

# ANNOTATED MINUTES

Monday, August 23, 2004 - 2:00 PM  
Multnomah Building, First Floor Commissioners Boardroom 100  
501 SE Hawthorne Boulevard, Portland

## BOARD BRIEFING

*Chair Diane Linn convened the meeting at 2:03 p.m., with Vice-Chair Serena Cruz and Commissioners Lisa Naito and Maria Rojo de Steffey present, and Commissioner Lonnie Roberts excused.*

- B-1 Briefing on the Implementation of the Mental Health System of Care for Children and Families. Presented by Commissioner Lisa Naito, Patricia K. Pate, Dr. Peter Davidson, Nancy Winters and Godwin Nwerem. 75 MINUTES REQUESTED.

**CHAIR LINN THANKED EVERYONE FOR COMING, INCLUDING GUESTS FROM PACIFIC UNIVERSITY, AND ADVISED THAT COMMISSIONER ROBERTS IS HOME ILL.**

**PATRICIA PATE, PETER DAVIDSON, NANCY WINTERS AND GODWIN NWEREM PRESENTATIONS AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING HISTORY OF ORIGINAL REDESIGN WORKGROUP; OVERVIEW OF MENTAL HEALTH SYSTEM REDESIGN PROCESS, IMPLEMENTATION AND CULTURALLY SPECIFIC SERVICES; AGENCY CONCEPT; BUSINESS MODEL; SPECIALIZED CONTRACTS AND COORDINATED SERVICES TO ADDRESS FAMILY SYSTEMS; EARLY INTERVENTION; SPECIAL POPULATION NEEDS; RECRUITING RESPITE SERVICES; STATE FUNDING REQUIREMENTS. MS. PATE EXPLANATION OF PROPOSED BUDGET MODIFICATION DCHS-01 REALLOCATING EXISTING RESOURCES TO MANAGE TRANSITION OF APPROXIMATELY 30 CHILDREN FROM STATE SERVICES TO COUNTY.**

**MS. PATE AND DR. DAVIDSON RESPONSE TO  
QUESTIONS AND DISCUSSION OF  
COMMISSIONERS NAITO AND CRUZ  
REGARDING STATE FUNDING FORMULA AND  
MANAGING CAPITATED SYSTEM. STAFF  
DIRECTED TO PROVIDE BOARD WITH  
ADDITIONAL INFORMATION.**

*There being no further business, the meeting was adjourned at 3:10 p.m.*

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Tuesday, August 24, 2004 - 6:00 PM  
Multnomah Building, First Floor Commissioners Boardroom 100  
501 SE Hawthorne Boulevard, Portland

**PUBLIC HEARING**

*Chair Diane Linn convened the meeting at 6:01 p.m., with Vice-Chair  
Serena Cruz and Commissioners Lisa Naito and Maria Rojo de Steffey present,  
and Commissioner Lonnie Roberts excused.*

PH-1 The Multnomah County Board of Commissioners will conduct a Public Hearing on the Library Director's recommendations regarding the Library's Internet Access Policies. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

**CHAIR LINN THANKED EVERYONE FOR  
COMING AND ADVISED THAT COMMISSIONER  
ROBERTS IS HOME ILL. CHAIR LINN  
EXPLAINED THAT THE ENTIRE BOARD HAS  
BEEN BRIEFED ON THE PROPOSED INTERNET  
POLICIES AND THANKED MOLLY RAPHAEL AND  
HER STAFF FOR THEIR WORK ON THE ISSUE.**

**FRIENDS OF THE MULTNOMAH COUNTY  
LIBRARY PRESIDENT STEPHANIE VARDAVAS,  
REPRESENTING HER OWN PERSONAL VIEWS,  
PRESENTED TESTIMONY ADVISING THAT SHE  
IS GENERALLY OPPOSED TO INTERNET  
FILTERS FOR LIBRARIES BECAUSE THE  
SOFTWARE DOES NOT WORK. MS. VARDAVAS**

**GAVE EXAMPLES OF SEVERAL NON OBSCENE AND/OR PORNOGRAPHIC SITES BLOCKED BY INTERNET FILTERS AND ADVISED THAT SHE DOES SUPPORT THE PROTECTION OF CHILDREN WITH PARENTAL GUIDANCE. ACLU OF OREGON REPRESENTATIVE ANDREA MEYER TESTIMONY IN OPPOSITION TO INTERNET FILTERING, URGING THE BOARD TO SEND THE LIBRARY DIRECTOR RECOMMENDATIONS BACK TO THE ADVISORY COMMITTEE. MS. MEYER ADVISED IT IS THE ACLU'S POSITION THAT BLOCKING INFORMATION TO YOUNG ADULTS IS CENSORSHIP AND AN OREGON CONSTITUTIONAL VIOLATION. TEACHER MARTHA DECHERD TESTIMONY IN OPPOSITION TO INTERNET FILTERING, ADVISING THAT IT DOES NOT PROTECT LIBRARY PATRONS FROM INAPPROPRIATE CONTENT SUCH AS PORNOGRAPHY AND BLOCKS ACCESS TO NEEDED INFORMATION. TEACHER DEB WHEELBARGER TESTIMONY IN OPPOSITION TO INTERNET FILTERING, GIVING EXAMPLES OF HOW FILTERING SYSTEM BLOCKS ACCESS TO MANY APPROPRIATE INFORMATIONAL SITES. MS. WHEELBARGER URGED THE BOARD TO KEEP THE LIBRARY'S CURRENT POLICY. MARIAN CREAMER TESTIMONY IN OPPOSITION TO THE PROPOSED LIBRARY INTERNET FILTERING SYSTEM, ADVISING THAT PARENTS SHOULD CONTROL THEIR CHILD'S ACCESS THROUGH EDUCATION AND NECESSARY SKILL-MAKING TOOLS, NOT THROUGH CENSORSHIP. BRAD PERKINS TESTIMONY ADVISING HE DOES NOT SUPPORT THE PROPOSED LIBRARY INTERNET FILTERING SYSTEM, BUT THAT CHILDREN STILL NEED TO BE PROTECTED FROM INAPPROPRIATE SITES. BARBARA SNOW TESTIMONY ADVISING SHE WAS IN FAVOR OF PROPOSED POLICIES BUT IS NOW UNDECIDED. LIBRARY FILTERING COMMITTEE MEMBER URSULA LEGUIN TESTIMONY SUGGESTING THE UNRELIABILITY OF FILTERING SYSTEMS WILL NOT CLEAN UP WORDS BUT WILL CENSOR**

**THEM. MS LEGUIN ADVISED SHE WANTS THE LIBRARY TO CONTINUE TEACHING FOLKS HOW TO USE THE INTERNET. FORMER LIBRARY BOARD MEMBER SUSAN HATHAWAY-MARXER TESTIMONY EXPRESSING CONCERN THAT ADOPTION OF POLICY WILL DENY ACCESS TO YOUNG PERSONS, AND THAT THE POLICY DOES NOT ADDRESS PRINTED PORNOGRAPHY MATERIALS LEFT IN LIBRARY PRINT BINS OR RESTROOMS. MS. HATHAWAY-MARXER RESPONSE TO QUESTIONS AND COMMENTS OF CHAIR LINN. HERMAN FRANKEL TESTIMONY IN SUPPORT OF THE POLICY RECOMMENDATIONS. PARENT FRAN KOHLER TESTIMONY ADVISING HE IS TORN BETWEEN BOTH SIDES OF ISSUE. MR. KOHLER SUGGESTED THAT CHILDREN OF LOWER INCOME CLASSES USING LIBRARY INTERNET SERVICES WILL BE DENIED INFORMATION THAT CHILDREN OF HIGHER INCOME CLASSES WOULD BE ABLE TO ACCESS. RECENT UNIVERSITY OF PORTLAND GRADUATE JACK WELCH TESTIMONY ADVISING ACCESS TO INTERNET WAS VERY IMPORTANT TO HIM AND THAT HIS PARENTS TAUGHT HIM WHAT WAS APPROPRIATE. ROY BURKETT TESTIMONY COMMENDING MOLLY RAPHAEL AND STAFF FOR THE PROPOSED POLICIES. MR. BURKETT QUESTIONED HOW FILTERING WILL BE IMPLEMENTED FOR YOUNG CHILDREN; HOW PARENTS WILL BE ALLOWED TO MAKE DECISIONS; AND WHETHER ADULTS WHO HAVE CERTAIN ADDICTIONS WILL BE ABLE TO CHOOSE TO ALWAYS FILTER. AT THE REQUEST OF COMMISSIONER CRUZ, LIBRARY DIRECTOR MOLLY RAPHAEL EXPLAINED THE PROPOSED PROCESS FOR MR. BURKETT AND THE AUDIENCE.**

**COMMISSIONERS CRUZ AND ROJO STATED THAT LIKE MS. SNOW, THEY FELT COMFORTABLE BEFORE HEARING TONIGHT'S TESTIMONY AND THAT THEY WILL PONDER**

***THE ISSUE FURTHER. COMMISSIONERS CRUZ,  
ROJO, NAITO AND CHAIR LINN THANKED  
EVERYONE FOR COMING TO THE HEARING.***

*There being no further business, the meeting was adjourned at 6:50 p.m.*

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Thursday, August 26, 2004 - 9:00 AM  
Multnomah Building, First Floor Commissioners Boardroom 110  
501 SE Hawthorne Boulevard, Portland

**EXECUTIVE SESSION**

*Chair Diane Linn convened the meeting at 9:00 a.m., with Vice-Chair Serena Cruz and Commissioners Lonnie Roberts and Maria Rojo de Steffey present, and Commissioner Lisa Naito arriving at 9:12 a.m.*

- E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660(1)(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. 30 MINUTES REQUESTED.

***EXECUTIVE SESSION HELD.***

*There being no further business, the meeting was adjourned at 9:18 a.m.*

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Thursday, August 26, 2004 - 9:30 AM  
Multnomah Building, First Floor Commissioners Boardroom 100  
501 SE Hawthorne Boulevard, Portland

**REGULAR MEETING**

*Chair Diane Linn convened the meeting at 9:29 a.m., with Vice-Chair Serena Cruz and Commissioners Lisa Naito, Lonnie Roberts and Maria Rojo de Steffey present.*

**CONSENT CALENDAR**

***UPON MOTION OF COMMISSIONER ROBERTS,  
SECONDED BY COMMISSIONER ROJO, THE  
CONSENT CALENDAR (ITEMS C-1 THROUGH C-7)  
WAS UNANIMOUSLY APPROVED.***

**NON-DEPARTMENTAL**

- C-1 Reappointment of Mike Houck to the SUSTAINABLE DEVELOPMENT COMMISSION

**DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES**

- C-2 RESOLUTION Authorizing Private Sale of Certain Tax Foreclosed Property to Douglas J & Charity L Tucker, Husband and Wife

***RESOLUTION 04-125.***

**SHERIFF'S OFFICE**

- C-3 ORDER: Acknowledgement of Found Unclaimed Property and Authorization of Transfer for Sale or Disposal

***ORDER 04-126.***

**DEPARTMENT OF COMMUNITY JUSTICE**

- C-4 Budget Modification DCJ-05 Adding \$19,991 Additional Project Safe Neighborhood Grant Monies to the Department of Community Justice Federal/State Fund Budget

**DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES**

- C-5 Government Expenditure/Revenue Contract (190 Agreement) 4600003710 with the City of Gresham, for Traffic Signal System Improvement Project, Phase 3A and 3B
- C-6 Budget Modification MCSO 04-EXT-19 Increasing Revenue and Expenditure Budgets in Special Operations Fund 1516 by \$13,810.32 to Reflect Monies Collected by Multnomah County and Passed Directly through to Other Agencies

**DEPARTMENT OF COUNTY HUMAN SERVICES**

C-7 ORDER Authorizing Designees of the Mental Health Program Director to Direct a Peace Officer to Take an Allegedly Mentally Ill Person into Custody

***ORDER 04-127.***

**REGULAR AGENDA**  
**PUBLIC COMMENT**

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.

***NO ONE WISHED TO COMMENT.***

***AT THE REQUEST OF CHAIR LINN AND UPON MOTION OF COMMISSIONER ROBERTS, SECONDED BY COMMISSIONER ROJO, CONSIDERATION OF THE FOLLOWING TWO ITEMS WAS UNANIMOUSLY APPROVED.***

**DEPARTMENT OF HEALTH**

UC-1 Government Revenue Contract (190 Agreement) 0410533 with the State of Oregon, Department of Human Services, Designating the Multnomah County Health Department as the "Regional Lead Agency" for Hospital Health System Emergency Preparedness

***COMMISSIONER NAITO MOVED AND COMMISSIONER ROBERTS SECONDED, APPROVAL OF UC-1. DR. GARY OXMAN AND ASSISTANT COUNTY ATTORNEY PATRICK HENRY EXPLANATION AND RESPONSE TO QUESTION OF COMMISSIONER CRUZ REGARDING THE URGENCY FOR BOARD ACTION DUE TO STATE REQUIREMENT. AGREEMENT UNANIMOUSLY APPROVED.***

**DEPARTMENT OF COUNTY HUMAN SERVICES**

UC-2 Renewal of Government Revenue Contract (190 Agreement) 0405113 with the Oregon Department of Human Services, for Multnomah County's Mental

Health Organization, Verity, to Provide Child, Adolescent and Adult Mental Health Services through the Oregon Health Medicaid Project

**COMMISSIONER ROBERTS MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF UC-2. PATRICIA PATE AND ASSISTANT COUNTY ATTORNEY PATRICK HENRY EXPLANATION AND RESPONSE TO BOARD QUESTIONS. MR. HENRY ADVISED THEY HAVE SET UP A MEETING WITH THE OREGON DEPARTMENT OF HUMAN SERVICES TO DISCUSS THE PROBLEM OF THE STATE REQUIRING SUCH A SHORT TURN-AROUND ON CONTRACTS THAT NEED TO BE REVIEWED BY COUNTY ATTORNEY AND ELECTED OFFICIALS ALIKE. AGREEMENT UNANIMOUSLY APPROVED.**

**NON-DEPARTMENTAL**

- R-1 2004 Multnomah County Salary Review Commission Report to the Board. Presented by Auditor Suzanne Flynn and Salary Review Commission Chair Mary Ann Wersch. 15 MINUTES REQUESTED.

**AUDITOR SUZANNE FLYNN PRESENTATION AND INTRODUCTION OF HER APPOINTED VOLUNTEER SALARY REVIEW COMMISSIONERS ERIC WILSON, DAVID RHYS, RICK HOWELL AND MARY ANN WERSCH. MS. FLYNN ADVISED THAT THE SALARY REVIEW COMMISSION IS APPOINTED EVERY TWO YEARS PER THE MULTNOMAH COUNTY CHARTER. SALARY REVIEW COMMISSION CHAIR MARY ANN WERSCH PRESENTATION, ADVISING THE COUNTY BOARD HAS GONE SEVEN YEARS WITHOUT SALARY INCREASES AND THAT THE SALARY REVIEW COMMISSION RECOMMENDS THAT THE COUNTY COMMISSIONER'S SALARIES BE SET AT \$71,850 AND THE CHAIR'S SALARY BE SET AT \$110,170. CHAIR WERSCH THANKED CAROL BROWN, ATTORNEY AGNES SOWLE, AUDITOR SUZANNE FLYNN AND JUDY ROSENBERG FOR THEIR ASSISTANCE TO THE**

**SALARY REVIEW COMMISSION. CHAIR LINN  
THANKED CHAIR WERSCH AND THE SALARY  
REVIEW COMMISSIONERS FOR THEIR  
VOLUNTEER TIME AND EFFORTS.**

- R-2 Sauvie Island Bridge Briefing on New Bridge Design and Work of the Citizen's Advisory Committee. Presented by Commissioner Maria Rojo de Steffey and Ian Cannon, Bridge Engineering Services Manager. 20 MINUTES REQUESTED.

**COMMISSIONER ROJO AND IAN CANNON  
PRESENTATIONS AND RESPONSE TO BOARD  
QUESTIONS ON ISSUES INCLUDING  
DISPOSITION OF THE OLD BRIDGE AND PLANS  
FOR BICYCLE AND PEDESTRIAN LANES. MR.  
IAN ACKNOWLEDGED AND THANKED SAUVIE  
ISLAND RESIDENT AND CITIZEN'S ADVISORY  
COMMITTEE MEMBER IN THE AUDIENCE  
TODAY.**

- R-3 RESOLUTION Establishing Fees and Charges for MCC 11.05 Land Use General Provisions, 11.15 Zoning, 11.45 Land Divisions, 37 Administration and Procedures, 38 Columbia River Gorge National Scenic Area, and Repealing Resolution No. 04-008

**COMMISSIONER ROJO MOVED AND  
COMMISSIONER NAITO SECONDED, APPROVAL  
OF R-3. ROB BAYLEY AND REBECCA ESAU  
EXPLANATION AND RESPONSE TO REQUEST OF  
COMMISSIONER CRUZ THAT PORTLAND STAFF  
PRESENT FUTURE FEE INCREASES AND  
CHANGES TO MULTNOMAH COUNTY FOR INPUT  
PRIOR TO CITY COUNCIL CONSIDERATION AND  
VOTE. RESOLUTION 04-128 UNANIMOUSLY  
ADOPTED.**

**SHERIFF'S OFFICE**

- R-4 Second Reading and Possible Adoption of a Proposed ORDINANCE Amending MCC Chapter 15, Sheriff, Relating to Alarm Systems

**ORDINANCE READ BY TITLE ONLY. COPIES  
AVAILABLE. COMMISSIONER CRUZ MOVED**

**AND COMMISSIONER NAITO SECONDED, APPROVAL OF SECOND READING AND ADOPTION. LARRY AAB EXPLANATION. NO ONE WISHED TO TESTIFY. ORDINANCE 1047 UNANIMOUSLY ADOPTED.**

**DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES**

R-5 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Portland, Environmental Services, for Non-Housing, Public Purposes

**COMMISSIONER CRUZ MOVED AND COMMISSIONER ROJO SECONDED, APPROVAL OF R-5. GARY THOMAS EXPLANATION. MINDY BROOKS TESTIMONY IN SUPPORT AND APPRECIATION OF PROPERTY TRANSFER TO PORTLAND. RESOLUTION 04-129 UNANIMOUSLY ADOPTED.**

R-6 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Portland, Parks and Recreation, for Non-Housing, Public Purposes

**COMMISSIONER CRUZ MOVED AND COMMISSIONER ROBERTS SECONDED, APPROVAL OF R-6. RILEY WHITCOMB EXPLANATION AND TESTIMONY IN SUPPORT AND APPRECIATION OF TRANSFER. RESOLUTION 04-130 UNANIMOUSLY ADOPTED.**

R-7 RESOLUTION Approving Transfer of Tax Foreclosed Properties to the City of Portland, Office of Transportation, for Non-Housing, Public Purposes

**COMMISSIONER CRUZ MOVED AND COMMISSIONER ROBERTS SECONDED, APPROVAL OF R-7. STEVE PLANCHOW AND LINDA BIRTH TESTIMONY IN SUPPORT AND APPRECIATION OF TRANSFER. RESOLUTION 04-131 UNANIMOUSLY ADOPTED.**

R-8 RESOLUTION Approving Transfer of Tax Foreclosed Property to Multnomah County Land Use and Transportation Program, for Non-Housing, Public Purposes

**COMMISSIONER CRUZ MOVED AND COMMISSIONER NAITO SECONDED, APPROVAL OF R-8. ALISON WINTER EXPLANATION AND TESTIMONY IN SUPPORT AND APPRECIATION OF TRANSFER FOR TRANSPORTATION RIGHT OF WAY PURPOSES. RESOLUTION 04-132 UNANIMOUSLY ADOPTED.**

R-9 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Gresham, for Non-Housing, Public Purposes

**COMMISSIONER ROBERTS MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-9. MIKE GREEN EXPLANATION AND TESTIMONY IN SUPPORT AND APPRECIATION OF TRANSFER TO GRESHAM. RESOLUTION 04-133 UNANIMOUSLY ADOPTED.**

R-10 RESOLUTION Authorizing the Sale of Properties Acquired by Multnomah County through the Foreclosure of Liens for Delinquent Property Taxes

**COMMISSIONER CRUZ MOVED AND COMMISSIONER NAITO SECONDED, APPROVAL OF R-10. GARY THOMAS EXPLANATION AND RESPONSE TO QUESTION OF COMMISSIONER CRUZ REGARDING FORMER GAS STATION PROPERTY AT 7600 NORTH WILLAMETTE BOULEVARD, ADVISING THE COUNTY ACQUIRED THE BROWNFIELD PROPERTY TEN YEARS AGO. COMMISSIONER CRUZ COMMENTS IN APPRECIATION FOR THE EFFORTS OF MR. THOMAS AND THE PATIENCE OF THE NEIGHBORING RESIDENTS. RESOLUTION 04-134 UNANIMOUSLY ADOPTED.**

#### **DEPARTMENT OF COUNTY HUMAN SERVICES**

R-11 Budget Modification DCHS-01 Reallocating Mental Health OHP Funds to Fund 5.52 FTE for the Transition Related to the Implementation of the 2003 Legislatively Approved State Children's Mental Health System Change Initiative Budget Note [Continued from August 5, 2004]

**COMMISSIONER NAITO MOVED AND COMMISSIONER ROJO SECONDED, APPROVAL OF R-11. PATRICIA PATE EXPLANATION. COMMISSIONER CRUZ ADVISED SHE IS STILL NOT COMFORTABLE WITH THIS REQUEST AND WILL NOT BE SUPPORTING THE BUDGET MODIFICATION TODAY. COMMISSIONER ROBERTS STATED HE IS NERVOUS ABOUT WHAT THE STATE WILL DO BUT WILL TRUST STAFF RECOMMENDATIONS. COMMISSIONER NAITO ADVISED SHE TRUSTS STAFF AS WELL AND THANKED MS. PATE AND STAFF FOR THEIR EFFORTS. CHAIR LINN ADVISED SHE AGREES WITH COMMISSIONER NAITO. MS. PATE THANKED COMMISSIONER CRUZ FOR HER CONCERNS AND THANKED ASSISTANT COUNTY ATTORNEY PATRICK HENRY FOR HIS EFFORTS. BUDGET MODIFICATION APPROVED, WITH COMMISSIONERS NAITO, ROBERTS, ROJO AND LINN VOTING AYE, AND COMMISSIONER CRUZ VOTING NO. IN RESPONSE TO A COMMENT OF MS. PATE, COMMISSIONER NAITO SUGGESTED THAT MS. PATE LET THE BOARD KNOW WHEN SHE NEEDS THE COMMISSIONERS TO WRITE A LETTER TO THE E-BOARD.**

R-12 NOTICE OF INTENT to Submit a Proposal to the US Department of Health and Human Services for a Safe and Bright Futures for Children Initiative Grant

**COMMISSIONER ROBERTS MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-12. CHIQUITA ROLLINS EXPLANATION. COMMISSIONER NAITO ACKNOWLEDGED AND EXPRESSED HER APPRECIATION FOR THE LEADERSHIP OF MS. ROLLINS. NOTICE OF INTENT UNANIMOUSLY APPROVED.**

R-13 NOTICE OF INTENT to Submit a Proposal to the US Department of Justice for a Safe Start: Promising Approaches for Children Exposed to Violence Grant

**COMMISSIONER ROBERTS MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-12. CHIQUITA ROLLINS EXPLANATION, ADVISING THERE WAS AN ERROR IN THE AGENDA PLACEMENT REQUEST AND THAT THE GRANT IS FOR \$210,000 A YEAR FOR UP TO FOUR YEARS, WHICH IS BETTER THAN THEY FIRST THOUGHT. NOTICE OF INTENT UNANIMOUSLY APPROVED.**

**PATRICIA PATE THANKED THE BOARD FOR ITS SUPPORT AND INTRODUCED TRACI GOFF WHO HAS WRITTEN FOUR GRANTS IN HER FIRST FIVE WEEKS OF EMPLOYMENT WITH THE COUNTY. CHAIR LINN WELCOMED MS. GOFF.**

*There being no further business, the meeting was adjourned at 10:37 a.m.*

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Tuesday, August 31, 2004 - 10:00 AM  
Multnomah Building, Third Floor Conference Room 315  
501 SE Hawthorne Boulevard, Portland

## **BOARD BRIEFING**

*Chair Diane Linn convened the meeting at 10:03 a.m., with Vice-Chair Serena Cruz and Commissioners Lisa Naito, Lonnie Roberts and Maria Rojo de Steffey present.*

- B-3 Briefing on the Design Team Progress to Plan for the Potential Repeal of the Multnomah County Temporary Personal Income Tax. Presented by Dave Boyer and Karyne Dargan. 1 HOUR REQUESTED.

**COMMENTS BY DESIGN TEAM CHAIR DIANE LINN AND DESIGN TEAM CO-CHAIR SERENA CRUZ. INTRODUCTION OF BRIEFING PARTICIPANTS AND AUDIENCE MEMBERS. PRESENTATION, COMMENTS AND DISCUSSION BY CO-CHAIR CRUZ, CHAIR LINN, COMMISSIONER NAITO, COMMISSIONER ROBERTS AND CHIEF FINANCIAL OFFICER DAVE BOYER. MR. BOYER AND BUDGET**

**DIRECTOR KARYNE DARGAN RESPONSE TO BOARD QUESTIONS. LAURIE OHMANN OF PUBLIC STRATEGIES GROUP PRESENTATION OF PROPOSED WORK PLAN STEPS AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION.**

*Commissioner Roberts was excused at 11:14 a.m.*

**MS. DARGAN PRESENTED CALENDAR UPDATE.**

*There being no further business, the meeting was adjourned at 11:17 a.m.*

BOARD CLERK FOR MULTNOMAH COUNTY, OREGON

***Deborah L. Bogstad***



Multnomah County Oregon

# Board of Commissioners & Agenda

connecting citizens with information and services

## BOARD OF COMMISSIONERS

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## **AUGUST 23, 24, 26 & 31 BOARD MEETINGS FASTLOOK AGENDA ITEMS OF INTEREST**

Pg 2	2:00 p.m. Monday Briefing on Implementation of the Mental Health System of Care for Children and Families
Pg 2	6:00 p.m. Tuesday Public Hearing on County Library Internet Access Policies
Pg 2	9:00 a.m. Thursday Executive Session
Pg 4	9:30 a.m. Thursday Multnomah County Salary Review Commission Report
Pg 4	9:45 a.m. Thursday Sauvie Island Bridge Update
Pg 4	10:15 a.m. Thursday Hearing on Transfer of Tax Foreclosed Properties, for Non-Housing, Public Purposes
Pg 5	10:30 a.m. Thursday Budget Modification Reallocating Mental Health OHP Funds
Pg 5	10:00 a.m. Tuesday Design Team Update

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Thursday, 9:30 AM, (LIVE) Channel 30

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## **BOARD BRIEFING**

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Tuesday, August 24, 2004 - 6:00 PM  
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## **PUBLIC HEARING**

PH-1 The Multnomah County Board of Commissioners will conduct a Public Hearing on the Library Director's recommendations regarding the Library's Internet Access Policies. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

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Thursday, August 26, 2004 - 9:00 AM  
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## **REGULAR MEETING**

### **CONSENT CALENDAR - 9:30 AM**

#### **NON-DEPARTMENTAL**

C-1 Reappointment of Mike Houck to the SUSTAINABLE DEVELOPMENT COMMISSION

#### **DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES**

C-2 RESOLUTION Authorizing Private Sale of Certain Tax Foreclosed Property to Douglas J & Charity L Tucker, Husband and Wife

#### **SHERIFF'S OFFICE**

C-3 ORDER: Acknowledgement of Found Unclaimed Property and Authorization of Transfer for Sale or Disposal

#### **DEPARTMENT OF COMMUNITY JUSTICE**

C-4 Budget Modification DCJ-05 Adding \$19,991 Additional Project Safe Neighborhood Grant Monies to the Department of Community Justice Federal/State Fund Budget

#### **DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES**

C-5 Government Expenditure/Revenue Contract (190 Agreement) 4600003710 with the City of Gresham, for Traffic Signal System Improvement Project, Phase 3A and 3B

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#### **DEPARTMENT OF COUNTY HUMAN SERVICES**

- C-7 ORDER Authorizing Designees of the Mental Health Program Director to Direct a Peace Officer to Take an Allegedly Mentally Ill Person into Custody

**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.

**NON-DEPARTMENTAL - 9:30 AM**

- R-1 2004 Multnomah County Salary Review Commission Report to the Board. Presented by Auditor Suzanne Flynn and Salary Review Commission Chair Mary Ann Wersch. 15 MINUTES REQUESTED.
- R-2 Sauvie Island Bridge Briefing on New Bridge Design and Work of the Citizen's Advisory Committee. Presented by Commissioner Maria Rojo de Steffey and Ian Cannon, Bridge Engineering Services Manager. 20 MINUTES REQUESTED.
- R-3 RESOLUTION Establishing Fees and Charges for MCC 11.05 Land Use General Provisions, 11.15 Zoning, 11.45 Land Divisions, 37 Administration and Procedures, 38 Columbia River Gorge National Scenic Area, and Repealing Resolution No. 04-008

**SHERIFF'S OFFICE - 10:10 AM**

- R-4 Second Reading and Possible Adoption of a Proposed ORDINANCE Amending MCC Chapter 15, Sheriff, Relating to Alarm Systems

**DEPARTMENT OF BUSINESS AND COMMUNITY SERVICES - 10:15 AM**

- R-5 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Portland, Environmental Services, for Non-Housing, Public Purposes
- R-6 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Portland, Parks and Recreation, for Non-Housing, Public Purposes
- R-7 RESOLUTION Approving Transfer of Tax Foreclosed Properties to the City of Portland, Office of Transportation, for Non-Housing, Public Purposes

R-8 RESOLUTION Approving Transfer of Tax Foreclosed Property to Multnomah County Land Use and Transportation Program, for Non-Housing, Public Purposes

R-9 RESOLUTION Approving Transfer of Tax Foreclosed Property to the City of Gresham, for Non-Housing, Public Purposes

R-10 RESOLUTION Authorizing the Sale of Properties Acquired by Multnomah County through the Foreclosure of Liens for Delinquent Property Taxes

**DEPARTMENT OF COUNTY HUMAN SERVICES - 10:30 AM**

R-11 Budget Modification DCHS-01 Reallocating Mental Health OHP Funds to Fund 5.52 FTE for the Transition Related to the Implementation of the 2003 Legislatively Approved State Children's Mental Health System Change Initiative Budget Note [Continued from August 5, 2004]

R-12 NOTICE OF INTENT to Submit a Proposal to the US Department of Health and Human Services for a Safe and Bright Futures for Children Initiative Grant

R-13 NOTICE OF INTENT to Submit a Proposal to the US Department of Justice for a Safe Start: Promising Approaches for Children Exposed to Violence Grant

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Tuesday, August 31, 2004 - 10:00 AM  
Multnomah Building, Third Floor Conference Room 315  
501 SE Hawthorne Boulevard, Portland

**BOARD BRIEFING**

B-3 Briefing on the Design Team Progress to Plan for the Potential Repeal of the Multnomah County Temporary Personal Income Tax. Presented by Dave Boyer and Karyne Dargan. 1 HOUR REQUESTED.

**The Thursday, September 2, 2004 Board Meeting has been  
Cancelled for Lack of Agenda Items  
Next Meeting: Thursday, September 9, 2004**

**Lonnie Roberts**  
Multnomah County Commissioner  
District 4



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## **MEMORANDUM**

DATE: August 23, 2004

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, Commissioner Lonnie Roberts

RE: Notice of Meeting Excuse

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Commissioner Roberts will not be attending the Mental Health Board briefing today at 2pm. He is ill.

# AGENDA PLACEMENT REQUEST

BUD MOD #:

**Board Clerk Use Only:**

**Meeting Date: August 23, 2004**

**Agenda Item #: B-1**

**Est. Start Time: 2:00 PM**

**Date Submitted: 08/18/04**

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**Requested Date: August 23, 2004**

**Time Requested: 75 minutes**

**Department: Non-Departmental**

**Division: Commissioner Lisa Naito**

**Contact/s: Terri Naito, Patricia K. Pate, Director DCHS; Nancy Winters, Interim Director MHASD**

**Phone: 503-988-5217**

**Ext.: 85217**

**I/O Address: 503/600**

**Presenters: Commissioner Lisa Naito, Patricia K. Pate, Dr. Peter Davidson, Nancy Winters and Godwin Nwerem.**

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**Agenda Title: Briefing – Implementation of the Mental Health System of Care for Children and Families**

**NOTE: If Ordinance, Resolution, Order or Proclamation, provide exact title.  
For all other submissions, provide clearly written title.**

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**1. What action are you requesting from the Board? What is the department/agency recommendation?**

No action today. This is a briefing. The County is in the process of implementing reforms to mental health services for children and youth. The purpose of the briefing is to provide information about the system of care, including the implementation timeline and a review of the policy objectives previously adopted by the Board.

The briefing will also include a further discussion of the budget modification to be considered on the August 26, 2004 board agenda.

**2. Please provide sufficient background information for the Board and the public to understand this issue.**

**History**

Several years ago, Multnomah County went through a comprehensive process of reviewing its mental health system and making recommendations for improvement.

Since that time, many changes have been made to the adult system of care. The County is now turning its attention to the system of care for children, youth and families.

In 2001, Commissioner Lisa Naito convened the Child and Family System of Care Workgroup to develop recommendations for a developmental model of mental health intervention for children, adolescents and their families. The workgroup included a broadly representative and diverse group of providers, parents, school districts, clinicians, hospitals, cultural organizations, jurisdictional partners and other, related departments within the County. The Board of County Commissioners adopted the final report of the workgroup, entitled "Recommendations for Children's Mental Health Redesign," on March 7, 2002. For a full copy of the report, please see [www.co.multnomah.or.us/dchs/mho/mh\\_arev02\\_034final.pdf](http://www.co.multnomah.or.us/dchs/mho/mh_arev02_034final.pdf)

### **Systems Improvement Features**

The Board directed the department to include the following characteristics in any changes developed for the mental health services to children, youth and their families:

- Be child-centered and family focused.
- Offer a comprehensive continuum of services including outreach, prevention and early intervention.
- Be community-based with a focus of providing services in natural settings where children, youth and their families spend time --- homes, schools, child-care centers, etc.
- Be coordinated and integrated with other systems, such as juvenile justice, child welfare, foster care, school districts, etc.
- Have services selected be evidenced based and established on best practices,
- Have culturally competent services, including specialized culturally specific services.

### **Early Childhood, School Aged and Special Populations**

As a first step, the County will issue three requests for proposals (RFPs) for mental health services. Each contract will require expertise and a specialized, countywide infrastructure for these populations. The following outline the areas we will focus on.

#### **Early Childhood: Younger Kids and their Families**

The Early Childhood contract will focus on early identification of at risk families and children. Services will address barriers to healthy development. A key component of the services will address parent-child attachment problems occurring in the context of parental mental illness or addiction. Services will also attend to supporting parents by improving parenting strategies. The contract will include services to pregnant women with mental illness or addiction issues. The contract will also include services to children and families where the early onset of neurological problems & mental disorders are occurring in the child.

#### **School Aged: School Children and Youth and their Families**

Services will focus on early identification and intervention. Services will also work, as much as possible, to maintain children and adolescents with emotional & behavioral disorders in their home and in school. Ultimately, services will improve their academic success. In order to work successfully with all of the schools in the County, mental health services will be connected in all of the County's geographic areas and with culturally specific systems of care.

*Special Populations: Children and Youth Most At Risk for Out of Home Placement*

Special Populations will focus on services to families with children of any age who require mental health treatment in a placement outside of their home. For some children and their families, the pressure of parenting a child with a neurological brain disorder has become so overwhelming that specialized supports to reduce stress, support parents and improve functioning within the home will be provided. Many children and youth, who have been identified as having "no family," will need an enduring support structure built around them to teach the child to care for the people who care for him or her. The lack of involvement with a healthy network of personal and social support can lead to behaviors which place the child or adolescent at risk for criminal justice involvement, homelessness and victimization of self and others. The County, in managing resources, will require the Lead Agency for Special Populations to reduce the over utilization of residential services in the first phase of implementation.

**System Coordination**

System partners will include the:

- State (including Child Welfare and the Oregon Youth Authority);
- Child care (including Head Start and child care centers);
- Family Court;
- CareOregon;
- Public and private health care providers;
- Gang prevention agencies;
- Education (including school districts and alternative schools);
- Multnomah County Health Department (including school-based health clinics and home visiting services);
- Multnomah County Mental Health and Addiction Services Division (including the crisis system, Call Center, and the School Based Mental Health and Early Childhood programs);
- Multnomah County Office of School and Community Partnerships (including their family health promotion efforts, Touchstone, and Student Attendance Initiative);
- Multnomah County Department of Community Justice (Juvenile Justice Division and gang prevention); and
- School Aged and Early Childhood lead agencies.

**Intensive Acute and Out of Home Services**

The County will also contract for Intensive Acute & Out of Home Services as it does now, although the care coordination of these services will be expanded. Services will include: State hospital and the SCIP Unit (state hospital services for younger children aged 6-13 years), psychiatric residential treatment, acute care, subacute care, crisis respite, day treatment and other intensive school placements. Services will be managed through the Family Care Coordination Unit, together with Child Welfare, OYA and DCJ.

**Cultural Competency and Culturally Specific Services**

Anglo American children now represent less than fifty percent of the children in poverty in Multnomah County and their numbers, as a percentage, continue to fall. While African American and Native American children are not under-represented, they are ending up in crisis, high intensity and juvenile justice populations at inordinate rates. Asian, Slavic and Latino children are under-represented in our current system and we seek to remedy this by broadening our culturally competent and culturally specific services. All three of

the major contracts will require the Lead Agency to build cultural competency into their own service models and fully integrate their services with culturally specific providers for the ethnic and language minority populations recognized by the County.

### **Advisory Committees**

We are forming three community-based advisory groups to provide input and guidance as the system develops: Early Childhood, School Aged, and Special Populations. These committees will give their input to the County through an executive committee. We are looking for representation from a diverse group including parents, cultural organizations, advocates, jurisdictional agency partners and related departments within the County.

In addition, we are implementing a plan to involve NAMI employed parents in real-time decision making with the Family Care Coordination unit about treatment and support services for children being considered for mental health care outside the home. Their presence should help to bring parents, the County and the providers together in understanding options and developing the best possible supports for children and families. Transition to the new system will be slow, methodical and respectful to families' needs.

### **3. Explain the fiscal impact (current year and ongoing).**

The 2003 State Legislature approved changes to the Children's Mental Health System, which will be effective January 1, 2005. Approximately \$8-10 million in state revenue will come to Mental Health and Addiction Services. These are not additional revenues to the system; they are state revenues that will now be managed by the county. The rule changes specify that the County Mental Health Organization (Verity) will manage this revenue. Verity will then bear full risk for the care of several hundred children per year who are currently in Day Treatment, Residential and certain other intensive levels of care. With the transfer of revenues comes the transfer of risk. In particular, Verity must be able to develop effective alternatives to intensive treatment services in order to improve access to and shorten length of stay in hospital and residential care.

In a separate budget modification request, the department is requesting to reallocate existing resources to manage the transition of an estimated 30 children (based upon our most current information from the state), who will no longer be supported because of reduced state funding effective January 1 2005, out of residential care and into other appropriate community based supports and services. The cost per child per day in residential care is approximately \$279.00 or about \$8,200 per day for the estimated 30 children. For a month, it is approximately \$250,000 for 30 children. For a year, it is approximately \$3 million. The Department recommends approval of the budget modification to manage the financial risk to the County and to ensure an effective transition for affected children.

Other resources for the implementation of the system of care will come through **existing** contracts -- Primary Provider contracts -- between the County and numerous companies as well as in contracts between the state and these same and some other companies. The existing resources will be reconfigured for the new contracts associated with the three RFPs.

**NOTE: If a Budget Modification or a Contingency Request attach a Budget Modification Expense & Revenues Worksheet and/or a Budget Modification Personnel Worksheet.**

**If a budget modification, explain:**

- ❖ **What revenue is being changed and why?**
- ❖ **What budgets are increased/decreased?**
- ❖ **What do the changes accomplish?**
- ❖ **Do any personnel actions result from this budget modification? Explain.**
- ❖ **Is the revenue one-time-only in nature?**
- ❖ **If a grant, what period does the grant cover?**
- ❖ **When the grant expires, what are funding plans?**

**NOTE: Attach Bud Mod spreadsheet (FORM FROM BUDGET)**

**If a contingency request, explain:**

- ❖ **Why was the expenditure not included in the annual budget process?**
- ❖ **What efforts have been made to identify funds from other sources within the Department/Agency to cover this expenditure?**
- ❖ **Why are no other department/agency fund sources available?**
- ❖ **Describe any new revenue this expenditure will produce, any cost savings that will result, and any anticipated payback to the contingency account.**
- ❖ **Has this request been made before? When? What was the outcome?**

**If grant application/notice of intent, explain:**

- ❖ **Who is the granting agency?**
- ❖ **Specify grant requirements and goals.**
- ❖ **Explain grant funding detail – is this a one time only or long term commitment?**
- ❖ **What are the estimated filing timelines?**
- ❖ **If a grant, what period does the grant cover?**
- ❖ **When the grant expires, what are funding plans?**
- ❖ **How will the county indirect and departmental overhead costs be covered?**

**4. Explain any legal and/or policy issues involved.**

This is a briefing on the implementation of the Board-directed policy, adopted on March 7 2002. The full copy of the report is available at [www.co.multnomah.or.us/dchs/mho/mh\\_arev02\\_034final.pdf](http://www.co.multnomah.or.us/dchs/mho/mh_arev02_034final.pdf) and is attached to this agenda placement review.

Request for Proposals will be issued in mid-September 2004 for the first phase of the implementation. The proposals submitted must respond to specific questions and demonstrate both experience and the capacity to meet the standards of service and overall County requirements. Each proposal is fully evaluated by a selected team of experts and receives an overall score. Contract awards would be offered to the agencies that submitted the highest scoring proposals.

Because potential contract awards resulting from the RFP process will exceed the \$75,000 annual funding level, the RFP process is carefully monitored throughout to ensure every potential applicant has an equal opportunity to compete for public funding.

Procurement steps and Program requirements are thoroughly described in the RFP documents and during Pre-Proposal Conferences where questions are answered and guidance is provided to the public. Timelines are clearly established and strictly adhered to throughout the entire process. Once the RFP procurement process is completed, all records including submitted proposals and scoring sheets are made available to the public for review.

**5. Explain any citizen and/or other government participation that has or will take place.**

Commissioner Lisa Naito led the System of Care Workgroup to develop the "Recommendations for Children's Mental Health Redesign" adopted by the Board of County Commissioners on March 7 2002. Workgroup participants completed an extensive yearlong process with a diverse group of stakeholders, including providers, culturally specific providers, parents, agencies and advocates.

MHASD Staff and the Director of DCHS have met with State Mental Health, State Child Welfare, School Districts, Commission on Children, Families and Community, the Early Childhood Care and Education Committee, the Department of Community Justice, Parents, NAMI, the System of Care for Children & Families, Culturally Specific Committee, numerous providers, including Christie School, Morrison Center, Lifeworks Northwest (Tualatin Valley Centers), Cascadia, Albertina Kerr, Trillium, MHIOS, NARA, Asian Health Center and others to gather input, inform them of the changes and tell them about the upcoming rfp structure.

MHASD staff will be meeting with the Health Department, the Office of School and Community Partnerships and the Juvenile Rights Project.

We are forming three community-based advisory groups to provide input and guidance as the system develops: Early Childhood, School Aged, and Special Populations. These committees will give their input to the County through an executive committee. We are looking for representation from a diverse group including parents, cultural organizations, advocates, jurisdictional agency partners and related departments within the County.

We have distributed fact sheets and frequently asked questions to numerous stakeholders.

**Required Signatures:**

Department/Agency Director: \_\_\_\_\_  


**Date: August 18, 2004**

Budget Analyst  
By: \_\_\_\_\_

**Date:**

Dept/Countywide HR  
By: \_\_\_\_\_

**Date:**

## ***Child and Family System of Care Workgroup***

# ***Recommendations for Children's Mental Health Redesign***

**Final Report – 01/29/02**

### ***I. Background***

The Child and Adolescent Workgroup of the Mental Health Design Team final report in September 2000 recommended a developmental model of mental health intervention for children, adolescents and their families. Prevention and early intervention would be provided for those at risk of later involvement with the mental health system, and intervention would be based on age-appropriate outcomes within context of the family system. The report detailed recommendations to create an integrated system of care, broaden access to developmentally appropriate and comprehensive services, and unify the mental health system's structure.

A Child and Family System of Care Workgroup was subsequently convened by Commissioner Lisa Naito, to focus recommendations for the Department of Community and Family Services on Phase II and III of the Multnomah County Mental Health Redesign.

Goals adopted by the Workgroup were: children and families have access to a continuum of services in a timely manner, children and families have the ability to choose among services and providers; contracts for providers assure adherence to the System of Care Values and Principles; and providers coordinate services with other systems on behalf of consumers.

The Workgroup recognizes that much is right in our current children's mental health system: we have excellent services available; we have made great progress in delivering services in schools and other natural settings; and our community has come to recognize the mental health needs of young children. However, we have challenges, too. Our system is not serving all children who have needs, due to the combination of inadequate funding, gaps in services, capacity and quality, and lack of access and referral. There are large gaps in service for some ethnic or cultural groups. Parents too often are not fully included in planning for their child's care. The overall system is fragmented, lacks coordination, and doesn't adequately promote early care, often resulting in a crisis situation before the need for care is addressed.

The strength of our Child and Family System of Care in Multnomah County is that we recognize the need to work together to address these issues. The recommendations in this report will be presented to the Department of Community and Family Services, to use in the development of their Mental Health Redesign Plan for children. These recommendations also can serve as a framework for all partners in our Child and Family System of Care as we work toward our goals.

## II. **System of Care Values and Principles**

On November 29, 2001, The Board of County Commissioners for Multnomah County adopted Values and Principles for Child and Family Mental Health System Redesign\*, as recommended by the Child and Family System of Care Workgroup. (Bold type is added.)

### A. **Values**

1. The system of care will be **child centered and family focused** and the needs of the child and family determine the types and mix of services provided.
2. The system of care will be **community based**. Service management shall be individualized.
3. The system of care will be **culturally competent**. Agencies, programs, and services will be responsive to the cultural, racial, and ethnic differences of the children and families they serve.

### B. **Principles**

1. Child mental health consumers and their families will have access to a **comprehensive array of services** that address their physical, emotional, social, and educational needs.
2. Child mental health consumers and their families will receive services in accordance with the unique needs and potentials of each child guided by **individual service plans**.
3. Child mental health consumers and their families will receive services within the **least restrictive most normative environment** that is clinically appropriate.
4. The families and surrogate families of children with mental health disorders will be **full participants** in all aspects of the planning and delivery of services.
5. Child mental health consumers and their families will receive **integrated services**. Child-serving agencies and programs will be connected with planning, development, and coordination of services.
6. Child mental health consumers and their families will receive case management or other services so that **multiple services are delivered in a coordinated and therapeutic manner**, and that services meet their changing needs.
7. **Early identification and intervention** for children with emotional, behavioral or mental disorders and their families will be promoted to enhance the chances of positive outcomes.
8. Children with mental health disorders should be ensured **smooth transitions** to the adult service system as they reach maturity.
9. The **rights** of children with emotional, behavioral and mental disorders **will be protected and effective advocacy** for children and adolescents with such disorders will be promoted.
10. Child mental health consumers and their families will **receive services without regard** to race, religion, national origin, sex, physical disability, or other characteristics, and services will be **sensitive and responsive to cultural differences and special needs**.

\*These are adapted from CASSP Principles (Child and Adolescent Service System Program) as published in Stroul & Friedman's, A system of care for children and youth with severe emotional disturbance, 1986. Some language has been changed to be more inclusive of family involvement and to address children of all ages with a wide range of mental health risk factors and disorders.

### **III. Recommendations for All Children**

The Child and Family System of Care Workgroup recognizes that it is important to deliver services based on the strengths of the child and family. The mental health service system for children should therefore respond to children within context of how the child lives – in a family, involved in childcare or school, and as part of a culture and community.

Parents, or other primary caregivers, have a special role in developing and participating in their child's treatment plan. Throughout this report, "parent" will mean the responsible caregiver for a child, whether: both parents, a single parent, a grandparent or other relative, foster parents, or another person with custody of the child.

Children live in diverse families and cultures. To be effective, mental health services must be appropriate to the language, culture, community and values of the family and child.

A primary goal of mental health services for children is to help the child develop and thrive mentally, emotionally and behaviorally. This growth process needs to be encouraged, anticipated and planned for in mental health service delivery. Services should be delivered in the most natural, least restrictive and most appropriate setting to meet the needs of the child and family.

Because most preschool age children are involved in some type of out-of-home care, and the public education system has a responsibility for children over age 5, involvement of childcare and education systems in identifying children's needs and participating in treatment is essential. Research shows that delivering mental services in a school setting improves access for children and families.

In addition, most children receive health care through family practice physicians, pediatricians, County Health Clinics, or other settings. Health providers can assist families to identify and refer for mental health assessment and services, or offer mental health services on-site.

Many children or their families are involved in other systems as well. Coordination with these systems (such as addiction services, child welfare or corrections) is needed, as well as assistance to obtain services to meet the child or family's needs (such as adequate income, employment, housing, or food).

#### **Recommendations for All Children:**

##### **A. Child and Family Focused**

Services should be easy to locate and easy to get into; the type and mix of services should be based on the needs of the child and family. To accomplish this:

1. **Improve access to mental health services** for children, youth and their families.
  - a. Educate youth and families about mental health services and how to access them.
  - b. Provide outreach, education and early intervention specifically for children and youth.
  - c. Enhance the Call Center's ability to respond to youth and families, by adding staff with children's expertise and increasing multi-lingual/multi-cultural staff.
  - d. Inform families of the availability of culturally specific and linguistically appropriate services.
  - e. Develop community awareness of mobile crisis unit's service for children in crisis; strengthen mobile crisis coordination with children's providers;

- develop other crisis services in keeping with value of reaching out to all in need.
  - f. Develop walk-in clinic services that are comfortable for children, youth and families.
  - g. Assure that providers meet access requirements, including no-appointment necessary or other means for meeting urgent needs, and non-urgent new service within 2 weeks of the request.
  - h. Provide for immediate access to services for children, with no waiting lists or gaps in service availability.
  - i. Provide for a seamless transition from Oregon Health Plan (OHP) to non-OHP services.
2. Increase **family involvement** in treatment planning and coordination of care.
    - a. Support the parent as a full participant and equal partner in treatment planning, with a goal for the parent to assume as much of the coordination role as they are able.
  3. **Empower families** with information, support and training.
    - a. Use strategies such as family support groups, training sessions, and assistance of family members, to help inform and engage other families in clinical treatment.

## **B. Community Based**

Community based services and individualized service management should form the foundation for prevention, early intervention and treatment. To accomplish this:

1. Continue **prevention, outreach and early intervention**, using a public health model.
  - a. In collaboration with community partners, continue to provide pre-diagnosis consultation, education, screening, child and family support, and early intervention to optimize treatment outcomes, and to identify child and family needs and refer for appropriate treatment.
2. Promote **natural settings** as the preferred location for clinical services.
  - a. Promote selection of setting based on the child and family's needs and preference, e.g. childcare, schools, family homes, other community settings, or clinics.
  - b. Realign treatment practice through incentives, training and quality management.

## **C. Culturally Competent**

Reaching and effectively serving children from Multnomah County's increasingly diverse cultural, racial and ethnic membership is a major work area for the County and the community. The system should be responsive to cultural preferences and needs from outreach to families, through the provision of services to meet each child and family's needs. The Surgeon General's recent recommendations\* on eliminating racial/ethnic and socioeconomic disparities in access to services, suggested co-locating services with other key systems, and strengthening the capacity of schools as a link to meet the needs of youth and their families where they are. To accomplish this:

1. Increase **multi-lingual/multi-cultural staffing**, leadership and volunteerism throughout the system, so that minority children and youth are assessed and diagnosed appropriately, and treatment and support are sensitive to multi-cultural issues.

2. Map current service and demographic information; **identify underserved ethnic groups** and gaps in services; develop culturally competent resources or implement outreach plans to **increase numbers of children and youth served** from these groups.
3. Identify **effective treatment modalities** and best practices for reaching and serving cultural, racial and ethnic groups; incorporate these into provider's practice.

\*See "Report of the Surgeon General's Conference on Children's Mental Health, A National Action Agenda", DHHS, September 2000. Recommendations of the report include improving: public awareness, assessment and recognition of needs, access and coordination, and use of scientifically-proven prevention and treatment services.

#### **D. Comprehensive Array of Services**

A comprehensive array of services should be available to address children's and families' physical, emotional, social, safety and educational needs, with services appropriate for each age group: early childhood, school-age children, and teens/youth. To accomplish this:

1. **Fill gaps** in the continuum of services for children and youth.
  - a. In cooperation with providers, identify current service capacity and gaps, and build a more comprehensive array, include cultural competency throughout this process.
  - b. Contract and develop partnerships with the full range of providers, including acute and residential; no single provider currently offers a full range of services for children.
  - c. Develop a specific plan and enhance resources to serve high-need children.
  - d. Increase acute care alternatives for children, such as therapeutic respite care.
  - e. Expand availability of respite care to families.
  - f. Improve crisis response for children and youth.
  - g. Incorporate and integrate services with addictions services for youth.
  - h. Improve access to voluntary services for traditionally underserved populations to address minority over-representation in involuntary systems.
2. **Assure flexible services** to meet individual child and family needs.
  - a. Develop ways for the system to maintain and increase flexibility to allow the plan of care to specifically address the needs of the child and family.
  - b. Promote facilitating access to supportive, community and wrap-around services, including those not reimbursed by the Oregon Health Plan (OHP).
  - c. Through training and system development, expand beyond the appointment-based service model toward family and home-based models, in natural settings such as childcare and schools, and implement other evidence based best practices.
3. **Customize delivery systems** as needed for each age group: early childhood, school age, and teens/youth.
  - a. Develop appropriate incentives for providers to serve children with intensive needs in each age group.
  - b. Recognize the different developmental stages of children, and that natural settings and needs may change significantly with the child's age.

## **E. Integrated, Coordinated Services**

For children involved in the mental health system, there are always other systems involved in the child's life: their family, childcare and/or school, physician, and often other service providers as well. These services should be integrated and/or coordinated in a System of Care for the child and family. Each agency/system will be responsible to fulfill its own legal and contractual obligations, but should at the same time focus on contributing to a seamless and coherent plan of care that addresses the identified needs of the child and family. To accomplish this:

1. Develop **case management** as a standard of care to serve the majority of MH needs.
  - a. Promote case management as the point of responsibility within the mental health system to coordinate with the child and family's system of care, assure services in plan of care are delivered, and assure there is no break in services.
  - b. Focus case management especially on high-needs children: e.g. who are at risk of residential or hospital placement, are in foster care; are receiving services from juvenile justice or multiple systems; or have no family or a non-participating or non-compliant family.
  - c. Develop a way to coordinate and manage the points where kids cross systems, such as discharge planning from residential care, or entry into foster care.
  - d. Develop procedures with system of care partners for designating a primary case manager when more than one agency is involved.
  - e. Provide training for providers on case management.
2. Clarify and integrate County and provider **direct service roles**.
  - a. Provide pre-diagnosis prevention, outreach and early intervention through a public health model, using County general fund.
  - b. Provide intensive community support as a safety net to assure service delivery to children and families, when needed.
  - c. Clarify service priorities and responsibilities for multiple partners in the child and family system of care, including: County mental health; mental health providers; other County programs; State Mental Health, Developmental Disabilities, and Department of Human Services (DHS), community services, schools, and County funded services at schools.
  - d. Encourage public/ private partnerships.
3. Promote **involvement of other involved agencies/individuals** in developing a unified plan and participation in the system of care.
4. Improve **support for foster families**, and services for children in Foster Care.
  - a. Provide a comprehensive assessment and care plan for children in foster care within the timeline of the legally responsible agency.
  - b. Provide training for foster families on supporting young children with mental health needs, including crisis prevention, intervention, and specialized parenting skills.
  - c. Expand availability of respite care to foster families.
  - d. Work as a partner to support and develop capable foster care providers.

## **F. System of Care Clinical Development**

1. Identify evidence-based **best practices**, and realign treatment practice and funding across the system of care.

- a. Learn what works from research, best practices, and pilot projects; translate this into policy and systems development for the population.
  - b. Promote universal training and experience in developmentally appropriate assessment and intervention for professionals serving children.
  - c. Use training, advocacy and quality management to inform and motivate practitioners.
  - d. Work with providers to develop outcomes-based measurements.
  - e. Promote universal training and experience in wrap-around philosophy and service provision for all care providers in child and family serving systems.
2. Develop the **mental health work force**.
    - a. Collaborate with providers, the State and local schools and universities to increase the number of qualified multi-lingual, multi-cultural professional staff working in the community.
    - b. Provide cross training in increase knowledge throughout the system of care.
  3. Develop a **culturally specific** and linguistically appropriate service system.
    - a. Provide support to develop culturally specific and linguistically appropriate services.
    - b. Coordinate services between culturally specific/culturally competent providers and other systems for the child and family's benefit.

## **G. Collaboration**

County leadership should focus on collaboration with the multiple partners involved in the system of care for children and families.

1. **Collaborate with others** to further develop the system of care for children and families.
  - a. Work across county departments and with other governmental and private child-serving agencies, with a goal of expanding combined efforts for young children, school-age children and adolescents/young adults.
  - b. Adopt a stronger collaborative role in coordinating services funded by others, e.g. Intensive Treatment Services (ITS) Pilot Project and Psychiatric Day Treatment.
  - c. Increase coordination between mental health and academic partners, such as schools and the Educational Service Districts (ESD).
  - d. Expand **collaborations to pool and manage funding**, assuring clear and approved intergovernmental agreements among funders (which could include the county, state, schools, foundations, etc.) which:
    1. Achieve mutual benefits from the project,
    2. Specify the scope and funding for the project,
    3. Delegate specific decision making authority, and
    4. Provide clear termination procedures and conditions.
2. Create policies to **encourage blending, braiding, leveraging and/or pooling funds** across departments and with other government and community agencies.
  - a. Involve: government and private funders, business, partners, foundations, State Mental Health and Child Welfare, juvenile justice, education/schools, private insurers, primary care/public health, and youth addictions services partners.

- b. Explore ways to maximize flexibility and continuity, without adding bureaucracy or costs.
- 3. Push a **political and public relations agenda** in support of healthy child development as the critical link to society-wide benefits of competent, caring and connected future citizens.

## H. Funding

Funding for mental health services in the near term is expected to be limited to current funding levels. Funding strategies should focus on accountability for funds spent, and maintaining or increasing funds for underserved groups, including children.

- 1. Accurately **account for revenues and expenditures** for mental health services for children, including Oregon Health Plan and other state and county funds.
- 2. **Maintain and increase the proportion of children's Oregon Health Plan dollars** that are spent on child and family services.
- 3. **Reallocate existing resources and seek additional funding** as possible.
  - a. Reprioritize use of funds to achieve top priority outcomes.
  - b. Seek additional or new sources of funding, including funding collaborations, to support improved outcomes.
- 4. Develop a system to **coordinate benefits with physical health, and alcohol and drug** treatment services.
- 5. Prioritize savings from system redesign into **building capacity and expanding services** in the children's mental health system.
- 6. **Funding policies and mechanisms** should:
  - a. Support the System of Care Values and Principles.
  - b. Be invisible to the child and family.
  - c. Prevent any further erosion of funding for children's services.
  - d. Build children's services to the proportionate share of revenues as a floor.
  - e. Invest savings from the adult system in children and youth services to build prevention and early intervention, not limiting total funding to the "floor".

## I. Quality Management

A system of managing quality is especially important when transferring flexibility and risk to the provider system. To assure quality services are delivered:

- 1. Develop measures/means to assure that providers reach the desired outcomes over the multi-year plan, and measure progress and movement toward these goals.
- 2. Realign provider expectations through quality management, learning from model cases, training and technical assistance; develop a collaborative model for problem solving.
- 3. Provide monitoring, and utilize enforcement where needed.
- 4. Use outcome measurements that are valid, reliable, age/developmentally appropriate, and efficient/low cost.

## J. System Structure

- 1. Adopt a **unified Mental Health Plan**.
  - a. Establish a clear vision and a unified plan, including the needs of children and families; involve others to agree or amend the plan, and move forward.

2. Establish a **Child and Family System of Care Manager** position to coordinate and advocate for children and their families, and to spearhead action to implement the plan.
3. Increase **family involvement** in system development and design.
  - a. Reform CAMHSA membership to include more youth, parents and community members; develop the ability of the group to serve as lead advocate for children's mental health.
  - b. Seek input from families on the design of services.
4. **Contracts applied to children's services** shall incorporate:
  - a. System of Care Values and Principles adopted by Board of Commissioners.
  - b. Require Primary Providers to meet Cultural Competency requirements.
  - c. Incentives for individualized, community-based services that meet the treatment needs of children and their families.
  - d. Incentives for flexible services, non-traditional services, culturally specific services, case management, and intensive services, such as care coordination, respite care and in-home support services.
  - e. Accountability to serve traditionally underserved children: ethnic, linguistic and other minority children; young children; juveniles and young adults; and so-called "non-compliant" youth.
  - f. Incentives for collaboration with involved agencies, including childcare and schools, primary health, alcohol and drug providers, State Department of Human Services and Oregon Youth Authority, Juvenile Justice, Developmental Disabilities, and other community providers.
  - g. Incentives to serve, and accountability for, high-needs children.
  - h. Performance and outcome measures, implementation, and program evaluation, that support the System of Care Values and Principles, specifically including: respect for families, family involvement and empowerment, least restrictive/clinically appropriate services, coordinated/integrated services, culturally competent services, and timely access to appropriate services.
  - i. Encouragement to include family members and a diverse section of the community on their governing boards and committees.

#### **K. Training**

In order to help family members, providers, child-serving agencies, and other professionals such as primary care providers and teachers work collaboratively toward a child-centered, family-focused system of effective community-based mental health services, develop and provide education and training on the following topics:

1. The mental health system, community resources, wrap-around services, and how to access these;
2. Family involvement, and child-centered/family-focused service delivery;
3. Normal child development, and emotional and behavioral disorders;
4. Effective parenting/teaching/intervention strategies for children with mental health disorders;
5. Coordinating a child's care;
6. Legal rights and responsibilities and grievance procedures;
7. Level of care determination, evidence-based best practices, and unified plans of care;
8. Evaluative tools and measures.

#### **IV. Early Childhood Recommendations**

Recent insights from brain research, along with long-term studies on early childhood care and education, stress the critical importance of good early childhood experiences in the development of healthy mental and emotional functioning throughout life.

To promote healthy development of children, national early childhood mental health experts recommend strategies that: promote the emotional and behavioral well being of young children; address barriers faced by families; expand the competencies of caregivers; and ensure children and families have access to needed services and supports.

Guiding principles for best practices in an early childhood system of care include:

- Strengths-based assessment and services;
- Individualized service delivery;
- Recognition of a family's rights and the resiliency of family systems;
- Family-centered, culturally-sensitive, community-based, coordinated services;
- Service delivery which evolves from current and emerging literature and research;
- Knowledgeable, skilled professionals who choose evidence-based interventions;
- Timing, frequency, duration and intensity of services matched to child and family needs;
- Continuous quality improvement through evaluation of strategies, utilizing outcome measures, and peer review as a quality assurance check.

Young children do have mental health needs. Recent research documents that prevalence rates for mental health issues for young children are identical to rates for children over five: 21% of young children meet the criteria for a psychiatric disorder, and 9.1% for a severe disorder.

Therefore, young children need the same quantity and quality of mental health services and supports those older children and adults require. These services must be delivered in the most natural environment possible, and involve all adults in the child's life. All young child-serving disciplines and organizations must work collaboratively to identify and serve the child and family in a coordinated, timely and effective way. Some children, because of the severity and/or complexity of their needs, will require more intensive levels of care.

For young children (under age 6), the following principles developed by Jane Knitzer, Ed.D., are recognized as a foundation for service delivery and system development.

##### **Ten principles for an Early Childhood Mental Health Service System**

1. A family-centered early childhood mental health service system, including mental health and related services, should be designed to support parents of young children to nurture and build caring relationships with them.
2. A family-centered early childhood mental health service system, including mental health and related services, should be designed to support non-parental caregivers of young children to nurture and build caring relationships with them.
3. A family-centered early childhood mental health service system, including mental health and related services, should be delivered, to the greatest extent possible, in natural settings, including homes, child care, health care, and family support settings.
4. A family-centered early childhood mental health service system should be designed to respect developmental processes as well as be flexible and individualized to meet the needs of young children.

5. A family-centered early childhood mental health and related service system should be sensitive to cultural, community and ethnic values of families.
6. Caregivers, home visitors, family workers, and administrators working with infants, toddlers, and preschoolers should have access to clinical services, case consultation and clinical supervision to strengthen their competencies in promoting emotional development in all young children, in young children who are at high risk for developing diagnosable problems, and in young children with already diagnosed problems.
7. Family service workers, home visitors and others working with families of infants, toddlers, and preschoolers and their families (including kinship and other foster parents, grandparents, and non-custodial fathers), should have access to mental health program consultation, case consultation and back up support for families requiring more intensive interventions, particularly if there are issues of substance abuse, domestic violence, child maltreatment, depression, and other mental illness.
8. Caregivers, home visitors, family workers, and administrators working with families of infants, toddlers, and preschoolers should have access to clinical supervision and support in dealing with such staff issues as burnout, cultural, and work place conflicts.
9. Young children, families, and programs experiencing crises related to violence, community disasters or family specific crises should have immediate and as-necessary access to crisis intervention and support.
10. Developing a family- and caregiver-centered early childhood mental health service system requires building partnerships among both primary and secondary support services at the community- and state-levels.

### **Early Childhood Recommendations:**

Recommendations specifically for early childhood are based on the belief that that service to young children means service *through* parents and other caregivers. Appropriate service strengthens the family and achieves an optimal level of development for the child.

1. Expand or prioritize services to **high-risk groups**.
  - a. Adult mental health system should offer no-waiting treatment to new parents with mental health issues, including to mothers identified through Oregon Children's Plan pre-natal and at-birth assessments.
  - b. Expand services to offer mental health service in all Head Start and childcare locations.
2. Improve **outreach** to parents and children.
  - a. Integrate physical and mental health care – make sure there is mental health screening at well-baby visits.
  - b. Provide assessment and treatment at: Early Head Start/Head Start, Childcare settings, Foster Care homes, and Early Intervention/Early Childhood Special Education.
  - c. Prioritize “child find” in high-risk adult populations (e.g. adults with mental health or substance abuse problems, or depression; who are cognitively impaired, incarcerated, or on probation or parole; who are involved with animal control violations, or domestic violence services).
3. Improve the **appropriateness and universality of mental health assessment** for young children.
  - a. Adopt the “DC-0-3” as a diagnostic classification system for children 0-3 years of age (from Zero to Three’s National Center for Clinical Infant Programs).

- b. Promote mental health screening for infant's birth to school age as a part of regular health care.
  - c. Provide universal access to specialized and comprehensive mental health assessment for children birth to school age, as referred from health, childcare and early education systems.
4. Expand the **continuum of services** for young children.
    - a. Expand therapeutic childcare; expand hours to better meet full day needs of working parents.
    - b. Provide appropriate levels of day treatment within a seamless community-based system of care.
    - c. Develop blended services for young children who have both mental health issues and developmental delays.
    - d. Increase intensive in-home services to assist families of young children with high needs.
    - e. Advocate for mental health services to be delivered where young children are, including within families, in childcare settings, and in conjunction with well-baby and well-child health visits.
  5. Improve **coordination of services** for young children.
    - a. Coordinate and advocate with physicians, including pediatricians, family practitioners and child psychiatrists.
    - b. Coordinate services with the adult mental health and addictions system, when parents or other family members receive services.
  6. Improve **training** for people involved in the lives of young children.
    - a. Provide multi-disciplinary training to childcare providers and educators on promoting healthy social and emotional development, identifying children and families with mental health issues, and supporting young children with mental health disturbances.
  7. Enhance **financing** for mental health services for young children.
    - a. Coordinate benefits for young children with mental health disturbances.
    - b. Promote parity of funding for mental health services in early childhood.
    - c. Evaluate cost-effectiveness of services using best practices and performance measures.
    - d. Advocate for funding through Oregon Health Plan and other health plans for services, based on "DC 0-3" diagnostic categories.

## **V. Recommendations for School-Age Children**

The majority of children age 5 to 18 (and up to 21) are in school a large part of the day. In addition to their families, schools become a critically important part of children's lives.

Recent recommendations from the Surgeon General suggest tapping public schools to identify children with mental health issues, and improving service to racial and ethnic minority groups by locating services where adolescents spend time, i.e., schools. Schools have a special opportunity to identify children's issues because of the natural dynamics that occur between children and their peers and teachers, and children's responsiveness throughout the day.

Therefore mental health services for children should be provided in, or in coordination with, schools. There should be increased partnerships between schools, the County and providers to

provide appropriate screening, assessment and treatment. Training should be provided for school employees on: recognizing mental health issues; the impact on children, families and schools; responding to crisis; working with families and teams; and participating in a child's plan of care.

Parents of school age children should be full partners in developing the treatment plan or plan of care. Services must be appropriate for the child and family's language, culture, community and values. Coordination with other involved partners is also essential.

For children who have mental, emotional or behavioral disorders that qualify for special education services under an Individualized Education Program (IEP), schools, mental health providers and other involved systems should formally coordinate services with one another and with the child's family.

### **Recommendations for School-Age Children**

1. Improve outreach, screening and **assessment** for children and youth.
  - a. Promote use of a common framework for making decisions on level of care in the treatment of children and adolescents age 6 to 18.
  - b. Implement screening for all school age children upon entering school to promote early identification of mental health concerns or disorders.
  - c. Provide information, screening, assessment and referral in schools.
  - d. Provide case management/ coordination of services among the family, providers, schools, and other services.
2. Expand and strengthen the **continuum of services**.
  - a. Improve definitions of outcomes for day treatment services for children.
  - b. Develop community-based intensive services as an alternative to high-cost residential treatment.
  - c. Support services that improve school attendance, academic achievement and positive student behaviors.
  - d. Support culturally and developmentally appropriate school-based services to emphasize: early identification; ease of access; case management; integration of physical health/ mental health/alcohol and drug services; family involvement and choice; individualizes and flexible services; and ongoing treatment and follow-up.
  - e. Provide appropriate levels of service in integrated therapeutic and educational settings, such as therapeutic day schools or day supported classrooms.
3. Seek ways to replace funding and/or service capacity of **expiring grants**:
  - a. Safe Schools grant (\$2.75 M); and
  - b. Center for Substance Abuse Targeted Capacity Enhancement (\$750,000).
4. Improve **financing for high-need children** following residential placement.
  - a. Initiate planning with the State to look at children returning to the community following State-paid residential treatment; look at ways for funding to follow the child, or other ways to improve continuity and outcomes.
5. Develop a **coordinated system for mental health services throughout the schools**, building on the success of current highly effective programs.
6. Improve **long-range system-wide planning** between schools and the County.

## **VI. Recommendations for Special Youth Populations**

The Child and Family System of Care Workgroup recognizes that some children, especially older teens, have special needs, and may not be living with their families or attending school. Teens may have unique issues and cultures that need to be addressed to provide accessible, quality and effective mental health services. Such issues include:

**Teen years are the time when many serious and persistent mental health issues emerge** (schizophrenia, bi-polar, major depression), and are **also the greatest time for suicide attempts and suicide** to occur. Oregon's rate of suicide attempts for teens increased 5% in 2000; 76% of teen suicide attempts are by girls, and the highest rate of suicides is among sexual minority youth.

**Girls may face different challenges than boys.** Data shows that the pressures and pathways to self-destructive behaviors, as well as crime, are often different for girls than for boys. Girls' issues are more often internal (eating disorders, depression, substance abuse to mask pain of sexual abuse, running away, suicide attempts), whereas boys tend to externalize their issues, bringing them to the attention of Child Welfare and Juvenile Justice in greater numbers.

**Many teens are not eligible for the Oregon Health Plan** and therefore have limited access to mental health services. Even for pregnant and parenting teens, enrollment is very limited. Services are needed for teens who do not have insurance, or access to services through schools.

**It is a challenge for providers to reach and engage at-risk teens.** Teens may lack a strong support system, be parenting themselves, or be victims of violence, addiction or abuse. Too often, mental health services don't find teens who need services until there is a serious crisis.

**Services need to be developed** that respond to teen's developmental, gender, sexual identity and cultural needs. There frequently is a small "window of opportunity" to get a teen to go to counseling, and an immediate response needs to be available. Teens also need time to develop trust and relationships, but currently therapy is too often designed around structured office visits, which may not feel safe or comfortable for a teen.

**Transition to adult services** typically occurs at age 18, regardless of the youth's emotional maturity. This is a difficult time for families, who are losing legal authority over their child and are not always part of the adult treatment team. Transition for the teen and family should be planned for and supported, sensitive to the teen's emotional and behavioral needs.

**State Committed Youth.** A 1999 study showed that 19% of youth committed to the Oregon Youth Correctional Facility might have avoided commitment with appropriate services. Youth were typically: Anglo males, 15 years old, not enrolled in school, a history of problems with school, and with prior dependency referrals. Resources needed were: drug and alcohol secure treatment, mental health placements, culturally appropriate services, and long-term sex-offender treatment. Ease of access (such as no-waiting appointments) and specialized services are needed for this population.

### **Recommendations for Special Youth Populations:**

1. Improve access for youth.
  - a. Develop a youth, child and family-centered walk-in clinic at least during "after school/after work" hours, which feels safe for families, has experienced child and family-oriented staff (including expertise in children's medications), and ability to follow-through with the family and child, or teen.

- b. Respond immediately to requests for service for youth; there may be a limited window of opportunity and kids often can't wait.
  - c. Assure that there is no artificial limit on the number of visits a teen may need.
  - d. Recognize that teens sometimes lack consistent family or even foster family involvement, or other natural supports.
2. Improve **continuum of services for youth**.
- a. Develop sub-acute care and other alternatives to hospitalization for adolescents in the community.
  - b. Develop a secure adolescent assessment center; avoid use of arrest or admission to emergency room to obtain a needed assessment or services.
  - c. Educate schools and the public on how to deal with acting-out behavior of youth, rather than referring to the criminal system.
  - d. Develop vocational programs as alternatives for youth.
3. Improve services for **homeless youth**.
- a. Assure there is no waiting list for services for homeless youth.
  - b. Promote access to mental health services at homeless youth service locations.
  - c. Promote building trust between the youth and provider.
  - d. Promote ease of access by minimizing paperwork.
  - e. Train homeless youth providers on County mental health changes and opportunities for their youth.
4. Provide mental health and addictions services to address the needs and interests of **sexual minority youth**.
- a. Develop practical approaches to meeting these needs within school-linked and provider services.
  - b. Advocate with private mental health providers to recognize and support the special needs of sexual minority youth.
  - c. Provide training to educators on the special needs of sexual minority youth.
  - d. Adapt services to the needs of trauma and abuse survivors within this group.
5. Increase **services for girls**, especially trauma and abuse survivors, who are currently underserved within the mental health system.
6. Improve services for **youth also involved with the Juvenile Justice system**.
- a. Develop blended/braided funding to pick up costs for continued mental health services when youth go into detention (and Medicaid funds end), and when they come out of detention.
  - b. Improve providers' ability to address youth delinquency, and alcohol and drug problems, concurrently with mental health issues.
  - c. Ensure appropriate mental health services are available to youth being held in the County jail (e.g. due to Measure 11).
  - d. Provide on-site dual-diagnosis assessment for youth in the Juvenile Justice system, along with case management.
  - e. Integrate addiction and mental health services to serve dual diagnosis youth who are in the Juvenile Justice system.
  - f. Prioritize mental health services for youth and families in the Juvenile Justice system who have potential to harm themselves and public.
  - g. Resolve confidentiality issues to improve continuity of services for juvenile justice-involved youth.

7. Improve the process of **transition to the adult system**.
  - a. Involve both youth and parents in transition planning.
  - b. Work with schools to develop a uniform approach to transition to adult services, including development of Individual Transition Plans (ITP).
  - c. Provide assistance to parents and youth in applying for with Supplemental Security Income (SSI), Oregon Health Plan and Disability Services.
8. Improve access to and availability of **wrap-around services**, including:
  - a. Career development;
  - b. Housing;
  - c. Independent living skills;
  - d. Ongoing education.

## **VII. Recommendations for Quality Assurance Measures**

The child and family system of care is distinct from adult service systems and it is still evolving; thus, there is a need for targeted process and performance measures that are specific to the adopted System of Care Values. As the child and family system of care develops, so should its quality management program.

Accountability for the children's system of care will be driven by performance and outcome measures. Outcomes related to System of Care Values should be one factor used in contracting for child mental health services with community providers. They will also be used to assess the overall functioning of the system of care in Multnomah County.

To start with, the Performance Measurements Committee has identified five key areas to measure, which reflect the adopted System of Care Values. The group also recommends that the County's Quality Management Committee form a subcommittee to continue to address and monitor issues related to child and family mental health. Children and family members shall have a central role in evaluating and monitoring the quality of children's mental health services and in determining future areas for measurement. In addition to children and families, the subcommittee should include other children's system stakeholders who may not be members of the larger Quality Management committee, and the subcommittee should also utilize technical assistance from experts in the evaluation of children's systems of care.

The five key areas identified by the performance measures committee are:

### **AREA 1: Access**

GOAL: Children and Families will have timely access to appropriate mental health services

- Children and families will have timely access to a mental health assessment
- Services to children and families will be initiated in a timely manner following the initial assessment

### **AREA 2: Service Integration**

GOAL: Children and families receive services that are integrated, with linkages between child-serving agencies and programs

- For children who have high levels of need that cross multiple child-serving systems, services will be coordinated.

**AREA 3: Level of Restrictiveness**

GOAL: Children will receive services in the least restrictive, most normative environment that is clinically appropriate

- The level of restrictiveness of both a child’s living environment and school placement will stay the same or improve over the course of services
- Children are in the least restrictive educational and living settings that are clinically appropriate.

**AREA 4: Cultural Competence**

GOAL: Services meet the needs of children and families from diverse ethnic and cultural backgrounds

- Children and youth from diverse ethnic and cultural backgrounds will have equal access to assessment and services
- The cultural and ethnic demographics of children receiving mental health services should be consistent with the demographics of children who are enrolled in the Oregon Health Plan.
- Measures in Areas 1, 2, 3 and 5 will be analyzed for differences by race, ethnicity and language.

**AREA 5: Family Involvement**

GOAL: Families are full participants in all aspects of the planning and delivery of services

- Families will be involved in the planning and delivery of services for their children.
- Families will be satisfied with the quality and effectiveness of services.
- Family members will be actively and fully involved in decision-making bodies.

**AREA 6: Functional Status**

GOAL: Children and families improve functionally. Specific goals would be developed by the QM Committee, but would include measures such as:

- Number of days of school attended per year;
- Graduation rates from middle and high school;
- Number of days in detention/incarceration per year;
- Number of child abuse reports,
- Number of days per year spent in hospital or residential settings, as a ratio over days in all services

Mechanisms for monitoring these key areas include family surveys, chart reviews and outcomes measures. All reports to the QM committee should be broken down by age, race/ethnicity and language categories. Multnomah County should continue to improve quality management and refine performance measures.

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## ***Child and Family System of Care Workgroup***

### **List of Members**

**Chair:** Multnomah County Commissioner Lisa Naito

**Assistant Chair:** Mark McKechnie Juvenile Rights Project

**Committee Members:**

Rob Abrams Department of Community Services/ Children's Mental Health Partnership  
Linda Castillo DCFS/Cultural Competency Committee  
Phil Cox Oregon Youth Authority  
Peter Davidson, MD DCFS/ Mental Health and Addictions Services  
Karen Gorton Early Childhood Care and Education Council  
Vern Hoffer Portland Public Schools  
Mary Lou Johnson Centennial Public Schools  
Larry Marx, MD DCFS/ Mental Health and Addictions Services  
Carole Romm CareOregon  
Ralph Summers State Mental Health  
Kathy Turner Commission on Children Families and Community  
David Willis, MD, Northwest Early Childhood Institute

**Parents:**

Sandy Bumpus CAMHSA/National Alliance for the Mentally Ill  
Angela Steckly Mental Health and Addictions Services, Family Involvement Coordinator  
Mary Jo Thomas Foster Parent  
Cheri Waller Foster Parent

**Provider Panel:**

Gene Borkan, MD Providence  
Bruce Baker Morrison Center  
Norwood Knight-Richardson, MD Legacy  
Jackie Mercer Native American Recovery Association/Cultural Competency Committee  
Derenda Schubert, PhD Trillium  
Ginny Robinson Mt. Hood Mental Health  
Holden Leung Chinese Service Center/Cultural Competency Committee

**Multnomah County Staff Resources:**

Tom Wirshup DCFS/ Mental Health and Addictions Services  
Rich Scott Department of Community Justice  
Consuelo Saragoza Health Department  
Nancy Middlebrook DCFS/ Mental Health and Addictions Services, Addictions Program  
Vernon Baker DCFS/ Developmental Disabilities  
Mary Shortall (and/or Jeanne Wheaton) Aging and Disability Services  
Stephen Young DCFS/ Mental Health and Addictions Services

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# MULTNOMAH COUNTY OREGON



Department of County Human Services  
**Mental Health and Addiction Services Division**

## Mental Health System of Care for Children & Families **FACT SHEET**

### **Introduction**

Several years ago, Multnomah County went through a comprehensive process of reviewing its mental health system and making recommendations for improvement. Since that time, many changes have been made to the adult system of care. The County is now turning its attention to the system of care for children, youth and families.

The County is improving the mental health system of care for children and families to address several issues:

- **System fragmentation** – Currently, it is possible and even likely that a child and/or family will bounce from provider to provider with no overall system to track progress or to fundamentally “stick with” the child and family throughout their interaction with the system. The new system creates a set of lead agencies that find, own and stick with kids and families, thereby increasing the probability of family wellness.
- **Lack of Early Intervention** -- Too many children and youth are directed into the most intensive treatment and out-of-home placements, especially during a crisis, because the less expensive and potentially more effective system of early intervention and intensive community based support has not been fully developed. The new system creates alternative, effective treatment services that keep children united with their families, communities and schools as much as possible, while providing effective supports and treatment in the home environment at a lower cost.
- **Creating a Child-centered, Family Focused System** – The current system separates children services from adult services, driving an unnecessary and inefficient wedge between the care of parents and their children. Many mental health and addiction issues, particularly in early childhood, must be dealt with in the family and parenting setting. The new system creates a family focused infrastructure while ensuring adequate supports and services to children and youth.
- **Culturally Competent Services** – Currently, very few Latinos, Asians and Russians access needed mental health services even if services are available. In addition, African American and Native American children are overrepresented in facility-based care that does not effectively deal with their cultural needs. The new system builds culturally specific and culturally competent access, outreach, pre-treatment and treatment as an integral part of the overall system.

### **History**

In 2001, Commissioner Lisa Naito convened the Child and Family System of Care Workgroup to develop recommendations for a developmental model of mental health intervention for children, adolescents and their families. The workgroup included a broadly representative and diverse group of providers, parents, school districts, clinicians, hospitals, cultural organizations, jurisdictional partners and other, related departments within the County. The Board of County

Commissioners adopted the final report of the workgroup, entitled "Recommendations for Children's Mental Health Redesign," on March 7, 2002. For a full copy of the report, please see [www.co.multnomah.or.us/dchs/mho/mh\\_arev02\\_034final.pdf](http://www.co.multnomah.or.us/dchs/mho/mh_arev02_034final.pdf)

### **Systems Improvement Features**

The Board directed the department to include the following characteristics in any changes developed for the mental health services to children, youth and their families:

- Be child-centered and family focused.
- Offer a comprehensive continuum of services including outreach, prevention and early intervention.
- Be community-based with a focus of providing services in natural settings where children, youth and their families spend time --- homes, schools, child-care centers, etc.
- Be coordinated and integrated with other systems, such as juvenile justice, child welfare, foster care, school districts, etc.
- Have services selected be evidenced based and established on best practices,
- Have culturally competent services, including specialized culturally specific services.

### **Early Childhood, School Aged and Special Populations**

As a first step, the County will issue three requests for proposals (RFPs) for mental health services. Each contract will require expertise and a specialized, countywide infrastructure for these populations. Transition to the new system will be slow, methodical and respectful to families' needs. The following outline the areas we will focus on.

#### *Early Childhood: Younger Kids and their Families*

The Early Childhood contract will focus on early identification of at risk families and children. Services will address barriers to healthy development. A key component of the services will address parent-child attachment problems occurring in the context of parental mental illness or addiction. Services will also attend to supporting parents by improving parenting strategies. The contract will include services to pregnant women with mental illness or addiction issues. The contract will also include services to children and families where the early onset of neurological problems & mental disorders are occurring in the child.

#### *School Aged: School Children and Youth and their Families*

Services will focus on early identification and intervention. Services will also work, as much as possible, to maintain children and adolescents with emotional & behavioral disorders in their home and in school. Ultimately, services will improve their academic success. In order to work successfully with all of the schools in the County, mental health services will be connected in all of the County's geographic areas and with culturally specific systems of care.

#### *Special Populations: Children and Youth Most At Risk for Out of Home Placement*

Special Populations will focus on services to families with children of any age who require mental health treatment in a placement outside of their home. For some children and their families, the pressure of parenting a child with a neurological brain disorder has become so overwhelming that specialized supports to reduce stress, support parents and improve functioning within the home will be provided. Many children and youth, who have been identified as having "no family," will need an



enduring support structure built around them to teach the child to care for the people who care for him or her. The lack of involvement with a healthy network of personal and social support can lead to behaviors which place the child or adolescent at risk for criminal justice involvement, homelessness and victimization of self and others. The County, in managing resources, will require the Lead Agency for Special Populations to reduce the over utilization of residential services in the first phase of implementation.

### **Intensive Acute and Out of Home Services**

The County will also contract for Intensive Acute & Out of Home Services as it does now, although the care coordination of these services will be expanded. Services will include: State hospital and the SCIP Unit (state hospital services for younger children aged 6-13 years), psychiatric residential treatment, acute care, subacute care, crisis respite, day treatment and other intensive school placements. Services will be managed through the Family Care Coordination Unit, together with Child Welfare, OYA and DCJ.

### **Cultural Competency and Culturally Specific Services**

Anglo American children now represent less than fifty percent of the children in poverty in Multnomah County and their numbers, as a percentage, continue to fall. While African American and Native American children are not under-represented, they are ending up in crisis, high intensity and juvenile justice populations at inordinate rates. Asian, Slavic and Latino children are under-represented in our current system and we seek to remedy this by broadening our culturally competent and culturally specific services. All three of the major contracts will require the Lead Agency to build cultural competency into their own service models and fully integrate their services with culturally specific providers for the ethnic and language minority populations recognized by the County.

### **Role of the Lead Agency or Consortium of Providers**

Each major area of the children and family mental health system of care (Early Childhood, School Age and Special Populations) will have a lead agency or a consortium of providers under one contract. The lead agency will maintain the access points, infrastructure and clinical models for their population. Responsibilities include utilization management, fully integrating their services with culturally specific providers, conducting outreach, treatment readiness and aftercare and prioritizing their services for the children, youth and families that present with the highest risks. The lead agency will adopt a "no refusal" policy for children, youth and families when referred by the County's Family Care Coordination or Verity Member Services units. The County will use a carefully managed, fee for service business model with financial incentives aligned to promote rapid access to effective services.

### **Resources**

Our current information is that resources will come from existing State, federal and local sources for mental health for children and youth. The County will have a new role in managing resources to Multnomah County that were previously managed by the State Department of Human Resources. Resources, including many existing service contracts, will be reconfigured into the three Lead Agency contracts.



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**Timeline**

The County anticipates releasing the Request for Proposals for the three first-phase categories (Early Childhood, School Aged and Special Populations) in the fall of 2004. The first phase of new system of services will begin on January 1, 2005.

**Contact Information**

For more information, contact Nancy Winters, Interim Director of Mental Health and Addiction Services Division, Department of County Human Services, 503 988 4055 or [Nancy.Winters@co.multnomah.or.us](mailto:Nancy.Winters@co.multnomah.or.us).





# MULTNOMAH COUNTY OREGON

Department of County Human Services  
Mental Health and Addiction Services Division



## Mental Health System of Care for Children & Families FREQUENTLY ASKED QUESTIONS

### **Why is the County undertaking these changes at this time?**

In 2002, the Board of County Commissioners adopted a policy and planning document entitled "Recommendations for Children's Mental Health Redesign." The Child and Family System of Care Workgroup, led by Commissioner Lisa Naito, completed an extensive yearlong process with a diverse group of stakeholders, including providers, parents, agencies and advocates.

Per the Board's direction, the Mental Health and Addiction Services Division (MHASD) of the Department of County Human Services is implementing the changes for the Mental Health System of Care for Children and Families. Specifically, this effort will:

- Create an integrated system of care,
- Broaden access to developmentally appropriate and comprehensive services,
- Improve cultural competency, and
- Unify mental health system structures.

The 2003 State Legislature approved changes to the Children's Mental Health System, which will be effective January 1, 2005. Approximately \$10 million in state revenue will come to Mental Health and Addiction Services. These are not additional revenues to the system; they are state revenues that will now be managed by the county. The rule changes specify that the County Mental Health Organization (Verity) will manage this revenue. Verity will then bear full risk for the care of several hundred children per year who are currently in Day Treatment, Residential and certain other intensive levels of care. With the transfer of revenues comes the transfer of risk. In particular, Verity must be able to develop effective alternatives to intensive treatment services in order to improve access to and shorten length of stay in hospital and residential care.

### **How will the County make the changes?**

The County will issue three requests for proposals (RFPs): one for Early Childhood services, one for School Aged services and one for services to special populations. The County will ask for specific system delivery requirements that will decrease fragmentation and the likelihood that children and families will bounce from provider to provider; increase cultural competency so that children and families of color have access to high quality services; ensure that when a family as well as the child needs support and treatment, it is routinely available; attempt to keep children and youth united with their families and out of facility based care as often as is possible; and increase the potential for appropriate mental health services by having county case coordination available all the time to deal with crises and emergencies.

### **Where will the resources for the three RFPs come from? What is the total cost of the system now and what will it cost in the future?**

Existing state, federal and local resources will be used. Funds for existing programs, both county and provider-operated, will be reconfigured into the contracts for the three RFPs – early childhood, school aged and special populations. While there are no additional revenues available at this time, there are state resources dedicated to Multnomah County that were managed by the state in the past that will now be managed by the Multnomah County.

### **What is an RFP? What are the rules?**

A key step to implementing the changes to the Children's Mental Health System will be competitively seeking and awarding contracts through the Request For Proposal process. A Request For Proposal (RFP)

is a County-issued document that invites the public to submit proposals. These proposals must respond to specific questions and demonstrate both experience and the capacity to meet the standards of service and overall County requirements. Each proposal is fully evaluated by a selected team of experts and receives an overall score. Contract awards would be offered to the agencies that submitted the highest scoring proposals.

Because potential contract awards resulting from the RFP process will exceed the \$75,000 annual funding level, the RFP process is carefully monitored throughout to ensure every potential Offeror has an equal opportunity to compete for public funding. Procurement steps and Program requirements are thoroughly described in the RFP documents and during Pre-Proposal Conferences where questions are answered and guidance is provided to the public. Timelines are clearly established and strictly adhered to throughout the entire process. Once the RFP procurement process is completed, all records including submitted proposals and scoring sheets are made available to the public for review.

**What is the timeline for implementing these changes?**

The first phase of the new system of services for Early Childhood, School Aged and Special Populations will begin on January 1, 2005.

**Who will the County work with to coordinate the system?**

System access and coordination will be a strong priority. System partners will include the

- The State (including Child Welfare and the Oregon Youth Authority);
- Child care (including HeadStart and child care centers);
- Family Court;
- CareOregon;
- Public and private health care providers;
- Gang prevention agencies;
- Education (including school districts and alternative schools);
- Multnomah County Health Department (including school-based health clinics and home visiting services);
- Multnomah County Mental Health and Addiction Services Division (including the crisis system, Call Center, and the School Based Mental Health and Early Childhood programs);
- Multnomah County Office of School and Community Partnerships (including their family health promotion efforts, Touchstone, and Student Attendance Initiative);
- Multnomah County Department of Community Justice (Juvenile Justice Division and gang prevention); and
- School Aged and Early Childhood lead agencies.

**Are there plans for the creation of an advisory group?**

We will be convening a community-based advisory group to provide guidance and input as the system develops. Active subcommittees with diverse representation will be formed for early childhood, school aged and special populations, which will provide input to the full committee. We will seek representation from a broadly representative and diverse group of parents, school districts, clinicians, hospitals, cultural organizations, advocates, jurisdictional partners and other, related departments within the County.

**Who do I contact if I have more questions?**

Nancy Winters is the Interim Director of the Department of County Human Services' Mental Health and Addiction Service Division. Her phone number is 503 988 4055 and her email is Nancy.Winters@co.multnomah.or.us

