Multnomah County Oregon

Board of Commissioners & Agenda

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BOARD OF COMMISSIONERS

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MAY 9, 10 & 12, 2005 BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30
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Monday, May 9, 2005 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET WORK SESSION

WS-1 Multnomah County 2005-2006 Budget Work Session. This meeting is open to the public however no public testimony will be taken. 1 HOUR REQUESTED.

Cable Television Times/Channels:
Monday, 5/09/05 at 9:30 AM, (LIVE) Channel 21
Wednesday, 5/11/05 at 8:00 PM, Channel 29
Friday, 5/13/05 at 8:00 PM, Channel 29
Saturday, 5/14/05 at 2:00 PM, Channel 29
Produced through Multnomah Community Television

Tuesday, May 10, 2005 - **6:00 PM**
North Portland Library Conference Room
512 N Killingsworth, Portland

PUBLIC BUDGET HEARING

PH-1 Public Hearing on the 2005-2006 Multnomah County Budget. Testimony is limited to three minutes per person. Fill out a speaker form available in the Conference Room and turn it into the Board Clerk. The conference room will be open one hour prior to the meeting.

Cable Television Times/Channels:
Thursday, 5/12/05 at 6:00 AM, Channel 21
Saturday, 5/14/05 at 3:00 PM, Channel 29
Sunday, 5/15/05 at 4:00 PM, Channel 29
Monday, 5/16/05 at 8:30 PM, Channel 29
Produced through Multnomah Community Television

Thursday, May 12, 2005 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
NON-DEPARTMENTAL

C-1 Appointment of Sarah Marie Benjamin to the Multnomah County COMMUNITY HEALTH COUNCIL

DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES

C-2 RESOLUTION Authorizing Cancellation of Uncollectible Personal Property Taxes for Tax Years 1994/1995 through 2004/2005

REGULAR AGENDA - 9:30 AM
PUBLIC COMMENT - 9:30 AM

Opportunity for Public Comment on non-agenda matters. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

SHERIFF'S OFFICE - 9:30 AM

R-1 Budget Modification MCSO-03 Appropriating $168,968 in Federal/State Funds Due to E-Board Restoration of Funding from Senate Bill 1145 Revenue

SERVICE DISTRICTS - 9:35 AM

(Recess as the Board of County Commissioners and convene as the Budget Committee for **DUNTHORPE RIVERDALE SANITARY SERVICE DISTRICT NO. 1)**

R-2 Appointments of Dunthorpe Riverdale Sanitary Service District Budget Committee Member Ruth Spetter and Budget Committee Chair and Secretary for 2005-2006 [*2004-05 Appointments were Commissioner Lisa Naito as Chair and Commissioner Maria Rojo de Steffey as Secretary*]

R-3 Presentation of Budget Message Followed by PUBLIC HEARING to Consider and Approve the 2005-2006 Dunthorpe Riverdale Sanitary Service District No. 1 Proposed Budget for Submittal to the Tax Supervising and Conservation Commission. Presented by Tom Hansell.

(Recess as the Budget Committee for Dunthorpe Riverdale Sanitary Service District No. 1 and convene as the Budget Committee for **MID COUNTY STREET LIGHTING SERVICE DISTRICT NO. 14)**

R-4 Appointments of Mid County Street Lighting Service District Budget Committee Chair and Secretary for 2005-2006 [*2004-05 Appointments were Commissioner Maria Rojo de Steffey as Chair and Commissioner Serena Cruz as Secretary*]

R-5 Presentation of Budget Message Followed by PUBLIC HEARING to Consider and Approve the 2005-2006 Mid County Street Lighting Service District No. 14 Proposed Budget for Submittal to the Tax Supervising and Conservation Commission. Presented by Tom Hansell.

(Recess as the Budget Committee for Mid County Street Lighting Service District No. 14 and reconvene as the Board of County Commissioners)

DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES - 9:50 AM

R-6 PROCLAMATION Declaring the Week of May 15 though May 21, 2005, as NATIONAL TRANSPORTATION WEEK and NATIONAL PUBLIC WORKS WEEK and Recognizing the Contributions of All Multnomah County Transportation Employees

R-7 NOTICE OF INTENT to Apply for Transportation and Growth Management Grant from the Oregon Department of Transportation (ODOT) to Prepare the East of Sandy River Transportation System Plan

R-8 RESOLUTION Approving the East County Justice Facility Project Proposal and Directing Preparation of Project Plan. Presented by Commissioner Lonnie Roberts, Doug Butler and East County Justice Facility Work Group Members. 30 MINUTES REQUESTED.

DEPARTMENT OF HEALTH - 10:30 AM

R-9 Budget Modification HD-13 Appropriating $260,000 from the Oregon Department of Human Services for Personnel Costs Associated with the New Portland Metropolitan Health Preparedness Organization

R-10 Budget Modification HD-14 Appropriating $25,000 Additional Funds from Northwest Heath Foundation to the Integrated Clinical Services Budget

R-11 Budget Modification HD-17 Reclassifying Twelve Positions within the Health Department, as Determined by the Class/Comp Unit of Central Human Resources

DEPARTMENT OF COMMUNITY JUSTICE - 10:45 AM

R-12 RESOLUTION Establishing Fees and Charges for Chapter 17, Community Justice, of the Multnomah County Code and Repealing Resolution No. 03-098

DEPARTMENT OF COUNTY HUMAN SERVICES - 10:50 AM

R-13 NOTICE OF INTENT to Apply for a U.S. Administration on Aging Senior Medicare Patrol Project Grant

R-14 NOTICE OF INTENT to Apply for a U.S. Department of Housing and Urban Development's (HUD) Housing for People who are Addicted to Alcohol Grant

R-15 Budget Modification DCHS 20 Reclassifying a Vacant Data Analyst Position to Program Development Specialist in the Developmental Disabilities Division, as Determined by the Class/Comp Unit of Central Human Resources

R-16 Budget Modification DCHS-22 Reclassifying a Program Development Specialist Senior to Administrative Analyst in the Developmental Disabilities Services Division, as Determined by the Class/Comp Unit of Central Human Resources

NON-DEPARTMENTAL - 11:00 AM

R-17 Multnomah County Children's Receiving Center Briefing. Presented by Chad Westphal, Lynne Saxton and Andrew Grover. 30 MINUTES REQUESTED.

R-18 Multnomah County Financial Condition Report. Presented by Auditor Suzanne Flynn. 15 MINUTES REQUESTED.

R-19 First Reading of an ORDINANCE Amending Ordinance No. 1055, Adopting Provisions in Chapter 7 of the Multnomah County Code for the Review of Demands for Compensation under Oregon Revised Statutes Chapter 197 as Amended by Ballot Measure 37 Passed November 2, 2004

Thursday, May 12, 2005 - **11:50 AM**
(OR IMMEDIATELY FOLLOWING REGULAR MEETING)
Multnomah Building, First Floor Commissioners Conference Room 112
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660(2)(h). Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session. No Final Decision will be made in the Executive Session. Presented by Agnes Sowle. 10 MINUTES REQUESTED.

MULTNOMAH COUNTY 2005-2006 BUDGET WORK SESSIONS AND HEARINGS

All meetings are open to the public.
Public testimony will be taken at the public hearings listed in red *(italic)* below.
Unless otherwise noted, all sessions will be held in the Multnomah Building, First Floor Commissioners Boardroom 100, 501 SE Hawthorne, Portland.
Contact Board Clerk Deb Bogstad 503-988-3277 for further information.

Cable coverage of the budget work sessions, hearings and Thursday Board meetings will be produced through Multnomah Community Television. The cable channel program guide/playback schedule for each remaining sessions, hearings is listed below. The sessions, hearings and Board meetings will also be available for viewing via media streaming at http://www.co.multnomah.or.us/cc/pastmeetings.shtml. Contact Board Clerk Deb Bogstad 503-988-3277 for further information.

Thu, May 5
9:30 a.m. ***Chair's 2005-2006 Executive Budget Message Public Hearing/Consideration of Resolution Approving Executive Budget for Submission to Tax Supervising and Conservation Commission***

Thursday, 5/05/05 at 9:30 AM, (LIVE) Channel 30
Friday, 5/06/05 at 11:00 PM, Channel 30
Saturday, 5/07/05 at 10:00 AM, Channel 30
Sunday, 5/08/05 at 11:00 AM, Channel 30
Produced through Multnomah Community Television

Mon, May 9
9:30 a.m. to 10:30 a.m. **Budget Work Session**

Monday, 5/09/05 at 9:30 AM, (LIVE) Channel 21
Wednesday, 5/11/05 at 8:00 PM, Channel 29
Friday, 5/13/05 at 8:00 PM, Channel 29
Saturday, 5/14/05 at 2:00 PM, Channel 29
Produced through Multnomah Community Television

Tue, May 10
6:00 p.m. ***Public Hearing on the 2005-2006 Multnomah County Budget - North Portland Library Conference Room, 512 N Killingsworth, Portland***

Thursday, 5/12/05 at 6:00 AM, Channel 21
Saturday, 5/14/05 at 3:00 PM, Channel 29
Sunday, 5/15/05 at 4:00 PM, Channel 29
Monday, 5/16/05 at 8:30 PM, Channel 29
Produced through Multnomah Community Television

Thu, May 12
9:30 a.m. ***Public Hearing/Consideration of Approval of the 2005-2006 Dunthorpe Riverdale Sanitary Service District No. 1 Proposed Budget for Submittal to Tax Supervising and Conservation Commission***

MULTNOMAH COUNTY 2005-2006
BUDGET WORK SESSIONS AND HEARINGS

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Public Hearing/Consideration of Approval the 2005-2006 Mid County Street Lighting Service District No. 14 Proposed Budget for Submittal to Tax Supervising and Conservation Commission

Thursday, 5/12/05 at 9:30 AM, (LIVE) Channel 30
Friday, 5/13/05 at 11:00 PM, Channel 30
Saturday, 5/14/05 at 10:00 AM, Channel 30
Sunday, 5/15/05 at 11:00 AM, Channel 30
Produced through Multnomah Community Television

Tue, May 17
9:00 a.m. to 12:00 p.m. **Budget Work Session**

Tuesday, 5/17/05 at 9:00 AM, (LIVE) Channel 21
Friday, 5/20/05 at 8:00 PM, Channel 29
Saturday, 5/21/05 at 3:00 PM, Channel 29
Sunday, 5/22/05 at 5:00 PM, Channel 29
Produced through Multnomah Community Television

Tue, May 17
6:00 p.m. ***Public Hearing on the 2005-2006 Multnomah County Budget - Multnomah County East Building, Sharron Kelley Conference Room, 600 NE 8th, Gresham***

Tuesday, 5/17/05 at 6:00 PM, (LIVE) Channel 29
Friday, 5/20/05 at 11:00 PM, Channel 29
Saturday, 5/21/05 at 6:00 PM, Channel 29
Sunday, 5/22/05 at 1:00 PM, Channel 29
Produced through Multnomah Community Television

Thu, May 19
10:00 a.m. to 12:00 p.m. **Budget Work Session**

Thursday, 5/19/05 at 9:30 AM, (LIVE) Channel 30
Friday, 5/20/05 at 11:00 PM, Channel 30
Saturday, 5/21/05 at 10:00 AM, Channel 30

MULTNOMAH COUNTY 2005-2006 BUDGET WORK SESSIONS AND HEARINGS

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Sunday, 5/22/05 at 11:00 AM, Channel 30
Produced through Multnomah Community Television

Wed, May 25
10:00 a.m. to 11:00 a.m. ***Tax Supervising and Conservation Commission Public Hearing on the Multnomah County 2004-2005 Supplemental Budget***
Tax Supervising and Conservation Commission Public Hearing on the Multnomah County 2005-2006 Budget

Wednesday, 5/25/05 at 10:00 AM, (LIVE) Channel 21
Friday, 5/27/05 at 8:00 PM, Channel 29
Saturday, 5/28/05 at 3:00 PM, Channel 29
Sunday, 5/29/05 at 5:00 PM, Channel 29
Produced through Multnomah Community Television

Tue, May 31
9:00 a.m. to 12:00 p.m. **Budget Work Session If Needed**

Tuesday, 5/31/05 at 9:00 AM, (LIVE) Channel 21
Friday, 6/03/05 at 8:00 PM, Channel 29
Saturday, 6/04/05 at 3:00 PM, Channel 29
Sunday, 6/05/05 at 5:00 PM, Channel 29
Produced through Multnomah Community Television

Tue, May 31
6:00 p.m. ***Public Hearing on the 2005-2006 Multnomah County Budget - Multnomah Building, Commissioners Boardroom 100, 501 SE Hawthorne, Portland***

Tuesday, 5/31/05 at 6:00 PM, (LIVE) Channel 29
Friday, 6/03/05 at 11:00 PM, Channel 29
Saturday, 6/04/05 at 6:00 PM, Channel 29
Sunday, 6/05/05 at 1:00 PM, Channel 29
Produced through Multnomah Community Television

MULTNOMAH COUNTY 2005-2006
BUDGET WORK SESSIONS AND HEARINGS

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Thu, Jun 2
9:30 a.m.

Public Hearing and Resolution Adopting the 2005-2006 Budget for Multnomah County Pursuant to ORS 294
Public Hearing and Resolution Adopting the 2005-2006 Budget for Dunthorpe Riverdale Sanitary Service District No. 1 and Making Appropriations
Public Hearing and Resolution Adopting the 2005-2006 Budget for Mid County Street Lighting Service District No. 14 and Making Appropriations

Thursday, 6/02/05 at 9:30 AM, (LIVE) Channel 30
Friday, 6/03/05 at 11:00 PM, Channel 30
Saturday, 6/04/05 at 10:00 AM, Channel 30
Sunday, 6/05/05 at 11:00 AM, Channel 30
Produced through Multnomah Community Television

Maria Rojo de Steffey
Multnomah County Commissioner, District 1

Suite 600, Multnomah Building
501 SE Hawthorne Boulevard
Portland, Oregon 97214

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MEMORANDUM

TO: Chair Diane Linn
Commissioner Serena Cruz
Commissioner Lisa Naito
Commissioner Lonnie Roberts
Clerk of the Board Deb Bogstad

FROM: Laura Baum - Staff Assistant to Commissioner Maria Rojo de Steffey

DATE: May 10, 2005

RE: Commissioner Rojo de Steffey will not be attending the Public Hearing on Tuesday, May 10 2005

Commissioner Rojo de Steffey is unexpectedly unable to attend the Public Hearing on May 10, 2005 due to an air travel delay.

Lonnie Roberts
Multnomah County Commissioner
District 4

501 SE Hawthorne Boulevard, Suite 600
Portland, Oregon 97214
(503) 988-5213 phone
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Email: lonnie.j.roberts@co.multnomah.or.us
www.co.multnomah.or.us/cc/ds4/

MEMORANDUM

DATE: May 9, 2005

TO: Chair Diane Linn
Commissioner Maria Rojo de Steffey, District 1
Commissioner Serena Cruz, District 2
Commissioner Lisa Naito, District 3
Board Clerk Deb Bogstad

FROM: Kristen West
Staff Assistant to Commissioner Lonnie Roberts

RE: Notice of Meeting Excuse

Commissioner Roberts will not be attending the May 10, 2005 Public Hearing Regarding the 2005-2006 Budget. He will be at a public safety forum in Gresham. Thank you.

Diane M. Linn, Multnomah County Chair

501 SE Hawthorne Blvd., Suite 600
Portland, Oregon 97214
Phone: (503) 988-3308
Email: mult.chair@co.multnomah.or.us

CHAIR'S EXECUTIVE BUDGET MESSAGE
Thursday May 5, 2005

Citizens told us time and again in recent months that you want results. That's the ultimate return for your tax dollar investment in Multnomah County -- Results.

We've worked hard to slash spending during the past few years of my term, and we've cut our overall budget by more than 15%. At the same time we've increased the County's emergency reserves and maintained our excellent bond rating. But at times, less money has meant diminished results.

Frankly, we've become a lightning rod for criticism and frustration with government. Even though my office and the County's 4,600 hard working employees might feel those perceptions don't match reality, I believe we are viewed as a leader in the race to the bottom of public sentiment and their disdain with "business as usual" governing.

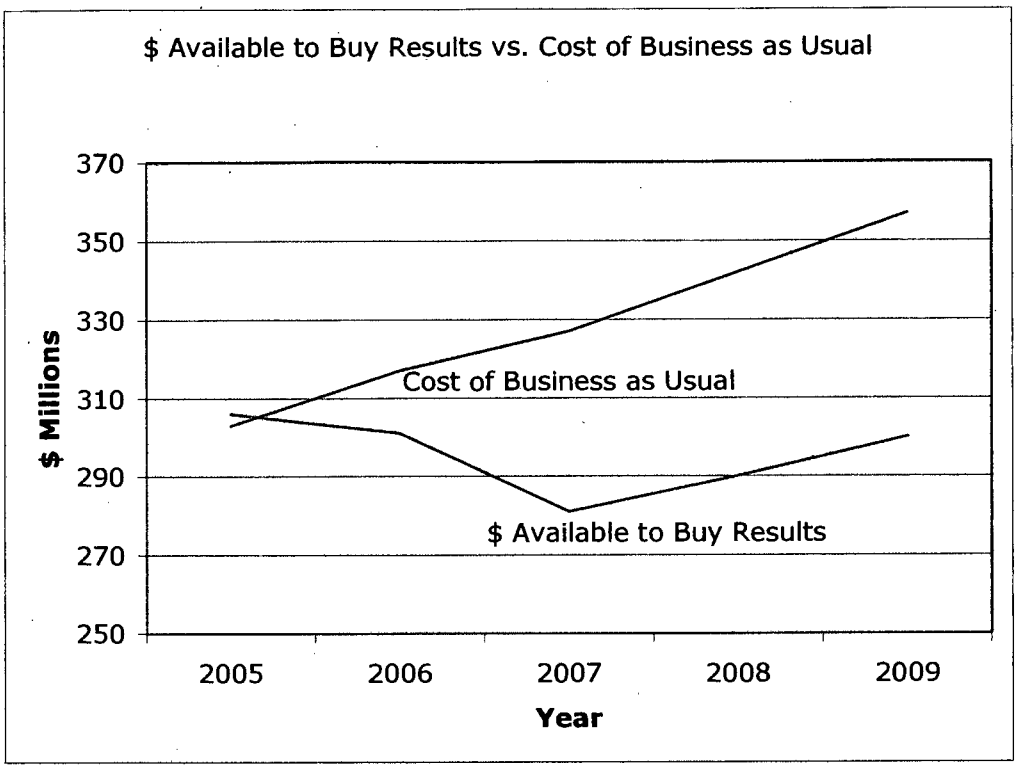
That's why Multnomah County must now lead the way in changing the business of governing in Oregon, and it starts right here, right now, with this budget and investing in results.

I need to point out that Commissioner Serena Cruz has played a vital role in providing the leadership to help us usher in a new era of budgeting. She co-chaired the Design Team with me which led the way for this new way of doing business.

All governments in Oregon have looked at past budgets as a way to spend tax dollars to pay for the *costs* of running government instead of a way to invest your dollars to *buy results*. If there's been any accountability at all, it's centered on process by tracking where your dollars went instead of showing what your dollars produced.

It's time to take action in Multnomah County. We cannot afford to continue down the same path.

We have to change the way we do business in Multnomah County!



We need to focus our time and energy on maximizing a return for 100% of what we're buying instead of focusing on the 5% we can't spend. *This budget delivers the results Multnomah County citizens have told us they most value and restores real accountability.*

For example we are making a $1 million investment in Bridges To Housing which will leverage $20 million in private dollars to serve homeless families. We are doing this because we have discovered that homelessness increases the cost of serving families with disabilities.

Crisis driven reactionary spending has plagued this State and this County for years. This is exactly why we're expanding the normal scope of this budget and focusing on delivering results for the next two years. Our aim is to get the biggest bang for your buck in 2006, and to prepare ourselves for producing *even more* with *even less* money in 2007.

I am especially proud that this budget includes buying down debt and reinvesting in reserves.

Multnomah County *will* live without the ITAX in 2007. We are keeping our promise and will say a permanent good-bye to our quarter share of the ITAX dollar.

I will continue my personal quest to work for a solution to adequately fund our schools. We must come together immediately from every corner of the State to deliver financial stability and efficiency for our public schools.

Moving on, we have over $300 million to invest in 2006, based on *achieving the results* of allowing our citizens to feel safe at work, school and home, to have clean, healthy neighborhoods with a vibrant sense of community, to produce better schools and raise student achievement, and to nurture a freshly thriving economy.

We can achieve those results and still reach out to the neediest members of our community.

We know these are the results Multnomah County residents want because we've been talking with you for months now in one of the most extensive and exhaustive efforts ever undertaken by local government.

So how do we ensure there is new action behind the old promise of "no more business as usual"? We start by breaking down traditional boundaries and barriers to Multnomah County government so people get concrete results at a price they are willing to pay.

Job number one in this budget – and what more than half of your tax dollars pay for – is to reduce crime and our fear of crime so people feel safe no matter where they live, work or play. Quite honestly, the devastation of meth has wrapped our neighborhoods in a blanket of fear that I can't ever remember seeing before.

We must take action and invest in immediate results. That means holding offenders accountable and making them pay a real price for their crimes. It does *not* mean releasing them from jail because we don't have enough beds. This budget opens 171 closed jail beds, yields an additional 52 beds, and guarantees the financial wherewithal for the Multnomah County Sheriff to meet the demands of our community.

Commissioner Lonnie Roberts has been a tireless advocate, voice and bridge builder with the Sheriff's office in this process to ensure we utilize every possible jail bed.

But if we want to maximize our efforts in public safety, we need a holistic approach. We must unify, integrate and balance all components of our community.

State reductions in local jail funding, and the lack of operating funds for the Wapato facility, have undermined our jail capacity. This budget takes a major step toward rebuilding that capacity.

In cooperation with the City of Portland we will open all three closed dorms at Inverness Jail. We will maintain our full bed capacity at the Farm until the newly renovated dorms are open at the downtown Detention Center next year. And we will continue to operate the Work Release Center at its present capacity.

Commissioner Naito, the Sheriff and I are working hard with our State legislative delegation on a cooperative agreement to open Wapato. This could realize substantial cost savings for both local and State taxpayers.

Even with our best efforts a joint project with the State may not happen. We will convene a task force to explore other strategies for opening Wapato, and we will keep working until it is open. In fact, the Board of County Commissioners just passed a Resolution to explore all opportunities. The question is **when** we open Wapato, not **if**.

In addition to opening hard beds, this budget funds alternative sentencing programs that have proven safe and cost effective in many other communities. These programs will free additional hard beds for higher risk offenders.

One of these programs is offender monitoring by electronic bracelet. I am funding an effort to initiate an electronic monitoring program to supervise at least 30 non-violent offenders.

I am also asking DCJ to work with me, the Sheriff and the Presiding Judge to integrate our pre-trial services programs. This reform has been called for by several internal and external reviews of our public safety system, and will save us both money and jail beds.

We will also continue funding for the Phone Notification System that is now starting on a trial basis. This program systematically reminds offenders of their court dates – a very simple process that, by avoiding failures to appear, once again easily *saves money and frees up jail beds for higher risk offenders.*

Two months ago I convened a Meth Task Force to formulate a comprehensive set of anti-meth strategies. This group is the first product of my pledge with Mayor Tom Potter to start integrating County and City public safety planning and funding. Just Tuesday morning I handed the preliminary recommendations of this group to Commissioner Naito and the Local Public Safety Coordinating Council. I look forward to their report back on how to best design and implement our plan to attack the meth problem. And, in addition to our reopened jail beds, my budget contains an additional half a million dollars as a down payment toward this effort.

Adding new jail beds means we have failed. We have failed as a society and as a government. Success against crime ultimately means fewer criminals in our jails and more productive citizens which in turn empowers us to invest more of our precious tax dollars toward the rest of our community's priorities.

But right now – today – we must live with what we have. We must make sure we don't pass on a legacy of escalating jail bed growth to our children.

That means prevention on the front end so we're not breeding even more crime in our homes and neighborhoods. That means proper supervision and treatment on the back end, so we're not locking down the same people time after time, many of whom are the most likely among us to be mentally ill and chemically dependent.

Public safety epitomizes our new approach to budgeting and governing in Multnomah County. This is all about breaking down the barriers and silos between our own departments and between the regional and state governments with whom we work.

We will never budget alone again. In fact, our efforts to build partnerships with other governments are producing some pretty compelling results.

The SUN Community Schools (SUN CS) strategy embodies this intersection of multiple governments working together in a results-oriented approach. Success in the classroom prevents crime on the streets. It's that simple. This partnership works because the six school districts, Multnomah County, the City of Portland, 20 nonprofit organizations, businesses and community members have come together to support kids succeeding in school. This includes Stand for Children. They have become a true partner in helping continue to improve the SUN model.

This year more than 10,000 students will be enrolled in extended day activities at more than 46 SUN Community Schools. Extended day programming provides a safe place for children and youth to be after school gets out.

But what about the rest of the public's priority list?

You've told us you want all children in Multnomah County to succeed in school.

In addition to our SUN Community School strategy, we will continue to support the education of our community's children. Across the board, national research has shown that the more we invest in kids, the less we need jails and social services, and the healthier our community and our economy becomes.

To do just that, Multnomah County begins our investment with pre-natal care for low income mothers. We target toddlers to promote positive parenting environments, healthy brain development, and access to free or no cost vaccination services. This alone benefited nearly 7,000 kids who would otherwise be at serious risk. We also help take care of special needs kids, with developmental disabilities, many whom struggle not just to keep pace, but to merely survive with dignity.

Limited dollars dictate that we must continue to invest in focused, research-based prevention efforts to give children the odds to become successful citizens. It's not only the smart thing to do; it's the right thing to do.

You've also told us you want a thriving economy.....

I'm told President Roosevelt once said, "...the best anti-poverty program is good job". He was right, but there's more to the story. A good job doesn't just fall from the sky. With a County unemployment rate at 7%, we know that. Good jobs are the long term product of the smart investment and hard work of both our leaders and our citizens. We need to do better. We need to continue our Strategic Investment program and build upon the successful partnerships with LSI Logic and Microchip Technologies that have

already brought more than 1,000 new jobs to East County in the last decade. We need to pay more attention to the needs of our small businesses, and the jobs they bring.

Helping keep classes sizes low and a full school year in place is fundamental to the economy. That why this community's support of the Multnomah County personal income tax is so important. We are all proud of this effort.

Finally, we need to maintain our investment the infrastructure of our County that links East to West --the Hawthorne, Morrison, Burnside, Broadway, Sauvie Island, and Sellwood Bridges. These are not just physical structures, these are vital economic arteries. Speaking of bridges, we owe a great deal of gratitude to Commissioner Maria Rojo de Steffey and her staff. Their tireless work has meant that the residents of Sauvie Island will have new bridge by 2008, and that we're off to great start in plans to replace a very decrepit Sellwood bridge. Thank you Maria.

You've told us you want clean, healthy neighborhoods with a vibrant sense of community.....

Multnomah County's libraries are treasures. Our libraries reflect who we are as a community. I think it's fair to say we're curious, diverse, enthusiastic, quiet, young, old, athletic, infirm, familial, friendly, poor, rich, and—literally numerous.

Used by 13,000 people each day, the libraries reach more citizens of Multnomah County than any other public or private cultural or educational service. The County's Library Director is responsible for over 400 employees and has a budget of $45 million dollars. With a circulation of 17 million items, Multnomah County has the highest circulation of a library system its size in the United States. Our community uses the library at an astounding rate----24 books are checked out per person on average per year.

You've told us you want government accountable at every level...that starts with how we elect our leaders.

Multnomah County is responsible for conducting all local, city, county, state and federal elections. The perception of trust and confidence in our government is dependent on a well managed, open, fair and accurate elections process. In 2004 voter registration increased by 40%.

Our budget process also marks a dramatic reinvestment with citizens to help define the priorities which guide where our tax dollars go. For the first time, citizens can know exactly what investments we make, with what results. This is the first year for this new approach. We owe a great deal of thanks to the many citizens who have volunteered their time and energy to this process. Our partnership is a foundation for years to come and for our journey ahead.

And, you've told us you want all Multnomah Country residents and their families to have their basic living needs met, here are some of the ways we'll get those results for your investment.

Multnomah County has a strong tradition of working hard to help our most vulnerable citizens -- our mentally ill, our seniors, those addicted to drugs and alcohol, those with severe mental and physical disabilities, and those who need basic health care and have no place else to go – so they can live meaningful and decent lives. When I first became Chair in 2001, our mental health system was in total crises.

Today things are different and better. Over-use of hospital emergency rooms to treat our mentally ill is no longer the norm. We knew the model was wrong, it cost incredible amounts of money, wasn't effective treatment, and probably did more harm than good. Today we have a coordinated 24-hour hotline staffed by mental health professionals, accessible walk in clinics, and a mobile crisis team that reacts immediately to defuse situations before they escalate to crisis.

The theme of this success story is clear. In times of challenge we need to act with strategic, system wide approaches that produce results. The measure of our success is not our good will or the amount of money we spend, it is the actual affect we have on improving the lives our citizens.

Multnomah County's has a 150-year track record -- a vital and rich tradition yet we perform in the shadow of Portland's city government. We're not trying to change any of that, in fact we embrace that. But we have to remember keeping the public *safe* also means stitching together the safety net for the most vulnerable and needy. It means giving people an honest chance to improve their lives and become productive citizens again.

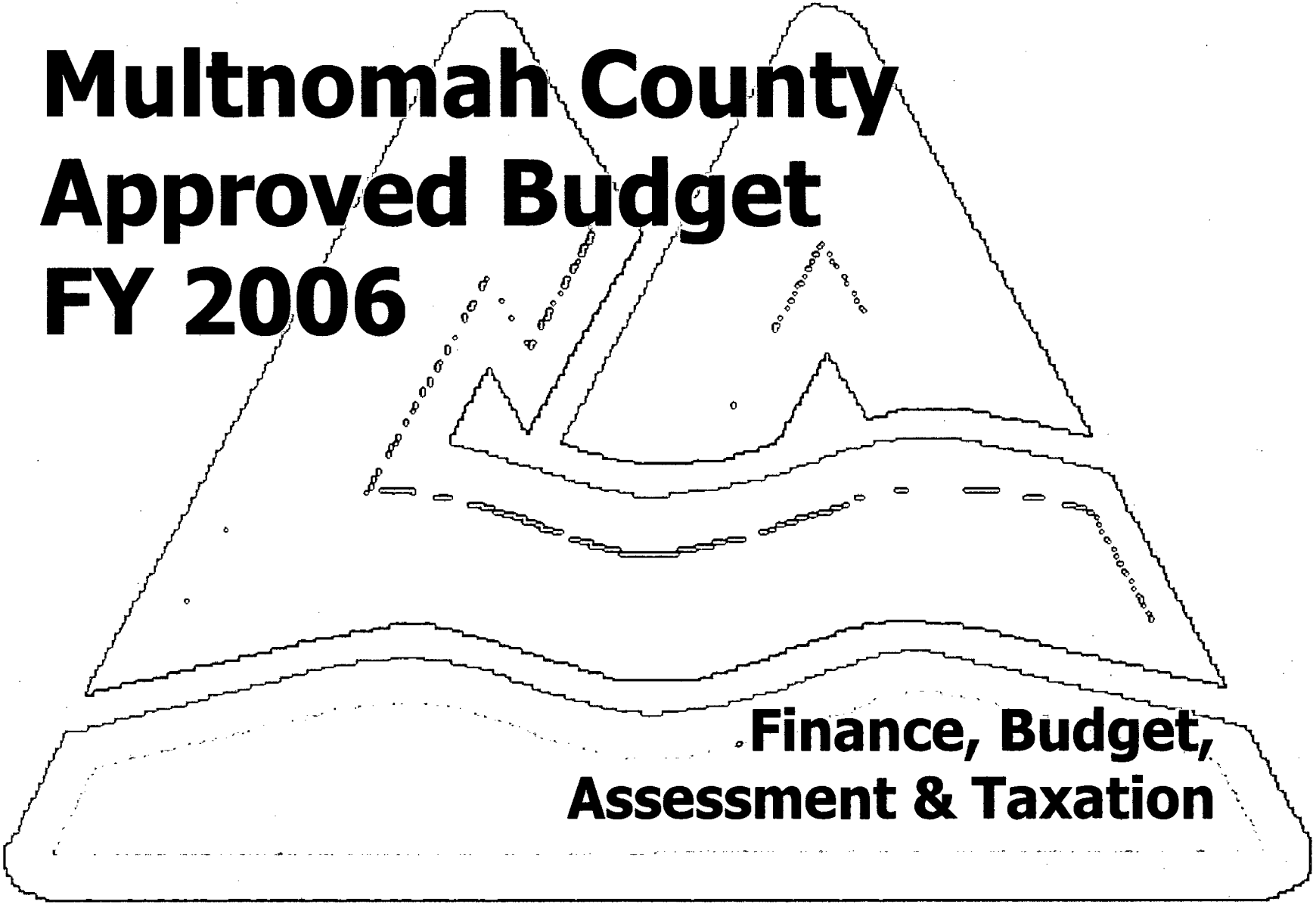
Most of the time, Multnomah County has carried on this work without notice. We go forward today, hoping that if this budget helps brings recognition, it's positive recognition for the hard work of Multnomah County employees.

A great deal of work went into producing the program offers, public involvement and other steps of this new way of budgeting. Our Budget Office, department directors, and County staff who served on *Outcome and Priority teams deserve much credit for their excellent and hard work*. Sheriff Bernie Giusto, Auditor Suzanne Flynn, and District Attorney Mike Shrunk also deserve credit for their hard work and commitment to making this new budgeting work. I also want to thank the Citizen Involvement Committee and the Citizen Budget Advisory Committees, as well as the City Club of Portland, for their substantial efforts to ensure public involvement in our deliberations.

All this work has provided an unprecedented amount of input that informed the Executive Budget. My colleagues on the Board of County Commissioners embraced this new way of doing business and I am proud of the work we are doing together on the 2006 budget. I look forward to continuing this process as we move adoption of a final budget on June 2nd.

But ultimately the residents of Multnomah County have given us their marching orders. They've told us to be fiscally responsible and to invest their dollars wisely for the best possible results. This budget will do that.

Multnomah County Approved Budget FY 2006



Finance, Budget, Assessment & Taxation

Budget Office

Agenda

- Schedule & Process
- All Funds Budget Overview & by Priority
- General Fund Overview
- Financial Context
- Executive Budget Report
- Purchasing Tool Overview

Budget Schedule & Process FY 2006

- May 5th - Board Approved Budget
- May 9 – Overview Approved Budget, Next Steps
- May 11 – First Round of Purchasing Completed by Board (**5:00 pm**)
- May 16 – Second Round of Purchasing Completed by Board (**12:00 pm**)
- May 17 – BCC Worksession; Budget Deliberations on Purchasing
- May 19 – BCC Worksession; Final Amendments Proposed
- May 25 – TSCC Hearing
- May 31 – Just in Case
- June 2 – Adopt FY 2006 Budget

- Three Evening Public Hearings
  - May 10th, North Portland Library
  - May 17th, Multnomah County East, Gresham
  - May 31st, Multnomah Building

All Funds Budget Overview

FY 2005 Adopted Budget	FY 2006 Approved Budget	Difference	Percent Difference
$1,092,793,082 ($93,000,000) ITAX	$1,175,028,793 ($89,100,000) ITAX	$82,235,711	7.5%
4,437.48 FTE	4,473.32 FTE	35.84 FTE	0.8%

Increase attributed to :

Bridge Fund – Grant funding received for Sauvie Island Bridge

CIP – Due to disposition sales revenue.

Behavioral Health Care Fund – increase in OHP revenues including partial restoration of OHP standard, implementation of the provider tax (HB 2747), additional funds associated with redesign of the children's intensive mental health services

Fund Level Comparison FY 2005 Adopted FY 2006 Approved

Fund		FY 2005 Adopted	FY 2006 Approved	Difference
General Fund	1000	409,015,566	426,103,354	17,087,788
Road Fund	1501	48,135,396	46,571,306	(1,564,090)
Willamette River Bridge Fund	1509	10,567,112	37,498,337	26,931,225
Library Serial Levy Fund	1510	45,947,886	47,189,498	1,241,612
Justice Bond Project Fund	2500	12,265,000	6,340,000	(5,925,000)
Capital Improvement Fund	2507	11,649,044	26,641,593	14,992,549
Behavioral Health Managed Care Fund	3002	25,961,516	40,870,725	14,909,209
All Other Funds		529,251,561	543,813,980	14,562,419
Total All Funds		1,092,793,082	1,175,028,793	82,235,711

Funding by Priority Area

	General Fund Total	OTO Resources	All Other Funds	% GF	% Total
Basic Living Needs	$ 71,800,000	$ 794,000	$ 226,379,000	22.55%	28.66%
Safety	157,526,000	7,624,000	57,765,000	49.48%	20.70%
Accountability	47,468,000	1,740,000	282,387,000	14.91%	31.71%
Thriving Economy	396,000		103,233,000	0.12%	9.96%
Education	18,948,000	651,000	17,734,000	5.95%	3.53%
Vibrant Communities	22,250,000	155,000	34,405,000	6.99%	5.45%
Total in Priority Areas	**$ 318,388,000**	**$ 10,964,000**	**$ 721,903,000**	**100.00%**	**100.00%**

Note:

GF OTO Resources Are Included in Total General Fund Figures.

They Are Called Out Separately to Identify OTO Resources That Support Each Priority Area

$89.1M of ITAX payment for Schools not included.

General Fund Budget Overview

FY 2005 Adopted Budget General Fund	FY 2006 Approved Budget General Fund	Difference	Percent Difference
$409,015,566 (93,000,000 ITAX)	**$426,103,354 (89,100,000 ITAX)**	**$17,087,788 (2,900,000 ITAX)**	**4.2%**
1,787.26 FTE	**2,045.51 FTE**	**258.25 FTE**	51.90 new FTE in Public Safety Remainder due to accounting change

Increase Attributed to:

- Property Tax Revenues up $7.7M or 4.2%
- BIT up $400k or 3.3%
- BWC up $10.2M or 62.5%
- FTE change in accounting practices to align positions with funding sources

Sunsetting and OTO Resources

Resources			
Estimated BWC		$	26,500,000
Required to Fund Reserves			(13,000,000)
BWC Available for Other Uses		$	13,500,000
City of Portland/Jail Beds			1,800,000
Transfer SIP Revenue to GF			400,000
Total Resources		**$**	**15,700,000**
Proposed Uses			
Debt Retirement/Cost Avoidance		$	5,800,000
SAP Purchase	3,000,000		
SAP Upgrade	1,350,000		
Asset Preservation/CIP	1,000,000		
Oregon Food Bank	450,000		
"Sunset" Programs in FY 06-07		$	2,267,000
River Rock/A&D Treatment	1,212,000		
School Mental Health	500,000		
Children's Assessment Services	186,000		
Regional Arts & Culture Council	137,000		
Sexual Minority Youth	124,000		
Elders in Action	90,000		
Soil/Water District	18,000		
Unallocated (In GF Contingency)		$	1,780,000
Matching for "Bridges to Housing"	1,000,000		
Methamphetamine Task Force	500,000		
Tax Supervising	280,000		
Sheriff Programs		$	5,737,000
Additional 171 Beds @ MCIJ	3,925,000		
Minimum Custody/MWRC	1,735,000		
School Resource Officers	77,000		
Subtotal - "Sunset" and OTO Uses		$	15,584,000
Unspecified GF Contingency			116,000
Total Expenditures		**$**	**15,700,000**

Prepared by the Multnomah County Budget Office

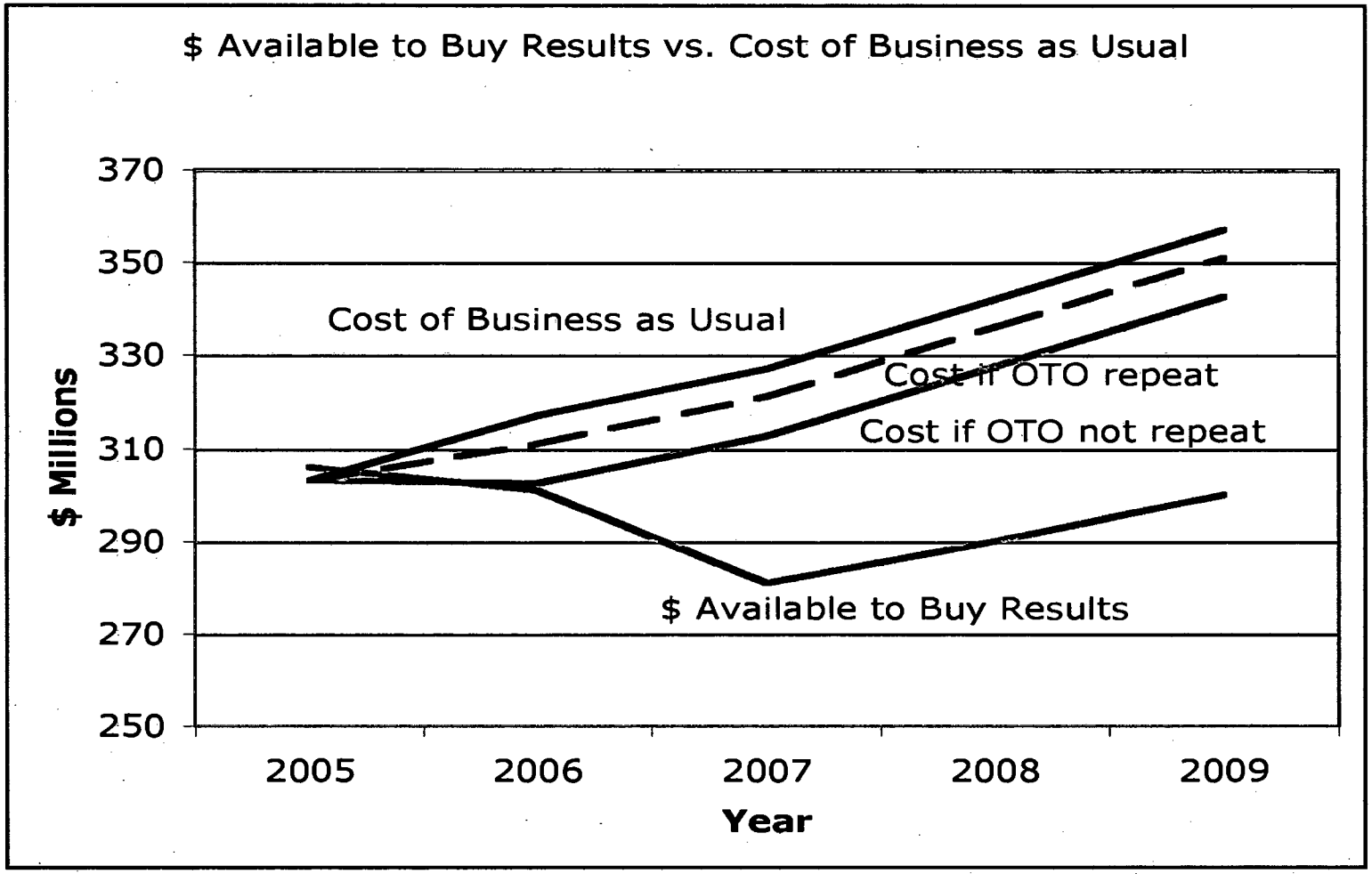
General Fund Financial Context

Reconcile Approved Budget to FY 05-06 Fiscal Parameters

Total Approved GF	**$**	**426,100,000**	
Less ITAX Payment to Schools		(89,160,000)	
Less GF Reserves		(13,000,000)	
Less General Fund Commitments		(2,356,000)	
Available to Fund County Programs	**$**	**321,584,000**	**(1)**
Less "Sunset" and OTO Uses		(15,584,000)	
Remaining GF to Allocate	**$**	**306,000,000**	
Established Target	$	301,000,000	
Allocate Investment Pool to Ongoing		1,500,000	
Ongoing Resources in Proposed Budget	**$**	**302,500,000**	
Balance to Investment Pool		*3,500,000*	**(2)**
Amount Allocated in Purchasing Tool	**$**	**318,084,000**	

(1) Available to Fund Programs - (2) Investment Pool

Multnomah County Budget Scenarios



Implications for FY 2007

- Investment Pool smaller than Dec 04, target. Consequence reduced ability to fund projects with ROI to reduce impact of FY 2007 shortfall.
- If the programs funded with OTO dollars are treated as on-going, the resulting cut for FY 2007 be significantly larger.
  - *Cost of Doing Business as Usual = $46 Million*
- FY 2007 Structural Deficit assuming OTO dollars are ongoing.
  - *Estimated Structural Deficit = $9 - $10 Million*
- FY 2007 Structural Deficit assuming OTO dollars do not recur.
  - *Estimated Structural Deficit = $3.5 -$4.5 Million*

Executive Budget Report

- By Priority Area in ranked order (high to low)
- Programs Color Coded
  - Green = Program offers purchased by the Chair
  - White = Program offers not purchased
  - Yellow = Program offers funded with one-time-only money.
- Several program offers were scaled or added after the Board's ranking process. These programs are shown with a "N/A" for the Board's ranking votes, score, and rank columns

The Purchasing Tool

- How to Use the Tool – Mike Jaspin

How Do I?

- DBCS Home
- Budget Home
- Find A Service

Budget Links

- Budget Office Evaluation
- 2006 Fiscal Parameters-ITAX Sunset
- Forecast Assumptions (ppt)
- Economic and Revenue Forecast 2004-2009
- 2006 Proposed Budget (Adopted Coming June 2, 2005)
- FY 2005 Budget
- FY 2004 Budget
- FY 2003 Budget
- FY 2002 Budget
- FY 2001 Budget
- FY 2000 Budget

Program Areas

- Budget Office
- Community Services
- Facilities & Property Mgt
- Finance
- FREDS
- Human Resources
- Information Technology
- Land Use & Transportation

Budget Office

The budget is available in pdf. format.
Click here if you need to get the Adobe Acrobat Reader

FY 2006 Proposed Budget

Below is the Chair's Proposed Budget as presented to the Board of County Commissioners on May 5, 2005. The Board subsequently approved the budget and will begin deliberations with final adoption slated for June 2, 2005.

Program offers sorted by Priority Area and included (funded) in the Chair's Budget can be viewed at: http://www2.co.multnomah.or.us/aspnet/budgetchair/Mainscreen.aspx

VOLUME ONE - POLICY DOCUMENT & LEGAL DETAIL

- Chair's Budget Message
- Budget Manager's Message (includes Financial Summaries)
- Priority Based Budgeting
- Legal Detail by Department by Fund (includes Fund Summaries)
- Financial Policies

- Appendix

VOLUME TWO - INTRODUCTIONS TO DEPARTMENT'S PROGRAM OFFERS

- Reader's Guide
- Sheriff's Office
- District Attorney
- Community Justice
- Health
- School & Community Partnerships
- County Human Services
- Library
- Non-Departmental
- Business & Community Services
- Capital Budget

Explanation and Notes

The 6 spreadsheets show program offers sorted by priority area and as they will appear in the funding tool.

Color Coding:

Green = Funded
Yellow = Funded with one-time-only resources
White = Not funded

Funded Status Coding:

1 = Funded
OTO = Funded with one-time-only resources
0 = Not funded

Ranking and Scoring

The ranking and scoring is based on the Board's high (H), medium (m), and low (L) voting during the ranking process and is shown on the far right of the table.

Several program offers were scaled or added after the Board's ranking process. These programs are shown with a "N/A" for the Board's ranking votes, score, and rank. Moreover, if a program was scaled, all the scaled portions were assigned a "N/A" score and rank. The intent was to not to infer how the Board would have ranked the various scaled offers.

However, the scaled offers are shown in the spreadsheets approximately where the original offer was ranked. In the funding tool, these offers will be displayed at the end of the this list because the program offers are shown in rank order in the tool.

A new or alternative program is shown at the end of the list.

The note field provides additional information that might not be in the program offer, provides guidance as to how program offers relate to one another when funding, or explains modifications since the Board ranked.

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
25030	A&D Detoxification	DCHS	760,691	1,497,318	2,258,009	1	1	15	5	0	0	
25050	MH Crisis Call Center ITAX	DCHS	1,140,108	1,046,282	2,186,390	1	1	15	5	0	0	
25048	MH Emergency Holds	DCHS	32,979	1,107,234	1,140,213	1	3	14	4	1	0	
15016	Child Support Enforcement	DA	888,147	2,247,873	3,136,020	1	3	14	4	1	0	
21007	Emergency Services	OSCP	528,624	1,396,472	1,925,096	1	3	14	4	1	0	
21009	Homeless Families	OSCP	811,981	2,963,995	3,775,976	1	3	14	4	1	0	
25031	A&D Adult Outpatient ITAX	DCHS	682,574	1,481,006	2,163,580	1	3	14	4	1	0	
25090	A&D Housing Services for Dependent Children	DCHS	10,953	367,747	378,700	1	3	14	4	1	0	
25078	MH For Uninsured County Residents ITAX	DCHS	2,101,681	100,902	2,202,583	1	3	14	4	1	0	
25082A	General DV Services	DCHS	1,051,999	675,300	1,727,299	1	3	14	4	1	0	
25094	Early Childhood MH Services	DCHS	43,395	1,066,966	1,110,361	1	3	14	4	1	0	
25095	School Aged MH Services	DCHS	205,322	6,893,633	7,098,955	1	3	14	4	1	0	
25096	Children's Intensive Community Based MH Services	DCHS	255,706	8,585,272	8,840,978	1	3	14	4	1	0	
25062	MH Residential Treatment ITAX	DCHS	835,072	1,579,925	2,414,997	1	3	14	4	1	0	
25060	MH Transitional Housing	DCHS	325,437	552,722	878,159	1	3	14	4	1	0	
40030	Medicaid/Medicare Eligibility	HD	40,574	739,446	780,020	1	3	14	4	1	0	
40057	Communicable Disease Prevention & Control	HD	2,593,127	1,795,738	4,388,865	1	3	14	4	1	0	
25101A	Culturally Specific Mental Health Services	DCHS	1,080,770	0	1,080,770	1	18	13	4	0	1	
25015	ADS Adult Protective Services	DCHS	893,904	3,067,710	3,961,614	1	18	13	4	0	1	
25017	DD Basic Needs	DCHS	1,087,187	58,162,873	59,250,060	1	18	13	3	2	0	
25092	Methamphetamine Treatment Expansion and Enhancement	DCHS	15,594	523,540	539,134	1	18	13	3	2	0	
25085	Youth Alcohol and Drug Outpatient Services	DCHS	142,342	405,752	548,094	1	18	13	3	2	0	
25074	Child Out of Home MH Services	DCHS	56,645	1,901,818	1,958,463	1	18	13	3	2	0	
25075A	MH Services for Young Children	DCHS	0	469,097	469,097	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25075B	MH Services for Young Children - CGF	DCHS	905,458	0	905,458	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25076	Child Abuse MH Services	DCHS	419,283	58,796	478,079	1	18	13	3	2	0	
25029	A&D Transitional Housing	DCHS	214,813	22,956	237,769	1	18	13	3	2	0	
25037	A&D Client Basic Needs Services	DCHS	57,555	7,292	64,847	1	18	13	3	2	0	
25038	A&D Adult Residential ITAX	DCHS	762,151	5,243,966	6,006,117	1	18	13	3	2	0	
25069	MH Outpatient Services	DCHS	344,953	11,581,752	11,926,705	1	18	13	3	2	0	
25061A	MH Older & Disabled Services	DCHS	0	0	0	0	18	13	3	2	0	Withrawn
25046	MH Inpatient Services	DCHS	125,035	4,198,043	4,323,078	1	18	13	3	2	0	
40039A	Primary Care (North & Northeast Clinics)	HD	2,876,365	10,328,513	13,204,878	1	32	12	3	1	1	
40039B	Primary Care (LaClinica, Westside including HIV Clinic)	HD	2,878,804	11,144,749	14,023,553	1	32	12	3	1	1	
40039C	Primary Care (East and Mid County)	HD	2,861,284	13,254,198	16,115,482	1	32	12	3	1	1	
25008A	ADS Public Guardian/Conservator Ramp-down Toward Closure	DCHS	674,005	154,741	828,746	1	32	12	3	1	1	
25083B	HUD DV Housing	DCHS	58,938	404,327	463,265	1	32	12	3	1	1	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
25032	A&D Youth Residential Treatment	DCHS	267,984	12,866	280,850	1	32	12	3	1	1	
25019	DD Access and Protective Services	DCHS	89,813	864,305	954,118	1	32	12	2	3	0	
15014	Victim's Assistance	DA	525,174	210,059	735,233	1	32	12	2	3	0	
40041	Dental Services	HD	2,257,670	9,399,951	11,657,621	1	32	12	2	3	0	
25100	MH Hospital Waitlist	DCHS	12,191	409,309	421,500	1	32	12	2	3	0	
40049	Children's Assessment Services at the Children's Receiving Center	HD	186,167	175,083	361,250	OTO	42	11	2	2	1	
25010A	ADS Long Term Care (LTC)	DCHS	1,168,960	19,266,778	20,435,738	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25010B	ADS Long Term Care (LTC) B-Scale	DCHS	300,000	677,874	977,874	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled; this option adds new CGF to bring Fed/State to CSL
21012	Housing Services	OSCP	359,414	520,643	880,057	1	42	11	2	2	1	
25054	MH Crisis Funds	DCHS	4,064	136,436	140,500	1	42	11	2	2	1	
25040	A&D Severely Addicted Multi-Diagnosed ITAX	DCHS	1,237,326	59,404	1,296,730	1	42	11	1	4	0	
25020	DD LifeLine Services	DCHS	937,629	2,324,659	3,262,288	1	42	11	1	4	0	
25018	DD Life-Line Services, ITAX	DCHS	607,807	27,101	634,908	1	42	11	1	4	0	
40050	Breast & Cervical Health	HD	69,118	441,525	510,643	1	42	11	1	4	0	
40023	HIV Care Services	HD	494,435	3,012,364	3,506,799	1	42	11	1	4	0	
50052A	Family Court Services	DCJ	481,754	868,982	1,350,736	1	42	11	1	4	0	
90031	Housing Program	CS	120,269	500	120,769	1	52	10	2	1	2	
40048	The Women, Infants and Children's (WIC) Program	HD	890,747	2,134,750	3,025,497	1	52	10	2	1	2	
25061B	MH Older & Disabled Services Additional Capacity	DCHS	0	0	0	0	52	10	2	1	2	Withrawn
25028	A&D Recovery Community Services Program	DCHS	854	28,689	29,543	1	52	10	2	1	2	
25009A	ADS Adult Care Home Program Reduced Service Level	DCHS	380,806	795,468	1,176,274	1	52	10	2	1	2	
10017	Early Childhood/Preventing Abuse	NOND	149,271	0	149,271	0	52	10	2	1	2	
25045	MH Respite/Sub-acute	DCHS	51,420	1,726,446	1,777,866	1	52	10	1	3	1	
25013	ADS Safety Net ITAX	DCHS	2,706,124	33,602	2,739,726	1	52	10	1	3	1	
25023A	A&D Community Services ITAX	DCHS	550,687	459,416	1,010,103	1	52	10	1	3	1	
25063	Intensive Multidisciplinary Services for Gang Affected Youth and Families	DCHS	224,814	10,793	235,607	0	52	10	1	3	1	
40061	STD, HIV, Hepatitis C Community Prevention Program	HD	3,014,382	1,886,322	4,900,704	1	52	10	1	3	1	
25101B	Culturally Specific Mental Health Services Enhanced	DCHS	2,001,144	0	2,001,144	1	N/A	N/A	N/A	N/A	N/A	Program offer 25101B scaled to B&C
25101C	Culturally Specific Mental Health Services Additional Contracts	DCHS	400,000	0	400,000	0	N/A	N/A	N/A	N/A	N/A	Program offer 25101B scaled to B&C
25067	MH Bienestar	DCHS	461,064	91,007	552,071	0	63	9	1	2	2	
25080	Gateway Children's Campus	DCHS	4,690	130,628	135,318	1	63	9	1	2	2	
25087	Family Involvement Team	DCHS	7,921	265,935	273,856	1	63	9	1	2	2	
25055	MH Commitment Investigators ITAX	DCHS	223,914	1,328,767	1,552,681	1	63	9	1	2	2	
25051A	MH Crisis Services ITAX	DCHS	2,728,379	1,611,884	4,340,263	1	63	9	1	2	2	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
25009B	ADS Adult Care Home Program Current Service Level	DCHS	156,994	229,876	386,870	1	63	9	1	2	2	
21011	Runaway Youth	OSCP	445,968	203,738	649,706	1	63	9	1	2	2	
25035A	A&D Abuse Prevention	DCHS	0	178,897	178,897	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25035B	A&D Abuse Prevention - CGF	DCHS	69,495	0	69,495	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
10018	Family Advocate Model-Child Abuse Prevention	NOND	0	199,939	199,939	1	72	8	1	1	3	
10025	Elders in Action	NOND	158,140	0	158,140	OTO	72	8	1	1	3	
25083A	Culturally Specific DV	DCHS	516,146	0	516,146	1	72	8	1	1	3	
40056	Health Inspections & Education	HD	2,405,497	25,138	2,430,635	1	72	8	1	1	3	
25073	MH/A&D Services to African American Women	DCHS	2,907	97,604	100,511	1	72	8	0	3	2	
25070A	MH Family Care Coordination ITAX	DCHS	149,563	620,674	770,237	1	72	8	0	3	2	
25011	ADS Community Access	DCHS	1,742,794	5,500,975	7,243,769	1	72	8	0	3	2	
25008B	ADS Public Guardian/Conservator Restore Current Service Level	DCHS	308,955	20,573	329,528	0	80	7	1	0	4	
21003	Energy Services	OSCP	1,142,029	8,072,071	9,214,100	1	80	7	0	2	3	
10050	Information and Referral/211	NOND	309,250	0	309,250	0	80	7	0	2	3	
25039	A&D Synthetic Opiate Medication	DCHS	534,020	362,063	896,083	1	80	7	0	2	3	
25051B	MH Crisis Services Additional Capacity	DCHS	232,253	0	232,253	1	80	7	0	2	3	
25056	MH Commitment Monitors	DCHS	116,651	653,035	769,686	1	80	7	0	2	3	
25026	A&D Acupuncture	DCHS	52,377	37,104	89,481	1	80	7	0	2	3	
25082B	Centralized DV Access Line	DCHS	63,557	0	63,557	1	80	7	0	2	3	
25103	African American DV Capacity Building	DCHS	50,862	0	50,862	0	80	7	0	2	3	
40034A	Corrections Health-Detention Center Up to 370 beds	HD	3,342,448	61,406	3,403,854	1	80	7	0	2	3	
40038	Corrections Mental Health Treatment	HD	1,841,704	16,837	1,858,541	1	80	7	0	2	3	
40035	Corrections Health -Donald E Long	HD	804,446	7,906	812,352	1	80	7	0	2	3	
40036	Corrections Health-River Rock Alcohol & Drug Treatment (RR) and Multnomah County Work Release Center (MWRC)	HD	169,526	1,838	171,364	1	80	7	0	2	3	
40037A	Corrections Health-Inverness Up to 465 beds	HD	2,838,854	63,212	2,902,066	1	80	7	0	2	3	
40037B	Corrections Health - Inverness 466 to 1,014 beds	HD	3,332,568	0	3,332,568	1	94	6	0	1	4	
40034B	Corrections Health - Detention Ctr From 371 to 702 beds	HD	2,626,214	0	2,626,214	1	94	6	0	1	4	
25071	MH Child & Family Match	DCHS	116,701	5,602	122,303	1	94	6	0	1	4	
25064	Eastern European MH	DCHS	77,344	3,713	81,057	0	94	6	0	1	4	
25065	Therapeutic School	DCHS	21,882	734,657	756,539	1	94	6	0	1	4	
25088	Mental Health Beginning Working Capital	DCHS	0	1,653,869	1,653,869	1	94	6	0	1	4	
25089	Family Alcohol & Drug Free Network (FAN)	DCHS	6,648	223,206	229,854	1	94	6	0	1	4	
25097	Public Health Clinic MH Outreach	DCHS	12,503	419,804	432,307	1	94	6	0	1	4	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
25091	"Housing a New Beginning", Resource Book for Women and Families in Recovery & Annual Conference	DCHS	204	6,822	7,026	1	94	6	0	1	4	
25049	MH Court Examiners	DCHS	82,501	3,960	86,461	1	94	6	0	1	4	
25053	MH Crisis Transportation	DCHS	1,563	52,476	54,039	1	94	6	0	1	4	
10027	Portland Business Alliance (Project Respond)	NOND	107,513	0	107,513	1	94	6	0	1	4	
10022	SIP Community Housing	NOND	0	615,027	615,027	1	94	6	0	1	4	
10042	Oregon Food Bank Debt Service Payment	NOND	64,450	0	64,450	0	109	5	0	0	5	This offer should not be funded if debt buy down offer 10057 funded.
25034	Gambling Addiction Treatment	DCHS	24,830	833,652	858,482	1	109	5	0	0	5	
25099	MH Provider Tax	DCHS	69,635	2,337,987	2,407,622	1	109	5	0	0	5	
10057	Oregon Food Bank - Retire Debt	NOND	450,000	0	450,000	OTO	N/A	N/A	N/A	N/A	N/A	New/Alternative program offer

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
15007	Felony Trial Unit C-Gangs	DA	1,615,444	0	1,615,444	1	1	15	5	0	0	
15008	Felony Trial Unit D-Violent Person crimes	DA	1,156,555	0	1,156,555	1	1	15	5	0	0	
15013	Domestic Violence Unit	DA	1,219,204	178,300	1,397,504	1	1	15	5	0	0	
15015	Child Abuse Team (MDT)	DA	879,199	501,700	1,380,899	1	1	15	5	0	0	
50036A	Juvenile Detention Services -- 32 bed base	DCJ	9,045,921	723,521	9,769,442	1	1	15	5	0	0	
50036B	Juvenile Detention -- 48 beds	DCJ	2,226,436	17,008	2,243,444	1	1	15	5	0	0	
60021C	MCSO Detention Center Option C	MCSO	2,668,541	0	2,668,541	1	1	15	5	0	0	
60021D	MCSO Detention Center Option D	MCSO	1,668,797	0	1,668,797	1	1	15	5	0	0	
60021E	MCSO Detention Center Option E	MCSO	2,114,051	0	2,114,051	1	1	15	5	0	0	
60021F	MCSO Detention Center Option F	MCSO	1,668,798	0	1,668,798	1	1	15	5	0	0	
60022C	MCSO Inverness Jail Option C	MCSO	2,128,991	1,743,971	3,872,962	0	11	14	4	1	0	Funded via offer 60022 I&J
60022D	MCSO Inverness Jail Option D	MCSO	2,376,831	1,448,496	3,825,327	0	11	14	4	1	0	Funded via offer 60022 I&J
60022E	MCSO Inverness Jail Option E	MCSO	2,042,226	1,566,744	3,608,970	0	11	14	4	1	0	Funded via offer 60022 I&J
60022F	MCSO Inverness Jail Option F	MCSO	2,747,348	0	2,747,348	0	11	14	4	1	0	Funded via offer 60022 I&J
60022I	REVISED MCIJ - Current Service Level 843 Beds	MCSO	13,831,622	9,025,559	22,857,181	1	N/A	N/A	N/A	N/A	N/A	
60022J	REVISED MCIJ - Additional 171 Beds	MCSO	3,925,048	0	3,925,048	OTO	N/A	N/A	N/A	N/A	N/A	
60021I	MCSO Detention Center Option I	MCSO	2,114,051	0	2,114,051	1	11	14	4	1	0	
60021J	MCSO Detention Center Option J	MCSO	1,668,798	0	1,668,798	1	11	14	4	1	0	
15005	Felony Trial Unit A- Property	DA	1,930,062	0	1,930,062	1	11	14	4	1	0	
15006	Felony Trial Unit B-Drugs	DA	1,527,183	305,946	1,833,129	1	11	14	4	1	0	
50008A	Substance Abuse Services For Men-Residential 47 beds	DCJ	2,141,091	54,038	2,195,129	1	11	14	4	1	0	
50012A	Substance Abuse Services For Women - Residential 30 Beds	DCJ	1,399,794	35,872	1,435,666	1	11	14	4	1	0	
50012B	Substance Abuse Services For Women - Residential 15 Beds	DCJ	474,065	11,965	486,030	1	11	14	4	1	0	
15009	Felony Pre-Trial	DA	848,289	0	848,289	1	11	14	4	1	0	
50013	Pretrial Services - Adult Offenders	DCJ	1,835,128	47,880	1,883,008	1	23	13	4	0	1	
50066	Adult Electronic Monitoring	DCJ	368,205	0	368,205	1	23	13	4	0	1	
60021B	MCSO Detention Center Option B	MCSO	2,996,209	0	2,996,209	1	23	13	4	0	1	
50069	Transitional Service Housing - Adult Offenders	DCJ	1,612,684	1,221,874	2,834,558	1	23	13	4	0	1	
60022B	MCSO Inverness Jail Option B	MCSO	1,975,569	1,949,479	3,925,048	0	23	13	3	2	0	Funded via offer 60022 I&J
50044	Gang Resource Intervention Team (GRIT)	DCJ	389,965	630,071	1,020,036	1	23	13	3	2	0	
50049	Juvenile Sex Offender Residential Treatment	DCJ	1,008,169	578,237	1,586,406	1	23	13	3	2	0	
50050A	RAD-Juvenile Secure Residential A&D Treatment	DCJ	1,043,805	791,741	1,835,546	1	23	13	3	2	0	
50038	Juvenile Sex Offender Probation Supervision	DCJ	909,684	6,945	916,629	1	23	13	3	2	0	
50006	Adult Offender Mental Health Services	DCJ	995,424	101,227	1,096,651	1	23	13	3	2	0	
50007	Adult Substance Abuse Services-Outpatient	DCJ	279,176	379,698	658,874	1	23	13	3	2	0	
50024	Adult Sex Offender Treatment & Management Program	DCJ	574,728	273,120	847,848	1	23	13	3	2	0	
50017	Adult High Risk Drug Unit	DCJ	421,152	860,615	1,281,767	1	23	13	3	2	0	
15010	Investigations (Felony)	DA	627,842	36,000	663,842	1	23	13	3	2	0	
15012	Juvenile Court Trial Unit	DA	1,636,373	942,769	2,579,142	1	23	13	3	2	0	
50051	Juvenile Multi-Systemic Treatment Therapy Team (MST)	DCJ	536,533	220,809	757,342	1	38	12	3	1	1	
50023	Adult Offender Field Services - Felony Supervision	DCJ	3,028,113	13,037,962	16,066,075	1	38	12	3	1	1	
50068	Transition Services Unit - Adult Offender Services	DCJ	603,960	112,632	716,592	1	38	12	3	1	1	
50042	Juvenile Formal Probation Services	DCJ	2,984,929	762,986	3,747,915	1	38	12	2	3	0	
50020	Adult Domestic Violence Supervision/Deferred Sentencing	DCJ	1,289,566	423,265	1,712,831	1	38	12	2	3	0	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
21004	Gang Prevention Services	OSCP	401,232	153,418	554,650	1	38	12	2	3	0	
50008B	Substance Abuse Services For Men- Residential 24 beds	DCJ	1,093,324	27,594	1,120,918	1	38	12	2	3	0	
50008C	Substance Abuse Services For Men - Residential 14 Beds	DCJ	638,100	32,831	670,931	1	38	12	2	3	0	
50009	Adult Drug Diversion Program	DCJ	852,700	31,885	884,585	1	38	12	2	3	0	
60022G	MCSO Inverness Jail Option G	MCSO	2,589,455	0	2,589,455	0	38	12	2	3	0	Funded via offer 60022 I&J
60022H	MCSO Inverness Jail Option H	MCSO	2,004,723	0	2,004,723	0	38	12	2	3	0	Funded via offer 60022 I&J
60018	MCSO Civil Process	MCSO	1,801,600	0	1,801,600	1	38	12	2	3	0	
50065	Adult Pretrial Release Program Option	DCJ	1,217,512	0	1,217,512	1	50	11	3	0	2	
21010	Homeless Youth System	OSCP	2,357,706	1,159,868	3,517,574	1	50	11	2	2	1	
10056	Court Appearance Notification System	NOND	40,000	0	40,000	1	50	11	2	2	1	
15017	Misdemeanor/Community Court	DA	2,983,387	62,500	3,045,887	1	50	11	2	2	1	
15021	Neighborhood DA	DA	1,017,036	553,791	1,570,827	1	50	11	2	2	1	
60016A	MCSO Booking & Release Option A (days)	MCSO	2,330,292	0	2,330,292	1	50	11	2	2	1	
60022A	MCSO Inverness Jail Option A	MCSO	1,891,527	2,316,869	4,208,396	0	50	11	2	2	1	Funded via offer 60022 I&J
25072	Sexual Offense and Abuse Prevention Program	DCHS	69,682	254,548	324,230	1	50	11	1	4	0	
50057	Youth Gang Outreach	DCJ	565,081	46,799	611,880	1	50	11	1	4	0	
50019	Adult DUII Felony & Misdemeanor	DCJ	50,343	207,707	258,050	1	50	11	1	4	0	
60021A	MCSO Detention Center Option A	MCSO	2,297,967	0	2,297,967	1	60	10	2	1	2	
60040	MCSO River Patrol	MCSO	1,065,502	678,622	1,744,124	1	60	10	2	1	2	
60036	MCSO Safe Communities - Eastside	MCSO	2,812,472	421,061	3,233,533	1	60	10	1	3	1	
60038	MCSO Safe Communities - Graveyard	MCSO	1,370,872	0	1,370,872	1	60	10	1	3	1	
60032	MCSO Court Services - Courthouse	MCSO	2,843,210	0	2,843,210	1	60	10	1	3	1	
60016B	MCSO Booking & Release Option B (Swing)	MCSO	2,074,523	0	2,074,523	1	60	10	1	3	1	
60015	MCSO Transport	MCSO	2,422,508	0	2,422,508	1	60	10	1	3	1	
60024	MCSO Community Defined Crime & Investigative Response	MCSO	2,479,144	417,240	2,896,384	1	60	10	1	3	1	
50025	Day Reporting Center - Adult Sanctions & Services	DCJ	838,951	1,036,010	1,874,961	1	60	10	1	3	1	
50041	Juvenile Informal Intervention	DCJ	1,320,455	509,205	1,829,660	1	60	10	1	3	1	
50030	Family Services Unit	DCJ	1,086,031	24,766	1,110,797	1	60	10	1	3	1	
50031A	River Rock Treatment Program For Adult Offenders - Residential	DCJ	1,887,233	127,735	2,014,968	OTO	60	10	1	3	1	
50031D	River Rock - Restore Full Year	DCJ	1,174,124	48,000	1,222,124	0	N/A	N/A	N/A	N/A	N/A	If this offer funded, then don't fund offer 50031C
50058	Chronic and Serious Youth Offender Program	DCJ	596,981	0	596,981	0	60	10	1	3	1	
50055	Communities of Color Partnership (COCP)	DCJ	172,314	787,144	959,458	1	60	10	1	3	1	
50062	Juvenile - Latino Shelter Care	DCJ	258,341	0	258,341	0	60	10	1	3	1	
50045	Juvenile Accountability Programs	DCJ	1,266,179	123,172	1,389,351	1	60	10	1	3	1	
50047	Early Intervention Unit (EIU)	DCJ	260,141	140,687	400,828	1	60	10	1	3	1	
40025	Public Health Emergency Preparedness	HD	135,667	679,596	815,263	1	60	10	1	3	1	
25036	A&D Sobering ITAX	DCHS	598,467	385,772	984,239	1	60	10	1	3	1	
25025A	A&D Outstationed Staff: Alcohol and Drug Assessment, Referral, and Consultation Services	DCHS	62,910	422,171	485,081	1	60	10	1	3	1	
15001	Medical Examiner	DA	1,139,843	0	1,139,843	1	80	9	1	2	2	
40002	Emergency Medical Services	HD	106,036	1,265,285	1,371,321	1	80	9	1	2	2	
50050B	RAD Expansion	DCJ	244,095	207,880	451,975	0	80	9	1	2	2	
50060	Assessment and Treatment for Youth and Families (ATYF)	DCJ	1,015,132	113,688	1,128,820	1	80	9	1	2	2	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
50031B	River Rock Treatment Program For Adult Offenders-Community Care	DCJ	348,320	8,834	357,154	1	80	9	1	2	2	
50022	Adult Offender Field Services - Misdemeanor Supervision	DCJ	2,404,537	56,557	2,461,094	1	80	9	1	2	2	
10043	Local Public Safety Coordinating Council	NOND	0	192,100	192,100	1	80	9	1	2	2	
50053	Reclaiming Futures	DCJ	71,935	344,760	416,695	1	80	9	0	4	1	
10033A	DSS-Justice	NOND	442,625	0	442,625	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
10033B	DSS-Justice scaled	NOND	285,633	0	285,633	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25027	African American Youth A&D Treatment	DCHS	16,705	560,859	577,564	1	80	9	0	4	1	
50071	Mandated Treatment Medium Risk Adult Offenders	DCJ	892,391	0	892,391	1	80	9	0	4	1	
60037	MCSO Safe Communities - Westside	MCSO	638,059	0	638,059	1	80	9	0	4	1	
90007	Emergency Management	CS	384,804	3,861,541	4,246,345	1	80	9	0	4	1	
60039	MCSO Close Street	MCSO	1,363,844	0	1,363,844	0	93	8	1	1	3	
60033	MCSO Court Services - JC, WE, Relief	MCSO	1,951,894	0	1,951,894	1	93	8	1	1	3	
60016C	MCSO Booking & Release - Option C (grave)	MCSO	1,948,965	0	1,948,965	1	93	8	1	1	3	
60012A	MCSO Enforcement Records - Option A	MCSO	2,051,071	0	2,051,071	1	93	8	0	3	2	
60008	MCSO Classification	MCSO	2,703,308	0	2,703,308	1	93	8	0	3	2	
60030	MCSO Traffic Safety	MCSO	1,113,455	108,000	1,221,455	1	93	8	0	3	2	
25024	DUII Evaluation	DCHS	579,524	336,480	916,004	1	93	8	0	3	2	
50027	Adult Community Service - Formal Supervision	DCJ	206,041	654,850	860,891	1	93	8	0	3	2	
50028	Adult Community Service - Community Court & Bench Probation	DCJ	683,010	15,908	698,918	1	93	8	0	3	2	
60041A	REVISED - MCSO School Resource Officers	MCSO	77,340	0	77,340	OTO	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
60041B	REVISED - MCSO Additional School Resource Officer	MCSO	166,348	0	166,348	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
71066	ESWIS - Complete Mainframe Migration and System Development	CBS	0	1,315,000	1,315,000	1	102	7	1	0	4	
60009	MCSO Auxiliary Services	MCSO	2,763,092	0	2,763,092	1	102	7	1	0	4	
60014A	MCSO Facility Security Option A - Jails & Library	MCSO	1,958,236	0	1,958,236	1	102	7	1	0	4	
60021G	MCSO Detention Center Option G (MCCF)	MCSO	2,104,078	0	2,104,078	1	102	7	1	0	4	
60021H	MCSO Detention Center Option H (MCCF)	MCSO	1,594,349	0	1,594,349	1	102	7	1	0	4	
60025B	MCSO Corrections Work Crews - General Fund Contribution	MCSO	1,465,392	0	1,465,392	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
60025A	MCSO Corrections Work Crews- Self Supporting	MCSO	25,152	1,022,447	1,047,599	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
60014B	MCSO Facility Security Option B - Courts	MCSO	1,703,866	738,583	2,442,449	1	102	7	0	2	3	
60011A	MCSO Corrections Records - Option A (Days)	MCSO	1,957,264	0	1,957,264	1	102	7	0	2	3	
60011B	MCSO Corrections Records - Option B (Swing & Grave)	MCSO	1,507,427	0	1,507,427	1	102	7	0	2	3	
50026	Londer Learning Center- Adult Sanctions & Services	DCJ	255,814	795,927	1,051,741	1	102	7	0	2	3	
40064	Regional Health System Emergency Preparedness	HD	121,671	283,756	405,427	1	102	7	0	2	3	
25025B	A&D Outstationed Staff: Alcohol and Drug Assessment, Referral, and Consultation Services - Additional Capacity	DCHS	33,529	0	33,529	0	114	6	0	1	4	
60012B	MCSO Enforcement Records - Option B	MCSO	60,313	0	60,313	0	114	6	0	1	4	
60017	MCSO Inmate Programs	MCSO	2,872,673	0	2,872,673	1	114	6	0	1	4	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
60026A	MCSO Wapato Jail Option A	MCSO	4,070,818	0	4,070,818	0	114	6	0	1	4	
60026B	MCSO Wapato Jail Option B	MCSO	2,897,287	0	2,897,287	0	114	6	0	1	4	
60026C	MCSO Wapato Jail Option C	MCSO	2,940,323	0	2,940,323	0	114	6	0	1	4	
60026D	MCSO Wapato Jail Option D	MCSO	2,676,258	0	2,676,258	0	114	6	0	1	4	
60026E	MCSO Wapato Jail Option E	MCSO	2,760,365	0	2,760,365	0	114	6	0	1	4	
60026F	MCSO Wapato Jail Option F	MCSO	2,791,631	0	2,791,631	0	114	6	0	1	4	
60020B	MCSO Minimum Security Custody Option B	MCSO	840,747	0	840,747	0	114	6	0	1	4	
60019	MCSO Inmate Welfare & Commissary	MCSO	0	3,193,953	3,193,953	1	124	5	0	0	5	
60020A	MCSO Minimum Security Custody Option A MWRC	MCSO	1,734,652	0	1,734,652	OTO	124	5	0	0	5	
60028	MCSO Regulatory Services - Alarms & Concealed Weapons	MCSO	60,328	370,935	431,263	1	124	5	0	0	5	
60005B	MCSO Training Option B	MCSO	186,556	0	186,556	0	124	5	0	0	5	
50070	Forest Project	DCJ	1,275,236	0	1,275,236	0	124	5	0	0	5	
71013A	Human Resources - Safety Program	CBS	0	286,524	286,524	1	124	5	0	0	5	
71013B	Office Support (for Safety Program)	CBS	0	30,371	30,371	1	124	5	0	0	5	
71063	Justice Bond Fund - DA Mainframe Migration (CRIMES)	CBS	0	350,000	350,000	1	124	5	0	0	5	
71064	Justice Bond Fund - Remaining Capital Projects	CBS	0	1,475,000	1,475,000	1	124	5	0	0	5	
25033	DUII Victims' Impact Panel	DCHS	2,524	84,726	87,250	1	124	5	0	0	5	
10031	Building Space for State-Required Functions	NOND	2,733,891	0	2,733,891	1	124	5	0	0	5	
50018	Adult Enhanced Bench Probation	DCJ	41,327	161,169	202,496	1	124	5	0	0	5	
50056	The Gun Elimination Program	DCJ	252,703	6,373	259,076	0	124	5	0	0	5	
50031C	Community A&D Treatment 14 Beds	DCJ	272,532	0	272,532	1	N/A	N/A	N/A	N/A	N/A	New/alternative program offer
60067	$2.1 million Non-Corrections Savings Package to be Determined by the Sheriff	MCSO	(2,100,000)	0	(2,100,000)	1	N/A	N/A	N/A	N/A	N/A	New/alternative program offer

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
10006A	Auditor's Office	NOND	989,704	0	989,704	1	1	15	5	0	0	
10008	County Attorney	NOND	0	2,603,804	2,603,804	1	1	15	5	0	0	
70004A	Budget Office	FBAT	1,261,974	0	1,261,974	1	1	15	5	0	0	
70010	A&T - Property Tax Collection	FBAT	2,939,084	0	2,939,084	1	1	15	5	0	0	
70020B	Property Assessment-Expand Residential Appraisal Staff (A&T)	FBAT	459,770	0	459,770	1	1	15	5	0	0	
71004	Human Resources - Central Payroll	CBS	0	592,861	592,861	1	1	15	5	0	0	
70028	A&T - Board of Property Tax Appeals	FBAT	77,818	0	77,818	1	7	14	4	1	0	
71008	Human Resources - Employee Benefits	CBS	0	63,549,479	63,549,479	1	7	14	4	1	0	
71038	Facilities Asset Management	CBS	0	3,942,105	3,942,105	1	7	14	4	1	0	
71039	Facilities Property Management	CBS	0	4,129,198	4,129,198	1	7	14	4	1	0	
10000	Chair's Office	NOND	997,630	0	997,630	1	7	14	4	1	0	
10001	District 1	NOND	330,000	0	330,000	1	7	14	4	1	0	
10002	District 2	NOND	330,000	0	330,000	1	7	14	4	1	0	
10003	District 3	NOND	330,000	0	330,000	1	7	14	4	1	0	
10004	District 4	NOND	330,000	0	330,000	1	7	14	4	1	0	
71059	Facilities Capital - Asset Preservation (AP Fund)	CBS	0	8,373,265	8,373,265	1	7	14	4	1	0	Includes $1.0 million of OTO CGF
90006	Elections	CS	3,121,943	7,500	3,129,443	1	7	14	4	1	0	
10039	PERS Pension Bond Sinking Fund	NOND	0	26,200,000	26,200,000	1	18	13	3	2	0	
70001	General Ledger	FBAT	1,007,597	500,000	1,507,597	1	18	13	3	2	0	
71032	Facilities Maintenance and Operations	CBS	0	9,944,994	9,944,994	1	18	13	3	2	0	
71018	Finance Operations	CBS	0	5,615,364	5,615,364	1	18	13	3	2	0	
71015A	Human Resources - Workers Compensation	CBS	0	2,422,579	2,422,579	1	18	13	3	2	0	
70012	A&T - Document Recording & Records Storage/Retrieval Systems	FBAT	1,407,673	0	1,407,673	1	18	13	3	2	0	
70018	Property Assessment-Commercial (A&T)	FBAT	1,279,459	0	1,279,459	1	18	13	3	2	0	
70019	Property Assessment-Personal/Industrial Property (A&T)	FBAT	1,941,869	0	1,941,869	1	18	13	3	2	0	
70005	Tax Administration (Non-ITAX)	FBAT	183,555	0	183,555	1	18	13	3	2	0	
70007	Treasury Office	FBAT	406,368	0	406,368	1	18	13	3	2	0	
70009	A&T - Records Management	FBAT	1,963,351	80,000	2,043,351	1	18	13	3	2	0	
70020A	Property Assessment-Residential (A&T)	FBAT	2,989,503	0	2,989,503	1	29	12	2	3	0	
71007	Human Resources - Employee & Labor Relations	CBS	0	3,569,092	3,569,092	1	29	12	2	3	0	
71025	Telecommunications Services	CBS	0	5,350,745	5,350,745	1	29	12	2	3	0	
71027	Wide Area Network Services	CBS	0	2,370,633	2,370,633	1	29	12	2	3	0	
60001	MCSO Executive Budget	MCSO	2,836,443	0	2,836,443	1	29	12	2	3	0	
10009	Public Affairs Office	NOND	789,180	0	789,180	1	29	12	2	3	0	
71058	Web Services	CBS	0	1,138,839	1,138,839	1	29	12	2	3	0	
10052	Productivity Improvement Process	NOND	147,380	0	147,380	1	36	11	3	0	2	
70003	Retirement Programs	FBAT	220,357	0	220,357	1	36	11	2	2	1	
71016	Human Resources - Classification & Compensation Program	CBS	0	301,639	301,639	1	36	11	2	2	1	
71012	Human Resources - Unemployment Insurance	CBS	0	2,027,513	2,027,513	1	36	11	2	2	1	
70006A	ITAX Administration	FBAT	4,383,782	0	4,383,782	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
70006B	ITAX Administration Current Service Level	FBAT	200,000	0	200,000	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
70025	Liability Risk Unit	FBAT	40,399	1,474,272	1,514,671	1	36	11	1	4	0	
71003A	SAP Support	CBS	0	4,563,889	4,563,889	1	42	10	2	1	2	Offer # from 71003 to 71003A and includes $1,260,000 of OTO CGF
71003B	SAP Debt Payoff	CBS	1,740,000	0	1,740,000	OTO	N/A	N/A	N/A	N/A	N/A	New/Alternative program offer
10006C	Priority Indicator Reporting	NOND	17,876	0	17,876	1	42	10	2	1	2	
10007	School Audits	NOND	153,762	0	153,762	1	42	10	2	1	2	
10040	Tax Anticipation Notes	NOND	830,000	0	830,000	1	42	10	2	1	2	
10034	Business Income Tax	NOND	2,694,900	0	2,694,900	1	42	10	1	3	1	
40017	Vital Records	HD	40,167	492,546	532,713	1	42	10	1	3	1	
70017	Property Assessment- Special Programs (A&T)	FBAT	656,713	0	656,713	1	42	10	1	3	1	
90014	County Surveyor's Office	CS	26,278	2,694,711	2,720,989	1	42	10	1	3	1	
71057	GIS Services	CBS	0	583,631	583,631	1	42	10	1	3	1	
71036	Facilities Capital Improvement Program (CIP Fund)	CBS	0	27,264,634	27,264,634	1	42	10	0	5	0	
71043	Electronic Services	CBS	0	838,529	838,529	1	42	10	0	5	0	
60002	MCSO Professional Standards	MCSO	1,073,372	0	1,073,372	1	42	10	0	5	0	
70000B	CFO Communications	FBAT	103,924	0	103,924	0	54	9	2	0	3	
21026	School Services: Evaluation	OSCP	141,013	0	141,013	0	54	9	2	0	3	
71045	Mail Distribution	CBS	0	1,974,994	1,974,994	1	54	9	2	0	3	
71046	Materiels Management	CBS	0	2,030,598	2,030,598	1	54	9	1	2	2	
10037	GO Bond Sinking Fund	NOND	0	16,866,791	16,866,791	1	54	9	1	2	2	
10038	Revenue Bonds	NOND	0	2,922,510	2,922,510	0	54	9	1	2	2	Fund replacement offer 10058
10005	Centralized Boardroom Expenses	NOND	901,204	0	901,204	1	54	9	1	2	2	
71005	Human Resources - Workforce Development & Employment (Recruitment)	CBS	0	1,010,065	1,010,065	1	54	9	1	2	2	
71006A	Human Resources - Diversity, Equity and Affirmative Action	CBS	0	412,471	412,471	1	54	9	1	2	2	
71026	Desktop Services	CBS	0	12,210,145	12,210,145	1	54	9	0	4	1	
70002	Property Risk Unit	FBAT	30,914	1,086,048	1,116,962	1	54	9	0	4	1	
71044	Records Section	CBS	0	527,870	527,870	1	54	9	0	4	1	
71048	Sheriff's Office Application Services	CBS	0	1,929,539	1,929,539	1	66	8	1	1	3	
70004C	Performance Measurement and Planning	FBAT	101,670	0	101,670	0	66	8	1	1	3	
10036	Capital Debt Retirement	NOND	1,494,000	14,045,092	15,539,092	1	66	8	1	1	3	
71010	Human Resources - Health Promotion (Wellness)	CBS	0	332,971	332,971	1	66	8	1	1	3	
71006D	Diversity-Cultural Competency	CBS	145,195	0	145,195	1	66	8	1	1	3	
70026	Central Grant Monitoring	FBAT	80,269	0	80,269	0	66	8	1	1	3	
70029A	A&T Business Application Systems Completion (A&T)	FBAT	0	451,500	451,500	1	66	8	1	1	3	
70013	Marriage License/Domestic Partner Registry	FBAT	106,858	0	106,858	1	66	8	1	1	3	
71052	Library Application Services	CBS	0	1,053,001	1,053,001	1	66	8	0	3	2	
71053	Health Application Services	CBS	0	1,501,848	1,501,848	1	66	8	0	3	2	
70029B	A&T Business Application Systems Upgrade (A&T)	FBAT	485,000	2,651,500	3,136,500	0	77	7	1	0	4	
10041	Equipment Acquisition Fund	NOND	0	221,200	221,200	1	77	7	1	0	4	
10012A	Citizen Involvement Committee	NOND	179,641	0	179,641	1	77	7	1	0	4	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
10012C	Public Electronic Communications	NOND	14,800	0	14,800	0	77	7	0	2	3	
10032	IBM Mainframe Migration	NOND	1,655,000	0	1,655,000	0	77	7	0	2	3	Fund replacement offer 10059
71015B	Office Support-WC	CBS	0	28,177	28,177	1	77	7	0	2	3	
71033A	Facilities Compliance - Reduced Service	CBS	0	1,390,139	1,390,139	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
71033B	Facilities Compliance - Current Service Level	CBS	0	350,000	350,000	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
71042	Fleet Services	CBS	0	6,839,582	6,839,582	1	77	7	0	2	3	
71049	Community Justice Application Services	CBS	0	1,937,880	1,937,880	1	77	7	0	2	3	
71054	DSCP Application Services	CBS	0	219,468	219,468	1	86	6	0	1	4	
71055	DCHS Application Services	CBS	0	2,120,151	2,120,151	1	86	6	0	1	4	
71056	DBCS Application Services	CBS	0	2,885,783	2,885,783	1	86	6	0	1	4	
71060	Facilities Capital - Justice Bond	CBS	0	3,200,000	3,200,000	1	86	6	0	1	4	
71062	IT Asset Preservation Program	CBS	0	2,904,101	2,904,101	1	86	6	0	1	4	
71065	HIPAA Security Rule Compliance	CBS	0	365,880	365,880	1	86	6	0	1	4	
71034	Facilities Operations - Pass Through	CBS	0	20,901,691	20,901,691	1	86	6	0	1	4	
10013	Cultural Diversity Conference	NOND	40,000	0	40,000	1	86	6	0	1	4	
10012B	Citizen Involvement Training	NOND	3,000	0	3,000	0	86	6	0	1	4	
10006B	Report to County Residents	NOND	33,241	0	33,241	0	95	5	0	0	5	
71067	Cost Effective Solutions	CBS	238,215	0	238,215	0	95	5	0	0	5	
70032	Investment and Performance Offer	FBAT	3,500,000	0	3,500,000	1	N/A	N/A	N/A	N/A	N/A	New/Alternative program offer
10058	Revenue Bonds - Revised	NOND	0	3,308,060	3,308,060	1	N/A	N/A	N/A	N/A	N/A	Replaces program offer 10038
10059	IBM Mainframe Migration - Revised	NOND	3,068,998	0	3,068,998	1	N/A	N/A	N/A	N/A	N/A	Replaces program offer 10032; includes $1,350,000 of OTO CGF to payoff debt

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
90012	Road Engineering & Operations	CS	44,482	3,769,616	3,814,098	1	1	15	5	0	0	
90016	Road Maintenance	CS	102,558	7,492,766	7,595,324	1	1	15	5	0	0	
90017	Bridge Maintenance & Operations	CS	43,952	2,508,742	2,552,694	1	1	15	5	0	0	
90018	Bridge Engineering	CS	34,774	3,693,648	3,728,422	1	1	15	5	0	0	
90029	Road Fund Transfer to Willamette River Bridge Fund	CS	166	5,335,214	5,335,380	1	1	15	5	0	0	
90019	Transportation Capital	CS	0	37,670,893	37,670,893	1	6	13	3	2	0	
90030	Road Fund Transfer to Bike & Pedestrian Fund	CS	166	74,000	74,166	1	7	10	2	1	2	
90021	Transportation Planning	CS	8,416	655,054	663,470	1	7	10	1	3	1	
10035	Convention Center Fund	NOND	0	16,463,000	16,463,000	1	7	10	1	3	1	
90026	County Road Fund Payment to City of Gresham	CS	3,917	530,993	534,910	1	7	10	0	5	0	
10024	State Regional Investment program	NOND	0	1,550,000	1,550,000	1	11	9	1	2	2	
90027	County Road Fund Payment to City of Fairview	CS	241	20,355	20,596	1	11	9	0	4	1	
90028	County Road Fund Payment to City of Troutdale	CS	258	22,765	23,023	1	11	9	0	4	1	
90032	Reduced Portland Pmt Alternative to 9025A	CS	157,116	21,806,700	21,963,816	0	14	8	1	1	3	
90025A	County Road Fund Payment to City of Portland	CS	157,116	21,806,700	21,963,816	1	14	8	0	3	2	
10021	SIP Direct Service Program	NOND	0	335,467	335,467	1	17	6	0	1	4	
10049	SIP/CSF City of Gresham	NOND	0	566,112	566,112	1	18	5	0	0	5	
10023A	SIP/CSF Strategic Partnerships	NOND	0	261,690	261,690	1	N/A	N/A	N/A	N/A	N/A	
10023B	SIP/CSF support for General Fund programs	NOND	0	131,690	131,690	0	N/A	N/A	N/A	N/A	N/A	
10020A	SIP Administration	NOND	0	206,984	206,984	1	N/A	N/A	N/A	N/A	N/A	
10020B	SIP Admin Special Programs	NOND	0	268,912	268,912	1	N/A	N/A	N/A	N/A	N/A	
10020C	SIP Support for General Fund programs	NOND	0	268,912	268,912	0	N/A	N/A	N/A	N/A	N/A	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
40020	Immunization	HD	160,631	1,512,803	1,673,434	1	1	15	5	0	0	
40026A	Healthy Birth and Early Childhood Services (Part A)	HD	3,079,907	5,308,045	8,387,952	1	1	15	5	0	0	
40026B	Healthy Birth and Early Childhood Services (Part B)	HD	2,823,083	2,844,478	5,667,561	1	3	14	4	1	0	
40047	School-Based Health Centers	HD	2,716,351	3,119,149	5,835,500	1	3	14	4	1	0	
25077A	School Mental Health ITAX	DCHS	526,714	720,947	1,247,661	OTO	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
25077B	School Mental Health CGF	DCHS	317,816	0	317,816	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
21005	Early Childhood Services	OSCP	1,657,524	227,244	1,884,768	1	3	14	4	1	0	
21016A	School Svcs - Full Svc Schools - Touchstone	OSCP	2,048,992	0	2,048,992	1	3	14	4	1	0	Removed Community Convener
21018	School Svcs - Social & Support Services for Educational Success	OSCP	2,286,729	380,538	2,667,267	1	8	13	3	2	0	Removed Community Convener
21025A	School Svcs - Full Svc Schools - School Attendance Initiative(alternative) (chose this or 21020)	OSCP	1,254,662	0	1,254,662	0	9	12	3	1	1	
21022	School Svcs - Alcohol, Tobacco and Other Drug Services	OSCP	232,267	0	232,267	0	10	11	2	2	1	
21024	School Svcs - Technical Assistance and Direct Services for Sexual Minority Youth	OSCP	124,213	0	124,213	OTO	10	11	1	4	0	
80004	Tools for School Success	LIB	0	1,026,584	1,026,584	1	10	11	1	4	0	CGF funding shifted to levy; support cost in levy cut to absorb added cost
25102	HERO Children's DV Program	DCHS	153,133	0	153,133	0	10	11	1	4	0	
21015A	School Svcs - Full Svc Schools - Community Schools (SUN) 43 Schools	OSCP	2,866,975	898,588	3,765,563	1	14	10	2	1	2	Removed Community Convener
21015B	School Svcs - Full Svc Schools - Community Schools (SUN) 3 Schools	OSCP	314,933	0	314,933	1	14	10	2	1	2	
25081A	DV Youth Prevention	DCHS	34,552	0	34,552	1	N/A	N/A	N/A	N/A	N/A	Original program offer scaled; This is CSL
25081B	DV Youth Prevention Enhanced	DCHS	148,361	0	148,361	0	N/A	N/A	N/A	N/A	N/A	Original program offer scaled
21023	School Svcs - Technical Assistance for Gender-Specific Services to Girls	OSCP	63,546	0	63,546	0	14	10	1	3	1	
21020A	School Svcs -Full Svc Schools- School Attendance Initiative (choose this or alternative prog 21025)	OSCP	754,662	0	754,662	0	18	9	2	0	3	
80015	Ready to Learn	LIB	260,750	525,172	785,922	1	18	9	0	4	1	
10016	Childhood Obesity Prevention	NOND	60,967	0	60,967	0	20	8	1	1	3	
21016B	School Svcs - Full Svc Schools - Touchstone (b)	OSCP	270,360	0	270,360	0	20	8	0	3	2	
40014	Lead Poisoning Prevention	HD	17,429	169,598	187,027	1	20	8	0	3	2	
21020B	School Svcs - Full Svc Schools - School Attendance Initiative (b)	OSCP	68,840	0	68,840	0	23	7	0	2	3	
10054	Child Care Quality	NOND	0	258,763	258,763	1	24	6	0	1	4	
10030	Multnomah County Schools	NOND	89,160,000	0	89,160,000	1	24	6	0	1	4	
40007	Students Today Aren't Ready for Sex (STARS)	HD	28,866	516,278	545,144	1	26	5	0	0	5	
10029	County School Fund	NOND	0	226,000	226,000	1	26	5	0	0	5	
21025B	School Svcs -Full Svc Schools- School Attendance Initiative (alternative) (b)	OSCP	68,840	0	68,840	0	26	5	0	0	5	

Prog #	Name	Dept.	General Fund	Other Funds	Total Cost	Funded Status	Rank	Score	H	M	L	Notes
80018	East & Mid-County Neighborhood Libraries	LIB	2,684,782	5,269,632	7,954,414	1	1	15	5	0	0	
80023	Southeast Neighborhood Libraries	LIB	1,700,143	3,354,538	5,054,681	1	1	15	5	0	0	
80028	Open Libraries 57 Hours	LIB	46,100	0	46,100	1	1	15	5	0	0	
80022	Westside Neighborhood Libraries	LIB	1,571,174	3,095,873	4,667,047	1	4	14	4	1	0	
80019	North and Northeast Neighborhood Libraries	LIB	2,457,428	4,843,541	7,300,969	1	4	14	4	1	0	
80006	Central Library Readers' Services	LIB	1,950,640	3,799,349	5,749,989	1	6	13	3	2	0	
40013	Vector & Nuisance Control	HD	1,264,381	40,138	1,304,519	1	8	12	2	3	0	
80016	Adult Outreach	LIB	0	731,852	731,852	1	9	11	2	2	1	CGF funding shifted to levy; support cost in levy cut to absorb added cost
90003	Animal Services - Field Services	CS	1,727,545	171,998	1,899,543	1	9	11	2	2	1	
90004	Animal Services - Shelter Services	CS	2,379,862	238,202	2,618,064	1	9	11	1	4	0	
90020A	Land Use Planning	CS	1,482,512	153,242	1,635,754	1	9	11	1	4	0	
80005	Central Library Research Tools & Services	LIB	2,195,837	4,267,792	6,463,629	1	9	11	1	4	0	
71002	Sustainability Team	CBS	0	208,464	208,464	1	14	10	1	3	1	
90023	Water Quality	CS	166,800	0	166,800	1	14	10	1	3	1	
80029	Open Libraries 64/70 Hours	LIB	1,981,288	0	1,981,288	0	16	9	2	0	3	
80030	New Columbia Neighborhood Library	LIB	1,941,584	0	1,941,584	0	16	9	2	0	3	
80031	Troutdale Neighborhood Library	LIB	731,625	0	731,625	0	16	9	2	0	3	
90020B	Land Use Planning cost recovery	CS	0	0	0	0	16	9	1	2	2	
10026	Regional Arts & Culture Council	NOND	137,050	0	137,050	OTO	16	9	1	2	2	
80025	Library District Study Proposal	LIB	50,325	0	50,325	0	16	9	1	2	2	
90010	Tax Title	CS	3,606	697,337	700,943	1	22	8	1	1	3	
10015A	CCFC Activities	NOND	0	738,089	738,089	1	24	7	0	2	3	
10015B	CCFC Activities-Maintains Current Level	NOND	144,019	0	144,019	0	22	8	0	3	2	
10015C	Family Advocate Model-Child Abuse Prevention	NOND	0	199,939	199,939	0	N/A	N/A	N/A	N/A	N/A	
71014	Human Resources - Bus Pass Program	CBS	0	850,000	850,000	1	25	6	0	1	4	
70024	Recreation Fund payment to Metro	FBAT	0	116,000	116,000	1	25	6	0	1	4	
10028	Soil & Water Districts	NOND	18,000	0	18,000	OTO	27	5	0	0	5	
80020	Bond Projects	LIB	0	885,000	885,000	1	27	5	0	0	5	
80003A	Central Library Borrowers' Services	LIB	2,464,746	4,943,566	7,408,312	1	6	13	3	2	0	

Group of 4

#1

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5.10.05

SUBJECT: _____

_____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Tony Hopson, Sr.

ADDRESS: S.E.I. 3920 N Kerby

CITY/STATE/ZIP: Portland OR 97227

PHONE: DAYS: 503-249-1721 EVES: _____

EMAIL: tonyh@selfenhancement.org FAX: _____

SPECIFIC ISSUE: _____

_____

WRITTEN TESTIMONY: _____

_____

_____

_____

_____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

DRAFT LETTER
April 29th, 2005

Diane Linn, Chair
Multnomah County Board of Commissioners
501 SE Hawthorne Boulevard, Suite 600
Portland, OR 97214

Dear Chair Linn,

On behalf of the Regional Centers, the Culturally Specific Service Providers Network, and the youth and families impacted by the School Aged Policy Framework; we would like to advocate for the entire framework to be fully funded and supported by the county. The School Aged Policy Framework, frequently referred to as the Sun System includes the following services; Anti-Poverty services, SSES, Sun Schools, Regional Centers, and PCDS. The framework represents an effort to raise the bar in quality of services, and provide services to diverse populations by increasing access for all children and families. This framework is groundbreaking due to its effort to bring partners together in an attempt to implement best practices in an inclusive, networked environment. Much effort has been put forth to design an integrated system of care that is geographically coordinated with other jurisdictions. It successfully provides access, intake, and linkages to serve communities countywide. This vision has only begun, and our families are starting to invest in the services, develop relationships, and find stability with the system. In addition to this important progress, there are many other positive outcomes:

1. Significant time and resources have been invested in developing a policy that is inclusive and reflective of Multnomah counties residents' priorities. This policy has been an important investment for the entire community not only in the planning process but in the implementation.

2. For the first time in Multnomah County history, majority culture and culturally specific providers are working together in cooperation and partnership to best serve the entire community. We feel that this model is the most appropriate to address the changing demographics of Multnomah County.

3. Additional dollars have been leveraged and partnerships have been developed based on a policy that prioritizes collaboration and best practices.

4. Services have been redistributed to serve high need communities and schools in each region of Multnomah County. The diversity of the clients in each region is represented in the services being provided.

5. The SUN System serves as a safety net and prevention tool in order to serve families and youth with mental health issues, and connect early childhood services with families.

6. It is significant to note that since the adoption of the framework numbers of clients served have increased and the clients have been served in a more meaningful way with fewer resources. This includes an increase of services to communities of color, marginalized communities, and low income populations. Because of the collaborative environment, regional centers have increased the number of communities of color served, and the diversity of staff represented.

7. Although the programs have only been up and running for a year, many positive outcomes are already evident. The County's effort to raise the bar has already demonstrated positive outcomes, and the entire system is invested in further developing benchmarks measuring quality of service. Additional data and time to evaluate the true value of this system is crucial for ensuring quality services for the community of Multnomah County.

8. This system is built on nationally recognized models of success and best practices that have been implemented in other parts of the country and have demonstrated significant impact and outcome achievement.

We know from our previous experience with the County in the adoption of the SAPF budget that you encourage community participation in the process, which results in a better end product for our community. As such, we will be contacting your staff in an effort to schedule a meeting with you. Thanks,

Respectfully,

Asian Family Center
Cascadia
El Programma Hispano
IRCO
Oregon Council for Hispanic Advancement
Metropolitan Family Services
Native American Youth and Family Center
Native American Rehabilitation Association
Portland Impact
Self Enhancement Inc.

Cc: Commissioner Lonnie Roberts, Commissioner Serena Cruz, Commissioner Lisa Naito, and Commissioner Maria Rojo De Steffey.

#2

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5.10.05

SUBJECT: _____

_____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Tony Hopson, Jr.

ADDRESS: S.E.I.

CITY/STATE/ZIP: _____

PHONE: DAYS: _____ EVES: _____

EMAIL: tonyhjr@selfenhancement.org FAX: _____

SPECIFIC ISSUE: _____

_____

WRITTEN TESTIMONY: _____

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_____

_____

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#3

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
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MEETING DATE: 5-10-05

SUBJECT: _____

_____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Sadie Feibel

ADDRESS: S.E. 1.

CITY/STATE/ZIP: _____

PHONE: DAYS: _____ EVES: _____

EMAIL: Sfeibel@pps.k12.or.us FAX: _____

SPECIFIC ISSUE: _____

_____

WRITTEN TESTIMONY: _____

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_____

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IF YOU WISH TO ADDRESS THE BOARD:

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#4

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
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MEETING DATE: 5.10.05

SUBJECT: _____

_____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: David Allen

ADDRESS: SE 1

CITY/STATE/ZIP: _____

PHONE: DAYS: _____ EVES: _____

EMAIL: davida@selfenhancement.org FAX: 5

SPECIFIC ISSUE: _____

_____

WRITTEN TESTIMONY: _____

_____

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_____

_____

IF YOU WISH TO ADDRESS THE BOARD:

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#5

Group of 4

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
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MEETING DATE: 05.10.05

SUBJECT: Latino Culturally Specific Wellness Program "MIOS"

AGENDA NUMBER OR TOPIC: County Budget Item for MIOS

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Emile Y Combe

ADDRESS: 59 N. E. Monroe

CITY/STATE/ZIP: Portland OR 97212

PHONE: DAYS: 503-288-8692 EVES: Ibid

EMAIL: emile FAX: _____

SPECIFIC ISSUE: Supporting MIOS appropriation; submitting MIOS Plan & Amendment Chapter 5

WRITTEN TESTIMONY: Attached

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
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CATHOLIC CHARITIES

May 10, 2005

Diane Lynn, Chair, Board of Multnomah County Commissioners
Serena Cruz, District 2
Maria Rojo de Steffey, District 1
Lisa Naito, District 3
Lonnie Roberts, District 4

Dear Chair Lynn and Commissioners,

This letter formally submits the MIOS Management Team's business plan (Latino Community Wellness Initiative: A Culturally Specific Community Based Mental Health and Substance Use Prevention Program, which each of you have previously received along with letters of support from the Oregon Council for Hispanic Advancement, Desarrollo Integral de la Familia, Suzannah Maria Gurule Foundation, Programa Hispano of Catholic Charities, and Latino Network, into the 2005-06 Multnomah County public hearing record. Attached to this letter is a copy of revisions and edits to "Chapter 5: Governance, Administrative and Management," changes which were unanimously adopted by the MIOS Management Team at our meeting on May 9, 2005.

With these changes, we recommend that the creation and initial support of the new Latino community based and culturally specific behavioral health 501-(c)-3 organization during Phase I of the organization development process should be carried out by a competent and experienced, existing, fully licensed dual diagnosis and treatment (mental health and substance use) organization. While we feel that the support to the MIOS program that has been carried out by Cascadia Behavioral Health Care has been excellent, it is our opinion that this question of who should provide organizational support to the proposed new Latino behavioral health 501-(c)-3 organization should be addressed at a later time and not in the business plan.

The new attached Chapter 5, with it's new figures and text edits, should be substituted in its entirety for the existing Chapter 5 currently included within the existing MIOS business plan.

Sincerely

Douglas S. Alles
Chair, MIOS Management Team
Cc: MIOS Management Team

CHAPTER 5: GOVERNANCE, ADMINISTRATIVE & MANAGEMENT

Introduction

Latino community leaders have been clear about their desire to create a Latino community-based culturally specific wellness organization to provide services to the Latino community in Portland from the inception of this project in November 2002.[1] The objective for the governance and management of this organization creates a culturally specific non profit behavioral health organization as follows:

> ***Objective:*** To create a Latino community based wellness organization (Latino BHO) which provides culturally and linguistically specific wellness services, including the strengthening of family and community linkages and relationships, mental health, alcohol and drug, crisis and other specialized behavioral services, to Latino families and children within the six county metropolitan and rural region from Vancouver, Washington extending south to Salem, Oregon.

Development of this entity will occur in two phases. During Phase I, a newly created Latino Wellness Corporation is formed under the governance and management of a Latino community based Board of Directors to manage all clinical, systems and program development, and fund development. A dual diagnosis and treatment licensed behavioral health care organization provides specific contractual support to this new Latino community based corporation under specific contractual provisions between the two corporations. In Phase II the Latino community based organization assumes all governance and management and clinical functions, and subcontracts only administrative support from a separate entity such as a licensed behavioral health care organization or other administrative services providing organization.

Phase-I Latino BHO Manages Clinical And Planning Functions

Figure 5.1 shows the interim organization structure and division of functions proposed for this program during the second phase of development. At this point, a private non-profit Latino community based wellness organization is created. The board of directors of this new organization is responsible for governance, systems and program development and fund development for the new organization. During this interim period the board also provides critical advice and guidance on culturally specific service design and implementation to the mainstream organization that provides licensing, liability coverage, clinical supervision and quality control, and administrative services. This arrangement is handled through a contractual agreement between a dual diagnosis and treatment licensed behavioral health care organization and the new private non-profit Latino Wellness organization. An advisory group of existing Latino service providers, including the MIOS Management Team, provides technical guidance to the board of directors of this new organization.

Phase-II Latino BHO Manages All Functions & Subcontracts Administration

Figure 5.2 shows the final organization structure and division of functions proposed for this program during the final phase of development. In this final configuration, the private non-profit Latino Wellness Corporation obtains all organizational and clinical licenses required by local, state and federal law, and assumes responsibility for all governance, clinical services, supervision and clinical quality control, planning, program development and fund development activities.

Administrative services, including budgeting, accounting, poayroll, personnel, and collections, are provided by contract with an existing behavioral health care organization or other organization which provides these kinds of administrative services.

Non-Profit Structure For Latino Behavioral Health Organization

The newly created Latino Wellness Corporation will be incorporated as an independent private non-profit 501-c-3 corporation under Oregon Statutes and Section 501-c-3 of the Internal Revenue Code.

Membership For Board Of Directors and Advisory Group of Latino Service Providers

The board of directors for the Latino Wellness Initiative should be predominately Latino and representative of the following sectors of the community:

- Latino consumers of wellness services
- Community health workers or promotores/as
- Latino business community representative(s)
- Nationally and/or regionally recognized Latino services and research specialist in Latino behavioral health
- Nationally and/or regionally recognized Latino children's services and research specialist in Latino behavioral health
- Geographical representation from each Oregon and Washington county participating in the program
- Universities
- Hospitals

[1] Latino Network Proposal for Culturally Specific Mental Health System Development, Latino Network, January 6, 2002.

Figure 5.1

Phase I Final Governance and Functional Responsibilities

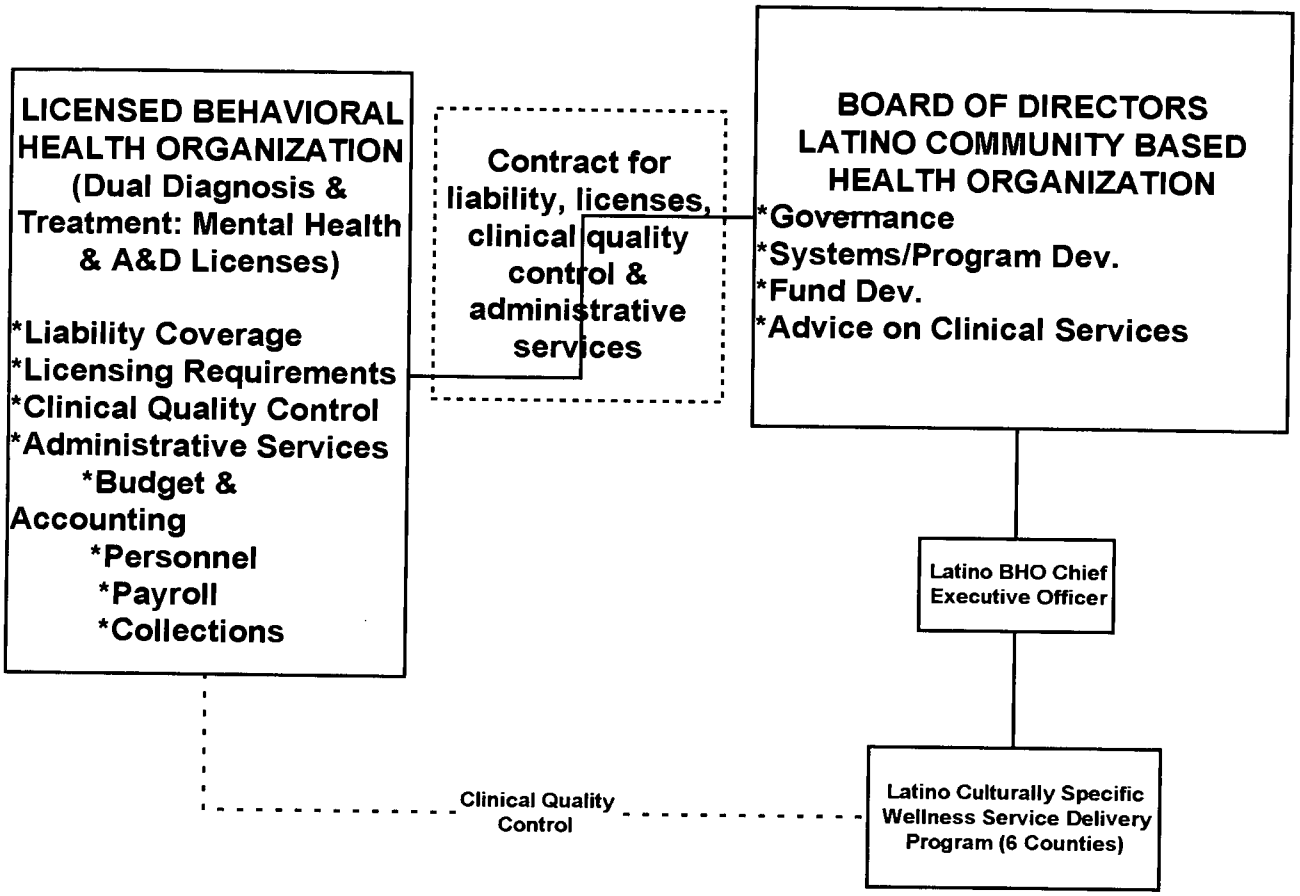
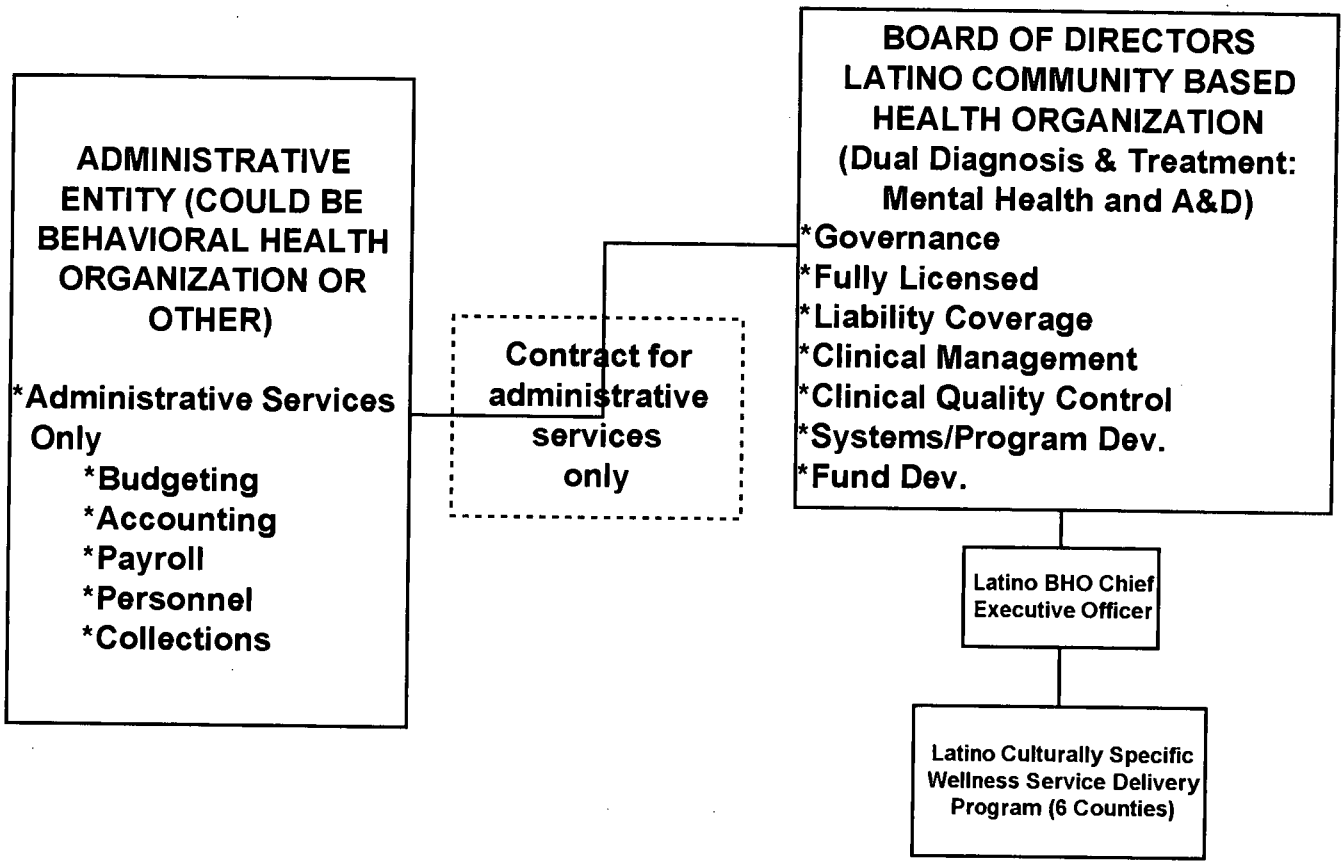


Figure 5.2

Phase II Interim Governance and Functional Responsibilities



The advisory group of Latino service providers should be predominately Latino, and consist of the original Latino service providers from the MIOS Management Team as well as other Latino service providers from the community:

- The original Latino service providers from the MIOS Management Team
  - Oregon Council for Hispanic Advancement
  - Desarrollo Integral de la Familia
  - Programa Hispano: Catholic Charities
  - SMG Foundation
  - Latino Network
- Other Latino mental health, substance use and wellness providers
- Cascadia Behavioral Health Care, Inc.

LATINO COMMUNITY WELLNESS INITIATIVE

A CULTURALLY SPECIFIC COMMUNITY BASED MENTAL HEALTH AND SUBSTANCE USE PREVENTION AND TREATMENT PROGRAM

FINAL REPORT
Second Edition
March 8, 2005

A Partnership Between:

Desarrollo Integral de la Familia
El Programa Hispano of Catholic Charities
Latino Network
Oregon Council for Hispanic Advancement
Susana Maria Gurule (SMG) Foundation
Cascadia Behavioral Health Care Inc.
Multnomah County

Prepared by:
Emile H. Combe, Ph.D., Latino Network
Lucrecia Suarez, LCSW, Conexiones, Model Design
James Carlson, Evaluation

Under the Guidance of the MIOS Management Team

LATINO COMMUNITY WELLNESS INITIATIVE

A CULTURALLY SPECIFIC COMMUNITY BASED MENTAL HEALTH AND SUBSTANCE USE PREVENTION AND TREATMENT PROGRAM

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Multnomah County

Prepared by:
Emile H. Combe, Ph.D., Latino Network
Lucrecia Suarez, LCSW, Conexiones, Model Design
James Carlson, Evaluation

Under the Guidance of the MIOS Management Team

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

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Marie Dahlstrom, MA, Counseling Psychology, SMG Foundation
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Rey España, Latino Network
Julie Larson, BA, Counseling, QMHP, Director of Cultural Competency, Program Manager of Mobile Crisis Services, Cascadia Behavioral Health Care

Project Management

Marie Dahlstrom, M.A., Director, SMG Foundation
Emile H. Combe, Ph.D., Co-Director, Community Development, Latino Network

Report Preparation

Emile H. Combe, Ph.D., Primary Author and Coordinator for Draft and Final Report
Lucrecia Suarez, LCSW, Conexiones, Primary Author, Culturally Specific Model Paper
James Carlson, Primary Author for Chapter 7: Research and Evaluation

Culturally Specific Community Based Wellness Model Development Committee

Lucrecia Suarez, LCSW, Appendix 1 Primary Author and Committee Coordinator
Marie Dahlstrom, MA in Counseling Psychology, SMG Foundation
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Joseph Gallegos, PhD, Associate Professor, Social Work; University of Portland
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Julie Larson, BA, Counseling, QMHP, Director of Cultural Competency, Program Manager of Mobile Crisis Services, Cascadia Behavioral Health Care

Special Thanks And Technical Assistance

Multnomah County Commissioners
- Diane Linn, Chairperson
- Maria Rojo de Steffey, District 1
- Serena Cruz, District 2
- Lisa Naito, District 3
- Lonnie Roberts, District 4

Peter Davidson, M.D., Medical Director, Mental Health and Addiction Services, Multnomah County; Multnomah County Clinical Services Coordinator for County Chair
Noël Wiggins, MSPH, Community Capacitation Center, Multnomah County Health Department
Leslie Ford, Chief Executive Officer, Cascadia Behavioral Health Care

Funding And Fiscal Management

Multnomah County Office of Mental Health Addiction Services
Cascadia Behavioral Health Care

For More Information Please Contact:

Name: Marie Dahlstrom
email: mdahlstrom@smg-foundation.org

CHAPTER 1: INTRODUCTION

History Of Wellness Project

In response to the tragic death in the spring of 2000 of a Mexican Mayan Indian from Yucatán, Mexico, who was shot and killed by Portland City police in a mental health hospital in Portland, Oregon,[1] Latinos in Multnomah County became indignant and outraged. Sr. Mejia Poot, who suffered from epilepsy and had not received medications for a number of days due to a lack of money to purchase them, was misdiagnosed by the mental health crisis system and hospitalized in a secure area of the mental health system within a designated hospital designed to securely hold such patients. The hospital, unable to manage Sr. Mejia Poot's agitation, called police who used lethal force to subdue him.

The Latino Network coordinated a joint initiative in November 2001 with several Latino social service agencies to advocate for a comprehensive, integrated, culturally and linguistically specific mental health and addiction system of within Multnomah County. Multnomah County responded by providing almost $800,000 to support this initiative from February 2003 through the end of June 2004. This program began as the pilot "MIOS Program," or "Mental Health Integration Organizations Service." With the development of this business plan this effort has become the "Portland Metropolitan Area Latino Community Based Wellness Initiative: A Culturally Specific Mental Health and Alcohol and Drug Program."

Overview Of Report

The report is made up of 9 chapters. Chapter 1 is the introduction to the report. The second chapter identifies the need for culturally specific wellness services for Latinos within each of the 6 targeted counties, based on a review of the research literature on prevalence studies for Latino adults and children within the United States. Chapter 3 provides an overview of the existing pilot program funded by Multnomah County, which has been in operation from January of 2003 through December of 2004. Chapter 4 describes in detail, the Latino wellness service delivery model, including specific design of mental health and substance use services, and comprehensive linkages to all other support systems available to the Latino community.

Chapter 5 describes the proposed governance and administrative structure of the new Latino Culturally Specific Community Based Behavioral Health Organization, which is being created to provide these services throughout the 6 county Portland metropolitan area. Chapter 6 outlines the staffing and training plan for the new Latino Culturally Specific Community Based Behavioral Health Organization. Chapter 7 outlines a 5-year phasing plan for expanding the program incrementally to cover the entire 6 county Portland metropolitan area. Chapter 8 describes the research and evaluation component proposed for this initiative, including a general outline of the research design proposed for the evaluation and identification of more detailed research questions, which need to be addressed to improve our understanding of what works and what does not work within the Latino community in the United States. Chapter 9 provides a detailed 5 year phased costs for implementation of the initiative throughout the 6 county service area.

Mental Health: A Report Of The Surgeon General[2]

The Surgeon General of the United States has documented that the U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system. A confluence of clinical, cultural, organizational and financial barriers have created a mental health system which under-serves minority communities in the United States. These barriers deter ethnic and racial minority group members from seeking services, and if individual members of groups succeed in accessing services, their treatment may be inappropriate to meet their needs.

Research and clinical practice have propelled advocates and mental health professionals to press for "linguistically and culturally competent and specific services" to improve utilization and effectiveness of treatment for different cultures. Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems (CMHS, 1998). Without culturally competent and specific services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next decades.

Recommendations Of The President's New Freedom Commission On Mental Health

The proposed program is also consistent with and implements the six goals identified in the President's New Freedom Commission on Mental Health report, as demonstrated in the discussion below:[3]

Goal 1: The first goal of the President's report is helping the Latino community understand mental health. This goal is specifically addressed in Chapter 4: Latino Culturally Specific Wellness Model. Initially the proposed model engages the Latino community initially through a framework of wellness and prevention, avoiding the stigma often assigned to mental health and substance use. Then for those clients who require a more in depth level of service, they are engaged by Latino culturally specific promotores/as (community mental health workers) through a process of "treatment readiness" which prepares them to understand the kinds of services which are available to help them.

[1] The Oregonian, "Forum Addresses Mejia Death," June 20, 2001.

[2] Mental Health: A Report of the Surgeon General, "Chapter 2: The Fundamentals of Mental Health and Mental Illness," http://www.surgeongeneral.gov/library/ mentalhealth/toc.html, undated.

[3] Achieving the Promise: Transforming Mental Health Care in America, President's New Freedom Commission on Mental Health, Final Report, July, 2003.

Goal 2: The second goal of the President's report is that Latino Mental health is extended family driven. The proposed model in Chapter 4 specifically targets the Latino extended family, and includes the important relationships of *compadrazgo* and *comadrazgo*, or ritual godparenthood, as significant extensions of the nuclear and extended family in Latino culture.

Goal 3: Goal 3 of the President's report proposes to eliminate disparities in mental health services thru programs which are culturally competent. The proposed program in Chapter 4 is both culturally competent and culturally specific, and is community based rather than based in a professional mental health office. The new 501-c-3 Latino Behavioral Health Organization described in Chapter 5: Governance, Administrative and Management System is controlled by a board of directors which is culturally and linguistically specific, and a Latino corporate and service delivery culture is created by hiring a Latino executive director and a predominance of culturally and linguistically specific staff in the area of service delivery.

Goal 4: The fourth goal of the President's report recommends early mental health screening, assessment, and referral through Latino Community Based Services. The service delivery model described in Chapter 4 is community based, and early mental health screening, assessment and referral occurs in the initial engagement of the Latino community in wellness and prevention phase of client contact. In particular, this program engages children in a school-based setting, again carrying out early screening, assessment and referral during the initial contact with Latino children and their parents.

Goal 5: Goal 5 of the President's report recommends the delivery of excellent mental health care and the acceleration of research accelerated ongoing evaluation and feedback. Chapter 8: Evaluation and Research Plan For Latino Community Wellness Initiative proposes evaluation and feedback through an ongoing evaluation process which is outlined in that chapter. In addition, this business plan recommends a specific research agenda to identify both best practices appropriate to the Latino community and the evaluation of the cost-effectiveness of the program. This research agenda is proposed to be carried out by a partnership between the new Latino Behavioral Health Organization, the Oregon Health Sciences University and Portland State University, and the SMG Foundation.

Goal 6: Goal 6 of the President's report recommends the use of technology to access mental health care and information. This proposal supports this goal in several ways. First, the model is based on current knowledge of the most effective mental health and substance use practices currently in use within the Latino community in the United States.[4] Second, the integration of a research program with the ongoing evaluation of program effectiveness insures continuous interaction between best practices research and ongoing program evaluation and modification. Third, a state of the art information system is included as a part of Chapters 8 and 9 to insure that ongoing evaluation of the program is carried out annually and linked to ongoing program planning and implementation.

Program An Integral Component Of Mental Health System

- ***Recommendation:*** The Portland Metropolitan Area Latino Community Based Culturally Specific Wellness Initiative should be recognized and adopted by county officials within each of the 6 counties within the service area as an integral component of the public and private mental health system.

- ***Recommendation*:** Adequate funding should be provided by each of the 6 counties to support the initiative within each county, along with additional funds obtained from federal, state, foundation and corporate sources.

[4] A review of the literature on this topic is included in Chapters 2, 4, and 8 of this report.

CHAPTER 2: NEED FOR A LATINO CULTURALLY SPECIFIC MENTAL HEALTH SYSTEM

Service Area

Proposed Service Area: The proposed service area for this initiative includes the 2 state Portland Metropolitan Area of Multnomah, Washington, Marion, Clackamas, and Yamhill Counties in the State of Oregon, and Clark County in the State of Washington.

Latino Population within Proposed Service Area: Figure 2.1 shows the projected 2003 Latino population estimates for each of these counties, and the total for the 2 state Portland Metropolitan Area, identified by: 1) total Latino population, Latino population 18 and over, and Latino population under 18 years of age. By far the majority of Latinos within the service area, between 72% and 86% in each of the six counties, are of Mexican origin.[5] The balance are from Central and South America and the Caribbean.

Figure 2.1:
Latino Population Within Proposed Service Area
Year 2003

	Mult. County, Or	Wash. County, Or	Marion County, Or	Clack. County, Or	Yamhill County, Or	Clark County, WA	Portland Metropolitan Target Area, OR–WA
Latino Population 18 & Over	36,183	35,113	32,007	10,485	5,908	10,673	130,369
Latino Population Under 18	21,038	21,422	22,399	6,661	3,805	7,742	83,067
Total Latino Population	57,221	56,535	54,406	17,146	9,713	18,415	213,436

Source: Claritas Demographic Date 2003.[6]

Who are the Latinos within the Proposed Service Area: In Oregon the Portland and Salem urban areas and their immediate rural agricultural hinterlands are experiencing several kinds of Latino in-migration.[7] Destinations for these migrant streams include both the urbanized area from Vancouver, Washington south to Salem, Oregon, as well as the agricultural areas contiguous and near to these urban areas:

- Farm worker network-based immigration, mostly born in rural Mexico with lower levels of human capital development such as education, specialized job skills and acculturation. Migrants from south Texas, Guatemala and other Central American countries.
- A growing population of Latinos that are more proficient in their native language than in Spanish, mostly from Guatemala and the southern Mexican states of Oxaja, Guerrero Michoacán and Yucatán. Migrants from Guatemala and Yucatán tend to speak various Mayan dialects, while those from Oxaja, Guerrero and Michoacán speak various dialects of Mixtec.
- Women migrants, often with their children, who have made their way north without the company of brothers, fathers or mates. Many of these migrants are from Mexico, and others come as widows of civil conflicts in Cuba, Guatemala, El Salvador, Nicaragua, Colombia and Chile, or as victims of family violence or crushing poverty.
- More acculturated streams of Latinos from all over Latin America and the Southwest, particularly California, focusing more on the Portland and Salem urban areas.

With the exception of the more acculturated streams of Latinos coming to the Portland and Salem metropolitan areas, most of these migrants come with lower levels of human capital, with few English skills, lower levels of academic achievement, lower levels of acculturation, and lower skills and employment experience. This transfer of poverty from rural agricultural areas in Mexico and Central America creates challenges for the successful integration of these diverse peoples into the fabric of life in the Pacific Northwest.

Prevalence Of Mental Health And Substance Use Among Service Area Latinos

Overview of Mental Health & Substance Abuse Prevalence Studies Among U.S. Latinos: Prevalence data for mental health and substance use among Latino populations is limited, as only a few Latino population studies have been carried out within the United States. A summary of the rates of psychiatric disorders across the four major studies of adult Latino mental health is included in Figure 2.2 below:[8]

Figure 2.2
Rates of Psychiatric Disorders Across Major Studies of Latino Mental Health

DIAGNOSIS	LA-ECA Mex. Am. Sample 1,243	ISLAND STUDY Puerto Rican Sample 513	MARIEL STUDY Cubans Sample 452	MAPPS Mex. Am. Sample 3,012
Major Depression	3.0%	3.0%	8.3%	9%
Panic Disorder	1.0%	1.1%	4.3%	1.7%
Phobia	7.3%	6.3%	15.6%	7.4%
Alcohol Disorders	5.3%	2.7%	6.0%	3.3%

Prevalence Studies of Latino Adults: No reliable prevalence data exists for either the adult or children Latino population within the proposed 6 county service area. However, the 1996 random interview sample of 3,012 Latino adults in Fresno County, California, referred to above as the MAPPS study, was carried out using the Composite International Diagnostic Interview Protocol developed jointly by the World Health Organization and

[5] U.S. Census Bureau, American Factfinder, QT-P9, Hispanic or Latino by Type: 2000, Census 2000, Summary File one (SF-1) 100% Data.
[6] Claritas Demographic Update has incorporated Census 2000 data as they were released through 2001 and 2002, and the 2003 Update is based entirely on 2000 census data, geography and definitions. The 2003 Update incorporates data from Summary File 3 (SF3)—results from the Census 2000 long form. Claritas (www.claritas.com) is located at 5375 Mira Sorrento Place, Suite 400, San Diego, CA 02121.
[7] McGlade, Michael, S., "Mexican Farm Labor Networks and Population Increase in the Pacific Northwest," Yearbook of the Association of Pacific Coast Geographers, University of Hawai'I Press, Volume 64, 2002; Michael McGlade and Marie Dahlstrom, Salir Adelante: A Needs and Assets Assessment of the Hispanic Community of Multnomah County, pp 6-11.
[8] Guarnaccia, Peter Ph.D. and Igda Martinez, B.A., Comprehensive In-Depth Literature Review and Analysis of Hispanic Mental Health Issues, New Jersey Mental Health Institute, Inc., 2002, pp.14-18.

the former U.S. Alcohol, Drug Abuse and Mental Health Administration. This study estimated the prevalence of mood, anxiety and/or drug and alcohol use problems among Latino adults 18 years and over.[9]

These estimates are summarized in Figure 2.3 below, and are used in the next sections to estimate the prevalence of these types of disorders among the adult Latino population within the study area.

Figure 2.3
Prevalence Factors for Mental Health & Substance Use Disorders among Adult Latinos in Fresno County, California 1996 data

Total Population: 764,810 Total Latino Pop.: 292,157 Total Sample N = 3,012	# of Cases in Sub-Sample	% of Sample
Diagnoses		
Mood disorders only	109	3.6%
Anxiety disorders only	186	6.2%
Mood & anxiety disorders	70	2.3%
Substance use only	79	2.6%
Dual diagnosis	63	2.1%
All types of diagnoses	508	16.9%

Prevalence Studies Among Latino Adolescents: Mental disorder prevalence factors for U.S. Latino adolescents 12 to 17 years of age have been provided by Dr. William Vega from an unpublished manuscript pending publication in the American Journal of Public Health.[10] Data were drawn from the SAMSHA National Household Survey on Drug Abuse (NHSDA) sample of adolescents 12 to 17 years of age to estimate prevalence and co-morbidity rates using the DISC predictive scales. Multivariate logistic regressions were used to derive significant correlates of each disorder and severe co-morbidity. The NHSDA was drawn using a multi-stage stratification procedure form the civilian, non-institutionalized U.S. population 12 to 17. A sample of 19,430 was drawn from the original total adolescent sample of 25,717, and 14% of this sample, or 2,708, were Latino.

The authors clearly acknowledge that these estimates are not equivalent to diagnostic case ascertainment, but that they can be used as general indicators of mental health problems within this population which has not been well documented to date. They state:

> "We do not make the assumption that these prevalence rates are equivalent to diagnostic case ascertainment, as the sensitivity and specificity rates of DPS items suggest that it is likely that positive screens for disorders may be overestimated by 10% to 15%. **However, these data are important indicators of mental health problems among age, gender and racial/ethnic differences that have not been well documented** (bold mine)[11]

Figure 2.4 summarizes these data, which are used in the next sections to estimate the prevalence of these types of disorders among the adult Latino population within the study area.

Figure 2.4
Twelve Month Prevalence of Approximate Psychiatric Disorders by DISC Predictive Scale Among U.S. Latino Adolescents 12 to 17 Years of Age

TYPE OF DISORDER	12-17 YEARS OLD
Anxiety disorder	42.9%
Affective disorder	13.1%
Substance use	9.1%
Disruptive behavior	34.7%
Other disorder	6.6%
ANY DISORDER	
• Low	43.8%
• High	58.8%

Prevalence Studies Among Latino Children Under 12: Studies identifying prevalence factors for Latino children under 12 are not available, so estimates of problems within this important segment of the Latino population have not been included in this report.

Conclusion: *No prevalence studies among Latino children under 12 were found, so estimates of problems within this population group have not been included in this report.*

Service Area Prevalence Estimates for Mental Health and Substance Use Among Adult Latinos Ages 18+: The prevalence estimates from Figure 2.4 have been applied to Latino population counts for each of the 6 counties within the proposed service area from the 2003 Census estimates to give a general idea of the magnitude of mood, anxiety and substance use problems within adult Latinos in the proposed 6 county service area. These estimates are provided in Figure 2.5. Although there may be differences between the Fresno County and study area Latino populations, this analysis suggests there are as many as 21,902 or more Latinos 18 years or older within the 6 county service area who are experiencing mental health and/or substance use problems at the current time.

Conclusion: *There are as many as 21,902 Latinos 18 years or older within the 6 county service area who are experiencing mental health and/or substance use problems at the current time.*

[9] William A Vega, Ph.D., Bohdan Kolody, Ph.D., Sergio Aguilar-Gaxiola, M.D., Ph.D., and Ralph Catalano, Ph.D., "Gaps in Service Utilization by Mexican Americans with Mental Health Problems," American Journal of Psychiatry, Table 1, 156:6, June 1999, page 930.

[10] Vega, William, Ph.D., Kevin Chen, Ph.D., and Ley A. Killeya-Jones, Ph.D., "Estimates of Twelve Month Prevalence of Approximate Mental Disorders by DISC Predictive Scales among U.S. Adolescents: Demographic Comparisons," unpublished manuscript in preparation for American Journal of Public Health, January 27, 2004.

[11] Vega, William Ph.D., et. al., op. cite, page 6.

Figure 2.5
Estimate of Need for Treatment Services for Mental Health & Substance Use Disorders Among Adult Latinos Ages 18 and Over in Proposed Portland Metropolitan Service Area

COUNTIES IN SERVICE AREA	MULT. COUNTY, OR	WASH. COUNTY, OR	MARION COUNTY, OR	CLACK. COUNTY, OR	YAMHILL COUNTY, OR	CLARK COUNTY, WA	TOTAL SERVICE AREA
Total 2003 Latino Pop. 18 & Over	36,183	35,113	32,007	10,485	5,908	10,673	130,369
Diagnoses							
Mood disorders only	1,303	1,264	1,152	377	213	384	4,693
Anxiety disorders only	2,243	2,177	1,984	650	366	662	8,083
Mood & anxiety disorders	832	808	736	241	136	245	2,998
Substance use only	941	913	832	273	154	277	3,390
Dual diagnosis	760	737	672	220	124	224	2,738
All Types of Diagnoses	6,079	5,899	5,377	1,761	993	1,793	21,902

Source: Latino Network: 2003 County Latino Census population estimates of adults 18 and over x Figure 2.2 prevalence data from Fresno County, California.

Service Area Prevalence Estimates of Mental Health and Substance Use Among Adolescent Latinos Ages 12-17: The prevalence estimates from Figure 2.4 have been applied to 2003 Latino population estimates for adolescents 12 to 17 for each of the 6 counties within the proposed service area to give a general idea of the magnitude anxiety and affective disorders, substance use and disruptive behaviors within adolescent Latinos in the proposed 6 county service area. These estimates are provided in Figure 2.6. Although there may be differences between the US 12 month adolescence prevalence of approximate mental disorders and study area Latino adolescent populations, this analysis suggests there are as many as 12,663 or more Latinos between the ages of 12 and 17 within the 6 county service area who are experiencing mental health and/or substance use problems.

Conclusion: *There are as many as 12,663 Latinos between the ages of 12 and 17 within the 6 county service area who are experiencing mental health and/or substance use problems.*

Figure 2.6
Estimate of Need for Treatment Services for Mental Health & Substance Use Disorders Among Latino Children and Adolescents 12-17 Years Old in Portland Metropolitan Service Area

LATINO POPULATION 12-17 YEARS OLD	MULT. COUNTY, OR	WASH. COUNTY, OR	MARION COUNTY, OR	CLACK. COUNTY, OR	YAMHILL COUNTY, OR	CLARK COUNTY, WA	TOTAL SERVICE AREA
2003 Projected Latino Population	1,740	6,164	4,239	5,497	1,165	2,732	21,538
Type of Disorder							
Anxiety disorders--42.9%	746	2,644	1,819	2,359	500	1,172	9,240
Affective disorders--13.1%	228	807	553	720	153	358	2,819
Substance use--9.1%	158	561	386	500	106	249	1,960
Disruptive behavior--34.7%	604	2,139	1,471	1,907	404	948	7,473
Other disorders—6.6%	115	175	280	363	77	180	1,190
ANY DISORDER							
• **Low—43.8%**	**762**	**2,700**	**1,857**	**2,353**	**499**	**1,169**	**9,340**
• **High—58.8%**	**1,023**	**3,624**	**2,493**	**3,232**	**685**	**1,606**	**12,663**

Sources: Latino Network: 2000 Population data from PCT12H, Sex by Age (Hispanic or Latino, Census 2000 Summary File 1 (SF1); Projected 2003 population data based on % growth from Claritas Demographic Data 2000 & 2003, op. cite. X disorder percentages taken from Figure 2.5.

Service Area Prevalence Estimates for Mental Health and Substance Use Among Latino Children Under Age 12: Because of the lack of studies on prevalence estimates for mental health and substance use problems among this Latino age group, it was impossible to estimate prevalence of these types of problems among children under 12 within the proposed 6 county service area.

Disparities In Mental Health Service Utilization By Latinos

Overview of Disparities in Mental Health Service Utilization by Latinos: A variety of studies have pointed out that Latinos, particularly Mexican Americans, have very low rates of use of mental health services within the United States.[12] Some of these studies, cited by

[12] Guarnaccia, Peter Ph.D., and Igda Martinez, Comprehensive in-Depth Literature Review and Analhysis of Hispanic Mental Health Issues, New Jersey Mental Health Institute, Inc., 2002, page 18.

Guarnaccia and Martinez (2002), are listed in the bibliography, and include Briones, et al., 1990; Hough et al., 1987; Wells et al., 1987; Pescosolido et al., 1998; Vega et al., 1999; Peifer et al., 2000; Vega and Alegria, 2001; Vega et al., 2001; U.S. Department of Health and Human Services [USDHHS], 2001. These studies have also shown that immigrants are even less likely to use mental health services than U.S. born Latinos. And when Latinos do seek help, they are more likely to contact the general medical sector and not specialized mental health or alcohol and drug service providers.

These findings are echoed in our national health policy. The 2001 mental health report of the Surgeon General states:[13]

> "The U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system (Neighbors et al., 1992; Takeuchi & Uehara, 1996; Center for Mental Health Services [CMHS], 1998). A constellation of barriers deters ethnic and racial minority group members from seeking treatment, and if individual members of groups succeed in accessing services, their treatment may be inappropriate to meet their needs....Research documents that many members of minority groups fear, or feel ill at ease with, the mental health system (Lin et al., 1982; Sussman et al., 1987; Scheffler & Miller, 1991). These groups experience it as the product of white, European culture, shaped by research primarily on white, European populations. They may find only clinicians who represent a white middle-class orientation, with its cultural values and beliefs, as well as its biases, misconceptions, and stereotypes of other cultures."

The Surgeon General's supplemental report on culture, race and ethnicity also summarizes these striking disparities in mental health services for racial and ethnic minority populations, stating that these populations: [14]

- Are less likely to have access to available mental health services,
- Are less likely to receive needed mental health care,
- Often receive poorer quality care, and
- Are significantly under-represented in mental health research.

Multnomah County Disparity Data: Multnomah County has documented the underutilization by Latinos of county mental health services within the county service system. Figure 2.7 provides data comparing Latino and Caucasian proportions of adult and children enrolled in the Oregon Health Plan and receiving county mental health services in comparison with the proportions of these populations in the 2000 census. These data show clearly that Latinos receive county mental health services far less frequently than their Caucasian counterparts. While Latino adults are 6.2% of the population, only 2.1% utilize county mental health services. Caucasians are 78.6% of the population and 76.4% utilize these services. Similarly, Latino children are 11.9% of the population, while only 4.2% utilize these services. In contrast 65% of Caucasian children make up the population while 66.8% utilize county mental health services.[15]

Figure 2.7
Latino Underutilization of Mental Health Services in Multnomah County

	LATINO	CAUCASIAN
Adults 18 and Over		
• % of 2000 Census	6.2%	78.6%
• % OHP Enrolled	4.6%	71.4%
• % Receiving Co. Services	2.1%	76.4%
Children Under 18		
• % of 2000 Census	11.9%	65%
• % OHP Enrolled	18.1%	53.9%
• % Receiving Co. Services	4.2%	66.8%

Barriers To Service Utilization By Latinos

What are the barriers which prevent Latinos from using mental health services in the United States? Guarnaccia and Martinez have identified a range of barriers which Latinos experience in seeking mental health care.[16] These barriers fall into several categories: provider barriers, barriers in the service system, community-level barriers, barriers in the social networks of people in the community, and person-centered barriers. Some of these barriers include:

- Service system barriers
  - Lack of health insurance[17]
  - Language barriers
  - Discrimination from the system
  - Lack of information about services (especially in Spanish)
- Community level barriers
  - Stigma of mental illness
  - Density of family and other support networks
- Person centered barriers
  - Lack of recognition of mental health problems
  - Stigma of mental illness
  - Self-reliant attitudes

[13] Mental Health: A Report of the Surgeon General, http://www.surgeongeneral.gov/library/mentalhealth/toc.html, 2001.

[14] Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-2.html

[15] Carlson, Jim, Racial and Ethnic Heritage of Persons Served: July 1, 2000 to June 30, 2001, Division of Mental Health and Addiction Services, Multnomah County Department of Human Services, June 2, 2002.

[16] Guarnaccia, Peter Ph.D., and Igda Martinez, op cite, page 19.

[17] E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, Rebecca Levan, Racial and Ethnic Disparities in Access to Health Insurance and Health Care, UCLA Center for Health Policy Research, April 2000.

CHAPTER 3: DEVELOPMENT OF LATINO COMMUNITY BASED WELLNESS INITIATIVE (MIOS)

Overview of The Initial Start-up Program

Multnomah County's commitment to Latino culturally specific mental health services goes back to the late 1900's. At that time, the County implemented two culturally specific programs: 1) the Hispanic Initiative funded by Multnomah County and operated by private non-profit organizations, and Bienestar de la Familia, a county program staffed by county employees. The Hispanic Initiative provided Latino culturally specific mental health services to Latino families within Multnomah County through Cascadia Behavioral Health Services, which in turn contracted or placed Latino mental health therapists in two Latino private non-profit agencies, Oregon Council for Hispanic Advancement (OCHA) and Programa Hispano of Catholic Charities. Bienestar de la Familia was focused in the Cully neighborhood and provided comprehensive and integrated mental health consultation, alcohol and drug evaluation, development disabilities services and a family resource center including family intervention and case management, youth education and recreation services, domestic violence advocacy and referrals, and community advocacy and coordination which linked Latinos with resources and adult programming.[18]

The MIOS project began in the year 2000, when OCHA and El Programa Hispano were each provided one bilingual-bicultural mental health therapist by Cascadia Behavioral Health Care and located in the service delivery offices of each of the two agencies. Cascadia was the employer for these services, with the program being funded through Multnomah County.

The Latino Network coordinated the initial fund development, proposal writing and contract development for the MIOS program from its inception in the spring of 2002 through initial contract execution with Cascadia Behavioral Health Care in February 2003. The Latino Network continued to manage the planning, program development and business plan preparation for expansion of this program to include the 6 county Portland Metropolitan Area from February 2003 through February 2004, under a direct contract with Multnomah County, with Cascadia acting as fiscal agent for the Network during this time. The Latino Network wrote the business plan under the guidance of the MIOS Management Team. The SMG Foundation first became active in the MIOS Management Team in September of 2004, and coordinated the culturally specific community based wellness model prepared by Lucrecia Suarez, LCSW, during the fall of 2003. SMG was then employed as a consultant to provide research and fund development services as well as coordination in finalizing the business plan in February 2004.

Cascadia Behavioral Health Care has been responsible for managing the administrative and clinical components of the MIOS program from the initiation of clinical services in January 2003 to the present. These functions have included overall fiscal management and administration of the clinical program, including management of all clinical subcontracts with Programa Hispano, OCHA and DIF as well as liability insurance, clinical supervision and quality control of all clinical services.

Overall program guidance has been carried out by the MIOS Management Team, which is made up of representatives of all the participating organizations with the exception of Multnomah County. These include:

- Oregon Council on Hispanic Advancement (OCHA)
- Desarrollo Integral de la Familia (DIF)
- El Programa Hispano
- SMG Foundation
- Latino Network
- Cascadia Behavioral Health Care, Inc.

Figure 3.1 provides overview of the organization structure which has been in place during the first year and a half of program operation.

MIOS First Year Outcome Measures

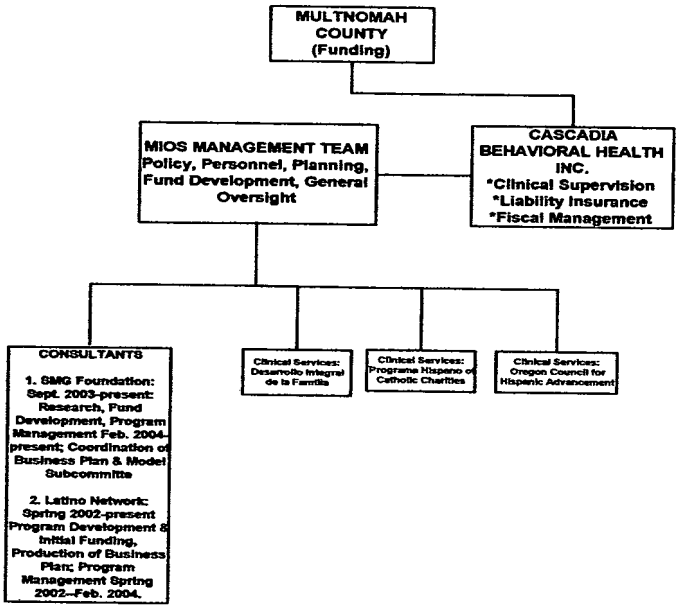
Figure 3.2 provides a summary of the major outcome measures collected for the first full year of operation of the "MIOS" Program.

Partners In The MIOS Program

A brief description of the organizations who are partners in the MIOS Program is included below. It should be emphasized that the Latino partner organizations all have extensive successful penetration into the Latino community and have effectively employed promotores/as, or community health workers, for some time. These partner organizations include:

- Desarrollo Integral de la Familia (social services)
- Catholic Charity's Program Hispano (social services)
- Oregon Council for Hispanic Advancement (social services)
- SMG Foundation (research and evaluation, prevention)

Figure 3.1
MIOS Organization Structure During Initial Period of Program Operation



[18] Department of Community and Family Services brochure Bienestar de la Familia, Multnomah County, undated.

Figure 3.2
MIOS Annual Report
February 10, 2003 to February 13, 2004

Direct clinical hours	• MIOS provided **1672** of direct clinical services to Spanish speaking clients in Multnomah County. o **356 hours of** Assessments o **702 hours of** Individual Therapy o **327** hours of Couple's and Family Therapy o **180** hours of Case Management and joint case planning o **42** hours of Psycho-educational group activity o **65 hours of** MD psychiatric evaluations and medication check
Unduplicated clients/families	• **157** unduplicated clients/familes were served. o **35** of these were served at El Programa Hispano o **58** were served at DIF o **64** were served through OCHA
Age & gender	• Age and gender distribution: o **56** males, **101** females o **36** were **18** years of age or younger
Services not reflected in data above	• Additional service activities not reflected in above data include: o Estimated **70 to 100** hours responding to AMIGO LINE or the agencies calls to screen requests for counseling, informal problem solving, information and referrals and setting appointments. o Clinicians providing consultation on a drop in basis for staff of agency they are based at. o Clinicians providing pre-treatment engagement type activities through brief informal presentations to classrooms or groups.
Miscellaneous	• Services were provided in the office or home depending on the clients needs and to some extent the agency philosophy the staff person was based at. Staff recorded **130** hours of driving time for home visits. (this is probably under-estimated, home visits are effective and time consuming). • Referral sources include: hospitals seeking discharge, schools, crisis system, shelters, other provider organizations, DHS, self and family referrals. • The most common diagnosis in adults are depression, adjustment disorders and anxiety, other diagnosis include, PTSD, schizophrenia, and bipolar disorder. • Common diagnosis for children and teens included adjustment disorder, PTSD, and some ADHD, and disruptive behaviors. • **6** clients presented with OHP VERITY insurance, **5** were enrolled in VERITY PLUS (indicating high acuity), and **1** had Medicare. • 119 referrals not served due to capacity.

- Latino Network (strategic planning, partnership coordination, program development and funding
- Cascadia Behavioral Health Care Inc. (fiscal agent or funding contracts, administrative management, clinical supervision, professional and general liability insurance)

Oregon Council for Hispanic Advancement (OCHA): The Oregon Council for Hispanic Advancement (OCHA) is a private, non-profit organization that was founded in 1983. OCHA's mission is to provide culturally specific services to Latino children and young adults in order for them to reach their potential in education and employment. OCHA provides services to over 1,000 Latino students and their families on a monthly basis with over 90% of OCHA's clients coming from low-income and poverty level households. OCHA is an affiliate of the National Council de la Raza.

The importance of OCHA and our role in education and workforce development systems are emphasized by Oregon's dramatically increasing Latino population and the unacceptable high school dropout rate amongst Latino teenagers. It is critical that Latino students are well educated and prepared to enter the workforce as they represent the largest group of future workers for the US.

OCHA has three successful core programs serving Latino youth and their families. OCHA believes strongly that in order to help Latino youth succeed; we must involve their parents to help them be strong advocates for their children and work with the student's family to help assure a stable home life. OCHA's programs are designed to empower Latino students to succeed by emphasizing personal responsibility. These programs include the Oregon Leadership Institute (OLI), Student Retention and LISTOS Alternative Learning Center:

OLI is a successful statewide leadership development and mentoring program for Latino young adults (ages 15-19). It was created to combat the high dropout rate among Latino high school kids by training Latino college students to mentor Latino high school students. Sixteen hundred students have graduated since the program's creation in 1986 with many OLI high school mentees continuing on to college and becoming themselves mentors to high school students. The theme of "giving back to the community" is a cornerstone of the OLI program. In the 2002-2004 school year, the OLI program had 100 OLI college student mentors and 250 high school student mentees. The program achieved a 96% student retention rate. Students who left the program did so because they moved or had to find full-time jobs.

The Student Retention program provides academic support services to Latino students from elementary through high school. Academic Support Specialists are based in schools that have a high Latino student population. The goal of the Student Retention program is to assure that all students enrolled in the program stay in school as well as successfully graduate from high school. There are two programs within the Student Retention program: Proyecto Conexion and Proyecto Adelante. Proyecto Conexion provides youth employment training and career development emphasis. Proyecto Adelante is geared towards providing academic support services to help students in improving their attendance and academic performance.

These services help decrease the high Latino dropout rate through homework clubs, tutoring, mentoring, parental involvement programs, student support groups, arts & culture activities, career development, college admission support activities and work readiness trainings. The program averages an overall 95% student retention rate.

LISTOS is a registered alternative school and is the only bilingual, bicultural alternative school serving Latino teenagers and young adults in Multnomah County. The Center places an emphasis on academic rigor and helping Latino youth strengthen their ability to make positive choices in their personal and professional lives. The Center is a candidate for accreditation with the Northwest Association of Schools, Colleges, and Universities. LISTOS currently has the highest student attendance and retention rate in its seven-year history. The math scores of LISTOS students showed a 250% increase in the 2002-2003 school year with 25% of LISTOS graduates entering college after their graduation.

OCHA also offers services through collaborative efforts with other Latino community based organizations; e.g., Portland Ninos with SMG Foundation and the MIOS project. OCHA offers clinical counseling services to at risk Latino youth with a general focus on short term counseling with some major themes centering on but not limited to stress and depression due to family violence, child abuse, marriage issues, parent-child relationships, homelessness and/or other issues. One on-site provider offers mental health screening and triage, assessment, and evaluation, to approximately eighty five (85) clients a year. Thirty nine percent (39%) of these clients receive treatment services. This organization is a member of the Latino Network and is active in the Network's Health and Mental Health Committee.

Desarrollo Integral de la Familia (DIF): Jugando Aprendemos/Learning Through Play - PCDS Programa: These are interactive parenting classes for parents of children 0-5 years of age. Parents learn stages of development, communication skills for toddlers, and preparation for kindergartener. The curriculum used for this program is also Parents As Teachers (PAT),. The main focus of this class is to teach parents to interact with their children by participating in scheduled activities like games, storytelling, and play-acting. Parents also learn positive communication skills and discipline. These classes focus on the child, but also provide important parent support. By participating in this class, parents benefit not just by building their parenting skills, but also by building their social skills, which in turn they model to their children. This class is offered in multiple locations, including elementary schools.

Listos Para Aprender/Ready to Learn: This is a home visiting parent program for families with children 0-3 years of age. Parents receive weekly or bi-weekly home visits and Parent Educations classes from a Family Support Worker/promotora using a research-based nationally recognized curriculum "Parents As Teachers (PAT)". The main focus of this curriculum is on the full neurodevelopment of the child. Using ASQ/SE tests, Family Support Workers /Promotoras screen the development of the child and make recommendations to the parents about how to stimulate development in deficient areas. Promotoras working with these families are well accepted and respected because they are natural leaders in their communities. During the home visits the Family Support Workers/promotoras can identify issues in the home, such as domestic violence or mental health needs that require further referrals.

Criando Jovenes en Tiempos Dificiles/Parenting Classes for Adolescents: These are parenting classes for parents with children 12-17 years of age. The parent educator provides home visits and parent support for Hispanic families refer by middle and highs schools, acts as a liaison between the parents and the youth. Topics include: Communications skills, violence prevention, risk factors for dating violence, resisting peer pressure, gang prevention, drugs, alcohol, Information and referrals The goal of this class is for parents to improve their communication skills with their youth. Both parent and the youth have to participate in the class, however, they are instructed separately. The youth and the parents have the opportunity to share their frustrations and talk openly about their issues and concerns with members of their own peer group. At the end of the class, they have an opportunity to come together to discuss their mutual concerns. If the parent educator identifies immediate needs for either the parent or the youth, she will refer them to the appropriate services in the Latino community.

Los Años Increibles/The Incredible Years: This is a parenting class for parents of children 3-9 years of age. "The Incredible Years" curriculum focuses on using play and praise to manage misbehavior. Many people who seek it out have hard to manage children. Parents learn how to use a reward system to discipline their children. Parents are also coached in setting limits and following through with them, and the appropriate use of time-outs. During this 11-week program, parents are given homework assignments. They are expected to keep track of their use of playtime, of praise, and sticker charts. The parents are held accountable by the Parent Educator to actually change their parenting methods and use the techniques taught in the class.

Mental Health: DIF provides mental health services in Spanish for families and children by a masters level mental health therapist with the support of mental health paraprofessionals/promotoras. The services are culturally specific and designed according to the need-level of each member of the family. The mental health therapist provides home visits as needed if the client is unable to meet in a traditional setting. She provides therapeutic interventions, psychoeducation and skills building in different settings such as Head Start programs, clinics and schools. The promotoras act as a bridge between the family or child and the mental health therapist and other resources in the community for individuals and families who are in need of mental health services.

Talleres de Bienestar Personal/Workshop of Personal Well Being: These educational workshops are for people with friends or family members who suffer from mental health illnesses, or who suffer from mental health illness themselves. The paraprofessional promotora provides culturally specific materials in Spanish with different topics, such as: depression, anxiety, bulimia and other topics. The materials list the common symptoms, warning signs, and medications, frequently asked questions, and community resources available for Latino families. The classes provide education on how to best support their loved ones or themselves. It also

serves as a forum for discussions and a place to connect with other people affected by mental health illnesses. The paraprofessional/promotora identifies families who are in need of individual or family therapy and refers them to the appropriate mental health services in the Latino community in the tri-county area.

Talleres/Workshops for Victims of Domestic and sexual violence: These are culturally specific support groups for women who are victims of domestic violence or sexual assault. There is one hour of cooking, sewing or art projects and one hour of education and support in areas such as family violence prevention, parenting, immigration issues and community resources. It would be culturally unacceptable for women to attend support groups, but they can attend skills classes. This allows them to acquire needed support and services without feeling shame within their families. During the time when the women are receiving services, the children are in a group with a mental health promotora trained in child development and violence prevention. She does violence prevention and intervention activities. The mental health promotora identifies characteristics in the child that are consequences of witnessing violence. Based on the individual assessments, the mental health promotora works closely with a mental health therapist and the parent educators to provide wrap-around services for the family, including parenting skills building classes with a focus on violence prevention and individual therapy.

El Programa Hispano of Catholic Charities

Agency Background: Since 1982, El Programa Hispano-Catholic Charities has been providing a wide array of social services to primarily low-income, monolingual Spanish-speaking immigrants who live in the Portland metro area.

Mission Statement: El Programa Hispano's mission is threefold: to increase self-sufficiency within the Latino community, to empower individuals to achieve a better quality of life, and to promote mutual understanding and respect among cultures.

Current Programs:

Domestic Violence and Sexual Assault Program: El Programa Hispano's Latina Domestic Violence Program was created in 1994 in order to address the many problems that affect Latina women and children victims of Domestic Violence, and to provide them with culturally competent services that assist them in leaving situations of Domestic Violence, to recover from the negative effects of abuse and to start new and healthier lifestyles. The purpose of our program is to reach out to Latina women who are experiencing and living with domestic violence in order to support them, enhance their safety, assist them in overcoming barriers such as language and culture, and to empower them to break free from the cycle of violence.

The Domestic Violence and Sexual Assault Program of El Programa Hispano assists Spanish-speaking women, men and adolescents affected by domestic violence and sexual assault. It is our goal to provide support, advocacy, and opportunity for self-empowerment, enabling survivors to exercise free and informed life choices. We work to ensure that the Latino community has equal access to community resources. We provide direct service and intensive case-management to victims of domestic violence and sexual assault. These direct services include: crisis intervention, safety planning, long-term case management, housing assistance, support groups in Spanish, transportation to and from appointments, home visits, mental health therapy, access to immigration / VAWA lawyers, and general advocacy.

Mental Health services: As part of a partnership with Multnomah County, Cascadia Behavioral Care, Oregon Council of Hispanic Advancement, DIF and SMG Foundation, Catholic Charities –El Programa Hispano offers bilingual bicultural mental health services to low income Latinos.

FLOAT: As part of a partnership with Central City Concern, El Programa Hispano provides addition treatment, counseling and housing resources to Latino families who are homeless or at risk of being homeless as a result of addictions or mental heath problems.

Health Promoters Program: As a partnership with Providence Health System, Catholic Charities –El Programa Hispano offers training and coordination to Community health promoters that work in parishes to educate the community about health issues, to organize health-related events, and to advocate for services. Since its beginning in 2000, 70 people have been trained as health promoters and continue serving their communities through monthly activities.

Outreach to Elderly Latinos: Multnomah County contracts El Programa Hispano to provide outreach to elder latinos and to refer them to County's services for elders and disabled.

Skill Building: We offer classes in English as Second Language (ESL), Citizenship, Driver's Education, Spanish Literacy, Financial Education, basic computers skills, job-related trainings, workshops for job seekers and a weekly job list in Spanish.

Anti-poverty Services: We provide Information and referral to social services, translation, interpretation, a monthly legal clinic in partnership with Legal Aid and the Oregon Law Center, a monthly dental clinic in partnership with Northwest Medical Team, and other services as part of our drop-in center.

Case Management: As part of the anti-poverty services, El Programa Hispano also provides case management to clients who need housing assistance and utilities assistance.

Social Support Services for Educational Success: This program is part of Multnomah County's school age policy framework. In partnership with the Oregon Council of Hispanic Advancement, El Programa Hispano provides academic support, skill building activities, mentoring, tutoring and recreation to Latino students attending schools at Park Rose, David Douglas, Centennial, Gresham-Barlow and Reynolds school districts. We also provide parents involvement, educations and leadership development to the families of the students.

SUN Schools: This program is also part of Multnomah County's school age policy frame work. El Programa Hispano manages two SUN schools: East Gresham Elementary and Hall Elementary.

Gang Prevention and Case Management: El Programa Hispano provides gang prevention services and case management for girls affected by gangs as part of a sub-contract with the Youth Employment Institute.

School Retention: This program provides services to Latino students attending Reynolds High School. Services include: Mentoring, tutoring, skill building, leadership development and parents involvement.

Low Income Tax Clinic: Through a grant from the Internal Revenue Service, El Programa Hispano provides advocacy and taxpayer education about the tax system to low income Latino families.

SMG Foundation: The SMG Foundation provides research, leadership and services to empower Oregon's Latino community to attain and improve individual and community wellness. SMG Foundations major programs include:

- Portland Niños (Portland Children) is a health education and outreach program for families of children ages 0-6. Classes on obesity prevention, healthy nutrition, cooking and exercise are all conducted cost-free to the community.
- Las Hermanas (Sisters) is a program designed for young Latina women ages 15-21 drawn from both the Woodburn and Metropolitan Portland area. Las Hermanas are trained in HIV/AIDS, pregnancy prevention, substance abuse and similar related health topics. Through the program, they use their leadership skills to host a weekly radio program, Tonalli on 90.7 FM.
- Mujer Sana, Promotoras (Healthy Women) is a program designed for Latina women who work as community educators or promotoras providing education and outreach to Latina women and their families. The promotoras of Mujer Sana provide health information while providing the opportunity for women to come together, establish relationships and enhance their knowledge about prenatal care, diabetes, cancer and other health issues. Women supporting women is the purpose of Mujer Sana. In partnership with El Hispanic News, the SMG Foundation also provides health education through its weekly health page.
- SMG Research Institute is a partnership with Oregon Health Science University (OHSU) Center for Health Disparities Research to increase Latino health research. Medical knowledge specific to Latinos will help prevent and treat diseases such as cancer, diabetes, heart disease and HIV/AIDS. Community based research in partnership with academia ensures that important knowledge gained by research leads to increased community resources and health literacy to reduce health disparities.
- Salud Familiar: Latino Health Conference is an annual event with the purpose of increasing Latino community members access to health information/resources and to enhance health providers' skills in providing culturally competent clinical care to Latinos. Training and development seminars provide continuing education for health providers and community health workers throughout the year.

Latino Network: Latino Network is private non-profit 501-c-3 organization whose mission is to advocate for the Latino community; to educate, inform and influences public policy, and to serve as a force for social change. The network accomplishes this mission through a number of program initiatives within the following areas:

- Capacity building within the Latino community, including multiple initiatives to develop both individual leadership and strengthen Latino community based organizations
- Latino community fund development, raising approximately $1,430,500 for Latino organizations within Multnomah County from 1999 to 2003,[19]
- Partnership and coalition building for systems development, including the Latino Culturally Specific Wellness Initiative and Somos El Futuro, a social service network that mobilizes and develops community resources to serve Latino youth on parole or probation
- Systems change advocacy in partnership with other culturally specific communities

Cascadia Behavioral Health Care Inc.:[20]
Community-based Cascadia Behavioral Healthcare provides high-quality, innovative services to strengthen the health of individuals, families, and their communities. Cascadia serves about 80% of adult Oregon Health Plan clients seeking mental health or addiction treatment in Multnomah County, seeing about 6,000 consumers per month. Clients are at or near the federal poverty level. We served more than 18,000 consumers in Multnomah County last year, plus more than 3,000 in Washington and Marion counties. Seventy-five percent of those served were white, non-Hispanic. Eight percent were African-American, 7 percent Hispanic, 2 percent Native American, 2 percent Asian/Pacific Islander, with the remainder "unknown" or "other." The most common concerns were schizophrenia, bipolar disorder, alcohol abuse/dependence, depression, and trauma history.

With total revenues of $38 million, Cascadia has a staff of more than 850. This includes 5 percent licensed medical providers (psychiatrists and psychiatric nurse practitioners), 2 percent nursing staff, 20 percent Bachelors level staff, and more than 25 percent Masters level clinicians. We have long been known for our multi-

[19] This total does not include approximately $900,000 in Multnomah County School Age Policy Framework granted to Latino service delivery agencies, which resulting in part from the Network's technical assistance, facilitation, coalition building and position paper preparation on behalf of these service agencies and the Latino community. This $900,000 is the Latino culturally specific services portion of the $3.4 million allocated to all culturally specific services by Multnomah County for the School Aged Policy Framework as a result of advocacy by the Coalition of Culturally Specific Communities in this effort.

[20] http://www.cascadiabhc.org/php/index.php.

disciplinary teams. Nearly one third of the Masters level clinicians are either licensed clinical social workers or licensed professional counselors. Four percent are Certified Addictions Counselors—as part of integrated treatment services, many are dually credentialed mental health professionals. We have cultural specialists serving the African-American, Hispanic, Asian, Native American, and Russian/Eastern European communities. Cascadia has more than 60 sites, with 50 of them housing, one for administration, and the rest clinics. The residential sites provide more than 600 units of housing for low income, mentally ill and/or chemically dependent consumers. The sites range from those having 24-hour staff to units where people live independently with minimal linkage to services. We have 12 respite beds for those who might otherwise need hospitalization. We also have a 10-bed, 90-day residential program for consumers in the criminal justice system who have mental health and alcohol and drug problems.

A community-owned non-profit governed by a board of directors, Cascadia was formed in January 2002 by the merger of Mt. Hood Community Mental Health and Network Behavioral HealthCare. Both non-profits had been operating in Multnomah County for more than two decades. In June, they were joined by Unity, Inc., which included Delaunay Family Services, Mental Health Services West, and programs from North/ Northeast Mental Health and Garlington Center. The companies that merged to form Unity also had decades of experience in Portland

Cascadia programs include:

- Acute care and crisis walk-in services
- Community Support Services
- Integrated Treatment interwoven with many other programs, designed to treat those who have concurrent mental health, addictions concerns and gambling
- DUII programs, providing a full range of individual and group outpatient treatment for those convicted of operating a vehicle while under the influence of alcohol and other drugs
- Bi-lingual, integrated services presence in Washington County, serving children, families, and adults
- A Marion County program drawing from a base as a primarily alcohol and drug treatment provider and including detox , dual diagnosis counselors, bilingual services, and services for youth
- Outpatient Programs for group, family, and individual therapy, using integrated principles, and case management when indicated, serving a broad age range and multiple diagnoses, including trauma history, depression, and anxiety. Includes DBT, a state of the art cognitive-behavioral psychology approach that helps those whose emotions lead them to suicidal or grossly self-destructive behaviors,
- Child and Family programs through partnership with larger Child & Family service providers (Trillium & Morrison Center), including home, clinic, and school-based services and Vanguard, which provides programs for gay, lesbian, bisexual, or trans youth, including community outreach and a drop-in center
- Older Adults built on the concepts of partnership, advocate involvement, and interagency collaboration, with an extensive outreach program to serve the home-bound or those in nursing homes
- Medical Services, including nurses, nurse practitioners, and psychiatrists working with consumers on psychiatric medication and mental/physical health issues.

Latino Community Outreach And Engagement

Service Agency Community Engagement: Figure 3.3 demonstrates that the Latino service agencies all effectively engage and are utilized by the Latino community. In addition, the Latino Network has been involved with community organizing and participation within Multnomah County for a number of years. Between November 2001 and December 31, 2002, the Latino Network was involved in 1,771 face-to-face contacts with Latino community members[21] in 184 meetings to develop the various action initiatives recommended in the Network's strategic action plan, to be published in mid-2004.

Figure 3.3
Latino Community Based Organizations:
Estimated Annual Latino Clients and Client Contacts
Various Time Periods in 2001 and 2002

COMMUNITY BASED ORGANIZATION	TOTAL # CLIENTS/YR	TOTAL # CLIENT CONTACTS/YR
Desarrollo Integral de la Familia[1]	Not Available	5,304
Catholic Charity's El Programa Hispano[3]	9,540	44,701
OCHA School Programs[3]		
Listos	**160**	**5,700**
Student	**700**	**2,800**
Retention		
TOTAL	860	8,560
TOTALS	Minimum of 10,400	58,565

Sources: Data was provided by each of the organizations listed in the table.

1. Contacts from Jan. to June 2002 x 2 to estimate annual contacts.
2. Contacts during 2001.
3. Data from academic school year 2001-2002.

Latino Network Community Engagement: The Latino Network has also been involved in extensive community involvement and focus group contacts in preparing the Salir Adelante[22] needs assessment, as well as monthly Latino Network and Latino Network public forum meetings, committee meetings, community meetings, public forums, and focus groups held during the past 2 years which are not included in these figures.

[21] This number, 1,771, includes duplications of persons; ie., the same person(s) have attended multiple meetings. The measure is the number of contacts, not persons, involved

[22] Salir Adelante, op. cite.

These activities demonstrate a broad base of successful community involvement by the Latino Network in the Latino community in the past several years. Some of these events the following:

- Salir Adelante Focus Groups in 1999 and 2000: 13 focus groups and 142 participants in North Portland and St. Johns, Cully Killingsworth, Southeast, Northeast, Gresham, Rockwood, Downtown and a Mayan speaking focus group of Kanjobal Guatemalans.
- Latino Network sponsored budget hearings for Multnomah County Commissioners and Portland Public Schools: 2000 and 2001
- Latino community and organizational participation in many Network Executive Committee, Action Committee, Membership, Coalition on Latino Education, Latino Youth Network, North Portland focus groups, and Mejia Poot Safety Committee.

CHAPTER 4: LATINO CULTURALLY SPECIFIC WELLNESS MODEL

Section I: Overview Of The Wellness Model

Purpose of the Model: The Latino culturally specific wellness model has been developed to guide the creation of a community of hope and well being for Latino extended families and children, by:

- Strengthening and building traditional Latino values, leadership, relationships and institutions within the Latino community, and
- Providing effective community-based linkages between Latino families and community institutions, and mainstream institutions, services and society.

Suarez[23] identifies the mission of the Latino wellness system of care to be "...to promote and support Latino families and individuals to achieve well being by promoting and providing culturally and linguistically specific wellness, prevention, mental health, addiction and intra-family violence support and treatment services. She goes on to point out that: "Wellness is the sense of power, strengths and connection that each individual, family or community experiences to create their preferred life. This implies that the person is capable of utilizing resources, developing linkages and getting support from the family or service system to find solutions and maintain well being." The wellness model that Suarez has proposed to guide wellness systems development in our Latino communities is about:

> "...strengthening or rebuilding natural support networks around individuals and families. It is also about preventing problems to developed and identifying problems early in their development at the same time that attending problems that arrive from a strength-based perspective."

Overview of the Model: Figure 4.1 provides an overview of the Latino Culturally Specific Wellness model presented in this report. The inner circle represents the primary unit or focus of services for the model, the Latino extended family and the children within that family. The primary mechanism to implement this model is the development of teams of Latino community health workers (CHWs), or "*promotores/as,*"[24] and other Latino staff to promote and provide culturally and linguistically specific wellness, prevention, mental health, addiction and intra-family violence support and treatment services. In this model, the primary linkage with and support mechanism for Latino families and children is carried out by the *promotores/as*, with the support of other technical staff such as counselors, therapists, and community organizers in the Latino community.

The middle and outer circles represent formal and informal Latino community institutions and values. The teams shown in the inner circle engage Latino extended families and their children to build and strengthen traditional Latino values, leadership, relationships and institutions within the Latino community; and to act as cultural "brokers" to link Latino families and community institutions to mainstream services, institutions and society. This model is presented in more detail in Figure 4.2.

Major Principles of the Model: The four major principles which form the philosophical foundation for the wellness model are shown in Figure 4.1, as the 4 phrases around the periphery of the figure:

- Relationship Centered Care
- Cultural Competency and Specificity
- Community Based
- Strength or Asset Based

Relationship Centered Care: The Pew Fetzer Task Force on Advancing Psychosocial Health Education has captured the essential Latino value of personalismo[25] as the cornerstone of the wellness model proposed in this report through their recognition of the seminal importance of the relationship between practitioner and client or patient as a critical philosophical foundation for the delivery of health services.[26]

> "The phrase "relationship centered care captures the importance of the interaction among people as the foundation of any therapeutic or healing activity. Further, relationships are critical to the care provided by nearly all practitioners...and a source of satisfaction and positive outcomes for patients and practitioners...The foundation of care given by practitioners is the relationship between the practitioner and the patient...this relationship is a medium for the exchange of all forms of information, feelings, and concerns, a factor in the success of therapeutic regimens, and an essential ingredient in the satisfaction of both patient and practitioner."

The Pew Fetzer Task Force frames health and wellness as the process by which individuals maintain their sense of coherence–the sense that life is comprehensible, manageable, and meaningful, and that they maintain the ability to function in the face of changes in themselves and their relationships with the environment. The corollary to this understanding of wellness is that the construct of illness places the patient's experience at the center of what it means to be emotionally well. They point out that this deepened perspective on health and illness will shape health care in the future. These concepts lie at the heart of a wellness system design and the culturally

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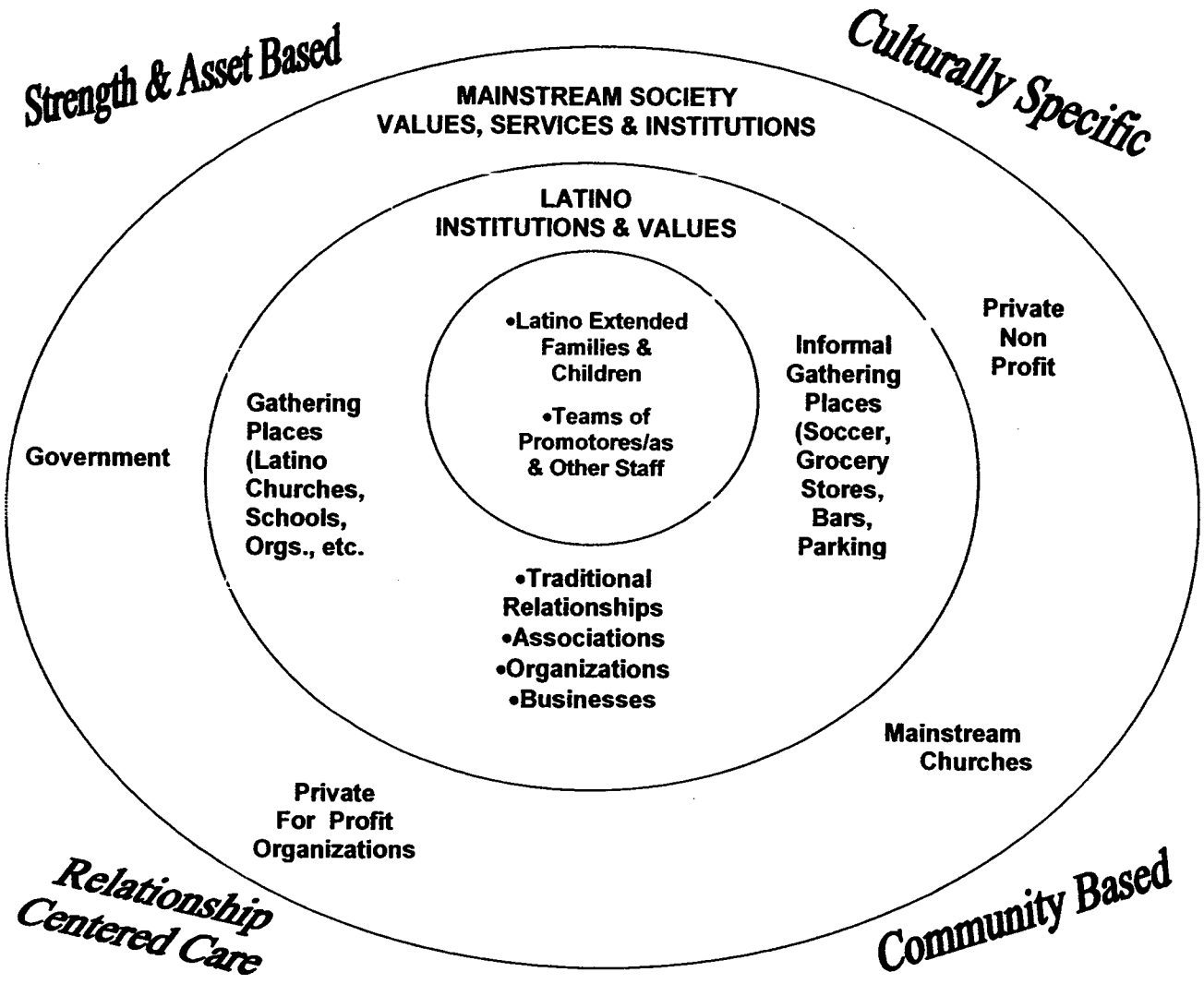
[23] Suarez, Lucrecia, A Latino Culturally Specific Wellness System of Care, MIOS Program, a partnership between the Oregon Council for Hispanic Advancement, Programa Hispano of Catholic Charities, Susannah Maria Gurule Foundation, Latino Network, Cascadia Behavioral Health Care, and Multnomah County, December 2003, pp 4, 6.

[24] In Spanish, the term *promotor* refers to the masculine, or male community health worker (CHW), while the term *promotora* refers to the feminine, or female community health worker (CHW). Because of traditional gender relationships in the Latino culture, it is critical that both male and female *promotores/as* be included on the wellness teams of culturally specific providers.

[25] See Page 20 of this chapter for a discussion of Latino values. Personalismo describes the characteristic of relationships which is oriented towards the personal, needing to make a connection with someone through genuine personal sharing.

[26] Carol P. Tresolini and the Pew-Fetzer Task Force, Health Professions Education and Relationship Centered Care, Pew-Fetzer Task Force on Advancing Psychosocial Health Education, 1994, pp 9, 11, 15.

FIGURE 4.1
OVERVIEW OF LATINO CULTURALLY SPECIFIC WELLNESS MODEL



culturally specific services which are so critical to address the needs of the Latino immigrant communities in the United States today. This is a fundamental philosophical foundation for the wellness model presented in this report.

The Task Force explicitly recognizes the connection between "relationship centered care" and our increasingly our diverse, multicultural society:

> "Many minority communities are maintaining separate identities and cultures... Differences in understandings and terms of reference across cultures create challenges for both health care practitioners and patients. Rapid and dramatic changes in communities resulting from migration, immigration, and demographic changes have made it difficult for practitioners to adjust to and learn about effective ways to care for patients from other cultures. Culture also determines our approaches to health, beginning with symptom interpretation and initial entry into the formal health care system."

Culture also has a profound impact on the effectiveness of health care interventions beyond initial entry, and continues throughout the entire process of interaction that occurs between patient and practitioner. The philosophical underpinnings of a Latino culturally specific approach to wellness are embodied in the notion of "relationship centered care."

Finally, an important corollary of "relationship centered care" is the requirement that staff be responsive to whatever problem, concern, dream or aspiration that might be brought up by a client. If wellness implies that the construct of illness places the patient's experience at the center of what it means to be emotionally well, then the system of care needs to be responsive to the client's concerns.

Cultural Competency and Specificity: The key to providing wellness services which are responsive to the Latino community involves clarity about the differences between "culturally competent" and "culturally specific" services and providers. The difference between culturally specific and culturally competent is defined by Multnomah County as:[27]

- A culturally competent service provider is any provider, including a mainstream provider, who meets the cultural needs of the diverse clients they serve. Such services may include, but are not limited to, use of bilingual and bicultural staff, provision in culturally appropriate settings, and use of bicultural "promotores/as" as intermediaries between Latino clients and licensed counseling staff.
- A culturally specific service provider has expertise in working with a particular population and is usually governed, as well as staffed, by members of the target community. The culturally specific provider works to develop appropriate service approaches for members of their community and to resolve conflicts with regulations that are a barrier to appropriate and effective services.

The wellness model proposed in this document assumes that services are provided by a Latino "culturally specific" service provider. In Chapters 5 and 6 the organization and governance structure proposed to implement this wellness model is culturally specific, not simply culturally competent. Creation of this new organization involves the development of an organizational culture and structure for a new Latino behavioral health organization which is fundamentally Latino in character.

Some key dimensions of cultural competency and specificity which have been incorporated into this model include:[28]

- Formal implemented policies and procedures
  - Staff recruitment and hiring
  - Staff training and professional development
  - Adaptation to Demographic Shifts
  - Translation, interpretation in dealing with non-bilingual and bicultural specialists
  - Signage
  - Connecting culture to quality, access and elimination of disparities thru performance
- Consumer driven system of care
- Culturally specific staff,[29] including
  - Organization's CEO,
  - Clinic Services Director,
  - All promotores/as and other intake staff who interface with clients for the first time
  - A majority of the counselors and other clinical staff
  - All staff who determine eligibility for different kinds of insurance (private insurance, Medicaid, Medicare, Oregon Health Plan, etc.,)
- Language, values and attitudes of staff and of the organization's culture, including, for example:
  - Personalismo: orientation toward the personal, needing to make a connection with someone through genuine, personal sharing.
  - Familiarismo: a duty to preserve the honor of the family since identity is closely defined by one's family as opposed to one's individual self; also the idea that the extended family is the primary source of support.
  - Respeto: dictates the appropriate deferential behavior toward others based on age, gender, and social or economic status.
  - Simpatia: the tendency to relate with others in a smooth, agreeable and conflict-free manner.
  - Tener fe: the belief that God completely directs our destiny and that we are powerless to intervene.
- Integrating community into the healing process and respecting traditional beliefs and practices in choice of treatment modality
- Honoring and practicing the personal relational and communications style characteristic of Latinos

[27] Implementing Cultural Competence: An Action Plan for Multnomah County: Summary, Multnomah County Mental Health and Addiction Services, Draft 7-31-02, page 9.

[28] Bureau of Primary Health Care, Cultural Competence: An Essential Ingredient for Quality, Access & Elimination of Disparities, http://bphc.hrsa.gov/quality/wordocs_pdfwp/culturalcompetence.ppt;Goode,T. Promoting Cultural Diversity and Cultural Competence in Primary Health Care Washington, D.C.: Georgetown University, National Center for Cultural Competence. 1997; Sue, S. "In Search of Cultural Competence in Psychotherapy and Counseling." American Psychologist, April 1998; McGlade, Michael, Voces de la Comunidad, SMG Foundation, undated, page 6. Cultural Competency Plan, Multnomah County Mental Health and Addictions Services, Preliminary Draft, 4-5-02.

[29] Persons who are not Latino but who are bilingual in Spanish and English can certainly be a part of this staff. Key positions of leadership, authority and influence in the clinic are encouraged to be Latino to create this organizational or corporate culture which is characterized as Latino. Key staff who interface with clients initially and who determine insurance eligibility, are encouraged to be Latino, bilingual and bicultural, and capable of treating all clients with the deep respect, honor, and "personalismo," consistent with the personal relational values which are characteristic of Latino culture.

- Community/consumer participation in board membership and planning
- Physical environment, materials, resources are encouraged to reflect Latino culture and are to be written in Spanish and English

- *Community Based Services*: The Latino Wellness System of Care is a community based system of care with the following characteristics:
- The Latino community has been involved in the needs assessment, design, planning, and administration of services at several levels, including:
    - Extensive grassroots Latino community focus group participation throughout Multnomah County from 1999 through 2003.[30]
    - Extensive participation by Latino service agencies and the Latino Network in system planning and design
- Services and activities are offered from locations within the Latino community, and not in the offices of mainstream service agencies: e.g., churches, schools, Latino agency service centers).
- The system is built on the existing natural support networks and existing culturally specific Latino service providers who are well known in the community, and who have demonstrated a level of community involvement from the Latino community.
- Services respond directly to the immediate needs and dreams of the individual and his/her family. Services are provided in locations which feel safe and appropriate for the individual and/or family
- Services are built on natural existing points of contact between Latino community and entry points of the system
- The cornerstone of this program model is the promotor/a, or community health worker, who is recruited from the Latino community and who relates directly to Latino families and children as a credible, culturally and linguistically specific provider whose background reflects a similar life circumstances to those receiving the services.
- All providers of services are Latinos, or are bilingual and bicultural.
- Whenever possible, individuals and families choose their providers, and the system's funds follow their choice. Nobody will be turned away due to a lack of insurance coverage or funding.
- Services are built in and for the natural geographical congregational points of our Latino communities. They are not restricted by jurisdictional boundaries.

Strength or Asset Based Approach: A strength or asset based approach to wellness, mental health, and drug and alcohol services is about self-help--supporting individuals and family to identify their talents, strengths, abilities, wisdom, believes, dreams and resources to manage problems, transitions, changes in their life and focus on solutions and assets. In this wellness model, finding skills that support and maintain the well being in the lives of Latino families and children is the goal of all interventions. The wellness model seeks the control or reduction of symptoms only as a first step into helping individuals and families reconnect to hope and to their power and strengths to recreate their life. The fundamental approach builds on the assets and strengths of the Latino family, children and community to create a supportive environment where by Latinos can, consistent with the Pew Fitzer Task Force vision previously quoted:

> "...maintain their sense of coherence--the sense that life is comprehensible, manageable, and meaningful, and that they maintain the ability to function in the face of changes in themselves and their relationships with the environment."[31].

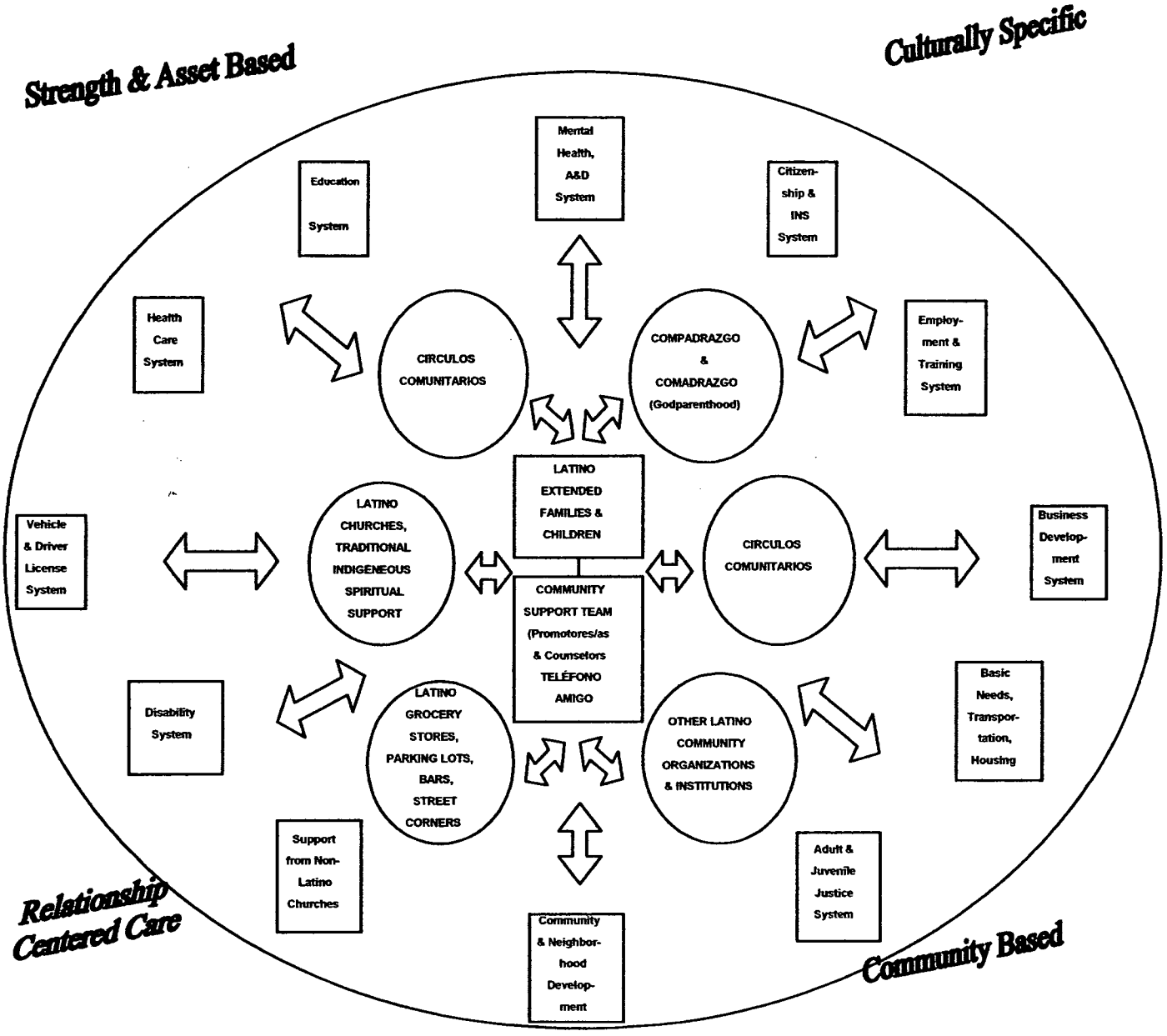
This wellness model maintains a wellness and strengths based approach from the first moment a contact is made with a individual and family and a relationship starts to build throughout the entire process of service delivery. It informs the provider's diagnostic methods and techniques, interview skills, service plan development, report writing, case management, and clinical skills. This fundamental value informs the organization's system capacity building, policy development, strategic planning, research agendas and professional identity building.

Structural Components of the Model: Figure 4.2 provides a more detailed look at the specific components of the proposed Latino Wellness system of care model presented in summary form in Figure 4.1. These include: 1) Latino extended families and children as the focal point for service; 2) culturally specific community based teams of Latino promotores/as (community mental health workers or CMHWs) and other support staff ; 3) use of circulos comunitarios, 4) using Latino formal and informal community institutions as key assets and strengths in the implementation of the wellness model, 5) multiple community-based entry points for Latino families into the system of community based teams, including but not limited to the circulos comunitarios, or "community circles," 6) linkages to the broader mainstream society and social services.

[30] Dahlstrom, Marie and Michael McGlade, Ph.D., Salir Adelante: A Needs and Assets Assessment of the Hispanic Community in Multnomah County, Latino Network, ndated, ~1999; McGlade, Michael, Ph.D., Voces de la Comunidad: A Report from the Multnomah County Latino Health Access Work Team, January 2003.

[31] Carol P. Tresolini and the Pew-Fetzer Task Force, op. cite.

Figure 4.2
LATINO CULTURALLY SPECIFIC COMMUNITY WELLNESS SERVICE DELIVERY MODEL

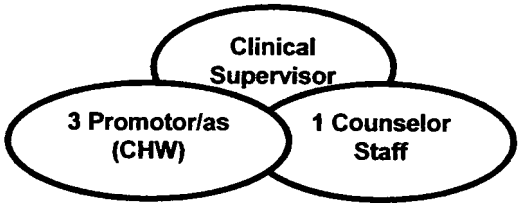


Latino Extended Families & Children are Focal Point for Services: The focus of this program is to support the needs of Latino families and children. In Latino culture, the family unit is a multi-generation extended family which includes parents and children, grandparents, aunts and uncles and their children on both the father's and mother's sides of the family. Additionally, compadrazgo and comadrazgo (god-parenthood) provides for specific obligations and rights between parents and those who are chosen to sponsor each child for baptism, confirmation, and marriage. Compadres and comadres may be related by kinship, or they may be related by friendship or position of influence in society. In some cases the extended family structure can be traced backward for several generations, and descendents from many branches of several families may be brought into a larger extended family structure, reinforced by these ritual relationships. This larger extended family may become a source of mutual support and aid, and family members from the many nuclear families may be extended invitations to become compadres and comadres. Children in this type of family are raised by their parents, but receive extended contact, nurturing, and parenting from many adults, and brothers and sisters also play a significant role in their growth and care.

Thus, the Latino extended family is the cornerstone of both emotional and economic support for family members, and especially for children, in traditional Latin American society. For this reason this family institution is the backbone of the wellness model presented in this paper, and the focal point for support, nurturing, and service delivery in this program.

Latino Culturally Specific Wellness Teams: Figure 4.3 identifies the kinds of culturally and linguistically specific staff that make up a Latino culturally specific wellness team of workers working from a community base within the Latino community. The three kinds of staff include: 1) three promotores/as, or community health workers (CHW), 2) one clinically trained counselor, therapist and/or social worker, and 3) a dual diagnosis licensed clinical supervisor with recognized licenses in both mental health and alcohol and drug treatment. The community health worker (CHW) or promotor/a is the central point of contact for client entry into the system. This team structure is the basic model of service delivery for this program.

Figure 4.3
Model of the Wellness Team



Circulos Comunitarios: One important mechanism to promote wellness, prevent family and community problems, and provide opportunities for healing are the "pláticas" (talks) and "prácticas" (practices) which occur in Latino círculos comunitarios (community circles) within the Latino community, usually organized by the promotores/as. These Círculos Comunitarios are responsive to the immediate needs of the neighborhood, and become forums where community groups can identify their needs, concerns, aspirations and dreams. They also provide a forum for developing solutions to address the concerns and aspirations identified within the Circulos Comunitarios.

Some of the kinds of personal and family goals and concerns addressed by these Circulos Comunitarios might include:

- Parent-child relationship
- Couples relationships
- Community and neighborhood improvements
- Developing local programs to address specific neighborhood and interest group concerns
- Sex education
- Language development: ESL and literacy
- Family, neighborhood and service provider conflict resolution
- Stress management and self care
- Educational system reform
- Parental involvement in supporting children's education
- Job training and development
- Holistic practices for stress and trauma
- Addiction education
- Health education
- Needs for recent immigrants entering USA
- Language gaps among parents and children

Latino Community Formal and Informal Institutions as Assets and Strengths:[32] Latinos have immigrated from a culture and society which is characterized by close personal relationships (personalismo), both within the family and within the community. Many of these communities are smaller close knit rural communities, and there has been much literature published on the way Latinos bring their community vision to create similar kinds of relationships in Latin American urban settings. These Latino community linkages are both community based lateral relationships and linkages with the larger public and private sectors which provide support in Latin American society. These relationships are important assets which support families in their country of origin and provide meaning and guidance for people as they live their lives. When Latinos immigrate to the United

[32] Kretzmann and McKnight have pointed to the importance of community institutions as assets for building communities from the inside out in Kretzmann, John and John McKnight, Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets, Institute for Policy Research, Northwestern University, 1993.

States they enter a society where these kinds of horizontal and vertical relationships do not exist for them, and in which the rules of engagement are carried out in a different language and in a different mainstream American cultural tradition which is radically different from that which Latinos are accustomed to live in.

Thus, Latino community institutions, both formal and informal, are key assets which can support Latino immigrant families and children in the United States. However, because in the United States these Latino community institutions and relationships are less formally developed and in many cases non-existent, this wellness model is designed to both create these kinds of relationships where they do not exist, and to strengthen them where they do exist. This is the fundamental rational for proposing a "community-based" system to address the wellness needs of the Latino community in the United States.

Some of the kinds of Latino institutions (assets) which exist in Latino communities in the United States which are included in this model are show on Figure 4.3 and include:

- The extended Latino family, already discussed above.
- Compadrazgo and comadrazgo, already discussed above
- Natural Latino community support networks and informal leaders who are sought out by community residents for their wisdom, compassion, guidance and support.
- Existing and new Latino interest groups, service agencies and advocacy organizations
- Latino traditional churches of different denominations; Catholic, Protestant, etc.
- Latino traditional indigenous and mestizo health and spiritual beliefs, practices and practitioners: e.g., curanderos or traditional healers and "shamans"
- Latino neighborhood stores and businesses
- Places where day laborers congregate to be picked up for odd jobs
- Latino news media: radio and newspapers
- Other formal and informal Latino community associations, organizations and institutions

Multiple Community Based Entry Points into the Wellness System: Latino families and children can access the Latino wellness system of care and its Latino community based teams through multiple community based and mainstream entry points. For example, these multiple entry points for families and children can include:

- Relationships with community health worker
- (CHW) or promotores/as, who are members of their church, neighborhood, apartment complex, Aztec dance group or school. These relationships are often linked to the natural Latino community support networks and informal leaders who are sought out by community residents for their wisdom, compassion, guidance and support.
- Presenting themselves at any of Latino Wellness
- System of Care partnership organizations (schools, churches, mental health organizations, clinic, social service provider organization, etc.) current family center service sites. These are existing and new points of penetration within the Latino community where Latinos are comfortable visiting on their own.
- Referrals from staff at any of the Latino Wellness System of Care partner organization to another partner organization: "There is a lady here wanting help to pay her rent because her husband is in jail and she has three kids and cannot work, she says she cries all the time and is feeling *desesperada* (overwhelmed, hopeless)"
- Calling El Teléfono Amigo, a central point of connection for Latino families and children:
    - El Teléfono Amigo is a phone number where Latino individual and families can find a friendly, familiar voice that can listen, help recognized what is working well and what is not, give suggestions to immediate urgent resolution, help connect with crisis system, or get a referral for a CHW and/or a counselor to visit them at their home, or get a referral for a mental health, a drug and alcohol or a psychiatric evaluation.
- It is an information and referral line, and an intake line. It is also what we want to call "una linea calida". "Calidez" refers to relationships, it describes warmth, empathy, and welcoming. "Un amigo calido" (a warm friend) is a friend that is available, emotionally present, great listener, help you find clarity, or a solution, has sense of humor and you can count on him/her. These are the characteristics of El Teléfono Amigo.
- It is equipped with well skilled generalize social work professionals that are able to discern high risks factors for mental health and addictions, and to ask strategic questions that help see a quick overview of the situation in order to discern the best intervention for the moment: Does the person/family needs:
- Calling a specific person in one of the System's partnership organization directly because someone referred them to this specific provider: "Ve a hablar con "X", ella/el me ayuda muchisimo, lo mas probable es que el/ella te pueda ayudar" (Go talk to "X" she helped me a lot and most likely she/he will be able to help you"
- Referrals from outside agencies requesting counseling or addiction support or therapeutic services for one of their clients

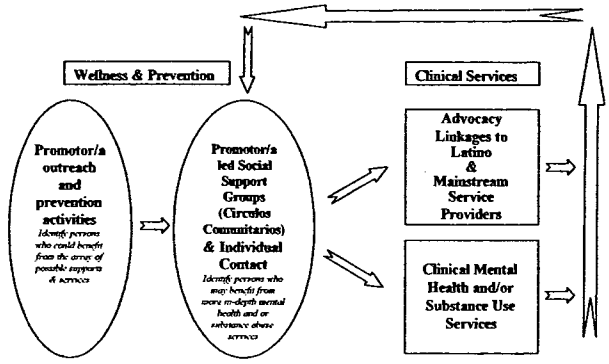
Linkages to Mainstream Service Delivery: The following types of linkages are proposed for development in this Latino culturally specific wellness model: 1) development of interagency memoranda of understanding to define joint protocols and procedures for collaboration and coordination of specific functions, particularly but not limited to service delivery, 2) seamless referral and follow-up procedures to insure that clients do not slip between the cracks at the interfaces between service providers, 3) joint coordination meetings for case management and joint program development, 4) joint training and education, and 5) joint research and evaluation. Consistent with relationship and client centered care, these linkages should be developed in response to the full range of concerns, issues, aspirations and hopes identified by the Latino community and the users of the services provided by this system.

These linkages should be developed between the following types of organizations existing within the proposed service area:

- Latino culturally specific service providers
- Latino grassroots organizations, both secular and faith based
- Mainstream mental health, alcohol and drug, and primary health care providers
- Other mainstream social service providers who offer services to Latinos in the Latino community.

Steps in Engaging the Latino Community in Wellness and Prevention: Figure 4.4 identifies the steps involved in engaging the Latino community and providing wellness services for those families who do not need specialized clinical services in mental health or substance use. The first two steps in Figure 4.4 reinforce wellness and prevention. They involve the initial engagement of community members by the promotores/as or community health workers, support to these community members regarding whatever immediate problems they may face,[33] and the creation of circulos comunitarios or community circles around different activities and concerns of interest to Latino community members. This engagement happens through home visits with individuals and families, and through referrals by schools, primary health clinics, social service agencies and other institutions having contact with Latino families in need of help. These home contacts and referrals lead to the creation of circulos comunitarios, which serve as vehicles of social support and community building, as well as a forum to provide case management to address specific individual and family concerns.

Figure 4.4
Steps in Engaging the Latino Community and Providing Wellness Services



In the final step identified in Figure 4.4, the client(s), in cooperation with the clinical team, determines the next steps in the process. Should the community member or family not need specific clinical services in mental health or substance use, the team member assists the community member or family to engage directly with whatever agency or organization is appropriate to address the specific concern or problem they face. Alternatively, should the community member or family need more specialized clinical services in mental health or substance use treatment, the team works with the client(s) to prepare them for direct engagement with a specialized counselor. The team member continues to support the client(s) during this more specialized treatment phase, and assists the client(s) in the post-treatment or after-treatment phase and reintegration of the client in the community, possibly through continued participation in a circulo comunitario.

Maintaining Family Wellness: One of the first components of the wellness model is to strengthen or rebuild natural support networks around families and children within the Latino community. As pointed out in the previous section entitled "Latino Community Formal and Informal Institutions as Assets and Strengths," Latino individuals and families have natural contacts and support with many formal or informal groups or organizations in the Latino community, including the extended family, churches, school, medical services, and co-workers in employment situations, Latino or Mexican neighborhood stores, immigration support service offices, and informal gathering places where Latino day-laborers are picked up for odd jobs.

[33] A wide variety of concerns might be addressed, including but not limited to those identified in Figure 4.2: Latino Culturally Specific Community Based Wellness Model, on page 4.7 of this chapter.

Some of the activities carried out by the staff teams to promote wellness in Latino families and children within the community circles include:

- Connecting and breaking isolation between families (i.e., use of circulos comunitarios)
- Facilitating the feeling welcome in any natural points of contact with the mainstream culture
- Facilitating the feeling engaging and being productive
- Helping families and children to nurture themselves in individual, family and group activities
- Promoting self-directed education among families and children
- Acknowledging the existing talents, wisdoms and skills of families and children
- Identifying and preventing potential problems in advance
- Finding people within the Latino community to help with problem solving
- Facilitating and creating opportunities for Latinos to celebrate who they are through reinforcement of traditional rituals, culture, food, music

Substance Use Prevention: Alcoholism and long histories of abuse have invaded many of our families in the Latino community. Many individuals live with the impact of past wars, and many have histories of disconnecting from their families due to immigration and other factors. Many members of our community have accepted the invitations to sell drugs and risk their life and family lives. Gangs *(pandillas)* have been a historical problem for many Latino families for many years. Some women continue to be sexually abused even in their marriages, and that child physical and sexual abuse continues for many families. Many Latino families have not had the opportunity of formal education, and many mainstream organizations have created arrange of barriers which make service delivery to the Latino community difficult.

In this approach to wellness, in order to address these kinds of problems, program staff establish long lasting relationship with the Latino community, and invite the community to have conversations and activities to increase the awareness of such risks through teams of promotores and service providers establishing personal relationships and the creation of circulos comunitarios (community circles) . As it is well known, personalismo and familiarismo are the main two values shared by most Latinos. In the Latino Wellness System of Care, staff honor that the relationship established with a individual and or his family is the factor that permits the process of change, and that the family is the unit of care and service. The term family includes both the extended family support system of grandparents, aunts, uncles, cousins, as well as the ritual kinship system of compadrazgo, including comadres and compadres.

The following example illustrates how the establishment of the relationship is the healing tool for prevention, and strengthening family relationships is the key to wellness:

A *Promotor,* as a member of his own church has established relationships with many Latino individuals and families who also participate in the church activities. In the many encounters he noticed that Mr. Jose, a father, is struggling with his adolescent son who he described as *desobediente (disobedient), rebelde (non-complaint)*, difficult to control to the point that he is leaving his room at night. "Me contesta pa' tras" (he talks back to me) he tells the *Promotor.* Since the relationship has been established the Promotor talks to him about what he has learned about the complexity of adolescents, and offers to help, invite him to a support group for parents, or to discuss the manner more in detail and assess the need to get professional assessment. The Promotor notices that the father has tried to talk to his son and that when he has done it he tends to be respectful, yet he gets frustrated easily at his son. He also notice that he, the father, promises to check upon him at night and he does not, and also that he may not have much information about adolescent drugs use or involvement with "pandillas" (gangs). He, then, more firmly invites him to go with him to a círculo communitario in which parents with same problem learn from each other, and explain that he will not be in trouble if he attends. The father asked the Promotor: what would you do in my situation?", and the Promotor shares some of his experience as a father about how to stop arguments with the youth, and how to increase supervision. Promotor maintains the relationship and respect the pace of the father to accept suggestions or support and his readiness to accept professional services.

As a result of these E*ncuentros* (encounters) with this father, the Promotor, in the Latino Wellness System of Care would have the opportunity to debrief the situation with his supervisor and the clinical team who gives input about next steps, how to prioritize this case with the promotor current work load, other resources available, other family members that should be invited, any community circle that this family should be connected with, and other impressions about how to proceed in assuring this father improves his effectives as a father and accomplish better emotional connection with his son and supervises him more closely

One of the main principles of the Latino Wellness is to assure that we maintain relationships that are nurturing, resourceful and that are present for the individuals and families in need. Whenever is necessary this father and his family can work together with the Promotor and a Counselor and this team will them be in charge of the care of this family throughout the whole treatment process. It may happen that later the promotor learns that this father continues to use alcohol every weekend and that in the past alcohol was a bigger problem but he has never received services, and that this youth has been involved in some minor crimes and the Juvenile Department has sent them a letter informing of the need to discuss the Juvenile process and probation plan for their youth. By this time, there is a relationship already established with the promotor and most likely this father may ask him for help to understand the letter and process his fears, specially those related to whether he can be deported to Mexico since no member of his family is legally documented. The promotor will support and

walk with the family, help answer the questions, or find the right person to help them find answers to their questions. In the Latino Wellness System of Care we want to create relationships that last and stay for years to come. So if this family in the future may have a problem with the younger daughter who may start having excessive worries about getting fat and not eating, this family will know of a PERSON, not a place they can count on in the community, this being a promotor, a counselor, a psychiatrist or all of them.

Wellness Maintenance and Prevention Among Younger Children: The approach taken by the clinical teams to support wellness maintenance and prevention among younger children is a school-based approach where the clinical teams work directly with children, parents and teachers in the schools. The best practices model chosen for this approach is "The Incredible Years: Parent, Teacher and Children Training Series," adapted in the model proposed in this document as a culturally and linguistically specific program appropriate for Latino children and families, especially monolingual parents.[34]

The purpose of the the Incredible Years Training Series series is to prevent delinquency, drug abuse, and violence. The series has two long-range goals. The first goal is to develop comprehensive treatment programs for young children with early onset conduct problems. The second goal is the development of cost-effective, community-based, universal prevention programs that all families and teachers of young children can use to promote social competence and to prevent children from developing conduct problems in the first place. The short-term goals of the series are to:

- Reduce conduct problems in children:
  - Decrease negative behaviors and noncompliance with parents at home.
  - Decrease peer aggression and disruptive behaviors in the classroom.
- Promote social, emotional, and academic competence in children:
  - Increase children's social skills.
  - Increase children's understanding of feelings.
  - Increase children's conflict management skills and decrease negative attributions.
  - Increase academic engagement, school readiness, and cooperation with teachers.

With this approach, intervention in the schools focuses on replacing coercive behavior by parents and teachers, and modeling and rewarding appropriate behavior with children 3 to 8 years of age. Training for each of these groups will include the following areas of emphasis:

- Basic parenting skills
- Child social skills and problem solving training for children
- Teacher classroom management

Section II: Mental Health And Alcohol And Drug Component Of The Wellness System

Overview: This section of the report provides an overview for the mental health and alcohol and drug component of the Latino community wellness system. In Figure 4.5 below, this component of the system includes the client family and wellness team at the center of the diagram, the Latino community institutions, values and support network which provide support to the family and it's children, and the more specialized Latino culturally and substance use services provided by both Latino and mainstream providers. These more specialized services may be provided by either Latino or mainstream organizations, but the services provided must be culturally specific and responsive to the Latino population, culture and community in a particular location.

Steps in Providing Clinical Mental Health and Substance Use Service to Latino Community Members: Figure 4.6 identifies the major phases or steps in which the clinical teams will engage the Latino community in providing Clinical Mental Health and Substance Use Services to community members. As we saw earlier in this chapter, the first and second phases, wellness and prevention, focus specifically on providing family and community support with a wellness and prevention orientation (see again Figure 4.4). The final step, clinical services, focuses on providing direct services in mental health and substance use, again for the purpose of supporting a wellness and prevention outcome. These steps, which are discussed in more detail below, can be conceptualized as follows:

- Wellness and prevention
  - Community engagement
  - Circulos comunitarios, or community circles
- Clinical services
  - Treatment readiness or pre-treatment
  - Out-patient treatment and/or referral to specialized services and/or institutional support
  - After-treatment services

[34] Consult the Multnomah County Incredible Years Project and the Washington County Enhanced First Step to Success Program in each of these counties respectively, for information on these programs; Constance M. Lehman, Ph.D., Evaluation of Incredible Years and Child Care Consultation, Regional Research Institute, Portland State University, Community Forum, Portland, OR, June 26, 2004.

Figure 4.5

Latino Culturally Specific Mental Health and Alcohol and Drug Component of Wellness Model

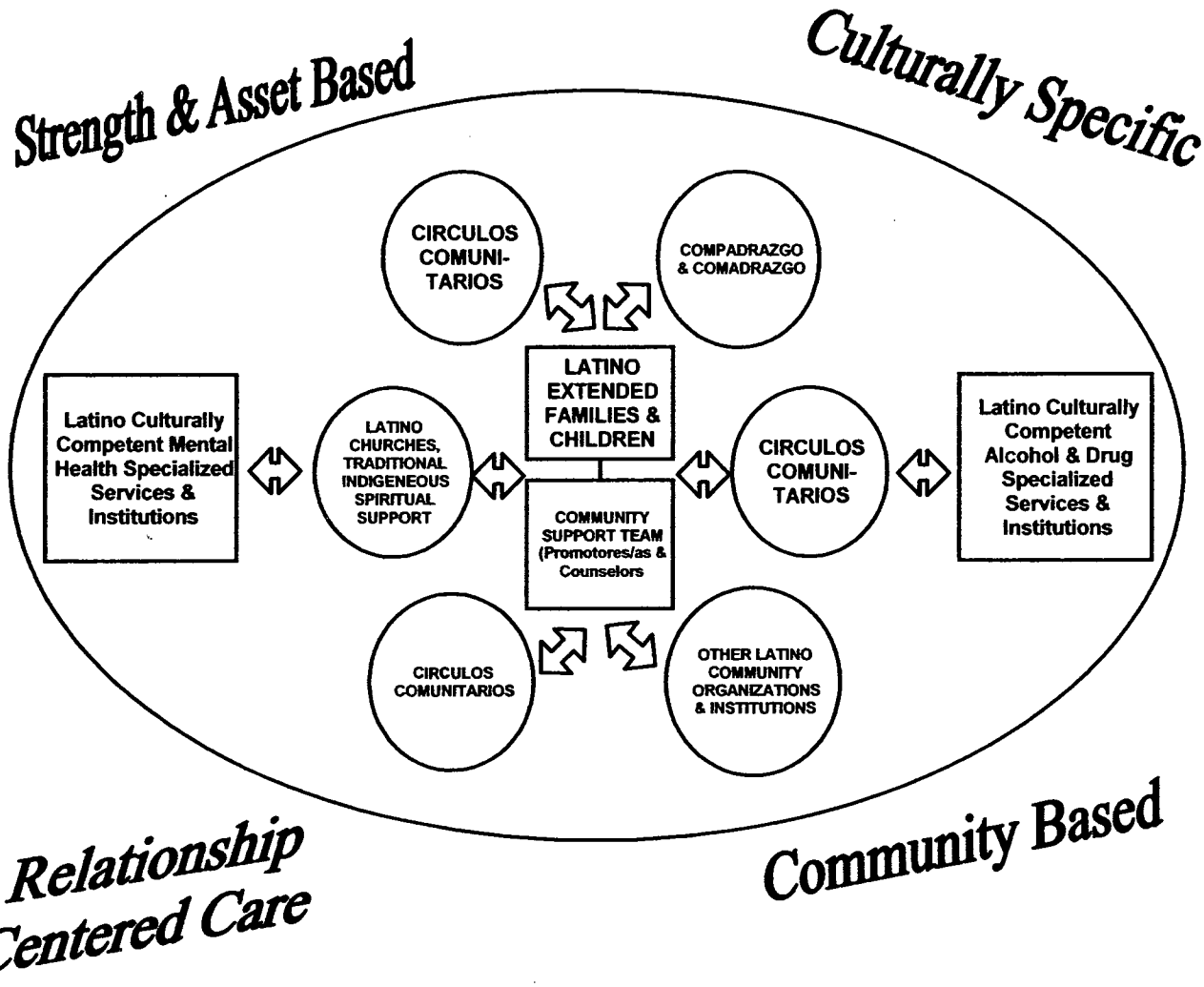
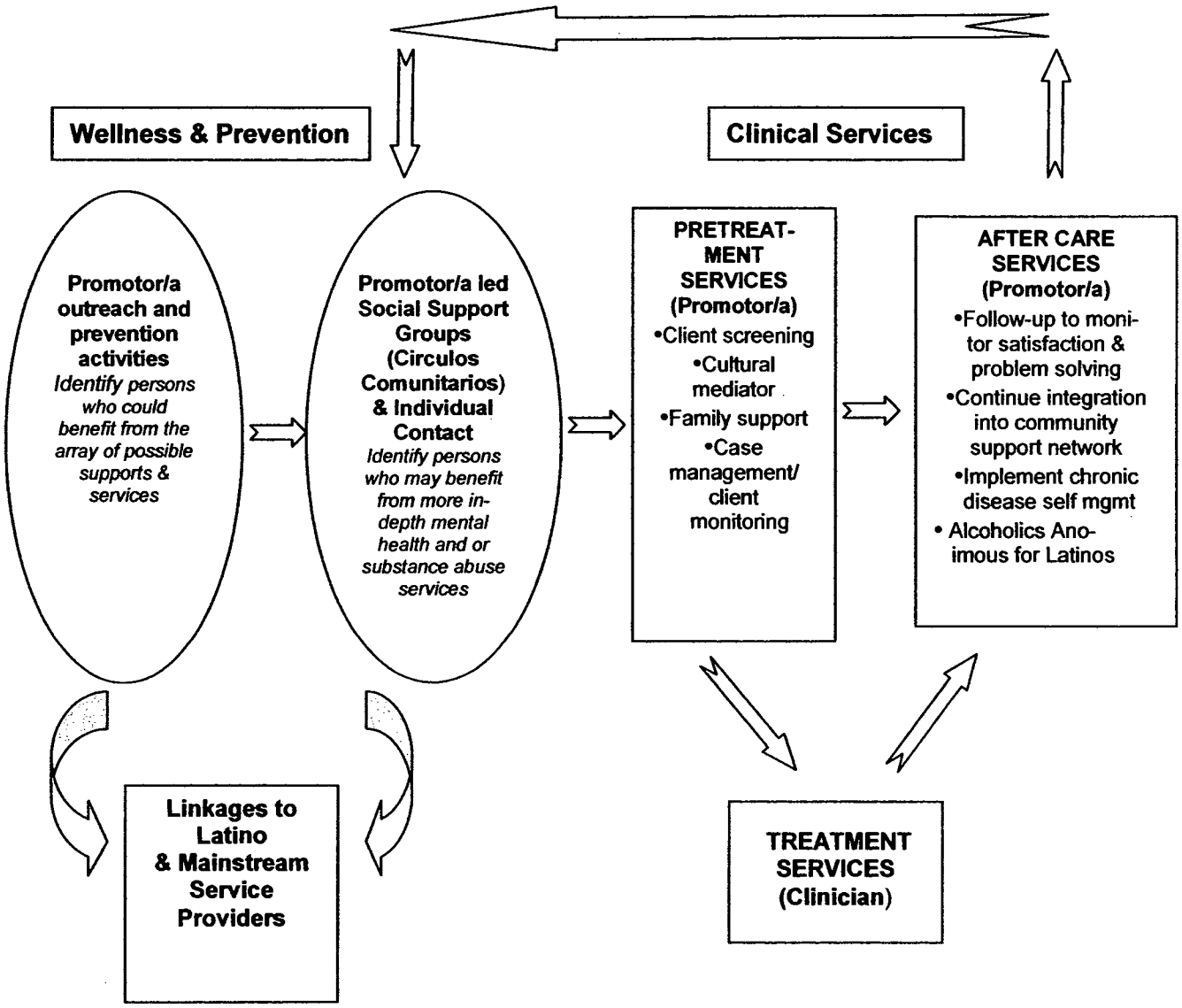


Figure 4.6
Steps in Engaging the Community in Mental Health and Substance Use Treatment Programs Through the Use of the Wellness Model



Clinical Services: Davidson[35] has pointed out that one way to contain the burgeoning costs of mental health and alcohol and drug services is through the use of promotores/as or community mental health workers (CMHWs) in a continuum of care service delivery model which includes pretreatment, treatment and post treatment services. This approach provides much less costly community based support and case management for families and children through promotores/as in the pretreatment and post treatment period of engagement with a client and his or her family, while providing more costly therapy and counseling by more specialized staff to a more limited group of clients with acute and severe problems during the actual treatment period of engagement.

Flexible hours that stretch into the evening, and some weekend programming (as capacity allows) will increase access after work and school hours when family issues often arise. Outreach to community member's natural environments and homes, provide additional observations that can identify early warning signs that can be addressed before crisis become unmanageable using strengths found in the person's natural environment. Staff of the Latino Wellness System of Care will network closely with other mental health staff in the mainstream system of care to use every opportunity to identify early risk factors.

The Latino Wellness System of Care team approach, using clinical staff and promotores/as as the basic treatment team, allows for flexibility in staffing and capacity to support a system and philosophy that flags risks and provides rapid intake for brief assessment and short term intervention that is flexible and able to go to a person's home if necessary.

When a clinical counselor or promotor/a assesses that there are imminent concerns, family and community support network will be activated. Clinicians and promotores/as will provide education about specific symptoms or events that are early warning signs in the language and cultural context that makes sense to the family. The client, family and support network will work closely with staff to develop and implement crisis plans.

Treatment Readiness: The objective of treatment readiness activities is twofold: 1) to prepare the client for treatment by facilitating a sense of hope that things can get better through additional counseling services beyond the promotor/a and the community circles, and 2) to solve immediate individual and family problems through case management and the coordination of clients with necessary resources within the community. The promotor/a or community mental health worker, as the primary linkage with potential clients and their families, engages the clients both on a one-on-one basis and through the community circles and assesses and screens the client and their family needs regarding their needs and current services they may be receiving. Conversations in a comfortable and personal relationship lead to emerging consciousness about further help, and at an appropriate point the promotor/a invites the client and family members to engage in more intensive counseling services with the clinical counselor or therapist.

Treatment: *Guarnaccia, Martinez and Acosta[36] point out that there is a serious lack of research on best practices for mental health treatment of Latinos. This lack of research is missing for all of the steps in the treatment process, including: 1) community engagement, 2) assessment and diagnosis, 3) treatment modalities, 4) medication treatment, and 5) outcome evaluation. In the approach adopted for this model, there are 5 major steps included in the treatment process:*

- Step 1 involves referral for more intensive work with the counselor. This is usually done by the promotor/a or community health worker, although through participation by the counselors in some of the community circle activities, the counselor may actually carry out this referral him/herself.
- Step 2 includes assessment and diagnosis. This step is done jointly by the counselor and the promotor/a, but responsibility for this step and it's documentation lies with the counselor.
- Step 3 involves development of a written treatment plan. This is a joint process which includes the counselor, the community mental health worker, and the client, and it is:
- Culturally specific
- Not open ended
- Goal focused with junctures for reassessment of client progress towards achieving the identified goals of the work
- Step 4 involves the actual treatment intervention, and consists of a defined number of meetings. A number of modalities will be used and adopted flexibly to operate within the cultural, linguistic and cognitive framework of the client. Some of these modalities may include:[37]
    - Ethnic matching to insure providing bicultural and bilingual therapists
    - Narrative therapy
    - Behavioral cognitive therapy
    - Motivational enhancement interviewing
    - Brief and solution-focused therapy
    - Art and music therapy
    - Somatic approaches to stress and trauma
    - Medication treatment
    - Alcoholics Anonymous for Latinos, which has been shown to be very effective throughout Latin America and the United States to address substance use issues

[35] Davidson, Peter, Public Funding For Mental Health Care in Oregon: What Comes Next, Multnomah County Mental Health and Addiction Services Division, January 22, 2003.

[36] Guarnaccia, Martinez and Acosta, op. cite, page 21.

[37] Guarnaccia, Martinez and Acosta, op. cite, page 23, cite cognitive behavioral therapy, family intervention, ethnic matching as modalities which have been adapted with some success. Other therapies included on this list have been identified by Latino therapists within the greater Portland Metropolitan area who have been associated with development of this wellness model.

After-treatment Care: Treatment closure and after-treatment care will be provided with clarity about a "door open" closure policy, where it is possible for the client to return for additional treatment if needed. In this step, the counselor, promotor/a, and client jointly develop a written after-care plan to insure ongoing support from the promotor/a, the family and the community after the treatment phase is over. After-treatment support will be provided in this wellness model in the following 3 ways:

- Continuing promotor/a support
- Reintegration or continued participation in the community circles
- Referral and encouragement to attend AA, NAMI or other Latino 12 Step Programs.

Upon completion of the appropriate treatment program, the clinical team insures that the clients receive appropriate aftercare or after treatment services, which can include integration or reintegration into their community support network and continued participation in the circulos comunitarios, as well as implementation of appropriate chronic disease self-management programs for related illnesses such as diabetes.

Crisis Intervention: All staff at the Latino Wellness System of Care, including clinicians and promotores/as (basic treatment teams) will be trained in early identification of risk factors and in strategies for early intervention and prevention of crisis. Since there is potential danger to self or others that is inherent in crisis situations, the clinical staff (QMHPs) in the basic treatment team will be responsible for assessing mental status, risk factors and directing treatment to stabilization. Promotores/as will work closely with the clinical staff person. All treatment teams will "cover" for each other's caseloads so that responding to escalating situations will be a priority.

The Latino Wellness System of Care model not only recognizes the importance of addressing the immediate need but also the value in constructing with clients concrete options and changes that might prevent crisis, and promote change to positive behavioral patterns and relationships that are well integrated in the individual or family life.

It is the goal of the Latino Wellness System of Care to prevent and manage crisis through these types of efforts before they require more restrictive intensive or "mainstream interventions." Community members often identify restrictive interventions to be traumatizing to the client and family compounded by linguistic and cultural differences, worries about costs add stress to families and inpatient care does not necessarily lead to desired outcomes. However, The Latino Wellness system of care recognizes that crisis will occur outside of their services and will work closely with the mainstream 24/7 crisis systems, including crisis lines, mobile response teams, police, detoxification centers, hospital emergency rooms, and jails to brokerage cultural issues and work as part of the team providing for the client and prepare for discharge.

At an administrative level, Memos of Understanding will be developed with the above mention 24/7 crisis intervention organizations to clarify roles and procedures about accessing Latino Wellness System of Care services in urgent situations and for follow ups. The Latino Wellness System of Care administration will attend meetings and serve on committees in the community that develop and impact crisis services. At a line staff level, selected Latino Wellness System of Care staff will be assigned liaison roles to build relations with line staff of crisis programs, provide training regarding appropriate clinical and cultural interventions and make themselves available for consultation and joint collaboration, especially in difficult to manage situations. The Latino Wellness System of Care staff will identify bilingual staff working in crisis and other systems and build strong working relations and encourage them to call sooner than later.

When a crisis has occurred resulting in known or unknown Latino community member being hospitalized or placed in a restrictive environment due to mental health problem, the Latino Wellness System of Care staff will make following up a priority. The staff will go on site to hospitals, jails or other facilities to screen and assess for services. Professional staff will assess the level of acuity and provide consultation to workers involved in the person's care, and identify and prepare community supports. Promotores/as work with the family, hear their story, provide education and support and help the family understand the client's needs.

The goal is to return the person to the community as soon as they are stable, and to ready the community to support them. Whenever possible short term intensive home based stabilization plans will be developed with as much input from family as possible. In some instances a promotores/as may come to the home for several hours a day as the person and family transition after an intense experience in the hospital.

Families will be encouraged and supported to play an active role, professional and promotores/as staff will model techniques for providing soothing and safe environments, monitoring medications and encouraging re-integration in the community. The basic team will explore with families their attempts to use alternative and traditional cultural healing practices and if they have used them or are interested in using them, families will be supported to do so. The basic treatment team (professional counselors and promotores) work as a team and share observations and progress. They will ensure the client gets the level of follow up and support needed. They will coordinate and help the family make appointments with the Latino Wellness System of Care bilingual psychiatrist or medication therapist, to monitor the response to medications, and to assess for side effects.

Latino Wellness System of Care will model for families and clients how to advocate for their needs by asking questions about the medications, reporting side effects and discussing use of herbs with the doctor in case of contra indications. Staff will work closely with caregivers and make sure they get relief and encourage other community members from churches or other

organizations to support the family. Families will be encouraged to talk and get support from other community members with similar experiences, like in the Spanish NAMI support groups or other community circles that already exist or that will be developed by the Latino Wellness System of care staff.

Referral of Severely Impaired Clients: This step involves referral of more severely impaired clients to specialized services within the existing mental health system. These specialized services may exist within the sponsoring agency (Cascadia Behavioral Health Care Inc.), or they may be in other parts of the system. These kinds of care will involve the continued participation and support of the promotor/a, and may include:

- More intensive out-patient and medication care with specialists, including training for family support within the home
- Referral to group homes where the family can come to learn how to provide ongoing support to the client.
- Referral to hospitals and other specialized facilities as appropriate.

CHAPTER 5: GOVERNANCE, ADMINISTRATIVE & MANAGEMENT

Introduction

Latino community leaders have been clear about their desire to create a Latino community-based culturally specific wellness organization to provide services to the Latino community in Portland from the inception of this project in November 2002.[38] The objective for the governance and management of this organization creates a culturally specific non profit behavioral health organization as follows:

> ***Objective:*** To create a Latino community based wellness organization (Latino BHO) which provides culturally and linguistically specific wellness services, including the strengthening of family and community linkages and relationships, mental health, alcohol and drug, crisis and other specialized behavioral services, to Latino families and children within the six county metropolitan and rural region from Vancouver, Washington extending south to Salem, Oregon.

Development of this entity will occur in two phases. During Phase I, a newly created Latino Wellness Corporation is formed under the governance and management of a Latino community based Board of Directors to manage all clinical, systems and program development, and fund development. Cascadia Behavioral Health Care provides specific contractual support to this new corporation under specific contractual provisions between the two corporations. In Phase II the Latino community based organization assumes all governance and management functions and subcontracts administrative support from Cascadia Behavioral Health Care.

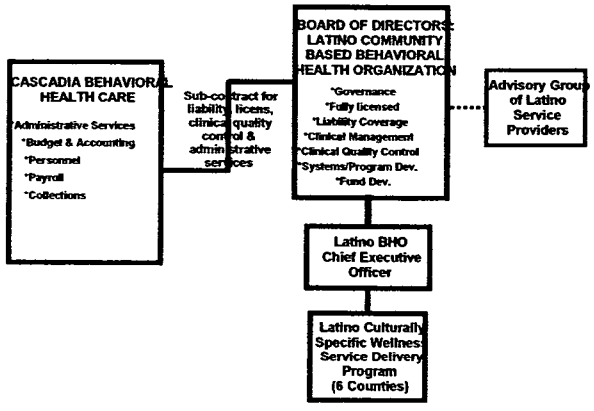
Phase-I Latino BHO Manages Clinical And Planning Functions

Figure 5.1 shows the interim organization structure and division of functions proposed for this program during the second phase of development. At this point, a private non-profit Latino community based wellness organization is created. The board of directors of this new organization is responsible for governance, systems and program development and fund development for the new organization. During this interim period the board also provides critical advice and guidance on culturally specific service design and implementation to the mainstream organization that provides licensing, liability coverage, clinical supervision and quality control, and administrative services. This arrangement is handled through a contractual agreement between Cascadia Behavioral Health Inc. and the new private non-profit Latino Wellness organization. An advisory group of Latino service providers provides technical guidance to the board of directors of this new organization.

Phase-II Latino BHO Manages All Functions & Subcontracts Administration

Figure 5.2 shows the final organization structure and division of functions proposed for this program during the third and final phase of development. In this final configuration, the private non-profit Latino Wellness Corporation assumes all governance and functional

Figure 5.1
Phase I Interim Governance and Functional Responsibilities



Non-Profit Structure For Latino Behavioral Health Organization

The newly created Latino Wellness Corporation will be incorporated as an independent private non-profit 501-c-3 corporation under Oregon Statutes and Section 501-c-3 of the Internal Revenue Code.

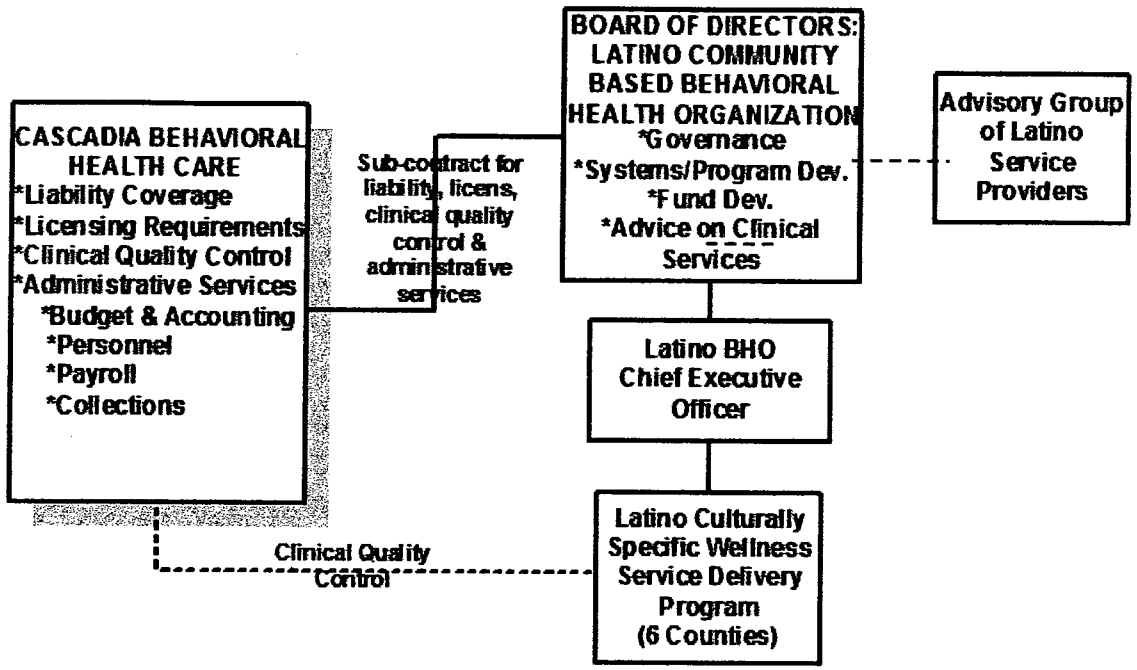
Membership For Board Of Directors and Advisory Group of Latino Service Providers

The board of directors for the Latino Wellness Initiative should be predominately Latino and representative of the following sectors of the community:

- Latino consumers of wellness services
- Community health workers or promotores/as
- Latino business community representative(s)
- Nationally and/or regionally recognized Latino services and research specialist in Latino behavioral health
- Nationally and/or regionally recognized Latino children's services and research specialist in Latino behavioral health
- Geographical representation from each Oregon and Washington county participating in the program
- Universities
- Hospitals

[38] Latino Network Proposal for Culturally Specific Mental Health System Development, Latino Network, January 6, 2002.

Figure 5.2
Phase II Final Governance and Functional Responsibilities



The advisory group of Latino service providers should be predominately Latino, and consist of the original Latino service providers from the MIOS Management Team as well as other Latino service providers from the community:

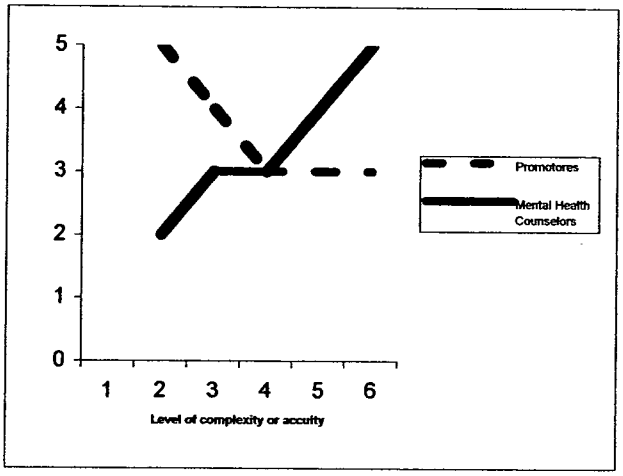
- The original Latino service providers from the MIOS Management Team
  - Oregon Council for Hispanic Advancement
  - Desarrollo Integral de la Familia
  - Programa Hispano: Catholic Charities
  - SMG Foundation
  - Latino Network
- Other Latino mental health, substance use and wellness providers
- Cascadia Behavioral Health Care, Inc.

CHAPTER 6: STAFFING AND TRAINING PLAN

Roles And Relationships Between Community Mental Health Workers And Counselors

Acuity and General Levels of Involvement of Promotores/as and Counselors:[39] Figure 6.1 describe different levels of involvement that promotores and counselors may share when working together with individuals or families, depending on the level of acuity or complexity of the presenting problem.

Figure 6.1:
Involvement in Treatment Interaction Based on Level of Complexity and Acuity of Presenting Problems



At the lower end of acuity and complexity it will be expected to see the promotor more involved with cases with consultation or a psychosocial evaluation from counselors. At this level clients may demonstrate to be motivated to change, able to maintain general functioning of daily responsibilities, yet troubled. He/she may be struggling with providing effective guidance to his/her children due to recent separation or divorce, for example. Or he/she may be a recent immigrant from Mexico and lacks community support, feeling mild depression, however able to seek for help and follow up with agreements. Most likely clients at the lower end of acuity would not present signs of severe illness or impairments, nor significant risk factors. Client's ability to think are intact. In this situation the promotor will provide consultations, education, basic skills, support and offer modeling. And the client may be participating in a ongoing class, facilitated by the same or other promotor about Holistic practices to overcome stress and trauma or parent-child or couple communication skills. At this level of acuity the mental health counselor will have a consulting role and available for any family that may later identify readiness for a specific healing process.

At the middle and toward the end of the scale is where the promotor/a and counselors will work more closely together. At the middle level of acuity, clients are emotionally more labile, and may experience some confusion but their orientation to reality is intact. He/she may be experiencing panic attacks or flashbacks that interrupt their daily functional routines. Or he/she may be experiencing anger outbursts that may have caused family disruptions or may have had children removed to foster care. The person may be forced to see the need to change, or may be able to identified the symptoms and may feel some motivation to change but feel hopeless or stuck. At this level both promotor and counselor will work together, which implies that the assessment and treatment plan will be done and developed together. For example in a case in which a young woman is overcoming past experience of sexual abuse, the counselor will facilitate a healing process for the client, through culturally and linguistically sensitive interventions. The counselor will offer the private space for the abuse stories to be expressed, validated, and healed. The promotor may support the person in establishing consistent routine for breathing exercise and flashback management techniques at home. Will offer support in helping client build social network and understand more about what healing means. The promotor may help the person participate in the ongoing class about Holistic Practices to overcome stress and trauma. The therapist and the promotor will meet together in a regular basis with client. And promotores and professional counselors will meet in a regular basis for clinical meetings.

Toward the end of the scale of acuity are the clients with significant severe mental illness, and those with moderate to severe risk factors: suicide level, significant impairment in reality, psychosis, delusions. The involvement of the counselor with specializa tion in chronic mental illness is crucial in leading a comprehensive treatment and clinical case management plan that integrates treatment to the Latino family members and the person with chronic illness; to assure that the treatment plan is well implemented and that communication among all parties involved is smooth and effective. The promotor takes a very important role in connecting with the CMI person and his/her family to help identified cultural beliefs regarding mental health and chronic mental illness, to support the family's need for alternative cultural practices to be integrated in the treatment plan and to help family understand the different "roads to healing": medication, counseling, spiritual practices, nutrition and physical wellness, social interactions. The promotor can also help with getting client to appointments, reinforce the safety plan and support if a hospitalization is needed. Most important, the promotor can offer a consistent relationship to clients and becomes a client's family and culture specialist working with a team of other professionals.

[39] Suarez, Lucrecia, A Latino Culturally Specific Wellness System of Care, MIOS Program, a partnership between the Oregon Council for Hispanic Advancement, Programa Hispano of Catholic Charities, Suzana Maria Gurule Foundation, Latino Network, Cascadia Behavioral Health Care, and Multnomah County, December 2003, pp. 24-28.

As mentioned above, one of the criteria to determine whether a promotor is more or less involved with a client is the state the client is in regards to readiness to receive help and believe that change can or not occur. At this level, as it has been mentioned before, the promotor represents an extension of the naturally-occurring mental health support system for the person in trouble or in pain.

Figure 6.2
Promotor/a and Therapists/Counselor Involvement at Different Stages of Treatment Process

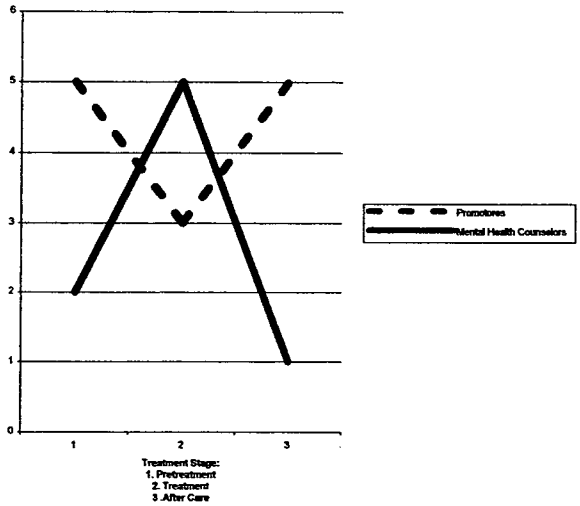


Figure 6.2 illustrates how promotores may be the key members of the clinical team helping families to reconnect with the hope that change can occur in their life and offer some skills and opportunities for learning to most functional families or to support members during the healing or more intense treatment process and to help them maintain their learning or skills to maintain themselves stable and productive for their families and society.

Core Roles & Competencies Of Mental Health Promotores/as: The key roles and competencies of community health workers (CHWs) or promotores/as adapted from Wiggins and Suarez[40] is presented below:

Recommended roles of community mental health workers: Community health workers can play a variety of roles depending on the needs of specific communities, as follows:

- Bridging cultural mediation between communities and the mental health, substance use, health and social service systems
  - Educating people about how to use the system
  - Educating the system about community strengths, needs and perspectives
  - Gathering information
  - Translating health related information into understandable *socioeconomic and cultural language of people*
- Providing culturally appropriate and accessible mental health and health education and Information
  - Teaching concepts of health *and wellbeing* promotion and disease prevention and *stress management*
  - Helping to manage chronic illnesses and *chronic mental illness*
- Assuring that people get the services they need
  - Making referrals
  - Motivating and encouraging people to obtain care
  - Accompanying people to services
  - Providing follow-up
- Providing informal counseling and social support
  - Giving individual support and informal counseling
  - Leading support groups
  - *Facilitating and promoting culturally specific healing practices*
- Advocating for individual and community needs
  - Acting as spokesperson/intermediary for community members
  - Helping to improve community conditions or situations
- Providing direct service
  - Administering selected screening procedures and first aid
  - Locating resources to ensure that people have adequate food, housing, employment
- Building individual and community capacity
  - Helping individuals develop skills and self-confidence and make healthy choices
  - Community organizing and community building

Recommended competencies of community mental health workers: Recommended competencies of community mental health workers include the following:

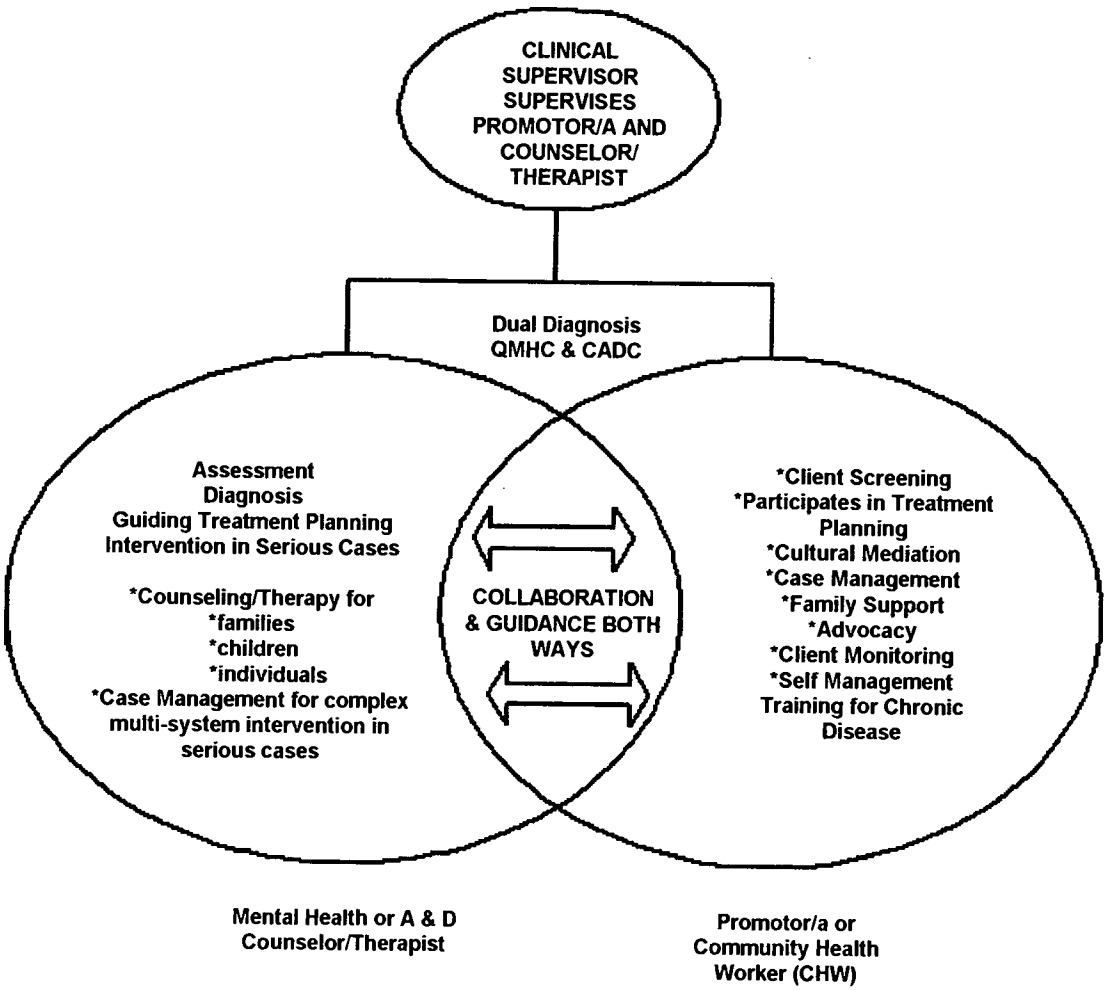
- Recognizing symptoms relating to mental health and substance use
- Identification of mental health risks, and consulting and linking with appropriate resources
- Monitoring of medication
- Communications skills
  - Ability to listen
  - Ability to use language confidently and appropriately
  - Ability to speak the language of the community
  - Ability to document work

[40] Wiggins, Noel, "Core Roles and Competencies of Community Health Advisors, ," in Lacy, Yvonne and Lissette Blondet, The Final Report of the National Community Health Advisory Study, A policy research project of the University of Arizona funded by the Annie E. Casey Foundation, June 1998, pp. 45, 46. Information in italics has been developed by Lucrecia Suarez, LCSW, specifically to adapt community health worker core roles and competencies for application by mental health community health workers.

- Interpersonal skills
  - Friendliness and sociability
  - Ability to work on a team
  - Ability to work with diverse groups of people
  - Ability to develop rapport and trust
  - Ability to "meet people where they are"
- Teaching skills
  - Ability to share information one-on-one
  - Ability to use appropriate educational methods
  - Ability to plan and conduct a class or presentation
  - Ability to find and bring back requested information
- *Counseling Skills*
  - *Ability to be empathetic and to offer reflective listening*
  - *Ability to give positive and constructive feedback*
  - *Ability to facilitate a person or family process to achieve identified goals*
  - *Ability to facilitate a support group*
  - *Ability to facilitate stress management skills groups*
- Service Coordination skills
  - Ability to identify and access resources
  - Ability to network and build coalitions
  - Ability to make "supported" referrals
  - Ability to provide follow-up
- Advocacy skills
  - Ability to speak up for individuals and communities
  - Ability to overcome barriers and withstand intimidation
- Capacity building skills
  - Leadership skills (such as strategizing, motivating, creating an action program, accepting responsibility)
  - Empowerment skills (such as helping people identify concerns and develop a plan to resolve problems)
  - Understanding of the community
  - Knowledge about *specific culturally diverse practices to overcome stress and trauma*
  - Knowledge about *mental health* and social service systems
- Knowledge base

Relationship and Responsibilities of Members of the Clinical Team: Figure 6.3 shows the responsibilities and relationship between the members of the Latino culturally specific team: 1) promotores/as, 2) counselor/therapist, and 3) supervisor. Interviews with Mark Spofford, Ph.D., and Graham Harriman, supervisors for the Multnomah County Health Department multicultural mental health and alcohol and drug program in the Latino community in Portland, Oregon, Dec. 3, 2003; with Virginia Salinas, counselor, and with Linda Castillo, clinical supervisor for Multnomah County Human Services Department Bienestar de la Familia Program,November 24, 25, 2003. The clinical supervisor supervises both the clinical staff and the promotor/a. This is an absolutely essential requirement for a successful team. The clinical counselor or therapist is responsible for assessment, diagnosis, treatment planning, and interventions with more seriously affected clients, including psychotherapy for families, children and individuals, as well as case management for more complex multi-system interventions requiring professional credibility and credentials. The promotor/a carries out client screening, acts as cultural mediator, manages cases, provides family support, and manages client monitoring to track client progress in an intervention process. The promotor/a also implements chronic disease self-management programs (tomando control de su salud).

Figure 6.3
Relationships between Team Members



Staffing Plan For New Behavioral Health Organization

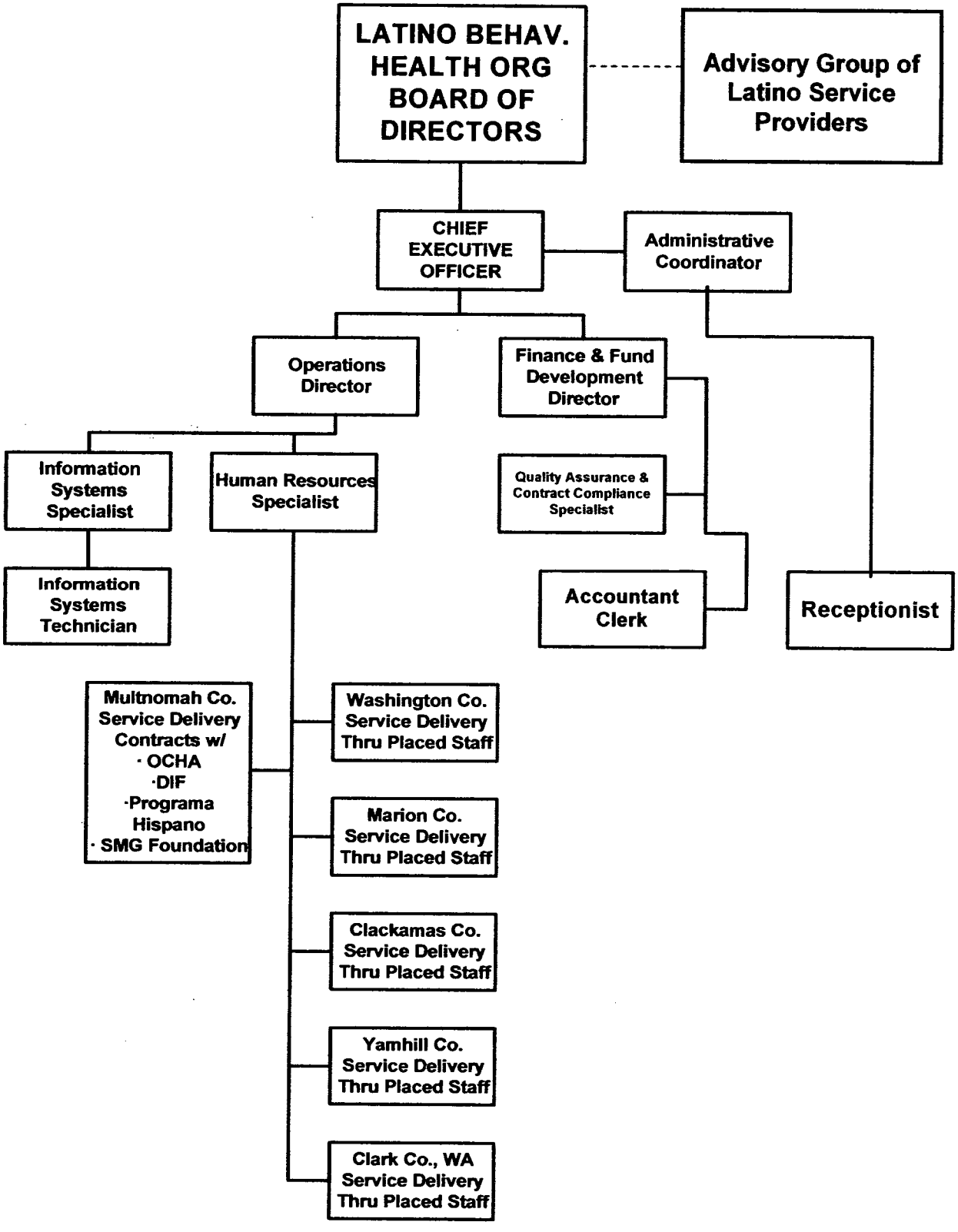
Figure 6.4 describes the model organizational setting within which the Latino wellness system operates. This figure allows services in one region or county, or in multiple regions or counties, depending on the need defined in the service area. The following key functions are shown: 1) governance, with the Board and CEO playing the major roles in governance, 2) systems and program planning, and fund development, 3) administrative and operations management and support staff, and 4) service delivery based on multiple teams of Latino culturally specific staff. A ratio of 3 promotores/as for each clinical staff is proposed in this model. Within Multnomah County service delivery will continue to be provided by Latino contractors: OCHA, DIF, SMG Foundation, and Programa Hispano. In the other counties service delivery will be provided by clinical teams placed in strategic locations within the Latino communities in each county.

Training Plan For Promotores/as, Counselors, And Other Staff[41]

Introduction: A major challenge facing programs which involve CHWs and other professional staff is the emergence of "status" differences between the CHWs and the other staff. All of the training workshops proposed for this program are designed as team building exercises, and promotores/as, counselors, supervisors, and other staff will all participate in all of these trainings for the purpose of creating coordinated teams of effective workers who understand the roles and responsibilities of each team member.

[41] Multnomah County Health Department CHS II Capacitation and Training Series – Spring 2002. This training plan is based largely on the conceptual framework and curriculum developed by Noël Wiggins, MSPH, for the Multnomah County Health Department's Community Capacitation Center. Many of the course descriptions and introductory paragraphs were derived verbatim from documents entitled "CHW Capacitation Series – Spring 2002" and "CHW Capacitation Series – Summer 2003," produced by Noël Wiggins for the Multnomah County Health Department.

Figure 6.4
Proposed Organization Structure for Delivery of Mental Health & A&D Services



This section identifies workshops in three areas to be made available for promotores/as, counselors, specialized clinical staff, clinical supervisors, and other staff who will participate in this program. The three workshop areas to be addressed include:

- Skill base courses
- Orientation to the wellness model, mental health, substance use, and the social service system
- Relation of mental health, alcohol and drugs to health issues

Skill Base Courses: Each skill base course is designed to enhance team member competency in essential areas of team practice. Therefore, skill base courses are included for all team member, regardless of the formal education, experience or health area(s) in which each team member is working.

Introduction to Popular Education: Popular education is a way of thinking about and practicing education that is aimed at creating more just and equitable communities. Originally developed by Brazilian Paulo Freire, it grew out of the same historical roots that produced the model of *promotores de salud* (health promoters) throughout Latin America. In this workshop, participants will come to understand the critical link between popular education methodology and the work of the team members. Members will develop the ability to use key methods of popular education, and be able to explain the philosophical ideas that underlie these methods. By increasing their understanding of the historical realities that produced popular education, they will enhance their ability to use it to strengthen their communities.

Culturally Specific Communication Skills: Because the work of the team depends on building trust and maintaining relationships between team members, community members, and clients and their families, effective culturally specific communication skills are essential. Further, strategies for effective communication are important tools that the team members can pass on to community members. In this session, participants will increase their understanding about the basic elements of culturally specific communication within the Latino community. They will develop greater appreciation for the role of feelings in the communication process. Finally, they will learn strategies for communicating non-violently.

Counseling Skills: In this introduction to the counseling process, the facilitator will help participants understand how the counseling process is based on 2 main foundations: rapport and trust. By the end of the workshop, participants will be able to define both rapport and trust and identify two key elements of each. They will also be able to name 3 key components of the contracting process and know how to develop a contract (work plan) with the community members with whom they work.

Outreach Skills: Outreach within the Latino community can be done in many ways and in many settings. In this workshop, participants will become familiar with some of the most common ways of conducting outreach within the Latino community. By the end of the session, they will be able to: 1) demonstrate 3 outreach skills which are effective within the Latino community; 2) describe 2 ways of establishing credibility; 3) identify 2 agency referrals; and 4) state 2 reasons it is important to acknowledge differences when serving community members.

Self-Care Skills: On a daily basis, team members are confronted by painful and unjust situations including poverty, racism, family dysfunction, illness and death. As members of the communities they serve, it can be especially challenging for team members to develop and maintain the boundaries they need to keep themselves healthy as they do their work. In this workshop, participants will become more aware of how their personal and professional histories affect them and their performance on the job. They will identify and discuss issues inherent in practice that may "push their buttons" or trigger unwanted emotional responses. Finally, they will name and practice 3 strategies for remaining emotionally, physically and spiritually healthy.

Orientation to the Wellness Model, Mental Health and Social Service System: Historically, one of the most important roles played by the culturally specific wellness teams is that of bridge between their communities and the health and social service profession. In order to play that role effectively, it is essential that they have opportunities to become more familiar with aspects of the system and how to navigate it. Orientation courses are designed to help the teams develop that familiarity.

Introduction to the Latino Culturally Specific Wellness Model: Prevention and Community Building: This workshop will focus on the theoretical, and practical issues which created the Latino Culturally Specific Wellness Program. Where did the idea come from for this project? How will it be accomplished? What are the goals? What is the culturally specific wellness model which has been developed, and how will it work in practice? In this workshop, participants will become familiar with the four major principles which form the philosophical foundation for the wellness model: 1) relationship centered care, 2) cultural competency and specificity, 3) community based services, and 4) a strength or asset based approach to services and counseling. This workshop will also look at the six specific components of the proposed Latino Wellness system of care model. These include: 1) Latino extended families and children as the focal point for service; 2) culturally specific community based teams of Latino promotores/as (community mental health workers or CMHWs) and other support staff ; 3) use of circulos comunitarios, 4) using Latino formal and informal community institutions as key assets and strengths in the implementation of the wellness model, 5) multiple community-based entry points for Latino families into the system of community based teams, including but not

limited to the circulos comunitarios, or "community circles," 6) linkages to the broader mainstream society and social services. Finally, culturally specific approaches to foster mental health and prevent alcohol and drug use will be covered in this workshop.

Introduction to Mental Health: Treatment Readiness, Treatment, Aftercare: This workshop will focus on the roles of each of the team members in each of the different phases of the process of mental health intervention within the Latino community. As pointed out in Chapter 2,[42] the concept of mental health is not a part of the cultural framework for most Latino immigrants to the United States, and strong feelings of stigma are attached to the notion of mental illness in traditional Latino communities. To address this, techniques of intervention to prepare clients and their families to be receptive to the idea of utilizing counseling services will be covered during the treatment readiness phase. Treatment will be addressed by providing information on those culturally specific approaches to mental health treatment which have been known to be effective within Latino communities. Finally, effective approaches to aftercare will also be addressed as a part of this workshop.

Crisis Issues and the Crisis System: This workshop will cover the topics of culturally specific approaches to crisis issues within the Latino community and how to coordinate Latino crisis services with the mainstream crisis system of care already established within the region.

Children and Adolescents: Mental Health and Alcohol and Drug Approaches: A specialized workshop on culturally specific approaches to working with children and adolescents will be developed and presented relative to mental health and substance use within the Latino community.

Orientation to Medication in the Latino Community: A specialized workshop will be presented on how to address issues which have been identified relative to medication treatment for Latinos with mental health problems. Reception of the most recent medications at therapeutic levels, the strength and addictive potential of psychotropic medications, availability of psychotropic medications through family members within countries of origin, and the possibility of differential response of some Latinos than European Americans to psychotropic medications, particular anti-psychotics, and differential Latino metabolizing of some medications and sensitivity to side effects compared to European Americans.[43]

Suicide Prevention: This training will help all staff learn their respective team roles in suicide prevention within the Latino community, and how to work in a coordinated fashion relative to suicidal clients. Strengthening of support within the Latino nuclear and extended family will be a topic emphasized in this training.

Depression and Anxiety Within the Latino Community: Some of the common symptoms of depression and anxiety within the Latino community will be explored, along with some helpful skills to use with clients who are experiencing these symptoms. Also highlighted will be how to handle issues of suicidal/homicidal ideation. And how to handle crises which may be encountered with people who are experiencing a high level of distress. The last part of this session will address self management Plans and the administration of the PHQ and its relevance to this project. This session will also provide an opportunity to adapt the depression registry to learn the basis and principles of the depression registry while learning some of the key queries and forms which will be crucial to the work. Time for input and questions is allowed and valued.

Chronic Care: This workshop session will focus on the provision of chronic care in a culturally specific manner within the Latino community. More specifically, how can this patient centered approach to healthcare be of benefit to the Latino community, and how can CHWs, counselors, supervisors and other staff function as an effective culturally specific team The use of registries, planning, outreach and patient self-management within the context of the nuclear and extended family will be introduced in this session.

Domestic Violence and Sexual Abuse: How to respond to mental health symptoms commonly experienced by domestic violence and sexual abuse victims/survivors, such as depression, anxiety, and post traumatic stress disorder will be covered. The issues of housing and foster care will be addressed.

Orientation to Case Management and Social Work: It is crucial in the work of CHWs that they be aware of the systems that support the mental health needs of patients. This time will focus on the role of case management, social work, and other mental health providers . There will also be time to discuss how the community health workers will complement the existing mental health services.

Introduction to Public Health, the Role of CMHWs, & the CHW Profession: CHWs/*promotores* have played a vital role in the U.S. public health system for over forty years. Nonetheless, their role has frequently been misunderstood and overlooked by other profes-sionals. Some CHWs themselves have been largely unaware of the larger system of which they are a part. In this workshop, both CHWs and other team members will have the opportunity to: develop familiarity with the "core functions" of public health; learn about differences between the medical system, the public health system, the mental health system, and the notion of wellness;

[42] See page 2.8.

[43] Guarnaccio, Peter Ph.D., Igda Martinez, B.A., and Henry Acosta, M.A., MSW, LSW, op. cite., page 25.

identify key public and mental health agencies; and define and apply a wellness and public health approach to solving problems. Finally, they will be introduced to the CHW Special Primary Interest Group (SPIG) of the American Public Health Association (APHA). The CHW SPIG is responsible for representing the interests of CHWs within APHA. In order to understand the health and social service system, CHWs need to begin by developing a greater awareness about their own profession and its emerging role within that system. In this class, CHWs will become familiar with the history of the CHW profession, both in the U.S. and around the world. They will enhance their understanding of the variety of roles that CHWs play in communities throughout the U.S. and learn about recent studies that have attempted to define CHW roles and competencies. Finally, they will expand their awareness about recent developments in the CHW profession and identify ways that they can become more involved in the development of the profession.

Social Justice Roots of the CHW Model: Historically, CHW/promotor programs have been a response to the systematic denial of health care to populations around the world. They have been efforts to help people improve their health by gaining more control over their lives. In this workshop, participants will increase their awareness about the social justice context in which they do their work. By the end of the session, team members will be able to: 1) provide a definition of "social justice"; 2) identify 2 political roles that CHWs have played; 3) name 2 reasons why CHWs are especially able to help communities work for social justice; and 4) explain 2 differences between liberating practice and maternalistic/paternalistic CHW practice.

Evaluative Training: This session will address how evaluative methods will be applied to the project and how they can help with a Quality Assurance/Quality Improvement plan. The role of Community Health Workers as key players in carrying out specific tasks (encounter forms, progress notes, intake data) to support this work will be highlighted.

Safety Issues for CMHWs: An important part of orientation for any CHW is an orientation to the possible risks and dangers s/he may encounter in the course of her/his work. In this workshop, participants will identify potential dangers and learn ways to keep themselves safe in a variety of settings. Both facilitators are experienced CHWs and between them have over 20 years of experience in the field.

Confidentiality: This training will address the importance of confidentiality in working with patients. Legal and ethical policy and practices governing information from field visits, consultations and counseling sessions, and from medical charts will be addressed.

Mentor Matches: Mentors will allow individual time for the new CHW to spend time observing home visits, processing duties, and receiving support for their new roles. These relationships are crucial in building a sense of direction for the work while also allowing for a development of comradery among CHWs. Each new CHW will have a minimum of 6 hours of mentor time in the training process.

Site Visits: Representative sites involved in this program will be visited to begin to learn how mental health, alcohol and drug, prevention, specialized mental health and alcohol and drug services, and primary health care services are delivered, learn the roles of different staff members involved, and introduce promotores/as into these areas of service.

Relation of Mental Health and Substance Use to Health Issues: In order to be effective in their work, the staff teams need to become well-versed in the relationship between physical health and the emotional and spiritual challenges facing the Latino community . Recent research is confirming what many health professionals have long known: there is a close tie between both the causation and treatment of chronic diseases and mental health issues. The top ten leading causes of death for Hispanics of all age groups are:[44]

- Heart disease
- Malignant neoplasms
- Accidents and adverse effects
- Human immunodeficiency virus infection (HIV)
- Homicide and legal intervention
- Cerebrovascular diseases
- Diabetes mellitus
- Chronic liver disease and cirrhosis
- Pneumonia and influenza
- Certain conditions originating in the prenatal period.

The relationship between mental health and substance abuse and these health issues in the Latino community will be explored in detail in this workshop. For example, participants will become familiar with diabetes, one of the most common chronic diseases in the Latino community. By the end of the workshop, they will be able to: 1) Name the 3 types of diabetes; 2) Identify 3 risk factors, symptoms, and complications of diabetes; 3) Name 3 things to consider to successfully manage diabetes; and 4) Educate others about the basics of diabetes. Teaching methods used include *The Diabetes River*, a technique that has been successfully used throughout the U.S. The relationship between other chronic diseases common within the Latino community and mental health will also be addressed in this workshop.

[44] National Alliance for Hispanic Health, Quality Health Services for Hispanics: The Cultural Competency Component, Department of Health and Human Services-Health Resources and Services Administration, Bureau of Primary Health Care, Office of Minority Health, Substance Abuse and Mental Health Services Administration, 2001, page 53.

Regional Resources Available To Support Training Needs

Multnomah County Health Department Capacitation Center: The Multnomah County Health Department Capacitation Center is a program of the Multnomah County Health Department which provides popular education based training to prepare "promoters" (community health workers, or CHW's), mental health "promoters" and community leaders and members to work at the community level within Multnomah County. The Center provides leadership development, networking opportunities, and initial and on-going training for these trainees. The Center also provides technical assistance and resources to programs utilizing these types of workers. In addition, the Center also assists a wide variety of community groups to develop skills and leadership through the use of Popular Education methodology. The Capacitation Center is particularly experienced in working with the Latino community, and their staff has over 30 years of cumulative successful experience in both using and providing training with the popular education model in El Salvador, Mexico, Azerbaijan, Hood River and Portland, Oregon.

Multnomah County Health Department SAMSHA Program: The Multnomah County Health Department has been a leader in the public sector in integrating community health workers, or promotores, into the provision of public health services within the County's primary health care system. Under a special grant from SAMSHA, the Health Department has been a leader in integrating the use of community mental health workers in teams with clinical counselors and working out of a primary health care base. This program has provided essential information which has informed the development of the Latino culturally specific community based wellness model. In particular, the section entitled "Relationship and Responsibilities of Members of the Clinical Team," from Chapter 6: Staffing and Training Plan, was developed from the experiences of this program. Training information was also borrowed extensively from this program.

Multnomah County Bienestar de la Familia: Bienestar de la Familia (Well Being of the Family) is a bi-lingual and bi-cultural multidisciplinary team which includes the following expertise: alcohol and drugs, development disabilities, family resource program, mental health consultants, based in schools and communities, and early childhood specialists. Its mission is to increase access for Latino families and children to health and mental health services that are culturally and linguistically specific. The model includes numerous partnerships with other social service entities and integrated services with primary health care.

Desarrollo Integral de la Familia (DIF): DIF has extensive experience in training promotores/as (community health workers) in the areas of domestic violence, sexual abuse and parenting within the Latino community.

SMG Foundation: SMG Foundation has extensive experience in training promotores/as in research techniques which are culturally and linguistically specific to the Latino community.

Annual Training Costs

Popular education methodology, originally developed by Brazilian Paulo Freire, has been effectively used as a training methodology in community development and health throughout Latin America and many other places in the world since the 1970's.[45] The Latino Culturally Specific Wellness Initiative will provide training based primarily on this approach for the clinical teams, which include the 3 community based promotores/as, or community mental health workers, as well as trained counselors and supervisors. Because workshops utilize popular education methodology and target the development of teams of supervisors, counselors and CMHWs in developing effective coordinated teams of workers, two trainers are required for each workshop: 1) a counseling trainer, and 2) a community mental health worker trainer. Costs per hour for these two trainers, including all materials, is assumed to be $150/hour. Figure 6.5 provides an overview of the unit costs for the initial training for new clinical teams. Figure 6.6 provides an overview of the annual unit costs for continuing education for existing teams after the initial training has been carried out.

[45] Freire, P (1973), Education for Critical Consciousness, New York: The Continuum Publishing Company; Freire, P., (1982). Pedagogy of the Oppressed, New York: The Continuum Publishing Company; Freire, P., The Politics of Education: Culture, Power, and Liberation, Bergin and Garvey; Gore, J (1993). The Struggle for Pedagogies: Critical and Feminist Discourses as Regimes of Truth, New York: Routledge; Hammond, JL (1998), Fighting to Learn: Popular Education and Guerilla War in El Salvador, New Brunswisk, NJ: Rutgers University Press; Johnson, DW, et al. (1984). Circles of Learning: Cooperation in the Classroom, Alexandria, VA: Association for Supervision and Curriculum Development; Johnson, DW, Johnson, R (1975), Learning Together and Alone: Cooperative, Competitive, and Individualistic Learning,. Englewood Cliffs, NJ: Prentice-Hall, Inc; Wallerstein N, Bernstein E (1994), "Introduction to community empowerment, participatory education, and health," Health Education Quarterly, 21(2): 141-148; Walters, S, Manicom, L (1996), Gender in Popular Education: Methods for Empowerment, London: Zed Books; Werner, D (1973), Donde No Hay Doctor: Una guíapara los campesinos que viven lejos de los centros médicos, Palo Alto, CA: The Hesperian Foundation, (Also available in English and many other languages.); Werner, D, Bower, B (1982), Helping Health Workers Learn, Palo Alto, CA, The Hesperian Foundation. (Also available in Spanish and many other languages).

Figure 6.5
Unit Costs for Continuing Education Training Workshops for Continuing Trainees

WORKSHOP	TRAINING CONTACT HOURS	PREPARATION HOURS (2 prep hr. for every Training hr)	ANNUAL UNIT COST
Three 2 day training workshops/yr.	3 workshops 2 training days/workshop 6 contact hr/day contact (36 hr)	3 workshops 24 prep hr//workshop (hr) (72 hr)	$16,200
Three 1 day training workshops/yr.	3 workshops 1 day/workshop 6 contact hr/day contact (18 hr)	3 workshops 12 hr//workshop (36 hr)	$8,100
TOTAL			**$24,300**

Figure 6.6
Annual Unit Costs for Training Workshops for New Trainees

WORKSHOP	TRAINING CONTACT HOURS	PREPARATION HOURS (2 prep hr. for every Training hr)	ANNUAL UNIT COST
Introduction to Popular Education	6 hours	12 hours	$2,700
Culturally Specific Communication Skills	6 hours	12 hours	$2,700
Counseling Skills	12 hours	24 hours	$5,400
Outreach Skills	6 hours	12 hours	$2,700
Self-Care Skills	6 hours	12 hours	$2,700
Introduction to the Latino Culturally Specific Wellness Model	12 hours	24 hours	$5,400
Introduction to Mental Health: Treatment Readiness, Treatment, Aftercare	12 hours	24 hours	$5,400
Crisis Issues and the Crisis System	6 hours	12 hours	$2,700
Children and Adolescents: Mental Health and Alcohol and Drug Approaches	12 hours	24 hours	$5,400
Orientation to Medication in the Latino Community	6 hours	12 hours	$2,700
Suicide Prevention	6 hours	12 hours	$2,700
Depression and Anxiety Within the Latino Community	12 hours	24 hours	$5,400
Chronic Care	6 hours	12 hours	$2,700
Domestic Violence and Sexual Abuse	12 hours	24 hours	$5,400
Orientation to Case Management and Social Work	12 hours	24 hours	$5,400
Introduction to Public Health, the Role of CHWs, & the CHW Profession	6 hours	12 hours	$2,700
Social Justice Roots of the CHW Model	12 hours	24 hours	$5,400
Evaluative Training	6 hours	12 hours	$2,700
Safety Issues for CHWs	6 hours	12 hours	$2,700
Confidentiality	6 hours	12 hours	$2,700
Mentor Matches	6 hours	12 hours	$2,700
Site Visits	18 hours	Zero hours	$2,700
TOTAL			**$81,000**

CHAPTER 7: DEVELOPMENT PHASING

Service Delivery Phasing

Figure 7.1 provides an overview of the proposed annual phasing for development of the wellness teams for each of the targeted counties within the Portland Metropolitan Service Area counties. All wellness teams are phased into the selected locations within each of the 6 targeted counties within the first 4 years of operation.

Figure 7.1
Phasing of Wellness Teams by County and by Year
Portland Metropolitan Service Area

YEARS	Mult. 57,221	Wash. 56, 535	Marion 54,406	Clackamas 17,146	Yamhill 9,713	Clark 18,415	Total
Year 1	1 E. Co. Rockwood 1 Clara Vista (NE)	1 Hillsboro	1 Woodburn	1 OR City	1 Newberg	1 N. County	7
Year 2	1 E. Co. Gresham 1 N. Portland	1 Migrant 1 Beaverton	1 Salem 1 Migrant	1 Mollala		1 Vancouver	8
Year 3	1 N. E. Portland	1 Cornelius 1 Migrant	1 Migrant 1 Woodburn				5
Year 4	1 S.E. Portland	1 Forest Grove	1 Mt. Angel				3
Year 5-10 (Total Each Year)	6	6	6	2	1	2	23

Source: Latino Network and MHIOS Management Team.

The number of teams in each county is generally proportional to the size and distribution of the Latino population within each county. The Latino population for each county is shown in underneath the county name for each county in the table. The locations identified for each team are based on the known concentrations of Latino populations within each county. Specialized wellness teams have been placed within those counties with rural agricultural migrant camps.

In Chapter 9, this phasing plan is used to prepare the annual budgets for each of the five years projected for the start-up and stabilization of the Latino Community Based Culturally Specific Wellness Program.

Staffing And Evaluation Phasing

Staffing and evaluation phasing assumptions are documented in Chapter 9: Five Year Phased Cost Estimates:

- Figure 9.4: Five Year Phased Evaluation Costs.
- Figure 9.5: Five Year Phased Administrative Costs.

CHAPTER 8: EVALUATION AND RESEARCH PLAN

Literature Review

Introduction: There is a growing but significantly limited literature on the provision of mental health/ substance abuse services for Hispanics; however, that literature still has significant gaps. Some research does exist on differential access and utilization of mental health services by Hispanics. Additional literature is available showing the efficacy of community health workers, a major focus of the Latino Community Wellness Initiative; however, even this literature is on areas other than mental health. There is a significant gap in research on efficacy of mental health/ substance abuse services for various Latino populations.

The following review outlines:

- Research on access and utilization of mental health and substance use services by Latinos
- Use of community health workers (promotores/as) in health services,
- Opportunities to expand the field of knowledge regarding mental health and substance abuse services for Hispanics.

Access to and Utilization of Mental Health/Substance Abuse Services by Hispanics: Several studies have documented that Hispanics make significantly less use of specialty mental health services than other poor populations. The 1990-1992 National Comorbidity Study found that poor Latinos (family income of less than $15,000) had lower access to mental health specialty than poor non-Latino whites. [46] It is important to note that this study only included English speakers. The authors of this study note "psychiatric patients with limited English proficiency underutilized specialist outpatient services and that those who did receive such services were less likely to participate in psychotherapy than fluent English speakers." They hypothesize that limited English proficiency among poor Latinos, along with a greater cultural emphasis on self reliance, may reduce their use of mental health services.

Locally conducted evaluation by the Multnomah County Division of Mental Health and Addiction Services [47] found that both Hispanic adults and children underutilized mental health services in relation to Whites or African Americans. These results are shown in the following Figures 8.1 and 8.2.

The children's data show that even when African Americans and Hispanics have equal percentages of children enrolled in the Oregon Health Plan (18% of OHP child enrollees are African American, 18% of OHP child enrollees are Hispanic) that Hispanic children receive a much reduced level of actual services. Only 4% of children served were Hispanic; 20% of children served were African American. This may indicate an extraordinarily lower need for mental health services in Hispanic children, but more likely indicates the existence of barriers such as language or cultural appropriateness.

Figure 8.1
Utilization of Children's Mental Health Services Multnomah County, Oregon July 1, 2000 to June 30, 2001

Ethnicity	Ethnic Breakdown of Children in Multnomah County 2000 Census	Percent of Children Enrolled in the Oregon Health Plan in Multnomah County	Percent of Children Receiving Multnomah County Mental Health Services During Fiscal Year 2001
African American	8.0%	18.3%	20.2%
Hispanic	11.9%	18.1%	4.2%
White	65.8%	53.9%	66.8%

The data for Hispanic adults in Multnomah County show a different pattern. Hispanics adults are under-represented in OHP enrollment in relation to their population in the community while African Americans have relatively greater OHP enrollment. The differing enrollment of Hispanics and Blacks in the Oregon Health Plan does not appear to be related to differences in income as both 26% of African Americans and 26% of Hispanics were below the federal poverty level in the 2000 Census. [48]

Figure 8.2
Utilization of Adult Mental Health Services Multnomah County, Oregon Fiscal Year 2001

Ethnicity	Ethnic Group as a % of Adult Multnomah County 2000 Census	Ethnic Group as a % of Adults Enrolled in the Oregon Health Plan in Multnomah County	Ethnic Group as a % of Adults Receiving Multnomah County Mental Health Services
African American	5.0%	13.5%	11.7%
Hispanic	6.2%	4.6%	2.1%
White	78.6%	71.4%	76.4%

Thus, it appears that there are barriers to enrollment in the Oregon Health Plan for adult Hispanics. Furthermore, Hispanic adults are also much less likely than enrolled African Americans or Whites to receive mental health services.

[46] Alegria, M., et.al. "Inequalities in Use of Specialty Mental Health Services Among Latinos, African Americans, and Non-Latino Whites", Psychiatric Services http://psychservices. psychiatryonline.org December 2002 53(12): 1547-1555.

[47] Carlson, James, Racial and Ethnic Heritage of Persons Served July 1, 2000-June 30, 2001, Multnomah County Division of Mental Health and Addiction Services, unpublished document, June 5, 2002.

[48] http://factfinder.census.gov Tables P159B and P159H.

William Vegas [49] groundbreaking research explodes the myth that Hispanics can be treated as a single community when providing mental health services. His research focused on the following key questions:

- How likely are immigrant and U.S.-born Mexican Americans to use mental health services if they have psychiatric disorders?
- What are the current patterns of provider selection among these Mexican Americans?
- How are sociodemographic correlates (e.g., place of residence, birthplace, gender, age, education, family income, employment status) and psychiatric status (e.g., diagnosis and impairment level) associated with utilization?

Vegas' research is instructive as it is able to separate the question of whether or not there are differences in the prevalence of mental health disorders from differences in the rates of usage; only those with mental health disorders are studied, therefore differences in use are not due to differences in prevalence. Vegas' found that:

- Among respondents with DSM-III-R-defined disorders, only 28% had used a single service or a combination of services in the past 12 months. Mexican immigrants had a utilization rate (15.4%) which was only two-fifths that of Mexican Americans born in the United States (37.5%). Overall 71% received no care, though this estimate excludes informal care providers.
- The following types of providers were used by persons with diagnosed mental disorders:
    - 8.8% of those with a diagnosed disorder used mental health care providers;
    - 18.4% used providers in the general medical sector;
    - 12.7% used other professionals;
    - 3.1% used informal providers.
    - 'Among both the foreign- and the U.S. born, use of informal providers was low and certainly not a basis in either group for a "displacement" explanation of low utilization of mental health care services.' [50]
- Factors associated with higher utilization of mental health services included female sex, higher educational attainment, unemployment, comorbidity (persons with two or more diagnosable conditions had a higher rate of use) and level of impairment (those reporting higher impairment consistently had higher utilization rates).

The implications of Vegas' research are profound when considering mental health care provision to a primarily Mexican-American Latino population, such as that found in NW Oregon. Vega writes that:

> "When immigrants do seek services, they are not likely to use family physicians, probably because they have no insurance, regular doctor, or source of care. The findings that they were as likely as the U.S. born to use general physicians and that the utilization rate for general physicians was higher in rural areas suggest that the publicly financed rural public health clinic system is a frontline provider of care for Mexican American patients presenting with psychiatric disorders. Little attention has been given in past research to the importance of this provider system for identifying, treating, and referring individuals with psychiatric disorders. This finding of use of general physicians is reinforced by the minimal use of counselors by immigrants, who apparently are isolated from the American "culture of counselors" because of their low acculturation and physical isolation in rural areas. Moreover, it is very interesting to find that even among immigrants with high levels of impairment; the rate of mental health service utilization did not increase. This underscores the possibility of cultural inappropriateness—perhaps compounded by low access in rural areas—as an explanation for low utilization of mental health specialty care providers among immigrants who have disorders."

Use Of Community Health Workers: The use of community health workers is not a new concept. A wealth of evaluation literature documents this history. At this point it can safely be said that community health workers, in a variety of communities—both urban and rural—can successfully:

- Improve access to health care; improve show up rates for appointments; decrease non-urgent use of emergency rooms and other urgent care services [51] [52] [53] [54] [55] [56]
- Decrease cost of health care [57]

[49] Vega, W., et.al. "Gaps in Service Utilization by Mexican Americans with Mental Health Problems", American Journal of Psychiatry June 1999; 156(6): 928-934.
[50] Vega, W., op.cit.

[51] Zuvekas, A., et.al., "Impact of Community Health Workers in Access, Use of Services, and Patient Knowledge and Behavior", Journal of Ambulatory Care Management 1999;22(4): 33-44.
[52] N. Wiggins, "Demonstrated Outcomes of Community Health Worker Programs", unpublished review developed for the Providence Health System, Portland, OR, 1997.
[53] Navarro, A., et.al., "Por La Vida Model Intervention Enhances Use of Cancer Screening Tests Among Latinas", American Journal of Preventive Medicine, 1998;15(1): 32-41.
[54] Bird, J. A., et.al., "Opening Pathways to Cancer Screening for Vietnamese-American Women. Lay Health Workers Hold a Key", Preventive Medicine, 1998; 27: 821-829.
[55] Sung, J., et.al., "Effect of a Cancer Screening Intervention Conducted by Lay Health Workers Among Inner-City Women", American Journal of Preventive Medicine 1997;13(1): 51-57.
[56] Colombo, T., et.al. "The Effect of Outreach Workers' Educational Efforts on Disadvantaged Preschool Children's Use of Preventive Services", American Journal of Public Health, (AJPH) May 1979; 69(5): 465-468.
[57] Frye, R., "Model community health program reduces Medicaid costs 27%", Health Care News Server, July 31, 1997.

- Increase linkages between service recipients and a broader network of community service agencies [58]
- Contribute to empowering individuals and communities [59] [60] [61] [62]

Despite this rich history of research on community health workers, there is little, if any, literature that specifically focuses on the use of community health workers with mental health and substance abuse services, especially with services to the Latino population.

Opportunities to Expand the Field of Knowledge: Vega outlines a research agenda that is highly relevant to the MIOS program. He states that:

> "Future research should focus on testing five competing explanations to determine their relative importance in the low service utilization among Mexican Americans with psychiatric disorders. Is utilization of mental health specialty care providers primarily influenced by:
>
> - Cultural beliefs about mental health problems?
> - Ineffective and inappropriate therapies?
> - A dearth of Spanish-language mental health care?
> - Access problems or other barriers, or
> - The protective effects of family and social support networks?

The discrete effects of these explanatory factors have not been simultaneously estimated in any sample. This shortcoming has frustrated both scholarship and attempts to design service systems that equitably and effectively serve Mexican Americans." [63]

Given the paucity of research on mental health/ substance abuse systems of care for Latinos, the MIOS proposal represents an opportunity to greatly expand current knowledge. The opportunity is magnified because the proposed service system will encompass two states and six counties, with varying mental health/substance abuse delivery systems. County human service delivery systems span the range from an almost completely subcontracted model (Washington County) to an almost entirely county operated system (Clackamas County). Both are suburban counties to the south of the Portland metropolitan area, which has a mix of subcontracted and county operated human services. The inclusion of Clark County, a suburban county across the Columbia River north of Portland, adds a perspective outside that of the Oregon Health Plan. Much of the area in the remaining three counties is rural, though each county include towns of substantial size, such as Marion County, which contains Oregon's capital. This is fertile ground for a formative evaluation, which can compare and contrast how the community health worker model evolves in different service systems, all within geographic proximity.

Evaluation Plan

The evaluation plan follows two tracks to allow for the greatest flexibility.

- A formative evaluation, included in core grant funding;
- Additional research projects, funded by supplemental grant requests.

The formative evaluation and research tracks are described separately, as they have different purposes, timelines, research designs and most likely different funders. The formative evaluation will guide program implementation by providing real time feedback on how well the program is running. The formative evaluation will monitor things like how much service is being provided, to whom, outcomes of service, and whether clients are satisfied with the services they receive. It will include perceptions of the service providers themselves about how to improve the service system. The formative evaluation is, therefore, a tool for program improvement, as well as a way for grant funders to see results of their investment. The research projects are more rigorous studies to contribute to the scientific literature concerning mental health/ substance abuse services for Latinos. Research project design makes use of carefully selected control and/or comparison groups. Comparing outcomes of these groups—some of which receive service and some of which don't receive service, or receive different types of services, allows inference as to why outcomes occur. Comparison groups help us understand if persons who did not receive service would have improved on their own, or if different types of service are more effective. Because of the more rigorous methodology, research is more expensive to conduct. Because it has a longer time frame it is less useful in guiding program implementation and more useful for contributing to general knowledge. Funders for pure research will be solicited after approval of funds to actually implement the MIOS program. The functioning MIOS Program will provide the foundation for this research.

MIOS Research Partnership: Both the formative evaluation and research tracks will be overseen by the MIOS Research Partnership, a steering committee comprised of:

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[58] J. Kent, C. Smith, "Involving the Urban Poor in Health Services Through Accommodation—The Employment of Neighborhood Representatives", American Journal of Public Health, *(AJPH)* June 1967: 997-1003.
[59] A. Schultz et.al., " 'It's a 24-Hour Thing . . . a Living-for-Each-Other Concept': Identity, Networks, and Community in an Urban Village Health Worker Project", Health Education & Behavior, August 1997; 24(4): 465-480.
[60] L. Warrick et.al., "Evaluation of a Peer Health Worker Prenatal Outreach and Education Program for Hispanic Farmworker Families", Journal of Community Health, February 1992; 17(1): 13-26.
[61] E. Eng, R. Young, "Lay Health Advisors as Community Change Agents", Family and Community Health, 1992; 15(1): 24-40.
[62] V. Booker et.al. "Changes in Empowerment: Effects of Participation in a lay Health Promotion Program", Health Education & Behavior, August 1997; 24(4): 452-464.
[63] Vega, W., op.cit.

- Oregon Health Sciences University Center for Health Disparities Research
- Portland State University Regional Research Institute
- Private non-profit Latino social service organizations
    - Oregon Council on Hispanic Advancement (OCHA)
    - Desarrollo Integral de la Familia (DIF)
    - El Programa Hispano (Catholic Charities)
    - Susannah Maria Gurule (SMG) Foundation
- Lead researchers and other associated investigators involved with specific research projects
- MIOS Project Staff

The strengths of the academic research partners are described in a later section of this chapter.

The purposes of the MIOS Research Partnership are to:

- Guide the formative evaluation;
- Determine which research questions would be most useful to program implementation;
- Determine which of the potential research questions could make the most significant contributions to the knowledge of delivering mental health/ substance abuse services to the Latino population in a way that promotes community wellness;
- To solicit lead researchers for said research projects who would write the grant applications to fund their research;
- To serve as an ongoing consultation body to ground both the formative evaluation and formal research in the community being served.

Community-Based Research: Collaborative research partnerships, such as the MIOS Research Partnership are well established approaches to investigating and actively resolving health care disparities. The East Side Village Health Worker Partnership in Detroit, Michigan has presented data from 1996 to 2001, showing the strengths of community-based participatory research and intervention collaboration among academia, public health practitioners, and the east side Detroit community. [64] Johns Hopkins Medical Institutions and an African-American community in Baltimore have a 15-year collaboration to reduce the highest rates of premature disease and death in Maryland. That collaboration has documented significant decreases in morbidity and mortality as a result of improved control of hypertension. [65] A team from the University of Michigan School of Public Health has completed a review and synthesis of community-based research which is defined as "a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute 'unique strengths and shared responsibilities' to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained with action to improve the health and well-being of community members." [66] That review outlines the following key principles:

- The concept of community as an aspect of collective and individual identity is central to community-based research.
- Community-based research seeks to identify and build on strengths, resources, and relationships that exist within communities of identity to address their communal health concerns.
- Community-based research involves a collaborative partnership in which all parties participate as equal members and share control over all phases of the research process, e.g., problem definition, data collection, interpretation of results, and application of the results to address community concerns.
- Community-based research seeks to build a broad body of knowledge related to health and well-being while integrating that knowledge with community and social change efforts that address the concerns of the communities involved.
- In community-based research researchers learn from the knowledge and 'local theories' of community members and community members acquire further skills in how to conduct research.
- Community-based research involves a cyclical, iterative process that includes partnership development and maintenance, community assessment, problem definition, development of research methodology, data collection and analysis, interpretation of data, determination of action and policy implications, dissemination of results, action taking (as appropriate), specification of learnings, and establishment of mechanisms for sustainability.
- Community-based research addresses the concept of health from a positive model that emphasizes physical, mental, and social well-being.

[64] Schulz, A., et.al. "The East Side Village Health Worker Partnership: Integrating Research with Action to Reduce Health Disparities", U.S. Government Printing Office Public Health Reports, Nov-Dec 2001; 116(6): page,548.

[65] Levine, D., D. Becker, L. Bone " Narrowing the Gap in Health Status of Minority Populations: A Community—Academic Medical Center Partnership", American Journal of Preventive Medicine 1992;8(5): 319-323.

[66] B. Israel, A. Schulz, E. Parker, A. Becker "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health", Annual Review of Public Health, 1998: 19:173-202.

- Community-based research seeks to disseminate findings and knowledge gained to all partners involved, in language that is understandable and respectful, and 'where ownership of knowledge is acknowledged'. [67]

The proposed MIOS Research Partnership flows from this rich history of academic and community collaboration.

Formative Evaluation: The formative evaluation will answer the questions:

- How many people are being served?
- What types and intensity of services are being received?
- What is the client satisfaction with those services (Focus groups and promotor/a solicitation of client response)?
- What is the clinical outcome of those receiving clinical services (Promotor/a and clinician assessment)?
- What is the experience of the promotores/as and clinicians working in the system?
- What is the experience of the agencies receiving referrals from the clinician-promotor/a teams? Has the system of service for Latinos improved? What are the opportunities for continued improvement? (Questionnaires and/or interviews and focus groups with leaders and workers with community institutions)?

The formative evaluation will provide ample data to direct system implementation and to demonstrate basic outcomes (clinician/promotor/a assessments and client satisfaction). Due to cost considerations, the formative evaluation will not be able to establish control or comparison groups and determine whether the Latino culturally specific wellness model is superior to either the existing system or to other systems of care. Answers that question will come from the formal research projects that will be associated with the MIOS Program.

The formative evaluation is shown in Figure 8.3: Evaluation Schematic for MIOS. It proposes both quantitative and qualitative assessments of both individual client and overall system functioning.

Individual client level: A preliminary definition of individual client level outcome measures might include:

- Type and intensity of contact (documented by administrative records)
- Outcomes of referrals (obtained from promotor/a follow-up)
- Outcome measures resulting from clinical services (clinician and promotor/a assessments)
- Satisfaction with services (focus groups and questionnaires)

System level: A preliminary definition of system level outcome measures might include:

- Number and type of referrals to and from MIOS services (administrative records)
- Functioning of the clinician/promotor/a teams as seen by the clinicians and promotores/as (interviews with clinicians and promotores/as)
- Functioning of the clinician/promotor/a teams as seen by the teams and their immediate partners within the service agency to assess the strategy of inserting culturally competent clinical/promotor/a teams into existing mental health service providers (focus groups)
- Assessment of the functioning of the overall referral system (interviews with agency directors and other key administrative staff)

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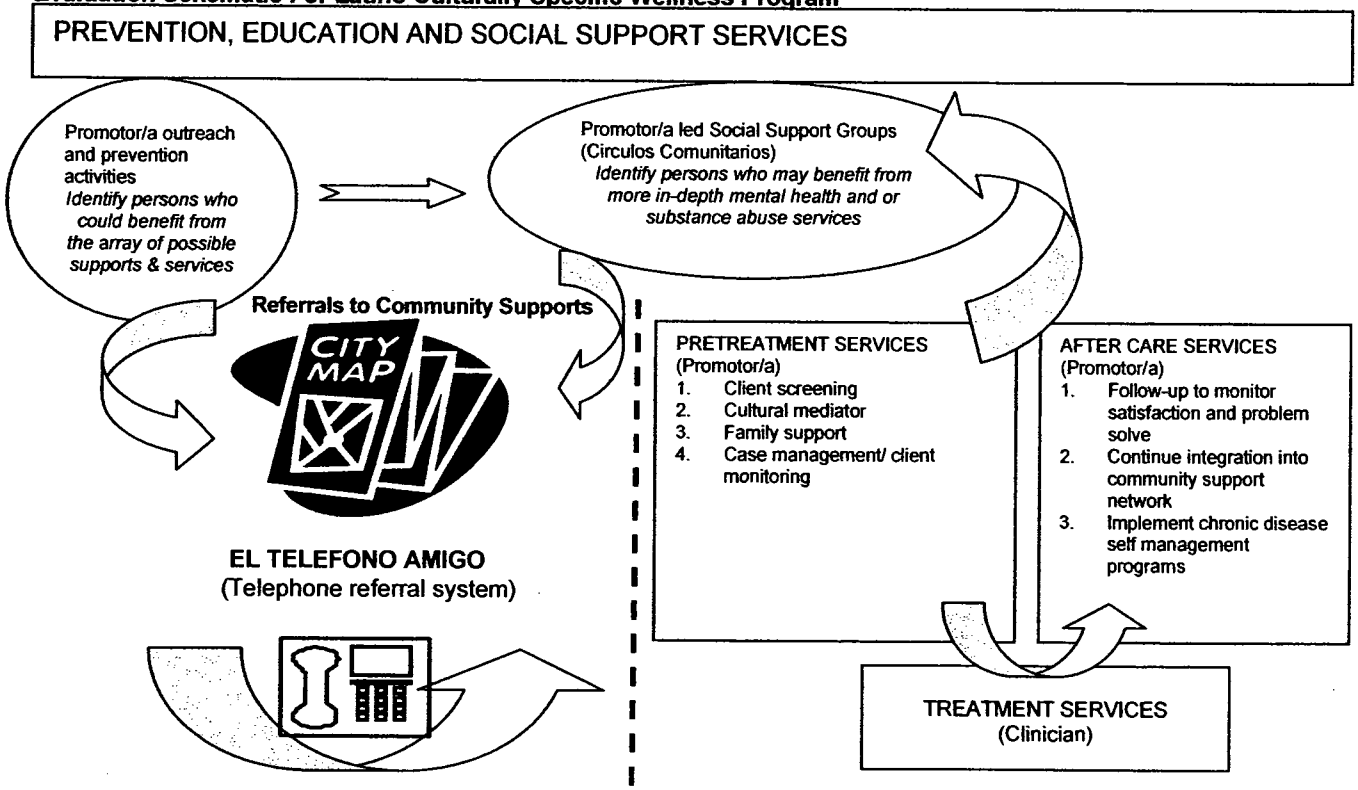
[67] B. Israel et.al. Ibid.

Figure 8.3

Evaluation Schematic For Latino Culturally Specific Wellness Program



Formative Evaluation Staffing: The formative evaluation will be designed in detail—including the definition of the specific outcome measures, instrument development, sampling procedures, and data analysis procedures—through a contract with a Ph.D. level professional researcher with experience in this field. Day to day implementation of this design will be carried out by a lead investigator, who does not need to be Ph.D. level but needs both practical evaluation experience and the ability to train and supervise bilingual/ bicultural evaluation interns. Each clinician/ promotora team will have a part-time evaluation intern assigned to it to ensure integrity of data collection. The lead investigator will train and supervise these evaluation interns and supervise data collection and analysis. Both the lead investigator and evaluation interns will train the clinicians and promotoras in what data is to be collected and how to collect it. There will be subcontracts for focus groups and interviews.

Lead Investigator: The formative evaluation will be carried out by a lead investigator selected by the MIOS Research Partnership. This position is budgeted for 1.0 FTE (full-time equivalent position). The lead investigator may be one person or several part-time staff, depending upon the expertise, interests, and availability of local researchers.

The duties of the lead investigator will be to work with the MIOS Research Partnership to:

- Train student evaluation interns to carry out all phases of the formative evaluation, preparing them for careers in program evaluation
- Ensure that the formative evaluation design is carried out on a day to day basis;
- Supervise data collection and data entry
- Perform data analysis;
- Write interim and final reports;
- Participate with the MIOS Research Partnership to ensure that the evaluation findings are appropriately used to manage the program.

Student Evaluation Interns: The lead investigator will be assisted in data collection by one part-time evaluation intern per clinician-promotora team. Each evaluation intern will visit each clinician-promotora team approximately twice a week. The intent is not only to conduct the evaluation in a cost-effective manner but to train a pool of bilingual and bicultural researchers in evaluation methodology. The evaluation interns would be both graduate and undergraduate students who are preparing for careers in Latino health or human service professions and who wish to focus on research or to include research as part of their education. Preference will be given to bilingual and bicultural candidates.

Each intern, depending upon their level of interest, time availability, and financial need may choose to work with one or two teams. Interns will receive an annual stipend of $5,000 per clinician-promotora team for which they assume responsibility. Each intern would be responsible for working with the promotoras and clinician to ensure that all administrative and client outcome data is being collected according to protocol. If problems in data are identified that cannot be corrected through brief on-site training they would report the need for further training to the Lead Investigator. The student evaluation interns would be responsible for gathering and returning that data to the lead researcher and for data entry. The Lead Investigator would work with them to train them in data analysis, report writing, and report presentation.

Focus Group and Interview Subcontracts: There will be considerable workload to conduct focus groups that: 1) assess clients' satisfaction with prevention, education, and social support activities; 2) assess client's satisfaction with clinical services and after care. Additional focus groups will be required to conduct interviews of clinicians and promotores/as in regard to their team functioning.. These activities will be performed by a subcontractor or subcontractors. The subcontractor(s) will be expected to have excellent grounding in the Latino community and also the expertise to assess service system functioning, at both the level of the clinician/ promotor/a teams and at the system level.

Individual Research Projects to Supplement the Formative Evaluation: Any number of research projects could study additional specific aspects of grant implementation and impact.

- Comparison of the client outcomes of the Latino Wellness System of Care with clients outcomes from other treatment approaches and client outcomes if no care is available;
- Determination of the factors that influence Latino use of mental health and substance abuse services (see Vega's suggestions on previous pages);
- More focused comparison of the use of emergency rooms and other social and health services for individuals who are served by MIOS versus control groups of persons who do not receive service or receive service from other providers (to address cost-benefit of the program);
- Further study of the prevention and education functions of the promotoras. These focused studies could examine incidence of and system response to child neglect or abuse, domestic violence, legal system issues, etc.
- A study of the role that clinician-promotora teams, and the project overall, has upon community network building and social empowerment of the Latino community.

These and other potential questions cannot be reasonably handled by a single funding source or a single research project. Therefore, the MIOS Research Partnership will work with local service agencies and project staff to identify the most relevant questions, solicit lead researchers, and act as sponsor for their research proposals. The MIOS Research Partnership will then work to coordinate the multiple evaluation and research projects.

Evaluation Budget

The evaluation budget allows for: 1) Funds to carry out a formative evaluation; 2) a base level of operating funds for the MIOS Research Partnership. Figure 8.4 shows the total evaluation budget. Please note that these budgets are provided in constant 2004 dollars. In Chapter 5: Five Year Phased Cost Estimates, costs are adjusted for inflation.

Formative Evaluation Budget: Figure 8.5 provides the detailed evaluation budget phased over five years. Many of the formative evaluation costs are directly linked to the number of clinician/promotor/a teams in the field; hence the phase-in schedule for the teams is shown on row one as a reference.

Figure 8.4
Total Evaluation Budget

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Funds for formative evaluation of Latino Community Wellness Initiative	**$258,574**	**$258,304**	**$292,804**	**$313,613**	**$313,804**	**$1,437,099**
Funds for MIOS Research Partner-ship	**$68,200**	**$59,200**	**$50,200**	**$50,200**	**$50,200**	**$278,000**
TOTAL	**$326,774**	**$317,504**	**343,004**	**363,813**	**$364,004**	**$1,715,099**

Figure 8.5
Detailed Budget for Formative Evaluation

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Number of Clinician/Promotor/a Teams:	7	15	20	23	23	23
EVALUATION ITEM						
Contract for evaluation design (design of data collection instruments, sampling methodology, data base design, analysis protocol)	$65,000					$65,000
Lead Researcher* (implementation of evaluation design; intern training and supervision)	$85,000	$85,000	$85,000	$85,000	$85,000	$425,000
Fellowships for evaluation interns @ $5,000 per clinician/promotor/a team.	$35,000	$75,000	$100,000	$115,000	$115,000	$440,000
Subcontract for 18 Focus groups Year 1; 24 Focus groups Years 2 -5 (see detail focus group budget below)	$45,180	$60,240	$60,240	$60,240	$60,240	$286,140
Subcontract for interviews of mental health administrative staff @ $900/ interview & report—1 interview per county/ year (see detail budget below)	$5,400	$5,400	$5,400	$5,400	$5,400	$27,000
Transportation for researchers to teams @ $0.36/mile and 100 miles to and from each /team/week ($1,872 /team/year)	$13,704	$28,080	$37,440	$43,056	$43,056	$165,336
Telephone & connectivity @ $120/month @ 10% per year increase	$1,440	$1,584	$1,724	$1,917	$2,108	$8,773
Printing and office supplies @ $250/month	$3,000	$3,000	$3,000	$3,000	$3,000	$15,000
1 computer	$2,500					$2,500
Analytic software	$2,000					$2,000
1 printer	$350					$350
Rent, utilities for research office	Donated by research partners					
TOTAL	**$258,574**	**$258,304**	**$292,804**	**$313,613**	**$313,804**	**$1,437,099**

* Lead researcher cost includes benefits.

- Each evaluation intern will annually receive $5,000 per clinician/promotor/a team for which they are responsible. Evaluation interns may choose to support up to two clinician/promotor/a teams, depending on their level of interest and financial need.
- Focus groups will be used at three points of service delivery:
    - Client experience with prevention, education, and social support services—clients in Circulos Comunitarios
    - Client experience with clinical services and after care—clients receiving clinical services
      It is expected that focus groups with clients who receive clinical services will be smaller, in order to allow for more open exchange of potentially sensitive topics.
    - Clinician/promotora teams and the staff they work with in their respective mental health agencies. The purpose of these groups is to assess how well a culturally competent team can be inserted into various existing mental health agencies from the standpoint of the practitioners. Training, coordination, and integration issues will be raised to guide program implementation.

Focus group expense is calculated as follows. The focus group schedule for each of the five years is shown below in Figure 8.6:

Figure 8.6
Number of Focus Groups Schedule for Five Years

Focus Group Topics	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Prevention, education, and (clients in education and support programs)	6	6	6	6	6	30
Clinical services and aftercare system (clients in clinical services)	5	6	6	6	6	29
Clinician promotora teams	7	12	12	12	12	65
TOTAL	**18**	**24**	**24**	**24**	**24**	**114**

Focus groups will be targeted to specific questions and locations of particular interest that are identified by the ongoing formative evaluation. It is expected that each participating county will have at least 3 focus groups per year during Years 2-5. Figure 8.7 shows the detailed budget for Focus Groups.

Figure 8.7:
Detailed Budget for Focus Groups

Focus Group Session Costs	Cost
Recruiting (staff time)	$120
Transportation	$50
Refreshments/snacks	$40
Participant stipends	$200
Childcare	$50
Moderator (assume contribution to topic guide planning sessions)	$250
Subtotal	**$710**
Focus Group Preparation and Analysis	
Topic guide planning and translation (prorated among 10 groups)	$150
Transcription	$150
Translation	$250
Data coding and analysis	$500
Report writing ($2,500 prorated among 10 groups)	$250
Meetings and administration, assistant moderation	$500
Subtotal	**$1,800**
TOTAL COST PER FOCUS GROUP	**$2,510**

Interviews will be used to determine system functioning from the standpoint of agency directors and their key program staff. More candid responses are likely from informal one-to-one interviews than from focus groups, which are a much more public situation. The interviewer will ideally be someone who has some knowledge of Oregon's mental health system and issues, is known and trusted by respondents, and who is not otherwise a part of the project evaluation. A primary issue of concern will be examination of the strategy of integrating clinician/promotor/a teams into existing mental health agencies. The interviews will also focus on system integration issues.

Interview costs are calculated in Figure 8.8 as follows:

Figure 8.8
Interview Cost

Meet with MIOS Research Partnership to determine issues	$100
Scheduling	$ 75
Conduct interview (including transportation)	$200
Debrief with focus group coordinator to target focus groups to issues raised by the interviews	$ 75
Report writing	$350
Reporting to MIOS Research Partnership	$100
TOTAL COST PER INTERVIEW	**$900**

MIOS Research Partnership Base Funding: The review of community-based-research collaboratives by the University of Michigan underscores the need for community research collaboratives to be adequately funded:

> "Given the many challenges, strategies are needed to ensure that the benefits of involvement in community-based research outweigh the costs. Such strategies include financial compensation for all participants involved (i.e. not only the university participants), financial remuneration for institutional commitment and involvement, public events recognizing partner contributions, newspaper coverage of partnership efforts, provision of technical assistance, training and educational opportunities as desired, and letters of commendation sent to organizational leaders and beyond (e.g. health department director and mayor's office)."[68]

The base level of operating funds for the MIOS Research Partnership will give it the capacity to carry out its initial planning and oversight functions, and provide a base from which to seek funds for additional research and expanded Partnership activities. The proposed MIOS Research Partnership budget allows for a base level of activity needed to form the Partnership and for meeting monthly to oversee MIOS evaluation and research. Additional funds needed beyond this level would be arranged through separate funding requests. Figure 8.7 provides a detailed budget for the MIOS Research Partnership:

- A minimum of $500 per month is allowed for staff support for each of the four social service agencies who form the MIOS Collaborative. This is intended to cover time needed to prepare for and participate in monthly meetings as well as to cover agency staff time spent in subcommittee work.
- Funds are allocated to bring in national experts on evaluation of services to Latinos to guide development of the formative evaluation and additional research agenda. The majority of funds are allocated during Year 1 ($18,000), cutting in half by Year 2. Thereafter, the MIOS Research Partnership is expected to have developed enough locally available expertise to guide project activities.
- An annual conference is budgeted to allow broader participation in MIOS Research Partnership activities and to assist in dissemination of results.
- Assessment of the functioning of the overall referral system (Interviews with agency directors and other key administrative staff)

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[68] B. Israel et.al., op.cit

Figure 8.9
Detailed Budget for MIOS Research Partnership

ITEM	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Center for Health Disparities Research staff support @ $500/month	$6,000	$6,000	$6,000	$6,000	$6,000	$30,000
Regional Research Institute staff support @500/month	$6,000	$6,000	$6,000	$6,000	$6,000	$30,000
MIOS Collaborative agencies @ $500/month X 4 participating agencies	$24,000	$24,000	$24,000	$24,000	$24,000	$120,000
Consultation from national experts (travel & per diem)	$18,000	$9,000	0	0	0	$27,000
Annual conference	$10,000	$10,000	$10,000	$10,000	$10,000	$50,000
Refreshments/snacks @ $50/ meeting X 12 meetings per year	$600	$600	$600	$600	$600	$3,000
Telephone and connectivity @ $100 per month	$1,200	$1,200	$1,200	$1,200	$1,200	$6,000
Printing and office supplies @ $200 per month	$2,400	$2,400	$2,400	$2,400	$2,400	$12,000
TOTAL	**$68,200**	**$59,200**	**$50,200**	**$50,200**	**$50,200**	**$278,000**

Formative Evaluation Staffing: The evaluation will be carried out by a lead investigator, subcontracts for focus groups and interviews, and student evaluation interns. The clinician/promotor/a teams will be trained to keep the administrative records needed to monitor service delivery and basic client outcomes.

Lead Investigator: The formative evaluation will be conducted by a lead investigator selected by the MIOS Research Partnership. This position is budgeted for 1.0 FTE (full-time equivalent position) during Year 1, when three counties are being implemented. Funding is increased to 1.50FTE during Years 2 through 5 when all six counties are operational. The lead investigator may be one person or several part-time staff, depending upon the expertise, interests, and availability of local researchers.

The duties of the lead investigator will be to work with the MIOS Research Partnership to:

- Finalize selection of all data collection instruments;
- Design systems for data collection;
- Supervise data collection and data entry;
- Supervise data analysis;
- Write interim and final reports;
- Participate with the MIOS Research Partnership to ensure that the evaluation findings are appropriately used to manage the program.
- Train evaluation interns to carry out all phases of the formative evaluation, preparing them for careers in program evaluation.

Focus Group and Interview Subcontracts: There will be considerable workload to conduct focus groups that: 1) assess clients' satisfaction with prevention, education, and social support activities; 2) assess client's satisfaction with clinical services and after care. Additional workload will be required to conduct interviews of: 1) clinicians and promotores/as in regard to their team functioning, and 2) agency administrators and other administrative staff regarding functioning of the clinical and social support service system. These activities will

be performed by a subcontractor or subcontractors. The subcontractor(s) will be expected to have excellent grounding in the Latino community and also the expertise to assess service system functioning, at both the level of the clinician/promotor/a teams and at the system level.

Student Evaluation Interns: The lead investigator will be assisted in data collection by one evaluation intern per clinician-promotora team. The intent is not only to conduct the evaluation in a cost-effective manner but to train a pool of bilingual and bicultural researchers in evaluation methodology. The evaluation interns would be both graduate and undergraduate students who are preparing for careers in Latino health or human service professions and who wish to focus on research or include research as part of their education. Preference will be given to bilingual and bicultural candidates.

In Year 1 there will be an estimated 7 clinician/promotor/a teams located across three participant counties. Each intern, depending upon their level of interest, time availability, and financial need may choose to work with one or two teams. Hence, there could be anywhere from 3 to 7 interns during Year 1. Interns will receive an annual stipend of $5,000 per clinician-promotora team for which they assume responsibility.

Each intern would be responsible for working with the promotoras and clinician to ensure that all administrative and client outcome data is being collected according to protocol. If problems in data are identified that cannot be corrected through brief on-site training they would report the need for further training to the Lead Investigator. The student evaluation interns would be responsible for gathering and returning that data to the lead researcher and for data entry. The Lead Investigator would work with them to train them in data analysis, report writing, and report presentation.

Research Projects To Supplement Formative Evaluation

- Any number of research projects could do further study of grant implementation and impact.
- A more complete formative evaluation comparing how the project is implemented in various counties and social service delivery systems;
- Determination of the factors that influence Latino use of mental health and substance abuse services (see Vega's suggestions on previous pages);
- More focused comparison of the use of emergency rooms and other social and health services for individuals who are served by MIOS versus control groups of persons who do not receive service or receive service from other providers;
- Further study of the prevention and education functions of the promotoras. These focused studies could examine incidence and system response to child neglect or abuse, domestic violence, legal system issues, etc.
- A study of the role that clinician-promotora teams, and the project overall, has upon community network building and social empowerment of the Latino community.

These and other potential questions cannot be reasonably handled by a single funding source and a single evaluation. Therefore, the MIOS Research Partnership will work with local service agencies and project staff to identify the most relevant questions, solicit lead researchers, and act as sponsor for their research proposals. The MIOS Research Partnership will then work to coordinate the multiple evaluation and research projects.

Academic Research Partners

Following is a description of the academic research partners who will be working with the Latino Culturally Specific Wellness Program:

SMG Research Institute: As previously presented in Chapter 3, pages 5 and 6, the SMG Foundation provides research, leadership and services to empower Oregon's Latino community to attain and improve individual and community wellness. A more detailed description of the following SMG Foundation's major programs is included in Chapter 3:

- Portland Niños (Portland Children)
- Las Hermanas (Sisters)
- Mujer Sana, Promotoras (Healthy Women)
- SMG Research Institute partnership with Oregon Health Science University (OHSU) Center for Health Disparities Research to increase Latino health research.
- Latino Community Based Wellness Program
- Salud Familiar: annual Latino Health Conference

Center for Health Disparities Research at Oregon Health Sciences University: The mission of the Center for Health Disparities Research is to use sustainable community-academic research collaborations to create new knowledge and enhance understanding of strategies to eliminate health disparities. To this end, the Center will conduct collaborative multi-level (e.g. social, clinical and behavioral) health disparities research; build collaborative research infrastructure and capacity; promote community-based agencies and programs; and disseminate and translate research findings into actions to eliminate health disparities. These collaborative community-academic research programs will accurately reflect the strengths, needs and ultimately benefit Oregon's and the Nation's racial and ethnic minority populations and other underserved populations (e.g. poor and geographically isolated populations). The Center's goals are to:

- Develop community-academic collaborative health disparities research infrastructure and capacity at OHSU and collaborating institutions and community agencies.
- Conduct collaborative community-academic research that targets the multiple factors that contribute to health disparities.
- Disseminate and translate research findings into culturally competent strategies and actions to eliminate health disparities.

The goals of the Center are achieved through the work of two Center Cores—the Administrative Core and Partnership Core—in collaboration with institutional partners, community partners, urban and rural minority populations and other underserved populations. The Administrative Core consists of 2 Co-Directors, of which SMG Foundation is a member, as well as a 20 member statewide Steering Committee.

Regional Research Institute for Human Services (RRI): The RRI is organizationally within the Portland State University Graduate School of Social Work and supports faculty research as well as providing research and evaluation expertise to the social service community. It was established in 1972, and since that introduction has received awards in excess of $30 million in grants and contracts. The aim of the Institute is to improve human services through applied social research. The RRI has undertaken more than 100 projects, many of them national in scope, in such fields as child and adult mental health, substance abuse treatment, practice improvement in substance abuse treatment, family and child welfare, childcare, employment, rehabilitation, and "self-help." Four federally-funded research centers have been housed at the RRI: the Research and Training Center on Family Support and Children's Mental Health (National Institute of Disability and Rehabilitation Research), the Center for the Study of Mental Health Policy and Services (National Institute of Mental Health), Reclaiming Futures (Robert Wood Johnson Foundation) and Developing Leadership in Reducing Substance Abuse (Robert Wood Johnson Foundation).

Research & Training Center on Family Support and Children's Mental Health: The RTC was first funded in 1984 and has since competed successfully for two additional five-year funding cycles. The RTC is national in scope, and has provided leadership in the area of family-centered services, family participation and family/professional collaboration. The RTC is jointly funded by the National Institute for Rehabilitation Research; U.S. Department of Education; and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The RTC currently supports research on:

- Support for caregivers who are seeking to enter or maintain paid employment
- Strategies for parents working to enhance the educational success of their children while reconciling their own work obligations
- Models for including children with mental health needs in regular child care settings
- Research-based approaches to assist early childhood education settings to develop effective mental health programs
- Evaluation of individualized, family-centered services that vary across sites or contexts
- Approaches to individualized care using teams of service-providers
- Ways to extend resources to groups and individuals who lack access to research knowledge and skills training processes for families to help them evaluate the care their children are receiving, and
- Research that supports disadvantaged and under-represented students responding to opportunities for training and mentoring.

The Center also publishes "Focal Point" a newsletter that is mailed to 32,000 individuals. Each year the RTC sponsors a national conference on family research and innovative programs, *Building on Family Strengths,* which is attended by more than 350 people. The RTC has extensive resources for disseminations, supporting the publication of fact sheets, monographs, training materials, articles and presentations.

Center for the Study of Mental Health Services and Policy: The CSMHSP is a social work research development center, the fourth of seven such centers funded by NIMH. The purpose of this Center is to produce high quality social work researchers in an active program of public mental health research. This is accomplished through: (1) an organized program of faculty development; (2) recruitment, support and mentorship of doctoral students in mental health research; (3) expansion and strengthening of current relationships with other research organizations at PSU and Oregon Health Sciences University (OHSU) and community agencies as research collaborators and research practicum sites; and (4) enhancement of the institutional infrastructure. The Center funds both social work faculty and doctoral students to complete research development activities and pilot projects. Current pilot projects include a study of the impact of caring for a child with an emotional disorder on the parents ability to maintain regular employment; and the development of a mental health screening tool for use in the juvenile justice system. Cultural competence issues are addressed in all Center activities.

CHAPTER 9: FIVE YEAR PHASED COST ESTIMATES

Five Year Total Costs

Figure 9.1 summarizes the annual costs for 5 years for the Latino Community Based Culturally Specific Wellness Program. It should be emphasized that these costs are estimates and will need further refinement as further planning occurs in the future. The first year of the five year costs is taken from Figure 9.5: Annual Cost Per Service Team. A number of assumptions have been made in preparing this budget. They include:

- The program is assumed to be phased in over a 4 year period, based on the phasing assumptions defined in Chapter 7: Service Delivery Program Development Phasing
- Year 1 costs are included as 2004 dollars.
- Inflation for personnel is assumed to be 3%/year for years 2 through 5.
- Inflation for non-personnel is assumed to be 4%/year for years 2 through 5.

Figure 9.1
Five Year Phased Evaluation Costs

LINE ITEM	YEAR 1 7 Teams	YEAR 2 7+8=15 Teams	YEAR 3 15+5=20 Teams	YEAR 4 20+3=23 Teams	YEAR 5 23 Teams
CLINICAL SERVICES EXPENSES					
*Personnel Expenses	$1,554,700	$3,431,445	$4,712,518	$5,581,977	$5,749,437
*Operating Expenses	$477,190	$1,063,452	$1,474,653	$1,763,686	$1,834,233
TRAINING EXPENSES	$162,000	$216,918	$163,273	$194,724	$200,566
EVALUATION EXPENSES	$326,774	$317,504	$343,004	$363,813	$364,004
ADMINISTRATIVE EXPENSES					
*Personnel Expenses	$268,000	$368,740	$501,806	$516,860	$532,366
*Operating Expenses	$121,480	$98,259	$102,190	$106,277	$110,528
TOTAL	$2,910,144	$5,496,318	$7,297,443	$8,527,337	$8,303,247

Five Year Clinical Team Service Delivery Costs

Figure 9.2 provides a summary of the five year phased clinical team service delivery costs for the Latino Community Based Culturally Specific Wellness Program.

Figure 9.2
Five Year Phased Clinical Team Service Delivery Costs

LINE ITEM	YEAR 1 7 Teams	YEAR 2 7+8=15 Teams	YEAR 3 15+5=20 Teams	YEAR 4 20+3=23 Teams	YEAR 5 23 Teams
Personnel Expenses	$1,554,700	$3,431,445	$4,712,518	$5,581,977	$5,749,437
Operating Expenses	$477,190	$1,063,452	$1,474,653	$1,763,686	$1,834,233
TOTAL	$2,031,890	$4,494,897	$6,187,171	$7,345,663	$7,583,670

Five Year Training Costs

Figure 9.3 provides the five-year phased training costs for the Latino Community Based Culturally Specific Wellness Program. These costs are taken from Figure 6.5 in Chapter 6: Staffing and Training Plan.

Figure 9.3
Five Year Phased Training Costs

LINE ITEM	YEAR 1 7 Teams	YEAR 2 7+8=15 Teams	YEAR 3 15+5=20 Teams	YEAR 4 20+3=23 Teams	YEAR 5 23 Teams
Number of New Trainees	30	35	22	13	13
Number of Returning Trainees	0	30	65	78	78
New Trainee Groups (~15 trainees/group)[1]	2	2	1	1	1
Continuing Education Training Groups	0	2	3	4	4
Initial Startup Training Costs (~$1,000/group)	$162,000	$162,000	$81,000	$81,000	$81,000
Continuing Education Training Costs ($24,300/group)	$0	$48,600	$72,900	$97,200	$97,200
TOTAL	$162,000	$210,600	$153,900	$178,200	$178,200

1. Experienced popular education trainers indicate that the ideal number of trainees in any given popular education based training workshop is about 20 persons. The minimum number of trainees should not drop below about 15, and the maximum should be no more than about 25. Class sizes have been estimated based on these figures.

5 Year Evaluation Costs

Figure 9.4 provides the costs for the 5 year phased evaluation program, taken from Figure 8.4 in Chapter 8: Evaluation and Research Plan for Latino Community Based Culturally Specific Wellness Initiative.

Figure 9.4
Five Year Phased Evaluation Costs[1.]

NUMBER OF CLINICIAN/PROMOTOR/A TEAMS	YEAR 1 7 Teams	YEAR 2 7+8=15 Teams	YEAR 3 15+5=20 Teams	YEAR 4 20+3=23 Teams	YEAR 5 23 Teams
Evaluation design contract (data collection instruments, sampling methodology, data base design, analysis protocol)	$65,000	$0	$0	$0	$0
Lead Researcher[1]	$85,000	$87,550	$90,177	$92,882	$95,668
(implementation of evaluation design; intern training and supervision)					
Fellowships for evaluation interns @ $5,000 per clinician/promotor/a team.	$35,000	$77,250	$106,090	$125,664	$129,434
Subcontract for 18 Focus groups (see detail focus group budget in Chapter 8)	$45,180	$62,047	$63,909	$65,826	$67,801
Subcontract for interviews of mental health administrative staff @ $900/ interview & report—1 interview per county/ year (see detail budget below)	$5,400	$5,562	$5,729	$5,901	$6,078
Transportation for researchers to teams @ $0.36/mile and 100 miles to and from each /team/week ($1,872 /team/year)	$13,704	$29,203	$40,495	$48,432	$50,369
Telephone & connectivity @ $120/month @ 10% per year increase	$1,440	$1,647	$1,865	$2,156	$2,108
Printing and office supplies @ $250/month	$3,000	$3,000	$3,000	$3,000	$3,000
1 computer	$2,500	$0	$0	$0	$0
Analytic software	$2,000	$0	$0	$0	$0
1 printer	$350	$0	$0	$0	$0
SUBTOTAL	**$258,574**	**$258,304**	**$292,804**	**$313,613**	**$313,804**
Funds for MHIOS Research Partnership	**$68,200**	**$61,568**	**$54,296**	**$56,468**	**$58,727**
TOTAL	**$326,774**	**$319,872**	**$347,100**	**$370,081**	**$372,531**

[1.] The lead researcher cost includes benefits.

5 Year Support And Administrative Costs

Figure 9.5 provides an estimate of phased administrative costs for the Latino Community Based Culturally Specific Wellness Program for each of the 5 years of program operation included in this report.

Figure 9.5
Five Year Phased Administration Costs

LINE ITEM	YEAR 1 7 Teams	YEAR 2 7+8=15 Teams	YEAR 3 15+5=20 Teams	YEAR 4 20+3=23 Teams	YEAR 5 23 Teams
PERSONNEL ITEMS					
Executive Director	$90,000	$92,700	$95,481	$98,345	$101,296
Finance & Fund Development Director	$50,000	$51,500	$53,045	$54,636	$56,275
Operations Director ($45k/yr)	$0	$46,350	$47,741	$49,173	$50,648
Administrative Coordinator	$38,000	$39,140	$40,314	$41,524	$42,769
Human Resources Specialist	$0	$46,350	$47,741	$49,173	$50,648
Quality Assurance & Contract Compliance	$0	$0	$47,741	$49,173	$50,648
Information Systems Specialist	$60,000	$61,800	$63,654	$65,564	$67,531
Information Systems Technician	$0	$0	$47,741	$49,173	$50,648
Accountant Clerk	$30,000	$30,900	$31,827	$32,782	$33,765
Receptionist	$0	$0	$26,523	$27,318	$28,138
SUBTOTAL	**$268,000**	**$368,740**	**$501,806**	**$516,860**	**$532,366**
OPERATING ITEMS					
Rent: Administration Only	$27,760	$28,870	$30,025	$31,226	$32,475
Insurance	$4,700	$4,888	$5,084	$5,287	$5,498
Utilities	$4,600	$4,784	$4,975	$5,174	$5,381
Building Maintenance/ Supplies	$5,400	$5,616	$5,841	$6,074	$6,317
Office Supplies	$2,600	$2,704	$2,812	$2,925	$3,042
Postage	$1,950	$2,028	$2,109	$2,193	$2,281
Telephone	$7,600	$7,904	$8,220	$8,549	$8,891
Program related supplies	$12,000	$12,480	$12,979	$13,498	$14,038
Printing/ Photocopying	$6,600	$6,864	$7,139	$7,424	$7,721
Books & Publications	$450	$468	$487	$506	$526
Equipment Rental and Maintenance	$2,920	$3,037	$3,158	$3,285	$3,416
Equipment Purchase (Computers)	$10,000	$3,120	$3,245	$3,375	$3,510
Mileage and Parking	$7,200	$7,488	$7,788	$8,099	$8,423
Recruiting	$1,200	$1,248	$1,298	$1,350	$1,404
Meeting/ Group Supplies/ Refreshments	$1,500	$1,560	$1,622	$1,687	$1,755
Information Systems Software[1]	$25,000	$5,200	$5,408	$5,624	$5,849
TOTAL OPERATING COSTS	**$121,480**	**$98,259**	**$102,190**	**$106,277**	**$110,528**

1. Both accounting and research software are included in this total.

Clinical Team Annual Service Delivery Costs

Figure 9.6 provides the annual costs of operating each service team which delivers services within the Latino Community Based Culturally Specific Wellness Program. A service team is made up of 1 counselor and 3 promotores, or Community Mental Health Workers (CMHW). One clinical supervisor is needed to supervise 3 teams.

Figure 9.6
Annual Cost Per Service Team[1]

LINE ITEM	EXPENSE
PERSONNEL	
Mental Health Counselor	$40,000
Promotora	$29,500
Promotora	$29,500
Promotora	$29,500
MIOS Clerical/ Reception Support @ 1.0 FTE	$25,000
Clinical Supervisor @ .30 FTE	$13,500
Fringe Benefits (30% of total salary costs)	$50,100
Independent Contractors	$5,000
TOTAL PERSONNEL	**$222,100**
OPERATING	
Rent (Location for Clinical Team)	$13,880
Insurance	$2,350
Utilities	$2,300
Building Maintenance/ Supplies	$2,700
Auditing/ Accounting	$1,060
Office Supplies	$2,600
Postage	$650
Telephone	$3,800
Program related supplies	$4,000
Printing/ Photocopying	$2,200
Books & Publications	$450
Vehicle Operation (Van for Group Work)	$3,500
Equipment Rental and Maintenance	$1,460
Equipment Purchase (Computers)	$4,500
Mileage and Parking	$3,600
Staff Development	$3,500
Depreciation Expense	$850
Recruiting	$1,200
Client "Wrap Around" Support Funds	$11,070
Meeting/ Group Supplies/ Refreshments	$500
Contracted Billing Fee for Insured Clients	$2,000
TOTAL OPERATING COSTS	**$68,170**
TOTAL COST/SERVICE TEAM	**$290,270**

#6

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT: Latina Culturally Specific Wellness Program "MIOS"

AGENDA NUMBER OR TOPIC: County Budget Item for MIOS

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: ~~Erika Ponce~~ Lorena Connelly LORENA

ADDRESS: DIF @ Foster Road & 67th SE

CITY/STATE/ZIP: Portland

PHONE: DAYS: _____ EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Supporting MIOS appropriation; submitting MIOS plan & Amendment Ch 5

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#7

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT: Latina Culturally Specific Wellness Program
MIOS

AGENDA NUMBER OR TOPIC:

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Rosario ~~Gonzalez~~ Cholula

ADDRESS: DEF Foster Road & SE 67th

CITY/STATE/ZIP:

PHONE: DAYS: EVES:

EMAIL: FAX:

SPECIFIC ISSUE: Supporting MIO Sapprovalon; submitting MIOS Plan & Amendment Chapter 5

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#8 Group of 4

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: Mental Health Services Head Start

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Ron Herndon

ADDRESS: 3417 N & 7th

CITY/STATE/ZIP: Portland, OR 97212

PHONE: DAYS: 503-282-1975 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#9

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: ~~Early~~ Propose Cuts of Mental Health Services

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Leticia Jimenez

ADDRESS: 9005 N. Westanna Ct.

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: 503.282.1975 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#10

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Early Childhood Mental Health

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Richard Luccetti

ADDRESS: 608 SE 181st ave

CITY/STATE/ZIP: Portland 97233

PHONE: DAYS: 503-282-1447 EVES: 971-506 5869

EMAIL: rluccetti@aol.com FAX: _____

SPECIFIC ISSUE: Mental Health.

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

A Unique Approach to Mental Health Care for Young Children—The Multnomah County, Oregon, Early Childhood Mental Health Program

In 1990, Ronnie Herndon, a director of the Department of Health and Human Services' Head Start program, concluded that the children in his program who had significant mental health problems were unlikely to receive conventional mental health services. A needs assessment was conducted, and the Multnomah County (Oregon) Early Childhood Mental Health (ECMH) program was founded. The program places early-childhood mental health clinicians and child psychiatrists in public community agencies that serve young children and their families—schools, day care centers, housing complexes, churches, and community service agencies. These clinicians work in tandem with families and staff from the early-childhood community, creating a mental health care system for children that embraces the principles of prevention through intervention.

The program became fully operational in September 1994, expanding to two Head Start programs. It now operates in four Head Start programs, one Early Head Start program, two public school district special education programs, a public school prekindergarten program, and a nonprofit child care resource and referral agency.

Nine host early-childhood organizations in Multnomah County—the most populous county in Oregon, which includes the city of Portland—serve as the program's physical facilities. These organizations provide child care and education and early intervention in 38 public schools, 11 housing complexes, nine child care centers, five community service providers, four churches, and numerous home-based child care settings. Because the ECMH program operates out of these facilities rather than having its own premises, resources that would otherwise have gone toward capital expenditures can be dedicated to the provision of services.

Disruptions to emotional development in early childhood can have serious long-term consequences. Early-childhood mental health care has been shown to optimize the ability of children to participate in school and other community programs. Early-childhood programs that combine a strong child-focused program with a strong family component are particularly effective. However, families are often reluctant to label a young child as having a mental health problem. For children from low-income families and children with developmental disabilities, there is an even greater risk that mental health problems will go undetected and untreated, and these children are more vulnerable to these kinds of problems than are other children. Even when it is recognized that a child requires mental health care, many families find that traditional services do not fit their needs. Transportation and scheduling constraints can also limit access to mental health care services for children.

By making mental health services available in schools, child care facilities, and homes, the Multnomah County ECMH program overcomes these access barriers. Children and their families can move seamlessly between the various preventive and interventional services that the program provides in a familiar environment, as a natural extension of their current child care or educational program. This integration of mental health care services with existing early-childhood services is the primary innovation of the ECMH program.

One of the benefits of providing mental health services alongside other child care and family services is the elimination of the stigma that is often associated with traditional, clinic-based mental health services. Another key strength of this approach is its ability to involve family members in the child's mental health care. Mental health interventions that are integrated into a child's daily routine can enhance the partnership between the family and the early-childhood program, promote coordination of services, and invite collaboration by parents. The Multnomah County ECMH program involves family members fully in consultations, assessments, and treatment and even in the hiring of mental health professionals.

The "typical" child treated through the Multnomah County ECMH program has a score of 53 on the Children's Global Assessment of Functioning Scale (CGAS), which indicates variable functioning with sporadic difficulty. (Possible scores on the CGAS range from 0 to 100, with higher scores indicating better functioning.) The range of scores among children targeted by the ECMH program is from 39, which represents major impairment in functioning, to 79, which represents only slight impairment.

The program is staffed by 17.5 full-time-equivalent (FTE) positions: mental health consultants (12.5 FTEs), subcontracted outpatient therapists (2.5 FTEs), a county child and adolescent psychiatrist with early-childhood expertise (.05 FTE), a subcontracted outpatient project supervisor (.5 FTE), an office assistant (.4 FTE), and a subcontracted outpatient child and adolescent psychiatrist (.1 FTE). The program's director is Barbara L. Brady, L.C.S.W., who is also the administrator of the county's early-childhood and child abuse mental health programs, and the program's county supervisor is Bruce Spilde, L.C.S.W. The subcontracted agency is Morrison Child and Family Services, with Margie MacCloud, L.C.S.W., as clinical director and Kathryn Falkenstern, L.C.S.W., as project supervisor.

The mental health consultants provide both primary prevention services—contributing to each school or center's programs and curricula and working with parents—and secondary prevention services—consulting with staff and families about specific children who exhibit social, emotional, or behavioral difficulties. They also provide assessment and treatment, working closely with agency staff and administrators. The county child and adolescent psychiatrist provides clinical consultation and training to these mental health consultants. The outpatient psychiatrist provides evaluations and consultations for referred children. The benefit of a psychiatrist's perspective has the potential to enhance the staff's future interactions with the children and their families.

In addition to conducting on-site evaluations of children, the ECMH program provides counseling, abuse prevention services, parenting education, and information and referral services and facilitates parent-child activities and child development activities.

The annual budget for the program was $1,224,764 in fiscal year 2000–2001, the bulk of which ($1,072,702) was provided by the county. Other sources of funding included a grant from the Portland public school system and funding from each of the nine host programs. Mental health consultants who are employed by the county and its subcontractors are funded jointly by the county and the various early-childhood programs through which the ECMH program operates. Funds earmarked for program expansion have been used to provide cash enhancements to Medicaid- and county-funded outpatient agencies to enable these agencies to visit the children and their families in their homes, classrooms, and child care centers and to improve the frequency, intensity, and flexibility of services. In fiscal year 2000–2001, a focus on staff productivity enabled the program to expand its target population by more than 70 percent while increasing the number of FTEs dedicated to the program by only 24 percent.

From an initial population base of 220 children in 1990, the Multnomah County ECMH program has expanded to serve more than 7,000 children. In fiscal year 1999–2000, the program provided direct clinical services to 130 children, consultations for 816 children, and primary prevention services to more than 3,000 children through its school and community sites. Another 4,000 children and their families benefited from the program as a result of its collaboration with the local child care resource and referral centers. During fiscal year 2000–2001, direct clinical services were provided to about 230 children. These numbers represent a significant contribution to the mental health field given that these children and families would not otherwise have received mental health services.

Multnomah County is unique in its implementation of this model of service delivery in such a large metropolitan area and across such a broad spectrum of the early-childhood community by using a blend of state, local, and federal funds. Unlike in the Midwest and the East, where there is a history of private child care institutions, Oregon and other western states have relied almost entirely on government agencies to provide these services.

Last year, the model of service delivery embodied in the Multnomah County ECMH program generated the formation of the Early Childhood Mental Health Partnership. Through this partnership, the executive leadership of all the major early-childhood organizations work together to encourage policy makers to improve the system of care for young children. The ECMH program is well known and well regarded in the early-childhood community and is requested by additional educational and child care organizations each year—for example, five new organizations sought involvement with the program in fiscal year 1999–2000. The program was presented to the National Head Start Conference in July 2000 and to the American Academy of Child and Adolescent Psychiatry's System of Care Workgroup in October 2000.

Surveys of families and participating agencies have revealed a high level of satisfaction with the program: an average of almost 100 percent of families and almost 100 percent of agency staff that were recently surveyed indicated that they were satisfied. Ninety-nine percent of children who receive direct services are maintained within their educational care setting without disruption to their care or to their education. This is a significant indicator that problems are being addressed adequately. Quarterly utilization and quality assurance reviews by the management staff of the various participating agencies have shown that the care provided through the program is appropriate to the assessed needs, that care is provided at a frequency and intensity appropriate to the assessed needs and risks, and that coordination of services with families and early-childhood caregivers and educators is excellent.

Over the next several years the program plans to expand services to all the local Head Start and child care programs, as funding allows. The program's collaborative structure for management, evaluation, and services has formed the basis of three recent requests for federal grants to expand services into more child care and Head Start settings. The county is exploring the possibility of obtaining an increase in federal financial participation toward that same end.

For more information, contact Barbara L. Brady, Administrator, Early Childhood Mental Health Program, 421 S.W. 6th Avenue, Suite 500, Portland, Oregon 97204-1620; phone, 503-988-3999, extension 24960; fax, 503-988-3328; e-mail, barbara.l.brady@co.multnomah.or.us.

#11

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: May 10, 2005

SUBJECT: Proposed Mental Health cuts for Albina HeadStart

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Malinda C. Brown

ADDRESS: 1340 NE Bryant CT

CITY/STATE/ZIP: Portland, OR. 97211

PHONE: DAYS: 503 528-9553 EVES: 503-358-9396

EMAIL: MalindaCBrown@Hotmail.com FAX:

SPECIFIC ISSUE:

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#12

Group of ~~4~~ 3

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: Cultural Mental Health Services.

AGENDA NUMBER OR TOPIC: Early Childhood Mental Health

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Yolanda Flores

ADDRESS: ~~4800 N~~ 9449 N Geneva Ave

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: 503-936-6739 EVES: 503-286-4057

EMAIL: yflores@pps.k12.or.us FAX: 503-916-2861

SPECIFIC ISSUE: Early Childhood Mental Health Services and (Bienestar de la Familia) Prog.

WRITTEN TESTIMONY: Mental Health Services for Head Start families are essential and very much needed to stop the cycle of future bigger problems. Prevention is the key. Please do Not cut these services. Give children a chance.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#13 Yolanda Flores 4

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: Cultural Mental Health Services
Services to Early Childhood Education & "Bienestar De la Familia"

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Pedro Cabrera

ADDRESS: 6873 N. Sabra st.

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: (503) 756-2039 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: Estos Servicios Me estan
Ayudando porq estoy pasando por un mal momento
familiar y en lo personal me ha servido y a mis
hijos, no se si no hubiera conocido estos
servicios posiblemente yo anduviera en la calle.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#14

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Cultural Mental Health Services

AGENDA NUMBER OR TOPIC: ~~Services~~ Early Childhood Mental Health Consultants

FOR: [redacted] AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Chad Flowerday

ADDRESS: 14908 SE Linden Lane

CITY/STATE/ZIP: Milwaukie, OR 97267

PHONE: DAYS: (503) 916-6294 EVES: _____

EMAIL: CFlowerd@pps.k12.or.us FAX: _____

SPECIFIC ISSUE: Proposed cuts to early childhood mental health services

WRITTEN TESTIMONY: I teach in PPS Head Start. Multnomah County currently provides Mental Health support services to my classroom in terms of counseling / play therapy / and general classroom behavior management advice. THIS SERVICE IS INVALUABLE TO our program and this community.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
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3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#15

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SAPF ATOD Services

AGENDA NUMBER OR TOPIC: Support School Svcs Alcohol Drug Funds

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Julie Dodge

ADDRESS: 1010 SE 15th

CITY/STATE/ZIP: Portland Or 97214

PHONE: DAYS: 503 645 3581 x253 EVES: 503 239 4732

EMAIL: julied@lifeworksnw.org FAX: 503 690 9605

SPECIFIC ISSUE:

WRITTEN TESTIMONY: Attached

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

LIFEWORKS NORTHWEST

RE: Offering 21022 – School Services – Alcohol, tobacco and other drug services

SAPF Contract: The SAPF alcohol, tobacco and other drug services contract now serves as primary outreach and referral point for youth and families seeking substance abuse services. Currently provided by LifeWorks NW and NARA, these services involve five staff members making face to face contact with every middle and high school in Multnomah County to offer alcohol/drug screening, intervention services, and consultation. In cases where youth would not otherwise be able to access treatment due to financial, cultural or geographic barriers, we provide treatment for them in their school.

The entire outreach team are staff of color, and the team is multi-lingual (including Spanish). Our staff serve traditional schools, alternative schools, and group homes. Nearly 1/3 of the currently active youth are Latino.

So far this year: 152 youth have received or are receiving services that they would not otherwise be able to access. Since October 1, 2004, staff have provided 369 hours of outreach to schools, and have spent 402 hours coordinating individual youth services with school staff. The hours spent in outreach and coordination alone account for nearly the equivalent of a full time staff member.

Why Continue:

1. *Expertise:* Individuals who provide alcohol drug services are specifically trained to do so. Most master's programs do not include addiction treatment training. Our staff all meet state certification standards for alcohol/drug counselors, and several are dually certified (mental health & addiction). Our experience is that people who are not trained to identify and refer youth with substance abuse concerns tend not to make the referrals.

2. *No other fund source:* These services are typically not covered by any other fund source. Outreach and case management are not billable to OHP or insurance companies. DCHS slots cannot be used to pay for the outreach or coordination.

3. *School partnership:* The SAPF contract requires a partnership with school districts to allow our alcohol/drug counselors to conduct services on site. Without this leverage, we would lack facilities to serve youth in their communities.

Priority: The Board ranked these services as 10th of the 26 Education Area offerings. This high ranking would suggest that the services are valued, and needed. Regardless of whether they are housed in OSCP or DCHS, without county general funding, the services will not exist.

The outcome of this reduction is that we will again see a significant reduction in youth accessing substance abuse services. This will cost the county more in education assistance, public safety expense, and limit our ability to create a thriving economy.

Background: Reported marijuana use among Multnomah County 11th graders increased 20% in just one year, from 2003 to 2004. Comparison rates for youth methamphetamine use are not available. However, 30-40% of adults arrested in Multnomah county have used methamphetamine in the past year, and nearly 30% of adults who are arrested test positive for meth.. Meth use interferes with student success rates, and increases public safety concerns. It is a particular concern in East Multnomah county, outer SE Portland, and North Portland. However, none of these neighborhoods have substance abuse treatment programs located there.

Over the past three years, the youth substance abuse treatment system in Multnomah County has undergone significant change. Prior to June, 2003, the primary referral points for youth to access substance abuse services were through DCJ's Diversion programming, and through the county Youth and Family Service Centers. In the spring of 2003, the diversion services were eliminated, which resulted in a nearly 50% drop in youth substance abuse referrals. In the winter of 2004, the Youth and Family Service Centers were replaced by the School Aged Policy Framework. This change also resulted in a drop in youth accessing addiction services.

Our staff have weekly contact with the following schools and community locations. Most of these are located in North Portland, and Mid and East county.

Grant High School
Nickerson Adolescent Day Treatment Program & School
Cleveland High School
Madison High School
Benson High School
Roosevelt High School(s)
Gresham High School
Parkrose High School
Centennial Learning Center
Springwater
Clackamas House
Reynolds High School
Reynolds Learning Academy
Fir Ridge
Sam Barlow High School
Asian Family Center
POIC
SEI

For further information, contact:

Tom Brewer, Service Director
Adult & Youth Addictions
LifeWorks NW
503-645-3581 ext 481
thomasb@lifeworksnw.org

Julie Dodge, Service Director
Prevention & Youth Addictions
LifeWorks NW
503-645-3581 ext 253
julied@lifeworksnw.org

#16

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Office of Public Guardian

AGENDA NUMBER OR TOPIC: County Budget

FOR: _____ AGAINST: X (unsure) THE ABOVE AGENDA ITEM

NAME: Molly A. Weinstein

ADDRESS: 5806 N Williams Ave.

CITY/STATE/ZIP: Portland, OR 97217-2168

PHONE: DAYS: 503 289-3410 EVES: none

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Restore to current level

WRITTEN TESTIMONY: Yes -

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

My name is Molly A. Weinstein a lifelong resident of Multnomah County. I am a retired attorney; my practice emphasized working with the elderly. In addition, for 11 1/2 years I was the Legal Services Developer for Seniors in the State Senior an Disabled Services Division. Therefore I worked a great deal on issues of Conservatorship and Guardianship. I have represented all sides in these issues and served myself as guardian and conservator.

I am distressed to read that the Chair has failed to restore the current service level of the Office of the Public Guardian. As I read the 6 community supported priorities stated in her letter of May 5, 2005 and in the budget document, the functions of the Guardian impact half of them, particularly that the basic needs of Multnomah County residents should be met. The residents served by the Office of the Public Guardian are those who are completely without other support; the assistance provided by that Office is given only as a last resort. True the ITAX may phase out in a few years, but for now the stated use for those funds is to support housing and living assistance to seniors and the disabled. That is precisely what the Office does.

I can tell you that the Office of the Public Guardian for Multnomah County is an essential service for this community. Not only does it improve the lives of some of our most vulnerable citizens, it is efficient use of our tax dollar and saves money through taking people out of inappropriate services such as the criminal justice system. The staff of the Office has a special expertise which gives service effectively and directly. Most importantly the Office of the Public Guardian sees that food, clothing, housing and medical care are provided. Isn't that the business of the County?

Submitted by Molly A. Weinstein
5806 N. Williams Avenue
Portland, Oregon 97217-2168
503 289-3410

May 10,2005
North Portland Library

#17

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: School Age Policy Framework

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Jackie Mercer

ADDRESS: 1776 SW Madison

CITY/STATE/ZIP: Portland Oregon

PHONE: DAYS: 503-307-2246 EVES: _____

EMAIL: Narajam@Aol.com FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#10 Group of 10

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SUN Community schools

AGENDA NUMBER OR TOPIC:

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Jane Kellum

ADDRESS: 10000 N. Burr

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: 503 916-5718 EVES:

EMAIL: FAX:

SPECIFIC ISSUE: Support SUN CS

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#19

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Sun

AGENDA NUMBER OR TOPIC: _____

FOR: Y AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Anthea Vang

ADDRESS: 9036 N. Colbert

CITY/STATE/ZIP: Port 97203

PHONE: DAYS: _____ EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: Sun Schools means to me. . . —

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#20

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SUN

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Kathy Phouthirath

ADDRESS: 10130 N. Tyler ave

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: 503-283-3849 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Support Sun School

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#21

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/16/05

SUBJECT: SUN

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Eduardo Reyes

ADDRESS: 7122 N Akmaur Portland

CITY/STATE/ZIP: OR 97203

PHONE: DAYS: 503 289-8523 EVES: _____

EMAIL: N/A FAX: _____

SPECIFIC ISSUE: Support of SUN Community Schools

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#22

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/5/05

SUBJECT: Sun Community Schools

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Colleen Orr

ADDRESS: 7521 N Gloucester Ave #1

CITY/STATE/ZIP: Portland OR 97203

PHONE: DAYS: 503 721 3906 EVES: 503 709 7061

EMAIL: Corr318616@hotmail.com FAX: 503 721 4988

SPECIFIC ISSUE: Sun School - continuing

WRITTEN TESTIMONY: Sun School means to me...

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#23

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: SUN

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Cindy Lopez

ADDRESS: 9205 N. Syracuse st.

CITY/STATE/ZIP: Portland OR 97203

PHONE: DAYS: (503) 286-7524 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#24

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Sun Community Schools

AGENDA NUMBER OR TOPIC:

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Chantel Orr

ADDRESS: 7521 N Gloucester Ave #1

CITY/STATE/ZIP: Portland OR 97203

PHONE: DAYS: 503 721 3901 EVES: 503 709 7061

EMAIL: _____ FAX: 503 721 4988

SPECIFIC ISSUE: Continuing budget for Sun School

WRITTEN TESTIMONY: Sun School means to me . . .

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#25

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: MAY/10/05

SUBJECT: Sun

AGENDA NUMBER OR TOPIC:

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Cobra Johnson

ADDRESS: 7447 N. NEW YORK AVE.

CITY/STATE/ZIP: Portland, Oregon, 97203

PHONE: DAYS: EVES:

EMAIL: FAX:

SPECIFIC ISSUE: Support Sunschool

WRITTEN TESTIMONY: Sun School means to me . . . .

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#26

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Sun Schools

AGENDA NUMBER OR TOPIC: _____

FOR X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: J. Clark (James Clark)

ADDRESS: 10000 N. Burr

CITY/STATE/ZIP: _____

PHONE: DAYS: 916-6262 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: Sun Schools is

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#27

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/15

SUBJECT: Sun

AGENDA NUMBER OR TOPIC: _____

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Abeba Anarouko ANANOUKO

ADDRESS: 8696 N. Columbia Blvd Apt #104

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS (503) 240-0031 EVES: Same

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: Sun Schools means to me . . .

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#28

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: Gang prevention + intervention programs

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Gloria Wiggins

ADDRESS: 451 NW 1st

CITY/STATE/ZIP: Gresham OR 97030

PHONE: DAYS: 503 6698350 EVES: 503 667 0716

EMAIL: gwiggins@catholiccharitesoregon.org FAX: 503 666 7484

SPECIFIC ISSUE: Gang prevention + intervention Services

WRITTEN TESTIMONY: Gangs are a huge problem in my community. We need to provide prevention services to stop kids from joining gangs and we also need intervention services to save those kids who already became involved.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#29

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT:

AGENDA NUMBER OR TOPIC: BUDGET CUTS FOR GANG SVS.

FOR: ____ AGAINST: ✓ THE ABOVE AGENDA ITEM

NAME: RICARDO LOPEZ

ADDRESS: 451 N.W. FIRST

CITY/STATE/ZIP: PORTLAND, OR 97030

PHONE: DAYS: (503) 669-8350 EVES: (503) 317-0677

EMAIL: ricardonfs13@yahoo.com FAX:

SPECIFIC ISSUE: PREVENTION & INTERVENTION CUTS

WRITTEN TESTIMONY: IF YOUR PRIORITY IS SAFETY THEN ADDRESSING THE GANG ISSUES IS KEY TO DEALING WITH SAFETY.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#30

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: GANG PREVENTION

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: [redacted] JOE WIGGINS

ADDRESS: 502 SW VICTORIA CT

CITY/STATE/ZIP: GRESHAM OR 97080

PHONE: DAYS: 503 667 0716 EVES: 503 667 0716

EMAIL: FAX:

SPECIFIC ISSUE: GANG PREVENTION

WRITTEN TESTIMONY: THE COUNTY BUDGET SHOULD REFLECT THE REALITY THAT GANGS ARE CRIMINAL ENTERPRISES INVOLVED IN DRUGS, VIOLENCE THEFT ETC PREVENTION COST LESS THAN LAW ENFORCEMENT

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#31

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT: _____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Richard Rivera Vasquez

ADDRESS: 451 NW 1st Portland, OR

CITY/STATE/ZIP: Portland, OR 97030

PHONE: DAYS: (503) 669-8350 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Gang Prevention & intervention

WRITTEN TESTIMONY: Hello I am here to support my counseler Ricardo and to say that we need him.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#32

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05-10-05

SUBJECT: _____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Heidi Sanchez Valladares

ADDRESS: ~~4824 SE Pine Street~~ 451 NW First ~~St~~

CITY/STATE/ZIP: Portland OR 97230

PHONE: DAYS: 503-669-8350 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Gang prevention & interventoon.

WRITTEN TESTIMONY: I am here to ~~provide~~ support my counselor Ricardo & ~~not~~ Not cut his program because we need him & because with out him we might get involve with ganges members.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#33

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: GANG Prevention & INTERVENTION Budgets Cuts.

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Blanca Orduo

ADDRESS: 619 NE. 188th AVE.

CITY/STATE/ZIP: PORTLAND OR. 97230

PHONE: DAYS: _____ EVES: _____

EMAIL: N/A FAX: _____

SPECIFIC ISSUE: GANG (Prevention & INTERVENTION) Budget Cuts.

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#34

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: A.P.I.

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Vilay. Chanthavong Jan Thao Vong

ADDRESS: 4424 NE Glisan st

CITY/STATE/ZIP: Portland OR 97213

PHONE: DAYS: 503 2959396 EVES:

EMAIL: Konlao1@netzero.com FAX:

SPECIFIC ISSUE: API needs / challenges.

WRITTEN TESTIMONY: Position ~ SSSES youth & family support.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#35

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT: C/ Head Start Mental Health

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: X THE ABOVE AGENDA ITEM

NAME: Lola m Carter

ADDRESS: 8414 N Bayard

CITY/STATE/ZIP: Port OR 97217

PHONE: DAYS: 503/283 4599 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#36

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/09

SUBJECT: Funding for Portland Women's Crisis Line
↳ Safety Planning / Budget

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Kathryn Arnone

ADDRESS: 4905 SE 33rd Pl

CITY/STATE/ZIP: Portland OR 97202

PHONE: DAYS: 503-251-6194 EVES: 503-777-6972

EMAIL: K.arnone@comcast.net FAX: _____

SPECIFIC ISSUE: Support proposed budget $63,557 for centralized info + referral for Sexual Assault + Domestic Violence

WRITTEN TESTIMONY: PWCL serves an average of 2500 callers per month. A live, trained Crisis Line Specialist answers the phone, 24/7. We are the entry point for SA/DV info + referral. Without this money, we cannot maintain staffing 24/7.

Thank you

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#37

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: cut in Public Guardian Program

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: ✓ THE ABOVE AGENDA ITEM

NAME: Jeff Brandon

ADDRESS: 5434 SW 18th DR

CITY/STATE/ZIP: Portland OR 97239

PHONE: DAYS: 503/8695925 EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: cut in program funding

WRITTEN TESTIMONY: I will read from my notes — explaining why this program should not be cut.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#38

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: MAY 10 2005

SUBJECT: Cuts to Public Guardian Office

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Kathryn Labadie "LAA BADAY"

ADDRESS: 2486 N.W. Raleigh

CITY/STATE/ZIP: Portland Or 97210

PHONE: DAYS: 503 248-0270 EVES: same

EMAIL: klab2486@comcast.net FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: NO --

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#39

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5-10-05

SUBJECT: SAPE System

AGENDA NUMBER OR TOPIC:

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Diane Feldt

ADDRESS: 5139 N. Lombard

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: 503 285-9871 EVES:

EMAIL: dianef@cascadia hhc.org FAX:

SPECIFIC ISSUE: SAPE System

WRITTEN TESTIMONY: Yes

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

CASCADIA
Behavioral Healthcare

May 10, 2005

TO: Chair Diane Lynn
County Commissioners Serena Cruz, Maria Rojo de Steffey, Lisa Naito, and Lonnie Roberts

FROM: Diane Feldt, SAPF Region 1 & SMYRC Program Manager

I'm Diane Feldt. For the past 14 months it has been my job to oversee Cascadia's Sexual Minority Youth Resource Center, SMYRC, and Region 1 of the School Age Policy Framework System. Including SMYRC in the SAPF System mix has provided schools with valuable training and consultation regarding the well being of gay lesbian bi-sexual transgender and questioning youth. SMYRC's work has prevented harassment, provided support and kept young people in school.

Region 1 is a collaborative partnership including Neighborhood House, Friendly House, Lifeworks NW, Metropolitan Family Services, the YWCA and Cascadia. As partners we came together to prepare then implement-contracted services in a Region that is demographically diverse and geographically challenged. We also began the process of service integration within those contracted services. We believe our design extracts the most benefit from limited resources. By allowing SUN Community Schools to access rental assistance we engaged Touchstone workers to provide outreach and comprehensive case management. We may even have kept some students from becoming part of the high mobility trends that negatively impact school success. We recognize and honor the unique aspects of the many neighborhoods in Region 1 and given funding limitations and within component model expectations, shape what we do to the needs we find.

We recognize cuts are necessary. The hits to this system include Alcohol, Tobacco and Other Drugs outreach, assessment and referral, the School Attendance Initiative and four Regional Resource Specialists. I understand the County's drug/alcohol treatment services will be taking on the functions of the ATOD contract. I ask if outreach and assessments in schools will continue? If not I question how students will be screened and provided the linkage to treatment they need? Through the efforts of Region 1's Resource Specialist Rose City Chevrolet is conducting a raffle hoping to raise $135,000 for North Portland schools. Given that I think the role is worth keeping. I helped create what became the School Attendance Initiative. Unfortunately the need has not vanished with the funding. I would be happy to work with any assortment of folks from the County and schools to reconfigure and find ways to refinance this effort. If they don't make it to school, particularly in K-6, school completion will never happen. At its zenith the North Team had five staff and 998 referrals half were k-6. I believe this year's cuts will look mild compared to what is to come next year. I encourage the County to be proactive, work with community partners, to begin seeking alternative funds now for vulnerable programs.

CASCADIA BEHAVIORAL HEALTHCARE 5139 N LOMBARD STREET PORTLAND OR 97203 PH: 503.285.9871 FAX: 503.978.8640

#40

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05.10.05

SUBJECT: Cuts to Behavioral Specialists for Preschool Children

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Susan Anderson

ADDRESS: 5020 NE Killingsworth #501

CITY/STATE/ZIP: Portland Or. 97218

PHONE: DAYS: (503) 280-0534 EVES: (503) ~~280-0534~~ 287-5348

EMAIL: susan1965@comcast.net FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#41

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 05-10-05

SUBJECT: _____

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Midge Purcell

ADDRESS: 6514 SE 36th Ave

CITY/STATE/ZIP: Portland ~~OR~~ 97202

PHONE: DAYS: 503 235 2305 EVES: 503 367 3185

EMAIL: midge@stand.org FAX: _____

SPECIFIC ISSUE: OSCP Funding

WRITTEN TESTIMONY: yes

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
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4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

#42

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 9/10/05

SUBJECT: PUBLIC GUARDIAN PROGRAM

AGENDA NUMBER OR TOPIC:

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Helen-Ruth Stephens

ADDRESS: 1969 NW Johnson St Apt 522

CITY/STATE/ZIP: WILMINGTON DE 97209-1315

PHONE: DAYS: 503-222-5491 EVES: 503-222-5491

EMAIL: helen_ruth@hotmail.com FAX:

SPECIFIC ISSUE: Cutting Public Guardian Program by $350,000 is unconscionable

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

#43

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 3/10/05

SUBJECT: Budget Cuts LIBRE gang intervention

AGENDA NUMBER OR TOPIC: _____

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Oscar Sweeten Lopez

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: DAYS: _____ EVES: _____

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: _____

WRITTEN TESTIMONY: _____

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3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

#44

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: FUNDING

AGENDA NUMBER OR TOPIC:

FOR: X AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Douglas J. LinHART

ADDRESS: 4513 NE 18AVE

CITY/STATE/ZIP: PORTLAND OR 97211

PHONE: DAYS: 503-544-1830 EVES: ~~503~~ - SAME

EMAIL: DJLinHART@yAHoo.com FAX:

SPECIFIC ISSUE: FUNDING LONDER LEARING CENTER

WRITTEN TESTIMONY:

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
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4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

#45

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SUN Comm. Schools

AGENDA NUMBER OR TOPIC: SUN Comm. Schools

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Brandie Fazal

ADDRESS: 9222 n. Bristol Ave.

CITY/STATE/ZIP: Portland, OR 97203

PHONE: DAYS: (503) 916-5260 x1444 EVES: (503) 473-4107

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Continuing Funding for SUN Comm. Schools

WRITTEN TESTIMONY:

In support of SUN Comm. Schools and their effectiveness.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes.**
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
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#46

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SUN Comm. Schools

AGENDA NUMBER OR TOPIC: SUN Budget

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Diego Vazquez

ADDRESS: 9421 N Saint Louis Ave

CITY/STATE/ZIP: Portland OR

PHONE: DAYS: (503) 286-7526 EVES: /

EMAIL: / FAX: /

SPECIFIC ISSUE: Sun School Support

WRITTEN TESTIMONY: I'm supporting Sun School to stay open for all kids to enjoy. It is necesary that it stays open because kids like me need this class.

IF YOU WISH TO ADDRESS THE BOARD:

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4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

#47

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Sun Community Schools

AGENDA NUMBER OR TOPIC: Sun budget

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Rasheeda Webber

ADDRESS: 8756 N. Chautauqua

CITY/STATE/ZIP: Portland OR, 97217

PHONE: DAYS: (503) 807-9976 EVES: _____

EMAIL: www.RasheedaWebber@yahoo.com FAX: _____

SPECIFIC ISSUE: Sun Community schools (Funding)

WRITTEN TESTIMONY: Supports and participates in Sun Community Schools. Against it in closing down.

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
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IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

#48

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: SUN Comm. Schools

AGENDA NUMBER OR TOPIC: SUN Budget

FOR: ✓ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: HANIF FAZAL

ADDRESS: [redacted] 9222 N. Bristol Ave.

CITY/STATE/ZIP: Portland OR

PHONE: DAYS: (503) 488-5162 EVES: (503) 891-8718

EMAIL: hanif@openmeadow.org FAX: _____

SPECIFIC ISSUE: Sun School Support

WRITTEN TESTIMONY: As A director of the STEP up Program, I want to express my strong support for Sun schools. Sun School has been A vital part of our programs success. Sun has been instrumental in the coordination of After school programming/program in A variety of areas. Sun has also been A strong liason between the school & After school programs as well as serving the role of assisting After-school programs in working together.

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IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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#49

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: _____

AGENDA NUMBER OR TOPIC: 1

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Bill Fields

ADDRESS: 3120 SE Brooklyn

CITY/STATE/ZIP: Portland Or 97202

PHONE: DAYS: _____ EVES: 503-231-9520

EMAIL: _____ FAX: _____

SPECIFIC ISSUE: Maintain Public Guardian program

WRITTEN TESTIMONY: _____

IF YOU WISH TO ADDRESS THE BOARD:

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IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

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2. Written testimony will be entered into the official record.

Written Only

MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP

Please complete this form and return to the Board Clerk
*****This form is a public record*****

MEETING DATE: 5/10/05

SUBJECT: Cultural Mental Health Services

AGENDA NUMBER OR TOPIC: Early Education Mental Health Consultant

FOR: _____ AGAINST: _____ THE ABOVE AGENDA ITEM

NAME: Kathy Taylor
Portland Public Schools

ADDRESS: Peninsula Head Start - 8125 N Emerald

CITY/STATE/ZIP: Portland, Ore 97217

PHONE: DAYS: 503-916-6294 EVES: _____

EMAIL: kathytay@pps. FAX: _____

SPECIFIC ISSUE: Early Education Mental Health Consultants

WRITTEN TESTIMONY: These positions and services are vital to our families in Head Start and many other programs in the community. We work with very vulnerable, needy & high risk families. Our families have many stresses & crises in their lives. Mental Health

(over)

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is a key compotent of getting our
families help. The Mental Health
consultant that works in our programs
works with teachers, family service workers
and other staff to connect with families
asking for mental health. Our families
will not directly, on their own go to
a community mental health program many
times they need encouragement and
support to even ask for help. The Mental
Health Conseeltant has budged that gap
time and time again.

Early Childhood Education in Portland Public Schools is a high priority, ~~It should~~ Early Childhood Services should be a high priority for Mult. Co as well