E.8th Ave.
Eugene, OR 97401

Telephone: (541) 682-4671

Signature: _____

Attachment 5

COUNTY FUNDS MAINTENANCE OF EFFORT ASSURANCE

County: Lane

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 2005-2007 is equal to or greater than the amount of county funds expended during 2003-2005.

Rob Rochstroh
Name of County Mental Health Program Director

Signature

Date

Attachment 6

SERVICE DELIVERY AREA MANAGER

As Service Delivery Area Manager with responsibility for Lane County, I have reviewed the Biennial County Implementation Plan for 2005-2007. My comments are attached.

Name: John Radich
Address: Lane County DHS Service Delivery Area
2885 Chad Dr.
Eugene, OR 97401

Telephone: (541) 687-7373 ext.301

Signature: _____

Office of Mental Health and Addiction Services
2005-2007 County Implementation Plan Guidelines

Attachment 7
Integrated Program Area Grid

Mental Health	Alcohol & Drug	Gambling	Priorities	Evidence Based A	Evidence Based Y
1. Ensure Access to high quality treatment services.					
☑	☑		Increase percent of engaged clients who are retained in treatment 90 days or more.		
☑	☑		MHO providers will continue to provide access and authorizations to appropriate levels of care for OHP members		
☑			Work to assure an adequate level of medication management out-patient services community wrap around and crisis care.	☑	☑
☑			Maintain access to psychiatric medication management services	☑	☑
☑			Develop alternative prescribers and develop low cost clinics		
☑			Explore alternatives to psychiatric medications when appropriate and desired by clients.		
☑	☑	☑	Explore options to increase home-based and community-based activities, e.g. money management, life skills, in-home care, recreation and socialization activities.		
☑	☑	☑	Explore options to integrate with consumer/survivor-operated services and other partners to develop a more holistic approach.		
☑	☑	☑	Work to maintain current level of community-based services that value empowerment and self determination.		
☑			Work to assure an adequate level of medication management, outpatient services, community wraparound and crisis care and follow-up.	☑	
☑	☑		Reduce utilization of inpatient services – maximize use of alternative; higher intensity of community based services, such as assertive community treatment.	☑	☑
☑	☑	☑	Maintain adequate level of case management/service coordination for **youth**		☑
☑	☑	☑	Maintain adequate level of case management/service coordination for **adults**	☑	
☑	☑	☑	Ensure timely responses to request for services		
☑			Continue appropriate transitional planning by using bed utilization review process (prioritize optimum use of beds for highest level of need).		
☑	☑	☑	Maintain transitional services planning		
☑			Implement **ITS** integration partnership for youth		☑
☑			Expand Recovery Model Approach	☑	☑
☑	☑	☑	Ensure ongoing dual diagnosis care for individuals, including those with mental illness, problem gambling disorders, and addictions.	☑	☑
☑	☑	☑	Incorporate strength-based approaches to services across the continuum of care.	☑	☑
☑	☑	☑	Stabilize the continuum of care with essential services.	☑	

2. Improve Mental Health Crisis System					
☑			Maintain or increase dedicated services for crisis psychiatric supports		
☑			Provide community training for all providers to develop crisis plans		
☑			Develop a Hospital Diversion and Transition team, using ACT approach	☑	☑
☑			Expand mobile outreach for clients in crisis.		
3. Improve housing support					
☑			Explore alternatives to inpatient care, including in-home services and foster care		
☑			Explore options with local housing authority for Section 8, homeless population		
	☑		Continue to support the alcohol and drug housing project.		
4. Enhance consumer and family involvement					
☑	☑	☑	Plan and implement regularly scheduled community-based consumer/survivor and family forums		
☑	☑	☑	Increase commitment to engage consumer/survivors on the MHAC/LADPC to improve avenue of consumer/survivor input.		
☑	☑	☑	Support consumer/survivor peer groups that value empowerment and self-determination		
☑	☑	☑	Maintain or increase support of family support networks that value empowerment and self determination.		
☑			Maintain or increase support for consumer/survivor run organizations that value empowerment and self determination.		
☑	☑	☑	Maintain or increase support of family support networks		
☑			Develop Consumer Council		
5. Strengthen prevention efforts.					
	☑	☑	Delay the initial onset of youth engaged in problem behavior, including gambling, and alcohol & drug use.		☑
	☑	☑	Develop, promote and utilize the six Center for Substance Abuse Prevention strategies for gambling and substance abuse prevention efforts. (Information dissemination, education, identification and referral, alternative activities, policy/environmental, and community-based processes.)	☑	☑
	☑	☑	Develop and support prevention efforts targeted at reducing risk factors.	☑	☑
	☑	☑	Support community-based prevention efforts working toward increasing protective factors.	☑	☑
	☑		Incorporate strength-based approaches to services across the continuum of care.	☑	☑
6. Integrate systems					
☑	☑	☑	Work with existing Mental Health Advisory Committee/Local Alcohol & Drug Planning Committee, and local partners, e.g. Dept. of Human Services, Dept. of Youth Services, Senior & Disabled Services, Commission on Children and Families, Vocational Rehabilitation, Public Safety Coordinating Council, Domestic Violence Council, United Way, etc.		
☑			Work with local consultant to implement mental health training of criminal justice officers		

7. Promote community awareness and advocacy.					
☑			Explore options to increase mental health education with local education districts		
☑	☑	☑	Increase information to community and family members through continued use of media.		
☑	☑	☑	Build relationships among key leaders in rural communities to increase success of rural outreach efforts		
	☑	☑	Heighten awareness among the Latino community about the risk factors contributing toward problem behaviors, including problem and pathological gambling and substance abuse.		
☑	☑	☑	Increase awareness of Latino community regarding behavioral health services available.		
☑	☑	☑	Explore funding options for OHP members no longer qualifying for mental health benefits.		

Attachment 8
Workplans

Mental Health Plan
Goal: Reduce the negative consequences of mental health disorders

High Level Outcome: Community Integration through increasing the percentage of mental health consumer/survivor s involved in activities that decrease dependence on the mental health system

Intermediate Outcome	Priority	Strategies (*Given current budget)	2005-2007 Resource Allocation
1. Increase percent of consumer/ survivors with improved level of functioning.	1. Increase consumer/ survivor and family involvement, including all culturally diverse populations with local mental health planning.	Strategy 1. Plan and implement regularly scheduled community-based consumer/survivor and family forums. Strategy 2: Increase commitment to engage consumer/survivors on the MHAC to improve avenue of consumer/survivor input. Strategy 3. Support consumer/survivor peer groups that value empowerment and self-determination.	Resource level unknown. Resource allocations include: 1.Staff Time 2.Blended funds from County, State, MHO and County general funds 3. Office space made available for consumer organizations at Lane County Mental Health
	2. Ensure access to medication, including all culturally diverse populations, for youth and adults	Strategy 1.: Maintain access to psychiatric medication management services Strategy 2.: Develop alternative prescribers and develop low-cost clinics Strategy 3.: Explore funding options for OHP members no longer qualifying for mental health benefits Strategy 4.: Explore alternatives to psychiatric medications when appropriate and desired by clients	Resource level unknown. Resource allocations include: 1. Closed door pharmacy established at Lane County Mental Health 2. Co-payment fund established for people unable to pay for prescriptions 3. Blended funds from County, State, MHO and County general funds
	3. Ensure home based and community-based activities, including all culturally diverse populations, for both adults and youth	Strategy 1: Explore options to increase home-based and community-based activities, e.g., money management, life skills, in-home care, recreation and socialization activities. Strategy 2: Explore options to integrate with consumer/survivor-operated services and	Resource level unknown. Resource allocations include: 1. Blended funds from County, State, MHO and County general funds. 2. Continued funding for Community Support Coordinator

Intermediate Outcome	Priority	Strategies (*Given current budget)	2005-2007 Resource Allocation
		other partners, e.g., Vocational Rehabilitation, to develop a more holistic approach.	
2. Increase average length of time between acute care episodes	1. Ensure appropriate transition, aftercare and case management/ service coordination, including all culturally diverse populations	Strategy 1: Work to assure an adequate level of medication management, outpatient services, community wrap around, crisis care, and follow-up care.	Resource level unknown. Resource allocation include 1.Blended funds from County, State, MHO and County general funds. 2. With closure of LCPH, County is looking at Hospital Diversion and Transition team. Cost of this team and funds available not determined at this time.
	2. Ensure housing alternatives for all clients, including all culturally diverse populations	Strategy 1: Explore alternatives to inpatient care, including in-home services and foster care Strategy 2: Explore options with local housing authority for Section 8, homeless population	Changes planned in progress 1. With closure of LCPH, County is looking at Hospital Diversion and Transition team. Cost of this team and funds available not determined at this time. 2. Blended funds from County, State, MHO and County general funds.
3. Decrease percent of consumers readmitted into intensive care at a more intense level within six months	1. Ensure appropriate assessment and access to appropriate treatment services for all clients, including all culturally diverse populations	Strategy 1.: LaneCare providers will continue to provide access and authorizations to appropriate levels of care for OHP members Strategy 2.: Work to assure a adequate level of medication management, out-patient services, community wrap around and crisis care	Resource level unknown. Resource allocation include 1. Blended funds from County, State, MHO and County general funds

Intermediate Outcome	Priority	Strategies (*Given current budget)	2005-2007 Resource Allocation
	2. Ensure consumer and family provided services for clients, including all culturally diverse populations	Strategy 1.: Maintain or increase support of family support networks that value empowerment and self-determination. Strategy 2.: Maintain or increase support for consumer/survivor run organizations that value empowerment and self-determination.	Resource level unknown. Resource allocation include: 1. Blended funds from County, State, MHO and County general funds 2. Increase consumer support with location of consumer organizations at Lane County Mental Health
4.Decrease percent of consumer/ survivors readmitted into care at a more intense level within 30 days.	1. Ensure well-developed crisis plans for all consumers/ survivors at risk of using acute services for all clients, including all culturally diverse populations	Strategy 1. Provide community training for all providers to develop crisis plans	Resource level unknown. Resource allocation include: 1. Staff Time 2. Blended funds from County, State, MHO and County general funds
	2. Ensure appropriate case management/ service coordination services for all clients, including culturally diverse populations	Strategy 1: Maintain adequate level of case management/service coordination for youth and adults Strategy 2. Ensure timely responses to requests for services.	Resource level unknown. Resource allocation include: 1. Blended funds from County, State, MHO and County general funds
	3. Ensure urgent crisis access to immediate psychiatric supports for youth and adults, including all culturally diverse populations	Strategy 1: Maintain adequate dedicated funding for crisis psychiatric supports.	1.Increase allocation for child psychiatric services based on demand. 2.Explore funding options for proposed crisis center to reduce acute inpatient services & reliance on Emergency Room 3.Resource allocation is blended funds from County, State, MHO and County general funds.

Intermediate Outcome	Priority	Strategies (*Given current budget)	2005-2007 Resource Allocation
5. Increase percent of consumer/ survivors admitted to community-based services in a timely manner following discharge from more intense care.	1. Ensure residential, transitional and permanent services for youth and adults, including all culturally diverse populations	Strategy 1: Continue appropriate transitional planning by using bed-utilization review process (prioritize optimum use of beds for highest level of need) Strategy 2: Advocate to retain this targeted funding. Strategy 3: Maintain transitional service planning	Resource level unknown. Resource allocation includes 1. Blended funds from County, State, MHO and County general funds. 2. Discharge & transition team
	2. Ensure residential, transitional and permanent services for youth and adults, including all culturally diverse populations	Strategy 1: Implement pilot project for youth in partnership with Joint Commission on Accreditation of Health Care Organization, JCAHO Strategy 2. Explore 'Recovery Model' approach. Strategy 3: Explore options with local housing authority for Section 8, homeless population	1.Resource allocation dependent on state decision for funding of Integration of children and Adolescent Intensive Treatment Services Pilot Project . (ITS) 2. Blended funds from County, State, MHO and County general funds.
	3. Increase or maintain consumer/ survivor- based and family- based services for all clients, including all culturally diverse populations	Strategy 1: Maintain or increase support of family support networks Strategy 2. Maintain or increase support for consumer/survivor -run organizations	Resource level unknown. Resource allocation includes 1. Blended funds from County, State, MHO and County general funds. 2. Col-locate consumer and family organizations with Lane Co. Mental Health

Intermediate Outcome	Priority	Strategies (*Given current budget)	2005-2007 Resource Allocation
6. Increase percent of consumer/survivors entering service at an appropriate level of care	1. Ensure access to community based services for adults and youth clients, including all culturally diverse populations	Strategy 1.: Work to maintain current level of community-based services that value empowerment and self-determination	Resource level unknown. Resource allocation includes 1. Blended funds from County, State, MHO and County general funds 2. Lane Co. Mental Health Court
	2. Integrate Mental Health services with the criminal justice system, alcohol and drug services, developmental disabilities program, senior and disabled services, for adults and youth, including all culturally diverse populations	Strategy 1: Work with existing Mental Health Advisory Committee and local partners, e.g. Department of Youth Services, Public Safety Coordinating Council, Senior and Disabled Services, Vocational Rehabilitation Department, and the Commission on Children and Families, to develop appropriate strategies to implement this priority. Strategy 2: Work with local consultant to implement mental health training of criminal justice officers	Resource level unknown. Resource allocation includes 1. Blended funds from County, State, MHO and County general funds
	3. De-stigmatize mental illness for all clients, including all culturally diverse populations	Strategy 1.: Explore options to increase mental health education with local education districts Strategy 2.: Increase information to community and family members through continued media articles	Resource level unknown. Resource allocation include: 1. Blended funds from County, State, MHO and County general funds
	4. Ensure residential, transitional and permanent services for both adults and youth clients, including all culturally diverse populations	Strategy 1: Explore development of local sub-acute care for adolescents in partnership with appropriate organizations	Resource level unknown. 1. Blended funds from County, State, MHO and County general funds

Alcohol & Other Drug Abuse Plan

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
Reduce Adult Substance Abuse **HLO #1: REDUCE ADULT SUBSTANCE ABUSE**	**A) Reduce the impact of alcohol and drugs on the community**	A1) Strengthen and build upon existing prevention and treatment initiatives and services. A2) Support community norms and laws change regarding the use of alcohol. A3) Increase health care integration of prevention and treatment.	A1-3) Staff support to enhance collaborative efforts within community based efforts, including prevention coalitions and Alcohol & Drug Issues Forum A1) Support alcohol & drug treatment services for youth, women, adults and minorities
	B) Stabilize the A&D system with essential services ranging from prevention through treatment	B1) Increase the flexibility of funding to help clients have access to different levels of care B2) Stabilize the service provider system with longer term contacts and funding *(not services supported by "soft" dollars)* B3) Increase funding rates for women's and youth residential adult and youth drug free outpatient, adult methadone outpatient and adult detoxification treatment services as well as A&D diversion programs *(requires additional funding to implement).*	

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
		B4) Increase funding for prevention services to support the Center for Substance Abuse Prevention, CSAP, strategies for effective prevention: information dissemination, education, problem ID and referral, positive alternative activities for youth, supporting community-based coalitions, and environmental or community norms and laws *(requires additional funding to implement)*.	B4) Receipt of Drug Free Communities Grant
	C) Incorporate "strength-based" approaches to services across the continuum of prevention and treatment service	C1) Promote strength-based treatment models across the continuum of youth and adult treatment services. Specific service priorities include funding for case management services that help the client/family access needed services and family skills enhancement/ development strategies C2) Promote strength-based prevention models (including universal, selected and indicated strategies) across the continuum of prevention services based on the Institute of Medicine Model (e.g., parenting)	
	D) Increase knowledge and access to services for very	D1) Improve the effectiveness of and access to services reaching varied high risk populations including but not limited to cultural and ethnic minorities,	

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
	high risk and/or inadequately/underserved segments of the county's varied population(s). **** All strategies listed here require additional or stabilized funding to implement***	homeless, and sexual minorities. D2) Enhance treatment engagement and treatment completion for clients in the criminal justice system with A&D abuse/dependency problems. D3) Improve the capacity of our A&D system to address the unique clinical needs of elders, partner and child abuse/trauma victims and perpetrators. D4) Enhance specialized services for individuals with co-occurring disorders including but not limited to developmental disabilities and/or cognitive impairment, A&D dependency/addiction, mental health and pathological gambling. D5) Develop common understanding and guidelines across programs and professionals D6) Cross train A&D and other experts, including Domestic Violence. D7) Develop interventions that address co-occurring issues.	D4) Dedicate funds from local beer and wine tax and LaneCare to develop local co-occurring treatment program.
REDUCE ATOD USE DURING PREGNANCY	**A) Increase knowledge of the importance of**	A1) Provide parental education about prenatal behavior and its impact on the unborn child through prenatal home	A1) Work with community partners, including Healthy Start, to provide accurate information.

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
PRIORITIES STRATEGIES HLO #7: REDUCE ATOD USE DURING PREGNANCY PRIORITIES STRATEGIES	**prenatal health and healthy behaviors.**	visiting, teen parent groups, and other prenatal support activities. A2) Provide residential and outpatient services for teen and adult pregnant or parenting women that is available and accessible to all, including minority and rural populations. A3) Enhance community understanding of the negative impacts of ATOD on the unborn child through public education.	A2) Continue to allocate funds to support treatment services targeting women, and pregnant or parenting teens. A3) Continue collaboration with substance abuse prevention efforts to disseminate accurate information.
DECREASE TEEN ATOD USE HLO # 10-12: DECREASE TEEN ATOD USE	**A) Reduce youth use of alcohol, tobacco and other drugs**	A1) Promote substance abuse prevention best practices in schools and communities. A2) Involve local media to inform community about youth use of ATOD A3) Enhance community-based prevention coalitions addressing youth ATOD issues. A4) Support community norms and laws change regarding the use of alcohol.	*Items in italics will be supported if prevention funds above the base allocation is received.* A1) * Prevention Coordinator * *School-based prevention coordinator* A2) *Staff support to Media United Against Drugs * Support for PSAs, print media, etc. A3) *Staff support to community based coalitions * Funding to support evidence based activities A4) Staff time

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
		A5) Support, enhance or create meaningful and consistent criminal justice responses to youth use of ATOD A6) Restrict youth access to ATOD A7) Promote earlier identification of high risk youth A8) Create tobacco-free environments by a) recruiting Lane County high school youth to participate in activities to create tobacco free environments; b) meeting with local media to highlight the problems of secondhand smoke exposure and advocate for change	A5) Staff time A6) Some activities funded through separate state grant funds *A7) Support to Family Resource Centers for services targeting children and parents where alcohol & drug issues exist* *A8) Tobacco Prevention: un-funded*
	B) Stabilize the A& D system with essential services ranging from prevention through treatment	B1) Develop or enhance local treatment options for youth, including detox and residential care for males and females. *(requires additional or stabilized funding to implement).* B2) Increase funding for prevention services to support the Center for Substance Abuse Prevention, CSAP, strategies for effective prevention: • information dissemination • prevention education	B1) No prevention funds allocated All prevention services funded fit into one or more of these categories *B2) Support for parent education targeting Latino parents*

Intermediate Outcome	Priority	Strategies	2005-2007 Resource Allocation
		• community based processes, • environmental/social policy • alternative activities • identification and referral.	
	C) Incorporate "strength-based", family-focused approaches to services across the continuum of prevention and treatment services. *(requires additional or stabilized funding to implement).*	C1) Promote strength-based treatment models across the continuum of youth and adult treatment services. Specific service priorities include funding for case management services that help the client/family access needed services and family skills enhancement/development strategies C2) Promote strength-based prevention models (including universal, selected & indicated strategies) across the Institute of Medicine model continuum of care.	C1) No prevention funds allocated C2) Prevention staff through public education partners

2005-2007 County Implementation Plan

Attachment 8

2005-2007 Prevention Plan

County: Lane Prevention Coordinator: Cindy Ann (C.A.) Baskerville

Using the grid below, list all the proposed programs for which the County is requesting funding. Include all the Program Outcomes (process objectives) and Intermediate-Level Outcomes (educational, attitudinal & behavioral objectives) for each of the proposed programs.
Proposed programs below reflect only those that will be supported with Baseline prevention funds. All other prevention programs will be proposed in the competitive process developed through OMHAS.

Proposed Programs	**Proposed Outputs** *(Process Objectives)*	**Proposed Outcomes** *(Educational, Attitudinal & Behavioral Objectives)*
1. Substance Abuse Prevention Coordination/Systems Collaboration	1A) Convene a minimum of ten coordinators meetings annually 1B) Coordinate with other prevention partners, including Juvenile Crime Prevention, the Commission on Children & Families and Success By Six, on monthly basis 1C) Provide six trainings/technical assistance to prevention partners and practioners annually	1A) 80% of participating coordinators will report an increased knowledge of countywide prevention efforts as measured by self report annually 1B) Increased collaboration will be reflected in countywide plans; including the comprehensive plan, juvenile crime prevention and substance abuse prevention submitted biennially 1C) 50% of participants receiving training or technical assistance will report and increase in prevention knowledge as measured by self report
2. Community –Based Prevention Coalitions	2A) The three existing community-based coalitions will develop annual workplans addressing risk factors contributing toward problem youth behavior and increasing protective factors and assets. 2B) One additional community-based coalition will be developed annually. 2C) Staff support will be provided to offer technical assistance and training to community members on a monthly basis. 2D) Provide substance abuse prevention funds to support evidence-based practices as identified by community-based coalition plans	2A) Workplans will be developed by each community-based coalition as demonstrated by their annual plan submitted to H&HS. 2B) One additional community-based coalition will be mobilized as demonstrated by documented membership agreements. 2C) Each community-based coalition will receive staff support as documented in monthly MDS reports. 2D) 100% of prevention activities supported with substance abuse prevention funds will be based on research and prevention best practices.

2005-2007 County Implementation Plan

Problem Gambling Prevention Plan
Attachment 8

County: Lane **Prevention Coordinator:** Julie Hynes

Proposed Programs	Proposed Outputs	Proposed Outcomes
1. "My Money's On Me!" youth program Gambling prevention program for elementary school, middle school, and at-risk adolescent youth.	1. Develop and provide a minimum of 12 interactive presentations per school year on problem gambling for the following youth: • Elementary school students • Middle school students • Adolescent youth at-risk for, or with a history of, problem behaviors 2. Build relationships with educational community to promote healthy school-related gambling policies	1-E. 70% of youth participants will demonstrate increased knowledge about problem gambling 2-E. 70% of youth participants will demonstrate increased knowledge about treatment resources 3-A. 50% of youth participants will demonstrate attitudinal improvement in relation to gambling 4-B. At least one Lane County school will incorporate a healthy gambling policy into existing school policies
2. General community outreach Heighten community awareness about problem gambling and increase community awareness of the availability of problem gambling services available in Lane County	1. Develop and provide a minimum of 12 presentations per year to community groups, professional groups, partner agencies, and other groups 2. Develop and provide one media campaign addressing problem gambling prevention (as funding permits) 3. Work with existing community partners to expand awareness and involvement around problem gambling issues 4. Build relationships among key leaders in rural communities	1-E. At least eighty percent of participants will report services as good or excellent 2-E. At least eighty percent of participants will report increased awareness resulting from presentations 3-E. At least eighty percent of participants will rate introduction of problem gambling issues to their agencies/ groups as useful

	to increase success of rural outreach efforts 5. Continue to identify and address ongoing problem gambling issues through Lane County gambling advisory committee	
Proposed Programs	**Proposed Outputs**	**Proposed Outcomes**
3. Latino outreach Heighten Latino community awareness about problem gambling and increase community awareness of the availability of problem gambling services available in Lane County	1. Develop and provide at least 3 presentations per year providing information about problem gambling to the Latino community (e.g., to Latino service providers, students, Latino chemical dependency groups, DUII groups, and in places of worship) 2. Develop at least one educational material on problem gambling to the Latino community	1-E. At least eighty percent of participants will demonstrate increased knowledge about problem gambling and gambling probabilities 2-B. At least two Latino community members involved in gambling treatment reporting treatment referral as a result of outreach activities

2005-2007 Problem Gambling Treatment Enhancement Plan

1. **Contact:** Peg Jennette

2. **Participating Agency:** ACES Counseling

3. **Treatment Enhancement Service Areas Considered as Priorities**
   A focus group, which included several ACES Meridian Gambling Treatment Program providers, was held in January 2004 to identify priority treatment enhancement areas for problem gamblers. Lane County did not receive A&D83 funding allocations as proposed for problem gambling crisis respite care during the 2003-2005 biennium. The focus group reviewed the past and current needs for problem gambling crisis respite care. After some discussion, the group expressed that problem gambling crisis care is readily available and accessed through Josephine County's problem gambling respite program. The group identified other priority areas for treatment enhancement funds:

   - Provide crisis respite with adequate mental health care
   - Continue to utilize crisis respite services through Josephine County, and provide transportation funding for Lane County residents
   - Dual diagnosis: coordinate with psychiatrist for medication issues/needs
   - Provide funding for continued dual diagnosis services after clients reach 50 hour "cap" for maximum allowable services

Treatment Enhancement Service Area Addressed in this Proposal
Provide funding for continued dual diagnosis services after clients reach 50 hour "cap" for maximum allowable services

Why this Service was Chosen:

ACES Counseling Center Meridian Gambling Treatment Program reports a high incidence of co-occurring disorders among their clients. Indeed, this finding is supported by gambling research; Shaffer, Hall, & Vander Bilt (1997) reported that individuals with concurrent psychiatric problems display much higher rates of disordered gambling than either adolescents or adults in the general population. Additionally, high rates of personality disorders (e.g., obsessive-compulsive, avoidant, schizotypal and paranoid) are noted in the research (National Opinion Research Center, 1999). With regard to problem gambling alcohol and other drug co-occurrence, the body of research supports this finding as well; 1999 study (Pasternak & Fleming) revealed that almost one in every three persons with a gambling problem also abused alcohol (compared to about one in ten without gambling problems), and about twice as many problem gamblers used tobacco.

Since a 50-hour maximum per-client cap has been placed upon gambling treatment services, ACES has expressed the need for extending gambling treatment, particularly for those clients with co-occurring issues. Lane County Health & Human Services has long recognized the need for a co-occurring disorder treatment program. In early 2003, H&HS proposed the idea of a 'pilot project' to the state Office of Mental Health & Addiction Services. Although the Lane County pilot project has not yet been realized, the commitment toward a co-occurring program has remained. Throughout the 2005-2007 biennium planning process, mental health and alcohol and drug providers, family

members, consumers and MHAC/LADPC members continued to identify treatment for co-occurring disorders as a goal. Funds used for any such pilot project will not come from state funds but will come from local beer and wine tax and LaneCare, Lane County's mental health organization. However, if additional state gambling treatment enhancement funds do become available, Lane County will apply for gambling treatment enhancement funds to support dual diagnosis services specifically for gambling treatment clients.

The following workplan was submitted as part of Lane County's application for the Oregon Children's Plan Special Projects Proposal. Although un-funded, this proposal represents significant community collaboration and highlights the need for mental health services targeting children & youth at risk.

Attachment 9

Oregon Children's Plan Special Projects Proposal
2003

High Level Outcomes Oregon Children's Plan & Local Early Childhood Plan	**Intermediate Outcome**	**Local Early Childhood Plan Priorities and Strategies**	**Applicable Component from *Charting the Future***
#4: Reduce child maltreatment.	1. Percentage of parents reporting increased parenting skills 2. Percentage of children receiving early intervention services.	**Priority A.**: Increase parent-child attachment by increasing parenting skills and nurturance. Strategy 1. Identify families with high levels of stress and increased risk of poor childhood outcomes through universal screening. Strategy 2. Reduce isolation and provide parental support and education for families with high levels of stress through home visiting, parenting classes, and other community based services. **Priority B**. Increase capacity and accessibility of community-based supports for families	✓ Information and Referral ✓ Triage ✓ Alcohol and Drug Services ✓ Mental Health Services
#7: Reduce ATOD Use During Pregnancy	1. Decrease percent of infants whose mothers used alcohol, tobacco and other drugs during pregnancy	**Priority A.** Increase knowledge of the importance of prenatal health and healthy behaviors. Strategy 1. Provide parental education about prenatal behavior and its impact on the unborn child through prenatal home visiting, teen parent groups, and other prenatal support activities.	✓ Information and Referral ✓ Triage ✓ Alcohol and Drug Services ✓ Mental Health Services

Attachment 10

Concept Paper for Developmental Disabilities/Mental Health Dual Diagnosis Service Enhancement Pilot Project

Concept Paper (Revised)
for
Developmental Disabilities/Mental Health Dual Diagnosis Service Enhancement
Pilot Project

June 27, 2001

As the mental health managed care organization for Lane County residents who qualify for Oregon Health Plan benefits, it is LaneCare's responsibility and mission to ensure that all qualified OHP members are able to access quality services within a comprehensive, integrated, and coordinated continuum of care. LaneCare recognizes that ensuring access for members whose special needs, vulnerabilities, or circumstances may limit their ability to obtain appropriate services, requires special planning, programs, training, and outreach efforts by LaneCare and its providers.

LaneCare's commitment to all members includes ensuring that appropriate services are available and accessible for those members who simultaneously experience the effects of both mental illness and a developmental disability. While the incidence of individuals with a dual diagnosis of developmental disability and mental illness is less well documented than other dual diagnosis issues (ie: mental illness/substance abuse), the individuals affected present unique challenges to our service delivery system. Untreated mental health issues can diminish the quality of lives or contribute to crises that result in emergency room visits, psychiatric hospitalizations, or disrupted living situations. LaneCare members with this dual diagnosis are entitled to the high quality of care provided other LaneCare members. It is important, therefore, that LaneCare develop and support mental health services that address the specific needs of people who have both mental illness and a developmental disability.

This paper proposes a collaborative pilot project that would continue and expand the collaboration that has occurred during the past year between an ad hoc committee of several mental health and DD staff members. This ad hoc committee is composed of several DD staff members and mental health clinicians with special interests and skills in meeting the needs of people who have dual developmental disabilities and mental health diagnoses. After attending a NADD dual diagnosis conference in San Francisco in Fall 2000, committee members have been meeting regularly to discuss ways to improve coordinated efforts between mental health and DD providers. While the committee membership includes staff with training and interest in this area (Developmental Disabilities Program Manager, LaneCare Medical Director, Lane Care Quality Coordinator, and several DD case mangers and LaneCare clinicians), none of the members has sufficient time to take the lead in designing a Pilot Project to implement many of the collaborative ideas that have been proposed.

It is therefore proposed that LaneCare and Lane County Developmental Disabilities sponsor a Dual Diagnosis Service Enhancement Pilot Project during LaneCare Year Five, October 1, 2001 to September 30, 2002. The overall Project goal is to design an implement a model of collaboration between Mental Health and Developmental Disabilities providers based on community needs, research, and best practices to:

1) Identify the number of LaneCare members who meet the criteria for both DD and mental health.
2) Increase the number of trained providers to respond to LaneCare members who present with both DD and mental health issues (especially during times of crisis) by providing a series of trainings so that:
    - Mental health treatment providers will have increased skills in working with people with developmental disabilities as well as a better understanding of the DD system.
    - DD caseworkers will have a better understanding of mental health diagnoses, treatment, and system issues.
3) Increase the availability and effectiveness of mental health services to clients with DD issues so that:
    - The number of crises leading to emergency room visits and psychiatric hospitalizations is reduced.
    - Fewer members experience disrupted living situations.
4) Expand the opportunities for professionals in both areas to consult and work together:
    - Develop a plan for providing collaborative assessment, case management, and treatment planning to problem solve and avert crises or disrupted placements.
5) Make recommendations for long term system-wide improvements to services for this targeted group individuals.

The pilot project design has not been fully developed. A small planning group from LaneCare administration and Lane County Developmental Disabilities Services have recommended:

- Hiring a Project Coordinator to take the lead in designing and implementing the Pilot Project.
- Modeling the Pilot Project somewhat after Lane Care's successful Senior Outreach Project.
- Incorporating the ad hoc committee as an integral part of the Pilot Project and building upon the work that has already been started.
- Designing a model of collaboration that includes:
    - Training providers and care givers.
    - Offering consultation to case managers on individual cases.
    - Educating emergency room psychiatric personnel on this topic.
    - Providing information and referral materials for the service delivery system.

We are requesting that LaneCare commit PEO funds ($10,000), effective October 1, 2001 to September 30, 2002 to help achieve the 5 goals stated above.

Budget:

LaneCare PEO funds:

$6,000 Funding for a Project Coordinator (temporary DD staff position)
$2,000 Training and educational materials
$2,000 Case consultation and Care Planning
$10,000

Lane County Developmental Disabilities (in kind and funds):

2 DD case managers to act as lead case managers, FTE =
Office space and support services for Project Coordinator, =
$2,000 Training and educational materials

Project Evaluation:

Project Coordinator to submit quarterly reports to LaneCare to include:

- Number, services, and outcomes for LaneCare members served by project.
- Number of trainings and attendees.
- Progress reports on policies/procedures to facilitate improved collaboration.
- Budget reports.

Attachment 11

Notes from Community Forum and Focus Groups

A&D Issues Forum
Meeting Minutes
December 18, 2003

Present: Kathy Donais, ACES; David Mikula, Center for Family Development; Jennifer Holland, Oregon Department of Human Services/Self Sufficiency Program; Pat Ewing, Integrated Health Clinics; Janet Perez, Lane County Alcohol, Drug, Offender Program; Seraphina Clarke, Lane County Department of Children and Families; Lisa Smith, Lane County Department of Youth Services; CA Baskerville, Julie Hynes, Peg Jennette and Julie Losco, Lane County Health & Human Services; Linda Eaton, Lane County Parole & Probation Services; Mary Bork, Lane Education Service District; Sylvia Roehnelt, Max Singleton, Eric VanHouten, Looking Glass; Shannon Thienes and Phil Zoller, Mental Health Advisory Committee; Ann-Marie Bilderback, Prevention & Recovery NW; Cheryl MacGinitie, Relief Nursery; Larry Weinerman, White Bird (Chrysalis); Micki Knucklens; Willamette Family.

1. Agenda Review.

2. Introductions.

3. Review of SB 555. The group reviewed the directive in Senate Bill 555 of one integrated plan among state agencies and local communities that addresses the needs, strengths and assets for children from 0 to 18 years of age and their families and includes the full continuum of services from prevention through treatment and aftercare. A summary of the high-level outcomes, priorities and strategies related to alcohol/drugs that are contained in the Lane County SB555 Plan was distributed. The group reviewed each item and made suggestions for revisions appropriate to the current conditions in Lane County. The document with revisions incorporated is attached.

   The full SB555 county plan can be accessed on the county website. Go to **lanecounty.org** and click on *Departments.* When the page comes up, scroll down and click on *Children and Families.* When the page comes up, scroll down again to *SB555 Coordinated Planning for Children and Families in Lane County.* Then click on *Phase II.* The plan is a great source of data that is also very useful when writing grant applications.

4. Review of 2005-07 Implementation Plan Requirements. The requirements for the A&D system section of the implementation planning guidelines received from the Office of Mental Health and Addiction Services (OMHAS) were reviewed. The requirements for this planning process include:

   - No transfer of funds between mental health program services and alcohol/drug program services;
   - All providers of services must hold a current license from the state;
   - Services for minorities must be maintained at the 2003-05 biennium level;

- Prevention funding may not be shifted to support treatment (this could put the block grant funding in jeopardy).

This year is the first time that the requirement to maintain funding within specified service elements has been relaxed. However, if changes are made to the funding support for certain services, the document must justify the shift.

5. Review of Map of Services. Documents were distributed that showed the continuum of care for adults and one for youth. These were reviewed to update them with current conditions.

6. Review of 2003-05 Implementation Plan Priorities. The group reviewed priorities declared in the implementation plan for the current biennium. A copy of the identified needs and gaps from the plan was distributed.

7. Identification of Current Gaps/Needs. Shannon spoke about the Mental Health Advisory Committee's commitment to piloting a project for treatment of individuals with co-occurring mental health and addiction disorders. This treatment protocol has been identified as a gap in services for the past two bienniums and will continue to be spotlighted as a target for development.

The group brainstormed changes that have occurred since the previous planning process. These included:

Adult Services -

1. Loss of TCE grant funds supporting 51 slots of intensive outpatient services for adults addicted to heroin including 9 specific to minorities (terminated September 2003);
2. Decrease in county DUII assessment services (loss of ADES position);
3. Decrease in county assessment/referral/pre-treatment services for offenders (loss of position in ADO);
4. Decrease in county methadone treatment services (OHP – 75% capacity and TCE funding - 26 slots lost);
5. Loss of methadone treatment services (closure of CODA);
6. Loss of OHP funded outpatient services for adults (75% of capacity lost with termination of benefits to Standard Population;
7. Decreased access to residential treatment (funding for 5 beds lost);

Youth Services -

8. Loss of 5 state funded outpatient treatment slots (funds were shifted July 2003 to support services to women);
9. Loss of TCE grant funds supporting acupuncture services for girls (terminated September 2003);
10. Loss of 23 TCE funded outpatient treatment slots;
11. Decreased residential services for boys (funding for 8 beds lost);
12. Declining funding for Juvenile Breaking The Cycle Grant will result in loss of A&D screening for about 800 youth;
13. Loss of half the capacity of the shelter program for juveniles;
14. Loss of 8% of the county general fund that supports services to youth beginning 2004-05;

15. Loss of 10 fte serving youth at DYS in 2005;
16. Loss of court staff supporting Youth Drug Court in 2005;
17. Loss of residential services for girls at Willamette Family Services in 2005;

Service Enhancements include:

1. Existence of Serbu funding for Youth Drug Court Coordinator;
2. Existence of federal funding for services to youth in custody of Youth Drug Court;
3. Existence of federal grant funded mental health and addiction assessment and treatment services including juvenile counselors in rural areas (Safe Schools and Healthy Start).

8. Priorities for Funding 2005-07. After discussion of the changes that have taken place and those anticipated in the next two years (including the potential loss of funding if the income tax surcharge is removed) the group reaffirmed that protecting the continuum of care and stabilizing the treatment system is their highest priority. Therefore, the recommendation is to make no changes to the existing array of treatment services.

9. Announcements.

WhiteBird is working with Lane County Mental Health to develop a project that will provide crisis mental health screening in the Eugene/Springfield urban area. It is expected that this project will more appropriately serve the target population and will remove that function from the hospital emergency departments.

The Department of Health & Human Services recently submitted a proposal in response to a request from the state for services to be funded under the Oregon Children's Plan. The OCP was developed to meet the needs of children that are at high-risk due to mental or emotional disorders or parental addiction disorders or mental illness and who do not meet eligibility criteria for the Oregon Health Plan and have no other access to health care. The proposed project will serve approximately 300 families with necessary mental health and addiction treatment. The proposal builds on the existing early childhood system and further develops resources that were identified as needs in the Early Childhood Plan. Specifically, the project will provide information and education disseminated through 850 early childhood care providers; screening and referral for mental health and addiction services to 300 parents/families; alcohol and drug addiction treatment for 100 women and 120 children; and mental health interventions for 75 families. Willamette Family Services will provide the addiction treatment. The mental health treatment providers will be selected through a competitive process if the proposal receives funding.

HLO #1: REDUCE ADULT SUBSTANCE ABUSE

PRIORITIES & STRATEGIES

A) Stabilize the A&D system with essential services ranging from prevention through treatment.

A1) Strengthen and build upon existing prevention and treatment initiatives and services.

A2) Support community norms and laws change regarding the use of alcohol.

A3) Increase health care integration of prevention and treatment.

B) Reduce the impact of alcohol and drugs on the community

B1) Increase the flexibility of funding to help clients have access to different levels of care

B2) Stabilize the service provider system with longer term contracts and funding *(not services supported by "soft" dollars)*

B3) Increase funding rates for women's and youth residential adult and youth drug free outpatient, adult methadone outpatient and adult detoxification treatment services as well as A&D diversion programs *(requires additional funding to implement).*

B4) Increase funding for prevention services to support the Center for Substance Abuse Prevention, CSAP, strategies for effective prevention: information dissemination, education, problem ID and referral, positive alternative activities for youth, supporting community-based coalitions, and environmental or community norms and laws *(requires additional funding to implement).*

B5) Enhance specialized services for individuals with co-occurring disorders including but not limited to developmental disabilities and/or cognitive impairment, A&D dependency/addiction, mental health and pathological gambling.

C) Incorporate "strength-based" approaches to services across the continuum of prevention and treatment service

C1) Promote strength-based treatment models across the continuum of youth and adult treatment services. Specific service priorities include funding for case management services that help the client/family access needed services and family skills enhancement/ development strategies

C2) Promote strength-based prevention models (including universal, selected and indicated strategies) across the continuum of prevention services based on the Institute of Medicine Model (e.g., parenting)

C3)Increase knowledge and access to services for very high risk and/or inadequately/underserved segments of the county's varied population(s).

D)Increase knowledge and access to services for very high risk and/or inadequately/ underserved segments of the county's varied population(s)

All strategies listed here require additional or stabilized funding to implement

D1) Improve the effectiveness of and access to services reaching varied high risk populations including but not limited to cultural and ethnic minorities, homeless, elders, and sexual minorities.

D2) Enhance treatment engagement and treatment completion for clients in the criminal justice system with A&D abuse/dependency problems.

D3) Improve the capacity of our A&D system to address the unique clinical needs of people who are abused or have experienced trauma including elders, partners and children as well as perpetrators.

D4) Enhance specialized services for individuals with co-occurring disorders including but not limited to developmental disabilities and/or cognitive impairment, A&D dependency/addiction, mental health and pathological gambling.

D5) Develop common understanding and guidelines across programs and professionals

D6) Cross train A&D and other experts, including Domestic Violence.

D7) Develop interventions that address co-occurring issues.

HLO #7: REDUCE ATOD USE DURING PREGNANCY PRIORITIES STRATEGIES

A) Increase knowledge of the importance of prenatal health and healthy behaviors.

A1) Provide parental education, screening and referral about ATOD use and its impact on the unborn child through prenatal home visiting, teen parent groups, and other prenatal support activities.

A2) Provide residential and outpatient services for teen and adult pregnant or parenting women that is available and accessible to all, including minority and rural populations.

A3) Enhance community understanding of the negative impacts of ATOD on the unborn child through public education.

HLO # 10-12: DECREASE TEEN ATOD USE

A) Reduce youth use of alcohol, tobacco and other drugs.

A1) Promote substance abuse prevention best practices in schools and communities.

A2) Promote and support best practice in substance abuse treatment for specific populations.

A3) Involve local media to inform community about youth use of ATOD

A4) Enhance community-based prevention coalitions addressing youth ATOD issues.

A5) Support community norms and laws change regarding the use of alcohol.

A6) Support, enhance or create meaningful and consistent criminal justice responses to youth use of ATOD

A7) Restrict youth access to ATOD

A8) Promote earlier identification of high risk youth

A9) Create tobacco-free environments by

- recruiting Lane County high school youth to participate in activities to create tobacco free environments;
- meeting with local media to highlight the problems of secondhand smoke exposure and advocate for change

B) Stabilize the A& D system with essential services ranging from prevention through treatment

B1) Develop or enhance local treatment options for youth, including detox and residential care for males and females. *(requires additional or stabilized funding to implement).*

B2) Increase the flexibility of funding to help clients have access to different levels of care

B3) Increase funding for prevention services to support the Center for Substance Abuse Prevention, CSAP, strategies for effective prevention:

- information dissemination
- prevention education
- community based processes,
- environmental/social policy
- alternative activities
- identification and referral.

B4) Stabilize the service provider system with longer term contracts and funding *(not services supported by "soft" dollars)*

B5) Increase funding rates for women's and youth residential adult and youth drug free outpatient, adult methadone outpatient and adult detoxification treatment services as well as A&D diversion programs *(requires additional funding to implement).*

B6) Enhance specialized services for individuals with co-occurring disorders including but not limited to developmental disabilities and/or cognitive impairment, A&D dependency/addiction, mental health and pathological gambling.

C) Incorporate "strength-based", family-focused approaches to services across the continuum of prevention and treatment services. *(requires additional or stabilized funding to implement).*

C1) Promote strength-based treatment models across the continuum of youth and adult treatment services. Specific service priorities include funding for case management services that help the client/family access needed services and family skills enhancement/development strategies

C2) Promote strength-based prevention models (including universal, selected & indicated strategies) across the Institute of Medicine model continuum of care.

Notes from Community Forum
January 28, 2004

Attending: Debra Depew, Gregg Swan, Don Leslie, Ruthie Manley, Ellen Peters, Bob Richards, Leslie Bradley, R. Drake Eubank, Nancy Terry, Dave Howard, Angeri Tapsseott, Gary Cornelius, Ann-Marie Bilderback, Susan Schloss, Mike Vaughn, Kyda Dodson, Mary Johnsen, Tod Schneider, Basilio Sandoval, Trina Morgan, Lois Day, Lucy Zammarelli, Sylvia Roehnelt, Lynn Greenwood, Hillary Wylie, Tevina Benedict, Mari Jones, Karen Gaffney, James Massey, Shannon Thienes, Rob Rockstroh, Marcia Johnson, Damien Sands, Al Levine, Bruce Abel, Susanne Boling, Kathryn Henderson, David Piercy

Providers/Community Partners

1. Relevant priorities for 05-07
    a. Rural Services need to be more emphasized
    b. Gatekeeping- there is no one access point where the community can contact to figure out what services are available and how to enter the mental health system. Have to make a variety of phone calls to a variety of people – No coordination.
    c. Use of strength-based or evidenced based practices for mental health
    d. Mental health prevention part of a public awareness campaign. Prevention needs to be emphasized at the front end.
    e. Coordination with the public safety organization. Maximize working with public safety. The police departments need to be included more in strategic planning. Ideas such as mobile vans, training police officers to deal with our clients, where to take clients now that the LCPH will be closed. Should be much more coordination.
    f. Need best practices for youth
    g. More emphasis on co-occurring disorders
    h. Need to stabilize a quality workforce to provide MH services. Need to pay providers of these services a decent wage to insure a quality workforce. Need a trained workforce to deliver MH services.
    i. Need to integrate Lane County government services more with other government services such as the state and cities.
    j. There is an after hours gap is this community for crisis. Don't know where to go

A&D services

1. Priorities
    a. Suggestion made "Stabilize the A&D system with essential services" – that the services be specified such as they are in MH.
    b. Services suggested to be specified include:
        - Prevention/early intervention
        - Community based school based services
        - Assessment to treatment
        - Detox services
        - Outpatient
        - Intensive outpatient
        - Residential(gender specific, youth)
        - Transition services
        - Continuing care
        - Case management/service coordination
        - Housing

- Child care
- Transportation
- Dual diagnosis
- Medication- best practices – what world
- Culturally appropriate

Needs of adult/senior

1. Identification of those who need services – outreach
2. Training of social workers in hospital settings to identify mental health or a&d issues.
3. State partner coordination
4. Gatekeeper for services – difficult to manage the system
5. Home-based services

Needs of Children/adolescents

1. Holistic plus wraparound services
2. In need of youth detox , methadone services, residential services and crisis services
3. Trauma support for youth who have been victims of crime
4. More mentoring and peer support
5. Family outreach

Needs of Ethnic/Minorities

1. Latino outreach- need to be culturally competent when offering services – understand the culture.

Family Advisory Committee
1/20/04

What do you want from the mental health system that you are currently not getting?

1. Support for Families/Parents
   - Help with keeping parents informed regarding options and activities for their children
   - Respite care for parents/families
   - Provide family members with most current, accurate information so they can ask for specifically what they need
   - Develop support groups for parents
   - Disseminate information regarding support and resources for parents
   - Intervene with children at earlier ages

2. School-Based Support
   - Summer school and other school-based resources for children with special needs
   - Inclusion of special needs children in school-based activities
   - In & out of district options
   - Additional resources in schools, which are over crowded and cannot meet demand

3. Coordination
   - Better coordination between schools and mental health
   - Greater access to services; i.e. through schools
   - Increase information sharing regarding current research regarding children's mental health and make it available to teachers, parents, and providers
   - Increase information sharing between schools and mental health
   - Increase coordination
   - Adjust mental health providers' time to allow for 1 hour/week to meet with families for coordination of services, i.e. I.E.P.

4. Training & Education
   - Increase training for teachers and other care providers
   - Train parents (and others) to be advocates
   - Provide Life Skills training for youth with special needs
   - Ask local providers, (i.e. Direction Service), to train others to be advocates
   - Educate parents and community members about mental illness and special needs
   - Offer parenting education/skills training for parents with children with special needs
   - Offer 'Options to Anger' classes for youth with special needs
   - Offer special certification for mental health workers who are competent to work with children with special needs
   - Offer special training for professionals teaching them how tow work with youth with special needs

5. Resource Development
   - Rural resources
   - Increase affordable activities for special needs children, grades k-12

A & D Prevention Focus Group

1/8/04

Attending: Mary Bork, Lisa Smith, Kathryn Henderson, Bob Proctor, Chris Rubin, Kathryn Henderson, Brinda Narayan-Wold, Julie Hynes, Janet Perez, Serafina Clarke, Shannon Thienes, Susanne Boling, Peg Jennette, Jennifer Holland, Mike Meyer, CA Baskerville

A. Community Coalitions

1. Staff Support
   - STAFF
   - Add STAFF time
   - Add STAFF time to existing coalitions
   - Increase community organizing/mobilizing support
   - Support new coalitions if a body of interested people + commitment has formed
   - STAFF support to mobilize new communities; i.e. Florence area
   - Assistance with community development:
     - How do coalitions know they are affecting 8th grade drug use?
     - How can they assess their needs?
     - How do they meet/address those needs?
     - Support & energize coalitions
   - STAFF support regarding leadership, support, development
   - Support and recognize work of coalitions
   - Support for PR for coalitions—How do we get people involved?
   - Engage youth in coalitions

2. Collaboration
   - Monthly reports to A&D Issues Forum
   - Quarterly reports to MHAC/LADPC
   - Increase linkages between schools and coalitions & other partners
   - Engage youth in coalitions

3. Public Relations
   - Use county PIO to assist in PR
   - Build momentum, develop sustainable structure, publicize
   - Support and recognize work of coalitions
   - Support for PR for coalitions—How do we get people involved?

4. Training
   - Train community members regarding prevention, it works, collaboration, etc.
   - Provide increased funding to train coalitions in evidence-based practices

5. Funding
   - Seed money for projects
   - Pay attention to size of community; larger communities may require greater funding

B. Decrease 8th Grade Drug Use

1. Existing Resources
   - Utilize existing plans (including FRCs)
   - Utilize the Oregon Children's Plan
   - Enhance systems coordination to make most out of limited resources
   - Assess what we currently collaborate with, including information dissemination
   - Link to community/system; i.e. FRCs
   - Meet youth where they are: schools

2. Positive Youth Development/Support
   - Support youth leadership; i.e. peer programs in various locations/communities, older youth as mentors and educators, teen theatre, etc.
   - Explore asset-based strategies

3. Technical Assistance
   - Connect people with 'what works'
   - Conduct constant evaluation for impact
   - Support 'what works'
   - Technical assistance to communities regarding affecting laws and norms
   - Improve referral process to resources, including FRCs
   - Help support schools to implement best practices

4. Advocacy & Funding
   - Re-fund school-based prevention coordinators
   - Support diversion programs; support for youth not meeting criteria for treatment but who need intervention, education, and for their parents
   - Support for school-based support that treatment providers could offer

Attachment 12

County Contact Information

Attachment 12

County Contact Information Form

1. County Contact Information

County: Lane County
Address: 125 E. 8th Ave.
City, State, Zip: Eugene, OR 97401

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

Name: William VanVactor Title: County Administrator

2. Addiction Treatment Services Contact Information

Name: Peg Jennette
Agency: Lane County Health & Human Services
Address: 125 E. 8th Ave.
City, State, Zip: Eugene, OR 97401
Phone: (541) 682-3777 Fax: (541) 682-3804
E-mail: Peg.Jennette@co.lane.or.us

3. Prevention Services Contact Information

Name: C.A. Baskerville
Agency: Lane County Health & Human Services
Address: 125 E. 8th Ave.
City, State, Zip: Eugene, OR 97401
Phone: (541) 682-3031 Fax: (541) 682-3804
E-mail: Cindy.Baskerville@co.lane.or.us

4. Mental Health Services Contact Information

Name: Marcia Johnson
Agency: Lane County Health & Human Services
Address: 125 E. 8th Ave.
City, State, Zip: Eugene, OR 97401
Phone: (541) 682-3814 Fax: (541) 682-3804
E-mail: Marcia.Johnson@co.lane.or.us

5. Gambling Treatment/Prevention Services Contact Information

Name: Julie Hynes
Agency: Lane County Health & Human Services
Address: 125 E. 8th Ave.
City, State, Zip: Eugene, OR 97401
Phone: (541) 682-3928 Fax: (541) 682-3804
E-mail: Julie.HYNES@co.lane.or.us