HSRI

Multnomah County Mental Health System Analysis

Final Report, August 2018

Executive Summary

In 2017, Multnomah County contracted with the Human Services Research Institute (HSRI) to conduct an analysis of the county's publicly funded mental health system. The population of focus was individuals of all ages who rely on public funds for mental health services. Our overarching intent for this project was to provide Multnomah County with a comprehensive, data-driven understanding of the existing mental health system that also examined the system's alignment with community needs and existing resources. The ultimate goal is to support the county in ensuring a 21st century mental health system driven by quality and scientific merit, efficient in coordinating service and support provision across agencies, and focused on outcomes leading to recovery with minimal barriers to access.

By many measures, the mental health system in Multnomah County aligns with the principles of a good and modern system. It has an array of services and incorporates evidence-based practices and services to support social determinants of health. Peer support is widely incorporated throughout the service continuum, and trauma-informed, culturally responsive approaches are widely embraced. There appear to be strong efforts to ensure that services are provided in the least restrictive environment, and in the community whenever possible. Throughout this process, we encountered talented and dedicated individuals—advocates, providers, County staff, and administrators—who have committed themselves to continuously improving the mental health system. These stakeholders are engaged in many collaborative and

ongoing efforts to continuously enhance the accessibility, equity, and effectiveness of the system and its services and programs.

> Efforts are needed to explore the disconnect between the system's aims and how the system is experienced by a significant number of stakeholders.

However, our community engagement process—which included interviews with 139 stakeholders and two community feedback sessions attended by approximately 159 individuals—revealed that many stakeholders, including service users and their family members, do not experience the mental health system as accessible, comprehensive, person-centered, trauma-informed, and culturally responsive. Additionally, our analysis of available quantitative data found that that although community members are accessing important services and supports, others who could benefit from these services may not be accessing them. Finally, stakeholders were concerned about whether and how entities within the system are working together and with the state to produce desired outcomes. Efforts are needed to explore this disconnect between the system's aims and how the system is experienced by a significant number of stakeholders. There are likely several factors that might explain this disconnect that are discussed in depth in this report:

- The system is highly complex, with multiple layers of oversight and accountability at local, regional, state, and federal levels. Because of this complexity, and because funding for mental health services is limited, there are multiple pathways and touchpoints in which service access and service denial occur, making system navigation difficult, particularly for individuals with limited capacity to meet the various requirements for service engagement, including individuals who are homeless and those with co-occurring mental health and substance use issues.
- Although there are progressive, innovative, and evidence-based practices in the county, stakeholders described many of these programs and services as in insufficient supply and/or difficult to access. In particular, stakeholders called for enhancements to peer support and additional capacity for outreach and engagement services and long-term community-based services tailored to meet the complex and often co-occurring needs of specific populations.
- Additional, concerted action is needed to ensure integration of physical health and mental health services. In particular, integration should be targeted at ensuring that community members receive mental and physical health care in the settings of their choice, which includes accessing mental health services in primary care settings.
- The mental health workforce—particularly those working in community-based settings—is overburdened and underpaid. Further, the workforce is not reflective of the racial, ethnic, and cultural diversity of the service user population.

- Although the work of MHASD and other entities is informed by people with lived experience, and although the County supports peer services through multiple avenues, stakeholders felt that even more inclusion is needed.
- There is a lack of clarity among stakeholders regarding which entity (or which entity wearing which hat) bears responsibility for system access, service quality, and population health. Stakeholders are also unclear about whether and how data, contracting, and service arrangements are consistently used by the different entities in the state and county to support the wellbeing of service user populations.

We offer three recommendations as high-priority recommendations:

1. **Engage in ongoing dialogue with service users and their families and other stakeholders to ensure a shared and actionable vision for the mental health system.** Our stakeholder engagement process reflected widespread views that Multnomah County lacks a vision—shared across all major system stakeholders—that can be translated into action.
2. **Establish a director-level lived experience leadership position.** Based on stakeholder interviews and best practice for state and county mental health systems around the country, Multnomah County would benefit from having a person who represents the perspective of lived experience as a user of publicly funded mental health services at a leadership level.
3. **Integrate and analyze data on funding and services to support system improvements.** Conduct future analyses to understand how funding flows through the mental health system and related systems, identify opportunities for expanding capacity, provide clarity for stakeholders, and otherwise inform system planning and improvements.

We also offer a longer series of recommendations that involve continuation of and enhancements to existing efforts of a variety of system stakeholders. They include recommendations related to:

- Access Barriers
- Data Sharing
- Services for Children and Youth
- Services for Persons with Complex Needs
- Co-Occurring Mental Health and Substance Use Services
- Homeless Services
- Services for Justice-Involved Persons
- Peer Respite
- Community Transitions and Crisis Follow-Up
- Health Equity and Cultural Competence
- Peer Support and Psychiatric Rehabilitation Services
- Supports for Caregivers and Families of Adults with Mental Health Needs
- Services for Older Adults

- Collaboration with the Intellectual and Developmental Disabilities System
- Workforce Recruitment and Retention
- Physical and Behavioral Health Integration

This report represents one step in an ongoing and complex process of systems improvement and transformation that has been underway for many years. It is not the end of a process; instead, it's intended to support ongoing efforts and further the conversation. Although the county faces considerable challenges, there are also considerable resources here—chiefly the skilled and passionate stakeholders deeply committed to systems transformation who live and work in Multnomah County.

Introduction and Background

The Human Services Research Institute (HSRI) was contracted by Multnomah County to conduct an analysis of the county's mental health system. Our overarching intent for this project was to provide Multnomah County with a comprehensive, data-driven understanding of the existing mental health system and to examine the system's alignment with community needs and existing resources. The ultimate goal is to support the county in ensuring a 21st century mental health system driven by quality and scientific merit, efficient in coordinating service and support provision across agencies, and focused on outcomes leading to recovery with minimal barriers to access. Specific project aims were as follows (more detail about the study aims can be found in the Background and Methods section):

- **Aim 1**: Develop a detailed inventory of all mental health services provided by the County and its community-partner contractors that includes service type, populations served and capacity for culturally specific services, and funding source.
- **Aim 2**: Catalog connections (communication mechanisms, collaborations, and handoffs) between each of the mental health services identified in Aim 1, and between the Aim 1 services and adjacent systems and services.
- **Aim 3**: Provide a detailed picture of how funding and reimbursement mechanisms flow through county systems, with a focus on state and County general revenues and federal Medicaid dollars.

- **Aim 4**: Identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to certain populations because of geography, language, financing, or other barriers.

Our Approach

To explore the study aims, we used three research methods: a review and synthesis of existing documents, reviews, and reports; a quantitative examination of aggregated service use and budget data obtained from local entities; and qualitative analysis of in-depth interviews with 139 stakeholders representing a range of perspectives, including people with lived experience of the mental health system and their family members. We also incorporated data from two community listening sessions attended by 159 individuals and additional community feedback gathered online.

HSRI's work is rooted in SAMHSA's vision of a *good and modern behavioral health system*[1] that focuses on the health and wellbeing of the whole population to prevent mental health problems before they occur, identify and intervene early when issues are present, and provide person-centered, trauma-informed, culturally responsive, and recovery-oriented services and supports to those with mental health–related needs. Our work involves espousal of the *"nothing about us without us"* mantra of the consumer/survivor/ex-patient movement,[2] which holds that behavioral health systems should be continuously and significantly informed and driven by people who use those services. We also bring a *population health* lens to our work, to understand mental health needs in the context of policies and interventions that come to bear on the outcomes of the entire population.[3,4] A well-functioning system attends not only to the intensive needs of children, youth, and adults with serious mental health conditions but also to the outpatient and community-based service and support needs of individuals, and, critically, to the social and emotional well-being of the majority of the population who have not been diagnosed with a mental health condition—especially children, youth, and young adults. Finally, this project is informed by the *social determinants of health*, which are "the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age."[5] These social determinants have a significant bearing on the wellbeing—including mental health—of populations. Therefore, a good and modern behavioral health system incorporates a continuum of social support services that includes employment, housing, and self-help alongside clinical treatment.[6]

Project Scope

In this report "mental health services" are those that a) promote social and emotional wellness, b) prevent or reduce the severity or incidence of mental health problems, and/or c) address existing mental health-related needs through treatment and support. Mental health services funded through private insurance or delivered through the veterans' health system are not covered in detail in this report. Substance use services and programs—regardless of how they're financed—are not covered in depth, although services specifically designed to support individuals with co-

occurring substance use and mental health needs are discussed. “Behavioral health” refers to both mental health and substance use services.

The populations of focus include individuals of all ages who receive mental health services through the publicly funded mental health system. This includes Medicaid-funded individuals who receive mental health services through the physical health system or within schools, and those who receive mental health services through the criminal justice system. It also includes people who are uninsured or underinsured who rely on the public health system to access support. The population of focus does not include veterans or military service members who receive services through the veterans’ health system. It also does not include individuals who have a substance use disorder, a brain injury, or an intellectual or developmental disability who do not have a co-occurring mental health problem.

Strengths and Limitations

As with any project of this kind, our approach comes with strengths and limitations. Although we incorporated rigorous qualitative methods to explore stakeholder experiences with the mental health system, we still only spoke with a small proportion off the thousands of Multnomah County residents who have mental health-related needs. As is clear from the demographic information we present here, the Multnomah County service user population is incredibly diverse, and we cannot claim to fully represent the full range of their views and experiences, or those of their loved ones.

There were also limitations associated with the quantitative data that was available for this analysis. Because of time and resource constraints, detailed analysis of service claims and utilization data and participant-level outcomes were beyond the scope of this project. Rather, we relied on aggregated data provided by Multnomah County (the Multnomah County Mental Health and Addiction Services Division and Health Department), Health Share, Oregon State Hospital, and other entities during the study period. Relying on available aggregated data – and time and resource constraints – made it difficult to fully chart how funding and reimbursement mechanisms flow through different county systems, and to conduct a detailed analysis of utilization of specific service types. A more rigorous and comprehensive analysis of quantitative data to more fully examine person-, family-, and system-level outcomes would also add to the work presented here and should be considered for future assessments.

In addition to its limitations, this project has unique strengths. Our community engagement strategies created multiple avenues for feedback, including in-person visits, telephone conversations, email feedback over a three-month period. This approach enabled us to incorporate a wide range of stakeholder perspectives. We augmented these qualitative data with information from a range of sources, including past reports and quantitative data, to provide as nuanced a picture possible of the mental health system.

More detail on our analytic methods and data sources can be found in the Background and Methods section.

Organization of the Publicly Funded Mental Health System in Multnomah County

In the state of Oregon, many publicly funded health and social services are organized at the county or regional level. These include mental health and substance use services and programs, public health, community justice, and housing. Although these systems are managed and operated locally, they are funded by a range of sources, many of which derive from the state of Oregon and the federal government. Each of these funding streams come with its own set of regulations and limitations, resulting in highly complex systems. When examining mental health and related systems in Multnomah County, this complexity quickly becomes evident.

This section describes the structure of the mental health system in Multnomah County, along with its relationship to other related health and social service systems. Figure 1 provides one view into how publicly funded mental health services are organized in Multnomah County. The figure depicts the system as having three levels (each of these levels are discussed further in the sections that follow):

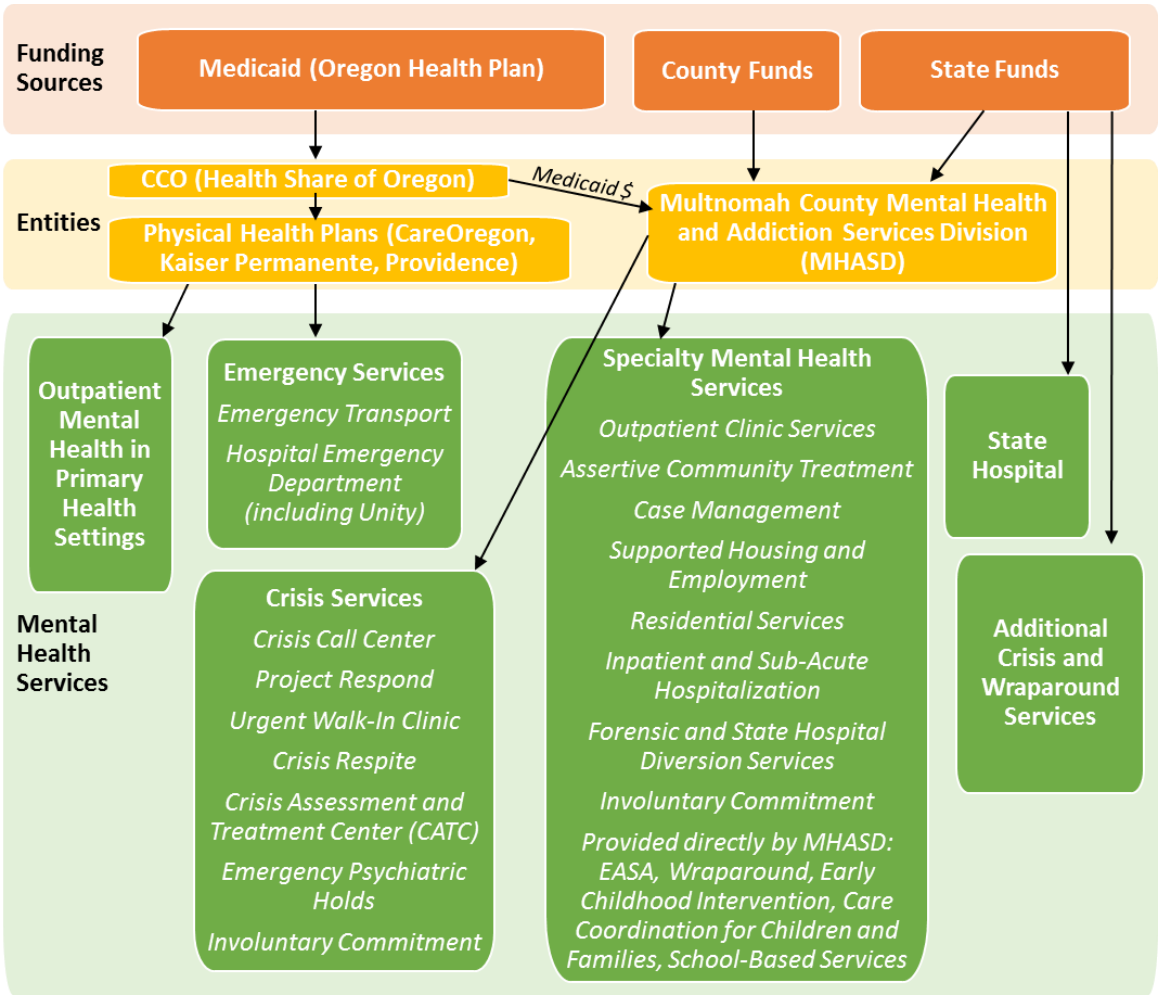
1. **Funding Sources** that support all aspects of the system, including administrative costs and direct services.
2. **Entities** that administer the funding sources by managing the costs, utilization, and quality of mental health services.

3. **Mental Health Services** delivered in a range of settings to populations with different levels of need.

The arrows represent how dollars from the three primary funding sources flows to mental health services via the two primary entities that have authority and responsibility for managing and overseeing those services.

Figure 1

The publicly funded mental health system in Multnomah County is financed by a combination of local, state, and federal dollars and which flows through Health Share to managing entities, physical health plans and MHASD, which administer a range of services.



Acronyms: CCO – Coordinated Care Organization, EASA – Early Assessment and Support Alliance

Notes: For simplicity, Figure 1 includes only publicly funded mental health services administered through Health Share or MHASD. It also does not include services that are funded through other payers such as Medicare and the Veterans Administration, which are administered at the federal level. This figure does not include services for individuals with mental health needs that are administered through other agencies, including Corrections Health, the Department of Community Justice, the Department of County Human Services, the Joint Office of Homeless Services, the Multnomah County Sheriff's Office (MCSO), and local police departments in the county. The figure does not represent that the Oregon Health Plan directly funds services for a small number of Medicaid enrollees who are not assigned to a CCO. Figure 1 does not include substance use disorder treatment services, which are also primarily organized through MHASD.

Health Share and MHASD

At the state level, the Oregon Health Authority (OHA) is responsible for Oregon's Medicaid program, which is called the Oregon Health Plan. In Multnomah County, Medicaid funding for mental health services flows through Health Share of Oregon (referred to in this report as Health Share), the region's coordinated care organization (CCO).[1]

Created in 2012 as part of a large-scale service delivery reform, CCOs oversee management of the physical health, behavioral health, and dental benefits for people on Medicaid in 15 regions throughout the state.[2] In 2012, Multnomah County joined with Clackamas and Washington counties and six regional healthcare systems to form Health Share, the region's CCO.[7] Health Share delegates managed care functions and health care risk to physical, behavioral health, and dental plans, which are sometimes referred to as "risk accepting entities" (RAEs). RAEs bear financial responsibility for quality, cost, and outcomes for the Medicaid population.

Oregon Health Authority is currently embarking on "CCO 2.0," an effort to lay the groundwork for the next contracting period for CCOs, which begins in January 2020. Issues related to the CCO role and MHASD's relationship with Health Share are discussed in the Findings section under "Stakeholder Concerns about the Organization of Current Systems."

Using Medicaid funds, Health Share oversees physical health plans (Care Oregon, Kaiser Permanente, and Providence) that pay directly for outpatient mental health services delivered in physical health care settings (additional

Key Terms

In this report, **specialty mental health system** refers to a continuum of mental health services spanning early intervention and care coordination to intensive outpatient and residential, and inpatient treatment for children, youth, and adults with significant mental health-related needs.

Health Share, the region's CCO, delegates management of physical health, behavioral health, and dental benefits for people on Medicaid. Health Share contracts with MHASD to manage Medicaid-funded specialty mental health services in Multnomah County.

A risk accepting entity, or RAE, bears financial responsibility for the service quality and cost and health outcomes of the entire Medicaid population. For Medicaid members in Multnomah County, MHASD is the behavioral health RAE.

1 Prior to 2018, a second CCO, FamilyCare, also operated in Multnomah County. In February 2018, the CCO FamilyCare closed its doors, and its approximately 60,000 members were transferred to Health Share, which is now the sole CCO in the county, bringing the average monthly membership to approximately 170,000.

2 https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx

detail about these services can be found under "Mental Health Services in Physical Health Care Settings" in the *Findings: System Strengths and Challenges* section). Health Share physical health plans also pay directly for mental health-related transportation (emergency and non-emergency) and mental health-related hospital emergency department services for people with Medicaid (additional detail about these services can be found under "Crisis Services and Crisis Alternatives" in the *Findings: System Strengths and Challenges* section).

Through a partnership with Health Share, the Multnomah County Mental Health and Addiction Services Division (MHASD) manages most other Medicaid-funded mental health services. Under this arrangement, MHASD acts as the behavioral health RAE for Health Share. MHASD has multiple roles and functions in the publicly funded mental health system (see sidebar on the following page). In addition to managing the specialty mental health system for individuals on Medicaid, MHASD also oversees and manages specialty mental health services for people who are uninsured or underinsured. Specialty mental health services include inpatient and sub-acute hospitalizations, outpatient clinic services, residential services, early intervention, case management, care coordination, school-based mental health services, Assertive Community Treatment (ACT), and supported housing and employment. MHASD also oversees crisis services for the whole Multnomah County population (regardless of insurance type).

MHASD's aims are as follows:

> *…to enhance and maintain high-quality, accessible and culturally appropriate systems of care for children, youth, and adults with mental illnesses and emotional and addictive disorders. Through consumer-driven, culturally responsive and evidence-based practices, MHASD serves all county residents as a public safety net, regardless of their insurance, income or cultural experience. The division prioritizes services that are culturally appropriate and supported by peers with lived experience.*[8]

In addition to its partnership with Health Share, MHASD partners with several other entities in the state and county. These include partnerships related to health care, housing, public safety, children's services, and education. MHASD's partnerships take the form of jointly funded efforts, formal and informal work groups and committees, and formal and informal relationships that facilitate communication and coordination across sectors. These partnerships and collaborations are discussed in greater depth in the sections that follow.

In 2016, through a partnership called Health Share Pathways, Multnomah County joined with Clackamas and Washington counties to share risk and utilization management, as well as to strategically plan behavioral health systems and services in the tri-county area. Because this report is focused on Multnomah County, the Health

Share Pathways partnership is not discussed in depth. MHASD also oversees and manages substance use disorder services, although because of the project's scope, these services are not explored in this report.

Outside of MHASD, the Oregon State Hospital and some additional crisis and Wraparound services are funded directly through the state and not overseen by Health Share physical health plans or MHASD. A number of other County agencies offer mental health or mental health-related services, including Corrections Health, the Department of Community Justice, the Department of County Human Services, the Joint Office of Homeless Services, the Multnomah County Sheriff's Office, and local police departments in the county. These services are discussed throughout the report.

Funding Sources and Services

Publicly funded mental health services in Multnomah County are primarily financed through a combination of Medicaid, county, and state funds. Additional funding sources include federal, state and local grants for specialty or pilot programs. This report does not include detailed discussion of other federal public insurance payers (e.g., Medicare, Veterans benefits).

MHASD's revenues come primarily from three sources: Medicaid funds (which flow through Health Share and are managed by MHASD), state funds, and county funds. Other revenues, which comprise 2% of the total, include grants from local public schools, the city of Portland, and the federal government.

Figure 2 depicts the distribution of Medicaid, state, and county revenue sources for the $93.4 million in expenditures on publicly funded mental health services funded and managed by MHASD in FY18.

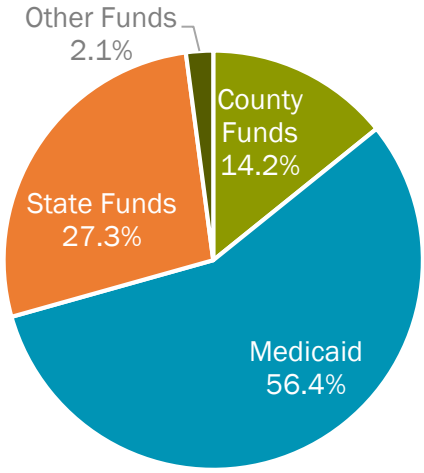
MHASD Roles

MHASD performs multiple roles when it comes to mental health:

- Contracting for a range of services for individuals on Medicaid and for individuals who are uninsured or underinsured
- Performing regulatory functions delegated by the state (as the Local Mental Health Authority)
- As the behavioral health RAE, managing the Medicaid-funded mental health services for Health Share
- Providing direct clinical services, including early childhood prevention and treatment services, school-based mental health services, programs for young people experiencing psychosis, and care coordination for children and families
- Managing the crisis service system for the whole population, regardless of insurance type
- Overseeing substance use services (not discussed in depth in this report)

Figure 2

MHASD-funded and managed mental health services in Multnomah County are primarily funded through a combination of Medicaid, state, and county revenue.



Source: Health Department Budget, fiscal year 18 and Health Share Pathways Budget, calendar year 2017

Note: This figure does not include services for individuals with mental health needs that are administered through other agencies, including the Department of Community Justice, the Department of County Human Services, the Joint Office of Homeless Services, Corrections Health, the Multnomah County Sheriff's Office, and local police departments in the county. Detailed, comparable budget information was not available for these services. Figure 2 does not include substance use services, nor does it include Medicaid-funded mental health related services paid directly by Health Share through its physical health plans.

In addition to the funding displayed in Figure 2, Health Share physical health plans paid a total of $5.6 million in mental health-related claims in FY17. These include $3.7 million in mental health outpatient claims delivered in physical health settings, $1.5 million for mental health-related emergency department visits, and approximately $330,000 for mental health-related emergency transport.[3] These services are discussed in more detail later in the report (outpatient mental health services delivered in primary care settings are discussed in "Integration of Physical and Behavioral Health Services," and emergency department and emergency transportation are discussed in "Crisis Services and Crisis Alternatives").

Table 1 presents the range of specialty mental health services financed and managed by MHASD, along with service costs and funding sources. In Table 1:

- **County** funds refer primarily to county general fund revenue.
- **State** funding includes state general fund revenue as well as SAMHSA mental health block grant funding and other federal funding administered as state grants through the Oregon Health Authority.

[3] In FY2017, approximately $23 million was spent on non-emergency medical transportation (NEMT) for Health Share members. Because NEMT events are not easily categorized by diagnosis, we were unable to identify mental health-specific NEMT events for this analysis. (substance use-related events are not included in the data we analyzed for this study.

- **Other** funds come from a range of sources, including grants from local cities, fee-for-service reimbursement from private insurance, and funding from local school districts.

Notably, Table 1 doesn't include the $17.5 million in substance use disorder treatment and prevention and other services,[4] which are outside the scope of this report, nor does it include the approximately $13.9 million in administrative costs, which include administration and operations for MHASD and the Medicaid insurance plan, medical records, and mental health quality management and protective services.

[4] Other services include the Family Involvement Team and the Law Enforcement Assisted Diversion (LEAD) program

Table 1

MHASD funds and manages a range of mental health services; in FY17, about half of its approximately $93.4 million in mental health spending was dedicated to residential, outpatient, and crisis services.

Service	Budget	County	State	Medicaid	Other
Residential Services for 644 beds, including Secure Residential Treatment Facilities, Residential Treatment Homes, Adult Foster Care Homes, supported housing, and Transitional Housing	$13,829,881	8%	89%	1%	2%
Specialty Services for Adults including Assertive Community Treatment (ACT), Intensive Case Management, and supported employment.	$11,766,460	0	0	100%	0
Outpatient Mental Health Services for Children and Adults spanning a continuum of emergent, urgent, and routine levels of care.	$22,017,490	0	0	100%	0
Inpatient Services including hospitalization and a small amount of sub-acute inpatient services for adults and children	$5,599,975	0	0	100%	0
Crisis Services including a hotline, mobile crisis outreach, and a walk-in clinic. Crisis services are available 24-hours per day to all, regardless of insurance	$10,219,297	30%	32%	38%	0
Wraparound and Intensive Care Coordination that follows System of Care principles and values for children in need of intensive mental health services	$4,412,745	1%	15%	85%	0
Commitment Services including Emergency Psychiatric Holds, Involuntary Commitment Program, Commitment Monitors, and State Hospital Waitlist Reduction Program	$4,212,279	30%	70%	0	0
Community-Based Child and Family Services spanning a continuum of prevention, early intervention, and treatment.	$3,908,516	41%	10%	39%	10%
School-Based Services delivered by mental health professionals in school settings as well as mental health consultation for children, parents, and school staff	$3,575,208	45%	35%	0	20%
Coordinated Diversion in the Community Court, Mental Health Court, and Forensic Diversion programs to divert individuals from the jails to the community	$3,026,921	19%	69%	0	13%
Crisis Assessment and Treatment Center (CATC), a 16-bed short-term alternative to inpatient hospitalization.	$2,996,267	21%	0	79%	0
Adult Mental Health Initiative (AMHI), which diverts individuals from Oregon State Hospital and coordinates services to move individuals to the least restrictive setting	$2,843,755	0	73%	27%	0
Early Assessment and Support Alliance (EASA), and early psychosis intervention program for ages 12-25 involving treatment, and education, employment, and family support	$1,674,450	0	80%	12%	8%
Culturally Specific Outpatient Services for adults from five underserved communities who do not have insurance or would otherwise be unable to access these services	$1,618,420	100%	0	0	0
Treatment and Medication for the Uninsured through the Multnomah Treatment Fund (MTF) for individuals without financial resources	$1,319,766	100%	0	0	0
Other services including Mental Health First Aid, Peer-Run Supported Employment Center, and Domestic Violence Related Services	$369,021	100%	0	0	0

Source: Health Department Budget, FY18 and Health Share Pathways Budget calendar year 2017

Demographic Characteristics of Mental Health Service User Populations

Demographic information for different mental health service populations is detailed in Table 2, on the following page. These populations include:

- 1,284 people without insurance or who are underinsured who received specialty mental health services through MHASD in FY17. This includes individuals covered by Medicare who have insurance gaps.
- 19,774 people on Medicaid who received specialty mental health services funded and managed by MHASD in FY17.
- 11,829 people on Medicaid who received outpatient mental health services in physical health care settings in FY17. These services were funded by Medicaid and paid directly by Health Share physical health plans without MHASD involvement.
- All 158,823 individuals enrolled in Medicaid as Health Share members in FY17.
- The entire Multnomah County population drawn from 2016 census data.

In total, over 38,000 individuals are served annually through services offered by MHASD, and its crisis services system has approximately 80,000 contacts per year. However, detailed demographic information for this full population was unavailable for this analysis

While age of individuals who received Medicaid-funded specialty mental health services mirrored the population age, individuals who were uninsured and those receiving outpatient mental health services in physical health care settings were more likely to be adults. The gender of specialty mental health service users was roughly the same as the Medicaid and general populations, but a higher proportion of women (62%) made up the population of individuals who received Medicaid outpatient mental health services in primary health care settings.

African Americans are overrepresented in the publicly funded mental health system (between 11 and 16% of publicly funded mental health service users are African American) compared to the general population (6%), but they are not over-represented compared to the overall Medicaid population (13%). Compared to the Medicaid and general populations, Asians and those with Hispanic ethnicity are somewhat underrepresented. Those whose preferred language is other than English are also underrepresented in all publicly funded mental health service user populations compared to the Medicaid and general populations. Issues related to race, ethnicity, language, and culture are explored in greater depth in the *Findings* section of this report, under “Culture and Discrimination.”

Table 2

Number and characteristics of individuals receiving publicly funded mental health services, Medicaid enrollees, and the general population in Multnomah County, FY17

	Specialty MH Services - People Who Are Uninsured or Underinsured (N=1,284)		Medicaid Specialty MH Services (N=19,774)		Medicaid Outpatient MH Services in Physical Health Care (N=11,829)		All Health Share (Medicaid) Enrollees (N=158,823)		Multnomah County general population (N=807,555)	
	n	%	n	%	n	%	n	%	n	%
Age										
Under 18	116	9%	3,983	20%	1,186	10%	49,753	31%	155,858	19%
18 to 64	1,034	81%	15,012	76%	9,762	83%	97,477	61%	549,945	68%
65 & older	134	10%	779	4%	881	7%	11,593	7%	101,752	13%
Gender										
Female	633	49%	10,286	52%	7,339	62%	82,398	52%	407,008	50%
Male	651	51%	9,488	48%	4,490	38%	76,425	48%	400,547	50%
Preferred Language										
Other than English	48	6%	2,022	10%	985	8%	31,304	20%	170,394	21%
Race/Ethnicity										
Caucasian	421	71%	9,391	71%	6,006	73%	60,496	59%	646,044	80%
Black or African American	97	16%	1,867	14%	870	11%	13,602	13%	46,838	6%
Hispanic	55	9%	982	7%	568	7%	11,921	12%	92,061	11%
Asian	13	2%	742	6%	491	6%	11,490	11%	60,567	8%
American Indian or Alaska Native	6	1%	302	2%	124	2%	1,634	2%	12,113	2%

Sources: Multnomah County, Health Share, and U.S. Census V2017 Estimates

Notes: Reliable information about individuals who identify as transgender, non-binary, or another gender identity were not available for this analysis. Preferred language other than English for the Multnomah County General Population is based on the population over 5 years of age reporting language other than English spoken at home. Language data were missing for 490 uninsured/underinsured individuals and 153 individuals who received outpatient mental health services in physical health settings. Race and ethnicity data were missing for 692 uninsured/underinsured individuals, 6,490 Medicaid specialty mental health service user enrollees, 3,610 individuals who received outpatient mental health services in physical health care settings, and 57,075 Health Share members.

Findings: System Strengths & Challenges

Our findings are organized based on a thematic framework that originated with the study aims and was continuously revised and amended by HSRI researchers throughout the data gathering and analytic process (for more information about our analytic methods, see *Background and Methods*). Figure 3 presents this framework, providing an at-a-glance picture of the major themes discussed in this section.

When possible, we present qualitative data alongside quantitative information to corroborate stakeholder claims or provide greater clarity. The perspectives here are shown to represent the range of stakeholder experiences and opinions that were expressed to HSRI researchers during the study.

As previously mentioned, we use the description of a "good and modern" behavioral health service system, articulated in the seminal 2011 paper from the Substance Abuse and Mental Health Services Administration (SAMHSA) as a framework for assessing need and system gaps. A "good and modern" system is described as follows:[9]

> *...a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addiction and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.*

Figure 3

Our thematic framework originated with study aims and was shaped throughout the data gathering and analytic process

By many measures, the mental health system in Multnomah County aligns with that definition. It has an array of services and incorporates evidence-based practices and services to support social determinants of health. Peer support is incorporated throughout the service continuum, and trauma-informed, culturally responsive approaches are widely embraced. There appear to be strong efforts to ensure that services are provided in the least restrictive environment, and in the community whenever possible. Through our community engagement process, we encountered many talented and dedicated individuals—advocates, providers, county staff, and administrators—who have committed themselves to continuously improving the mental health system. These stakeholders are engaged in a number of collaborative and ongoing processes to continuously enhance the accessibility, equity, and effectiveness of the system and its services and programs.

However, our community engagement process also revealed that many stakeholders, including service users and their family members, do not necessarily experience the system as "good and modern." Additionally, our analysis of available quantitative data found that that although community members are accessing important services and supports, others who could benefit from these services may not be accessing them. Finally, stakeholders were concerned about whether and how entities within the system are working together and with the state to produce desired outcomes. These issues are discussed in depth throughout this section of the report.

Access and Coordination

Issues related to access and coordination were frequently mentioned by stakeholders in interviews and listening sessions. These included issues related to access to information and navigating service pathways, other access barriers, and data sharing practices employed to enhance care coordination activities.

Access to Information and Service Pathways

In community listening sessions, stakeholders envisioned a system with multiple access points and "no wrong door" that connected individuals to flexible supports in their communities. They spoke of a need for community "hubs" where individuals with complex needs can get connected to a range of resources, rather than being required to seek out disparate services from multiple systems. In some respects, the County's Mental Health Call Center[5] is designed to perform this function by serving as a central hub for access to information and treatment referrals as well as a crisis support resource (the same number connects callers to the crisis line and the Urgent Walk-In Clinic). In addition to the Mental Health Call Center, numerous service directories are available to Multnomah County residents to locate and access mental health services. These include the Health Share *Mental Health and Substance Use Provider Directory*[6] and resource guides developed by the Portland Police Bureau.[7] NAMI Multnomah has developed multiple resources, including a Multnomah County resource guide and a toolkit to support families navigating the mental health system for children and youth in the Portland Metro area.[8] NAMI Oregon operates a Resource Helpline that offers information on local resources throughout the state.[9]

Stakeholders have described and provided us with multiple resources, including the service directories and guides for system navigation noted above, but it appears that many in the community are unaware of these resources and/or do not consider them adequate to meet the needs of the community. In interviews and community listening

[5] 503-988-4888; https://multco.us/mhas/webform/contact-us
[6] https://healthshare-bhplan-directory.com/
[7] https://www.portlandoregon.gov/police/63941
[8] The guide and toolkit, along with other local mental health resources, can be found on the DIY Advocacy Center website at https://diyadvocacycenter.com/family-resources/. Additional resources may be accessed through the NAMI Multnomah website at http://namimultnomah.org/
[9] https://namior.org/resources/community-resources/; the Helpline number is 800-343-6264 or 503-230-8009

sessions, many stakeholders noted that service users, social service providers, educators, and even some mental health providers lack information about the full range of services and supports that exist within the system. The complexity of the system appears to contribute to this "information gulf," as does a perceived lack of resources about services.

One of the most common themes in stakeholder interviews and community listening sessions was a lack of predictable pathways for individuals to access services. Stakeholders with extensive experience navigating the system for themselves and others variously described the process of accessing services as follows:

> **Stakeholders with extensive experience of the system said that accessing services was...**
>
> - Like trying to open a locked door that requires a "secret combination"
> - Successful only for those with an "inside scoop" about what is available
> - A "maze with no route out"

- Like trying to open a locked door that requires a "secret combination," which is different for different types of people
- Successful only for those with an "inside scoop" about what is available
- A "maze with no route out"
- Requiring a "super-complex flow chart"

Based on interviews with stakeholders and feedback from community listening sessions, access issues seemed to be most pronounced for outpatient and community-based services. Services for individuals—particularly adults—experiencing acute crises seemed relatively easy to identify and access (these services are described later in *Findings*, under the heading of "Crisis Services and Crisis Alternatives").

> **"I'm tenacious. I will speak up for myself. But there are so many people who don't have these skills."**

Stakeholders pointed out that many individuals—and particularly those with complex needs—are multi-system involved and face the daunting task of navigating multiple systems, not just the mental health system. While some care coordination services are available to support individuals and families in this process (these resources are discussed in other sections of the report), they appear to be in limited supply and are themselves only available to individuals who've already begun to access the system. In general, stakeholders were concerned that **individuals with more limited self-advocacy skills are less likely to successfully navigate the system because of its complexity**. For example, a service user who described a complex scenario they had to navigate to receive medication management services noted, "I'm tenacious. I will speak up for myself. But there are so many people who don't have these skills."

Other Barriers to Access

Stakeholders noted other issues that resulted in access barriers for individuals with mental health-related needs, namely barriers for persons with physical disabilities and for individuals who are not insured by Medicaid.

In community listening sessions and interviews, stakeholders with both physical limitations (including physical disabilities) and mental health needs described access barriers that have resulted in an additional layer of limited access to mental health services. These barriers included challenges with using public transportation, unreliable medical transportation, and service locations that are not wheelchair-accessible.

Individuals without Medicaid who relied on public funding for services seemed to have particularly challenging experiences accessing the range of mental health services in the county. As noted above, MHASD offers some services for individuals who are uninsured or who have limited insurance coverage. These include the Multnomah Treatment Fund, Culturally Specific Services, Crisis Services, and jail and hospital diversion services. However, these services have limited funding and capacity. One provider stakeholder noted that oftentimes, people with Medicare are grouped with uninsured clients by community providers. This is a particular concern given the limited funds available to fund services for people who are uninsured, including people who are undocumented.

Although grouping individuals with Medicare—a federal insurance program—with those who are uninsured can be problematic when funds are limited, stakeholders also described access barriers for persons on Medicare. As a federal insurance program with federally regulated policies, Medicare reimburses a much more limited array of mental health services. Stakeholders—including service users with Medicare—noted that Medicare-funded individuals are not able to access mental health services that they saw as important for their wellness.

Data Sharing to Improve Clinical Care

In Oregon and nationally, mental health is behind the curve when it comes to the use of data sharing to improve clinical care.[10,11] The causes of this dynamic are manifold and include the fact that mental health providers have been excluded from national incentive programs that promote the widespread use of health information exchanges, and because of privacy regulations such as 42 CFR part 2, which places restrictions on all data related to substance use disorder treatment. We observed multiple local initiatives to reverse these trends, and in general, stakeholders we interviewed recognized the importance of using technology to improve mental health system performance. Several stakeholders positively endorsed the Emergency Department Information Exchange (EDIE) system, a real-time data platform that provides notifications related to emergency department use. Health Share is also extending PreManage—an extension of EDIE that allows data sharing in community settings—to providers in Multnomah County. The Unity Center has access to both EDIE and PreManage, and many stakeholders described this as a system strength.

There seemed to be consensus among provider stakeholders that EDIE and PreManage serve as important resources to providers throughout the state and can lead to improved communication and collaboration if used to their potential.

Stakeholders noted that County Corrections doesn't yet have access to PreManage, although linking in the criminal justice system would extend the initiative's benefits. Similarly, stakeholders noted that linkages to child-serving agencies including child welfare and education systems would enhance data sharing and support coordinated care for children and youth.

Beyond the system of mental health providers, stakeholders described initiatives and needs for data sharing across systems—including between mental health providers and first responders, housing providers, and the criminal justice system.

> Stakeholders we interviewed recognized the importance of using technology to improve mental health system performance.

One stakeholder representing first responders noted that, currently, data from first responders goes out to clinical providers, but there is relatively little data coming back to first responders. Similarly, stakeholders from the jails described current data-sharing practices as a "one-way relationship" in which data from the justice system (which is often public information) are shared out with community providers, but data from the mental health system are not accessible by jail staff. Across the justice system, a new initiative called SCOPE is being planned to support data sharing, which is a need that was identified by multiple stakeholders in the criminal justice system. Because the County manages Corrections Health, their electronic medical record is integrated with County clinics, which is also a positive aspect of the system.

Several stakeholders endorsed the activities of local providers such as Central City Concern and Cascadia that have used data within their agencies in innovative ways to coordinate and improve care. However, these two agencies—two of the largest in the county—are not part of the EPIC electronic health record system, which is used by physical health providers and some other mental health service providers in the state.

Services for Children and Youth

MHASD oversees a continuum of services for children and youth and serves over 11,000 children and youth each year in clinics, homes, schools, and the community. In FY17, 4,179 of these children and youth (ages 0-20) received community-based mental health services, and 75% demonstrated improvements in their global distress score[10] over the year.[12] In our analysis, we identified many outstanding programs that appear to be effective in supporting the social and emotional wellbeing of children and youth in Multnomah County. Leadership from MHASD participates in numerous initiatives designed to support children, youth, and families. These include the regional advisory committee for the Children's System of Care, the Student Threat

[10] The global distress score is calculated by averaging all items on the ACORN, a short self-report survey administered to all specialty behavioral health service users.

Assessment Team within the Multnomah Education Service District and Portland Public Schools, and an MOU Group that involves partnerships across 45 schools in the county to improve the capacity to support children with behavioral health needs. MHASD reports that it has increased screening efforts and, resultingly, increased service use for children of all age groups since 2015.[13]

Since 2015, Health Share has made targeted investments in promoting early life health as part of its "Health Share 2.0" work.[14] These include efforts to enhance substance use disorder treatment for pregnant women and implement Help Me Grow, a system that connects families at risk of multi-system involvement to services and resources. Launching in the coming months, Health Share's "Ready and Resilient" initiative involves a range of strategies related to prevention, early intervention, and recovery support, with an emphasis on health equity. [15]

Stakeholders also noted the OPAL-K system as being a positive step for the county, enabling child psychiatrists to consult with pediatricians and primary care providers around the state. (The newly funded OPAL-A initiative is a similar system for adults.)

Despite a range of initiatives and programs to support families, and despite MHASD's service enhancements, stakeholders voiced a perception that the overall amount and quality of mental health services for children and youth statewide have declined in recent years. Reasons for these challenges are complex, and many likely originate with state and federal policy (some of these issues are further discussed in a later section "Stakeholder Concerns about the Organization of Current Systems"). Stakeholders representing services for children and youth noted that, in general, state initiatives related to integration and systems improvements have prioritized physical health services for adults and failed to focus on systems that serve children and youth with mental health–related needs. They noted that funding streams have not been sufficiently braided according to best practice for systems of care governance, and families still experience significant barriers in navigating these systems.

Preventive and Community-Based Services for Children and Youth

Stakeholders endorsed the critical importance of "upstream" services that engage and support children, youth, and families before they reach a crisis point and become multi-system-involved. Furthest upstream are mental health promotion and prevention services, including services to promote healthy attachment and positive parenting practices and other targeted prevention services for children and families who may be at risk of developing mental health problems. MHASD prevention service offerings include evidence-based practices such as Incredible Years parent groups, early childhood classroom consultation, and prevention services at Head Start. While current wellness promotion and prevention activities were a valued community resource, stakeholders noted these activities are limited. Although the funding for mental health consultation in Head Start has been stable in recent years, stakeholders said that other prevention and early intervention services are limited and lack ongoing, stable funding.

Stakeholders also spoke of a need for enhancements to "downstream" community-based services such as in-home supports, family skills building, family peer support, and, in particular, school-based services. Stakeholders also saw a need for additional collaboration and integration with schools and physical health care systems to support the social and emotional wellbeing of children and youth.

School-Based Health Centers and School-Based Mental Health Services

School-based health services are provided through the County Health Department in 12 School-Based Health Centers (SBHCs) in Multnomah County. Students receiving services at these SBHCs are screened for mental health, substance use, housing problems, and food insecurity and are then provided services within the clinic or referred out to services.

> Mental health–related issues accounted for 4 of the top 5 reasons for frequent visits to SBHCs for grades K-8 and 2 of the top 5 for grades 9-12.

School-based mental health services—overseen by MHASD—are provided within the SBHCs and also outside of those clinics in other school settings. According to MHASD, school-based mental health services were delivered to 1,514 students in FY17.[16] Additional detail on mental health-related school-based clinic visits were unavailable for this analysis, although the Health Department provided HSRI with data on the reasons for services for individuals with five or more visits to school-based health centers in the 17-18 school year as of March 2018: Among the 421 children in grades K to 8 who had frequent visits to SBHCs, mental health-related issues accounted for four of the top five issues; among the 394 high schoolers with frequent visits, mental health-related issues accounted for two of the top five issues.[17]

School-based mental health services have expanded in recent years thanks to an investment led by the Multnomah County Chair. In FY16, MHASD added five additional culturally specific mental health consultants to its staffing, and FY18 marked the beginning of a pilot of school-based mental health services in grades K-3. The pilot involves complex case management and psychiatric consultation for students and families in all six school districts. Currently, MHASD has mental health consultants in 11 of the 12 SBHCs, totaling over 9 full-time equivalents (FTEs) of staffing. Additionally, another 13.2 FTEs of mental health professional staffing is available outside of the SBHCs in a total of 47 schools throughout the county.

Stakeholders we interviewed had the perception that there are relatively fewer school-based mental health services outside of the Portland metropolitan area, such as in the eastern part of the county. While there are fewer SBHCs in the Eastern part of the county, there are more schools that offer school-based mental health services. MHASD reports that they have 10 clinicians serving Portland Public Schools and 13 serving other districts in the County. Notably, allocation of mental health services across schools is left to each school district.

Services for Young Adults Transitioning to the Adult System and Those Experiencing a First Episode of Psychosis

Stakeholders noted that youth transitioning from the child-serving to adult-serving systems face a significant gap in services, reflecting state and national trends for individuals with mental health-related needs in this age group.[18]

Stakeholders spoke favorably of the Early Assessment and Support Alliance (EASA) program, which provides comprehensive supports for youth and young adults aged 12 to 25 experiencing a first episode of psychosis. In FY17, the program received 203 referrals and enrolled 136 individuals and reported an 85% reduction in hospitalization six months after enrollment.[19] Among other local initiatives for transition-age youth is the regional STRIDE program, designed to connect youth (regardless of insurance type) to services and resources.[11] Administered by LifeWorks NW, STRIDE's priority populations include youth experiencing homelessness, LGBTQ youth, youth transitioning out of foster care or residential services, and youth who've been screened out of the EASA program.

An interviewee from Youth Villages described its LifeSet program, which is based on a Transitional Living program model and provides case management, support, and counseling for youth transitioning to adulthood who were formerly involved in the foster care or juvenile justice systems. A randomized evaluation of the Transitional Living model in Tennessee documented positive impacts of the program on housing stability and economic well-being.[20] In Multnomah County, the LifeSet program is funded through philanthropic donations and has capacity to serve 40 youth at a time. Representatives from Youth Villages noted that although Multnomah County youth are eligible to participate, they have received few, if any, referrals for this service.

While they endorsed local programs for transition-age youth, stakeholders described them as having limited capacity and being difficult to access. Stakeholders saw a need for more services that engage families as partners more readily than the current programs (these dynamics are discussed later in this section, under "Support and Information for Families and Caregivers").

Intensive Services for Children and Youth

Stakeholders endorsed several intensive services for children and youth, including the Catholic Community Services Wraparound with Intensive Services (WISe) program and Crisis and Transition Services (CATS). They noted that these services provided valuable community-based and in-home supports for families to navigate complex systems and understand how to support children and youth with complex needs. However, they were also quick to note that these services have limited capacity. In FY17, 390 children and youth were enrolled in either Wraparound or Intensive Care Coordination, with approximately 200 children, youth, and families engaged at any point.[21]

[11] http://www.oregon.gov/oha/HSD/AMH-YHUB/Documents/STRIDE_intro_ltr.pdf

Despite these resources, several stakeholders were concerned that there were limited intensive service options for children and youth. As with adults, demand for intensive services frequently hinges on the extent to which community-based and diversionary resources are available in the community. Many stakeholders stressed that a lack of access to community-based services results in an increased demand for intensive services. While several stakeholders voiced a need for more inpatient and residential beds for children and youth, others offered an alternative perspective: the system doesn't need more beds, it needs to get the right kids into the right beds, including—importantly—their own beds in their homes. Stakeholders representing this point of view felt that the most significant gap in quantity of services for children and youth was home-based services, not residential and inpatient. Accordingly, the challenge on the residential side was related to appropriate use of the existing resources, ensuring that residential treatment services are reserved for those children and youth whose needs could not otherwise be met in the community.

Several stakeholders voiced a need for more inpatient and residential beds for children and youth; others felt the system doesn't need more beds, it needs to get the right kids into the right beds—especially their own beds in their homes.

Intersection with Child Welfare and Juvenile Justice Systems

Stakeholders saw a particular need for more support services for families who are involved in the child welfare system (children and youth in foster care or at risk of foster care placement), and stakeholders also saw a need for a stronger trauma-orientation within the child welfare system. They described needs for more communication and collaboration between foster care case workers and mental health providers, which is hampered by large caseloads, limited funding, inadequate numbers of qualified foster homes, and systems that are not set up to support cross-system collaboration.

Beginning with the statewide Children's System Change Initiative in 2005, leadership at the county, regional, and state levels have been working in multiple areas to improve partnerships to address the mental health–related needs of families in the child welfare system with an emphasis on meeting needs in community-based rather than institutional settings. Health Share has staff member who acts as a liaison with the child welfare system for children and youth on Medicaid. The Oregon Health Authority has also established incentive programs to track whether children who enter into foster care receive timely assessments for physical, mental, and dental health-related needs. In 2015, MHASD met its target goal for assessments in all three areas, with 85% of children receiving a mental health assessment within 60 days.[22] Health Share's "Ready and Resilient" initiative includes specific strategies related to improving systems of care for children and youth with complex needs with a particular focus on children involved with the foster care system.

Stakeholders noted that there is a significant unmet need for funding and attention for justice-involved youth. One stakeholder wished there were similar initiatives for youth as there are for adults (local justice reinvestment funding, grant-funded initiatives). More focused resources for this population are warranted; approximately half of youth in Juvenile Detention received mental health medications in FY17.[23] In 2016, a statewide task force composed of judges and juvenile directors concluded that current systems lack capacity to deliver sufficiently trauma-informed services for youth with significant mental health needs (recommendations resulting from this work are included in Appendix C).[24]

Services for People with Complex Needs

Stakeholders described services and programs that support individuals with co-occurring mental health and substance use disorders, brain injury, personality disorders, extensive trauma histories, and chronic medical conditions. MHASD has a range of services and programs targeted to "priority populations," including services for individuals recently discharged from Oregon State Hospital, justice-involved populations, families involved with the child welfare system, and people who are experiencing homelessness or are unstably housed. They also described a limited number of services for veterans who are unable to access services through the Multnomah County Veterans Services Office. In recent years, MHASD and its partners have expanded Assertive Community Treatment (ACT) and care coordination based on feedback from the community.

Although these initiatives are ongoing, and although there was universal recognition that these services are a critical component of the mental health system, a common theme in stakeholder interviews and community feedback sessions was that **the system needed additional capacity to engage and support populations with complex—and often co-occurring—needs**. One stakeholder who works with high-need populations said they frequently encounter a "whose person is this?" response when working to connect people to services; the answer to the question should be "everyone's" but it ends up being "no one's."

Separately, stakeholders described housing support and criminal justice systems as "default" mental health systems for individuals with complex needs. As such, building up capacity in these systems to address mental health–related needs is critical—and many efforts are currently underway. However, it is important to recognize that the "default" nature of these systems are a result of an inadequate mental health system and inadequate coordination between all systems. Therefore, a long-term response to the system should involve revisiting and transforming the mental health system to better meet the needs of populations that are homeless and/or justice-involved rather than (or in addition to) evolving housing and justice systems to provide mental health supports.

Stakeholders endorsed several short-term, intensive programs. Funded through a combination of funds from Medicaid and county general revenue, Tri-County 911 conducts proactive outreach with individuals referred by first responders in Clackamas, Washington, and Multnomah counties (see sidebar). Homeless outreach services exist in the county and were also endorsed as effective; however, these services were seen as in short supply and focused only on those with the most significant need. In separate interviews, two first responder interviewees noted a need for coordination to determine which program would work best for which individuals because there are so many disparate programs to work with individuals with complex needs. While stakeholders valued TC911, homeless outreach programs, and others, they pointed out that these short-term programs are targeted to a small number of individuals with extremely complex needs that aren't designed to provide long-term and ongoing supports.

Longer-term services that are specially tailored to meet the needs of individuals with complex needs, such as Assertive Community Treatment (ACT), forensic services, Wraparound for children and youth, and co-occurring services, were described by stakeholders as being difficult to access and having insufficient capacity to meet community need. Currently, the system has capacity to serve approximately 350 individuals with Medicaid through ACT; stakeholders from MHASD noted that this number is adequate for the Medicaid population, but that additional capacity is needed for individuals who are not covered by Medicaid. Multiple stakeholders were concerned about the

Short-term Intensive Services

Tri-County 911 (TC911)
Multnomah County residents comprise just over 60% of the program population. Individuals are referred by first responders and must have had 10 or more contacts with first responders in the past six months. In the past year, 614 individuals were referred to the program and 470 were served (approximately 80 individuals were on a waitlist at the time of HSRI's interview with TC911). A 2014 evaluation found that TC911 participants had fewer emergency department and primary care visits than the control group, and that the program reduced inpatient hospitalizations for individuals with the highest intensity needs.

Homeless outreach services
Stakeholders described these services as short in supply and focused only on those with the most significant need. They noted homeless outreach providers often lack capacity to work with individuals who are staying in a shelter, even when they might benefit from such services, because they have limited capacity and may prioritize individuals living on the streets.

limited availability of dialectical behavior therapy (DBT) and other services designed to support individuals with personality disorders (several provider stakeholders noted that individuals with a personality diagnosis on record were not eligible for ACT). Currently, DBT providers have waitlists due to inadequate capacity, and MHASD reported that it is working to add network providers to expand access to DBT.

Stakeholders who work with people who are homeless described logistical challenges of navigating the system without a home address and telephone number; because accessing public benefits—including housing and mental health treatment—often requires filling out paperwork and waiting to be contacted, those who struggle with organizing day-to-day life are the most likely to fall through the cracks. Transportation was identified as a key barrier, particularly for individuals who are not eligible to receive non-emergency medical transportation, which is funded through Medicaid. While the public transportation system is adequate for individuals who are "organized," many are banned from using public transportation because of past behaviors, including riding without a fare, which can involve large fines. In the summer of 2018, the public transportation system will offer discounted fares based on income rather than disability, which may increase access to public transportation.

In sum, stakeholders observed relatively adequate capacity for the system to engage with individuals and families with complex needs on a short-term basis, but inadequate capacity to keep them engaged over the long term to support rehabilitation, recovery, and wellness and address underlying housing instability, substance use problems, legal issues, chronic medical conditions, disability, and trauma.

> Stakeholders observed relatively adequate capacity for short-term services but inadequate capacity to engage people in longer-term services to support rehabilitation and recovery.

Limitations of an Appointment-Based System

Stakeholders called for more programs that offer multiple avenues for engaging with people with complex needs. They described the current system as predominantly "appointment-based" and inappropriate for those with the most complex needs. In this context, stakeholders described individuals with complex needs as "square pegs" that don't fit in the "round holes" of the current mental health system.

> Stakeholders described individuals with complex needs as "square pegs" that don't fit in the "round holes" of the current mental health system.

A commonly identified need was for programs that engaged with individuals in the community on a more flexible basis rather than requiring individuals to keep appointments as a precondition of receiving service. Stakeholders reflected that programs that discharge people for "acting up" or not showing up for

appointments are premised on unrealistic expectations for people whose lives are chaotic because of housing instability, substance use problems, and other issues. For example, a stakeholder who works with people who are homeless noted that in many instances, individuals are closed out of services because of "no-shows" and weren't even aware that they had an appointment. Providers from the appointment-based system pointed out additional deficiencies in the appointment-based approach. They noted no-show rates as being very high, presenting challenges related to billing and sustainability, and being demoralizing for providers.

These limitations of an appointment-based system resulted in some stakeholders speculating that mental health provider agencies in the county are serving the "easiest" service users and "kicking out" or turning away those with higher levels of complexity. Other stakeholders voiced concern that community-based service providers are expected to support individuals who need more intensive services than they can provide. Some stakeholders speculated that insufficient numbers of residential treatment options were at the root of this challenge and voiced a need for expanded capacity for intensive residential options and state hospital beds. On the other hand, other stakeholders emphasized a need for enhanced flexible community supports before calling for increased intensive services.

> A program-centered system requires individuals to make and keep appointments, regardless of their life circumstances.
>
> A person-centered system meets people where they are, accommodating those who may not be able to reliably make and keep appointments.

Ultimately, relying on an appointment-based system that requires individuals to come into clinics—and in which making and keeping appointments is a pre-condition for treatment—is inherently "program-centered." Stakeholders were clear about the need for a more "person-centered" system that meets people where they are at in the community and accommodates even those with the most complex needs. Such a system would offer services in the home or in other locations throughout the community to "meet people where they are," and would incorporate more flexibility in appointment times and higher levels of outreach and engagement between contacts. Programs such as Assertive Community Treatment that are already available in the county might be further expanded along with less-intensive walk-in services that could be delivered through health clinics and community agencies, including peer-run agencies. The Boston Health Care for the Homeless[12] program provides another model for consideration. Involving a team of psychiatrists, a clinical nurse specialist, psychologists, clinical social workers, and licensed mental health counselors, the program delivers psychiatry and medication management, individual and group counseling, child and family therapy, substance use disorder services and referral to detoxification, and rehabilitation programs to

[12] https://www.bhchp.org/behavioral-health

individuals with complex needs in the Boston area. They provide these services in clinics, shelters, churches, community centers, and on the street.[13]

Co-Occurring Mental Health and Substance Use Issues

While the substance use disorder treatment system for individuals with primary substance use disorders without significant mental health issues was outside the scope of this study, it is important to mention that the challenges experienced by the substance use disorder treatment system mirror many of those documented in this analysis and come to bear on the overall strength of health and social service systems in Multnomah County. Anecdotally, stakeholders noted that challenges related to workforce recruitment and retention, system sustainability, data sharing, and outcomes-based care are even greater for substance use disorder treatment providers because of historic and ongoing underinvestment.

Many stakeholders described the unique challenges experienced by and dearth of services created for individuals with co-occurring mental health and substance use disorders—many of whom are also unstably housed and involved in the justice system. In particular, stakeholders identified a gap for co-occurring services for youth, including services in schools that address this need. Stakeholders noted that in many instances, mental health services will not see an individual who is actively using substances; individuals who are seeking mental health treatment will need to first access detoxification services (which are themselves difficult to access) and then work quickly to access mental health services once they've completed detox. Individuals may resume using substances during the waiting period for mental health treatment, which results in having to start the detoxification process over again. This cycle is most likely to continue when an individual is unstably housed and/or lacking a telephone to receive calls from providers regarding intake appointments.

Stakeholders were concerned that there is no comprehensive system-wide strategy to meet the needs of people with co-occurring mental health and substance use disorders, though stakeholders from MHASD recognized this aspect of the system as an area for growth and identified that they are in regular conversation with Health Share to strengthen this aspect of the system. In general, stakeholders noted that while there are some co-occurring services, the County is limited in terms of policy to support an adequate continuum of such services. One stakeholder with expertise in co-occurring mental health and substance use issues emphasized that any system-wide strategy should include ensuring that the mental health system has the responsibility and resources to address the substance use disorder–related needs of those who use mental health services, with a workforce capable of addressing co-occurring needs. It also should include collaborating with substance use disorder treatment providers to identify and address the mental health support needs of individuals who use their services.

[13] A map depicting the various service locations is available here: https://www.bhchp.org/sites/default/files/bhchp_locations_map.pdf

Stakeholders identified numerous barriers to increasing the County's capacity to meet co-occurring mental health and substance use disorder-related needs. Stakeholders said there are not enough providers with training and qualifications to provide co-occurring treatment services. Another issue is related to provider credentialing, including creating the appropriate incentives for providers to obtain and maintain certification to provide mental health and substance use services. Several representatives from provider organizations noted the high incidence of substance use–related issues for people who are experiencing crisis, indicating that substance use problems are a significant driver of intensive service need. Integrating mental health and substance use services is challenging in part because of how these services are financed. For example, substance use residential services are state-funded, while mental health services are often funded through a combination of state and federal dollars. These different funding streams make braided funding difficult.

Housing Support Services

The cost of living in Multnomah County has far outpaced the county's median income in recent years, rendering housing unaffordable for many, especially individuals who rely on disability or another fixed income.[25] According to the Robert Wood Johnson Foundation County Health Rankings, 22% of households in Multnomah County had at least one of four housing problems (overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities), which is higher than the national and state averages.[26] The 2017 Point-in-Time Count of Homelessness in Multnomah County documented 4,177 individuals experiencing homelessness, a 10% increase from the prior count in 2015. Importantly, the numbers of individuals in unsheltered housing situations decreased by 12% and is the lowest it has been since 2009, owing to significant community investments in resources for individuals experiencing homelessness in recent years.[27] There are numerous county initiatives underway to address housing issues, and MHASD and other mental health system stakeholders actively participate in this work.

Given the central importance of having a stable home for recovery and wellness, the high rates of homelessness and high cost of housing in Multnomah County were central concerns voiced by nearly all stakeholders who participated in this analysis. They said that it is simply impossible for individuals on fixed incomes (such as SSI, SSDI) to afford market-rate housing, or even affordable housing units. Stakeholders noted that Section 8 vouchers and project-based housing are available in the county, but they are not sufficient to meet community need. Short-term housing was seen as dwindling, with remaining short-term housing options described by stakeholders as "scary places" and "glorified squats." Multiple stakeholders identified

> Cost of living has far outpaced the county's median income, and housing is unaffordable for those who rely on disability income.
>
> Yet stable housing is critically important for recovery and wellness.

being discharged to homelessness as common and very concerning, and many noted that housing is especially difficult to find for people with criminal histories.

In FY17, 892 individuals were served by mental health–specific housing support services in Multnomah County through the homeless services system, including 154 served by the Street Outreach Team.[28] Individuals counted in the 2017 Point-in-Time count were asked to self-report if they experienced any disabling conditions, including "serious mental illness." Of the 1,668 unsheltered individuals, 45% (747) self-identified as having a serious mental illness.[29] Taken together, these figures suggest that while the county is providing services to meet mental health-related support needs to a significant number of individuals, unmet needs persist. Consistent with this finding, stakeholders described shortages along the continuum of housing support services and services that were mismatched with community need, prompting one stakeholder to call the housing support system "the Land of Misfit Toys." Similarly, another stakeholder who works with homeless populations noted that many individuals living in shelters are there because they "failed out" of the mental health system, making shelters the "default mental health system." Stakeholders who work with homeless populations said that it can be difficult for individuals who are homeless to enroll in Medicaid, even if they are eligible. Similarly, it is difficult to maintain enrollment in public benefits when unstably housed. One stakeholder said that, ideally, providers should have the flexibility to conduct outreach and engagement activities first without worrying about enrollment.

> Many individuals living in shelters are there because they "failed out" of the mental health system, making shelters the "default mental health system."

Multiple stakeholders identified a lack of mental health supports in short-term housing and other homeless services. They identified a need to expand mental health programming, including peer services, in shelters and a need for more street-based mental health outreach services. One barrier is that these services are not easily Medicaid-reimbursable. In October, the MacArthur Foundation awarded Multnomah County a $2 million grant to reform the criminal justice system, some of which will be used to establish a Mental Health Alternative shelter for justice-involved women (focused on women of color) with mental health conditions. That project is currently in the planning stages. For the past four years, MHASD has worked with housing system partners to develop emergency and transitional housing for individuals with significant mental health needs that frequently result in crisis and inpatient service use. For example, beginning in FY18, a joint initiative of a Home For Everyone[14] and the Health Department has focused on expanding short-term housing for individuals who frequently experience mental health crisis in the Portland metro area.[30] Stakeholders from MHASD reported that locating affordable units can be difficult

[14] A Home for Everyone is a community-wide initiative to end homelessness, led by Home Forward, Multnomah County, the City of Portland, the City of Gresham, and representatives from the faith, philanthropic, and business communities: http://ahomeforeveryone.net/

given limited dedicated funding for these initiatives. A dedicated transitional housing program for individuals with mental health needs experiencing homelessness is scheduled to open in September 2018. The program will be focused on supporting independent living skills and connecting individuals to appropriate long-term supported housing when needed.

Stakeholders described a mismatch between service intensity and level of need throughout the housing service continuum. For example, some individuals in secure residential facilities could likely be residing in the community, while individuals with complex needs might be discharged to homelessness or to a motel when a more intensive housing program would be more appropriate. Licensed residential services were described as "provider-driven," with residential providers "cherry-picking" those with less intense needs and calling police or sending individuals to emergency rooms inappropriately. Stakeholders representing the crisis system said there's a small number of individuals with very intensive needs for safe independent living, and that these unmet housing support needs result in high levels of inappropriate utilization of inpatient services. Stakeholders also said that because of a lack of permanent supportive housing and poor mechanisms for moving people into these long-term solutions, short-term housing supports are inappropriately utilized.

One challenge for ensuring adequate capacity of housing supports is related to the patchwork nature of funding for these services—each with its own set of requirements and regulations. In addition to the Health Department and Department of Community Justice, these housing support services are funded by a range of sources, including the Portland Housing Bureau, Home Forward (the regional HUD Authority), the Joint Office of Homeless Services, Multnomah County Department of Human Services, and federal Continuum of Care funds. Stakeholders noted that as a result of this administrative complexity, it is difficult to braid or blend funding to support projects in a streamlined way. They also expressed concern that efforts to comply with different requirements and regulations results in inefficient use of available resources. Additionally, data system limitations can make it difficult for local organizations to prioritize individuals with the most complex needs and move people throughout the system. Stakeholders described a number of initiatives underway to address this gap. Through the Coordinated Access system, individuals are placed on waiting lists for housing based on a vulnerability assessment to prioritize those with the highest need.[15] The system is currently in place for four populations of people experiencing homelessness: Adults unaccompanied by minor children, families with minor children, unaccompanied youth, and persons fleeing domestic violence. There's also a Veteran By-Name list to connect veterans who are experiencing homelessness to services. The planned FUSE initiative—a Joint Office of Homeless Services project—will draw from different data systems to identify and target services to high utilizers.[16]

[15] http://ahomeforeveryone.net/coordinatedaccess/
[16] http://www.csh.org/fuseRC

Mental Health in the Criminal Justice System

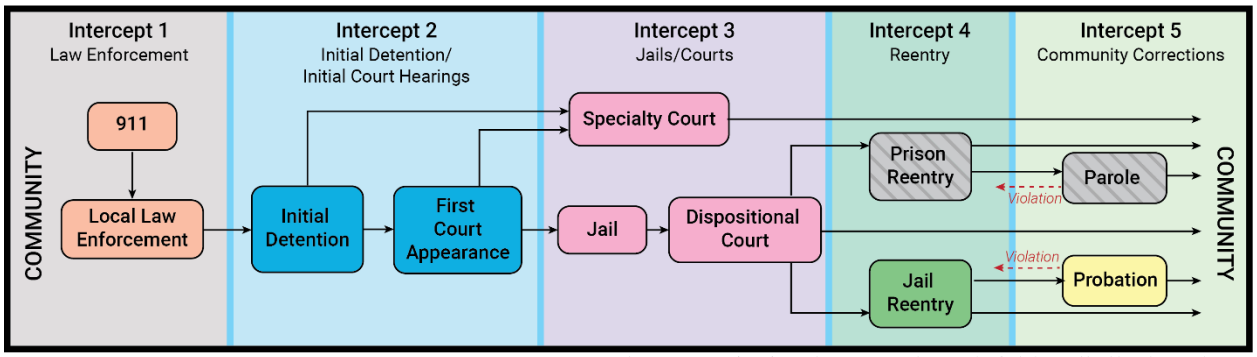
In recent years, the criminal justice system in Multnomah County has paid increasing attention to mental health issues and seems to have evolved to better-meet the needs of people with mental health conditions who are justice-involved. Stakeholders described this process as ongoing. The state-mandated Local Public Safety Coordinating Council (LPSCC), whose membership includes public safety heads and multiple County departments—including MHASD—coordinates a range of cross-system strategies, including those related to improving the response to individuals with mental health needs. In FY17, the LPSCC convened a total of 85 meetings of its Executive Committee or subcommittees.[31]

> The criminal justice system in Multnomah County has paid increasing attention to mental health and seems to be better-meeting the needs of people with mental health conditions who are justice-involved.

Although there appears to be a strong commitment to improving the criminal justice system's capacity to address mental health needs, stakeholders identified several current challenges, discussed in this section. The Sequential Intercept Model is used by many communities—including Multnomah County—as a conceptual framework to understand and address mental health issues and the criminal justice system.[32] The model, depicted in Figure 4, was originally developed through the work of the SAMHSA GAINS Center.

Figure 4

SAMHSA GAINS Center Sequential Intercept Model



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

In a robust system, interventions are targeted at each point of intercept between the mental health and criminal justice systems to prevent individuals from entering (Intercept 1) or penetrating deeper into the criminal justice system. Ideally, most people are reached and connected to services and supports in the earlier stages, with decreasing numbers at each intercept. Stakeholders we interviewed—including leadership within MHASD, the Health Department, and the criminal justice system—recognized the importance of mental health and demonstrated a commitment to working on mental health-related initiatives at each intercept point in the criminal

justice system. Representatives of the criminal justice system meet regularly with other members of the community to discuss mental health-related systems issues and coordinate initiatives, and there are numerous workgroups and initiatives underway.

Law Enforcement and Other First Responders

There has been significant attention paid to improving the capacity of police officers to respond to mental health-related issues in the community, with the Portland Police Bureau at the center of numerous reforms and initiatives in recent years. These reforms were prompted by a 2012 lawsuit filed by the U.S. Department of Justice against the city alleging improper use of force against individuals with mental health problems. The lawsuit resulted in a settlement agreement that prompted numerous reforms, including the establishment of a community oversight board, increased training for officers, and specialized units to respond to mental health-related calls.[33] Stakeholders noted that there has been a culture change in recent years within the Portland Police Bureau as a result. Within Portland, mental health-related efforts are overseen by a Behavioral Health Unit, which coordinates its efforts with MHASD.[17]

Currently, all Portland Police Bureau officers receive the Crisis Intervention Team (CIT) training, and as of December 2017, approximately 130 of 950 officers were trained in Enhanced CIT, and the Portland Police Bureau works to ensure that these officers are dispatched on mental health-related calls whenever possible based on priority criteria. In addition to CIT training, the Portland Police Bureau operates three Behavioral Health Response Teams (BHRTs) in which an officer is paired with a clinician from Cascadia's Project Respond to conduct proactive outreach with individuals who have multiple contacts with police. The BHRTs operate approximately four days per week and have approximately 1,000 referrals per year (the Portland Police Bureau reports they serve about half of those individuals through the BHRT). In 2018, the Portland Police Bureau will add two additional BHRTs and will expand coverage to five days per week. An additional initiative, the Service Coordination Team, provides access to housing and behavioral health treatment for those with drug and alcohol addiction, homelessness, and frequent police contact. Housing, access to treatment, and wrap-around services are operated by Central City Concern. Additionally, the Service Coordination Team includes capacity to work with individuals with significant mental health-related needs, including co-occurring disorders, and are working directly with the BHRTs. A 2017 evaluation of the program found that participation was associated with reduced police contacts after participation.[34]

Although a detailed analysis of mental health-related initiatives in all communities within Multnomah County was outside the scope of this analysis, several stakeholders noted that the robustness of the Portland Police Bureau's Behavioral Health Unit is not reflective of law enforcement agencies in other parts of the County. Stakeholders also mentioned that perhaps because of the DoJ involvement, police officers are reluctant to intervene and put hands on a person, even when they are considered to be

[17] https://www.portlandoregon.gov/police/62135

a threat. This dynamic results in such interactions falling to Emergency Medical Services providers, which stakeholders saw as inappropriate.

Other Jail Diversion Efforts and Mental Health in Jails

Stakeholders discussed a range of current and planned strategies to divert individuals with mental health issues who have been charged with a crime. These initiatives are the result of significant coordinated action between mental health and justice stakeholders; between 2004 and 2011, Multnomah County nearly doubled the number of individuals in the corrections system who were provided with mental health services.[35] The Law Enforcement Assisted Diversion (LEAD) program, which replicates a successful Seattle program, connects individuals with low-level drug possession charges to case management and engagement services before their case is filed. Two therapeutic courts, the Community Court Program and Mental Health Court, served 904 individuals in FY17, 54% of whom were in good standing or had successfully completed services at the end of the fiscal year.[36] Some stakeholders were unenthusiastic in their endorsement of mental health courts and other community-based restoration processes, noting that criminal charges should not be one's ticket to community based mental health services, which should be accessible to everyone.

Despite local diversion initiatives, stakeholders representing police and other first responders were concerned that many individuals with mental health-related needs end up being sent to jail. Stakeholders described scenarios in which staff at the Unity Center call the police on individuals who are presenting there for services, or who are currently receiving services. They were concerned that in these instances, the only remaining option is often to take these individuals to jail, resulting in a cycle of jail, crisis service use, and police response. A 2015 analysis of individuals held in Multnomah County jail who remained detained in jail for mental health concerns documented potential concerning racial disparities: 41% of the 80 individuals in the target population were black, compared to 20% of all individuals booked that month. The authors also found that only 6% of the individuals had received a community-based mental health service in the 120 days prior to their bookings.[37]

Several stakeholders described access to medication as a challenge for people who are arrested and put in jail; individuals who do not have documentation about their medications lose access to those medications when they are in jail and may have to wait to see a prescriber. MHASD reported that they have been working with Corrections Health to improve data sharing to ensure individuals do not lose access to medications when in jail.

Oregon State Hospital and Aid and Assist

There are three legal status categories for individuals who receive services at Oregon State Hospital:[38]

1. **Civil commitment** for individuals who have not committed a crime but have been found by the court to require 24-hour care that is unavailable in the community, or for individuals with legal guardians who have worked through the court system to pursue civil commitment

2. **Forensic commitment** for individuals who have successfully pled Guilty Except for Insanity (GEI) to a crime related to a mental health condition. Many of these individuals are under the jurisdiction of the Psychiatric Security Review Board (PSRB), a state entity that supervises individuals who have been forensically committed at Oregon State Hospital and upon return to the community.[39]

3. Individuals ordered to the hospital under the ORS 161.370 statute of Oregon law to receive treatment that will help them understand criminal charges that have been brought against them to assist in their defense, often referred to as the **Aid and Assist** population.

Table 3 presents the number of stays, proportion of total stays, and median length of stay for individuals who were discharged from Oregon State Hospital in calendar year 2017, by legal status category. For Multnomah County and the state in general, over 60% of stays were related to Aid and Assist orders. Median length of stay for the Aid and Assist population was shorter than for civil commitments, and much shorter than for forensic commitments.

Table 3

A majority of Oregon State Hospital stays are related to Aid and Assist orders, with shorter lengths of stay compared to individuals with civil and forensic commitments.

	Number of Stays	% of Total Stays	Median Length of Stay
Civil Commitment			
Multnomah County Residents	77	33%	107
All Oregon State Hospital	311	31%	132
Forensic Commitment			
Multnomah County Residents	10	4%	508
All Oregon State Hospital	66	7%	556
Aid and Assist			
Multnomah County Residents	145	63%	71
All Oregon State Hospital	626	62%	72
All Legal Status Categories			
Multnomah County Residents	232	100%	88
All Oregon State Hospital	1003	100%	97

Source: Oregon State Hospital.

Note: Multnomah County assignation is based on the most recently updated County of Commitment.

In interviews, stakeholders asserted that because the census at the Oregon State Hospital is dominated by the Aid and Assist population, this results in fewer beds available to individuals with civil commitments, some of whom are stuck in other facilities awaiting those beds.

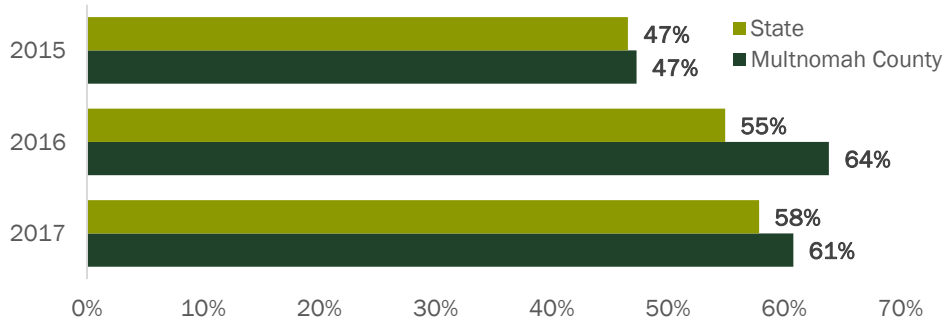
In 2017, county and state efforts have focused on reducing the numbers of individuals on forensic commitments and Aid and Assist orders at the Oregon State Hospital. These have included locally expedited evaluations to reduce the amount of time individuals spend waiting in jails, administration of an Aid and Assist Court, and

investments in supportive housing for this population. In FY17, MHASD and the Oregon Health Authority invested $768,000 in forensic diversion efforts for individuals on Aid and Assist orders. Comparing estimated costs of three-month stays at the Oregon State Hospital to expenditures on community-based restoration, MHASD estimates that the program has resulted in over $6 million in savings.[40] The Multnomah County Forensic Diversion Program diverts individuals charged with a felony or misdemeanor from the Oregon State Hospital to the community and served 390 individuals in FY17, 74% of whom remained engaged throughout the year.[41]

Figure 5 depicts the proportion of individuals at Oregon State Hospital who were on Aid and Assist orders between calendar years 2015 and 2017. At the state level, numbers have steadily increased during this period. At the county level, however, there was a decrease in the proportion of individuals on Aid and Assist orders in 2017 compared to the previous year, providing some evidence that this trend is reversing.

Figure 5

The proportion of Multnomah County residents on Aid and Assist orders at Oregon State Hospital increased in 2016 but decreased slightly in 2017.



Source: Oregon State Hospital, 2018

Despite the recent reductions, stakeholders described a need for continued and sustained reform. They noted that the Aid and Assist program as currently implemented still results in individuals with mental health conditions being held in institutions for long periods of time for low-level crimes, which they saw as fundamentally inequitable.

In 2017, county and state efforts have focused on reducing the numbers of Aid and Assist individuals at the Oregon State Hospital.

But stakeholders described a need for continued reform.

Services to Support Transitions from Inpatient and Justice Settings

In its 2016 *Annual Medicaid Quality Report*, MHASD reported there were 191 fewer hospitalizations in FY16 than FY15, representing the lowest rate since Multnomah County assumed its role as managing the specialty behavioral health benefit for Medicaid enrollees.[42] Approximately 16% of adult Multnomah Mental Health enrollees who received an outpatient visit within 30 days of discharge were

readmitted to an inpatient hospitalization during FY17,[43] a figure that is consistent with the national average of 15%.[44] Notably, this figure only includes individuals who are already receiving outpatient services, not individuals who are not engaged with specialty mental health services who may have mental health-related needs. The Multnomah Intensive Transition Team (MITT), formed in October 2016, was created to engage unaffiliated individuals and has served increasing numbers since its formation, with a goal of seeing 80% of unaffiliated Medicaid enrollees in 2017. According to 2017 data, the MITT surpassed this goal: 181 Medicaid-insured individuals hospitalized for a mental health issue did not have an open authorization for mental health services at the time of their hospitalization; 132 of these individuals were engaged with the MITT, and of those, 116 (88%) received follow-up care within seven days.[45]

The Unity Center offers Peer Bridging services for individuals who have had three or more visits at Unity. Eligible individuals receive peer support to help them connect to community-based services for 45 to 90 days. Several stakeholders said that peer bridging services lacked capacity and noted that this resource is difficult to fund in the current system.

For justice-involved individuals transitioning to the community, MHASD developed and funds a Forensic Assertive Community Treatment Team, and its jail diversion services work with individuals while incarcerated and in the community to establish connections to treatment and meet court requirements for conditional release.

Despite these promising trends and current capacity, transitions to the community from inpatient settings—and also from jail or prison—were described as a major challenge by multiple stakeholders. Service users and providers described experiences of people being discharged from inpatient and criminal justice settings without adequate medications. Transitions for people with complex medical conditions were described by several providers as being particularly problematic—for example, people with significant medical conditions being discharged to homelessness without adequate arrangements for their medical care.

Stakeholders who work with complex need populations described a shortage of intensive residential and other "step-down" services to smooth and extend transitions from intensive settings to the community, stating that after an inpatient stay, individuals with intensive service needs face a "cliff" in which they go from receiving around-the-clock support to very limited community-based supports, with no intensive longer-term residential support services to fill the gap.

> "A problem with transitions is that a person is discharged to what is available rather than to what the person needs or wants."

Stakeholders also described a dynamic in which individuals from the Aid and Assist population are discharged from the Oregon State Hospital back to the jails and are then "discharged to nothing." Stakeholders said that the issues associated with the Aid and Assist population are highly related to a lack of community-based services for

this population to break the cycle of homelessness and recidivism. Stakeholders from the criminal justice system said that many community providers don't want to take justice-involved individuals, a dynamic that has been observed in other jurisdictions; in a recent study assessing community mental health providers' views on justice-involved individuals, researchers documented lower regard for justice-involved individuals than individuals without justice involvement.[46] Other stakeholders identified barriers related to ensuring connection to insurance and other benefits. Solutions offered included increased staffing for positions both within criminal justice settings and in community settings to engage with people while incarcerated and work with them for a set period once they return to the community. However, stakeholders within the criminal justice system noted that it can be difficult to staff transition services given the variability of release dates, particularly in jails with very short lengths of stay. Recently, the Oregon Consumer Advisory Council (OCAC) has advocated at the state level to expand Peer Bridger services for individuals returning to the community from Oregon State Hospital.

A common theme in stakeholder discussions about community transitions was that these issues are related to larger issues of access to and capacity for community-based services for people with complex needs, which are discussed throughout this section. Echoing stakeholder concerns about supporting service user choice throughout the mental health service system, one stakeholder identified that the fundamental problem with transitions is that in the current system, "a person is discharged to what is available rather than to what the person needs or wants." Stakeholders said that these dynamics result in unmet needs and a revolving door with the jail and crisis and inpatient services for many individuals in the county.

Crisis Services and Crisis Alternatives

County crisis response services are available 24 hours per day, seven days per week and include a crisis hotline, mobile crisis outreach through Project Respond; an Urgent Walk-In Clinic operated by Cascadia; psychiatric emergency services at the Unity Center for Behavioral Health; and the Crisis Assessment and Treatment Center (CATC), a 16-bed, short-term secure alternative to hospitalization operated by MHASD. Individuals experiencing mental health-related crisis also use emergency departments at local hospitals. All crisis-related issues, regardless of payer type, are routed through the County's Mental Health Call Center. In fiscal year 2017, the crisis system had an estimated 85,000 contacts, 79,551 of which were Call Center calls.[47] In addition to the Mental Health Call Center, Lines for Life, a regional nonprofit, operates a helpline for individuals in crisis, including individuals experiencing thoughts of suicide. In calendar year 2017, Lines for Life fielded 7,535 calls. Of these calls, approximately one-third were related to suicide, and 27% were related to mental health problems.[48]

In addition to accessing services through MHASD's Call Center and Urgent Walk-In Clinic, many Multnomah County residents with urgent mental health issues use emergency transportation and visit emergency departments, including but not limited to the Unity Center's Psychiatric Emergency Services. In Multnomah County,

emergency transportation and emergency department claims for all Health Share members are paid through Health Share via physical health until the person is admitted to an inpatient mental health service, at which point care is coordinated by MHASD. In FY17, 805 Health Share members used emergency transport related to a mental health issue (substance use-related events are not included in the data we analyzed for this study) for 805 individuals. In FY17, a total of 2,576 Health Share members visited an emergency department for a mental health issue. A majority of emergency department visits were to facilities within Multnomah County, but 10% were to emergency departments outside of Multnomah County.

Stakeholders described numerous initiatives to identify and address issues related to the system's capacity to respond to mental health crisis. The Metro Acute Care Advisory Council is a monthly collaboration between local health systems and county governments. Each of these meetings involves stakeholders coming together to coordinate policy, identify resources, and address system gaps related to acute care, including emergency department boarding and transitions from hospital to community. MHASD recently held a series of Crisis Feedback Sessions in which stakeholders representing service users, advocacy, police, and other community members came together to discuss crisis services and inform crisis system developments.

Table 4 presents demographic characteristics of individuals who used mental health related emergency transportation and emergency department services and individuals who used Project Respond in FY17.

Table 4

Characteristics of individuals who used Medicaid-funded mental health–related emergency transportation and ED services and individuals who used Project Respond

	Medicaid MH-Related Emergency Transport (N=805)		Medicaid MH-Related Emergency Department (N=2,576)		Project Respond (N=2,210)		Multnomah County General Population (N=807,555)	
	n	%	n	%	n	%	n	%
Age								
Under age 18	52	6%	249	10%	180	8%	155,858	19%
18 to 64	695	86%	2,236	87%	1,758	80%	549,945	68%
65 and older	58	7%	91	4%	125	6%	101,752	13%
Gender								
Female	391	49%	1,381	54%	972	44%	407,008	50%
Male	414	51%	1195	46%	1,149	52%	400,547	50%
Preferred Language								
Other than English	29	4%	95	4%	86	4%	170,394	21%
Race/Ethnicity								
Caucasian	495	75%	1,321	72%	1,188	75%	646,044	80%
Black or African American	90	14%	271	15%	208	13%	46,838	6%
Hispanic	37	6%	128	7%	97	6%	92,061	11%
Asian	21	3%	67	4%	35	2%	60,567	8%
American Indian/ Alaska Native	10	2%	35	2%	19	1%	12,113	2%

Sources: Multnomah County MHASD, Health Share, and U.S. Census V2017 Estimates

Notes: The emergency transportation and emergency department data used for this analysis include all claims related to a mental health issue, regardless of whether a person receives services through the specialty mental health system. Approximately 4% of individuals who used Project Respond identified as transgender, non-binary, or another gender identity; reliable information about individuals who identify as transgender, non-binary, or another gender identity were not available in the Health Share or census data. Preferred language other than English for the Multnomah County General Population is based on the population over 5 years of age reporting language other than English spoken at home. Language data were missing for 18 emergency department service users. Race and ethnicity data were missing for 147 emergency transport service users, 740 emergency department service users, and 624 Project Respond service users.

In general, stakeholders expressed that there were multiple clinical options for adults experiencing acute crisis. And for some Multnomah County residents, the crisis service array appears to be effective in averting the need for emergency department services. For example, according to MHASD, an estimated 94% of the 4,127 individuals who used the Urgent Walk-In Clinic during FY17 did not need to be referred to an emergency department for acute services.[49]

Stakeholders who work with children and youth noted that the county's crisis response system is generally less comprehensive for children and youth than for adults. For example, the psychiatric emergency service at Unity Center is only for adults age 18 and older. In interviews and community listening sessions, stakeholders described scenarios in which families and caregivers of children and youth in crisis call law enforcement because of a lack of alternative options to getting support for their loved one. Similarly, representatives from the Portland Police Bureau noted that

they frequently receive calls from families who have been unable to receive help for their children and have reached a crisis point.

Stakeholders expressed concern about the needs of individuals before they reach a crisis point, and the needs of individuals after a crisis has subsided. Several stakeholders noted that while the system is relatively capable of "stabilizing people" it lacks the resources to "keep people stable" over time. Stakeholders working within the crisis response system identified a "delay between need and ability of the system to address their symptoms." In this dynamic, individuals who use the crisis response system receive a referral to ongoing supports but experience a "waiting period" between the referral date and initial data of service. In 2017, over 80% of children and 65% of adults were offered a non-urgent appointment within 14 days of request, marking an increase in access compared to 2015 and 2016.[50] Although these numbers have increased, there remains a sizable number of individuals who do not receive an appointment within two weeks. It is during this gap that individuals are likely to become disengaged, resulting in a perpetuation of unmet needs. Stakeholders voiced concern that this dynamic results in crisis response providers being heavily relied upon to perform outreach and engagement activities.

Several stakeholders noted that while the system is relatively capable of "stabilizing people" it lacks the resources to "keep people stable."

Several also articulated a "gray area" for people who do not meet eligibility criteria for emergency services but are still struggling with significant mental health-related challenges.

Many stakeholders said that welcoming safe spaces for people who are in crisis or headed toward a crisis are missing or in inadequate supply in the county. They articulated a "gray area" for people who do not meet eligibility criteria for emergency services but are still struggling with significant mental health-related challenges. For these individuals, there may be missed opportunities to receive support before their needs reach a "crisis" point. One of the most commonly identified service gaps were low-barrier, voluntary, community-based services for individuals to access when they are having a difficult time but are not yet experiencing a crisis. These services could take the form of flexible clinical supports and voluntary drop-in programs such as the "living room" model.[51]

Multiple stakeholders noted that a peer respite—a peer-run organization that provides short-term peer support in a homelike residential setting[18]—would be an important complement to current crisis response services, echoing recent calls from the Oregon Consumer Advisory Council for the Oregon Health Authority to support establishing such programs.[52] Peer respites typically have a non-clinical orientation, are staffed and managed by peer specialists, and have a governing or oversight body with a majority of members having lived experience of the mental health system. In peer respites, "guests" are engaged by peer support staff using trauma-informed principles that emphasize building healing, trusting relationships. Preliminary research on peer respites has found that they are associated with reductions in inpatient and emergency service use and that they support individuals in managing stressful situations and building relationships with other people with lived experience.[53,54] Barriers to establishing more peer respites included limited funding and support for peer-run organizations, as well as some state laws that require that such services have licensed prescribers on site, which runs counter to the peer respite approach.

Culture and Discrimination

Issues related to culture and discrimination were raised by multiple stakeholders and have been a focus of numerous past state and local assessments. These issues were raised in the context of racial and ethnic disparities, stigma and discrimination against individuals who've been diagnosed with mental health issues, and the role of trauma and needs for trauma-informed services and systems.

Differences in Access by Race, Ethnicity, and Language

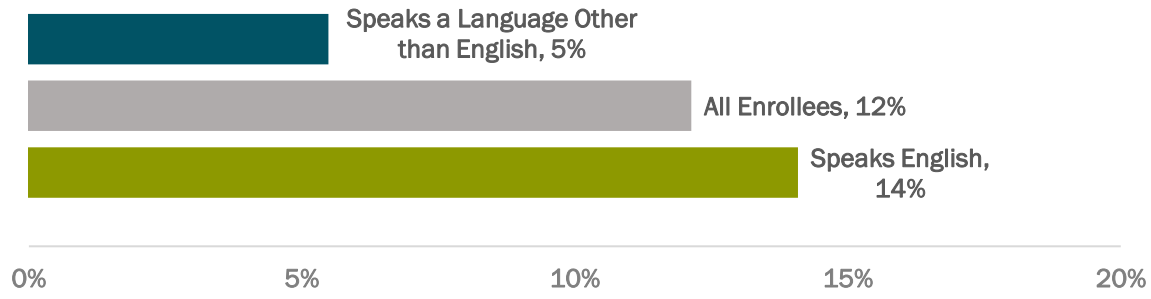
As shown in Table 2 , under "Demographic Characteristics of Mental Health Service User Populations," African Americans are overrepresented in the publicly funded mental health system compared to the general population, while Asians and those with Hispanic ethnicity are underrepresented. Those whose preferred language is other than English are also underrepresented in all publicly funded mental health service user populations. Myriad factors result in this disproportionate representation, some of which were identified by stakeholders during interviews and listening sessions (discussed in depth later in this section).

To further understand issues related to racial and ethnic differences in access to Medicaid services, it is helpful to examine penetration rates. A penetration rate is the number of Medicaid enrollees who receive a service divided by the total number of Medicaid enrollees. Penetration rates account for the fact that some racial and ethnic groups are over- and under-represented in Medicaid compared to the general population and allow for deeper understanding of disparities in access among Medicaid enrollees.[55] Figures 6 and 7 present specialty mental health service penetration rates for Medicaid enrollees in FY17 by language (Figure 6) and by race and ethnicity (Figure 7).

[18] www.peerrespite.net

Figure 6

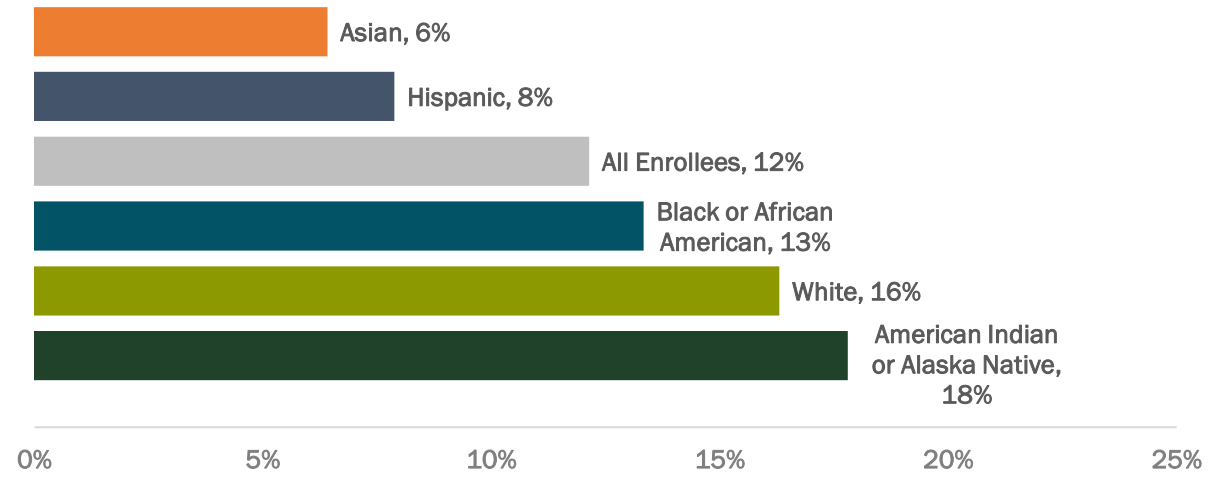
Specialty mental health service penetration rates for people who **speak a language other than English** are less than half that of all Medicaid enrollees, and nearly a third that of **enrollees who speak English**



Source: MHASD, FY17 Enrolled and Served by Preferred Language

Figure 7

Specialty mental health penetration rates differed significantly for several racial and ethnic groups, including **Asians** and **Hispanics** (lower than average) and **American Indians or Alaska Natives** (higher than average)



Source: MHASD, FY17 Enrolled and Served by Race and Ethnicity

According to MHASD, FY17 was the first year that that those reporting Black or African American race did not show a disparity in penetration compared to the general population. Disparities in penetration rates for English speakers and non-English speakers and for racial and ethnic minority groups are reflected in themes gathered during the community engagement process and are discussed further in the following sections.

Cultural Responsivity

MHASD coordinates a range of culturally specific services for five communities that have historically experienced barriers to accessing culturally responsive mental health services: Pacific Islander, African American, Eastern European, Latino, and Native American. In FY17, 934 individuals received culturally specific mental health services to individuals without insurance who would not otherwise be able to access services through MHASD.[56] (Notably, this total includes all persons served under this County-funded program offer and does not include those culturally diverse populations served by Multnomah Mental Health or in other programs.) Beginning in late 2016, MHASD services in Head Start included culturally specific treatment services for 48 Latino and African American children in Head Start. In FY17, 3,600 children aged 0 to 6 received such services through MHASD.[57]

Culturally specific services were highly valued by all stakeholders interviewed, and many lauded the County's commitment to these services. They noted that the County has supported alliances across agencies that provide culturally specific services and that the County has effectively worked with these agencies to incorporate creative strategies to fund them more effectively. Monthly, MHASD convenes the Alliance of Culturally Specific Behavioral Health Providers and Programs, composed of agencies that contract through MHASD and Health Share. The Alliance regularly searches for opportunities to improve and expand culturally specific services. Despite these efforts, and despite recent increases in penetration rates for African Americans, Medicaid mental health service penetration rates for racial and ethnic minority groups remain lower than for whites except for American Indian or Alaska Natives (see Figure 7 above).[58]

Most stakeholders in interviews and community listening sessions said that culturally specific services are in inadequate supply. Culturally specific services for children and youth, and more intensive services for adults (for example, intensive outpatient) were described as particularly needed. Stakeholders also saw a need for more capacity to perform outreach and engagement with underserved communities and saw a need for more culturally specific peer support services and training.

> Multiple stakeholders of color—including providers and service users—described the system itself as "White."
>
> African Americans are more than three times as likely to not see a clinician who is also African American in comparison to White enrollees.

Stakeholders noted that in Multnomah County, the majority of mental health professionals are white, and multiple stakeholders of color—including providers and service users—described the system itself as "white." Stakeholders noted that there are limited bilingual or multilingual providers, and limited providers from cultures

that mirror those of the service user population. Several user stakeholders noted that even culturally specific services were not delivered by people from that culture. Reliable and current data reflecting the race and ethnicity of mental health service providers in Multnomah County is unavailable, but in 2015 and 2016, MHASD conducted a voluntary survey of qualified mental health professionals (QMHPs) and prescribers in the specialty mental health service network. All large and medium-sized agencies in the county (14 in total) responded to the survey, while 9 smaller agencies did not respond. Through this analysis, MHASD identified that African Americans experienced the largest disparity; African Americans are more than three times as likely to not see a clinician who is also African American in comparison to White enrollees.[59]

Multiple stakeholders described the workforce in intensive service settings (for example, Unity and local hospital emergency departments) as particularly lacking in staff diversity. Providers described challenges with hiring and retaining staff from diverse backgrounds, with dynamics similar to those for the workforce as a whole at play (for more discussion of these dynamics, see "Hiring and Retaining a Qualified, Competent Workforce" on page 58). Provider stakeholders who have had success in recruiting a diverse workforce described having built relationships with communities over time, and then hiring from within those communities—particularly for peer support and case management roles. Staff retention dynamics related to staff leaving for higher-paying positions outside of community settings seemed to be even more pronounced for bilingual/bicultural staff, who may be recruited to provide culturally specific services in those settings.

> Stakeholders who provide culturally specific services spoke of the importance of having a trauma focus that accounts for historical oppression and experiences of discrimination and racism.

Echoing themes from the community listening sessions and other interviews, a service user interviewee said that they needed to receive mental health services from someone who knows what it is like to be a person of color in Multnomah County (including having a deep understanding of historical trauma, microaggressions, and racism), and that they have not been able to find that kind of support despite having been engaged with the system for many years. Stakeholders who provide culturally specific services echoed this sentiment and spoke of the importance of having a trauma focus that accounts for historical oppression and experiences of discrimination and racism. They also spoke of the importance of a family orientation in several cultural groups; one provider working with Latino communities said that their focus needs to be almost entirely on families, not individuals, and that this takes a different orientation, different staff competencies, and a different level of resources. This viewpoint was reflected in 2017 recent study of mental health disparities among Latino Oregonians, which highlighted the critical importance of family and community for Latino communities and barriers associated with stigma and fear of seeking out mental health services.[60]

Stakeholders providing culturally specific services noted that individuals from some smaller cultural groups may be reluctant to access mental health services because of privacy concerns or "everyone knowing your business," which could explain the underrepresentation of individuals with Hispanic ethnicity in the service user population data presented in this report. Other stakeholders described fears of accessing the mental health system among undocumented persons. These concerns are perhaps reflected in the underrepresentation of those with Hispanic ethnicity in the mental health service user population.

Several stakeholders described insufficient translation and interpreter services, and materials not being available in other languages. MHASD reports that in 2016, clinicians at its contracted agencies speak 33 languages in addition to English.[61] Multnomah County also has contracts with three different translation and interpretation vendors, and stakeholders from MHASD reported that MHASD is working with Health Share to better-identify providers who can offer services in non-English languages throughout the county. However, stakeholders also noted that the current system seems overly focused on language services and pointed out that culturally responsive services should include far more than just speaking another language; they must be fully informed by the culture, including specific cultural attitudes around mental health. Stakeholders voiced a need for more culture-related trainings and cultural consultants.

LGBTQ-Specific Services

A substantial research literature documents that LGBTQ[19] youth and adults have a higher prevalence of behavioral health problems and face barriers to treatment that include provider stigma and discrimination and a lack of culturally sensitive services.[62,63,64,65] These disparities experienced in the health and mental health spheres are further compounded by more global experiences of work and housing discrimination and public homophobia and transphobia, each of which negatively impacts mental health and wellbeing. As in other parts of the country, stakeholders noted that transgender individuals in Multnomah County are highly over-represented among the homeless populations and have a high co-occurrence of substance use problems.

> Sexual and gender minorities have an even harder time finding housing programs that they experience as safe and accepting where they can receive gender-responsive supports and be protected from victimization.

In interviews and community listening sessions, stakeholders from the LGBTQ community described many system-wide barriers to access as being particularly

[19] While lesbian, gay, bisexual, transgender, and queer populations are often grouped together in reports like this one, it is important to note that this group is composed of multiple unique groups with varied demographic profiles and health and mental health-related needs and preferences.

pronounced for LGBTQ individuals. For example, while finding safe and supportive housing is difficult for all individuals with mental health conditions who are unstably housed in the county, sexual and gender minorities have an even harder time finding programs that are experienced as safe and accepting where they can receive gender-responsive supports and can be protected from victimization. Stakeholders also noted that although there are some LGBTQ-specific services in the community (according to stakeholders from Multnomah County, there is a current budget request to increase LGBTQ mental health services), it is still difficult to find providers who can be responsive to their needs across the service continuum.

Experiences of Discrimination Based on Mental Health Diagnosis

In interviews, service users described providers having preconceived ideas about them based on their diagnosis. For example, one person noted, "the whole system is based on not believing people" and voiced a need for more curiosity, open-mindedness, listening, and to be seen and treated as a human being first and foremost. Other service user stakeholders echoed this sentiment, describing experiences with providers as lacking compassion, defensive, and unwilling to acknowledge their own biases. Another stakeholder noted that many service users have a "fear of retribution" if they advocate for services and supports that they want. They described instances in which clinicians discounted their experiences, including one service user who described a hospital psychiatrist who dismissed a physical health concern that was later revealed to be a significant problem requiring extensive medical treatment. This service user described a powerful reaction of shame, anger, and feeling disrespected and overlooked; this experience was compounded because the doctor was white and the service user was a person of color, and they saw the doctor's reaction as one that was racially biased as well as biased because of their mental health diagnosis. One said that the message they seem to get is that the goal of treatment is to "fix myself" when their goal is to "accept myself." Other service users we spoke with echoed this theme, with one stating, "we are people first." Service users and advocates articulated a vision for a mental health system—and a county community—that engages with one another on a person-to-person level without attention to labels and assumptions about mental health conditions.

> Stakeholders articulated a desire for a system based on curiosity, open-mindedness, and listening—and one that emphasizes people's humanity rather than labels and assumptions.

Experiencing the System as Trauma-Informed

Although nearly all services and programs in the county describe themselves as "trauma-informed," multiple stakeholders at the provider and service user levels did not experience them as such. In interviews and community listening sessions, multiple stakeholders described personal experiences in which providers were perceived as lacking empathy and seemed more interested in focusing on mental

health symptoms than on experiences of trauma. This experienced emphasis on symptoms more than on one's past experiences and environment—a common theme in stakeholder feedback—runs counter to the "what happened to you vs. what is wrong with you" approach that underlies trauma-informed care.[66] One local expert in trauma said they would give an overall rating of 3 out of 10 in terms of the degree to which mental health services in the county are trauma-informed. Gaps include inadequate training on what trauma is and what trauma-informed work entails as well as ongoing coaching and support. Notably, there is currently an initiative to ensure all staff in the criminal justice system receive trauma training through the GAINS Center, and some provider agencies currently offer trainings on trauma-informed approaches.

In particular, crisis and emergency services were described as not trauma-informed by service user, family, and advocate stakeholders in interviews and community listening sessions. These include the emergency transportation, emergency rooms, and the Unity Center. Stakeholders described some emergency medical transportation and emergency department staff as lacking understanding of and empathy for mental health issues. Regarding the Unity Center, stakeholders described use of pepper spray and tasers, calling the police on patients, police carrying guns into Unity,[67] locking people in the waiting room while they wait to be evaluated, banning individuals from returning, limited supports for family members, and the use of seclusion and restraint. Multiple stakeholders also expressed dislike of the use of telepsychiatry services at Unity, stating that having to speak to a prescriber on a screen was unpleasant, particularly when in crisis. Notably, a majority of provider stakeholders and others endorsed Unity as a highly positive addition to the system, citing reduced pressure on first responders and local emergency rooms and increased capacity to address acute service needs. These perspectives are not necessarily contradictory but reflect differing viewpoints on system issues and priorities. They also may reflect the fact that the Unity Center is a relatively new addition to the county's mental health system; several stakeholders described that the Unity Center may have gotten off to a "rocky start," facing significant challenges due to its position within the system and the needs of the community.

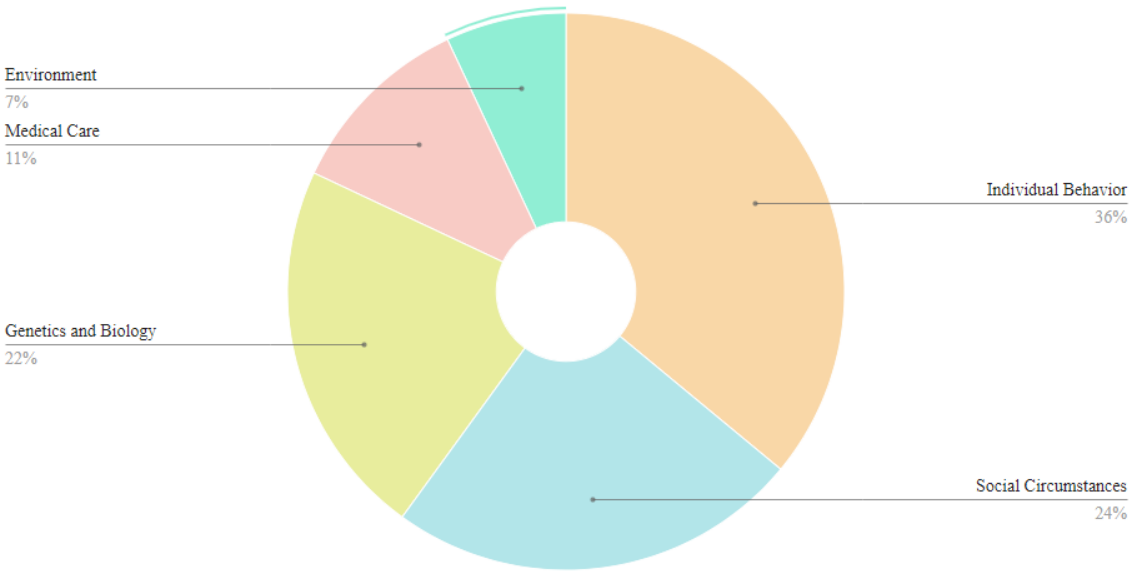
Peer Support, Peer-Run Organizations, and Other Psychiatric Rehabilitation Services

In interviews and community listening sessions, stakeholders described a need for expanded access to and capacity for community-based services that support the social determinants of health. These include peer support as well as psychiatric rehabilitation services such as supported employment and education, and other services that promote community inclusion and social connectedness. Stakeholders saw a need for services that support individuals to deal with the stresses of living in poverty, receiving public benefits, and experiencing housing and food insecurity and social isolation. They also voiced a need for more services that support service users to develop self-advocacy skills. These peer support and psychiatric rehabilitation services—along with housing support services—are key in supporting the social

determinants of health. Roughly 10% to 20% of health determinants—including mental health determinants—derive from medical care, while social, behavioral, and environmental factors account for the remaining 80% to 90% of health outcomes.[68,69,70] In interviews and community listening sessions, stakeholders emphasized that services that support social determinants of health should be expanded and more easily accessible across the county.

Figure 8

Clinical care accounts for only 11% of our overall health.



Source: GoInvo

In interviews and community listening sessions, stakeholders said that more psychiatric rehabilitation services are needed. Peer drop-in centers like Folk Time's center in Northeast Portland and clubhouses like Northstar were described as important community resources that could be promoted and expanded. The County also funds a peer-run supported employment center, which had an estimated 230 members in FY17, 38% of whom held paid employment positions during that year.[71] Dual Diagnosis Anonymous of Oregon coordinates a range of mutual support groups and provides peer support services to individuals with co-occurring mental health and substance use issues throughout the state, including in Multnomah County.[20] Stakeholders described these and other small community-based programs as having untapped potential, and they noted that additional resources would result in greater system capacity and effectiveness in supporting the social determinants of health.

According to its *Annual Medicaid Quality Report*, there were 122 peer specialists in the Medicaid specialty behavioral health network in 2016 (although this number could underrepresent the total number of peer specialists as some agencies do not submit claims for peer-delivered services), and the numbers of members receiving peer-delivered services have grown in recent years.[72] Peer supports are available in

[20] http://www.ddaoforegon.com/

many different interventions throughout the system, for adults as well as for children, youth, and families. For example, adult peer support services are incorporated into ACT, at the Unity Center and the CATC, and in homeless outreach services. Peer services for children, youth, and families are available through the NAMI Family Partners, the Oregon Family Support Network, Youth ERA, the Latino Network, and others. Locally as well as nationally, peer support is growing and evolving rapidly in mental health and substance use systems and other arenas, including criminal justice and public health.[73,74] Similarly, family peer support—which involves current or former caregivers of children with serious mental health conditions who work with other caregivers in systems navigation, advocacy, and the provision of emotional support—has evolved over recent years.[75] Stakeholders were almost universal in their enthusiastic endorsement of the benefits of peer support, particularly for engaging populations with complex needs, fostering hope for recovery, and countering harmful stereotypes about people with mental health conditions.

Many stakeholders voiced a need for an expansion of this important aspect of the system, especially for community-based services and for people who aren't engaged in specialty mental health services. Stakeholders from the peer support community described peer support as currently siloed and program-specific. Although peer support is incorporated into many existing programs, stakeholders said that low-barrier, self-referred, flexible, community-based peer support was particularly difficult to access and particularly needed. Stakeholders also saw a need for expanding peer support for substance use issues, and for more coordination and collaboration between peer support for mental health and for substance use issues. Stakeholders voiced a need for peer support to be accessible to individuals transitioning from the Oregon State Hospital through the state's Psychiatric Security Review Board (PSRB) program and through Peer Bridging services. Transition Projects operates its own peer support training program focused on individuals who have experienced mental health concerns, substance use disorders, homelessness, and who are veterans, and this program could serve as a resource for future expansion of peer support to reach populations currently underserved in the county.

Another related practice, community health workers, was endorsed by stakeholders as a practice that could be expanded and tailored to reach specific underserved populations. Community health workers are members of a particular community who provide flexible, non-clinical supports to other community members; they are also referred to as *promotores*, indigenous paraprofessionals, natural helpers, and community health representatives. A recent review of the research on community health worker–delivered interventions found that these services are effective in improving mental health outcomes and in addressing disparities for underserved populations.[76] In 2017, Health Share has made a $3.3 million investment in developing infrastructure for community health workers through the Oregon Community Health Worker Association (ORCHWA).[77]

In interviews and in community listening sessions, stakeholders with expertise in peer support observed that there remains ambiguity among many clinical providers and agency administrators about peer roles within the mental health system. They noted

that in some settings, peer support workers are expected to take on clinical roles that are out of sync with the principles and practice of peer support. Although some community-based agencies were seen as effectively incorporating peer roles and values,[21] others seemed to struggle with these issues. Stakeholders noted that peer support workers are often paid lower wages but expected to perform the same duties as social workers. Stakeholders described dynamics in which it was "easy to delegitimize peer support services," especially among providers who adhered to the medical model of mental illness. They also described power differentials and instances in which providers didn't seem to value and recognize the power of lived experience.

> In many agencies, peer support workers face a "glass ceiling," with few managerial or leadership positions to move into.

Stakeholders noted that peer support helps to counter harmful stereotypes and promote recovery in powerful ways. They stressed the importance of peer supervision to help peer specialists stay true to their values, provide training and professional development opportunities, and brainstorm solutions to doing peer support in "a system built on oppression." Stakeholders also noted that in many agencies, peer support workers face a "glass ceiling" for professional development, with few managerial or leadership positions for peers to move into. These challenges are not unique to Multnomah County and have been documented in recent research examining peer roles in community mental health organizations.[78] Such challenges can be mitigated by attention to recruitment and position descriptions/role clarity, adequate supervision and support, and flexible workplaces.

Stakeholders also voiced a need for more education for Health Share about the benefits and role of peer-delivered services. Notably, in 2016, Health Share conducted a region-wide assessment to support development of peer-delivered substance use recovery service that included consideration of peer support for individuals with co-occurring mental health and substance use disorders.[79]

Stakeholders said it would be useful to have a symposium to bring stakeholders together to create a shared vision of what peer support should look like. Some stakeholders described historic difficulties between the County and peer-run organizations that may have resulted in a reluctance to contract with peer-run organizations to provide services. They were concerned that the County may see peer-run organizations as high-risk and may subject these organizations to more scrutiny. There are also barriers to peer-run organizations participating in Medicaid related to billing requirements that are out-of-step with peer values and practices, although stakeholders described some state efforts to work with peer-run organizations to address these barriers.[80]

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[21] Stakeholders referenced Project Impact at OHSU and Central City Concern as being exemplars in this area.

There appears to be some movement toward private insurance reimbursement for peer support services. For example, beginning on January 1, 2018, Moda Health Plan, a large private insurance company in Multnomah County, began reimbursing peer support services. This could result in increased opportunities for the peer support workforce in the future that may positively impact the sustainability of peer-run organizations and scope of peer services across the county.

Support and Information for Families & Caregivers

Stakeholders described innovative resources to support families in navigating the system for their loved ones, including those available through NAMI Family Partners, which are available to families receiving the highest levels of care. Although these and other services appear to meet an important community need, many stakeholders identified a need for even more family support services. In interviews and community listening sessions, **family member and caregiver stakeholders described a lack of emotional support, education about mental health needs, or information** about how the system worked and **options for finding help for loved ones with unmet needs**.

Stakeholders also emphasized a need for better support for families and caregivers around information-sharing and education about mental health in general and navigating the system for/with a loved one. HIPAA and privacy regulations were identified as a barrier to supporting families and caregivers in this way, but several stakeholders also noted that HIPAA regulations can be misinterpreted by providers or used as an "excuse" to not engage with families and supportive others. They identified missed opportunities for fostering partnerships between family/caregivers, providers, and service users. One family described the process as one in which they "kept running into brick walls" when seeking support for a loved one. Another said that there must be a way for families to be supported to get help for a loved one "without going to court to take their rights away." Another described the heartbreak of "watching while [loved one] dies" and feeling unable to do anything about it. Other stakeholders described adversarial relationships with providers, who seemed reluctant to engage with them even when a release of information was in place and when they were invited to take part in the care planning process by the service user.

Services for Older Adults

Several stakeholders noted that mental health services designed specifically for older adults are limited, which is a growing concern given the aging of the population. In particular, stakeholders voiced a need for proactive services that support individuals to stay in their homes and address the significant social isolation that this population experiences. Stakeholders representing first responders

> Stakeholders voiced a need for proactive services that support older adults to stay in their homes and to address the significant social isolation this population experiences.

noted instances in which older adults experiencing isolation end up in the emergency room because of unmet mental health support needs. In-home services and supports seem to be particularly important for older adults because health problems and transportation challenges may make it difficult for them to attend office-based appointments. Another stakeholder noted that peer support for older adults is underutilized in Multnomah County and described programs in neighboring counties that offer peer support to older adults as effective in addressing the needs of this population.

The older adult service users we spoke with pointed out that many community-based mental health providers are multiple generations younger than they are, and that these age differences made it difficult to form a therapeutic relationship with these providers. Stakeholders also noted that many older adults are unaware of mental health resources that could benefit them. There may be a need to work with Aging and Disability Resource Centers and other organizations that serve older adults to ensure that there's awareness and promotion of mental health resources.

One stakeholder we interviewed is the coordinator for Aging Well, a Cascade AIDS Project initiative focused on understanding the needs of a specific sub-population of older adults – HIV/AIDS long-term survivors and other aging adults affected by the HIV epidemic. This includes aging adults who are both HIV-positive and HIV-negative. Many of these individuals lived through a period in the 1980s and 1990s in which hundreds of thousands of individuals with HIV/AIDS passed away. Many of those who survived experienced profound loss, and were subjected to experimental treatments with side effects that resulted in long-lasting physical and mental health problems. According to the preliminary observations of this stakeholder expert, the experiences of this population are characterized by prolonged exposure to complex trauma, unresolved grief, and social isolation, in addition to a host of ongoing medical concerns. These assertions are supported by a 2006 study of 1,000 older adults with HIV in New York City, which concluded that this population lacks support networks and will increasingly rely on costly care services for support as they age.[81] Hopefully the Cascade AIDS Project work, undertaken in collaboration with numerous community partners, will result in increased recognition of this population, an understanding of their unique needs, and a community response.

Mental Health and Intellectual and Developmental Disability Systems

Stakeholders described a "rift" between the intellectual and developmental disability (IDD) system and mental health system that results in those with both IDD and mental health needs being underserved. For example, one stakeholder described the juncture between the mental health and IDD systems as a "gray area" with many unavailable services. Stakeholders noted that because these systems are separate, some individuals with co-occurring mental health and IDD get passed back and forth between the systems without coordination of services. Residential supports for people with co-occurring mental health and IDD were identified as a gap. It was also noted

that it is common for individuals with an IDD diagnosis to be denied mental health services, and that an IDD diagnosis can disqualify a person from certain services, such as Dialectical Behavioral Therapy (DBT). Stakeholders described the rationale for these denials as that it is unclear whether a person with an IDD can benefit from them; however, provider stakeholders we spoke with felt that their judgments regarding potential benefits are not always properly considered. One stakeholder also noted that IDD case managers with knowledge of the mental health system have a "secret code" to navigate the utilization management review for the people they work with, compared to IDD case managers without this expertise.

Stakeholders also saw a need for more training and education among mental health providers and, critically, administrators and leadership—to better understand the mental health-related needs of people with IDD. They also saw opportunities for increasing peer support for individuals with IDD, which would involve demonstrating to Health Share and MHASD that this service is of potential value for individuals with IDD.

There appears to be positive movement within the Health Department to improve the system's capacity to support individuals with IDD and mental health needs. A newly established position at Multnomah County is tasked with serving as a liaison between the mental health and IDD systems, assisting IDD case managers to learn to navigate the mental health system for the individuals they work with. The Department of Community Human Services, Health Department, and MHASD have also formed a Multidisciplinary Team to identify individuals who are served across health, behavioral health, and IDD systems and strategize to better meet their needs.

Hiring and Retaining a Qualified, Competent Workforce

Stakeholders identified workforce shortages as a significant challenge across the system and saw workforce development and training as critical for improving the mental health system and achieving better population health.

> Stakeholders saw workforce recruitment, training, and development as critical for improving the mental health system and achieving better population health.

Stakeholders from community-based providers almost universally described challenges with workforce retention and recruitment as being an increasingly significant barrier to providing high-quality services. Stakeholders noted that low reimbursement rates result in low-wage jobs, particularly for the direct support workforce. Stakeholders said that because of the housing market, many individuals who staff mental health services can't afford to live in the county. According to one analysis using 2015 data from the Bureau of Labor statistics, 27% of community and social service positions in the Portland metro area had median hourly wages below the living wage for a family of four with two

working adults.[82] Stakeholders described a dynamic in which staff leave community-based agencies for positions at the County or other health plans and health systems that offer salaries that are higher than what community provider agencies are able to pay. Notably, these dynamics were identified in a recent market rate study by Health Share, prompting a series of recommendations related to correcting compensation gaps through a review of current reimbursement rates for key behavioral health services and development of a comprehensive workforce strategy.[83,84]

One clinician stakeholder we spoke with expressed a need for more leadership opportunities for community-based front-line clinicians to help them to stay engaged and excited about the work that they do and capitalize on their energy and commitment to the populations they served. Stakeholders also saw a need for more support for the physical and emotional wellbeing of service providers. Stakeholders identified shortages of prescribers, peer specialists, and experienced social workers. They noted that there are few loan repayment programs, and a limited number of psychiatry residency positions. Stakeholders noted that in particular, there are not enough providers willing to work with populations with complex needs, and that there are limited incentives (e.g. higher pay, enhanced benefits packages) to bring in additional providers to work with individuals with complex needs. Provider stakeholders we spoke with said that few clinicians – including front-line clinicians – have the training needed to work with people with complex needs. Many positions in specialty programs that work with those with the most complex needs do not pay adequately and lack strong supervision, resulting in high turnover.

Stakeholders emphasized that these dynamics ultimately result in limited capacity for providers to establish lasting therapeutic relationships with service users and high rates of turnover. The Tri-County Behavioral Health Providers Association reported that some of its members have turnover rates in the 40-60% range, which it characterized as unsustainable. Another stakeholder described a resulting dynamic in which the system is "subsidizing care on the backs of the lowest paid workers." Yet another noted that it is "offensive to the field and to the clients" that they are continuously working with the field's most inexperienced clinicians and having to tell their stories over and over again. This stakeholder pointed out that service users are aware of these dynamics and are resigned to "take the clinician they get," even when they know the person will be moving on quickly and may not have the competencies to meet their needs.

> Stakeholders envisioned a "more resilient system" where agencies care for their employees who in turn care for the people they work with.

Stakeholders envisioned a "more resilient system" in which mental health agencies care for their employees who in turn care for the people they work with. In the agency-employee relationship, this "care" takes the form of living wages, high-quality training, and reasonable workloads.

Integration of Physical and Behavioral Health Services

Importantly, many individuals with mental health service needs in the public system do not receive specialty mental health services. In 2017, Health Share conducted a review of the mental health needs of its 146,160 Medicaid enrollees in Multnomah County. They found that 17% (24,170 Medicaid enrollees) had a mental health diagnosis at least two times in the last three years. Less than one-third (28%) of these Medicaid enrollees (6,808 Medicaid enrollees with mental health issues) were enrolled with an agency providing specialty mental health services at the time of the review.[85] These data demonstrate that many individuals with mental health-related needs are not engaged with the specialty mental health system. They support recent efforts to focus on the capacity of the physical health care system to identify and address mental health-related needs of individuals who – for various reasons – do not access specialty mental health services.

> **Less than a third of people on Medicaid with mental health issues are engaged with the specialty mental health system.**

In the past two decades, efforts at integrating physical and behavioral health services have been complex and ongoing in Oregon and in the United States.[86] The rationale for integration is well-established, with clear evidence that unaddressed mental health and substance use problems are associated with poorer health outcomes and higher costs.[87,88] Despite this evidence, however, the promise of integration has yet to be realized across the country, even in states like Oregon that have implemented innovative population health strategies like CCOs. A national 2014 survey of 257 accountable care organizations (ACOs) – including Oregon's CCOs – found that full integration of behavioral and physical health care remains low; fewer than one-third of ACOs surveyed had behavioral health services integrated into physical health care settings, and only 14% reported complete or nearly complete integration.[89]

This section summarizes stakeholder-reported challenges about integration of physical and behavioral health services, specifically the integration of physical and mental health services. Funding and oversight mechanisms for integrated services within Medicaid are extremely complex; state, regional, and county stakeholders reported ongoing work to adequately finance and oversee services in integrated settings within fiscal restraints set at the federal level. Additionally, there was confusion among stakeholders about the distinction between the physical and specialty mental health systems, and which populations can and should receive mental health services in physical health care settings as opposed to specialty care.

Integrated Clinics in Multnomah County

Even before the formation of CCOs in 2012, there has been a strong emphasis on integration of physical and behavioral health services in Oregon and Multnomah County. Since 2008, Multnomah County health clinics have integrated services as part of their Patient-Centered Primary Care Home (PCPCH) designation under the state Oregon Health Authority.[22] To be considered a PCPCH, clinics are required to have a strategy for screening for mental health, substance use, and developmental issues, and a process referral to services that are identified through this process.[90] The PCPCH standards also include measures related to more in-depth integration activities such as mechanisms for co-management of services and fully-integrated co-located services. All of the Multnomah County Health Centers – including all Student Health Centers – meet these standards for PCPCH designation. After age 12, all individuals receiving services through Multnomah County Health Centers receive an annual depression screening and SBIRT (Screening, Brief Intervention, and Referral to Treatment) for substance use disorders, and all children under 4 are screened using the Ages and Stages Questionnaire.

SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) demonstration program is designed to promote integration of physical health, mental health, addiction, and prevention services into specialty behavioral health settings for individuals with significant mental health conditions and substance use problems.[23] In 2016, Oregon was one of eight states participating in this demonstration program, which is currently underway. Cascadia[24] and LifeWorks[25] operate CCBHCs in Multnomah County. These clinics provide a comprehensive range of services along with care coordination and are required to meet specific criteria for staffing, oversight, and quality improvement. Stakeholders described the local CCBHCs as being well-integrated with policies and staffing that appear to be effectively meeting both the behavioral and physical health care needs of the populations they serve. Stakeholders were also concerned about the sustainability of these clinics because they are supported through a time-limited federal initiative. In May 2018, SAMHSA released a Funding Opportunity Announcement to expand the program, signaling continued federal support for this model.[26]

Although there are multiple PCPCHs and CCBHCs throughout the county, stakeholders noted that these clinics are heterogeneous in terms of the level and type of integration activities incorporated and populations that are served. Limited information related to integrated services and how to access them may contribute to stakeholder perceptions that integration is not occurring in the county.

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[22] http://www.oregon.gov/oha/hpa/csi-pcpch
[23] https://www.samhsa.gov/section-223
[24] https://cascadiabhc.org/integrated-healthcare-2/ccbhc/
[25] https://www.lifeworksnw.org/what-we-do/certified-community-behavioral-health-clinics-ccbhc/
[26] https://www.samhsa.gov/grants/grant-announcements/sm-18-019

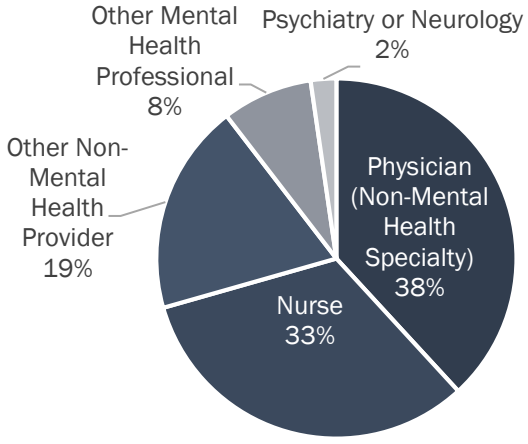
Mental Health Services in Physical Health Care Settings

In addition to the PCPCHs and CCBHCs noted above, local, regional, and state leadership has been engaging in efforts to promote broader coordination between physical and behavioral health services. At the financing level, Health Share and County Health Department (including MHASD) have been working to incorporate Alternative Payment Methodologies (APMs) across their networks. APMs can be used to reimburse health centers for total costs of care, including physical as well as behavioral health services, and coordination of those services.[91] At the service delivery level, MHASD participates in a joint strategic planning group with physical health care providers to support coordination between physical and behavioral health services within the county, including promoting broader use of mental health and substance use disorder screening in primary care settings.

According to the data, a significant number of Medicaid-funded individuals who have mild to moderate mental health issues receive their care in physical health service settings. In FY17, Health Share's physical health plans paid over $3.7 million in mental health outpatient claims for 11,829 individuals. Over 80% of these individuals received services in physical health care settings for anxiety, depression, or an adjustment disorder.[92] Approximately half of services were rendered by a primary care physician or other non-mental health specialist, approximately one-quarter were rendered by a nurse (including psychiatric nurses), while only 10% of services were delivered by mental health professional, psychiatrist, or neurologist (Figure 9).

Figure 9

Medicaid-funded outpatient mental health services delivered outside the specialty mental health system were predominantly delivered by physical health professionals, with mental health professionals delivering only about 10% of services (n=31,534 procedures)

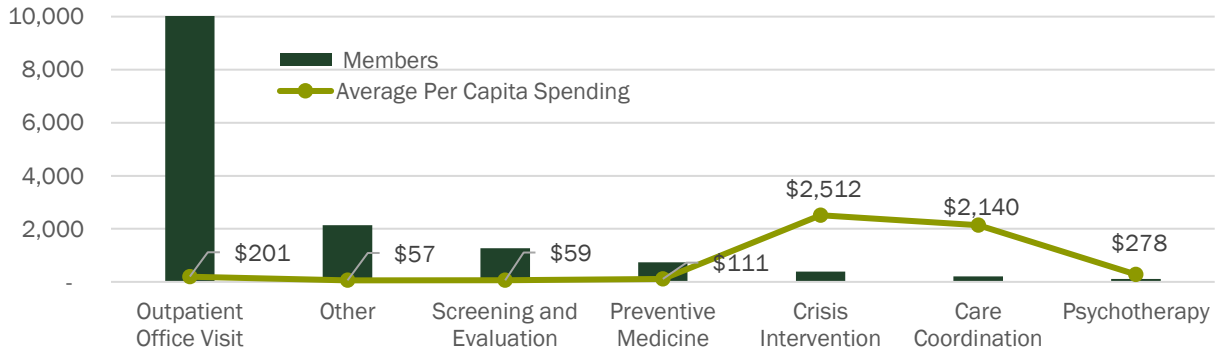


Source: Health Share mental health-related outpatient claims data, FY17

Figure 10 depicts the types of mental health services that were delivered to Health Share members through its physical health plans (outside of the specialty system managed by MHASD). Outpatient office visits were the most commonly delivered mental health service in outpatient primary health settings in Multnomah County, with over 10,000 individuals receiving this service in FY17. Outpatient office visits cost approximately $200 per person. A much smaller number of individuals received higher-cost crisis intervention and care coordination services (these services are different than the crisis and care coordination services offered through MHASD and specialty mental health services).

Figure 10

Most Health Share members received mental health outpatient office visit services



Source: Health Share mental health-related outpatient claims data, FY17.
Note "Crisis Intervention" services in this figure include only those paid by the Health Share physical health plan. They do not include County-managed mental health crisis services.

Although there are numerous initiatives related to integration of mental health services into physical health care, and although over 11,000 Medicaid-funded individuals received a mental health service in a physical health care setting in FY17, stakeholder interviewees representing the physical health care system and experts in physical and behavioral health integration noted challenges in accessing mental health services for Medicaid-funded individuals who have mild to moderate mental health issues who receive their care in physical health service settings.

Several stakeholders we interviewed said that FamilyCare, a CCO that recently closed, had policies that better-allowed for reimbursement for mental health care providers in physical health care settings. These stakeholders were concerned that Health Share's policies would not allow for similar reimbursement and would result in more limited access to behavioral health services in physical health care settings for individuals at 15 clinics that formerly offered Medicaid-reimbursed mental health provider services through FamilyCare. Stakeholders described a process in which, after they were transferred to Health Share, people with mental health service needs who were formerly FamilyCare members were required to receive an additional assessment and service approval through MHASD. Another stakeholder described an instance in which an individual was denied mental health services at a physical health care clinic and told to seek services at MHASD, only to be assessed and told that they

were not eligible for specialty mental health services. These stakeholders expressed concern that former FamilyCare members will no longer be able to receive mental health services in physical health care settings and/or will have disrupted continuity of services. They described the process as frustrating and likely to result in individuals eschewing care altogether. Stakeholders were concerned that this dynamic will result in unmet needs for a significant proportion of the Medicaid population, including missed opportunities to address mild and moderate mental health concerns before they rise to the level of serious concerns and/or mental health crisis. They also noted that this more limited access to mental health supports results in the burden of care falling back onto primary care physicians who are already overextended.

Stakeholders with expertise in physical health systems said that the physical health care system in Multnomah County has the capacity to treat mild and moderate mental health issues within physical health care settings in an integrated manner. Moreover, these stakeholders stressed that many individuals would prefer to receive their mental health services where they receive their physical health care. Stakeholders noted that many Medicaid members with mild to moderate issues do not want to access services through the specialty mental health system, which they see as being for individuals with serious mental health conditions. They emphasized that people want to be able to choose where they receive their mental health services and were concerned that existing policy and practice limits that choice. Notably, stakeholder interviewees representing leadership at the County were in agreement that individual choice in service setting is important.

From a health equity lens, recent research suggests that integrated models of mental health services (that is, models that involve colocation of physical and mental health services and collaborative care models in physical health care settings) are most effective in improving mental health outcomes for racial and ethnic minorities and reducing disparities in the initiation of mental health treatment.[93] Receiving mental health services in physical health care settings is thought to reduce barriers to access through practical convenience and privacy, which is particularly important for individuals who may refrain from seeking services because of culturally-based stigma about mental health problems and services.

Stakeholder Concerns about the Organization of Current Systems

> "In this multilayered and complex system, there is no single entity accountable for the wellbeing of the whole population and overseeing the 'big picture'."

During interviews, stakeholders attributed many systemic challenges to the organization of the health and behavioral health systems in Oregon and the state-designated roles of counties and CCOs in the delivery and administration of health and social services. They described the system itself as "convoluted," and characterized by "role confusion." Stakeholders noted that in this multilayered and complex system, there is no single entity accountable for the wellbeing of the whole population (or even of the Medicaid-funded population), and that there doesn't seem to be any single entity overseeing the "big picture."

> The promise of integrating physical, behavioral, and dental health care under the CCO model was described by one stakeholder as a "brilliant idea that hasn't been realized."

The promise of integrating physical, behavioral, and dental health care under the CCO model was described by one stakeholder as a "brilliant idea that hasn't been realized." As noted in the section on *Organization of the Publicly Funded Mental Health System in Multnomah County*, CCOs were formed based on the rationale that having a single regional payer across the physical health, behavioral health, and dental sectors will better support the full spectrum of population needs through integrated data systems, improved coordination, and facilitated access.[94]

Among many stakeholders, there seemed to be confusion about what entities bear risk for what populations, with many stakeholders expressing frustrations about disconnects and inconsistencies in the current arrangements. As the risk accepting entities (RAEs) orchestrating all Medicaid-funded health services in a geographical area, CCOs were created to bear responsibility for the service quality and cost and health outcomes of the entire Medicaid population. In the case of Multnomah County, Health Share physical health plans are the RAEs for the physical health of Medicaid members in Multnomah, Washington, and Clackamas Counties. At present, however, MHASD has the central role in the administration of specialty mental health and substance use disorder services and acts as the RAE for the behavioral health portion of the Medicaid benefit for Multnomah County residents. MHASD's role as RAE for Health Share was explored in detail in a 2014 *Consultation on Managed Care and Local Mental Health Authority Roles*, conducted by the Technical Assistance Collaboration and University of Massachusetts Center for Health Law and Economics for MHASD.[95]

In theory, the RAE assumes financial risk for the whole person, including their physical, dental, and behavioral health needs as well as their social determinants of health. Multiple stakeholders said that in practice, the current model – in which MHASD is the RAE for behavioral health and Health Share physical health plans are the RAEs for physical health – has perpetuated a bifurcated system rather than an integrated one. They emphasized this bifurcation of the Medicaid-funded system as a key barrier to integration – and to population health. As one stakeholder put it, keeping the administration of mental health and physical health separate in this way perpetuates the false idea that mental health and physical health are separate concepts.

> Separating the administration of mental health and physical health perpetuates the false idea that mental health and physical health are separate concepts.

Several stakeholders with years of experience in the system noted that there hasn't been a significant difference in the system integration since the CCOs have been formed because behavioral health remains carved out and managed by the County. Stakeholders also expressed concern that under current arrangements, there are insufficient incentives for a single entity to take responsibility for the long-term health of populations across the region. In particular, stakeholders noted that Health Share and MHASD have not sufficiently focused on the social determinants of health, particularly in regard to addressing housing, employment, and social service needs alongside behavioral and physical health needs.

Stakeholders noted that the development of the CCO model has resulted in yet another layer of administration that complicates rather than simplifies. Multiple stakeholders pointed out that the additional layer of administration also represents additional cost, using resources that presumably could be used to enhance services in a more streamlined system.

Numerous stakeholders described a series of dynamics, many of which originated at the state level, that have led to the system's current structure. These include turnover at the highest levels of leadership at the state, state budget shortfalls, and rapid creation of CCO structures that were codified quickly without enough consideration of the policy implications of these arrangements. Stakeholders said that the current CCO structure is not properly defined, was not properly developed, and hinges on being incentivized through the collection of a series of process and outcomes metrics that have not materialized. We spoke with multiple stakeholders who were involved in the state's Behavioral Health Collaborative work.[27] The Behavioral Health Collaborative, convened by the OHA in 2016 and 2017, was composed of state and local stakeholders who were tasked with recommending state-level system changes to improve behavioral and physical health systems. Several of these stakeholders expressed frustration with the process and with the resulting recommendations,[96] which they

[27] https://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Behavioral-Health-Collaborative.aspx

saw as unspecific and difficult to realistically implement. Stakeholders described some of the Behavioral Health Collaborative report's recommendations as creating yet another layer of administration that is unlikely to result in meaningful change.

Turnover of behavioral health leadership and state-level reorganization and changes appear to have contributed to the perspective of stakeholders who stated that there has been limited leadership at the state level for behavioral health in the past. Many stakeholders expressed hope that new leadership at the OHA will be more effective at and interested in promoting behavioral health at the State level, and that there will be more collaboration and coordination between counties and states in the future. As new CCO contracts are developed in the coming year as part of the "CCO 2.0" effort,[28] there was some optimism that the state may move to address some of the issues associated with integration of physical and behavioral health and other issues discussed in this analysis.

Additional Stakeholder Perceptions of State and County Systems

In addition to commonly-identified challenges related to the CCO structure, stakeholders reflected on a number of other state and county-level policies and practices that impact the performance of the publicly funded mental health system.

Advocacy and Lived Experience Representation at the County

There are multiple long-standing and active advocacy organizations within Multnomah County, and national leaders in the consumer/survivor/ex-patient movement call Multnomah County home. In addition to grassroots organizations, the Adult Mental Health and Substance Abuse Advisory Committee (AMHSAAC), meets monthly and is composed of majority service users and family members. The AMHSAAC is designed to provide guidance to MHASD, which reported that its recommendations have resulted in system improvements, such as the formation of the MHASD Office of Consumer Engagement. The System of Care Collaborative (SOCC), composed of youth, family members, mental health providers, and others, is the advisory body that focuses on the system of care for children and families.

Advocates we spoke with described mental health advocacy in the county as "something that waxes and wanes," "disjointed," "wheel-spinning," "splintered," and having room to grow. While some stakeholders endorsed the AMHSAAC as an opportunity to provide feedback to MHASD, others described it as lacking focus and having limited impact on policy and practice. Several stakeholders said more coordinated advocacy efforts would benefit the community and expressed optimism for opportunities for future growth. Others noted that different advocacy organizations do not seem to know about each other, even those that share common ground and perspectives. Stakeholders also saw a need for more tools for advocates to become acquainted with the complex system to better identify levers for change. In

[28] http://www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx

addition to discussing the local advocacy community, several advocate stakeholders referenced a vibrant and fairly well-organized statewide advocacy community. Advocate stakeholders who represented the child and youth system voiced a need for getting the "right families with skills" to participate on boards and committees, to ensure equitable representation, and to also be effective. They saw a need to support people to develop advocacy skills and overcome barriers related to language, transportation, and childcare.

> "From living in this system, I would say the most pressing issue is that the system programs are designed by people who don't have lived experiences."

Several advocate stakeholders we spoke with expressed frustration and resignation that past efforts to engage with the County on meaningful system change have been – in their view – fruitless. Multiple stakeholders noted that the County lacked individuals with lived experience of the mental health system, particularly at top levels of leadership. For example, one individual expressed the following in a community listening session: *"From living in this system, I would say the most pressing issue is that the system programs are designed by people who don't have lived experiences."* Similarly, an advocate stakeholder interviewee emphasized that until people with lived experience are represented at leadership levels, the system will remain unchanged.

An emerging literature documents the importance of lived experience leadership within mental health systems.[97,98] Best practice is that leadership is not limited to gathering service user experience information, but rather having a seat at the table with other senior leaders and impacting policy, management, planning, education, program development, quality initiatives, and evaluation.[99] In February 2018, the Oregon Consumer Advisory Council outlined a rationale for the creation of a peer delivered services coordinator for each CCO and county and noted that Clackamas County serves as an example of a jurisdiction in the state that has effectively expanded peer services under the guidance of a peer leadership position.[100]

Currently, MHASD operates an Office of Consumer Engagement, which is tasked with supporting "the expansion, coordination and quality of peer services in Multnomah County."[101] Several stakeholders we interviewed expressed concern that there is no Director position in the OCE (OCE staff are supervised by a peer supervisor from a contracted agency as well as a member of the MHASD leadership team). The County provided a rationale for this arrangement based on "best practice" for peer supervision and noted that this office continues to develop.

Provider Collaboration and Competition

Provider stakeholders—representing many of the largest provider agencies in Multnomah County—criticized the County's contracting process as creating an unhelpful sense of competition among large provider organizations in the community. While some pointed out that some level of competition can support high-quality services, others expressed concern that the current dynamics contribute to service gaps and inhibit meaningful system transformation. They described the contracting process as "piecemeal," with MHASD issuing RFPs for specific services without a clearly articulated vision for how the services reflect an overarching vision for meeting community need. While provider organizations have shared goals and mutual respect, they operate as self-described "frenemies" who were "stuck in vendor relationships" rather than true collaborators because they are continuously competing with one another for service contracts. They noted that these competitive dynamics are heightened because there are scarce resources system-wide.

> While provider organizations have shared goals and mutual respect, they operate as self-described 'frenemies' "stuck in vendor relationships."

Stakeholders also reflected that the contracting process contributes to a system that is experienced as siloed and disjointed. At present, the service array is viewed by stakeholders as one that lacks logic and guiding principles; for example, one person noted that it is difficult to understand what it is that different agencies do, and that there is a proliferation of duplication as well as gaps throughout the system. Many stakeholders voiced a need for a more coordinated approach. One stakeholder noted that while different entities in the county have shared goals, they are working separately from one another. That said, stakeholders noted (and we observed) that there's no shortage of work groups and task forces in the county and in the state, and stakeholders from County departments described a wealth of initiatives aimed at increasing intra-agency collaboration. One stakeholder with decades of experience as a service provider observed that these task forces "have activity but no vision."

Stakeholders from provider organizations envisioned a system in which there was more communication and bridges between organizations, which they believed could be achieved without necessarily increasing funding. Stakeholders saw a need for a system in which providers came together with County leadership to articulate a shared vision and divide up responsibility for meeting different community needs based on organizational capacity and interest rather than engaging in a competitive RFP process for specific services. They urged that contracting be developed based on agency areas of expertise, which would reduce a sense of competition to "do everything." This business model would be based on "partnership" rather than on competition and would allow for more targeted use of resources. Stakeholders—including provider stakeholders—envisioned a system in which contracts were awarded and renewed based on demonstrated impact on person-centered outcomes such as quality of life.

Toward an Outcomes-Driven System

Some stakeholders at the County described the system as "data-driven," but other stakeholders expressed doubt that the state, regional, and local data practices were truly driving system improvements that result in better service user outcomes and experience. Regarding the use of performance metrics, stakeholders expressed concern that County leadership gets "lost in the weeds," overly focused on process and not sufficiently focused on outcomes. Stakeholders saw a need for a standard set of measures reported by all providers that reflect person-level outcomes, not just processes and systems-level factors. These stakeholders saw a need for metrics that accounted for social determinants of health, including housing stability, employment, and education.[102]

There are numerous challenges to realizing the vision of a data-driven system articulated by stakeholders. In general, behavioral health-related metrics – particularly outcome metrics, are under-developed compared to physical health measures, which is a nationwide issue being addressed on multiple local, state, and federal fronts.[103,104] Further, different funders and entities require collection and reporting of different metrics, and data collection and reporting requires significant staff time, which can be challenging to support when resources are limited. Stakeholders from Health Share and MHASD said that they are working to expand outcomes measurement efforts, including improving the system's capacity to monitor and track collection of the ACORN (A Collaborative Outcomes Resource Network) tool, which has been used in the tri-county area to track and monitor outcomes since 2009.

> **Stakeholders view the service array as lacking logic and guiding principles.**
>
> **Stakeholders envision a system based on providers interacting as partners rather than as competition, allowing for more targeted use of resources.**

Medicaid Utilization Review Practices

Utilization review is the process an insurer uses to determine the appropriateness of recommended treatment. As the Behavioral Health Plan for Health Share, MHASD uses the level of care system in their utilization review processes for Medicaid-funded individuals.[105] Providers typically make level of care determinations for outpatient services delivered in levels A through C, and intensive community-based services in Level D require prior authorization from MHASD. Utilization review guidelines state that "medically appropriate services are those services which are required for prevention, diagnosis or treatment of physical, substance use or mental disorders and which are appropriate and consistent with the diagnosis", and further state "the determination of medical necessity must be made on an individual basis and must consider the functional capacity of the individual."[106]

Several provider stakeholders we interviewed said that the regional utilization review processes were overly stringent in their interpretation of utilization review guidelines. They cited frequent conflicts between clinical recommendations and care managers overseeing utilization review regarding what constitutes a "medically necessary" service, particularly for Level D services. These stakeholders reported that services that could support someone from experiencing a severe crisis if instituted early are often denied.

These providers noted that repeated service denials have destabilized programs and have, for some stakeholders, resulted in a lack of trust between providers and the County. These stakeholders described a need for "trauma-informed" leadership and administration when discussing utilization review and related practices, with one person noting that the County should extend its stated commitment to trauma-informed care to its administrative processes and dealings with the provider community. One provider stakeholder noted that relationships with the County around utilization review are getting better, and another stakeholder noted that the Exceptional Needs Care Coordination team, which provides specialized case management to coordinate services for individuals with complex needs and multiple system involvement, was helpful but lacked capacity at only three staff.

We spoke with providers that do not currently contract with Health Share because of low rates and stringent utilization review practices. With the departure of FamilyCare, these providers—all of whom serve children and youth with complex needs—were in a state of uncertainty about their solvency in the coming years. One provider in this situation said that they will likely need to transition many of their services that were once more flexible and community-based to an office-based model due to Health Share's lower rates of reimbursement.

Next Steps and Future Directions

HSRI applauds the tireless efforts of Multnomah County's mental health stakeholders to support the wellbeing of Multnomah County residents. We have been continuously impressed by this community's passion, knowledge, and skills. This section outlines recommended next steps and future directions to build on these assets to further improve the mental health system.

The recommendations offered here have been crafted in recognition of the complexity of the system, the variety of entities and stakeholders needed to effect change, the breadth and depth of strengths and challenges, and the ongoing work that is already underway in Multnomah County and the state of Oregon. Specifically, we are aware that:

- Many mental health system improvement efforts are already underway. We have attempted to align and frame these recommendations in light of existing initiatives. But given the amount of action across the county and state, we have likely missed a few.
- Some of these recommendations are not new. They are, however, grounded in our analytic process and reflect the current views of the stakeholders we engaged with. Readers may find it helpful to consider them in the context of other recent state and local assessments that have resulted in their own recommendations (for a summary, see Appendix C).

- To implement these recommendations will require coordinated action between departments and systems within the county and with state entities like the Oregon Health Authority. Successful implementation of some of these recommendations may also hinge on state and federal factors that are outside of the control of county stakeholders.
- These recommendations are highly interrelated. In many cases, work in one area will support progress in other areas. In other cases, resource limitations may require that leadership make tradeoffs about areas of focus. While we offer a suggested priority for these recommendations, it is likely that leadership will need to establish a process for refining and prioritizing system change efforts.
- These recommendations are not exhaustive. The findings offered here are based on this specific analysis and its limited scope. The recommendations here are meant to form the basis of future work. Any future action should be taken in alignment with and consideration of ongoing and existing initiatives in other systems, including local and state initiatives related to integration, Medicaid reform, health equity, the criminal justice system, and child welfare.

The next steps laid out in this section are meant to serve as guideposts for future action. Critically, this is the beginning of process, not the end.

Priority Recommendations

We offer the following three recommendations as having particularly high priority based on this analysis.

1. Engage in ongoing dialogue with service users and their families and other stakeholders to ensure a shared and actionable vision for the mental health system.

Our stakeholder engagement process reflected widespread views that Multnomah County lacks a vision – shared across all major system stakeholders – that can be translated into action. It also highlighted disconnects between system aims and service user experience.

1.1 Identify factors that contribute to the information gap between available resources and community awareness of those resources.

1.2 Work with local, regional, and state stakeholders—including the OHA, Health Share, and service users and providers—to identify and adopt a set of common metrics that align with this shared vision to support a system driven by person-centered outcomes including health and wellbeing and quality of life.

1.3 Develop a process for ensuring all services are experienced as trauma-informed, drawing from national best practice in trauma-informed approaches.

1.4 Convene provider agencies to assess their unique strengths and map current programs and service offerings. Develop a strategy to align agency strengths and

organizational capacity with community need to maximize resources and reduce duplication. Consider adopting an alternative business model for contracting services based on a shared vision for a mental health system that capitalizes on unique strengths and expertise of local providers.

2. Establish a director-level lived experience leadership position.

Based on stakeholder interviews and best practice for state and county mental health systems around the country, Multnomah County would benefit from having a person who represents the perspective of lived experience as a user of publicly funded mental health services at a leadership level. This position might be Director of the Office of Consumer Engagement at MHASD. Establishing a county-level leadership position demonstrates a fundamental belief in the power of personal experience in effecting change and would be one concrete step the current leadership could take to address stakeholder concerns about its commitment to a person-centered system.

2.1 Responsibilities could involve:

- Spearheading efforts to adopt a shared vision and enhancements to peer support services, including aligning local efforts with state and national best practice
- Working with advisory bodies and councils to craft recommendations and set priorities that can be translated to action
- Collaborating with local advocacy groups (including groups representing children, youth, and families and substance use recovery groups) to promote greater cohesion and identify shared goals and common ground
- Ensuring local advocates have needed tools to understand the complex system and identify levers for change
- Promoting positive relationships between the advocacy community, provider agencies, and County administrators
- Identifying and promoting additional opportunities for increasing the lived experience voice throughout the mental health system
- Liaising with other systems (housing, criminal justice, child welfare, education, and others) to support them to incorporate lived experience perspectives in their efforts

2.2 In the spirit of integration, work with Health Share to explore establishing a similar leadership position, or arrange for peer leadership within MHASD to work closely with Health Share on issues that impact individuals receiving mental health services in physical health care settings.

3. Integrate and analyze data on funding and services to support system improvements.

Conduct future analyses to better understand how funding flows through the mental health system and related systems, identify opportunities for expanding capacity, provide clarity for stakeholders, and otherwise inform system planning and improvements.

3.1 Develop a process for streamlining existing data across mental health and related systems to allow for rapid access, querying, and visualization of information about services, programs, funding streams, and capacity.

3.2 Conduct a comprehensive assessment of data and services across the county to identify service and financing gaps and areas of potential duplication and inefficiency.

3.3 On an ongoing basis, visualize data, generate simple reports, and respond to queries as needed to ensure all stakeholders have a common understanding of complex systems that influence population health in the region.

3.4 Consider adopting a universal measure of social determinants of health for all individuals receiving publicly funded services to better understand population needs and functional outcomes.

Continuation and Enhancement of Existing Efforts

The Oregon Health Authority is currently embarking on "CCO 2.0," representing an opportunity for county and regional stakeholders to advocate for and support service system reforms in multiple areas. The *Behavioral Health Draft Work Plan* of the Oregon Health Policy Board includes consideration of many of the issues discussed in this analysis, including integration, financing, care coordination, workforce issues, evidence-based practice, cultural best practice, and children's behavioral health issues including meeting the needs of children in foster care.[107] Stakeholders at the local and state levels appear to be in agreement that the goals of system reforms should be to maintain the positive gains from past efforts while addressing continued issues such as physical and behavioral health integration, health equity, supporting the social determinants of health, and outcomes-driven quality improvement.

The following recommendations are offered with the full recognition that local, regional, and state stakeholders are already working to address these issues. In some cases, these recommendations offer encouragement to continue or expand existing efforts. In others, they point out additional areas of focus or strategies that might be incorporated into existing efforts.

Access Barriers

1. Review the physical accessibility of mental health services in the county to ensure individuals with physical disabilities and other physical limitations have access to the same range of services as those without physical limitations.

2. Explore options for enhancing the capacity of services that support individuals who are uninsured or who have limited insurance, including the Multnomah Treatment Fund, Culturally Specific Services, and others.
3. Examine access barriers for people on Medicare and work with local, state, and federal entities to reduce them.

Data Sharing

1. Continue to expand EDIE and PreManage to improve data sharing throughout emergency and community mental health settings, and explore expanding these initiatives to justice, housing, child welfare, and education systems.
2. Explore ways to close the loop of data sharing with first responders and other justice system stakeholders so they are well-equipped to respond to needs in real-time.
3. Explore whether and how proven locally developed and provider-specific data practices can be scaled out to improve the mental health system as a whole.
4. Include service users (and families, caregivers, and supportive others when appropriate and desired by the person) in data sharing processes whenever possible so they can be active members in their care by incorporating supported decision-making approaches and person-centered technologies.

Services for Children and Youth

1. Work collaboratively with the state to address policy barriers to service access for children, youth, and families (including efforts encompassed by the CCO 2.0 initiative).
2. Continue to expand access to school-based mental health services.
3. Assess capacity and access to services for transition-age youth to ensure existing resources are fully utilized and adequate to meet community need.
4. Expand crisis options and access to intensive in-home services for children, youth, and families.
5. Work with Health Share to ensure children, youth, and families who were previously members of FamilyCare do not experience discontinuity of services or reduced access to mental health services.
6. Continue and capitalize on local, state, and federal initiatives to improve services for children and youth involved in the child welfare and criminal justice systems.

Services for Persons with Complex Needs

1. Continue efforts to expand access to Assertive Community Treatment, particularly for individuals who do not have Medicaid.
2. Continue efforts to expand access to Dialectical Behavioral Therapy.

3. Identify populations in need of service navigation support and match them with services that are appropriate based on their unique needs and cultural preferences. Interventions should include community health workers, peer support, case management.

4. Review the current outpatient service array to identify opportunities to move from an appointment-based model to a more flexible community-based model more responsive to people with complex needs. This may include offering services outside of the business day and in community settings as well as incorporating more flexible policies related to discharge for no-shows and problematic behaviors.

5. Expand and enhance awareness and availability of walk-in services available through health clinics and peer-run agencies for persons with complex needs who are not engaged with the mental health system.

Co-Occurring Mental Health and Substance Use Services

1. Create a comprehensive plan for co-occurring mental health and substance use issues. This plan must align with related efforts around workforce development, physical and behavioral health integration, health equity, and evidence-based practice. It should include a consideration of the full continuum of community-based services, from preventive services and peer support to intensive services.

2. Examine the current capacity for co-occurring services for youth along the service continuum, systematically identifying gaps and strategies to fill those gaps.

3. Convene stakeholders to create strategies to reduce policy barriers related to the timing of and access to detoxification and other mental health services.

4. Align with workforce development efforts to ensure staff in mental health and substance use disorder treatment settings have the training and qualifications needed to support people with co-occurring issues.

5. Align with physical and behavioral health integration efforts and explore strategies for identification, early intervention, and treatment of co-occurring issues in physical health care settings.

6. Work with the OHA to identify strategies to overcome policy barriers related to disparate funding streams for substance use and mental health treatment services.

Homeless Services

1. Continue to join in efforts to increase housing affordability in the county (for service users as well as for mental health professionals).

2. Support housing systems in aligning requirements and regulations of different funding sources to reduce inefficiencies and work creatively to maximize limited resources.

3. Continue to enhance mental health-specific housing support services in coordination with housing systems. These should include access to flexible supports and peer services in short-term housing.
4. Consider expansion of the Street Outreach Team.
5. Continue to support Coordinated Access and related initiatives.
6. Coordinate with housing systems to better-align service intensity and level of need throughout the housing service continuum, with a focus on ensuring adequate capacity and incentives to support individuals with the most intensive needs in the community.

Services for Justice-Involved Persons

1. Continue to support and align efforts between mental health service providers and the criminal justice system across each intercept to ensure individuals with mental health-related needs are diverted from the justice system to services and supports in the community.
2. Continue efforts to reduce the numbers of individuals on Aid and Assist orders at Oregon State Hospital.
3. Ensure training and staff competency throughout the justice system that includes trauma-informed approaches and mental health recovery.

Peer Respite

1. In response to current efforts of state and local advocates, establish a peer respite informed by best practice in governance, peer support, and connections with the broader system.
2. Work with state and local partners (OHA, Health Share, MHASD) to identify sustainable funding sources for peer respite, including Medicaid. Work to identify strategies to ensure Medicaid funding in a way that aligns with the values of the peer respite model.
3. Work collaboratively with current crisis service providers and first responders to articulate a vision for how the peer respite complements the existing system and ensure that its policy and practice are in alignment with county-wide goals and initiatives.

Community Transitions and Crisis Follow-Up

1. Assess current capacity of programs that support individuals to transition to the community from acute and inpatient settings to identify gaps, particularly regarding establishing connection to long-term community-based services.
2. Work with the state to expand Peer Bridger services and other peer support services for individuals returning to the community from Oregon State Hospital, including individuals in the Psychiatric Security Review Board program.

3. Work with current providers of transition services to ensure service user preference and choice are maximized during community transitions.

Health Equity and Cultural Competence

1. Continue to use quantitative (e.g., penetration rates, provider race and ethnicity) and qualitative data (e.g., community feedback, engagement with cultural representatives) in ongoing efforts to enhance the cultural responsiveness of the system.
2. Collaborate with state and local partners to increase funding for culturally specific services, particularly services for children and youth, intensive services for adults, outreach and engagement initiatives, and peer support.
3. Partner with the state and Health Share to use (or increase the use of) community health workers to perform culturally specific mental health outreach and support.

Peer Support and Psychiatric Rehabilitation Services

1. Support the financial sustainability of peer-run organizations through a variety of funding streams, including public dollars, private and philanthropic investments, and other revenues. This should include partnering with peer-run organizations and other local providers to use local data to articulate a business case for investment.
2. Work with the state, other funders (e.g., public and private foundations), and local partners (Health Share, private insurers, and other County offices and departments) to identify additional funding for these services to expand capacity and ensure they are operating to fidelity.
3. Create a strategy to increase public awareness of existing drop-in and self-refer peer services and psychiatric rehabilitation services, and to identify and address policy or programmatic barriers to access.
4. Support current local and statewide efforts to strengthen the peer support workforce through proven strategies including ensuring adequate support, supervision, and flexibility for peer workers. These efforts should be informed by the literature on national and international best practice.[108,109]
5. Reduce ambiguity around peer roles within the system through training to ensure providers and administrators have adequate understanding of the peer role. Efforts should build on best practice, including consideration of local programs that are successfully incorporating peer roles. As peer roles are further incorporated into the system, providers and administrators will have increased understanding through working alongside people with lived experience, which has been shown to be the most effective means of education about peer support.[110]
6. Work with provider communities to expand professional development for peer support workers. Enhancing professional development includes promoting a "career ladder" with managerial and leadership positions that involve lived

experience within agencies and entities throughout the county. Professional development also includes trainings, conferences, and other formal and informal leadership opportunities.

Supports for Caregivers and Families of Adults with Mental Health Needs

1. Partner with advocacy groups, providers, and other system stakeholders to identify and address systemic barriers to supporting and informing families and caregivers of adult service users so they can be engaged as active partners whenever possible and appropriate.
2. Work with the provider community to identify and implement best practice for communicating with family members and caregivers in a supportive and compassionate way, whether a release of information is present (in compliance with HIPAA).
3. Establish strategies to ensure that families and caregivers understand their rights and are aware of available community resources when a loved one is struggling with a mental health problem.

Services for Older Adults

1. Create a plan to address the needs of the growing population of older adults with mental health service needs through expanded access to community support services, including in-home supports and peer support. The plan should include a consideration of the high-need cohort of older adults living with or affected by HIV, which is being examined through Aging Well, a Cascade AIDS Project initiative.
2. Create a strategy to ensure that older adults experiencing social isolation are aware of local mental health resources, in partnership with Aging and Disability Resource centers and other organizations that serve older adults.

Collaboration with the Intellectual and Developmental Disabilities System

1. Continue existing efforts to ensure that all IDD case managers have a good understanding of the mental health system and how to access mental health services.
2. Review current capacity for residential supports for people with IDD and mental health needs.
3. Offer training for mental health providers and administrators to better understand the mental health–related needs of people with IDD.
4. Explore other options for filling gaps or “gray areas” between mental health and IDD systems.

5. Work with Health Share and the state to expand peer support for persons with co-occurring mental health and IDD.

Workforce Recruitment and Retention

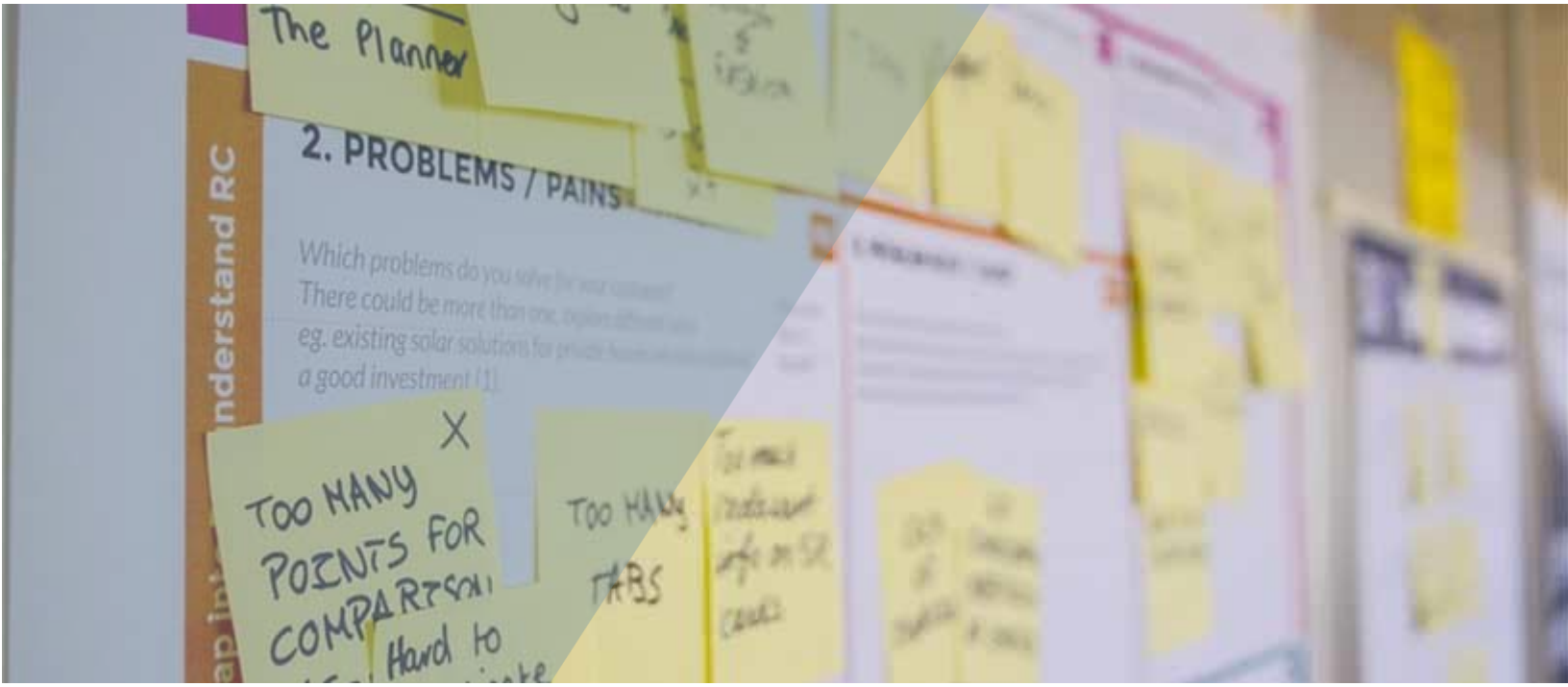
1. Continue to support Health Share to correct compensation gaps through a review of reimbursement rates.
2. Explore strategies to attract and retain qualified providers to work in community-based mental health settings. Strategies must include addressing the wage gap but may also involve offering more leadership opportunities for clinicians within community-based settings, enhancing loan repayment programs, and offering other incentives.
3. Ensure that front-line providers have the necessary training, qualifications, supervision, and support to engage and support individuals with complex needs.
4. Work with local training programs, colleges, and universities to increase training slots for providers in identified shortage areas such as prescribers, peer specialists, and providers who work with children and youth.
5. Engage in efforts to better-track the race and ethnicity of mental health providers across the system and use these data to drive targeted recruitment strategies to recruit and retain providers who reflect the racial, ethnic, and cultural diversity of the service user populations in Multnomah County.
6. Continue working with the HSO to identify providers who can offer services in languages other than English and use data on current capacity to target resources to meet gaps in providing linguistically competent mental health services.
7. Expand efforts to ensure connection to benefits and entitlements, particularly for individuals who are justice-involved and those with unstable housing.

Physical and Behavioral Health Integration

1. Engage with the State through the "CCO 2.0" process to explore alternative arrangements for organizing behavioral health services that better support integration.
2. Continue the collaboration between the OHA, Health Share, and Multnomah County to align provider and payer incentives, expand co-located physical and behavioral health services, and streamline documentation requirements to truly support integrated care.
3. Work with Health Share, providers, and other stakeholders to test and implement policies related to determining when to support individuals in physical health systems versus in the specialty mental health system, with an emphasis on service user choice.

4. Ensure continued integration in PCPCHs and CCBHCs and engage in efforts to expand these models so more individuals in Multnomah County have access to integrated services.
5. Enhance culturally specific integrated services, including culturally specific mental health services in physical health care settings.
6. Ensure stakeholders throughout Multnomah County are aware of options for accessing integrated services by working with all Health Department Clinics and other major health systems in the area to clarify their behavioral and physical health integration models and referral processes for specialty mental health services.
7. Explore whether former FamilyCare members who received behavioral health services in clinic settings prior to FamilyCare's closure have experienced discontinuity in access, and engage in efforts to reconnect these members to services if access issues are identified.

Background and Methods



Project Aims in Depth

In the fall of 2017, the Human Services Research Institute was contracted by Multnomah County to conduct an analysis of their mental health system. Our overarching intent for this project was to provide Multnomah County with a comprehensive, data-driven understanding of the existing mental health system that included a consideration of the alignment of community needs and existing resources. The ultimate goal is to support the county in ensuring a 21st century mental health system driven by quality and scientific merit, efficient in coordinating service and support provision across agencies, and focused on outcomes leading to recovery with minimal barriers to access. Key considerations include the culturally specific needs of populations, the way funding flows through the system, and collaboration and coordination between different entities and systems in the county. Specific project aims and guiding questions were as follows:

Aim 1: Develop a detailed inventory of all mental health services provided by the County and its community-partner contractors that includes service type, populations served and capacity for culturally specific services, and funding source.

- 1.1 What mental health services are available in Multnomah County, and how is each service funded?
- 1.2 To what extent are available mental health services in Multnomah County culturally and linguistically appropriate and tailored to meet the needs of specific

population groups, including members of racial and ethnic minority groups, New Americans, LGBTQ individuals, youth and young adults in transition, older adults, individuals transitioning to the community from the Oregon State Hospital, justice-involved populations, individuals with disabilities, individuals with co-occurring substance use disorders, individuals who are homeless, military service members and their families, individuals with traumatic brain injury, and those who are underinsured or uninsured?

Aim 2: Catalog connections (communication mechanisms, collaborations, and handoffs) between each of the mental health services identified in Aim 1, and between the Aim 1 services and adjacent systems and services.

- 2.1 What are the connections between each of the services identified in Aim 1, including formal and informal communication mechanisms, collaborations, and handoffs?
- 2.2 What are the connections between each of the services identified in Aim 1 and adjacent systems and services, including hospitals and health systems, nonprofit treatment providers, law enforcement and corrections, community justice systems, homelessness and housing services, school-based services, crisis services, aging and disability systems, public health, and Coordinated Care Organizations.

Aim 3: Provide a detailed picture of how funding and reimbursement mechanisms flow through county systems, with a focus on state and County general revenues and federal Medicaid dollars.

- 3.1 What are the current utilization and expenditure patterns for mental health services in Multnomah County?
- 3.2 How do utilization and expenditure patterns differ by payer source, including Medicaid and state and county general revenue dollars?

Aim 4: Identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to certain populations because of geography, language, financing, or other barriers.

- 4.1 How does Multnomah County's mental health system compare with national guidelines for good and modern systems, including the use of evidence-based and promising practices?
- 4.2 Are existing services sufficient in quantity and quality to meet community need?
- 4.3 Are existing services not accessible to certain populations because of geography, language, financing, or other barriers?
- 4.4 Are there services that are currently unavailable or unavailable in sufficient quantity that would better meet the needs of the community?

About Us

HSRI is a 501(c) (3) nonprofit corporation, formed in 1976 and located in Tualatin, Oregon and Cambridge, Massachusetts. We help public agencies develop effective, sustainable systems to deliver high-quality health and human services and supports in local communities. We help create positive change by taking a person-centric approach. We believe that systems are more effective—and less costly—when service users have a direct say in the services they receive and help define their desired outcomes. Across our focus areas, we work to:

- Help design data systems and analytics solutions that produce actionable insights
- Partner with leaders and change agents to identify best practices, add value, and solve problems
- Help design robust, sustainable systems based on qualitative and quantitative data, engaging service users, self-advocates, and other stakeholders early and often
- Assist organizations in building the capabilities they need to sustain systems change

In the behavioral health space, our goal is to deliver actionable, viable, and culturally relevant strategies that promote wellness and recovery. We examine the entire interplay of community factors and supports that influence behavioral health—not just the formal systems. By taking such a broad view, we're able to identify and highlight a range of existing strengths, assets, and successful practices. On the flip side, this approach enables us to pinpoint barriers related to access, discontinuity of care, system fragmentation, and more.

Analytic Methods and Data Sources

For this analysis, we sourced data in multiple formats from a range of entities within the county. A team at HSRI located, gathered, and synthesized existing quantitative and qualitative data from a variety of sources, including existing reports, local health care entities, stakeholder interviews, and community engagement sessions.

Existing Reports and Peer-Reviewed Literature

Data sources, referenced throughout the report, included reports and articles from a variety of published and unpublished sources. HSRI staff worked with county stakeholders to identify and gather existing needs assessments, gap analyses, reports and inventories, meeting agendas and minutes, websites, and other relevant documents from the past 20 years. A list of documents reviewed for this report can be found in Appendix D. At least one member of the HSRI study team read through and summarized each document (key documents were reviewed by more than one team member). To place the local Multnomah County and Oregon State issues in the context of the national healthcare environment, peer-reviewed research articles and

national literature have also been drawn on as part of this project and are referenced throughout the report.

Aggregated Data from Health Care Entities

HSRI and staff from Multnomah County reached out to a range of entities within the county to locate and obtain aggregated data—where available—on service user characteristics, utilization, and revenues and expenditures for mental health services. These data included:

- **Program Offers and Health Department Budget Data.** HSRI worked with the County to gather and review publicly available data reported in program offers and the Health Department budget. We reviewed program descriptions, performance measures, staffing, expenditures, and revenue data for all mental health-related program offers for FY17 and, when applicable, FY18.
- **Health Share.** Health Share provided HSRI with aggregated data for fiscal year 2017 (FY17) for this study. The data included information about claims, costs, and service user demographics for mental health-related service events in three service categories: outpatient treatment, emergency transportation, and emergency department. These data represent Medicaid-funded mental health services that were delivered outside of the specialty mental health system.
- **Oregon State Hospital**. Staff from the Oregon State Hospital provided HSRI with data on average census, length of stay, and Aid and Assist populations for the state and for Multnomah County residents.
- **Service User Demographics.** Data on age, gender, race, ethnicity, and preferred language were gathered from the Health Department, the Mental Health and Addiction Services Division, Oregon State Hospital, and Health Share to examine the characteristics of service users across different service types.
- **Other Data Sources.** Other data sources, referenced throughout this report include data points obtained by local stakeholders, including provider organizations and other County departments.

Stakeholder Interviews

Stakeholder interviewees were identified through multiple means. Initially, the County project team identified a preliminary list of key stakeholders, including advocates, providers, and administrators. Additional stakeholder interviewees were identified through a process of "snowball sampling" in which interviewees were asked to identify other stakeholders who have unique perspectives and/or particular expertise related to the mental health system. Working with the County project team, HSRI engaged local advocacy groups—including NAMI Multnomah, Mental Health America of Oregon, and the AMHSAAC—to inform service users and family members in their networks of the study and invite them to participate.

Between December 2017 and March 2018, researchers at the Human Services Research Institute conducted 75 interviews with 139 individuals as part of the

Multnomah County Mental Health System Analysis. Of those, 31 individuals represented the perspective of service users and/or family members. A list of organizations represented among stakeholder interviewees is included in Appendix A. In total, 73 individuals participated in in-person interviews during site visits, and the remaining 65 were interviewed by telephone.

Interviews were semi-structured using an interview guide that was developed based on study aims, with review and feedback from the County team. HSRI interviewers with expertise in qualitative research conducted the interviews in a semi-structured style, using the guide as a starting point but allowing for flexibility and pursuing other areas as they emerged. All interviews were conducted with two or more HSRI staff, with one taking notes and the other leading the conversation. Interviews were audio-recorded with interviewee permission. Using notes and the recording, an HSRI team member created a notes summary of each interview, which was then reviewed for accuracy by the second team member.

Community Engagement and Feedback

Multnomah County hosted two community listening sessions for this study. The first was held on December 12, 2017. The two-hour meeting took place in a public library and was attended by 87 community members (not including HSRI and County staff). After an introduction from County Commissioner Sharon Meieran and a study overview from HSRI, the attendees were asked to break into groups and discuss two questions:

1. What is your vision for an improved mental health system five years from now?
2. What are the most pressing issues and challenges for people with mental health-related needs in Multnomah County?

After small group discussions, a volunteer from each group reported what was discussed to the larger group, and the evening closed with a full-group discussion, with several community members sharing their personal experiences with the system. County and HSRI staff were present in nearly every group as note-takers, and all groups were asked to submit their notes to HSRI.

A similar listening session led by the county took place on February 6, 2018 and was attended by 72 community members. The one-hour listening session was held after a screening of a short film *Not Broken*, about youth with lived experience of mental health conditions. Notes from this session were provided to HSRI by county staff and synthesized for analysis.

In addition to the two listening sessions, the County created a web portal and invited members of the public to share their experiences of and vision for the mental health system for the project. The portal was open from November 22, 2017 to February 28, 2018 and received over 100 submissions from community members. Finally, individuals were invited to contact members of the County staff and HSRI team directly with written feedback and information. Emails and other materials from

community members that were sent to the County were forwarded to HSRI for incorporation into the study as community feedback.

Challenges and issues identified through the community feedback process are incorporated in the findings throughout the report, and Appendix B includes a *Community Vision of an Improved Mental Health System* that HSRI summarized based on the community listening session notes.

Analytic Process

HSRI used a combination of inductive and deductive analytic approaches to work with the various qualitative and quantitative data sources for this study. Our analytic process is informed by grounded theory,[111] a qualitative research method, and mixed methods approaches to systems research.[112] Beginning in the data gathering phase, the HSRI team engaged in an ongoing process of reflection to identify emergent themes related to the study aims. When the data collection period neared its conclusion, these themes were then refined and organized into a thematic framework. This framework was continuously revised throughout the remainder of the data gathering and first stage of the analytic process. Near the close of the analytic process, stakeholder interview summaries were organized based on the thematic framework to produce an initial memo detailing preliminary qualitative findings. Following County review and feedback and thematic framework revision, the remaining interviews, document summaries, quantitative data, and other community engagement and feedback data were organized into the thematic framework and presented in this report.

Ethics Review

Quantitative data analyzed for this study were obtained in aggregated format and did not include protected health information (PHI) or personally identifiable information (PII). Community feedback was generated through anonymous, public events. However, our interviews with stakeholders—particularly service users and their family members who shared personal experiences with the mental health system—were treated as human subjects research to ensure confidentiality, informed consent, and an absence of coercion. The HSRI Institutional Review Board reviewed all study protocols to ensure all activities were conducted in accordance with federal, institutional, and ethical guidelines. Stakeholder interviewees were given descriptions of the study activities, including a detailed discussion of potential benefits and risks of participation, and each provided informed consent before participating.

Appendices

Appendix A: List of Stakeholder Interviewee Organizations

In addition to the following organizations, HSRI interviewed 20 individuals who have lived experience as service users and/or family members and are not affiliated with a particular organization.

- Albertina Kerr
- American Medical Response
- Cascade AIDS Project
- Cascadia Behavioral Healthcare
    - Cascadia Plaza
    - Project Respond
    - Peer & Wellness Services
    - Homeless Services
- Central City Concern
    - Old Town Clinic
- Children's Health Alliance
- CODA
- Collective Medical Technologies
- Disability Rights Oregon
- Gresham Fire Department
- Health Share of Oregon
- Legacy Health
- Lifeworks Northwest
- Lines for Life
- Lutheran Community Services Northwest
- Mental Health Association of Oregon
- Mental Health Association of Portland
- Moda Health

- Multnomah County Department of Community Justice
- Multnomah County Department of County Human Services
    - Intellectual and Developmental Services
- Multnomah County Health Department
    - Corrections Health
    - Mental Health and Addiction Services Division (detail below)
- Multnomah County and City of Portland Joint Office of Homeless Services
- Multnomah County Local Public Safety Coordinating Council
- Multnomah County Mental Health and Addiction Services Division
    - Crisis Assessment and Treatment Center (CATC)
    - Office of Consumer Engagement
    - Tri County 911 Service Coordination Program
- Multnomah County Sheriff's Office
- NAMI Multnomah
- NAMI Oregon
- Northstar Clubhouse
- Oregon Department of Justice/Multnomah County Circuit Court
- Oregon Health and Science University
    - Avel Gordly Center for Healing
    - Child and Adolescent Psychiatry
    - Psychiatry
- Oregon Health Authority
- Oregon Mental Health Consumers Association
- Oregon State Hospital
    - Oregon State Hospital Advisory Board
- Outside In
- Portland Fire and Rescue
- Portland Police Bureau
    - Behavioral Health Response Team

- Portland Public Schools
- Portland State University
- Providence Medical Group
- Transition Projects
- Tri-County Behavioral Health Providers Association
- Trillium Group and Trillium Family Services
- Unity Center for Behavioral Health
- Western Psychological and Counseling
    - Conexiones
- Youth Villages

Appendix B: Community Vision for an Improved Mental Health System

During community listening sessions in December 2017 and February 2018, community members articulated the following vision for a future improved mental health system in Multnomah County:

System Characteristics

- Everyone has health coverage, with mental health and substance use services covered at parity with physical health services
- Integrated mental health and substance use systems
- A single-payer health care system
- Adequate funding
- Better coordination between systems, including criminal justice, mental health, substance use, and physical health
- Medical records would follow service users
- A data-driven system that tracks access, outcomes, cost, and quality by population group
- Close the state hospital
- Flexible services and supports
- Choice in services and supports
- A well-trained, highly competent workforce

System Orientation

- Proactive rather than reactive approaches
- An emphasis on prevention, including maternal and infant social and emotional wellness
- Alternative approaches available (e.g. natural remedies, acupuncture, massage)
- Holistic supports that help people to be healthier, support good nutrition
- Trauma-informed services and training
- Families included in decision-making
- The service user voice is supported and heard at all levels
- People with lived experience included in strategic planning and work groups
- An empathetic, whole person (mind/body/soul) orientation
- Promotion of natural community supports

Accessibility

- Multiple access points (e.g. medical, faith-based, jail) with "no wrong door"
- People have access to navigators who can help them work their way through the system and understand their benefits and the services available to them
- Coordinated care, including Wraparound services and Assertive Community Treatment
- Each neighborhood has a center that provides comprehensive services
- A hub where services come to the person, so that people do not have to navigate or ping pong to so many providers
- Better access to outpatient substance use treatment
- Improved access to appropriate services for people with physical disabilities, including those who are deaf and hard of hearing and have impaired vision

Peer Support

- Widely available peer supports
- A strong peer workforce
- Peer role more honored and recognized
- Set priorities to integrate peers at all levels

Criminal Justice

- Triage system in jail for people with mental health issues, staffed by people with compassion and understanding
- Better court systems
- Focus on rehabilitation
- Maximum effort to divert from criminal justice and decriminalization of mental health issues

Cultural Responsiveness

- Culturally specific services provided by culturally specific agencies
- Cultural trauma included in workforce training
- Support for immigrants and refugees to access services
- Adequate translation and interpreter services

Community Education

- Broad public awareness and education about mental health
- Workshops/education for the community that is culturally appropriate (different languages, different events)
- Give families skills to keep them together

Housing

- Safe, warm dry affordable housing in adequate supply
- Housing that is truly supportive
- Safer shelters
- Smaller shelters (200 beds is too large)
- Shelters that are spread out across the county
- Emergency shelter beds always available

Appendix C: Summarized Recommendations from Past State and County Documents, 2008 to 2018

The summarized recommendations that follow were extracted from reports identified through the document review for the HSRI Mental Health System Analysis. Please refer to the original reports for additional detail and context for these recommendations.

The recommendations presented here provide a summary of systems improvement activities over the years. Many of these recommendations have been achieved, while others may have yet to be realized. We have included all of the recommendations here to support the county in its future planning efforts and recognize the efforts of the county and its stakeholders to engage in continuous systems improvement efforts over the years.

State Documents

Wellness and Healing Practices Committee. (2018, February 4). *Recommendation for State Support to Establish Peer Run Programs*. Portland, OR: Oregon Consumer Advisory Council.

- Ensure peer services are made available as an essential option within the array of services, with dedicated funds
- Prioritize peer culture and values and create a peer-delivered service coordinator for each CCO and county
- Oregon Health Authority to facilitate provision of technical assistance and work collaboratively with Oregon Consumer Advisory Council towards the goal of establishing and advancing peer-run respites in Oregon not based on the certification standards for residential clinical facilities, which differ significantly from the successful models of peer respites

Jetmalani, A., (2018) Core Strategies to Improve Outcomes for Youth and Families in Oregon in a Trauma-Informed System

- Continue to build prenatal and early childhood strategies
    - Increase services for families who are identified as having prenatal risk factors with entry via many doors
    - At risk families should have access to no cost early childhood mental health services (IECMH) via providers who can bill for 6 visits prior to diagnosis
    - Increase numbers of trained early childhood providers who are linked to relief nurseries and primary care
    - Substance use programs that provide residential treatment with mothers and babies together

- Increase efforts to support programs that promote good social skills and mental health in the schools
    - Social emotional curriculum that is evidence based from kindergarten
        - In middle and high school: Suicide screening and skill development for distress tolerance
    - Anti-bullying programs endemic in schools from grade school on
        - Not expel the bully or no tolerance programs but prosocial support oriented for culture change (many examples of programs that work)
    - Embed mental health services in or near middle schools and high schools
    - Create peer delivered services in the schools
    - Implement social media and smart phone management strategies via youth adult partnerships
- Mental Health
    - Create multiple walk in centers where youth and families can go for evaluation of suicidal ideation
        - Utilize consistent evidence-based services that evaluate risk and provide appropriate supports
    - Increase crisis and transition support services to bridge people in crises to outpatient care utilizing peer support and clinical expertise
    - Create three partial hospital programs attached to the three busiest EDs in the tri-county area.
    - Increase the pipeline of experts in the field with experience in training that matches needed expertise in the field (increase the quality of care)
        - Increase training slots for adult and child psychiatry
        - Increase the number of psychologists trained in community mental health
    - Eliminate barriers to adequate compensation for non-physician outpatient care in CCMH and co-located PMCMH settings (CCO capitation, commercial payer credentialing, billing codes)
- DD and DHS:
    - Create rapid access comprehensive assessments for youth with complex needs

        - Create payment methodologies for multiple providers to evaluate a child and family on the same day
        - Connect complex assessment teams to existing but expanded residential or sub-acute programs:
            - DD: developmental pediatrics, Child Psychiatry, Psychology, OT speech
            - Mental health: Child psychiatry and Child psychology
- High intensity community programs
    - Increase the volume and efficacy of intensive in-home services by increasing utilization of evidence based family approaches (MST)
    - Utilize Treatment Fostercare Oregon, Nest or Mockingbird models to create temporary high intensity programs for youth unable to stay home, requiring foster care but too complex for routine foster care
- Address housing insecurity for families with high complexity aggressive youth via incentive grants to property owners
- Connect mental health, physical health, dental, housing, food and other programs to Boys and Girls Clubs
- Create paying jobs, paying vocational skills training and social programs with peers for at risk youth

Waddell EN, Anastas T, Howk S, Remiker M, Branca K, Fagnan LJ, Moore R, Oregon Rural Practice-based Research Network, Oregon Health Authority. (March 2017). *Behavioral Health Home Learning Collaborative Years 1 - 3 Final Report* Portland, Oregon: Oregon Health & Science University

- Recognize, respect, and address differing professional cultures between medical and behavioral health staff; Fully integrated care requires some flexibility and adaptation on both the medical and the behavioral sides
- Cross train behavioral health home staff to bridge cultures and develop an emerging integrated workforce
- Adjust panel size and scheduling to accommodate clients with complex social needs
- Make client records available to both the primary care and behavioral health providers
- Schedule regular, interdisciplinary care team meetings
- Enter data in shared electronic health record using structured fields

- Create patient registries to inform resource allocation, enable proactive patient outreach, and track population health outcomes for quality improvement efforts and to demonstrate a return on investment
- Create and sustain interdisciplinary quality improvement teams with balanced representation from behavioral health, primary care, and site administration
- Reimburse prevention and wellness support services offered through community-based peer supports
- Offer flexibility in alternative payment structures to match the structure and target population of the behavioral health home
- Provide financial and technical support for behavioral health homes seeking to move to a shared electronic health record
- Support agency efforts to develop and implement universal consent and release of information documents
- Contribute to regional efforts to build and operate Health Information Exchanges
- Evaluate program effectiveness of behavioral health home models through a combination of locally collected and administrative data sources
- Acknowledge and respond to technological, practice and measurement challenges presented in behavioral health homes
- Validate clinic-based quality measures against state-level encounter data to improve the quality of data reported on both sides

St Amour, D. (2017). *Mental Health Service Disparities of Latino Oregonians: A Qualitative Analysis*. Portland, OR: Commission on Hispanic Affairs. Available at http://www.oregon.gov/Hispanic/pdfs/Mental%20Health%20Service%20Disparities%20of%20Latino%20Oregonians%20OCHA%20Final%20Report%20-%20St.%20Amour.pdf

- Integrate primary care and mental health services for Latinos
- Integrate mental health into existing centers in the community
- Use platforms for providing mental health services for Latinos, including schools, legal services, churches
- Expand culturally specific mental health clinics for Latinos
- Develop the bilingual and bicultural workforce, including community health workers
- Increased mental health awareness and education in the Latino community
- Increased funding, better insurance reimbursement and a more streamlined reimbursement process

Oregon Health Authority. (2016). *Youth Suicide Intervention and Prevention Plan, 2016–2020*. Salem, OR: Oregon Health Authority. Available at http://www.oregon.gov/oha/HSD/AMH/Documents/Suicide%20Intervention%20and%20Prevention%20Plan.pdf

- Integrate and coordinate suicide prevention activities across multiple sectors and settings
- Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors
- Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery
- Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors
- Promote efforts to address safety among individuals with identified suicide risk
- Provide training to community and clinical service providers on the prevention of suicide and related behaviors
- Promote suicide prevention as a core component of health care services
- Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors
- Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides
- Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action
- Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings

Juvenile Justice Mental Health Task Force. (2016, January). Report and Recommendations. Salem, OR: Oregon State Court. Available at http://courts.oregon.gov/OJD/docs/OSCA/JFCPD/Juvenile/JJMHTF/Finalized.Report.1.pdf

- The task force recommends that child serving systems should base development of policies, practices and programs on a basic set of core values and principles
- The Judicial, Executive and Legislative branches should work together to create a Children's Cabinet to centralize and better coordinate the work of governmental agencies, task forces, committees and work groups that address systems reform issues

- The legal framework for information sharing between governmental agencies and service providers needs to be built in order to allow for effective coordination of efforts between schools, law enforcement, service providers, child welfare, juvenile departments and the courts
- Efforts need to be made to identify and treat children with mental health issues before they reach the juvenile justice system
- Youth who are referred to the juvenile department should be screened for mental health issues and connected with appropriate services if needed
- Juvenile departments, mental health and Coordinated Care Organizations should work together to ensure interventions that youth are referred to are producing positive outcomes
- Additional legal protections regulating the use of psychotropic medications for youth involved in the juvenile justice system should be enacted to ensure children receive the same level of protection, regardless of which system they are involved in
- Youth who cannot be safely maintained at home with serious mental health needs should be placed in the least restrictive available trauma-informed treatment setting
- Juvenile departments and the Oregon Youth Authority should ensure that youth have adequate mental health services set up in the community when youth are released from custody; Coordinated Care Organizations should be mandated to schedule appointments with these youth prior to their release from custody to ensure adequate supports are in place when the youth returns to the community

Oregon Health Authority. (2016). *Behavioral Health Collaborative Report*. Salem, OR. Available at http://www.oregon.gov/oha/OEI/Documents/BHC-Recommendations.pdf

- Establish a single point of shared responsibility for local communities through a regional governance model
- Set a minimum standard of care for all behavioral health workers
- Conduct a needs assessment of current workforce and create a plan on how to build the workforce
- Strengthen the use of health information technology and data to further the outcome-driven measurement and care coordination across an integrated system

Addictions and Mental Health Division. (2011, January 27). *Integrated Service Array Progress Review Data Analysis*. Salem, OR: Oregon Health Authority.

- Data Reporting - Addictions and Mental Health (AMH) should convene a workgroup of stakeholders and AMH staff to review proportion of usable to unusable data, improve data reporting and provide consistency across mental health organizations in the manner data is reported; The Integrated Service Array (ISA) Progress Review/Behavioral and Emotional Rating Scale-2 (BERS-2) should be administered more frequently to measure changes in children over a shorter time than one year
- Decline in ISA Services at age 16 - Consideration should be given to reasons why children are less likely to enter the ISA after age 16 and what might be done to address this
- Danger to Self - Explore extent and feasibility of suicide risk screening across the state
- Improved Child and Family Team participation by primary caregivers - Exploration of how more primary caregivers could be encouraged/incentivized to attend their child's Child and Family Team
- School work for ISA children - Active work on how to obtain education system data, specifically around whether or not children are producing acceptable quality schoolwork when they are in the ISA and how this could happen on a more frequent basis
- Delinquency - Screening for and use of evidence-based practices to prevent delinquent behaviors in this group of children
- Aggression - Use of trauma informed services to ameliorate/reduce instances of aggression; Increase use of effective practices such as Collaborative Problem Solving, Neuro-sequential Model of Therapeutics© (Child Trauma Academy) or Cognitive Behavioral Therapy
- Substance use - Work should continue on integration and collaboration around co-occurring treatment options for youth in the early stages of substance use, and for those at risk/suspected of it

Oregon Department of Human Services/Addictions and Mental Health Division. (2009). *Addictions and Mental Health Division Cultural Competency Plan*. Salem, OR.

- Conduct initial and ongoing organizational self-assessments of Cultural Competence-related activities; Integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, client satisfaction assessments, and outcome-based evaluations
- Create an infrastructure for performance accountability

- Conduct needs assessments that comprise respondents from a wide range of cultural groups on a regular basis; Adapt and change program services based on identified needs; Develop specific procedures to ensure comparability of access and receipt of services across cultural groups; Ensure that people affected are involved in the development and ongoing implementation and evaluation of these procedures
- AMH and its partners/contractors will make efforts to hire, retain, and promote qualified employees from diverse cultural/racial backgrounds
- Staff training and development in the areas of cultural competence are implemented at all levels and across disciplines for leadership and governing body, as well as for management and support staff
    - The cultural competence training is incorporated into ongoing organization staff training plan, tracked annually
- Develop and maintain data or a database which track use and outcomes for all clients/consumers across all levels of care, ensuring comparability of services (aggregated by programs,) access, and outcomes; Ensure data systems are compatible

Governor's Mental Health Task Force. (2004, September 23). *A Blueprint for Action*. Salem, OR: Office of the Governor, State of Oregon.

- Pass legislation requiring private insurers to provide parity coverage for mental health and substance abuse services
- Sufficient funds for restructuring of Oregon State Hospital and construction and operation of community facilities to support populations no longer hospitalized
- Implement programs and provide funding for community providers to achieve community-based systems of care
- Local mental health authorities with the state will assist individuals to leave acute care and state hospitals, including individuals subject to PSRB jurisdiction
- Offer training for courts, district attorneys, defenders, correction officers and police to identify and properly respond to persons with mental illness and understand community MH and SU programs
- OMHAS work with counties to create 24/7 acute care crisis centers to permit diversion prior to arrest
- Construct and operate community facilities to serve individuals under Psychiatric Security Review Board (PSRB) jurisdiction

Multnomah County Documents

Cohen, Cheryl. (2017, March 3). "Health Share Market Rate Study Report". Message to Community Partners. Health Share of Oregon: Portland, OR.

- Leverage the Market Rate Study to address how the Oregon Health Authority behavioral health fee schedule perpetuates the underfunding of the system statewide, especially for substance use disorder providers. Specifically, compare the DMAP behavioral health fee schedule against the study results to make recommendations for the DMAP schedule
- Analyze the disparities between payment to mental health and addiction providers and develop an incremental plan for parity
- Revise the risk corridor calculation for outpatient mental health case rates to increase returns on provider payments and mitigate paybacks while remaining budget neutral
- Request the Tri-County Behavioral Health Providers Association work with their members to develop a plan to ensure that funding increases be translated into increased salaries and benefits
- Collaborate with the Providers Association and other stakeholders to develop a broader behavioral health workforce strategy to improve staff hiring and retention, as well as address provider productivity barriers

Mercer, J., Bajpai, D., & Archer, J. (2017, March). *Building a Recovery-Oriented System of Care*. Multnomah County Mental Health and Addiction Services Division: Portland, OR.

- Assign an individual to coordinate the development of a Recovery-Oriented System of Care for Health Share members
- Secure a broad range of support through leverage with partner systems
- Assemble a Guiding Coalition to provide oversight, mutual accountability and monitoring
- Include consumers, families, recovery organizations, faith community, system partners (child welfare, employment, corrections) as members of the Guiding Coalition
- Disseminate pertinent data on the population, services, supports, and resources
- Review policies and practices relating to behavioral health to see what needs to be changes, deleted, or added to support a ROSC
- Build relationships with the recovery organizations and self-help groups (AA, NA, and Al-Anon) in the Portland area to garner their support, ideas, and services
- Support workforce development initiatives with a focus on peer mentor certification and minority recruitment
- Develop a set of core competencies for persons/organizations delivering services; Develop a comprehensive anti-stigma campaign and a communications plan for internal and external use

- Build linkages with primary care and ensure access to all medications with FDA approval for the treatment of alcohol and opioid use disorders

American Federation of State, County, and Municipal Employees (AFSCME) Council 75. (2017, March 27). *The Unheard Voices in the Conversation about Behavioral Health in the Portland Metro Area*. Portland, OR. Available at https://static1.squarespace.com/static/58ee7966d482e9cd1f9da132/t/58efd18c5016e1685c57798f/1492111761859/OR+BH+White+Paper_FINAL+032717.pdf

- Require written plans to prevent disruptive labor unrest and provide whistleblower protections
- Implement regulations mandating staffing ratios and caseload limits
- Increase agency transparency in their use of public dollars
- Increase agency accountability with use of public funds and evaluation practices
- Change regulations to improve client choice
- Promote professional development opportunities for direct service employees

Adult Mental Health and Substance Abuse Advisory Committee. (2017, January). Draft Recommendations for Peer Network and AMHSAAC Effectiveness.

- Provide an inclusive environment that includes appropriate accommodations where all voices are honored and included by empowering all peer voices
- Improve the behavioral health system through a transparent feedback loop by leadership by being accountable and action driven to increase the peer delivery system
- Improve communication and transfer knowledge, including cultural wisdom, between AMHSAAC and Community Partners
- Increase collaboration with all community partners including increased representation of peer agencies and substance use disorder agencies

March, S. (2015, April 10). *Report to Management: MHASD Claims Processing*. Portland, OR: Multnomah County Auditor.

- Perform data monitoring and analysis in a timely basis
- Include the universe of relevant claims, rather than a sample
- Continuously update the process to keep pace with changes in payment models, codes, and best medical practices

Joplin, L. & Sihler, A. (2015, February). *Multnomah County Feasibility Assessment: Mental Health Jail Diversion Project Executive Summary*.

South Easton, MA: Lore Joplin Consulting. Available at https://multco.us/file/38219/download

- Improve information sharing (including confidentiality restrictions)
- Coordinate better across systems
- Identify defendants with mental illness at booking and engage them while in jail
- Data collection and analysis are needed to determine the cost-effectiveness of diverting someone with mental illness from Multnomah County jails to community-based treatment
- Explore apparent racial disparities in the detention of people who have mental illness
- Additional culturally specific treatment programs for racial and ethnic minorities and LGBT individuals
- Greater capacity across the continuum of care
    - 24-hour drop-off center
    - Dual-diagnosis treatment
    - Residential dual-diagnosis treatment for women
    - Outreach and engagement
    - Adequate supplies of appropriate housing

English, K. & Gyurina, C. (2014, June). Multnomah County – Mental Health and Addiction Services: Consultation on Managed Care and Local Mental Health Authority Roles. Boston, MA: Technical Assistance Collaborative. Available at http://multnomah.granicus.com/MetaViewer.php?view_id=3&clip_id=874&meta_id=57659

- Financial Systems Management
    - Invest in an accounting system designed for managed care operations
    - Disaggregate financial accounting to report separately for each line of business
    - Maximize Medicaid revenue
    - Hire an actuary
- Utilization Management
    - Evaluate financing of the Medicaid substance use benefit
    - Improve access to community-based treatment alternatives for youth

- Seek alternative strategies for utilization management which align more closely with the changes Health Share is making related to global payments and case rates
- Monitor and assess compliance with federal mental health and addiction parity regulations

- Health Share and Multnomah County should ensure that a solid base data is used in calculating case rates, and they should be transparent with providers about how these rates are being developed
- The quality management functions should serve to assess how well the CCO and its provider network are meeting the goals of the Oregon Health Plan, to control the rate of growth in Medicaid expenditures while improving the quality of care and the health of the population(s) served
- The County should review its staffing functions, and reassign or hire staff to functions appropriate to staffing a managed behavioral healthcare organization; It will be important that a staff person should be hired or assigned to be fully dedicated to managing the health plan; The County should work with Health Share to establish common definitions of administrative duties and associated costs for tracking and reporting purposes.
- Local Mental Health Authority (LMHA) Recommendations
  - Focus attention on the LMHA; MHASD leadership must focus its attention on fulfilling the LMHA mandated duties and on the effective operation of the Community Mental Health Program (CMHP)
  - Engage the State Mental Health Authority
  - Reduce reliance on Emergency Departments
  - Improve integration of care for people with mental health and substance use disorders
  - Facilitate throughput with effective use of resources - the ability to move an individual through a continuum of care and supports
  - Commitments; Multnomah County may be better served by opening dialogue with involved stakeholders to determine how to facilitate use of inpatient and jail diversion services, and the existing involuntary outpatient commitment criteria
  - Addressing homelessness
- Options for MHASD roles:
  - Option 1: Continue as a risk accepting entity (RAE) as part of Health Share
  - Option 2: Propose to become a single RAE for the region

- Option 3: Serve as the RAE for specialized behavioral health services only
- Option 4: Propose to become an Administrative Services Organization

Children's Mental Health System Advisory Council. (2014). Advisory Committee Recommendations in *Annual Medicaid Quality Report: 2014*. Portland, OR: Multnomah County Mental Health and Addiction Services Division/Multnomah Mental Health. Available at https://multco.us/file/42286/download

- Transition plans shall follow all existing Oregon Administrative Rules
- A commitment is made to improve the education and training of families, youth, system of care partners, and mental health providers. The following are to be incorporated into the "norm" of how we support all participants in children/youth treatment plans and transitions:
    - Youth client is repeatedly offered training opportunities to support them in meeting the goals identified in their Plan
    - Youth is provided educational opportunities to learn about the system of care and services available to them
    - Youth is provided youth-friendly information on age-specific decision making responsibilities/rights; vocabulary to communicate their needs; and understanding of supplemental support as they move into the ages of consent
    - Tools are provided for youth to better understand their treatment process, including:
        - Creation of a telephone line and website that can help transition-age youth navigate new processes in the adult system;
        - web-based tool/website where youth will have access to relevant programs available to them;
        - workshops for youth who are transitioning to the "adult services world" in a youth-friendly format (i.e. not just PowerPoint presentations);
        - peer to peer support (it is important to hear the experiences from individuals who have been through this process).
    - Family members are repeatedly offered training opportunities to help them support their loved one, especially in areas identified in their child's plan
    - Family members are given information about available education and support services in the community. Information provided should

include community-based classes (such as “NAMI Basics” provided by NAMI affiliates, “Collaborative Problem Solving” provided by OHSU, and other identified classes), as well as parent and family support services in the community (such as those provided by NAMI affiliate offices, Oregon Family Support Network, therapeutic services that may assist with parent/caregiver’s needs, Family Partners, FACT Oregon, etc.

- All mental health treatment providers, case managers, Wraparound facilitators, and Family Partners are provided with and expected to participate in the following:
  - Training opportunities that support each stakeholder in meeting the individualized needs of the identified child and their family, such as: how to communicate with families in crisis, suicide risk assessment and knowledge of resources in the community
  - Cultural competency and sensitivity training opportunities
  - Trauma-informed care training opportunities
  - Training on suicide risk assessment and safety protocol specific to increased risks during acute or residential discharges and upon return to home and outpatient care.

- Attempts will be made to identify a prospective “consistent person” who is welcomed and encouraged to participate in transition meetings and key decision points in youth’s treatment; This person, serving in a support role to the family, will also be encouraged to follow the ongoing process of treatment and supports that are in place to meet the youth’s and family’s needs
- Newly adopted practices or policies that address the recommendations made in this report are given a review period of at least 30 days for CMHSAC to provide input in order to ensure a holistic incorporation of family, youth, and provider perspectives
- A commitment is made to reinforce best practices in the following areas, as identified by CMHSAC members:
  - Legal decision-making milestones for youth are clearly communicated with identified youth and their families, and the family and youth are supported in negotiating these milestones
  - Planning for relapse and suicide risk assessment is included in a thorough and detailed safety plan
  - The safety plan is clearly communicated to all members described in the plan

- A commitment is made to expand the continuation of collaborative opportunities to additional stakeholders impacted by the topic of Transition of Care (i.e. primary care and pediatrics)
- An analysis is conducted on how the contents of this Issue Report intersect with the System of Care Readiness Assessment and Wraparound expansion.

Adult Mental Health and Substance Abuse Advisory Committee. (2014). Advisory Committee Recommendations in *Annual Medicaid Quality Report: 2014*. Portland, OR: Multnomah County Mental Health and Addiction Services Division/Multnomah Mental Health. Available at https://multco.us/file/42286/download

- Customer service training for providers and consumer education about the grievance system
- Have an independent review process by peers
- Trend analysis of grievance actions written into policy
- Create tools to support consumers with the grievance process
- Building trust in the grievance system
- Develop Peer Support models addressing definitions, roles, measures, services to provide, supervision, and ongoing training
- Develop a peer "hub" or network for professional support and development
- Develop the message why peers are important
- Develop policies and procedures to support peer services
- Increase funded peer training
- Implement Client (Patient) Decision Aids for both Clinical and System Navigation
- Implement training for providers on customer service, supervision expectation for interaction skills, and person centered approaches
- Increase peers to assist with system navigation
- Analyze service gaps to develop a plan to educate consumers (clients) on choice
- Active use of effective clinically informed outcome measures

Kristina Smock Consulting. (2014, April). *Poverty in Multnomah County*. Portland, OR: Multnomah County Department of County Human Services. Available at https://multco.us/file/34343/download

- Identify and address the inequities that create disproportionate rates of poverty among people of color, immigrants and refugees, women, children, single-parent households and persons with disabilities

- Supports and services must be tailored to meet the distinct characteristics and needs of different types of poverty, demographic groups, and geographic areas
- Expand access to education, training, and workforce development programs to enable workers to secure family-wage jobs
- Provide increased access to child care, transportation, and other supports to enable workers to maintain their employment
- Ensure that people in poverty are able to access income supports for which they are eligible
- Provide opportunities for households to build financial assets
- Securing the county's future requires a focus on and investment in the well-being and development of our children and youth
- We must invest in services and supports that ease the experience of poverty and in structural and policy actions that seek to end the conditions that cause poverty
- Align the County's resources and services with those of other public and private partners to maximize effectiveness; This includes partnering with the communities most impacted by poverty, building on the effective work of local nonprofits and faith-based organizations, engaging the business community as part of the solution

March, S., Ulanowicz, M, & Dewees, N. (2004, (April 24). ***Mental Health and Addiction Services: Managing Risk in a Changing Environment*****. Portland, OR: Multnomah County Auditor.**

- Only revenues and expenses directly related to the insurance plan should be included in the Behavioral Health Fund
- The Division should develop a methodology by which other mental health system components can charge the insurance plan for services to its members or the plan and that methodology should be consistently applied
- The Board of County Commissioners, working with the Division, should develop an appropriate plan for managing the fund balance for the Behavioral Health Fund
- The Division should develop definitions to categorize administrative costs that are similar to industry standards
- The County formally evaluate the risk and viability of running an insurance plan in an environment where the CCO covers multiple counties and is composed of providers who may have competing views of the system of care and risk sharing

Stewart, G., Gerritsen, L., Covelli, E., & Henning K. (2012, March 21). *Report on Police Interactions with Persons in Mental Health Crisis*. Portland, OR: Portland Police Bureau. Available at https://www.portlandoregon.gov/police/article/440249

- The creation of a police-friendly (no refusal) facility to a quick-release, priority access facility, that will accept persons with co-occurring mental health crisis and substance abuse
- Assess where we are with the implementation of recommendations associated with the "Sequential Intercept Mapping and Taking Action for Change"
- The institution of a system-wide review of outcomes related to all mental health holds, with an emphasis on holds which do not qualify for a notice of mental illness resulting in an involuntary hospitalization or admission to the CATC. This should be re-occurring (possibly quarterly) and outcomes should be shared with police officers to help improve their responses to these issues
- Continued exploration of Bureau of Emergency Communications coordinating with the mental health system (this is currently occurring but should be supported)
- Renewed promotion of the dedicated police line in the Multnomah County 24-hour Mental Health Call Center available to officers wanting immediate access to mental health information, if available, during the course of an encounter
- The police and mental health community should explore how the approximately 3,200 holds which police are not involved with, intersect with the criminal justice system
- The Bureau should continue to explore improved responses to persons in mental health crisis. Current issues include:
    - Improved tracking (currently being implemented)
    - Examining the co-occurrence of substance abuse with mental illness and/or behavior crisis
    - Implementing the Mobile Crisis Unit(s) in the most effective way possible

Giuliano, M & Nunley, W. (2011, July-August). *Safer PDX Summer 2011 Technical Assistance Report*. Portland, OR. Cascadia Behavioral Healthcare.

- The Portland Police Bureau, Cascadia Behavioral Health Center, and Safer PDX Steering Committee should define the framework for referral, service, and outcomes of this critical service
- The MCU and Safer PDX should establish transparent, consistent health service and public safety performance and person-centered, satisfaction measures for the

MCU. Performance measures should include the services provided and outcomes of the PPB MCU provider(s), Project Respond MCU provider(s), and overall unit

- The MCU should define formal business agreements, linkage relationships, and definition of service limitations. If its mission is to provide linkage services and not direct case management, definition of what procedures and policies for concluding service independent of access to person-centered, recovery-oriented services must be established. Transition to non-MCU based Project Respond services as an iterative step should be considered
- The MCU seeks to establish additional value beyond the current service of PPB, Project Respond, and PPB-Project Respond coordinated responses to emotional and/or psychiatric crisis. Based on the results of the first year of root-cause analyses, it is anticipated that the value added for this program will likely include communication of frequent police contact for individuals currently receiving services. Based on work in other communities, simply notifying current providers and additional natural supports of police involvement may lead to a change or addition of service options for the community member experiencing unnecessary police contact during their mental health recovery
- Preferred recommendation redesign: the workflow and scope of triaging calls involving mental health, substance abuse, public safety options include moving mental health, substance abuse, non-responsive to queries or commands in the community calls to BOEC, one newly created organization, or newly developed capacity within an existing community mental health organization with demonstrated ability at crisis assessment/triage
- Reorganization of workflow: such as reassigning BOEC mental health, all mental health crisis calls (including to Project Respond) to one agency that exclusively and transparently performs the clinical assessment and person-centered outreach and engagement. Contracting out or fully increasing MCCC capacity and transparency through a community-based authority could be considered
- After either of the above approaches is chosen, definition of formal, transparent, and measured
    - linkages of first responders is essential. Both the individual response (if in crisis, these are the response choices for individuals, families, friends, professionals (mental health, substance abuse, psychiatric, and other medical providers), and public safety (before, during, and after incarceration). The Local Public Safety Coordinating Council (LPSCC) or an alternate forum should be empowered to establish a tenable annual plan for reporting and problem solving for mental health crisis and public safety response
- Each organization should define the service provided, evolve to define the additional service

- provision donated to other community partners, and establish a tenable strategy for transparently limiting itself to that definition. Strengths identified during the consultation include police identification that serving and protecting all community members is their duty (however, the rates of victimization and challenges of stigma for people recovering from mental illness are recommended to be further defined by community advocacy leaders, individuals as empowered forensic and additional peer specialists)

- Establishing one site for all community organizations (including ER, police, probation/parole) and community members (independent of engagement with formal psychiatric services or diagnoses/coverages) for crisis assessment (using the strengths of the medical model including diagnoses and care coordination), medication optimization, person-centered recovering planning (blending individual based and evidence-based practices)
- Engage the ER, acute hospitals, and jail to transparently define their admitting service, volume of service, practices, outcomes, challenges and linkage capacity

City Club of Portland Report. Improving the Delivery of Mental Health Services in Multnomah County. Available at https://www.pdxcityclub.org

- Make budget more transparent, and make it available online
- Make contracting info with providers available online
- Expand contracting enforcement standards and publicly report compliance and non-compliance with those standards
- Change procurement processes so oversight and management are independent
- Abandon ACORN and only use LOCUS for assessments. Identify and use additional outcome measures
- Allocate resources to analyzing data to drive system improvements
- Redesign MH services to
    - Remove jurisdictional barriers
    - Increase proportion of resources devoted to direct care
    - Reduce administrative layers
    - Reduce duplication among service providers
    - Ensure uniform quality standards
- Consider regionalization
- Improve public involvement processes

Sequential Intercept Mapping and Taking Action for Change. (2010). *Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System. Multnomah County, OR Final Report*. Policy Research Associates. Delmar, NY. Available at https://multco.us/file/35510/download

- At all stages of the Sequential Intercept Model, data should be developed to document the involvement of people with severe mental illness and often co-occurring substance use disorders involved in the Multnomah County criminal justice system; Consider the "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services
- Expand forensic peer counseling, support, and specialists to promote recovery
- Integrate peer support into the current crisis response process
- Continue to include and build upon the work of the family members who have shown interest in collaborating to improve the continuum of criminal justice/behavioral health services
- Review screening and assessment procedures for mental illness, substance abuse, and cooccurring disorders across the intercepts
- Increase information sharing to enhance rapid identification of current mental illness and history of services so diversion can be immediately initiated
- Establish formal collaboration with the Department of Veterans Affairs
- Improve coordination with law enforcement and develop crisis stabilization bed capacity
- Develop Intercept II diversion options. (Initial detention and initial hearing)
- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others involved in re-entry; including transition case management
- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration
- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community
- Explore methods to help people obtain birth certificates or other needed identification
- Expand supportive employment options

- Explore expansion of housing options for people with mental illness involved with the criminal justice system
- Develop data to document the impact homelessness or unstable housing has upon people with mental illness and other behavioral health problems involved in the criminal justice system
- Assess successful use of evidence-based and promising practices in each of these areas:
    - Cultural competence
    - Impact of trauma
    - Transitional planning and Linkages to the community
    - Screening, assessment, engagement and treatment of Co-occurring disorders

Mental Health and Addiction Services Division. (2008, September). Draft Strategic Plan. Portland, OR: Multnomah County Department of Human Services. Available at http://www.localcommunities.org/lc/418/FSLO-1223399730-773418.pdf

- Increased involvement of consumers and families in the planning and delivery of services
- Development of a closer connection between mental health and physical health systems
- Increased financing and system accountability
- Improvements in systems of care to better meet consumer child, adult and family needs

Appendix D: List of Background Documents and Reports

Addictions and Mental Health Division. (2009). Addictions and Mental Health Division Cultural Competency Plan. Oregon Department of Human Services. Salem, OR.

Addictions and Mental Health Division. (2007, March). Report to the Oregon Legislature on Planning for Mental Health Services. Salem, OR: Department of Human Services.

Addictions and Mental Health Division. (2009, September 8). Draft Children's Mental Health System 2007-2009 Summary and Overview. Salem, OR: Oregon Department of Human Services.

Addictions and Mental Health Division. (2008). Report on Oregon's Statewide Services for People with Co-Occurring Mental Health and Substance Use Disorders Surveyed Spring 2007. Oregon Department of Human Services. Salem, OR.

Addictions and Mental Health Division. (2009, May). Oregon's Young Adults in Transitions: Progress Report. Salem, OR: Department of Human Services.

Addictions and Mental Health Division. (2011, January 27). Integrated Service Array Progress Review Data Analysis. Salem, OR: Oregon Health Authority.

Adventist Health-Portland. (2016). 2016 Community Health Needs Assessment. Portland, OR. Available at https://www.adventisthealth.org/Portland/pages/about-us/community-benefits/needs-assessment.aspx.

AFSCME Council 75. (2017, March 27), The Unheard Voices in the Conversation about Behavioral Health in the Portland Metro Area. Portland, OR. Available at https://static1.squarespace.com/static/58ee7966d482e9cd1f9da132/t/58efd18c5016e1685c57798f/1492111761859/OR+BH+White+Paper_FINAL+032717.pdf.

Adult Mental Health and Substance Abuse Advisory Council. (2017, January through June). Finalized AMHSAAC Meeting Minutes. Portland, OR. Available at https://multco.us/mhas/adult-mental-health-and-substance-abuse-advisory-council.

Adult Mental Health and Substance Abuse Advisory Council. (2016, December). Final By-Laws. Portland, OR. Available at https://multco.us/mhas/adult-mental-health-and-substance-abuse-advisory-council.

Adult Mental Health and Substance Abuse Advisory Council. (2017, January). Draft Recommendations for Peer Network and AMHSAAC Effectiveness.

Barry, R., Bedford-Nowland, E., Foley, G., Gibson, N., Hatcher, J., Johnson, D., Luciani, A., & Reyes, A., (2016). Study of the Service Coordination Team and its influence on chronic offenders. Portland, OR: Portland State University Capstone Class UNST 421 Section 572-Winter Term 2016. Available at http://www.centralcityconcern.org/research/.

Boston Health Care for the Homeless Program. (n.d.) Available at https://www.bhchp.org/behavioralhealth.

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