BEFORE THE BOARD OF COUNTY COMMISSIONERS

FOR MULTNOMAH COUNTY, OREGON

In the Matter of Approving the Amended Comprehensive Plan of the Multnomah Commission on Children and Families for FY 1995-1997

RESOLUTION
95-240

WHEREAS, the Omnibus Budget Reconciliation Act of 1993 established the Family Preservation and Support Services Act to promote the expansion of Family Support and Family Preservation Services and stimulate systemic reform, and

WHEREAS, the Oregon Commission on Children and Families (OCCF) is the recipient of these funds and has made an allocation of funds to the Multnomah Commission on Children and Families (MCCF), and

WHEREAS, this funding stream for it must be incorporated as an amendment to the MCCF's Comprehensive Plan (Exhibit A), and

WHEREAS, The MCCF has approved the Plan amendment (Exhibit B), and

NOW, THEREFORE, BE IT RESOLVED that the Board of Commissioners of Multnomah County hereby approves the Amended Comprehensive Plan for the Period of July 1, 1995 to June 30, 1997 and authorizes its official submission by the County Chair.

ADOPTED this 21st day of November, 1995.

MULTNOMAH COUNTY, OREGON

By _____
Beverly Stein, County Chair

REVIEWED:
LAURENCE KRESSEL, COUNTY COUNSEL
for Multnomah County, Oregon

By _____
Katie Gaetjens, Assistant

RESAMCOM

CREATING A CHOSEN FUTURE

CONTENTS OF ATTACHED

I. Original Plan Without Benchmarks Charts
(see Table of Contents)

II. Amended Plan With Benchmarks Charts

A. Amended Plan

B. Benchmarks Charts

C. Policy Considerations

EXHIBIT A

Creating a Chosen Future

Phase One Comprehensive Plan of the
Multnomah Commission on Children and Families

July, 1994

This document was approved by the
Multnomah Commission on Children and Families
on July 20, 1994.

for more information:

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Creating a Chosen Future

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WHAT WE BELIEVE IN

Through the dedicated and principled efforts of an MCCF ad hoc committee, we have become clear on who we are, what we believe in and what we stand for. Since we had been called together to seek wellness for local children and families, the committee deemed it fitting to first explore what we meant by the term.

WELLNESS DEFINED

After a lot of discussion we adopted the definition of the Oregon Children's Care Team:

"Wellness is defined as the preservation of each child's potential for physical, social, emotional and cognitive and cultural development."

It follows from this definition that a wellness delivery system must have a strong prevention component as its base, as well as provision for comprehensive treatment services. Such a model needs to be based on an understanding of the stages of child development, and with an emphasis on promoting early childhood development and developmental competencies across the entire age spectrum of childhood. We expect the result of this to be children who become responsible adults and productive citizens contributing to their community.

The MCCF has further developed this definition of wellness and described what wellness looks like at each stage of development for the child, the family, the neighborhood and the community. We also have developed a narrative depicting our image of wellness and a graph representing a functional supportive community system of care (see attachments).

NECESSARY CONDITIONS

To build and maintain wellness, several things must be present for the child, the family, the neighborhood and the community at every developmental stage.

A child flourishes when he or she has a loving, competent adult in his or her life; food, clothing and stable housing; optimal physical, dental and mental health; and appropriate opportunities to develop at each stage.

The family is its best in every stage when it has access to effective and culturally appropriate systems of health and mental care, housing, child care, public safety, transportation, education, employment, recreation and social development.

The neighborhood is a supportive environment for everyone when neighbors know each other, play together, and have a sense of pride and ownership in their neighborhood; and when they respect and enrich each other by sharing cultural traditions and by valuing safety and security.

The community establishes systems which support the wellness of all children and families, and encourage the development of a safe and healthy environment. It supports and recognizes the responsibility of both parents *and* the community for achieving wellness.

CORE VALUES

The core values of the MCCF include an appreciation for strong families; diverse, thriving communities; and a coordinated system of services and supports promoting optimum growth and development for every child. Each value has a corresponding standard (see attachments).

- We value children, and their right to achieve their dreams.
- We value the safety and security of every child and every youth.
- We value the family unit and consider it every child's first source for growth and support.
- We value loving, skillful parenting.
- We value the community as every family's primary source for support and nurturance.
- We value the healthy growth and development of children and youth, as they progress through developmental stages in their own way and time.
- We value the inherent strengths, skills and capacities of every child, youth and family, and recognize these strengths as vital community resources.
- We value the perspectives and opinions of young people.
- We value and embrace the diversity of the children, youth and families in our community, and the cultural wealth that enriches us all.
- We value equal opportunity, equal access, social justice and support for individual freedom.
- We value a community support system that encourages coordination and collaboration, makes best use of available resources, identifies and develops new resources, and values its workers.
- We value results. We value efficiency, accountability and the ability to get the task done.
- We value community opinions and an open and accessible process.
- We value all people and recognize that among individual children, youth and families there exist varying capabilities at different times and at different developmental stages.

COMMUNITY STRENGTHS & NEEDS

Given the MCCF's declared value of building on community strengths, and given the importance of focusing resources on the highest priority needs it made sense to assess community conditions before proposing any changes. We wanted to know what supports already existed and which critical needs required additional attention. To inform ourselves in these areas we have pursued two processes to date (July, 1994) and propose to continue our assessment work over the next several months.

CELEBRATION OF COMMUNITY STRENGTHS

"Front porches." "The bicycle shop owner who always has room for one more kid." "The businessman who hired a Russian speaking clerk because Russian was the native tongue of his newest customers." These are some of the neighborhood resources that were identified in the six *Celebration of Community Strengths* meetings held throughout Multnomah County in April 1994. Sponsored by the Multnomah Commission on Children and Families (MCCF), the Board of County Commissioners, and County Chair Beverly Stein, these meetings took a different approach to the concept of needs assessments.

Inspired by the community capacity building work of John Kretzmann and John McKnight, MCCF members invited residents to come out and talk about their communities' strengths. Multnomah County is divided into six service districts, or Family Support Network areas, making one meeting per district a logical strategy.

A steering committee of MCCF members and staff, Portland Educational Network (PEN) of Portland State University staff, and city and county volunteers designed and implemented the meetings, and developed and coordinated resources. Fred Meyer and Starbucks donated refreshments and Children First, a statewide advocacy group, arranged for child care services.

Community organizations, including the Leaders Roundtable, Ecumenical Ministries of Oregon and the Rainbow Coalition, co-sponsored and promoted the event and provided over 60 volunteers to help facilitate the small groups. PEN donated the technology and personnel to create maps of each district on which to place the resources identified.

Some of the identified community strengths, of course, were well respected local human service provider agencies, many of which were well known to MCCF members and staff. Some of them, on the other hand, were less familiar although highly regarded. The organizations identified have been tabulated and staff is working to complete the list from internal data bases.

MCCF members, however, know that many resources exist in every community – resources that daily sustain and support the people who live and work there. The strengths that usually remain unreported in a more traditional needs assessments were, to some, of the greatest interest: access to transportation, an architectural legacy, cultural identity, older home neighborhoods with a sense of history, ethnic and cultural diversity, high volunteer involvement, pedestrian-friendly shopping, bridges, parks, public art, street musicians, and value driven social service programs are a few examples.

MCCF members have expressed interest in further developing our findings. (For a more extensive listing of the community strengths identified in these sessions, see attachments).

Approximately 400 people attended the meetings (from 50 to 125 at each), generating over 3,000 community strengths. PEN staff is compiling this information and designing the product that will illustrate the community strengths identified. Further use of the process will recognize that some populations were not fully represented at the meetings. Additional *Community Strengths* meetings with culturally specific communities are being considered.

WHAT WE ALREADY KNEW

Dozens of plans with comprehensive needs assessments already exist in Multnomah County dealing with child care, alcohol and other drug abuse, out-of-home care, delinquency, youth employment, diversion, and the needs of homeless youth, gay and lesbian youth, young African American male youth, south-east Asian youth, girls, infants and toddlers, and youth who are at risk for being abused or neglected. These are only a few examples.

MCCF staff have been gathering and reviewing all these data and will be providing them to planning teams that will be convened around each of the benchmarks (or benchmark clusters) in August - October.

TECHNICAL NOTES

MONITORING & EVALUATION

Assuring a rigorous technical evaluation of social service programming is the essence of what distinguishes benchmark driven programming from most others. The Multnomah Commission on Children and Families' core values call for the best use of available resources, efficiency, accountability and the ability to get the task done. The most concise statement of this is the value which declares "We value results."

It's impossible to view our results, if any, if we don't apply technically and socially appropriate evaluation procedures. With this in mind we propose an evaluation framework that will allow results to be viewed and considered not only by technical program staff, but by MCCF members and general community members as well. The proposed framework is composed of four stages, each one progressively becoming more technical, more costly and more pioneering.

STAGE ONE: Compliance review
This is a simple comparison of contract requirements with contractor *performance*. In brief, did the contractor provide the services that the contract called for? This is assessed on a routine basis through data collection (client tracking reports), monthly or other required periodic reports submitted by the contractor, and through annual fiscal audits. When a potential problem is detected this level of review is conducted by means of specially required or more frequent reports and by site visits and phone interviews.

Compliance evaluation is the absolutely "bare-bones" approach to evaluation.

STAGE TWO: Process Evaluation
This assesses the *quality* of the program and the services it provides. It involves program attributes such as accessibility, philosophy/methodology, and staffing. Other areas include assessment of population(s) served, conditions under which services are offered, and the nature of proposed service effects. This is assessed through structured, formal site reviews, peer reviews, client satisfaction surveys, and client tracking data.

This level of evaluation, combined with compliance review, provides basic accountability.

STAGE THREE: Client Impact Evaluation
This is an advanced and technically difficult process, measuring the impact, if any, that the services a client received had on the client or his/her family and community. It deals with program or service *effectiveness* in achieving their pre-identified goals. Essentially we seek to answer the question "now that we know that a service of a known quality and quantity has been delivered, what difference has it made in the lives of the people served, and was that difference worth the cost of the service?"

Part of what makes this such a challenging process is that it involves developing all aspects of the program from preliminary design, to outcome identification, to evaluation analysis.

STAGE FOUR: Social Change Evaluation
This is the most advanced, most costly and most infrequently applied technology. It's possibly the most urgent. It seeks to measure community-wide *social change* within a given issue, like the proliferation of hand guns and related violence, or a reduction in institutional racism. It measures the cumulative impact of social programs, political and economic changes, and all other influences on the issue.

This is benchmark level evaluation. Keep your checkbook handy.

TO THE PLAN REVIEWERS

A. The MCCF's core benchmarks are listed on page 3 of this document. All OCCF benchmarks have been chosen; no waivers are requested.

B. All MCCF decisions related to defining wellness; creating the vision, values, and goals; selecting core benchmarks; and establishing a preliminary macro budget have followed the same process:
   1. MCCF staff prepares background and support information and brings it to the Planning Committee.
   2. Planning Committee reviews staff prepared information, deliberates on the issues, forms a recommendation and brings it to the MCCF at a general meeting.
   3. MCCF members receive and discuss the recommendation at a general meeting, revise as needed and vote to accept.

DIVERSITY

Multnomah County Chair Beverly Stein appointed a broadly diverse group of people to the Multnomah Commission on Children and Families, including representatives, advocates and members of ethnic, cultural, sexual and linguistic minorities.

In addition the MCCF has selected core values which support diversity and multi-culturalism. The MCCF has declared that "we value and embrace the diversity of the children, youth and families in our community, and the cultural wealth that enriches us all," and "we value equal opportunity, equal access, social justice and support for individual freedom."

In June the MCCF Planning Committee considered the need to involve more cultural and ethnic minority people in the planning process, and charged staff with polling MCCF members with an expressed interest in cultural and ethnic minority children and families, and who might have suggestions for increasing the cultural competency of the MCCF. A number of ideas were generated ranging from providing more training for MCCF Commissioners, to developing a caucus addressing the needs of young people of color and their families, to having the MCCF take leadership in addressing linguistic diversity. The question of to whom the term "diversity" applies was raised; MCCF members chose to rely on language from a Portland Public Schools' policy statement that considers diversity to be within the following categories:

> *"actual or perceived race, national origin, cultural heritage, familial status, age, gender, sexual orientation, religion, disability, linguistic diversity or socio-economic status."*

These thoughts will form the basis for serious discussions regarding the MCCF's approach to and beliefs regarding diversity as they apply both to the MCCF and its processes, including community involvement, and to system and service recommendations.

GLOSSARY

One recommendation made at one of the Commission's community planning sessions was:

> *"Use more inclusive language, and assume responsibility for teaching new partners 'alphabet soup' type jargon (RFP, DCT, PCDC, CDC, HCDC, BCC, MCCF, BLT, etc.)"*

In response to this we present this beginning glossary to serve as an entry point for those who seek to better understand what we're all talking about.

ADAPT	*Alcohol Drug Abuse Prenatal Treatment*
ADC	*Aid to Dependent Children*
A&D	*Alcohol and drug*
A&OD	*Alcohol and other drugs*
AODA	*Alcohol and other drug abuse*
AOI	*Association of Oregon Industries*
AYOS	*Albina Youth Opportunity School*
C of C	*Chamber of Commerce*
CARES	*Child Abuse Response and Evaluation Services*
CHN	*Community Health Nurse*
CSD	*Children's Services Division*
CYSC	*Children & Youth Services Commission (of Multnomah County)*
DA	*District Attorney*
DARE	*Drug Abuse Resistance Education*
DV	*Domestic violence*
ECE	*Early childhood education*
EMO	*Ecumenical Ministries of Oregon*
GIFT	*Gang Influenced Female Team*
JJD	*Juvenile Justice Division*
LEP	*Limited English Proficiency*
MADD	*Mothers Against Drunk Drivers*
MC	*Multnomah County*
MCCF	*Multnomah Commission on Children and Families*
MYCAP	*Minority Youth Concerns Action Program*
NE	*Northeast*
OAEYC	*Oregon Association for the Education of Young Children*
OBC	*Oregon Business Council*
OCF	*Oregon Community Foundation*
OCCF	*Oregon Commission on Children & Families*
ODE	*Oregon Department of Education*
OHSU	*Oregon Health Sciences University*
OMA	*Oregon Medical Association*
OSMYN	*Oregon Sexual Minority Youth Network*
PCC	*Portland Community College*
PCDC	*Parent Child Development Center*
PDC	*Portland Development Commission*
PEN	*Portland Educational Network*
PFLAG	*Parents and Friends of Lesbian and Gays*
PHN	*Public Health Nurse*
PIC	*Portland Industry Council*
PIVOT	*Partners in Vocational Opportunity Training*
POIC	*Portland Opportunities Industrialization Center*
PPB	*Portland Police Bureau*
PSR	*Physicians for Social Responsibility*
PSU	*Portland State University*
RDI	*Regional Drug Initiative*
RFP	*Request for proposal*
RWQC	*Regional Work Force Quality Committee*

Creating a Chosen Future

The Comprehensive Plan of the Multnomah Commission on Children and Families

for Achieving 15 Key Benchmarks

amended December 1, 1994

Multnomah Commission on Children and Families
1120 SW Fifth Avenue, Portland, Oregon 97204

(503) 248-3981

MULTNOMAH COMMISSION ON CHILDREN AND FAMILIES
BASE PLAN AMENDMENT, DECEMBER, 1994

THE COMMISSION'S WORK, JULY - NOVEMBER 1994

Following submission of the Comprehensive Plan in July, the Multnomah Commission on Children and Families convened ten planning teams around four benchmarks clusters to develop more thorough plans for attaining our chosen outcomes. Those four clusters are:

EARLY CHILDHOOD
Meet developmental standards by kindergarten
Increase quality child care
Reduce drug-affected babies
Increase prenatal care

PREVENTING VIOLENCE, ABUSE AND NEGLECT
Reduce child abuse and neglect
Reduce domestic violence
Reduce violence by and against children and youth
Reduce the rate of teen pregnancy

CAPABLE ADULTS AND FAMILIES
Reduce number of families living in poverty
Increase safe, stable housing
Increase number of families able to care for their own children
Increase high school graduation

JUVENILE JUSTICE/CHILD WELFARE
Reduce Minority over-representation
Reduce juvenile crime
Reduce adolescents' alcohol, drug and tobacco use

Each planning team was chaired by one or two MCCF Commissioners and staffed by county personnel donated by the Office of District Attorney, the Library Department, the Health Department, the Juvenile Justice Division and the Community and Family Services Division. The MCCF appreciates the generosity and competent work of these individuals and their department heads, without whom this work would not have been possible. Membership on the teams included service providers, service recipients, experts, business people and other interested citizens.

The planning teams identified for each benchmark the ideal spectrum of services and supports envisioned in a well community, the existing systems of services and the gaps, those services and supports that are missing. The teams recommended how best to proceed in order to achieve changes in the benchmarks, including prioritizing the gaps they identified. Their reports were forwarded to the MCCF for consideration.

Est. % of resources	*DIRECTIONS*
22%	Neighborhood-based Services
18%	Comprehensive, Wrap-Around, Family-Centered Services
08%	Targeted Services
19%	Diversity-Inclusiveness
15%	Healthy Beginnings
01%	Community Development
02%	Services Improvement
15%	Systems Improvement

BLENDING COMMUNITY MAPPING RESULTS WITH SYSTEM ANALYSIS

The six Community Strengths meetings that were held in April yielded a vast amount of information that Portland State University staff analyzed and formatted. Interesting variations from district to district were discovered. In order to develop a coherent picture of all of Multnomah County's resources and gaps, the Community Strengths results should be integrated with the planning teams' findings. Furthermore, a number of efforts are underway by various groups to catalogue Multnomah County's extensive resources. We will continue to work together with Portland State University staff and those other groups to accomplish our desired results. In the meantime, the planning teams' work and the results of the Community Strengths meetings will be used to inform MCCF decisions.

DIVERSITY

The MCCF has defined diversity as applying to:

> *"actual or perceived race, national origin, cultural heritage, familial status, age, gender, sexual orientation, religion, disability, linguistic diversity or socio-economic status."*

The MCCF has selected core values which support diversity and multi-culturalism. The MCCF has declared that "we value and embrace the diversity of the children, youth and families in our community, and the cultural wealth that enriches us all," and "we value equal opportunity, equal access, social justice and support for individual freedom."

The Commission has intensified its efforts to bring diversity into our process. As the MCCF convened benchmark planning teams, invitations to participate in the teams went to a broad segment of the population. Planning teams were instructed to ensure that all interested and affected parties were at the respective tables and were encouraged to actively seek representation from members of diverse populations. While records of the ethnicity of planning team members

Benchmark: Early Childhood Education

BENCHMARK ALLOCATION: 20% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

The organizations listed below are considered to be examples of community partners. We recognize that many more names may be added to this list.

A partial list of public partners includes the following:

- City of Portland
- Community Colleges
- Elected officials (federal, state, local)
- Employment Department
- The Child Care Division (CCD)
- Child Care Resource & Referral
- Four year colleges
- Health & Human Services
- Multnomah County ESD
- Multnomah County Health Department
- Multnomah County Libraries
- Public School systems
- State of Oregon Adult and Family Services Division
- State of Oregon Children's Services Division (CSD)
- State of Oregon Department of Education

A partial list of private partners includes the following:

- Association for Portland Progress
- Chamber of Commerce
- Corporations
- Foundations
- Hospitals
- Media - print & broadcast
- Non-profit organizations
- Professional organizations
- Service organizations
- Volunteer Center

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Early childhood care and education (readiness to learn) is emerging as a national priority, being the first of six national educational goals, as a state priority under the leadership of the Oregon Commission on Children and Families, and as a local priority under the leadership of Multnomah County Chair, Beverly Stein. As our communities seek root causes for youth violence, an ill prepared workforce and family dysfunction, research clearly points to the earliest years as critically formative and predictive of success.

There is agreement, and substantive evaluation, of effective systems which support children and families from the earliest age. The Carnegie Foundation Report "Ready To learn" by Ernest Boyer cites seven conditions necessary for children to be ready to enter school:

1. A healthy start
2. A language rich environment with caring, empowered parents
3. Quality early care and education, including preschools and child care
4. A responsive, family-friendly workplace for parents
5. Responsible, nonviolent and educational TV programming on all major networks
6. Safe, supportive neighborhoods where learning can take place
7. A society where there is a web of supports for families and greater intergenerational connections

Compelling research on the long term benefits of early childhood care and education and family support, new targeted federal moneys, and the statewide reallocation of social services block grant offer rationale for prioritizing this field of service.

In striving for the achievement of this benchmark particular care must be taken to protect the rights of individuals and families. Creating a wellness philosophy within the county for every child, requires recognition of the family's strengths and belief system. Respect and support must be given to individual and cultural differences, recognizing the family's rights to choice.

The definition and interpretation of terms used in early childhood care and education often elicits controversy. Curriculum, Ready To Learn, and even the phrase care and education itself invokes differing opinions. Public perception of these terms is of even greater concern.

Controversy continues over the importance of children and the necessity of parent education and support. While public concern and interest is expressed, economic and political decisions are made that actually impede the healthy development of children and do not support the integrity of the family.

The categorization of children into specific age groups precludes the development of a comprehensive continuum of services. A full spectrum of child care and related services is needed to reach older school age children.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

The organizations listed below are considered to be examples of community partners. We recognize that many more names may be added to this list.

A partial list of public partners includes the following:

- City of Portland
- Colleges-four year
- Community Colleges
- Elected officials (federal, state, local)
- Employment Department:
- The Child Care Division-CCD Certification
- Child Care Resource & Referral
- Health & Human Services
- Multnomah County ESD
- Multnomah County Health Department
- Multnomah County Libraries
- Public School systems
- State of Oregon Adult and Family Services Division
- State of Oregon Children's Services Division (CSD)
- State of Oregon Department of Education

A partial list of private partners includes the following:

- Association for Portland Progress
- Chamber of Commerce
- Corporations
- Foundations
- Hospitals
- Media - print & broadcast
- Non-profit organizations
- Professional organizations
- Service organizations
- Volunteer Center

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Developmentally appropriate child care is an economic development issues as well as a family issue.

Child care is impacted by 3 concerns:

- Accessibility
- Affordability
- Quality

Since this benchmark seeks to increase the number of child care providers meeting quality standards, it is significant to note that child care quality is impacted by:

- The setting of high and consistent standards
- Provider training and technical assistance
- Implementation of developmentally appropriate practices
- Provider compensation
- A system of monitoring compliance with established standards

Child care providers are often a child's first teacher out of the home, and play a vital role in a child's early development and education. Their capacity for providing healthy, developmentally appropriate and safe care is essential.

Child care providers are among the lowest paid workers in the chronically underpaid field of human services. Many child care workers live below the poverty line and qualify for public assistance. Few have medical insurance or other benefits.

Only recently (7/94) family (home) child care became subject to registration with the State. 80% of child care in Oregon is provided in a home.

Staff turnover, most often due to low wages and benefits, undermines efforts to achieve quality standards.

Baseline data is not available to assess issues of quality (i.e. "group size" currently existing in child care programs).

To coordinate the achievement of this benchmark with other closely related efforts, we need to recognize school age child care as separate from but related to the issues involved in early childhood care and education.

There is a growing need for additional child care slots and the availability of Head Start slots for every eligible child.

Child care resources for parents in treatment programs are not adequately developed.

State subsidy practices undermine the efforts which seek to achieve compensation for full cost of care.

Benchmark: Reduce the Number of Babies Born Drug Affected

BENCHMARK ALLOCATION: 1% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Multnomah County Alcohol and Drug Program Office, including the Target Cities program
- Current alcohol & drug treatment service providers in Multnomah County
- Current programs focusing on perinatal substance use, including:
  - Project Network
  - ADAPT
  - SAFE
- Multnomah County Health Department Field Services
- Major health care systems, including:
  - Kaiser
  - OHSU
  - Legacy
  - Multnomah County Health Department
  - Sisters of Providence
  - Portland Adventist

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Drug-affected babies result from pregnancy of an alcohol and/or drug abusing or addicted women, or from use of tobacco during pregnancy. Reduction of drug-affected babies is, therefore, tied to reduction of chemical abuse among women of child-bearing age.

Within the past 8 years, educational campaigns have increased public awareness of the dangers of drug use during pregnancy. Also, advocacy for the special addiction treatment issues pertaining to pregnant women, and women with children, has resulted in increased availability of specialized treatment services.

Some child-care programs have been made available to women in treatment, with some targeted outreach to ethnic and cultural populations at increased risk.

Treatment on demand is not available.

Current reporting systems under-identify use of drugs and alcohol. A research study is under way in Oregon to determine the prevalence of drug use during pregnancy, testing for THC, barbiturate, cocaine, opiate, methamphetamine. About 24% of pregnant women report smoking during their pregnancy.

A high percent of chemically dependent women were sexually abused as children, and often have experienced other violence in their lives. This means the service system needs to have comprehensive strategies including treatment, mental health services, family treatment, parenting education, basic skills training and community support.

Benchmark: Increase Prenatal Care

BENCHMARK ALLOCATION: 2% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Oregon Health Division media campaign on need for prenatal care.
- Oregon Health Systems in Collaboration-partner with Oregon Health Division for media campaign and incentive coupon project.
- Black United Fund
- March of Dimes
- Major health care systems:
  - Kaiser
  - OHSU
  - Legacy
  - Health Department
  - Sisters of Providence
  - Portland Adventist
- Current community providers:
  - NARA/NW
  - Neighborhood Health Clinic
  - Outside-In
  - Center for Maternity & Family Support

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Approximately one fourth of all pregnant women in Multnomah County in the last several years have not received adequate prenatal care. This has remained consistent over time. Three main factors limit access to adequate prenatal care:

1. Limited financial access.
   Although the ability of women to access care has improved somewhat in the last 3 years due to Medicaid changes (allowing eligibility to women at 133% of federal poverty limits) and the Oregon Health Plan, there is still a gap in economic access for low income women who are "not poor enough" to be on welfare, but who don't earn enough to be able to purchase adequate service.

2. Not understanding the importance of care.
   Many people don't realize how important quality prenatal care is, and why, and how and where to get it.

3. Prenatal care that doesn't meet the clients need.
   Care is often not culturally appropriate. The information given or procedures done may not be understood, explained, or fit the client's situation. Additionally, people affected by alcohol and other drugs may be uncomfortable seeking care at the very time it's most important.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

Bradley Angle House, Raphael House, West Women's and Children's Shelter, YWCA Women's Resource Center, Portland Women's Crisis Line, Community Advocates for Safety & Self Reliance, Children First, Multnomah Co. Legal Aid, Multnomah Bar Association Young Lawyers 7 Volunteer Lawyers Projects, Oregon Coalition Against Domestic & Sexual Violence, Multnomah Co. Family Violence Intervention Steering Committee, OHSU, Nursing Schools, Child Abuse Unit, Multnomah Co. Health Dept., Physicians for Social Responsibility, PPB Domestic Violence Reduction Unit, United Way, Portland Rotary, Ecumenical Ministries, Albina Ministerial Alliance, Lesbian Community Project, International Refugee Center, SOAR, Urban League, Coalition of Black Men, Emanuel Hospital's CARES Program, Imani Women's Center, School Districts (K-3 reps, ECE reps), Child care providers, Oregon Association for the Education of Young Children, OSU Extension Service, CASA, Association for Portland Progress, Schools, Morrison Center, Dr. Sudge Budden, Housing Authority of Portland Drug Elimination Team, Mental Health providers, public and private, CSD, MDT, Junior League of Portland, Multnomah County Libraries, Volunteers of America, Men's Resource Center, PCDC's, Multnomah County Connections Teen Parent Program, SKIP, STEPS, Even Start, Multnomah County Health Nursing Office, Head Start, Insight Teen Parent Program, Multnomah county Jail, Family court Services, William Temple House, Our Father's Ministry, Lutheran Family Services, Parents Anonymous, Peninsula Child Care Center, Metro Child Care R & R, Parent Cooperative Preschools, churches, parks and recreation programs, National council of Jewish Women; libraries, Baby's First, Pacific University, hospitals, Portland Family Calendar, United Way, Portland Office of Neighborhood Associations, Oregonian, Metro Crisis Intervention, Waverly, Mid-county Family Center, DARE, GREAT Oregon Peace Institute, Save Our Youth, the Solo Center, Tri County Youth Consortium, Eastwind, PACE, Mental Health Services West, Foster Parents Association, Morrison Center, Reach Out, Harry's Mother, Association of Retarded Citizens, Oregon Medical Association, OHSU, Kaiser, ASAP, Human Solutions, Portland Public Schools at Columbia Villa, Community Service Centers, Robert Wood Johnson, Shepard's Home, SAFAH , RASP, media, ASAP, Council for Prostitution Alternatives.

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Reported child abuse in Multnomah County has varied only slightly in the last 6 years from a high of 14.3 to a low of 12.4 abused children per 1,000 young persons under 18 years. For 1993, the rate of reported abuse was 13.3 abused children per 1,000. These statistics reflect incidents reported to Children's Services Division (CSD), and most likely are lower than the actual rate of child abuse.

Who is abused, and who is the abuser and why do they abuse are important indicators of how we, as a community, need to address these problems. Infants comprise the largest single age class of child abuse and neglect victims, because they are inherently more vulnerable, family stress is high at the time of birth, and many babies are born drug affected. Female children are 57% of Oregon's victims of child sexual abuse, mental injury, and threat of harm. Many abused girls and boys experience developmental delays, since they have learned to "shut down" their emotions as a way of coping with the ever present threat of harm.

Children with disabilities are over-represented in all categories of maltreatment. In one study where information was collected from a nationally representative sample involving 35 Child Protective Services (CPS) agencies (Crosse, Kaye, and Ratnofsky, 1993), CPS case workers reported maltreatment in children with disabilities 1.7 more times than in children without disabilities. In 47% of these cases, the disabilities directly led to, or contributed to the maltreatment. Physical abuse was reported by CPS caseworkers at a rate of 2.1 times, sexual abuse 1.8 times, and physical neglect 1.6 times that of children without disabilities.

Abusers are usually family members of the victims. Parents are the perpetrators in 59% of all abuse, and familial abusers constitute 85% of all cases. Family stress from a variety of sources is correlated to reports of child abuse and neglect. These sources include alcohol and other drug problems, early, single parenting, unemployment, parental criminal involvement, major child care responsibilities, parental history of childhood abuse, and domestic violence, which itself can be considered a form of violence against children who witness, it in at least 3 specific ways:

1. Children are invisible victims. Witnessing one parent beat another causes immediate and long term trauma.
2. Children are accidental victims. They are often hit trying to protect a parent or when they simply are caught in harm's way
3. Children are intentional victims. 45% to 75% of men who batter women also batter their children. Mothers in a violent relationship are among those most likely to physically discipline their children for as long as they remain in the violent relationship

The need to solve the problem of child abuse and neglect has led to extensive research. This research points to parent education and support as one way of reducing child abuse. *Parents as Teachers* and *Healthy Start* are 2 programs that have been thoroughly evaluated, and provide parent education and support. Research also indicates that parents' psychological maturity and emotional well being increases sensitive parenting.

Positive parent-child bonding, essential to a child's well being, takes place when parents are sensitive to infants and provide responsive and affectionate caregiving. Abusive parents tend to lack effective child management techniques and experience and are more harsh and negative when interacting with infants.

Benchmark: Reduce Domestic Violence within Families

BENCHMARK ALLOCATION: 3% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

Bradley Angle House, Raphael House, West Women's and Children's Shelter, YWCA Women's Resource Center, Portland Women's Crisis Line, Community Advocates for Safety & Self Reliance, Children First, Multnomah Co. Legal Aid, Multnomah Bar Association Young Lawyers 7 Volunteer Lawyers Projects, Oregon Coalition Against Domestic & Sexual Violence, Multnomah Co. Family Violence Intervention Steering Committee, OHSU, Nursing Schools, Child Abuse Unit, Multnomah Co. Health Dept., Physicians for Social Responsibility, PPB Domestic Violence Reduction Unit, United Way, Portland Rotary, Ecumenical Ministries, Albina Ministerial Alliance, Lesbian Community Project, International Refugee Center, SOAR, Urban League, Coalition of Black Men, Emanuel Hospital's CARES Program, Imani Women's Center, School Districts (K-3 reps, ECE reps), Child care providers, Oregon Association for the Education of Young Children, OSU Extension Service, CASA, Association for Portland Progress, Schools, Morrison Center, Dr. Sudge Budden, Housing Authority of Portland Drug Elimination Team, Mental Health providers, public and private, CSD, MDT, Junior League of Portland, Multnomah County Libraries, Volunteers of America, Men's Resource Center, PCDC's, Multnomah County Connections Teen Parent Program, SKIP, STEPS, Even Start, Multnomah County Health Nursing Office, Head Start, Insight Teen Parent Program, Multnomah county Jail, Family court Services, William Temple House, Our Father's Ministry, Lutheran Family Services, Parents Anonymous, Peninsula Child Care Center, Metro Child Care R & R, Parent Cooperative Preschools, churches, parks and recreation programs, National council of Jewish Women; libraries, Baby's First, Pacific University, hospitals, Portland Family Calendar, United Way, Portland Office of Neighborhood Associations, Oregonian, Metro Crisis Intervention, Waverly, Mid-county Family Center, DARE, GREAT Oregon Peace Institute, Save Our Youth, the Solo Center, Tri County Youth Consortium, Eastwind, PACE, Mental Health Services West, Foster Parents Association, Morrison Center, Reach Out, Harry's Mother, Association of Retarded Citizens, Oregon Medical Association, OHSU, Kaiser, ASAP, Human Solutions, Portland Public Schools at Columbia Villa, Community Service Centers, Robert Wood Johnson, Shepard's Home, SAFAH , RASP, media, ASAP, Council for Prostitution Alternatives.

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

In 1993-94, Multnomah County domestic violence programs received over 29,000 crisis calls reporting domestic violence and seeking help. Domestic violence has major consequences for medical services, police, and business. One-third of all emergency room visits by women are due to domestic violence. Local 911 emergency services received over 13,000 calls reporting domestic violence assaults. One-third of the homicides in Multnomah County involved family or domestic violence. Domestic violence is the single greatest reason women leave the workforce, and can cause absenteeism and lowered productivity by both victim and perpetrator.

More babies are born with birth defects as a result of the mother being battered during pregnancy, than from the combination of all diseases for which we immunize pregnant women. At least 8% of pregnant women are battered during pregnancy, are twice as likely to miscarry and 4 times as likely to have low birth weight infants, 40% more likely to die in the first year. 45% of female alcoholics report being battered prior to their drinking.

Who are the victims, who are the abusers and why do they abuse? Overwhelmingly, it is women who are the victims, both in Multnomah County and nationally. A 1994 U.S. Department of Justice survey of 400,000 victims, reported that 90% of the victims were women. In Multnomah County 85% of those receiving restraining orders because of domestic violence are women. And equally overwhelmingly, it is men who are the perpetrators of domestic violence. The U.S. Department of Justice survey also indicated that between 90 and 95% of all perpetrators were men, husbands, ex-husbands, boyfriends or lovers.

Witnessing domestic violence has long-term negative effects on children. and is a greater predictor of perpetrating or being the victim of domestic violence than is being abused as a child. In one study, 85% of children from violent homes admitted to a drinking problem starting as early as age 11, and over 50% had used methamphetamines or marijuana, 10% habitually. Youth reporting violence between their parents have a higher rate of violence in their dating relationships, and are more frequently involved in the juvenile justice system, or have academic or social problems.

The links between child abuse, neglect and domestic violence, require that we address all three problems in order to reduce the incidence of any one. The presence of domestic violence is the single risk factor most identifiably predicting child abuse. One expert declares the linkage so close that domestic violence can be considered the primary cause of child abuse.

At least 3.3 million children in the U.S. between 3 and 17 years of age are annually at risk of exposure to parental violence. In Oregon, 41% of child fatalities and critical injuries from abuse and neglect occur in families with adult domestic violence. Adult domestic violence is a form of violence against children who witness it in at least 3 specific ways:

1. They are invisible victims: Witnessing one parent beat another causes immediate and long term trauma.
2. They are accidental victims: They are often hit trying to protect a parent or when they simply are caught in harm's way
3. They are intentional victims: 45% to 75% of men who batter women also batter their children. Mothers in a violent relationship are far more likely to physically discipline their children than after they have left it.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

A NOTE TO THE READER:
Many on this list were not at the table for this process, and the group developing this list had a lot of concern about publishing it without some explanation; there was a fear that those not listed would be offended and might choose not to participate in the future, and that some listed might feel misrepresented as having participated. This list is offered as "some of the organizations that could be valuable contributors to future work around preventing violence."

- Portland Parks Bureau
- Portland Productions
- Community Wellness Center
- Youth Outreach Program
- Portland Youth Redirection
- Multnomah County Community and Family Services Division
- Central NE Crime Prevention
- Gang Related Intervention Team
- American Friends Services Committee
- Victims/Offenders Reconciliation Program
- Southeast Uplift
- The Children's Program
- Oregon Health Sciences University
- PSU Endangered Child Program
- Self Enhancement, Incorporated
- Oregon Health Division
- Urban League (Public Health & Violence)
- Physicians for Social Responsibility (PSR)
- TCYSC Family Mediation Program
- Multnomah County Health Department
- Portland Police Bureau
- Multnomah County Sheriff's Office
- Children First
- Oregon Peace Institute
- County Commissioner Sharron Kelley
- Phoenix Rising
- Youth Service Centers
- Public/Private Schools
- OSMYN
- OMEGA/Boy's & Girls Club in N. Portland
- Student Unions
- Youth organizations
- Oregon Coalition Against Sexual and Domestic Violence
- House of Umoja
- Coalition of Black Men
- Legal community
- MC Task Force on Gay/Lesbian Youth
- A&D service providers
- Ecumenical Ministries of Oregon (EMO)
- Service organizations
- Citizen's Crime Commission
- Public Safety Council
- PFLAG
- People of Faith Against Bigotry
- United Way and their related programs

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

There is scientific and experiential evidence that several social factors contribute to violence by and against children and youth. These include:

- A rise in both actual experiences involving violence, and increasing positive depictions of violence in our language and all forms of communication and entertainment media.
- American culture's emphasis on competition and "polar thinking."
- Changes in family environments, including poor family bonding, repeated exposure to domestic violence and physical and sexual abuse, and a decrease in inter-generational contact.
- Economic and demographic shifts limiting young people's opportunity for a productive and secure future.
- Fragmentation of the immediate, and deterioration of the natural supports provided by the community.
- The limitations imposed by institutional racism/other forms of class devaluation.
- Abuse of alcohol and other drugs.
- The availability and acceptability of guns and other weapons to settle disputes.
- A shortage of places where young people can feel safe, and a lack of non-violent role models in many families and communities.

At the same time, there are many strengths in the community. These include:

- A variety of high-quality providers of youth services.
- Multiple organizations with expertise in conflict resolution.
- Strong and growing political leadership to address the issue of violence.
- A public health sector with growing technical expertise in the science of violence prevention.
- Strong individuals and organizations that offer role models, support, and activities for youth from our culturally diverse communities.
- A strong base of knowledge and leadership from individuals and organizations in law enforcement, health and social services, conflict resolution and mediation, and other disciplines.

There is a large body of support for addressing violence by and against children and youth, including support from the grass roots, the spiritual community, social service providers, people in education and health, and from elected officials.

Although the topic is framed in many ways, public safety is reported as one of the highest, if not the highest priority issue in most community polling. There is the potential for vast community support (including funding) if a strong leadership unites all the partners around a common agenda.

The proliferation and use of guns and other weapons among young people are among the most specific and urgent community concerns.

Violence takes several forms: physical violence; emotional violence; sexual and dating violence; self-directed violence; and hate, bias and prejudice.

The objectives dealing with domestic violence, juvenile crime, alcohol and other drugs, and others are directly related to this objective.

This community has a substantial peace and justice movement which can play a major role in planning and implementing this objective.

Many people want a quick, single method fix, but nearly everyone working in the field agrees that we waste time seeking this mythical remedy.

A few of the organizations contributing to current local efforts include:

- A Child/Family Mediation program at Tri-County Youth Services Consortium
- Local gang related organizations, which include experts on street violence
- Outside In, helping young men find alternatives to the violence of prostitution
- The Coalition of Black Men, a local resource committed to reducing violence
- Peer mediation programs, existing at local schools, and expandable
- The Metropolitan Human Rights Commission, conducting a campaign to reduce hate-directed violence and bias

POTENTIAL PARTNERS:
Some of the organizations that we may work with

1. Corporate partners (i.e., NIKE) or professional partners (i.e., Doctors)
2. Teen moms, and teens who have made other choices
3. Multnomah County Network on Teen Pregnancy & Young Parenting (including the prevention committee and the young parent caucus)
4. *Oregonian*
5. culturally specific newspapers and other publications, including school/youth oriented publications
6. Portland Parks & Recreation
7. Multnomah County Health Department
8. School-based health clinics
9. Schools
10. Oregon Teen Pregnancy Task Force
11. HIV prevention outreach services
12. Tri-county Youth Services Consortium
13. Planned Parenthood
14. Boys and Girls Clubs
15. Salvation Army
16. Self Enhancement
17. Employment programs (PIC, Steps to Success, Job Corps)
18. Child Care Council
19. Gang related community-based organizations
20. GIFT program
21. Boys & Girls Aid Society
22. Multnomah County Libraries
23. youth and youth groups
24. families
25. religious organizations

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Multnomah County's teen pregnancy rate is among the highest of 36 other counties in Oregon. Since 1989 teen pregnancy in Multnomah County has remained relatively stable, both rising and falling only moderately, from a high of 30.1 pregnancies per 1,000 females aged 10-17 to a low of 26.3 per 1,000. This range is *substantially* far from the statewide benchmark of 9.8 per 1,000.

Year	Mult. County	Oregon
1989	28.9	19.6
1990	28.4	19.7
1991	30.1	19.3
1992	26.3	17.9
1993	27.4	18.2

In 1992 there were 1,069 births to Multnomah County teens under 20 years. In 23.2% of these cases it was the mother's second or more child.

Many of the fathers of teen births are over age 20. For 1,751 births in 1989-1992 among teenage girls under 20 between 1989-1992 in Multnomah County for which the father's age was known (41% of the cases) 56% of the male partners were over 20, and 17% were over 25.

According to The Alan Guttmacher Institute's *Sex and America's Teenagers*, 1994, a larger percent of teens are having sex than in previous decades.

Age	% Sexually Active	Age	% Sexually Active
12	9%	16	42%
13	16%	17	59%
14	23%	18	71%
15	30%	19	82%

A study by Debra Boyer, Ph.D., University of Washington, has correlated teen pregnancy with sexual/physical abuse, other trauma. In her research Dr. Boyer determined that 62% of 535 pregnant teens had been sexually molested or raped prior to the pregnancy. Other unranked high risk factors for teenage pregnancy include:

1. Leaving middle/high school before completion
2. Unstructured, unsupervised time
3. Low or no access to contraception
4. Sibling or parent who was a teen parent
5. Early initiation of sexual activity
6. Homelessness
7. Severe Poverty
8. Substance abuse
9. Low self-esteem
10. Gang affiliation

Of 1,857 1992 Multnomah Co. teen pregnancies, 60% were to mothers 18/19 years old. Of the mothers 17 and under, 65% were Caucasian, 22% African-American, 7% Hispanic, and 1% Native American. 57% of those pregnancies resulted in live births, 75% of which were to first time mothers of whom 54% were 18/19 years old. Teen mothers already parenting comprised the other 25%, the vast majority (80%) age 18 or 19. Only 5% of the teen births occurring in 1992 were to mothers in this benchmark's target age (10 - 17 years) who had previously given birth.

Geographically, teen birth rates differ markedly from area to area in the county. For mothers ages 15-17, the north and northeast integrated service districts had rates almost double the rate in southeast; while southeast's rate of teen births (33.9/1,000) was over 80% more than southwest's.

A few local peer-to-peer programs include Planned Parenthood's "Teens & Company," Youth Unlimited's various video productions, and Project Action's social marketing campaign and teen-to-teen skills building workshops.

Prevention programs must have clarity of goals and objectives, particularly if the program has some of the following purposes, but hasn't clearly stated them:

- Prevent young women from becoming pregnant
- Prevent young women from having babies
- Prevent young people from having sex
- Prevent young women from having abortions
- Supply young people with birth control
- Promote religious values, or community values, or create new values

Benchmark: Reduce the Number of Families Living in Poverty

BENCHMARK ALLOCATION: 2% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

1. **National/local Public Policy Makers** who will work for a unified national agenda that affirms:
   - **Communities** in poverty are unhealthy for the entire country, diminishing the quality of life and availability of opportunities for all residents. A community that must compete internationally can not do so if vast numbers of residents are left behind.
   - **Business** has a vital role in ending poverty. Involvement in the process of education is necessary, as is acknowledging the value of health care, child care and an adequate minimum wage and providing continuing education. Some businesses are deeply committed in their practices to these ends; others need encouragement.
   - **Government** is responsible to set and enforce policies to ensure that profit is not the only bottom-line outcome for business practice.
2. **Local coordinating bodies** need to make eradication of poverty a top priority. Extensive coordination among policy makers in the fields of income supports, education, employment and social services is needed to achieve this goal.
   - **The Multnomah County Community Action Commission** (MCCAC) is a lead policy body addressing poverty issues.
   - **The Multnomah Commission on Children and Families** (MCCF) must develop a formal relationship with MCCAC, becoming partners in moving families out of poverty.
3. **Funding bodies** need to make eradication of poverty a top priority.
   - Oregon Adult and Family Services
   - Multnomah Co. Community and Family Services Division, particularly Community Action Program
   - Portland Bureau of Housing and Community Development
   - Portland Development Commission
   - Multnomah County Health Dept.
   - Specific federally funded programs

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Every child deserves to have a family and community committed to that child's well-being. The foundation for a child's healthy development is three nutritious meals a day, stable housing, access to health care, positive school experience, and a safe nurturing, family-centered environment.

Poverty limits a child's ability to reach full potential in every aspect of life. Too many Multnomah County children are living in conditions that are in sharp contrast to the basic goal of achieving wellness. Studies consistently show that child poverty negatively affects health, mental health, cognitive and behavioral development, and other problems.

More children and families in Multnomah County are living in poverty today; in 1990, 16% of those in poverty were children, compared to 11% in 1970. Poverty limits a family's ability to afford basic school supplies or quality child care, impedes a parent's ability to put nutritious food on the table each day, and can limit access to health care.

Frustration and despair is the result of the daily struggle to attempt to meet basic needs with inadequate resources. The lack of options associated with poverty makes poor families vulnerable to a variety of problems at higher rates than the general population; including mental and physical health concerns, developmental delays and teen pregnancy.

Poverty and hunger, the daily lot of many Multnomah County children, are in sharp contrast to achieving the basic goals of wellness for every child, the overall goal of the Multnomah Commission on Children and Families, defined as ***"the preservation of each child's potential for physical, social, emotional and cognitive and cultural development."*** Children in poverty are, by default, denied the opportunity to reach their potential in virtually every aspect of their lives.

Although subsidized public support is available for some poor families, the poverty guidelines are unrealistically low compared to what is needed to achieve a minimum standard of living. Persons receiving Aid to Dependent Children assistance and food stamps receive only approximately two-thirds of the federal poverty guidelines.

Who lives in poverty? Nearly one-fifth (19%) of Multnomah County's children live in poverty, further concentrated in certain demographics:

- Nearly one-quarter (24%) of children under 5 live in poverty.
- Nearly one-third (31%) of the female-headed households with children live in poverty.
- Ethnic minority families are poor in significantly higher proportions than the population as a whole. More than one-third (35%) of African-American families in Multnomah County live in poverty.
- Among homeless families, 606 children were counted on 11/17/93, an increase of more than one third from the previous year.
- 95 homeless youth, unaccompanied by an adult, were counted on 11/17/93, an increase of more than one half from the previous year.

Domestic Violence forces many women to become single heads of households, and are placed at risk of poverty and homelessness. Over three-fourths (77%) of the women in the local Community Action Program's Homeless Families Program have experienced three or more types of violent acts in domestic relationships. Reducing domestic violence in our society will also reduce the needs of many families living in poverty.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

The Housing and Community Development Commission (HCDC) is the policy-making body charged with implementing the County-wide Housing Affordability Strategy (CHAS). The HCDC has representation from the Cities of Gresham and Portland, and Multnomah County.

Other public entities involved in funding or developing housing or funding related services are:

- Housing Authority of Portland
- Portland Bureau of Housing and Community Development
- Portland Development Commission
- Gresham Community Development
- Multnomah County Community and Family Services Division (CFSD), Community Development Program
- Multnomah County CFSD Community Action Program

Other partners could include housing developers for low-income and special needs populations, such as community development corporations.

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Every child deserves to have a family and community committed to that child's well-being. Unstable, unsafe housing is not compatible with achieving wellness, the goal of the Multnomah Commission on Children and Families, defined as *"the preservation of each child's potential for physical, social, emotional and cognitive and cultural development."*

Children in unsafe, unstable, sometimes overcrowded housing are severely hampered in their opportunities to reach their potential. Housing instability or lack of safety is closely associated with poverty (addressed in a separate benchmark).

Housing is becoming less affordable and less available in Multnomah County at the same time that poverty has increased:

- Fewer than one-half (42%) of renters pay under 30% of income for housing, the standard percentage for housing affordability.
- Poverty among families with children has increased. In 1990, 19% of children lived in poverty. Yet, public housing waiting lists are full and are closed.
- For 10 years, rental vacancy rates have been extremely low, indicating a tight housing market, particularly in close-in neighborhoods.
- Homelessness among families with children is increasing. On November 17, 1993, 606 children were homeless.

Home is unsafe for many women and children:

- Domestic violence shelters in Multnomah County turned away 87% of the women and children requesting shelter in 1990.
- Many unaccompanied youth report becoming homeless because of abuse or alcohol or drug use of parents.
- There is an absence of neighborhood safety in some areas.

Rent Burden issues are an increasing problem:

- 58% of renters pay over 30% of income for housing, the standard percentage for housing affordability. In other words, most renters are carrying a high rent burden compared to their income.
- The Housing Authority of Portland has nearly 10,000 households on its Public Housing/Section 8 waiting lists. Some lists are closed.
- Data gathered through 1990 shows the Portland metro area enjoyed a relatively high degree of housing affordability, but housing prices have increased dramatically since. There has been a general decline in housing affordability and in the available housing stock for sale.
- Many families with children are at-risk of homelessness.

Homelessness is an increasing risk for many:

- Federal, state and local housing policies, a decrease in affordable, private market housing, and changes in family life, result in many families being headed by economically vulnerable, single mothers.
- Four factors on the pathway to homelessness are: (1) lack affordable housing, precipitating the loss of permanent housing (2) residential mobility, destabilizing families (3) discrimination in the housing market, constraining housing choices, and (4) multiple stressors demoralizing fragile family systems

Half of all "severely distressed" Oregon neighborhoods are in Multnomah County, mostly in North and Northeast Portland. A severely distressed neighborhood is defined as including high rates of poverty, female-headed households, high school dropouts, unemployed males and families receiving public assistance (Children First, 1994).

Other major issues impacting the goal of safe stable housing include domestic violence, and a sharply increasing number of homeless youth, unaccompanied by an adult (see poverty benchmark for more information).

Benchmark: Increase Families Caring for their Children (Part 1: All families)

BENCHMARK ALLOCATION: 12% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Oregon Health Sciences University
- Regional Research Institute, Portland State University
- National Resource Center for Family Support Programs
- National Resource Center on Family-Based Services
- National Resource Center for Crisis Nursery and Respite care programs
- Birth to Three, National Center for Clinical Infant Programs
- National Committee For the Prevention of Child Abuse Program models which have proven to be successful include:
- The Healthy Start Program
- Intensive Family Preservation Services (Homebuilders)
- Relief Nursery Program (The Family Nursery)
- Intensive Family Services
- Parent Training Services
- Family Centers (Parent Child Development Services and Youth and Family Services)
- Multnomah County Health Department Connections program
- Mentoring Programs (Big Brother/Sister, Rotary etc.)
- Respite programs
- Helplines (Parents Anonymous)
- Substance abuse and A.A. program
- news, entertainment and advertising media
- government organizations
- business organizations
- religious organizations
- community service
- non-profit organizations

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

The objective of this benchmark is to increase the number of families who are able to care for their own children reducing the need to place children in substitute care and reducing the need for intensive crisis intervention services.

Changing demographics and a dramatic increase in the demand for substitute care, nationally and in Oregon, serve as major obstacles in identifying reliable indicators to measure progress towards achieving this benchmark. While the rate of children from Multnomah County in foster care is high compared to other Oregon counties, the rate is lower than the national rate. Further, the demand for foster care in the Portland metropolitan area is growing slower than in other regions of the state, although the demand for out-of-home placements at mass shelters is increasing. Since the demands for substitute care vary widely, several indicators should be considered to form a reliable basis for evaluating progress.

One reasonable indicator that we are progressing towards achieving this benchmark would be a reduction in the average daily population (ADP) of children in foster care for Multnomah County as compared to the national average. (Similar indicators could measure progress in reducing the need for mass shelters. Currently, the ADP of children in paid foster care in Multnomah County is 80 percent of the national average. A reasonable goal would be a decrease in the ADP for Multnomah County to 75 percent of the national rate within five years.

Another indication of progress would be a drop in the ranking of Multnomah County compared to other counties in the rate substitute care placement. Currently, we rank second among Oregon's 36 counties. A reasonable goal would be a drop in the ranking to the lower two thirds of Oregon counties.

Thirdly, a 10 percent reduction in the length of time that children stay in substitute care over the next five years would be another goal.

A fourth indicator of progress would be a reduction in the disparity in the rates of placement of minority and non-minority children.

Finally, to assure that child safety is not sacrificed in the name of reducing placements, there should be no increase in the number of founded cases of child abuse.

Several underlying principles, based in part on the Principles of Family Support developed by the National Family Resource Coalition, create a solid foundation:

- Services are family-centered , addressing the needs of the child within the context of the family.
- Services are built upon the strengths of the families involved in the program with a focus on wellness and prevention and designed to foster resiliency.
- Central to the core of each program is the commitment to empower parents and support them as the best advocates for their children.
- The relationship between program and family is one of equality and respect.
- Participants are the program's most vital resource. Parents' ability to serve as resources to each other and to participate in program governance are recognized through the establishment of community networks, support groups and advisory boards and committees.
- Programs are voluntary, neighborhood based and accessible to families using the service, and when appropriate, should be provided in the home.
- Programs are inclusive and non-stigmatizing.
- Programs are designed to be to be culturally and socially relevant to the families they serve. When possible, staff and volunteers working in the program should reflect the ethnic and cultural makeup of the families served.
- Parent education, information about human growth and development and skill building for parents are essential elements for programs.
- Programs that are non-custodial should be voluntary. Seeking help and support is viewed as a sign of strength, not an indicator of deficits and problems.
- Programs offer safe environments, especially to the most vulnerable.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Multi-disciplinary Team
- Juvenile Rights Project
- Portland State University
- Portland police
- School police
- Children's Services Division
- Juvenile Court
- CASA
- Harry's Mother/Garfield House Shelter
- Foster Parents Assn.
- Foster Grandparents Assn.
- Mental health providers
- Health providers
- CARES program
- School counselors
- Family Centers
- Family Crisis Nursery
- Casey Family Program
- Substitute Care Agencies

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

There appears to be a strong community value in Multnomah County that it is usually in the best interests of children to live with their families. The safety of the child must be balanced with attachment to family and, when, necessary the child placed in substitute care. By far, the majority of substitute care placements are made to foster family homes.

An escalating number of infants and young children (under 5 years) are being placed in substitute care.

In 1993, 2,342 families in Multnomah County received out-of-home placements of children aged birth-17 years through Children's Services Division. Based on a 1993 child population (birth-17) of over 143,000, children in Multnomah County were placed in foster care at a rate of 16.29 per thousand, the 2nd highest rate among 36 Oregon counties.

Multnomah County CSD worker caseloads average, significantly above national averages. Majority of families whose children enter out of home placements are previously known to CSD through Hotline calls. No one has responsibility for serving these families known to be at risk.

A single child welfare worker, rather than a team, is often asked to make decisions about the future of the child regarding removal, transition, treatment and permanency. Child welfare workers are not available 24 hours a day to respond with law enforcement to crises.

There are not adequate coordinated, accessible "front end" or treatment resources (including needs assessment, family mediation, parenting help, family and individual counseling and respite care).

In addition to the needs of younger children and their families, there remains a serious need to be responsive to the families of adolescents and pre-adolescents that are at increased risk for having a youth run away from home due to family problems including

- poverty, unemployment
- lack affordable housing, precipitating the loss of permanent housing
- residential mobility, destabilized families
- mental health concerns
- lack of parenting skills, lack of communication skills, lack of conflict resolution skills
- multiple stressors demoralizing fragile family systems

More than half the families of adolescents seeking family crisis intervention services are turned away or placed on a waiting list.

Emergency shelter beds have declined the last few years for youth who have run away from home and need safety before social workers can evaluate the youth's family's ability to become reunited.

Male and female youth as young as 14 or 15 who have run away from home are often left with three primary options:

- sleeping and eating at an age-inappropriate, night-time only homeless shelter, unaccompanied by an adult (if any beds are available)
- sleeping on the streets, under bridges, or in abandoned buildings
- working in prostitution or other sex industry jobs

Benchmark: Increase Youth Graduating from High School

BENCHMARK ALLOCATION: 8% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Multnomah Education Service District (MESD)
- Portland Public Schools (PPS)
- Barlow/Gresham Schools
- Bonneville School District (SD)
- Centennial SD
- Corbet SD
- David Douglas SD
- Gresham Grade SD
- Orient SD
- Parkrose SD
- Reynolds SD
- Riverdale SD
- Sauvie Island SD
- Portland Leaders Roundtable Caring Communities
- Youth Gang Task Force
- The PEN (Portland Education Network)
- Multnomah County Health Department
- Multnomah County Libraries
- Committed Partners for Youth
- PSU Project PLUS
- Portland Public Schools' Teen Parent Program
- Private Industry Council
- Pacific University & PSU Upward Bound Programs
- Portland Impact
- RWQC Council
- Job Corps
- Business Youth Exchange (Chamber of Commerce)
- Business/industry organizations, and associations
- Multnomah County
- I Have a Dream Foundation
- Mott Foundation
- Neil Goldschmidt Foundation

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Increasing the percentage of youth graduating from high school and its inverse - decreasing the percentage of students dropping out - is a popular issue at the present time. Starting with the 1988-89 school year, the Oregon Department of Education (ODE) began requiring regular dropout reports from every school district in the state. This was the first time a uniform reporting system had been required. The ODE's analysis provides annual, one-year statistics as well as a synthetic four-year rate. For 1992-93, the dropout rate statewide was 5.7% and the four year rate was calculated to be 21.4%.

The Portland School Board adopted it as one of its major goals in 1990. PPS staff responded by creating a wide variety of "dropout retrieval programs." PPS staff also initiated the "Dropout Monitoring Study" which tracks the Class of 1994 from the end of 8th grade through the senior year. By the end of year 3 (grade 11) 31.5% of all students in the study had dropped out and not reentered another PPS school or program.

Implementation of the Katz Plan will require new ways of analyzing graduation and dropout rates as well as an increase in "relevancy" in the curriculum. It also requires alternative learning centers for dropouts and those at risk for failure.

Research points out the following reasons for students dropping out of school:

1. Lack of self-respect, respect from family and community.
2. Language and cultural issues; inability to adapt to mainstream culture and maintain first culture at the same time (Oregon Department of Education statistics say Hispanic students drop out at more than twice the average rate statewide; Am. Indian students are close behind)
3. Mobility (Oregon Department of Education statistics say a high proportion of dropouts were enrolled in the school district 1 year or less; mobility was also cited in Portland Public Schools' *Dropout Monitoring Study*)
4. Teen pregnancy, parenting, independent living burdens
5. Disrupted/dysfunctioning nuclear families
6. Alcohol/other drug abuse
7. Discipline problems
8. Gang involvement
9. Poor achievement
10. Homelessness
11. Inability to adapt to school setting (Oregon Department of Education statistics say students in large schools are more likely to drop out)
12. Inability of the school to provide a program leading to success for that student
13. Limited ability of schools to provide a bilingual program to meet the needs of non-English speaking students

Benchmark: Reduce Minority Over-Representation in Juvenile Justice /Child Welfare Systems

BENCHMARK ALLOCATION: 10% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Multnomah County Juvenile Justice Division
- Multnomah County Community & Family Services Division
- Multnomah County Adolescent Mental Health/Youth Program Office
- Multnomah County Alcohol and Drug Program Office
- Multnomah County Health Department
- other Multnomah County divisions and programs
- Intervention Committee of the former Multnomah County Children and Youth Services Commission
- Detention Reform Committee
- Oregon Children's Services Division (CSD), child welfare & juvenile corrections
- Oregon Commission on Children and Families
- Alternative schools
- Tutoring services
- Employment programs
- Gang resources - juvenile justice, law enforcement and community-based
- Church programming, including mentoring services
- Alcohol and other drug treatment programs, in-patient and out-patient
- Residential treatment programs
- Transitional housing programs
- Shelter care facilities
- Mental health agencies
- city, county & state law enforcement, including the school police
- Child Welfare
- school district supported services
- Family Service Centers
- Juvenile Parole

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Social justice for minority youth is an issue for both the juvenile justice and the child welfare systems.

Most planning has involved the juvenile justice system. The Multnomah County Juvenile Justice Division has concentrated on reducing the over-representation of African-American youth in the juvenile justice system through a variety of programs funded with state, federal and county money.

The MCCF is committed to these efforts and to similar future efforts related to the child welfare system. The MCCF's predecessor funded programs targeting minority youth in the state training schools, and funded a SE Asian youth needs assessment.

There has been a decrease in minority overrepresentation in the juvenile justice system in the past three years, especially for African American youth, but the reasons for this have not been fully examined.

For many years, the juvenile justice system has been the focus of research on the perception of bias toward minority youth. Studies of Multnomah County include the ongoing Office of Juvenile Justice & Delinquency Prevention study, begun in 1992 by the State Commission on Children and Families, and the more recent research of the Oregon Supreme Court Task Force on Racial/Ethnic Issues in the Judicial System.

The Supreme Court Task Force's report called for:

- A comprehensive statewide plan to reduce minority over-representation and disproportionate confinement in the juvenile justice system
- More skilled interpreters to assist non-English speaking parents/care-givers
- More trained and culturally-sensitive experts available to juvenile court staff and practitioners

No comparable research of similar issues within the child welfare system has been undertaken since 1982.

Although it is phrased more generally, this initiative deals nearly entirely with young, African American males.

Over-representation for young African American males becomes more acute as system penetration increases from early warnings, to diversion, to early detention, to commitment to state training schools, to remand to the adult system.

While the nature of reasons for over-representation are not fully addressed, the research to date indicates a need for further and more refined analysis of the system data, controlling for the influence of the number of prior referrals, crime severity, and selection factors. All of these can affect the accumulation of cases at certain decision points in juvenile justice processing.

Qualitative data analysis suggest the need for additional research on the availability of client resources and services.

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Multnomah County Juvenile Justice Division
- Multnomah County Community & Family Services Division
- Multnomah County Adolescent Mental Health/Youth Program Office
- Multnomah County Alcohol and Drug Program Office
- Multnomah County Youth Employment and Empowerment Program
- Multnomah County Health Department
- other Multnomah County divisions and programs
- Juvenile Court
- Youth Service Center diversion programs
- Mall security businesses
- African-American churches
- Crime prevention units of neighborhood associations
- Law enforcement: Portland Police, Multnomah County Sheriff, Oregon State Police, school police
- Alcohol and drug prevention programs
- Hispanic youth programs
- Casey Foundation
- Alternative schools
- Tutoring services
- Employment programs
- Gang Resources - Juvenile Justice, law enforcement and community-based
- Church programming, including mentoring services
- Alcohol and other drug treatment programs, in-patient and out-patient
- Residential treatment programs
- Transitional housing programs
- Shelter care facilities
- Mental health agencies
- Child Welfare
- School district supported services
- Family Service Centers
- Juvenile Parole
- organizations accessing the federal crime bill appropriations

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

The increase in violent crime by juveniles, including the increased use of weapons is a serious problem in Multnomah County. The rates have increased far in excess of population growth.

Increase in violent crime continues to put great pressure on the number of available close custody beds to Multnomah County.

The county has experienced growth in referrals for sexually assaulted behavior by juveniles, and a greater number of adjudicated juvenile sex offenders.

Citizens are frightened and are demanding "quick fixes."

The gang phenomenon is not going away. Attention has been focused on North/Northeast Portland, but serious problems in Southeast Portland and East County have not been addressed.

We are seeing an increase in multi-cultural gangs, Hispanic gangs, skinheads, SE Asian youth, involvement of girls in gangs.

Although Multnomah County has a new Detention facility, only 60 beds are dedicated to Multnomah County youth requiring pre-dispositional, secure confinement. The remaining beds are dedicated to Regional Detention, treatment and assessment programs, or are currently undesignated pending state wide planning efforts.

The Juvenile Justice Division is involved with the Annie E. Casey Foundation to implement program and policy changes to increase the use of detention alternative programs while still assuring public safety.

Juvenile justice is in the midst of tremendous change at all levels, much of which is a result of public pressure, pending legislation regarding waivers to adult court, and proposals to strengthen juvenile justice while allowing the system resources to rehabilitate youth.

Programming for female offenders and for minority youth, and community-based options are still lacking. With changes in policy, very few young women will be eligible for confinement in secure detention.

There is a tremendous push for "quick fix" methods, including recently approved ballot measures, seeking to remand all youth who commit felonies to adult court and to be served in the adult system.

A strong commitment is needed in this county to both assist in and advocate for adequate services at all levels in the juvenile system, and to educate the public as to what is being done and can be done to reduce juvenile crime without putting all of our resources into an adult prison system that is too expensive and is not working.

Benchmark: Reduce Adolescents' Use of Tobacco, Alcohol, other Drugs

BENCHMARK ALLOCATION: 6% of available funds

POTENTIAL PARTNERS:
Some of the organizations that we may work with

- Youth
- Families
- Schools
- Businesses
- Religious Community
- Community Groups
- Health Care Providers
- A&D Providers
- Media
- Criminal Justice System
- Local, State, and Federal Government

SITUATION ANALYSIS/COMMUNITY FINDINGS:
What we know about the way things are now, and how people in the community are responding

Adolescent use of tobacco products, alcohol, and other drugs is a significant concern in Multnomah County. Available data points to the conclusion that, in spite of steady declines in drug use among juveniles in years past, more recent information nationally and locally, signals a change in this pattern with strong indications of increase in use.

It should be noted that available statistics only reflect data regarding students in school even though use of tobacco, alcohol, and other drugs is believed highest among out-of-school youth, a substantial population.

Foremost among the findings of this report is the need for new funding patterns that encourage collaboration and integration of services. Our service delivery system aims at providing a broad-based, integrated, full continuum of services for youth and families, but relies on categorical funding methods which create inappropriate competition among services areas as well as between service providers. This is a major systems barrier, which not only doesn't reward, but actually *inhibits* collaboration and integration of services.

It should also be recognized that though there are substantial state and federal resources for alcohol and drug treatment programs, the adolescent population is the recipient of only a small portion of these resources and require specialized services so that resource service dollars available may not go as far with the adolescent population as with the adult population.

Volunteer members of the county's Regional Drug Initiative Youth Coalition served as a focus group to provide input to this planning effort. Their recommendations regarding drug prevention included the following:

- Use peers as educators on topics pertaining to youth.
- Provide in-school drug education programs beginning at the earliest possible age.
- Assure interactive learning situations for youth.
- Designate school counselors who are available to help.
- Make choices and consequences clear for adolescents.

In a 1992 research project among middle and high school students, Seattle-based Comprehensive Health Education Foundation in determined that "the issue of greatest reported personal significance to students was drugs" although there was "only limited recognition that alcohol products and cigarettes are drugs, with some students reporting that to be 'a drug' a substance must be illegal. Students explained their concerns by identifying how drugs affected "nearly all aspects of their lives: sex, sexually transmitted diseases, violence (and sexual violence in particular), safety, abuse, fitness and exercise, communication, personal relationships with family and friends, entertainment and news media, peer pressure, law enforcement personnel, and their plans for the future."

Portland 11th graders who were asked in 1992 if they had used alcohol and/or other drugs in the preceding month reported 23% illegal drug use, 43% alcohol use, and 22% tobacco use; 8th graders reported slightly lower usage.

Multnomah County Alcohol & Drug Program Office estimates that 10% of Multnomah County's 23,000 high school students have "serious problems with alcohol and/or other drugs."

A P P E N D I X

POLICY CONSIDERATIONS

by benchmark

Proposed to the Multnomah Commission on Children and Families
by Planning Teams, October 1994

BENCHMARK: EARLY CHILDHOOD EDUCATION

1. Consider policy requiring all new businesses and programs to provide a child and family impact study
2. Consider policy which supports the development and implementation of a transition plan for every child as she/he moves from home to child care or preschool to school
3. Consider stricter regulation and higher standards for child care providers along with adequate compensation
4. Consider a policy calling for universal screening at birth and throughout early childhood
5. Consider a policy requiring all individuals who provide care to children with the support of public funding, to complete child safety and development training

BENCHMARK: INCREASE QUALITY CHILD CARE

1. Consider dedicating a portion of the county business tax to constructing new, or remodeling existing, child care environments

BENCHMARK: REDUCE THE NUMBER OF BABIES BORN DRUG AFFECTED

1. Consider a policy calling for smoke free treatment services
2. Consider a policy which eliminates categorical funding, allowing alcohol/other drug funds to buy child care and other family supports
3. Address confidentiality issues that serve as barriers to coordinated care
4. Consider policies to improve the transition between treatment phases
5. Consider a policy banning TV alcohol advertising.
6. Consider supporting laws restricting teens' access to tobacco products
7. Consider a policy calling on health care providers to include smoking cessation interventions as part of primary health care

BENCHMARK: INCREASE PRENATAL CARE

1. Consider advocating for the state to increase Medicaid eligibility for pregnant women to 185%, maximum allowed by federal law
2. Consider expanding Medicaid outreach efforts, including returning to use of outstationed, community based eligibility process
3. Consider encouraging employer policies which allow women to use paid sick time to attend prenatal visits

BENCHMARK: REDUCE CHILD ABUSE AND NEGLECT

1. Consider a policy defining the circumstance of a child living in a home experiencing domestic violence as being child abuse
2. Consider advocating for adequate legal protection for children
3. Consider advocating for children's rights and safety in domestic relations and in custody cases in family court proceedings
4. Consider policy supporting universal hospitals' screening

BENCHMARK: REDUCE DOMESTIC VIOLENCE WITHIN FAMILIES

1. Consider policies strengthening restraining orders
2. Consider recommending legislation to increase the severity of repeated Domestic Violence Assault IV offenses
3. Consider policy of removing the abuser, not the abused, from the home

BENCHMARK: REDUCE JUVENILE CRIME

1. Consider writing a policy specifically requiring all services and supports to be culturally relevant, gender specific, and appropriate for diverse populations, including ethnic, cultural and sexual minorities
2. Study the establishment at the county or state level of a Juvenile Psychiatric Security Review Board to oversee the placement and monitor the activities of youth who are serious offenders and who have serious mental health issues, but who do not fit into the programs available through the Juvenile Justice System

BENCHMARK: REDUCE ADOLESCENTS' USE OF TOBACCO, ALCOHOL, OTHER DRUGS

1. Consider the MCCF and Board of County Commissioners adopting a resolution strongly opposing the legalization of drugs
2. Consider working with employers of youth to develop and implement drug and alcohol free work place policies
3. Consider MCCF recommending to Board of County Commissioners:
   - More resources for enforcing laws related to the sale of tobacco products to minors, paid for with additional taxes on tobacco sales
   - County policy prohibiting alcohol/tobacco products advertisements on County owned property
   - County Public Health Officer to declare tobacco, alcohol, other drugs a public health hazard for pregnant women, minors, others
4. Consider a policy in county school districts requiring parent education on alcohol and other drug use, prior to students' enrollment
5. Consider asking County Public Health Officer to recommend implementation of programs proven effective in reducing tobacco use among adolescents after reviewing strategies, policies, outcomes in other areas
6. Consider revising current funding policies; allow programs to offer services for the immediate, on-demand needs of teens, and preteens
7. Consider eliminating or reducing the restrictions created by categorical funding, by focusing on outcomes rather than just service areas

EXHIBIT B

OREGON Commission on Children & Families

County Plan Amendment, 1995-1997 Biennium

County Name: Multnomah

Please complete a separate form for each amendment. For each portion being amended, please explain what is changing by bolding or underlining anything that is added or changed.

For program fiscal changes, please follow instructions 1 through 6 below signature lines.

Date 9/15/95

BENCHMARK	DIRECTION	TOOL	PARTNERS	NEW						COMMENTS
Identify the core benchmark addressed	**Include desired outcome**	**Implementation**	**Please indicate which program is being addressed.[1]**	**Check if new program.[2]**	**Indicate % of FP & FS**	**Indicate grant stream.[3]**	**Current budget amount.[4]**	**Amended amount.[5]**	**Revised budget amount.[6]**	**Please explain what community changes or conditions drive this plan amendment.**
Child Abuse Benchmark	Increase opportunity for reducing family tension, increasing parenting skill development, expand existing network.	Family Relief Nursery	Volunteers of America Crisis Relief Nursery		10%		- $0 -	$33,000	$33,000	New funding source to enhance existing services and implement additional elements of Comprehensive Plan.
		Respite Care for families in crisis	Contract with existing or new providers	✓	8%		- $0 -	$26,400	$26,400	
		Parent-Child Development Services (Healthy Start type model)	Family Centers, other providers		32%		1.44 mill	$105,000	$1,545,600	
		Crisis response teams for families in danger of entering child welfare system	Family Centers, SOSCF, other providers - under development	✓	40%		- $0 -	$132,000	$132,000	
		Flexible client services fund	SOSCF	✓	10%		- $0 -	$33,000	$33,000	

Local CCF Chair Approval [signature] Date November 21, 1995

County Board Approval* (*May submit this signature **after** 9/15/95.) Date

Regional Coordinator Approval Date

- List only programs (budget line items) which are changing.
- For new programs, update Program Directory electronically.
- Indicate funds for this program: FPSP - FY 1996/97.
- Indicate amount shown for this program in your most recently revised budget.
- Enter the change from Current Budget Amount to Revised Budget Amount.
- Indicate new amount for this program.

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