Child & Family Behavioral Health Policy Vision

HEALTH SYSTEMS DIVISION
Child and Family Behavioral Health Unit

October 2020

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Executive Summary

The Child and Family Behavioral Health unit within the Oregon Health Authority (OHA) Health Systems Division (HSD) Office of Behavioral Health, implements and manages Medicaid and other publicly funded mental health, suicide prevention, and substance use disorder services and supports for children, youth, young adults, and their families. The unit works with other state agencies and OHA divisions to develop policy and guidance for delivering services to children and families statewide. Additionally, the unit coordinates with consumers, families, youth and young adults, coordinated care organizations (CCOs), health providers, counties, external agencies, and other contractors to develop a continuum of care that adequately meets the needs of children and families.

In September 2020, the Oregon Secretary of State released a report[1] outlining the gaps and needed improvements in the Child and Family Behavioral Health system in Oregon. This paper incorporates the recommendations of that report, and outlines both current and envisioned work of the Child and Family Behavioral Health unit.

The unit operates under a mission statement and incorporates System of Care values and principles, trauma informed principles, a health equity framework; and is working to create a clearer and more useful data set to guide the direction and emphasis of the work. Work is managed through contracts with counties and private and public entities, non-profit providers, and other key stakeholders such as residential treatment providers, within Oregon.

The unit is integrating the OHA Health Equity Committee definition in its work[2]:

> Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
>
> Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> - The equitable distribution or redistributing of resources and power; and
> - Recognizing, reconciling and rectifying historical and contemporary injustices.

[1] https://sos.oregon.gov/audits/Documents/2020-32.pdf

[2] https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

Introduction

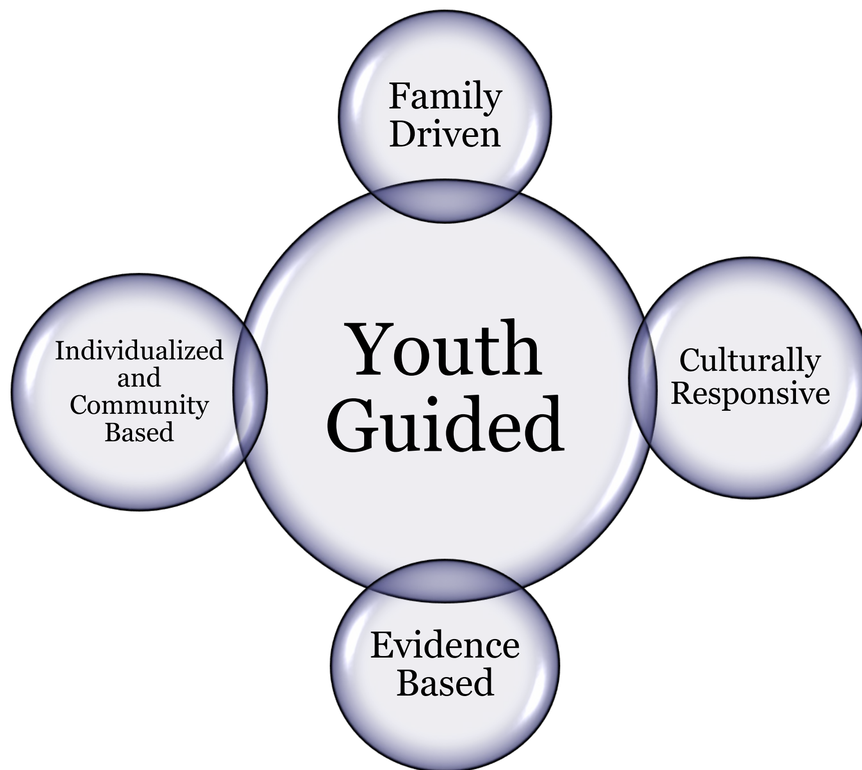
This paper outlines the vision and five-year work plan for policy and program direction to be co-created with consumer and stakeholder input.

The mission of the Child and Family Behavioral Health (CFBH) unit in the Oregon Health Authority (OHA) is to incorporate System of Care values, developmental science and trauma informed approaches in order to champion effective and efficient statewide behavioral health services, supports and safety for Oregon's children, youth, young adults and their families. The unit works to ensure that behavioral health services for children, youth, young adults ages 0-25 and their families, are responsive to their needs so that youth and families have access to the right services, at the right time and for the right duration.

Supporting System of Care values and principles

The priority is to create a sustainable continuum of quality care that is simple, responsive and meaningful based on System of Care (SOC) values and principles.

System of Care describes a philosophy which supports a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. SOC work is based on this definition and a set of Core Values and Guiding Principles[3].



[3] https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

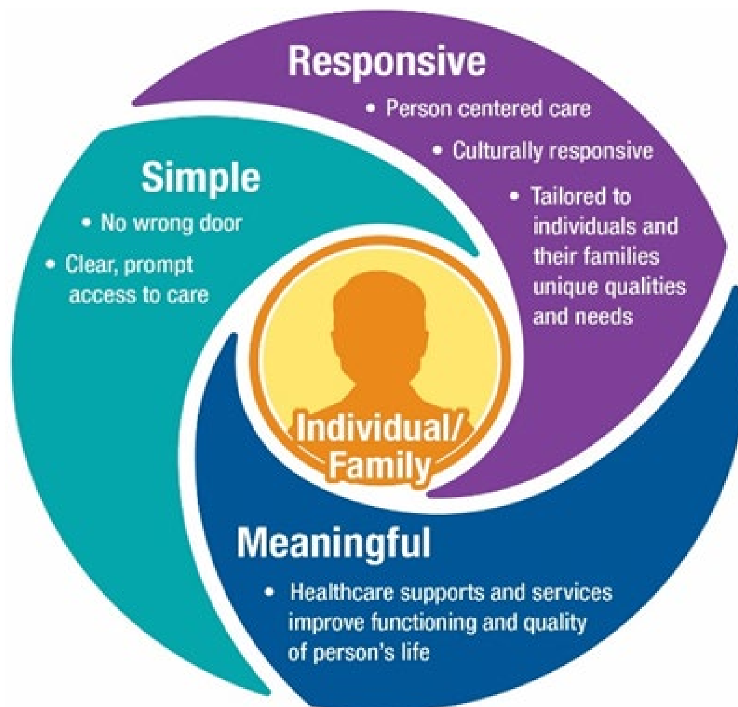
System of Care values and principles are aligned with the Office of Behavioral Health model for system improvement. Below are the components of that model.

Simplicity:

Outcomes are improved, and negative impacts and costs are reduced, when children, youth, young adults and families have access to the services and supports they need when they need them. Access can't be improved when there aren't adequate services and supports. Improving access will require investments, both in programs and in the workforce needed to deliver them. OHA needs to do more to support and retain the existing workforce while growing it. Even when services are available, frequently people struggle navigating systems with too many hurdles. OHA must hold ourselves, our funders and our providers accountable to relentlessly remove barriers and simplify access.

To improve **simplicity** of access to needed services:

- Reduce barriers to accessing and receiving needed culturally and linguistically responsive care, such as financial, transportation, language access (translation, language and sign language interpretation), diverse culturally competent workforce, process steps
- Integrate Traditional Health Workers including peers/ community health workers/ promotores[4] as part of the care team, improve the coordination of services and strive for a "no wrong door" system
- Increase transparency in services offered
- Reduce provider burden



[4] Promotores are lay health workers (community health workers) in Spanish speaking communities.

Responsiveness*:*

The path forward recognizes the depth of existing health inequities. People within Oregon's communities of color find it nearly impossible to access services that are provided by people who understand them, who look like them, or even speak their language when it's not English.

Frequently, people with the most severe and complex conditions are the least able to obtain services to help them to maintain access to basic life essentials such as a reliable source of food or safe and supportive housing, and that meet their behavioral health needs. OHA must be accountable to persistently engage people needing care, and reshape services to match what people need, rather than matching people to programs. The path forward must recognize and address and heal the trauma that accompanies mental illness and addiction.

Be **responsive** to people's unique individual needs and characteristics:

- Be person-centered, culturally and linguistically responsive and specific, and realize the impact of trauma in all its forms
- Promote cultural and geographic equity by addressing ethnic, racial, and geographic disparities and healing intergenerational and historical trauma
- Improve continuity of care by effectively engaging, and assisting with navigation and reforming systems to be easier to navigate
- Support development of culturally and linguistically responsive services, implement training and technical assistance
- Utilize evidence-informed practices, promising practices and traditional culturally based practices
- Support the integration of physical and behavioral health

Meaningful outcomes:

The way to a more responsive and effective system is through measuring and rewarding achievement of clear, meaningful outcomes which can be shared across relevant agencies. Needed multi-agency collaboration can lead to shared outcomes.

Accountability for improving the outcomes of people who are currently being poorly served, or missed, within our existing systems can be led by OHA and shared across agencies. The path forward requires, creates and rewards clear accountability for improvements in individual outcomes for children, youth, young adults and their families, including from communities experiencing most inequities due to racism and discrimination.

To result in **meaningful** improvements in people's lives:

- Support excellent clinical care including culturally and linguistically responsive clinical care
- Elevate goals that are deeply important to groups and populations who are facing the most inequities and struggle, as well as those of other populations
- Foster community and family connection; seek feedback from individuals and communities
- Create a continuous meaningful community engagement process and foster long-term trusting relationships and connection with historically and currently disenfranchised communities or families

- Develop and implement policies and procedures that strategically eliminate population-specific health inequities
- Enhance integration and utilization of Traditional Health Workers in service delivery
- Utilize data by race, ethnicity, language, disability, sexual orientation and gender identity to better understand service populations
- Design methods to track treatment progress and outcomes
- Measure outcomes on clinical and social indicators
- Target outcomes that are transformative
- Invest adequate resources for improvements in outcomes

The Child and Family Behavioral Health Unit

The Child and Family Behavioral Health unit within the Office of Behavioral Health implements and manages mental health, suicide prevention, and substance use disorder services and supports for children, youth, young adults, and their families. The unit develops policy and guidance for delivering services to children and families statewide, attending to the intersection for children and families also receiving services from other state agencies including Education, Oregon Youth Authority and county juvenile justice, and ODHS Child Welfare and Intellectual and Developmental Disabilities (I/DD). Additionally, the unit supports development of a continuum of care to adequately meet the needs of children, youth, young adults and families together with consumers, CCOs, health providers, counties, and other contractors.

The CFBH unit has evolved considerably since becoming an independent unit in the Addictions and Mental Health division of the Oregon Department of Human Services (ODHS) in 2007. The original "Kids Team" programs have expanded from outpatient, subacute and inpatient services to a diverse array of services and supports spanning levels of care and considering developmental needs, location, and availability of insurance or Medicaid coverage. A more detailed description of some of the current team achievements can be found in the March 2020 OHA Recovery Report[5].

The CFBH unit located in the Health Systems division of OHA, consists of the Director, in addition to a Manager and team reporting to the Director. There is increased recognition of the need for strong youth and family services and OHA received significant investment in 2019. This has led to the expansion of the unit to 18 staff and the elevation of the Unit to have its own director. The need for a vision, policy direction and plan for moving forward has never been greater or more compelling. What is done for children and youth assists greatly in reducing the need for lifelong behavioral health services. Data shows over 75% of adult mental health disorders develop by age 14[6].

In March 2020, the CFBH unit developed a vision that will be used to launch an updated statewide needs assessment recommended here. The Director will lead the updated statewide needs assessment of the child and family behavioral health continuum of care, which will include Wraparound, secure inpatient, residential, day treatment, Young Adults in Transition services and Mental Health and Substance Use Disorder outpatient services. The needs assessment work is anticipated to begin November 2020.

Staff have reviewed and summarized previous needs assessments, audits and reports and are incorporating that work into the ongoing vision and policy direction. A systemwide assessment and feedback to this CFBH unit vision paper will be completed during October 2020-October 2021.

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[5] https://content.govdelivery.com/accounts/ORDHS/bulletins/27f7aea

[6] (2003) Kim-Cohen, J; Caspi, Avshalom; Moffitt, Terrie; Harrington, HonaLee; Milne, Barry; Poulton, Richie. *Prior Juvenile Diagnoses in Adults with Mental Disorder.* Archives of General Psychiatry, Vol 60

Primary recommendations for success:

Address gaps and quality in the children's behavioral health continuum of care:

The children's behavioral health system in Oregon needs a full spectrum of effective supports from prevention to intensive acute care to be meaningfully responsive to needs. These services must address the needs of the population from birth through 25 years of age.

Accurate and timely data across child-serving systems:

Data allows for decisions about program and policy direction to be made with accuracy and consistency. The CFBH unit needs access to timely and consistent data beyond the current metrics, databases, and tools used to assess programs and services in order to create a sustainable continuum of quality care. Data on capacity need and utilization is particularly critical for creating, and sustaining current contracts administered by the CFBH unit. Key outcomes for children, youth, young adults and families are also extremely important and guide system improvement going forward.

Increase youth and family participation in service planning and system development through increased collaboration with consumers and youth and family advocacy organizations:

System of Care core values call for the system to be "Family Driven and Youth Guided" which means that the CFBH unit partners with youth and families at the service level up through the policy level. When program and policy creation is centered on the experiences of those who currently receive services, it is possible to expand or create new services and supports with the knowledge of what has worked and what has not been successful. Other existing family, youth and consumer advisory groups have an important role to play in providing feedback based on lived experience in child serving systems. Accessing communities of color through community engagement will assist with getting a health equity perspective.

Promote and develop a culturally and linguistically responsive continuum of care:

Behavioral health services and supports meet an array of social, emotional and behavioral needs. Providers must be trained and skilled at providing services in multiple languages, working with interpreters when necessary and being capable to deliver culturally responsive behavioral health services to Black, Latinx, Asian, Pacific Islander, Tribal, and LGBTQIA2S+ [7] communities. Collective impact on child serving agencies, incorporation of the core value of family and youth driven, ensuring that there is truly "no wrong door" to access services[8], all underscore the need for culturally and linguistically responsive services that meet Culturally and Linguistically Appropriate Services (CLAS) standards[9] and that are trauma informed to ensure health equity.

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[7] Lesbian, Gay, Bisexual, Transgender and Transsexual, Queer, Questioning, Intersex, Asexual, Two Spirit and all the ways people may identify

[8] A single access point inclusive of "no wrong door," is a significant strategy used by other states with advanced Systems of Care.

[9] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Increase cross system collaboration:

Investing in Behavioral Health catalyzes positive impact across child serving systems. The collective impact of behavioral health on other child serving systems makes responsiveness critical. Many youth who receive behavioral health services also receive services and participate in the child welfare, juvenile justice, education and I/DD systems. The difficulty in accessing services and supports, duplicated service requirements and challenges navigating across systems all emphasize the importance of creating a System of Care that does not present youth and families with barriers.

Emphasize and promote trauma-informed practice:

The CFBH unit have championed trauma informed care in Oregon, through policy work, Children's System Advisory Council (CSAC) activities, and adoption of this work as a unit mission. CSAC work during the last decade resulted in adoption of a Trauma Informed Services policy[10] by the Addictions and Mental Health division. The policy requires providers of publicly contracted Behavioral Health services to deliver care in a trauma informed manner. The Unit has also championed an internal facing OHA Trauma Informed Approach and Healing Culture policy and will be revising the Trauma Informed Services policy to align, once adopted.

Anticipated next steps and timeline:

- OHA leadership to review proposed solutions which align with strategic priorities and approve these concepts to be moved forward to consumers and stakeholders for feedback and meaningful engagement.
- CFBH unit will organize stakeholder feedback by engaging youth, families, state agencies, current contractors, local System of Care governance structures, advisories, providers, and associations in a meaningful conversation to ensure agreement and collective commitment to system improvement and reform.
- CFBH unit will align efforts with work being done by other child serving agencies and the System of Care Advisory Council.

Timeline:

[10] https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Trauma-Informed%20Services%20Policy.pdf

Foundational information and historical perspective

Overview of state history with children's behavioral health[11]:

Section 4901 of the Balanced Budget Act of 1997, public law 1005-33 amended the Social Security Act by adding a new title XXI, the Children's Health Insurance Program (CHIP). This effectively established Children's mental health services as part of Medicaid, in Oregon. The "Kids team" was part of a larger Medicaid policy unit and was formed in 1999. It expanded in 2003 to accommodate the work associated with the Children's System Change Initiative, an investment in the expansion of supports and resources for children, youth and families.

In 2003 the Children's System Change Initiative[12], authorized by Budget Note HS-3[13], directed Department of Human Services Addictions and Mental Health Division (DHS/AMH) to create a shift in the culture of service delivery toward a more family-focused, strengths based and coordinated system to reduce the need for costly, state funded long-term residential treatment services. These changes in 2004 through 2006, resulted in the movement of many youth who had been served in treatment facilities to being served in the community, with intensive community treatment services and supports, day treatment and therapeutic foster care. The units in the Oregon State Hospital serving children and adolescents were both downsized and moved to a secure residential setting in the community for a more normalized, community-based and de-institutionalized treatment setting.

In 2007 the Children's Behavioral Health unit is officially formed, with a dedicated manager. It was managed by a team lead prior to that time.

In 2009, HB 2144 catalyzed three demonstration sites for the first implementation of the Wraparound model. In 2014, through legislative investment, Wraparound services and supports were further expanded under the System of Care Wraparound Initiative (SOCWI). SOCWI funding, allocated to CCOs, supported a full statewide expanded implementation of the Wraparound model and created local System of Care councils to identify and resolve barriers impacting youth involved with multiple systems. By 2017 the Wraparound approach had been implemented statewide.

In 2011, coordinated care organizations were formed, and they launched in 2012. CCOs are the Oregon implementation response to the requirements of the Affordable Care Act and allow for a global budget so that members may receive supports which may not meet the definition of "medically necessary". Treatment focused on only what is "medically necessary" creates a barrier for some children, youth and families. CCOs were designed to be responsive to local unique service needs, allowing Medicaid recipients to have their dental, medical and behavioral health services coordinated and locally determined. All physical, behavioral and dental health benefits are managed through the CCOs, with OHA serving to allocate, administer, and monitor state and federal funding.

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[11] https://sos.oregon.gov/audits/Documents/2020-32.pdf

[12] HS-3 directed DHS/AMH to increase the availability and quality of individualized, intensive, and culturally competent home and community-based services so that children with serious mental, behavioral and emotional disorders and their families can be served in the most natural and least restrictive setting appropriate for their needs.

[13] http://www.localcommunities.org/lc/154/FSLO-1232522290-319154.pdf

In 2014 a Statewide System of Care Steering Committee formed to begin to address barriers that had been identified at the local and regional levels. This group is comprised of principal leaders of state agencies serving child welfare, education, juvenile justice, intellectual and developmental disabilities, and behavioral health.

In 2017 Governor Kate Brown convened a Children's Cabinet to create pathways toward prosperity for Oregon children and families living in poverty. The Cabinet is made up of leading experts in health, housing, human services, early learning, and education from the public, private, and non-profit sectors. Working collaboratively, the Cabinet has identified the highest priority concerns and existing gaps in services for working families and their children. The Cabinet identified evidence-based solutions providing significant return on investment toward helping families achieve success. The Governor's Children's Agenda builds on existing programs to both: a) address root causes of family instability, and b) create a more resilient safety net that helps kids and families who face increased challenges[14].

In 2019 legislative investments were again significant in support of the work of the CFBH unit. Through budgetary funding for suicide prevention and school based mental health, numerous bills impacting suicide prevention work throughout the system, SB 1 (2019), creating the SOC Advisory Council, and creation of an intermediate level of care, Intensive In-Home Behavioral Health Treatment (IIBHT), along with expansion of the existing Crisis and Transition Services (CATS) program, critical progress was made in further developing and funding the child and family behavioral health system.

In March 2020 a State level System of Care Advisory Council (SB 1 2019) was established by gubernatorial appointments, to represent all aspects of the System of Care. The primary duty of the council is to develop and maintain state System of Care policy and a comprehensive, long-range plan for a coordinated state System of Care encompassing public health, health systems, child welfare, education, juvenile justice and services and supports for behavioral health and people with intellectual and developmental disabilities.

Oregon's youth suicide rates climbed every year from 2011-2018, when Oregon had the nation's 11th highest rate of youth suicide. Each time an Oregon family and community experiences a youth suicide death, the ripples of impact are extensive. Suicide prevention is everyone's business. Governor Kate Brown included more than $6 million for suicide prevention in her budget for the 2019-2021 biennium, marking the first time this work has been sustainably funded by the state. In the following sections of this paper, it will be outlined how that funding has been utilized by the CFBH unit.

In September 2020 the Oregon Secretary of State office released an audit entitled Children's Mental Health: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis[15]. The CFBH unit participated fully in this audit process, agrees with their findings and endorses their recommendations specific to the children's system, which are reflected in this paper.

Oregon has had many successes as recipients of several county-based and two tribal System of Care--Children's Mental Health Initiative, Substance Abuse and Mental Health Services Administration (SAMHSA) grants, which have bolstered local SOC expansion and funded Wraparound programs for the period of their grants.

[14] https://www.oregon.gov/gov/policy/Documents/Children%27s%20Agenda-GOVERNOR%20KATE%20BROWN.pdf

[15] https://sos.oregon.gov/audits/Documents/2020-32.pdf

SOC development in Oregon has been driven by countless parents, caregivers and youth who have spoken up to inform state agencies and legislators what they need. Oregon has been persistent, in the absence of a statewide SAMHSA grant or lawsuits that, in other states, catalyze SOC with urgency, funding and with attention from leadership. Oregon legislature, the work of many Oregonians, and the work of the CFBH unit have made this possible to date, but more work remains to be accomplished.

Primary Recommendations

1. Address gaps and quality in the children's behavioral health continuum of care.

Associated SOC Guiding Principles:

- Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports
- Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings
- Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed
- Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family
- Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate

The CFBH unit promotes quality through implementation of evidence-based practices, workforce development and support, and the development of a continuum of care which is inclusive, responsive, and incorporates developmental, culturally responsive and trauma informed principles to guide the work. The CFBH unit needs to develop capacity and support workforce development in order to ensure availability and access to a broad, flexible array of effective services and supports in all regions of the state.

A full spectrum of supports includes:

- Flexible, available, and culturally and linguistically responsive services and support options which meet the needs of families and adequately engage children, youth and young adults in services.
- A full range of community-based treatment options for children, youth, young adults and families living in rural, frontier, and urban locales spanning behavioral health promotion, prevention, outpatient, crisis, and intensive in-home treatment prior to utilization of intensive treatment services.
- Adequate and flexible capacity for intensive treatment services in facility settings (day treatment, inpatient, subacute, Psychiatric Residential Treatment Services (PRTS), Long Term Psychiatric Care, Substance Use Disorder residential services and Young Adults in Transition-Residential Treatment Homes (YAT-RTH)) that address mental health and substance use disorders.
- Provision of high fidelity, evidence-based services and use of best practices at all levels of intervention.
- A workforce that:
    - Meets the demand for services,
    - Is appropriately trained and supported,
    - Is well-funded to serve families when and where they need help,

- Is diverse enough to meet the cultural and linguistic needs of the population they serve.

Urban areas host most of the intensive treatment options, early childhood mental health and other specialty services. Rural and frontier communities do not have the same system access as the more urban areas of the state. It will be necessary to strengthen and expand existing or establish desired services for rural and frontier communities through telehealth and creating new connections.

The Oregon Office of Rural Health (ORH)[16] defines *rural* as all geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more. *Frontier* counties are defined as those with six or few people per square mile. Ten of Oregon's 36 counties are designated as frontier. The average availability of mental health providers per 1,000 people in rural and frontier counties is .54 FTE (full time equivalent) and 21 rural and frontier service areas have *no* mental health providers. A strategic focus on prevention, increasing numbers of culturally specific providers and equitable geographic expansion can help mitigate and reduce the frequency and extent of critical needs in rural and frontier communities.

For most youth involved in child serving systems, the available services and supports vary based on CCO and local county capacity[17]. For youth with complex mental health needs involved in child serving systems, CCOs provide Wraparound and Intensive Care Coordination for those on the Oregon Health Plan. Overcoming barriers around direct access and coordination with other systems remain an ongoing challenge.

The CFBH unit supports health equity[18] with special attention to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersectionalities among these identities or communities or other socially determined circumstances which may manifest for children, youth, young adults and families. The CFBH unit aims to do this through equitable distribution of resources and power and through recognizing, reconciling and rectifying the historical and contemporary injustices we encounter in our work[19]. The CFBH unit supports contractual work with multiple entities to accomplish these goals, which are being monitored and supported by CFBH unit staff.

Recommended strategies:

Workforce development and support

The CFBH unit seeks to actively build workforce with focus on diversity, skill levels, knowledge of different treatment modalities, and which demonstrates connectedness to others. The CFBH unit has a goal of recognizing the reputation and professional standing of peer support and peer delivered services (PDS) and elevating it to a commensurate level with clinical staff.

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[16] https://www.ohsu.edu/oregon-office-of-rural-health/about-oregon-office-rural-health

[17] Secretary of State Audits Division Director Team, "Oregon Health Authority: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis" September 2020, Report 2020-32

[18] Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

[19] https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

The CFBH unit will actively build workforce with diversity and skills, through inclusion of peer support specialists and those delivering peer delivered services in workforce development activities for all of the workforce:

- Supporting attendance at professional conferences
- Promotion and implementation of evidence-based practices (EBP), best practices and promising models
- Providing trainings, certifications and technical assistance
- Conducting summits
- Working with licensing bodies to require certifications based in competencies

The CFBH unit will support, expand and evaluate current investments:

Evidence-based practice … is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences[20]. This definition encapsulates the goals of the CFBH unit in using well researched interventions to help children, youth and young adults feel better quickly and get back to their daily functioning.

The CFBH unit supports evidence-based practices that are culturally responsive or culturally specific and which create meaningful client participation in their own recovery. Children, youth and young adults deserve the best care available so that they can fully access educational and employment opportunities. Their families appreciate timely evidence-based interventions which deliver desired outcomes. Many Oregon universities only provide a brief overview of any evidence-based practice before allowing graduation in advanced mental health practice. This gap in workforce expertise offers the opportunity for the CFBH unit to guide additional training and outcome monitoring of practices most likely to benefit the most underserved and vulnerable children, youth, young adults and their families.

- **Parent Child Interaction Therapy (PCIT)** is a unique evidence-based dyadic psychotherapy model. The therapist observes the interaction from behind a one-way mirror and coaches the parent to use therapeutic strategies through a wireless communication system. PCIT is designed for children ages 2-6 years of age and their parents, when children may have significant social, emotional, or behavioral disorders which could increase their risk of maltreatment, interfere with their development, attachment, and with their readiness to learn[21]. Used worldwide, PCIT is effective across cultures and ethnicities. The average length of treatment is 16 to 20 sessions. OHA provides funding for PCIT program development in 22 counties and over 60 locations under the Oregon Health Plan (PCIT may also be covered by private health insurance). 85% of Oregon families who take part in at least four PCIT sessions show significant improvement in child behavior, positive communication and positive parenting skills[22].

[20] American Psychological Association (APA) by the APA Council of Representatives during its August 2005 meeting; https://www.apa.org/practice/guidelines/evidence-based-statement

[21] Parent-child interaction therapy: an evidence-based treatment for child maltreatment. Thomas R, Zimmer-Gembeck MJ. Child Maltreatment. 2012 Aug;17(3):253-66 and Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. doi: 10.1177/1077559512459555. Epub 2012 Aug 31.

[22] Parent-Child Interaction Therapy (PCIT) on child behavior problems - Video abstract [ID 207370]; The full text is available for free via open access here: Reconceptualizing attrition in Parent–Child Interaction Therapy: | PRBM

- **Parent Management Training -Oregon (GenPMTO) model** is an evidence-based intervention that helps parents strengthen families at all levels (children, youth, parents, and couples). Successful treatment generally lasts 10-25 sessions. Based on more than 50 years of research, GenPMTO promotes parenting and social skills and prevents, reduces and reverses the development of moderate to severe conduct problems in children and youth ages 2-17 and their parents. GenPMTO programs can be tailored for diverse populations and have been successful in widescale applications in the United States and several other countries. In 2020, OHA funded training for program implementation and statewide system development. 32 therapists from two agencies serving nine counties have started providing GenPMTO to Oregon families. GenPMTO has flexibility and can be used for preventive or clinical intervention, in group or family delivery formats, as an in-home service or via telehealth.
- **Child Parent Psychotherapy (CPP)** is a dyadic evidence-based intervention for children ages 0-6 years of age and their caregiver who have experienced trauma such as domestic violence[23]. A central goal is to support and strengthen the caregiver-child relationship while focusing on safety, emotional regulation and adaptive prosocial behavior. Over the course of treatment, the caregiver and child are guided to create a joint narrative of the psychologically traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect. Average length of treatment is 30-50 sessions. Since 2014, OHA, in collaboration with Greater Oregon Behavioral Health Inc. (GOBHI), has funded training for clinicians in 20 counties and multiple agencies.
- **Collaborative Problem Solving (CPS)** model is an evidence-based model developed at Massachusetts General Hospital (MGH) by Dr. Ross Greene and Dr. Stuart Ablon. The CPS model helps adults better understand why a child may display challenging behaviors and how to effectively intervene. The approach focuses on helping youth build skills like flexibility, frustration tolerance and problem solving, rather than simply motivating children and youth to behave better. The process begins with identifying triggers to a child's challenging behavior and the specific skills they need help developing. The next step involves partnering with the child or youth to build those skills and develop lasting solutions to problems, that work for everyone.

  The model can be implemented by parents, teachers, and mental health professionals in a variety of settings. CPS is listed on the Blue Menu of Evidence-Based Psychosocial Interventions for Youth[24] from the PracticeWise Evidence-Based Services Database, and on the California Evidence-Based Clearinghouse for Child Welfare[25]. ThinkKids at MGH offers a robust certification process for those interested in becoming proficient in the model[26].

- **Trauma Focused Cognitive Behavioral Therapy (TF-CBT)** is a brief, structured, evidence-based psychotherapy model for children 3-18 years of age and their caregiver(s) who are experiencing significant emotional and behavioral difficulties related to traumatic life events. Typically, treatment lasts 8-25 sessions. Research demonstrates TF-CBT reduces the following symptoms: child posttraumatic stress

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[23] Traumatic and stressful events in early childhood: Can treatment help those at highest risk? Chandra Ghosh Ippen, William W. Harris, Patricia Van Horn, Alicia F. Lieberman; https://doi.org/10.1016/j.chiabu.2011.03.009

[24] https://www.practicewise.com/Community/BlueMenu

[25] https://www.cebc4cw.org/program/collaborative-problem-solving/

[26] www.thinkkids.org

disorder, depressive and anxiety symptoms, child externalizing[27] behavior problems (including sexual behavior problems related to trauma), and shame and embarrassment. TF-CBT consistently obtains outcomes that surpass the outcomes of nondirective supportive therapy and standard community care. Additionally, there is evidence for TF-CBT effectiveness using virtual delivery platforms[28]. Training for 115 Oregon therapists is planned for 2020-2022.

- **Positive Parenting Program ("Triple P" or PPP)** is a multi-tiered system of five levels of education and support for parents and caregivers of children and adolescents. A prevention and early intervention program, the first three levels in the Triple P system help parents learn strategies that promote social competence and self-regulation in children. Parents become better equipped to handle the stress of everyday child rearing and children become better able to respond positively to their individual developmental challenges and moderate to severe behavior problems.
- **Mental Health Approaches to Intellectual and Developmental Disability**: OHA is training clinicians who work with these overlapping populations in a train the trainer model, in which the following resource manual is most useful. *Mental Health Approaches to Intellectual/Developmental Disability: A Resource for Trainers* is a landmark contribution to the field of support for persons with Intellectual or Developmental Disabilities (I/DD) and Mental Health concerns. This book can be used by a variety of different professionals and care providers for a multitude of different purposes including: (a) to train others for professional development (train-the-trainer model), (b) as a resource guide for individual study, or (c) as a reference guide. It is designed to be used with a wide range of audiences from direct support workers to professionals from various disciplines.[29]

  Suggested support for I/DD/MH practices includes:

  - Key training and measures to support selected practices
  - Certification and fidelity monitoring
  - Outcome data and timely data analysis
  - Value based payments for certified providers with positive performance
  - Rule changes and review processes that improve quality

Increase oversight and support of children's outpatient services

- CFBH unit staff to participate in provider certification (site) reviews to provide technical assistance and promote better quality and access.
- Develop a team within the CFBH unit with expertise in outpatient behavioral health services.
- Participate in a review of the Oregon Administrative Rules 309-019 Outpatient Behavioral Health Services with a special focus on children, young adults, racial equity and trauma informed care.

[27] child defiance, aggression, tantrums, talking back, destructive or other maladaptive behaviors

[28] Meta-Analysis of Trauma-Focused Cognitive Behavioral Therapy for Treating PTSD and Co-occurring Depression Among Children and Adolescents; June 2015; *Counseling Outcome Research and Evaluation* 6(1) DOI: 10.1177/2150137815573790

[29] https://thenadd.mybigcommerce.com/mental-health-approaches-to-intellectual-developmental-disability-a-resource-for-trainers/

Address identified gaps in the continuum of care:

Mobile Response and Support Services (MRSS) 2021-23 Policy Option Package (POP):

Oregon Health Authority submitted a Policy Option Package for Mobile Response and Support Services (MRSS), a key element to a successful children's System of Care. The POP seeks to institute a 24/7, 365 days a year MRSS program designed to provide mobile response before situations become unmanageable emergencies.

- MRSS is specific to children, young adults and their parent/caregivers as part of Oregon's children's System of Care through use of a centralized referral system. MRSS staff will support young people and their parents/caregivers in averting unnecessary emergency department visits, out-of-home placements, placement disruptions, arrests/ incarceration and will reduce overall system costs.
- MRSS will offer response services including face to face interventions, telehealth, and stabilization services for 4 to 8 weeks which include individual therapy, family therapy, in home services, peer delivered services, and skills training. Staff will facilitate the youth and parent/caregiver's transition into identified supports, resources and services consistent with their treatment needs, supporting a sustainable plan which could include linking the family with Wraparound, Intensive Care Coordination, outpatient services, community-based supports and informal and natural resources.
- MRSS provides ongoing support to foster youth and their caregivers to reduce crises and thus decrease the number of times a youth may need a change in foster home settings. Evidence from other states shows that MRSS type services and supports dramatically increase the stability of placements and can successfully decrease police involvement and emergency room use, while providing treatment to youth and their families in their home and community.

Young Adult Transitional Services 2021-23 Policy Option Package:

Young adults ages 14 to 25 in transition are underserved across the continuum of care. They are at a developmentally unique time in their lives with significant social, emotional, physical, and cognitive changes occurring. Research shows that young adults in transition have high rates of serious mental health and substance use concerns with low rates of engagement in mental health services[30].

Oregon's current behavioral health system is not sufficiently equipped to respond to the unique developmental needs of this population, or to provide timely treatment for young adults at recommended levels of care. Many young adults previously engaged as children under age 18, in the behavioral health system, disengage during the transition to the adult behavioral health system. Youth and young adults across Oregon deserve accessible, non-stigmatizing and developmentally appropriate services to help them transition successfully into adulthood.

[30] Substance Abuse and Mental Health Services Administration. (2014). *The CBHSQ Report: Serious Mental Health Challenges among Older Adolescents and Young Adults.* Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/sites/default/files/sr173-mh-challenges-young-adults-2014/sr173-mh-challenges-young-adults-2014/sr173-mh-challenges-young-adults-2014.htm

The OHA Young Adult POP will:

- Establish a Center for Training and Technical Assistance for Youth and Young Adult Behavioral Health that would develop fidelity models and best practice, outcome measures, and technical assistance for youth and young adult serving programs.
  Expand Young Adult in Transition residential system with four additional five-bed RTH for a total of 54 beds and a 10-bed Secure Residential Treatment Facility specializing in the young adult population (ages 17.5 – 25).
- Expand the Early Assessment and Support Alliance (EASA) program from a two-year program to a three-year program. The third year is based on a step-down framework and would provide youth and young adults (ages 14-25) continued transition services, access to a strengthened peer support component, and enhanced life and self-care elements.
- Provide additional funding to Young Adult Hubs, which are modeled after Transition to Independence Process[31] and provide mental health services, case management, and support for disconnected youth.

In 2019, OHA and DHS performed a joint capacity study that indicated Oregon needs an additional 47 beds at the PRTS level of care to support children and youth with intense mental health needs. Approximately 245,000 children and youth in this age group are covered by the Oregon Health Plan (OHP) at any point in time, which equates to 0.6 beds of PRTS capacity for every 1,000 children and youth covered by OHP.

The OHA Youth and Young Adult 2021-23 Policy Option Package would also develop PRTS capacity through establishment of 47 additional PRTS beds and ongoing funding that can support sustainability and needed capacity infrastructure. This will support a comprehensive continuum of care for children's mental health intensive inpatient programs.

Psychiatric Residential Treatment Services (PRTS) Capacity Building Project:

Oregon has seen a decrease in mental health residential and subacute beds, including at the Psychiatric Residential Treatment Facility (PRTF) level of care[32], which serves ages 6 to 18. Oregon has three types of licensed PRTF facilities, including PRTS facilities.

CCOs must cover PRTS as a required element of the CCO benefit package. This means CCOs must demonstrate that the services, or some equivalent substitute, are available for all who need it according to federal medical criteria. Among in-state PRTS providers who contract with commercial insurance carriers and OHP CCOs, OHA estimates that 25 percent of PRTS beds are occupied by children on commercial insurance and the remaining 75 percent are occupied by children on OHP (of which roughly 20 percent are children in the child welfare system)[33]. OHA and ODHS have a combined PRTS Capacity Building Project that will create a needs assessment and develop strategies to build and monitor this intensive level of behavioral health capacity.

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[31] https://pubmed.ncbi.nlm.nih.gov/25342546/

[32] PRTF is a federal designation of services offered at a non-hospital facility that is accredited by a national accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations (JAHCO) and the Commission on Accreditation of Rehabilitation Facilities (CARF), directed by a physician, and provides active treatment that is likely to benefit a youth. 42 CFR 441.151 through 42 CFR 441.182.

[33] These numbers do not reflect children served in out-of-state PRTS programs.

OHA and ODHS leadership have committed to:

- Engage PRTS providers, CCOs and commercial insurance carriers to identify future state options recognizing collective resources and knowledge.
- Review current services with a health equity lens and make recommendations to ensure culturally specific service delivery.
- Identify start-up funds needed to help offset one-time costs for developing additional capacity.
- Explore funding models to ensure capacity is available when needed.
- Develop programmatic and policy change recommendations that encourage and support capacity development and operational sustainability.
- Track provider outcomes and ongoing system capacity needs.
- Coordinate with the System of Care Advisory Council with an analysis of the current continuum of care and develop long-term recommendations for the appropriate needed settings.

In March of 2020, OHA hosted a visioning event with Patti Dobrowolski[34] and national System of Care expert Liz Manley with psychiatric residential providers, acute care providers, ODHS and state Senator Sara Gelser to develop a vision around the intensive service array.

This group identified three key areas to address:

- “Reframe”, “Re-rule”, “Rebrand” and “Respond” in relationship to PRTS
- Braided funding
- Work on legislative requests for further investment in the children’s continuum of care.

This collaborative group will continue as Oregon’s Coronavirus (COVID-19) response allows, to develop a work plan in consultation with consumers and stakeholders statewide and be a key partner in needs assessment content development.

Fidelity Wraparound

Wraparound is a care coordination model tailored to the needs of youth and families with complex behavioral health needs and involved in multiple systems. Wraparound has been implemented statewide and is part of the array of services provided to CCO members. However, young people not enrolled with CCOs (on “Open Card”) do not receive Wraparound due to the differences in reimbursement rates. The CFBH unit proposes adding Wraparound as a Medicaid covered service, perform a fiscal analysis to establish a budget and open billing codes. Once completed, young people on “Open Card” would have the same access to Wraparound as CCO members.

Respite services

Family members and caregivers in Oregon do not have access to crisis mental health respite when caring for a young person experiencing behavioral health concerns. The result is increased use of the emergency room, risk for child welfare involvement and calls to law enforcement. OHP currently provides crisis respite for adults, but the

[34] upyourcreativegenius.com

same Medicaid and "Open Card" codes do not exist for children and youth. The unit proposes addressing the need for respite care services for young people and their caregivers, keeping it cost neutral, and adding crisis mental health respite to the State Plan (Medicaid) Amendment.

ODHS Child Welfare has a workforce proposal that uses the 240 contracted Behavioral Rehabilitation Services (BRS) Proctor Foster Care beds as a statewide Medicaid respite network (for all youth covered by OHP, not just ODHS clients.) BRS Proctor Foster Care beds extend the entirety of the I-5 corridor and into Eastern Oregon, through the GOBHI network of Proctor Foster Care. This proposal expands what once was a resource for ODHS foster parents to all caregivers.

Substance use disorder (SUD) services:

Most substance use disorders begin before age 25. Studies show that for youth (ages 12-17) and young adults (ages 18-25), frequent marijuana use is associated with opioid misuse, heavy alcohol use and depression. It is common for SUD to be an intergenerational problem. OHA is working to end this cycle. The CFBH unit will work with a variety of partners, programs and systems to deliver developmentally focused, age-appropriate SUD services. This collaboration promotes prevention, best practices and cross-system alliance throughout Oregon's SUD treatment system.

Supporting the child and family System of Care to ensure good family communication, safe and nurturing trauma informed environments, teaching emotional regulation, decision-making skills and providing developmentally and culturally responsive education systems act as protective factors for resisting later drug use. There is a need for substance use education curriculum across our systems.

The CFBH unit, in partnership with ODHS, established the Youth and Young Adult SUD Collaboration and invited youth with lived experience and experts, including Dr. John Seeley from the University of Oregon and Dr. Rebecca Marshall, the lead evaluator for Oregon Health & Science University's Crisis and Transition Services (CATS) Outcomes Team. While members of this collaboration agree that prevention strategies are much needed in Oregon, they will also be focusing on educating the workforce and stakeholders on the importance of expanding access to treatments for co-occurring disorders for individuals struggling with both a substance use disorder and a mental health disorder. This collaboration has reviewed and agrees with the youth-focused goals and objectives of the Alcohol and Drug Policy Commission 2020-2025 Plan[35] and will advise and support this work moving forward.

Commercially Sexually Exploited Children Services

OHA currently supports an intensive, secure treatment facility for Commercially Sexually Exploited Children (CSEC) in the Portland metro area. Youth are identified through the Department of Justice, law enforcement, or ODHS as having been at risk for sexual exploitation or have been commercially trafficked. The program, called SAGE (**S**upport, **A**chieve goals, **G**row, **E**mpower), currently serves 12 female identified youth ages 11-16 in a secure setting. In 2019, the CFBH unit funded an extension of this treatment facility with four additional beds. This extension allows for supported transitional treatment as youth return, back to community living.

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[35] The Alcohol and Drug Policy Commission (ADPC) is an independent state government agency that was created by the Oregon Legislature to improve the effectiveness and efficiency of state and local Substance Use Disorder (SUD) prevention, treatment and recovery services for all Oregonians.
https://www.oregon.gov/adpc/SiteAssets/Pages/index/Statewide%20Strategic%20Plan%20Final%20(1).pdf

Despite this extension, the availability of supports and services in the state for youth with sexually traumatizing histories is limited. Prevalence estimates of sexually exploited youth are difficult to identify. One recent California screening demonstrated that 10.1% of youth in high risk settings showed clear signs of being trafficked36. It is well established that commercial sexual exploitation of children in the U.S. requires a coordinated response from multiple systems, including child welfare, mental health, public health, education, law enforcement, and juvenile justice[37] [38] [39] [40] [41].

Expansion of identification and treatment for children who are victims of sexual exploitation is warranted. A cross system work group including youth and family, providers, Oregon Youth Authority (OYA), OHA, child welfare and law enforcement could identify next steps in expansion. At a minimum, additional capacity is necessary as is identification and treatment for male identified youth. Additionally, an intensive outpatient level of treatment and supports is needed by youth and families who do not want or need a secure treatment setting.

Equitable racial and geographic evaluation, quality improvement and expansion

Oregon lacks mental health supports that meet the needs of youth and families of color in a culturally responsive manner. Many of Oregon's nine federally recognized tribal members remain on OHP "Open Card" benefit that provides less access to providers and services, including Wraparound.

This inequity impacts Latinx and immigrant communities accessing a continuum of care that is culturally and linguistically responsive. When conducting the updated needs assessment, it will be essential to engage with individuals from communities of color to identify needs and challenges and co-create culturally responsive solutions.

Oregon also struggles to provide a continuum of care in rural, frontier and urban areas of the state. Mental health promotion and prevention efforts have historically been limited statewide. A more specific inquiry into how social determinants of health are impacting children's behavioral health supports and how that can be alleviated is warranted.

The CFBH unit in collaboration with consumers, the OHA Office of Equity and Inclusion, the Office of Rural Health, county mental health programs, CCOs, and others will develop a tool to evaluate the current programing in the unit including:

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[36] Basson, D., Langs, J., Acker, K., Katz, S., Desai, N., & Ford, J. (2018). *Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies*. Oakland, CA: West Coast Children's Clinic)

[37] Epstein, R., & Edelman, P. (2014). *Blueprint: A Multidisciplinary Approach to the Domestic Sex Trafficking of Girls.* Washington, DC: Center on Poverty and Inequality, Georgetown Law.

[38] Bounds, D., Julion, W.A., & Delaney, K.R. (2015). Commercial Sexual Exploitation of Children and State Child Welfare Systems. *Policy, Politics & Nursing Practice,* 16(1-2), 17-26.

[39] Institute on Medicine & National Research Council, 2013; Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. Washington, D.C.: National Academies Press. Retrieved from http://www.nap.edu/catalog/18358

[40] Salisbury, Dabney, & Russell, (2015). Diverting victims of commercial sexual exploitation from juvenile detention: Development of the InterCSECt screening protocol. *Journal of Interpersonal Violence,* 30(7), 1247-1276.

[41] Shields, R.T., & Letourneau, E.J. (2015). Commercial sexual exploitation of children and the emergence of safe harbor legislation; implications for policy and practice. *Current Psychiatry Reports, 17(3), 553.*

- Crisis and Transition Services (CATS)
- School Based Mental Health (SBMH)
- Early Assessment and Support Alliance (EASA)
- Intensive In-Home Behavioral Health Treatment (IIBHT) implementation with focus on rural and frontier regions
- Intensive Service Array including Day Treatment, Subacute, PRTS, Secure Inpatient Programs

2. Ensure accurate and timely data is available across child-serving systems

The CFBH unit will make policy and program decisions based on accurate and timely data that is sourced from program outcome data measures, CCO metric data, consumer feedback, Medicaid data and the System of Care data dashboard. Other sources of relevant data include data sets from the Oregon Department of Education (ODE), Medical Examiner's office, health complexity, rural health reports, and All Payer All Claims data. Data is analyzed and evaluated with ongoing contract monitoring and compliance activities and supported by the Health Policy and Analytics division. Analysis is then shared with OHA leadership, CCOs, programs, and the public.

Associated SOC Guiding Principle:

- Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

A recently created (August 2020) data dashboard supporting the Statewide System of Care Advisory Council will provide child serving agencies with needed data on utilization of services across child serving systems. With use of this data, the unit will be able to:

1. Make data informed decisions
2. Aid in a strategic approach to financing by identifying populations of focus
3. Agree on underlying values and intended outcomes
4. Identify the services and supports and desired practice model to achieve outcomes,
5. Determine how services and supports will be organized into a coherent system design,
6. Identify the administrative infrastructure needed to support the delivery system and
7. Project costs for the continuum of care.

Recommended strategies:

Establish performance and outcome measures

OHA and ODHS will work with the System of Care Advisory Council and national experts to define performance and outcome measures which can be tracked to support and monitor the children’s behavioral health continuum of care.

CFBH unit has started work with the System of Care Advisory Council to put together a workgroup to redesign SB 944 (2017) legislation and investment to better meet the capacity and outcome data needs of the system within the intensive service array and connection to community-based services[42].

Assessment of existing program data

The CFBH unit will engage consumers, partners and advisory groups to do an assessment of all the data points available (locally and nationally) and collaboratively determine program and system level data that are meaningful to develop policy and program decisions for Children's Behavioral Health.

Examples of data available:

- **Health Complexity Data**[43] including August 2020 findings (includes young adults 18-20 years of age)
- **Student Health Survey**[44] (SHS) is a collaborative effort with ODE to improve the health and well-being of all Oregon students to help them succeed. This comprehensive, school-based, anonymous and voluntary health survey is available to many 6th, 8th, and 11th graders and is a key part of statewide efforts to help local schools and communities ensure that all Oregon youth are healthy and successful learners.

  The SHS is designed to address:

  - Student health and safety
  - Student mental and behavioral health
  - School climate and culture
  - The impact of COVID-19

  Prior to 2020, student health data was collected through the Oregon Healthy Teens[45] **,** the Student Wellness Survey, and the Youth Behavior Risk Survey[46]. Going forward, these surveys are replaced by the Student Health Survey.

- **Medicaid Management Information System Data**
- **The Oregon Office of Rural Health**[47] (ORH) has been the coordinating body for rural and frontier health in Oregon since 1979. ORH partnered with Oregon Health and Science University (OHSU) in 1989 to increase its ability to bring statewide resources to rural areas. In addition to many services they create a report of unmet health care needs in Oregon[48]. The report outlines information on availability of health and

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[42] Secretary of State Audits Division Director Team, "Oregon Health Authority: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis" September 2020, Report 2020-32

[43] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx;

https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Statewide-Report-2020-August.pdf

[44] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/Pages/student-health-survey.aspx

[45] https://www.oregon.gov/oha/PH/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx

[46] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/YRBS/Pages/index.aspx

[47] https://www.ohsu.edu/oregon-office-of-rural-health/about-oregon-office-rural-health

[48] https://www.ohsu.edu/sites/default/files/2020-08/2020%20Areas%20of%20Unmet%20Health%20Care%20Needs%20Report.pdf

mental health services in Oregon per 1000 residents, and information on poverty rates, among other data points.

Qualitative data collection and assessment

Collect, integrate and analyze qualitative data, such as consumer feedback sessions, surveys, complaints and appeals.

Define benchmarks and methodology

Define benchmarks for children's mental health and substance use service performance measures tied to goals, and document the methodology used to track the measures with appropriate data. Consider creating five unit-specific indicators. Possible measures to consider are: third grade test scores, child abuse rates, school attendance, capacity waitlist, emergency department utilization, recidivism, length of stay in highest levels of care, high school completion, suicide rates.

Incorporate social determinants of health

Partner with internal OHA unit to address and integrate work on social determinants of health as related to children, youth and young adults and their families.

Performance dashboards

Create and disseminate meaningful measures and outcomes for each CFBH unit staff to generate a data dashboard with OHA's Performance Management System and Quality Performance Reviews beginning with Mission Essential Functions.

Performance dashboards currently developed include:

- Suicide prevention and intervention activities
- Restorative Services
- Young Adult residential referral process
- Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP) Referral and Capacity

The overall Child and Family Behavioral Health unit dashboard is under construction but is likely to include at a minimum:

- Youth and Young Adult suicide rates
- Emergency Department utilization for behavioral health needs
- PRTS/Secure Inpatient Program utilization
- Children in temporary lodging

Strengthen and expand resources for data collection and assessment

Additional staffing

Develop and deliver a proposal to request additional resources for a data analyst within the CFBH unit. OHA is developing a legislative concept for 2021-23 legislative session to request these resources.

Electronic CANS (e-CANS) solution

Develop and deliver a proposal to expedite collection of Child and Adolescent Needs and Strengths (CANS tool) data to support Wraparound. OHA has a POP in the 2021-23 legislative session for Compass (data system) modernization that would include an e-CANS solution.

Suicide Intervention and Prevention Plan:

- Develop a data use agreement between Health Systems division and the Oregon State Police Medical Examiner's office for timely access to suicide death data.
- Support and equip our research and evaluation partners (University of Oregon Suicide Prevention Lab, Portland State University) with adequate funding and appropriate access to data systems.
- Embed data review in the 2020-2025 Youth Suicide Intervention and Prevention Plan (YSIPP).
  - "Essence Report" which is a monthly report that combines public health surveillance updates, data from emergency department and urgent care suicide-related visits, poison control center calls, and suicide prevention line (Lines for Life) calls in 2020 compared to the same time last year.
  - Medicaid data on outpatient crisis and suicide care.
  - The CFBH unit coordinators are also working on a data use agreement for access to medical examiner database, combined data with vital stats, Medicolegal Death Investigation (MDI) log and National Violent Death Reporting System information.

3. Increase youth and family participation in service planning and system development through partnerships with consumers and youth and family advocacy organizations.

Associated SOC Guiding Principle:

- Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, Tribes, and nation.

The CFBH unit will develop and use a consistent and sustainable method of meaningful engagement and embedding the voice of youth and families, youth and family advocacy organizations to collaborate on programs and policies impacting youth and families.

When communities have opportunities to engage in respectful ways and feel that they can trust CFBH/OHA, they will be more willing to openly share the barriers and challenges they experience; this helps the agency to better understand population-specific inequities. This can introduce future dialogues about creative and sustainable solutions to uplift behavioral health equity in communities across the state. Community engagement is a path to

empower communities by making them part of the decision-making process and creating accountability on the part of CFBH/OHA to the community.

The unit has existing contracts with both Oregon Family Support Network and Youth ERA. Both organizations ensure that there is support and training for youth and family advocates at the policy level and sustain the peer delivered services continuum across Oregon.

Hart's Ladder[49] is a youth participation model used to assess an organization's or group's quality of youth and young adult participation. This model is used by the Youth and Young Adult Engagement Advisory (YYEA) and the Healthy Transitions Grant coordinators to work with councils and committees to facilitate conversations and create plans to move up the ladder of participation. An assumption in using Hart's Ladder is that behavioral health programs and services for youth and young adults will be more effective with meaningful participation from youth and young adults with lived experience, in decision making.

Recommended strategies:

Consumer engagement

In partnership with the OHA Ombudspersons' team, the Director of Consumer Activities, and OHA's consumer advisory councils, the unit shall create a strategy and infrastructure ensuring that consumers and advocates are meaningfully engaged and heard, and their voices are embedded in our work.

This infrastructure shall include:

Improved recruitment

Develop a comprehensive strategy for active recruitment and engagement of more youth, family and consumer advocate voices to include:

- Geographic diversity
- People experiencing I/DD and other disabilities
- Black
- Tribal communities and tribal consultation
- Communities of color
- LGBTQIA2S+
- Those who have had negative experiences in the mental health system
- Communities and individuals who don't have access to systems
- System of Care representatives
- Culturally specific community-based organizations

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[49] Youth Participation Models [Infographic]. School-Based Health Alliance. https://www.sbh4all.org/training/youth-development/youth-engagement-toolkit/youth-participation-models/ Adapted from Hart, R. (1992). Children's Participation from Tokenism to Citizenship, Florence: Unicef Innocenti Research Centre, as cited in www.freechild.org/ladder.htm

Feedback loop for youth, family and advocate input

The CFBH unit will develop and document a process for maintaining regular youth, family and advocate input to OHA, providers and systems. This process will include:

- A meaningful accountability structure for the CFBH unit to go back to youth, family and advocates with plans based on feedback and consumer envisioning
- Create mechanisms for youth, family and advocate input especially youth and family of all ages, prior to firm policy decision and implementation
- A process to engage youth Advisory Councils for programs and policy development, review and evaluation
- Evaluation of youth engagement to include Hart's Ladder described above

Increase youth and family SOC participation

The CFBH unit will meaningfully utilize the local System of Care entities throughout the state and support them to ensure youth and family voices are at the table.

- Each CCO convenes System of Care entities that bring together child serving system representatives, youth and family members with the goal of identifying barriers and collaboratively expanding supports and services for youth and families.
- Each of the SOC entities prioritize issues that are specific to the youth and families in their community, and thus provide a diverse representation of the needs experienced by youth and families with complex needs. Through partnerships with the Oregon Family Support Network, Youth ERA, and Portland State University's System of Care Institute, technical assistance focuses on meaningful engagement and retention. OHA Wraparound and System of Care work provides support, compliance oversight and resources to ensure SOC entities have the tools they need to partner with youth and family members with lived experience in child serving systems.

Amplify youth advocacy efforts

Connect behavioral health youth advocacy groups to other statewide child serving system youth advocacy groups.

Suicide Prevention and Intervention Plan:

- Recruit members age 18 or younger to the executive committee of the Alliance to Prevent Suicide.
- Recruit youth members (age 24 and younger) to serve on each committee of the Alliance to Prevent Suicide.
- Contract with YouthERA and Association of Oregon Community Mental Health Programs for active and intentional youth and young adult support such as giving background information on initiatives prior to meetings, support for youth members during meetings, and follow up after meetings.
- Identify meaningful ways to elevate youth stories of hope, help, and strength.
- Encourage contracted suicide prevention staff to attend YYEA meetings to gather feedback on programs.
- Hold youth focus groups for key messaging campaigns regarding suicide prevention and wellness.

4. Promote and develop Health Equity in the Continuum of Care

Associated SOC Guiding Principle:

- Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; services should be sensitive and responsive to these differences.

The CFBH unit will lead the creation of a continuum of care that centers and responds to the voices and needs of communities impacted by institutional racism and oppression. The CFBH unit is committed to addressing the need for culturally specific providers in urban, rural and frontier communities with the goal of creating a continuum of services and supports available to all Oregonians regardless of race, ethnicity, languages spoken, disability, gender identities, sexual orientation and intellectual functioning. In the aftermath of George Floyd's death, and the many deaths that preceded him, the need for culturally specific support and providers has become a state issue.

CFBH will use a continuous community engagement model that values building long-term trust and relationships with communities who may have experienced behavioral health inequities. Meaningful community engagement is not transactional and should not occur only when the agency needs input, information or feedback for specific initiatives. Instead, by approaching community engagement in ongoing, culturally and linguistically appropriate ways, CFBH will build trust and relationships, better understand communities, and better address their behavioral health inequities and what is needed to support the health and wellness of all Oregonians.

Addressing health equity with currently contracted providers remains a CFBH unit goal since Fall 2018. The unit has been reviewing and amending contract language to reflect key targets used in the CLAS standards. These approaches to contracts ensure that providers are developing specific strategies for meeting the needs of Black, Latinx, Indigenous, tribal members, LGBTQIA2S+ individuals and people with disabilities.

Further, ensuring the application of CLAS standards is valued in OHA. In order to develop a continuum of care that incorporates everyone, CLAS standards will be used in conjunction with OHA's strategic plan for equity. OHA developed a strategic goal, in partnership with community, to eliminate health inequities within 10 years. The urgency behind meeting this goal has been highlighted by the COVID-19 pandemic and state budget crisis. Each proposed budgetary and legislative action has a potential impact on service delivery and therefore a potential disparate impact on tribal communities and communities of color. Without intentional antiracist[50] decision-making, health inequities can increase, and the disparity gap may grow.

A key learning from COVID-19 both in Oregon and across the country is how deeply COVID-19 exacerbates existing racial and economic inequities with wide-ranging health, social, and economic implications. For example, long-standing health inequities have caused higher rates of chronic health problems within communities of color compared to white communities. Because COVID-19 puts people with underlying health conditions at greater risk, people of color face a greater chance of experiencing severe COVID-19 illness. State public health experts recognize that this virus has had disproportionate infection rates and other negative effects on specific

[50] One who is supporting an antiracist policy through their actions or expressing an antiracist idea. Retrieved from: https://www.penguin.co.uk/articles/2020/june/ibram-x-kendi-definition-of-antiracist.html

communities, including Native American, Tribal members, Black, African American, Latinx, Asian, Pacific Islander, linguistically diverse populations, and those with disabilities.

At OHA, we particularly seek to address social determinants of health and the systemic racism and other health and economic inequities tribal communities and communities of color experience, which have been compounded by COVID-19, focusing on health and economic disruptions, food insecurity and housing, and safety and violence prevention. Our short-term plan reflects our commitment to get better at community engagement, to engage our partners upfront and authentically respond to their input.

With these thoughts in mind, the Office of Behavioral Health has distributed federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to address COVID-19 impact for communities of color in this way:

- In June 2020 the Oregon Legislature allocated $25.6 million from the state's Coronavirus Relief Fund to provide culturally responsive behavioral health funding in response to the impacts of the COVID-19 pandemic. The Coronavirus Relief Fund was established from Oregon's share of federal CARES Act distributions to states. Funds will be available to provide services through December 2020.
- Each Community Mental Health Program (CMHP) has received funding to support COVID-related behavioral health needs for historically underserved populations, including communities of color, tribal communities, homeless service providers, and community-based organizations. Funds support culturally and linguistically appropriate services and services for seniors. Outreach and wrap-around efforts include coordination with contact tracers.
- For Community Based Organizations, Recovery Support Organizations and Tribal Behavioral Health, to provide culturally and linguistically appropriate services including COVID-related behavioral health outreach, support, and navigation services to help people not currently connected to services, funding went out through a competitive grant process.
- Funding for Residential Treatment Facilities to increase capacity and help prevent COVID infection in behavioral health facilities. Funds are being used to establish alternate sites as needed in response to COVID.
- Oregon Behavioral Health Access System funding is being used to enhance statewide crisis lines, including addition of culturally specific access lines, developing a single web-based portal, creating a statewide provider directory, and increasing access to tele-mental health services. Resources are also being used to publicize information about how to access behavioral health services.
- OHA is using an additional portion of this funding to establish an opioid harm reduction clearinghouse for the purchase and distribution of supplies that prevent overdose and the spread of communicable disease.

CFBH unit staff have been working directly with programs receiving funding, to support and guide them in doing this important work. All CMHPs are required to serve children, youth and young adults through the above funding. Some additional notable projects include:

- 18 mini-grants to support COVID-safe LGBTQ+ suicide prevention efforts. Priority was given to organizations that could demonstrate a focus on equity, people of color, or other marginalized subgroups within the LGTBQ+ population.

- Supporting Trauma Informed Oregon[51] in doing work to support communities experiencing health inequity related to COVID-19.

Recommended strategies:

Implement community input, CLAS standards and health equity recommendations

Gather input/review by the OHA Office of Equity and Inclusion (OEI), consumer groups or representatives of communities of color, tribal communities through tribal consultation, LGBTQIA2S+ identified individuals, and people with disabilities; of action steps, implementation of CLAS standards, and Oregon Administrative Rule revisions as indicated. Continue evaluating CFBH contracts, developing and drawing guidance from CLAS standards, and collaborating with current contractors, OEI and Oregon Tribes on the development of a review tool for new and renewing contracts.

Implement REALD standards

Create work plan to implement REALD[52] (Race, Ethnicity, Language and Disability) standards in CFBH unit contracts.

Technical assistance on CLAS standards

Coordinate with Office of Behavioral Health Licensing and Certification unit on site reviews to provide feedback and technical assistance to behavioral health providers regarding CLAS standards implementation for children, youth, young adults and families.

Determine further action steps

Conduct a facilitated visioning on further action steps the unit can take to address racial inequity in the work of the CFBH unit.

Suicide Prevention and Intervention strategies:

- Provide suicide prevention trainings in multiple languages and in multiple cultural adaptations
- Increase the emphasis on community connectedness in addition to targeted prevention
- Suicide prevention specifically for people with intellectual and developmental disabilities to include training for providers
- Incorporate requirement in contracts for hiring of culturally and linguistically diverse staff
- Advocate for funding to adapt suicide prevention activities and trainings to culturally diverse populations
- Require contractors to develop a strategy for and actively recruit culturally diverse trainers for suicide prevention trainings

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[51] https://www.traumainformedoregon.org

[52] https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

- Identify and amplify suicide prevention work and suicide prevention leaders doing work in communities of color

5. Increase sustainable cross system collaboration

Associated SOC Guiding Principle:

- Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

Youth and families receiving services from all child-serving systems will experience an integrated, barrier-free collaborative environment that supports their needs by getting the right service, at the right time for the right duration to continue on their developmental path. CFBH unit will support and prioritize active cross-system collaboration to support and advance the behavioral health continuum of care for youth and families.

Within the CFBH unit there are positions that specifically focus on System of Care values in qualifications and in practice: System of Care Policy Coordinator, Wraparound and SOC Coordinator and both the Child and Family Behavioral Health Director and Manager. Since 2017, liaison roles have been created for: ODE, OYA, Child Welfare and the Oregon Tribes. All positions in the unit require knowledge of and implementation of System of Care values and principles and trauma informed principles.

Recommended strategies:

Formalize agreements with ODHS to assess ongoing needs for intensive mental health treatment services

OHA would assess needs statewide and track performance measures of mental health services for children by foster care status. This work is to be completed by December 2021[53].

Facilitate the effective functioning of the System of Care Advisory Council

Facilitation would include the collaborative development of data to inform the system and statewide System of Care policies, long range plans and supportive legislation.

Suicide Prevention and Intervention Plan:

- Include clear and measurable action items in the YSIPP 2021-2025 update around integration and coordination of activities across systems and agencies. This is a listed strategic “bucket” that has been added to the YSIPP framework.
- Engage cross-system stakeholders in the development of YSIPP while gathering feedback.
- Provide space and time for cross-system champions of suicide prevention to collaborate through the Alliance to Prevent Suicide.

[53] Secretary of State Audits Division Director Team, “Oregon Health Authority: Chronic and Systemic Issues in Oregon’s Mental Health Treatment System Leave Children and Their Families in Crisis” September 2020, Report 2020-32

CFBH unit's active and prioritized participation in initiatives and projects with the I/DD system.

Some current examples include:

- 2017 ODHS-OHA Continuum of Care Project: continued specific focus on individuals with Intellectual and Developmental Disability and neurodiversity and the need for service improvements.
- Nationally, up to 80 percent of children in foster care have significant mental health issues. Children who qualify for I/DD services often have co-occurring mental health needs. The prevalence of psychiatric disorders among children and youth with intellectual disability is estimated to be between 30-50%[54]. The current Oregon service array does not adequately meet the service needs of children and youth with co-occurring I/DD and behavioral health needs. Currently, behavioral health benefits are managed through medical necessity criteria which do not allow for modifications to meet the needs of youth with I/DD.
- Service delivery enhancement for children and youth with I/DD:
  - Increased outpatient intensive services to meet behavioral health needs of youth who qualify for I/DD services and are neurodiverse.
  - Payment mechanism (including reimbursement for appropriate durations of service) for behavioral health treatment, evidence-based practices that are delivered on a timeline appropriate for I/DD youth.
  - Investment in Train the Trainer model on mental health treatment for children and youth with I/DD.
  - On-going OHA and ODHS sponsorship and support for the I/DD Mental Health Summit[55] and maturing of existing learning communities.

  OHA has contracted with National Association Dually Diagnosed (NADD). NADD is a leader in education, consultation, and training related to the I/DD/MH dual diagnosis. NADD's mission is to promote leadership in the expansion of knowledge, training, policy, and advocacy for mental health practices that promote quality life for individuals with dual diagnosis (I/DD/MH) in their communities. NADD influences policies at the national, state, and local levels leading to more community-based, whole-person treatment for the mental health needs of those with I/DD[56].

  OHA's work with NADD will include:

  - Provide consultation and technical assistance in conjunction with OHA and other state agencies to create and implement a statewide Strategic Plan with a focus on policy, practice, workforce development, and oversight.
  - Provide consultation and technical assistance to providers throughout Oregon, specific to best practices regarding services and supporting the social and emotional wellness for this population
  - The DM-ID-2 (Diagnostic Manual – Intellectual Disabilities 2) provides guidance for assessing and diagnosing specific disorders in individuals with I/DD and provides information on recognizing

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[54] Einfeld, S. L., Ellis, L. A., Emerson, E. (2011). Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review. J Intellect Dev Disabilities, 36 (2), 137-43.

[55] https://www.iddmhsummit.com/

[56] http://thenadd.org/

challenging behaviors of individuals with I/DD and how to differentiate between behavioral problems and psychiatric disorders. With NADD, the development of a 4-hour DM-ID 2 Training with up to 6-month unlimited access for the Oregon community is available.

OHA/ODHS Improvement Project:

The project includes over 60 items identified between the two agencies of areas to improve access and a responsive system for children in child welfare custody. These items range from enrollment processes to access to cross-system need to ensure children are receiving the right service at the right time.

OHA behavioral health and ODHS child welfare leadership oversee the project plan and support prioritization of items to be completed. At this time over 20 items in this project have been completed.

Collaboration with Oregon Department of Education (ODE):

ODE and OHA began work together in earnest, when COVID-19 precautions began, as part of the directive under Executive Order 20-08, that OHA support ODE in providing continuity of mental and behavioral health supports to students during the school closure, lasting from March 2020 through the end of the 2019-2020 academic year.

- During this time, the OHA/ODE mental health collaborative was established to identify the needs of local communities, districts, and schools. Guidance documents were developed and rapidly released statewide to school administrators, educators, and families to provide critical support. Examples include suicide risk among children and adolescents, substance abuse prevention, Oregon tribal nation information, supporting educators' resiliency and well-being, and mental health school reopening guidance. A project and workgroup formed under this collaborative to conduct an analysis of existing data sources to develop a comprehensive picture of Oregon's school-centered mental health landscape.
- During 2020-21, the ODE project entitled Strengthening Mental Health in Education (SMHiE), will gather and analyze data, conduct listening sessions with stakeholders, and ultimately identify ways to increase capacity to address the diverse needs of Oregon's school districts and schools.

OHA's active and meaningful participation in Youth Advisory Councils and Committees:

Advisory Group	Focus area/summary:
Alliance to Prevent Suicide	The Oregon Alliance to Prevent Suicide, formed in 2016, serves as an advisory committee to OHA on the implementation and evaluation of the Youth Suicide Intervention and Prevention Plan (YSIPP). The multi-disciplinary Alliance includes legislators, parents, youth, health systems, consumer advocates, educators, government agency representatives (ODHS and ODE) and those with lived experience. The Alliance has specific committees focused on school and education, workforce development, continuity of care, and outreach and awareness. The Alliance has work focused on high-risk populations including LGBTQ+ youth and tribal youth.
Children's System Advisory Council (CSAC)	The Children's System Advisory Council serves as an advisory council for the Child and Family Behavioral Health unit. Council membership includes family members, youth and young adults, representatives from child welfare, intellectual/ developmental disabilities, juvenile justice, education, coordinated care organizations, behavioral health providers and CFBH unit. Prior to Senate Bill 1(2019) established the Governor-appointed System of Care Advisory Council, CSAC provided oversight of children's mental health system

Advisory Group	Focus area/summary:
	planning, coordination, policy development, fiscal development, and evaluation of service delivery/functioning.
Children's Services Advisory Group (CSAG)	The Children's Services Advisory Group consists of family members, representatives of advocacy organizations and professionals who provide services and supports to people with developmental disabilities. CSAG focuses on identifying gaps in services, what is working and not working within the service delivery system, and how the ODHS Office of Developmental Disabilities Services (ODDS) can work with stakeholders to ensure that services are effective and efficient for youth and families. OHA has representation on this group as a state agency stakeholder.
Child Welfare Advisory Committee (CWAC)	The Child Welfare Advisory Committee counsels ODHS on the development and administration of the policies, programs and practices.
Higher Education Coordinating Commission (HECC)	The State of Oregon's Higher Education Coordinating Commission is the primary state entity responsible for ensuring pathways to postsecondary education success for Oregonians statewide, convenes groups and institutions working across the public and private higher education arenas. The HECC is a 14-member volunteer commission appointed by the Governor, with nine voting members confirmed by the State Senate. The HECC develops and implements policies and programs to ensure that Oregon's network of colleges, universities, workforce development initiatives and pre-college outreach programs are well coordinated to foster student success.
Oregon Tribes	OHA passed an updated tribal consultation policy in March 2018 designed to increase meaningful government-to-government collaboration. Full implementation of this policy will require regular communication with tribal communities, training for state employees on how to engage with tribal communities effectively and strengthened relationships between CCOs and tribes/Native American Rehabilitation Association (NARA).
School Safety Taskforce	Oregon legislators created the Task Force on School Safety in 2014, bringing together policy makers from the Governor's office, legislature, education, law enforcement, fire and rescue and public mental health to collectively focus on strengthening safety in Oregon schools[57].
SACSE State Advisory Council for Special Education (ODE)	SACSE advises the State: • of unmet needs in the education of children with disabilities, • and comments publicly on any rules or regulations proposed by the State regarding the education of students with disabilities, • in developing evaluations and reporting data to the U.S. Office of Special Education,

57 https://www.oregon.gov/osp/docs/2019-Legislative-Report-OTFSS.pdf

Advisory Group	Focus area/summary:
	• in developing corrective action plans to address findings identified in federal monitoring reports and • in developing and implementing services for children with disabilities (34 CFR 300.169).
System of Care Advisory Council	This 25-person System of Care Advisory Council was created by SB 1 (2019) and began its work in March 2020. Its purpose is to improve the effectiveness of child serving state agencies and the continuum of care that provides services to youth, ages 0 – 25, and their families by providing a centralized and impartial forum for statewide policy development, funding strategy recommendations and planning. By September 2021 the Council will deliver a detailed System of Care policy and long-range plan.
Young Adult Leadership Councils (YALC)	Young Adult Leadership Councils are groups of young people with lived experience and their allies who come together to help shape the direction of the EASA, emphasizing participatory decision making and peer support. There are regional YALCs, which focus on regional community needs and specific EASA sites along with a statewide YALC, with a stronger focus on statewide needs. The councils help guide the direction of EASA programs by providing an experience of healing and growth, creating an outlet for expression, educating and supporting EASA participants and graduates, responding to/gathering and using feedback and advocating for change.
Youth and Young Adult Engagement Advisory (YYEA)	The Youth and Young Adult Engagement Advisory is a statewide group of young adults that provides feedback and guidance to state-level advisory committees, including CSAC and the Alliance to Prevent Suicide. The group is dedicated to amplifying youth and young adult voices in decision-making across local and state agencies involved in behavioral health and suicide prevention. YYEA is currently developing a mentorship program with CSAC to increase young adult voice and leadership with the goal of providing guidance to other advisory councils across the state.
Youth and Young Adult Substance Use Disorder (SUD) Collaboration	OHA, in collaboration with ODHS, developed this collaboration to focus on the Youth and Young Adult population and the needs for the SUD continuum of care addressing behavioral health needs co-occurring with SUD needs.

6. Promote and emphasize trauma-informed approaches and trauma-informed care

Trauma-informed approach and/or care is grounded in a recognition of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to build or rebuild a sense of control and empowerment and avoid re-traumatization[58].

Trauma-Informed Principles:

1. Safety Throughout the organization, staff and the people they serve feel physically and psychologically safe.

2. Trustworthiness and transparency Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

3. Peer support and mutual self-help These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

4. Collaboration and mutuality There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.

5. Empowerment voice, and choice An organization aims to strengthen the staff, client, and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

6. Cultural, historical, and gender issues An organization actively moves past cultural stereotypes and biases, offers culturally responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

The CFBH unit promotes and utilizes a trauma informed approach integrated with a culturally appropriate and responsive continuum of care for children and families so that healing and recovery can occur.

A trauma informed continuum of care is staffed with individuals who have received training and operate in awareness; ***r***ealize and ***r***ecognize when trauma has occurred and impacted a child, young adult or their family, ***r***espond appropriately through services and supports and, have the intention of not ***r***e-traumatizing children, young adults and their families. These tenets are referred to as the 4 *R*'s.

Trauma informed approaches and principles are critical concepts for children's behavioral health and support the unit's work and strategies[59]. Using brain NEAR (Neuroscience, Epigenetics, ACEs and Resilience) science and other key concepts, contractors and service recipients can assist children, youth, young adults and their families regain resilience and achieve post traumatic healing and growth. The integration of trauma informed approaches

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58 Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. Retrieved from: https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf

59 Secretary of State Audits Division Director Team, "Oregon Health Authority: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis" September 2020, Report 2020-32, page 8

and principles with health equity work is critical. Behavioral health needs of communities of color must be addressed with commitment to an equity-based focus on healing trauma and promoting resilience.

Examination of current systems and processes will assist in eliminating re-traumatization, and support workforce development, agency infrastructure and an awareness base that reinforces application of trauma informed principles across the system and throughout the state. The unit supports the work of Trauma Informed Oregon (TIO) through contractual funding, partnership in OHA needed work, and in attending the Steering Committee to observe/monitor the input they are receiving from a wide variety of consumers including communities of color, people with lived experience, professionals, and trauma experts in schools, healthcare, and other settings.

Recommended strategies:

Update trauma-informed policies

Revise the OHA Trauma Informed Services policy[60] that applies to publicly funded behavioral health providers and to include Oregon Consumer Advocate Coalition, other advisory groups, CCOs and provider partners and consumers. This work will begin early 2021.

Finalize the OHA Trauma-informed Approach and Healing Culture policy and support and participate in related agency wide training starting at the highest leadership levels. The policy has been sent to OHA leadership for approval to begin implementation, October 2020. The policy outlines the support, training and accountability needed to shift OHA divisions to a trauma informed culture, aware of and responsive to the impact of trauma on the lives of individuals. This policy supports OHA leaders and staff in doing the necessary work to promote and sustain trauma informed approaches and care *within the agency* and in doing business going forward.

Support CCO 2.0 contract compliance

Monitor and enforce phased nature of the CCO 2.0 contract. Work with the OHA transformation center to assure that CCOs have needed information to meet contractual requirements. The agency shall hold contracted organizations accountable for trauma informed practices using site reviews, and other quality assurance and contract compliance tools when needed.

- CCO 2.0 requires that CCOs make sure all staff who have contact with members are trained in trauma informed care, and that they require their providers to have a workforce prepared to deliver services in a culturally and linguistically responsive and trauma-informed manner.
- CCO 2.0 also requires assessing for adverse childhood experiences, trauma and resiliency in a culturally and linguistically responsive manner within a trauma informed network, and that CCOs use data to develop their workforce ability to provide services in a culturally and linguistically responsive and trauma informed manner, with particular attention to marginalized populations.

60 https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Trauma-Informed%20Services%20Policy.pdf

Technical assistance to support partners

Maintain and sustain contractual relationship with Portland State University for TIO to continue to implement support for Oregonians who need information and resources to effectively become trauma informed. Continue to link TIO and partners needing technical assistance to become more trauma informed. Maintain/strengthen contractual obligations for TIO to train and support the interface between trauma and suicide.

Add compliance provisions to CFBH contracts

Include provisions in all CFBH contracts that support and promote the use of trauma informed principles in the work being conducted, with appropriate compliance activities as needed.

Disaster preparedness:

Participation in emergency management networks to mitigate the risk of traumatic outcomes for children and families in Oregon.

- Support OHA's COVID-19 response as required and as related to coping with trauma in a pandemic.
- Support responses as needed for other potential disasters: local suicide postvention, school gun violence, wildfires, earthquakes and other climate related disasters.

Suicide Prevention and Intervention Plan:

- Create guidance documents and recommend programming to illuminate the connection between trauma and suicide.
- To elevate best practices and training programs for providers consistent with trauma informed practices for children and youth.
- Pilot project with postvention response leads to support dealing with vicarious trauma.

Summary

These recommendations and strategies will be presented to youth and family consumers, current contractors and advocacy agencies, providers, local and state level advisory councils and the System of Care Advisory Council for input. The CFBH unit will utilize and promote trauma-informed, evidence-based approaches utilizing System of Care values and principles in technical assistance, meetings, and other business with children, youth, young adults, families, agency partners and other stakeholders.

In conjunction with the Secretary of State report findings, the CFBH unit intends to significantly improve the behavioral health environment for youth, families and providers, without the pressure of a mandated response to a lawsuit or highly specific, time limited grant requirements that could be difficult to sustain.

COVID-19 has magnified the collective impacts of job loss, sickness and isolation. The need for a continuum that is simple, responsive and meaningful has become critical. Systemic oppression, historical trauma and intergenerational traumas borne of societal factors, notably poverty and lack of opportunity, must be addressed as a key part of this effort. A cross-system collaboration and commitment will further support the work.

By focusing on the six areas of the proposed recommendations the CFBH unit supports a more accessible, better integrated, individualized and accountable continuum of care for children, youth, young adults and their families. In conclusion, these six areas of recommendations adopted in the child and family behavioral health system will move it forward.

Appendix:

Reports/references:

ODHS/OHA Continuum of Care
https://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Projects/OHA-DHS-Continuum-Of-Care-Proposal-Stakeholder-Engagement-IDD-Letter.pdf

SOS Audit 2020
https://sos.oregon.gov/audits/Documents/2020-32.pdf

NJ Concept Paper
https://www.nj.gov/dcf/about/divisions/dcsc/Childrens.Initiative.Concept.Paper.pdf

Governor's Mental Health Advisory Workgroup (2001)
http://www.localcommunities.org/lc/516/FSLO-1232525057-83516.pdf

Article on Evidence Based Practice for Minority Youth
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4547560/

Tribal BH Strategic Plan
https://www.oregon.gov/oha/HSD/AMH/docs/Tribal-BH-Strategic-Plan-2019-2024.pdf

Core Competencies for Family Support
Purdy, F. (2010). *The Core Competencies of Parent Support Providers*. Rockville, MD: National Federation of Families for Children's Mental Health.