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DEPARTMENT OF JUSTICE  
GENERAL COUNSEL DIVISION

June 30, 2010

VIA E-MAIL

David Deutsch  
Civil Rights Division, Special Litigation Section  
U.S. Department of Justice  
950 Pennsylvania Avenue, NW  
Washington, DC 20530

Re: CRIPA Investigation of the Oregon State Hospital  
DOJ Matter No. 100-804-GH1444-06

Dear Mr. Deutsch:

The information that you requested in your June 9, 2010, records request is enclosed. Please let me know if you have any follow up questions after you have reviewed the information.

As you know, this records request focuses on community placement information rather than Oregon State Hospital information. As we have consistently stated since the beginning of this matter in 2006, we believe that community placement issues are outside the scope of a Civil Rights of Institutionalized Persons Act (CRIPA) investigation. By providing this public information, Oregon is not conceding that community placement issues fall within the scope of CRIPA and your office's current investigation of the Oregon State Hospital.

Sincerely,

A handwritten signature in black ink, appearing to read "Micky Logan".

Micky Logan  
Senior Assistant Attorney General  
Health and Human Services Section

MFL:kxc/JUSTICE.2116054-v1  
Enclosures

cc: Dr. Bruce Goldberg, Director of Oregon DHS  
Claudia Black, Health Care Policy Advisor to Governor  
Richard Harris, Administrator of Addictions and Mental Health Division  
Nena Strickland, Interim Superintendent of Oregon State Hospital  
Aaron Zisser, Trial Attorney, US DOJ Civil Rights Division

**Addictions and Mental Health Response to DOB 06-09-10 Letter  
June 28, 2010**

1. *Statistics showing the monthly census, from June 1, 2009, to June 1, 2010, indicating the number of patients in each of the following statuses:*
  - a. *patients being treated at OSH pending a determination of their competency to aid and assist counsel;*
  - b. *patients under civil commitment at OSH;*
  - c. *patients under PSRB authority, broken down by offense type/classification (e.g. Class A felonies, etc.); and*
  - d. *individuals under PSRB authority who are on conditional release, broken down by offense type/classification.*

Please refer to Question 1 Exhibits:

1.1 Patient Census (a – c)  
C&D – PSRB Data

2. *A description of all efforts undertaken in the last year in accordance with the facility's program for discharge planning and community integration. Please include any existing description of the facility's program for discharge planning and community placement, including those patients under PSRB jurisdiction.*

Please refer to Question 2 Exhibits:

2.1 – CRIPA Investigation of OSH  
2.2 – Description of all efforts undertaken in the past year . . .  
2.3 - Community Transition Team  
ECMU Residential Treatment Application Fill In  
Forensic Privileges 10.20.09  
Placement and Planning form Process  
PSRB EOJ ECMU Process  
PSRB Response

3. *Oregon's plan for implementing Olmstead v. L.C., 527 U.S. 581 (1999), including any related reports, progress summaries, revisions and memoranda related to plan implementation activities.*

Please refer to Question 1 Exhibit:

Oregon's Olmstead Plan final draft 05-18-10

Oregon met with stakeholders to discuss this draft document and to receive their suggested changes, is in the process of incorporating those suggestions into the draft Olmstead plan. Oregon anticipates the final Olmstead plan will be completed in the next few weeks at which time it will be posted on the Addictions and Mental Health website.

To achieve the intent of the Olmstead decision, Oregon will provide the opportunity for people to move to independent housing that promotes recovery, resiliency, independence and wellness in a system that is consumer driven and assists people in obtaining "a key to their own door." Oregon plans to achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing unneeded hospitalizations at OSH. At this time, work is being done on several goals to ensure the conditional release readiness determinations and community placements of patients under PSRB jurisdiction by OSH and PSRB occur more smoothly by decreasing delays caused by inconsistencies, lack of information, lack of training, and backlogs.

4. *All current policies, procedures, and guidelines related to admission, discharge and discharge readiness, eligibility for community living arrangements, descriptions of the different lists that patients may be placed on after a determination that they are ready to place or pending such a determination, the system for requesting and obtaining evaluation from community providers regarding "A Commit List" patients, the PSRB hearing, administrative review, and revocation processes, and utilization review.*

Please refer to Question 4 Exhibits:

4.1 thru 4.4 – Fitness to Proceed

PSRB Community Risk Assessment 8-15-05

PSRB Specific OAR

(see also question 4 and question 5 Exhibits listed under question #5)

5. *All current policies, procedures and guidelines related to participation of community mental health in hospitalized individuals' treatment and discharge planning, including policies and examples of documents demonstrating how treatment plans and other pertinent information is conveyed to the responsible community programs upon an individual's discharge.*

Please refer to Questions 4 & 5 Exhibits including the following policies and documentation:

- 1.007 - Patient Transfers from Oregon State Hospital
- 6.001 - Intraprogram and Interprogram Patient Transfers
- 6.007 - Interstate Repatriation Patients
- 6.013 - Discharge and Continuing Care Planning
- 10 – ATS Policy 3.018, Pass to Discharge
- 11 – Discharge Plan Details Form
- 12 – Interdisciplinary Tx Care Plan Addendum
- 13 – Forensic Forms for Admission
- 14 – Conditional Release Planning
- 15 – Description of PSRB Placement Resources 8-4-08
- 16 – Medical Record Policies
- 17 – Oregon Revised Statutes
- 18 – Oregon Administrative Rules
- 19 – Steps for PSRB Conditional Release from OSH
- 21 – Conditional Release Checklist
- 22 – Discharge Checklist
- 23 – PSRB Conditional Release Plan
- 24 – Co-management from ECMU
- 25 – Co-management Policy Draft
- 26 B – AMH/PSRB/OSH Planning & Placement List
- 27 H – PSRB Specific OARs
- 29 – OSH Planning and Placement Terms
- RTF Description for all Cottages 2008
- Written Plan 35A 2008
- Written Plan 48B 2008
- Written Plan 48B-W 2009
- Written Plan 48C 2008
- Written Plan 50C 2008
- Written Plan 50D 2008
- Written Plan 50E 2008
- Written Plan 50F 2008
- Written Plan 50G 2008

Written Plan 50H 2008  
Written Plan 50I 2008  
Written Plan 50J 2008

6. *The names and capacity of community providers/facilities that have been used in the past two years for community placements for patients being discharged from OSH, and a description of these facilities (i.e., group home, nursing home, supportive housing), including whether they have served PSRB patients. Please provide individual contact information for each provider/facility, including phone, email and address.*

Please find attached the names and current licensed capacity of facilities and Oregon's current vacancy listing for specific residences for both the PSRB and the Extended Care Management Unit at OSH. These residential beds are available to anyone leaving OSH based on the identified treatment needs as determined by the individual treatment plan at the time of discharge. For persons under the jurisdiction of the PSRB to gain admission to any facility, the PSRB and the county in which the person will live and the residential provider reach agreement regarding the terms of the PSRB conditional release plan. Please see attached for contact information and current capacity for Oregon facilities.

Also, please refer to Question 6 Exhibits:

Adult Mental Health Community Residential Capacity Cover  
Enhanced Care Services and Resources  
Facility Capacity Listing 1  
PSRB Housing List 100621  
Residential Definitions

7. *A list and description of all available alternative community services and supports for patients being discharged from OSH, (i.e., case management and support services, community treatment teams, specialized residential/outpatient services, crisis stabilization, community housing services, and psychosocial rehabilitation services), including locations, capacities, eligibility requirements, and waiting lists. Please also indicate whether each of these programs serves PSRB patients, non-PSRB patients, or both, and provide contact information.*

- Please find attached a listing of the services and supports available in Oregon including Oregon Mental Health Organization Service Areas, Oregon Health Plan Eligibility and Benefits, Oregon Health Plan, Medicaid, CHIP Population by County and MHO, Oregon Mental Health Organization Key Personnel Lists and Oregon Mental Health Organization Subcontractor Lists. OHP mental health services are delivered primarily through a network of managed mental healthcare plans covering a wide array of mental health services including acute hospitalization and outpatient care delivered by a network of mental health providers under contract with the mental health organizations. Those persons under the PSRB have access to these services based on the terms of the conditional release plan that is developed and approved by the PSRB.
- **County PSRB Contacts List**  
Community Mental Health Programs (CMHP's) are certified to provide treatment services to their communities and funds are provided from AMH to support those services provided. Some Counties provide these services directly and in some counties a subcontractor is contracted with to provide this service. In most counties there is an identified PSRB contact who would assist with coordination of services for a PSRB individual referred for evaluation to their county.

Also, please refer to Question 7 Exhibits:

- 1 - AMH MHOs Service Areas march 2010
- 2 - Benefit Packages
- 3 - OHP Medicaid Chip Population by County & MHO May 2 2010
- 5 - ABHA Subcontracted Activities 2010
- 5 - Clackamas Schedule 9 – Subcontracted Activities
- 5 - FamilyCare Schedule 9 – Subcontracted Activities 2010
- 5 - GOBHI Sub Contractor List 2010
- 5 - JBH Schedule 9 Subcontractors List 2010
- 5 - LaneCare Schedule 9 Subcontracted Activities 2010
- 5 - MVBCN Schedule 9 Subcontractors List 2010
- 5 - Verity Delegated Activities & Subcontracted Activities 2010
- 5 - Washington Schedule 9 Delegated & Subcontracted Activities
- County PSRB Contacts
- DHS Medical Assistance Program Codes
- Oregon Supported Employment Sites and Contact Information

8. *A list and description of mobile mental health services available in the community for patients being discharges from OSH, such as ACT, including locations, capacities, eligibility requirements, and waiting lists. Please also indicate whether each of these programs serves PSRB patients, non-PSRB patients, or both, and provide contact information.*

Please refer to Question 8 Exhibits:

Assertive Community Treatment

Oregon Supported Employment Sites and Contact Information

9. *A list and description of any other community services available or needed to support integrated community living for patients being discharged from OSH, (e.g., peer supports, intensive care management). Please also indicate whether each of these programs serves PSRB patients, non-PSRB patients, or both, and provide contact information.*

- PSRB Intensive Case Management Program in Multnomah County  
Two programs: Cascadia (10 individuals served)  
CODA (5 individuals served)  
Individuals live in fair market housing with intensive case management services provided twice daily in their home or community. Participating individuals have the expectation that they will be involved in work, school or volunteer activities as well as treatment and self help activities.
- Contacts:
  - Cascadia  
Bonnie Lambert, 503-238-0705 x 228  
[bonnie.lambert@cascadiabhc.org](mailto:bonnie.lambert@cascadiabhc.org)
  - CODA  
Carolyn Mounts, 503-252-3304 x14  
[CarolynMounts@codainc.org](mailto:CarolynMounts@codainc.org)

Also, please refer to Question 9 Exhibit:

9.1 – AMH Response

10. *Statistics showing the following since January 1, 2009, broken down the (i) all non-PSRB OSH patients (ii) each offense classification for PSRB patients currently at OSH, (iii) each offense classification for patients currently on conditional release, and (iv) PSRB patients unconditionally discharged since January 1, 2009:*
- a. The number of patients whose length of stay is or has been less than 90 days, 90 to 180 days, 80 days to one year, one to two years, two to three years, etc.*
  - b. The number of patients who waited or have been waiting less than 90 days, 90 to 180 days, 80 days to one year, one to two years, two to three years, etc., between the date of admission and the date of a determination that the facility is not the most integrated, appropriate setting, broken down by patients on the Exceptional Barriers list, A Commit List, B Commit List, or similar lists;*
  - c. The number of patients who waited or have been waiting less than 90 days, 90 to 180 days, 80 days to one year, one to two years, two to three years, etc., between the date of discharge from OSH and the date a determination was made that the facility is not the most integrated, appropriate setting, broken down by patients on the Exceptional Barriers list, A Commit List, B Commit List, or similar lists;*
  - d. The number of patients who waited or have been waiting less than 90 days, 90 to 180 days, 80 days to one year, one to two years, two to three years, etc., for placement in a less restrictive unit within the facility;*
  - e. The number of patients for whom a ready-to-place or similar designation was withdrawn, broken down by the respective designations (e.g., Exceptional Barriers list, A Commit List, B Commit List);*
  - f. The number of patients who had previous placements at OSH of 90 days or more, broken down by the length of stay during the previous placement (e.g., 90 to 180 days, 80 days to one year, one to two years, two to three years, etc.); and*
  - g. The number of patients discharged into each type of placement/facility (e.g., home, nursing home, supported living facility, community-based ICF/MR, personal care home, shelter, etc.).*

Please refer to Question 10 Exhibits:

- 10 a – Patients Length of Stay
- 10b.1 – Conditional Release List Breakdown
- 10b.2 – Ready to Place
- 10c -
- 10e – Ready to Place Status
- 10f – LOS of Patients Previous Admission
- 10g – Patient Placement at Discharge

11. *Statistics showing the number of patients who, since January 1, 2008, were being treated at OSH at the time that the maximum term of PSRB supervision in their case expires, broken down by offense classification. Indicate also the number of patients, within each offense classification, who are subsequently discharged or civilly committed.*

Please see attached statistics, as well as this abbreviated summary:

At OSH when PSRB jurisdiction ended (1-1-2008 to 6-1-2010)	62
Breakdown:	
A Felony	13
B Felony	11
C Felony	26
Misdemeanor	12
Unclassified	0

12. *A list of any current patients or guardians of current OSH patients who have objected to placement in the community, and copies of these patients' current treatment plans. Indicate whether each patient is under PSRB authority or civil commitment and provide total numbers for each category.*

None

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**Patient Census**  
6/1/09-6/1/10

All Patients	6/1/2009	7/1/2009	8/1/2009	9/1/2009	10/1/2009	11/1/2009	12/1/2009	1/1/2010	2/1/2010	3/1/2010	4/1/2010	5/1/2010	6/1/2010
Aid and Assist (.370)	99	104	103	98	92	94	99	95	102	93	90	92	98
Civil Commit	114	108	104	101	103	107	103	102	114	114	114	115	106
PSRB	260	263	264	266	274	268	270	274	270	271	271	272	273
PSRB Revoked	101	103	101	100	102	95	97	102	96	93	92	90	87
Other	49	58	59	58	55	50	49	55	50	52	49	47	48
<b>Total</b>	<b>623</b>	<b>636</b>	<b>631</b>	<b>623</b>	<b>626</b>	<b>614</b>	<b>618</b>	<b>628</b>	<b>632</b>	<b>623</b>	<b>616</b>	<b>616</b>	<b>612</b>
<b>PSRB Patients</b>													
PSRB Class A Felony	127	131	131	131	130	128	128	126	130	126	125	124	125
PSRB Class B Felony	59	57	57	60	61	62	63	64	64	66	66	67	66
PSRB Class C Felony	50	48	49	50	56	55	55	53	53	56	57	57	57
PSRB Class A Misd	15	17	17	17	17	16	17	17	16	15	15	15	17
Unk	7	7	7	7	7	7	7	7	7	7	7	8	8
<b>Total</b>	<b>258</b>	<b>260</b>	<b>261</b>	<b>265</b>	<b>271</b>	<b>268</b>	<b>270</b>	<b>267</b>	<b>270</b>	<b>270</b>	<b>270</b>	<b>271</b>	<b>273</b>
<b>PSRB Revoked Patients</b>													
Revoked Class A Felony	54	54	53	53	55	51	51	51	51	50	50	47	48
Revoked Class B Felony	23	24	24	24	24	21	23	23	23	22	23	22	22
Revoked Class C Felony	15	16	15	13	14	14	15	15	14	13	13	12	11
Revoked Class A Misd	4	4	5	5	5	5	4	4	4	4	4	4	4
Unk	2	2	2	2	2	5	2	2	2	2	2	2	2
<b>Total</b>	<b>98</b>	<b>100</b>	<b>99</b>	<b>97</b>	<b>100</b>	<b>96</b>	<b>95</b>	<b>95</b>	<b>94</b>	<b>91</b>	<b>92</b>	<b>87</b>	<b>87</b>

Question #1 pt C		6/1/2010	5/1/2010	4/1/2010	3/1/2010	2/1/2010	1/1/2010	12/1/2009	11/1/2009	10/1/2009	9/1/2009	8/1/2009	7/1/2009	6/1/2009
Total Terms under PSRB based on DOJ		757	761	763	768	764	764	763	764	766	763	764	762	763
A Felony		363	363	363	364	364	363	361	363	365	365	366	369	367
B Felony		146	149	150	150	148	150	150	148	151	152	152	149	151
C Felony		146	150	151	154	152	151	154	156	158	154	154	153	154
Misdemeanor		21	18	18	19	19	19	18	17	12	12	12	11	11
Unclassified		81	81	81	81	81	81	80	80	80	80	80	80	80
Question #1 pt D														
Additional Question #1		6/1/2010	5/1/2010	4/1/2010	3/1/2010	2/1/2010	1/1/2010	12/1/2009	11/1/2009	10/1/2009	9/1/2009	8/1/2009	7/1/2009	6/1/2009
Terms on CR based on hearing date		378	377	377	377	376	374	373	372	370	368	368	368	367
A Felony		197	197	197	197	197	197	197	197	197	196	196	196	195
B Felony		67	67	67	67	66	66	66	65	65	65	65	65	65
C Felony		58	58	58	58	58	56	56	56	56	56	56	56	55
Misdemeanor		7	6	6	6	6	6	5	5	3	2	2	2	3
Unclassified		49	49	49	49	49	49	49	49	49	49	49	49	49
FYI		6/1/2010	5/1/2010	4/1/2010	3/1/2010	2/1/2010	1/1/2010	12/1/2009	11/1/2009	10/1/2009	9/1/2009	8/1/2009	7/1/2009	6/1/2009
Terms not on CR, AWOL or UL (e.g. at OSH)		364	369	370	375	373	375	376	377	381	382	382	380	382
A Felony		159	159	159	160	160	159	158	159	161	162	163	166	165
B Felony		79	82	83	83	82	84	84	83	86	87	87	84	86
C Felony		85	89	89	92	91	92	95	97	99	96	96	95	97
Misdemeanor		14	12	12	13	13	13	13	12	9	10	10	9	8
Unclassified		27	27	27	27	27	27	26	26	26	27	26	26	26

June 17, 2010

RE: Response to The Department of Justice pertaining to the CRIPA investigation of the Oregon State hospital

Question #2 – Civil

Beginning in November 2008, AMH along with The Oregon State Hospital began the “Rapid Discharge Project” (RDP)

A weekly schedule was created that involved Extended Care Management Unit staff (ECMU), hospital staff, and county residential specialists. County representatives are either present in the RDP meetings or scheduled on conference calls.

At the time the process began, there were a combined 83 individuals in ready-to-place (RTP) status between the Oregon State Hospital-Portland (OSH-P) and Blue Mountain Recovery (BMRC) Campuses; as of June 1 there are 45 people identified in RTP status.

Through the department-wide Transformation Initiative process, AMH conducted a rapid process improvement (RPI) event dedicated to improving the hospital discharge process. The “Transforming Individuals” initiative identified three major components related to the discharge process. One component of the RPI has been the development of standardized discharge criteria (Exhibit Two). The new criteria will become operational on July 1, 2010.

A second component is the implementation of the Co-management plan (Exhibit Three). Co-management is designed to introduce incentives for better cooperation between the hospital and Oregon counties via a methodology for sharing costs associated with individuals remaining hospitalized beyond their RTP date.

As part of the AMH 2009-2011 strategic plan, a new initiative was introduced to develop a new program titled *The Community Based Care (CBC) Hospital Diversion Program*. In an effort to enhance the breadth and depth of community based services and to ensure successful utilization of new state hospital facilities, the project is focused on identifying development needs and opportunities for serving 70 individuals in the community currently hospitalized on Gero-psychiatric units at the Oregon State Hospital-Salem (OSH).

By November 2010, the diversion team will develop a new program model with a capacity to serve 70 individuals that will provide the necessary community-based services and supports for individuals with physical disabilities, head injuries, dementia, and other neurological disorders who have traditionally remained at the hospital for those reasons.

Department of Justice request for information June 2010

#2: A description of all efforts undertaken in the last year in accordance with the facility's program for discharge planning and community integration. Please include any existing description of the facility's program for discharge planning and community placement, including those patients under the PSRB jurisdiction.

- In November of 2008 the Adult Treatment Services Program (ATS) and the Extended Care Management Unit (ECMU) started the Rapid Discharge Planning meeting. Every week staff from ATS, ECMU and the county liaisons meet to discuss discharge planning. This meeting used to occur monthly and now occurs weekly. In 2009 there was an increase in 33 discharges from OSH-Portland with this new process.
- In July 2010 ATS will implement the Ready to Place form and policy. The RTP form will be completed on all patients each month to address their readiness for discharge. A patient will be identified RTP once they have addressed issues of risk; to self or others, are able to care for their basic needs, or with supports available in the community, and are medically stable enough to transfer to a less restrictive facility.
- In July 2010 ATS will implement the use of the Level of Care Utilization System (LOCUS). The LOCUS will be used as a level of service and supports definition and will be used in conjunction with the RTP form.
- Since January of 2007 ATS has delivered group services through the treatment mall. Groups in the treatment mall all have a focus towards helping patients learn skills to be successfully discharged into the community. Wrap groups have been included in the groups available to individuals via the treatment mall.
- Since March of 2008 Geropsychiatric Services' (GTS) has delivered group services to the Certified Medicaid and Medicare Services (CMS) unit. Patients from the other three units participate in the mall if they are cognitively able. All patients receive either on unit or mall group rehabilitation services to prepare them for discharge.
- The Geropsychiatric Services Program meets monthly with county liaisons, staff from Senior and People with Disabilities (SPD) and Extended Care Management Unit (ECMU) to discuss discharge planning options for GTS patients.

- In May 2010 Senior and People with Disabilities (SPD) re-configured the Money Follows the Person federal grant to include individuals at Oregon State Hospital who are eligible for SPD residential . They are working with staff from OSH to develop resources and placements for GTS patients.
- In February 2010 the NewPATH Project was developed. This project is funded through OSH's hospital replacement project. NewPATH (New Person-Centered Alternatives to Hospitalization) is a community based hospital diversion program. NewPATH and SPD staff are currently completing a comprehensive assessment of individual GTS patients' needs and are using this information to determine new options for community diversion.
- In March 2010, OSH and, County and State SPD met and coordinated a new process for the coordination of Medicaid and service eligibility determinations in order to resolve long standing barriers to timely eligibility determination for individuals at OSH.



Oregon Department of Human Services  
Addictions & Mental Health Division  
Extended Care Management Unit



ECMU Psychiatric Residential Treatment Program – Application for Admission

Applicant Name D.O.B. / / Prime / OHP #

Current Placement (Applicant) Current Address or Fax (Applicant)

Referrer Phone # - -

Prior Placement \_\_\_\_\_ Current Commitment ☐ Y ☐ N Expires \_\_\_\_/\_\_\_\_/\_\_\_\_

County Of Responsibility \_\_\_\_\_ County Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Benefits Eligible ☐ Y ☐ N Type ☐ SSI ☐ SSDI ☐ OHP ☐ VA ☐ M-care Income \$ \_\_\_\_/mo Private insurance ☐ Y ☐ N

If No Benefits SSD/I applied ☐ Y ☐ N OHP Presumptive ☐ Y ☐ N

Guardian ☐ Y ☐ N Name \_\_\_\_\_ Phone # \_\_\_\_\_

Probation/Parole ☐ Y ☐ N Officer Name \_\_\_\_\_ Agency \_\_\_\_\_ Phone# \_\_\_\_\_

Is applicant a convicted felon? ☐ Y ☐ N Applicant required to register as a Sex Offender ☐ Y ☐ N Arson History ☐ Y ☐ N

Number of Previous Hospitalization(s) \_\_\_\_\_ Name/Location(s) \_\_\_\_\_

Previous Admission to Oregon State Hospitals ☐ Y ☐ N Dates \_\_\_\_\_

Eligibility for other services ☐ DD Eligible ☐ SPD Eligible ☐ DD Applied ☐ SPD Applied ☐ DD Denied ☐ SPD Denied

DIAGNOSTIC SUMMARY ☐ Severe and Persistent Mental Illness ☐ Traumatic/Acquired Brain Injury ☐ Developmental Delay

Axis I : \_\_\_\_\_

Axis II : \_\_\_\_\_

Axis III : \_\_\_\_\_

Axis IV : \_\_\_\_\_

Axis V : Current GAF \_\_\_\_\_ Highest Past GAF \_\_\_\_\_

LOCUS COMPOSITE SCORE \_\_\_\_\_ Current Diagnosis by ☐ MD / Psychiatrist ☐ Psychologist ☐ QMHP

Needs to be addressed by Program / Placement

- ☐ [V] Violence
- ☐ [SX] Sexual Safety Concerns
- ☐ [H] Self Harm
- ☐ [A] Aggression / Current last 30 days
- ☐ [MED] Medical
- ☐ [DD] Developmental Delay
- ☐ [IM] Injectable Medication
- ☐ [SK] Basic Living Skills Training
- ☐ [AP] Arson / Property Destruction

- ☐ [RS] Restraint and Seclusion Needs
- ☐ [ADL] Personal care training needs
- ☐ [Rx] Medication Non compliance
- ☐ [MO] Supervision
- ☐ [SA] Substance Abuse
- ☐ [TNC] Treatment non-compliance
- ☐ [BF] Benefit / Resource issues
- ☐ [DB] Diabetic Oversight & Assistance
- ☐ [BF] Benefits Issues / No resources

- ☐ [X] High Acuity / Low Baseline
- ☐ [PD] Polydipsia
- ☐ [CSC] Community safety concerns
- ☐ [F] Guardianship / Guardian Barriers
- ☐ [BI] TBI/ABI
- ☐ [L] Legal Issues
- ☐ [SZ] Socialization Concerns
- ☐ [MB] Management of Disruptive Behavior
- ☐ [SZ] Socialization Training

Checklist for Attached Documentation

- ☐ CIS Admission Packet
- ☐ Hepatitis B and C Results
- ☐ Tuberculosis Testing Results
- ☐ Recent History & Physical (H&P)

- ☐ Psychiatric / Psychological / Social Work History
- ☐ 1 month (IDT) report (OSH specific)
- ☐ 1 month (BIO) summary report (OSH specific)
- ☐ Care Coordinator Report (OSH specific)

- ☐ Thirty (30) Days Chart Notes – Hand Written
- ☐ One (1) (MAR's)
- ☐ Alcohol and Drug Assessment – When Applicable
- ☐ Risk Assessment – When Applicable
- ☐ Sex offense risk assessment – When Applicable

Suggested Placement/ Desired Geographic Area

Referrer Signature & Credentials \_\_\_\_\_ Date \_\_\_\_\_

### Personal Care Plan

- 4- Full Assistance - (client is unable to do any part of the task or task must be done entirely by someone else)  
 3- Substantial Assistance (client can perform only a small portion of a task and requires assistance with a majority of the task)  
 2- Minimal Assistance – (client is able to perform a majority of a task, but requires some assistance)  
 1- Supervision- (client is able to perform the tasks independently but occasionally needs cueing and observation)  
 0 - Independent (able to perform tasks independently without supervision)

Activities of Daily Living (ADLs)	0	1	2	3	4	Hrs/Day	Hrs/Mo
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Oxygen or Respiratory Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
First Aid and Handling of Emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Instrumental Activities of Daily Living (IADLs)	0	1	2	3	4	Hrs/Day	Hrs/Mo
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Grocery Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Use of the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Totals</b>							

list all significant medical issues requiring ongoing monitoring, treatment or intervention

### Applicant Questionnaire

What is your preferred location?

Are you willing to participate in treatment activities? ☐ Yes ☐ No

Are you willing to take medication for your symptoms? ☐ Yes ☐ No

Are you interested in working or volunteering? ☐ Yes ☐ No  
If so, what type?

Are you interested in going to school? ☐ Yes ☐ No  
If so, where and for what?

What do you hope to accomplish during your stay in a program?

What do you feel you need to be successful in your recovery?

How do you think you will benefit from a residential treatment program?

Are you a Smoker? ☐ Yes ☐ No

Do you have any comments or concerns? If so, please discuss them.



# Authorization for Use & Disclosure of Information

*This form is available in alternative formats including Braille, computer disk, and oral presentation.*

Section A	Legal Last Name	First	MI	Date of Birth
	Other Names Used By Client/Applicant			Case ID#

By signing this form, I authorize the following record holder (individual, school, employer, agency, or medical or other provider) to disclose the following specific confidential information about me:

Section B	Release From	Specific Information to be Disclosed	Mutual Exchange: Yes / No

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS \_\_\_\_\_ Mental Health \_\_\_\_\_ Alcohol/Drug diagnoses, treatment, referral \_\_\_\_\_ Genetic Testing \_\_\_\_\_

Section C	Release To (address required if mailed) If releasing to a team, list members	Purpose	Expiration Date or Event*
	Extended Care Management Unit	Residential Treatment	

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Section D	Full Legal Signature of Individual OR Authorized Personal Representative		Relationship to Client	Date
	Name of Staff Person (print)		Initiating Agency Name/Location	Date

**\* The authorization is valid for one year from the date of signing unless otherwise specified.**

Full Legal Signature of Agency Staff Person Making Copies	This is a true copy of the original Authorization document.
Print Staff Name	

**See Important Information on Page 2 of This Form →**

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## Important Information for the Client

**To provide or pay for health services:** If the Department of Human Services (DHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

**This is a Voluntary Form.** DHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

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## Using This Form

1. **Terms Used: Mutual exchange:** A “yes” allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative’s authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

**Re-disclosure:** Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.



***These answers are in response to DOJ CRIPA letter, question #2:***

The Community Transition Team management changes:  
January-April 2009: PEM/C for Transition Team  
April-August 2009: PEM/C Vacant Position  
August 17th 2009-present: PEM/C for Transition Team

**Community Transition Team**

- ***Planning and Placement Meeting:*** This meeting occurs every 2<sup>nd</sup> and 4<sup>th</sup> Thursday from 3:30-5:00pm at the Brooks Conference Room at OSH. This meeting is facilitated by Community Transition Program Manager and Psychiatric Social Worker. In attendance are OSH Social Workers, OSH Administration, Executive Director of PSRB, PSRB Utilization Coordinator and CMHP representatives. We review the "PnP List" which is a list that Psychiatric Social Worker updates with all patients who are in process for Conditional Release from and End-of-Jurisdiction OSH to the community. We review the status of the listed patients. A recent focus of the meeting is to review the B-Commit list and any patients who have the "Conditional Release Privilege" (as designated by OSH Risk Review Panel) but are not moving forward due to barrier. We work to remove the barrier and match clients with vacancies in the community. (Example: CTT0\_PnPOverview.doc, CTT1\_NewPlanning&Placement.xls, see attached 36 files of PnP meetings from January 2009-present).
- ***Coordination and Staffing of PSRB clients:*** The CTT team conducts ongoing coordination and staffing of PSRB clients who have been referred to CTT Social Workers. This is conducted via CTT team meetings, clinical supervision, administrative supervision, focused group meetings, Interdisciplinary Treatment Team Meetings, ongoing phone calls to PSRB, coordination with Community Mental Health Providers, communication with friends/family/support network of patients and attorneys. (Example: CTT3\_meeting1.1.10.doc, CTT4\_meeting9.3.09.doc, CTT5\_meeting12.31.09.doc) Examples can also be found by reviewing CTT PSW Groupwise calendars).

- **November 2009 CTT Report:** OSH administration asked the CTT team for a report about our team. We drafted a report that describes our work on the transition team. (Example: CTT2\_OVERVIEW\_PROJECT.doc)
- **PSRB Liaison:** CTT manager was requested to be the PSRB Liaison or "Single-Point-of-Contact" for the PSRB. All of these efforts are to expedite information to the PSRB for hearings and increase Conditional Releases to community. (Example: CTT6\_PSRB\_LIAISON\_DRAFT.doc)
- **CTT Referral Form:** CTT Team designed a referral form in collaboration with all PSRB SW. This was designed to improve the communication about referrals to transition team. (Example: CTT7\_Referral\_Form.doc)
- **Conditional Release Orientation Group, Conditional Release Survival Group, and Bounce Back from Revocation Group:** The CTT team provides over 300+ treatment mall hours per month. Some of the groups are specifically targeted towards transition and discharge. (Example: CRO Manual files, CTT8\_conditionalreleaseorientationcatalog.doc, CTT9\_bouncingbackfromrevocation.doc)
- **Implementation of Lean Daily Management System & Visual Board:** The CTT team has a LDMS "Visual Board" which the team can check on transition/discharge data and metrics. We have a "Lean Visual Board" which has CTT data, metrics, Olmstead Information, CRIPA information, Lean information, etc. This board serves as a centralized location for process improvement and data. (Example: (Example: CTT10\_2009\_METRICS.doc, Visual Board is located on 40 Building, Second Floor near Room 202).
- **Planning, Analysis and Research Project:** CTT collaborated with the PAR department to research the quality of transition services by CTT. The project concluded and the results showed many strengths and some clear ways to improve our process. We plan to conduct annual research using these tools. (Example: CTT11\_CRO Executive Summary 2010-05-13 - Prelim Results.pdf, CTT12\_Survey Executive Summary 2010-05-13.pdf, CTT13\_Survey Report 2010-05-13.pdf)

- **CTT Caseload:** CTT manager implemented a weekly updated CTT caseload list and sends it to all PSRB discharge staff weekly. (Example: CTT14\_CASELOADS.doc)
- **RSD Data:** The CTT Recreational Therapists and Occupational Therapists keep real-time data about the clients they serve on CTT. (Example: CTT15\_RSDtransitiondata.xls)
- **Clinical Lead Worker:** The CTT Team received a "Clinical Lead Worker" position. The Lead Worker is helping improve the clinical system for Social Work and Transition. (Example: CTT14\_Social Work Lead Worker Position Description.doc)
- **Steps for PSRB Conditional Release:** A handout is delivered to patients on 35a to assist them in understanding the PSRB discharge process. (Example: CTT15\_STEPS FOR PSRB CONDITIONAL RELEASE FROM OSH.1.doc)
- **Discharge Checklist & CR Checklist:** Social Workers utilize a discharge and CR checklist to ensure all steps are done for discharge: (Example: CTT16\_Discharge checklist.doc, CTT17\_CRchecklist.doc)
- **Conditional Release Map:** CTT worked in collaboration with AMH to update the Conditional Release Map. This helps us understand the multi-step process of transition/discharge. We continually try to streamline steps and are advocating for a Rapid Process Improvement to make the process more efficient. \*The CTT18 file is the original map from 6/3/05, the CTT19 file is the 3/2/10 update. (Example: CTT18\_Conditional Release Schematic Flow Chart.jpg, CTT19\_Conf CR Map DRAFT 3.2.10.bmp)
- **Caseload Rebalance:** CTT and SW Department has rebalanced caseloads and prioritizes transition/discharge clients for the CTT caseload. (Example: CTT20\_CASELOAD REBALANCE.doc)
- **CTT Audit:** CTT manager periodically reviews charts to track client's progress. The attached document is the format for the review. CTT manager was only able to review one chart using this format in December 2009, but he is able to spot-check charts for relevant documentation. (Example: CTT21\_AUDIT\_09.doc)

- **CTT Outreach and Crisis Reorganization:** CTT team redesigned our outreach system to focus more on transition from the hospital. (Example: CTT21\_OUTREACH\_REORGANIZATION.doc, CTT22\_Outreach\_Crisis\_Protocol.doc)
- **CTT Process Improvements:** CTT was requested to create a document of "What's working/Not Working." We created the document and started a CTT Workgroup to address the issues. (Example: CTT23\_What'sWorking.NotWorking.doc)
- **Trip-Slip Improvement:** CTT identified the "Trip-Slip" process at OSH as a barrier for transition visits to community and facilities. The CTT workgroup designed an electronic trip-slip process. The proposal is still pending approval/denial. (Example: CTT24\_Trip Slip\_final\_v2.doc)
- **Western Psychiatric State Hospital Association Question:** CTT manager discussed wanting to improve transition/discharge with the Quality Improvement Department. He requested that QI contact the WPSHA to network. We received 7 responses from the WPSHA. The questions asked were: Do any of the hospitals use evidence-based practices related to transition services? If so, what are those practices? (i.e. evidence-based group curriculums that help patients prepare for transition to the community) What types of data do the other hospitals collect related to transition services? (i.e. readmission rates, reasons for revocations of forensic patients, length of time in the community, post-discharge follow-up surveys, surveys of community providers, success rates at various community settings, etc.) (Example: CTT25\_WPSHAresponses.doc)
- **CTT Committees and Meetings:** CTT manager participates on the "Care of Patients Committee", "Risk Review Panel", "Consumer Group", "CADC Advisory Group" all of which encompass quality improvement efforts of conditional release, transition and discharge of patients. Jacob Mains (Psychiatric Social Worker) has joined the AMH workgroup to discuss community housing options for psychiatric patients. Kellie Mulkey (Psychiatric Social Worker) attends the Multnomah County Meeting to coordinate with PSRB, County Mental Health and CMHP. Maren Walta (Psychiatric Social Worker) participates on the "Cottage Referral Team" to help the referral and

transition of patients to OSH cottages (Example: Review CTT Groupwise calendar for verification).

- **Discharge Plan Details Form:** The transition/discharge Social Worker uses the discharge details form to communicate to Community Provider (e.g. living arrangement, case manager, diagnosis, medication, primary care provider, mental health provider, social support, guardian, financial status, payee, educational/vocational, other activities, anticipated problems and recommendations. (Example: CTT26\_DischargePlanDetails.doc)
- **CTT Data:** CTT maintains basic data for transition and discharge. We continually assess weekly, monthly, and annually the patients who get Risk Review Conditional Release Privileges, OSH request for evaluation, PSRB order for evaluation, Conditionally Releases, and Revocations. We've kept this data from 2005 to present. (Example: Kellie Mulkey's Data Sets in I:Drive folder "Outreach")
- **Creating 35c Transition Ward:** Starting May 2010 CTT dedicated two FTE Psychiatric Social Workers (Jacob Mains, Vickie McGuire) to work on Ward 35c to help it become a transition ward. (Example: Review Groupwise calendars for verification).
- **Consumer Group Meeting:** CTT manager attends the OSH consumer group at least once per month. A copy of the current vacancy list is brought to the meeting to encourage patients to learn about vacancies in community. (Example: CTT27\_CMHP Vacancies.doc)
- **Community Transition Team- Mission Statement:** CTT worked on a mission statement to focus on goals: "The Community Transition Team is responsible for facilitating transition of forensic clients leaving Oregon State Hospital. Team members offer community reintegration outings, conditional release social work services, treatment groups, and leisure education /exploration. These services are intended to empower consumers to leave the hospital and successfully live in the community."



## **FORENSIC PATIENT PRIVILEGES**

**October 21, 2009**

Forensic patients are served throughout OSH and prominently in Buildings 50, 48, 35, 34 and 40. According to OSH Policy 6.029 Forensic Risk Review Panel, the Panel approves privileges for these patients. Privileges are individually identified by check box on the Risk Review Form. Until a patient is granted privileges their movement outside the secure perimeter is in transport restraints and with sufficient staff to assure safety and security. These provisions may be modified by physician order for medical reasons.

Here follows the privileges allowable to forensic patients (there are additional privileges for patients in the Transitional Living Cottages that are outlined in a companion document). These ratios constitute the greatest range of independence allowed. A treatment team may limit privileges to less independence, or greater restriction, to match patient needs for safety and security.

### **ON GROUNDS:**

#### **-With staff**

1:1

2:4

2:8

#### **-With Peers**

Requires the patients to write a plan of their destinations (not more than two locations) and the approximate arrival and departure time in each place. The treatment team must approve the plan. The patients sign out and back in. On grounds with peers is intended to be a small group like

two women or

two men or

one man and one woman and an additional person of either gender.

Treatment staff will be assigned to complete unobtrusive checks to observe these patients following their itinerary.

#### **-Authorized Person(s)**

Example: walking on grounds with family while visiting. See full explanation under Off Grounds with Authorized Person.

#### **-Solo for work**

Travel to a work assignment with a completed Unsupervised Worksite Agreement approved by the treatment team and vocational services.

**-Other**

To indicate a different staff to patient ratio than listed above. Or to document the risk mitigation when unusual circumstances of compelling clinical benefit are considered.

**OFF GROUNDS**

**-With staff**

2:1

1:1

2:4

2:8 within the city of Salem by Unit Director approval for each occurrence.

2:8 outside the city of Salem by Unit Director and Program Director approval for each occurrence.

**-CMHP (Community Mental Health Program or Residential Provider).**

Passes up to 48 hours as part of a planned transition to community placement with each occurrence approved by the Unit Director and Program Director.

**-Authorized Person(s)**

Visits with family and others up to 48 hours implemented by Unit Director and Program Director approval for each occurrence.

Requires completion and signature by the authorized person of the Responsible Person form that includes itinerary and leaving and return times.

The treatment team protocol for an Authorized Person pass consists of

1. The treatment team gets to know the proposed authorized person.
2. At least three outings with the patient and the proposed authorized person supervised by staff and followed by treatment team debriefings.
3. Brief visits preceding longer or overnight visits. The treatment team will debrief all such passes.

**-Other**

To indicate a different staff to patient ratio than listed above. Or to document the risk mitigation when unusual circumstances of compelling clinical benefit are considered. For example to attend Community College classes, search for a job, or go to work.

### **TRANSITIONAL LIVING COTTAGES**

The treatment team may recommend and request that the patient be approved for transition through the cottage program. The Risk Review Panel considers the benefit and risk mitigation and makes a recommendation to the Clinical Executive Committee. The Committee considers the case and may approve or deny. The Clinical Executive Committee may also consider a cottage referral directly from the patient or another source such as the Transition Team. Consideration of and approval for a patient to participate in the Transitional Living Cottages may be made by the Clinical Executive Committee at any time that the patient has Conditional Release Planning, On Grounds 2:8, and participates in treatment.

### **OTHER REQUESTS**

- Unannounced security checks by staff: indicates that the treatment team should assign staff to check on the patient's whereabouts and activities without announcement to assure compliance with a plan / agreement.
- Initiate conditional release planning/evaluation: indicates that the patient is approaching maximum treatment benefit and ready to enter the stage of transition to community. This stage of treatment sometimes requires considerable effort and time.
- Initiate discharge planning-jurisdiction / sentence ending: indicates the approaching end of the court commitment to PSRB jurisdiction. Choices are Discharge or Civil Commitment.
- Conditional release pending PSRB approval: indicates that OSH Risk Review approves the patient for conditional release as soon as the PSRB allows.

## OMHAS/PSRB/OSH Planning and Placement List

### Process

1. **Request:** A request is put in writing by the Social Worker to the PSRB Board to have an evaluation sent to a community provider. A Social Worker and Psychiatrist sign the request.
2. **Order:** This is the date the PSRB sent out the order for the evaluation.
3. **Evaluation:** An evaluation is completed by the community provider and includes but is not limited to:
  - An interview with the resident
  - Review of the residents records
  - Assessments
  - Answer to these three questions:
    1. Is the patient affected by mental disease or defect?
    2. Does the patient present a substantial danger to others?  
If the patient is affected by mental disease or defect, which is in a state of remission, may the disease, with reasonable medical probability, occasionally become active and, when active, render the patient a danger to others.
    3. Provide your recommendation regarding whether the patient is appropriate for conditional release in the community. If yes, what supervision and treatment are necessary to allow the patient to remain safely in the community? Can you or your mental health program provide these services or can your agency monitor the provision of the services by other agencies or individuals?
4. **Accept:** Refers to whether the community program accepts the resident.
5. **Denial:** Refers to the community denying placement and specific reasons why. Includes recommendations for future placement or what the individual would need to work on before being accepted.
6. **Benefit Status:** The benefit status is set up prior to the resident going out into the community by the OSH Social Worker but the community program must register with the local Social Security Department shortly upon release to the community.
7. **Hearing:** Every patient has to have a hearing prior to leaving OSH. Four items are needed for a hearing and they include the following:
  - (1) Evaluation

- (2) Update – three weeks prior to the hearing
- (3) Summary of Conditional Release Plan
- (4) Request for Hearing

Note: Two types of Hearing

(1) Full Hearing

- a. Provider
- b. Patient
- c. Social Worker
- d. Victim
- e. Family
- f. Other

States Attorney and PSRB Board decide on Conditional Release

Hearings are held at **Oregon State Hospital 77 Building**

(2) Ad. Min. Hearing. (Paper Review)

## AMH Procedure (DRAFT)

### Procedure for referral process to ECMU for PSRB Clients nearing End of Jurisdiction:

1. At least 6 months prior to end of jurisdiction the OSH Social Worker or Community Provider will send a referral packet to the AMH PSRB Utilization Coordinator for review.  
(Documents and required information attached)
2. This packet will be reviewed for completeness and eligibility for ongoing ECMU services beyond PSRB jurisdiction.
3. The PSRB Utilization Coordinator will review within 3 working days for an initial determination of ECMU Eligibility.
4. An eligibility determination email will be sent by the PSRB Utilization Coordinator to the referral source and next steps will be outlined.
5. If the individual is determined eligible an ECMU coversheet will be attached to the packet indicating which potential referral sources will receive this packet and it will be sent to the responsible county.
6. PSRB individuals eligible for ECMU supports following end of jurisdiction will be referred to residential programs at appropriate levels of care and they will screen for placement for either waitlist status or immediate placement, following the PSRB Conditional Release Process if prior to EOJ.
7. Follow-up communication from the PSRB Utilization Coordinator will follow regarding placement referral assuring planning is completed prior to end of jurisdiction.
8. If the individual is determined to not be eligible for ongoing ECMU services or placement the referral source will be notified by the PSRB Utilization Coordinator and other resources will be pursued. The standard ECMU appeals process will be followed if the determination is appealed.

## Question 2 – PSRB

- **Vacancy Reporting**  
Vacancy Report Documents are completed bi-weekly by Addictions and Mental Health Staff (PSRB Utilization Coordinator) to identify where openings are available in the community and referrals are needed.
- **Planning and Placement Process**  
Planning and Placement Documents are completed bi-weekly by Oregon State Hospital Community Transition Team Social Work Staff to identify referrals that have been made to community placements and where the referrals are at in the process. A meeting of OSH Social Work Staff, AMH Staff, and the PSRB Executive Director is scheduled for the 2<sup>nd</sup> and 4<sup>th</sup> Thursday's of the month to discuss individuals currently referred and additional referrals needed.
- **Forensic Patient Privileges**  
The Risk Review Panel is made up of Security Staff from OSH, a Psychologist trained in Risk Assessment, a Social Worker with a community transition perspective, and an executive manager who is a designee from the Chief Medical Officer. Packets are prepared and submitted by the Interdisciplinary Teams for individual patients, identifying current level of functioning and how the request for privilege would allow the person to complete treatment goals on the hospital grounds or off grounds. A short term assessment of risk and treatment (START) is also completed to further identify the individual's risk and success formulations. Other privilege requests include recommendation for Transitional Cottages, Initiate Conditional Release Planning, Conditional Release Pending PSRB approval, Community Mental Health Program Supervision when transitioning to a community program. The risk review panel reviews the packet, clinical records and interviews the team and at times the individual patient before granting privileges. Privileges move individuals through the hospital levels of care and provide additional transition supports when granted the initiate conditional release planning privileges.

- PSRB End Of Jurisdiction- Extended Care Management Unit (ECMU) Process and ECMU Residential Treatment Application  
For individuals not yet conditionally released nearing end of jurisdiction a referral to ECMU is made 6 months prior to end of jurisdiction. This referral is reviewed for eligibility and packets are sent to community providers for consideration of placements at end of jurisdiction.
- Coordination Calendars Jan-Dec 2009 and Jan-Dec 2010  
Coordination Calendars are sent to the OSH Social Workers and Community Providers to inform about hearing dates and deadlines for paperwork to submit prior to getting a hearing on the PSRB docket, Planning and Placement dates and meetings of community providers.

**Oregon Department of Human Services/Oregon Health Authority**

**Addictions and Mental Health Division**

**Olmstead Plan draft**

**May 13, 2010**

To achieve the intent of the Olmstead decision (~~Appendix 4~~), Oregon intends to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness in a system that is consumer driven and assists people in obtaining “a key to their own door.” Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

This Olmstead plan will provide the reader with a brief history of the current barriers, Oregon’s solution to those barriers as well as future plans and projects to prevent these and other barriers from recurring. The plan consists of three sections and thirteen strategies to assure that people transition to the community expeditiously as they work towards self-sufficiency.

## **Section I**

### **OSH Length of Stay (LOS)**

The emphasis on community-based treatment for mental health services grew in the 1980s, based on recommendations by a series of commissions, task forces appointed by the Governor and DHS, and Executive Orders. The closure of Dammasch State Hospital in 1995 was a landmark step to moving from state hospital care to community mental health services. The “deinstitutionalization” movement in Oregon paralleled a national movement. Oregon has been intentional in its goal of keeping people as independent as possible, as demonstrated by the closure of the Dammasch State Hospital, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities.

To reduce the LOS at the OSH, the Addictions and Mental Health Division (AMH) is working closely with consumers of mental health services and supports, OSH staff, community mental health programs, providers of mental health services and supports, stakeholders and advocates to identify past practice, current barriers and future solutions to more timely discharges that would contribute to a reduced LOS at OSH. Currently the average LOS across the state hospital system is 338 days. This work was done in concert with the Transformation efforts that are being utilized throughout the Oregon Department of Human Services. In 2007, DHS embarked on a Transformation which is a systematic approach to fundamentally changing the way business is done. At AMH, these structures and tools are being used to provide more and effective client services and to improve accountability. The goal is to build a foundation for continuous improvement by repeatedly measuring performance, quickly resolving problems and efficiently using resources. OSH, AMH and community mental health partners currently have several initiatives underway which will address the barriers to diversion, de-institutionalization and community integration previously outlined in this plan.

#### **I. Transitioning People to the Community**

Staff from OSH and AMH, consumers of mental health services and supports, community mental health program representatives, providers of mental health services and supports worked together and identified several barriers that resulted in people staying too long at OSH. These barriers and accompanying solutions are the basis for AMH’s transformation initiative for transitioning people to the community. The main goal is to assure that people are discharged from OSH more quickly using both a standardized set

## **Section I**

### **OSH Length of Stay (LOS)**

of readiness discharge criteria and a standardized level of care tool. (*Appendix B*) The tool selected is the Level of Care Utilization of Services 10<sup>th</sup> edition. (*Appendix C*) AMH is implementing training of the LOCUS using a “train the trainer methodology” to train a core group of individuals from OSH, AMH, the community mental health programs, providers of mental health services and supports as well as consumers of mental health services and supports how to apply the tool as part of both the OSH discharge process and to determine the level of care, supports and services an individual needs to be successful in the community. These representatives can then provide training to their peers so that a large number of people will be trained to the same assessment tool across the state. Oregon believes that this current transformation initiative will be successful in decreasing the LOS at OSH by providing standardization to both the discharge criteria and standardization in the use of an assessment tool used statewide. Those standardization components, increased statewide training capacity to those who administer and provide the services and supports, plus improving the entire discharge process from OSH to the community will prove successful for Oregonians in obtaining “a key to their own door.” Both the standardized ready to place criteria and the LOCUS were adopted April 2010 and are scheduled for implementation May 2010.

## **II. Psychiatric Security Review Board (PSRB)**

In 2009, the Governor directed the Department of Human Services (DHS) and Addictions and Mental Health (AMH) to research and make recommendations to improve the process for moving people under the jurisdiction of the Psychiatric Security Review Board (PSRB) into the community when they were deemed ready. The research included reviewing current process, policies, procedures, Oregon Administrative Rules and Statutes, and interviewing OSH staff, patients, patient families, advocates, community providers, AMH staff, PSRB staff and board members. After gathering data, recommendations were created and a Coalition group was formed in 2010 to review and approve them. The Coalition group includes the Executive Director of PSRB, OSH Superintendent, and Assistant Director of AMH with assistance from the Governor’s Office, the AMH researchers, and Oregon Department of Justice (ODOJ). The Coalition’s charge is to determine goals, create implementation strategies, and implement approved recommendations.

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### **OSH Length of Stay (LOS)**

At this time, work is being done on several approved short term goals to ensure the conditional release readiness determinations and community placements of patients under PSRB jurisdiction by OSH and PSRB occur more smoothly by decreasing delays caused by inconsistencies, lack of information, lack of training, and backlogs.

In addition, OSH in conjunction with both AMH and the PSRB needs to provide a standardized assessment of need in order to identify appropriate treatment resources both in the community and the forensic hospital.

#### **III. Community Residential Capacity Utilization Review**

To determine “patient flow” within the community residential system, AMH conducted a utilization review of 10 residential care providers. These providers were selected for interview because their residents typically experience unusually long lengths of stay. The 10 providers represented 5 residential treatment facilities, 2 secure residential treatment facilities, and 3 residential treatment homes. This study yielded some interesting information and allowed AMH staff to refine its tools and methodology. Subsequently, AMH contracted with Acumentra Health, a nonprofit organization whose focus is improving the quality and effectiveness of healthcare by providing external quality reviews of services and supports, to conduct a more comprehensive system-wide utilization review. The basic goals for the utilization review work of Acumentra is to assess the appropriateness of current placements and determine the appropriateness of placements. The Acumentra Health utilization study is anticipated to be completed September 2010 with results to be posted on the AMH website.<sup>1</sup> AMH believes that this study will yield data that will further efforts to provide people the right amount of treatment in the most appropriate settings for the right amount time.

#### **IV. Peer Bridger Program (OSH)**

The fourth strategy that will help address the LOS concerns at OSH will build on the current Peer Bridgers Program that OSH adopted in 2008. The program uses peers who have received inpatient public mental health services to formally support and mentor patients ready to be discharged. A

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<sup>1</sup> AMH [web link]

## **Section I**

### **OSH Length of Stay (LOS)**

Peer Bridgers' representative will work closely with the person once s/he has been discharged into the community. This program is modeled on a New York state program. A multi-year evaluation of the New York Peer Bridgers program demonstrated that state hospital patients participating in the program were re-hospitalized an average of 19%, while a control group of patients averaged a 60% re-hospitalization rate. OSH has four Peer Bridgers/Recovery Specialists. In addition Oregon is expanding its work with peer delivered services in the community as well with the belief that increased peer services and supports with people receiving mental health treatment will enhance and provide the necessary bridge, when combined with community based treatment for both successful community living and decreased re-hospitalizations. This initiative will be more fully addressed later in this plan. (*Appendix E*)

#### **V. New Treatment Model at OSH**

Oregon believes that providing at least 20 hours of active treatment in a treatment setting that more closely mirrors treatment in the community will promote recovery, resiliency, independence and wellness for those people receiving services. In anticipation of the new Oregon State Hospital physical facility and in keeping with Oregon's Olmstead goals, OSH has adopted and is currently implementing an innovative "treatment mall" approach to treatment and service delivery for people needing state hospital level of care. The purpose of this strategy is to better prepare people for a more independent living setting after leaving the hospital.

The new treatment mall is based on a treatment philosophy utilized by new and renovated psychiatric hospitals. It employs a community design of centralized care in which the patients' living areas are connected to a "neighborhood" mall that connects to a larger "downtown" mall so that patients can access at least 20 hours of active treatment services per week provided on the treatment mall and have more opportunities for healthy socialization and wellness activities. While patients will live on a unit, they will receive treatment, eat meals, attend classes and participate in activities in the mall areas. There is growing evidence that this centralized model can provide lasting benefits, including a decrease in hospital readmission rates, increased skills in symptom management and improved quality of life. This also prepares the person for a treatment experience that more closely mirrors how community members receive treatment, services and supports; that is to

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say we leave our homes to seek treatment, employment, services and supports in the communities in which we live. Current new treatment malls operating are the Gero Psychiatric Mall which opened June 1<sup>st</sup>, 2008, the 40 Treatment Mall which opened March 3<sup>rd</sup>, 2009, Portland Mall which opened February 2007 and the 50 Treatment Mall which opened January 19<sup>th</sup>, 2010. For the new facility, the treatment malls and scheduled opening dates are: ABC Harbors. Scheduled to open December 3<sup>rd</sup>, 2010 with the remaining malls Trails (PSR), Bridger's transition, Neuro and New Generation to open based on the facility construction schedule.

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## **Section II**

### **Establishment of Independent Living Environments**

#### **VI. Supported Housing**

Prior to the 1999 Olmstead decision, Oregon closed the Dammasch State Hospital, (Dammach) located in Wilsonville in July 1995. To accomplish this Oregon focused on providing less restrictive community based services for those people living in Dammasch. Dammasch opened in 1961 and was successfully closed 1995, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities. The former Dammasch site is now home to Villebois, a planned community.<sup>2</sup> Currently at Villebois, there are 10 beds available in two residential treatment homes (Hearthstone and Fieldstone) and 64 supported housing opportunities in three settings (The Charleston, Renaissance Court and Rain Garden).

The current average length of stay in Oregon's residential treatment programs varies by the type of facility and ranges from just under 400 days in adult foster homes to nearly 600 days in residential treatment facilities. The average length of stay in Oregon state hospitals for the civilly committed population is just over one year with a small group of clients staying more than five years. The time many people are staying in these institutions is far too long. The length of stay can only be reduced with an investment in supportive housing resources.

To meet the growing need for community services for people with mental illness, over the past 15 years Oregon had focused on increasing facility-based care in local communities rather than expanding state hospital services for people who are civilly committed. For the past several biennia, the Oregon legislature has approved funding to increase facility-based care which resulted in an increase in residential treatment facilities throughout the state. This increase has provided community treatment opportunities for

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<sup>2</sup> Inspired by traditional European villages, Villebois, which translates to "village near the woods," is a 500-acre master-planned community in Wilsonville, Ore. At the heart of Villebois will be the Village Center, characterized by elements such as apartments and row homes as well as ground level retail and commercial space. Surrounding the Village Center are three distinct neighborhoods, Villebois features diverse housing types, including apartments, community housing and condominiums, attached row and town homes, as well as single-family detached homes on lots of varying sizes. The entire community is connected by more than 130-acres of trails and open green spaces, including parks and nature preserves that join to trails that lead well beyond Villebois.

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### **Establishment of Independent Living Environments**

people who are discharged from OSH and Blue Mountain Recovery Center (BMRC).

The current service delivery system is overly reliant on the use of residential facilities, which are less flexible and more costly than a community-based supportive housing system. The residential facility system lacks the supportive housing resources that keep people living in their own homes rather than small or large group settings.

To address these deficiencies, housing opportunities in the community with an array of supportive services is not only more effective treatment for many, but it provides an increase in capacity by reducing the length of stay in residential facilities by providing more permanent housing plus services. Without an investment in supportive housing, intensive outpatient and peer services Oregon will not be able to move individuals from state or community facilities to self-sufficiency.

Central to Oregon's mental health policy direction is the need for an individually driven treatment system that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." A foundational component of recovery is safe and affordable housing with access to treatment services and supports when they are needed; in other words the right amount of services at the right time for the right amount of time. To create an effective and efficient array of housing services and supports and in response to the aforementioned utilization study results, Oregon is establishing more independent living environments through increased supportive housing capacity, increased rental subsidies and associated housing supports and services and increased supported employment opportunities. This strategy is captured and documented in AMH's supportive housing initiative. (*Appendix E*) AMH will work with community partners to provide rental assistance for at least 400 people by June 30, 2011, through a combined effort of the supportive housing initiative and the AMHI initiative.

## **Section III**

### **Prevention of State Hospitalization**

Oregon is working to provide treatment to people at the earliest point possible within the course of their illness. Understandably, this will occur at different times for every person but the primary goal is to prevent state hospitalization and the associated stigma that accompanies a person when they re-enter the community.

Oregon is focusing investments on several key issues to prevent people from being hospitalized at OSH; those issues are the establishment, promotion and sustainment of a recovery oriented system of care, investment in early psychosis and early assessment screening, peer delivered services and wellness programs.

#### **VII. Improving Service Access Through Local Accountability**

The seventh strategy that Oregon is developing is the Adult Mental Health Initiative (AMHI). AMHI is designed to promote more effective utilization of current capacity in facility based treatment settings, increase care coordination and increase accountability at a local and state level. It is also designed to promote the availability and quality of individualized community-based services and supports, so that adults with mental illness are served in the least restrictive environment possible and use of long-term institutional care is minimized.

AMHI is working with local or regional MHOs, Community Mental Health Programs (CMHPs), providers and stakeholders, to design and implement financing, contracting and service-delivery strategies that bring together isolated service components to assist individuals in a collaborative clinically appropriate approach to recovery. Services will be community-based with management, decision-making and service delivery occurring at the local level. AMHI will build on and compliment other efforts currently under way such as implementing a standardized assessment tool, utilizing a standardized discharge processes from state institutions and introducing newly approved Medicaid State Plan Amendments. The intent of AMHI is to manage utilization to get the right level of service to individuals at the right time and place. AMHI will be system-wide care management to move individuals to self sufficiency.

Oregon believes that the AMHI initiative will provide the ongoing

## **Section III**

### **Prevention of State Hospitalization**

framework, continued development and support of a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. In addition, there will be coordinated care for people accessing publicly funded health services and early intervention for mental health and substance abuse issues will be maximized. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions. Ramifications of these health disparities and chronic conditions will be addressed in the Wellness section of this plan.

#### **VIII. Recovery-oriented System of Care**

Recovery is a lifelong process that brings with it many experiences of both success and temporary setbacks. For a successful recovery-oriented system of care to thrive, there needs to be adequate funding for services and supports, adequate access to services and supports at the time a person needs them and for the right amount of time for people to succeed in treatment. In March 2007 the Addictions and Mental Health Division's (AMH) Community Services Workgroup (CSWG) published its final report. The purpose of the report was to inform AMH, the Department of Human Services (DHS), the Governor and the Legislature about the range of community-based services needed to complement the replacement of state hospital facilities and to assure the successful operation of the new hospitals. *(Appendix D)*

The CSWG report indicated that without a fully funded and operational services and supports system, the staff would be frustrated in its efforts to provide treatment to people in the community versus the state hospital. Unless the state invests in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant new investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

#### **IX. Early Psychosis and Early Assessment Screening**

Early intervention in psychosis is a well-researched model. It is based on the observation that identifying and treating someone in the early stages of a psychosis can significantly improve their longer-term outcome. Beginning in 2007, HB 2144 created the Children's Wraparound Initiative in order to build a system of care that collaborates across agencies, families and youth to improve access and expand the array of coordinated community-based,

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### Prevention of State Hospitalization

culturally and linguistically appropriate services and natural supports for children and youth with serious mental health needs. The Children's Wrap Around initiative is cross-divisional with the Children, Adults and Families (CAF) division of DHS, touching the lives of children from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. (*Appendix E*)

The 2007 Oregon legislature funded EASA to bring the most current, evidence-based treatment to individuals in the early stages of illness. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective, and prevents the long term morbidity associated with chronic psychotic illness. There are currently seven community mental health programs with EASA sites representing nine counties. EASA uses evidence-based practices to do early assessment and intervention for young adults having their first experience with psychosis. Its primary purpose is to reduce the disability associated with psychosis.

#### **X. Peer Delivered Services**

Research increasingly demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people who have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

Oregon is expanding its work with peer delivered services with the knowledge that increased peer services and supports combined with community based treatment will enhance and provide people the necessary bridge for both successful community living and decreased re-hospitalizations.

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Providing community-based treatment to both young adults in transition and adults needing mental health treatment, services and supports is a cornerstone of recovery. AMH in collaboration with local community mental health programs funded a “warm” line. This warm line is designed and provided by people who have or have had mental health challenges and are able to support their peers telephonically when they are struggling with a variety of mental health concerns. The warm line was frequently used. For 2009, the average number of calls responded to per month was approximately 350-400, with an average call length of 30 minutes, using 100 trained operators statewide.

AMH is implementing rules, policies and procedures to promote and increase the utilization of peer delivered services (PDS) in Oregon. AMH is streamlining and consolidating service delivery through the March 2010 adoption of the Integrated Services and Supports Administrative Rules (ISSR) that includes defining peer delivered services and identifying service areas for employment and volunteer opportunities. AMH aligns its focus with national and international recovery thinking, person-centered health care planning, client self-determination and a holistic wellness approach in its mental health and addiction services delivery transformation. This focus is demonstrated by a policy and procedure for reviewing and approving peer delivered services training and curricula which meet Center for Medicare and Medicaid Services (CMS) and national consumer operated organization standards.

#### **XI. Wellness**

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die approximately 16 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council. AMH will build on current activities within the Wellness Initiative by working closely with AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers

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### Prevention of State Hospitalization

with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities.

The Community Services Workgroup report states that AMH “. . . should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.” The Oregon study concludes that premature mortality among people receiving mental health services is a health care crisis and recommends AMH (via a Wellness Task Force) work with community agencies to implement changes in care coordination, wellness screening and use of peer-to-peer support services to empower people with serious mental illness and/or substance use disorders in achieving lifestyle changes that will improve their overall health. The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health care providers. It blends the work of the AMH Wellness Task Force, DHS Core Integration Team, the Oregon Public Health Division, hospitals, mentors, consumers, family members, community stakeholder groups, providers and national experts to move as a united force to end health inequities and take immediate action to eliminate contributing factors to preventable diseases. Here are three current wellness projects:

**A Public Health Approach** – Health integration is our future and will translate into increased access to appropriate health care services through a public health care approach across the lifespan. Integrated physical health care and behavioral health care experts are joining forces to provide a full range of health promotion and intervention services – collaborating, collocating, cross-training with our health care workforce to reach individuals and families where they live...in their community.

The Oregon Public Health Division (PHD) and Oregon Addictions and Mental Health Division (AMH) are taking a lead role in our statewide AMH Wellness Initiative. Currently, we are working on new policy recommendations to dramatically address the use of tobacco products at all DHS-AMH treatment or residential service sites. In addition to the local projects reflected below, PHD and AMH are teaming up with statewide representatives from the mental health and addictions recovery community

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### Prevention of State Hospitalization

to build community wellness champions in every county and/or region of the state to build a local peer wellness program.

**Tobacco Freedom** – An approach to support self-determination, utilizing a person's motivation to choose to be free from an addictive substance; equipping individuals, residential treatment settings and community consumer run organizations with cessation supports and treatment strategies.

**Community Peer Wellness Forums** – Quarterly education forums bring together providers, customers, family members, and local complimentary healing vendors to increase awareness of health promotion and wellness options in the community, promote a healing network, and raise community action to increase prevention efforts and health care services to meet the needs of all citizens. The face-to-face interaction between community members from all walks of life breaks down social barriers, dispelling myths about mental illness and eliminate stigma.

**Nutrition and Exercise** – A multi-pronged approach to increase adoption of healthy food options and appropriate levels of exercise; i.e., dance, yoga, walking for the populations we serve in all therapeutic and independent settings.

The goals for the above initiatives include:

- Decrease access and use of tobacco products by clients and staff.
- Health promotion with appropriate NRT supports in place for AMH clients.
- Expansion of a peer services network in the community providing wellness coaching.
- Increase access to holistic, person-centered healthcare in the public service arena through collaboration and collocation.
- Increase in opportunities for workforce development in health care services; promoting physical health and behavioral health care integration.

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- Increase in complimentary therapeutic interventions available to persons receiving services.
- Increase in client self-empowerment and self-determination in fulfilling their personal wellness plans.
- Statewide agency coordination on health and wellness efforts.
- Shared resources and resource savings through greater state and community partnership.
- Decrease in the number of productive years of life lost to preventable conditions.

#### **XII. Oregon Health Authority**

Oregon has a unique opportunity to provide services and supports in a more integrated manner through the Oregon Health Authority (OHA). The OHA was created by legislation in 2009 (House Bill 2009) to be implemented at the beginning of the July 2011 biennium. The mission of the OHA is to help people and communities achieve optimum physical, mental and social well being through partnerships, prevention and access to quality, affordable health care. The ultimate aim of the OHA is to ensure access to health care while making changes that will stem rising costs, improve quality and promote good health. This provides Oregon with an opportunity to have the needs of this population considered in important health care reform. OHA knows what it needs to do to improve health care: focus on health and preventive care, provide care for everyone and reduce waste in the health care system. OHA will be tackling these problems in both the public and private sectors.

#### **XIII. Consumer Participation**

Oregon Revised Statute (ORS) 430.075 provides that at least 20 percent membership of task forces, commissions, advisory groups and committees primarily related to mental health or addictions issues must be composed of consumers of services. This important legislation was passed in 2007 with the full support of local and statewide consumer groups, ensuring that the

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## **Prevention of State Hospitalization**

voice of people who are currently receiving mental health or addiction services or have received services are included in policy and decision making. In order to encourage statewide participation, individuals receive compensation for their travel expenses. Reimbursement comes from a combination of federal (i.e. Mental Health Block Grant) and General Fund sources. To expand consumer voice statewide, Oregon is promoting consumers as educators of mental health and addiction services. Oregon will continue to actively seek consumer participation in the development of community based programs. Oregon will actively seek and support consumer participation as members of quality improvement site reviews and will provide increased consumer education regarding Olmstead and policy development and implementation. AMH will seek funding to support community based consumer organizations thru an Office of Consumer Activities.

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## Summary

Looking to the future, Oregon is embarking on 15 new policy driven initiatives. Many of which are identified in this document. (*Appendix E*) These initiatives will move Oregon to a more recovery focused system and will substantially increase the availability, utilization and quality of individualized, integrated, culturally competent, home and community-based services for children, youth, and adults.

Oregon's goal to achieve the intent of the Olmstead decision is to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

Oregon's system is now under stress because the state had relied on creating a facility-based approach to service delivery. The mental health system at present is meeting less than 50 percent of the need for public services for adults and children. As identified in the CSWG report "... without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals." These services and supports must be consumer driven not only at the clinical level, but with consumer's providing an active voice through participation in local and state governance bodies.

It is critical that each community or regional system of care in our state have enough resources to fund a set of core services and supports. Oregon will not be successful with the replacement state hospital facilities envisioned by the State Hospital Master Plan. The facilities will be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate if every region is not funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area. A robustly funded community-based system of care is not only essential to the operation of the state hospital it is essential in meeting Oregon's Olmstead goals.

## **Appendix A**

**Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)**

OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* v. L. C.,  
by *zimir*, guardian ad litem and next  
friend, *et al.*

certiorari to the united states court of appeals for the eleventh circuit

No. 98-536. Argued April 21, 1999--Decided June 22, 1999

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U. S. C. §§12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities. §12132. Congress instructed the Attorney General to issue regulations implementing Title II's discrimination proscription. See §12134(a). One such regulation, known as the "integration regulation," requires a "public entity [to] administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d). A further prescription, here called the "reasonable-modifications regulation," requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," but does not require measures that would "fundamentally alter" the nature of the entity's programs. §35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U. S. C. §1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of [their] disability[ies]," accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding. The court also rejected the State's defense that requiring immediate transfers in such cases would "fundamentally alter" the State's programs. The Eleventh Circuit affirmed the District Court's judgment, but remanded for reassessment of the State's cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget.

*Held:* The judgment is affirmed in part and vacated in part, and the case is remanded.

138 F. 3d 893, affirmed in part, vacated in part, and remanded.

*Justice Ginsburg* delivered the opinion of the Court with respect to Parts I, II, and III-A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 11-18.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General's construction of the ADA. This Court affirms the Court of Appeals decision in substantial part. Pp. 11-12.

(b) Undue institutionalization qualifies as discrimination "by reason of ... disability." The Department of Justice has consistently advocated that it does. Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. *E.g., Bragdon v. Abbott*, 524 U. S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to "discrimination," for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see §12132, and specifically identifies unjustified "segregation" of persons with disabilities as a "for[m] of discrimination," see §§12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, cf., *e.g., Allen v. Wright*, 468 U. S. 737, 755; and institutional confinement severely diminishes individuals' everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress' ADA findings, the Medicaid statute "reflected" a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 12-18.

*Justice Ginsburg*, joined by *Justice O'Connor*, *Justice Souter*, and *Justice Breyer*, concluded in Part III-B that the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities. The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State

proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State's facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 18-22.

*Justice Stevens* would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined *Justice Ginsburg*'s judgment and Parts I, II, and III-A of her opinion. Pp. 1-2.

*Justice Kennedy* concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities). This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 1-10.

*Ginsburg*, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, in which *Stevens*, *O'Connor*, *Souter*, and *Breyer*, JJ., joined, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer*, JJ., joined. *Stevens*, J., filed an opinion concurring in part and concurring in the judgment. *Kennedy*, J., filed an opinion concurring in the judgment, in which *Breyer*, J., joined as to Part I. *Thomas*, J., filed a dissenting opinion, in which *Rehnquist*, C. J., and *Scalia*, J., joined.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.*,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend*, *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Ginsburg* announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer*, *JJ.*, joined.

This case concerns the proper construction of the anti-discrimination provision contained in the public services portion (Title II) of the Americans with Disabilities Act of 1990, 104 Stat. 337, 42 U. S. C. §12132. Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. In so ruling, we affirm the decision of the Eleventh Circuit in substantial part. We remand the case, however, for further consideration of the appropriate relief, given the range of facilities the State maintains for the care and treatment of persons with diverse mental disabilities, and its obligation to administer services with an even hand.

I

This case, as it comes to us, presents no constitutional question. The complaints filed by plaintiffs-respondents L. C. and E. W. did include such an issue; L. C. and E. W. alleged that defendants-petitioners, Georgia health care officials, failed to afford them minimally adequate care and freedom from undue restraint, in violation of their rights under the Due Process Clause of the Fourteenth Amendment. See Complaint ¶¶ 87-91; Intervenor's Complaint ¶¶ 30-34. But neither the District Court nor the Court of Appeals reached those Fourteenth Amendment claims. See Civ. No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), pp. 5-6, 11-13, App. to Pet. for Cert. 34a-35a, 40a-41a; 138 F. 3d 893, 895, and n. 3 (CA11 1998). Instead, the courts below resolved the case solely on statutory grounds. Our review is similarly confined. Cf. *Cleburne v. Cleburne Living Center, Inc.*, 473 U. S. 432, 450 (1985) (Texas city's requirement of special use permit for operation of group home for mentally retarded, when other care and multiple-dwelling facilities were freely permitted, lacked rational basis and therefore violated Equal Protection Clause of Fourteenth Amendment). Mindful that it is a statute we are construing, we set out first the legislative and regulatory prescriptions on which the case turns.

In the opening provisions of the ADA, Congress stated findings applicable to the statute in all its parts. Most relevant to this case, Congress determined that

"(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

"(3) discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . . ;

.....

"(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . failure to make modifications to existing facilities and practices, . . . [and] segregation . . ." 42 U. S. C. §§12101(a)(2), (3), (5).<sup>1</sup>

Congress then set forth prohibitions against discrimination in employment (Title I, §§12111-12117), public services furnished by governmental entities (Title II, §§12131-12165), and public accommodations provided by private entities (Title III, §§12181-12189). The statute as a whole is intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." §12101(b)(1).<sup>2</sup>

This case concerns Title II, the public services portion of the ADA.<sup>3</sup> The provision of Title II centrally at issue reads:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." §12132.

Title II's definition section states that "public entity" includes "any State or local government," and "any department, agency, [or] special purpose district." §§12131(1)(A), (B). The same section defines "qualified individual with a disability" as

"an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

On redress for violations of §12132's discrimination prohibition, Congress referred to remedies available under §505 of the Rehabilitation Act of 1973, 92 Stat. 2982, 29 U. S. C. §794a. See 42 U. S. C. §12133 ("The remedies, procedures, and rights set forth in [§505 of the Rehabilitation Act] shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.").<sup>4</sup>

Congress instructed the Attorney General to issue regulations implementing provisions of Title II, including §12132's discrimination proscription. See §12134(a) ("[T]he Attorney General shall promulgate regulations in an accessible format that implement this part.").<sup>5</sup> The Attorney General's regulations, Congress further directed, "shall be consistent with this chapter and with the coordination regulations . . . applicable to recipients of Federal financial assistance under [§504 of the Rehabilitation Act]." 42 U. S. C. §12134(b). One of the §504 regulations requires recipients of federal funds to "administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 CFR §41.51(d) (1998).

As Congress instructed, the Attorney General issued Title II regulations, see 28 CFR pt. 35 (1998), including one modeled on the §504 regulation just quoted; called the "integration regulation," it reads:

"A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d) (1998).

The preamble to the Attorney General's Title II regulations defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" to mean "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 CFR

pt. 35, App. A, p. 450 (1998). Another regulation requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," unless those modifications would entail a "fundamenta[al] alter[ation]"; called here the "reasonable-modifications regulation," it provides:

"A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

We recite these regulations with the caveat that we do not here determine their validity. While the parties differ on the proper construction and enforcement of the regulations, we do not understand petitioners to challenge the regulatory formulations themselves as outside the congressional authorization. See Brief for Petitioners 16-17, 36, 40-41; Reply Brief 15-16 (challenging the Attorney General's interpretation of the integration regulation).

## II

With the key legislative provisions in full view, we summarize the facts underlying this dispute. Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women have a history of treatment in institutional settings. In May 1992, L. C. was voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where she was confined for treatment in a psychiatric unit. By May 1993, her psychiatric condition had stabilized, and L. C.'s treatment team at GRH agreed that her needs could be met appropriately in one of the community-based programs the State supported. Despite this evaluation, L. C. remained institutionalized until February 1996, when the State placed her in a community-based treatment program.

E. W. was voluntarily admitted to GRH in February 1995; like L. C., E. W. was confined for treatment in a psychiatric unit. In March 1995, GRH sought to discharge E. W. to a homeless shelter, but abandoned that plan after her attorney filed an administrative complaint. By 1996, E. W.'s treating psychiatrist concluded that she could be treated appropriately in a community-based setting. She nonetheless remained institutionalized until a few months after the District Court issued its judgment in this case in 1997.

In May 1995, when she was still institutionalized at GRH, L. C. filed suit in the United States District Court for the Northern District of Georgia, challenging her continued confinement in a segregated environment. Her complaint invoked 42 U. S. C. §1983 and provisions of the ADA, §§12131-12134, and named as defendants, now petitioners, the Commissioner of the Georgia Department of Human Resources, the Superintendent of GRH, and the Executive Director of the Fulton County Regional Board (collectively, the State). L. C. alleged that the State's failure to place her in a community-based program, once her treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA. L. C.'s pleading requested, among other things, that the State place her in a community care residential program, and that she receive treatment with the ultimate goal of integrating her into the mainstream of society. E. W. intervened in the action, stating an identical claim.<sup>6</sup>

The District Court granted partial summary judgment in favor of L. C. and E. W. See App. to Pet. for Cert. 31a-42a. The court held that the State's failure to place L. C. and E. W. in an appropriate community-based treatment program violated Title II of the ADA. See *id.*, at 39a, 41a. In so ruling, the court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of" their disabilities, accounted for their retention at GRH. Under Title II, the court concluded, "unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding." *Id.*, at 37a.

In addition to contending that L. C. and E. W. had not shown discrimination "by reason of [their] disability[ies]," the State resisted court intervention on the ground that requiring immediate transfers in cases of this order would "fundamentally alter" the State's activity. The State reasserted that it was already using all available funds to provide services to other persons with disabilities. See *id.*, at 38a. Rejecting the State's "fundamental alteration" defense, the court observed that existing state programs provided community-based treatment of the kind for which L. C. and E. W. qualified, and that the State could "provide services to plaintiffs in the community at considerably less cost than is required to maintain them in an institution." *Id.*, at 39a.

The Court of Appeals for the Eleventh Circuit affirmed the judgment of the District Court, but remanded for reassessment of the State's cost-based defense. See 138 F. 3d, at 905. As the appeals court read the statute and regulations: When "a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting--the most integrated setting appropriate to that patient's needs"; "[w]here there is no such finding [by the treating professionals], nothing in the ADA requires the deinstitutionalization of th[e] patient." *Id.*, at 902.

The Court of Appeals recognized that the State's duty to provide integrated services "is not absolute"; under the Attorney General's Title II regulation, "reasonable modifications" were required of the State, but fundamental alterations were not demanded. *Id.*, at 904. The appeals court thought it clear, however, that "Congress wanted to permit a cost defense only in the most limited of circumstances." *Id.*, at 902. In conclusion, the court stated that a cost justification would fail "[u]nless the State can prove that requiring it to [expend additional funds in order to provide L. C. and E. W. with integrated services] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides." *Id.*, at 905. Because it appeared that the District Court had entirely ruled out a "lack of funding" justification, see App. to Pet. for Cert. 37a, the appeals court remanded, repeating that the District Court should consider, among other things, "whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget." 138 F. 3d, at 905.<sup>7</sup>

We granted certiorari in view of the importance of the question presented to the States and affected individuals. See 525 U. S. \_\_\_\_ (1998).<sup>8</sup>

### III

Endeavoring to carry out Congress' instruction to issue regulations implementing Title II, the Attorney General, in the integration and reasonable-modifications regulations, see *supra*, at 5-7, made two key determinations. The first concerned the scope of the ADA's discrimination proscription, 42 U. S. C. §12132; the second concerned the obligation of the States to counter discrimination. As to the first, the Attorney General concluded that unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II. See 28 CFR §35.130(d) (1998) ("A public entity shall administer services . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), pp. 8, 15-16 (unnecessary segregation of persons with disabilities constitutes a form of discrimination prohibited by the ADA and the integration regulation). Regarding the States' obligation to avoid unjustified isolation of individuals with disabilities, the Attorney General provided that States could resist modifications that "would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

The Court of Appeals essentially upheld the Attorney General's construction of the ADA. As just recounted, see *supra*, at 9-10, the appeals court ruled that the unjustified institutionalization of persons with mental disabilities violated Title II; the court then remanded with instructions to measure the cost of caring for L. C. and E. W. in a community-based facility against the State's mental health budget.

We affirm the Court of Appeals' decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.

A

We examine first whether, as the Eleventh Circuit held, undue institutionalization qualifies as discrimination "by reason of . . . disability." The Department of Justice has consistently advocated that it does.<sup>9</sup> Because the Department is the agency directed by Congress to issue regulations implementing Title II, see *supra*, at 5-6, its views warrant respect. We need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844 (1984), is in order; "[i]t is enough to observe that the well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Bragdon v. Abbott*, 524 U. S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.*, 323 U. S. 134, 139-140 (1944)).

The State argues that L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities. See Brief for Petitioners 20. Nor were they subjected to "discrimination," the State contends, because " 'discrimination' necessarily requires uneven treatment of similarly situated individuals," and L. C. and E. W. had identified no comparison class, *i.e.*, no similarly situated individuals given preferential treatment. *Id.*, at 21. We are satisfied that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA.<sup>10</sup>

The ADA stepped up earlier measures to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The Developmentally Disabled Assistance and Bill of Rights Act (DDABRA), a 1975 measure, stated in aspirational terms that "[t]he treatment, services, and habilitation for a person with developmental disabilities . . . *should be* provided in the setting that is least restrictive of the person's personal liberty." 89 Stat. 502, 42 U. S. C. §6010(2) (1976 ed.) (emphasis added); see also *Pennhurst State School and Hospital v. Halderman*, 451 U. S. 1, 24 (1981) (concluding that the §6010 provisions of the DDABRA "were intended to be hortatory, not mandatory"). In a related legislative endeavor, the Rehabilitation Act of 1973, Congress used mandatory language to proscribe discrimination against persons with disabilities. See 87 Stat. 394, as amended, 29 U. S. C. §794 (1976 ed.) ("No otherwise qualified individual with a disability in the United States . . . *shall*, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." (Emphasis added)). Ultimately, in the ADA, enacted in 1990, Congress not only required all public entities to refrain from discrimination, see 42 U. S. C. §12132; additionally, in findings applicable to the entire statute, Congress explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." See §12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); §12101(a)(5) ("individuals with disabilities continually encounter various forms of discrimination, including . . . segregation").<sup>11</sup>

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Cf. *Allen v. Wright*, 468 U. S. 737, 755 (1984) ("There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action."); *Los Angeles Dept. of Water and Power v.*

*Manhart*, 435 U. S. 702, 707, n. 13 (1978) (" `In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.' " (quoting *Sprogis v. United Air Lines, Inc.*, 444 F. 2d 1194, 1198 (CA7 1971)). Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. See Brief for American Psychiatric Association et al. as *Amici Curiae* 20-22. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. See Brief for United States as *Amicus Curiae* 6-7, 17.

The State urges that, whatever Congress may have stated as its findings in the ADA, the Medicaid statute "reflected a congressional policy preference for treatment in the institution over treatment in the community." Brief for Petitioners 31. The State correctly used the past tense. Since 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program. See 95 Stat. 812-813, as amended, 42 U. S. C. §1396n(c); Brief for United States as *Amicus Curiae* 20-21. <sup>12</sup> Indeed, the United States points out that the Department of Health and Human Services (HHS) "has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses." *Id.*, at 25-26 (further observing that, by 1996, "HHS approved up to 2109 waiver slots for Georgia, but Georgia used only 700").

We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Title II provides only that "qualified individual[s] with a disability" may not "be subjected to discrimination." 42 U. S. C. §12132. "Qualified individuals," the ADA further explains, are persons with disabilities who, "with or without reasonable modifications to rules, policies, or practices, . . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

Consistent with these provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting. See 28 CFR §35.130(d) (1998) (public entity shall administer services and programs in "the most integrated setting *appropriate* to the needs of qualified individuals with disabilities" (emphasis added)); cf. *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 288 (1987) ("[C]ourts normally should defer to the reasonable medical judgments of public health officials."). <sup>13</sup> Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. See 28 CFR §35.130(e)(1) (1998) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept."); 28 CFR pt. 35, App. A, p. 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."). In this case, however, there is no genuine dispute concerning the status of L. C. and E. W. as individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. See *supra*, at 7-8. <sup>14</sup>

## B

The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. 28 CFR §35.130(b)(7) (1998). The Court of Appeals construed this regulation to permit a cost-based defense "only in the most limited of circumstances," 138 F. 3d, at 902, and remanded to the District Court to consider, among other things,

"whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget," *id.* , at 905.

The Court of Appeals' construction of the reasonable-modifications regulation is unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks. If the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. See Tr. of Oral Arg. 27 (State's attorney argues that Court of Appeals' understanding of the fundamental-alteration defense, as expressed in its order to the District Court, "will always preclude the State from a meaningful defense"); cf. Brief for Petitioners 37-38 (Court of Appeals' remand order "mistakenly asks the district court to examine [the fundamental-alteration] defense based on the cost of providing community care to just two individuals, not all Georgia citizens who desire community care"); 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177 (District Court, on remand, declares the impact of its decision beyond L. C. and E. W. "irrelevant"). Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

When it granted summary judgment for plaintiffs in this case, the District Court compared the cost of caring for the plaintiffs in a community-based setting with the cost of caring for them in an institution. That simple comparison showed that community placements cost less than institutional confinements. See App. to Pet. for Cert. 39a. As the United States recognizes, however, a comparison so simple overlooks costs the State cannot avoid; most notably, a "State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions." Brief for United States as *Amicus Curiae* 21.<sup>15</sup>

As already observed, see *supra* , at 17, the ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Cf. *post* , at 2-3 ( *Kennedy, J.* , concurring in judgment). Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. See *supra* , at 8. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time "to stabilize acute psychiatric symptoms." App. 98 (affidavit of Dr. Richard L. Elliott); see 138 F. 3d, at 903 ("[T]here may be times [when] a patient can be treated in the community, and others whe[n] an institutional placement is necessary."); Reply Brief 19 (placement in a community-based treatment program does not mean the State will no longer need to retain hospital accommodations for the person so placed). For other individuals, no placement outside the institution may ever be appropriate. See Brief for American Psychiatric Association et al. as *Amici Curiae* 22-23 ("Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times--perhaps in the short run, perhaps in the long run--for the risks and exposure of the less protective environment of community settings"; for these persons, "institutional settings are needed and must remain available."); Brief for Voice of the Retarded et al. as *Amici Curiae* 11 ("Each disabled person is entitled to treatment in the most integrated setting possible for that person--recognizing that, on a case-by-case basis, that setting may be in an institution."); *Youngberg v. Romeo*, 457 U. S. 307, 327 (1982) (Blackmun, J., concurring) ("For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know.").

To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. See Tr. of Oral Arg. 5 (State's attorney urges that, "by asking [a] person to wait a short time until a community bed is available, Georgia does not exclude [that] person by reason of disability, neither does Georgia discriminate against her by reason of disability"); see

also *id.* , at 25 ("[I]t is reasonable for the State to ask someone to wait until a community placement is available."). In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.<sup>16</sup>

\* \* \*

For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. The judgment of the Eleventh Circuit is therefore affirmed in part and vacated in part, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Stevens* , concurring in part and concurring in the judgment.

Unjustified disparate treatment, in this case, "unjustified institutional isolation," constitutes discrimination under the Americans with Disabilities Act of 1990. See *ante* , at 15. If a plaintiff requests relief that requires modification of a State's services or programs, the State may assert, as an affirmative defense, that the requested modification would cause a fundamental alteration of a State's services and programs. In this case, the Court of Appeals appropriately remanded for consideration of the State's affirmative defense. On remand, the District Court rejected the State's "fundamental-alteration defense." See *ante* , at 10, n. 7. If the District Court was wrong in concluding that costs unrelated to the treatment of L. C. and E. W. do not support such a defense in this case, that arguable error should be corrected either by the Court of Appeals or by this Court in review of that decision. In my opinion, therefore, we should simply affirm the judgment of the Court of Appeals. But because there are not five votes for that disposition, I join *Justice Ginsburg* 's judgment and Parts I, II, and III-A of her opinion. Cf. *Bragdon v. Abbott* , 524 U. S. 624, 655-656 (1998) ( *Stevens* , J. concurring); *Screws v. United States* , 325 U. S. 91, 134 (1945) (Rutledge, J. concurring in result).

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[June 22, 1999]

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*Justice Kennedy* , with whom *Justice Breyer* joins as to Part I, concurring in the judgment.

I

Despite remarkable advances and achievements by medical science, and agreement among many professionals that even severe mental illness is often treatable, the extent of public resources to devote to this cause remains controversial. Knowledgeable professionals tell us that our society, and the governments which reflect its attitudes and preferences, have yet to grasp the potential for treating mental disorders, especially severe mental illness. As a result, necessary resources for the endeavor often are not forthcoming. During the course of a year, about 5.6 million Americans will suffer from severe mental illness. E. Torrey, *Out of the Shadows* 4 (1997). Some 2.2 million of these persons receive no treatment. *Id.* , at 6. Millions of other Americans suffer from mental disabilities of less serious degree, such as mild depression. These facts are part of the background against which this case arises. In addition, of course, persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility. See, *e.g.* , *Cleburne v. Cleburne Living Center, Inc.* , 473 U. S. 432, 461-464 (1985) (Marshall, J., concurring in judgment in part and dissenting in part) (discussing treatment of the mentally retarded).

Despite these obstacles, the States have acknowledged that the care of the mentally disabled is their special obligation. They operate and support facilities and programs, sometimes elaborate ones, to provide care. It is a continuing challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time.

Beginning in the 1950's, many victims of severe mental illness were moved out of state-run hospitals, often with benign objectives. According to one estimate, when adjusted for population growth, "the actual decrease in the numbers of people with severe mental illnesses in public psychiatric hospitals between 1955 and 1995 was 92 percent." Brief for American Psychiatric Association *et al.* as *Amici Curiae* 21, n. 5 (citing Torrey, *supra* , at 8-9). This was not without benefit or justification. The so-called "deinstitutionalization" has permitted a substantial number of mentally disabled persons to receive needed treatment with greater freedom and dignity. It may be, moreover, that those who remain institutionalized are indeed the most severe cases. With reference to this case, as the Court points out, *ante* , at 7-8, 17-18, it is undisputed that the State's own treating professionals determined that community-based care was medically appropriate for respondents. Nevertheless, the depopulation of state mental hospitals has its dark side. According to one expert:

"For a substantial minority. . . deinstitutionalization has been a psychiatric *Titanic* . Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The

'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies." Torrey, *supra*, at 11.

It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.

It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 (ADA) to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision. The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference. It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires. This is illustrative of the factors a responsible physician will consider in recommending the appropriate setting or facility for treatment. *Justice Ginsburg's* opinion takes account of this background. It is careful, and quite correct, to say that it is not "the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter . . ." *Ante*, at 20.

In light of these concerns, if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition. This danger is in addition to the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts. It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

## II

With these reservations made explicit, in my view we must remand the case for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed.

At the outset it should be noted there is no allegation that Georgia officials acted on the basis of animus or unfair stereotypes regarding the disabled. Underlying much discrimination law is the notion that animus can lead to false and unjustified stereotypes, and vice versa. Of course, the line between animus and stereotype is often indistinct, and it is not always necessary to distinguish between them. Section 12132 can be understood to deem as irrational, and so to prohibit, distinctions by which a class of disabled persons, or some within that class, are, by reason of their disability and without adequate justification, exposed by a state entity to more onerous treatment than a comparison group in the provision of services or the administration of existing programs, or indeed entirely excluded from state programs or facilities. Discrimination under this statute might in principle be shown in the case before us, though further proceedings should be required.

Putting aside issues of animus or unfair stereotype, I agree with *Justice Thomas* that on the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she "received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic." *Post*, at 1-2 (dissenting opinion). In my view, however, discrimination so defined might be shown here. Although the Court seems to reject *Justice Thomas's* definition of discrimination, *ante*, at 13, it asserts that unnecessary institutional care does lead to "[d]issimilar treatment," *ante*, at 16. According to the Court, "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable

accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Ibid* .

Although this point is not discussed at length by the Court, it does serve to suggest the theory under which respondents might be subject to discrimination in violation of §12132. If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established. In terms more specific to this case, if respondents could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities), I believe it would demonstrate discrimination on the basis of mental disability.

Of course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. The judgment, however, is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions. In addition, as the Court notes, *ante*, at 6-7, by regulation a public entity is required only to make "reasonable modifications in policies, practices, or procedures" when necessary to avoid discrimination and is not even required to make those if "the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998). It follows that a State may not be forced to create a community-treatment program where none exists. See Brief for United States as *Amicus Curiae* 19-20, and n. 3. Whether a different statutory scheme would exceed constitutional limits need not be addressed.

Discrimination, of course, tends to be an expansive concept and, as legal category, it must be applied with care and prudence. On any reasonable reading of the statute, §12132 cannot cover all types of differential treatment of disabled and nondisabled persons, no matter how minimal or innocuous. To establish discrimination in the context of this case, and absent a showing of policies motivated by improper animus or stereotypes, it would be necessary to show that a comparable or similarly situated group received differential treatment. Regulations are an important tool in identifying the kinds of contexts, policies, and practices that raise concerns under the ADA. The congressional findings in 42 U. S. C. §12101 also serve as a useful aid for courts to discern the sorts of discrimination with which Congress was concerned. Indeed, those findings have clear bearing on the issues raised in this case, and support the conclusion that unnecessary institutionalization may be the evidence or the result of the discrimination the ADA prohibits.

Unlike *Justice Thomas* , I deem it relevant and instructive that Congress in express terms identified the "isolat[ion] and segregat[ion]" of disabled persons by society as a "for[m] of discrimination," §§12101(a)(2), (5), and noted that discrimination against the disabled "persists in such critical areas as . . . institutionalization," §12101(a)(3). These findings do not show that segregation and institutionalization are always discriminatory or that segregation or institutionalization are, by their nature, forms of prohibited discrimination. Nor do they necessitate a regime in which individual treatment plans are required, as distinguished from broad and reasonable classifications for the provision of health care services. Instead, they underscore Congress' concern that discrimination has been a frequent and pervasive problem in institutional settings and policies and its concern that segregating disabled persons from others can be discriminatory. Both of those concerns are consistent with the normal definition of discrimination--differential treatment of similarly situated groups. The findings inform application of that definition in specific cases, but absent guidance to the contrary, there is no reason to think they displace

it. The issue whether respondents have been discriminated against under §12132 by institutionalized treatment cannot be decided in the abstract, divorced from the facts surrounding treatment programs in their State.

The possibility therefore remains that, on the facts of this case, respondents would be able to support a claim under §12132 by showing that they have been subject to discrimination by Georgia officials on the basis of their disability. This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. For example, the evidence might show that, apart from services for the mentally disabled, medical treatment is rarely offered in a community setting but also is rarely offered in facilities comparable to state mental hospitals. Determining the relevance of that type of evidence would require considerable judgment and analysis. However, as petitioners observe, "[i]n this case, no class of similarly situated individuals was even identified, let alone shown to be given preferential treatment." Brief for Petitioners 21. Without additional information regarding the details of state-provided medical services in Georgia, we cannot address the issue in the way the statute demands. As a consequence, the judgment of the courts below, granting partial summary judgment to respondents, ought not to be sustained. In addition, as *Justice Ginsburg's* opinion is careful to note, *ante*, at 19, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. We must be cautious when we seek to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute.

I would remand the case to the Court of Appeals or the District Court for it to determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested above.

For these reasons, I concur in the judgment of the Court.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.*,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend*, *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Thomas*, with whom *The Chief Justice* and *Justice Scalia* join, dissenting.

Title II of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 337, 42 U. S. C. §12132, provides:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, *or be subjected to discrimination* by any such entity." (Emphasis added.)

The majority concludes that petitioners "discriminated" against respondents--as a matter of law--by continuing to treat them in an institutional setting after they became eligible for community placement. I

disagree. Temporary exclusion from community placement does not amount to "discrimination" in the traditional sense of the word, nor have respondents shown that petitioners "discriminated" against them "by reason of" their disabilities.

Until today, this Court has never endorsed an interpretation of the term "discrimination" that encompassed disparate treatment among members of the *same* protected class. Discrimination, as typically understood, requires a showing that a claimant received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. This interpretation comports with dictionary definitions of the term discrimination, which means to "distinguish," to "differentiate," or to make a "distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit." Random House Dictionary 564 (2d ed. 1987); see also Webster's Third New International Dictionary 648 (1981) (defining "discrimination" as "the making or perceiving of a distinction or difference" or as "the act, practice, or an instance of discriminating categorically rather than individually").

Our decisions construing various statutory prohibitions against "discrimination" have not wavered from this path. The best place to begin is with Title VII of the Civil Rights Act of 1964, 78 Stat. 253, as amended, the paradigmatic anti-discrimination law.<sup>1</sup> Title VII makes it "an unlawful employment practice for an employer ... to *discriminate* against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U. S. C. §2000e-2(a)(1) (emphasis added). We have explained that this language is designed "to achieve equality of employment opportunities and remove barriers that have operated in the past to favor an identifiable group of white employees over other employees." *Griggs v. Duke Power Co.*, 401 U. S. 424, 429-430 (1971).<sup>2</sup>

Under Title VII, a finding of discrimination requires a comparison of otherwise similarly situated persons who are in different groups by reason of certain characteristics provided by statute. See, e.g., *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U. S. 669, 683 (1983) (explaining that Title VII discrimination occurs when an employee is treated "in a manner which but for that person's sex would be different") (quoting *Los Angeles Dept. of Water and Power v. Manhart*, 435 U. S. 702, 711 (1978)). For this reason, we have described as "nonsensical" the comparison of the racial composition of different classes of job categories in determining whether there existed disparate impact discrimination with respect to a particular job category. *Wards Cove Packing Co. v. Atonio*, 490 U. S. 642, 651 (1989).<sup>3</sup> Courts interpreting Title VII have held that a plaintiff cannot prove "discrimination" by demonstrating that one member of a particular protected group has been favored over another member of that same group. See, e.g., *Bush v. Commonwealth Edison Co.*, 990 F. 2d 928, 931 (CA7 1993), cert. denied, 511 U. S. 1071 (1994) (explaining that under Title VII, a fired black employee "had to show that although he was not a good employee, equally bad employees were treated more leniently by [his employer] if they happened not to be black").

Our cases interpreting §504 of the Rehabilitation Act of 1973, 87 Stat. 394, as amended, which prohibits "discrimination" against certain individuals with disabilities, have applied this commonly understood meaning of discrimination. Section 504 provides:

"No otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In keeping with the traditional paradigm, we have always limited the application of the term "discrimination" in the Rehabilitation Act to a person who is a member of a protected group and faces discrimination "by reason of his handicap." Indeed, we previously rejected the argument that §504 requires the type of "affirmative efforts to overcome the disabilities caused by handicaps," *Southeastern Community College v. Davis*, 442 U. S. 397, 410 (1979), that the majority appears to endorse today. Instead, we found that §504 required merely "the evenhanded treatment of handicapped persons" relative to those persons who do not have disabilities. *Ibid.* Our conclusion was informed by the fact that some

provisions of the Rehabilitation Act envision "affirmative action" on behalf of those individuals with disabilities, but §504 itself "does not refer at all" to such action. *Ibid.* Therefore, "[a] comparison of these provisions demonstrates that Congress understood accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so." *Id.*, at 411.

Similarly, in *Alexander v. Choate*, 469 U. S. 287, 302 (1985), we found no discrimination under §504 with respect to a limit on inpatient hospital care that was "neutral on its face" and did not "distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having," *id.*, at 302. We said that §504 does "not ... guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed." *Id.*, at 304.

Likewise, in *Traynor v. Turnage*, 485 U. S. 535, 548 (1988), we reiterated that the purpose of §504 is to guarantee that individuals with disabilities receive "evenhanded treatment" relative to those persons without disabilities. In *Traynor*, the Court upheld a Veterans' Administration regulation that excluded "primary alcoholics" from a benefit that was extended to persons disabled by alcoholism related to a mental disorder. *Id.*, at 551. In so doing, the Court noted that, "[t]his litigation does not involve a program or activity that is alleged to treat handicapped persons less favorably than nonhandicapped persons." *Id.*, at 548. Given the theory of the case, the Court explicitly held: "There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Id.*, at 549.

This same understanding of discrimination also informs this Court's constitutional interpretation of the term. See *General Motors Corp. v. Tracy*, 519 U. S. 278, 298 (1997) (noting with respect to interpreting the Commerce Clause, "[c]onceptually, of course, any notion of discrimination assumes a comparison of substantially similar entities"); *Yick Wo v. Hopkins*, 118 U. S. 356, 374 (1886) (condemning under the Fourteenth Amendment "illegal discriminations between persons in similar circumstances"); see also *Adarand Constructors, Inc. v. Peña*, 515 U. S. 200, 223-224 (1995); *Richmond v. J. A. Croson Co.*, 488 U. S. 469, 493-494 (1989) (plurality opinion).

Despite this traditional understanding, the majority derives a more "capacious" definition of "discrimination," as that term is used in Title II of the ADA, one that includes "institutional isolation of persons with disabilities." *Ante*, at 13-14. It chiefly relies on certain congressional findings contained within the ADA. To be sure, those findings appear to equate institutional isolation with segregation, and thereby discrimination. See *ante*, at 14 (quoting §§12101(a)(2) and 12101(a)(5), both of which explicitly identify "segregation" of persons with disabilities as a form of "discrimination"); see also *ante*, at 2-3. The congressional findings, however, are written in general, hortatory terms and provide little guidance to the interpretation of the specific language of §12132. See *National Organization for Women, Inc. v. Scheidler*, 510 U. S. 249, 260 (1994) ("We also think that the quoted statement of congressional findings is a rather thin reed upon which to base a requirement"). In my view, the vague congressional findings upon which the majority relies simply do not suffice to show that Congress sought to overturn a well-established understanding of a statutory term (here, "discrimination").<sup>4</sup> Moreover, the majority fails to explain why terms in the findings should be given a medical content, pertaining to the place where a mentally retarded person is treated. When read in context, the findings instead suggest that terms such as "segregation" were used in a more general sense, pertaining to matters such as access to employment, facilities, and transportation. Absent a clear directive to the contrary, we must read "discrimination" in light of the common understanding of the term. We cannot expand the meaning of the term "discrimination" in order to invalidate policies we may find unfortunate. Cf. *NLRB v. Highland Park Mfg. Co.*, 341 U. S. 322, 325 (1951) (explaining that if Congress intended statutory terms "to have other than their ordinarily accepted meaning, it would and should have given them a special meaning by definition").<sup>5</sup>

Elsewhere in the ADA, Congress chose to alter the traditional definition of discrimination. Title I of the ADA, §12112(b)(1), defines discrimination to include "limiting, segregating, or classifying a job applicant

or employee in a way that adversely affects the opportunities or status of such applicant or employee." Notably, however, Congress did not provide that this definition of discrimination, unlike other aspects of the ADA, applies to Title II. Ordinary canons of construction require that we respect the limited applicability of this definition of "discrimination" and not import it into other parts of the law where Congress did not see fit. See, e.g., *Bates v. United States*, 522 U. S. 23, 29-30 (1997) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion") (quoting *Russello v. United States*, 464 U. S. 16, 23 (1983)). The majority's definition of discrimination--although not specifically delineated--substantially imports the definition of Title I into Title II by necessarily assuming that it is sufficient to focus exclusively on members of one particular group. Under this view, discrimination occurs when some members of a protected group are treated differently from other members of that same group. As the preceding discussion emphasizes, absent a special definition supplied by Congress, this conclusion is a remarkable and novel proposition that finds no support in our decisions in analogous areas. For example, the majority's conclusion that petitioners "discriminated" against respondents is the equivalent to finding discrimination under Title VII where a black employee with deficient management skills is denied in-house training by his employer (allegedly because of lack of funding) because other similarly situated black employees are given the in-house training. Such a claim would fly in the face of our prior case law, which requires more than the assertion that a person belongs to a protected group and did not receive some benefit. See, e.g., *Griggs*, 401 U. S., at 430-431 ("Congress did not intend by Title VII, however, to guarantee a job to every person regardless of qualifications. In short, the Act does not command that any person be hired simply because he was formerly the subject of discrimination, or because he is a member of a minority group").

At bottom, the type of claim approved of by the majority does not concern a prohibition against certain conduct (the traditional understanding of discrimination), but rather imposition of a standard of care.<sup>6</sup> As such, the majority can offer no principle limiting this new species of "discrimination" claim apart from an affirmative defense because it looks merely to an individual in isolation, without comparing him to otherwise similarly situated persons, and determines that discrimination occurs merely because that individual does not receive the treatment he wishes to receive. By adopting such a broad view of discrimination, the majority drains the term of any meaning other than as a proxy for decisions disapproved of by this Court.

Further, I fear that the majority's approach imposes significant federalism costs, directing States how to make decisions about their delivery of public services. We previously have recognized that constitutional principles of federalism erect limits on the Federal Government's ability to direct state officers or to interfere with the functions of state governments. See, e.g., *Printz v. United States*, 521 U. S. 898 (1997); *New York v. United States*, 505 U. S. 144 (1992). We have suggested that these principles specifically apply to whether States are required to provide a certain level of benefits to individuals with disabilities. As noted in *Alexander*, in rejecting a similar theory under §504 of the Rehabilitation Act: "[N]othing ... suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services ... ." 469 U. S., at 307; see also *Bowen v. American Hospital Assn.*, 476 U. S. 610, 642 (1986) (plurality opinion) ("[N]othing in [§504] authorizes [the Secretary of Health and Human Services (HHS)] to commandeer state agencies ... . [These] agencies are not field offices of the HHS bureaucracy and they may not be conscripted against their will as the foot soldiers in a federal crusade"). The majority's affirmative defense will likely come as cold comfort to the States that will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual. In keeping with our traditional deference in this area, see *Alexander*, *supra*, the appropriate course would be to respect the States' historical role as the dominant authority responsible for providing services to individuals with disabilities.

The majority may remark that it actually does properly compare members of different groups. Indeed, the majority mentions in passing the "[d]issimilar treatment" of persons with and without disabilities. *Ante*, at 15. It does so in the context of supporting its conclusion that institutional isolation is a form of discrimination. It cites two cases as standing for the unremarkable proposition that discrimination leads to deleterious stereotyping, *ante*, at 15 (citing *Allen v. Wright*, 468 U. S. 737, 755 (1984); *Manhart*, 435 U. S., at 707, n. 13)), and an *amicus* brief which indicates that confinement diminishes certain everyday

life activities, *ante*, at 15 (citing Brief for American Psychiatric Association et al. 20-22). The majority then observes that persons without disabilities "can receive the services they need without" institutionalization and thereby avoid these twin deleterious effects. *Ante*, at 15. I do not quarrel with the two general propositions, but I fail to see how they assist in resolving the issue before the Court. Further, the majority neither specifies what services persons with disabilities might need, nor contends that persons without disabilities need the same services as those with disabilities, leading to the inference that the dissimilar treatment the majority observes results merely from the fact that different classes of persons receive different services--not from "discrimination" as traditionally defined.

Finally, it is also clear petitioners did not "discriminate" against respondents "by reason of [their] disabili[ties]," as §12132 requires. We have previously interpreted the phrase "by reason of" as requiring proximate causation. See, e.g., *Holmes v. Securities Investor Protection Corp.*, 503 U. S. 258, 265-266 (1992); see also *id.*, at 266, n. 11 (citation of cases). Such an interpretation is in keeping with the vernacular understanding of the phrase. See American Heritage Dictionary 1506 (3d ed. 1992) (defining "by reason of" as "because of"). This statute should be read as requiring proximate causation as well. Respondents do not contend that their disabilities constituted the proximate cause for their exclusion. Nor could they--community placement simply is not available to those without disabilities. Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement, does not establish that the denial of community placement occurred "by reason of" their disability. Rather, it establishes no more than the fact that petitioners have limited resources.

\* \* \*

For the foregoing reasons, I respectfully dissent.

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## FOOTNOTES

### Footnote 1

The ADA, enacted in 1990, is the Federal Government's most recent and extensive endeavor to address discrimination against persons with disabilities. Earlier legislative efforts included the Rehabilitation Act of 1973, 87 Stat. 355, 29 U. S. C. §701 *et seq.* (1976 ed.), and the Developmentally Disabled Assistance and Bill of Rights Act, 89 Stat. 486, 42 U. S. C. §6001 *et seq.* (1976 ed.), enacted in 1975. In the ADA, Congress for the first time referred expressly to "segregation" of persons with disabilities as a "for[m] of discrimination," and to discrimination that persists in the area of "institutionalization." §§12101(a)(2), (3), (5).

### Footnote 2

The ADA defines "disability," "with respect to an individual," as

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment." §12102(2).

There is no dispute that L. C. and E. W. are disabled within the meaning of the ADA.

**Footnote 3**

In addition to the provisions set out in Part A governing public services generally, see §§12131-12134, Title II contains in Part B a host of provisions governing public transportation services, see §§12141-12165.

**Footnote 4**

Section 505 of the Rehabilitation Act incorporates the remedies, rights, and procedures set forth in Title VI of the Civil Rights Act of 1964 for violations of §504 of the Rehabilitation Act. See 29 U. S. C. §794a(a)(2). Title VI, in turn, directs each federal department authorized to extend financial assistance to any department or agency of a State to issue rules and regulations consistent with achievement of the objectives of the statute authorizing financial assistance. See 78 Stat. 252, 42 U. S. C. §2000d-1. Compliance with such requirements may be effected by the termination or denial of federal funds, or "by any other means authorized by law." *Ibid.* Remedies both at law and in equity are available for violations of the statute. See §2000d-7(a)(2).

**Footnote 5**

Congress directed the Secretary of Transportation to issue regulations implementing the portion of Title II concerning public transportation. See 42 U. S. C. §§12143(b), 12149, 12164. As stated in the regulations, a person alleging discrimination on the basis of disability in violation of Title II may seek to enforce its provisions by commencing a private lawsuit, or by filing a complaint with (a) a federal agency that provides funding to the public entity that is the subject of the complaint, (b) the Department of Justice for referral to an appropriate agency, or (c) one of eight federal agencies responsible for investigating complaints arising under Title II: the Department of Agriculture, the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of the Interior, the Department of Justice, the Department of Labor, and the Department of Transportation. See 28 CFR §§35.170(c), 35.172(b), 35.190(b) (1998).

The ADA contains several other provisions allocating regulatory and enforcement responsibility. Congress instructed the Equal Employment Opportunity Commission (EEOC) to issue regulations implementing Title I, see 42 U. S. C. §12116; the EEOC, the Attorney General, and persons alleging discrimination on the basis of disability in violation of Title I may enforce its provisions, see §12117(a). Congress similarly instructed the Secretary of Transportation and the Attorney General to issue regulations implementing provisions of Title III, see §§12186(a)(1), (b); the Attorney General and persons alleging discrimination on the basis of disability in violation of Title III may enforce its provisions, see §§12188(a)(1), (b). Each federal agency responsible for ADA implementation may render technical assistance to affected individuals and institutions with respect to provisions of the ADA for which the agency has responsibility. See §12206(c)(1).

**Footnote 6**

L. C. and E. W. are currently receiving treatment in community-based programs. Nevertheless, the case is not moot. As the District Court and Court of Appeals explained, in view of the multiple institutional placements L. C. and E. W. have experienced, the controversy they brought to court is "capable of repetition, yet evading review." No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), p. 6, App. to Pet. for Cert. 35a (internal quotation marks omitted); see 138 F. 3d 893, 895, n. 2 (CA11 1998) (citing *Honig v. Doe*, 484 U. S. 305, 318-323 (1988), and *Vitek v. Jones*, 445 U. S. 480, 486-487 (1980)).

#### Footnote 7

After this Court granted certiorari, the District Court issued a decision on remand rejecting the State's fundamental-alteration defense. See 1:95-cv-1210-MHS (ND Ga., Jan. 29, 1999), p. 1. The court concluded that the annual cost to the State of providing community-based treatment to L. C. and E. W. was not unreasonable in relation to the State's overall mental health budget. See *id.*, at 5. In reaching that judgment, the District Court first declared "irrelevant" the potential impact of its decision beyond L. C. and E. W. 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177. The District Court's decision on remand is now pending appeal before the Eleventh Circuit.

#### Footnote 8

Twenty-two States and the Territory of Guam joined a brief urging that certiorari be granted. Seven of those States filed a brief in support of petitioners on the merits.

#### Footnote 9

See Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1978), p. 45 ("[I]nstitutionalization result[ing] in separation of mentally retarded persons for no permissible reason . . . is 'discrimination,' and a violation of Section 504 [of the Rehabilitation Act] if it is supported by federal funds."); Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1981), p. 27 ("Pennsylvania violates Section 504 by indiscriminately subjecting handicapped persons to [an institution] without first making an individual reasoned professional judgment as to the appropriate placement for each such person among all available alternatives."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), p. 7 ("Both the Section 504 coordination regulations and the rest of the ADA make clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes."); *id.*, at 8-16.

#### Footnote 10

The dissent is driven by the notion that "this Court has never endorsed an interpretation of the term 'discrimination' that encompassed disparate treatment among members of the *same* protected class," *post*, at 1 (opinion of *Thomas*, J.), that "[o]ur decisions construing various statutory prohibitions against 'discrimination' have not wavered from this path," *post*, at 2, and that "a plaintiff cannot prove 'discrimination' by demonstrating that one member of a particular protected group has been favored over another member of that same group," *post*, at 4. The dissent is incorrect as a matter of precedent and logic. See *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U. S. 308, 312 (1996) (The Age Discrimination in Employment Act of 1967 "does not ban discrimination against employees because they are aged 40 or older; it bans discrimination against employees because of their age, but limits the protected class to those who are 40 or older. The fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out *because of his age*."); cf. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U. S. 75, 76 (1998) ("[W]orkplace harassment can violate Title VII's prohibition against 'discriminat[ion]' . . . because of . . . sex," 42 U. S. C. §2000e-2(a)(1), when the harasser and the harassed employee are of the same sex."); *Jefferies v. Harris County Community Action Assn.*, 615 F. 2d 1025, 1032 (CA5 1980) ("[D]iscrimination against black females can exist even in the absence of discrimination against black men or white women.").

#### Footnote 11

Unlike the ADA, §504 of the Rehabilitation Act contains no express recognition that isolation or segregation of persons with disabilities is a form of discrimination. Section 504's discrimination proscription, a single sentence attached to vocational rehabilitation legislation, has yielded divergent court interpretations. See Brief for United States as *Amicus Curiae* 23-25.

#### Footnote 12

The waiver program provides Medicaid reimbursement to States for the provision of community-based services to individuals who would otherwise require institutional care, upon a showing that the average annual cost of such services is not more than the annual cost of institutional services. See §1396n(c).

#### Footnote 13

Georgia law also expresses a preference for treatment in the most integrated setting appropriate. See Ga. Code Ann. §37-4-121 (1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.").

#### Footnote 14

We do not in this opinion hold that the ADA imposes on the States a "standard of care" for whatever medical services they render, or that the ADA requires States to "provide a certain level of benefits to individuals with disabilities." Cf. *post*, at 9, 10 ( *Thomas, J.*, dissenting). We do hold, however, that States must adhere to the ADA's non-discrimination requirement with regard to the services they in fact provide.

#### Footnote 15

Even if States eventually were able to close some institutions in response to an increase in the number of community placements, the States would still incur the cost of running partially full institutions in the interim. See Brief for United States as *Amicus Curiae* 21.

#### Footnote 16

We reject the Court of Appeals' construction of the reasonable-modifications regulation for another reason. The Attorney General's Title II regulations, Congress ordered, "shall be consistent with" the regulations in part 41 of Title 28 of the Code of Federal Regulations implementing §504 of the Rehabilitation Act. 42 U. S. C. §12134(b). The §504 regulation upon which the reasonable-modifications regulation is based provides now, as it did at the time the ADA was enacted:

"A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program." 28 CFR §41.53 (1990 and 1998 eds.).

While the part 41 regulations do not define "undue hardship," other §504 regulations make clear that the "undue hardship" inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient's program with respect to number of employees, number and type of facilities,

and size of budget; (2) [t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) [t]he nature and cost of the accommodation needed." 28 CFR §42.511(c) (1998); see 45 CFR §84.12(c) (1998) (same).

Under the Court of Appeals' restrictive reading, the reasonable-modifications regulation would impose a standard substantially more difficult for the State to meet than the "undue burden" standard imposed by the corresponding §504 regulation.

## FOOTNOTES

### Footnote 1

We have incorporated Title VII standards of discrimination when interpreting statutes prohibiting other forms of discrimination. For example, Rev. Stat. §1977, as amended, 42 U. S. C. §1981, has been interpreted to forbid all racial discrimination in the making of private and public contracts. See *Saint Francis College v. Al-Khazraji*, 481 U. S. 604, 609 (1987). This Court has applied the "framework" developed in Title VII cases to claims brought under this statute. *Patterson v. McLean Credit Union*, 491 U. S. 164, 186 (1989). Also, the Age Discrimination in Employment Act of 1967, 81 Stat. 602, as amended, 29 U. S. C. §623(a)(1), prohibits discrimination on the basis of an employee's age. This Court has noted that its "interpretation of Title VII ... applies with equal force in the context of age discrimination, for the substantive provisions of the ADEA `were derived *in haec verba* from Title VII.'" *Trans World Airlines, Inc. v. Thurston*, 469 U. S. 111, 121 (1985) (quoting *Lorillard v. Pons*, 434 U. S. 575, 584 (1978)). This Court has also looked to its Title VII interpretations of discrimination in illuminating Title IX of the Education Amendments of 1972, 86 Stat. 373, as amended, 20 U. S. C. §1681 *et seq.*, which prohibits discrimination under any federally funded education program or activity. See *Franklin v. Gwinnett County Public Schools*, 503 U. S. 60, 75 (1992) (relying on *Meritor Savings Bank, FSB v. Vinson*, 477 U. S. 57 (1986), a Title VII case, in determining that sexual harassment constitutes discrimination).

### Footnote 2

This Court has recognized that two forms of discrimination are prohibited under Title VII: disparate treatment and disparate impact. See *Griggs*, 401 U. S., at 431 ("The Act proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation"). Both forms of "discrimination" require a comparison among classes of employees.

### Footnote 3

Following *Wards Cove*, Congress enacted the Civil Rights Act of 1991, Pub. L. 102-166, 105 Stat. 1071, as amended, which, *inter alia*, altered the burden of proof with respect to a disparate impact discrimination claim. See *id.*, §105 (codified at 42 U. S. C. §2000e-2(k)). This change highlights the principle that a departure from the traditional understanding of discrimination requires congressional action. Cf. *Field v. Mans*, 516 U. S. 59, 69-70 (1995) (Congress legislates against the background rule of the common law and traditional notions of lawful conduct).

### Footnote 4

If such general hortatory language is sufficient, it is puzzling that this or any other court did not reach the same conclusion long ago by reference to the general purpose language of the Rehabilitation Act itself. See 29 U. S. C. §701 (1988 ed.) (describing the statute's purpose as "to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps *in order to maximize their employability, independence, and integration* into the workplace and the community" (emphasis added)). Further, this section has since been amended to proclaim in even more aspirational terms that the policy under the statute is driven by, *inter alia* , "respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice, of individuals with disabilities," "respect for the privacy, rights, and equal access," and "inclusion, integration, and full participation of the individuals." 29 U. S. C. §§701(c)(1) - (3).

#### Footnote 5

Given my conclusion, the Court need not review the integration regulation promulgated by the Attorney General. See 28 CFR §35.130(d) (1998). Deference to a regulation is appropriate only " 'if Congress has not expressed its intent with respect to the question, and then only if the administrative interpretation is reasonable.' " *Reno v. Bossier Parish School Bd.* , 520 U. S. 471, 483 (1997) (quoting *Presley v. Etowah County Comm'n* , 502 U. S. 491, 508 (1992)). Here, Congress has expressed its intent in §12132 and the Attorney General's regulation--insofar as it contradicts the settled meaning of the statutory term--cannot prevail against it. See *NLRB v. Town & Country Elec., Inc.* , 516 U. S. 85, 94 (1995) (explaining that courts interpreting a term within a statute "must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of that term") (internal quotation marks omitted).

#### Footnote 6

In mandating that government agencies minimize the institutional isolation of disabled individuals, the majority appears to appropriate the concept of "mainstreaming" from the Individuals with Disabilities Education Act (IDEA), 84 Stat. 175, as amended, 20 U. S. C. §1400 *et seq.* But IDEA is not an antidiscrimination law. It is a grant program that affirmatively requires States accepting federal funds to provide disabled children with a "free appropriate public education" and to establish "procedures to assure that, to the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled." §§1412(1), (5). Ironically, even under this broad affirmative mandate, we previously rejected a claim that IDEA required the "standard of care" analysis adopted by the majority today. See *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley* , 458 U. S. 176, 198 (1982) ("We think ... that the requirement that a State provide specialized educational services to handicapped children generates no additional requirement that the services so provided be sufficient to maximize each child's potential commensurate with the opportunity provided other children") (internal quotation marks omitted).

## **Appendix B**

### **AMH Transformation 01 Initiative Charter**

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AMH Transformation Team  
AMH Transformation Initiative O1-

**Streamlining transitions through the addictions and mental health system**  
Initiative Charter

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<p><b>Situation/Problem Definition</b> (What problems are we trying to solve with this initiative? Please create context for the initiative by referring back to the team's larger situation as described in your team charter.)</p>	<p>Children, adults, and older adults who receive mental health and addiction services require individualized services. There are system-wide hindrances to individualized care and appropriate transitions.</p> <ul style="list-style-type: none"> <li>▪ Criteria for admission, continued stay and discharge are not agreed upon or routinely addressed during the referral and step down processes. Roles and responsibilities are not standardized across the state.</li> <li>▪ No standardized means to determine what type or intensity of care a person could transition into;</li> <li>▪ There is disagreement in the system about the types of treatment services that need to be developed.</li> <li>▪ The Oregon system of community based, residential mental health system has much work to do in terms of integrating the transitional model. Residential treatment homes still often resemble "mini-institutions" with long lengths of stay. The current system is not research or criteria based resulting in a "bottleneck" phenomenon and the belief that more secure placements are needed.</li> <li>▪ People may have to go a long distance to receive the particular service they need because not all services are provided in all area (requires integration with Initiative 02)</li> <li>▪ The system of residential mental health service delivery in Oregon consists of OSH, AMH, CMHP's, and community providers. The components are isolated from one another and lack communication or common purpose.</li> <li>▪ Accountability &amp; incentives with providers are lacking, which contributes to bottlenecks in transitioning people through the system and inefficient use of resources; (requires integration with Initiative 05)</li> </ul>
<p><b>Vision for Success, objectives, and metrics</b> (What does success look like for this initiative? What specific benefits,</p>	<p>The AMH vision for success means that people receive the right type and intensity of services, for the right amount of time, and that they get better. A vision of success looks like</p>

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*tangible and intangible, will we achieve and when? Please create context by referring back to the team's vision for success, objectives, and metrics as described in your team charter.)*

people living and healing in their communities, in the safest and least restrictive environment, with a focus on recovery and resiliency. People and their families need facilities, services, and programs in rural and urban areas, close to home.

AMH can accomplish this by:

- Clarifying roles, responsibilities, policies, & procedures between AMH staff and community mental health programs;
- Adopting a standardized client assessment of acuity for people receiving mental health services;
- Decreasing the amount of time a person remains in services that do not match their acuity or need;
- Simplifying and standardizing documentation requirements for providers;
- Simplifying and standardizing a funding and payment system for providers;
- Simplifying the data process to gather real-time information from providers about the quality and quantity of services they are providing;
- Agreeing on how the different levels, types, and intensities of care are used. For example, are placements temporary for treatment only? Or are they intended to be a home base for people stabilized in that level of care?

AMH will be tracking the following potential benefits:

- Cost savings: Decrease spend in higher intensities of care than the person is assessed as needing & decrease spend in vacant beds
- Cycle time: Decrease the amount of time it takes to transition people who are clinically ready to move to a less intense or restrictive type of care;
- Customer satisfaction;
- Error rates with referrals; and
- Waitlists.

**Guiding Principles**

*(How will we operate as an initiative team as we achieve success?)*

The teams working on this initiative will be creating and implementing more streamlined processes and standardized policies, with that in mind, they will operate

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	<p>with the following principles when making decisions:</p> <ul style="list-style-type: none"> <li>▪ Integrate co-occurring assessment and treatment options into the transition process through different levels of care;</li> <li>▪ Responsible and accountable parties will be identified at the community level for the client at every transition through the different levels of care;</li> <li>▪ Documentation requirements will be kept to a minimum, decreasing the number of steps, and increasing the speed of the process of transitioning clients through the different types of care;</li> <li>▪ Standardized placement, continued stay and discharge criteria in all program areas;</li> <li>▪ Change regulatory framework to promote client transitions through the different levels of care;</li> <li>▪ Create a financial system to promote client transitions through the different types of care, including incentives for providers to transition clients through the different types of care;</li> <li>▪ Track the progress of transitioning clients through the different levels of care with a core set of outcomes and use this information to make corrections mid-stream; flexibility and making changes based on what data is telling us is a must; and</li> <li>▪ Include advocates, community representatives, providers, and family members in the planning process as appropriate.</li> </ul>
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<p><b>Approaches to be used to solve the problems and achieve success</b> <i>(What tools and techniques will we use on this initiative?)</i></p>	<p>This initiative involves children, adults, and older adults in multiple types of care across the continuum. There will be several projects and events planned to clarify definitions, roles, responsibilities, philosophies, policies, &amp; procedures. Using the principles listed in this charter, the teams focusing on this initiative will employ:</p> <ul style="list-style-type: none"> <li>• Base lining &amp; Benchmarking;</li> <li>• Current &amp; Future State Mapping;</li> <li>• Rapid &amp; Continual Process Improvement Principles;</li> <li>• Lean Principles;</li> <li>• Project Management; and</li> <li>▪ Metric Review &amp; benefit tracking.</li> </ul>
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<p><b>Scope</b> -- organizational unit, process, function, and geographic <i>(Which parts of our agency, which processes, which functions, and which offices will be in scope for this initiative?)</i></p>	<p>This initiative includes the various systems and processes that touch the OSH system, the community mental health program system, the mental health organization system, and the addiction services system, from prevention through acute care.</p>										
<p><b>Deliverables</b> <i>(What specific documents will we develop and deliver to our sponsors as we achieve success on this initiative?)</i></p>	<p>Each event and project will have a charter, a final report, an implementation plan, and metrics to monitor. A weekly status report will track the progress of the initiative as a whole. A document describing the benefits as they are realized will also be developed.</p>										
<p><b>Timing and milestones</b> <i>(When will our work occur? What milestones must we meet for this initiative?)</i></p>	<table border="0"> <tr> <td>By Jan 2009</td><td>Initiative leader identified</td></tr> <tr> <td>By Jan 2009</td><td>Initiative roadmap</td></tr> <tr> <td>By Jan 2009</td><td>Initiative charters</td></tr> <tr> <td>By Feb 2009</td><td>Initiative sponsor &amp; steering team identified</td></tr> <tr> <td>By Feb 2009</td><td>Initiative status &amp; progress reporting begins</td></tr> </table>	By Jan 2009	Initiative leader identified	By Jan 2009	Initiative roadmap	By Jan 2009	Initiative charters	By Feb 2009	Initiative sponsor & steering team identified	By Feb 2009	Initiative status & progress reporting begins
By Jan 2009	Initiative leader identified										
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By Feb 2009	Initiative status & progress reporting begins										
<p><b>Major activities</b> <i>(What are the major activities required for this initiative? If you are planning to use Lean, please describe here the approximate number and scope of the RPI Events required. Note that you will have the opportunity prior to those events to create event charters.)</i></p>	<p>The O1 initiative roadmap will outline the timelines and sequencing for specific projects and events that will contribute to the success of the initiative. This initiative includes those processes and services that are touched by children, adults, and older adults, in the full continuum of care administered by AMH.</p> <ul style="list-style-type: none"> <li>▪ The first part of the O1 Initiative will include two projects. These projects will focus transitioning adults, including those young adults identified as in a transitional age, into community-based services from Acute care settings, long-term care (OSH and SAIP), , and high-intensity residential settings such as secure residential facilities.</li> <li>▪ The second part of the O1 Initiative includes three projects that focus on services for adults, children, and older adults. For example, these projects will look at those services that don't fit in traditional mental health provisions such as the gero-psych services located at OSH, and site development for enhanced care.</li> <li>▪ Part three will focus on Addiction services for children</li> </ul>										

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	<p>and adults, and case management between residential and outpatient treatment.</p> <p>Each event will be outlined in its own charter; will have an event team, which will include an event sponsor and an event lead. Several events will utilize Lean to assist with simplifying the current process.</p>
<p><b>Dependencies</b> (What major dependencies on others does this initiative have?)</p>	<p>This initiative affects children, adults, and older adults in Oregon who are a part of a large and complex system of services. AMH is dependent on the flexibility of the system to respond to the treatment and service needs of Oregonians.</p>
<p><b>Decision making</b> (How will we make decisions on this initiative?)</p>	<p>The initiative's work team along with the Initiative Lead will strive for consensus in the decision process. Decisions reached by the work team will be sent simultaneously to lean leaders, transformation project manager, and AMH sponsor for correction and revision if needed. The Initiative Lead will log decisions.</p>
<p><b>Issue resolution</b> (How will we identify and resolve issues that impede progress on this initiative?)</p>	<p>Issue resolution will follow the same path as decision making. If the initiative's work team cannot resolve issues in a reasonable period of time, the team will seek external assistance. The Initiative Lead will log issue resolutions.</p>
<p><b>Risk mitigation</b> (How will we identify and plan to mitigate risks we uncover on this initiative?)</p>	<p>A risk benefit analysis will be completed on all initiatives. Risk areas will be viewed in terms of dependent, independent, and extraneous variables for each initiative</p>
<p><b>Initiative Sponsor and steering body members</b> (Who will guide our work, set scope, provide resources, and approve our recommendations? When choosing, consider in particular the scope of this initiative – scope may suggest specific individuals who might be natural candidates to be sponsors.)</p>	<p>Initiative Sponsor: Len Ray Initiative Steering Body Members: Nancy Griffith: Oregon State Hospital Ralph Summers: Medicaid Unit Edie Woods: contracts Unit</p>
<p><b>Initiative leader</b> (Who will drive the daily work for this initiative?)</p>	<p>Initiative Lead: Tim Pea</p>
<p><b>Initiative core team members</b> (Who will be on the initiative's core working team?)</p>	<p>Rebecca Curtis, Cissie Bollinger, Shannon Casey, Elaine Sweet, Dean Carlisle, Melanie Tong, Rick Wilcox, Chris Potter</p>

## **Appendix C**

### **Level of Care Utilization of Services 10<sup>th</sup> edition**

# LOCUS

## LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

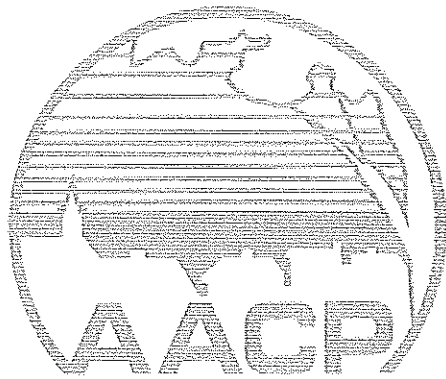


AMERICAN ASSOCIATION  
OF COMMUNITY PSYCHIATRISTS

March 20, 2009

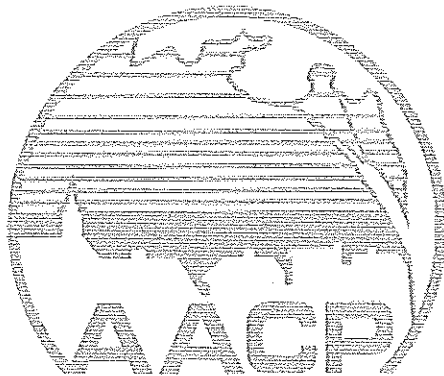
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## INTRODUCTION TO ADULT VERSION 2010

With the arrival of managed care programs and principles, the use of quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes is increasingly important. In the past there have been no widely accepted standards to meet these needs. The development of LOCUS has provided a single instrument that can be used for these functions in a wide variety of settings, including both mental health and addictions. It provides a common language and set of standards with which to make such judgements and recommendations. Clinicians now have an instrument, which is simple, easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

LOCUS has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each "level" of care in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

This system is a dynamic one, and it has evolved over the years of its development. Since its inception, LOCUS has included content related to recovery status, stage of change, and choice. Its simple style and structure has invited use not only by a variety of clinicians with various levels of training, but by consumers themselves, allowing assessment to become a collaborative process. Engagement in this collaboration is central to person centered treatment planning. With this new revision of LOCUS, the first since 2000, language within the rating scales has been further simplified and stages of change (as conceived by Prochaska and DiClemente) have been assigned to ratings in Dimension VI, now called Engagement and Recovery Status. We strongly encourage collaboration between the clinician and the person being assessed whenever this is possible. As systems develop services and processes that facilitate recovery, these changes will allow LOCUS to be an even more powerful tool to assist these transformations.

Version 2010 makes these changes to address semantic concerns, but once again, there are no significant changes in content from Version 2000. Reliability and validity testing results will not be affected by these changes, but additional testing is planned in the future.

The instrument has multiple potential uses:

- To assess immediate service needs (e.g., for clients in crisis)
- To plan resource needs over time, as in assessing service requirements for defined populations
- To monitor changes in status or placement at different points in time.

As with previous versions, the current document is divided into three sections. The first section defines six evaluation parameters or dimensions: 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. A five-point scale is constructed for

each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

The second section of the document defines six “levels of care” in the service continuum in terms of four variables: 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term “level” is used for simplicity, but it is not our intention to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service intensities, combining crisis, supportive, clinical, and environmental interventions, which may vary independently. Patient placement criteria are then elaborated for each level of care. Separate admission, continuing stay, and discharge criteria are not needed in this system, as changes in level of care will follow from changes in ratings in any of the six parameters over the course of time.

The final section describes a proposed scoring methodology that facilitates the translation of assessment results into placement or level of care determinations. Both a grid chart and a decision flow chart are provided for this purpose.

We hope that this version of LOCUS will continue to stimulate considerable comment, discussion, and testing as reliability and validity studies continue. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. The specific needs of special populations, such as children, adolescents, and the elderly will not be adequately addressed in this adult version. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing. The AACCP welcomes any comments or suggestions. Please send your comments to:

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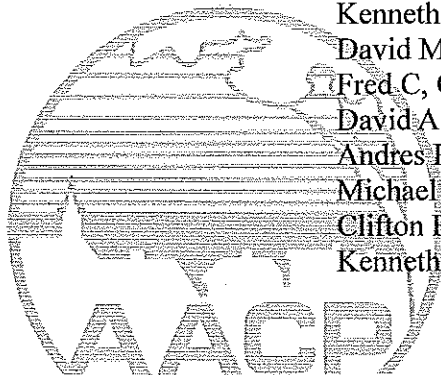
## Acknowledgments

This document was prepared by the American Association of Community Psychiatrists' Health Care Systems Committee Task Force on Level of Care Determinations. It was developed in cooperation with St. Francis Medical Center of Pittsburgh and the suggestions from multiple reviewers across the country. We would also like to acknowledge the intellectual stimulation provided by the review of multiple documents previously developed to address similar issues. Of particular influence in the conceptualization of LOCUS were the Patient Placement Criteria-1 of the American Society of Addiction Medicine (ASAM-PPC), the Level of Care Assessment Tool of US Healthcare (LOCAT), and the Level of Need-Care Assessment (LONCA) Method.

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## Level of Care Utilization System for Psychiatric and Addiction Services

### Instructions for Use

Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution.

Since LOCUS is designed as a dynamic instrument, scores should be expected to change over time. Scores are generally assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the parameters, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and at the higher levels of care or resource intensity.

Once scores have been assigned in all six evaluation parameters, they should be recorded on a worksheet and summed to obtain the composite score. Referring to the LOCUS Placement Grid, a rough estimate of the placement recommendation can be obtained. For greatest accuracy, the LOCUS Level of Care Decision Tree should be employed and it is recommended that it be used in most cases.

In assigning levels of care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the level of care recommended by LOCUS may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This will again, lead us to err on the side of caution and safety rather than risk and instability.

## LOCUS Instrument Version 2010

### Evaluation Parameters for Assessment of Service Needs

#### Definitions

##### I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

##### 1 - Minimal Risk of Harm

- a- No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- b- Clear ability to care for self now and in the past.

##### 2 - Low Risk of Harm

- a- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- b- Occasional substance use without significant episodes of potentially harmful behaviors.
- c- Periods in the past of self-neglect without current evidence of such behavior.

##### 3 - Moderate Risk of Harm

- a- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- b- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- c- History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- d- Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- e- Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

#### **4 - Serious Risk of Harm**

- a- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- b- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
- c- Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- d- Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

#### **5 - Extreme Risk of Harm**

- a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
  - without expressed ambivalence or significant barriers to doing so, or
  - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
  - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- c- Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

## **II. Functional Status**

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

### **1 - Minimal Impairment**

- a- No more than transient impairment in functioning following exposure to an identifiable stressor.

### **2 - Mild Impairment**

- a- Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- b- Recent experience of some minor disruptions in aspects of self-care or usual activities.
- c- Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
- d- Demonstrating significant improvement in function following a period of difficulty.

### **3 - Moderate Impairment**

- a- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- b- Appearance and hygiene falls below usual standards on a frequent basis.
- c- Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.
- d- Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
- e- Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- f- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

### **4 - Serious Impairment**

- a- Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.
- c- Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- d- Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- e- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

### **5 - Severe Impairment**

- a- Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- b- Development of complete withdrawal from all social interactions.
- c- Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- d- Extreme disruptions in physical functioning causing serious harm to health and well being.
- e- Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

## **III. Medical, Addictive, and Psychiatric Co-Morbidity**

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

### **1 - No Co-morbidity**

- a- No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- b- Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

### **2 - Minor Co-morbidity**

- a- Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- b- Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-existing psychiatric disorder.
- c- May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.

### 3 - Significant Co-morbidity

- a- Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- b- Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
- c- Medical conditions exist which may adversely affect the course of the presenting disorder.
- d- Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
- e- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
- f- Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

### 4 - Major Co-morbidity

- a- Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
- b- Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- c- Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- d- Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
- e- Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

### 5 - Severe Co-morbidity

- a- Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- b- Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

- c- Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- d- Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.
- e- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-existing substance use disorder, or seriously worsen it.

#### **IV. Recovery Environment**

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

##### **A) Level of Stress**

##### **1 - Low Stress Environment**

- a- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- b- No recent transitions of consequence.
- c- No major losses of interpersonal relationships or material status have been experienced recently.
- d- Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
- e- Living environment poses no significant threats or risk.
- f- No pressure to perform beyond capacity in social role.

## **2 - Mildly Stressful Environment**

- a- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
- b- A transition that requires adjustment such as change in household members or a new job or school.
- c- Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
- d- A recent onset of a transient but temporarily disabling illness or injury.
- e- Potential for exposure to alcohol and/or drug use exists. \*
- f- Performance pressure (perceived or actual) in school or employment situations creating discomfort.

## **3 - Moderately Stressful Environment**

- a- Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- b- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
- c- Recent important loss or deterioration of interpersonal or material circumstances.
- d- Concern related to sustained decline in health status.
- e- Danger in or near habitat.
- f- Easy exposure and access to alcohol and drug use. \*
- g- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

## **4 - Highly Stressful Environment**

- a- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- b- Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- c- Inability to meet needs for physical and/or material well being.
- d- Recent onset of severely disabling or life threatening illness.
- e- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. \*
- f- Episodes of victimization or direct threats of violence near current home.
- g- Overwhelming demands to meet immediate obligations are perceived.

## **5 - Extremely Stressful Environment**

- a- An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
  - ongoing injurious and abusive behaviors from family member(s) or significant other.
  - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
  - persecution by a dominant social group.
  - sudden or unexpected death of loved one.
- b- Unavoidable exposure to drug use and active encouragement to participate in use. \*
- c- Incarceration or lack of adequate shelter.
- d- Severe pain and/or imminent threat of loss of life due to illness or injury.
- e- Sustained inability to meet basic needs for physical and material well being.
- f- Chaotic and constantly threatening environment.

\* These criteria apply to persons with past or present difficulties with substance use.

## **B) Level of Support**

### **1 - Highly Supportive Environment**

- a- Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.  
*(Selection of this criterion pre-empts higher ratings)*

### **2 - Supportive Environment**

- a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- c- Professional supports are available and effectively engaged (i.e. ICM).  
*(Selection of this criterion pre-empts higher ratings)*

### **3 - Limited Support in Environment**

- a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
- b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- d- Resources may be only partially utilized even when available.
- e- Limited constructive involvement with any professional sources of support that are available.

#### **4 - Minimal Support in Environment**

- a- Very few actual or potential sources of support are available.
- b- Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- d- Client may be on bad terms with and unwilling to use supports available in a constructive manner.

#### **5 - No Support in Environment**

- a- No sources for assistance are available in environment either emotionally or materially.

### **V. Treatment and Recovery History**

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

#### **1 - Fully Responsive to Treatment and Recovery Management**

- a- There has been no prior experience with treatment or recovery.
- b- Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- c- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

#### **2 - Significant Response to Treatment and Recovery Management**

- a- Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- b- Recovery has been managed for moderate periods of time with limited support or structure.

### **3 - Moderate or Equivocal Response to Treatment and Recovery Management**

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- b- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
- c- Unclear response to treatment and ability to maintain a significant recovery.
- d- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

### **4 - Poor Response to Treatment and Recovery Management**

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- b- Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

### **5 - Negligible Response to Treatment**

- a- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- b- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

## **VI. Engagement and Recovery Status**

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

### **1 - Optimal Engagement and Recovery**

- a- Has complete understanding and acceptance of illness and its effect on function.
- b- Actively maintains changes made in the past (Maintenance Stage).
- c- Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- d- Understands recovery process and takes on a personal role and responsibility in a recovery plan.

## **2 - Positive Engagement and Recovery**

- a- Has significant understanding and acceptance of illness and its effect on function.
- b- Willing to change and is actively working toward it (Action Stage).
- c- Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- d- Shows recognition of personal role in recovery and accepts significant responsibility for it.

## **3 - Limited Engagement and Recovery**

- a- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- b- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- c- Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- d- Does not use available resources independently or only in cases of extreme need.
- e- Has limited ability to accept responsibility for recovery.

## **4 - Minimal Engagement and Recovery**

- a- Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- b- Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- c- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- d- Avoids contact with and use of treatment resources if left to own devices.
- e- Does not accept any responsibility for recovery or feels powerless to do so.

## **5 - Unengaged and Stuck**

- a- Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- b- Inability to understand recovery concept or contributions of personal behavior to disease process.
- c- Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- d- Extremely avoidant, frightened, or guarded.

## LEVELS OF CARE

### Definitions

#### **BASIC SERVICES - Prevention and Health Maintenance**

##### **Definition:**

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children.

1. **Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.
2. **Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.
3. **Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.
4. **Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

##### **Placement Criteria:**

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

## I. LEVEL ONE - Recovery Maintenance and Health Management

### Definition:

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. In some cases, services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to two hours per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to four months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level.
3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 17) will be accessible.

### Placement Criteria:

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.
2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.
3. **Co-morbidity** - a rating of two or less is generally required for this level of care.
4. **Recovery Environment** - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.
6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.
7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

## II. LEVEL TWO - Low Intensity Community Based Services

### Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.
3. **Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 17) will be accessible.

### Placement Criteria:

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.
2. **Functional Status** - ratings of three or less could be managed at this level.
3. **Co-Morbidity** - a rating of two or less is required for placement at this level.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale "B" of dimension four.

6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

### **III. LEVEL THREE - High Intensity Community Based Services**

#### **Definition:**

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.
2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.
3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 17) will also be available.

### Placement Criteria:

1. **Risk of Harm** - a rating of three or less can be managed at this level.
2. **Functional Status** - a rating of three or less is required for this level of care.
3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.
6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

### IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

1. **Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).
2. **Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.
3. **Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

#### Placement Criteria:

1. **Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.
2. **Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
3. **Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in that circumstance).
4. **Recovery Environment** - an "A" scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "B". (Availability of Assertive Community Treatment would merit a rating of one on scale "B"). A "B" scale rating of three or less could otherwise generally be managed at this level.
5. **Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
6. **Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
7. **Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)

## V. LEVEL FIVE - Medically Monitored Residential Services

### Definition:

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

1. **Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.
2. **Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On-site treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.
3. **Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.
4. **Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

### Placement Criteria:

1. **Risk of Harm** - a rating of four requires care at this level independently of other parameters.
2. **Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
3. **Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
4. **Recovery Environment** - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

## **VI. LEVEL SIX - Medically Managed Residential Services**

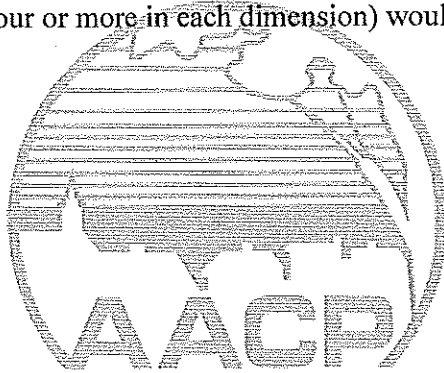
### **Definition:**

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

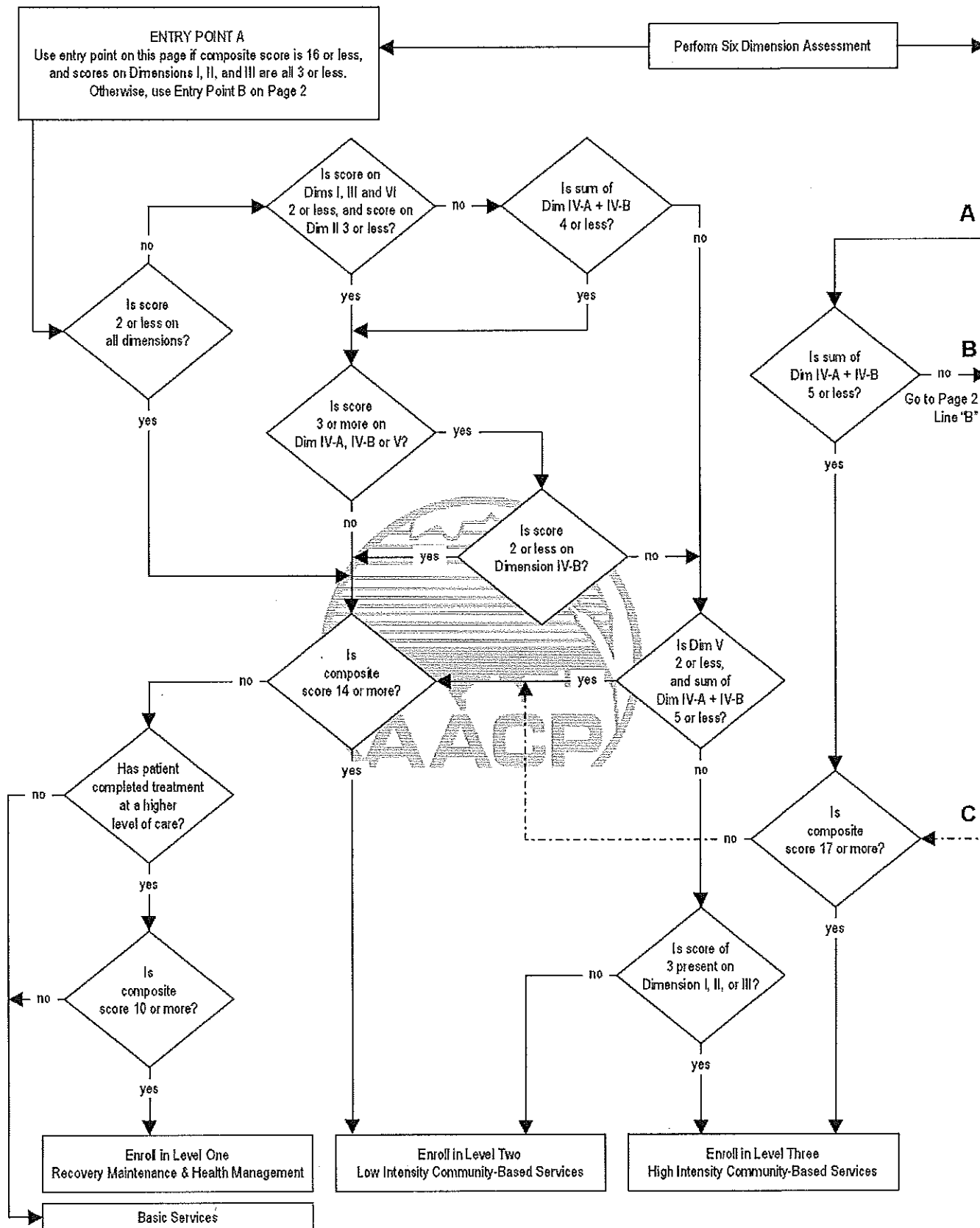
1. **Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.
2. **Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client's needs.
3. **Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.
4. **Crisis Resolution and Prevention Services** - These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

**Placement Criteria:**

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.
4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.
5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.
6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.
7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

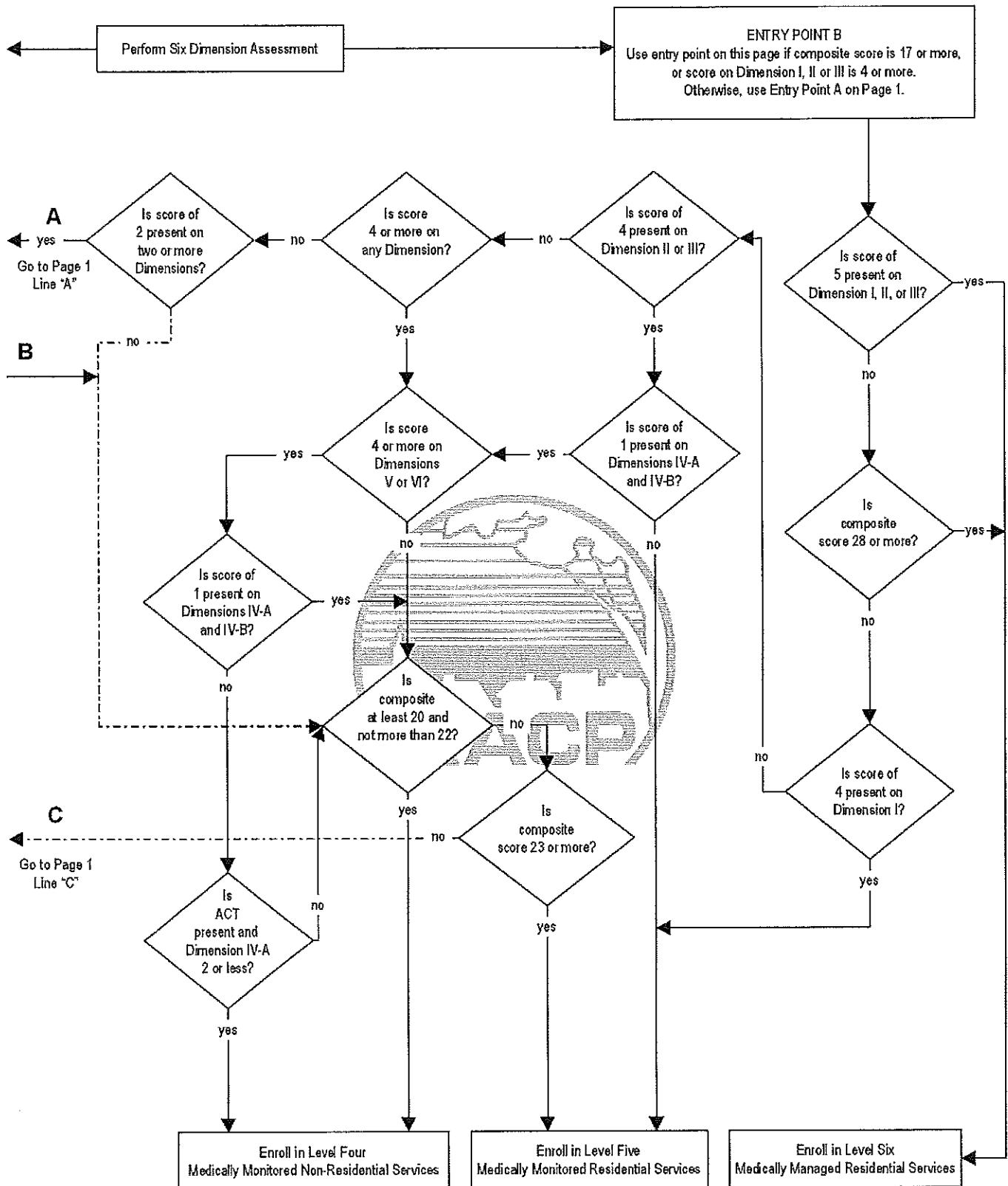


# AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

# AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

# AACP LEVEL OF CARE DETERMINATION GRID

Level of Care	Dimensions	Recovery Maintenance Health Management	Low Intensity Community Based Services	High Intensity Community Based Services	Medically Monitored Non-Residential Services	Medically Monitored Residential Services	Medically Managed Residential Services
		Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
I.	Risk of Harm	2 or less	2 or less	3 or less	3 or less	④	⑤
II.	Functional Status	2 or less	2 or less	3 or less	3 or less	④*	⑤
III.	Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④*	⑤
IV A.	Recovery Environment "Level of Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B.	Recovery Environment "Level of Support"				3 or less	4 or more	4 or more
V.	Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI.	Engagement & Recovery Status	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
	<b>Composite Rating</b>	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

\* Unless sum of IV A and IV B equals 2

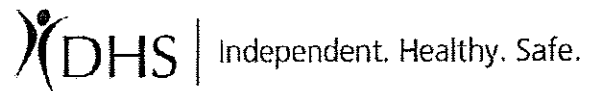
○ indicates independent criteria -  
requires admission to this level  
regardless of composite score

**Appendix D**

**Community Services Work Group Report**

**&**

**Funding Recommendations**



**Oregon Department of Human Services  
Community Services Workgroup Report**

*A Complement to the Master Plan Phase II Report  
on the Replacement of the Oregon State Hospital*

**Version II, March 2009**

## **Introduction**

The State Hospital Master Plan Phase II Report released in February 2006 recommended significant investment in community mental health services in Oregon. The report stated, "Without the enhanced community programming, demand for Oregon State Hospital (OSH) beds will substantially exceed projections of size and cost."

To address in more detail the need for community mental health services, the Addictions and Mental Health Division (AMH) convened the Oregon State Hospital Master Plan Community Services Workgroup (CSWG) in September 2006. Over the succeeding months, the CSWG received extensive input into the types of services needed, especially for those services that prevent individuals from needing more expensive and intensive services. The report provided a narrative description of each type of service, systematic estimates of the need for and costs of these services, and a timeline for implementing the services. The CSWG issued its report, including comprehensive program and financial recommendations in February 2007.

## **Update on 2007 recommendations**

The Oregon Legislature provided an additional \$20.9 million in general fund for adult-focused community mental health services. This initial investment was a first step in improving Oregon's mental health system. However, the amount provided was only 1/6 the amount recommended by the Community Services Workgroup. The funding was released to local Community Mental Health Programs (CMHPs) in late 2007 and early 2008.

The following are examples of how local communities utilized funds to develop and/or enhance services:

- **Crisis and Acute Care Services**
  - Development of programs to assist in the diversion of clients from hospital level of care.
  - Development of respite beds.
- **Jail Diversion**
  - Implementation of mental health courts and other programs that enhance the relationship of the mental health care system with law enforcement and county jails.

- **Supported Employment**
  - Funding for 440 indigent clients, who for various reasons were not able to be part of the Oregon Health Plan.
- **Early Assessment and Support Alliance (EASA)**
  - Program staff trained, and programs are in the early phases of implementation.
  - Approximately 180 additional non-Medicaid youth, age 16-24, and their families are being served.
- **Case Management**
  - Enhancement of existing services to improve quality of services for clients.

## **Current Status**

In 2008, AMH reconvened the CSWG to update the original report as Oregon moves forward on building the new state hospitals. The 2008 CSWG agreed with the philosophy and recommendations in the 2007 report. The CSWG continued to stress that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. The significant difference in this report is that the CSWG no longer defines front-end and back-end services. The CSWG recommends that the system should be seen as a continuum of services that individuals may need to access at different points in their lives, as they manage their illness and progress in their recovery.

The CSWG issues this revised report as an addendum to the previous year's report, in order to inform the Department of Human Services (DHS)/AMH, the Governor, and the Legislature on the continuum of services required to complement the replacement of the state hospital facilities and to assure the new hospitals' success.

The CSWG acknowledges that the realities of available funding will influence the decisions made in response to this report. The CSWG recognizes that there are not yet sufficient numbers of qualified mental health professionals and other trained staff to fully implement the recommendations in the immediate future. However, the community system must be fully funded and functional by 2015. This allows both funding and staff development to occur over the next three biennia.

Regardless of funding realities, this revised report needs to be seen in its entirety. The components of the system are interconnected and interdependent. An array of services must be available that support individuals in recovery by allowing them to access services that meet their needs and desires. These services must be available regardless of the individual's location. Funding must be sufficient to develop sustainable programs throughout the state, and not to be so small that there is no way to create and maintain the programs and services.

## **Values**

As has been articulated in previous reports and recommendations, community mental health services must be developed with values that support and empower individual recovery. The following statements, adapted from the Governor's 2004 Mental Health Task Force Report, summarize the values that drive the recommendations in this report.

- Recovery is a journey of personal healing and transformation, and is the goal of all mental health services.
- Treatment and supports must be consumer-directed.
- Services provided by persons who are recovering from mental health problems serve an invaluable role in supporting other people in recovery.
- Services must be available in communities where people live.
- Services must be evidenced-based.
- Safe and affordable housing is key to recovery.
- Services must be culturally and age specific.
- Services must recognize the effects of and support recovery from trauma.
- An effective mental health system coordinates and collaborates with the broader system of community services.

## **Determining the level of unmet need in Oregon**

The prevalence rate for severe mental illness among adults in Oregon is 5.4 percent, which translates into 154,867 individuals in Oregon.<sup>1</sup> Some of these individuals are served in the public system while others receive services through the private sector.

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<sup>1</sup> Based on estimates from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

A national research report states that approximately one-third of individuals with a serious mental illness are uninsured.<sup>2</sup> The same report states that under-insurance, even in states with parity, is a large barrier to accessing mental health services. Therefore, these rates under-report the number of individuals needing publicly funded services.

Extrapolating this data to Oregon, approximately 27,609 persons with a mental illness are currently uninsured and not receiving services in Oregon. Due to the nature of mental illness, with people fluctuating in their level of need during different stages of their illness, this report estimates that approximately 21,000 additional individuals need publicly funded mental health services at some time during a biennium.

These recommendations also assume a three percent population growth per biennium. All funding for services described in this report are General Fund dollars. This report assumes that new funding invested in one biennium will be included in the department's Essential Budget Level for the following biennium, so funding identified for each biennium is new funding.

Another category of unmet need is for the individuals who are not able to fully access services. They may be receiving some services through community programs. However, due to funding restrictions, regional differences, lack of treatment providers or other barriers, these individuals cannot obtain the full array of services they need. At this time, AMH cannot determine this level of unmet need. Still, the CSWG believes that the recommendations and assumptions specified in this report under represent the true need in our communities.

Traditional funding and targeted programmatic funding silos do not serve the best interest of the individuals we need to serve. Services must be seen as an array of options that allow people to access appropriate services depending on their individual need and desires. Local communities should be encouraged to develop innovative services that meet the needs of their communities and the people they serve.

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<sup>2</sup> Coverage for All: Inclusion of Mental Illness and Substance use Disorders in State Healthcare Reform Initiatives  
June 8th, 2008, NAMI

## **Recommendations for community services**

Services needed in an effective community mental health system are outlined in these recommendations. In addition to identifying new services, the expansion of current services to meet the unmet needs is outlined. The costs for this expansion are stated in terms of additional funds needed each biennium from 2009-2011 through 2013 - 2015. Actual funding estimates are attached in Appendix A.

The recommendations are encompassed in the following categories:

- Expand early intervention and prevention services;
- Increase the availability of crisis services;
- Ensure access to acute care and alternative services;
- Increase the availability of case management services;
- Provide access to medications and medication management services;
- Develop supported employment and supported education services;
- Decrease criminal justice involvement with the correct treatment and services;
- Treat co-occurring disorders;
- Reduce health disparities through wellness;
- Increase safe, affordable and permanent housing;
- Institute culturally appropriate mental health services;
- Create services and programs for elders and young adults;
- Invest in peer-delivered and trauma informed services;
- Develop appropriate residential capacity; and
- Ensure proper oversight of the mental health service delivery system.

### ***Recommendations details***

#### **Early intervention and prevention services**

##### ***Overview***

Early intervention and prevention services provide the best opportunity for ensuring an individual's long-term recovery. These services focus on early identification, support and mental health treatment for the individual, including supports for the family as well. Educating individuals regarding their illnesses and assisting them in developing skills to manage their symptoms are key components of the services.

##### ***Recommendations***

All newly identified individuals should have access to early assessment and support. The state needs to invest enough resources to provide a complete range of services to this population.

#### *Assumptions*

Based on epidemiological research, the statewide need for services is estimated to be 360 new clients and their families per year. About 270 persons per year would require services funded by General Fund monies. The average length of service would be 24 months.

### **Crisis services**

#### *Overview*

Crisis services at the community level are critical. Mobile Crisis Outreach Services provide crisis intervention in the community, at the location of need. Mobile crisis outreach increases the opportunity of stabilization in a client's community and not in the hospital. Crisis respite services provide a place in the community to stabilize a crisis, avoiding unnecessary hospitalization.

#### *Recommendations*

Oregonians should have access to appropriate crisis services in every community. The particular services would vary depending upon the specific needs in each community. The state should provide guidance on a core set of services.

#### *Assumptions*

To accurately determine the unmet need for crisis services can be difficult. Individuals without ongoing supports often bounce in and out of crisis. The Mental Health Alignment Workgroup (MHAWG) estimated that 25% of those not receiving ongoing services will need crisis services.<sup>3</sup> CSWG believes this is still a valid starting point.

### **Acute care and alternative services**

#### *Overview*

Acute care hospitals serve as an entry point to the public mental health system and play a vital role in the continuum of care. Unfortunately, due to lack of funding, limited number of mental health professionals and expertise, acute in-patient psychiatric services are limited to just a few hospitals. Access in community hospitals for Psychiatric Hold Rooms (for short term involuntary care) and sub-

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<sup>3</sup> Report to the Governor from the Mental Health Alignment Work Group; January 2001.

acute residential programs are also limited. Access issues are compounded in rural areas due to the considerable distance from hospitals with psychiatric units.

#### *Recommendation*

Acute care hospitals must be adequately compensated for the services they provide. Aside from the challenges facing hospital acute care service, options need to be expanded to provide sub-acute care when appropriate. This opportunity provides less expensive care options for patients who do not need hospital level of care, as well as providing a “step down” level of care for people leaving the hospital. Special consideration must also be given to the challenges in rural communities.

#### *Assumptions*

In calendar year 2007, AMH served 5873 adults in acute care;<sup>4</sup> local hospitals have estimated that this is only 50% of the need. The existence of significant administrative burdens, financial losses for community hospitals and the shortage of state-owned psychiatric beds have contributed to the closure of hospital acute care beds. It is likely that if these issues are not addressed additional acute care beds will close, placing increased pressure on other parts of the system.

## **Case management services**

#### *Overview*

Case management services are provided to persons in and out of a clinic setting. As part of the continuum of care, these services provide the linkage to services and supports. Case managers help individuals stay in their local communities and provide the additional supports for successful community reintegration after stays in the state hospitals.

#### *Recommendation*

Case managers play a critical role in an individual’s recovery by linking them to treatment services, community services and naturally occurring supports. Individuals needing ongoing mental health services and supports should have regular access to case managers. Every person leaving the state hospital should also have access to case management services. The level of case management services should be determined based on each individual’s specific needs.

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<sup>4</sup> Oregon Patient Resident Care System.

### *Assumptions*

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to case management services. Approximately 15 percent of persons with a serious mental illness require Assertive Community Treatment (ACT) level of service.

## **Access to Medications and Medication Management**

### *Overview*

For many persons with a serious mental illness medications are essential to healthy living in the community. However, for individuals without medical coverage, medications are too expensive to obtain. Accessing the medical professionals who can prescribe medications and monitor reactions is also problematic for individuals without medical coverage.

### *Recommendation*

Community mental health programs need funding to cover the cost of medications for persons who have a gap in medical coverage and do not qualify for medication scholarship programs. Medication funding and access to licensed medical professionals who can assess and prescribe medications are a necessity.

### *Assumption*

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to medications subsidized by the state.

## **Supported employment and education**

### *Overview*

Ensuring access for persons with a serious mental illness to evidenced based services that place and support them in competitive employment or education that leads to employment is necessary for continued recovery. As part of the continuum of care, supported employment and supported education assist clients in becoming productive community members and improves quality of life.

### *Recommendation*

Oregon is a leader in the development of both supported employment and supported education. Supported employment is an evidence-based practice that has proven results. Supported education is a promising best practice. These services are currently only available in select Oregon counties; however, they should be available to all individuals who want them.

### *Assumptions*

Studies estimate that 70 percent of persons with a serious mental illness express a desire to work. This means that more than 14,000 individuals may need supported employment or supported education services. Because studies have not been conclusive regarding the optimum length of supported employment services, this report assumes that 25 percent of those not receiving services should have supported employment or education services.

## **Reducing criminal justice involvement**

### *Overview*

In 2005 AMH and the Oregon Jail Managers Association survey reported nine percent of inmates have severe mental illness and the Oregon Sheriffs Jail Command Council reports 20 percent of their inmates have a mental illness. Jail systems are ill equipped to handle inmates with mental illnesses. When incarcerated, individuals with mental illness deteriorate quickly due to lack of treatment services. Reducing criminal justice involvement includes: jail diversion services, mental health courts and re-entry programs, all of which help individuals successfully manage their illness while they are in prison or jail, and develop a plan for when they return to their community.

### *Recommendation*

As a result of inadequate resources for non-Medicaid eligible individuals, law enforcement has had to accept a far more central role in handling mental health crises in the community than it should have to assume. Services need to be in place to divert people with a serious mental illness from the criminal justice system, providing immediate services when a person is released from a local jail. These services are not widely available in every Oregon county.

### *Assumptions*

According to the survey referenced above, the average number of daily jail bookings in Oregon is 540, which means that about 100 people with a serious mental illness are booked every day. Assuming that some of the bookings are repeat offenders, and some individuals can be served in traditional ACT programs, approximately 1,030 non-Medicaid eligible people per year will need forensic intensive case management services. Every county needs enhanced liaisons with local law enforcement.

## Co-occurring disorder services

### *Overview*

Individuals with Co-occurring Disorders (COD) are more likely to be homeless and die at the average age of 43.9 years compared to 74.9 for the rest of the population. COD is defined as a person with both a severe psychological disorder and a substance abuse disorder. Treatment for persons with a co-occurring disorder is most effective when addiction and mental health services are integrated.

### *Recommendation*

Communities need access to specialized COD services. The system needs a standardized and universal screening protocol for all persons enrolling in mental health and addictions services. Addictions and mental health providers and physical health care providers must be trained to use these screening tools. Communities throughout Oregon have also identified detox for people with COD services as a high priority. Beds are particularly needed to serve the indigent population, which is growing as a result of the economic downturn.

### *Assumptions*

Research indicates that the prevalence of co-occurring disorders in the population of adults accessing community-based mental health services averages between 20-30 percent, with outlying variables being age and mental health diagnosis.<sup>5</sup> Washington State prevalence data note that 27 percent of individuals entering state treatment programs have a COD.<sup>6</sup>

## Focusing on wellness

### *Overview*

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die almost 25 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council.

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<sup>5</sup> Rush, B. & Koegel, C.J. (2008). Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System. *Canadian Journal of Psychiatry*; 53 (12): 810-821. **Note:** Research conducted in the United States.

<sup>6</sup> Washington State Department of Social and Health Services; Division of Alcohol and Substance Abuse. (2008). *Abuse Trends in Washington State*.

### *Recommendation*

Oregon must develop and support a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. Coordinated care for people accessing publicly funded health services will maximize early intervention for mental health and substance abuse issues. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions.

AMH should build on current activities within the Wellness Initiative. This should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.

### *Assumption*

In the study referenced above, DHS gathered data on 527,564 persons who were treated for substance abuse, mental health problems or both, between 1996 and 2005, and matched with death records from 1999 to 2005. The data showed that people with mental illness die much younger than others in their age cohort. Based on these numbers, an important tool to adequately address this level of disparity is for Oregon to develop a wellness model focused on people with mental illness.

## **Housing that is safe, affordable and permanent**

### *Overview*

Stable housing is an essential element for anyone living with mental illness. Unfortunately many individuals become homeless, or lack safe and affordable housing. The stability of safe, permanent housing plays a vital role in an individual's recovery.

### *Recommendations*

To help individuals locate and remain in safe, affordable and permanent housing, there needs to be:

- Appropriate transitional housing,
- Supportive housing options, and
- Rental assistance.

Additional funding is critical to the ongoing ability of the system to provide stable and affordable housing for individuals with mental illness. While developing additional facilities and providing supported housing are critical, rental assistance plays a vital role in keeping individuals in safe and stable environments. In

combination, supportive housing and rental assistance provide critical alternatives to group homes and other structured facilities.

#### *Assumption*

A 2005 state survey conducted by AMH found that more than 12,861 people were in immediate need of affordable housing, that over 2,500 needed supportive or structured housing, and that an estimated 3,000 adults with mental illness were homeless at the time of the survey.

### **Institute culturally appropriate mental health services**

#### *Overview*

Oregon population is mostly Caucasian with a growing percentage of population being Hispanic, African American, Native American, Asian, and other ethnic populations. AMH data indicate that African Americans and American Indians/Alaska Natives tend to be represented in outpatient services at rates higher than their rates in the general population while Asian and Hispanic populations are served at lower rates.

#### *Recommendation and Assumptions*

The mental health system needs to provide culturally competent mental health services. The state and community mental health programs must provide culturally competent services. This requirement must go beyond the current requirement that information be provided to potential consumers, family members and others in a multi-lingual format.

AMH should develop outreach and intervention tailored to communities and populations by providing resources to pay for culturally-specific positions. These positions would function as project *promotores de salud* or community mental health workers to act as links between communities and the mental health care system, organizing their communities to achieve better mental health.

AMH should also continue efforts to reach African-Americans. Services should be delivered close to where individuals live, in settings that these individuals are willing to attend. Services could be modeled after many of the peer-programs that have proven successful.

### **Age specific services**

#### *Overview*

Two populations of Oregonians require specific attention in the development of mental health resources due to barriers preventing their access to the mental health

system. These are youth, ages 16 to 24, and older adults, age 65 and over.

According to AMH's 2009 Report to the Oregon Legislature on Planning for Mental Health Services, almost every county noted a gap in mental health services for its older adult population.

Transition age youth and young adults are difficult to engage in services. They often do not understand how to access benefits. They do not have access to professionals who can help them navigate into adult services. The system has not developed the appropriate tools to be relevant to this age cohort. Additionally, the children's delivery system and the adult delivery system speak different languages and there is little connection and interface between the two distinct system. Currently, service rates drop by 80 percent for these youth and young adults.

#### *Recommendation*

CMHPs should have specialized staff that can help coordinate services and develop the capacity needed to serve these youths and older adults.

#### *Assumptions*

According to US census data, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Oregon needs to position itself to provide more services for this age cohort.

More than 34,000 children under the age of 17 receive mental health services. Since 80 percent drop from services, often entering the adult system much more impaired, Oregon is missing the opportunity to help more than 27,000 youths transition to adulthood smoothly and with the resources that they need.

## **Peer delivered services**

#### *Overview*

Research is mounting that demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people that have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

An excellent example of peer-supported services is the establishment of Dual Diagnosis Anonymous of Oregon, Inc. (DDA). DDA conducts meetings throughout Oregon that are based on the 12 Steps of Alcoholics Anonymous plus 5 steps that focus on dual disorders of substance abuse and mental illness. In less than 3 years, DDA has grown to over 2,500 people attending meetings with more than 90 groups in 24 counties. As another example, the David Romprey Oregon Warm Line, staffed by peers, is a valuable companion to the delivery system.

#### *Recommendation and Assumptions*

Peer delivered services can and should be included in all the categories described above. For example, ACT services are enhanced when the team includes a peer counselor or case manager, and peers can provide support even in acute care settings. As the mental health services are funded and directed to the CMHPs, peer-delivered services should be incorporated into the development of services.

### **Contractual oversight**

The community mental health system in Oregon relies on a strong partnership between AMH and CMHPs. Nearly all of the community mental health services are contracted through the CMHPs. Frequently when mental health service funding is enhanced, the CMHPs are expected to implement additional services without consideration of the costs associated with the administration of those services. Proper administration ensures that the planning, development, and delivery of mental health services occur with regulatory assurance and quality.

### **Residential Programs**

#### *Overview*

Community residential programs provide a stepping-stone for people leaving the state hospital. The State Hospital Master Plan Phase II Report emphasizes the importance of a strong residential system as part of an effective mental health system. The report states, "...availability and access to these programs (*community residential*) are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community."<sup>7</sup> The table below demonstrates the needed residential services by region between 2005 and 2030.

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<sup>7</sup> Oregon State Hospital Master Plan Phase II Report.

*Community Residential Bed Need by Region<sup>8</sup>*

Region	2005 <sup>a</sup>		2011b		2030b	
	Civil	Forensic	Civil	Forensic	Civil	Forensic
North Willamette Valley	749	118	865	233	996	365
South Willamette/Central Coast	356	27	380	51	430	101
North Coast	22	8	38	24	41	28
Southern Oregon	281	11	292	25	318	52
Central Oregon	29	7	67	45	87	66
Eastern Oregon	116	5	119	9	129	20
<b>TOTAL</b>	<b>1,553</b>	<b>176</b>	<b>1,761</b>	<b>387</b>	<b>2,001</b>	<b>632</b>

*a Actual distribution of beds in 2005*

*b Assumes 50% civil and 50% forensic development*

AMH developed 283 community placements in the 2005-2007 biennium and is projected to develop 299 in the 2007-2009 biennium. If funding for mandatory caseload growth is continued as part of the department's base budget, AMH has determined that the need for community residential placements can be met with projected budget. AMH will plan future development to address current disparities in residential bed distribution. Special attention will need to be paid to the Central Oregon region, as it is the region that is most in need for residential development.

## **Further considerations**

The CSWG identified additional issues but did not make specific recommendations for funding. The following warrant consideration as "front end" services are implemented:

### ***Transportation***

Mental health services need to be accessible to all who need them. While a majority of the population is located in areas with a public transportation system, many counties and municipalities have limited or non-existent public transportation. Distances to mental health services are significant in the rural areas. These issues need to be addressed as communities plan mental health services.

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<sup>8</sup> Ibid.

## **Rural costs**

Another concern for rural communities is delivering mental health services on a much smaller scale. This often increases the cost of those services. CMHPs should work closely with AMH to assure the cost of rural services is considered as new funding is allocated. Additionally, rural communities should be encouraged to partner across traditional county lines. Regionalization could provide a mechanism to maximize resources.

## **Improved information system infrastructure**

Effective planning for mental health services and effective monitoring of outcomes require information systems that can produce timely meaningful data. Electronic medical records would improve the coordination of individuals care across the system. Funding for the replacement state hospital facilities includes some funding for the Behavioral Health Improvement Project (B-HIP) to replace the hospital components of the archaic data systems upon which the mental health system relies. It is critical that the community services portion of the new data system also be funded.

## **Funding disparities**

Each community or regional system of care in our State must have enough resources to fund a set of core services and supports. The Oregon State Hospital Master Plan will not be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate unless every region is funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area.

Our current system has great disparity in the level and type of state investment in our regions and communities. Historical precedent, insufficient funding of behavioral health care, significant cuts in indigent and Oregon Health Plan funds in recent years, extraordinary population growth in a handful of counties and an inability to fully address disparity all contribute to the current unmet need. AMH should work with the CMHPs as plans for the allocation of new funds are determined. AMH and the CMHPs have agreed that the use of the Kessler Prevalence Formula<sup>9</sup> would guide future allocations of new funds.

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<sup>9</sup> Epidemiological estimate of how common a condition is within a population over a certain period of time.

## **Conclusion**

The Oregon State Hospital Master Plan Phase II Report focuses on the replacement of hospital facilities. However, the number of patients to be served and the costs associated with building and running the new facilities, are predicated on a significant enhancement of the community mental health system. Without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

This report serves as an addendum to the 2007 report, informing the Governor, the Legislature and DHS what community-based services are needed to support the new state hospitals.

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Early intervention & prevention	Crisis services	Acute Care	Case management services
Unmet need: 21,000	270	5,250	6,000	17,850
<i>Assumptions</i>	360 newly identified individuals per year - 75% would need state funded services	25% of those not receiving services will need crisis services	Currently only funding approximately 50% of need	85% of not receiving services need access to CM & medication support; 15% need ACT level of services
Length of Service	2 years	1.5 episodes	7 days acute, 14 days sub acute	Ongoing
Other	Includes statewide coordination & evaluation		Need funding for acute care specialist - \$200,000	ACTs serve 10-12 people
Cost per person, per:	\$14,000 (year)	\$735 (episode)	\$1,000(acute daily) \$800 (daily subacute)	\$14,000 (ACT - year) \$2,500 (CM - year) \$600 (medications -
<i>Funding Need</i>				
100%	\$7,560,000	\$5,788,125	\$131,396,800	\$92,820,000
50%	\$3,780,000	\$2,894,063	\$65,698,400	\$46,410,000
25%	\$1,890,000	\$1,447,031	\$32,849,200	\$23,205,000
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$4,300,000	\$3,000,000	\$2,500,000	\$2,000,000
09-11 (50%)	\$3,091,000	\$4,342,748	\$66,252,955	\$47,045,345
11-13 (50%)	\$86,866	EBL	\$32,198,936	\$26,582,577
13-15	\$84,434	EBL	\$31,297,366	\$28,032,750

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Supported employment & education	Alternatives to criminal justice involvement	Co-occurring disorder services	Focus on wellness
Unmet need: 21,000	5,250	1,030	3,659	154,867
<i>Assumptions</i>	25% need support at any given time	The majority of those involved in the criminal justice system can be served by ACTs		Provide ongoing leadership & coordination on statewide wellness activities
Length of Service	Ongoing	Ongoing	Ongoing	Support task forces
Other	Includes 1 time investment of new VR staff (\$8,700,000)			3 staff
Cost per person, per:	\$6,000 (year)	\$25,000 (year)	\$5,000 per client	
<i>Funding Need</i>				
100%	\$71,700,000	\$51,500,000	\$36,590,000	\$602,463
50%	\$35,850,000	\$25,750,000	\$18,295,000	\$301,232
25%	\$17,925,000	\$12,875,000	\$9,147,500	\$150,616
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$2,000,000	\$4,000,000		
09-11 (50%)	\$33,850,000	\$24,415,000	\$18,807,260	\$602,463
11-13 (50%)	\$17,925,000	\$11,865,690	\$9,140,328	EBL
13-15	\$17,925,000	\$11,533,451	\$8,884,399	EBL

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Safe & affordable housing	Culturally appropriate services	Age specific services	Peer Programs
Unmet need: 21,000	5,420			
<i>Assumptions</i>	5,420 need rental assistance (RA), 2,000 people need supportive housing (SH)	Support for Afrocentric center & outreach to targeted communities	Need specialized staff in CMHPs to serve older adults & transition age youth	Establish peer services coordinators in every CMHP, Support Peer Bridgers & Dual Diagnosis Anonymous
Length of Service	Ongoing		Ongoing	Ongoing
Other	Need additional supports for people in Villebois		Need to provide training for the specialists	
Cost per person, per:	\$500 (RA - month) \$1,875 (SH - month)		\$92,226 (Youth - year) \$72,000 (Older Adults - year)	\$92,226 (Peer Specialists - yearly)
<i>Funding Need</i>				
100%	\$15,504,000	\$2,924,606	\$10,838,916	\$6,086,916
50%	\$7,752,000	\$1,462,303	\$5,419,458	\$3,043,458
25%	\$3,876,000	\$731,152	\$2,709,729	\$1,521,729
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$1,000,000	\$1,000,000		
09-11 (50%)	\$7,455,056	\$1,924,606	\$7,943,012	\$3,128,675
11-13 (50%)	\$3,623,157	EBL	\$1,488,495	\$1,520,536
13-15	\$3,521,709	EBL	\$1,446,817	\$1,477,961

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Local oversight	Total
Unmet need: 21,000		
<i>Assumptions</i>	Provide CMHPs 10% of new funding to ensure proper programmatic oversight	
Length of Service		
Other		
Cost per person, per:		
<i>Funding Need</i>		
100%	\$43,331,183	\$476,643,009
50%	\$21,665,591	\$238,321,504
25%	\$10,832,796	\$119,160,752
<i>New Biennial Funding Targets</i>		
07-09 LAB	\$2,100,000	\$21,900,000
09-11 (50%)	\$21,192,828	\$240,050,948
11-13 (50%)	\$10,299,714	\$114,731,300
13-15	\$10,011,322	\$114,215,209

## **Appendix E**

### **AMH Strategic Planning 2009 – 11 Initiatives**

**DHS Addictions and Mental Health Division (AMH)**  
**Strategic Planning 2009-11 Initiatives**  
**October 13, 2009**

**1915(i) Medicaid Home and Community Based State Plan Amendment –  
Ralph Summers**

AMH will submit to the federal Centers for Medicare and Medicaid Services an amendment to the Oregon, Medicaid State Plan. The State Plan Amendment will authorize both Rehabilitative and Habilitative services for people with serious mental illness, a history of hospitalization and need for daily service contact. AMH expects to be able to expand the array of services available in community based settings to better meet needs of consumers and simplify the billing and documentation requirements for providers. Target date for submitting the request is January 1, 2010. Target date for authorization is July 1, 2010.

**Alcohol and Drug Policy Commission – Karen Wheeler**

HB 3353 abolished the Governor's Council on Alcohol and Drug Abuse and established the Alcohol and Drug Policy Commission. AMH is responsible for hiring the Executive Director to support the commission. The commission will provide the following deliverables: A blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon. This includes:

- A strategy for organizing and delivering state-funded treatment and prevention services.
- Funding priorities for treatment and prevention services.
- Strategies to maximize accountability and measure performance of treatment and prevention services.
- Methods for standardizing data collection and reporting.
- A policy and funding strategy that supports a consolidated treatment and prevention system, reducing fragmentation in the delivery of services.
- A plan for sustaining focus and leadership on alcohol and drug services and for building a lasting constituency for continuing effective state action.
- A plan for evaluating the state action based upon the "blueprint" in future years/biennia.

### **Blue Mountain Recovery Center: The Future – Richard Harris**

The purpose of this initiative is to consider alternative and current use of the facility and program to determine what use would best meet the needs of Oregonians, patients, staff and the local community and region. The goal is to develop a plan for the future of BMRC. The first objective is to develop a plan and strategy to determine the method of developing an array of options for the future BMRC. The second phase would engage all stakeholders in developing and defining the realistic possible options for the future of BMRC. The third phase would be to engage DHS, the Legislature and the community, staff and patients/consumers in developing a plan for the future of BMRC.

### **OSH Geriatric Downsizing – Linda Hammond**

The purpose of this initiative is to develop a new program called the Community Based Care (CBC) Hospital Diversion program. Service models within this new program will be designed to provide the intensity and type of services that will address behaviors that cause people to be referred to the state hospital and that slow their return to the community. The program would target persons with psychiatric and medical needs who qualify for the SPD 1915© Home and Community Based Care waivers or the “Dollars Follow the Person” initiative and who have needs that exceed all existing CBC resources. Models will promote policies of self direction, and person centered care; provide access to necessary medical, nursing and licensed specialists and care planning necessary to support the persons return to a permanent placement. The pilot is expected to lead to a new service model that will retain or rapidly return to community care, people with physical disabilities, head injuries or dementia that frequently spend too much time in the Oregon State Hospital.

### **Impaired Health Professionals – Karen Wheeler**

The 2009 Legislature passed HB 2345-B which will become effective July 1, 2010. HB 2345-B requires DHS, AMH to establish a consolidated impaired health professionals program. This program monitors the substance use disorder and mental health treatment of impaired health professionals who are either self-referred or diverted by their licensing boards in lieu of disciplinary action. AMH will work closely with the health licensing boards during 2009/2010 to build a

consolidated program including a plan to transition participants who are participating in the separate programs by July 1, 2010.

### **Integrated Services and Supports Rule Implementation – Mike Morris**

The Integrated Services and Supports Rule was filed for public review September 15, 2009 and is expected to be finalized this fall. This rule integrates the standards for most of the mental health and addiction services in the state. The implementation will address training for providers, developing guidelines for reviewers and providers, and redesigning site review processes.

### **Children's Wraparound – Bill Bouska**

Near the end of the 2009 Legislative session, Governor Kulongoski signed House Bill (HB) 2144, and the Children's Wraparound Initiative became law. The implementation of children's Wraparound is a major cross-division transformation initiative. The beginning phase of the Children's Wraparound Initiative is to develop an integrated system of care to maximize positive outcomes for children with behavioral health care needs and who are in the custody of DHS. Initially efforts will focus on children, from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. In late fall, DHS will release system of care project site descriptions. This will give communities the opportunity to evaluate their readiness as a system of care project site and decide if they are ready to apply. Applications will be due during the month of January 2010. In February, as part of HB 2144, the work group must present its findings and a progress report to the legislature. Community system of care project sites will begin to take shape in March 2010.

### **Integrated Services & Management Demonstration – Jane-ellen Weidanz**

The Addictions and Mental Health Division recommended to the legislature a system change effort focused on an integrated management and service model including health, mental health and addictions services. The legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in a simpler, more efficient use of state, federal and local resources and provide better services to those in need.

### **Peer Delivered Services – Len Ray**

AMH believes that developing, funding and supporting peer delivered services (PDS) follows a national trend that is proving to be a key component of a successful service delivery system and an important addition to the health care workforce. AMH recognizes the indisputable value of PDS in transforming the mental health and addiction service delivery system that is based on a recovery model. AMH will work with service population stakeholder groups to develop strategies to increase the use and availability of PDS. The focused investment in this initiative is an investment in the future, an investment in the workforce, and an investment that will demonstrate significant results in transforming and redesigning the service delivery system in the development of new policies, procedures, and partnerships within the state and across the nation.

### **Strategic Prevention Framework – Rick Cady**

SAMHSA's Center for Substance Abuse Prevention awarded Oregon a State Prevention Framework Grant July 1, 2009; \$2,135,724 per year for five years. AMH must submit and have approved by April, 2010 a statewide plan. Once approved, AMH will be able to begin working with ten counties – communities and tribes. The implementation of the Strategic Prevention Framework will provide the Oregon prevention system a common framework for assessing state and local needs and priorities, making data-driven decisions about the right Evidence-based Programs delivered to the right audiences and mobilize communities and tribes in the implementation of the Evidence-based Programs. Also, the SPF will identify gaps in the prevention system infrastructure and afford AMH and the communities and tribes methods for evaluating Evidence-based Program outcomes. The initial phase of the implementation process will install the prevention framework in ten communities/tribes. Of the ten communities at least two to three will be rural and one or more of the recognized tribes. The long term five year plan is to roll out the framework to the balance of the state.

### **Supportive Housing Increase – Darcy Strahan**

AMH is transitioning housing development for people with mental illness to a supportive housing model and away from a structured housing model (residential

treatment homes or facilities) to more fully integrate individuals into their communities. The current focus on structured housing development has been to fill the gaps in the housing needs for people leaving the state hospital. Residential facilities should be seen as one part of the service delivery system, not an end placement as some have become. As individuals move through the service delivery system, the end result should be full integration into their community of choice, living in their own homes with appropriate and flexible support services available as needed.

### **MH Adults Residential Utilization Analysis – Jon Collins**

To better understand current efficiency, effectiveness, and utilization, a comprehensive review of adult mental health residential services is being conducted. Results will help guide planning for further usage and development of this level of care. The review includes but is not limited to analysis of current utilization data to better understand:

#### **Capacity**

- In-flow and out-flow
- Exchange between various levels of care
- Length of stay impact
- Financial modeling

In addition to a review of data, information will be gathered through direct interviews with providers and chart reviews and interviews with two or three model states. Information from all sources will be synthesized to better describe current state and future goals for service delivery to clients currently utilizing residential services.

### **Wellness – Pat Davis-Salyer**

The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health. It blends the excellent work of the AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities. It gives voice to those who have not been heard and acknowledges the tragedy of life lost of those who have passed. AMH is restructuring how we work

to better share resources, reconfigure provider systems to improve access, remove barriers to health care, equip community grass root organizations to provide healthy lifestyle education, enhance prevention, and early intervention programs across the lifespan, and therefore, promote and ensure recovery. Wellness is the goal of all interventions.

### **Young Adults in Transition – Damien Sands**

The Young Adults in Transition includes young adults aged 14 to 25. The initiative will promote access to a system of services and supports that are young adult-directed, and developmentally appropriate. This initiative will implement strategies that promote a Young Adult system through the elimination of barriers to access and through the creation of developmentally appropriate and effective services and supports. This initiative will effectively bridge adolescent and adult systems; and thereby provide young adults with opportunities to realize their full potential and have healthy, productive lives.

### **The Criminal Justice Door to the Mental Health Systems – Richard Harris and Jane-ellen Weidanz**

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to stand trial or who have been found Guilty Except for Insanity. Both entry points do not allow the community mental health system or AMH the ability to determine if someone needs the level of services provided by the state hospital or if the person could be appropriately served in other settings or if the person does not need mental health services at all. The state is the recipient not the participant in the entire process.

This initiative will begin the dialogue between all parties, including consumers, the court system, community mental health programs, law enforcement, to determine if there are more appropriate processes and options available so that only those individuals who need services, receive them, and only those individuals in need of hospital level services are committed to the hospital. The goals are to identify and implement system changes to improve the “criminal justice door” to the mental health system and may result in legislation, rule or policy process changes.



# OREGON STATE HOSPITAL

PORTLAND – SALEM

## POLICIES AND PROCEDURES

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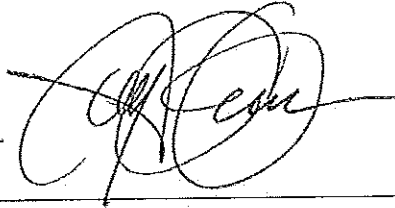
SECTION 1: Administration

POLICY: 1.007

SUBJECT: Patient Transfers From Oregon State  
Hospital

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APPROVED: ROY J. ORR  
SUPERINTENDENT



DATE: June 19, 2008

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### I. POLICY

- A. The basis for transfer to Blue Mountain Recovery Center (BMRC) Training Centers, or other Department of Human Services (DHS) approved treatment centers can be:
  - 1. County of residence;
  - 2. Clinical needs of patient;
  - 3. System-wide capacity issues.
- B. Notification: The patient and, if appropriate, the patient's family, must be informed of the request for transfer and the reasons for the transfer request by an Oregon State Hospital Treatment Team member. The liaison from the county of responsibility mental health program must be consulted about the transfer.
- C. Voluntary patients and patients on a "guardianship voluntary" will be discharged from Oregon State Hospital (OSH) and the patient or guardian will need to sign a voluntary admission form from the receiving facility in advance of the transfer.
- D. For patients under the Psychiatric Security Review Board (PSRB), the PSRB must be informed of the intent to transfer and notified when the transfer has taken place. (See Administrative Rule 309-31-010.) All forensic patients, regardless of legal status, must be approved for transfer by the Forensic Risk Review Panel.
- E. If the patient is in disagreement with the request, or the approval or rejection of the request, he or she may file an Emergency Grievance. See Resolution of Disputes (A.1 on page 2 of this Policy and Procedure).

## **II. PROCEDURES**

- A. The transfer request may be initiated via telephone by an Interdisciplinary Treatment Team (IDT) member by calling the potential receiving facility. Verbal approval may precede the transfer request form; however, the patient shall not be transferred before the Oregon State Hospital Superintendent or designee signs Part I of the transfer request form.
- B. The patient and, if appropriate, the patient's family, must be informed of the request to transfer and the reasons for transfer by an Oregon State Hospital Treatment Team member. The patient shall be notified of their right to file an Emergency Grievance.
- C. The transfer request form, with Parts I and II completed, shall be submitted to the OSH Superintendent for approval.
- D. Consultation with the responsible county mental health program must be documented on the transfer form (Part II).
- E. The receiving facility will complete Part III and return the original transfer form to OSH Medical Record Services. The patient may be transferred before this form returns to Oregon State Hospital based on verbal acknowledgement from the receiving Administrator or designee.
- F. The IDT contact person will send a copy of the completed transfer form to the responsible community mental health program.
- G. If a patient files a grievance, it shall be treated as an emergency grievance. The grievance shall be resolved prior to transfer.

## **III. RESOLUTION OF DISPUTES**

- A. Transfers from OSH (refer to OAR 309-31-010(5))

- 1. Patient Appeals

If a patient disagrees with the request to transfer, the patient may file an emergency grievance. (See Policy and Procedure 7.006, Patients Rights, Subject: Patient Grievances, Section 6).

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SUBJECT: Patient Transfers From Oregon State  
Hospital

POLICY NUMBER 1.007

DATE: June 19, 2008

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2. Hospital Appeal Process

The Superintendent may ask the Mental Health and Addiction Services Division Administrator to convene a meeting to review the case for a final decision when the receiving hospital or treatment center disagree.

IV. REFERENCES

ORS 179.473 and ORS 426.060.  
OAR 309-33-100 and OAR 309-31-010.  
OAR 309-42-000 (Admission and Release of Residents).  
Oregon State Hospital Policy and Procedure 7.006, Patient Grievances.  
Joint Commission Comprehensive Accreditation Manual for Hospitals, PC.15.10  
through PC.15.30  
Licensure and Certification Standards, 333-510-0070

Replaces Oregon State Hospital Policy and Procedure 1.007, *Patient Transfers from Oregon State Hospital*, dated 12/19/2006

# OREGON STATE HOSPITAL

PORTLAND – SALEM

## POLICIES AND PROCEDURES

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SECTION 6: Patient Care

POLICY: 6.001

SUBJECT: Intraprogram and Interprogram Patient Transfers

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APPROVED: ROY J. ORR  
SUPERINTENDENT

DATE: March 20, 2009

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### I. POLICY

It is the policy of Oregon State Hospital (OSH) to treat patients in the most appropriate and least restrictive setting. To facilitate this process, procedures to determine the manner and timeliness of transfer are established.

### III. PROCEDURES

#### A. Intraprogram Transfers

Each specialty service within OSH (Psychiatric Recovery Services and Forensic Psychiatric Services) shall have written policies governing transfers within its own program area.

##### 1. Procedures shall assure:

- a. Medical record documentation regarding the need for transfer;
- b. An exchange of clinical information between sending and receiving treatment teams to assure continuity of care. It is strongly recommended that the two IDT's meet to review the case;
- c. A resolution mechanism, should there be disagreement between the treatment team or physicians involved in the transfer;
- d. Documentation that the patient and, if appropriate, the patient's family were fully informed of the reasons for the proposed transfer;

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**SUBJECT:** Intraprogram and Interprogram Patient Transfers

**POLICY NUMBER 6.001**

**DATE:** March 20, 2009

**PAGE 2 OF 4**

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- e. That treatment shall be provided in the least restrictive environment possible and that patients being transferred to a more restrictive environment are informed of the conditions and/or behaviors required to return to the least restrictive environment;
  - f. Specific policies regarding emergency transfers;
  - g. Procedures for completing the medical record before the record is transferred with the patient. All programs should have uniform policy regarding transfer of records and entry into OP/RCS (see Policy 2.007, Medical Records and OSH Computer Manual);
- 2. Nursing Policy and Procedure T-2, Transfer, should be followed;
  - 3. The transferring ward will take the patient off their computer census and the receiving ward will enter the patient on their census.
  - 4. If relevant, criteria and conditions for transfer back to the ward of origin should be negotiated at the time of the proposed transfer.
  - 5. The receiving unit will assure that the physician orders are reviewed and updated within the first 24 hours by the designated physician (unless the physician remains the same) and that the treatment plan is reviewed and updated within 72 hours following the transfer; and,
  - 6. All patient property will be inventoried by both the sending and receiving wards, and that property to be transferred will be documented in the patient chart.

**B. Interprogram Transfers**

All specialty services with OSH (Psychiatric Recovery Services and Forensic Psychiatric Services) shall follow these procedures when initiating transfers between services:

- 1. Requests for transfers must have a sign-off by the treating physician or unit director if originating in Forensic Psychiatric Services.
- 2. The medical record shall indicate, in writing, the following:

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SUBJECT:     Intraprogram and Interprogram Patient  
                 Transfers

POLICY NUMBER 6.001

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- a. Reason for transfer;
  - b. Description of exchange of information between sending and receiving treatment teams; and
  - c. Documented assurance that patient and, if appropriate, the patient's family, are being fully informed of the reason for transfer.
3. Transfer requests are negotiated between physicians in collaboration with their program directors or designee. The latter may include the unit director, supervising physician, or supervising nurse.
4. All transfers to or from forensic programs but not between forensic programs shall be approved by the Risk Review Board prior to transfer. Transfers involving potentially aggressive patients shall require a Risk Review Board involving both the sending and receiving treatment teams.
5. If relevant, criteria and conditions for transfer back to the program of origin should be negotiated at the time of the proposed transfer.
6. If there is disagreement, the transfer request shall be reviewed by the Chief Medical Officer in consultation with the programs.
7. OSH Policy 2.007, Medical Records, should be followed.
8. Nursing Policy and Procedure T-2, Transfer, should be followed.
9. All patient property will be inventoried by both the sending and receiving wards, and that property to be transferred will be documented in the patient chart.
10. The receiving program will assure that the physician orders are reviewed and updated within the first 24 hours by the designated physician and that the treatment plan is reviewed and updated within 72 hours following the transfer.
11. The transferring ward will take the patient off their computer census, and the receiving ward will enter the patient on their census.
12. Emergency transfers shall be approved by the Chief Medical Officer in consultation with program directors. All medical record and risk

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**SUBJECT:**    Intraprogram and Interprogram Patient  
                 Transfers

**POLICY NUMBER 6.001**

**DATE:**        March 20, 2009

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management requirements must be completed within the above guidelines. Forensic patients shall be reviewed at a Risk Review Board within 15 days of transfer.

#### **IV. REFERENCES**

Medical Staff Manual  
Nursing Policy and Procedure T-2, Transfer  
JCAHO Manual  
OSH Policy and Procedure 4.009, Handling Personal Property and Valuables  
OSH Policy and Procedure 2.007, Medical Records  
OSH Computer Manual

Replaces OSH Policy and Procedure 6.001, *Intraprogram and Interprogram Patient Transfers*, dated 6/13/2006.

# OREGON STATE HOSPITAL

PORTLAND – SALEM

## POLICIES AND PROCEDURES

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SECTION 6: Patient Care

POLICY: 6.007

SUBJECT: Interstate Repatriation of Patients

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APPROVED:   
MARVIN D. FICKLE, M.D.  
SUPERINTENDENT

DATE: July 18, 2006

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### I. POLICY

Treatment is generally best accomplished in familiar surroundings. Oregon State Hospital (OSH) will assist patients who wish to return home or effect family reunification. Where applicable, the Interstate Compact will be used to facilitate the process.

### II. PROCEDURES

- A. When it has been determined within the provisions of ORS 428.310 that a transfer of a patient to another state would be in the patient's best interest and the treatment team and patient agree, the following procedures shall be initiated:
1. The Social Worker on the Treatment Team shall forward a referral packet of typical referral information, such as admitting information, physical information, course of hospitalization and potential discharge information to the Director of Social Work with a request for Interstate Transfer.
  2. The Social Worker or other Treatment Team member will contact family members and community mental health members in the receiving state to discuss the possibility and reasonableness of such a transfer.
  3. The Director of Social Work will forward the packet to the Interstate Compact Coordinator at the Office of Mental Health and Addiction Services for a referral to a state if there is an Interstate Compact for that state.
  4. Interstate Compact Transfer Coordinator at the Office of Mental Health and Addiction Services will notify the Director of Social Work

at Oregon State Hospital the results of the transfer request and/or negotiation.

5. The Transfer Coordinator will also provide a letter from the receiving state authorizing the transfer. A copy of that letter will be forwarded to the Medical Records with the original going into the patient's medical record.
6. Upon approval from the receiving state the Director of Social Work will coordinate with the Treatment Team the approximate date of the expected transfer and which staff will accompany the patient during the actual trip and additional details like where the patient will be going and expected time of admission, and best time of day for arrival in the receiving state and identification of a facility where the patient will be admitted.
7. The Director of Social Work will coordinate with Purchasing regarding approximate flying schedules and will develop an out of state travel worksheet with potential cost information and approximate flying dates.
8. The Treatment Team Social Worker will draft a summary for the Superintendent of the case. This summary will include identifying information about the patient, clinical information such as diagnosis and course of treatment and will include patient's current condition for travel and any safeguards needed. In addition, the summary will include the plans in the receiving state such as admission to state psychiatric hospital on such and such a date at approximately such and such a time. The Unit Social Worker will begin coordinating transportation with the Communication Center for the actual trip. Once approved by the Superintendent, the Social Worker will direct Purchasing to get the tickets and coordinate with the Unit for receiving of the tickets and final details regarding the trip. The Unit Social Worker will also assure that the patient has two forms of identification including picture ID for documentation at any transportation site such as airports. The transporting staff will also assure that all medications and transfer medical record information such as discharge details plan form and any other material will be delivered to the receiving facility with the patient.
9. When a state is not a member of the Interstate Compact, the Unit Social Worker will consult with the Director of Social Work regarding making arrangements for possible transfer to another state. If the receiving hospital or mental health program agrees to accept the patient, the Director of Social Work will coordinate transportation as designated above.

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SUBJECT: Interstate Repatriation of Patients

POLICY NUMBER 6.007

DATE: July 18, 2006

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- B. When another state requests the transfer of a patient to OSH, the Interstate Transfer Coordinator shall route the request to the Director of Social Work.
1. The Director of Social Work shall determine if information is adequate.
  2. The Director of Social Work shall send the information to the appropriate social worker and physician for discussion with community mental health clinical staff and shall contact the family to verify their interest.
  3. Upon receiving the recommendation from the social worker or physician, the Director of Social Work shall inform the Interstate Transfer Coordinator of the pending transfer.
  4. When the transfer is approved, information that has been obtained shall be routed to Medical Record Services for filing. The Communications Center shall also be notified of the transfer. Any transfer coordination for travel shall be arranged by the Communications Center.

### III. REFERENCES

ORS 428.310 - Articles I through XIV.

Replaces OSH Policy and Procedure 6.007, *Interstate Repatriation of Patients*, dated 9/16/2003.

# OREGON STATE HOSPITAL

PORTLAND -- SALEM

## POLICIES AND PROCEDURES

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SECTION 6: Patient Care

POLICY: 6.013

SUBJECT: Discharge and Continuing Care Planning

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APPROVED:   
MARVIN D. FICKLE, M.D.  
SUPERINTENDENT

DATE: MARCH 29, 2005

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### I. POLICY

- A. Planning for discharge shall begin at admission, continue until discharge occurs as part of the IDT treatment planning process and shall be recorded in the patient's IDT care plan and in supporting records.
- B. The patient's treatment team, in consultation with the patient; patient's family, if indicated; and appropriate community staff, shall determine when the patient is ready for discharge. In Forensic Psychiatric Services, consultation and/or approval may be by the Forensic Risk Review Board, the Psychiatric Security Review Board (PSRB), the Department of Corrections, or the courts. The patient's physician has the final authority to issue a discharge.
- C. The patient and family or significant other, if available, shall participate as much as possible in the development and implementation of the discharge plan. Oregon State Hospital (OSH) must respect and encourage the right of patients to make their own choices regarding discharge plans, given their capabilities at the time. In some cases, specific conditions may be required as part of the agreement to discharge (trial visit or conditional release).
- D. The discharge plan shall consider the patient's continuing medical and psychiatric treatment needs; basic needs such as housing, finances, and employment; social needs such as family support and other needed social contact, and the safety needs of the patient and the community.
- E. If a patient refuses to participate in all or part of the discharge plan or the planning process, social workers shall document the refusal and the nature of the plans offered and efforts made on behalf of the patient.

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**SUBJECT:** Discharge and Continuing Care Planning

**POLICY NUMBER 6.013**

**DATE:** March 29, 2005

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- F. For Psychiatric Recovery Services – Adolescent and Geriatric patients, the responsible Community Mental Health Program (CMHP) or Mental Health Organization (MHO) shall be consulted and expected to assist in the development of the discharge plan, unless the CMHP declines to provide this service. Exceptions would be when 1) SCF is the guardian or is providing courtesy case management, and the coordination of the discharge is with them; or 2) when a patient escapes or is released by the court; and in those cases, the CMHP or MHO or SCF, as appropriate, shall be notified.
- G. Psychiatric Recovery Services - Adult patients will be involved with the CMHP or MHO prior to discharge.
- H. In Forensic Psychiatric Services, it is necessary to gain Forensic Risk Review Board approval on all patients to initiate discharge planning activities except when a patient is to return to a correctional setting or court, this includes Civilly Committed patients in Forensic Psychiatric Services.
- I. For all Forensic Psychiatric Services discharges, the CMHP, MHO, or Corrections authorities in the location where the patient is to reside shall be contacted to arrange mental health or other supportive resources.
- J. For all patients under the jurisdiction of the Psychiatric Security Review Board PSRB, it is necessary to gain the written approval of the PSRB before the conditional release or discharge takes place.
- K. Treatment team members must use clinical judgment and negotiate with the patient in deciding when family members or significant others need to be notified of the patient's discharge. In general, those who have a positive interest or involvement with the patient should be notified if the patient has consented to release the information.
- L. If a court unexpectedly releases a patient or a voluntary patient suddenly leaves, an effort will be made to assure adequate discharge arrangements. These efforts and outcomes are to be carefully documented in the discharge progress notes.
- M. Discharge plans for patients leaving to another institutional setting (e.g., jails, corrections, medical hospitals) should include recommendations for mental health care both in that institutional setting and for discharge planning from that facility.

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SUBJECT: Discharge and Continuing Care Planning

POLICY NUMBER 6.013

DATE: March 29, 2005

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- N. Patients being transferred to another Class 1 facility such as Eastern Oregon Psychiatric Center, or Faulkner Place, while still under civil commitment, must be managed according to OSH Policy and Procedure 1.007, Patient Transfers From Oregon State Hospital.

## II. DEFINITIONS

- A. "Qualified Mental Health Professional (QMHP)" means a licensed physician or psychiatrist or a person with a graduate degree in psychology, social work, psychiatric nursing, recreational therapy, another mental health related field or is a registered occupational therapist.
- B. "Patient" means any patient at OSH.

## III. PROCEDURES

- A. Patient participation in the discharge plan shall be documented in part by the patient's signature on the Treatment Plan and the Discharge Plan Details form.

Patient participation, including comments or objections, and family or significant other participation in the discharge plan, shall also be documented in the progress notes. If a patient is unable to sign or participate, this shall be documented, with explanation, in the progress notes and noted on the treatment plan and Discharge Plan Details forms.

- B. To assure that the discharge process is adequately documented, efforts to obtain outside agency consultations or services in support of a discharge plan, whether the request is honored or not, shall be documented in the patient's chart.
- C. For unexpected releases, efforts to arrange discharge plans shall be documented on the Discharge Plan Details form or in the progress notes, as is appropriate, including any refusal by the patient to cooperate with the plan.
- D. The social worker or designee shall document the progress of developing the discharge plan in the progress notes.

**E. Notification of Family or Significant Others:**

When a patient is a minor or is under guardianship, the legally responsible parties must be involved in the discharge planning process. In other circumstances, whenever there is a possibility of supportive benefit to the patient or to the family in the community, it is highly recommended that family members/significant others be involved in discharge planning, but only after gaining written consent for the release of this information from the patient.

**F. Documentation of the Discharge Plan:****1. Discharge Planning Progress Notes**

The Social Worker will write discharge planning progress notes throughout the course of hospitalization. Documentation will begin at the time of admission, projecting the level of care that may be needed when the patient leaves the hospital. As the Social Worker begins more specific discharge planning, progress notes will document actions taken during the process up to discharge.

**2. Discharge Progress Notes**

This is done by the social worker at the time of discharge and describes recent social work services provided and outcomes, gives a general description of continuing care plans, makes recommendations for continued treatment and approaches to use, states what information was provided to the community and identifies strategies, barriers, strengths and weaknesses of the plan.

**3. Discharge Plan Details Form**

This is initiated by the social worker and may contain recommendations from all disciplines. It provides the practical details of the discharge plan, e.g., housing, supervision, addresses, support systems, persons to contact, appointments, special care needs, recommendations, etc. The patient or legal guardian is to sign at the bottom of the form to indicate involvement in the plan. If the patient or legal guardian refuses to sign, a staff member present shall write "patient (or guardian) refuses to sign" in the open space provided for the signature and initial the statement. The physician's signature indicates

agreement with the plan and is especially important when the patient is released to foster care or group living settings to assure continuance of the patient's medications. The social worker signs to indicate the form is complete. Copies of the form go to the patient, care provider, CMHP, MHO, or other involved agencies (photocopies may be needed), and the patient's chart.

4. RN Discharge Assessment and Instructions

This form is completed by the RN prior to the patient's release and provides a physical and mental assessment of the patient, specific medication instructions, recommended medical treatments and diet instructions and other recommended nursing care needs. The patient, guardian, or responsible party signs the form, as does the nurse. Copies go to the patient or the patient's guardian and/or to the person who is responsible for the patient care.

5. Discharge Summary

This is completed by the patient's physician, and includes the course of hospitalization, continuing care plan, and recommendations for needed treatment. A copy is sent to the responsible community mental health program and other continuing care providers, as identified by the physician at the end of the report.

IV. REFERENCES

ORS 179.505 regarding Release of Information.

Health Care Financing Administration Regulations: 42 CFR 405.1037.

ORS 426.500 (2), Prepare a Written Discharge Plan for Each Chronically Mentally Ill Person...

OAR 309-31-200 through 309-31-255, Admission and Discharge of Mentally Ill Persons.

ORS 192.496(1-3), Public Records Exempt from Disclosure.

OSH Policy and Procedure 1.007, Patient Transfers from Oregon State Hospital

OREGON STATE HOSPITAL  
PSYCHIATRIC RECOVERY SERVICES

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Division: Patient Care

Number: 3.018

Subject: Pass to Discharge, ATS

Approved:

Date: 7/11/08

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I. POLICY

PRS uses pre-discharge passes when it has been determined by the Treatment Team and the community provider that the pass will be beneficial to assist the patient in transitioning from the hospital to the community living environment. Generally, passes of three days or less shall be sufficient for achieving this goal. The Program Director must review and approve passes for longer than a three day time period.

II. PROCEDURE

A. The IDT shall determine a discharge plan and the need for pre-discharge passes for each patient.

1. The IDT will include the need for pre-discharge passes in the patient's Treatment Care Plan and document the rationale for the passes in the patient's chart.
2. The conditions of the pre-discharge pass are to be established by the treatment team and community provider and communicated in writing via the Off Grounds Supervision Agreement.

B. The Social Worker is responsible for coordinating the pre-discharge pass and assuring adequate communication occurs between the Treatment Team and community provider.

1. The Social Worker informs the community provider of the conditions of the pass including dates, times and special arrangements that may be necessary and assures the provider receives the information in writing. Monday discharges to structured housing after a pre-discharge pass should be scheduled to occur in the afternoon.

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Subject: Pass to Discharge, ATS

Number: 3.018

Date: 7/11/08

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2. The Social Worker informs the community provider of the need to review and sign the Supervised Pass Agreement and assures that the form is taken with the patient and signed off by the provider prior to the patient being left at the site. The form is placed in the front of the patient's chart.
  3. The Social Worker assures that the patient reviews and signs the Transition Pass Contract prior to the patient leaving the hospital and places in the front of the patient's chart. Exception to this shall be reviewed and approved by the treatment team.
  4. The Social Worker or designated IDT member contacts placement each day of the pass to check on patient progress.
  5. The Social Worker or designated IDT member contacts the community provider's Residential Administrator prior to a scheduled discharge from pass to confirm their decision to accept the patient.
- C. If there is a need for a pass longer than three days, the treatment team shall submit a written request including rationale to the Program Director.
- D. The MD is responsible for writing orders for the pass and discharge assuring that adequate medications and other needs are addressed.

# OREGON STATE HOSPITAL

## DISCHARGE PLAN DETAILS- PAGE 1 OF 2

### Patient Information

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Admission Date: \_\_\_\_\_ Medicare A \_\_\_ B \_\_\_ #: \_\_\_\_\_  
 Pre-discharge Pass Date: \_\_\_\_\_ Private Insurance or OHP#: \_\_\_\_\_  
 Discharge Date: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

#### Living Arrangement: \_\_\_\_\_ cc DC summary

Person/Facility  
 Providing Care: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

County: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

#### Case Manager: \_\_\_\_\_ cc DC summary

Agency: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

Appt Date: \_\_\_\_\_ Time: \_\_\_\_\_

### PATIENT NEEDS, RESOURCES AND SCHEDULE OF CONTACTS

#### Discharge Diagnosis

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

#### List of Medications Is On Attached Printout

#### Rx Supply Given for 14 Days

Prescriptions Written for \_\_\_\_\_ Days with \_\_\_\_\_ Refills

Medical (Somatic) Considerations: \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Appt Date/Time \_\_\_\_\_ cc DC summary

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Phone \_\_\_\_\_

Other Medical Provider(s) \_\_\_\_\_ Appt Date/Time \_\_\_\_\_

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

### ADDRESSOGRAPH

File: Behind Face Sheet  
 Thin: Do Not Thin  
 OSH STK: 11826 MR 6 - 07/2005  
 MR #: 59-06-0403-00

Medical Record

**OREGON STATE HOSPITAL**  
DISCHARGE PLAN DETAILS – PAGE 2 OF 2

**Mental Health Continuing Care Providers:** \_\_\_\_\_ **Agency:** \_\_\_\_\_

**Prescriber:** \_\_\_\_\_ **Appt Date/Time** \_\_\_\_\_ **cc DC summary**

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Other MH Provider(s):** \_\_\_\_\_ **Appt Date/Time** \_\_\_\_\_ **cc DC summary**

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**ECMU Representative:** \_\_\_\_\_ **County of Responsibility** \_\_\_\_\_

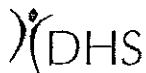
<b>Social Support:</b> (family, friends, significant others) _____ _____ _____ _____	<b>Guardian:</b> <b>Name:</b> _____ <b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ <b>Phone #:</b> _____ <b>Fax #:</b> _____												
<b>Financial Status and Instructions:</b> (income amount/source, healthcare coverage) _____ _____ _____ <b>DSO Prime No:</b> _____	<b>Payee or Social Security Representative:</b> <b>Name:</b> _____ <b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ <b>Phone #:</b> _____ <b>Fax #:</b> _____												
<b>Education/Vocational Needs:</b> (coursework, skills training, rehabilitation) _____ _____ _____	<b>Other Activities, Psychiatric Needs and Recommendations:</b> (physical/leisure activities, recovery/self help activities, Substance Abuse treatment) _____ _____ _____												
<b>Anticipated Problems and Recommendations:</b> (relapse prevention suggestions) _____ _____													
<b>Signatures:</b> <table border="0" style="width:100%"> <tr> <td style="width:33%">_____</td> <td style="width:33%">_____</td> <td style="width:33%">_____</td> </tr> <tr> <td align="center">Patient (or Responsible Person)</td> <td align="center">Social Worker</td> <td align="center">Phone Number</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td align="center">Physician (print name)</td> <td align="center">Physician</td> <td align="center">Phone Number</td> </tr> </table>		_____	_____	_____	Patient (or Responsible Person)	Social Worker	Phone Number	_____	_____	_____	Physician (print name)	Physician	Phone Number
_____	_____	_____											
Patient (or Responsible Person)	Social Worker	Phone Number											
_____	_____	_____											
Physician (print name)	Physician	Phone Number											

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**ADDRESSOGRAPH**

File: Behind Face Sheet  
 Thin: Do Not Thin  
 OSH STK: 11826 MR 6 – 07/2005  
 MR #: 59-06-0403-00

Medical Record



Department of Human Services

OREGON STATE HOSPITAL  
Interdisciplinary Treatment Care Plan Addendum  
Assessment of Community Support Needs

**Social Work Activity Summary for the Month of:**

(Note changes from Initial Psychosocial Assessment)

**Family Contact**

*Name*

*Address*

*Phone*

**Cultural Language Needs**

**Current Identification**

*Type of ID*

*Comments*

Birth Certificate ☐ Yes ☐ No

Social Security Card ☐ Yes ☐ No

Picture I.D. ☐ Yes ☐ No

Immigration Issues ☐ Yes ☐ No

**Financial Information**

Receipt VA / Railroad Retirement Funds Type: Amount:

Social Security Status Amount: Comments

Medicaid ☐ Yes ☐ No Prime Number:

Medicare ☐ Yes ☐ No Number:

Medicare Part D Enter Company Enter Number

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iling Social Work Assessment

Thinning Do not thin

MR#

Form # OSH-STK-76010 (3/09)

Page 1 of 4

**ADDRESSOGRAPH:**

IDT Addendum: After 2 months

IDT Notes: After 6 months



Department of Human Services

OREGON STATE HOSPITAL  
Interdisciplinary Treatment Care Plan Addendum  
Assessment of Community Support Needs

Financial Information

Private Insurance    Enter Private Insurance Company name    Enter number

LIS (Low Income Subsidy)    Complete: Enter Complete Date    ☐ N/A

Legal Information

☐ N/A    Guardian: Enter Guardian name    Enter Guardian Phone  
Address: Enter Guardian Address

☐ N/A    Warrants/Detainers Describe:

☐ N/A    GEI Index Offense:

☐ N/A    Attorney Name:    Enter Attorney phone

☐ N/A    Probation Officer Name:    Enter Probation Officer phone

Barriers to Discharge

Barriers	Status

Current Privileges

Discharge Status (Non PSRB)

☐ Not Ready for Discharge Enter Date

☐ Ready for Discharge Enter Date

☐ Withdrawn Enter Date

☐ Re-determined Ready Enter Date

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iling    Social Work Assessment

Thinning    Do not thin

MR#

Form #    OSH-STK-76010 (3/09)

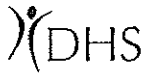
Page 2 of 4

ADDRESSOGRAPH:

IDT Addendum: After 2 months

IDT Notes: After 6 months

- -



Department of Human Services

OREGON STATE HOSPITAL  
Interdisciplinary Treatment Care Plan Addendum  
Assessment of Community Support Needs

PSRB Only

Last Hearing: Enter Date Disposition:

☐ OSH Risk Review: Enter Date Disposition:

If Patient is not ready for discharge or  
to initiate conditional release planning mark: N/A

☐ N/A Projected level of Care: ☐ Other:

☐ N/A Final Determination Level of Care: ☐ Other:

☐ N/A Developmental Disabilities Eligible: ☐ Yes ☐ No

☐ N/A Housing Referrals/Residential Evaluations/PSRB Program Referrals

☐ Accepted ☐ Denied

☐ Accepted ☐ Denied

☐ Accepted ☐ Denied

☐ Accepted ☐ Denied

☐ N/A Exceptional Barrier Referral Completed: Enter Date Enter Status

☐ N/A Community Support and Referrals

Support	Need	Prospective Provider	Referral Date	Outcome
Medication Management	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Case Management	<input type="checkbox"/> Yes <input type="checkbox"/> No			
AA/NA	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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iling Social Work Assessment  
Thinning Do not thin MR#  
Form # OSH-STK-76010 (3/09)

Page 3 of 4

ADDRESSOGRAPH:

IDT Addendum: After 2 months

IDT Notes: After 6 months

- -



Department of Human Services

OREGON STATE HOSPITAL  
Interdisciplinary Treatment Care Plan Addendum  
Assessment of Community Support Needs

Discharge			
<input type="checkbox"/> Discharge	Date: _____	<input type="checkbox"/> Pass to Discharge	Date: _____
<input type="checkbox"/> Conditional Release/Trial Visit	Date: _____		
Facility Name & Address: _____			
_____			

County of Responsibility: \_\_\_\_\_

☐ N/A County of Placement: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Date: \_\_\_\_\_

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iling Social Work Assessment  
Thinning Do not thin MR#  
Form # OSH-STK-76010 (3/09)

Page 4 of 4

ADDRESSOGRAPH:

IDT Addendum: After 2 months

IDT Notes: After 6 months

- -

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER**

**January 19, 2010**

\*NOTES: Forms found behind FRONT section are only filed there after discharge. In the main chart, the PHYSICIAN ORDER section is located behind the OTHER ASSESSMENT section. When purged to the main chart, forms in the PHYSICIAN ORDER section are filed in chronological order. From 10/1/2006 - 11/18/2007 discipline progress notes were filed under their respective discipline sections. On 11/19/2007 the discipline progress notes, except nursing services, and group progress notes were filed under the IDT/MD Note section. On 8/7/08 a new GROUP NOTE divider was added and all group notes are now filed in this section.

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
Summary Admission & Discharges	Front	Do Not Purge	
Disclosure of Protected Health Information	Front	Do Not Purge	DHS-2097
Authorization for Use & Disclosure of Information	Front	Do Not Purge	DHS-2099
Access to Record Request	Front	Do Not Purge	DHS-2093
Patient Picture	Administration	Do Not Purge	
Face Sheet	Administration	Do Not Purge	
Discharge Plan Detail	Administration	Do Not Purge	11826
Death Certificates	Administration	Do Not Purge	
Autopsy Report	Administration	Do Not Purge	
Procedure for Deceased Patient	Administration	Do Not Purge	
Failing Message	Administration	Do Not Purge	MER 0075
Disclosure of Hospitalization & Consent to Notify	Administration	Do Not Purge	03389
Authorized Visitors List - PRS GTS	Administration	Do Not Purge	75038
Admission History and Baseline Assessment - Psychiatry	Physician Assessmt	Do Not Purge	03827
Preliminary Admission History	Physician Assessmt	6 Months	75018
History & Physical Examination	Physician Assessmt	Initial and Two Annuals	12657
History & Physical Update	Physician Assessmt	Initial and Two Annuals	76008
Gynecological Exam	Physician Assessmt	Do Not Purge	76007
Abnormal Involuntary Movement Scale (AIMS)	Physician Assessmt	Current & One Previd	12221
Dysphagia Screening	Physician Assessmt	Do Not Purge	75070
Dysphagia Assessment	Physician Assessmt	Initial and Two Annuals	76013
Court Ordered Evaluation/Letter (by physician)	Physician Assessmt	3-Years	03827
Discharge Summary	Physician Assessmt	Do Not Purge	03827
Documentation Outside Medical Service	Consultations	6 Months To 2 Years	03398
Consultation Reports	Consultations	6 Months To 2 Years	
Psychology Admission Assessment	Psychology	Do Not Purge	03827
Psychology Baseline Assessment - Forensic	Psychology	Do Not Purge	03827
Court Ordered Evaluation/Letter (by psychologist)	Psychology	3 Years	03827
Psychology Reports/Evaluations	Psychology	Do Not Purge	03827
Psychology Annual Update	Psychology	2 Years	03827
Nursing Assessment	Nursing Assessment	Do Not Purge	75094
Nursing Assessment - Fall Assessment & Guidelines	Nursing Assessment	Do Not Purge	75063
Nursing Assessment - Pain Assessment	Nursing Assessment	Do Not Purge	75062
Psychosocial History/Psychosocial Assessment	Social Service	Do Not Purge	03827/76009

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER  
January 19, 2010**

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
Social Work Baseline Assessment - Forensic	Social Service	Do Not Purge	03827
Psychosocial History Update Annual	Social Service	2 Years	03827
Request for Initial 90 Day Authorization (AMH)	Social Service	Do Not Purge	
Request and Determination for Continued Stay (AMH)	Social Service	Do Not Purge	
RSD 10-Day Initial Assessment	Rehab Svcs Assess	Do Not Purge	75045
RSD Baseline Assessment - Forensic	Rehab Svcs Assess	Do Not Purge	03827
RSD Recreation Therapy Functional Assessment	Rehab Svcs Assess	Do Not Purge	75072
OT Assessment	Rehab Svcs Assess	Do Not Purge	03827
Physical Therapy Assessment	Rehab Svcs Assess	Do Not Purge	PT-0226
Physical Therapy Progress Notes	Rehab Svcs Assess	6 Months to 1 Year	10335
Dual Diagnosis Assessment	Other Assessment	Do Not Purge	03827
Food & Nutrition Services Consultation	Other Assessment	1 Year	76006
Nutrition Service Food Preference	Other Assessment	Most Current	FSO 0204
Rating Scales (BPRS, MoCA, SLUMS, etc.)	Other Assessment	Most Current	
GTS Referral Screening	Other Assessment	6 Months	75019
ATS Behavioral Risk Assessment	Other Assessment	Do Not Purge	75026
ATS Behavioral Risk Assessment Addendum	Other Assessment	Do Not Purge	75026A
GTS Behavioral Risk Assessment	Other Assessment	Do Not Purge	75095
Forensic Risk Review	Other Assessment	2 Years	Pending
Forensic Risk Review Privilege Request	Other Assessment	2 Years	75049
Forensic Risk Review Privilege(s) Granted	Other Assessment	5 Years	75050
Forensic Risk Review Discharge Planning Update	Other Assessment	2 Years	75051
Forensic Treatment Services Referral Form	Other Assessment	1 Year	FTS 0167
Speech and Language Assessment	Other Assessment	Do Not Purge	
Interpreter Service Language Proficiency Asst.	Other Assessment	1 Year	MER-0144
Polygraph Assessments	Other Assessment	1 Year	03827
Educational Assessments	Other Assessment	12 Months	
Classification Status & Reinstatement PT Privilege	Other Assessment	6 Months	
Admission Physician Order	Physician Orders	Do Not Purge	14737
Admission Medication Reconciliation	Physician Orders	Do Not Purge	75097/75097A
Physician Orders	Physician Orders	1 Year/25 Pages	14737
Physician Order Life Sustaining Treatment(POLST)	Physician Orders	Do Not Purge	
IDT Problem/Strength List	IDT/MD Notes	Per Treatment Team	13720
IDT Initial Treatment Plan/Nursing Care Plan	IDT/MD Notes	6 Months	04101
IDT Initial Nursing Care Plan	IDT/MD Notes	6 Months	75091
IDT Treatment & Care Plan	IDT/MD Notes	Per Treatment Team	10647
IDT - Assessment of Community Support Needs	IDT/MD Notes	6 months	Pending
IDT Treatment & Care Plan Addendum	IDT/MD Notes	Per Treatment Team	04403
IDT Nursing Emergent Care Addendum	IDT/MD Notes	Per Treatment Team	00073
Patient Education Assessment Summary	IDT/MD Notes	Do Not Purge	75065
IDT Diagnosis, Discharge and Signature	IDT/MD Notes	Per Treatment Team	04413
IDT Treatment & Care Plan Review Date Index	IDT/MD Notes	Per Treatment Team	04492
My Relapse Prevention Plan	IDT/MD Notes	Do Not Purge	75098
Interdisciplinary Annual Review (IAR)	IDT/MD Notes	2 Years	03827
IAR - Patient Input Form	IDT/MD Notes	2 Years	75055/75057

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER  
January 19, 2010**

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
IDT Treatment Team/Physician Progress Record (See Note p.1)	IDT/MD Notes	1 Year	03837/76002
Physician's Hospital Transfer Note	IDT/MD Notes	1 Year	05810
Emergency Seclusion or Restraint Review	IDT/MD Notes	1 Year	75061
Information & Progress Note - Emergency Administration of Significant Procedure Without Informed Consent (Form #4)	IDT/MD Notes	6 - 12 Months	04341
Contracts - Awards/Behavior/Phone/Others	IDT/MD Notes	Per Treatment Team	
Plans - Personal Improvement/S-R/Other	IDT/MD Notes	Per Treatment Team	
Group Notes (Handwritten/Typed)	Group Note	6 months	03837/75057
RSD Monthly Summary	Group Note	6 months	75079
VSD Monthly Summary	Group Note	6 months	
Admission Progress Record	Progress Record	Do Not Purge	10796
Progress Record (Lined/Unlined)	Progress Record	6 Months	10335/75017
Emergency Seclusion or Restraint Entry Note	Progress Record	6 Months	03828
Emergency Seclusion or Restraint Flowsheet	Progress Record	6 Months	75042
Safety Devices-Documetation - Not listed on TCP	Progress Record	6 Months	75076
Nursing Assessmt-Intraward Transfer(Data Base IV)	Progress Record	6 Months	75031
Nursing Assessment-Inter Unit Transfer-Medical Unit	Progress Record	6	
Nursing Assessment Transfer/Disch - Emergency (Data Base V)	Progress Record	6 Months	75047
Nursing Assessment Transfer/Disch Planned (Data Base VI)	Progress Record	6 Months	75015
Nursing Assessment: Intra Unit Transfer	Progress Record	6 Months	76000
Patient Statement	Progress Record	6 Months	75015
Nursing Assessment - Discharge Assessment & Instructions (Data Base VII)	Progress Record	6 Months	00108
MAR Routine	Flow Sheets	3-6 Months	13713 C
MAR PRN/STAT/ONE-TIME ONLY	Flow Sheets	3-6 Months	03319
MAR Nursing PRN Notes Supplemental	Flow Sheets	3-6 Months	03329
MAR Treatment	Flow Sheets	3-6 Months	05705 C
MAR Diabetic	Flow Sheets	3-6 Months	75037 A&C
MAR Diabetic Form B	Flow Sheets	3-6 Months	75036
Monthly MAR/TAR/PRN/D-MAR Signature Verification	Flow Sheets	3-6 Months	76018
Behavioral Precautions Flow Sheet	Flow Sheets	3-6 Months	75048
Safety Devices Documentation Listed on TCP	Flow Sheets	1 Month	75075
Safety Devices Doc. Listed on TCP Meals Only	Flow Sheets	1 Month	75077
Clozapine Side Effect Monitoring	Flow Sheets	6 Months	00092
Skin Care Record	Flow Sheets	6 Months	00109
Multipurpose Flow Sheet	Flow Sheets	3 Months	11737
Intake/Output Flowsheet	Flow Sheets	3 Months	0161
Vital Signs & Height/Weight Record	Flow Sheets	3 Months	75081
Patient Computer Ed. Time Spent Flow Sheet	Flow Sheets	3 Months	
TB Surveillance Profile	Diagnostic Test	Do Not Purge	03673

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER**

January 19, 2010

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
Immunization Record	Diagnostic Test	Do Not Purge	03663
Diagnostic Test Index	Diagnostic Test	Do Not Purge	11592
Critical Lab Values Communication Log	Diagnostic Test	Do Not Purge	75096
Laboratory Reports - Bacteriology/Microbiology	Diagnostic Test	Per Treatment Team	75014
Laboratory Reports - Chemistry	Diagnostic Test	Per Treatment Team	75009
Laboratory Reports - Hematology	Diagnostic Test	Per Treatment Team	75010
Laboratory Reports - Misc.	Diagnostic Test	Per Treatment Team	75011
Laboratory Reports - Serology - Thyroid Test	Diagnostic Test	Per Treatment Team	75016
Laboratory Reports - Therapeutic Drug Level	Diagnostic Test	Per Treatment Team	75012
Laboratory Reports - Urinalysis	Diagnostic Test	Per Treatment Team	75013
Outside Laboratory Reports	Diagnostic Test	Per Treatment Team	
X-Ray Reports	Diagnostic Test	As Needed	12603
EKG Reports	Diagnostic Test	2 Years	
Pathology Reports	Diagnostic Test	2 Years	
Eye Examination Report	Diagnostic Test	2 Years	
Dental Examination	Diagnostic Test	2 Years	
Hearing Evaluation Record School	Diagnostic Test	2 Years	
Audiometric Evaluation Record	Diagnostic Test	Current and One Pre	75008
IC Treatment with Psychoactive Meds (Form #1)	Informed Consent	Current	04351
IC Treatment with Psychoactive Meds (Form #1A)	Informed Consent	Current	
IC Physician Statement Regarding Capacity (1B)	Informed Consent	Current	
IC Independent Consultation/Good Cause (Form #2)	Informed Consent	Current	04371
IC Involuntary Admin Significant Procedure Committed Patient Good Cause (Form #3)	Informed Consent	Current	12317
Medication Educator Note	Informed Consent	6 Months	75017
Medication Administrative Hearing-Final Order	Informed Consent	Current	
IC - Information & Progress note Emergency Admin Significant Procedure (Form #4)	Informed Consent	6 Months	04341
IC Voluntary and Hospital Holds (Form #5)	Informed Consent	Current	04842
IC Psychoactive Meds for Vol., HH, (Form #5A)	Informed Consent	Current	04862
IC Electrotherapy (Form #6)	Informed Consent	Current	04331
IC For Treatment with Significant Procedure (Form #7)	Informed Consent	1 Year	04381
IC For HIV Testing - Competent (Form #8)	Informed Consent	Do Not Purge	75005
IC For HIV Testing - Incompetent (Form #9)	Informed Consent	1 Year	75006
IC For Use of Substance for Pain (Form #10)	Informed Consent	Per Treatment Team	75092
HIV Test Initiation	Informed Consent	1 Year	75043
IC Influenza Immunization	Informed Consent	1 Year	75089
Hepatitis "A" Immunization Consent	Informed Consent	1 Year	
Hepatitis "B" Surface Antibody Test	Informed Consent	1 Year	
IC Immunization Polio, MMR, DPT, etc.	Informed Consent	1 Year	
IC Pneumococcal Immunization	Informed Consent	Do Not Purge	
Audio Visual Authorization	Informed Consent	6 Months	75068
Pastoral Services Consent	Informed Consent	Do Not Purge	75041
Authorization For Use and Disclosure of Information	Informed Consent	6 Months	DHS-2099
Access to Record Request	Informed Consent	6 Months	DHS-2093
Statement of Confidentiality for Attorneys	Informed Consent	6 Months	75066
Disclosure of Protected Health Information (PHI)	Informed Consent	Do Not Purge	DHS-2097

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER  
January 19, 2010**

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
Personal Property - Clothing Stored on Ward	Property/Financial	Per Form	11653
Personal Property Small Storage Stored Off Ward	Property/Financial	Do Not Purge	05755
Personal Property Large Storage Stored Off Ward	Property/Financial	Do Not Purge	75053
Release of Personal Property	Property/Financial	3 Months	11797
Billing Collections Notification Letters	Property/Financial+	3 Months	
Social Security Information	Property/Financial+	3 Months	
Tax Statement	Property/Financial+	6 Months	
An Important Message From Medicare - English	Property/Financial	6 Months	75074
An Important Message From Medicare - Spanish	Property/Financial	Do Not Purge	75074-SP
Consent To Withdrawal Funds From Patient Trust	Property/Financial+	6 Months	12326
Request Reimbursement Reduction of Cost of Care	Property/Financial+	6 Months	
Purchase of Outside Medical Services	Property/Financial+	6 Months	09710
Med Referral For Financial/Placement Services	Property/Financial	6 Months	MED0028
Trust Account Application	Property/Financial+	Do Not Purge	11988
Commitment Papers (Date Order) Civil/Criminal	Legal	When Expired	
Notification of Mental Illness	Legal	6 Months	MER-0080
Hospital Hold Warning Notice	Legal	3 Months	CMO0061
Application for Voluntary Admission	Legal	Do Not Purge	12193
Conditions of Trial Visit	Legal	Do Not Purge	
Order Transferring Jurisdiction	Legal	Do Not Purge	
Transfers of Committed Person from Oregon State Hospital	Legal	Do Not Purge	
PSRB Hearing/Conditional Release Plan	Legal	Do Not Purge	
Against Medical Advice	Legal	Do Not Purge	
Guardian/Legal Representative Papers	Legal	Do Not Purge	
PSRB Sex Offender Registration Obligation Notific.	Legal	Do Not Purge	
Self Determination Act	Legal	Do Not Purge	75040
Philosophy on Use of Seclusion & Restraints	Legal	Do Not Purge	75060
Notice of Privacy Practices-Acknowledgment	Legal	Do Not Purge	DHS 2092
Patient Rights and Notice of Privacy Practices	Legal	Do Not Purge	03653
Patient Rights - Forensic Psychiatric Services Miranda Rights	Legal	Do Not Purge	
Patient Rights - Residential Treatment Services	Legal	Do Not Purge	70585
Patient & Family Responsibilities	Legal	6 Months	75080
Detainers	Legal	Do Not Purge	
72-Hour Release Form	Legal	3 Months	
Amendment of Health Records Request	Legal	6 Months	DHS-2094
Restriction of Use and Disclosure	Legal	6 Months	DHS-2095
Authorization to Withhold Resuscitation	Legal	Do Not Purge	
Living Will	Legal	Do Not Purge	
Making Health Care Decisions	Legal	Do Not Purge	19960
Off Ground Supervision Agreement	Legal	3 Months	04416
Self-Pass Agreement - PRS	Legal	3 Months	75084
Reporting of Child/Sexual Abuse	Legal	Do Not Purge	MER-0052
Review of Policy	Legal	Do Not Purge	MER-0077
Unauthorized Leave Information	Legal	Do Not Purge	75003
DMV Reports	Legal+	Do Not Purge	

**OREGON STATE HOSPITAL  
MEDICAL RECORD ORDER  
January 19, 2010**

FORM NAME	SECTION	PURGE TIME LINE	OSH STK #
LEDS Reports	Legal+	Do Not Purge	
Victim Notification Form	Legal	Do Not Purge	
Arson Report	Legal	Do Not Purge	
Visitor Approval Letters - Forensic	Legal		
Reports From Other Facilities (Dated Prior to Admission or Post Discharge)	Correspondence	1 to 6 Months	
Emergency Room Aftercare Instruction	Correspondence	1 to 6 Months	
Letter Received Regarding Patients	Correspondence	1 to 6 Months	
Letter/Notes Written by Patient	Correspondence	1 to 6 Months	
Letter by OSH Staff Regarding Patient	Correspondence	3 Months	
Police Reports	Correspondence	6 Months	
Notice of Independent Examination	Correspondence	1 to 6 Months	03686
Arson Report	Correspondence	Do Not Purge	
+Removed - Not Retained Post Discharge			
List of Purged Documents	All Sections Purged	Do Not Purge	75021

## Meeting Notes

### SEIU Labor – Management Meeting – May 24, 2010

**Attending:** Nena Strickland, Interim Superintendent-Admin; Nancy Frantz-Geddes, DNS Admin; Cheryl Miller, HR; Brant Johnson, SEIU-48B; Kerry Reichiro, SEIU-Med Clinic; Donna Glathar, SEIU503; Randy Davis, SEIU-Cottages; Mesme Tomason, ADNS Admin; Nancy Griffith, PRS Admin; Kathy Deacon, CNO-Admin; Lee Orton, SEIU-POSH; Kevin Richey, SEIU-POSH; Laurie Robertson, SEIU-POSH; Jeff Hodson, SEIU-48B; and Doris Reyes, Admin.

**Excused:**

**Also Attending:**

Topic	Key Discussion Points	Action/Information	Responsible Persons	Due Date
-------	-----------------------	--------------------	---------------------	----------

PRELIMINARY ADMISSION HISTORY

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Identifying Data: \_\_\_\_\_

\_\_\_\_\_

Chief Complaint: \_\_\_\_\_

\_\_\_\_\_

History of Present Illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past Psychiatric History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug and Alcohol History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assets: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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ADDRESSOGRAPH

File:  
 White: Physician Assessment  
 Yellow: Send to Medical Record Services  
 Thin: Six Months  
 OSH STK: 75018-MR 3-11/2008  
 MR#: 65002-0050-00

# OREGON STATE HOSPITAL PHYSICIAN'S ORDERS

ALLERGY AND MEDICATION SENSITIVITY FORMATION	(TRANSFER THESE SENSITIVITIES TO EACH NEW ORDER SHEET)		SEND DUPLICATES TO APPROPRIATE DEPARTMENT	PROB. # ▽
	1.	3.		
	2.	4.		
	DATE & TIME			
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)	ADMIT ORDERS:			
	Admit to 50H			
	Diagnosis:			
	Axis I:			
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)	Axis II:	NURSE	DATE & TIME	
	Axis III:			
	Allergies:			
	Diet:			
	Restrict to Unit for 72 hours			
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)	Vital signs BID for 3 days then routine if stable			
	Routine Admit Labs			
	EKG	NURSE	DATE & TIME	
	CXR			
	Urine Drug Screen			
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)	Medication of Serum Levels of:			
	Routine admit physical exam			
	STRs for all patient movement outside secure			
	perimeter (including off grounds appointments)			
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)				
WARD:  For Verbal or Telephone Orders, the complete order was read back to verify accuracy. (Initial when completed)				

Oregon State Hospital  
Admission Medication Reconciliation  
Physician's Orders

## Medication Inventory

Source of Information (check all that apply):

Page 1 of     

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Patient               | <input type="checkbox"/> Transfer Facility | <input type="checkbox"/> Pharmacy      | <input type="checkbox"/> Family          |
| <input type="checkbox"/> Medication Containers | <input type="checkbox"/> Jail/Corrections  | <input type="checkbox"/> Provided List | <input type="checkbox"/> Doctor's Office |
| <input type="checkbox"/> Other: _____          |  |  |  |

## ALLERGIES: \_\_\_\_\_

☐ No Pre-Admission Medications

<b>Physician Medication Orders</b> On Admission Check Only One Box Per Medication listed			<b>Pre-Admission and Admission Medications</b> List all of the patient's medications prior to admission including OTC and herbal supplements				
Discontinue	Continue	New Order	Medication Name	Dose	Route	Frequency	Last Taken Date/Time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Medications brought with patient:

☐ Yes    ☐ No☐ Sent Home

Date/Time: \_\_\_\_\_

☐ Sent to Pharmacy

Date/Time: \_\_\_\_\_

To list additional pre-admission/  
new medication orders, use  
order continuation form.  
# 75097A

RN Signature \_\_\_\_\_

Date/Time \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date/Time \_\_\_\_\_

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ADDRESSOGRAPH

File: PHYSICIANS ORDERS  
 Thin: DO NOT THIN  
 Form #: 75097 / 04-2007  
 MR #: 65-01-0070  
 Distribution: Original: Patient Chart  
 Copy: Pharmacy

# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

DATE (Include Year):

--	--	--	--	--	--	--	--	--	--

## DYSKINESIA SYMPTOMS

1. Muscles of facial expression									
2. Lips and perioral area									
3. Jaw									
4. Tongue									
5. Upper (arms, wrists, hands, fingers)									
6. Lower (legs, knees, ankles, toes)									
7. Neck, shoulders, torso, hips									
TOTAL - Movement Ratings									
GLOBAL JUDGEMENTS									
Severity of Abnormal Movements									

## EXTRAPYRAMIDAL AND OTHER SYMPTOMS

1. Rigidity									
2. Tremor									
3. Bradykinesia									
4. Akathisia									

## DENTAL PROBLEMS

1. Current problems with teeth and/or dentures	No = 0 Yes = 1								
2. Does patient usually wear dentures?	No = 0 Yes = 1								
SIGNATURE OF RATER:									

FOR EACH ITEM, RATE HIGHEST SEVERITY OBSERVED:

(Instructions on Reverse Side)

CODES: 0 - None 1 - Minimal 2 - Mild 3 - Moderate 4 - Severe

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ADDRESSOGRAPH

## EXAMINATION PROCEDURE

Either before or after completing the examination procedure, observe the patient unobtrusively, at rest (e.g., in waiting room).

The chair to be used in this examination should be a hard, firm, and without arms.

---

1. Ask the patient whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is, to remove it.
2. Ask the patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient now?
3. Ask patient whether he/she notices any movements in mouth, face, hand, or feet. If yes, ask to describe and to what extent they currently bother the patient or interfere with his/her activities.
4. Have the patient sit in a chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position.)
5. Ask the patient to sit with hands unsupported. If male, between legs; if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
6. Ask the patient to open mouth. (Observe tongue at rest within mouth.)  
Do this twice.
7. Ask the patient to protrude tongue. (Observe abnormalities of tongue movement.)  
Do this twice.
8. Ask the patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend patient's left and right arms (one at a time). (Note any rigidity and rate.)
10. Ask the patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)
12. Have the patient walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

**INFORMED CONSENT FOR COMPETENT PATIENT  
OR PATIENT WITH GUARDIAN****Treatment with Psychoactive Medications/Significant Procedure**

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT THOROUGHLY, DISCUSSED THE MATERIAL WITH YOUR PHYSICIAN, AND HAVE ALL THE INFORMATION THAT YOU DESIRE.

All of the following have been explained to me to my satisfaction by Dr. \_\_\_\_\_

The nature and seriousness of my mental condition. The diagnosis is \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The target symptoms for treatment with medication/significant procedure are \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The proposed medication(s) with dosage range: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication(s) may be given by mouth or injection on a daily basis or as necessary. The physician has explained the above medication(s) to me, the amounts to be given, how often I will receive them and the possibility of taking more.

Psychoactive medications have been used for a long time and are known to be effective. The exact reason for the effectiveness of psychoactive medications has not been clearly established; however, the effects appear to be related to their alteration of certain chemical processes within the brain.

Psychoactive medications have potential side effects in many systems of the body. Most of the side effects are minor and reversible. However, in some cases, adverse reactions are serious and may not be reversible, such as tardive dyskinesia, a movement disorder which may be permanent. Tardive dyskinesia is involuntary movement of the mouth, tongue, limbs, body, or hands and feet for which no effective treatment is available at this time. I also

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**ADDRESSOGRAPH**

File      Original: Informed Consent  
            Copy: Quality Improvement  
            Copy: Patient or Legal Guardian  
Thin:     One Year  
Form #    OSH-STK 04351 MR-6 11/2007

understand that the continuous use of these medications may hide or worsen symptoms of tardive dyskinesia. The symptoms may not appear until the medication is withdrawn. I understand that I should promptly notify my doctor or another member of the staff if there are any unexpected changes in my condition. Certain psychoactive medications may result in metabolic disorders such as hyperlipidemia and diabetes, which may impact your health. Such medications are known to have less significant or rare side effects. Details are described in the attached medication literature.

Certain medications have the potential for being addictive and may produce serious withdrawal symptoms.  
☐ Does apply. ☐ Does not apply.

Certain medications have the potential for the side effects of tardive dyskinesia.  
☐ Does apply. ☐ Does not apply.

Certain medications have the potential for resulting in metabolic disorder such as hyperlipidemia and diabetes.  
☐ Does apply. ☐ Does not apply.

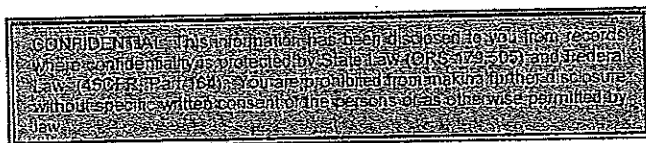
Other less significant or rare side effects are listed on the medication information sheet provided to you.

The improvement associated with psychoactive medications may be permanent or temporary. The medications will not cure the illness, but usually will help control some of the more disabling symptoms. Relapses of the illness may occur when the medication is discontinued. Without this medication, the present mental disorder may improve spontaneously, continue with little or no change for an indefinite period of time, or worsen.

Alternatives to this treatment are no treatment; psychotherapy; milieu, social, activity, and behavior therapies. These alternatives may be useful in addition to the proposed medication(s), but are not preferable because:

I have the right to accept or refuse this treatment and the right to revoke my consent for any reason at any time prior to or during treatment. This consent is being granted without threat or coercion, expressed or implied. I do understand that no guarantees or assurances have been made to me concerning the results of treatment with this medication.

I understand, in giving my approval to the recommended procedure, I am giving approval for a period of one year, unless there is substantial increase in risk of the procedure or unless I withdraw my consent. If I disapprove the recommended treatment, I understand my disapproval is for one year, unless there is deterioration in my condition.



ADDRESSOGRAPH

File Original: Informed Consent  
Copy: Quality Improvement  
Copy: Patient or Legal Guardian  
Thin: One Year  
Form # OSH-STK 04351 MR-5 11/2007

The special circumstances that apply to my case are: (Indicate "none" if there are no special circumstances).

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I certify that the information on this form was explained to the patient.

Did the patient require an interpreter? ☐ Yes ☐ No

Was an interpreter provided? ☐ Yes ☐ No

I certify that I made conscientious attempts to obtain informed consent and that the patient did have the ability to give informed consent (agreement to or refusal of the significant procedure, as the case may be).

Date

Physician's Signature

I have carefully read and understand the foregoing and hereby consent ☐ do not consent ☐ to treatment with this medication.

Date

Patient

Time

Consenting Authority

Relationship

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ADDRESSOGRAPH

File Original: Informed Consent  
Copy: Quality Improvement  
Copy: Patient or Legal Guardian  
Thin: One Year  
Form # OSH-STK 04351 MR-6 11/2007

PHYSICIAN STATEMENT REGARDING  
CAPACITY TO GIVE INFORMED CONSENT  
TO MEDICATION/SIGNIFICANT PROCEDURE

1. This individual is presently showing symptoms of a mental disorder known as \_\_\_\_\_

These symptoms are \_\_\_\_\_

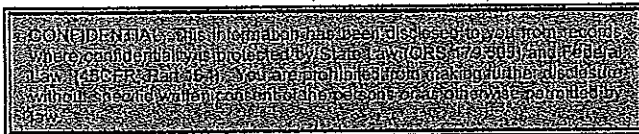
Seriousness of the disorder: \_\_\_\_\_

2. In my professional opinion, the patient would benefit from the administration of the following psychiatric medications (including dosage range)/significant procedure: \_\_\_\_\_

3. Purpose of proposed treatment: \_\_\_\_\_

4. Reasons why alternatives to this treatment are not the most appropriate (these include psychotherapy, milieu, social, activity, behavior therapies, nonmedical therapies, and no treatment): \_\_\_\_\_

5. Intended outcome of proposed treatment: \_\_\_\_\_



ADDRESSOGRAPH

6. Significant risks of the above medications at the proposed doses are (check all that apply):

☐ Tardive dyskinesia

☐ Hyperlipidemia/diabetes

☐ Blood dyscrasias

☐ Addiction

☐ Blood pressure issues

☐ Other risks: Such medications are known to have less significant or rare side effects, and are described in the attached medication literature. \_\_\_\_\_

7. Predicted medical/psychiatric consequences of not accepting the proposed medication/procedure: \_\_\_\_\_

8. Describe patient's understanding of possible benefits to proposed treatment: \_\_\_\_\_

9. Describe patient's understanding of possible risks to alternative treatment/no treatment: \_\_\_\_\_

10. Describe patient's ability to accurately describe the nature of his/her illness/condition and treatment choices: \_\_\_\_\_

11. Describe how the patient answered the question "How do you weigh the risks and benefits of recommended treatment versus alternative treatment/no treatment": \_\_\_\_\_

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ADDRESSOGRAPH

File Original: Informed Consent  
Copy: Quality Improvement  
Copy: Patient or Legal Guardian  
ThIn: One Year  
Form # OSH-STK 76001 MR-1 11/2007

12. What reason does patient give for not wanting the proposed treatment: \_\_\_\_\_

13. Describe possible mental impairments that may impact the ability to give informed consent (such as impaired attention span, impaired memory, intellectual deficits, psychosis, delirium, dementia, affective state, anxiety, or other condition): \_\_\_\_\_

14. Other observations that may be relevant: \_\_\_\_\_

15. If the patient refuses medication based on religious reasons, please describe: \_\_\_\_\_

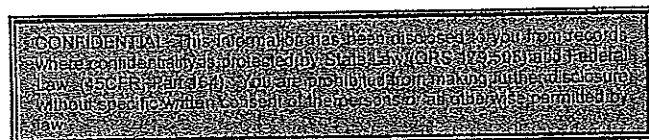
16. Did the patient require an interpreter? \_\_\_\_ Yes \_\_\_\_ No

Was an interpreter provided? \_\_\_\_ Yes \_\_\_\_ No

I certify that I made two conscientious attempts to obtain informed consent on \_\_\_\_\_ Date \_\_\_\_\_ and \_\_\_\_\_ Date \_\_\_\_\_, and in my opinion, the patient did not have the ability to give informed consent.

Date

Physician's Signature



ADDRESSOGRAPH

File Original: Informed Consent  
Copy: Quality Improvement  
Copy: Patient or Legal Guardian  
Thin: One Year  
Form # OSH-STK 76001 MR-1 11/2007

OREGON STATE HOSPITAL

HIV TEST  
INITIATION FORM

HIV screening is recommended for everyone age 18 and over admitted to Oregon State Hospital.

<b>Reason for Testing: Please check one</b>	
<input type="checkbox"/>	Part of diagnostic workup of signs or symptoms suggestive of HIV disease.
<input type="checkbox"/>	Self-initiated and asymptomatic
<input type="checkbox"/>	Test requested according to OSH policy
<input type="checkbox"/>	Occupational exposure
<input type="checkbox"/>	Other: Specify _____
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> American Indian/Alaskan Native	
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Previous HIV Test Status: Check One</b>	
<input type="checkbox"/>	No previous test
<input type="checkbox"/>	Previous test negative
<input type="checkbox"/>	Previous test positive
<input type="checkbox"/>	Unknown
<b>Name of</b> _____	
<b>Practitioner ordering test:</b> _____	<b>Date:</b> _____

Check all applicable boxes before forwarding to laboratory.

- ☐ Pre-test counseling completed
- ☐ Patient Consent Obtained
- ☐ Orders Written in Chart
- ☐ Forward the pink copy of this form to Laboratory

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Unit: \_\_\_\_\_

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ADDRESSOGRAPH

Original: Informed Consent  
Pink: Laboratory  
Thin: 12 Months  
Form #: 75043-MR 5-02/2009

OREGON STATE HOSPITAL

INFORMATION ON HIV INFECTION

TO BE DISTRIBUTED TO PATIENTS  
AFTER ADMISSION AND WHENEVER HIV EDUCATION IS GIVEN  
(HIV EDUCATION IS RECOMMENDED YEARLY)

WHAT IS HIV INFECTION?

Human Immune Virus (HIV) infection is a serious, fatal illness. HIV infection is due to a virus which causes a breakdown in the body's immune system, making a person especially prone to infections and other health problems. At this time, there is no recognized vaccine or cure for this infection though medications such as Zidovudine (AZT) and others can help to prolong life.

WHO GETS HIV INFECTION AND HOW?

Anybody can get HIV infection. Homosexual or bisexual men and IV drug users are at high risk of developing HIV infection. The infection is increasing within minority groups, women, and teenagers.

The body substances which are known to transmit HIV infection are blood, semen, vaginal secretions, and in a few cases, breast milk.

You can get this disease through:

Intimate sexual contact when your partner has the disease.

Sharing needles/syringes with a person who has HIV infection, or a needle stick from a dirty needle used by an HIV infected person.

Transfusion of HIV contaminated blood.

Passage of HIV infection from a woman to her unborn or newborn child.

Wounds, broken skin or mucous membranes contaminated with blood, semen, or vaginal secretions from an infected person.

WHAT CAN YOU EXPECT WHEN YOU HAVE HIV INFECTION?

The course of HIV infection is different from person to person. However, in the first months of the disease, persons may have a flu-like illness which can last for up to two weeks and then stops. Once infected, a person may not have any health problems for years. Once infected, a person will continue to be infectious and can pass the infection on to others. Acquired Immunodeficiency Disease (AIDS) is the last stage of HIV infection when people are very ill with multiple infections and other problems. HIV infected persons may live for years (ten years is the average) before developing AIDS; during this period, they can give the disease to others by methods listed above.

**WHAT ARE OTHER IMPORTANT SEXUALLY TRANSMITTED DISEASES?**

Syphilis, Gonorrhea, Hepatitis B, Herpes and Chlamydia are serious infectious diseases which are caused through sexual contact when you or your partner has any of the infections. Ask to see the book, "Control of Communicable Diseases in Man," which should be on your ward if you are interested in knowing more about these or other sexually transmitted diseases, or ask the doctor or nurses on your ward.

**WHAT IS AN ACCIDENTAL EXPOSURE AND HOW DO YOU REPORT IT?**

An accidental exposure is an exposure to HIV or Hepatitis B infections which you might have in the hospital. If you have an accidental exposure, there is a slight chance that you can get these diseases.

Learn what accidental exposures are (following) and use caution so that they do not happen to you. You should not come in contact with the body substances of other people.

Accidental exposures which you might have at Oregon State Hospital include:

**- For HIV and Hepatitis B infections:**

- Used needle stick or used sharp instrument cut.
- Wound, broken skin, or mucous membrane contact with blood.
- Skin contact with large amounts of blood, or prolonged contact with blood.
- Wound, broken skin, or mucous membrane contact with other body substances when blood is visible.

**- For Hepatitis B infection only:**

- Bite when the skin is broken.
- Spit to the eye, mouth, or mucous membrane.
- Wound or broken skin contact with saliva.

If you have one of the above accidental exposures, you need to tell the nurse and ask whether you should have your blood tested. Testing will help you to find out if you have HIV or Hepatitis B infections, as a result of the accidental exposure.

Sexual contact is prohibited at OSH for the safety of all patients. If you should have sexual contact, including intercourse, you risk getting HIV or Hepatitis B, as well as other infections. Do not have sex, but if you do, report it so that blood testing can be considered to see if you develop HIV and Hepatitis B infections; remember, reporting sex is to your advantage.

## OREGON STATE HOSPITAL

Department of Human Services

## INFORMED CONSENT FOR TESTING HIV ANTIBODIES FOR COMPETENT PATIENT OR PATIENT WITH GUARDIAN

### BACKGROUND

Acquired Immodeficiency Syndrome (AIDS) is a life threatening disorder of the immune system. It is caused by a virus called HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous (IV) drug use or in the past; as a result of blood transfusion ) or from an infected mother to her newborn infant. Persons at high risk of AIDS include males who have had sexual contact with another male, IV drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected.

Persons who have a history of high-risk behaviors should change those behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important behaviors should change to include safer sex practices (including abstinence, monogamy, or condom use for sexual contact with someone other than a long-term, strictly monogamous partner) and not sharing needles.

### THE HIV TEST

Before consenting to an HIV Test, PLEASE read the following information:

1. Purpose: This test is being done to determine whether you may have been infected with HIV. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. Positive test results. If your test is positive, you may be infected with HIV
3. Accuracy: The result is not 100% accurate. Possible errors include:
  - a. False positives: The test gives a positive result even though you are not infected. This happens only rarely and is more common in persons who have engaged in high-risk behaviors. Retesting should be done to confirm the validity of a positive test.
  - b. False negatives: This test gives a negative result even though you are infected with HIV. This is most likely to happen in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

### ALTERNATIVES TO THE HIV TEST

There are no others ways to assess the presence of HIV except for this test. Failure to have it done may result in a delay in initiating a proper diagnosis.

### RISK FROM HAVING THE HIV TEST

The major risk of an HIV test is the result of venipuncture (inserting a needle into the vein to obtain a blood sample). A positive test may result in uninsurability for life, health, or disability insurance policies

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ADDRESSOGRAPH

File: Original -- Informed Consent Section  
 Yellow -- Medical Record Services  
 Pink -- Patient or Legal Guardian  
 Thin: 12 Months  
 Form # OSH-STK 75005-MR 4-04/2006  
 MR # 65-13-0033-12

## OREGON STATE HOSPITAL

Department of Human Services

for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result from disclosure of a positive test result.

The fact that you have had an HIV test and the test result themselves are confidential, except where you have authorized the disclosure, or where the disclosure is otherwise required or permitted by OREGON law. You should make certain whether you are being asked to give authorization for others to have this information and, if so, who those others might be.

### YOU HAVE THE RIGHT TO ASK QUESTIONS AND OBTAIN FURTHER INFORMATION

If you have any questions relating to AIDS, the HIV test and the consequences of being tested, you are entitled to answers to these questions by the person offering the test or other knowledgeable person before you agree to testing.

### OTHER SOURCES OF INFORMATION

For more information about AIDS and the HIV test, you may call your local health department. You may also call the AIDS hotline at 223-AIDS if calling from the Portland Metropolitan area, or 1-800-777-AIDS if calling from outside the Portland Metropolitan area.

### DOCUMENTATION OF INFORMED CONSENT

I have read the above information and it has been orally summarized for me. My signature indicates that:

- I understand the information about AIDS and the HIV test that has been given to me;
- I have been given full opportunity to ask questions to obtain further information;
- All of my questions have been answered to my satisfaction;
- I have no further questions;
- I give my permission to Oregon State Hospital and agents thereof to perform and receive the results of an HIV test of my blood to detect whether I may have been infected by HIV;
- I authorize the above-named persons and those permitted by Oregon Law to receive the test results and the following persons who have been identified to me (names) to receive results.

If none, specify "None" -----

Date Signature of Patient

Date Signature of Parent or Guardian, if applicable

Date Signature of Person Obtaining Consent Print Name

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### ADDRESSOGRAPH

File: Original -- Informed Consent Section  
 Yellow -- Medical Record Services  
 Pink -- Patient or Legal Guardian  
 Thin: 12 Months  
 Form # OSH-STK 75005-MR 4-04/2006  
 MR # 65-13-0033-12

**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**HOSPITAL ADMISSION PHYSICAL EXAMINATION      USUAL TIME**

- |  |                   |       |
|--|-------------------|-------|
| <input type="checkbox"/> Decision making straight forward or of low complexity ..... | (30 minutes)..... | 99221 |
| <input type="checkbox"/> Decision making of moderate complexity.....                 | (50 minutes)..... | 99222 |
| <input type="checkbox"/> Decision making of high complexity.....                     | (70 minutes)..... | 99223 |

**SUBSEQUENT MEDICAL E & M SERVICES**

- |  |                        |       |
|--|------------------------|-------|
| <input type="checkbox"/> History taken or exam given problem focused<br>Decision making straight forward or of low complexity..... | (15 minutes).....      | 99231 |
| <input type="checkbox"/> History taken or exam given expanded problem focused<br>Decision making of moderate complexity.....       | (25 minutes).....      | 99232 |
| <input type="checkbox"/> History taken or exam given detailed<br>Decision making of high complexity.....                           | (35 minutes).....      | 99233 |
| <input type="checkbox"/> Discharge Services.....   | (30 minutes or less).. | 99238 |
| <input type="checkbox"/> Discharge Services.....   | (over 30 minutes)..... | 99239 |

**\*\*\*ALSO USE THE PROLONGED SERVICE CODES BELOW IF SERVICE EXCEEDS THE USUAL TIME\*\*\***

**OTHER SERVICES – EXPLAIN**

Describe: \_\_\_\_\_

**Required Information:** List all medical diagnoses that pertain to the medical services rendered. (No abbreviations)

**ICD.9 CM  
CODES**

Primary Medical Dx: \_\_\_\_\_

Secondary Medical Dx: \_\_\_\_\_

Additional Medical Dx: \_\_\_\_\_

**COUNSELING & COORDINATION OF CARE SERVICES**

**\*\*\*CHECK ONE BOX HERE FOR SERVICE PROVIDED AND (SEE \* BELOW)\*\*\***

- |   |  |
|---|--|
| <input type="checkbox"/> Interview patient for informed consent                         | <input type="checkbox"/> Work with patient and community providers |
| <input type="checkbox"/> Interview patient for side effects of medication               | <input type="checkbox"/> IDT meeting with the patient present      |
| <input type="checkbox"/> Interview patient for master treatment planning                | <input type="checkbox"/> Counseling the patient                    |
| <input type="checkbox"/> Interview patient for suicide eval. & precautions              | <input type="checkbox"/> AIMS testing                              |
| <input type="checkbox"/> Work with patient and others regarding seclusion and restraint | <input type="checkbox"/> Brief psychiatric rating scales           |

**\*CHECK ONE BOX BELOW FOR TIME SPENT.**

- |  |  |
|--|--|
| <input type="checkbox"/> 15 minutes    99231 | ***For service in this section, include both time spent with the patient and           |
| <input type="checkbox"/> 25 minutes    99232 | ***the time spent with others coordinating care. Use <u>Prolonged Service Code</u> for |
| <input type="checkbox"/> 35 minutes    99233 | ***services longer than 35 minutes in a single day.                                    |

**PROLONGED E & M SERVICES**

**FACE-TO-FACE WITH PATIENT**

**COORDINATION OF CARE**

First Full Hour Beyond the Usual Time \_\_\_\_\_ 99356 \_\_\_\_\_ 99358

Full Half Hour Beyond the First Hour \_\_\_\_\_ 99357 \_\_\_\_\_ 99359

X \_\_\_\_\_ (Indicate the Number of Full Half-Hours)

(MUST BE COMPLETED)

Patient Name: \_\_\_\_\_ Provider's Signature \_\_\_\_\_

Case # \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX: \_\_\_\_\_

OSH STK 75030 MR - 3 - 2/2006

PAGE 1

Supervising Physician Signature

**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**PSYCHIATRIC AND PSYCHOLOGICAL DIAGNOSTIC ASSESSMENTS**

- |  |       |
|--|-------|
| <input type="checkbox"/> Mental Status Exam (new onset or recurring illness).....  | 90801 |
| <input type="checkbox"/> Mental Status Exam -communication aids used.....  | 90802 |
| <input type="checkbox"/> Psychological testing and results charting..... Hrs. _____ Min. _____                                   | 96101 |
| <input type="checkbox"/> Neuropsychological testing battery..... Hrs. _____ Min. _____<br>(Halstead-Reitan, Luria, WAIS-R, etc.) | 96118 |

**PSYCHOTHERAPY**

- |  | Without<br>Eval<br>& Mgmt | With<br>Eval<br>& Mgmt |
|--|---------------------------|------------------------|
| <input type="checkbox"/> Individual Psychotherapy for 20 - 30 minutes.....                             | 90816                     | 90817                  |
| <input type="checkbox"/> Individual Psychotherapy for 45 - 50 minutes.....                             | 90818                     | 90819                  |
| <input type="checkbox"/> Interactive Individual Psychotherapy-communication aids used .....(20-30 min) | 90823                     | 90824                  |
| <input type="checkbox"/> Interactive Individual Psychotherapy-communication aids used .....(45-50 min) | 90826                     | 90827                  |
| <input type="checkbox"/> Family Psychotherapy- patient was not present .....                           |                           | 90846                  |
| <input type="checkbox"/> Family Psychotherapy- patient was present.....                                |                           | 90847                  |
| <input type="checkbox"/> Group Psychotherapy.....  |                           | 90853                  |

**PSYCHIATRIC SOMATOTHERAPY**

- |   |       |
|---|-------|
| <input type="checkbox"/> Limited review of meds. with the patient for 10 minutes or less..... | M0064 |
| <input type="checkbox"/> Covering prescription, use, and review of meds with patient.....     | 90862 |
| <input type="checkbox"/> Electroconvulsive therapy (& monitoring) - single seizure.....       | 90870 |

**OTHER SERVICES - EXPLAIN**

- |  |       |
|--|-------|
| <input type="checkbox"/> Other unlisted psychiatric or psychological service or procedure..... | 90899 |
|--|-------|

Describe: \_\_\_\_\_

**CONSULTATION SERVICES**

Name of Referring  
Physician (Required) \_\_\_\_\_

**\*\*\*CHECK 1 BOX FOR THE SERVICE PROVIDED AND 1 BOX FOR THE APPLICABLE LEVEL\*\*\***

- |  |       |
|--|-------|
| <input type="checkbox"/> Initial psychiatric consultation for informed consent   |       |
| <input type="checkbox"/> Psychiatric consultation: Case review and staff conference  |       |
| <input type="checkbox"/> Neurology consultation  |       |
| <input type="checkbox"/> Level - Detailed history & exam - low complexity decision making.....   | 99253 |
| <input type="checkbox"/> Level - Comprehensive history & exam - moderate complexity decision making.....   | 99254 |
| <input type="checkbox"/> Follow-up psychiatric consultation for informed consent (same physician)<br>detailed interval history & exam - high complexity decision making..... | 99263 |

**OTHER CONSULTATION SERVICES**

**(Must be Completed)**

Patient Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Case #: \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX #: \_\_\_\_\_ Supervising Practitioner's Signature: \_\_\_\_\_

**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**HOSPITAL ADMISSION PHYSICAL EXAMINATION      USUAL TIME**

- ☐ Decision making straight forward or of low complexity .....(30 minutes)..... 99221
- ☐ Decision making of moderate complexity.....(50 minutes)..... 99222
- ☐ Decision making of high complexity.....(70 minutes)..... 99223

**SUBSEQUENT MEDICAL E & M SERVICES**

- ☐ History taken or exam given problem focused  
Decision making straight forward or of low complexity..... (15 minutes)..... 99231
- ☐ History taken or exam given expanded problem focused  
Decision making of moderate complexity.....(25 minutes)..... 99232
- ☐ History taken or exam given detailed  
Decision making of high complexity.....(35 minutes)..... 99233
- ☐ Discharge Services..... (30 minutes or less).. 99238
- ☐ Discharge Services..... (over 30 minutes)..... 99239

**\*\*\*ALSO USE THE PROLONGED SERVICE CODES BELOW IF SERVICE EXCEEDS THE USUAL TIME\*\*\***

**OTHER SERVICES – EXPLAIN**

Describe: \_\_\_\_\_

**Required Information:** List all medical diagnoses that pertain to the medical services rendered. (No abbreviations)

**ICD.9 CM  
CODES**

Primary Medical Dx: \_\_\_\_\_

Secondary Medical Dx: \_\_\_\_\_

Additional Medical Dx: \_\_\_\_\_

**COUNSELING & COORDINATION OF CARE SERVICES**

**\*\*\*CHECK ONE BOX HERE FOR SERVICE PROVIDED AND (SEE \* BELOW)\*\*\***

- ☐ Interview patient for informed consent
- ☐ Interview patient for side effects of medication
- ☐ Interview patient for master treatment planning
- ☐ Interview patient for suicide eval. & precautions
- ☐ Work with patient and others regarding seclusion and restraint
- ☐ Work with patient and community providers
- ☐ IDT meeting with the patient present
- ☐ Counseling the patient
- ☐ AIMS testing
- ☐ Brief psychiatric rating scales

**\*CHECK ONE BOX BELOW FOR TIME SPENT.**

- ☐ 15 minutes 99231      \*\*\*For service in this section, include both time spent with the patient and
- ☐ 25 minutes 99232      \*\*\*the time spent with others coordinating care. Use Prolonged Service Code for
- ☐ 35 minutes 99233      \*\*\*services longer than 35 minutes in a single day.

**PROLONGED E & M SERVICES**

**FACE-TO-FACE WITH PATIENT**

**COORDINATION OF CARE**

First Full Hour Beyond the Usual Time \_\_\_\_\_ 99356 \_\_\_\_\_ 99358

Full Half Hour Beyond the First Hour \_\_\_\_\_ 99357 \_\_\_\_\_ 99359

X \_\_\_\_\_ (Indicate the Number of Full Half-Hours)

**(MUST BE COMPLETED)**

Patient Name: \_\_\_\_\_ Provider's Signature \_\_\_\_\_

Case # \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX: \_\_\_\_\_

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PAGE 1

Supervising Physician Signature \_\_\_\_\_

**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**PSYCHIATRIC AND PSYCHOLOGICAL DIAGNOSTIC ASSESSMENTS**

- |  |       |
|--|-------|
| <input type="checkbox"/> Mental Status Exam (new onset or recurring illness).....              | 90801 |
| <input type="checkbox"/> Mental Status Exam -communication aids used.....                      | 90802 |
| <input type="checkbox"/> Psychological testing and results charting..... Hrs. _____ Min. _____ | 96101 |
| <input type="checkbox"/> Neuropsychological testing battery..... Hrs. _____ Min. _____         | 96118 |
| (Halstead-Reitan, Luria, WAIS-R, etc.)   |       |

**PSYCHOTHERAPY**

- |  | Without<br>Eval<br>& Mgmt | With<br>Eval<br>& Mgmt |
|--|---------------------------|------------------------|
| <input type="checkbox"/> Individual Psychotherapy for 20 - 30 minutes.....                             | 90816                     | 90817                  |
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| <input type="checkbox"/> Family Psychotherapy- patient was not present .....                           |                           | 90846                  |
| <input type="checkbox"/> Family Psychotherapy- patient was present.....                                |                           | 90847                  |
| <input type="checkbox"/> Group Psychotherapy.....  |                           | 90853                  |

**PSYCHIATRIC SOMATOTHERAPY**

- |   |       |
|---|-------|
| <input type="checkbox"/> Limited review of meds. with the patient for 10 minutes or less..... | M0064 |
| <input type="checkbox"/> Covering prescription, use, and review of meds with patient.....     | 90862 |
| <input type="checkbox"/> Electroconvulsive therapy (& monitoring) - single seizure.....       | 90870 |

**OTHER SERVICES - EXPLAIN**

- |  |       |
|--|-------|
| <input type="checkbox"/> Other unlisted psychiatric or psychological service or procedure..... | 90899 |
|--|-------|

Describe: \_\_\_\_\_

**CONSULTATION SERVICES**

Name of Referring  
Physician (Required) \_\_\_\_\_

**\*\*\*CHECK 1 BOX FOR THE SERVICE PROVIDED AND 1 BOX FOR THE APPLICABLE LEVEL\*\*\***

- |  |       |
|--|-------|
| <input type="checkbox"/> Initial psychiatric consultation for informed consent   |       |
| <input type="checkbox"/> Psychiatric consultation: Case review and staff conference  |       |
| <input type="checkbox"/> Neurology consultation  |       |
| <input type="checkbox"/> Level - Detailed history & exam - low complexity decision making.....   | 99253 |
| <input type="checkbox"/> Level - Comprehensive history & exam - moderate complexity decision making.....   | 99254 |
| <input type="checkbox"/> Follow-up psychiatric consultation for informed consent (same physician)<br>detailed interval history & exam - high complexity decision making..... | 99263 |

**OTHER CONSULTATION SERVICES**

**(Must be Completed)**

Patient Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Case #: \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX #: \_\_\_\_\_ Supervising Practitioner's Signature: \_\_\_\_\_  
OSH STK # 75030 MR 3 - 2/2006 Page 2 (if needed)

**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**HOSPITAL ADMISSION PHYSICAL EXAMINATION** **USUAL TIME**

- ☐ Decision making straight forward or of low complexity .....(30 minutes)..... 99221
- ☐ Decision making of moderate complexity.....(50 minutes)..... 99222
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Decision making straight forward or of low complexity..... (15 minutes)..... 99231
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Describe: \_\_\_\_\_

**Required Information:** List all medical diagnoses that pertain to the medical services rendered. (No abbreviations)

**ICD.9 CM  
CODES**

Primary Medical Dx: \_\_\_\_\_

Secondary Medical Dx: \_\_\_\_\_

Additional Medical Dx: \_\_\_\_\_

**COUNSELING & COORDINATION OF CARE SERVICES**

\*\*\*CHECK ONE BOX HERE FOR SERVICE PROVIDED AND (SEE \* BELOW)\*\*\*

- |   |  |
|---|--|
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| <input type="checkbox"/> Work with patient and others regarding seclusion and restraint | <input type="checkbox"/> Brief psychiatric rating scales           |

**\*CHECK ONE BOX BELOW FOR TIME SPENT.**

- |   |  |
|---|--|
| <input type="checkbox"/> 15 minutes 99231 | ***For service in this section, include both time spent with the patient and           |
| <input type="checkbox"/> 25 minutes 99232 | ***the time spent with others coordinating care. Use <u>Prolonged Service Code</u> for |
| <input type="checkbox"/> 35 minutes 99233 | ***services longer than 35 minutes in a single day.                                    |

**PROLONGED E & M SERVICES**

**FACE-TO-FACE WITH PATIENT**

**COORDINATION OF CARE**

First Full Hour Beyond the Usual Time _____	99356	_____	99358
Full Half Hour Beyond the First Hour _____	99357	_____	99359

X \_\_\_\_\_ (Indicate the Number of Full Half-Hours)

(MUST BE COMPLETED)

Patient Name: \_\_\_\_\_ Provider's Signature \_\_\_\_\_

Case # \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX: \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_

OSH STK 75030 MR - 3 - 2/2006

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**OREGON STATE HOSPITAL FEE-FOR-SERVICE CODING FORM  
PSYCHIATRIC, PSYCHOLOGICAL, AND CONSULTATION SERVICES**

Revised 02/06

**Required Information**

Date service was provided \_\_\_\_\_ Practitioner \_\_\_\_\_

**PSYCHIATRIC AND PSYCHOLOGICAL DIAGNOSTIC ASSESSMENTS**

- ☐ Mental Status Exam (new onset or recurring illness)..... 90801
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- ☐ Neuropsychological testing battery..... Hrs. \_\_\_\_\_ Min. \_\_\_\_\_ 96118  
(Halstead-Reitan, Luria, WAIS-R, etc.)

**PSYCHOTHERAPY**

- |  | Without<br>Eval<br>& Mgmt | With<br>Eval<br>& Mgmt |
|--|---------------------------|------------------------|
|--|---------------------------|------------------------|

**PSYCHIATRIC SOMATOTHERAPY**

- ☐ Limited review of meds. with the patient for 10 minutes or less..... M0064
- ☐ Covering prescription, use, and review of meds with patient..... 90862
- ☐ Electroconvulsive therapy (& monitoring) - single seizure..... 90870

**OTHER SERVICES - EXPLAIN**

- ☐ Other unlisted psychiatric or psychological service or procedure..... 90899

Describe: \_\_\_\_\_

**CONSULTATION SERVICES**

Name of Referring  
Physician (Required) \_\_\_\_\_

**\*\*\*CHECK 1 BOX FOR THE SERVICE PROVIDED AND 1 BOX FOR THE APPLICABLE LEVEL\*\*\***

- ☐ Initial psychiatric consultation for informed consent
- ☐ Psychiatric consultation: Case review and staff conference
- ☐ Neurology consultation
- ☐ Level - Detailed history & exam - low complexity decision making..... 99253
- ☐ Level - Comprehensive history & exam - moderate complexity decision making..... 99254
- ☐ Follow-up psychiatric consultation for informed consent (same physician)  
detailed interval history & exam - high complexity decision making..... 99263

**OTHER CONSULTATION SERVICES**

**(Must be Completed)**

Patient Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Case #: \_\_\_\_\_ Current Ward: \_\_\_\_\_

Current DSM-IV DX #: \_\_\_\_\_ Supervising Practitioner's Signature: \_\_\_\_\_

## DECLINATION / PATIENT SELF-MAIL MEMO

### Staff Instructions:

- \*Offer each patient an opportunity to register to vote within 5 days of admission
- \*Assist patient in completing form *without influencing their choice of party affiliation*
- \*Check the memo and the registration forms for completion **BEFORE** sending them to the Patient Affairs Office

**STAFF:** Read below options carefully. Patients and staff need to sign where appropriate.

---

### OSH MAILS REGISTRATION

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(send completed memo and completed registration form to Pt. Affairs Office)

### DECLINATION

Check line if patient : \_\_\_\_\_ gives **ANY** verbal/physical indication they are not interested at this time  
\_\_\_\_\_ unable to cooperate due to mental state  
\_\_\_\_\_ is already registered  
\_\_\_\_\_ is NOT a U.S. Citizen  
\_\_\_\_\_ is NOT an Oregon Resident

Patient Name (printed): \_\_\_\_\_ Admission Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Send completed memo to Pt. Affairs Office)

### PATIENT SELF-MAIL OPTION

Patient Name (printed): \_\_\_\_\_ Admission Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Send completed memo to Pt. Affairs Office)

# Oregon Voter Registration Card

**you may use this card to:**

- register to vote in Oregon
- The deadline to register to vote is the 21st day before an election.*
- change your name, mailing address, residence address or political party affiliation on your voter registration
- become eligible to sign petitions, including initiative, referendum and recall petitions

**how to register to vote**

- Fill out the form using black pen, and print clearly.  
*If the form is incomplete, it may be rejected.*
- Sign the form.
- Mail or drop off the completed form at your County Elections Office.  
*Addresses are on the back of this form.*

Your County Elections Office will mail you a Voter Notification Card to confirm your registration.

**selecting a political party**

Some political parties require you to be registered in their party to vote for their candidates at a Primary Election.

**identification**

New laws require that people must provide identifying information to register to vote. If you have a current, valid Oregon DMV Driver's License/ID, you must provide that number in section 4. If you do not have a current, valid Oregon DMV Driver's License/ID, you must provide the last four digits of your Social Security number in section 4a.

If you do not have a current, valid Oregon DMV Driver's License/ID or a Social Security number, you must affirm this by marking the boxes in sections 4 and 4a, and if you are registering by mail, you must provide a copy of one of the following:

- valid photo identification
- a paycheck stub
- a utility bill
- a bank statement
- a government document

→ proof of eligibility under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) or the Voting Accessibility for the Elderly and Handicapped Act (VAEH)

**assistance**

If, because of a disability, you need assistance registering to vote or voting please contact your County Elections Official.

**for more information:**



STL 500 n

**1 qualifications:** If you mark no in response to either of these questions, do not complete this form.

Are you a citizen of the United States of America? ☐ Yes ☐ No  
Will you be 18 years of age on or before election day? ☐ Yes ☐ No

**2 personal information:** denotes optional information

name last first middle

Oregon residence address (include apt. or space number) city zip code

date of birth (month/day/year) county of residence\*

phone number\* email address\*

mailing address (required if different than residence address) city zip code

**3 political party:** choose one of the following

☐ Constitution ☐ Democratic ☐ Libertarian  
☐ Pacific Green ☐ Republican ☐ Not a member of a party  
☐ Other

**4 Oregon DMV Driver's License/ID number:** If you fill in this section, do not send a copy of ID

valid Oregon DMV Driver's License/ID number

☐ Mark here only if you do not have a valid Oregon DMV Driver's License/ID and go to step

**4a:** last four digits of Social Security number. If you fill in this section, do not send a copy of ID

Last four digits of Social Security number

☐ Mark here only if you do not have a valid Oregon DMV Driver's License/ID or a Social Security number. If you are registering by mail, please include a copy of acceptable identification listed to the left.

**5 signature:** I swear or affirm that I am qualified to be an elector and I have told the truth on this registration card.

signature \_\_\_\_\_ date today \_\_\_\_\_

**6:** If you sign this card and know it to be false, you can be fined up to \$125,000 and/or jailed for up to 5 years.

**6:** registration updates: If you are previously registered and updating your information, fill out this section.



Secretary of State  
Bill Bradbury  
Salem OR 97310-0722

first class  
postage  
required



please write your County Elections Office address below:

**Vote!**  
Oregon Voter Registration

fold card here

**Curry County**  
3rd St, Ste 150  
City OR 97814-3398  
23 8207

**Deschutes County**  
Box 888  
Deschutes OR 97339  
36 6756

**Grant County**  
Portland Ave  
Grant OR 97027  
55 8510

**Harney County**  
Box 178  
Harney OR 97103-0178  
25 8511

**Jefferson County**  
Jefferson County Courthouse  
Baxter  
Jefferson OR 97423-1899  
36 3121 ext 301

**Lincoln County**  
E 3rd, Rm 23  
Lincoln OR 97554-1919  
47 6553

**Curry County**  
PO Box 746  
Gold Beach OR 97444  
541 247 3297  
1 877 739 4218

**Deschutes County**  
Deschutes Services Bldg  
1300 NW Wall St, Ste 200  
Bend OR 97701  
541 388 6546

**Douglas County**  
PO Box 10  
Roseburg OR 97470-0004  
541 440 4252

**Gilliam County**  
PO Box 427  
Condon OR 97823-0427  
541 384 2311

**Grant County**  
201 S Humbolt, Ste 290  
Canyon City OR 97820-0039  
541 675 1675

**Harney County**  
Courthouse  
450 N Buena Vista  
Burns OR 97720  
541 573 6641

**Hood River County**  
601 State St  
Hood River OR 97031-1871  
541 386 1442

**Jackson County**  
1101 W Main St, Ste 201  
Medford OR 97501-2389  
541 774 9148

**Jefferson County**  
68 SE "D" St, Ste C  
Madras OR 97741  
541 475 4451

**Josephine County**  
PO Box 69  
Grants Pass OR 97526-0203  
541 474 5243

**Klamath County**  
305 Main St  
Klamath Falls OR 97601  
541 883 5134  
1 800 377 6084

**Lake County**  
513 Center St  
Lakeview OR 97630-1639  
541 847 6006

**Lane County**  
275 W 10th Ave  
Eugene OR 97401-3008  
541 882 4234

**Lincoln County**  
225 W Olive St, Rm 201  
Newport OR 97385  
541 285 4131

**Linn County**  
300 4th Ave SW  
Albany OR 97321

**Malheur County**  
251 "B" St W  
Courthouse Suite 4  
Vale OR 97918  
541 473 5151

**Marion County**  
4283 Commercial St SE,  
#300  
Salem OR 97302-3987  
503 588 5041  
800 655 5385

**Morrow County**  
PO Box 338  
Heppner OR 97836-0338  
541 676 6804

**Multnomah County**  
1040 SE Morrison St  
Portland OR 97214-2495  
503 888 3720

**Polk County**  
850 Main St  
Dallas OR 97338-3179  
503 623 8217

**Sherman County**  
PO Box 365  
Moro OR 97039-0365  
541 585 3806

**Tillamook County**  
201 Laurel Ave.  
Tillamook OR 97141  
503 842 3402

**Umatilla County**  
PO Box 1227  
Pendleton OR 97801  
541 278 6254

**Union County**  
1001 4th St, Ste D  
LaGrande OR 97850  
541 883 1006

**Wallowa County**  
101 S River St  
Room 100, Door 18  
Enterprise OR 97828-1335  
541 428 4543 ext 15

**Wasco County**  
Courthouse  
511 Washington St, Rm 201  
The Dalles OR 97058  
541 505 2530

**Washington County**  
3700 SW Murray Blvd  
Ste 101  
Beaverton OR 97005  
503 846 5900

**Wheeler County**  
PO Box 327  
Fossil OR 97830-0327  
541 763 2400

**Yamhill County**  
Elections  
535 NE 5th St, Rm 119  
McMinnville OR 97128-4593  
503 434 7518

## UNAUTHORIZED LEAVE INFORMATION

Escape - Walkaway - Missing - Other

(Shaded areas to be completed within 30 days of admission or transfer)

Date ____/____/____	Patient's Name			Sex ____	Age ____
	Last	First	Middle		
Physical Description:					
Height ____	Weight ____ lbs.	Eye Color ____	Hair Color ____	Race ____	
Distinguishing Features, Scars, Marks, Tattoos, etc. _____					
Last Known Clothing Description _____					
Physical Description Accurate at Time of Unauthorized Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Revise					
Circumstances of Leave _____					
_____					
_____					
Time of Leave ____ am/pm Last Known Location _____					
OSH Program _____		Ward/Unit _____		DOC Inmate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commitment Type _____		Date ____/____/____		Length ____ County ____	
PSRB? <input type="checkbox"/> Yes <input type="checkbox"/> No		Detainer? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, to Whom? _____	
Security Level: <input type="checkbox"/> Maximum <input type="checkbox"/> Medium <input type="checkbox"/> Minimum					
Criminal Offense(s) _____					
Most Serious Convictions _____					
Return Status _____					
Circumstances of Return _____					

ADDRESSOGRAPH:

\_\_\_\_\_  
Name of Staff Completing This Form

\_\_\_\_\_  
Title

File: Legal Section of Ward Chart

Thin: Do Not Thin

State of Oregon  
 Dept of Human Resources  
 MENTAL HEALTH & DEVELOPMENTAL  
 DISABILITY SERVICES DIVISION

# CONFIDENTIAL INFORMATION

No Further Release Authorized

Photo Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Taken	OSH ID #
SID #	FBI #	DOB	SSN
Last Contact Staff			
Criminal History			
Primary Risk Behaviors			
Suicide Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No		Arson Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Institution Will Extradite? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Bank Account Information			
Employee Contacts			
Patient Contacts			
Community Contacts:			
Name	Address	Phone	Relationship
Attending Physician		Physician Orders	
Meds? <input type="checkbox"/> Yes <input type="checkbox"/> No		Diagnosis	
Additional Comments			

## ADDRESSOGRAPH:

Name of Staff Completing This Form

Title

File: Legal Section of Ward Chart

Thin: Do Not Thin

## Notifications

BY WARD: ☐ OSH Communications Center ☐ Copy of this patient's visitors log for the past 90 days sent to Communication Center

BY COMMUNICATION CENTER: Requires Emergency Law Enforcement Response?

☐ Yes

☐ Salem Police 588-6123

(Indicate notice to Marion and Polk County Sheriff's offices)

☐ State Police Regional Dispatch 378-2575

☐ No

☐ State Police Regional Dispatch 378-2575

☐ Information entered into the NCIC system:

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_ am/pm

☐ OSH Superintendent

☐ Program Director

☐ OSH Security Director

☐ Unit Director

☐ Unit Psychiatrist/Psych OD

☐ Program/Unit Based Supv. R.N.

☐ Supervising Physician

☐ Division Communication Manager

☐ PSRB (If PSRB patient)

☐ Fire Marshall (If appropriate)

☐ DOC (If appropriate)

☐ Judge

Other Jurisdiction:

☐

☐

Name

Address

Phone

Relationship

☐ Relative

☐ Relative

TO BE COMPLETED BY COMMUNICATION CENTER:

☐ Victim

☐ Victim

☐ Victim

### FAX Distribution:

#### All three pages:

☐ State Police Regional Dispatch 585-6635

#### Pages one and two:

☐ Division Administrator 378-3796

☐ DHR 378-2897

☐ PSRB (If applicable) 1-503-229-5085

☐ DOC (If applicable) 378-5817

#### Page one ONLY:

(Send if PSRB, or if authorized by OSH Supt. or Division Communication Manager)

☐ Statesman Journal 399-6706

☐ Oregonian 1-503-227-5306

☐ AP-Salem 363-9502

☐ AP-Portland 1-503-228-5514

☐ KGW 1-503-226-5050

☐ KATU 2 1-503-231-4263

☐ KOIN 6 1-503-464-0806

☐ KPTV 12 1-503-224-0101

Name of Staff Performing Notifications

ADDRESSOGRAPH:

Date of Notification

Time of Notification

File: Legal Section

Thin: Do Not Thin

# Oregon State Hospital

Department of Human Services

## PERSONAL PROPERTY SMALL STORAGE STORED OFF WARD

Name: \_\_\_\_\_  
Last First

Date: \_\_\_\_\_

Medical Record Number Ward: DOB: \_\_\_\_\_

IF ADDITIONAL SPACE IS NEEDED, USE A SECOND FORM

BANK BOOKS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

SS CARDS: 1. \_\_\_\_\_

2. \_\_\_\_\_

DRIVER'S LICENSE: 1. \_\_\_\_\_

2. \_\_\_\_\_

ID CARDS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

CREDIT CARDS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

JEWELRY: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

RAZORS: 1. \_\_\_\_\_

2. \_\_\_\_\_

MISCELLANEOUS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

UNENDORSED CHECKS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

FILES, KNIVES, SCISSORS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

KEYS: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

### RECEIVED IN SMALL STORAGE

By: \_\_\_\_\_

Date: \_\_\_\_\_

ADMISSION - OR AT TIME OF STORAGE

DISCHARGE - OR AT TIME OF REMOVAL FROM SMALL STORAGE

Staff Signature Date: \_\_\_\_\_

Signature or Person Receiving Property Date: \_\_\_\_\_

Patient's or Second Staff Signature Date: \_\_\_\_\_

Signature of Staff Releasing Property Date: \_\_\_\_\_

CONFIDENTIAL: This information has been disclosed to you from records  
whose confidentiality is protected by State law (ORS 279.605) and Federal law  
(45 CFR Part 164). You are prohibited from making further disclosure without  
specific written consent of the persons or as otherwise permitted by law.

ADDRESSOGRAPH

File: Property/Financial - White: Patient  
- Green: Communication Center  
- Pink: Medical Record

Thin: Do Not Thin  
OSH-STK MR3-05755 05-4/2006  
MR # 63-14-0656-00

Date This Page Began \_\_\_\_\_

## DISPOSITIONS/DELETIONS

[illegible]

Date \_\_\_\_\_

1. DESTROYED/WORN OUT      3. LOST      5. CLOTHING SHOP DONATION = Place # 5 in Date "eld of Property Description  
2. SENT HOME/GIVEN AWAY      4. OSH STORAGE      6. PATIENT TRANSACTION

# ADDRESSOGRAPH

## Department of Human Services

## Date This Page Began \_\_\_\_\_

## DISPOSITIONS/DELETIONS

[illegible]

Inventory Of Property At \_\_\_\_\_ TRANSFER \_\_\_\_\_ DISCHARGE (INDICATE MOVEMENT)

**I agree with the listing of property on the property sheet(s)**

Staff Signature \_\_\_\_\_ Ward \_\_\_\_\_ Date \_\_\_\_\_

I agree with the listing of property and have received the property for transfer to another ward or discharge from hospital.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**CODES FOR INCOMING ITEMS AND DISPOSITIONS/DELETIONS**

- |                         |                |                           |
|-------------------------|----------------|---------------------------|
| 1. DESTROYED/WORN OUT   | 3. LOST        | 5. CLOTHING SHOP DONATION |
| 2. SENT HOME/GIVEN AWAY | 4. OSH STORAGE | 6. PATIENT TRANSACTION    |

## ADDRESSOGRAPH

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# OREGON STATE HOSPITAL

Department of Human Services

## TRUST ACCOUNT APPLICATION

For security reasons, patients at Oregon State Hospital cannot keep funds (cash, checks, money orders, etc.) in excess of \$25 on the wards or cottages.

You may deposit your funds in a trust account and use them while a patient here. Otherwise, you, your guardian, conservator or designee may make arrangements to deposit your funds in a bank or other financial institution or with a family member or a friend. If you choose to deposit your funds in a place other than a trust account, Oregon State Hospital will not be responsible for any arrangements that you, your guardian, conservator or designee make.

Funds deposited in a trust account will bear interest. If you deposit your funds in a trust account, you may withdraw all or part of your funds during normal business hours. However, you cannot keep in excess of \$25 on the ward. You may also stop future deposits of your funds into the trust account. To stop future deposits of your funds, notify the Business Office in writing; include an address where Oregon State Hospital should forward your funds. In order to withdraw all or part of your funds, complete and submit the form, "Consent To Withdrawal of Funds from Patient Trust Account," to the Business Office.

To indicate how you want to deposit your funds, check the appropriate box on this form. Your choices for depositing funds are: Temporary safekeeping in a trust account pending consultation with an attorney; trust account; bank or other financial institution or family member or friend. If you do not check a box, Oregon State Hospital will deposit your funds in a trust account.

### CHECK ONE OF THE FOLLOWING:

- ☐ I wish to consult with an advisor, attorney or friend before completing this form. I agree to place my money temporarily in a trust account for safekeeping.
- ☐ I have read the foregoing and wish to open a trust account.
- ☐ I will deposit my funds with a bank or financial institution or friend and will make my own arrangements for the secure transmittal of funds.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

Before completing this form, you may consult with a family member, friend, advisor, attorney or with a staff member of this institution. If you wish to talk with a lawyer, but do not have one, you may obtain one through the Oregon State Bar Referral Service, telephone 503-684-3763 or toll free 1-800-452-7636. Reduced consultation fees are available by application through the Referral Service's "Modest Means Program."

If you so desire, you may designate another person to receive copies of all documents relating to the money in your trust account. If so, list the name and address of your designee below:

Name of person	Address	City	State	Zip
<b>To be completed by Oregon State Hospital staff:</b>				
Name of patient	Patient #	Social Security #	Ward	
<b>If applicable:</b> I have presented this application to the patient who is unwilling or unable to understand it and/or complete it.				
Name of OSH staff	Signature of OSH staff		Date	

Copy Distribution: white -- Business Office; canary -- Patient

OSH-STK-11988

3-11/2001

**SELF-DETERMINATION ACT**

INSTRUCTIONS: THIS FORM IS TO BE COMPLETED FOR PERSONS 18 YEARS OF AGE OR OLDER.

1. Does the patient or guardian provide or say they have a:

- |  |           |          |
|--|-----------|----------|
| A. Advance Directive                       | Yes _____ | No _____ |
| B. Health Care Representative              | Yes _____ | No _____ |
| C. Power of Attorney for Health Care       | Yes _____ | No _____ |
| D. Declaration for Mental Health Treatment | Yes _____ | No _____ |

If the patient does not have documents A through C above, was the MAKING HEALTH CARE DECISIONS pamphlet provided? Yes \_\_\_\_\_ Refused by patient \_\_\_\_\_

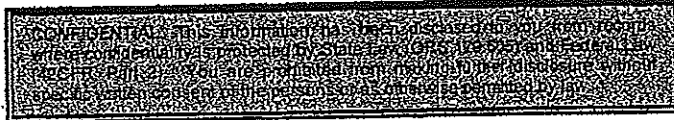
\_\_\_\_\_ Check if the patient is unable or unwilling to provide information related to the Self-Determination Act.

2. If there is an Advance Directive, Health Care Representative - Power of Attorney, or a Declaration for Mental Health Treatment, was a copy placed in the medical record? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, where is the copy located? \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nursing Signature: \_\_\_\_\_ Date: \_\_\_\_\_



ADDRESSOGRAPH

File LEGAL SECTION  
Thin: Do not Thin  
Form # OSH-STK-75040-MR 4-5/2003  
MR# 65-15-0048-00



# OREGON STATE HOSPITAL 50H PATIENT CARDEX

ROOM:

<b>DATES</b>		Patient Alias:		
Admit Date:	4/27/2010			
Transfer To 50H:		Height:	Weight	
County:		Hair	Eye:	
Date Of Psychiatric Consult completed:		DOB:		
		OSH#		
<b>STAFF ASSIGNMENTS</b>				
Primary RN:				
Case Monitor:				
2nd Case Monitor:				
Attending MD:				
Social Worker:				
RSD:				
Psychologist:				
Mental Health Specialist:				
		PRIMARY DIAGNOSIS:		
<b>BEHAVIOR OR SUICIDAL PRECAUTION</b>		MEDICAL ISSUES:	CRIMINAL OFFENSE	
<b>DIET</b>				

WRITE IN PENCIL.

## 50H Admission Clothing Needs

Patient's Name: \_\_\_\_\_

Patient's OSH #: \_\_\_\_\_

Admit Date: \_\_\_\_\_

### Shirts

*Please circle desired sizes*

S/S dress - M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____
L/S dress - M, L, 1X, 2X, 3X	How many? _____
Flannel - M, L, 1X, 2X, 3X, 4X	How many? _____
Sweatshirt - S, M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____
T-shirt, forest green - S, M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____
T-shirt, light blue - M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____
T-shirt, white - S, M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____

### Pants

*Where applicable, please list waist sz and length ~ ex: 36", 34"*

Dress - even sizes 28" - 50"	How many? _____
Elastic waist - M, L, 1X, 2X, 3X, 4X	How many? _____
Jeans - even sizes 30" - 60"	How many? _____
Pants, sweat - S, M, L, 1X, 2X, 3X, 4X, 5X, 6X	How many? _____
Shorts, sweat - M, L, 1X, 2X, 3X	How many? _____

### Coats

*Please circle desired sizes*

Windbreaker - S, M, L, 1X, 2X, 3X, 4X	(ONE ONLY)
Heavy Denim - LG, 1X, 2X, 3X, 4X	(ONE ONLY)
Cap, stocking      Yes      No	(ONE ONLY)

### Shoes

*Please circle desired sizes*

Tennis, low top velcro - 7, 7.5, 8, 8.5, 9, 9.5, 10, 10.5, 11, 12, 13	(ONE ONLY)
Tennis, high top lace - 6.5, 7, 7.5, 8, 8.5, 9, 9.5, 10, 10.5, 11, 12, 13, 14, 15	(ONE ONLY)
Shower - S, M, L, XL, XXL	(ONE ONLY)

### Undergarments

Belt - even sizes 24" - 54" \_\_\_\_\_ (ONE ONLY)

### Socks

Ankle	Yes	No	How many? _____
Dress	Yes	No	How many? _____
Tube	Yes	No	How many? _____

Suspenders      Yes      No      (ONE ONLY)

### Underwear

*Please circle desired sizes*

Boxers - M, L, XL, XXL	How many? _____
Briefs - S, M, L, XL, 2X, 3X, 4X, 5X, 6X	How many? _____

State of Oregon  
Oregon State Hospital  
Department of Human Resources  
Mental Health Division

Court Ordered Evaluation Only  
Patient's Rights - Forensic Psychiatric Center

Printed Patient's Name: \_\_\_\_\_

OSH #: \_\_\_\_\_

It is my duty to warn you before you make any statement:

1. You have the right to remain silent.
2. Anything you say can be used against you in a Court of Law.
3. You have the right to consult an attorney before making any statement.
4. You have the right to ask your attorney to be present during the interview.
5. You have the right to not discuss or answer any questions at any time.
6. You should understand there is no privilege of confidentiality between doctor and patient in a court ordered examinations.

Do you understand these rights? \_\_\_\_\_

Do you have any questions regarding these rights? \_\_\_\_\_

Are you willing to proceed with the interview? \_\_\_\_\_

(If so Please sign below.)

Patient's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_ at \_\_\_\_\_

## OREGON STATE HOSPITAL

## PATIENT'S RIGHTS

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**AS CONTAINED IN OREGON REVISED STATUTE 426.385**

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The Basic Patient's Rights Provided by Statute, described in this document, may be asserted by and exercised by the patient or the patient's legal guardian. All persons receiving treatment at Oregon State Hospital shall have the right to:

- A. Care provided in a setting which is LEAST RESTRICTIVE to liberty, LEAST INTRUSIVE, and provides the greatest degree of independence possible, consistent with the patient's treatment, safety, and security needs;
- B. AN HUMANE LIVING ENVIROMENT that affords reasonable protection from harm and affords reasonable privacy;
- C. Communicate freely in person and by reasonable access to telephone;
- D. Send and receive sealed mail (except this right may be limited for security reasons);
- E. Wear his/her own CLOTHING;
- F. Keep his/her PERSONAL POSSESSIONS, including toilet articles;
- G. RELIGIOUS FREEDOM;
- H. A private STORAGE AREA with free access thereto;
- I. A written, INDIVIDUALIZED TREATMENT CARE PLAN, kept current with his/her progress and to participate in the development and review of his/her treatment plan at a level appropriate to his/her capabilities;
- J. Be provided with a REASONABLE EXPLANATION of all service considerations;
- K. Not be required to perform routine LABOR TASKS of the facility except personal housekeeping duties, without reasonable and lawful compensation;
- L. Be free from potentially UNUSUAL OR HAZARDOUS TREATMENT PROCEDURES, including electroshock therapy, unless they have given their express and informed consent. This right may be denied to such person for good cause only by the Superintendent or his/her designee but only after consultation with and approval of an independent examining physician. Any denial shall be entered into the patient's treatment record and shall include the reason for the denial;

OREGON STATE HOSPITAL  
PATIENT'S RIGHTS

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AS CONTAINED IN OREGON REVISED STATUTE 426.385

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- M. Not have MECHANICAL RESTRAINTS applied unless it is determined by the Chief Medical Officer of the hospital or his/her designee to be required by the medical needs of the person;
- N. Not participate in EXPERIMENTATION OR RESEARCH without informed voluntary written consent;
- O. Receive MEDICATION only for his/her own clinical needs;
- P. Not be involuntarily TERMINATED or transferred from services without prior notice, notification of available sources of necessary continued services, and exercise of a grievance procedure;
- Q. ASSERT GRIEVANCES regarding the infringement of rights described in this document and to have those grievances considered in a fair, timely, and impartial grievance procedure;
- R. Exercise the rights specified in this document without any form of REPRISAL OR PUNISHMENT;
- S. Be REPRESENTED BY COUNSEL whenever his/her substantial rights may be affected;
- T. Petition for a writ of HABEAS CORPUS;
- U. Such OTHER RIGHTS as may be specified by regulation;
- V. Exercise all CIVIL RIGHTS in the same manner and with the same effect as one not admitted to the facility, including, but not limited to, the right to dispose of property, execute instruments, make purchases, enter contractual relationships, and vote, unless he/she had been adjudicated incompetent and has not been restored to legal capacity. Disposal of personal property in possession of the person in a state institution is subject to limitations for security reasons;
- W. Develop ADVANCE DIRECTIVES for your care in the case of future serious medical or psychiatric illness; and
- X. Request documents in ALTERNATIVE FORMATS such as large print, braille, verbal presentation, foreign language, or accommodation related to services.

OREGON STATE HOSPITAL

PATIENT'S RIGHTS AND  
NOTICE OF PRIVACY PRACTICES

I have reviewed and explained patient rights and alternative formats to: \_\_\_\_\_  
Patient Name

Interpreter Present: Yes \_\_\_\_\_ No \_\_\_\_\_

Nursing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My patient rights have been reviewed and explained to me with a copy of the Patient Rights form provided. I have also been provided a copy of the Notice of Privacy Practices and have had a chance to ask questions about how my personal health information will be used. I have been informed that I may request documents in alternative formats such as large print, braille, verbal presentation, foreign language or accommodation related to services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient is unable to sign – Nursing Signature: \_\_\_\_\_

Date: \_\_\_\_\_

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

ADDRESSOGRAPH

File: Legal Section  
Thin: Do Not Thin  
Form #: OSH-STK 03653 -- MR 6-- 02-2006  
MR #: 50-15-0120-00

OREGON STATE HOSPITAL  
PATIENT'S RIGHTS

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AS CONTAINED IN OREGON REVISED STATUTE 426.385

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- C. Communicate freely in person and by reasonable access to telephone;
- D. Send and receive sealed mail (except this right may be limited for security reasons);
- E. Wear his/her own CLOTHING;
- F. Keep his/her PERSONAL POSSESSIONS, including toilet articles;
- G. RELIGIOUS FREEDOM;
- H. A private STORAGE AREA with free access thereto;
- I. A written, INDIVIDUALIZED TREATMENT CARE PLAN, kept current with his/her progress, and to participate in the development and review of his/her treatment plan at a level appropriate to his/her capabilities;
- J. Be provided with a REASONABLE EXPLANATION of all service considerations;
- K. Not be required to perform routine LABOR TASKS of the facility except personal housekeeping duties, without reasonable and lawful compensation;
- L. Be free from potentially UNUSUAL OR HAZARDOUS TREATMENT PROCEDURES, including electroshock therapy, unless they have given their express and informed consent. This right may be denied to such person for good cause only by the Superintendent or his/her designee but only after consultation with and approval of an independent examining physician. Any denial shall be entered into the patient's treatment record and shall include the reason for the denial;
- M. Not have MECHANICAL RESTRAINTS applied unless it is determined by the Chief Medical Officer of the hospital or his/her designee to be required by the medical needs of the person;
- N. Not participate in EXPERIMENTATION OR RESEARCH without informed voluntary written consent;
- O. Receive MEDICATION only for his/her own clinical needs;
- P. Not be involuntarily TERMINATED or transferred from services without prior notice, notification of available sources of necessary continued services, and exercise of a grievance procedure;
- Q. ASSERT GRIEVANCES regarding the infringement of rights described in this document and to have those grievances considered in a fair, timely and impartial grievance procedure;
- R. Exercise the rights specified in this document without any form of REPRISAL OR PUNISHMENT;
- S. Be REPRESENTED BY COUNSEL whenever his/her substantial rights may be affected;
- T. Petition for a writ of HABEAS CORPUS;
- U. Such OTHER RIGHTS as may be specified by regulation;
- V. Exercise all CIVIL RIGHTS in the same manner and with the same effect as one not admitted to the facility, including, but not limited to, the right to dispose of property, execute instruments, make purchases, enter contractual relationships, and vote, unless he/she had been adjudicated incompetent and has not been restored to legal capacity. Disposal of personal property in possession of the person in a state institution is subject to limitations for security reasons;
- W. Develop ADVANCE DIRECTIVES for your care in the case of future serious medical or psychiatric illness; and
- X. Request documents in ALTERNATIVE FORMATS such as large print, braille, verbal presentation, foreign language, or accommodation related to services.

**PATIENT AND FAMILY RESPONSIBILITIES**

I have reviewed and explained patient and family responsibilities to: \_\_\_\_\_

Nursing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My patient and family responsibilities have been reviewed and explained to me with a copy of the Patient and Family Responsibilities form provided. I have been informed that I may request documents in alternative formats such as large print, Braille, verbal presentation, foreign language or accommodation related to services.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Patient is unable to sign – Nursing Service: \_\_\_\_\_

Date \_\_\_\_\_

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ADDRESSOGRAPH

File: Legal  
Thin: Six Months  
Form #: OSH-STK 75080 - MR -1 11/2003  
MR #: 65-15-0065-06

## PATIENT AND FAMILY RESPONSIBILITIES

Oregon State Hospital recognizes that recovery and health care delivery is a partnership between the hospital, the patient and other important supports. Oregon State Hospital has many responsibilities in this partnership, detailed elsewhere. Below are listed some of the responsibilities of the patients and the patients' supports in this partnership.

Patient and family responsibilities include the following:

- Providing information. The patient and family are responsible for providing, to the best of his or her knowledge, accurate and complete information about present symptoms, past illnesses and hospitalizations, medications, and other matters related to his or her health.
- The patient and family are responsible for reporting perceived risks in the provision of care, unexpected changes in the patient's condition, and to provide feedback about care needs and expectations.
- Asking questions. Patients and families are responsible for asking questions when they do not understand what they are been told about their care or treatment, or what they are expected to do.
- Following instructions. The patient and family are responsible for following the treatment plan and instructions given by staff members. They should express any concerns they have about their ability to follow and comply with their treatment plan. Every effort shall be made to modify a patient's treatment plan to the patient's specific needs. When such modifications to the treatment plan are not recommended by the treatment team, the patient and family are responsible for understanding the consequences of not following the treatment plan.
- Accepting consequences. The patient and family are responsible for outcomes if they do not follow the patient's treatment plan or instructions given by staff members.
- Following rules and regulations. The patient and family are responsible for following the hospital's rules and regulations concerning patient care, safety and security, and conduct (this includes following tobacco-free and contraband policies).
- Verbal aggression and physical violence on the part of patients, family members, visitors, or staff are prohibited behaviors at Oregon State Hospital. Staff members are responsible to attempt to prevent and contain aggression and violence. Acts of violence resulting in injury will be investigated, and involved persons may be subject to prosecution at the discretion of the District Attorney. Visitors exhibiting verbal aggression or disorderly conduct including intoxication may be indefinitely excluded from the hospital premises.
- Showing respect and consideration. Patients and family members are responsible for being considerate toward hospital personnel and property. Patients and family members are responsible for being considerate of other patients, helping control noise and environmental disturbances, and respecting others' property.
- Meeting financial commitments. The patient and family are responsible for promptly meeting any financial obligations agreed to with the hospital.

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ADDRESSOGRAPH

File: Legal  
Thin: Six Months  
Form #: OSH-STK 75080-MR-1 11/2003  
MR #: 65-15-0065-05

## PATIENT AND FAMILY RESPONSIBILITIES

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- Following instructions. The Patient and family are responsible for following the treatment plan and instructions given by staff members. They should express any concerns they have about their ability to follow and comply with their treatment plan. Every effort shall be made to modify a patient's treatment plan to the patient's specific needs. When such modifications to the treatment plan are not recommended by the treatment team, the patient and family are responsible for understanding the consequences of not following the treatment plan.
- Accepting consequences. The patient and family are responsible for outcomes if they do not follow the patient's treatment plan or instructions given by staff members.

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the person or as otherwise permitted by law.

ADDRESSOGRAPH

File: Legal  
Thin: Six Months  
Form #: OSH-STK 75080 - MR -1 11/2003  
MR #: 65-15-0065-06

Patient Copy

**PATIENT AND FAMILY RESPONSIBILITIES**

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- Following rules and regulations. The patient and family are responsible for following the hospital's rules and regulations concerning patient care, safety and security, and conduct (this includes following tobacco-free and contraband policies).
- Verbal aggression and physical violence on the part of patients, family members, visitors, or staff are prohibited behaviors at Oregon State Hospital. Staff members are responsible to attempt to prevent and contain aggression and violence. Acts of violence resulting in injury will be investigated, and involved persons may be subject to prosecution at the discretion of the District Attorney. Visitors exhibiting verbal aggression or disorderly conduct including intoxication may be indefinitely excluded from the hospital premises.
- Showing respect and consideration. Patients and family members are responsible for being considerate toward hospital personnel and property. Patients and family members are responsible for being considerate of other patients, helping control noise and environmental disturbances, and respecting others' property.
- Meeting financial commitments. The patient and family are responsible for promptly meeting any financial obligations agreed to with the hospital.

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the person or as otherwise permitted by law.

ADDRESSOGRAPH

File: Legal  
Thin: Six Months  
Form #: OSH-STK 75080 - MR -1 11/2003  
MR #: 65-15-0065-06

Patient Copy



## Authorization for Use & Disclosure of Information

*This form is available in alternative formats including Braille, computer disk, and oral presentation.*

Legal Last Name of Client/Applicant	First	MI	Date of Birth
Other Names Used By Client/Applicant			Case ID#

**By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:**

<b>Section A</b>	Release From ONE Record Holder – (Individual, School, Employer, Agency, Medical or Other Provider)	Specific Information to be Disclosed	Mutual Exchange: Yes / No
<p>If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:</p> <p> HIV/AIDS: _____ Mental Health: _____  Alcohol/Drug diagnoses, treatment, referral: _____ Genetic Testing: _____ </p>			

<b>Section B</b>	Release To (address required if mailed) If releasing to a team, list members.	Purpose	Expiration Date or Event*
<p><b>* This authorization is valid for one year from the date of signing unless otherwise specified.</b></p> <p>I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.</p> <p>I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, vocational rehabilitation records, or referral information, without specific authorization.</p>			

<b>Section C</b>	Full Legal Signature of Individual OR Authorized Personal Representative		Relationship to Client	Date
	Name of Staff Person (print)		Initiating Agency Name/Location	Date
	Full Legal Signature of Agency Staff Person Making Copies			<b>This is a True Copy of the Original Authorization Document.</b>
	Print Staff Person Name			

## Required Information for the Client

**To provide or pay for health services:** If the Department of Human Services (DHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

**This is a Voluntary Form.** DHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

---

## Using This Form

1. **Terms Used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing. Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed and the purpose.

**Re-disclosure:** Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

OREGON STATE HOSPITAL

# ADMISSION PROGRESS RECORD

[illegible]

All notes must be signed and discipline indicated. Discipline code shall also be entered in "Discipline" column as follows:

entered in "Discipline" column as follows:

P	-	Psychologist	MHS	-	Mental Health Specialist
SW	-	Social Worker	TS	-	Therapy Supervisor
RN	-	Registered Nurse	RSD	-	Rehabilitation Services Dept.
LPN	-	Licensed Practical Nurse	PT	-	Physical Therapist
MHT	-	Mental Health Therapist	OTHER	-	Use approved abbreviation
CM	-	Case Monitor			for position

File: Progress Record

Thin: Do Not Thin

Form #: 10796 4 07/2006 MR#: 66-06-0047-06

NOTE: MD NOTES IN IDT  
SECTION ONLY

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

### ADDRESSOGRAPH

[illegible]

ADDRESSOGRAPH

**NOTE: MD NOTES IN IDT  
SECTION ONLY**

CONFIDENTIAL. This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 197.506) and Federal Law (45CFR Part 164); you are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

**OREGON STATE HOSPITAL  
DISCLOSURE OF HOSPITALIZATION AND  
CONSENT TO NOTIFY PERSON OF SECLUSION AND RESTRAINT**

**SECTION I - DISCLOSURE OF HOSPITALIZATION**

In accordance with Oregon Law (ORS 192.502(2)) the fact that you are a patient at Oregon State Hospital is not public information. Your permission is needed for the staff to inform your family and friends that you are a current patient. To help staff respond to phone calls from your family, friends or other interested persons, please list below those person(s) whom you wish to know that you are here. You may add or delete names at any time.

       Anyone                             No One                             Only the Following

NAME(S)	RELATIONSHIP	REMOVED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

All Additions are completed on the reverse side after this form has been initially signed and dated.

**SECTION II - REQUEST/CONSENT TO NOTIFY PERSON OF SECLUSION OR RESTRAINT**

Notification of seclusion or restraint to a specific family member will be done by the hospital staff upon your request. When family notification is not requested, please check "no". You may add or delete a name at any time. I request/consent that a family member be notified if seclusion or restraint is initiated during this hospitalization:

       Yes           No    If Yes

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

**SIGNATURE**

Patient/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

ADDRESSOGRAPH

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

File: Behind Face Sheet  
Thin: Do Not Thin  
OSH STK: 03389- MR 7-9/2006  
MR #: 65-00-0048-00

## OREGON STATE HOSPITAL

## SECTION 1 - CONTINUED

NAME(S)	RELATIONSHIP	ADD	REMOVED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____			
NAME(S)	RELATIONSHIP	ADD	REMOVED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____			
NAME(S)	RELATIONSHIP	ADD	REMOVED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____			
NAME(S)	RELATIONSHIP	ADD	REMOVED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____			
NAME(S)	RELATIONSHIP	ADD	REMOVED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT SIGNATURE _____	DATE _____
-------------------------	------------

## ADDRESSOGRAPH

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 479.505) and Federal Law (45CFR Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

File: Behind Face Sheet  
 Thin: Do Not Thin  
 OSH STK: 03389- MR 7-9 /2006  
 MR #: 65-00-0048-00

## OREGON STATE HOSPITAL

### PHILOSOPHY ON THE USE OF SECLUSION AND RESTRAINTS

- Oregon State Hospital has the responsibility to maintain patient dignity and rights using the least restrictive means possible.
- Oregon State Hospital provides humane patient care and treatment as well as safety for patients, staff and the public.
- The goal of Oregon State Hospital is to provide an environment that strives to prevent, reduce, and eliminate the use of seclusion and restraint.
- Oregon State Hospital shall not use seclusion and/or personal or physical restraints except in situations where there is a substantial likelihood of immediate physical harm to the patient or others that is serious, probable, or imminent and less restrictive measures other than the use of seclusion or personal or physical restraints have been considered and have been found ineffective in managing the behavior.
- Oregon State Hospital supports patient's right to have a family member or significant other notified promptly if seclusion or restraint is initiated.
- Oregon State Hospital seclusion and restraint shall not be used for the convenience of staff, or as a substitute for an activity or treatment, or as punishment.
- Oregon State Hospital shall not use medication as a restraint but it shall be prescribed and administered only according to acceptable medical, nursing, and pharmaceutical practices.
- Patients shall not be permitted to use physical restraints or seclusion on other patients.

The Oregon State Hospital Philosophy on the Use of Seclusion and Restraint has been reviewed and explained to me and a copy provided.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient is unable to sign - Nurse's Signature

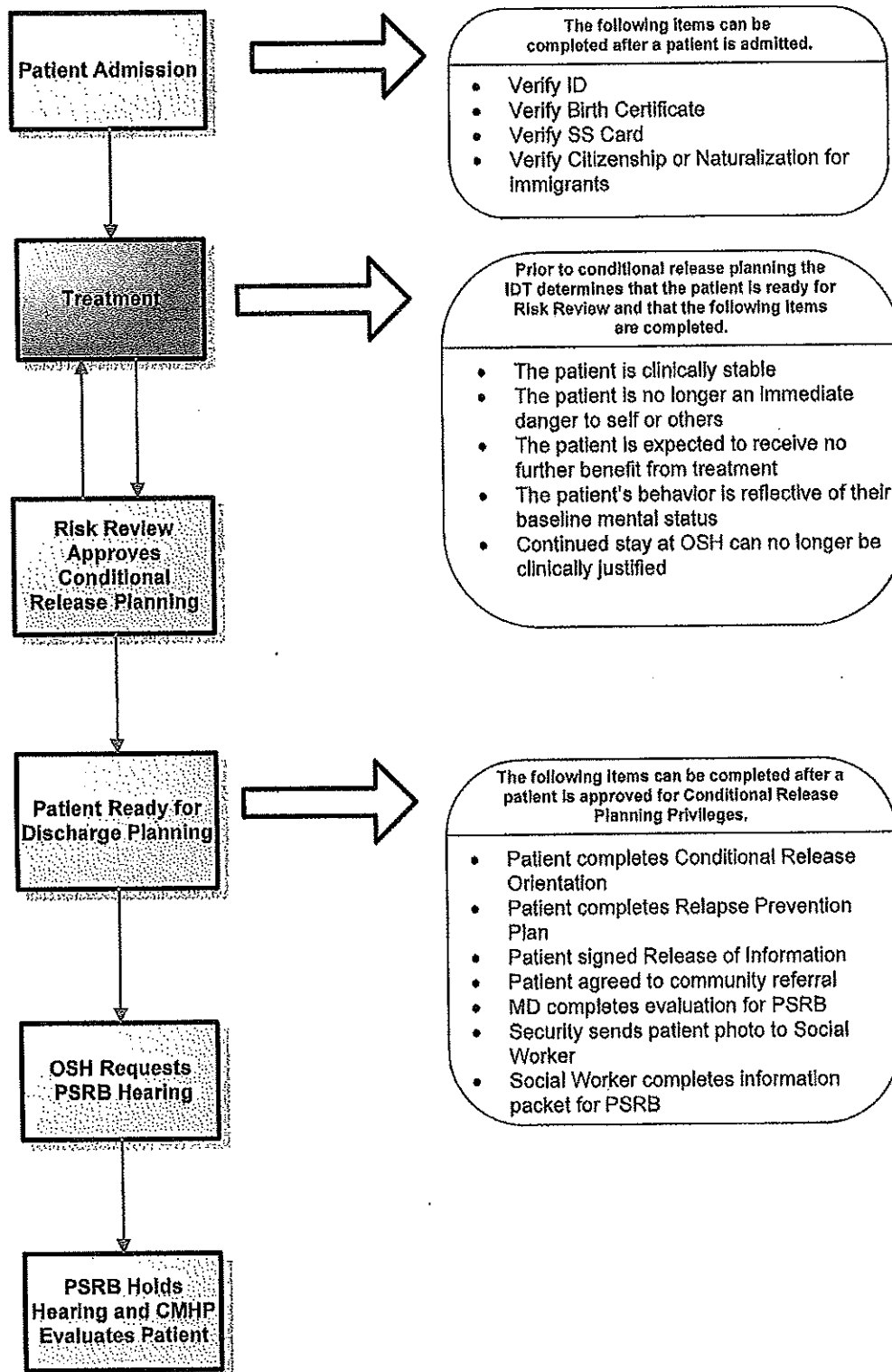
\_\_\_\_\_  
Date

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the persons or as otherwise permitted by law.

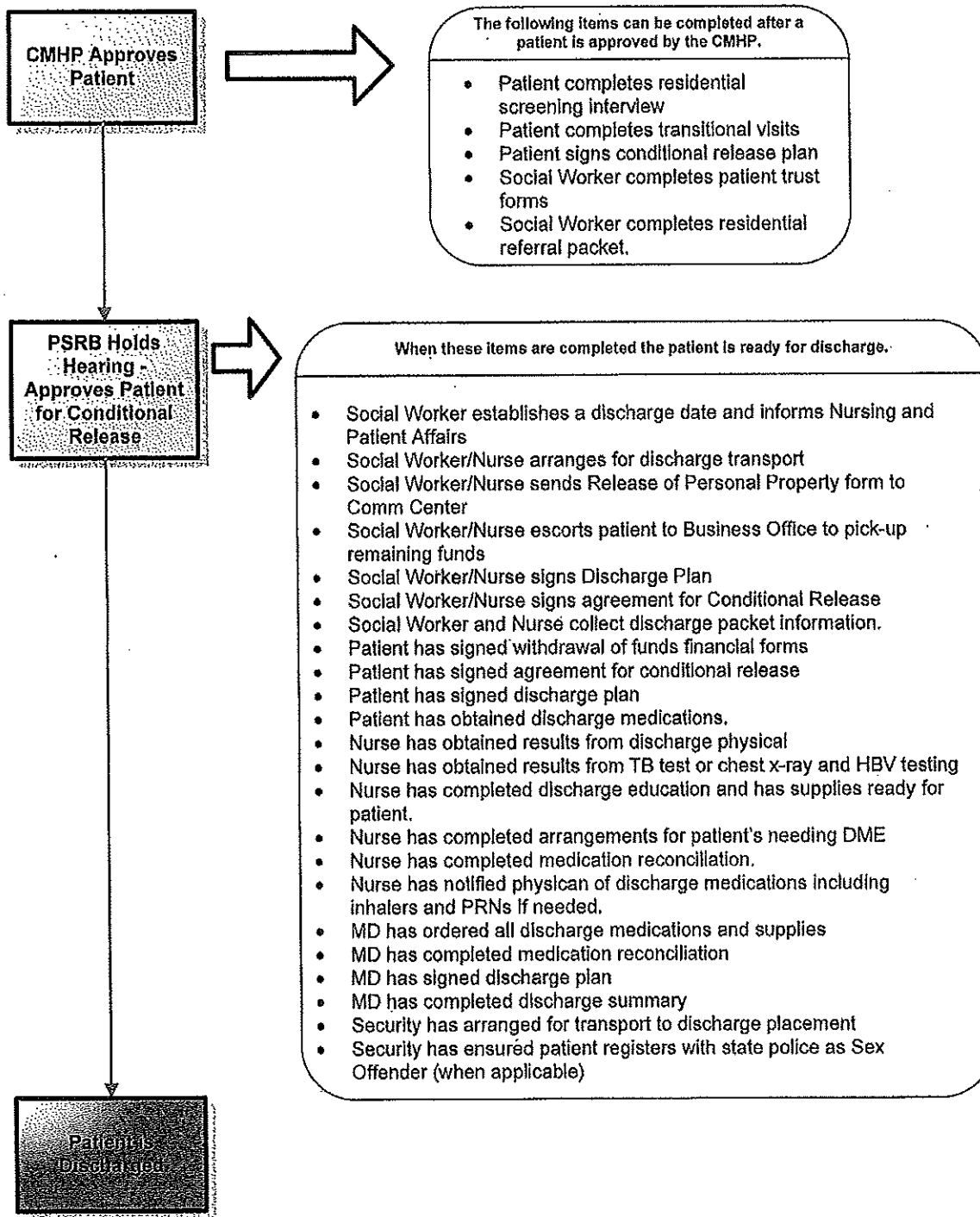
ADDRESSOGRAPH

File: Legal  
Thin: Do Not Thin  
OSH STK: 75060-MR-3 -04/2004  
MR #: 50-15-0135-00

## Conditional Release Planning: Steps to "Ready for Discharge"



## Conditional Release Planning: Steps to "Ready for Discharge"



Benton County – Janus House is a co-ed Residential Treatment Facility with mostly county and ECMU placements and 1 PSRB bed

Clackamas County – Adult Foster Homes take combination of ECMU, county, and PSRB clients

King Road Residential Treatment Home takes combination of ECMU, county, and PSRB clients

Columbia County – 8 Bed Residential Treatment Facility for PSRB clients, co-ed, Co-occurring disorder treatment with stepdown option planned in form of supported housing

Also have A&D treatment only option through 30-day residential A&D treatment at Pathways, then transition to apartment in the program

Coos County – 5 Bed Residential Treatment Home for PSRB clients, co-ed; developing a stepdown option of supported housing

Deschutes County – 5 Bed Residential Treatment Home for PSRB clients, can be co-ed, currently all male

Adult Foster Homes are available as stepdown options and take ECMU, county and PSRB combination of clients

Douglas County – Adult Foster Homes take combination of ECMU, county, and PSRB clients

Jackson County - Adult Foster Homes take combination of ECMU, county, and PSRB clients – Supported housing as stepdown from AFH

- Hazel Center Secure Residential Treatment Facility – 8 Beds for ECMU clients, 8 Beds for PSRB clients – co-ed
- Developing a 5 Bed Residential Treatment Home as stepdown option for Hazel Center – this would have 3 designated beds for PSRB

Josephine County - Adult Foster Homes take combination of ECMU, county, and PSRB clients

Klamath County – Phoenix Place Residential Treatment Facility has 9 Beds, mostly ECMU and County – do take PSRB

Lane County – Alder House and William Ware Residential Treatment Homes take combination of ECMU, county, and PSRB clients  
Heeran Center SRTF and Paul Wilson SRTF generally have 1 slot for PSRB – this may expand in the future

Lincoln County – Benton Place Residential Treatment Home has 2 PSRB beds and 3 ECMU beds – all male

Linn County – Springer House Residential Treatment Facility takes 1 PSRB client, the remainder are county or ECMU and respite beds

Malheur County - Adult Foster Homes take combination of ECMU, county, and PSRB clients

Supported Housing Recovery House was designated for PSRB, but have not been able to keep this resource to capacity  
Malheur County wants to develop a Secure Residential Treatment Facility in next 1-2 years

Marion County – Via Verde Residential Treatment Home – 5 beds for PSRB, co-ed

Adult Foster Homes take combination of ECMU, county, and PSRB clients  
Stepping Stones Supported Housing – primary A&D treatment issues, co-ed

Telecare Secure Residential Treatment Facility – 16 beds all PSRB, all male

Multnomah County – multiple providers

- Cascadia Behavioral Healthcare – 4 Residential Treatment Homes that are each 5 PSRB beds; One Residential Treatment Facility with 6 PSRB beds and 6 ECMU beds; two Secure Residential Treatment Facilities with 1 PSRB bed each; stepdown to Intensive Case management program
- CODA, Inc. – 2 Residential Treatment Homes with 4 PSRB beds, all male, Co-occurring disorders treatment program; stepdown to Intensive Case management program

- LukeDorf, Inc. – One 15 Bed Residential Treatment Facility, all PSRB, can be co-ed, currently all male; One 5 Bed Residential Treatment Home – all PSRB, co-ed, for clients with medical issues
- Mentor, Inc. – One 5 bed Residential Treatment Home, all PSRB, all male, for adult men with acquired brain injury
- Providence – Two 5 bed Adult Foster Homes, all PSRB, one all male and one all female; stepdown options to Supported Housing at Halsey Street Apartments

Umatilla County – One Residential Treatment Home with 2 PSRB slots; One Secure Residential Treatment Facility with 10 PSRB slots, co-ed; other beds are for crisis respite, ECMU, county

Development of State-operated group home in Pendleton underway – this will be 16 beds (4 women and 12 men)

Washington County – Connell House Secure Residential Treatment Facility recently closed by AMHD – if reopens they have capacity for 8 PSRB clients and 4 County/ECMU clients

Residential Treatment Homes through LukeDorf, Inc. have 7 bed PSRB capacity, co-ed

Yamhill County – Harmony Living ECF and Parkside will take PSRB clients on case-by-case basis

OREGON STATE HOSPITAL  
MEDICAL RECORD SERVICES  
POLICY AND PROCEDURES

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SECTION A: MEDICAL RECORD ON UNIT

POLICY: A8

SUBJECT: ADMISSION: Routine: First Admission and Readmission;  
30-Day Readmission

APPROVED:

DATE: 5/1/09

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I. POLICY

To provide a uniform collection of patient information upon a patient's admission or readmission to the hospital and to enhance continuity of patient care.

II. DEFINITIONS

Routine Admission: When a person presents for treatment as a first time patient or as a returning patient, who was discharged more than 30 days ago.

30-Day Readmission: A patient returns for treatment within 30 calendar days, not counting the day of the previous discharge, and whose previous admission type was not a short stay, court-ordered evaluation, or 30-day Readmit.

III. RESPONSIBLE POSITION(S) ALLOCATED SECTION(S)

Unit Staff	A, B
Clinical staff	B3
Medical Record Services Staff	C

IV. PROCEDURE

A. ROUTINE: FIRST ADMISSION AND READMISSION

1. When a patient is admitted to the hospital, unit staff shall enter the following admission information onto the OP/RCS admission screens via the unit computer terminal.
  - a. Name – Of the patient (Last, First, Middle)
  - b. Alias – If an alias is known to be used
  - c. Gender – Male or female
  - d. Date of birth
  - e. Address – The address of the patient prior to coming to the hospital
  - f. Admission/Screening Date anytime – The date and time the patient was actually admitted to the hospital
  - g. Attending/Screening Physician – The physician responsible for the patient's care

- h. Attending/Screening Social Worker – The social worker responsible for the patient's care
  - i. Attending Therapist – The therapist responsible for the patient's care
  - j. Commitment Type – The commitment type as listed on the legal paper accompanying the patient upon admission
  - k. County of Responsibility
  - l. Commitment County – The county which committed the patient to the hospital
  - m. Screening County – The county which committed the patient to the hospital
  - n. Veteran Status
  - o. Social Security Number
  - p. State of Residence
  - q. County of Residence
  - r. Place of Birth
  - s. Referral Source – Indicate the referral source which accompanies the commitment type
  - t. U.S. Citizen – Indicate yes or no
  - u. Living Arrangement – Indicate the patient's living arrangement prior to admission to the hospital
  - v. Ethnic Category
  - w. Religion
  - x. Oregon Driver's License Number
  - y. Marital Status
  - z. Education – Indicate the highest level of education attained by the patient
  - aa. Emergency Notification – The individual to be contacted in case of an emergency
  - bb. Relationship – Indicate the relationship of the emergency notification person to the patient
  - cc. Name – The name of the person to be notified in case of an emergency
  - dd. Address – Address of the person to be notified in case of an emergency
  - ee. Home Phone – The home phone number of the person to be notified in case of an emergency
  - ff. Business Phone – The business phone number, if applicable, for the person to be notified in case of an emergency
  - gg. Suicide Alerts
  - hh. Security Risk
  - ii. Fire Setter
  - jj. Able to Care for Self
  - kk. Danger to Others
  - ll. Allergies
2. Call MIS Department for help encoding a patient's admission in the OP/RCS system, if needed, and if they are not available, call MRS for assistance.

3. Contact MRS for the patient's addressograph card and previous medical record for readmit patient during normal business hours. When admission occurs during non-business hours, contact the Communications Center and request that the patient's medical record be pulled and sent to the admitting unit.

NOTE: If the patient's medical record is in the Record Storage Center, the unit shall be notified, and the record will be forwarded to the unit upon receipt.

4. Send a copy of legal papers, guardianship papers, or detainers to MRS within 24 hours after the patient's admission to the hospital.
5. Send the yellow copy of the Preliminary Admission History (OSH-STK-03359-MR) to MRS within 24 hours of admission.
6. Send the yellow copy of Informed Consent for Treatment with Psychotropic Medications, Form #1 (OSH-STK 04351-MR) or Informed Consent Information and Progress Note for Emergency Administration of Significant Procedure Without Consent, Form #4 (OSH-STK 04341).
7. Reprint Face Sheet 72 Hours post-admission with admission diagnosis printed.

#### B. 30-DAY READMISSION

1. Process the admission by following steps A 1 through 6.
2. When Face Sheet is complete, stamp with 30-Day Readmit stamp. When additional Face Sheets are printed, they will need to be stamped with 30-Day Readmit.
3. Clinical documentation that can be copied and stamped with the 30-Day Readmit stamp includes the following:
  - a. Physical Examination and Medical History: If the patient has had one completed within the last 10 days, it may be copied and stamped. An interval note describing any changes since the last physical examination shall be noted on the Preliminary Admission History form or on a dictated Admission History.
  - b. Admission History: A copy of the previous dictated Admission History may be copied and stamped. When an update to the Admission History is needed, this can be dictated or a handwritten admission progress note may be completed.

- c. Discharge Summary: A copy of the prior discharge can be copied, stamped, and filed with the Admission History.
- d. Psychology Assessment: A copy of the previous report can be used in the current ward chart. If additional information is available, an updated psychology assessment can be dictated.
- e. Psychosocial Assessment: A copy of the previous report can be used. If an interval note is needed, it can be dictated.
- f. RSD Assessment: A copy of the previous Comprehensive Assessment can be used with an update dictation, if necessary.
- g. Laboratory Tests and Consultation Index: Laboratory tests which are ordered routinely for all admissions (CBC, urinalysis, VDRL, etc.) do not need to be ordered on 30-Day Readmits unless the physician feels they are clinically indicated. The results of the previous admission tests should have been recorded on the Lab Diagnostic Test Index sheet, which shall be copied and stamped "30-Day Readmit" and filed in the current ward chart.
- h. Living Will/Advance Directive: If the patient had one included in a prior admission, it may be copied and stamped.

NOTE: Any other documentation not included in this procedure must be redone for the current admission. Examples include the Nursing Assessment, Informed Consents, etc.

#### C. ADMISSION ASSISTANCE FROM MEDICAL RECORD SERVICES

- 1. Forward new or previous medical records to unit.
- 2. Forward the blue addressograph card.
- 3. Forward copy of the patient's driving record, filed in the Legal section.
- 4. Code admission diagnosis, using DSM-IV-TR and ICD-9-CM, within 72 hours of admission. When the yellow Preliminary Admission History copies are delayed in arriving at MRS, contact the unit.
- 5. Make data corrections or additions to OP/RCS, if needed.

#### V.

#### REFERENCES

The Joint Commission – Hospital and Behavioral Healthcare Standards Manuals

OREGON STATE HOSPITAL  
MEDICAL RECORD SERVICES  
POLICY AND PROCEDURES

SECTION A: MEDICAL RECORD ON UNIT

POLICY: A6

SUBJECT: Discharge Plan Details Form

APPROVED:

DATE: 5/1/09

I. POLICY

The Discharge Plan Details form will be completed and copies distributed on the day of discharge in order to provide accurate information to the patient and those involved in his/her after care.

II. DEFINITIONS

None

III. RESPONSIBLE POSITION(S)

ALLOCATED SECTION(S)

Social Worker  
Physician

A, B, C  
A, B3

IV. PROCEDURE

- A. The Social Worker, in collaboration with the Physician, is responsible for completion and distribution of the Discharge Plan Details form.

NOTE: The Discharge Plan Details form is not required for patients who leave on Unauthorized Leave status or are discharged to a state correctional facility.

- B. The form must be written legibly and filled out completely. Write "NA" or "none" instead of leaving a section blank.
1. The Medication section must be completed with a list of discharge medications attached to the form.
  2. Signatures of the social worker and physician are required. The patient's signature and community contact person's signature should be obtained whenever possible.
- C. Make copies and distribute the completed form as follows:
- Original to chart
  - Copy to Medical Record Services

SUBJECT: Discharge Plan Details Form

POLICY NUMBER: A6

DATE: 5/1/09

Page 2 of 2

- Copy to patient
- Copy to community mental health program
- Copy retained by social worker

V. REFERENCES

OREGON STATE HOSPITAL  
MEDICAL RECORD SERVICES  
POLICY AND PROCEDURES

SECTION A: MEDICAL RECORD ON UNIT

POLICY: A9

SUBJECT: Discharge: Short Stay

APPROVED:

DATE: 5/1/09

I. POLICY

To provide guidelines for documentation and processing of Short Stay Admission medical records

II. DEFINITIONS

Short Stay – any admission (except Court Orders and Criminal Court Commitments) where the patient is discharged within seven (7) calendar days, counting the day of admission and the day of discharge.

III. RESPONSIBLE POSITION(S)

ALLOCATED SECTION(S)

Physician

A

Social Service

B

Unit Staff

C

IV. PROCEDURE

A. Physician:

1. When a patient is discharged within seven calendar days, the Short Stay Hospital Course section of the Preliminary Admission History form (OSH-STK-75018) needs to be completed. If the Admission History was dictated within 24 hours, dictate the Short Stay Hospital Course.
2. A final diagnosis must be given, or if it remains the same as the admission diagnosis, it needs to be indicated on form.

B. Social Service:

1. Shall complete the Discharge Plan Details form in collaboration with the attending physician. The form should be completed as thoroughly as possible, since for a short stay admission the Discharge Plan Details and the Preliminary Admission History will serve as both the admission and discharge documentation.

SUBJECT: Discharge: Short Stay Admission

POLICY NUMBER: A9

DATE: 5/1/09

Page 2 of 2

C. Unit Staff:

1. The chart shall be processed the same as any other discharge chart from the hospital. The chart shall be reviewed for completeness on the unit and sent to Medical Record Services by the fifth working day following discharge, counting day of discharge as day one.

V. REFERENCES

OREGON STATE HOSPITAL  
MEDICAL RECORD SERVICES  
POLICY AND PROCEDURES

SECTION A: MEDICAL RECORD ON UNIT

POLICY: A7

SUBJECT: Admission: Patient Screening for Evaluation  
Services—After Hours Admission

APPROVED:

DATE: 5/1/09

I. POLICY

To provide documentation guidelines for screening a patient for admission during business hours. After hours, including weekends and holidays, only Forensic Psychiatric Services conducts screenings.

II. DEFINITIONS

None

III. RESPONSIBLE POSITIONS

ALLOCATED SECTIONS

Communications Center Staff  
Physician  
Unit Staff  
File Coordinator/Receptionist

A, C, D  
B  
E  
F

IV. PROCEDURE

A. Communications Center Staff

Business Hours (M-F 0800-1700):

1. When a patient presents at the Communications Center for admission/screening, the Communications Center staff will notify the unit or Evaluation Service, and security staff will assist with patient escort to the correct area, if needed.

NOTE: Most screenings occur after hours, holidays, and weekends.

After-Hours (M-F 1701-0759 and all weekends/holidays):

1. Access the computerized Master Patient Index in the MCICS system to determine if the patient has been admitted or screened previously at Oregon State Hospital (OSH) or Dammasch State Hospital.
2. Advise the Officer of the Day (OD) if the person has been admitted or screened at OSH or DSH previously.

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3. If a previous medical record exists, retrieve the record from MRS via the Communications Center for the screening physician.
4. If the patient is admitted, the unit will enter the admission data in the hospital's OP/RCS computer system.
5. If the patient is only screened and not admitted, the Communications Center staff completes the screening admission screens. See Section C for data elements.

B. Physician

Business Hours and After-Hours:

1. During the screening process the Preliminary Admission History form (OSH-STK-75018) or a dictated Admission History shall be completed by the physician.
2. If the patient is screened and not admitted, complete pages one through four, including the Disposition portion of the Preliminary Admission History or include the Disposition in the dictated Admission Screening Note. The Disposition section needs to include:
  - a. The outcome of the screening
  - b. Condition at time of departure
  - c. Aftercare
  - d. Medications, if any

C. Data elements to be encoded in the hospital computer systems (OP/RCS) are as follows:

1. If the patient is screened and not admitted, the computerized facesheet must also be completed, providing the following information:

a. Patient Name	j. Social Security Number
b. Alias	k. State of residence
c. Sex	l. Place of birth
d. Date of Birth	m. U.S. citizen
e. Address	n. Ethnic category
f. Screening Date/Time	o. Emergency notification
g. Screening Physician	p. Reason not admitted
h. Screening Social Worker	q. Community Referral Agency
i. County of Responsibility	r. Referral Source code

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D. Patient screened and NOT ADMITTED

1. Send the Preliminary Admission History form and any referral papers the patient may have brought with him/her to Medical Record Services.

E. Patient is screened and ADMITTED, the unit staff shall:

1. Complete the computerized admission screens on OP/RCS, which include demographic, legal, diagnostic, etc., information in order to complete the computerized facesheet. See Policy A8 for complete admission data entry instruction.
2. Print a copy of the computerized facesheet and file the facesheet in the front of the ward chart.
3. File the Preliminary Admission History form (OSH-STK-75018) or the IDT-Initial Treatment Plan (OSH-STK-04101) in the correct section of the ward chart. Send the yellow copy of the Preliminary Admission History to Medical Record Services, when completed.

F. Medical Record Services:

1. Admission: Will supply the unit with the patient's previous chart if applicable and send a new chart for the current admission.
2. Screening only: Make a new chart for a first time encounter or add the screening information to the chart if a previous patient.

V. REFERENCES

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TITLE 16  
CRIMES AND PUNISHMENTS

*pg 3 gives  
referenced  
ORS*

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163. Offenses Against Persons  
164. Offenses Against Property  
165. Offenses Involving Fraud or Deception  
166. Offenses Against Public Order; Firearms and Other Weapons; Racketeering  
167. Offenses Against Public Health, Decency and Animals  
169. Local and Regional Correctional Facilities; Prisoners; Juvenile Facilities

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Chapter 161 — General Provisions

2009 EDITION

GENERAL PROVISIONS

CRIMES AND PUNISHMENTS

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161.015 General definitions  
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using physical force, including deadly physical force, when and to the extent that the officer or official reasonably believes it necessary to:

- (a) Prevent the escape of an inmate from a Department of Corrections institution, including the grounds of the institution, or from custody;
  - (b) Maintain or restore order and discipline in a Department of Corrections institution, or any part of the institution, in the event of a riot, disturbance or other occurrence that threatens the safety of inmates, department employees or other persons; or
  - (c) Prevent serious physical injury to or the death of the officer, official or another person.
- (3) Notwithstanding subsection (2)(a) of this section, a corrections officer or other official employed by the department may not use deadly physical force to prevent the escape of an inmate from:
- (a) A stand-alone minimum security facility;
  - (b) A colocated minimum security facility, if the corrections officer or other official knows that the inmate has been classified by the department as minimum custody; or
  - (c) Custody outside of a Department of Corrections institution:
    - (A) While the inmate is assigned to an inmate work crew; or
    - (B) During transport or other supervised activity, if the inmate is classified by the department as minimum custody and the inmate is not being transported or supervised with an inmate who has been classified by the department as medium or higher custody.
- (4) Nothing in this section limits the authority of a person to use physical force under ORS 161.205 (2) or 161.265. [2005 c.431 §2]

**161.270 Duress.** (1) The commission of acts which would otherwise constitute an offense, other than murder, is not criminal if the actor engaged in the proscribed conduct because the actor was coerced to do so by the use or threatened use of unlawful physical force upon the actor or a third person, which force or threatened force was of such nature or degree to overcome earnest resistance.

(2) Duress is not a defense for one who intentionally or recklessly places oneself in a situation in which it is probable that one will be subjected to duress.

(3) It is not a defense that a spouse acted on the command of the other spouse, unless the spouse acted under such coercion as would establish a defense under subsection (1) of this section. [1971 c.743 §34; 1987 c.158 §22]

**161.275 Entrapment.** (1) The commission of acts which would otherwise constitute an offense is not criminal if the actor engaged in the proscribed conduct because the actor was induced to do so by a law enforcement official, or by a person acting in cooperation with a law enforcement official, for the purpose of obtaining evidence to be used against the actor in a criminal prosecution.

(2) As used in this section, "induced" means that the actor did not contemplate and would not otherwise have engaged in the proscribed conduct. Merely affording the actor an opportunity to commit an offense does not constitute entrapment. [1971 c.743 §35]

## RESPONSIBILITY

**161.290 Incapacity due to immaturity.** (1) A person who is tried as an adult in a court of criminal jurisdiction is not criminally responsible for any conduct which occurred when the person was under 12 years of age.

(2) Incapacity due to immaturity, as defined in subsection (1) of this section, is a defense. [Formerly 161.380; 1995 c.422 §58]

**161.295 Effect of mental disease or defect; guilty except for insanity.** (1) A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

(2) As used in chapter 743, Oregon Laws 1971, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder. [1971 c.743 §36; 1983 c.800 §1]

**Note:** See note under 161.015.

**161.300 Evidence of disease or defect admissible as to intent.** Evidence that the actor suffered from a mental disease or defect is admissible whenever it is relevant to the issue of whether the actor did or did not have the intent which is an element of the crime. [1971 c.743 §37]

**161.305 Disease or defect as affirmative defense.** Mental disease or defect constituting insanity under ORS 161.295 is an affirmative defense. [1971 c.743 §38; 1983 c.800 §2]

**161.309 Notice prerequisite to defense; content.** (1) No evidence may be introduced by the defendant on the issue of insanity under ORS 161.295, unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(2) The defendant may not introduce in the case in chief expert testimony regarding partial responsibility or diminished capacity under ORS 161.300 unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(3) A defendant who is required under subsection (1) or (2) of this section to give notice shall file a written notice of purpose at the time the defendant pleads not guilty. The defendant may file such notice at any time after the plea but before trial when just cause for failure to file the notice at the time of making the plea is made to appear to the satisfaction of the court. If the defendant fails to file notice, the defendant shall not be entitled to introduce evidence for the establishment of a defense under ORS 161.295 or 161.300 unless the court, in its discretion, permits such evidence to be introduced where just cause for failure to file the notice is made to appear. [1971 c.743 §§39,40,41; 1983 c.800 §3; 2003 c.127 §2]

**161.310** [Repealed by 1971 c.743 §432]

**161.313 Jury instructions; insanity.** When the issue of insanity under ORS 161.295 is submitted to be determined by a jury in the trial court, the court shall instruct the jury in accordance with ORS 161.327. [1983 c.800 §16]

**161.315 Right of state to obtain mental examination of defendant; limitations.** Upon filing of notice or the introduction of evidence by the defendant as provided in ORS 161.309 (3), the state shall have the right to have at least one psychiatrist or licensed psychologist of its selection examine the defendant. The state shall file notice with the court of its intention to have the defendant examined. Upon filing of the notice, the court, in its discretion, may order the defendant committed to a state institution or any other suitable facility, if the defendant is 18 years of age or older, for observation and examination as the court may designate for a period not to exceed 30 days. If the defendant is under 18 years of age, upon filing of the notice, the court, in its discretion, may order the defendant committed to a secure intensive community inpatient facility designated by the Oregon Health Authority for observation and examination as the court may designate for a period not to exceed 30 days. If the defendant objects to the examiner chosen by the state, the court for good cause shown may direct the state to select a different examiner. [1971 c.743 §42; 1977 c.380 §3; 2007 c.14 §5; 2009 c.595 §101]

**161.319 Form of verdict on guilty except for insanity.** When the defendant is found guilty except for insanity under ORS 161.295, the verdict and judgment shall so state. [1971 c.743 §43; 1977 c.380 §4; 1983 c.800 §4]

161.320 [Repealed by 1971 c.743 §432]

**161.325 Entry of judgment of guilty except for insanity; order to include whether victim wants notice of hearings or release of defendant; blood or buccal testing upon judgment.** (1) After entry of judgment of guilty except for insanity, the court shall, on the basis of the evidence given at the trial or at a separate hearing, if requested by either party, make an order as provided in ORS 161.327 or 161.329, whichever is appropriate.

(2) If the court makes an order as provided in ORS 161.327, it shall also:

(a) Determine on the record the offense of which the person otherwise would have been convicted;

(b) State on the record the mental disease or defect on which the defendant relied for the guilty except for insanity defense; and

(c) Make specific findings on whether there is a victim of the crime for which the defendant has been found guilty except for insanity and, if so, whether the victim wishes to be notified, under ORS 161.326 (2), of any Psychiatric Security Review Board hearings concerning the defendant and of any conditional release, discharge or escape of the defendant.

(3) The court shall include any such findings in its order.

(4) Except under circumstances described in ORS 137.076 (4), whenever a defendant charged with any offense listed in ORS 137.076 (1) has been found guilty of that offense except for insanity, the court shall, in any order entered under ORS 161.327 or 161.329, direct the defendant to submit to the obtaining of a blood or buccal sample in the manner provided in ORS 137.076. [1971 c.743 §44; 1977 c.380 §5; 1979 c.885 §1; 1981 c.711 §1; 1983 c.800 §5; 1991 c.669 §8; 1999 c.97 §2; 2005 c.337 §1]

**161.326 Commission of crime by person under board jurisdiction; notice to victim.** (1)

Whenever a person already under the board's jurisdiction commits a new crime, the court or the board shall make the findings described in ORS 161.325 (2).

(2) If the trial court or the board determines that a victim desires notification as described in ORS 161.325 (2), the board shall make a reasonable effort to notify the victim of board hearings, conditional release, discharge or escape. [1981 c.711 §9]

**Note:** 161.326 and 161.387 were added to and made a part of ORS chapter 161 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

**161.327 Order giving jurisdiction to Psychiatric Security Review Board; court to commit or conditionally release defendant; notice to board; appeal.** (1)(a) Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a felony, or of a misdemeanor during a criminal episode in the course of which the person caused physical injury or risk of physical injury to another, the court shall order that a psychiatric or psychological evaluation be performed and a report of the evaluation be provided to the court if an evaluation was not performed or a report was not provided to the court prior to trial. Upon receipt of the evaluation, the court shall order that the person be placed under the jurisdiction of the Psychiatric Security Review Board for care and treatment if the court finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others requiring commitment to:

(A) A state hospital designated by the Oregon Health Authority if the person is at least 18 years of age; or

(B) A secure intensive community inpatient facility designated by the authority if the person is under 18 years of age.

(b) The period of jurisdiction of the board is equal to the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(c) When a court orders a psychiatric or psychological evaluation of a financially eligible person

under this subsection, the court shall order the public defense services executive director to pay a reasonable fee for the evaluation from funds available for the purpose.

(2) The court shall determine whether the person should be committed to a state hospital, or to a secure intensive community inpatient facility, designated by the authority or conditionally released pending any hearing before the board as follows:

(a) If the court finds that the person presents a substantial danger to others and is not a proper subject for conditional release, the court shall order the person committed to a state hospital designated by the authority if the person is at least 18 years of age, or to a secure intensive community inpatient facility designated by the authority if the person is under 18 years of age, for custody, care and treatment pending hearing before the board in accordance with ORS 161.341 to 161.351.

(b) If the court finds that the person presents a substantial danger to others but that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court may order the person conditionally released, subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state, county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others.

(4) In determining whether a person should be conditionally released, the court may order evaluations, examinations and compliance as provided in ORS 161.336 (4) and 161.346 (2).

(5) In determining whether a person should be committed to a state hospital or to a secure intensive community inpatient facility or conditionally released, the court shall have as its primary concern the protection of society.

(6) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed, and all other conditions of release, and the person shall be on conditional release pending hearing before the board in accordance with ORS 161.336 to 161.351. Upon compliance with this subsection and subsections (1) and (2) of this section, the court's jurisdiction over the person is terminated and the board assumes jurisdiction over the person.

(7) An order of the court under this section is a final order appealable by the person found guilty except for insanity in accordance with ORS 19.205 (5). Notwithstanding ORS 19.255, notice of an appeal under this section shall be served and filed within 90 days after the order appealed from is entered in the register. The person shall be entitled on appeal to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is financially eligible, suitable counsel shall be appointed in the manner provided in ORS 138.500 (1), and the compensation for counsel and costs and expenses of the person necessary to the appeal shall be determined and paid as provided in ORS 138.500.

(8) Upon placing a person under the jurisdiction of the board, the court shall notify the person of the right to appeal and the right to a hearing before the board in accordance with ORS 161.336 (7) and 161.341 (4). [1979 c.867 §5; 1979 c.885 §2; 1981 c.711 §2; 1981 s.s. c.3 §129; 1983 c.800 §6; 1989 c.790 §48; 1995 c.208 §1; 2001 c.962 §89; 2003 c.576 §§578,579; 2005 c.685 §§1,1a; 2009 c.595 §102]

**Note:** 161.327 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised

Statutes for further explanation.

**161.328 Initiation of civil commitment proceedings.** Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a misdemeanor during a criminal episode in the course of which the person did not cause physical injury or risk of physical injury to another, and if the court has probable cause to believe that the person is dangerous to self or others as a result of a mental disorder, the court may initiate civil commitment proceedings under ORS 426.070 to 426.130. [1981 c.711 §3; 1983 c.800 §7; 1987 c.903 §36; 1995 c.529 §1]

**161.329 Order of discharge.** Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others and is not in need of care, supervision or treatment, the court shall order the person discharged from custody. [1971 c.743 §45; 1977 c.380 §6; 1981 c.711 §4]

**161.330** [Repealed by 1971 c.743 §432]

**161.332 "Conditional release" defined.** As used in ORS 161.315 to 161.351 and 161.385 to 161.395, "conditional release" includes, but is not limited to, the monitoring of mental and physical health treatment. [1977 c.380 §1; 1983 c.800 §8]

**161.335** [1971 c.743 §46; 1973 c.137 §1; 1975 c.380 §1; repealed by 1977 c.380 §10 (161.336 enacted in lieu of 161.335)]

**161.336 Conditional release by Psychiatric Security Review Board; supervision by board; termination or modification of conditional release; hearing.** (1) If the Psychiatric Security Review Board determines that the person presents a substantial danger to others but can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the board may order the person conditionally released, subject to those supervisory orders of the board as are in the best interests of justice, the protection of society and the welfare of the person. The board may designate any person or state, county or local agency the board considers capable of supervising the person upon release, subject to those conditions as the board directs in the order for conditional release. Prior to the designation, the board shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the board. After receiving an order entered under this section, the person or agency designated shall assume supervision of the person pursuant to the direction of the board.

(2) Conditions of release contained in orders entered under this section may be modified from time to time and conditional releases may be terminated by order of the board as provided in ORS 161.351.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others. The person may be continued on conditional release by the board as provided in this section.

(4)(a) As a condition of release, the board may require the person to report to any state or local mental health facility for evaluation. Whenever medical, psychiatric or psychological treatment is recommended, the board may order the person, as a condition of release, to cooperate with and accept the treatment from the facility.

(b) The facility to which the person has been referred for evaluation shall perform the evaluation and submit a written report of its findings to the board. If the facility finds that treatment of the person is appropriate, it shall include its recommendations for treatment in the report to the board.

(c) Whenever treatment is provided by the facility, it shall furnish reports to the board on a regular basis concerning the progress of the person.

(d) Copies of all reports submitted to the board pursuant to this section shall be furnished to the person and the person's counsel. The confidentiality of these reports is determined pursuant to ORS 192.501 to 192.505.

(e) The facility shall comply with any other conditions of release prescribed by order of the board.

(5) If at any time while the person is under the jurisdiction of the board it appears to the board or its chairperson that the person has violated the terms of the conditional release or that the mental health of the individual has changed, the board or its chairperson may order the person returned for evaluation or treatment to a state hospital designated by the Oregon Health Authority if the person is at least 18 years of age, or to a secure intensive community inpatient facility designated by the authority if the person is under 18 years of age. A written order of the board, or its chairperson on behalf of the board, is sufficient warrant for any law enforcement officer to take into custody such person and transport the person accordingly. A sheriff, municipal police officer, constable, parole and probation officer, prison official or other peace officer shall execute the order, and the person shall be returned as soon as practicable to the custody of the authority. Within 20 days following the return of the person to the custody of the authority, the board shall conduct a hearing. Notice of the time and place of the hearing shall be given to the person, the attorney representing the person and the Attorney General. The board may continue the person on conditional release or, if it finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others and cannot be adequately controlled if conditional release is continued, it may order the person committed to a state hospital designated by the authority if the person is at least 18 years of age, or to a secure intensive community inpatient facility designated by the authority if the person is under 18 years of age. The state must prove by a preponderance of the evidence the person's unfitness for conditional release. A person in custody pursuant to this subsection has the same rights as any person appearing before the board pursuant to ORS 161.346.

(6) The community mental health program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall be transported as soon as practicable to a state hospital designated by the authority if the person is at least 18 years of age, or to a secure intensive community inpatient facility designated by the authority if the person is under 18 years of age. A person taken into custody under this subsection has the same rights as any person appearing before the board pursuant to ORS 161.346.

(7)(a) Any person conditionally released under this section may apply to the board for discharge from or modification of an order of conditional release on the ground that the person is no longer affected by mental disease or defect or, if still so affected, no longer presents a substantial danger to others and no longer requires supervision, medication, care or treatment. Notice of the hearing on an application for discharge or modification of an order of conditional release shall be made to the Attorney General. The applicant, at the hearing pursuant to this subsection, must prove by a preponderance of the evidence the applicant's fitness for discharge or modification of the order of conditional release. Applications by the person for discharge or modification of conditional release shall not be filed more often than once every six months.

(b) Upon application by any person or agency responsible for supervision or treatment pursuant to an order of conditional release, the board shall conduct a hearing to determine if the conditions of release shall be continued, modified or terminated. The application shall be accompanied by a report setting forth the facts supporting the application.

(8) The total period of commitment and conditional release ordered pursuant to this section may not exceed the maximum sentence provided by statute for the crime for which the person was found guilty

§4; 2007 c.288 §7; 2009 c.595 §105]

**161.350** [1971 c.743 §49; 1975 c.380 §3; repealed by 1977 c.380 §16 (161.351 enacted in lieu of 161.350)]

**161.351 Discharge of person under jurisdiction of board; periodic review of status.** (1) Any person placed under the jurisdiction of the Psychiatric Security Review Board pursuant to ORS 161.336 or 161.341 shall be discharged at such time as the board, upon a hearing, shall find by a preponderance of the evidence that the person is no longer affected by mental disease or defect or, if so affected, no longer presents a substantial danger to others which requires regular medical care, medication, supervision or treatment.

(2) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect. A person whose mental disease or defect may, with reasonable medical probability, occasionally become active and when it becomes active will render the person a danger to others, shall not be discharged. The person shall continue under such supervision and treatment as the board deems necessary to protect the person and others.

(3) Any person who has been placed under the jurisdiction of the board and who has spent five years on conditional release shall be brought before the board for hearing within 30 days of the expiration of the five-year period. The board shall review the person's status and determine whether the person should be discharged from the jurisdiction of the board. [1977 c.380 §17 (enacted in lieu of 161.350); 1981 c.711 §13; 1985 c.192 §4; 1989 c.49 §1]

**161.360 Mental disease or defect excluding fitness to proceed.** (1) If, before or during the trial in any criminal case, the court has reason to doubt the defendant's fitness to proceed by reason of incapacity, the court may order an examination in the manner provided in ORS 161.365.

(2) A defendant may be found incapacitated if, as a result of mental disease or defect, the defendant is unable:

- (a) To understand the nature of the proceedings against the defendant; or
- (b) To assist and cooperate with the counsel of the defendant; or
- (c) To participate in the defense of the defendant. [1971 c.743 §50; 1993 c.238 §1]

**161.365 Procedure for determining issue of fitness to proceed.** (1) Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.

(2) If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed for the purpose of an examination for a period not exceeding 30 days to a state mental hospital designated by the Oregon Health Authority if the defendant is at least 18 years of age, or to a secure intensive community inpatient facility designated by the authority if the defendant is under 18 years of age. The report of each examination shall include, but is not necessarily limited to, the following:

- (a) A description of the nature of the examination;
- (b) A statement of the mental condition of the defendant; and
- (c) If the defendant suffers from a mental disease or defect, an opinion as to whether the defendant is incapacitated within the definition set out in ORS 161.360.

(3) Except when the defendant and the court both request to the contrary, the report may not contain any findings or conclusions as to whether the defendant as a result of mental disease or defect was subject to the provisions of ORS 161.295 or 161.300 at the time of the criminal act charged.

(4) If the examination by the psychiatrist or psychologist cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of mental disease

or defect affecting capacity to proceed.

(5) The report of the examination shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.

(6) When upon motion of the court or a financially eligible defendant, the court has ordered a psychiatric or psychological examination of the defendant, a county or justice court shall order the county to pay, and a circuit court shall order the public defense services executive director to pay from funds available for the purpose:

(a) A reasonable fee if the examination of the defendant is conducted by a psychiatrist or psychologist in private practice; and

(b) All costs including transportation of the defendant if the examination is conducted by a psychiatrist or psychologist in the employ of the Oregon Health Authority or a community mental health program established under ORS 430.610 to 430.670.

(7) When such an examination is ordered at the request or with the acquiescence of a defendant who is determined not to be financially eligible, the examination shall be performed at the defendant's expense. When such an examination is ordered at the request of the prosecution, the county shall pay for the expense of the examination. [1971 c.743 §51; 1975 c.380 §4; 1981 s.s. c.3 §131; 1983 c.800 §11; 1987 c.803 §18; 1993 c.238 §2; 2001 c.962 §90; 2005 c.685 §5; 2009 c.595 §106]

**161.370 Determination of fitness; effect of finding of unfitness; proceedings if fitness regained; pretrial objections by defense counsel.** (1) When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed by a psychiatrist or psychologist under ORS 161.365, the court may make the determination on the basis of such report. If the finding is contested, the court shall hold a hearing on the issue. If the report is received in evidence upon such hearing, the party who contests the finding thereof shall have the right to summon and to cross-examine any psychiatrist or psychologist who submitted the report and to offer evidence upon the issue. Other evidence regarding the defendant's fitness to proceed may be introduced by either party.

(2) If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in subsection (12) of this section, and the court shall commit the defendant to the custody of the superintendent of a state mental hospital designated by the Oregon Health Authority if the defendant is at least 18 years of age, or to the custody of the director of a secure intensive community inpatient facility designated by the authority if the defendant is under 18 years of age, or shall release the defendant on supervision for as long as such unfitness shall endure. The court may release the defendant on supervision if it determines that care other than commitment for incapacity to stand trial would better serve the defendant and the community. It may place conditions which it deems appropriate on the release, including the requirement that the defendant regularly report to the authority or a community mental health program for examination to determine if the defendant has regained capacity to stand trial. When the court, on its own motion or upon the application of the superintendent of the hospital or director of the secure intensive community inpatient facility in which the defendant is committed, a person examining the defendant as a condition of release on supervision, or either party, determines, after a hearing, if a hearing is requested, that the defendant has regained fitness to proceed, the proceeding shall be resumed. If, however, the court is of the view that so much time has elapsed since the commitment or release of the defendant on supervision that it would be unjust to resume the criminal proceeding, the court on motion of either party may dismiss the charge and may order the defendant to be discharged or cause a proceeding to be commenced forthwith under ORS 426.070 to 426.170 or 427.235 to 427.290.

(3) The superintendent of a state hospital or director of a secure intensive community inpatient facility shall cause the defendant to be evaluated within 60 days from the defendant's delivery into the superintendent's or director's custody, for the purpose of determining whether there is a substantial probability that, in the foreseeable future, the defendant will have the capacity to stand trial.

(4) In addition, the superintendent or director shall:

(a) Immediately notify the committing court if the defendant, at any time, gains or regains the capacity to stand trial or will never have the capacity to stand trial.

(b) Within 90 days of the defendant's delivery into the superintendent's or director's custody, notify the committing court that:

(A) The defendant has the present capacity to stand trial;

(B) There is no substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial; or

(C) There is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial. If such a probability exists, the superintendent or director shall give the court an estimate of the time in which the defendant, with appropriate treatment, is expected to gain or regain capacity.

(5) If the superintendent or director determines that there is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial, unless the court otherwise orders, the defendant shall remain in the superintendent's or director's custody where the defendant shall receive treatment designed for the purpose of enabling the defendant to gain or regain capacity. In keeping with the notice requirement under subsection (4)(b) of this section, the superintendent or director shall, for the duration of the defendant's period of commitment, submit a progress report to the committing court, concerning the defendant's capacity or incapacity, at least once every 180 days as measured from the date of the defendant's delivery into the superintendent's or director's custody.

(6) A defendant who remains committed under subsection (5) of this section shall be discharged within a period of time that is reasonable for making a determination concerning whether or not, and when, the defendant may gain or regain capacity. However, regardless of the number of charges with which the defendant is accused, in no event shall the defendant be committed for longer than whichever of the following, measured from the defendant's initial custody date, is shorter:

(a) Three years; or

(b) A period of time equal to the maximum sentence the court could have imposed if the defendant had been convicted.

(7) The superintendent or director shall notify the committing court of the defendant's impending discharge 30 days before the date on which the superintendent or director is required to discharge the defendant under subsection (6) of this section.

(8) When the committing court receives a notice from the superintendent or director under either subsection (4) or (7) of this section concerning the defendant's progress or lack thereof, the committing court shall determine after a hearing, if a hearing is requested, whether the defendant presently has the capacity to stand trial.

(9) If under subsection (8) of this section the court determines that the defendant lacks the capacity to stand trial, the court shall further determine whether there is a substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial and whether the defendant is entitled to discharge under subsection (6) of this section. If the court determines that there is no substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial or that the defendant is entitled to discharge under subsection (6) of this section, the court shall dismiss, without prejudice, all charges against the defendant and:

(a) Order that the defendant be discharged; or

(b) Initiate commitment proceedings under ORS 426.070 or 427.235 to 427.290.

(10) All notices required under this section shall be filed with the clerk of the court and delivered to both the district attorney and the counsel for the defendant.

(11) If the defendant regains fitness to proceed, the term of any sentence received by the defendant for conviction of the crime charged shall be reduced by the amount of time the defendant was committed under this section to the custody of a state mental hospital, or to the custody of a secure intensive community inpatient facility, designated by the Oregon Health Authority.

(12) The fact that the defendant is unfit to proceed does not preclude any objection through counsel and without the personal participation of the defendant on the grounds that the indictment is insufficient,

that the statute of limitations has run, that double jeopardy principles apply or upon any other ground at the discretion of the court which the court deems susceptible of fair determination prior to trial. [1971 c.743 §52; 1975 c.380 §5; 1993 c.238 §3; 1999 c.931 §§1,2; 2005 c.685 §6; 2009 c.595 §107]

**161.375 Escape of person placed at hospital or facility; authority to order arrest.** (1) When a patient, who has been placed at the Oregon State Hospital for evaluation, care, custody and treatment under the jurisdiction of the Psychiatric Security Review Board or by court order under ORS 161.315, 161.365 or 161.370, has escaped or is absent without authorization from the Oregon State Hospital or from the custody of any person in whose charge the superintendent has placed the patient, the superintendent may order the arrest and detention of the patient.

(2) When a patient, who has been placed at a secure intensive community inpatient facility for evaluation, care, custody and treatment under the jurisdiction of the Psychiatric Security Review Board or by court order under ORS 161.315, 161.365, 161.370 or 419C.527, has escaped or is absent without authorization from the facility or from the custody of any person in whose charge the director of the facility has placed the patient, the director of the facility shall notify the Director of the Oregon Health Authority. The Director of the Oregon Health Authority may order the arrest and detention of the patient.

(3) The superintendent or the Director of the Oregon Health Authority may issue an order under this section based upon a reasonable belief that grounds exist for issuing the order. When reasonable, the superintendent or the Director of the Oregon Health Authority shall investigate to ascertain whether such grounds exist.

(4) Any order issued by the superintendent or the Director of the Oregon Health Authority as authorized by this section constitutes full authority for the arrest and detention of the patient and all laws applicable to warrant or arrest apply to the order. An order issued by the superintendent or the Director of the Oregon Health Authority under this section expires 72 hours after being signed by the superintendent or the Director of the Oregon Health Authority.

(5) As used in this section, "superintendent" means the superintendent of the Oregon State Hospital or the superintendent's authorized representative. [1997 c.423 §1; 2005 c.685 §7; 2005 c.843 §24a; 2009 c.595 §108]

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**Note:** 161.375 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

**161.380** [1971 c.743 §53; renumbered 161.290]

**161.385 Psychiatric Security Review Board; composition, term, qualifications, compensation, appointment, confirmation and meetings; judicial review of orders.** (1) There is hereby created a Psychiatric Security Review Board consisting of 10 members appointed by the Governor and subject to confirmation by the Senate under section 4, Article III of the Oregon Constitution.

(2) The membership of the board may not include any district attorney, deputy district attorney or public defender. The Governor shall appoint:

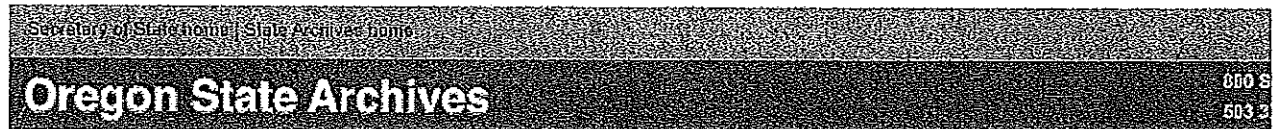
(a) A psychiatrist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Oregon Health Authority or a community mental health program;

(b) A licensed psychologist experienced in the criminal justice system and not otherwise employed on a full-time basis by the authority or a community mental health program;

(c) A member with substantial experience in the processes of parole and probation;

(d) A lawyer with substantial experience in criminal trial practice;

(e) A psychiatrist certified, or eligible to be certified, by the Oregon Medical Board in child psychiatry who is experienced in the juvenile justice system and not employed on a full-time basis by the authority or a community mental health program;



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### **DEPARTMENT OF HUMAN SERVICES, ADDICTIONS AND MENTAL HEALTH DIVISION: MENTAL HEALTH SERVICES**

#### **DIVISION 31**

#### **PROGRAMS FOR MENTAL OR EMOTIONAL DISTURBANCES**

#### **Hospital Programs**

**309-031-0010**

#### **Forensic Psychiatric Services**

(1) Purpose. This rule prescribes procedures for the assignment to state institutions of persons committed to the Mental Health and Developmental Disability Services Division by a court of criminal jurisdiction and persons ordered to a state institution by the Psychiatric Security Review Board. This rule also designates the state institution to receive other dangerous persons in certain instances.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 161.390, 179.040, and 430.041 and carries out the provisions of ORS 161.295 through 161.370, 161.725 to 161.735, 426.005 to 426.680, 427.175 and 427.180.

(3) Definitions. As used in this rule:

(a) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(b) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(c) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(d) "Psychiatric Security Review Board" is the Board created by ORS 161.385.

(e) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(f) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(g) "Superintendent" means the executive head of the state institution as listed in subsection (3)(f) of this rule.

(4) Designation of State Institution for Admission of Persons Under Jurisdiction of Court or Psychiatric Security Review Board:

(a) If a court orders a person committed to a state institution for an evaluation under ORS 161.365 to determine a defendant's fitness to proceed to trial, under ORS 161.315 to determine a defendant's criminal responsibility, or under ORS 161.725 to determine if a defendant is a habitual criminal, the person will be admitted to the Forensic Psychiatric Service of Oregon State Hospital according to conditions set forth in subsection (b) of this section, unless otherwise ordered by the Administrator;

(b) The Clinical Director of the Forensic Psychiatric Service may, upon finding that requests for admission to the Service pursuant to subsection (a) of this section are sufficient in number to require the establishment of a waiting list to govern admissions, establish a waiting list based on such factors as:

(A) Severity of the mental disorder;

(B) Degree to which the person presents an immediate and serious danger to others;

(C) Adequacy of the facility having custody to continue care and custody of the person; and

(D) Sequence in which the order or request for admission was received by the Forensic Psychiatric Service.

(c) If a court orders a person committed to a state institution after being found unfit to proceed with trial under ORS 161.370, or if a court or the Psychiatric Security Review Board orders a person committed to a state institution under ORS 161.336, 161.341, or 161.346, the person shall be admitted to the Forensic Psychiatric Service of Oregon State Hospital, unless otherwise ordered by the Administrator.

(5) Interinstitutional Transfers:

(a) If, in the opinion of the Superintendent of Oregon State Hospital or his designee, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient of the Forensic Psychiatric Service be transferred within Oregon State Hospital, or to Dammasch State Hospital, Eastern Oregon Hospital and Training Center, or Fairview Training Center, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the superintendent of the receiving institution, arrange for transfer. A patient of the Forensic Psychiatric Service may request such a transfer through a written request to the Superintendent of Oregon State Hospital. Transfers made to the Mental Retardation Section of Eastern Oregon Hospital and Training Center or Fairview Training Center shall comply with the eligibility requirements outlined in OAR 309-042-0000 (Admission and Release of Residents), as determined by the Diagnosis and Evaluation Service of the Mental Health and Developmental Disability Services Division;

(b) If, in the opinion of the superintendent of a state institution, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient or resident be transferred to the Forensic Psychiatric Service, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the Superintendent of Oregon State Hospital, arrange for transfer;

(c) If a request for transfer to or transfer from the Forensic Psychiatric Service of Oregon State Hospital is rejected by the receiving state institution, the referring institution may request the Administrator to convene the Interinstitutional Disposition Board to determine the placement consistent with the person's needs and the safety of others. The Board shall be convened as expeditiously as possible but in no case later than two weeks after such request. The decision of the chairperson shall be final;

(d) In all cases, the patient or resident shall be informed in writing of the impending transfer or rejection of the transfer request and shall be given an opportunity to request a hearing. Within seven days after a patient or resident signs a request for hearing, a hearing shall be held before the Interinstitutional Disposition Board to determine whether the patient or resident shall be transferred. The patient or resident may be transferred on an emergency basis pending the decision of the Board for a period not to exceed 15 days;

(e) The Interinstitutional Disposition Board shall not consider the request for transfer or other written evidence or oral statements unless the patient or resident has the opportunity to cross-examine the person making the statement. At the hearing before the Board, the patient or resident shall have the right to present evidence, to cross-examine all witnesses, and to be represented by an attorney upon request. These rights shall only be denied when good cause is shown;

(f) The patient or resident shall have the right to be present at the Interinstitutional Disposition Board hearing on request, except when the Board finds that the testimony of the treating physician or any other witness in the presence of the patient or resident would be damaging to the future treatment and care of the patient or resident. In that instance, the testimony and cross-examination of those witnesses shall be conducted out of the presence of the patient or resident;

(g) Based upon the testimony given before the Interinstitutional Disposition Board, the Administrator of the Division or the Administrator's designee shall determine the best placement for the patient or resident and issue a written order directing that the patient or resident be transferred or that the transfer be denied. The order shall contain a statement of the facts upon which the order is based.

(6) Interinstitutional Disposition Board:

(a) The Interinstitutional Disposition Board is composed of the following representatives:

(A) The Administrator of the Division or the Administrator's designee, who shall serve as chairperson;

(B) The Superintendent of Oregon State Hospital or alternate;

(C) The Superintendent of Dammasch State Hospital or alternate;

(D) The Superintendent of Eastern Oregon Hospital and Training Center or alternate; and

(E) The Superintendent of Fairview Training Center or alternate.

(b) The Administrator may invite such other persons to sit with the Board as the Administrator believes may be helpful in reaching a decision;

(c) The Administrator shall inform all members of the Interinstitutional Disposition Board of the standards for confidentiality of records in ORS 179.505, 192.500 and 42 CFR Part 2, as well as prescribed penalties for failure to comply with these standards.

(7) Release of Patient or Resident. A patient or resident who is under a court having criminal jurisdiction, the Corrections Division of the Department of Human Services, or the Psychiatric Security Review Board will not be released or otherwise discharged from the custody of the Mental Health and Developmental Disability Services Division without the specific approval of the appropriate legal authority. This approval will be documented in the patient's or resident's clinical record.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 161, ORS 179, ORS 426, ORS 427 & ORS 430

Stats. Implemented:

Hist.: MHD 38, f. 4-5-76, ef. 4-26-76, MHD 7-1978, f. & ef. 8-30-78; MHD 13-1982, f. & ef. 7-2-82

### **Admission and Discharge of Mentally Ill Persons**

**309-031-0200**

#### **Purpose and Statutory Authority**

(1) Purpose, Summary, and Scope. These rules prescribe criteria and procedures for admission and discharge of mentally ill persons at state or other inpatient psychiatric hospitals for which the Division provides Medicaid reimbursement. The purpose of these rules is to define the appropriate use of these psychiatric hospitals and to encourage use of community services.

(2) The criteria limit hospital admissions to state or other inpatient psychiatric hospitals to adults with severe mental disorders who need hospital care or treatment. Minors are prohibited admission to adult wards. The procedures provide that persons be admitted or discharged after consultation with the responsible community mental health program.

(3) The criteria limit hospital admissions to child and adolescent treatment programs in state or other inpatient psychiatric hospitals to those children and adolescents most in need. The procedures provide that admissions for children and adolescents be coordinated through the local community coordinating committee in the child's or adolescent's county of residence.

(4) The scope of these rules is limited to persons civilly committed or voluntarily admitted. When a hospital is overcrowded, voluntary admissions may be curtailed.

(5) Statutory Authority. These rules are authorized by ORS 430.041, and 179.040, 426.220, and 430.630 (1) and carry out the policies of ORS 40.610 and the provisions of ORS 179.321(1), 179.325, 179.360 (1), 179.475, 419.511, 426.005 through 426.070, 426.130(3), 426.175 through 426.220, 426.300 through 426.309, 430.021, and 430.620 through 430.670.

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

### 309-031-0205

#### Definitions

As used in these rules:

- (1) "Admission" means accepting a person for treatment of a mental illness by a state or other inpatient psychiatric hospital on a voluntary basis (ORS 426.217 or 426.220) or civil commitment (ORS 426.005 through 426.217).
- (2) "Commitment" means the involuntary admission of a person to a state or other inpatient psychiatric hospital under warrant of detention (ORS 426.070), civil commitment (ORS 426.130(3)), two-physician hold (ORS 426.175), emergency commitment (ORS 426.180 to 426.210), or peace-officer hold (ORS 426.215).
- (3) "Community Coordinating Committee" means a committee composed of representatives from the local community mental health program, Children's Services Division, Juvenile Court, local education district, and a representative of Oregon State Hospital's Child and Adolescent Treatment Program. The committee carries out the intake function to assure the need for hospitalization.
- (4) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.
- (5) "Community Outreach Team" means a component of Oregon State Hospital's Child and Adolescent Treatment Program responsible for coordinating all community screenings, crisis and regular admissions, and discharge and follow-up activities.
- (6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.
- (7) "DSM-III-R" means **Diagnostic and Statistical Manual of Mental Disorders, Third Edition, American Psychiatric Association, 1987.**
- (8) "Hospital-Community Linkage Agreement" means the written agreement between community mental health programs and a state psychiatric hospital concerning the policies and procedures to be followed when a patient is admitted and discharged. (See ORS 430.630(6) and OAR 309-014-0035(2) (c)).
- (9) "Other Inpatient Psychiatric Hospital" means those parts of a licensed psychiatric hospital receiving Medicaid reimbursement for eligible patients through the Mental Health and Developmental Disability Services Division.
- (10) "Parent" means a custodial parent, the adult next of kin, or the legal guardian of a minor. (See ORS

426.220.)

(11) "Patient" means a child, adolescent or adult admitted to a state or other inpatient psychiatric hospital.

(12) "Program Bed Capacity" means the greatest number of patients at a state psychiatric hospital that can be managed in a safe, therapeutic environment.

(13) "Program Office" means the Office of Programs for Mental or Emotional Disturbances of the Mental Health and Developmental Disability Services Division.

(14) "Psychiatric Emergency" means an imminent threat to life or of serious bodily injury to self or others resulting from severe mental disorder.

(15) "Psychotic" means a gross impairment of reality testing, as defined in the **DSM-III-R Glossary**. Persons with a psychotic disorder may "hear voices", talk incoherently or illogically, strongly hold irrational beliefs, fail to react to the external environment, or experience unwarranted feelings of deep depression, extreme elation or intense anxiety. Their thinking is so disordered that they have substantially lost touch with reality.

(16) "Resident" means the resident of a county in which the person maintains a current mailing address or, if the person does not maintain a current mailing address within the state, the county in which the person is found, or the county in which a court committed mentally ill person has been conditionally released. ORS 430.630(4)(a).

(17) "Responsible Community Mental Health Program" means the community mental health program (CMHP) that serves the county where the person is a resident.

(18) "Severe Mental Disorder" means psychotic disorder or other mental disorder of comparable severity. Any severe mental disorder may exist in stages and forms manageable in the community, and may be either active or in remission.

(19) "State Psychiatric Hospital" means Dammasch State Hospital, Eastern Oregon Psychiatric Center, or General Psychiatric Services, Geropsychiatric Treatment Program and the Child and Adolescent Treatment Program at Oregon State Hospital.

(20) "Superintendent" means the chief executive officer of the state or other inpatient psychiatric hospital, or that officer's designee. If the superintendent is not a physician licensed by the State Board of Medical Examiners, the chief medical officer shall assume the duties prescribed in these rules. ORS 179.360(1)(f) and ORS 426.020.

[Publication: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

**309-031-0210**

**Criteria for Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals****(1) Admission Criteria:**

(a) Mental disorder. All admissions, voluntary and civilly committed, shall be limited to adults whose mental disorder is severe; and

(b) Need specialized care and/or treatment available in a state or other inpatient psychiatric hospital and not otherwise available to the patient in a community program. A patient needs hospital care and/or treatment if failure to receive it would result in serious harm.

**(2) Discharge Criteria:**

(a) Mental disorder. The superintendent or designee shall discharge any patient (whether voluntarily admitted or civilly committed) whose mental disorder:

(A) Is no longer present, in remission; or

(B) Can receive appropriate care and/or treatment which is available to the patient in a community program.

(b) However, a patient whose disorder is in remission should not be released if continued hospital care or treatment is needed to help the patient remain in remission for a reasonable time after release;

(c) Medical Judgment. The findings of severe mental disorder required by sections (1) and (2) of this rule, shall be according to reasonable medical judgment.

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

**309-031-0215**

**Procedures for Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals**

(1) Screening. The responsible community mental health program (CMHP) shall, if possible, screen and refer persons whose admission to a state or other inpatient psychiatric hospital is sought. The purpose of this screening is to determine the availability of appropriate care or treatment in the community. For state hospitals, hospital-community linkage agreements shall specify the procedures for screening, including identification of any significant procedure order that will need to be transferred from one facility to another. The CMHP shall communicate the results of screening by telephone.

(2) Scheduling. In order to provide a comprehensive evaluation in a state hospital, admission should occur between 8:30 a.m. and 4 p.m., Mondays through Fridays except holidays. The responsible CMHP should telephone the hospital to make appointments for these evaluations and should be available for telephone consultation.

(3) Temporary Admissions. In exceptional situations, persons who meet the admission criteria and who

need immediate hospitalization may be temporarily admitted to a state hospital at any time. Exceptional situations include but are not restricted to persons:

- (a) For whom screening or scheduling by the responsible CMHP is not feasible;
- (b) Who pose a psychiatric emergency, as used under OAR 309-114-0015;
- (c) Who present themselves at the hospital having traveled long distances;
- (d) Who have been committed by warrant of detention, two-physician hold, emergency commitment, or peace-officer hold;
- (e) For whom team evaluation cannot be scheduled; or
- (f) Whom a private physician has referred;

(g) The superintendent or designee shall notify the responsible CMHP of temporary admissions. This notice shall be given either immediately, if the CMHP is open or has a 24-hour crisis response, or at the beginning of the next CMHP workday. The hospital team shall re-evaluate each temporary admission after consultation with the CMHP, during scheduled hours. This consultation shall determine whether appropriate care or treatment is available in the community. No temporary admission shall extend beyond the next scheduled admission day.

(4) Authority. The superintendent or designee has the final authority on the decision to admit and discharge voluntary patients and to discharge civilly committed patients. The Division has authority to assign civilly committed patients to the appropriate facility, unless the Division has delegated this authority to a county.

(5) Records. The superintendent or designee shall document in the patient's clinical record:

- (a) Those aspects of the history and/or examination used in arriving at the conclusions that a patient is severely mentally disordered and needs hospital care or treatment, or that the patient poses a psychiatric emergency, as used under OAR 309-114-0015;
- (b) Sufficient medical orders to provide for the initial care, safety, and treatment of the patient;
- (c) The procedures by which the patient was admitted or discharged;
- (d) The reasons for discharge; and
- (e) The recommendations of the CMHP, the hospital's action in response, and the hospital's reasons if these recommendations have not been followed.

(6) Notice. When a patient is admitted or discharged, the superintendent or designee shall promptly notify the responsible CMHP. For civilly committed patients, the court shall also be notified. If the patient has had no responsible CMHP or if the responsible CMHP is unknown, the superintendent or designee shall determine the patient's county of residence, in order to determine which CMHP is responsible for the patient. The superintendent or designee shall inform the patient of the CMHP responsible for him or her.

(7) Referral. If admission is denied, the superintendent or designee shall promptly notify the responsible CMHP and, for civilly committed patients the court, and for patients referred by private physicians, the physician. The superintendent or designee shall refer the person to appropriate community care including crisis respite services, and should assist the person in obtaining alternative care.

(8) Periodic Review. Patients who remain in a state or other inpatient psychiatric hospital after 15 days shall be reviewed by staff of the responsible CMHP. The purpose of this review is to determine the availability of appropriate resources for care or treatment in the community. For state psychiatric hospitals, hospital-community linkage agreements shall specify the procedure for review. The CMHP shall, directly or by telephone, notify the hospital staff of the recommendations resulting from this review. The recommendation shall be either:

(a) That appropriate resources do not exist in the community, and that the CMHP recommends continued hospitalization. A new review shall be conducted within 60 days. Hospital-community linkage agreements may specify more frequent review; or

(b) That appropriate resources do exist in the community. The CMHP, with the cooperation of the hospital staff, shall develop a discharge plan for the patient.

(9) Utilization Review. Each state psychiatric hospital shall systematically review admissions and discharges at that hospital. A plan for this utilization review shall be established by the superintendent or designee, submitted to the Division within 30 days of adoption of this rule, and approved by the Division. This review will monitor the number and appropriateness of temporary and regular admissions, the length of stay, discharges, and the quality of care and treatment provided.

Stat. Auth.: ORS 179.040

Stats. Implemented: ORS 179.321, 426.070, 426.385, 427.031 & 427.255

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87; MHS 14-2007(Temp), f. 11-30-07, cert. ef. 12-1-07 thru 5-29-08

### **309-031-0220**

#### **Additional Procedures for Voluntary Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals**

In addition to the criteria of OAR 309-031-0210 and the procedures of OAR 309-031-0215, the following procedures shall apply to voluntary admission and discharge:

(1) Voluntary Admission Procedure. Persons who apply for voluntary admission may be admitted to a state or other inpatient psychiatric hospital only when the superintendent or designee has:

(a) Informed the person regarding the procedures for voluntary admission and discharge, including the 72-hour hold after withdrawal of consent under section (3) of this rule; and

(b) Witnessed the signature on a form approved by the Division.

(2) Discharge at the Patient's Request. Patients voluntarily admitted and not involuntarily committed to the Mental Health and Developmental Disability Services Division and assigned to a state or other psychiatric hospital shall be discharged within 72 hours of receipt of written notice of a desire to be discharged, pursuant to ORS 426.220(1), as follows:

- (a) All patients shall be released within 72 hours of receipt of written notice from the patient;
- (b) Written notice under this section may be submitted to the superintendent or designee, the patient's attending physician, or the hospital staff that provides immediate care and supervision. If a patient gives oral notice, the staff shall assist the patient in giving written notice;
- (c) If the medical staff believes that discharge would be detrimental to the health and safety of the patient or others, but the patient does not meet the criteria for involuntary commitment, OAR 309-031-0210, the patient shall be discharged against medical advice. The patient shall be informed of this medical opinion;
- (d) If the medical staff believes that the patient meets the criteria for involuntary commitment, the staff shall so inform the patient. The staff may initiate an involuntary commitment proceeding;
- (e) An adult seeking voluntary admission to a state psychiatric hospital may be required, as a condition of admission, to waive his or her right to terminate the voluntary admission for a period not to exceed 30 days. The admitting medical staff may require this waiver if they believe that the person's mental disorder could not otherwise be successfully treated.
- (3) Transfer to Another Medical Facility. If a patient voluntarily admitted develops a surgical or medical condition that requires transfer to another medical facility, that patient may be discharged from the state or other inpatient psychiatric hospital at the time of transfer.

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 50(Temp), f. & ef. 12-21-77; MHD 6-1978, f. & ef. 3-20-78; MHD 24-1982, f. 10-13-82, ef. 11-15-82; Renumbered from 309-031-0020; MHD 7-1987, f. & ef. 12-30-87

### **309-031-0250**

#### **Program Bed Capacity**

- (1) In order to prevent unsafe or untherapeutic conditions due to overcrowding, the Program Office, in consultation with the superintendent or designee, shall establish the Program Bed Capacity for each state psychiatric hospital. The Program Bed Capacity shall depend on such factors as budgeted staffing levels, licensed bed capacity, and ward geography.
- (2) Whenever the Program Bed Capacity is exceeded, the Superintendent or designee shall take immediate steps to reduce the hospital population. These steps may include denying voluntary admissions. Whatever the hospital population, a person who poses a psychiatric emergency shall have high priority for admission or retention.

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 7-1987, f. & ef. 12-30-87

### **309-031-0255**

#### **Variances**

A variance from these rules may be granted to a Superintendent of a state or other inpatient psychiatric hospital. A variance may be requested on a case-by-case basis, or may exempt a state or other psychiatric hospital from a general rule or rules and substitute an alternative practice.

(1) A superintendent of a state or other psychiatric hospital requesting a variance shall submit, in writing, to the Office for Mental or Emotional Disturbances:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) The duration that the alternative practice will remain in effect.

(2) The Assistant Administrator of the Office for Mental or Emotional Disturbances shall approve or deny the request for variance in writing.

(3) The Assistant Administrator of the Office for Mental or Emotional Disturbances shall notify the Superintendent of the decision. Notice shall be given, in writing, within 30 days of receipt of the request by the Office for Mental or Emotional Disturbances.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Mental Health and Developmental Disability Services Division, whose decision shall be final.

Stat. Auth.: ORS 179, ORS 414, ORS 419, ORS 426 & ORS 430

Stats. Implemented:

Hist.: MHD 7-1987, f. & ef. 12-30-87

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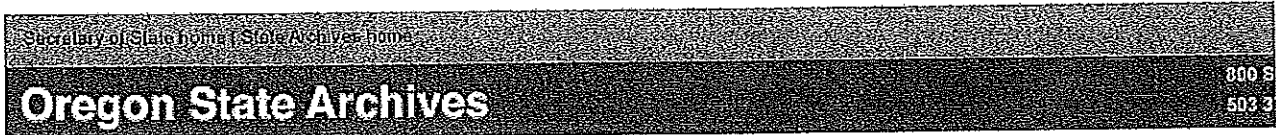
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## **DEPARTMENT OF HUMAN SERVICES, ADDICTIONS AND MENTAL HEALTH DIVISION: MENTAL HEALTH SERVICES**

### **DIVISION 33**

### **INVOLUNTARY COMMITMENT PROCEEDINGS**

#### **General Standards for Civil Commitment**

**309-033-0200**

#### **Statement of Purpose and Statutory Authority**

(1) Purpose. These rules prescribe general standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.060, 426.072(3), 426.075, 426.110(2), 426.120, 426.140(2), 426.170, 426.180, 426.217, 426.220, 426.225, 426.228, 426.231, 426.232, 426.233, 426.236, 426.241(5), 426.495, 426.500, 430.041, 430.205 through 430.210 and carry out the provisions of ORS 426.005 through 426.309. These rules replace OAR 309-033-0100 through 309-033-0170, which were in effect from September 2, 1992 through August 31, 1994.

Stat. Auth.: ORS 426.005 - ORS 426.309

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0000

**309-033-0210**

#### **Definitions**

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same

meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assignment" means the designation, pursuant to ORS 426.060, by the Division or its designee of the hospital, facility or CMHP where the committed person is to receive care, custody and treatment during the commitment period.

(3) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(4) "Caregiver" means the person who is appointed by the court under ORS 426.125 to be allowed to care for a mentally ill person on conditional release.

(5) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(6) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(7) "Community hospital" means any hospital that is not a state hospital.

(8) "County governing body" means the county court or the board of county commissioners of one or more counties who operate a CMHP, or in the case of a Native American Reservation, the Tribal Council, or if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation selected by the county.

(9) "County of residence" means the county where the person currently maintains a mailing address or, if the person has no current mailing address within the state, the county where the person was found or the county in which a committed person has been conditionally released as defined by ORS 426.241(4).

(10) "Court" means the circuit court acting pursuant to ORS chapter 426.

(11) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(12) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(13) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(14) "Director of the county of commitment" means the director for the county where the person is committed.

(15) "Director of the county of placement" means the director for the county where the committed person is to be placed.

(16) "Director of the county of residence" means the director for the county of residence.

(17) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(18) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(19) "Hospital hold" means the taking of a person into custody by order of a physician pursuant to ORS 426.232.

(20) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(21) "Nonhospital hold" means the taking of a person into custody by order of a director pursuant to the provisions of ORS 426.233. A director's hold and a trial visit hold are variations of a nonhospital hold.

(22) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(23) "Placement of a committed person" means the physical act of removing a committed person from the courtroom to the place where the person has been assigned to receive care, custody and treatment, or the transfer of a committed person from one location where the person has been assigned to receive care, custody and treatment to another location for the same purpose.

(24) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(25) "Psychologist" means a clinical psychologist licensed by the Oregon Board of Psychologist

Examiners.

(26) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

- (a) Psychiatrist licensed to practice in the State of Oregon;
- (b) Physician licensed to practice in the State of Oregon;
- (c) Graduate degree in psychology;
- (d) Graduate degree in social work;
- (e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;
- (f) Graduate degree in another mental health-related field; or
- (g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(27) "Recertification" means the certification of continued commitment provided for under ORS 426.301.

(28) "Secure transport provider" means a secure transport provider approved according to OAR 309-033-0440, Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or on Diversion to an Approved Holding or Nonhospital Facility.

(29) "State hospital" means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(30) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 426.005, ORS 426.060, ORS 426.110(2), ORS 426.232, ORS 426.236 & ORS 430.041.

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0010; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

### **309-033-0220**

#### **General Standards**

(1) Goals. The goals of the Division in implementing these civil commitment standards are:

- (a) To promote the well-being of persons who are allegedly mentally ill and who are mentally ill during involuntary care, custody and treatment of mental illness pursuant to ORS chapter 426;
- (b) To promote the protection of the civil rights of each person who is allegedly mentally ill and who is mentally ill;

(c) To encourage consistent application of ORS chapter 426 as it specifically pertains to each of the following groups:

(A) Persons who are alleged to be mentally ill; and

(B) Persons who are mentally ill.

(d) To encourage the provision of care, custody and treatment of persons in the least restrictive environment that currently is available within existing resources;

(e) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through civil commitment, whenever possible;

(f) To encourage that the director monitors the commitment process in their county, is knowledgeable of the statutes and administrative rules pertaining to civil commitment, provides leadership so that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS chapter 426;

(g) To provide for the safety of the community when threatened by a person who is dangerous as a result of mental illness.

(2) State's interest. The state's interest is to establish sufficient facts for the court to make a decision that is consistent with the intent of ORS chapter 426.

(3) Declaration for mental health treatment. The director shall establish procedure and policy which assures that every person who may become incapacitated by mental illness and unable to consent to treatment is educated about the Declaration for Mental Health Treatment at the time of admission or at the time of discharge from a hospital.

Stat. Auth.: ORS 426.060

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0030

### **309-033-0230**

#### **Custody of Persons Alleged to Be Mentally Ill Prior to Filing a Notification of Mental Illness**

(1) Custody by a physician pursuant to ORS 426.231. A physician taking a person into custody pursuant to ORS 426.231 at a hospital approved under OAR 309-033-0550, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility, shall detain the person for no more than 12 hours and during that time shall either:

(a) Authorize the person for transportation to an approved hospital and provide transportation according to the agreement required under OAR 309-033-0550; or

(b) Release the person, if the physician determines that the person no longer is dangerous to self or others.

(2) Custody by a peace officer or secure transport provider. A peace officer taking a person into custody shall remove the person to an approved hospital as directed by the director in the county where the

person was taken into custody. The peace officer or approved secure transport provider shall only take a person into custody under the provisions of one of the following:

(a) Custody on peace officer's own initiative. A peace officer may take a person into custody pursuant to the provisions of ORS 426.228 when the peace officer has probable cause to believe that the person is dangerous to self or others, and is in need of immediate care, custody or treatment for a mental illness;

(b) Custody on the director's authority. The director may direct, pursuant to the provisions of ORS 426.233(1), a peace officer or an approved secure transport provider to take into custody a person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness;

(c) Custody of a committed person on the director's authority. The director may direct a peace officer or an approved secure transport provider to take into custody, pursuant to the provisions of ORS 426.233 (1), a committed person who is on trial visit, outpatient commitment or conditional release in the community, who is dangerous to self or others or who is unable to provide for basic personal needs, who is not receiving the care that is necessary for health and safety, and who is in need of immediate care, custody or treatment for mental illness.

(d) A peace officer may transfer a person in custody under this section to the custody of an approved secure transport provider. The peace officer may meet the approved Secure transport provider at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsection (3) of this section to the authorized person.

(3) Peace officer's written report. When taking a person into custody pursuant to ORS chapter 426.228 (1) by a peace officer's own initiative, a peace officer shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(4) Director's written report. When a peace officer or approved secure transport provider takes a person into custody pursuant to ORS chapter 426.228(4) at the direction of the director, a director shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(5) Transportation to a hospital or nonhospital facility more than one hour away. If the peace officer determines that more than one hour is required to transport the person to a hospital or nonhospital facility approved by the Division, the peace officer or approved secure transport provider shall obtain a certificate, if possible, from a physician prior to transporting the person. A physician authorizing transport shall sign a certificate, on a form approved by the Division, only if the person's condition, in

the opinion of the physician, meets all of the following requirements:

- (a) The travel will not be detrimental to the person's physical health;
  - (b) The person is dangerous to self or others; and
  - (c) The person is in need of immediate care or treatment for mental illness.
- (6) The director directs peace officers or approved secure transport providers to appropriate facility. The director shall adopt written procedures for directing peace officers or approved secure transport providers to transport persons taken into custody, pursuant to ORS 426.228, to an approved hospital or nonhospital facility:
- (a) The written procedures shall include one of the following, whichever, in the opinion of the director, serves the best interests of persons with mental illness and the community:
    - (A) A list of approved hospitals or nonhospital facilities where peace officers or approved secure transport providers are to transport persons;
    - (B) A procedure for contacting the director 24 hours-a-day, seven days-a-week.
  - (b) The director shall distribute copies of the written procedures to the sheriff and the chief of police of each municipality in the county and approved secure transport providers. The procedures shall be distributed as often as the procedure is amended.
  - (c) The director may develop a written agreement with the law enforcement agencies in the county which designates a site or sites where the director can safely evaluate the person and determine which facility, in the director's opinion, can best serve the person's needs within the resources available. If such an agreement exists in a county, the director may direct a peace officer to transport a person in custody under ORS 426.228 to a site designated in the agreement. Once the director makes a determination, the peace officer shall transport and deliver the person to a hospital or nonhospital facility as directed by the director. The agreement shall:
    - (A) Designate the site or sites where the director can safely evaluate the person's needs for treatment;
    - (B) Define the minimum response time for the director meeting the peace officer at the site; and
    - (C) Be signed by all parties to the agreement.

Stat. Auth.: ORS 426.228, ORS 426.231 & ORS 426.236

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0040; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

**309-033-0240**

#### **Initiation of the Civil Commitment Process**

(1) Initiation. The civil commitment process is initiated when an NMI is filed with the circuit court. The NMI shall be filed with the court as directed below:

(a) Public petition. When an NMI is given to the director of the county where the allegedly mentally ill person resides pursuant to ORS 426.070, the director shall immediately file the NMI with the court in the county where the allegedly mentally ill person resides. The following persons may give an NMI to the director:

(A) Any two persons;

(B) A county health officer; or

(C) Any magistrate.

(b) Hospital hold with no request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, Hospital Hold, and the director in the county where the person resides makes no request for the physician to file the NMI in the county where the person resides, the physician shall file the NMI with the court in the county where the person is hospitalized;

(c) Hospital hold with request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, and the director in the county where the person resides requests the physician to do so, the physician shall file the NMI with the court in the county where the person resides;

(d) Hospital hold subsequent to peace officer custody with no request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located makes no request, pursuant to ORS 426.234(2)(b), the physician shall file the NMI with the court in the county where the person initially was taken into custody by the peace officer;

(e) Hospital hold subsequent to peace officer custody with request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located requests the physician to do so, the physician shall file the NMI with the court in the county where the person is hospitalized.

(f) Nonhospital hold with no request from director. When a director in the county where the director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides makes no request for the director to file the NMI be filed in the county where the person resides, the director shall file the NMI with the court in the county where the person initially was taken into custody; and

(g) Nonhospital hold with request from director. When a director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides requests the director to do so, the director shall file the NMI with the court in the county where the person resides.

(2) Initiation of commitment proceedings by two persons, a county health officer or magistrate. The NMI shall be given to the director in the county where the allegedly mentally ill person resides. If the person has no residence, then the NMI shall be given to the director in the county where the person currently is located. The director shall file the original NMI with the court on the day the NMI is received or, if the NMI is received outside the court's routine business hours, the next day the court is open for business. The director shall retain a copy of the NMI in the clinical record as required by OAR 309-033-0930(2)(f), Procedures for the Investigation.

(3) Initiation by hospital hold. The physician who takes a person into custody, pursuant to ORS 426.232, in a hospital approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, shall:

(a) File an NMI with the appropriate court as described in OAR 309-033-0240(1), Initiation; and

(b) Immediately notify the director in the county in which the person was hospitalized, unless the person resides in a county other than the county where the person is hospitalized in which case the physician shall immediately notify the director in the county where the person resides.

(4) Initiation by nonhospital hold. The director, after authorizing the taking of a person into custody pursuant to the provisions of ORS 426.233 (the director's hold and trial visit hold), shall file a NMI with the appropriate court as described in OAR 309-033-0240(1).

(5) How a director requests where the NMI is filed. A director may request that the physician, in the case of a hospital hold, or the director of the county where the person was taken into custody, in the case of a nonhospital hold, file the NMI according to the provisions of ORS 426.234 by either:

(a) On a case by case basis. Making the request immediately upon receipt of the notice required by ORS 426.234(2)(a) or (b), or 426.234(3)(a); or

(b) Upon general request. Sending a written general request to a hospital or a director.

Stat. Auth.: ORS 426.070, ORS 426.232, ORS 426.234 & ORS 426.236

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0050; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

### **309-033-0250**

#### **Standards for Custody, Hospital and Nonhospital Holds, Emergency Commitment and Emergency Hospitalization of Persons Under Warrant of Detention**

(1) Criteria for placement into custody. Only persons who are a danger to self or others and who are in need of treatment for mental illness shall be placed in custody at a facility approved by the Division.

(2) Warrant of detention. Upon the receipt of a warrant of detention issued by the court pursuant to ORS 426.070(5)(b), the director or the sheriff of the county shall take the person into custody and remove the person to a hospital approved by the Division. Whoever takes the person into custody shall inform the person of his/her rights with regard to representation by or appointment of counsel as described in ORS 426.100 and be given the warning described under ORS 426.123 and OAR 309-033-0540(2)(a),  
Warning.

(3) Hospital hold. Only a physician with admitting privileges or on staff at a hospital approved by the Division and who has completed a face-to-face examination of the person may retain the person in custody in the hospital as provided by ORS 426.232. When implementing hospital holds, the hospital shall assure the following:

(a) The consulting physician is not required to have admitting privileges at the hospital;

(b) The hospital shall not require the consulting QMHP to be a member of the hospital's allied staff. However, the hospital may extend allied staff privileges to the consulting QMHP;

(c) The admitting physician shall document the following information on the NMI, retaining a copy of the NMI in the clinical record:

(A) Examples of indicators that support the physician's belief that the person has a mental illness;

(B) Examples of thoughts, plans, means, actions, history of dangerousness or other indicators that support the physician's belief that the person is imminently dangerous.

(4) Peace officer custody requested by director. This section establishes standards and procedures for a director to direct a peace officer to take into custody a person who the director has probable cause to believe is dangerous to self or any other person and who the director has probable cause to believe is in need of immediate care, custody or treatment for mental illness:

(a) A county governing body may authorize the director, or a person named and recommended by the director, to direct a peace officer or approved secure transport provider to take allegedly mentally ill persons into custody. Such an authorization shall be made formally and in writing by the county governing body of the director. The director shall keep a copy of each authorization in each person's personnel file:

(b) Prior to directing a peace officer or approved secure transport provider to take a person into custody, a director shall have face-to-face contact with the person and document on forms approved by the Division, the evidence for probable cause to believe that the person is:

(A) Dangerous to self or others; and

(B) In need of immediate care, custody or treatment for a mental illness.

(5) When a person in custody can be released. A person shall who is detained, in custody, or on a hold shall be released as described:

(a) Physician's release of a person on peace officer custody. When a person is brought to a hospital by a peace officer or approved secure transport provider pursuant to ORS 426.228, Peace Officer Custody, the treating physician shall release the person if, upon initial examination prior to admission, the physician makes the determination that the person is not dangerous to self or others. It is not necessary to notify the court of the release;

(b) Physician's release of a person on transport custody. At any time during the 12 hour detention period, the treating physician shall release a person detained pursuant to ORS 426.231, Transport Custody, whenever the physician makes the determination that the person is not dangerous to self or others. In no case shall a physician involuntarily detain a person at a hospital approved solely for Transport Custody under OAR 309-033-0550 longer than 12 hours. It is not necessary to notify the court of the release;

(c) Physician's release of a person on a hospital hold. The treating physician shall release a person retained or admitted to a hospital pursuant to ORS 426.232, Hospital Hold, whenever the physician makes the determination that the person is not dangerous to self or others. The treating physician shall immediately notify the director and the circuit court where the NMI was filed. See OAR 309-033-0240; or

(d) Director's release of a person on a nonhospital hold. The director shall release a person detained in a nonhospital facility, approved under OAR 309-033-0530, pursuant to ORS 426.233, Nonhospital Hold, whenever the director, in consultation with a physician, makes the determination that the person is not dangerous to self or others. The director shall immediately notify the circuit court.

(6) When a person in custody cannot be released. Once the person is admitted to a hospital or nonhospital facility, a person taken into custody pursuant to ORS 426.070 (warrant of detention), may only be released by the court. However, a person may be discharged from a hospital or nonhospital facility when the person is transferred to another approved facility.

Stat. Auth.: ORS 426.070, ORS 426.231, ORS 426.232, ORS 426.233, ORS 426.234 & ORS 426.228  
Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0060; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

### 309-033-0260

#### Diversion from Commitment Hearing

(1) Notice to court by director. The director and a psychiatrist may certify a person for diversion at any time up to three judicial days after the person has been taken into custody.

(2) Treatment plan. The director and the treating psychiatrist shall prepare a treatment plan that describes, in general terms, the types of treatment and medication to be provided during the diversion. The general treatment plan shall be descriptive of the range of services and medications to be provided, and shall include a description of:

(a) Any of the following classes of medication, if medication is to be administered:

(A) Antipsychotics;

(B) Antidepressants;

(C) Mood stabilizers;

(D) Anti-anxiety medications; or

(E) Anti-side effect medications.

(b) Mental health interventions, therapies or diagnostic procedures to be employed;

(c) The person's preferences about medications and therapies and any limitations on the specific use of medications or therapies to which the director and the treating psychiatrist have agreed;

(d) Location where treatment is to be initiated and the type of hospital or nonhospital facilities where the person may be transferred during the diversion; or

(e) Other conditions or limitations agreed to by the person and the director concerning the care or treatment that is to be provided.

(3) Notice to person. At the initiation of the diversion period, the director and the psychiatrist shall inform the person verbally, and in writing, of the usual and typical restraints or seclusion which may be employed in an emergency to assure health or safety.

(4) Psychiatrist to provide information. The psychiatrist shall provide the information described in OAR 309-033-0620(5)(a), Procedures for Obtaining Informed Consent and Information to be Given, when administering a specific medication.

(5) Consent for non-psychiatric care. A treating physician shall obtain the person's consent for non-psychiatric medical care and treatments which may be prescribed during the diversion. The general treatment plan for psychiatric intervention shall not include plans for non-psychiatric medical care or treatment.

(6) Refusal of treatment/demand for discharge. The person on diversion may refuse psychiatric treatment described in the general treatment plan or demand discharge at any time during the diversion by signing the form described in this paragraph or, if the person refuses to sign the form, by verbally making his or her refusal of treatment or demand for discharge known to two staff of the facility. In accepting the person's refusal of treatment or demand for discharge the staff of the facility shall:

(a) Provide the person a warning, both verbally and in writing, at the person's first indication that he/she wishes to refuse treatment or demand discharge, which states:

**"If you refuse psychiatric treatment described in the general treatment plan or demand to be discharged you may be required to appear at an involuntary civil commitment hearing. It is your right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. However, if a judge finds you not to be a mentally ill person you may be released. The treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing."**

(b) If the person refuses treatment, demands discharge or requests a hearing, offer the person the following form to sign:

**"Warning**

**If you refuse psychiatric treatment described in your general treatment plan or demand discharge you may be required to appear at an involuntary civil commitment hearing. You have a right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. The psychiatric treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing.**

**I refuse the treatment described in my general treatment plan.**

**I request a hearing before the circuit court.**

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**Signature of Certified Person."**

(c) If the person refuses to sign the form described in this section and verbally or nonverbally refuses treatment, the staff of the facility shall document the person's refusal on the form and in the person's clinical record;

(d) Immediately upon the person's refusal of treatment, demand for discharge or request for a hearing, the treating physician shall treat the person as a person in custody, as provided under ORS 426.072, and shall immediately notify the director. The director shall immediately request a hearing.

(7) Director of the county of residence approval of payment for diversion. A person shall be on diversion only if payment for the care, custody and treatment is approved verbally by the director of the county of residence as provided under ORS 426.237(1)(b)(B). The director of the county of residence's approval shall be documented by a written statement, signed by the director, and distributed by the end of the diversion period as follows:

(a) The original shall be filed in the clinical record at the CMHP; and

(b) A copy shall be delivered to each facility serving the person during the diversion.

Stat. Auth.: ORS 426.236 & ORS 426.237

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0070

**309-033-0270**

**Provision of Care, Custody and Treatment of Persons Committed to the Division**

(1) Provision of rights. In addition to the rights provided under ORS 426.385, committed persons also have the rights provided under ORS 430.205 through 430.210 and this rule, including:

(a) A Committed Person's Right to Fresh Air. For the purpose of this rule, these terms have the following meanings:

(A) "Fresh air" means the inflow of air from outside the facility where the committed person is receiving services. "Fresh air" may be accessed through an open window or similar method as well as through access to the outdoors.

(B) "Outdoors" means an area with fresh air that is not completely enclosed overhead. "Outdoors" may include a courtyard or similar area.

(b) If a committed person requests access to fresh air and the outdoors or the committed person's treating health care provider determines that fresh air or the outdoors would be beneficial to the committed person, the facility in which the committed person is receiving services shall provide daily access to fresh air and the outdoors unless this access would create a significant risk of harm to the committed person or others.

(c) The determination whether a significant risk of harm to the committed person or others exists shall

be made by the committed person's treating health care provider. The treating health care provider may find that a significant risk of harm to the committed person or others exists if:

(A) The committed person's individual circumstances and condition indicate an unreasonable risk of harm to the committed person or others which cannot be reasonably accommodated within existing programming should the committed person be allowed access to fresh air and the outdoors; or

(B) The facility's existing physical plant or existing staffing prevent the provision of access to fresh air and the outdoors in a manner that maintains the safety of the committed person or others.

(d) If a facility determines that its existing physical plant prevents the provision of access to fresh air and the outdoors in a safe manner, the facility shall make a good faith effort at the time of any significant renovation to the physical plant that involves renovation of the unit or relocation of where committed persons are treated to include changes to the physical plan or location that allow access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.

(2) Provision of care at a state hospital. The superintendent of the state hospital serving the county of commitment shall be responsible for all admissions to the state hospital:

(a) The superintendent, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to the state hospital;

(b) The superintendent shall implement policies and procedures which afford a committed person placed in a state hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(3) Provision of care at a community hospital. The director shall assign and place a committed person only at a community hospital approved under OAR 309-033-0530:

(a) The admitting physician, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a community hospital;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a community hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(4) Provision of care at a nonhospital facility or an outpatient program. The director shall only assign and place a committed person in a nonhospital facility that is licensed or certified by the Division:

(a) The administrator, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a nonhospital facility or an outpatient program;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a nonhospital facility or an outpatient program the rights provided by ORS 426.385, 430.205 through 430.210 and this rule;

(c) The director shall place on a trial visit a committed person who is discharged from a state hospital or a community hospital when the director assigns and places the person in a nonhospital facility;

(d) The director shall place a committed person, who the court has ordered on outpatient commitment at the commitment hearing, on outpatient commitment when the director assigns and places the person in a nonhospital facility.

(5) Provision of medical services for a committed person. The superintendent of a state hospital, the treating physician at a community hospital or the director may transfer a committed person to a general hospital, or transfer a committed person from a psychiatric ward to a medical ward for medical care:

(a) The treating physician shall only provide medical care with the consent of the committed person in accordance with OAR 309-033-0600 through 309-033-0650;

(b) The superintendent or treating physician shall transfer a committed person to a general hospital for medical services on a pass or discharge the person from the state hospital when it is determined that the person will not return to the state hospital within a reasonable length of time, or that discharge is clinically appropriate and is required for the person to have access to third-party insurance benefits;

(c) The treating physician shall immediately notify the director that a person was transferred to another hospital for medical care under this subsection.

Stat. Auth.: ORS 426.060, 426.385 & 430.205 - 430.210

Stats. Implemented: ORS 426.005 - 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0080; MHS 5-2009, f. & cert. ef. 12-17-09

### **309-033-0280**

#### **Procedures for Committed Persons on Outpatient Commitment or Trial Visit**

(1) Outpatient commitment. At the time of the commitment hearing the director may place a committed person on an outpatient commitment if adequate treatment services are available in the county. The director shall be responsible for:

(a) Enrolling the committed person in treatment services and assuring that the committed person has an opportunity to participate in the development of the treatment plan;

(b) Distributing the conditions of placement as pursuant to ORS 426.278 and OAR 309-033-0280(3), Distribution of the Conditions of Placement, below;

(c) Monitoring and documenting the provision and consumption of services which fulfill the conditions set for the outpatient commitment;

(d) Petitioning the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(e) With the participation of the committed person, changing the conditions to less restrictive conditions, if appropriate; and

(f) Documenting in the clinical record any conditions of placement requiring modification by means of a report which:

(A) Documents the need for a change in the conditions of outpatient commitment;

(B) Sets new conditions of commitment;

(C) Describes the reasons for the new conditions;

(D) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the report; and

(E) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons described in OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(2) Trial visit. The director may grant a trial visit to any committed person during a period of commitment, upon approval of the director of the county of placement. A director may grant a trial visit to any committed person during a period of community inpatient treatment. While it may be clinically advisable, the director is not required to obtain the consent or signature of the committed person:

(a) Trial visit of a committed person shall not exceed the time remaining in the period of commitment;

(b) Conditions for trial visit shall include designation of a facility, service or other provider to provide care or treatment;

(c) The director shall place the person on trial visit in accordance with OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division;

(d) The director shall evaluate any complaints received from any person concerning the behavior or treatment of a committed person on trial visit. The director shall document the results of the evaluation in the clinical record;

(e) Modification of the conditions of trial visit. The director may modify the conditions of placement for trial visit:

(A) Any modification shall not include a treatment option which is more restrictive than the current conditions of placement;

(B) The director shall petition the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(C) The director shall document in the clinical record any conditions of placement requiring modification by means of a report which:

(i) Documents the need for a change in the conditions of outpatient commitment;

(ii) Sets new conditions of commitment;

(iii) Describes the reasons for the new conditions;

(iv) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the clinical record; and

(v) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate

persons provided under ORS 426.278 and OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(f) Transfer of trial visit to another county. The director may transfer a person on trial visit to another county only if the director for the county where the person will reside agrees to accept the trial visit:

(A) The director of the county where the person currently resides shall provide the director of the county where the person will reside a copy of the current treatment plan for the person on trial visit;

(B) Immediately upon accepting the trial visit the director of the county where the person will reside shall enroll the person on trial visit in treatment services and shall make any modifications in the trial visit as necessary and distribute the modified conditions of placement as required under OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(3) Distribution of the conditions of placement. When a committed person is placed on conditional release, outpatient commitment or trial visit, or when the conditions of placement are modified in any manner, the current conditions of placement shall be distributed by the director to the following persons, pursuant to ORS 426.278:

(a) The committed person;

(b) The director of the county in which the committed person is to receive hospital, nonhospital or outpatient treatment;

(c) The administrator of any facility, service or other provider designated to provide care or treatment;

(d) The court of current commitment; and

(e) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in a different county than the county of the court that made the current commitment.

Stat. Auth.: ORS 426.127, ORS 426.273 & ORS 426.278

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0090

**309-033-0290**

### **Assignment and Placement of Persons Committed to the Division**

(1) Assignment authority. The Division, pursuant to ORS 426.060(2)(d), delegates the responsibility for the assignment and placement of committed persons to the director of the county of commitment:

(a) The director may assign or transfer a committed person to any facility or program approved by the Division which, in the opinion of the director, will appropriately meet the mental health needs of the committed person;

(b) The director may discharge the committed person from commitment by notifying, in writing, the court having jurisdiction, if the director determines the person no longer is a mentally ill person as defined by ORS 426.005(2).

(2) Assignment outside the county of residence. The director of the county of commitment may assign the committed person to a facility in a county other than the county of residence only with the approval of the director of the county of residence and the director of the county of placement:

(a) When the director of the county of commitment assigns a committed person under this section, the director of the county of commitment shall transfer the responsibility for assignment and placement to the director of the county of placement;

(b) The Assistant Administrator shall assign a committed person under this section when the director of the county of commitment, the director of the county of residence and the director of the county of placement determine that they cannot agree on the assignment of the person and request the Division to make the assignment:

(A) The Assistant Administrator shall determine fiscal responsibility for the services to be delivered to the committed person and shall look to existing applicable laws, contracts and interagency agreements;

(B) The decision of the Assistant Administrator shall be final.

(c) When placement is determined, the director of the county of placement shall accept the responsibility for further assignment and placement;

(d) The director of the county of commitment shall petition the court in the county where the person was committed to transfer jurisdiction to the court in the county where the person is to reside, pursuant to ORS 426.275(5).

(3) Assignment to a state hospital. The director of the county of commitment shall only assign and place a committed person in a state hospital with the consent of the superintendent.

(4) Assignment procedure. The director of the county of commitment shall make the assignment in writing immediately upon commitment of a person by the court or at the time the placement of a committed person is changed during the commitment period. The director shall:

(a) Retain an original assignment order on file in safe keeping for seven years;

(b) Deliver a signed original copy of the assignment order to the person prior to placement;

(c) Enter into the Division's current computer data system information about the committed person including:

(A) Name and any known aliases;

(B) Date of birth;

(C) Address of current residence;

(D) Address where assigned for treatment if different from residence;

(E) Name and telephone number of the administrator of the hospital, facility or program responsible for the person's treatment; and

(F) Any other data as requested by the Division.

(d) Out of county assignments shall include a statement that assignment and placement responsibility is transferred to the director of the county of placement.

(5) Appeal of assignment procedure. At any time during the period of commitment, a committed person may appeal to the Assistant Administrator for Mental Health for a change in assignment made by a director.

(a) How to make an appeal. The committed person shall make the appeal in writing and shall include the following information in the appeal:

(A) A statement that the committed person appeals the current assignment;

(B) The reason(s) the committed person believes the current assignment is inappropriate; and

(C) The proposed alternate placement and the reasons the committed person is requesting the alternate placement.

(b) Appeal of an assignment to a community hospital or to the community. The Assistant Administrator shall make a determination of an appealed assignment for persons currently assigned to community hospitals or community placements. The Assistant Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Assistant Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment; and

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case.

(B) The Assistant Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or

Division will allow.

(c) Appeal of an assignment to a state hospital. The Administrator shall make a determination of an appealed assignment for persons currently assigned to a state hospital or where the appeal requests assignment to a state hospital. The Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Administrator shall consider the opinion of the superintendent, or designee, of the state hospital affected by the appeal, and the report of the Assistant Administrator. In making the report to the Administrator, the Assistant Administrator:

- (i) Shall review the written appeal;
- (ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;
- (iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;
- (iv) May require the director to submit a written statement which gives the reason(s) for the assignment;
- (v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case;
- (vi) Shall make a recommendation about the proposed assignment; and
- (vii) Shall submit the report within three business days after the Division receives the appeal.

(B) The Administrator shall use the following criteria when making a determination of an appealed assignment:

- (i) The assignment shall be in the best interests of the committed person;
- (ii) The assignment shall assure the safety of the person and the community; and
- (iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

Stat. Auth.: ORS 426.060

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0100

**309-033-0300**

### **Transfers Between Classes of Facilities**

(1) Transfers between classes of facilities. The director may transfer a committed person from one class of facility to another in the same class or in a less restrictive class as provided by ORS 426.060. However, the director shall transfer a committed person who has voluntarily agreed to placement at the

facility only with the written consent of the person. The director shall transfer committed persons as provided by OAR 309-033-0400 through 309-033-0420, Standards for Transportation and Transfer of Persons in Custody or on Diversion, and OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division. The director shall modify the conditions of trial visit to reflect the change of placement and shall notify the following persons of the transfer:

- (a) The committed person;
  - (b) The court in the county where the person was committed;
  - (c) The court in the county where the person is to be placed;
  - (d) The director in the county where the person is to reside;
  - (e) The administrator of the facility designated to provide care or treatment; and
  - (f) Any other provider designated to provide care or treatment.
- (2) Transfers restricted by rule. The director may transfer a committed person from a facility of one class to another facility of a same class or lower class by:
- (a) Assigning the committed person to the new facility; and
  - (b) Modifying the person's commitment status as follows:
    - (A) Persons transferred to a Class 2 or Class 3 facility. When the director transfers a committed person to a Class 2 or Class 3 facility, the director shall place the person on trial visit (see OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division);
    - (B) Transfers between Class 1 hospitals or facilities. The director shall transfer a person between Class 1 hospitals or facilities without placing the committed person on trial visit; or
    - (C) Transfer to any facility and discharged from commitment. When the director determines a committed person is no longer a mentally ill person, the director shall discharge the person from commitment (see OAR 309-033-0330, Discharge of Committed Persons from Commitment Status) and enroll the person in services voluntarily at the receiving facility.
- (3) Transfers from a facility of one class to a facility of a more restrictive class:
- (a) Involuntary transfers of committed persons. The director shall transfer a committed person, who is on trial visit, to a facility of a more restrictive class only:
    - (A) By order of the court after a hearing, pursuant to ORS 426.275; or
    - (B) Initiate involuntary procedures as provided in this paragraph and as provided by ORS 426.233(1) (see subparagraph (c) of this paragraph).
  - (b) Voluntary transfers of committed persons. The director may transfer a committed person, who is on trial visit, to a facility of a more restrictive class with the committed person's consent. However, if the committed person revokes his/her consent to the current more restrictive placement and requests to be

placed at another facility of a less restrictive class, as soon as reasonably possible the director shall:

(A) Transfer the person to a facility where the person consents to receive services; or

(B) Initiate involuntary procedures as provided in this paragraph and by ORS 426.233(1).

(c) Emergency transfers of committed persons. As provided by ORS 426.233(1), the director may transfer a committed person, who is on trial visit, to a hospital or nonhospital facility approved by the Division when the director has probable cause to believe the person is dangerous to self or others or unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety, and is in need of care, custody or treatment for mental illness. Upon the recommendation of the investigator, the director shall request the court to revoke the person's trial visit or recertify the person for continued commitment at a more restrictive facility as provided by ORS 426.275.

(4) Authority to retake persons. A Class 1 or Class 2 facility shall immediately notify a peace officer and the Division of any person who has left the facility without lawful authority and shall immediately request the assistance of a peace officer(s) in retaking and returning the person to a Division-approved hospital or facility. The director shall show the peace officer a copy of the order of commitment.

Stat. Auth.: ORS 426.060, ORS 426.223, ORS 426.233, ORS 426.273, ORS 426.275 & ORS 426.278

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0110

### **309-033-0310**

#### **Recertification for Continued Commitment**

(1) Recertification for continued commitment of persons placed in a state hospital:

(a) After consulting with the director of the person's county of residence, the superintendent shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director.

(b) The superintendent shall notify the court concerning:

(A) The date the recertification was issued to the person; and

(B) Whether the person protests, within 14 days of the issuance of the recertification, to continued commitment.

(2) Recertification for continued commitment of persons placed in a community hospital or nonhospital facility:

(a) After consulting with the director of the person's county of residence, the director shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director of the person's county of residence.

(b) The director shall notify the court concerning:

(A) The date recertification was issued to the person; and

(B) Whether the person protests continued commitment, within 14 days of the issuance of the recertification.

(3) Documentation of recertification for continued commitment in the clinical record. The director or the superintendent making the recertification shall include in the clinical record:

(a) The date and time the director's approval of continued commitment was obtained prior to the recertification being issued to the person;

(b) The date and time the recertification was issued to the persons;

(c) A copy of the recertification issued to the person;

(d) Concerning the notification to the court of the date the recertification was issued to the person:

(A) The date and time that the court was notified of the issuance of the recertification to the person; and

(B) A copy of the notification.

(e) Concerning the notification to the court of whether the person protests continued commitment, within 14 days of the issuance of the recertification:

(A) The date and time that the court was notified of whether the person protests; and

(B) A copy of the notification to the court whether the person protests.

(f) If an examination is requested by the person:

(A) The name of the psychiatrist or the certified mental health examiner ordered by the court to conduct the examination;

(B) The date that the examination was conducted; and

(C) A copy of the examination report sent to the court.

(g) If the court orders continued commitment, a copy of the order continuing the commitment; and

(h) If the court orders the release of the person:

(A) A copy of the order requiring release;

(B) If the person consents to services upon discharge, a copy of an aftercare plan signed by the person and the name of the case manager responsible for arranging outpatient services; or

(C) If the person refuses services upon discharge, a statement signed by the person indicating the person's refusal of outpatient services; and

(D) The date and time the person was released from the facility.

Stat. Auth.: ORS 426.301, ORS 426.307 & ORS 430.041

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0120

### 309-033-0320

#### **Revocation of Conditional Release, Outpatient Commitment or Trial Visit**

(1) Conditional release. A caregiver appointed by the court to care for a committed person on conditional release is responsible for reporting to the court any violation of the conditions of placement. If a person on conditional release, whose conditions of placement include any service agreed to be provided by a CMHP, violates the conditions of conditional release, the director shall include in the clinical record a revocation report which documents the following:

(a) The person's noncompliance with those conditions of placement that include services provided by the CMHP;

(b) Efforts by the CMHP to inform the caregiver of the noncompliance and the caregiver's response to these efforts;

(c) Requests by the caregiver for the CMHP to assist in obtaining compliance from the committed person, or in notifying the court of the person's failure to comply with the conditions of placement, and the CMHP response to the requests for assistance;

(d) Documentation of the disposition made by the court, if the caregiver submits notification to the court; and

(e) The date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

(2) Outpatient commitment and trial visit. The director is responsible for reporting to the court any violation of the conditions of placement for persons on outpatient commitment (including community inpatient or outpatient treatment) or trial visit. For persons on outpatient commitment or trial visit, the director shall include in the clinical record a revocation report which includes the following:

(a) Documentation of the person's noncompliance with the conditions of placement;

(b) Documentation of efforts from all parties attempting to obtain compliance from the committed person and the response of the person to these efforts;

(c) A copy of the notification to the court of the person's failure to comply with the conditions of placement;

- (d) Documentation of the disposition made by the court;
- (e) Documentation of the distribution of any modified conditions of placement or disposition placing the person in inpatient treatment to all parties originally receiving copies of the conditions of placement; and
- (f) Date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

Stat. Auth.: ORS 426.275

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0130

### **309-033-0330**

#### **Discharge of Committed Persons, Who Are Placed in the Community, from Commitment Status**

(1) Only director of county of placement may discharge. Only the director of the county of placement may change the commitment status of a committed person placed in a community hospital or other community facility:

(a) The director shall discharge a person from commitment when:

(A) Release from treating facility. The director believes the committed person is no longer a mentally ill person as defined in ORS 426.005, and the person is to be released from the treating facility.

(B) Transfer to voluntary status. The director believes it is in the best interests of the person to transfer a committed person to voluntary status, but the person is to remain at the treating facility.

(b) The director shall discharge a person from commitment by notifying the last committing court and the court of residence, pursuant to the provisions of ORS 426.300.

(2) Discharge required unless new assignment and placement made. The director of the county of commitment shall discharge a person from commitment when a committed person is discharged from a hospital, nonhospital or residential facility, or an outpatient treatment program where the person has been assigned and placed unless the director of the county of commitment assigns and places the person with another provider of service as provided by OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division.

(3) Persons required to notify director prior to discharge. The following persons shall notify the director of the county of commitment 48 hours before discharging a person from a hospital, nonhospital or residential facility, or outpatient treatment:

(a) If the committed person is in a state hospital, the superintendent or designee shall notify the director;

(b) If the committed person is in a hospital serving as a regional acute care hospital or a private hospital, the treating physician shall notify the director;

(c) If the committed person is in a nonhospital or residential facility, the administrator of the facility shall notify the director;

(d) If the person is on trial visit, outpatient commitment or conditional release receiving outpatient

treatment, and is not living in a nonhospital or residential facility, the administrator of the program where the person is receiving outpatient treatment shall notify the director.

(4) Procedures for discharge. The director shall give written notice to the committed person within thirty days after the commitment was terminated. The notice shall state the date the commitment expired or was terminated. A copy of the notice shall be kept in the person's clinical record.

Stat. Auth.: ORS 426.300

Stats. Implemented: ORS 426.005 - ORS 426.309

Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0140

### **309-033-0340**

#### **Variances**

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

- (a) The section of the rule from which the variance is sought;
- (b) The reason for the proposed variance;
- (c) The alternative practice, service, method, concept or procedure proposed;
- (d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and
- (e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 430.041

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DEPARTMENT OF HUMAN SERVICES,  
ADDICTIONS AND MENTAL HEALTH DIVISION: MENTAL HEALTH  
SERVICES

## DIVISION 120

## PATIENT TRANSFERS

## Assignment and Transfer of Inmates

309-120-0000 [Renumbered to 309-120-0200]

309-120-0005 [Renumbered to 309-120-0205]

309-120-0030 [Renumbered to 309-120-0270]

309-120-0035 [Renumbered to 309-120-0275]

309-120-0040 [Renumbered to 309-120-0280]

309-120-0045 [Renumbered to 309-120-0285]

309-120-0050 [Renumbered to 309-120-0290]

309-120-0055 [Renumbered to 309-120-0295]

309-120-0070

OYA

Purpose

These rules prescribe procedures by which offenders in Oregon Youth Authority (OYA) close custody facilities may be transferred to a state mental hospital or a facility designated by the Department of Human Services (DHS) for evaluation and treatment.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505

Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505

Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

### 309-120-0075

#### Definitions

As used in these rules:

- (1) "Close custody facility" means any of the secure facilities operated by the OYA, including, but not limited to, youth correctional facilities, work/study camps, and transition camps.
- (2) "Facility designated by the Department of Human Services (DHS)" means a hospital or secure non-hospital facility designated by DHS to provide evaluation and treatment services for offenders under the age of 18.
- (3) "Hearing Officer" means an independent decision maker designated to conduct an administrative commitment hearing for an offender.
- (4) "Mentally ill offender" means an offender who, because of a mental disorder or a severe emotional disorder, is one or more of the following:
  - (a) Dangerous to self or others;
  - (b) Is unable to provide for basic personal needs and is not receiving such psychiatric care as is necessary for health or safety; or
  - (c) An offender, who unless treated, will continue, with a reasonable medical probability, to physically or mentally deteriorate so that the offender will become a person described under either or both subparagraph (4)(a) or (4)(b) of this rule.
- (5) "Offender" means a person placed in OYA close custody facility, including inmates in the legal custody of the Department of Corrections (DOC).
- (6) "State Mental Hospital" as defined in ORS 426.010. Except as otherwise ordered by the DHS pursuant to ORS 179.325, the Oregon State Hospitals in Salem, Marion County, and Portland, Multnomah County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, will be used as state hospitals for the care and treatment of mentally ill offenders age 18 and over who are transferred by the OYA pursuant to these rules.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505

Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505

Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

### 309-120-0080

#### Procedures for Transfer

- (1) The OYA close custody facility Superintendent, the Director of the OYA, or the Director's designee

may request that the Superintendent of a state mental hospital or a facility designated by DHS for evaluation and treatment accept a transfer of a mentally ill offender to a state mental hospital or facility designated by DHS.

(2) If the Superintendent of the state mental hospital or facility designated by DHS approves a transfer request made under paragraph (1) of this rule, the offender will be transferred.

(3) An offender may be transferred to a state mental hospital or a facility designated by DHS for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended with offender consent or following an administrative commitment hearing pursuant to paragraph (4) of this rule.

(4) Administrative commitments for offenders in the legal custody of the DOC and in the physical custody of the OYA will be accomplished through a hearing conducted by an OYA hearing officer in accordance with these rules. DOC offenders in OYA physical custody requiring mental health evaluation and treatment will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS and returned directly to the OYA facility.

(5) The DHS will provide for an administrative commitment hearing conducted by a hearing officer employed or under contract with the OYA for administrative commitment or extension of the transfer of the offender if:

(a) The DHS determines that administrative commitment for treatment for a mental illness is necessary or advisable or that DHS needs more than 30 days to stabilize or evaluate the offender; and

(b) The offender does not consent to the administrative commitment or an extension of the transfer.

(6) The administrative commitment hearing process will, at a minimum, include the following procedures:

(a) Not less than 24 hours before the administrative commitment hearing is scheduled to occur, the hearing officer will provide written notice of the hearing to the offender and the offender's parent/guardian if the offender is less than 18 years of age.

(b) The notice will include the following information:

(A) A statement that an administrative commitment to a state mental hospital listed in ORS 426.010 or a facility designated by DHS, or an extension of the transfer, is being considered.

(B) A concise statement of the reason for administrative commitment or extension of the transfer.

(C) The offender's right to a hearing.

(D) The time and place of the hearing.

(E) Notice that the purpose of the administrative commitment hearing is to determine whether there is clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005 such that administrative commitment or an extension of the transfer is warranted.

(F) The names of persons who have given information relevant to of the administrative commitment or extension of the transfer, and the offender's right to have these persons present at the administrative commitment hearing for the purposes of confrontation and cross-examination.

(G) The offender's right to admit or deny the allegations and present letters, documents, affidavits, or persons with relevant information at the administrative hearing in support of his/her defense or contentions, subject to the exclusions and restrictions provided in these rules.

(H) The offender's right to be represented by an attorney at his/her own expense. Assistance by a qualified and independent person approved by the hearing officer will be ordered upon a finding that assistance is necessary based upon the offender's financial inability to provide an assistant, language barriers, or competence and capacity of an offender to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An offender subject to an administrative commitment hearing may not receive assistance from another offender.

(I) A copy of this rule.

(c) The administrative commitment hearing will be held no more than five (5) days from the date of the written notice of the hearing.

(A) Prior to the commencement of the administrative commitment hearing, the hearing officer will furnish the offender a written explanation of the proceedings.

(B) The administrative commitment hearing will be conducted by a hearing officer employed or under contract with the OYA. The hearing officer will not have participated in any previous way in the assessment process.

(C) At the administrative commitment hearing, the offender will have an opportunity to be heard in person and through his/her attorney or independent assistant, if any.

(d) The administrative commitment hearing will be conducted in the following manner.

(A) Statement and evidence of the DHS in support of the action.

(B) Statement and evidence of the offender.

(C) Questioning, examination, or cross-examination of witnesses, unless in the opinion of the hearing officer an informant or witness would be subjected to risk of harm if his/her identity is disclosed.

(i) The offender's attorney or assistant, if any, may cross-examine witnesses, unless the hearing officer determines that it is necessary to deny cross-examination to preserve the anonymity of the witness.

(ii) If the offender has no attorney, the OYA Superintendent or designee will, if he/she has not already done so, appoint a qualified and independent person not directly involved with the offender, to cross-examine the witness for the offender. The hearing may be recessed if necessary for this purpose.

(D) The administrative commitment hearing may be continued with recesses as determined by the hearing officer.

(E) The hearing officer may set reasonable time limits for oral presentation and may exclude or limit

cumulative, repetitious or immaterial evidence.

(F) The burden of presenting evidence to support a fact or position rests on the proponent of that fact or position. An offender may be administratively committed or the transfer extended only if the hearing officer finds by clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005.

(G) Exhibits will be marked and the markings will identify the person offering the exhibit. The exhibits will be preserved by the OYA as part of the record of the proceedings.

(H) Evidentiary rules are as follows.

(i) Evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs is admissible.

(ii) Irrelevant, immaterial, or unduly repetitious evidence will be excluded.

(iii) All offered evidence, not objected to, will be received by the hearing officer subject to his/her power to exclude irrelevant, immaterial, or unduly repetitious evidence.

(iv) Evidence objected to may be received by the hearing officer with rulings on its admissibility or exclusion to be made at the hearing or at the time a final order is issued.

(I) All testimony will be given under oath.

(J) The hearing officer may discontinue the commitment proceedings at any time and may return the offender to the OYA facility.

(7) The hearing officer will make a written summary of what occurs at the hearing, including the response of the offender and the substance of the documents or evidence given in support of administrative commitment.

(a) A mechanical recording of all oral testimony and presentations will be made. This tape may be reviewed by the hearing officer before any findings are determined, or in the event of a judicial review.

(b) Tapes will be kept at least 120 days after the final order is issued.

(8) The hearing officer will issue a written proposed order that contains:

(a) Rulings on admissibility of offered evidence and other matters;

(b) Findings of fact (each ultimate fact as determined by the hearing officer based on the evidence before it); and

(c) Conclusions and recommendations for action by the hearing officer.

(A) No Justification: The hearing officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS, in which case the hearing officer will recommend that the offender return to his or her former status with all rights and privileges of that status. The hearing record will be processed with final action subject to review by the

Director of DHS or designee. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, will not be grounds for a no justification finding, unless there is substantial prejudice to the offender.

(B) Justification: The hearing officer may find the evidence supports the offender's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS, in which case the hearing officer will so inform the offender and recommend that the offender's administrative commitment exceed 30 days. The hearing record will be processed with final action subject to review by the Director of DHS or designee. An offender's administrative commitment to a state mental hospital will not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.

(9) Hearing Record:

(a) Upon completion of a hearing, the hearing officer will prepare and cause to be delivered to the Director of DHS or designee a hearing record within three (3) days from the date of the hearing.

(b) The hearing record will include:

(A) Examination reports

(B) Notice of hearing and rights;

(C) Recording of hearing;

(D) Supporting material(s); and

(E) Findings of Fact, Conclusions, and Recommendation of the hearing officer.

(10) The results of any hearing held to place an offender in a state mental hospital for administrative commitment will be reviewed and approved by the Director of DHS or designee. The Director of DHS or designee will review the Findings-of-Fact, Conclusions, and Recommendation of the hearing officer, in terms of the following factors:

(a) Was there substantial compliance with this rule;

(b) Was the decision based on substantial information; and

(c) Was the decision proportionate to the information and consistent with the provisions of this rule.

(11) Within three (3) days of the receipt of the hearing officer's report, the Director of DHS or designee will enter an order, which may:

(a) Affirm the recommendation;

(b) Modify the recommendation;

(c) Reverse the recommendation; or

(d) Reopen the hearing for the introduction and consideration of additional evidence.

(12) When the Director of DHS or designee takes action to modify or reverse, he or she must state the reason(s) in writing and immediately notify the offender, hearing officer, and the Superintendent of the sending OYA facility.

(13) When the Director of DHS or designee reopens the hearing under this rule, the hearing officer will, pursuant to these rules, conduct the reopened hearing and prepare an amended hearing record within three (3) days of the reopened hearing. The Director of DHS or designee will review the hearing officer's recommendation and enter an amended order, which may affirm, modify, or reverse the hearing officer's recommendation.

(14) Extension of Transfer: If DHS determines that the administrative commitment must exceed 180 days in order to stabilize the offender; the administrative commitment must be renewed in a subsequent administrative commitment hearing held in accordance with these rules.

(15) Notwithstanding this rule, an administrative commitment may not continue beyond the term of legal custody to which the offender was sentenced.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505


Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505

Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

### **Assignment and Transfer of Inmates**

#### **309-120-0200**

##### **Purpose**

 Purpose. These rules prescribe procedures by which inmates of Department of Corrections facilities may be transferred to a state mental hospital listed in ORS 426.010.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(1) and (2); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06; Renumbered from 309-120-0000, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

#### **309-120-0205**

##### **Definitions**

As used in these rules:

(1) "Department of Corrections Facility" means any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(2) "Inmate" means any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(3) "Mentally Ill Inmate" means an inmate who, because of a mental disorder, is one or more of the following:

(a) Dangerous to self or others.

(b) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(c) An inmate who:

(A) Is chronically mentally ill, as defined in ORS 426.495;

(B) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the Department of Human Services under ORS 426.060;

(C) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in subparagraph (3)(c)(B) of this rule; and

(D) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the inmate will become a person described under either or both subparagraph (3)(c)(A) or (3)(c)(B) of this rule.

(4) "State Mental Hospital" as defined in ORS 426.010. Except as otherwise ordered by the Department of Human Services pursuant to 179.325, the Oregon State Hospital in Salem, Marion County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, shall be used as state hospitals for the care and treatment of mentally ill persons who are assigned to the care of such institutions by the Department of Human Services or who have previously been committed to such institutions.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(3); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06; Renumbered from 309-120-0005, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### 309-120-0210



#### Administrative Transfers (Mentally Ill Inmates)

(1) The Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee may request the Superintendent/designee of a state mental hospital listed in ORS 426.010 to accept a transfer of a mentally ill inmate to a state mental hospital pursuant to these rules.

(2) An inmate may be transferred to a state mental hospital for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended pursuant to a hearing conducted in accordance with these rules.

(3) If space is available and the Superintendent/designee of the state mental hospital approves, the inmate shall be transferred.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### 309-120-0215

#### Hearings Process

(1) The Department of Human Services shall provide for an administrative commitment hearing conducted by a hearings officer employed or under contract with the Department of Corrections for administrative commitment or extension of the transfer of the inmate if:

(a) The Department of Human Services determines that administrative commitment for treatment for a mental illness is necessary or advisable or that the Department of Human Services needs more than 30 days to stabilize or evaluate the inmate; and

(b) The inmate does not consent to the administrative commitment or an extension of the transfer.

(c) Inmates in the legal custody of the Department of Corrections and in the physical custody of the Oregon Youth Authority (OYA) will be administratively committed through an OYA hearing, pursuant to OAR 416-425-0020. Inmates in OYA physical custody will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human Services and returned directly to the OYA facility.

(2) It is the responsibility of the Superintendent/designee of the Oregon State Hospital to notify the hearings officer of the need for a hearing and to provide him or her with a transfer request containing the evidence justifying such action.

(3) The hearing shall be conducted by an independent hearing officer.

(4) The hearings officer shall not have participated in any previous way in the assessment process.

(5) The hearings officer may pose questions during the hearing.

(6) The evidence considered by the hearings officer will be of such reliability as would be considered by reasonable persons in the conduct of their serious affairs.

(7) When confidential informant testimony is submitted to the hearings officer, the identity of the informant and the verbatim statement of the informant shall be revealed to the hearings officer in writing, but shall remain confidential.

(8) In order for the hearings officer to rely on the testimony of a confidential informant, information must be submitted to the hearings officer from which the hearings officer can find that the informant is a person who can be believed or that the information provided in the case at issue is truthful.

(9) At the conclusion of the hearing, the hearings officer will deliberate and determine whether by clear

and convincing evidence that the inmate is a mentally ill person as defined in ORS 426.005 and will be administratively committed involuntarily to a state mental hospital. The hearings officer may postpone the rendering of a decision for a reasonable period of time, not to exceed three (3) working days from the date of the hearing, for the purpose of reviewing the evidence.

(10) An inmate subject to an administrative commitment to a state mental hospital has the rights to which persons are entitled under ORS 179.485.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0220

### Representation

(1) In all cases, the inmate is entitled to:

(a) Speak in his or her own behalf; and

(b) Be present at all stages of the hearings process, except when the hearings officer finds that to have the inmate present would present an immediate threat to facility security or safety of its staff or others. The reason(s) for the finding shall be part of the record.

(2) Assistance by a qualified and independent person approved by the hearings officer will be ordered upon a finding that assistance is necessary based upon the inmate's financial inability to provide an assistant, language barriers, or competence and capacity of the inmate to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An inmate subject to an administrative commitment hearing may not receive assistance from another inmate.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0225

### Notice of Hearing

(1) The inmate shall be given written notice that an administrative commitment to a state mental hospital listed in ORS 426.010, a hospital or facility designated by the Department of Human Services, or an extension of the transfer is being considered by the Department of Corrections and the Department of Human Services.

(2) The notice will be provided by the hearings officer. Such notice must be provided far enough in advance of the hearing to permit the inmate to prepare for the hearing, but in no case shall notice be provided less than 24 hours prior to the hearing. The hearing shall take place no later than five (5) days from the date of service of the notice.

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alternatives available for obtaining witness testimony, upon finding that the witness' testimony would not assist the hearings officer in the resolution of the proceeding, the witness' appearance at the hearing would present an undue risk to the safety, security, or orderly operation of the facility or the safety of the witness or others, or that the witness is not reasonably available. The reason(s) for exclusion shall be made part of the record.

(9) Persons other than staff requested as witnesses may refuse to appear or testify.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### 309-120-0245

#### Postponement

(1) A hearing may be postponed by the hearings officer for good cause and for reasonable periods of time.

(2) Good cause includes, but is not limited to:

(a) Illness or unavailability of the inmate;

(b) Gathering of additional evidence; or

(c) Gathering of additional documentation.

(3) The reason(s) for the postponement shall be made part of the record.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.

Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### 309-120-0250

#### → Findings

(1) No Justification: The hearings officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human Services, in which case the hearings officer will recommend that the inmate return to his or her former status with all rights and privileges of that status. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, shall not be grounds for a no justification finding, unless there is substantial prejudice to the inmate.

(2) Justification: The hearings officer may find the evidence supports the inmate's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human

Services, in which case the hearings officer will so inform the inmate and recommend that the inmate's administrative commitment exceed 30 days. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. An inmate's administrative commitment to a state mental hospital shall not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### **309-120-0255**

#### **Hearing Record**

(1) Upon completion of a hearing, the hearings officer shall prepare and cause to be delivered to the Superintendent/designee of the Oregon State Hospital a hearing record within three (3) days from the date of the hearing.

(2) The record of the formal hearing shall include:

- (a) Examination reports;
- (b) Notice of hearing and rights;
- (c) Recording of hearing;
- (d) Supporting material(s); and
- (e) "Findings-of-Facts, Conclusions, and Recommendation" of the hearings officer.

(3) The hearings officer will retain the recording and forward to the Superintendent/designee of the Oregon State Hospital items (2)(a), (2)(b), (2)(d), and (2)(e) of this rule.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

### **309-120-0260**

#### **Superintendent's Review**

(1) The results of any hearing held to place an inmate in a state mental hospital for administrative commitment will be reviewed and approved by the Superintendent/designee of the Oregon State Hospital.

(2) The Superintendent/designee of the Oregon State Hospital shall review the "Findings-of-Fact, Conclusions, and Recommendation" of the hearings officer, in terms of the following factors:

When an inmate is administratively transferred to a state mental hospital, no short-term transitional leaves, emergency leaves, or supervised trips shall be approved by the state mental hospital without approval of the functional unit manager of the Department of Corrections facility.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439  
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(6); MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0040, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

**309-120-0285**

### **Releases from a State Mental Hospital**

An inmate who is transferred to a state mental hospital may be discharged and transferred back to a Department of Corrections facility for one of the following reasons:

- (1) Completion of treatment;
- (2) He/she could receive mental health services within the Department of Corrections, and there was a mutually agreed upon continuity of care plan developed by the state mental hospital and the Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee; or
- (3) He/she does not meet the requirements to continue treatment at a state mental hospital.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439  
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(7); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0045, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

**309-120-0290**

### **Reporting of Unusual Incidents**

Reporting of unusual incidents involving inmates administratively transferred to a state mental hospital shall be handled in accordance with the Department of Corrections policy on Unusual Incident Reporting Process.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.  
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439  
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(8); MHD 3-1995, f. & cert. ef. 4-13-95;

## **TRANSITION UNIT 35A: STEPS FOR PSRB CONDITIONAL RELEASE FROM OSH**

1. **Approval by IDT for Conditional Release Planning privileges.** You have an IDT meeting every 60 days if you have been at OSH for a year or less and every 90 days if you have been at OSH for over one year. Your IDT will talk with you about your progress in meeting your treatment care planning goals and will make a determination about whether conditional release planning privileges will be requested from the OSH Risk Review Board.
2. **Approval by OSH Risk Review Board for Conditional Release Planning privileges.** A hearing before the OSH Risk Review Board will be requested by your IDT and scheduled accordingly. You and your IDT will be present at this hearing before the OSH Risk Review Board to request conditional release planning privileges.
3. **Completion of a Risk Assessment and Substance Abuse Assessment.** In order to make a more informed decision about your future discharge, the PSRB is requesting additional information about you from your IDT. These assessments may be ordered in your case, and can take up to 2-3 months to complete. You may have one or both of these assessments already completed. Check with your social worker about the status of these assessments in your case.
4. **Discussion with social worker about potential community placement options.** You will meet with the social worker to decide on an appropriate placement location. Once a placement is decided on, a referral or "Request for Evaluation" will be sent by your social worker to the PSRB.
5. **Social worker sends a form called a "Request for Evaluation" to the PSRB along with a Progress Note update (informing the PSRB about your progress).** It takes the PSRB approximately two weeks to process this form, although it may take longer. The PSRB will collect all of your records, including your hospital and legal records and send them to the community program or county mental health provider identified in the request for evaluation.

6. **The PSRB sends a form called "Order for Evaluation" which includes your hospital and legal records to the designated county mental health provider or community program.** It takes approximately four weeks for the designated county mental health provider or community program to review your records and contact the social worker to arrange for an interview. During this time, your case monitor and social worker will assist you in preparing for your upcoming interview.
7. **Community Placement interview.** Your interview often occurs at OSH, although sometimes it takes place in the community. Your social worker will make the necessary arrangements for your interview. Following your interview, the county mental health provider or community program who interviews you completes a written evaluation with a recommendation for your acceptance or denial. Completion of this written evaluation may take up to 30 days (or more) to complete. If you are accepted, a recommendation for a specific level of care is included in the written evaluation (examples of level of care include Secure Residential Treatment Facility, Residential Treatment Facility, Residential Treatment Home, Adult Foster Home, Semi-Independent). Depending on whether there is a bed opening at the residential facility, you may or may not be placed on a waitlist. If you are denied by the county mental health provider/community program, you will meet with your social worker to review the reasons for the denial and work on the next course of action.
8. **You may participate in an in-person visit to the residential facility where you have been accepted.** Your social worker will make arrangements for this visit and accompany you. The purpose of this visit is to increase your understanding of the residential facility through a tour of the facility and by meeting the program staff and residents. You will have the opportunity to ask questions you may have about the residential facility, review facility rules and other information such as residential level systems.

9. **Transitioning activities.** While you are still at OSH, you may attend weekly group activities at the community mental health outpatient center or group home where you have been accepted to increase your understanding of the program services (not all counties/programs offer this type of transitioning service). Additionally, the Community Transition Team and/or your social worker may arrange off-site trips and accompany you to your discharge area with the goal of increasing your understanding of community resources in your discharge community.
10. **Completion of a "Conditional Release Plan" once a bed opening is determined.** This is a three page form outlining your community provider information including your assigned Conditional Release Supervisor (your community case manager who reports to the PSRB monthly about your progress) and a description of your weekly activities. You will have the opportunity to review this form. You, your social worker and Conditional Release Supervisor all sign this form before it is submitted to the PSRB for review. A discharge date may be arranged by your social worker and Conditional Release Supervisor at this time.
11. **Conditional Release Hearing before the PSRB.** One of two types of hearings will be scheduled on your behalf to review your Conditional Release Plan, either a "Full Hearing" or an "Administrative Review Hearing." If you participate in a "Full Hearing," your attorney, psychiatrist, social worker and in some cases a representative from your community placement program will be present at the hearing to testify on your behalf. If you have an "Administrative Review Hearing," you will not be present at the hearing as only the PSRB will administratively review your Conditional Release Plan. If the PSRB requests a modification or change to your Conditional Release Plan, this may delay the discharge planning in your case, however your IDT and community placement program will work to resolve any such request by the PSRB. The PSRB can deny your discharge at this step depending on the situation, however it is not a common occurrence at this step. If this happens to occur, you will meet with your social worker to determine the next course of action.

12. **Conditional Release discharge.** This can occur as early as the day following your Conditional Release Hearing, although it usually is scheduled within a week following your Conditional Release Hearing. Your social worker will meet with you at least one week prior to your discharge date to discuss and plan for your day of discharge.

## CONDITIONAL RELEASE CHECK LIST

Name \_\_\_\_\_

## FINANCIAL

- ☐ Upon request for Order of Evaluation from PSRB, benefit application and sent to Patient Affairs, Bldg 35 (Mental Status Exam, Capability Statement)
- ☐ NWSDS completes application with patient
- ☐ Authorization to Forward Trust Funds sent to business office
- ☐ SW Director to sign money draw form (withdraw of funds paperwork) - & Housing Fund Request/Benevolent Fund Request if needed
- ☐ Verify what resources are in place at least one week prior to CR – Patient Affairs x. 52919
- ☐ Follow up with Business Office to see that paperwork is in their office one day before CR
- ☐ Notify billings office of pending CR/discharge at x. 59840
- ☐ Trust account closed out on day of CR/discharge

## MEDICAL

- ☐ MDs signature on D/C plan details
- ☐ 14 day supply of meds ordered and on unit (D/C Plan Details medication matches)
- ☐ 30 day Rx completed by MD
- ☐ Discharge physical completed
- ☐ TB test updated or recent chest x-ray
- ☐ Lab work copied if there is an active medical condition or for Lithium, Tegretol, or Clozaril and next scheduled blood draw

## LEGAL

- ☐ Agreement to conditional release read and signed by client
- ☐ Copy of Agreement to conditional release sent to PSRB
- ☐ PSRB summary of findings or release order in chart
- ☐ Release date established with community mental health provider
- ☐ PSRB notified of release date

## RESIDENTIAL

- ☐ Residential referral sent, including medical/clinical info
- ☐ Plan of Care Request form - Medicaid Policy Unit
- ☐ Confirm release date with residential provider
- ☐ Arrange transportation with communication center with trip slip
- ☐ Patient's family notified of release date, new address, and phone number
- ☐ Copy of Hepatitis B, TB test, and D/C physical sent
- ☐ Info on special diet or medical needs sent (The form is at the end of Structured Residential Form)
- ☐ Meds and prescriptions sent
- ☐ Copy of D/C plan details sent with med orders and MDs signature
- ☐ Relapse Prevention Plan forwarded to residential provider
- ☐ OT Assessment forwarded to residential provider if available

## OTHER

- ☐ S.O. Registration if needed
- ☐ Photograph of client (from Comm Center via email) to residential provider (Letter to PSRB)
- ☐ Property sheet to Comm Center
- ☐ D/C plan details sent to Patient Affairs and Medical Records, with med orders attached
- ☐ Fax NWSDS discharge plan details – attn. Karin Petit at 503.304.3464

## **DISCHARGE CHECKLIST**

### **RN RESPONSIBILITIES**

#### **2 WEEKS PRIOR TO DISCHARGE**

- \_\_\_\_\_ 1) Set up discharge physical
- \_\_\_\_\_ 2) TB test or chest x-ray and HBV testing/results
- \_\_\_\_\_ 3) Check for discharge transport and arrange for staff to accompany Patient if indicated
- \_\_\_\_\_ 4) Diabetic Patient: (order Accu-check glucometer from the lab. Check with unit social worker or Out Reach social worker for available funds). Start patient diabetic education per protocol.
- \_\_\_\_\_ 5) Medical equipment (eg. TENS unit, CPAP, Bi PAP): Call Director of S.W. at 5-2860 re: rental agreement
- \_\_\_\_\_ 6) Arrange for discharge physical

#### **5 DAYS PRIOR TO DISCHARGE**

- \_\_\_\_\_ 1) Request med review from pharmacy and place in MD's box
- \_\_\_\_\_ 2) Make sure diabetic patients have scripts for blood glucose monitor, lancets test strips, and syringes
- \_\_\_\_\_ 3) Complete RN discharge summary except for time and date
- \_\_\_\_\_ 4) Check for inhalers and/or treatments and send to pharmacy for labeling
- \_\_\_\_\_ 5) Make sure meds ordered are for 14 day supply
- \_\_\_\_\_ 6) Check for PRN usage, notify MD and assure these are ordered on med review, if indicated
- \_\_\_\_\_ 7) 30 day Rx completed by MD
- \_\_\_\_\_ 8) Check med review orders against prescription orders for accuracy

#### **24 HOURS PRIOR TO DISCHARGE**

- \_\_\_\_\_ 1) Check all inhalers and treatments for pharmacy labeling
- \_\_\_\_\_ 2) Check medication bottles, dosages, times, etc. for accuracy
- \_\_\_\_\_ 3) Count pills in each bottle to ensure adequate amount being sent
- \_\_\_\_\_ 4) Place medications and treatments in bag provided, in designated locked area
- \_\_\_\_\_ 5) Ensure that prescriptions, discharge summaries, copies of Lab Reports, H&P or any other documents requested by the receiving facility, are in the envelope provided by the Social Worker
- \_\_\_\_\_ 6) Send 14 day diabetic supplies for diabetic patients (don't forget syringes)

**COPIES IN FOLDER: H&P; PPD/CXR flowsheet; discharge MAR/MD orders.**

**BEFORE THE PSYCHIATRIC SECURITY REVIEW BOARD  
OF THE STATE OF OREGON**

In the Matter  
of

SUMMARY OF CONDITIONAL RELEASE PLAN

---

A conditional release plan of supervision and treatment is summarized below. All who will be providing services have agreed to this plan. Confirmations are available.

- 1. Conditional Release Supervisor** – the person who will coordinate and monitor all elements of the conditional release plan and report to the Board monthly.

Name			
Agency			
Mailing Address			
E-Mail Address		Fax	
Phone Numbers			
Backup Coverage		Phone	

- 2. Housing** – with whom and nature of the residence

Name of Facility		Type of Facility	
Address			
Phone		Fax	
Staffing	<input type="checkbox"/> Staff present 24 hours per day. Awake 24 hours? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	<input type="checkbox"/> Staff present when a resident is home		
	<input type="checkbox"/> Periodic Staffing		
	<input type="checkbox"/> Hours covered daytime		
	<input type="checkbox"/> Hours covered evenings		
	<input type="checkbox"/> Hours covered weekends		
	<input type="checkbox"/> Other:		
	<input type="checkbox"/> No staff		

The person shall have no overnight guests without prior authorization from the conditional release supervisor. The person must be at home between the hours of  p.m. and  a.m. The conditional release supervisor may authorize the following exceptions to the curfew:

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3. The person will participate in structured activity at a minimum of  hours per week, comprised of the following:

	Who will provide service	Frequency
Case manager sessions		
Individual therapy		
Group sessions (not included below)		
Home supervision visits		
Scheduled		
Unannounced		
Appt. w/med. prescriber		
Observed medication compliance		
Substance abuse treatment		
Self-help groups (NA/AA), verified		
RANDOM, UNANNOUNCED A/D screens		
Other (specify)		

Method of monitoring	

#### 4. Source of Income

Amount and source	
Payee?	
Money management required?	
Medical/Psychiatric insurance	

#### 5. Special Conditions/Prohibited Contacts

No contact with the victim(s) of the instant offense.

## 6. Submitting Parties

Signatures are required from the proposing party (Patient, Family, Attorney, State Hospital), the conditional release supervisor and the patient (if not the proposer). By signing, the parties recommend that the person should be conditionally released pursuant to the above outlined plan.

---

Name

---

Date

---

Relationship to Client

---

Conditional Release Supervisor

---

Date

---

Client

---

Date



# Oregon

Theodore R. Kulongoski, Governor

## Department of Human Services Health Services

Office of Mental Health and Addiction Services

500 Summer Street NE E86

Salem, OR 97301-1118

Voice 503-945-5763

Fax 503-378-8467

April 18, 2007

County Mental Health Directors  
Acute Care Hospitals  
Oregon State Hospital  
Blue Mountain Recovery Center

Re: Co-Management

In order to effectively manage the valuable resources of the state hospital and facilitate re-integration of patients from the state hospital into the community, AMH is initiating the implementation of the Co-Management Plan effective Monday, April 23, 2007.

The co-management plan requires that there be close collaboration and effective communication between both county and state staff responsible for the plan's implementation. Attached you will find a flow sheet which highlights elements of the operational process for referrals to state hospital long-term care and the new forms. A summary page with a brief explanation of each form is included. Please review the attached forms closely:

- Request for Long Term Psychiatric Care Determination
- Determination for Initial 90 day Authorization
- Request and Determination for Continued Stay

If you have questions regarding the operational process please contact D'Leah Cruz RN, C, Extended Care Manager at (503) 945-5840 or via email [dleah.cruz@state.or.us](mailto:dleah.cruz@state.or.us). For technical assistance or question with the forms themselves, please contact Linda Walter, RN, LCSW, Extended Care Management Unit at (503) 947-5542 or via email at [linda.walter@state.or.us](mailto:linda.walter@state.or.us). Thank you for your support in implementing this significant policy change.

Sincerely

D'Leah Cruz, RN, C  
Extended Care Manager

Enc. 9

DC/ls

cc: File

If you need this letter in alternate format, please call 503-945-5763 (Voice) or 503-945-5895 (TTY)

"Assisting People to Become Independent, Healthy and Safe"

An Equal Opportunity Employer

HSS1601 (04/05) ©

Addictions and Mental Health Division  
April 18, 2007

**NEW FORMS FOR CO-MANAGEMENT PLAN**

Please start using the new forms immediately and discard any old forms you may have.

1. **Flow sheet -- Co-Management Long Term Care Process**
2. **Flow sheet - Continued Stay Process**
3. **Request for Long Term Psychiatric Care Determination** -- This form is the request for approval for long-term care for the first 90 days. Please fill it out completely for every person being referred for long term care, including a narrative supporting the request. This form may be submitted by the MHO (where applicable) or the acute care hospital, but a representative from the county of responsiveness must approve the referral and sign off on the form. Please submit all required documentation with the form.
4. **Determination for Initial 90-Day Authorization** -- This form will indicate whether the request has been approved or denied by AMH/ECMU. The response will be faxed back to the acute care hospital and the identified county of responsiveness co-management contact person within 3 business days of receipt of the referral. A denial may be appealed within 3 business days of notification using the same process that had been in place prior to co-management.
5. **Request and Determination Form for Continued Stay** - This is a two page form which will be submitted to AMH/ECMU to request continued stay beyond the initial 90 day authorization. The state hospital treatment team will almost always submit this request, unless a patient actually remains on the state hospital wait list beyond the first 90 days. Please fill out completely, including a narrative supporting the request and a recommendation for a continued length of stay of 30, 60, or 90 days. Submit the form and the required documentation 7-14 days prior to the expiration date of the initial 90-day approval. The same form, indicating approval or denial, will be faxed back to the state hospital treatment team within 3 business days of receipt of the required documentation.

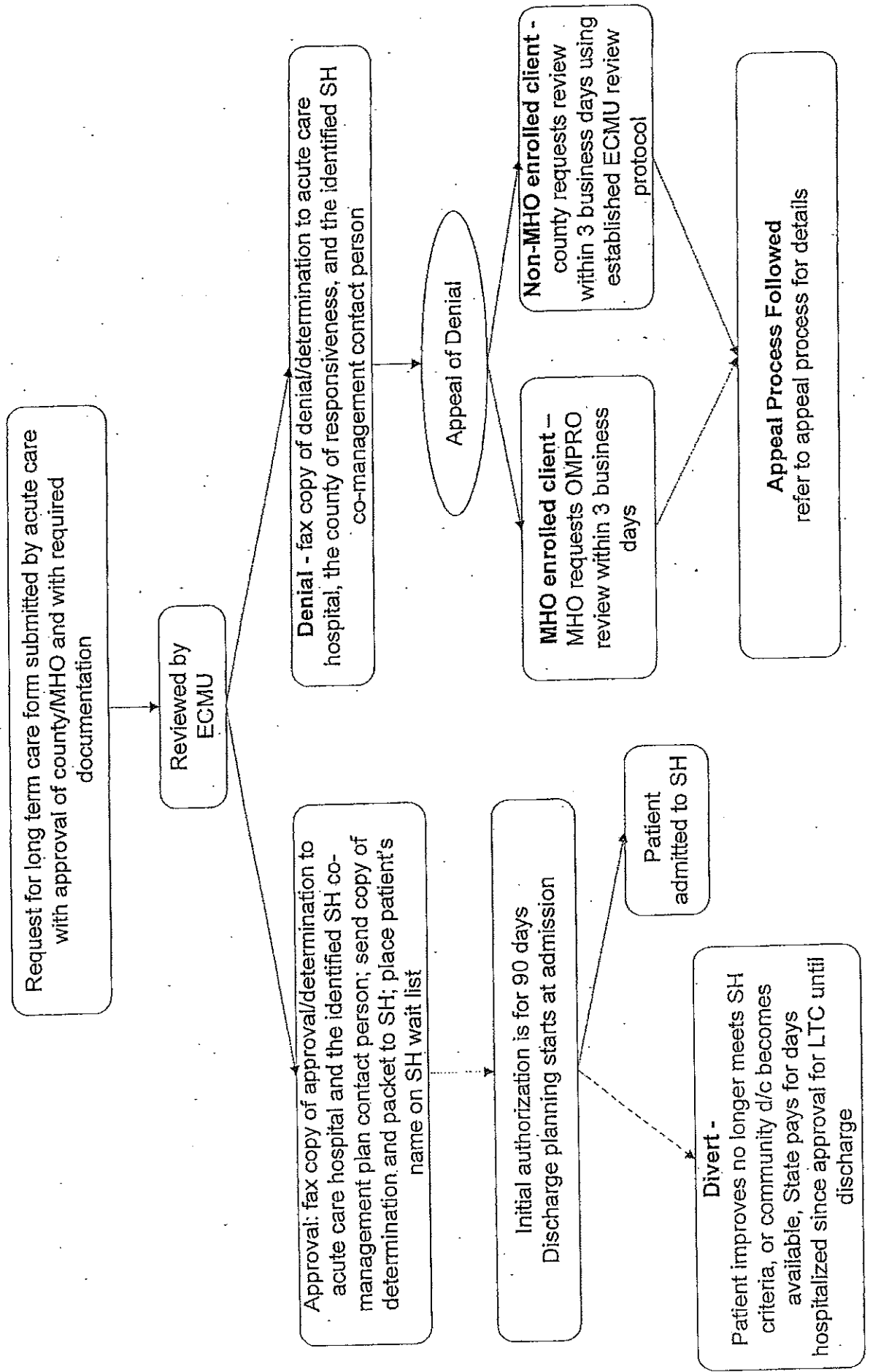
Addictions and Mental Health Division  
April 18, 2007

**New Forms for Co-Management cont.**

6. **Continued Stay Criteria Form** – This form clearly states the criteria to be met in order for a person to be approved for an additional 30, 60, or 90 days of state hospital level of care.
7. **Denial of Continued Stay for Extended Hospital Level of Care Form** – This form will contain a detailed explanation of the reason for denial and will be attached to form #5 if a request for continued stay is denied.
8. **Continued Stay Denial Appeals Process** – This form provides detailed instructions for appealing a denial of continued stay. Appeals must be submitted within 3 business days of notification of a denial for continued stay.

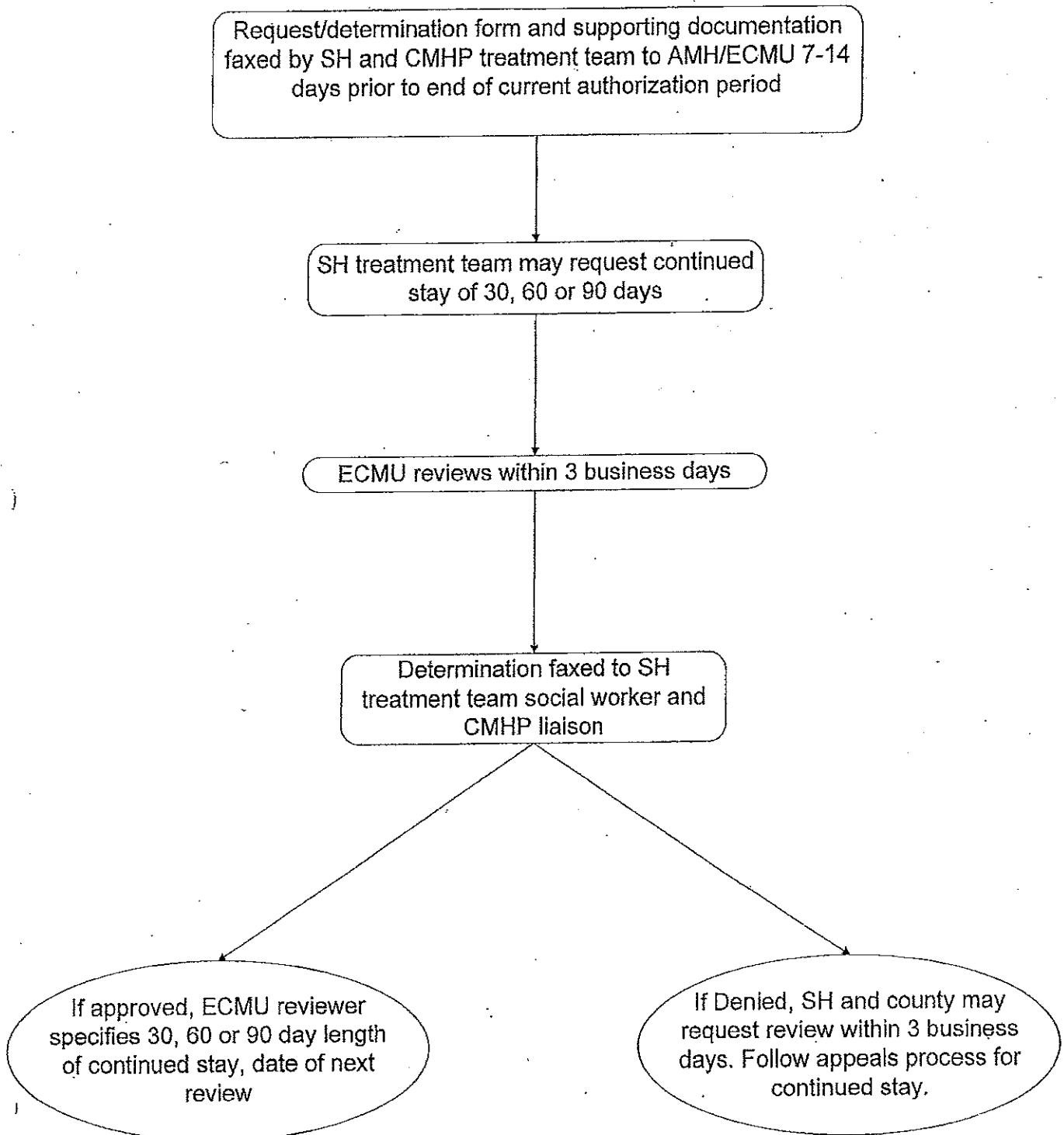
Addictions and Mental Health Division  
April 18, 2007

# Co-Management Long Term Care Process



Addictions and Mental Health Division  
April 18, 2007

## Continued Stay Process



Addictions and Mental Health Division  
April 18, 2007  
Request and Determination Form for Continued Stay

Patient Name:		DOB:
Submitted by:	County Authorization	Reviewed by:
Approval Date:	Next Review Date:	Denied <input type="checkbox"/> Reason:
30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/>		

Basis For Request

One of the following elements in **bold** would be sufficient for continued stay at the state hospital:

- **Safety**
- **Requires a highly structured supervised setting not available in a community setting.**
  - ☐ Demonstrated by: Continued actual danger to self, others or property that manifested by at least one of the following:
  - ☐ Continues to make suicide attempts or substantial (life threatening) suicide gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
  - ☐ Continues to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.
  - ☐ Continues to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment.
- **Medical/Psychiatric**
- **Requires intensity and frequency of medical/psychiatric services provided in a hospital level of care.**
  - ☐ Demonstrated by: Primary DSM IV diagnosis of severe psychiatric disorder with severe behavioral disturbance and a need for 24 hour hospital level medical supervision.
  - ☐ Need for extended regulation of medications due to significant complications arising from severe side effects of medications
- **Alcohol and Drug**
- **Requires detoxification services.**
  - ☐ Demonstrated by: need to differentiate between mental illness vs. drug induced symptoms and need for withdrawal of medications to clarify diagnosis and provide appropriate/effective pharmacological intervention.
- **Recovery Environment**
- **Level of care/supports not available and alternative level of care/supports are not sufficient to support safety and recovery; and**
- **The community mental health program of the County of Responsiveness has been actively engaged in discharge planning.**
  - ☐ Demonstrated by: symptoms and/or behavior management problems beyond the capacity of the extended/enhanced care service to manage within its programs; lack of an appropriate existing program vs. lack of capacity in an existing appropriate program.

Addictions and Mental Health Division  
April 18, 2007

Request and Determination Form for Continued Stay  
Page 2

The consideration of a consumer or guardian's refusal of community placement and services may be considered in determining Continued Stay, but is not sufficient to justify continued state hospitalization.

**Analysis of Documentation Supporting Request**

1. The CMHP should include all relevant information to justify continued stay at the hospital. Relevant information includes, but not limited to:
  - a. Efforts to provide the necessary community services identified in the discharge plan.
  - b. Special community service and support needs not readily available.
  - c. Description of steps to be taken to facilitate the discharge to the community.

**The above information must be documented in the patient's chart.**

The most recent treatment team note will be considered sufficient documentation for continued stay if the content addresses all three of the elements listed above.

**Narration Supporting Request:**

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## DENIAL OF CONTINUED STAY FOR EXTENDED HOSPITAL LEVEL CARE

REASON FOR DENIAL: \_\_\_\_\_

Date \_\_\_\_\_

Addictions and Mental Health Division

April 18, 2007

**REQUEST FOR LONG TERM PSYCHIATRIC CARE DETERMINATION  
REQUEST FOR INITIAL 90 DAY AUTHORIZATION**

Mental Health Organization:

Referral Date:

Patient Name:

DOB:

Medicaid Prime No:

DSM IV - Axis I

DSM IV - Axis II

DSM IV - Axis III

Admission Date:

Proposed Transfer  
Date:

**BASIS FOR REQUEST (NOTE: All documents must be attached.)**

- ☐ There is a need for either:
- ☐ Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an Oregon State Hospital or Extended Care Program, or
  - ☐ Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and
- ☐ The OMAP Member has received all Usual and Customary Treatment, including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

**DOCUMENTATION SUPPORTING REQUEST (NOTE: All documents must be attached.)**

- ☐ Physician's history and physical
- ☐ List of current Medications, dosages and length of time on Medication
- ☐ Reports of other Consultations
- ☐ Social histories
- ☐ Current week's progress notes

**ANALYSIS OF DOCUMENTATION SUPPORTING REQUEST**

Submitted by \_\_\_\_\_

\_\_\_\_\_  
Name, Title and Date of County Authorization

# Addictions and Mental Health Division

April 18, 2007

## DETERMINATION FOR INITIAL 90 DAY AUTHORIZATION

Client's Name:		Medicaid Prime No:
<input type="checkbox"/> Approved <input type="checkbox"/> Denied (see explanation below)	Referral Date:	Decision Maker:
	Approval Date:	Date of Determination:
		Date Authorization Expires (includes time on wait list):

## CRITERIA FOR LONG TERM PSYCHIATRIC INPATIENT CARE

- ☐ Primary DSM IV diagnosis is severe psychiatric disorder
- ☐ Documented need for 24-hour hospital level medical supervision
- ☐ At least one of the following conditions is met:
  - ☐ Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications.
  - ☐ Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record.
  - ☐ Continued actual danger to self, others or property that is manifested by at least one of the following:
    - ☐ has continued to make suicide attempts or substantial (life-threatening) suicide gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
    - ☐ has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.
    - ☐ has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment.
  - ☐ Failure of intensive extended care services evidenced by documentation in the Clinical Record of:
    - ☐ An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and
    - ☐ Multiple attempts to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.
- ☐ Has received all Usual and Customary Treatment, including if Medically Appropriate, establishment of a Medication program and use of Medication Override Procedure.

If denied, reason for denial:

<b>Policy Title:</b>	Co-Management		
<b>Policy Number:</b>		<b>Version:</b> 1.0	<b>Effective Date:</b> 07/01/10

Draft: 05/01/10

Approved By: *(Authorized Signer Name)*

Date Approved

Policy	Procedures	Forms, etc.	Definitions	References	Contact	History
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### Overview

**Description:** This policy supports federal and state policies that require individuals identified as no longer requiring hospital level of care to be promptly discharged to the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide the greatest degree of independence.

**Purpose/Rationale:** The purpose of this policy is to facilitate timely decisions and action during the referral and placement process for individuals leaving the state hospital system for placement into residential settings.

This policy is designed to encourage resourceful collaboration among the state hospital system, the county of responsibility (COR) and the proposed county of placement.

This policy will facilitate prompt discharges from the state hospital system, for those identified by their treatment teams as ready to place (RTP), into the residential setting in which the consumer is most likely to succeed.

**Applicability:** This policy applies to voluntary and civilly committed individuals residing at all Oregon State Hospital (OSH) campus and the Blue Mountain Recovery Center.

**Failure to Comply:** Failure to comply with this policy and related procedures and guidelines may result in decisions to deny funding.

### Policy

1. The Extended Care Management Unit (ECMU) of the Addictions and Mental Health (AMH) Division will approve placements into the state hospital system and will determine the number of approved inpatient treatment days.
2. AMH or it's designee will identify the County of Responsibility (COR) for each consumer.

3. The IGA authorizes DHS to reduce a county's monthly allocation when 1) the contractor is identified as the County of Responsibility (COR) for a consumer in the state hospital and 2) that same consumer remains in the hospital more than 30 days beyond those authorized by the Department. The reduction will be based on the following:

Days Beyond Authorization	Percentage of State Hospital Cost of Care
0 – 30	0 %
31 – 60	25 %
61 – 90	50 %
91 – 120	75 %
121 and over	100%

4. The percentage of the cost of care will be reduced by an additional 50% if the county's Average Daily Population (ADP) or identified DHS approved multi-county region's ADP is at or below the ADP targets established by AMH.

**Procedure(s) That Apply:**

AMH – "Co-Management"

**Form(s) that apply:**

**Definition(s):**

Average Daily Population: The average number of individuals from a specific county in the hospital on any given day and averaged over a pre-determined period of time.

County of Responsibility: As determined by Oregon Administrative Rule (OAR) and AMH policy, the county fiscally accountable for the placement and care of adult mental health consumers.

Hospital Community Liaison: The person or people in a state hospital setting responsible for receiving and forwarding documents related to continued stay and outpatient referrals.

Interdisciplinary Team: The group of people designated to advise in the planning and provision of services and supports to individuals, to include representatives from multiple disciplines or agencies.

State Hospital System: All Oregon state hospital campuses and the Blue Mountain Recovery Center.

**Reference(s):**

Americans with Disabilities Act of 1990 42 U.S.C. 12181

Olmstead vs. L.C. (98-536) 527 U.S. 581 (1999)

OAR Chapter 407, Division 005, "Prohibiting Discrimination Against Individuals with Disabilities"

2009-2011 Inter-Governmental Agreement for the Financing of Community Mental Health, Developmental Disability and Addiction Services

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**Keywords:**

Co-Management

County of Responsibility

Ready to Place

Service Element

Inter-Governmental Agreement

## Exhibit B

### AMH/PSRB/OSH Planning and Placement List

#### Process

1. **Request:** A request is put in writing by the Social Worker to the PSRB Board to have an evaluation sent to a community provider. A Social Worker and Psychiatrist sign the request.
2. **Order:** This is the date the PSRB sent out the order for the evaluation.
3. **Evaluation:** An evaluation is completed by the community provider and includes but is not limited to:
  - An interview with the resident
  - Review of the residents records
  - Assessments
  - Answer to these three questions:
    1. Is the patient affected by mental disease or defect?
    2. Does the patient present a substantial danger to others?  
If the patient is affected by mental disease or defect, which is in a state of remission, may the disease, with reasonable medical probability, occasionally become active and, when active, render the patient a danger to others.
    3. Provide your recommendation regarding whether the patient is appropriate for conditional release in the community. If yes, what supervision and treatment are necessary to allow the patient to remain safely in the community? Can you or your mental health program provide these services or can your agency monitor the provision of the services by other agencies or individuals?
4. **Accept:** Refers to whether the community program accepts the resident.
5. **Denial:** Refers to the community denying placement and specific reasons why. Includes recommendations for future placement or what the individual would need to work on before being accepted.
6. **Benefit Status:** The benefit status is set up prior to the resident going out into the community by the OSH Social Worker but the community program must register with the local Social Security Department shortly upon release to the community.
7. **Hearing:** Every patient has to have a hearing prior to leaving OSH. Four items are needed for a hearing and they include the following:
  - (1) Evaluation

## Exhibit B

- (2) Update – three weeks prior to the hearing
- (3) Summary of Conditional Release Plan
- (4) Request for Hearing

Note: Two types of Hearing

(1) Full Hearing

- a. Provider
- b. Patient
- c. Social Worker
- d. Victim
- e. Family
- f. Other

States Attorney and PSRB Board decide on Conditional Release

Hearings are held at **Oregon State Hospital 77 Building**

(2) Ad. Min. Hearing. (Paper Review)

**Exhibit H**  
**PSRB Specific OAR's**

**309-032-1540**

**Program Specific Service Standards**

(4) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board: Services and supports must include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(a) Providers of PSRB and JPSRB services acting through the designated Qualified Person, must submit reports to the PSRB or JPSRB as follows:

(A) Orders for Evaluation: For individuals under the jurisdiction of the PSRB or the JPSRB, providers must take the following action upon receipt of an Order for Evaluation:

(i) Within 15 days of receipt of the Order, schedule an interview with the individual for the purpose of initiating or conducting the evaluation;

(ii) Appoint a QMHP to conduct the evaluation and to provide an evaluation report to the PSRB or JPSRB;

(iii) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB or JPSRB responding to the questions asked in the Order for Evaluation; and

(iv) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the person designated to serve as the individual's Qualified Person, who must be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

(B) Monthly reports consistent with PSRB or JPSRB reporting requirements as specified in the Conditional Release Order that summarize the individual's adherence to Conditional Release requirements and general progress; and

(C) Interim reports, including immediate reports by phone, if necessary, to ensure the public or individual's safety including:

(i) At the time of any significant change in the individual's health, legal, employment or other status which may affect compliance with Conditional Release orders;

(ii) Upon noting major symptoms requiring psychiatric stabilization or hospitalization;

(iii) Upon noting any other major change in the individual's ISSP;

(iv) Upon learning of any violations of the Conditional Release Order; and

(v) At any other time when, in the opinion of the Qualified Person, such an interim report is needed to assist the individual.

## Exhibit H

(b) JPSRB providers must submit copies of all monthly reports and interim reports to both the JPSRB and the Division.

**859-060-0025**

### **Patient Request for Conditional Release**

In a hearing before the Board on a patient request for conditional release, the Board shall consider whether, although still affected by mental disease or defect, the patient can be adequately controlled in the community with treatment and supervision, and shall determine whether the person is a proper subject for conditional release in accordance with procedures set forth in Division 070.

Stat. Auth.: ORS 161

Stats. Implemented: ORS 161.341

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85

**859-060-0035**

### **Hospital Request for Conditional Release**

(1) At any time while a patient is committed to a state hospital designated by the Mental Health and Developmental Disability Services Division, the superintendent of the hospital or designee shall apply to the Board for conditional release if it is the opinion of the treating physician that the patient continues to be affected by mental disease or defect and continues to be a danger to others but can be controlled in the community with proper care, medication, supervision and treatment.

(2) The application shall be accompanied by an updated report setting forth facts supporting the hospital staff's opinion and a plan for treatment and supervision in the community which includes observations and facts which support staff recommendations.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.341

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95

**859-070-0010**

### **Board Order of Conditional Release**

In determining whether an order of conditional release is appropriate, the Board shall have as its goals the protection of the public, the best interests of justice, and the welfare of the individual. The Board may consider the testimony and exhibits at the hearing regarding the patient's behavior in the hospital including the patient's progress, insight and responsibility taken for the patient's own behavior:

## Exhibit H

(1) If the Board finds the person may be controlled in the community and a verified conditional release plan is approved by the Board, the Board may order the person placed on conditional release.

(2) If the Board finds the person could be controlled in the community but no conditional release plan has been approved by the Board, the Board may order the person committed but find the person appropriate for conditional release pending submission of a conditional release plan. The Board shall specify what conditions the plan should include and may approve the conditional release plan submitted by the staff of the hospital, by the patient or someone on the patient's behalf at an administrative hearing.

(3) If a verified conditional release plan has not been approved and the conditions need further examination and approval of the Board, the Board may commit the patient, find the patient appropriate for conditional release or continue the hearing.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.336

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95

**859-070-0015**

### **Elements of Conditional Release Order**

The Board shall consider any or all of the following elements of a conditional release plan and determine which are appropriate and necessary to insure the safety of the public:

(1) Housing: Housing must be available for the patient. The Board may require 24-hour supervised housing, a supervised group home, foster care, housing with relatives or independent housing.

(2) Mental health treatment: Mental health treatment must be available in the community. The Board-approved provider of the treatment must have had an opportunity to evaluate the patient and the proposed conditional release plan and to be heard before the Board. The provider must have agreed to provide the necessary mental health treatment to the patient. The treatment may include: individual counseling, group counseling, home visits, prescription of medication or any other treatment recommended by the provider(s) and approved by the Board.

(3) Reporting responsibility: An individual must be available to be designated by the Board as having primary reporting responsibility and must have agreed to:

(a) Notify the Board in writing of the patient's progress at least once a month;

(b) Notify the Board promptly of any grounds for revocation under OAR 859-080-0010;

(c) Notify the Board promptly of any significant changes in the implementation of the conditional release plan;

(d) Coordinate and monitor all elements of the conditional release plan.

## Exhibit H

(4) Special conditions: Special conditions may be imposed, including, but not limited to, the following: no consumption of alcohol, taking of antabuse, observation by designated individual of each ingestion of medication, submitting to drug screen tests, no driving, vocational activities, day treatment, attending school, working, or sex offender assessment and treatment.

(5) Parole and probation: Parole and probation supervision may be ordered.

(6) Agreement to conditional release: Patients shall agree to and sign a form promising to comply with the general conditions of release. This signed form shall be made a part of the conditional release plan. The conditions shall include notice that if the person leaves the state without authorization of the Board, the person may be charged with a new crime of escape.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.336

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95

**859-070-0020**

### **Mental Health and Developmental Disability Services Division Responsibility to Prepare Plan**

(1) When the state hospital staff feels that a patient may be ready for conditional release, the staff may request that the Board order an evaluation for community placement.

(2) The Mental Health and Developmental Disability Services Division is responsible for and shall prepare the conditional release plan. In order to carry out the conditional release plan, the Mental Health and Developmental Disability Services Division may contract with a community mental health program, other public agency or private corporation or an individual to provide evaluations for community placement, supervision and treatment.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.336 & ORS 161.390

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95

## Oregon State Hospital Planning and Placement Definition of Terms

**\*Conditional Release Planning (CRP)** designation by the Risk Review Panel indicates approaching maximum treatment benefit.

CRP is designated by the OSH Risk Review Panel when the analysis of risk in areas such as violence, sex offending, relapse into mental illness or substance abuse is approaching a level that can be mitigated by services in a non-hospital, community setting. This designation is the result of the patient's progress in treatment towards self-management.

The OSH Risk Review Panel works with the patient and treatment team to complete the structured risk assessments. The panel considers the patient's medical record in assessing risk. The patient's criminal history and mental health is represented in the risk analysis.

The Risk Review Panel summarizes the level of risk and the degree of structure and supervision needed to provide a safe and therapeutic conditional release agreement. This Conditional Release Planning (CRP) designation authorizes the treatment team to identify a community treatment provider and placement. The Risk Assessment is summarized on a document and retained in the medical record.

**\*Conditional Release Referral** from OSH to a County and Provider.

After Conditional Release Planning designation by the OSH Risk Review Panel the treatment team engages in informal talks with the PSRB, CMHP case managers, and community residential and treatment providers to explore potential community placements.

**\*OSH Request** for a PSRB authorized county/provider evaluation of the client for placement.

## Oregon State Hospital Planning and Placement Definition of Terms

When a placement appears likely to be a good match of patient and provider the OSH team formally requests that the PSRB order the designated CMHP to consider providing treatment and support services to the patient on a conditional release basis.

**\*PSRB Order** for a county/provider to evaluate a client for placement.

The PSRB may or may not agree to issue an order for evaluation based on it's assessment of the readiness of the patient and the ability of the Community Provider to offer the necessary services.

**\*Provider Evaluation** for client compatibility with service level offered.

When requested by the PSRB the community Provider completes a formal assessment of the patient and identifies services needed to successfully support a conditional release plan.

**\*Provider Accepted** by the county/provider for placement based on written evolution report to the PSRB.

The Provider sends written notice to the PSRB documenting the ability or inability to provide the services necessary to support the patient on conditional release.

**\*PSRB Hearing** of a Patient/Hospital/Community Plan for Conditional Release (Count only dates passed).

The PSRB conducts a formal public hearing in which the plan for conditional release is reviewed.

**\*CR Date**

## Oregon State Hospital Planning and Placement Definition of Terms

Discharge from the DHS designated treatment facility, OSH, and admission to the PSRB designated community placement.

**OREGON STATE HOSPITAL  
RESIDENTIAL TREATMENT FACILITY DESCRIPTION  
COTTAGES 1, 2, 5, 6, 7, 8**

**SERVICE PHILOSOPHY:**

The Cottages are a 36-bed resident co-educational Residential Treatment Facility. This co-ed program uses a recovery based model to help residents successfully transition into the community. The cottage serves Oregon State Hospital patients who have psychiatric disabilities and skill deficits that impede their placement into the community. Our goal is to teach residents social and community survival skills that will enhance their life satisfaction and decrease their risk of re-offending or relapse.

Recovery Model principles form the foundation of the treatment program and of the relationships between the staff and residents. Such principles include: maximizing residents' choices, allowing for natural consequences of choices, collaborative approaches in treatment planning, and fostering an atmosphere of hope through accurate communication to residents of the parameters of their circumstances and the options available to them. While these must be balanced with the mission to manage risk, the setting allows residents considerable freedom of movement.

The treatment program for the Cottages has been developed from a number of evidence-based practice treatment models which have been adapted for utilization with mentally ill persons. Professional mental health services provided bring together approaches from the rehabilitation and the mental health fields, including the attitude of recovery. These services combine pharmacological treatment, skills training, hope, and psychological and social support to residents and families in order to improve their lives and functional capacities.

The residents' treatment plan goals are developed in close collaboration with them and aim to assist in overcoming barriers to discharge. Risk management is a prime concern of community providers, supervisors, and PSRB, so residents are encouraged to address this issue through their treatment plans, their selection of treatment modalities, and by demonstrating the skills they have learned.

**UTILIZATION AND SERVICES:**

1. Utilization: 100% of beds will be utilized on a monthly average. 100% of the residents in the program will be actively moving toward Conditional Release and/or discharge.
2. Services: Residents will participate in centralized treatment in the OSH treatment mall, vocational settings and community transition. They will practice the following skills:
  - Understand and be able to meaningfully communicate to caregivers information about their mental illness, their warning signs, their medications, and their relapse prevention plan
  - Develop constructive leisure activities of interest to them
  - Establish a social support network
  - Be able to identify and appropriately use resources in the community

- Demonstrate essential living skills: cooking, budgeting, use of public transportation, household safety and maintenance
  - Learn to make informed choices
  - Increase appreciation for various cultures and the diversity of peoples' backgrounds and modes of self-expression
  - Opportunities to grow in their spirituality, whether through organized religion, creative expression, or otherwise
  - Use problem-solving skills in both group and individual settings
  - Be gainfully employed or involved in an educational program if they so choose
  - Stabilization on psychotropic medication as appropriate and monitored on a monthly basis
  - Medical problems are treated as they occur with referral to the medical clinic if necessary
3. Continuum of Care/Completed Treatment: 100% of residents completing treatment who are discharged will have an approved discharge plan, including a completed relapse prevention plan and referral to a community mental health provider and be involved in an aftercare program.

## C. CLINICAL SERVICES

### Overview:

The program focuses on providing the resources to assist residents to develop skills they need to survive in the community without relapsing. The primary emphasis of the program is on the recognition and promotion of the strengths and resources of the individual residents in their development of positive problem-solving skills necessary for their continued stay in the community.

The skill areas that will be practiced and are relevant to the expectations of community agencies include:

- Life skills – including hygiene, vocational skills, and money management.
- Attendance – setting and reliably following schedules of daily activities.
- Mental illness management – symptom identification, tracking, intervention, and medication management.
- Citizenship – following rules, community participation, work to maintain the cottage environment, and assisting others.
- Peer relationships – conflict management, establishing and maintaining supportive relationships, assertiveness, and communication skills.
- Risk reduction in problem areas – specialty problem areas include sex offending, substance abuse, criminality, etc. These are addressed through an integrated relapse prevention plan, development and practice of interventions, and skill at identifying and effectively handling high-risk situations.

### **Residence Milieu:**

A central component of the transition treatment program is to provide an opportunity to practice the skills learned in the treatment milieu in an environment where the residents can feel comfortable in taking the risks of trying new adaptive behaviors and assuming a greater responsibility in their lives.

The cottage's modified therapeutic community is based on two premises: 1) all behavior within the program environment is relevant to treatment; and 2) the resident is capable of taking a responsible role in the functioning of the residence and in understanding his/her own behavior. The staff role is to assist the resident to act, initiate, and manage his/her own affairs. Staff and residents view any deviation from responsibility as an opportunity to refocus the resident's attention on personal behavior, its effects on others, and the antecedent events that precipitated the behavior. Community Meetings provide residents with opportunities for direct communication and program development among themselves and with staff.

Essentially, the community is designed as an effective educational process where residents practice skills. All aspects of the program are considered potential opportunities for coping skill building, increasing knowledge, and clarifying values. The focus is on challenge without failure, and the learning environment is relaxed and supportive. Self-management approaches and self-reinforcement are utilized by residents, while staff members provide structure and act as facilitators of the process.

### **Goal Attainment:**

The framework for the overall treatment program is provided by the principles of the Recovery Model of treatment. These principles provide for the program to focus on the empowerment of the individual resident. Residents are involved in all phases of their treatment. Each staff member is a resource to the resident as they develop new accepted problem-solving skills. Functional assessments of the residents' abilities are tools for residents to utilize as they determine those areas they need further help with to assist them in attaining their goals within the community. Educational modules in the areas of greatest need for the current residents will be offered in the treatment mall.

## **ADMISSION/TRANSFER, CONTINUING CARE, AND DISCHARGE/TRANSFER CRITERIA**

### **Justification for Admission:**

The following criteria describing the resident's current condition indicate that the resident may seek admission to the cottages. All criteria must be met.

1. The resident is stabilized on psychotropic medication (if applicable).
2. Using the OSH Risk Review process, the resident's current risk is assessed for sexually or physically aggressive behavior against others.

3. The resident is behaviorally, medically, and mentally stable enough to benefit from participation on a treatment/transition cottage.
4. The resident could benefit from participation in this program. Priority consideration will be given to those residents who have identified skill deficits and who would benefit from a recovery model of treatment.

#### **Justification for Continued Stay**

Documentation of two or more of the following:

1. The resident complies with basic cottage and program rules and policies, and is not considered a security risk or a disruptive influence within the community.
2. The resident is making continual and reasonable progress toward completion of the goals identified in the treatment plan
3. The resident continues to show a need for a transitional level of care as demonstrated by mental/emotional instability, social deficits, or needs protection from victimization in another setting; or appropriate, less restrictive environment not available.

#### **Justification for Return to Higher Level of Security**

Risk assessment indicating of one or more of the following:

1. The resident, after assessment, is found not to meet admission criteria for the cottage.
2. The resident is non-compliant with basic cottage and program rules and policies to the extent that unit safety, security, and therapeutic milieu are significantly compromised.
3. The resident exhibits physically or sexually aggressive behavior towards others.

#### **Discharge Continuum (Civil)**

1. IDT approves release planning.
1. Patient ready for OSH discharge planning.
2. CMHP and housing provider approves patient.
3. Patient is discharged.

#### **Discharge Continuum (Forensic)**

1. Conditional Release Planning (CRP) designation by the OSH Risk Review Panel indicates approaching maximum treatment benefit.
2. Conditional Release Referral from OSH to a County and Provider.

3. OSH Request for a PSRB authorized county/provider evaluation of the client for placement.
4. PSRB Order for a county/provider to evaluate a client for placement.
5. Provider Evaluation for client compatibility with service level offered.
6. Provider Accepted by the county/provider for placement based on written evaluation report to the PSRB.
7. PSRB Hearing of a Patient/Hospital/Community Plan for Conditional Release (count only dates passed).
8. Conditional Release (CR) is discharge from the DHS designated treatment facility OSH and admission to the PSRB designated community placement.

## **EDUCATION SERVICES**

### **Resident Education**

Residents have the opportunity to attend the Education Lab classes, for GED and other needs, as well as attend classes through Chemeketa Community College. The treatment milieu also provides psycho-educational modules.

### **Family Education**

If the resident agrees, family members will be invited to attend IDT meetings. Pre-visitation interviews are conducted by the case manager. Information provided through OSH is also given to families of residents, and information is shared regarding medication for those family members who function as pass supervisor.

## **STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **Staffing by Shift:**

<b>Class</b>	<b>Day</b>	<b>Swing</b>	<b>Night</b>	<b>Centralized Treatment Mall</b>
RTF Administrator/ MH Supervising RN	.33			
Physician Specialist				1
Clinical Psychologist				1
Psychiatric Social Worker				1
Mental Health Specialist				1
Rehabilitation Therapist				1
MHRN	.33	.33	.17	1

Class	Day	Swing	Night	Centralized Treatment Mall
MHT 2/CMA	2	2		
MHT1/CMA			2	
MHT1	2	2		
MHTT			2	
MHTC	.66			

**Procedure For Supervision:**

The Organizational structure and leadership for the program flows administratively and clinically. The OSH Superintendent is the individual appointed by the governing body to act on its behalf in managing the hospital. The Chief Medical Officer oversees the clinical aspects of the hospital. Supervision occurs through administrative and clinical lines of authority throughout the hospital. Administrative supervision flows from the Superintendent to the Program Director, RTF Administrator and other management staff. Clinical supervision flows from the OSH Clinical Director to clinical discipline directors, who set standards of practice for each of their disciplines and through members of the Medical and Allied Health Professional staff who are clinically credentialed and privileged. Clinical Nursing supervision flows from the Director of Nursing Services to the Associate Director of Nursing to the Mental Health Supervision Nurse. The RTF Administrator provides on site management.

## RESIDENT MANAGEMENT

The program in the residential treatment facility provides the resident with the opportunity to develop the skills needed to survive in the community without relapsing. Residents are expected to actively participate in their treatment through interaction with staff and peers. Program schedules describe the resources that are available within the program and the expectations of residents as they participate in that program.

### 1. Risk Review Panel

The Risk Review Panel has the primary responsibility for making decisions that could impact the security of residents, staff and the community. All privileges that concern resident movement off of their assigned cottage must have Risk Review Panel approval. These privileges are granted based on security and clinical issues.

- Residents must have a Risk Review form completed and in their chart. This form, along with a current photo, will be taken to the Risk Review Panel when the treatment team first requests privilege(s) that allows the resident to leave the cottage. The Risk Review Panel will return the form which will list current privileges. Once this process is completed, any change in privileges must be requested of the Risk Review Panel.

### 2. Four principles define the modified therapeutic community:

Every task that can be organized and performed by residents is allocated to them.

A resident with a question or concern is encouraged to take it to a peer first. When resolution is not possible at that level, the resident goes to a staff person for assistance. Peer support allows residents to help each other and foster a cooperative relationship that reflects community living. The developmentally disabled person has different styles of learning from the non-disabled person; therefore, staff must adapt educational components to the learning style of the individual. Oftentimes, the developmentally disabled person is more limited by the teaching modalities utilized than by his/her capacity to learn.

The process is more important than the task being performed. Treatment focuses on reasoning and problem solving in daily issues and tasks rather than on the final result. The resident learns by trying new things and working with others. A primary focus is on creating a learning and treatment experience where residents work together and develop an understanding of themselves and others.

Demonstration creates more change than telling the resident "how." Experiential and application learning using role-playing are more effective than didactic instruction. Such demonstrations occur in mini-role plays by residents and staff when differences arise in the cottage. Staff and residents discuss possible choices and their consequences, rather than verbally confronting the participants.

An open communication system allows staff and residents to express thoughts and feelings honestly. Open and direct communication is essential in a modified therapeutic community, providing an atmosphere that fosters dignity and self-respect. Creating multiple channels of communication within the treatment community enables residents to share their concerns and issues in responsible ways and in a comfortable manner. Communication channels include discussion in treatment groups, individual meetings with peers, individual counseling with staff, community meetings, and daily journals, when indicated. Expressive therapies such as music and art help residents communicate issues and feelings that are normally threatening for them to share.

All communication in the cottage is to be unconditionally respectful; residents and staff refrain from threats, profanity, or street jargon. High level confrontation is prohibited. Residents must feel they will be helped, motivated, and encouraged to achieve their maximum potential. Responsibilities are clearly outlined and residents know where to go, to whom, and for what, opening the way for independent learning.

During residential treatment, emotional components are incorporated and included in the learning process, which includes many activities that are fun or dramatic when learning or practicing new skills. Residents in the cottage are in the maintenance stages of most skill development, and approaches utilized for these skills are more congruent with the community setting to which the residents are to return.

Oregon State Hospital

**FORENSIC PSYCHIATRIC SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 35A**

**A. SERVICE PHILOSOPHY:**

35A is a 35 bed co-educational Transition Unit. This co-ed program uses a recovery based model to help residents successfully transition into the community. 35A serves forensic, PSRB clients who have psychiatric disabilities and skill deficits that impede their placement into the community. Our goal is to teach residents social and community survival skills that will enhance their life satisfaction and decrease their risk of re-offending.

Our objective is to ensure that clients have the competency of supports necessary to:

- Understand and be able to meaningfully communicate to caregivers information about their mental illness, their warning signs, their medications, and their relapse prevention plan;
- Develop constructive leisure activities of interest to them;
- Establish a social support network;
- Be able to identify and appropriately use resources in the community;
- Demonstrate essential living skills: cooking, budgeting, use of public transportation, household safety and maintenance;
- Gain awareness of the extent of their personal power, autonomy and opportunity to make informed choices, along with the responsibility attached to that power;
- Increase appreciation for various cultures and the diversity of peoples' backgrounds and modes of self-expression;
- Opportunities to grow in their spirituality, whether through organized religion, creative expression, or otherwise;
- Use problem-solving skills in both group and individual settings; and
- Be gainfully employed or involved in an educational program if they so choose.

**B. GOALS, OBJECTIVES AND EXPECTED OUTCOMES:**

1. Utilization: 100% of beds will be utilized on a monthly average. 100% of the residents in the program will be actively moving toward Conditional Release.
2. Services Provided: All residents accepted into the program will be given skill training in managing their mental illness, in community living skills, and in managing problematic behaviors associated with their past criminal activities. Each resident is stabilized on psychotropic medication as appropriate and monitored on a monthly basis. Medical problems are treated as they occur with referral to the medical clinic if necessary.
3. Completed Treatment: This is a transition program and patients will be released when ready.
4. Continuum of Care: Residents completing the program will have completed relapse prevention plans and be involved in an aftercare program.

### C. POPULATION

41A is serving adults under PSRB, related to felonies and misdemeanors, judged guilty except for insanity.

**Age:**

18-19	0%
20-29	14%
30-39	29%
40-49	23%
50-59	29%
60-69	3%
70-89	3%

**PSRB:**

Yes	97%
No	3%

**Axis 1 Diagnosis (first 4 most common):**

298.9 Psychotic Disorder	14%
295.3 Schizophrenia, Paranoid Type	17%
295.7 Schizoaffective Disorder	20%
296.4 Bipolar I Disorder, Most Recent Episode Manic/Hypomanic, Unspecified	9%

**Race:**

White, not Hispanic	77%
Black, not Hispanic	3%
Hispanic, Mexican	3%
Other, Not Specified	3%
American Indian	3%
Asian	3%
Southeast Asian	6%

**County of Commitment:**

Multnomah	20%
Lane	20%
Jackson	11%
Benton	9%
Clackamas	9%
Lincoln	6%
Washington	6%
Linn	3%
Coos	2%
Deschutes	2%
Jefferson	2%
Marion	3%
Tillamook	3%

**Marital Status:**

Never Married	57%
Divorced	26%
Married	14%
Separated	3%
Widowed	0%

**Education Level Completed:**

17 <sup>th</sup> – 20 <sup>th</sup>	0%
13 <sup>th</sup> - 16 <sup>th</sup>	46%
9 <sup>th</sup> - 12 <sup>th</sup>	51%
8 <sup>th</sup> - 6 <sup>th</sup>	3%
1 <sup>st</sup> – 5 <sup>th</sup>	0%
None	0%

**D. CLINICAL SERVICES**

1. Overview:

The program focuses on providing the resources to assist residents to develop skills they need to survive in the community without re-offending. The primary emphasis of the

program is on the recognition and promotion of the strengths and resources of the individual resident in their development of positive problem-solving skills necessary for their continued stay in the community.

Program Goals: In working towards the achievement of the stated mission, 35A provides a transitional living experience for selected residents of the Forensic Services at Oregon State Hospital. The major goals of the program are:

- To provide resources that residents can utilize to prepare for employment and/or educational activities in the community;
- To provide resources for residents to utilize in developing constructive leisure activities of interest to them;
- To provide educational opportunities for resident to learn about their illness, the medications they need to manage the symptoms of their mental illness, and their own signs of impending relapse prevention plan for use in the community;
- To assist each resident in the development of an extensive community socialization network and the skills to develop such a network in the community of discharge;
- To provide resources for each resident to learn essential residential living survival skills such as cooking, budgeting, transportation, basic household maintenance, household safety, effective communication, etc.; and
- To assist each resident to develop positive problem-solving skills, both as individuals and as members of a group.

## 2. Goal Attainment:

The framework for the overall treatment program is provided by the principles of the Recovery Model of treatment. These principles provide for the program to focus on the empowerment of the individual resident. Residents are involved in all phases of their treatment. Each staff member is a resource to the resident to utilize as they develop new accepted problem-solving skills. Functional assessments of the resident's abilities are tools for residents to utilize as they determine those areas they need further help with to assist them in attaining their goals within the community. Educational modules will be offered by staff in the areas of greatest need for the current residents. Should a resident have a particular educational need not being offered in a group setting, the education will be provided utilizing the skills of the staff on a one-to-one basis.

**E. ADMISSION/TRANSFER, CONTINUING CARE, AND DISCHARGE/TRANSFER CRITERIA**

1. Justification for Admission:

The following criteria describing the client's current condition indicate that the client may seek admission to 35A. All criteria must be met.

1. The client is stabilized on psychotropic medication (if applicable).
2. The client is assessed as posing minimal current risk for sexually or physically aggressive behavior against others.
3. The client is behaviorally, medically, and mentally stable enough to benefit from participation on a treatment/transition unit.
4. The client could benefit from participation in this program. Priority consideration will be given to those residents who have identified skill deficits and who would benefit from a recovery model of treatment.

2. Justification for Continued Stay

Documentation of two of more of the following:

- The client complies with basic unit and program rules and policies, and is not considered a security risk or a disruptive influence within the community.
- The client is making continual and reasonable progress toward completion of the goals identified in the treatment plan.
- The client continues to show a need for a transitional level of care as demonstrated by mental/emotional instability, social deficits, or needs protection from victimization in another setting; or appropriate, less restrictive environment not available.

3. Justification for Return to Higher Level of Security

Documentation of one or more of the following:

- The client, after assessment, is found not to meet admission criteria for 41A.
- The client is non-compliant with basic unit and program rules and policies to the extent that unit safety, security, and therapeutic milieu are significantly compromised.
- The client exhibits physically or sexually aggressive behavior towards others.

4. Discharge Criteria

- a. Has achieved maximum benefit from current treatment and not mentally or emotionally unstable.
- b. Benefited from current treatment for conditional release or discharge.
- c. Benefited from current treatment and appropriate for transfer to another treatment program/modality.

**F. EDUCATION SERVICES**

1. Patient Education

Residents have the opportunity to attend the Education Lab classes, for GED and other needs in Eola Hall as well as attend classes at Chemeketa Community College. 35A also provides psycho-educational modules.

2. Family Education

Residents' family members will be invited to attend IDT meetings. Pre-visitation interviews are conducted by the case manager. Information provided through OSH is also given to families of residents, and information is shared regarding medication for those family members who function as pass supervisor.

**G. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

1. Staffing by Shift:

Class	Day	Swing	Night
Unit Director	1		
Physician Specialist	1		
Clinical Psychologist		1	
Psychiatric Social Worker	1		
Mental Health Specialist		1	
Occupational Therapist		1	
MH Supervising RN	1		
MHRN	2	2	2
MHTC	1		

Class	Day	Swing	Night
MHT 2	1	2	
MHT 1	4	3	
MHTT	1	2	4
Ward Clerk	1		

## 2. Procedure For Supervision:

The Organizational structure and leadership for the program flows administratively and clinically. The OSH Superintendent is the individual appointed by the governing body to act on its behalf in managing the hospital. The Chief Medical Officer oversees the clinical aspects of the hospital. Supervision occurs through administrative and clinical lines of authority throughout the hospital. Administrative supervision flows from the Superintendent to the Program Director, Unit Director and other management staff. Clinical supervision flows from the Chief Medical Officer to clinical discipline directors, who set standards of practice for each of their disciplines and through members of the Medical and Allied Health Professional staff who are clinically credentialed and privileged. Unit Directors provide leadership by defining the therapeutic program and services to specialized client cohorts and the unit physician provides the clinical supervision of staff that are not independently credentialed and privileged to practice. The Unit Director is a qualified mental health professional that directs and supervises all treatment in a partnership with the unit physician. At the unit level, qualified mental health professionals, including Unit Director, MHSRN, Psychologist, Mental Health Specialist and Psychiatric Social Workers provide clinical supervision to direct-care staff.

Position	Frequency and Type of Supervision	Supervisor
Unit Director	Individual meetings on as needed basis; weekly peer supervision meeting	Program Director
Staff Physician	Weekly	Program Director Chief Medical Officer
Clinical Psychologist	Weekly	Unit Director Chief Psychologist
Psychiatric Social Worker	Weekly	Unit Director Director of Social

Position	Frequency and Type of Supervision	Supervisor
		Work
Rehabilitation Therapist	Weekly	Unit Director Rehabilitation Therapy Supervisor
Mental Health Specialist	Weekly group or individual meeting	Unit Director Chief Psychologist
Mental Health Supervising Nurse	Weekly group or individual treatment	Assoc. Director of Nursing
Mental Health Therapy Coordinator	Weekly group or individual meeting	MHSRN
Mental Health Therapist 2	Weekly individual Group supervision Daily contact	MH Supervising RN
Mental Health Therapist 1	Weekly individual Group supervision Daily contact	MH Supervising RN
Mental Health Therapy Technician	Monthly meeting	MH Supervising RN
Ward Clerk	Daily Contact	Unit Director

## H. PATIENT MANAGEMENT

The program in 35A provides the patient with the opportunity to develop the skills they need to survive in the community without re-offending. The patient is expected to actively participate in their treatment through interaction with staff and peers. Program schedules describe the resources that are available within the program and the expectations of residents as they participate in that program.

### 1. Disposition Board

The Forensic Disposition Board has the primary responsibility for making decisions that could impact the security of patients, staff and the community. All privileges that concern patient movement off of their assigned unit must have Disposition Board approval. These privileges are granted based on security and clinical issues.

- Each patient must have a Custody/Classification Request form completed and in their chart. This form, along with a current photo, will be taken to the Forensic Disposition Board when the treatment team first request

privilege(s) that allows the patient to leave the unit. The Forensic Disposition Board will return the Privileges Granted form that will list current privileges. Once this process is completed, any change in privileges must be requested of the Forensic Disposition Board.

**I. PHYSICAL ENVIRONMENT**

The unit is located on the first floor of the 30 Building on Oregon State Hospital grounds.

**J. UNIT SCHEDULE**

Included in Patient Handbook

Oregon State Hospital  
**FORENSIC PSYCHIATRIC SERVICES**  
**CLINICAL UNIT DESCRIPTION**  
**Unit 48B**

**A. SERVICE PHILOSOPHY:**

Forensic Psychiatric Services, Unit 48B provides intensive behavioral management and admits newly committed adult males under the Psychiatric Review Board from throughout the state of Oregon in a maximum security setting. Oregon State Hospital is one of the two most restrictive facilities in Oregon's hospital health community.

Each person admitted to the Unit has a comprehensive evaluation by Psychiatry, Psychology, Social Work, Nursing, and Rehabilitation Services. Each person living on 48B is treated with respect and dignity.

Each person admitted from the community has an individualized Treatment Care Plan that specifies goals to be obtained to facilitate a move to a less restrictive treatment unit or be returned to a community setting.

Each person admitted to the Unit from a less restrictive therapeutic treatment environment has an individualized Treatment Care Plan that specifies goals to be obtained in order to return that person to a less restrictive environment.

Each person admitted to the Unit whose behavior presents a clear danger to self, others, or property, and cannot be maintained on a less restrictive unit, has an individualized Treatment Care Plan that emphasizes quality of life and the reduction of dangerous behaviors through the use of medication and behavioral management techniques.

**B. POPULATION:**

Unit 48B serves persons admitted under the following six criteria:

- Persons admitted for initial commitment to the Psychiatric Security Review Board, or pursuant to ORS 161.327.
- Persons under the jurisdiction of the Psychiatric Security Review Board on Conditional Release status who voluntarily return to Forensic Evaluation and Treatment Services as part of managing symptoms of their mental illness.
- Persons under the jurisdiction of the Psychiatric Security Review Board on Conditional Release status who fail to comply with their prescribed community based treatment plan and are revoked by the Board pursuant to ORS 161.336.
- Persons residing on less restrictive treatment units who exhibit behaviors that constitute a clear and convincing danger to self or others and are unable to be maintained in a less restrictive environment.

- Persons civilly committed to the Mental Health and Developmental Disabilities Services Division under the ORS 426, who exhibit behaviors that constitute a clear and convincing danger to self or others and are unable to be treated at another state hospital.
- Persons referred by court order under ORS 161.370 for treatment until able to aid and assist their attorney in a criminal court case.

The population is all male with the majority of persons between ages 20 and 55. The majority of the people come from Multnomah County with the remainder being from Oregon's other 35 counties.

The most frequent instance offenses leading to admission are assault and illegal drug use. Legal status at time of admission is predominantly initial commitment under the PSRB, followed by PSRB revocations, and voluntary admissions.

**Age:**

>-19 yrs	4%
20-29 yrs	36%
30-39 yrs	21%
40-49 yrs	29%
50-59 yrs	7%
60-69 yrs	4%

**PSRB:**

Yes	100%
No	0%

**Axis 1 Diagnosis (first 4 most common):**

295.7 Schizoaffective Disorder	32%
295.3 Schizophrenia, Paranoid Type	25%
296.4 Bipolar I Disorder, Unspecified	14%
298.9 Psychotic Disorder	11%

**Race:**

White, non-Hispanic	79%
Black, non-Hispanic	7%
American Indian	4%
Hispanic, Cuban	4%
Other, Non Specified	4%
Southeast Asian	4%

**County of Commitment:**

Multnomah	32%
Marion	18%
Clackamas	14%
Lane	14%
Coos	4%
Douglas	4%
Jackson	4%
Klamath	4%
Lincoln	4%
Linn	4%

**Marital Status:**

Never Married	89%
Divorced	11%
Married	0%
Separated	0%
Widowed	0%

**Education Level Completed:**

17 <sup>th</sup> - 20 <sup>th</sup>	0%
13 <sup>th</sup> - 16 <sup>th</sup>	6%
9 <sup>th</sup> - 12 <sup>th</sup>	93%
8 <sup>th</sup> - 6 <sup>th</sup>	0%
1 <sup>st</sup> - 5 <sup>th</sup>	1%

**C. CLINICAL SERVICES:**

Unit 48B provides clinical services on an individualized basis as determined by the Treatment Care Plan legal and mental status, and the steps needed to return to a less restrictive environment.

All persons admitted to the Unit are assigned a case monitor and a primary registered nurse. This enables the person to have a fixed point of communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment.

Clinical services for persons on initial commitment or voluntary status are focused through the Treatment Care Plan on the presenting problem(s) that led to admission and clear steps to be taken to resolve them. If this is not possible then focus is on improving their ability to manage their illness and development of skills necessary to prepare them for transfer to a less restrictive environment.

Persons admitted due to a danger to themselves or others receive clinical services focused through the Treatment Care Plan on stabilizing their mental illness and identifying issues relating to their quality of life if return to a less restrictive environment is determined to not be feasible.

Comprehensive assessments and testing are conducted when determined to be necessary in order to

develop individualized treatment plans. Each individual admitted shall have a completed Baseline Assessment in the areas of Vocational Skills, Activities of Daily Living, Intellectual Functioning, Educational Skills and Psychosocial Development.

The Interdisciplinary Treatment Team integrates assessments into an Individualized Treatment Care Plan. The IDT includes all ward staff. A typical meeting consists of the unit psychiatrist as the clinical leader, a clinical psychologist, a psychiatric social worker, a rehabilitation therapist, a mental health specialist, a registered nurse, the patient's case monitor, a unit director, the patient, family, and others identified as significant to the individual's treatment.

Through the Treatment Care Plan, patients have access to the following types of treatment services, based on individual need:

- Educational programs;
- Psychosocial rehabilitation, including symptom management, drug awareness, medication management, alternatives to substance abuse, anger management, stress management, activities of daily living;
- Vocational services;
- Therapeutic Recreation
- Occupational therapy;
- Services for individuals with cognitive disabilities and limitations.

Families are encouraged to be involved in the treatment process through visitation, membership in "Friends of Forensics," and phone calls. A patient handbook is available for families. Family education brochures are available on 48B. With a signed release of information form the RN, social worker, physician, mental health specialist, or unit director provides families with information.

#### **D. ADMISSION, CONTINUING CARE, AND DISCHARGE CRITERIA:**

Admission Criteria:

- Male and age 18 or older.
- Persons who are initially committed under jurisdiction of PSRB or pursuant to ORS 161.327.
- Persons conditionally released who return voluntarily as part of managing the symptoms of their mental illness.
- Persons under PSRB jurisdiction whose Conditional Release is revoked.
- Persons on a less restrictive unit whose behavior constitutes a danger to self, others, or property and are unable to be served in a less restrictive environment due to acute phase of mental illness, unpredictable and unstable behavior, or escape or unauthorized leave risk.
- Persons under civil commitment in a state facility whose unstable mental illness or unpredictable behavior poses a danger to self, others, or property and which cannot be adequately managed outside of a maximum security setting.
- Persons under ORS 161.370 for treatment until able to aid and assist their attorney in a criminal court case.

2. Continuing Care Criteria:

- Patients who continue to require intensive evaluation or acute psychiatric or behavioral management.
- Patients who continue to pose a high risk for escape or unauthorized leave and potential harm to the community outside of a maximum-security setting.
- Patients whose discharge plan is to return to a correctional facility.

3. Transfer To Less Restrictive:

Persons who are no longer in need of intensive evaluation or acute psychiatric or behavioral management and no longer pose a high risk for escape or unauthorized leave and potential harm to the community.

4. Discharge Criteria:

Patients on this unit typically are transferred to a less restrictive unit prior to release or discharge.

Persons under PSRB jurisdiction who are no longer suffering from a mental illness or no longer present a substantial danger to others will be recommended to the Risk Review Board and the PSRB for discharge.

Persons who continue to suffer from mental illness and present a potential danger to others but can be adequately controlled and treated in the community under the supervision of the PSRB will be recommended to the OSH Risk Review Board and the PSRB for conditional release.

Persons for whom existing court or PSRB jurisdiction has expired who do not meet criteria for civil commitment will be recommended to the OSH Risk Review Board for discharge.

Persons who are able to aid and assist their attorney may be discharged to court.

An individual's readiness for discharge or conditional release may be suggested by:

- The absence of suicidal and homicidal ideation, with no recent history of assaults or self-harm;
- No prominent hallucinations or delusional thinking;
- Good medication compliance and treatment participation;
- Attainment of short and long-term treatment plan goals;
- Good understanding of the signs and symptoms of their illness, with development of a personal relapse prevention plan; and,
- A detailed plan for follow-up treatment and supervision in the community.

- Understanding the nature of court proceedings and cooperate with their attorney per ORS 161.360.

**E. EDUCATION SERVICES:**

- Educational Services are provided under contract with Marion County Educational Services District for those persons admitted to the Unit between ages 18 and 22 and who meet the criteria set forth in Public Law 94 142, handicapped education.
- Adult basic education is available upon referral from the adjunctive treatment program.
- A computer learning lab is available in the law library on 47B

**F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION:**

<b>Unit 48B is staffed as follows:</b>	<b>FTE</b>
Unit Director	1.0
Physician Specialist	2.5
Psychologist	1.0
Social Worker	1.0
Rehabilitation Therapist	1.0
Mental Health Specialist	1.0
Mental Health Supervising Nurse	1.0
Registered Nurse	7.0
MHT Coordinator	1.0
MHT Shift Coordinator	1.0
LPN	2.0
MH Therapist II	8.0
MH Therapist I	13.0
MH Therapy Technician	12.0
Unit Clerk	1.0

**Minimum Staffing**

Shift by shift there is a system in place whereby the Unit Director reviews the census and acuity to determine if additional staff are needed beyond the minimum or if staffing can be decreased in response to a change in patient acuity.

The following chart identifies the minimum staffing per shift:

Day and Swing shifts:	7 direct care nursing staff, one of which must be an RN.
Night shift:	6 direct care nursing staff, 1 of which must be an RN.

Unit 48B has developed a clinical supervision plan to provide non-privileged MHT staff with supervision by unit-based privileged professional, credentialed staff. The unit credentialed staff receive clinical supervision through their professional disciplines according to the discipline's established standards of practice and ethics. Clinical supervision of non-privileged MHT staff is to:

- Improve patient care by assisting MHT staff in the development of new skills and knowledge;
- Improve patient care through discussion and proactive responses to clinical problems;
- Assist MHT staff in their professional development.

Clinical supervision is provided to MHT staff on a formal basis monthly to identify and discusses issues of concern, i.e., boundary issues, transference/counter-transference, care monitor issues, and professional development plans for MHT staff. Clinical supervisors meet monthly with the Unit Director and the Mental Health Supervising Registered Nurse to discuss issues which have arisen from the clinical supervision and which need management interventions, or discussion of issues that affect the delivery of treatment services for patients.

#### PROCEDURE FOR SUPERVISION

Position	Frequency and Type of Supervision	Administrative Supervisor	Clinical Supervisor
Unit Director	Individual meetings as needed; weekly supervision	Program Director	N.A.
Staff Physician	Individual meetings as needed; weekly supervision	Program Director	FPS Clinical Director/ Chief Medical Officer
Clinical Psychologist I	Individual meetings as needed; weekly supervision	Unit Director	Chief of Psychology
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	Director of Social Work
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Unit Psychologist
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Director of RSD or designee
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Unit Director	Assoc. Director of Nursing
MH Registered Nurse	Individual meetings as needed; weekly supervision	MHSRN	MHSRN
Mental Health Therapy Coord.	Individual meetings as needed; weekly supervision.	Unit Director	Unit Psychologist
Mental Health Therapists	Individual meetings as needed; daily supervision. Weekly supervision.	MHSRN	MH Charge RN Mental Health Specialist Unit Psychologist

NOTE: Assigned Clinical Supervisors for Therapy Services are those clinically privileged to provide staff clinical supervision. On Unit 48B the Clinical Supervisors are the unit psychiatrist, psychologist, social worker, and mental health specialist. The RN staff are responsible for the clinical supervision of patient care provided by MHT staff which falls under their CNA/CMA certificates under the State Board of Nursing.

## **G. PATIENT MANAGEMENT:**

Persons on Unit 48B can achieve privilege levels Zero Level, Level 1 and Level 2. These levels are earned by patients through successful completion of activities of daily living, and attendance in treatment groups. Access to privileges is correlated to these levels.

Persons residing on the unit participate in 1 weekly unit meeting, which gives them an opportunity to participate in decisions about their treatment environment, unit management, quality of life and clarification of rules.

The unit does not allow persons outside the secure perimeter without transport restraints unless approved by the Treatment Team and the Risk Review Board. Persons are given daily opportunity to rest from activities and to go outside to the secure yard.

## **H. PHYSICAL ENVIRONMENT:**

Unit 48B is on the second floor of a wing of the hospital, which has been remodeled to maximum security standards. Budgeted capacity is 28 beds.

Patients have either single-bed rooms, two-bed rooms, or multiple bed rooms, which are located off of a common hallway. All rooms are secured by a lockable steel gate.

The unit is able to operate within its perimeter with a common bathroom, showers, kitchen, dining room, and day rooms.

Treatment groups are offered on the ward and occasionally on 47B in the group room. Adjunctive treatment by Rehabilitation Services Staff is held on Unit 47C.

A common secure yard is available for the 48 building. Patients are given the opportunity to go to the yard daily.

Visitors are able to have non-contact visits with patients through a glass window with telephones and contact visits on 47B for adults and 48A for visitors with minors for those with Level 1 or 2 privileges or with Unit director and IDT authorization.

Visitors are not allowed inside the secure perimeter. However the visiting area is located next to the sally port at the unit entrance.

## **I. WARD SCHEDULE:**

Treatment team meetings, therapy groups, time in the yard, and patient unit meetings occur on a regularly scheduled basis. Adjunctive therapy is offered through Cascade Center. Patients are offered a minimum of 20 hours per week of treatment services.

All patients are offered the opportunity to participate in outdoor exercise. They are offered access to religious services and structured activities daily, evenings, and on weekends.

Unit staff overlaps shifts 7 days a week to communicate information on patient care and unit management issues. Once per week a staff leadership meeting is held to discuss overall operation of the unit and significant patient care issues.

All persons admitted are individually assessed for predictability of behavior and dangerousness to self or others

- Have reached a level 2 of ward privileges and have been referred to and accepted for transfer to a medium security ward.
- Have no incidents of inappropriate behavior for 3 months.
- Have been clinically assessed and present low risks of dangerous behaviors towards self or others.
- Any person whose discharge plan is to return to a correctional facility is not eligible.

Oregon State Hospital  
**FORENSIC PSYCHIATRIC SERVICES**  
**CLINICAL UNIT DESCRIPTION**  
**UNIT 48B-W**

**A. SERVICE PHILOSOPHY:**

Forensic Psychiatric Services, Unit 48B-W provides intensive behavioral management for women transferred from other OSH units who are committed under the Psychiatric Review Board, are Civilly Committed, or are referred by court order under ORS 161.370 from throughout the state of Oregon in a maximum security setting. Oregon State Hospital is one of the two most restrictive facilities in Oregon's hospital health community.

Each person transferred to the Unit will have had a comprehensive evaluation by Psychiatry, Psychology, Social Work, Nursing, and Rehabilitation Services from their respective units. It is expected that persons will also have in their medical records a START Assessment, a Functional Analysis, a Behavioral Support Plan and/or TCP interventions that specifically address problem behaviors. Each person living on 48B-W is treated with respect and dignity.

Each person transferred to 48B-W will have an individualized Treatment Care Plan (TCP) that specifies goals to be obtained to facilitate a return to the prior transferring unit. Treatment Care Plans and programs will be developed and/or adapted as needed to facilitate the person obtaining safety towards self and others to enable the person to return to the less restrictive treatment unit.

Each person admitted to the Unit whose behavior presents a clear danger to self, others, and/or property, and cannot be maintained on a less restrictive unit, has an individualized Treatment Care Plan that emphasizes quality of life and the reduction of dangerous behaviors through the use of medication and behavioral management techniques.

**B. POPULATION:**

Unit 48B-W serves persons residing on less restrictive treatment units (regardless of legal status) who exhibit behaviors that constitute a clear and convincing danger to self or others and are unable to be maintained in a less restrictive environment.

The following is based upon 5 beds (currently 4 clients = 80% of capacity):

**Age:**

>-19 yrs	0%
20-29 yrs	60%
30-39 yrs	20%
40-49 yrs	0%
50-59 yrs	0%
60-69 yrs	0%

**PSRB:**

Yes	60%
No	20%

**Axis 1 Diagnosis:**

295.7 Schizoaffective Disorder	20%
296.4 Bipolar Disorder, Unspecified	40%
309.8 Post Traumatic Stress Disorder	60%
Substance use diagnoses	40%

**Axis 2 Diagnosis:**

301.9 Personality Disorder	60%
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**Race:**

White, non-Hispanic	80%
Black, non-Hispanic	0%
American Indian	0%
Hispanic, Cuban	0%
Other, Non Specified	0%
Southeast Asian	0%

**County of Commitment:**

Multnomah	0%
Marion	20%
Clackamas	0%
Lane	0%
Coos	0%
Douglas	0%
Jackson	0%
Klamath	0%
Lincoln	20%
Linn	0%
Yamhill	20%
Washington	20%

**Marital Status:**

Never Married	60%
Divorced	0%
Married	20%
Separated	0%
Widowed	0%

**Education Level Completed:**

17 <sup>th</sup> – 20 <sup>th</sup>	0%
13 <sup>th</sup> - 16 <sup>th</sup>	20%
9 <sup>th</sup> - 12 <sup>th</sup>	40%
8 <sup>th</sup> - 6 <sup>th</sup>	20%
1 <sup>st</sup> – 5 <sup>th</sup>	0%

Currently 1 client has completed her GED and is attempting college coursework, and 1 client is working on her GED.

**C. CLINICAL SERVICES:**

Unit 48B-W provides clinical services on an individualized basis as determined by the Treatment Care Plan, legal and mental status, and the steps needed to return to the original unit of transfer.

All persons transferred to the Unit are assigned a case monitor and a back-up case monitor, and a primary registered nurse and a back-up registered nurse. This enables the person to have a fixed point of communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment.

Persons transferred due to a danger to themselves or others receive clinical services per the Treatment Care Plan which focus on the presenting problem(s) that led to the transfer and clear steps to be taken to resolve them, and stabilizing their mental illness to prepare them for transfer back to the original unit of transfer. The unit will have a Treatment Care Plan Coordinator to facilitate development of an individualized treatment plan.

Additional assessments and testing are conducted when determined to be necessary in order to develop individualized treatment plans. Each individual transferred shall have a completed Baseline Assessment in the areas of Vocational Skills, Activities of Daily Living, Intellectual Functioning, Educational Skills and Psychosocial Development.

The Interdisciplinary Treatment Team integrates assessments into an Individualized Treatment Care Plan. The IDT includes all ward staff. The core treatment team consists of: the unit psychiatrist as the clinical leader, a clinical psychologist, a registered nurse, the treatment care plan coordinator, the person's case monitor, the individual, and family (at the person's choosing). Other staff that work with the person may be included in treatment team meetings if identified as significant to the individual's treatment.

As specified on the Treatment Care Plan, persons have access to the following types of treatment services, based on individual need including:

- Educational programs
- Psychosocial rehabilitation (Evidence-Based curriculum) including symptom management, drug awareness, medication management, alternatives to substance abuse, anger management, stress management, activities of daily living
- Vocational Services
- Therapeutic Recreation
- Occupational Therapy
- Services for individuals with cognitive disabilities and limitations

Families are encouraged to be involved in the treatment process through visitation, membership in "Friends of Forensics," and phone calls. A Patient Handbook is available for families. Family education brochures are available on 48B. A signed "Release of Information Form enables the RN, social worker, physician, mental health specialist, or unit director to provide families with information regarding the individual and/or her treatment.

**D. TRANSFER, TRANSFER PROCEDURES, CONTINUING CARE, AND DISCHARGE CRITERIA:**

**Transfer Criteria:**

- Female and age 18 or older.
- START Assessment indicates intensive treatment services.
- Persons on a less restrictive unit whose behavior constitutes a danger to self, others, or property and are unable to be served in a less restrictive environment due to acute phase of mental illness, unpredictable and unstable behavior, or significant and unmanageable unauthorized leave risk (escape). These behaviors must include multiple attempts that do not improve with behavioral and/or medication interventions.
- Persons on a less restrictive unit who have chronically engaged in significant unsafe behaviors, and although may not be an imminent danger (behaviors somewhat improved and/or are sporadic), their overall dangerous behaviors continue and they are not benefiting from, and/or engaging in treatment on the less restrictive unit.

**2. Transfer Procedures:**

- A transfer referral shall be submitted to the 48B-W team outlining the reason for referral, presenting behaviors, and treatment needs.
- Members of the clinical teams between the referring unit and 48B-W will meet to assess the referral and to discuss clinical issues.
- If there is a disagreement between the two teams regarding the appropriateness of a referral, a representative will contact the Program Director, who will in turn contact the Chief Medical Officer. The Chief Medical Officer or designee will make the final decision about the transfer.
- No transfers may take place without collaboration between the teams and notification of the Program Director.
- No transfers are to take place on weekends (starting 3pm on Fridays) or after 5pm on weekdays.

**3. Continuing Care Criteria:**

- Persons who continue to require intensive evaluation or acute psychiatric or behavioral management.

- Persons who continue to pose a high risk for unauthorized leave (escape) and potential harm to the community outside of a maximum-security setting.
- Persons whose discharge plan is to return to a correctional facility.

#### **4. Transfer back to the Original Unit:**

- Persons who are no longer in need of intensive evaluation or acute psychiatric or behavioral management and no longer pose a high risk for unauthorized leave (escape) and potential harm to the community.
- Persons who have demonstrated safe behaviors over an acceptable period of time as determined by the treatment team.
- Persons who have engaged in the specified treatment protocols and have demonstrated the ability to meet their specified treatment goals.
- Persons may request an evaluation to be considered to return to a less-restrictive unit through their case monitor to present at their Interdisciplinary meeting review.

The teams from the original unit and 48B-W will collaborate regarding current treatment protocols for persons ready for transfer to ensure continuity of treatment when the client returns to the original unit.

#### **5. Discharge Criteria:**

Patients on this unit typically are transferred to a less restrictive unit prior to release or discharge. However, there may be some cases that permit discharge under the following criteria:

- Persons under PSRB jurisdiction who are no longer suffering from a mental illness or no longer present a substantial danger to others will be recommended to the Risk Review Board and the PSRB for discharge from jurisdiction.
- Persons who continue to suffer from mental illness and present a potential danger to others but can be adequately controlled and treated in the community under the supervision of the PSRB will be recommended to the Risk Review Board and the PSRB for evaluation for conditional release.
- Persons for whom existing court or PSRB jurisdiction has expired who do not meet criteria for civil commitment will be recommended to the OSH Risk Review Board for discharge.

An individual's readiness for discharge or conditional release may be suggested by:

- The absence of suicidal and homicidal ideation, with no recent history of assaults or self-harm.
- No prominent hallucinations or delusional thinking that interferes with daily

functioning.

- Good medication compliance and treatment participation.
- Attainment of short and long-term treatment plan goals.
- Good understanding of the signs and symptoms of their illness, with development of a personal relapse prevention plan.
- A detailed plan for follow-up treatment and supervision in the community.
- Understanding the nature of court proceedings and cooperate with their attorney per ORS 161.360.

#### **E. EDUCATION SERVICES:**

- Educational Services are provided under contract with Marion County Educational Services District for those persons admitted to the Unit between ages 18 and 22 and who meet the criteria set forth in Public Law 94 142, handicapped education. Adult basic education is available upon referral to the Supported Education Program. The computer learning lab is part of the Supported Education Services, and is located on 47C.

#### **F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION:**

<b>Unit 48B-W is staffed as follows:</b>	<b>FTE</b>
Unit Director*	1.0
Physician Specialist*	1.0
Psychologist*	1.0
Social Worker*	1.0
Rehabilitation Therapist*	1.0
Mental Health Specialist*	1.0
Mental Health Supervising Nurse*	1.0
Registered Nurse*	7.0
MHT Coordinator*	1.0
MHT Shift Coordinator*	1.0
LPN*	2.0
MH Therapist II*	8.0
MH Therapist I*	21.0
MH Therapy Technician**	24.0
Unit Clerk*	1.0

(\*) Covered by 48B-Men's Staff

#### **Minimum Staffing**

Shift by shift there is a system in place whereby the Mental Health Supervising RN and Unit Director review the census and acuity to determine if additional staff is needed beyond the minimum or if staffing can be decreased in response to a change in patient acuity.

The following chart identifies the minimum staffing per shift:

Day and Swing shifts:	3 direct care nursing staff; constants are additional. RN coverage from 48B-Men's
Night shift:	2 direct care nursing staff; constants are additional. RN coverage from 48B-Men's

Unit 48B-W has developed a clinical supervision plan to provide non-privileged MHT staff with supervision by unit-based privileged professional, credentialed staff. The unit credentialed staff receive clinical supervision through their professional disciplines according to the discipline's established standards of practice and ethics. Clinical supervision of non-privileged MHT staff is to:

- Improve patient care by assisting MHT staff in the development of new skills and knowledge;
- Improve patient care through discussion and proactive responses to clinical problems;
- Assist MHT staff in their professional development.

Clinical supervision is provided to MHT staff on a formal basis monthly to identify and discusses issues of concern, i.e., boundary issues, transference/counter-transference, care monitor issues, and professional development plans for MHT staff. Clinical supervisors meet monthly with the Unit Director and the Mental Health Supervising Registered Nurse to discuss issues which have arisen from the clinical supervision and which need management interventions, or discussion of issues that affect the delivery of treatment services for patients.

#### PROCEDURE FOR SUPERVISION

Position	Frequency and Type of Supervision	Administrative Supervisor	Clinical Supervisor
Unit Director	Individual meetings as needed; weekly supervision	Program Director	N.A.
Staff Physician	Individual meetings as needed; weekly supervision	Program Director	FPS Clinical Director/ Chief Medical Officer
Clinical Psychologist I	Individual meetings as needed; weekly supervision	Unit Director	Chief of Psychology
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	Director of Social Work
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Unit Psychologist
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Director of RSD or designee
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Nurse Manager Unit Director	Assoc. Director of Nrsng Nurse Manager
MH Registered Nurse	Individual meetings as needed; weekly supervision	MHSRN Unit Director	MHSRN

Mental Health Therapy Coord.	Individual meetings as needed; weekly supervision.	MHSRN Unit Director	MHSRN Unit Psychologist
Mental Health Therapists	Individual meetings as needed; daily supervision. Weekly supervision.	MHSRN Unit Director	MHSRN Mental Health Specialist Unit Psychologist

NOTE: Assigned Clinical Supervisors for Therapy Services are those clinically privileged to provide staff clinical supervision. On Unit 48B-W the Clinical Supervisors are the unit psychiatrist, psychologist, social worker, supervising RN and mental health specialist. It is possible that the unit director may have the credentials to provide clinical supervision. The staff RN is responsible for the clinical review of patient care provided by MHT staff, which falls under their CNA/CMA certificates under the State Board of Nursing.

#### **G. PATIENT MANAGEMENT:**

Persons on Unit 48B-W can achieve privilege levels Zero Level, Level 1 and Level 2. These levels are earned by patients through successful completion of activities of daily living, and attendance in treatment groups. Access to privileges is correlated to these levels.

Persons residing on the unit participate in 1 weekly unit meeting, which gives them an opportunity to participate in decisions about their treatment environment, unit management, quality of life and clarification of rules.

The unit does not allow persons outside the secure perimeter without transport restraints unless approved by the Treatment Team and the Risk Review Board. Persons are given daily opportunity to rest from activities and to go outside to the secure yard.

#### **H. PHYSICAL ENVIRONMENT:**

Unit 48B-W is on the second floor of a wing of the hospital, which has been remodeled to maximum security standards. Capacity is 5 beds.

Patients will have single-bed rooms which are located off of a common hallway. All rooms are secured by a lockable steel gate.

The unit is able to operate within its perimeter with a common bathroom, showers, kitchen, dining room, and day rooms.

Treatment groups are offered on the ward and occasionally on 47B in the group room. Adjunctive treatment by Rehabilitation Services Staff is held on Unit 47C.

A common secure yard is available for the 48 building. Patients are given the opportunity to go to the yard daily.

Visitors are able to have non-contact visits with patients through a glass window with telephones and contact visits on 47B for adults and 48A for visitors with minors for those with Level 1 or 2 privileges or with Unit director and IDT authorization.

Visitors are not allowed inside the secure perimeter. Visiting area is located next to the sally port at the unit entrance.

**I. WARD SCHEDULE:**

Treatment team meetings, therapy groups, time in the yard, and patient unit meetings occur on a regularly scheduled basis. Adjunctive therapy is offered through Cascade Center. Patients are offered, and encouraged to attend a minimum of 20 hours per week of treatment services.

All patients are offered the opportunity to participate in outdoor exercise. They are offered access to religious services and structured activities daily, evenings, and on weekends.

Unit staff overlaps shifts 7 days a week to communicate information on patient care and unit management issues. Once per week a staff leadership meeting is held to discuss overall operation of the unit and significant patient care issues.

Oregon State Hospital  
**FORENSIC EVALUATION AND TREATMENT SERVICES**  
**CLINICAL WARD DESCRIPTION**  
**Ward 48C**

**A. SERVICE PHILOSOPHY:**

Forensic Evaluation and Treatment Services Ward 48C provides admission, mental health evaluation and treatment services in a maximum-security setting. This is one of the two most restrictive facilities in Oregon's community and hospital mental health system. The focus in the delivery of mental health services is based on a recovery model that includes support for patients making personal choices, enhancement of patient strengths, harm reduction, respect for cultural backgrounds, and development of spirituality.

Services to patients admitted to this ward are based on comprehensive admission evaluations by Psychiatry, Psychology, Social Work, Nursing, Rehabilitation Services, and patient interests.

Services are provided in a manner recognizing the individual needs of each patient, but also protects patients from harming themselves or others.

Ward staff and management will balance between security and mental health treatment, and without jeopardizing security, increase patient responsibilities and the positive interactions between staff and patients.

The primary mission of the ward is to serve people who are admitted as unfit to proceed (ORS 161.370) and in need of treatment to restore the ability to aid and assist their attorney in a criminal court proceeding.

**B. POPULATION:**

Ward 48C is a 27-bed all male ward providing services to persons admitted under the following conditions:

Persons admitted under ORS 161.370 for treatment to restore fitness to proceed.

Persons admitted under ORS 161.327, guilty except for insanity, who, because of severe mental illness and/or management problems, continue to require a maximum-security setting.

Persons assigned or transferred from other state institutions for evaluation, treatment, and return to the institution, pursuant to ORS 179.425, ORS 179.477, ORS 419.511, ORS 420.505, OAR 309-120-000 through 309-120-060 and applicable interagency agreements.

Persons civilly committed under ORS 426.130 and in need of the structure of this maximum-security setting to assure safety.

**Age:**

18-19 yrs	4%
20-29 yrs	31%
30-39 yrs	35%
40-49 yrs	23%
50-59 yrs	8%
60-69 yrs	0%

**PSRB:**

Yes	0%
No	100%

**Axis 1 Diagnosis (first 4 most common):**

295.7 Schizoaffective Disorder	12%
295.3 Schizophrenia, Paranoid Type	31%
298.9 Psychotic Disorder	19%
299.8 Asperger's Disorder, Rhett's Disorder	8%

**Race:**

White, non-Hispanic	81%
Black, non-Hispanic	4%
American Indian	4%
Hispanic, Other	4%
Asian	4%
Other, Non Specified	4%

**County of Commitment:**

Multnomah	23%
Lane	15%
Washington	15%
Linn	12%
Douglas	8%
Marion	8%
Yamhill	8%
Deschutes	4%
Lincoln	4%
Malheur	4%

**Marital Status:**

Never Married	92%
Divorced	4%
Separated	4%

**Education Level Completed:**

13 <sup>th</sup> - 16 <sup>th</sup>	%
9 <sup>th</sup> - 12 <sup>th</sup>	%
8 <sup>th</sup> - 6 <sup>th</sup>	%
1 <sup>st</sup> - 5 <sup>th</sup>	%

**C. CLINICAL SERVICES:**

Ward 48C provides clinical services on an individualized basis as determined by the patient's Treatment Care Plan, their legal and mental status, and the steps needed to return to be released from the ward.

All persons admitted to the ward are assigned a case monitor and a primary registered nurse. This enables the person to have a fixed point of communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment.

Clinical services for persons on initial commitment or voluntary status are focused through the Treatment Care Plan on the presenting problem(s) that led to admission and clear steps to be taken to resolve them. If this is not possible, then focus is on improving their ability to manage their illness and development of skills necessary to prepare them for transfer to a less restrictive environment.

Persons admitted due to a danger to themselves or others receive clinical services focused through the Treatment Care Plan on stabilizing their mental illness and identifying issues relating to their quality of life if return to a less restrictive environment is determined to not be feasible.

Comprehensive assessments and testing are conducted, when determined to be necessary, in order to develop individualized treatment plans. Each individual admitted may have completed Baseline Assessments in the areas of Vocational Skills, Activities of Daily Living, Intellectual Functioning, Educational Skills and Psychosocial Development.

Treatment services generally focus on helping individuals to be able to aid and assist their attorney in their defense against charges in a criminal court proceeding. Psychoeducation includes the role of the judge, defense attorney, prosecuting attorney, and jury. It also covers plea options and general court proceedings.

The Interdisciplinary Treatment Team integrates assessments into an Individualized Treatment Care Plan. The IDT consists of the unit psychiatrist as the clinical leader, a clinical psychologist, a psychiatric social worker, a rehabilitation therapist, a mental health specialist, a registered nurse, the patient's case monitor, a unit director, the patient, and others identified as significant to the individual's treatment.

Families are encouraged to be involved in the treatment process through visitation, membership in "Friends of Forensics," and phone calls. Family education brochures are available on 48A. With a signed release of information form, families are given information by the attending physician, RN, social worker, mental health specialist, or unit director.

#### **D. ADMISSION, CONTINUING CARE, AND DISCHARGE CRITERIA:**

##### **1. Admission Criteria:**

- Males 18 years of age or older, and determined by the courts as unfit to proceed in the legal defense of their pending criminal charges as a result of mental disease or defect and committed under ORS 161.370.
- Males committed by court order for up to 30 days for evaluation of fitness to proceed (ORS

161.365) or criminal responsibility (ORS 161.315).

- Department Of Corrections inmates or MacLaren student transferred to OSH for evaluation or treatment pursuant to ORS 179.425, ORS 179.477, ORS 419.511, ORS 420.505, OAR 309-120-000 through 309-120-060 and applicable interagency agreements.
  - Males under the jurisdiction of the PSRB (ORS 161.327 and 161.336) who pose a severe risk of escape/UL and potential harm to the community.
  - Civilly committed patients under ORS 426.130 who require a maximum-security setting due to assessed behavioral dangerousness to self or others.
2. Continued Care/Transfer to a More Restrictive Setting Criteria:
- Patients who require 24-hour medical care.
  - Patients whose discharge plan is to return to jail or a correctional facility.
3. Transfer to a Less Restrictive Setting Criteria:
- Persons admitted under ORS 161.370 who are not able to aid and assist, are judged to require continuing inpatient treatment, and whose psychiatric condition and behavior are stabilized and who would pose minimal risks to self or other in a less secure environment.
4. Discharge Criteria:
- Patients are rarely released from custody, but are transferred to less restrictive wards, returned to jail, or returned to the custody of the Department of Corrections.
  - Persons for whom statutory or administrative authority terminates, and who do not meet the criteria for Civil Commitment.

#### **E. EDUCATION SERVICES:**

Educational services are provided under contract with Willamette Education Services District for those persons admitted to the unit who are between the ages of 18 and 22 and who meet the criteria set forth in Public Law 94-142.

Adult basic education is available, upon referral, from the adjunctive treatment program in the 47C Treatment Mall.

A computer-learning lab is available on 47C.

#### **F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION:**

<b>1. Staffing for Ward 48C includes:</b>	<b>FTE</b>
Unit Director	1.0
Psychiatrist	1.0
Psychologist	1.0
Psychiatric Social Worker	1.0
Rehabilitation Services Therapist	1.0
Mental Health Specialist	1.0
Supervising Registered Nurse	1.0
Staff Registered Nurse	6.0
MHT Coordinator	1.0
MH Shift Coordinator	2.0
MH Therapist II	4.0
MH Therapist I	37.0
MH Therapy Technician	44.0
MH Therapist II/LPN	1.0
Ward Clerk	1.0

## **2. Minimum Staffing**

Shift-by-shift there is a system in place whereby the Ward MHSRN, Program MHSRN, and or Staff RN reviews the patient census and acuity to determine if additional staff are needed beyond the minimum or if staffing can be decreased in response to a change in patient acuity.

Every attempt is made to maintain one RN on days and swing shift daily.

The following chart identifies the minimum staffing per shift.

Day and Swing shifts:	5 direct care nursing staff, one of which must be an RN
Night shift:	5.0 direct care nursing staff, one of which must be an RN

Clinical Supervision is provided according to this plan and resources are available.

Ward 48C has developed a clinical supervision plan to provide non-privileged MHT staff with supervision by unit-based privileged professional, credentialed staff. The credentialed staff receive clinical supervision through their professional disciplines according to the discipline's established standards of practice and ethics. Clinical supervision of non-privileged MHT staff is to:

- Improve patient care by assisting MHT staff in the development of new skills and knowledge;
- Improve patient care through discussion and proactive responses to clinical problems;
- Assist MHT staff in their professional development.

Clinical supervision is provided to MHT staff on a formal basis weekly to identify and discuss issues of concern, i.e., boundary issues, transference/counter-transference, care monitor issues, and professional development plans for MHT staff.

### Procedure for Supervision

<b>Position</b>	<b>Frequency and Type of Supervision</b>	<b>Administrative Supervisor</b>	<b>Clinical Supervisor</b>
Unit Director	Individual meetings as needed; weekly supervision	Program Director	N.A.
Staff Physician	Individual meetings as needed	Program Director	Chief Medical Officer
Clinical Psychologist I	Individual meetings as needed; weekly supervision	Unit Director	Chief of Psychology
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	FETS Supervising Social Worker
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Ward Psychologist
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Director of RSD Director of Ther. Rec.
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Unit Director	Assoc. Director of Nursing
MH Charge Nurse	Individual meetings as needed; weekly supervision	MHSRN	MHSRN

<b>Position</b>	<b>Frequency and Type of Supervision</b>	<b>Administrative Supervisor</b>	<b>Clinical Supervisor</b>
Staff Nurse	Individual meetings as needed; weekly supervision	MHSRN	MHSRN
Mental Health Therapy Coordinator	Individual meetings as needed; daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	Unit Director	MHSRN
Mental Health Therapists	Individual meetings as needed; daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	Unit Director	MHSRN Ward RN Ward Psychologist Mental Health Specialist Ward Social Worker Ward Psychiatrist

NOTE: Assigned Clinical Supervisors for Therapy Services are those clinically privileged to provide staff clinical supervision. On Unit 48C the Clinical Supervisors are the ward psychiatrist, psychologist, social worker, and mental health specialist. The RN staff is responsible for the clinical supervision of patient care provided by MHT staff, which falls under their CNA/CMA certificates under the State Board of Nursing.

#### **G. PATIENT MANAGEMENT:**

Persons on Ward 48C can achieve privilege levels ranging from Caution Level to Level 1 and Level 2. These levels are earned by patients through successful completion of activities of daily living, and attendance in treatment groups. Access to privileges is correlated to these levels.

Persons residing on the ward participate in a weekly ward meeting that are held daily, which gives them an opportunity to participate in decisions about their treatment environment, ward management, quality of life, and clarification of rules.

The ward does not allow persons outside the secure perimeter without transport restraints. Persons are given the daily opportunity to rest from activities and to go outside to the secure yard.

#### **H. PHYSICAL ENVIRONMENT:**

Ward 48C is on the third floor of a wing of the hospital that has been remodeled to maximum-security standards. Budgeted capacity is 27 beds.

Patients have private rooms, two-bed rooms and one three-bed room, which are located off a common hallway. A lockable steel gate is available to secure each room.

The ward is able to operate within its perimeter with a common bathroom, showers, kitchen, dining room, day room, and an air court.

Space is limited on the ward. Treatment groups are offered at on the Treatment Mall on Ward 47B and in adjunctive therapy spaces on Ward 47C. All other groups are held on the ward.

A common secure yard is available for the 48 building. Patients are given the opportunity to go to the yard daily.

Visitors are able to have non-contact visits with patients through a Plexiglas window with telephones. Visitors are not allowed inside the ward. However, the visiting area is located next to the sally port at the ward entrance.

Contact visits are allowed, by physician's order, if a patient has been on the ward for over 30 days. Contact visits are held on 47B. The length of contact visits are generally limited to one hour. During a contact visit, visitors are permitted to bring food from a commercial food establishment. All contact visits are monitored by a minimum of two staff.

#### **I. WARD SCHEDULE**

Treatment team meetings, therapy groups, time in the yard, and patient ward meetings occur on a regularly scheduled basis. Adjunctive therapy is offered through the treatment mall on 47C. Patients are offered a minimum of 20 hours per week of treatment services.

Patients are offered the opportunity to participate in outdoor exercise daily. They are offered access to religious services and structured activities daily, evenings, and on weekends.

Ward staff overlap shifts daily to communicate information on patient care and ward management

issues. Once a week a ward management meeting is held to discuss overall operation of the ward and significant patient care issues. This meeting includes the unit director, physician, psychologist, supervising RN, charge RN, rehab therapist, social worker, mental health specialist, and available MHT staff.

- The Ward is maximum-security. All persons admitted are individually assessed for predictability of behavior and dangerousness to self or others.

**FORENSIC PSYCHIATRIC SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 50C**

**A. SERVICE PHILOSOPHY AND VALUES/PRINCIPLES**

Unit 50C provides psychiatric rehabilitation and treatment to mentally ill adult males in a medium-secure setting within the Forensic Psychiatric Services (FPS). Its primary population consists of patients who have a major mental illness and whose symptoms are in at least partial remission.

- Each patient will have access to a comprehensive array of services designed to meet their individual needs.
- Each patient will have a comprehensive evaluation by psychiatry, psychology, social work, nursing, and rehabilitation services.
- Each patient will have an individualized Treatment Care Plan that is formulated by an interdisciplinary treatment team (IDT) working with the patient and that addresses each patient's treatment needs and specifies goals to be obtained to move to a less restrictive environment.
- Basic patient rights and rights as a citizen will be maintained.

The overall conceptual framework for treatment involves Psychiatric Rehabilitation that incorporates biomedical, psychosocial, and social (family and community) strategies to help persons with mental disorders achieve optimum functioning in both the personal and social aspects of their lives. The major goals of psychiatric rehabilitation are:

- To enable the mentally ill person to cope more effectively with the positive symptoms of their mental disorder (e.g., hallucinations).
- To enable the person to overcome negative or deficit symptoms of their mental disorder (e.g., social withdrawal).
- To assist the person in maintaining gains made during acute treatment and in delaying re-emergence of symptoms.
- To teach the person new social and personal living skills and to restore those life skills which have atrophied.
- To reduce the person's reliance on disruptive and disturbed behavior as a way of obtaining desired outcomes

**B. GOALS, OBJECTIVES AND EXPECTED OUTCOMES**

1. Utilization: Occupancy will be 100% of available bed-days per month.
2. Services Provided: Each patient is offered 20 hours per week of structured treatment including psychoeducational groups, group therapy, individual counseling, vocational services, educational services, and leisure/recreation activities. Patients are stabilized on psychotropic medications as appropriate. Medical problems are treated as they occur with referral to the medical clinic or outside medical resources if necessary.

3. Complete Treatment: Patients who participate fully in their treatment program will be eligible for referral to a more specialized program or to a lesser restrictive setting.

### C. POPULATION

Nine demographic descriptions are available regarding the current population. The following observations are based on a snapshot of 41 residents in October, 2006:

#### Gender:

Male	100%
Female	0%

#### Age:

<20	2%
20-29	25%
30-39	23%
40-49	11%
50-59	23%
60-69	11%
70+	5%

#### Commitment Type:

PSRB commitments	77%
PSRB revocations	23%

#### Primary Diagnoses (highest incidences):

295.3	Schizophrenia, Paranoid	20%
298.9	Psychotic Disorder, NOS	18%
295.7	Schizoaffective Disorder	11%
296.44	Bipolar Disorder	9%
295.9	Schizophrenia, Undifferentiated Type	7%

#### Grades Completed:

12 & Over	%
9 – 11	%
6 – 8	%
Under 6	%

Ethnicity:

White, non-Hispanic	84%
Hispanic, other	5%
Hispanic, Mexican	5%
American Indian	2%
Black, non-Hispanic	2%
Southeast Asian	2%

Marital Status:

Never married	70%
Divorced	25%
Married	5%

PSRB Clientele:

Yes	100%
No	0%

County of Commitment:

Multnomah	14%
Deschutes	11%
Umatilla	9%
Clackamas	7%
Clatsop	7%
Linn	7%
Marion	7%
Washington	7%
Douglas	5%
Lane	5%
Polk	5%
Benton	2%
Coos	2%
Jackson	2%
Josephine	2%
Klamath	2%
Lake	2%
Lincoln	2%
Wasco	2%

**D. CLINICAL SERVICES**

Unit 50C provides services to mentally ill individuals who present a variety of diagnoses and clinical needs. The unit provides an intermediate level of care as part of a treatment continuum between maximum and minimum custody levels. A basic role is to prepare patients to move to a less restrictive environment by providing psychoeducational groups, skill building, shorter-term psychotherapy, and medication.

It is expected that as part of their planned treatment, patients will eventually be referred to a less restrictive or more specialized program within the hospital. However, patients who make sufficient progress in meeting their treatment goals may be recommended for direct community placement.

Each patient's clinical needs and problem areas are reviewed on a regular basis by the IDT. The IDT consists of representatives from various disciplines including a psychiatrist as team leader, a registered nurse, a clinical psychologist, a psychiatric social worker, a mental health specialist, a rehabilitation services therapist, a case monitor, a unit director, the patient, and others identified as necessary.

Based on interdisciplinary assessments, the IDT produces an individualized Treatment Care Plan (TCP) designed to meet the specific needs of each patient. In addition to the regularly scheduled IDT meetings, the IDT also meets when necessary to review significant changes in a patient's behavior. A review of each patient's immediate status occurs daily through a review by the IDT and also daily by nursing staff at each change of shift.

Through the TCP, patients on Unit 50C may be involved in a variety of treatment interventions. These interventions may include individual therapy, group therapy, behavior management, medication, occupational therapy, recreation therapy, educational services, vocational services, pastoral services, and other services, e.g., family therapy, as appropriate.

A basic principle underlying treatment on Unit 50C is that in addition to their psychiatric illness, patients in the forensic programs often have certain skill deficits that prevent them from succeeding in a less restrictive environment. An essential goal of treatment is to provide a variety of treatment interventions which are based on an assessment of each patient's problems and needs.

In general, the types of treatment groups provided to 50C patients can be categorized as follows:

- Psychotherapeutic – e.g., Group Psychotherapy
- Psychoeducational – e.g., Symptom Management
- Skill Building – e.g., Problem Solving
- Leisure Activities – e.g., Arts & Crafts, Basketball, Fitness, Softball

Other treatment groups offered include Substance Abuse Education, AA and Medication Management.

While some of these services are provided on the unit, others are provided off the unit through the Community Reintegration Programs. These specialized programs are comprised of the Community Transition Program, Supported Employment and Education, Sex Offender Treatment, and Co-Occurring Disorders Treatment.

Each patient is assigned a case monitor and a primary registered nurse. This allows the patient to have a fixed point of communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment. All staff who provide clinical services are credentialed and privileged to provide clinical services independently, or are supervised. Groups facilitated by mental health therapy staff are supervised by a privileged professional staff. Mental health therapists work under the direct supervision of a registered nurse for the nursing care they provide.

Family members are encouraged to maintain regular contact with the IDT and, as appropriate, are included in IDT meetings and the conditional release/discharge planning process.

**E. ADMISSION, CONTINUING CARE AND DISCHARGE CRITERIA**

**1. Admission Criteria**

Males, 18 years or older, with priority given to those who are under the jurisdiction of the PSRB or are court committed, who suffer from a major mental illness, and who:

- a. Are psychiatrically stable such that they can be treated on a medium-security unit;
- b. In the past 30 days have not displayed behavior that has seriously disrupted the treatment environment;
- c. Have not been in seclusion or seclusion and restraint in the past 30 days;
- d. Have not made suicide threats or attempts in the past 30 days;
- e. Have not been assaultive in the past 30 days;
- f. Present a low risk of escape for the medium security setting;
- g. Accept encouragement to take care of their activities of daily living with cueing; and
- h. Have sufficient cognitive skills to benefit from the level of psychoeducational and therapeutic groups provided on the unit.

**2. Justification for Continuing Care**

- a. Generally cooperative in meeting unit and program expectations and rules.
- b. Making reasonable progress towards completion of goals identified in the treatment care plan.
- c. Is not physically or sexually aggressive towards others.
- d. Is not suicidal.

**3. Transfer to a More Restrictive Setting**

- a. Persons whose psychiatric condition or behavior pose risks for self or others and require a more intensive level of care and a more secure setting. This would include individuals who are acutely psychotic, or who have recently made or threatened a serious assault or suicide attempt.
- b. Persons who pose a high risk for escape/UL and potential harm to the community outside of a maximum-security setting.

**4. Transfer to a Less Restrictive Setting**

Persons who are psychiatrically stable, have had good behavioral control for a substantial period, pose a low risk to the community, and would benefit from transfer to a specialty program and/or less secure environment.

**5. Discharge Criteria**

- a) Persons under PSRB jurisdiction who are no longer suffering from a mental illness or no longer present a substantial danger to others will be recommended to the Forensic Risk Review Board and the PSRB for discharge.

- b) Persons who continue to suffer from a mental illness and present a manageable risk to others and who can be adequately controlled and treated in the community under the supervision of the PSRB, will be recommended to the Forensic Risk Review Board for approval to begin conditional release planning.
- c) Persons for whom existing court or PSRB jurisdiction has expired who do not meet criteria for civil commitment will be recommended to the Forensic Risk Review Board for discharge.
- d) An individual's readiness for discharge or conditional release may be suggested by the following:
  - i) The absence of suicidal and homicidal ideation, with no recent history of assaults or self-harm;
  - ii) Stable and managed mental illness symptoms;
  - iii) Medication compliance and treatment participation;
  - iv) Attainment of short- and long-term treatment plan goals;
  - v) Understanding of the signs and symptoms of their illness, with development of a personal relapse prevention plan; and
  - vi) A detailed plan for follow-up treatment and supervision in the community.

## **F. EDUCATIONAL SERVICES**

### **1. Patient Education**

Patients between the ages of 18 and 21, and who meet the criteria for handicapped education as set forth in PL 94-142, are eligible for educational services that are provided under contract with Willamette Educational Services District.

Adult educational services are available at Eola Community Center for those persons whose baseline assessment determines a need. This includes literacy training and GED preparation. A computer lab is also available for those patients wishing to become more proficient in computer skills.

Patients identified by the IDT as likely to benefit from vocational services are referred for pre-vocational services, patient pay, day worker (Salem Rehabilitation Facility), Supported Adult Education, or Vocational Rehabilitation services.

### **2. Family Education**

Families will be provided basic information about Oregon State Hospital and the Forensic Rehabilitation and Transition Services. They will receive information about the Psychiatric Security Review Board and the Friends of Forensic support and advocacy group.

Families will be contacted by Social Services to gather relevant patient information and be offered further information about specific aspects of mental illness as desired. Families

will be encouraged to participate in the treatment planning process as authorized by the patient. From this forum, education about symptom management, medications, treatment methods, and discharge planning will be available to interested families.

## **G. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **1. Staffing by Shift**

<u>Class</u>	<u>Day</u>	<u>Swing</u>	<u>Night</u>
Unit Director	1		
Physician Specialist	1		
MH Supervising Nurse	1		
Clinical Psychologist	1		
Psychiatric Social Worker	1		
Mental Health Specialist	1		
Recreational Therapist	1		
Recreation Assistant		.5	
Unit Clerk	1		
MH Registered Nurse	3	2.5	2
MHTC	1		
MHTSC	1		
MHT2	1	2	
MHT1	3	4	
MHTT			3

### **2. Procedure for Administrative Supervision**

The Unit Director is responsible for the overall administration of the unit including program development and coordinating and monitoring implementation and progress towards goals and objectives in the individualized TCP. The supervising nurse assures that nursing care needs of the patients are met and works closely with the Unit Director in the overall administration of the unit.

Position	Frequency and Type of Supervision	Supervisor
Unit Director	Individual meetings as needed; weekly peer supervision meeting.	Program Director
Staff Physician	Individual meetings as needed	Program Director
Mental Health Supervising Nurse	Individual meetings as needed	Nurse Manager
Clinical Psychologist	Individual meetings as needed; weekly supervision	Unit Director
Psychiatric Social Worker	Individual meetings as needed; weekly supervision	Unit Director
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director
Recreational Therapist	Individual meetings as needed; weekly supervision	Unit Director
Recreation Assistant	Individual meetings as needed; weekly supervision	Unit Director
Mental Health Registered Nurse	Individual meetings as needed; weekly supervision	MH Supervising Nurse
Mental Health Therapy Coordinator	Individual meetings as needed; daily supervision	MH Supervising Nurse
Mental Health Therapy Shift Coordinator	Individual meetings as needed; daily supervision	MH Supervising Nurse
Mental Health Therapists 1, 2, and Technician	Individual meetings as needed; daily supervision	MH Supervising Nurse

### 3. Procedure for Clinical Supervision

To provide clinical support to MHT staff by unit-based credentialed staff and to assure that staff providing direct services stays within the scope of their abilities and receives support and direction from the credentialed supervisor.

Specifically, clinical supervision of MHT staff is intended to:

- Improve patient care delivered by MHT staff by assisting in their development of new knowledge and skills;
- Improve patient care through discussion and proactive response to clinical problems; and
- Assist in the professional development of MHT staff.

### 4. Supervisory Assignments

Clinical support meetings between MHT staff and clinical support staff will occur 2 times per month lasting for at least 30 minutes per session. These sessions will cover such topics as transference and counter-transference, behavior management, case monitor responsibilities, clinical performance, and professional development.

## 5. Support and Training of Clinical Supervisors

The clinical support staff and unit physician will meet monthly to discuss issues and concerns raised by the clinical supervision of MHT staff. This meeting can be used to consult with peers, to review how best to handle specific situations or to discuss whether an MHT staff's behavior needs to be referred to the unit's management staff. This time can also be used for inservice training when training issues for supervisors are identified.

## 6. Clinical Supervisor/Management Supervision Overlap

The clinical support and unit physician will meet with the Unit Director and the Mental Health Supervising RN monthly during the schedule Unit Management Meeting to discuss issues that have arisen in clinical supervision and which now require management supervision. Any issues that would assist in the effective and efficient delivery of treatment services could be discussed at this meeting.

Position	Frequency and Type of Supervision	Supervisor
Mental Health Therapist 1	Daily direct observation Weekly meeting	Shift RN Assigned clinical support staff
Staff Psychiatrist	Monthly meeting	Chief Medical Officer
Psychologist I	Monthly meeting	Chief Psychologist
Psychiatric Social Worker	Monthly meeting	Director of Social Work
Registered Music Therapist	Monthly meeting	Rehabilitation Services Supervisor
Recreation Assistant	Monthly meeting	Rehabilitation Services Supervisor
Mental Health Supervising Nurse	Weekly meeting	Assoc. Director of Nursing
Mental Health Registered Nurse	Daily direct observation Weekly meeting	MH Supervising Nurse
Mental Health Therapy Coordinator	Daily direct observation Weekly meeting	Shift RN Assigned clinical support staff
Mental Health Therapist 2	Daily direct observation Weekly meeting	Shift RN Assigned clinical support staff

## 7. Documentation

Documentation will be maintained by each clinical supervisor to record attendance and note significant issues/concerns raised or training needs and will be provided to the Unit Director

All staff providing direct treatment services are either clinically privileged to provide these services or provide them under clinical supervision. Clinical supervision is as follows:

NOTE: Staff will be responsible for the supervision of patient care provided by MHT staff which falls under their State Board of Nursing CNA/CMA certification.

## **H. PATIENT MANAGEMENT**

A cardex meeting attended by the IDT is held Monday through Friday from 8:30 to 9:00 am. The purpose of this meeting is to review each patient's significant interactions within the milieu during the previous 24 hours and to initiate appropriate clinical action in response to clinical issues. Each patient's significant interactions are also reviewed at intershift report, which is held daily between each shift.

To help orient new patients to the unit, the Case Monitor and/or a current patient will provide a tour of the unit, a copy of the Unit Handbook and explains unit activities, procedures, and rules.

All patients participate in a community meeting with staff two times a week to discuss issues related to the unit and its environment, and to allow clarification of policies and rules.

A patient representative serves on the Consumer Group committee that meets weekly.

Unit 50C does not have a level system. All patients are given the same unit based privileges as detailed in the Unit Handbook. With the approval of IDT, patients are eligible to go off-unit for treatment and non-treatment activities with staff within the secure perimeter. With the approval of both the IDT and the Risk Review Board, patients may receive privileges to travel unescorted within the secure perimeter and passes on and off grounds outside of the secure perimeter.

## **I. PHYSICAL ENVIRONMENT**

Unit 50C is located on the second floor of Eola Hall, which is a medium-security, five-story building constructed in 1955 and remodeled in 1992. It is climate controlled, including having central air conditioning.

Unit 50C has its own kitchen and dining room, and meals are eaten on the unit. Patients sleep in two-bed, three-bed, or multiple-bed bedrooms. There are common showers and bathrooms. There are dayrooms, an activity room that includes a library, and laundry facilities on the unit.

Nearby, are recreation center, canteen, gym and a barbershop. A secure yard is available and patients are given the opportunity to use the yard daily.

## **J. UNIT SCHEDULE**

Patients are awakened at 7:15 a.m. and are expected to eat breakfast, take care of personal hygiene, and clean their personal living areas by 9 a.m.

Recreation and therapy activities occur at various times throughout the day and evening, and a continually updated schedule is posted on the unit. Clinics are usually scheduled in the morning. Patients are given the opportunity to use the secure yard daily, usually from 12:30 p.m. to 2 p.m., and again after dinner when there is sufficient daylight.

IDTs are held alternately between mornings and afternoons to allow case monitors to participate in treatment planning. A unit meeting with staff and patients is held Mondays at 8:15 a.m. or at 4:00 PM on alternating Mondays. Unit Management Meeting is held Mondays at 9:00 am. Unit staff meets at each change of shift to review each patient's status, and to discuss other unit matters as appropriate.

Oregon State Hospital

**FORENSIC PSYCHIATRIC SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 50D**

**A. SERVICE RATIONALE AND VALUE/PRINCIPLES**

Unit 50D provides care, custody and treatment for adult males from throughout the entire state of Oregon in a medium-security and safe environment, which allows patients to focus on their treatment in a unit-based therapeutic milieu. The needs of each patient are evaluated by the interdisciplinary team (IDT) with a broad range of treatment modalities used, geared to the total treatment and rehabilitation of each patient. Our goal is to help each patient develop responsible self and social and community survival skills that will enhance their life and decrease their re-offending.

1. Patient admitted to the unit will have a comprehensive evaluation by Psychiatry, Psychology, Social Work, Nursing and Rehabilitation Services.
2. Patient will have an individualized Treatment Care Plan (TCP) that specifies the steps to be obtained to move toward management of their mental illness relapse prevention and return to a community setting.
3. Patient will receive services as indicated by their unique needs as guided by an individualized Treatment Care Plan.
4. Patient will be involved in all phases of their treatment as provided by the phases of Recovery, and Psychosocial Rehabilitation, (i.e. self determination, patient centered, and skill building). The emphasis will focus on the recognition and recognition of each patient's strengths and empowerment of the individual to develop the skills necessary to attain their goals for discharge and survival in the community.
5. Patient will have access to a variety of services that address their physical, medical, social, spiritual, cultural, psychiatric, vocational, and educational needs.

The overall conceptual framework for the Recovery Model and Psychosocial Rehabilitation treatment philosophies incorporates biomedical, psychosocial, and social (family/community) strategies to help persons with mental disorders achieve optimum functioning in both the personal and social aspects of their lives. The major treatment goals are:

1. Help the mentally ill person to cope more effectively with the positive symptoms of mental disorders (e.g., hallucinations).
2. Help the person to overcome negative or deficit symptoms of mental disorder (social withdrawal).

3. To assist the person in maintaining gains made during acute treatment, and in delaying re-emergence of symptoms.
4. To teach the person new social and personal living skills and to restore those life skills which have atrophied.
5. To reduce the person's reliance on disruptive and disturbed behavior as a way of Obtaining desired outcomes.

## **B. GOALS, OBJECTIVES AND EXPECTED OUTCOMES**

1. Utilization: Occupancy will be 100% of available bed space per month.
2. Services Provided: Each patient is offered 20 hours per week of structured treatment including psycho educational groups, group therapy, individual counseling, vocational services, educational services, and leisure/recreation activities. Patients are stabilized on psychotropic medications as appropriate. Medical problems are treated as they occur with referral to the medical clinic or outside medical resources if necessary.
3. Complete Treatment: Patients who participate fully in their treatment program will be eligible for referral to a more specialized program or to a lesser restrictive setting.
4. Continuum of Care: 100% of patients referred to a specialized program or less restrictive setting will have satisfactorily met the major short-term goals of their treatment care plan by the appropriate target dates.

## **C. POPULATION**

Nine demographic descriptions are available regarding the current population. The following observations are based on a snapshot of 40 residents in the year 2006:

### Gender:

Male	100%
Female	0%

### Age:

18-19	0%
20-29	20%
30-39	14%
40-49	36%
50-59	23%
60-69	7%
80-89	0%

### Commitment Type:

PSRB commitment	75%
PSRB revocations	25%

Primary Diagnosis: (first 4 most common)

295.30	Schizophrenia, Paranoid	18%
295.70	Schizoaffective Disorder	25%
298.9	Psychotic Disorder, NOS	20%
296.4	Bipolar I Disorder, Most	9%

Grades Completed:

12 & over	%
9-11	%
6-8	%
Under 6	%
Unknown	%

Ethnicity:

White, non-Hispanic	75 %
Black, non-Hispanic	5%
Hispanic, Mexican	7%
American Indian	2 %
Hispanic, Other	2%
Hispanic, Puerto Rican	2%

Marital Status:

Never Married	70%
Divorced	14%
Separated	5%
Married	2 %
Widowed	2%

PSRB Clientele:

Yes	100%
No	0%

County of Commitment:

Multnomah	23%
Marion	16%
Lane	14%
Deschutes	7%
Benton	5%
Clackamas	5%
Douglas	5%
Linn	5%
Washington	5%
Clatsop	2%
Jackson	2%
Klamath	2%
Lake	2%
Malheur	2%

**D. CLINICAL SERVICES**

Unit 50D provides services to mentally ill individuals who present a variety of diagnoses and clinical needs. The unit provides an intermediate level of care as part of a treatment continuum between maximum and medium custody levels. A basic role is to prepare patients to move to a less restrictive environment within six to 18 months by following principles of Recovery and Psychosocial Rehabilitation, including psycho educational groups, skill building, short-term psychotherapy, and medication

It is expected that as part of their planned treatment, most patients will eventually be referred to a less restrictive or more specialized program within the hospital. However, patients who make sufficient progress in meeting their treatment goals may be recommended for direct community placement.

To assist patients in developing personal responsibility, healthy decision making, and sense of personal control, each patient progresses through a series of Recovery stages that reflect his progress towards recovery and transitioning into a lesser restrictive setting.

All patients admitted to Unit 50D are assigned to a primary registered nurse and a case monitor. This enables the patient to have a fixed point of communication regarding their treatment and allows ongoing monitoring of their progress in their current TCP. All professional and direct-care staff works directly with patients in a variety of group and individual activities.

Clinical services for patients are on an individual basis through Treatment Care Plans that focus on the presenting problems that led to admission and clear steps to be taken to resolve them. The Interdisciplinary Treatment Team consists of representatives from various disciplines, including a psychiatrist as the clinical leader, a registered nurse, a clinical psychologist, a psychiatric social worker, a rehabilitation therapist, a mental health specialist, the patient's case monitor, a unit director, the patient, and others identified as necessary. Based on clinical assessments, the Treatment Team develops an individualized Treatment Care Plan designed to meet the specific needs and goals of each patient. Reviews of the Treatment Care Plan are held to assess progress of

short and long term goals. Daily Cardex reviews are conducted to discuss pertinent patient progress, problems, and/or behavior. In addition, the Treatment Care Plan focus is on improving the patient's ability to manage their mental illness and the development of skills necessary to prepare them for discharge into the community.

Through the Treatment Care Plan, patients may be involved in a variety of treatment interventions. These interventions may include individual therapy, group therapy, symptom management, medication management, anger management, relapse prevention, educational development, vocational therapy, substance abuse treatment, assessment for treatment of sexual deviancy, development of leisure skills and community living skills, and other services as needed.

As part of the therapeutic milieu, 50D holds a Community Meeting three times a week. This gives patients the opportunity to bring up issues and concerns and allows for information sharing by staff.

The IDT team encourages the families of our patients to participate in the patient's IDT meeting, as they are considered a very important part in the treatment and life of our patients. The families are also encouraged to become active members of the "Friends of Forensics", an advocacy support group for the patients we serve.

#### **E. ADMISSION, CONTINUING CARE, AND DISCHARGE CRITERIA**

##### **1. Admission Criteria:**

Males, 18 years or older, with priority given to those who are under the jurisdiction of the PSRB or are court committed, who suffer from a major mental illness, and who:

- a. Are psychiatrically stable such that they can be treated on a medium-security unit.
- b. In the past 30 days have not displayed behavior that has seriously disrupted the treatment environment.
- c. Have not been in seclusion or seclusion and restraint in the past 30 days.
- d. Have not made suicide threats or attempts in the past 30 days.
- e. Have not been assaultive in the past 30 days.
- f. Present a low risk of escape.
- g. Are able to take care of their activities of daily living with minimum cueing and;
- h. Have sufficient cognitive skills to benefit from the level of psycho educational and therapeutic groups provided on the unit.

Patients who have been in movement restriction in the previous 30 days will be evaluated for appropriateness for transfer on a case-by-case basis.

##### **2. Justification for Continuing Care**

- a. Generally cooperative in meeting unit and program expectations and rules.
- b. Making reasonable progress towards completion of goals identified in the Treatment Care Plan.
- c. Is not physically or sexually aggressive toward others.
- d. Is not suicidal.

3. **Transfer to a More Restrictive Setting**

- a. Persons whose psychiatric condition or behavior pose risks for self or others and require a more intensive level of care and a more secure setting. This may include individuals who are acutely psychotic or who have recently made or threatened a serious assault or suicide attempt.
- b. Persons who pose a high risk for escape/UL and potential harm to the community, outside of a maximum security setting.

4. **Transfer to a Less Restrictive Setting**

- a. Persons who are psychiatrically stable, have had good behavioral control for a substantial period, pose a low risk to the community, and would benefit from transfer to a specialty program and/or a less secure environment.

5. **Discharge Criteria**

- a. Persons under PSRB jurisdiction who are no longer suffering from a mental illness or no longer present a substantial danger to others will be recommended to the hospital Risk Review Board and the PSRB for discharge.
- b. Persons who continue to suffer from a mental illness and present a minimal risk to others and who can be adequately controlled and treated in the community under the supervision of the PSRB, will be recommended to the Risk Review Board and the PSRB for conditional release.
- c. Persons for whom existing court or PSRB jurisdiction has expired who do not meet criteria for civil commitment will be recommended to the Risk Review Board for discharge.
- d. Persons who are no longer in need of intensive evaluation or acute psychiatric or behavioral management and no longer pose a high risk for escape/UL and potential harm to the community may also be considered, under applicable OARs, for transfer to other MHDDSD institutions such as Eastern Oregon Psychiatric Center.

An individual's readiness for discharge or conditional release may be suggested by the following:

- a. The absence of suicidal and homicidal ideation, with no recent history of assaults or self-harm.
- b. No prominent hallucinations or delusional thinking.
- c. Good medication compliance and treatment participation.
- d. Attainment of short and long term treatment plan goals.
- e. Good understanding of the signs and symptoms of their illness, with development of a personal relapse prevention plan.
- f. A detailed plan for follow-up treatment and supervision in the community.

## **F. EDUCATIONAL SERVICES**

### **1. Patient Education**

Based on individual needs and interests, patients are referred for supported educational services to the hospital's Rehabilitation Department. This includes patients admitted to the unit who are between the ages of 18-21 and who meet the criteria set forth in Public Law 95-142 regarding handicapped education.

Also available is a computer lab located on 50B of Eola Hall. Patients are enrolled on an individual basis and work at their own pace. There is a full-time teacher and an assistant assigned to the lab to assist patients in their educational advancement. In addition, the teacher conducts individual tutoring and small group teaching in a classroom setting. Through a grant, a patient library was established and is part of the patient education component on 50B.

A GED preparation lab and literacy training are provided for patients on 50B.

Patients identified by the IDT as likely to benefit from vocational services are referred for pre-vocational services, bench work, patient pay, day worker (Salem Rehabilitation Facility), or Vocational Rehabilitation services.

### **2. Family Education**

Families will be provided information about Oregon State Hospital and the Forensic Psychiatric Services Program. They will receive information about the Psychiatric Security Review Board and the Friends of Forensic support and advocacy group.

Families will be contacted by the unit social worker and offered further information about specific aspects of mental illness. Families will be encouraged to participate in the treatment planning process as authorized by the patient. From this forum, education about symptom management, medications, treatment methods, and discharge planning will be available to interested families.

## **G. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **1. Staffing by Shift**

<b>Class</b>	<b>Day</b>	<b>Swing</b>	<b>Night</b>
Unite Director	1.0		
Physician Specialist	1.0		
MH Supervising Nurse	1.0		
Clinical Psychologist	1.0		
Psychiatric Social Worker	1.0		
Mental Health Specialist	1.0		
Rehabilitation Therapist	1.0		
Unit Clerk	1.0		
MH Staff Nurse	3.0	2.0	2.0

Class	Day	Swing	Night
MHTC	1.0		
MHTSC	1.0	1.0	
MHT2	2.0	1.0	
MHT1	2.0	4.0	
MHTT			3.0

## 2. Procedure for Administrative Supervision

Administrative supervision flows from the Superintendent to the Program Director, Unit Director, and to other management staff. Clinical supervision flows from the Chief Medical Officer to Clinical Discipline Directors, who set the standards of practice for each of their disciplines.

Clinical Supervision is provided according to this plan and resources available.

Unit 50D's clinical supervision plan was developed to provide non-privileged MHT staff with supervision by our unit-based credentialed staff. All unit credentialed staff receive clinical supervision through their discipline according to the discipline's established standards of practice. Clinical supervision of non-privileged MHT staff is intended to:

- a. Improve patient care by assisting MHT staff in their development of new knowledge and skills.
- b. Improve patient care through discussion and proactive responses to clinical problems.
- c. Assist the MHTs in their professional development.

The clinical supervisors and MHT staff meet formally on a weekly basis to identify and discuss issues of concern, (i.e., counter-transference issues, boundary issues, review of clinical status of their assigned patients, and MHT professional development). Clinical supervisors meet monthly with the Unit Director and the MHSRN to discuss issues which have arisen from the clinical supervision and may need management interventions, as well as discussion of common issues that affect the efficient delivery of treatment services for patients.

The RN staff will be responsible for the supervision of patient care provided by MHT staff that falls under their State Board of Nursing CNA/CMA certification.

Position	Frequency and Type of Supervision	Administrative Supervisor	Clinical Supervisor
Unit Director	Daily/Weekly	Program Director	
Staff Physician	Monthly	Program Director	Chief Medical Officer
Psychologist	Monthly	Unit Director	Chief of Psychology
Social Worker	Monthly	Unit Director	Supervising Social Worker
Rehabilitation Therapist	Monthly	Unit Director	Director of RSD
Mental Health Specialist	Monthly	Unit Director	Unit Psychologist
MHSRN	Weekly	Unit Director	Assoc. Dir. of Nursing
MH Registered Nurse	Weekly	MHSRN	MHSRN/Associate Director of Nursing
MHTC	Daily/Weekly	MHSRN	MHSRN/Unit RN/Unit-Based Clinical Supervisor
Staff RN	Weekly	MHSRN	MHSRN
MH Shift Coordinator	Daily/Weekly	MHSRN	Assoc. Dir. of Nursing
Mental Health Therapists 1, 2 and Techs	Daily/Weekly	MH Supervising Nurse	MHSRN/Unit RN/Unit-Based Clinical Supervisor
Unit Clerk	Daily//Weekly	Unit Director	

NOTE: Assigned Clinical Supervisors for Therapy Services are those clinically privileged to provide staff clinical supervision. On Unit 50D the Clinical Supervisors are the unit Psychiatrist, Psychologist, Social worker, and the Mental Health Specialist. The RN staff is responsible for clinical supervision of patient care provided by MHT staff, which falls under their State Board of Nursing certificate.

## H. PATIENT MANAGEMENT

Unit 50D patients are expected to take responsibility and move towards transitioning into a lesser restrictive treatment setting. Basic expectations that apply to all patients at all times include respectful behavior towards others, maintaining acceptable personal hygiene, and following ward rules.

Patients are presented to the Risk Review Board by members of the IDT (usually the physician, psychologist, social worker, and unit director) for an increase of their security custody level. Until a patient is presented to the Risk Review Board, they remain at the maximum custody level. When the IDT feels a patient is ready, they are presented for an increase to either medium or minimum custody level with privileges ranging from 1:1 with staff escort on grounds, to unescorted off grounds when they are nearing discharge into the community.

Patients residing on the unit participate in a staff/patient community meeting by attending three times per week, which gives them the opportunity to participate in decisions about their environment, recreational activities, quality of life, and unit guidelines. Patients are also involved in the Forensic Consumer Group organization's activities.

## **I. PHYSICAL ENVIRONMENT**

Unit 50D is located on the second floor of Eola Hall, which is a medium security five story building constructed in 1955 and remodeled in 1992. The unit has its own kitchen and dining room. Meals, however, are prepared in the OSH kitchen and sent to the unit, where they are served and eaten. The building is climate controlled, including air conditioning.

Personal living space for the patients is provided in two, three or multiple-bed rooms which are located off a common hallway.

The unit is able to operate within its perimeter with common restrooms, showers, laundry facilities, kitchen, dining room, day rooms,

Treatment space has been developed on Unit 50A, which houses the Eola Community Center where therapy, educational and recreation groups and activities take place. Patients are also provided rehabilitative service activities and groups with Rehabilitation Services Department personnel. Patients have access to the OSH Recreation Center for leisure activities, use of the gym and fitness room, and services of a licensed barber, all within the secure perimeter.

Visitors are able to have daily contact visits with Unit 50D patients in the common, secure Visitors' Center located on the first floor of Eola Hall.

## **J. UNIT SCHEDULE:**

Patients are awakened as early as 6:30 a.m. for those having to be at work at 7:00 a.m. Other patients are expected to be up for breakfast at 7:30 a.m., take morning medications, take care of personal hygiene, and clean their personal living areas.

Throughout the day, patients are scheduled for various therapeutic, vocational, and recreation activities. In addition, there are appointments for medical and dental clinics as well as outside providers as necessary.

Community meetings are held on Mondays at 2:30 p.m. to 3:00 p.m. and on Tuesdays and Thursdays from 8:30 a.m. to 9:00 a.m.

All patients who are clinically suitable are given the opportunity to use the secure yard from 12:30 p.m. to 2:00 p.m., and again in the evening after dinner when there is sufficient daylight.

Unit Staff meet at each change of shift to review each patient's status, and to discuss other unit matters as appropriate. There is an expanded overlap on Tuesdays and Thursdays from 2:15 p.m. to 3:00 p.m. to allow more adequate discussions of clinical and management issues. The unit's management team meets Thursday from 1:45 p.m. to 2:15 p.m.

IDT's are held three days a week, alternating between morning and afternoons so that case monitors on various shifts can participate in treatment planning.

Oregon State Hospital  
**FORENSIC PSYCHIATRIC SERVICES**  
**CLINICAL UNIT DESCRIPTION**  
**Ward 50E**

**A. SERVICE PHILOSOPHY**

Ward 50E provides psychiatric rehabilitation and treatment to mentally ill adult males in a medium secure setting within the Forensic Psychiatric Services Program. Its primary population consists of patients who have limited cognitive capacity, organic mental disorders, or cognitive impairment due to brain trauma

Each patient has access to a comprehensive array of services designed to meet his individual needs.

Each patient receives a comprehensive evaluation by psychiatry, psychology, social work, nursing, and rehabilitation services.

Each patient is an integral member of the Treatment Team. The Interdisciplinary Treatment and the patient will develop and implement a Treatment Care Plan which addresses the patient's treatment needs and specifies the process of assisting the patient to return to the community.

Patients are treated with dignity and respect at all times. The program assures that each person's basic patient rights and rights as a citizen are maintained and that all patients have orientation and access to the OSH grievance procedure.

A basic principle underlying treatment on Ward 50E is that in addition to treatment of their psychiatric illness, patients often need assistance in developing positive behavioral and coping strategies that enable the patient to make choices that bring the necessary strength's to his life and enable the patient to be as independent as possible.

An essential goal of treatment, then, is assisting each patient to understand and develop skills acceptable to community expectations regarding behavior and daily living abilities by providing positive feedback for all increments of success.

**B. POPULATION**

Ward 50E provides treatment to men with a budgeted capacity of 36. Age range is 18-80 with the majority being between the ages of 25 and 45.

Multnomah County is the most represented county of residence. The most common primary diagnosis is schizophrenia.

The most common criminal offenses are sexual offenses, followed by burglary and robbery.

**Gender:**

Male	100%
Female	0%

**Age:**

18-19	10%
20-29	20%
30-39	20%
40-49	22%
50-59	17%
60-69	7%
80-89	5%

**Grades Completed:**

12 & Over	%
9 – 11	%
6 – 8	%
Under 6	%
Unknown	%

**Ethnicity:**

White, non-Hispanic	82%
Black, non-Hispanic	8%
Hispanic, Mexican	8%
Asian	3%

**Marital Status:**

Never married	95%
Divorced	3%
Married	3%

**PSRB Clientele:**

Yes	72%
No	28%

**Counties of Commitment:**

Multnomah	20%
Marion	12%
Lane	10%
Washington	10%
Umatilla	7%
Clackamas	5%
Columbia	5%
Jackson	5%
Lincoln	5%
Clatsop	2%

**(Counties of Commitment continued)**

Coos	2%
Josephine	2%
Klamath	2%
Linn	2%
Polk	2%
Tillamook	2%

**Primary Diagnosis (From Highest)**

295.5	Schizophrenia, Disorganized Type	15%
295.7	Schizoaffective Disorder	15%
298.9	Psychotic Disorder, NOS	10%
295.3	Schizophrenia, Paranoid Type	8%

**C. CLINICAL SERVICES**

The Interdisciplinary Treatment Team reviews each patient's clinical and treatment needs on a regular basis. The Interdisciplinary Treatment Team consists of representatives from various disciplines including a psychiatrist as team leader, a registered nurse, a clinical psychologist, a psychiatric social worker, a mental health specialist, a rehabilitation services therapist, a case monitor, a unit director, the patient, and others identified as appropriate to his treatment.

Based on Interdisciplinary assessments, the treatment team and patient develop an individualized Treatment Care Plan designed to meet individual needs. In addition to the regularly scheduled Treatment Team meetings, the Treatment Team and patient also meets whenever necessary to review significant changes in treatment needs. A review of each patient's immediate status occurs daily through a review by the Interdisciplinary Treatment Team, and also daily by nursing staff at each change of shift.

Through the Treatment Care Plan, patients on Ward 50E may be involved in a variety of treatment opportunities. These include individual therapy, group therapy, behavior management, medication, occupational therapy, recreation therapy, music therapy, art therapy, educational services, vocational services, pastoral services, and other services, as appropriate.

Types of treatment groups provided by ward staff or staff from the 50 Building Treatment Mall include:

- Symptom Management
- Medication Management
- Psycho-Educational
- Requirements to Aid and Assist in one's Defense;
- Substance Abuse
- Skill Building and Problem-Solving
- Arts and Crafts and other recreational activities

A case monitor and a primary registered nurse are assigned to assist each patient. This allows the patient to have a fixed point of communication regarding their treatment and facilitates ongoing opportunities to provide and receive input regarding his treatment goals. All staff that provide

clinical services have credentials and are and privileged to provide clinical services independently, or are supervised. A privileged professional staff supervises groups facilitated by mental health therapy staff. Mental health therapists work under the direct supervision of a registered nurse for the nursing care they provide.

Patients are encouraged to include family members in their recovery process by maintaining regular contact with the Treatment Team and participating in Treatment Team meetings and the conditional release/discharge planning process.

## **D. ADMISSION, CONTINUING CARE AND DISCHARGE CRITERIA**

### **1. Admission Criteria:**

Male patients whose Full Scale IQ is 70 to 74 or below are treated on Ward 50E; for female patients, 50J. Patients whose Full Scale IQ is 70 to 75 with assessed functional impairments have the same requirements. The hospital may elect to treat patients whose IQ is in the 75-85 range on 50E when their disabilities make them more likely to benefit from the special programming. Patients who have sustained brain injuries may also be appropriately placed on ward 50E.

When pre admission information supports the necessary criteria, patients are admitted to Ward 50E. Some patients enter the ward by transfer from another ward. Ward 50E criteria includes a need for hospital level care because of symptoms of mental illness or behavioral issues.

Patients on the ward may be in any of the legal status categories that apply to OSH admissions. Most are under the jurisdiction of the Psychiatric Security Review Board, having been found Guilty Except for Insanity of a crime (ORS 171.327 or 161.336.) Patients sent to FPS program for treatment until fit to proceed with trial for a crime (ORS 161.370) are treated on the ward when assessed to be in the categories described. Civilly committed patients (ORS 426.130 and 426.220) may also be treated on the ward for specific treatment focus.

### **2. Continuing Care:**

Persons who continue to require hospital-level psychiatric care due to one or more of the following:

- Symptom severity (e.g., poor reality testing caused by ongoing hallucinations or delusions);
- Inability to control behavioral issues (e.g., threats and intimidation, minor assaults);
- Severe deficits in adaptive functioning (e.g., inability to feed or clothe themselves without assistance);
- Potential risk to the community (e.g., threats to harm others, indications of escape risk, extensive history of violence in the community).
- Those persons under ORS 161.370 determined by the IDT to continue to be unfit to proceed.

**3. Transfer to More Restrictive Environment:**

Persons whose psychiatric condition or behaviors pose risks for self or others may require a more intensive level of treatment in a more secure setting. This would include individuals who are acutely psychotic, or who have recently made or threatened a serious assault or suicide attempt.

Persons who pose a high risk for escape/UL and potential harm to the community outside of a maximum-security setting.

**4. Transfer to Less Restrictive Environment:**

Persons who have recovered sufficiently, are able to demonstrate behavioral stability for a substantial period, pose a low risk to the community, and would benefit from transfer to a specialty program and/or less secure environment.

**5. Discharge Criteria:**

Persons under PSRB jurisdiction who have recovered in the treatment of their illness, or no longer present a substantial danger to others will be recommended to the FPS Risk Review Board and the PSRB for discharge.

Persons who continue have symptoms of a mental illness and present a potential danger to others but can receive treatment in the community, under the supervision of the PSRB, will be recommended to the FPS Risk Review Board.

Persons for whom existing court or PSRB jurisdiction has expired who do not meet criteria for civil commitment will be recommended to the FPS Risk Review Board for discharge.

Persons under ORS 161.370 who are determined as fit to proceed shall be discharged to the jurisdiction responsible.

Persons who are no longer in need of intensive evaluation or acute psychiatric or behavioral treatment and no longer pose a high risk for escape and potential harm to the community may also be considered, under applicable OARs, for transfer to other MHDDSD agencies, such as EOPC or the state-operated Community program.

An individual's readiness for discharge or conditional release may be suggested by:

- The absence of suicidal and homicidal ideation, with no recent history of assaults or self-harm;
- No prominent hallucinations or delusional thinking;
- Good medication compliance and treatment participation;
- Attainment of short- and long-term treatment plan goals;
- Good understanding of the signs and symptoms of their illness, with development of a personal relapse prevention plan; and
- A detailed plan for follow-up treatment and supervision in the community.

## **E. EDUCATION SERVICES**

Patients who are between the ages of 18 and 21 and who meet the criteria for handicapped education as set forth in PL 95-142 are eligible for education services that are provided under contract with Willamette Education Service District.

Basic Adult Educational Services are available at the 50 Building Treatment Mall for those referred by the Treatment Team. This includes Literacy Training and GED Preparation. A computer lab is also available for those patients wishing to develop computer skills.

Patients identified by the treatment team as likely to benefit from Vocational Services are referred for pre-vocational services, patient pay, day worker (Vocational Center) or Vocational Rehabilitation Services.

## **F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **1. Ward 50E staffing is as follows: FTE**

Unit director	1.0
Physician Specialist	1.0
Clinical Psychologist	1.0
Mental Health Specialist	1.0
Social Worker	1.0
Recreation Therapist	1.0
Supervising Nurse	1.0
Mental Health RN	5.5
MHT2/LPN	2.0
Mental Health Therapist II	1.0
Mental Health Therapist I	8.0
Mental Health Therapy Technician	3.0
Mental Health Therapy Technician (recreation technician)	0.5
Mental Health Therapist Coordinator	1.0
Mental Health Shift Coordinator	2.0
Office Specialist 2	.5

### **2. Minimum Staffing:**

Shift by shift, there is a system in place whereby the Unit Director, Ward MHSRN, Program MHSRN, reviews the patient census and acuity to determine if additional staff are needed beyond the minimum, or if staffing can be decreased in response to a change in patient acuity.

The following identifies the minimum staffing per shift.

Day and Swing shifts: 5 direct care nursing staff, one of which must be an RN.

Night shift: 3 direct care nursing staff, 1 of which must be an RN.

The Unit director is responsible for the overall administration of the ward including program development and coordinating and monitoring implementation and progress toward goals and objectives in the individualized Treatment Care Plan. The Supervising RN assures that nursing care needs of the patients are met and works closely with the Unit director in the overall administration of the ward.

### 3. Procedure For Administrative Supervision:

Position	Frequency and Type of Supervision	Supervisor
Unit director	Individual meetings as needed; weekly supervision	Program Director
Staff Physician	Individual meetings as needed	Clinical Director
Clinical Psychologist	Individual meetings as needed; weekly supervision	Unit director
Social Worker	Individual meetings as needed; weekly supervision	Unit director
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit director
Mental Health Specialist	Individual meetings as needed. Weekly supervision.	Unit director
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Unit director
Mental Health Nurse	Individual meetings as needed; daily supervision	MHSRN
MH Therapy Coordinator	Individual meetings as needed; daily supervision	MHSRN
Mental Health Therapist	Individual meetings as needed: Daily supervision	MHSRN

### G. PATIENT TREATMENT

Staff will orient new patients to the ward including a tour of the ward, a discussion of ward activities, procedures and rules, and answering any questions presented by the patient.

A patient representative serves on the consumer group committee that meets weekly.

Ward 50E uses a privilege system with increasing levels that range from Level 1 to Level 4. An individualized level system is developed for patients who are unable to advance on the level system. The purpose of the level system is to reinforce positive patient choices and responsible behavior. Each succeeding level carries with it an increase in expectations in activities of daily living and participation in treatment activities. With approval of the Treatment Team, patients are

eligible to go off-ward, within the secure perimeter, for treatment and non-treatment activities with staff. With approval of the Treatment Team and Risk Review Board, patients may receive privileges to travel unescorted within the secure perimeter.

Patients who meet set criteria of daily expectations, e.g., appropriate grooming and personal hygiene, attends assigned groups, etc., is eligible to use the ward clubhouse facilities.

## **H. PHYSICAL ENVIRONMENT**

Ward 50E is located on the third floor of the 50 Building, which is a medium security, five-story building constructed in 1955 and remodeled in 1992. It has its own dining room and patients eat meals on the ward. It is climate-controlled, including central air conditioning.

Patients sleep in two-bed, three-bed, or multiple-bed bedrooms. There are common showers and bathrooms. Laundry facilities are available on the ward, and there is a barbershop on Ward 50B. Nearby are a recreation center, canteen, swimming pool, and gym.

A secure yard is available and patients have the opportunity to use the yard daily.

## **I. WARD SCHEDULE**

Patients are awakened at 7:00 a.m. and are expected to eat breakfast, take care of personal hygiene, and clean their personal living areas by 9:30 a.m.

Recreation and therapy activities occur at various times throughout the day and evening, and a continually updated schedule is posted on the ward. Each patient receives his individual schedule that is updated as changes occur. Whenever possible, clinics are scheduled to avoid conflict with treatment groups.

Patients are given the opportunity to use the secure yard daily, usually from 12:30 p.m. to 2:00 p.m. or 3:00 p.m. to 4:00p.m. and again after dinner during summer months.

The ward has community meetings Monday through Friday at 8:45AM and Wednesday at 6:00 PM to discuss issues related to the ward.

Ward staff meets at each change of shift to review each patient's status and to discuss other ward matters as appropriate. On Tuesday and Thursday, the Interdisciplinary Team meets with the ward staff.

Oregon State Hospital

**FORENSIC PSYCHIATRIC SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 50F**

**A. SERVICE PHILOSOPHY**

Unit 50F provides mental health care, custody and treatment services primarily to persons with both mental illness and substance abuse who have been placed under the jurisdiction of Psychiatric Security Review Board (PSRB). Most patients receiving services on this unit have multiple problems such as mental illness, substance abuse or dependency, and poor work histories.

All patients will be treated with dignity and respect and will have individualized treatment plans. Treatment Care Plans (TCPs) and the therapeutic milieu will emphasize patient responsibility and empowerment.

Patients on this unit will be returning to a community setting and will require mental health treatment and recovery skills training to increase their options and opportunity for pro-social success in the larger community. Vocational skills are a significant determinant of successful tenure.

All patients are expected to participate actively in planning their multi-faceted treatment and recovery. They will also create a relapse plan and foster a personal recovery vision, and, upon discharge or conditional release, will commit to participating in ongoing recovery from the effects of mental illness and substance use.

**B. POPULATION**

Several demographic descriptions can be summarized. The following observations are based on a snapshot of 43 residents in August 2008:

**Gender:**

Male	100%
Female	0%

**Age:**

18-19	0%
20-29	23%
30-39	33%
40-49	16%
50-59	23%
60-69	5%

**Commitment Type:**

PSRB Commitments	70%
PSRB Revocations	30%

**Primary Diagnoses (four highest incidences):**

295.30 Schizophrenia, Paranoid Type	21%
295.70 Schizoaffective Disorder	19%
298.9 Psychotic Disorder NOS	16%
296.4 Bipolar I Disorder, Most Recent Episode Manic/Hypomanic, Unspecified	9%

**Ethnicity:**

White, non-Hispanic	79%
Black, non-Hispanic	9%
Hispanic, Mexican	5%
Hispanic, Other	5%
American Indian	2%
Asian	2%

**Marital Status:**

Never Married	70%
Divorced	14%
Married	12%
Separated	5%
Widowed	2%

**PSRB Clientele:**

Yes	100%
No	0%

**County of Commitment:**

Multnomah	30%
Washington	14%
Lane	9%
Jackson	7%
Marion	7%
Clackamas	5%
Deschutes	5%
Polk	5%
Union	5%
Clatsop	2%
Coos	2%
Harney	2%
Klamath	2%
Lake	2%
Umatilla	2%
Yamhill	2%

## **C. CLINICAL SERVICES**

Unit 50F specializes in services to individuals with substance abuse problems.

Services offered to individuals take into account both their legal and mental status, and are based on individualized assessments and TCP. TCPs are developed and implemented by the patient and the Interdisciplinary Treatment Team (IDT) consisting of a Psychiatrist, Unit Director, Psychologist, Mental Health Specialist, Social Worker, Nurse, Rehabilitation Services staff, and direct care Mental Health Therapy staff.

Each individual admitted to this unit will have an assigned primary nurse and a case monitor, who will assist in implementing the TCP. These staff will coordinate treatment services, advocate for and assure that the person's personal goals are considered in the plan, monitor that services are provided as planned, and assess the person's response to these services.

People are involved in treatment services on and off the unit, and on and off grounds to obtain and practice the skills to manage their mental illness and reside in a community setting without using alcohol or other drugs. All who are admitted to the unit are offered classes and therapy groups in substance abuse education (if applicable), wellness education, symptom management, and relapse prevention.

The IDT on this unit stresses the importance of pro-social interpersonal connections, community re-integration, and pre-vocational and vocational skills as they relate to successful community tenure. The team works closely with OSH programs such as Vocational Rehabilitation, Supported Employment, Quest Education, Supported Education, Co-occurring Disorders, and Community Re-Integration.

All patients who have committed a sex-related offense will be referred for a sex offender evaluation and will be enrolled in treatment while residing on 50F.

TCPs are reviewed at 30 to 90 day intervals, depending on length of stay. The IDT reviews the status of each patient daily at shift change.

Treatment groups and classes are scheduled on a quarterly basis on 50F. Most groups and classes will be completed within the same quarter; however, some groups will require two or more quarters.

### **1. Recovery Program (Including Alcohol and Drug Abuse treatment):**

The treatment program offered on Unit 50F in FPS is broad-based and attempts to positively impact all participants in the following areas:

- a. Orientation groups
- b. Substance abuse
- c. Vocational/Education services
- d. Treatment and management of mental illness
- e. Healthy living skills
- f. Recovery potentials and skills
- g. Community re-integration

**D. ADMISSION, DISCHARGE AND CONTINUED STAY CRITERIA**

**1. Admission Criteria:**

- a. Adult male, under jurisdiction of PSRB.
- b. Psychiatrically and medically stable to the extent that they can adequately manage themselves on a medium security unit.
- c. No immediate threat or recent history of sexual and/or assaultive acting out.
- d. Able to participate actively in unit programming.
- e. Compliant with recommended medication regime.
- f. Documented history of substance abuse/dependency and/or other addictions, and/or
- g. Documented history of pervasive personality disorder that has resulted in legal and other life-disruptive problems.

**2. Continued Stay Criteria:**

- a. The client complies with basic unit and program rules and policies, and is not considered a significant security risk or a disruptive influence within the unit community.
- b. The client is making continual and reasonable progress toward completion of the goals identified in the treatment plan.
- c. The client continues to demonstrate a need for medium-security.

**3. Criteria for Return to Higher Level of Security:**

- a. The client is non-compliant with basic unit and program rules and policies to the extent that unit safety, security, and therapeutic milieu are significantly compromised.
- b. The client exhibits physically or sexually aggressive behavior towards others.
- c. The client's current psychiatric or mental condition is beyond the scope of care or treatment that can be offered on a medium-security unit.

**4. Criteria for Transition to Lower Level of Security or Community:**

- a. The client appears to have gained maximum benefit from the current treatment episode, as evidenced by:
  - Completion of all treatment care plan goals and/or

- Demonstrated behavior consistent with minimum security

## E. EDUCATION SERVICES

Patients between the ages of 18 and 21 may be eligible for educational services through the local school system. Adults over the age of 21 who do not have a high school diploma or GED are expected to enroll in GED course work or pursue other literacy and community college services. All patients are encouraged to participate in continuing education through the Learning Lab or by using the Computer Lab.

## F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION

### 1. Staffing by Shift:

Class	Day	Swing	Night
Unit Director	1		
Physician Specialist	1		
MH Supervising Nurse	1		
Clinical Psychologist	1		
Psychiatric Social Worker	1		
Mental Health Specialist	1		
Occup Rec Asst	.5		
Unit Clerk	.5		
MH Staff Nurse	2	2	1
MHTC	1		
MHTSC	1		
MHT2	1	2	
MHT1	3	4	
MHTT			3

### 2. Minimum Staffing :

Shift by shift, there is a system in place whereby the Unit Director, the MHSRN, and/or the Program Associate Director of Nursing reviews patient census and acuity to determine if additional staff are needed beyond the minimum, or if staffing can be decreased in response to a change in patient acuity.

### 3. Administrative and Clinical Supervision:

The Unit Director is responsible for the overall administration of the unit, including program development and coordinating and monitoring implementation and progress toward goals and objectives in the individualized TCP. The Supervising RN assures that nursing care needs of the patients are met and works closely with the Unit Director in the overall administration of the unit.

Clinical Supervision is provided according to this plan and the resources available.

Clinical supervision will be provided to all staff to assure that support and clinical services delivered to patients on this unit are the highest quality. This plan also establishes the guidelines under which the unit-based credentialed staff will provide clinical supervision to the MHT staff.

- a. Those staff who are credentialed by their respective disciplines receive clinical supervision through their discipline according to that discipline's standard of practice.
- b. Clinical supervision of MHT staff is intended to:
  - Improve patient care delivered by MHT staff by assisting in their development of new knowledge and skills;
  - Improve patient care provided through the discussion and proactive response to clinical problems; and
  - Assist in the professional development of non-privileged clinical staff.

The Psychiatrist is the clinical leader on the treatment unit. As the clinical leader, he/she will provide clinical oversight to professional staff that will in turn provide clinical supervision to direct care staff.

The Unit Director and Mental Health Supervising RN will meet with the professional staff individually to help delineate issues that require administrative rather than clinical supervision and action.

The Psychologist, Social Worker, and Mental Health Specialist will function as clinical supervisors. In this capacity, they will provide:

- Group supervision for at least one-half hour each week for a small group of direct care staff, and
- Individual clinical supervision to each group member for at least one-half hour each month.

Clinical supervision will cover such topics as transference and counter-transference, case monitor responsibilities, clinical performance, and professional development.

MHT and nursing services staff will be paired in clinical teams by the IDT. Staff will be assigned to the clinical teams based upon their work shifts and interest in working with specific patient populations.

Each team will have the responsibility of providing:

- a. Case management for patients, and
- b. Assurances that TCPs are completed in a timely and quality manner.

Each clinical team will meet at least weekly to assure that all staff assigned to the team are active participants in the treatment decisions and the clinical supervision process.

Staff members will be expected to lead or co-lead patient structured activities, skill building groups, psycho educational groups, or psychotherapeutic groups.

<b>Position</b>	<b>Administrative Supervision</b>	<b>Administrative Supervisor</b>	<b>Clinical Supervision</b>	<b>Clinical Supervisor</b>
Unit director	Individual meetings as needed; weekly group meeting	Program Director		
Staff Physician	Individual meetings as needed; monthly supervision	Program Director		Chief Medical Officer
Psychologist I	Individual meetings as needed; biweekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Chief Psychologist
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Director of Social Work
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Chief Psychologist
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Director of RSD
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Associate Director of Nursing		Associate Director of Nursing
Staff Nurse	Individual meetings as needed; weekly supervision	MHSRN & Unit Director	Weekly meetings; daily contact and individual meetings as needed. Weekly sessions focused on milieu management and TCP interventions.	MHSRN  Clinical Supervisor
MH Therapy Coordinator	Individual meetings as needed; weekly supervision	MHSRN & Unit Director	Daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	Shift RN  Clinical Supervisor

<b>Position</b>	<b>Administrative Supervision</b>	<b>Administrative Supervisor</b>	<b>Clinical Supervision</b>	<b>Clinical Supervisor</b>
MH Therapy Shift Coord.	Individual meetings as needed; weekly supervision	MHSRN & Unit Director	Daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	Shift RN  Clinical Supervisor
MH Therapist 2	Individual meetings as needed; weekly supervision	MHSRN & Unit Director	Daily supervision for CNA/CMA related assignments. Weekly supervision of case monitor activities; weekly group supervision for skill building or psychoeducational groups/classes. Monthly individual supervision.	Shift RN  Clinical Supervisor
MH Therapist 1	Individual meetings as needed; weekly supervision	MHSRN & Unit Director	Daily supervision for CNA/CMA related assignments. Weekly supervision of case monitor activities; weekly group supervision for skill building or psychoeducational groups/classes. Monthly individual supervision.	Shift RN  Clinical Supervisor
Unit Clerk	Individual meetings as needed	Unit Director		

NOTE: Assigned clinical supervisors include the unit Psychologist, Mental Health Specialist, and Social Worker.

#### **G. PATIENT MANAGEMENT**

The patients on the unit elect a patient government. This body conducts unit meetings at least one time per week and oversees patient compliance with unit and milieu rules.

Staff attend these unit meetings and participate with training, problem solving, and announcements or when invited by the governing group.

- **Forensic Risk Review:**

- a. The Forensic Risk Review Board has the primary responsibility for making decisions that could impact the security of patients, staff and the community. Most privileges that concern a patient's movement off of their assigned unit must have Risk Review Board approval. These privileges are granted based on security and clinical issues.
- b. Each patient must have a Custody/Classification Request form completed and in their chart. This form, along with a current photo, will be taken to the Forensic Risk Review Board when the treatment team first request privilege(s) that allows the patient to leave the secure perimeter. The Forensic Risk Review Board will return the Privileges Granted form that will list current privileges. Once this process is completed, any change in privileges must be requested of the Forensic Risk Review Board. If a change is desired in the current privilege level, the following procedures must be followed:
  - The patient discusses with his/her case monitor a desire to change privilege level(s). If the case monitor agrees that the patient is ready for the requested privilege level, he/she will take the request to the treatment team for approval.
  - When IDT approves the request, the social worker will prepare a packet consisting of the Custody/Classification Request form and a current photo of the patient, and
  - The Risk Review Board will review the request at that time and send to the unit the Forensic Risk Review Board Privilege Granted Form updating the patient's privileges. Upon receipt of this form, a new order will be written in the patient's medical chart updating his privileges.
- c. Privileges concerning the type of custody (maximum, close, medium, or minimum), type of on-grounds or off-grounds privileges, and any other restrictions or conditions are all granted by this process.

## **H. PHYSICAL ENVIRONMENT**

Unit 50F is one of two remodeled units on the 3<sup>rd</sup> floor of the Eola Hall. The unit has four two-person bedrooms, five four-person bedrooms, and two six-person bedrooms, as well as TV viewing and recreation areas. The unit is maintained by patients and staff.



Oregon State Hospital

**FORENSIC PSYCHIATRIC SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 50G**

**A. PROGRAM DESCRIPTION**

**1. Service Philosophy and Value Principles:**

Unit 50G is a 40-bed all male treatment ward. The Unit uses a recovery-based treatment model. The Unit serves forensic, PSRB patients who have psychiatric disabilities and skill deficits that impede their placement into the community. The goal of Unit 50G is to teach patients social and community integration skills that will improve their opportunities for return to the community, enhance their life experience and decrease their risk of re-offending.

As part of the Unit Mission, we hold to the basic values;

- a. Healing occurs in a safe/connected environment, free of violence of any kind. Individuals have hope for recovery from life trauma and illnesses.
- b. Individuals are treated with respect and compassion.
- c. Individuals are the consumers and providers of their own care.
- d. Individual choice and responsibility is maximized.
- e. Decision-making is a shared process.
- f. Opportunities to learn and grow are valued and encouraged.
- g. Learning and growing take place in a social context and through interpersonal interactions.
- h. Although individuals may not always be in control of their symptoms or emotional responses, they can learn to manage and/or control the behaviors associated with them and thereby live more managed lifestyles.

**B. GOALS, OBJECTIVES AND EXPECTED OUTCOMES**

- 1. **Utilization:** 100% of beds will be utilized on a monthly average. 90% of the patients on 50G will be actively moving toward Conditional Release.

2. **Services Provided:** All patients on 50G will be given skill training in managing their mental illness, in community living skills and in managing problematic behaviors associated with their past criminal activities. Each patient is stabilized on psychotropic medication as appropriate and monitored on a monthly basis. Medical problems are treated as they occur with referral to the medical clinic, if necessary.
3. **Completed Treatment:** 85% of the revoked patients on the unit will complete the program and be conditionally released within 24 months from admission to a Community Facility.
4. **Continuum of Care:** 100% of the PSRB/Revoked patients completing the program will have completed a relapse prevention plan and be involved in an aftercare program. The goal is for one patient per month to be released into community care.

### C. POPULATION

Unit 50G became a treatment ward in September 2004 and serves persons admitted under the following six criteria:

1. Persons admitted for initial commitment to the Psychiatric Security Review Board.
2. Persons under the jurisdiction of the Psychiatric Security Review Board on Conditional Release status who voluntarily return to Forensic Evaluation and Treatment Services as part of managing symptoms of their mental illness.
3. Persons under the jurisdiction of the Psychiatric Security Review Board on Conditional Release status who fail to comply with their prescribed community based treatment plan and are revoked by the Board pursuant to ORS 161.336.
4. Persons residing on Units of similar security level whose level of progress indicates access to a sanctuary ward would increase their potential for further progress.
5. Persons residing on less secure Units who exhibit behaviors that constitute a clear and convincing danger to self or others, are unable to be maintained in the less restrictive environment, but who are not in need of maximum security level treatment.
6. Persons referred by court order under ORS 161.370 for treatment until able to aid and assist their attorney in a criminal court case.

#### Gender:

Male	100%
Female	0%

#### Age:

18-19	0%
20-29	32%
30-39	37%
40-49	17%
50-59	15%
60-69	0%

**Grades Completed:**

12 & Over	%
9 – 11	%
6 – 8	%
Under 6	%

**Ethnicity:**

White, non-Hispanic	80%
Black, non-Hispanic	7%
American Indian	5%
Hispanic, Mexican	2%

**Marital Status:**

Never Married	83%
Divorced	2%
Married	7%
Separated	2%

**PSRB Clientele:**

Yes	100%
No	0%

**Counties of Commitment:**

Multnomah	32%
Lane	17%
Marion	12%
Deschutes	7%
Clackamas	5%
Josephine	5%
Klamath	5%
Clatsop	2%
Douglas	2%
Jackson	2%
Linn	2%
Union	2%

**Primary Diagnosis (From Highest)**

295.3	Schizophrenia, Paranoid Type	10%
298.9	Psychotic Disorder, NOS	17%
295.7	Schizoaffective Disorder	24%
296.4	Bipolar I Disorder, Most Recent	7%
	Episode Manic/Hypomanic, Unspecified	

**D. CLINICAL SERVICES**

**1. Overview:**

Unit 50G focuses on providing the resources to assist patients to develop skills they need to survive in the community without re-offending. The primary emphasis of the program is on the recognition and promotion of the strengths and resources of the individual patient

in their development of positive problem-solving skills necessary for their continued stay in the community.

**2. Program Goals:**

In working towards the achievement of the stated mission, 50G provides a transitional living experience for selected patients of the Forensic Psychiatric Services at the Oregon State Hospital. The major goals of 50G are:

- To provide resources that patients can utilize to prepare for employment and/or educational activities in the community.
- To provide resources for patients to utilize in developing constructive leisure activities of interest to them.
- To provide educational opportunities for patient to learn about their illness, the medications they need to manage the symptoms of their mental illness, their own signs of impending relapse and a relapse prevention plan for use in the community.
- To assist each patient in the development of an extensive community socialization network while on 50G and in those skills, to development such a network in community of discharge.
- To provide resources for each patient to learn essential living survival skills such as cooking, budgeting, transportation, basic household maintenance, household safety, effective communication, etc.
- To assist each patient to develop positive problem-solving skills, both as individuals and as members of a group.

**3. Goal Attainment:**

The framework for the overall treatment program on 50G is provided by the principles of the Recovery Model of treatment. These principles provide for the program to focus on the empowerment of the individual patient. Patients are involved in all phases of their treatment. Each staff member is a resource to the patient to utilize as they develop new accepted problem-solving skills. Functional assessments of the patient's abilities are tools for patients to utilize as they determine those areas they need further help with to assist them in attaining their goals within the community. Educational modules will be offered by staff in the areas of greatest need for the current patients of 50G. Should a patient have a particular educational need not being offered in a group setting, the education will be provided utilizing the skills of the staff on a one-to-one basis.

**E. ADMISSION/TRANSFER, CONTINUING CARE AND DISCHARGE/TRANSFER CRITERIA**

**1. Justification for Admission:**

The following criteria describing the patient's current condition indicate that the patient may seek admission to 50G.

- The patient is stabilized on psychotropic medication (if applicable.)
- The patient is assessed as posing minimal current risk for sexually or physically aggressive behavior against others.
- The patient is behaviorally, medically and mentally stable enough to benefit from participation on a treatment/transition unit.
- The patient could benefit from participation in the 50G Recovery Model. Priority consideration will be given to those patients who have identified skill deficits and who would benefit from a recovery model of treatment.

**2. Justification for Continued Stay:**

Documentation of two or more of the following:

- The patient complies with basic unit and program rules and policies and is not considered a security risk or a disruptive influence within the community.
- The patient is making continual and reasonable progress toward completion of the goals identified in the treatment plan.
- The patient continues to show a need for a transitional level of care as demonstrated by mental/emotional instability, social deficits; or needs protection from victimization in another setting; or an appropriate less restrictive environment is not available.

**3. Justification for Return to Higher level of Security:**

Documentation of one or more of the following:

- The patient, after assessment, is found not to meet the admission criteria for 50G.
- The patient is non-compliant with basic unit and program rules and policies to the extent that unit safety, security and therapeutic milieu are significantly compromised.
- The patient exhibits physically or sexually aggressive behavior towards others.

**4. Discharge Criteria:**

- Has achieved maximum benefit from current treatment and not mentally or emotionally unstable.
- Has benefited from current treatment for conditional release or discharge.
- Has benefited from current treatment and appropriate for transfer to another treatment program/modality.

## **F. EDUCATION**

### **1. Patient Education:**

Patients have the opportunity to attend Education Lab Classes (for GED and other needs) in Eola Hall as well as attend classes at Chemeketa Community College. CTU also provides psycho-educational modules.

### **2. Family Education:**

Patients' family members will be invited to attend IDT meetings. Pre-visitation interviews are conducted by the case manager. Information provided through OSH is also given to the families of patients and information is shared regarding medication for those family members who function as pass supervisor.

## **G. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **1. Staffing by Shift:**

<b>CLASS</b>	<b>DAY</b>	<b>SWING</b>	<b>NIGHT</b>
Unit Director	1		
Physician Specialist	1.5		
Clinical Psychologist	1		
Psychiatric Social Worker	1		
Mental Health Specialist	1		
Rehabilitation Therapist	1		
MH Supervising RN	1		
MHRN	2	2	2
MHTC	1		
MHT 2	1	2	
MHT 1	4	3	
MHTT	1	2	4
Ward Clerk	1		

### **2. Procedure for Supervision:**

The Organizational structure and leadership for the program flows administratively and clinically. The OSH Superintendent is the individual appointed by the governing body to act on its behalf in managing the hospital. The Chief Medical Officer oversees the clinical aspects of the hospital. Administrative supervision flows from the Superintendent to the Program Director, Unit Director and other management staff. Clinical supervision flows from the Chief Medical Officer to clinical discipline directors, who set standards of practice for each of their disciplines and through members of the Medical and Allied Health Professional staff who are clinically credentialed and privileged. Unit Directors provide leadership by defining the therapeutic program and services to specialized patient cohorts and the unit physician provides the clinical supervision of staff that are not

independently credentialed and privileged to practice. The Unit Director is a qualified mental health professional who directs and supervises all treatment in a partnership with the unit physician. At the unit level, qualified mental health professionals, including unit director, psychologist, mental health specialist and psychiatric social workers provide clinical supervision to direct care staff.

POSITION	FREQUENCY AND TYPE OF SUPERVISION	SUPERVISOR
Unit Director	Individual meetings on as needed basis; weekly peer supervision meeting	Program Director
Staff Physician	Weekly	Program Director; Chief Medical Officer
Clinical Psychologist	Weekly	Unit Director; Chief Psychologist
Psychiatric Social Worker	Weekly	Unit Director; Director of Social Work
Rehabilitation Therapist	Weekly	Unit Director; Rehabilitation Therapy Supervisor
Mental Health Specialist	Weekly group or individual meeting	Unit Director; Chief Psychologist
Mental Health Supervising Nurse	Weekly group or individual treatment	Unit Director; Assoc. Director of Nursing
Mental Health Therapy Coordinator	Weekly group or individual meeting	Unit Director
Mental Health Therapist 2	Weekly individual; Group supervision; Daily contact	MH Supervising RN
Mental Health Therapist 1	Weekly individual; Group supervision; Daily contact	MH Supervising RN
Mental Health Therapy Technician	Monthly meeting	MH Supervising RN
Ward Clerk	Daily contact	Unit Director

## H. PATIENT MANAGEMENT

50G provides the patient with the opportunity to develop the skills they need to survive in the community without re-offending. The patient is expected to actively participate in their treatment through interaction with staff and peers. Program schedules describe the resources that are available within the program and the expectations of patients as they participate in that program.

### 1. Risk Review Board:

The Forensic Risk Review Board has the primary responsibility for making decisions that could impact the security of patients, staff and the community. All privileges that concern patient movement are granted based on security and clinical issues.

- a. Each patient must have a Risk Review Request form completed and in their chart. This form, along with a current photo, will be taken to the Risk Review Board

when the treatment team first request privilege(s) that allows the patient to leave the unit. The Risk Review Board will return the revised form that will list current privileges granted. Once this process is completed, any change in privileges must be requested of the Risk Review Board.

## **I. PHYSICAL ENVIRONMENT**

50G is located on the fourth floor of the 50 Building on Oregon State Hospital grounds, 2600 Center St. NE, Salem, Oregon 97301. The unit has access to multiple secure yards, garden beds, recreation center, canteen, gymnasium, fitness room, school, computer lab, visitors center and chapel. Additionally, patients with on-grounds privileges have access to a swimming pool, tennis courts, health and nature walks, and a managed café. Patients with off-grounds privileges have an opportunity for community-delivered treatment services and recreational outings.

OREGON STATE HOSPITAL  
FORENSICS PROGRAM SERVICES  
CLINICAL UNIT DESCRIPTION  
Unit 50H

**A. SERVICE PHILOSOPHY**

Forensic Evaluation and Treatment Services Unit 50H provides admission, mental health evaluation and treatment services in a medium security forensic setting. The focus is the delivery of mental health services based on the individual's strengths and needs. Services are based on comprehensive admission evaluations by Psychiatry, Psychology, Social Work, Nursing, and Rehabilitation Services.

The primary mission is to treat and educate people, to help them gain or regain fitness to proceed in a criminal trial.

**B. POPULATION**

Unit 50H is a 35-bed unit providing services to adult men admitted in compliance with Oregon Revised Statutes:

- ORS 161.370 for treatment to restore fitness to proceed in a trial. As soon as a patient is deemed able to aid and assist in his legal proceedings, he will be returned to the county of origin to complete his legal process.
- ORS 426.127, for civil commitment. If it is deemed that a patient will never be restored to competency, the patient will be returned to his county of origin. The county will then determine if a civil commitment is required for the safety of the patient or others.

**Age:**

18-19	0%
20-29	13%
30-39	33%
40-49	20%
50-59	30%
60-69	5%
70-89	0%

**PSRB:**

Yes	2%
No	98%

**Axis 1 Diagnosis (first 4 most common):**

298.9 Psychotic Disorder	48%
295.3 Schizophrenia, Paranoid Type	19%
295.9 Schizophrenia, Undifferentiated Type	10%
295.7 Schizoaffective Disorder	7%

**Race:**

White, not Hispanic	69%
Black, not Hispanic	19%
Hispanic, Mexican	5%
Southeast Asian	5%
American Indian	2%

**County of Commitment:**

Multnomah	33%
Lane	19%
Marion	12%
Douglas	7%
Washington	7%
Linn	5%
Clackamas	2%
Clatsop	2%
Jackson	2%
Malheur	2%
Umatilla	2%
Wasco	2%
Yamhill	2%

**Marital Status:**

Never Married	93%
Divorced	2%
Married	5%
Separated	0%
Widowed	0%

**Education Level Completed:**

17 <sup>th</sup> - 20 <sup>th</sup>	%
13 <sup>th</sup> - 16 <sup>th</sup>	%
9 <sup>th</sup> - 12 <sup>th</sup>	%
8 <sup>th</sup> - 6 <sup>th</sup>	%
1 <sup>st</sup> - 5 <sup>th</sup>	%
None	%

**C. CLINICAL SERVICES**

Clinical services are focused through the Treatment Care Plan by providing clear steps to resolve the presenting problem(s) that led to admission. Each individual admitted shall have a completed Baseline Assessment in the areas of Activities of Daily Living, Intellectual Functioning, Educational Skills and Psychosocial Development.

For those committed following ORS 161.370, treatment services focus on helping individuals to aid and assist in their own defense against criminal charges. Education is provided to enable the defendant to understand the nature of the proceedings against them as well, as to assist the defendant to cooperate with their counsel. For those and all other patients on 50-H, therapeutic

activities help each to address skill deficit areas, manage the symptoms of their mental illness and manage their medications. Groups provide information and offer an opportunity for discussion. Individual tutoring for patients who learn better in a one to one setting is provided as needed.

The Interdisciplinary Treatment Team (IDT) integrates assessments into an Individualized Treatment Care Plan. The IDT includes all of the unit staff. The members that gather for formal treatment planning include the psychiatrist as the clinical leader, clinical psychologist, psychiatric social worker, rehabilitation therapist, mental health specialist, registered nurse, the patient's case monitor, unit director, the patient, and others identified as significant to the individual's treatment.

Families are encouraged to visit and join support groups like the "Friends of Forensics". Brochures about mental illnesses are provided to families. With a signed release of information form, families are given information by the Registered Nurse, social worker, mental health specialist, or unit director. Patients will be offered the ability to have family members participate in the IDT meetings.

All persons admitted to the unit are assigned a case monitor and a primary registered nurse. This enables the person to have a fixed point of support and promotes communication regarding their treatment and progress made. First the underlying mental disorder if present is treated through medication and/or psychosocial rehabilitation.

#### **D. ADMISSION, CONTINUING CARE, AND DISCHARGE CRITERIA**

##### **1. Admission Criteria:**

Patients will receive services on the unit by transfer from an admission unit or by direct admission after screening for appropriateness.

Males 18 years of age or older, and determined by the courts as unfit to proceed as a result of mental disease or defect and committed under ORS 161.370.

Males committed by court order for up to 30 days for evaluation of fitness to proceed (ORS 161.365) or criminal responsibility (ORS 161.315).

##### **2. Continued Care:**

Patients committed under ORS 161.370 who continue to be unfit to proceed and are psychiatrically unstable.

##### **3. Discharge Criteria:**

When Patients are recommended to the court as able to participate in trial or as unlikely to become fit to proceed in a trial despite treatment, they are returned to the county jail, or returned to the custody of the Department of Corrections.

#### **E. EDUCATION SERVICES**

Educational services are provided under contract with Willamette Education Services District for those persons admitted to the unit who are between the ages of 18 and 22 and

who meet the criteria set forth in Public Law 94-142.

Adult basic education is available, upon referral, from the adjunctive treatment program in 50 Building Treatment Mall. A computer-learning lab is available within the building. A law library is available.

## **F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

### **1. Staffing for Unit 50H includes: FTE**

Unit Director	1.0	
Psychiatrist	1.5	
Psychologist	1.0	
Psychiatric Social Worker	1.0	
Rehabilitation Services Therapist or Occupational Therapist		1.0
Mental Health Specialist	1.0	
Supervising Registered Nurse	1.0	
Registered Nurse	6.0	
MH Therapy Coordinator	1.0	
MH Therapist II	3.0	
MH Therapist I	9.0	
MH Therapy Technician	10.0	
Office Specialist 2	1.0	

### **2. Minimum Staffing:**

<b>Staff type</b>	<b>Day</b>	<b>Swing</b>	<b>Night</b>
RN	1	1	1
MHTs	4	4	2

Clinical Supervision is provided according to this plan and necessary resources available.

Unit 50H has a clinical supervision plan to provide non-privileged MHT staff with supervision by unit-based privileged professional, credentialed staff. The unit credentialed staff receives clinical supervision through their professional disciplines according to the discipline's established standards of practice and ethics. Clinical supervision of non-privileged MHT staff is to:

- Improve patient care by assisting MHT staff in the development of new skills and knowledge;
- Improve patient care through discussion and proactive responses to clinical problems;
- Assist MHT staff in their professional development.

Clinical supervision is provided to MHT staff on a formal basis weekly to identify and discuss issues of concern, i.e., boundary issues, transference/counter-transference, case monitor issues, therapeutic interventions and professional development plans for MHT staff.

**3. Procedure for Supervision:**

<b>Position</b>	<b>Frequency and Type of Supervision</b>	<b>Administrative Supervisor</b>	<b>Clinical Supervisor</b>
Unit Director	Individual meetings as needed; weekly supervision	Associate Program Director	N.A.
Staff Physician	Individual meetings as needed	Program Director	Forensic Supervising Physician
Clinical Psychologist I	Individual meetings as needed; weekly supervision	Unit Director	Chief of Psychology
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	FETS Supervising Social Worker
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Unit Psychologist
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Director of RSD
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Unit Director	Assoc. Director of Nursing
Staff Nurse	Individual meetings as needed; weekly supervision	MHSRN	MHSRN
Mental Health Therapy Coordinator	Individual mtgs as needed; daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu mngmt and TCP interventions.	MHSRN	Unit RN Unit Psychologist
Mental Health Therapists	Individual mtgs as needed; daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu mngmt and TCP interventions.	MHSRN	Unit RN Unit Psychologist Mental Health Specialist

NOTE: Assigned Clinical Supervisors for Therapy Services are those clinically privileged to provide staff clinical supervision. On Unit 50-H the Clinical Supervisors are the unit psychiatrist, psychologist, social worker, and mental health specialist. The RN staff is responsible for the clinical supervision of patient care provided by MHT staff, which falls under their CNA/CMA certificates under the State Board of Nursing.

## **G. PATIENT MANAGEMENT**

Persons on Ward 50H are encouraged to participate in psycho educational groups, recreational/leisure activities and in performing their activities of daily living. Patients are rewarded with points for each group, activity or ADL they complete. They spend these points weekly in an on ward store. Once earned, a patient never loses his points. Patients living on 50H are expected to treat each other and staff with respect. Physical and verbal violence is unacceptable. Serious violations of rules may result in restriction to the ward until the Interdisciplinary Team and the Patient resolve the issue. Patients may be transferred to maximum security for acts of violence. Persons residing on the ward participate in a weekly ward meeting, which gives them an opportunity to participate in decisions about their treatment environment, unit management, quality of life, and clarification of rules.

The ward does not generally allow persons outside the secure perimeter without transport restraints. Exceptions are made to accommodate special medical needs. Patients are given the daily opportunity to rest from activities and to enjoy the outdoors in a secure yard.

## **H. PHYSICAL ENVIRONMENT:**

Unit 50H is on the fourth floor of a wing of the 50 building within a secure perimeter. There are three, two-bed rooms and seven larger bedrooms, which are located off a common hallway. On the ward there are laundry facilities, bathrooms, showers, a kitchen, a dining room, a day room, and an activity center. Treatment groups are offered at the Treatment Mall on 50A. Some groups meet on the ward. The ward has access to three outdoor recreation yards, a recreation center, canteen, and gymnasium. Patients are given the opportunity to go to the outdoor recreation at least one time each day. Patients receive visitors in the 50 Building Visitor Center on the first floor.

## **I. UNIT SCHEDULE**

Treatment team meetings, therapy groups, educational activities, time in the outdoor recreation area, and patient ward meetings occur on a regularly scheduled basis. Adjunctive therapy is offered on the treatment mall. The schedule of activities is posted on the ward. All patients are offered the opportunity to participate in outdoor exercise. They are also offered access to religious services and structured activities daily, evenings, and on weekends.

The staff shifts overlap daily to communicate information on patient care and unit administrative issues. Once per week, a ward leadership meeting is held to discuss overall operation of the ward and significant patient care issues. This meeting includes the unit director, physician, psychologist, supervising RN, rehabilitation therapist, social worker, mental health specialist, and available nursing staff.

Oregon State Hospital  
**FORENSIC PSYCHIATRIC SERVICES**  
**CLINICAL WARD DESCRIPTION**  
**Unit 50I**

**A. SERVICE PHILOSOPHY:**

Forensic Psychiatric Services Unit 50-I is a 33-bed co-ed unit serving people from throughout the state of Oregon who are sentenced under the supervision of the PSRB, in a maximum/medium security environment. The unit is designed to provide assessment, stabilization, and community reintegration in a patient goal oriented setting.

Each patient admitted to the unit will have a comprehensive evaluation by Psychiatry, Psychology, Social Work, Nursing, and Rehabilitation Services.

An individualized Treatment Care Plan (TCP) is developed for each patient. Patients are encouraged and empowered to be an active participant in the development of the TCP. The IDT specifies goals to be obtained to move to a less restrictive treatment unit or to be returned to a community setting. Whenever possible, the patient's family is encouraged to participate in the treatment and recovery.

The treatment program recognizes the dual roles of treating people with mental illness as well as protection of society.

50-I holds the value of treating all patients with respect and dignity and 50-I continually seeks input and evaluation for improvement.

The overall philosophy of the treatment is to move people toward a less restrictive environment and return to a community setting.

**B. POPULATION:**

Ward 50-I serves primarily women, and a few men by transfer from other hospital units, who are in need of continuing treatment with a focus on community transition and reintegration. Patients are under the supervision of the Psychiatric Security Review Board.

**Age:**

18-19 yrs	0%
20-29 yrs	32%
30-39 yrs	36%
40-49 yrs	25%
50-59 yrs	7%
60-69 yrs	0%

**PSRB:**

Yes	100%
No	0%

**Axis 1 Diagnosis (first 4 most common):**

295.7	Schizoaffective Disorder	39%
295.3	Schizophrenia, Paranoid Type	14%
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features	11%
295.9	Schizophrenia, Undifferentiated Type	2%
309.81	Posttraumatic Stress Disorder	2%

**Race:**

White, non-Hispanic	96%
Black, non-Hispanic	4%

**County of Commitment:**

Clackamas	4%
Coos	7%
Deschutes	4%
Douglas	4%
Jackson	4%
Klamath	11%
Lane	18%
Lincoln	4%
Linn	4%
Marion	7%
Morrow	4%
Multnomah	25%
Washington	4%
Yamhill	4%

**Marital Status:**

Never Married	64%
Divorced	29%
Married	4%
Separated	4%
Widowed	0%

**Education Level Completed:**

13 <sup>th</sup> - 16 <sup>th</sup>	%
9 <sup>th</sup> - 12 <sup>th</sup>	%
8 <sup>th</sup> - 6 <sup>th</sup>	%
1 <sup>st</sup> - 5 <sup>th</sup>	%

**C. CLINICAL SERVICES:**

Clinical services are provided to patients based on an individualized Treatment Care Plans that focus on holistic treatment issues identified by the patient, family and staff. Regular scheduled reviews of the Treatment Care Plan are held to assess progress of short and long-term goals with new or additional goals discussed. Reviews are also held weekly during inter-shift meetings and when special circumstances arise.

All patients admitted to the ward are assigned a case monitor and a primary registered nurse. This enables the patient to have a specific person for communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment.

Professional staff provide case coordination services by meeting with the case monitor, primary registered nurse, and individually with patients. This provides monitoring of treatment services and outcomes as specified on the Treatment Care Plan. Services to enable patients to manage the symptoms of their mental illness, manage their medication. Substance abuse treatment or treatment for specific needs are provided at the 50 Building Treatment Mall and on the ward.

The 50 Building Treatment Mall is an adjunctive treatment ward located within the secure perimeter and available to patients from 50-I on a daily basis. Treatment groups also take place in the 40 Building for clients with on-grounds privileges.

Other rehabilitative services are offered in the 50 Building. These include recreational, vocational, educational, and music therapy. Vocational testing, prevocational and vocational services are provided at the Vocational Center on hospital grounds.

Patients receive the services of a licensed barber/beautician on a scheduled basis in the 50 Building salon area. All patients have access to the canteen, fitness, and gymnasium on a regularly scheduled basis.

All clinical activities are in accordance with the ward milieu and Treatment Care Plans. Privileged professional staff, as defined in Section F, supervises all groups facilitated by mental health therapy staff.

#### **D. ADMISSION, CONTINUING CARE AND DISCHARGE CRITERIA**

##### **1. Admission Criteria:**

- Women found guilty except for insanity that are committed under ORS 161.327 or ORS 161.328.
- Men transferred from other forensic wards who would benefit from a co-ed treatment ward discharge planning and who are not a danger to self or others.
- Women or men under PSRB jurisdiction whose conditional release is revoked under ORS 161.336 and whose psychiatric and behavioral conditions can be managed on a medium security ward.

##### **2. Continuing Care:**

Patients who continue to require hospital-level psychiatric care due to one or more of the following:

- Symptom severity;
- Behavioral control;
- Severe deficits in adaptive functioning;
- Potential risk to the community.

**3. Transfer To a More Restrictive Setting:**

- Women are not transferred to a more restrictive setting as the ward serves both maximum and medium custody status.
- Men who require acute psychiatric or behavioral management or pose a high risk of escape and potential harm to the community outside a maximum-security setting.

**4. Transfer To a Less Restrictive Setting:**

Patients who are psychiatrically stable, have had good behavioral control for six months, pose a low risk to the community, and would benefit from transfer to a specialty program and/or a less secure environment, or to a program with greater opportunities for learning and practicing more independent living skills.

**5. Discharge Criteria:**

Patients under PSRB jurisdiction who are no longer mentally ill or no longer present substantial danger to others will be recommended to the Forensic Risk Review Board and the PSRB for discharge.

Patients who remain mentally ill and present a potential danger to others, but can be adequately controlled and treated in the community under the supervision of PSRB, will be recommended to the Forensic Risk Review Board and the PSRB for conditional release.

Patients for whom existing court or PSRB jurisdiction has expired and who do not meet criteria for civil commitment will be recommended to the Forensic Risk Review Board for discharge.

Patients who are no longer in need of intensive evaluation or acute psychiatric or behavioral management and no longer pose a high risk for escape or unauthorized leave and potential harm to the community may also be considered under applicable OARs for transfer to other MHDDSD institutions.

Patients recommended for conditional release or discharge will have an understanding of the signs and symptoms of their illness, a personal relapse prevention plan, and a detailed plan for follow-up treatment and supervision in the community.

**E. EDUCATION SERVICES:**

Educational services are provided at the 50 Building Treatment Mall under contract with Willamette Education Service District for those patients admitted between ages 18 and 22, and who meet the criteria set forth in Public Law 94-142, handicapped education.

Adult basic education is available at the 50 Building Treatment Mall for those patients whose baseline assessment determines a need.

All patients have access to the computers in the Learning Lab or the patient computers on the ward. Pre-GED and GED coursework is available to all patients. Additionally through Learning Lab patients can take college level courses through various distance-learning programs delivered by both the Community College and University systems.

## F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION

### 1. Ward 50I is staffed as follows: FTE

Unit Director	1.0
Physician Specialist	1.0
Psychologist	1.0
Mental Health Specialist	2.0
Social Worker	1.0
Recreation Therapist	1.0
Mental Health Supervising Nurse	1.0
Mental Health Registered Nurse	6.0
MH Therapist II	3.0
MH Therapist I	8.0
MH Therapy Technician	7.0
MHT Coordinator	1.0
Ward Clerk	1.0

### 2. Minimum Staffing:

The following chart identifies the minimum staffing per shift.

Day and Swing shifts: 6 direct care nursing staff, one of which must be an RN.

Night shift: 3 direct care nursing staff, one of which must be an RN.

Shift by shift there is a system in place whereby the Ward MHSRN, Program MHSRN, and/or RN reviews the patient census and acuity to determine if additional staff are needed beyond the minimum, or if staffing can be decreased in response to a change in patient acuity.

### 3. Procedure For Supervision:

Position	Administrative Supervision	Administrative Supervisor	Clinical Supervision	Clinical Supervisor
Unit Director	Individual meetings as needed; weekly supervision	Program Director		
Staff Physician	Individual meetings as needed	Supervising MD	Individual meetings as needed; monthly supervision	Clinical Director or Chief Medical Officer

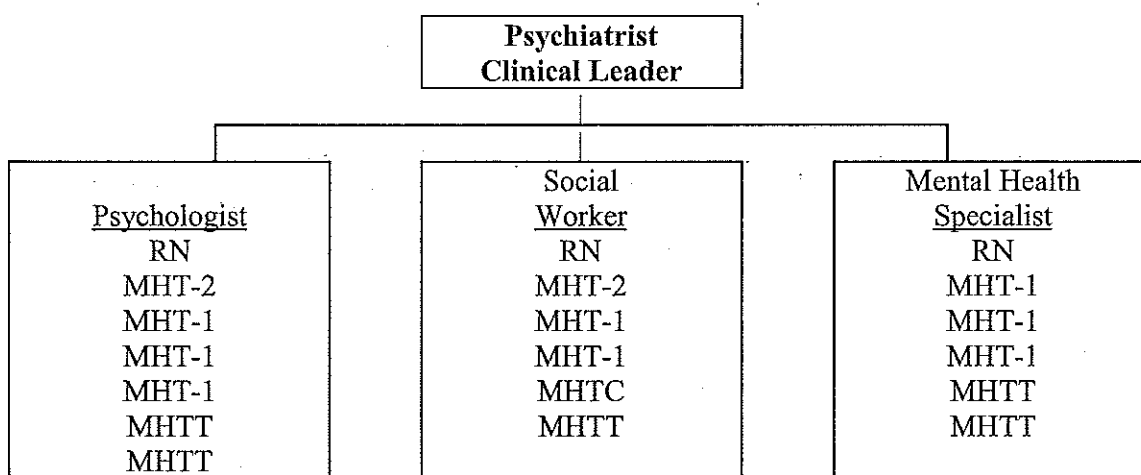
**Procedure For Supervision (cont.)**

Position	Administrative Supervision	Administrative Supervisor	Clinical Supervision	Clinical Supervisor
Clinical Psychologist	Individual meetings as needed; biweekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	FETS Psychologist 2
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	FETS Supervising Social Worker
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Discipline Director
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Discipline Director
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Assoc. Director of Nursing		Assoc. Director of Nursing
Staff Nurse	Individual meetings as needed; daily supervision	MHSRN	Weekly meetings; daily contact and individual meetings as needed; Weekly sessions focused on milieu management and TCP interventions.	MHSRN
MH Therapy Coordinator	Individual meetings as needed; daily supervision	MHSRN	Daily supervision for CNA/CMA related assignments; Weekly sessions focused on milieu management and TCP interventions.	QMHP
Mental Health Therapist 2	Individual meetings as needed; daily direct observation	MHSRN	Daily supervision for CAN/CMA related assignments. Weekly supervision of case monitor activities; weekly group supervision for skill building or psychoeducational groups/classes. Monthly individual supervision.	QMHP

**Procedure For Supervision (cont.)**

Position	Administrative Supervision	Administrative Supervisor	Clinical Supervision	Clinical Supervisor
Mental Health Therapist 1	Individual meetings as needed; weekly group supervision.	MHSRN	Daily supervision for CAN/CMA related assignments. Direct observation of skill building or psychoeducational and treatment groups. Weekly sessions focused on milieu management and TCP interventions.	QMHP
Mental Health Therapy Technician	Individual meetings as needed; weekly group supervision.	MHSRN	Daily supervision for CAN/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	QMHP

NOTE: Assigned clinical supervisors include the ward psychologist, mental health specialist, and social worker. The ward psychiatrist reviews supervision with all clinical supervisors monthly. Clinical supervision is provided according to this plan and necessary resources are available.



**G. PATIENT MANAGEMENT:**

Patients on Ward 50-I live in a maximum/medium security setting within a secure perimeter. Each of the requirements for the access to off-ward treatment activities is based on an assessment of the patients' ability to manage their behavior and benefit from treatment.

Patients residing on the ward participate weekly in a Ward Community Meeting. This gives patients the opportunity to participate in decisions about their treatment environment, ward management, quality of life, and clarification of rules. Some patients also attend Consumer Group weekly, which is a forensic patient self-advocacy group that meets at 50 Building Treatment Mall.

Patients granted privileges through the Risk Review Board may have various privileges ranging from travel within the secure perimeter to conditional release planning outside the secure perimeter without restraints.

## **H. PHYSICAL ENVIRONMENT:**

Ward 50-I is located on the top floor of 50 Building. It was completely remodeled in 1992 and offers an environment for co-ed interactions in a treatment environment. Ward 50-I has its own dayroom, recreation room, patient treatment area, and laundry. The kitchen and dining room are shared with the adjoining Ward, 50J.

The ward has 17 single rooms and 8 double rooms, plus wide hallways with skylights, which enhance the attractiveness of the ward.

Additional areas for treatment are available within the secure perimeter in the Treatment Mall on 50A and 50B.

The Ward has access to three secure yards, garden beds, recreation center, canteen, gymnasium, fitness room, school, computer lab and chapel for all patients. Additionally patients with on-grounds privileges have another garden space, swimming pool, tennis, health and nature walks, a managed café and other various recreational activities. Patients with off-grounds privileges have an opportunity for community delivered treatment services and recreational outings. Approved visitors may visit in the Visitors Center.

## **I. WARD SCHEDULE:**

All patient activities are posted on an easily identified Activity Schedule board for patients to read. Each patient has regularly scheduled meetings with the treatment team in which their treatment and activity schedules are reviewed.

Ward staff overlap each shift daily to communicate information on the therapeutic milieu. Twice a week the shifts meet to discuss program needs and changes. Once per week a leadership meeting is held to discuss overall operation of the ward and significant patient care issues.

Patients are awakened between 6:30 and 7:00 a.m.

Patients are offered the opportunity to go outside each day.

Some IDT members work at least one evening each week to extend services to patients and provide clinical supervision to other staff.

All patients will be scheduled for at least 20 hours per week of treatment, or as recommended by the treatment team due to individual abilities.



Oregon State Hospital  
**FORENSIC EVALUATION AND TREATMENT SERVICES**  
**CLINICAL UNIT DESCRIPTION**  
**Unit 50J**

**A. SERVICE PHILOSOPHY:**

Forensic Evaluation and Treatment Services Unit 50J is a 35-bed unit providing admission evaluations, treatment, and psychiatric rehabilitation for women and men from throughout the state of Oregon in a medium security setting.

All patients admitted to the Unit will have a comprehensive evaluation by Psychiatry, Social Work, Nursing, and Rehabilitation Services.

All patients will be assisted in understanding and managing their mental illness in a manner which gives them more control of their own treatment and recovery.

All patients will be treated with dignity and respect with emphasis on their abilities rather than their disabilities.

Each patient will receive individualized services as specified in his or her Treatment Care Plan, with goals of return to court as fit to proceed, preparation for conditional release, or movement to the least restrictive environment possible.

**B. POPULATION:**

At this time, Unit 50J serves 26 patients. The unit primarily serves women patients. They occasionally provide services to male patients under ORS 161.370 who have no history of sexual offenses or violence against women.

**1. Focus of Treatment:**

To provide treatment and rehabilitation to improve mental status and relieve acute symptoms of mental illness.

- To provide short term group and individual therapy to improve decision-making related to return to successful community placement.
- To provide psycho-educational groups and classes related to court procedures and the Psychiatric Security Review Board.
- To restore the individual to previously established functional ability levels.

**Age:**

18-19 yrs	0%
20-29 yrs	12%
30-39 yrs	31%
40-49 yrs	38%
50-59 yrs	12%
60-69 yrs	8%

**PSRB:**

Yes	92%
No	8%

**Axis 1 Diagnosis (first 4 most common):**

295.7 Schizoaffective Disorder	24%
295.3 Schizophrenia, Paranoid Type	12%
296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features	12%
298.9 Psychotic Disorder	8%
305.7 Amphetamine Abuse	8%

**Race:**

White, non Hispanic	92%
Black, non Hispanic	20%
Hispanic, Mexican	4%
Hispanic, Other	4%
Southeast Asian	4%

**County of Commitment:**

Multnomah	32%
Lane	12%
Marion	12%
Washington	12%
Douglas	8%
Lincoln	8%
Deschutes	4%
Josephine	4%
Klamath	4%
Linn	4%

**Marital Status:**

Never Married	72%
Divorced	12%
Married	16%
Separated	0%
Widowed	0%

**Education Level Completed:**

13 <sup>th</sup> - 18 <sup>th</sup>	%
9 <sup>th</sup> - 12 <sup>th</sup>	%
8 <sup>th</sup> - 6 <sup>th</sup>	%
1 <sup>st</sup> - 5 <sup>th</sup>	%

**C. CLINICAL SERVICES:**

Clinical services are provided to persons based on an individualized Treatment Care Plan that focuses on their legal and mental status. Reviews of the Treatment Care Plan are held monthly to assess progress in achieving short and long-term goals. Other staff reviews are also held weekly during inter-shift meetings and when special circumstances arise.

Over the past few years, the unit has implemented key principles of the Recovery Model. Patient-centered and strength-based treatment planning methods have been implemented. Additionally, treatment care plans have been simplified and have become increasingly individualized. Special treatment services designed to stabilize mental illness symptoms and prepare the patient to understand the legal charges are provided on the unit and at the 50 Building Treatment Mall on a scheduled weekly basis.

All patients admitted to the unit are assigned a case monitor and a primary registered nurse. This enables the patient to have a fixed point of communication regarding their treatment and facilitates ongoing monitoring of their progress in treatment.

Services to enable patients to understand and manage the symptoms of their mental illness, manage their medication, substance abuse treatment or treatment for specific dysfunctions are provided both at the 50 Building Treatment Mall and on the ward.

The 50 Building Treatment Mall is an adjunctive treatment unit located within the secure perimeter and available to patients from 50J on a daily basis.

Other rehabilitative services are offered in 50 Building. These include recreational, bench work, occupational, and music therapy. Vocational testing, prevocational and vocational services are provided within the secure perimeter and at the Vocational Center on hospital grounds.

Patients receive the services of a licensed barber/beautician on a scheduled basis at the recreation center. All patients have access to the canteen and gymnasium on a regularly scheduled basis.

All clinical activities are in accordance with the ward milieu and Treatment Care Plans. All groups facilitated by mental health therapy staff are supervised by privileged professional staff, as defined in Section F.

**D. ADMISSION, CONTINUING CARE AND DISCHARGE CRITERIA**

**1. Admission Criteria:**

- Women determined by the Court under ORS 161.370 as unfit to proceed, and committed for treatment.

- Women committed by court order for up to 30 days for an evaluation of fitness to proceed (ORS 161.365) or criminal responsibility (ORS 161.315).
- Women found guilty except for insanity who are committed under ORS 161.327 or ORS 161.328.
- Women under PSRB jurisdiction whose conditional release is revoked and whose psychiatric and behavioral conditions can be managed on a medium security unit.
- Adult females in the custody of the Oregon Youth Authority who are committed under ORS 420A.025.
- Men determined by the Court under ORS 161.370 as unfit to proceed, and who have no prior sexual offenses or incidents of violence against women.

**2. Continuing Care:**

- Persons who continue to require hospital level psychiatric care due to one or more of the following:
  - i. Symptom severity;
  - ii. Behavioral control;
  - iii. Severe deficits in adaptive functioning;
  - iv. Potential risk to the community.
- Those patients admitted under ORS 161.370 determined by the IDT to continue to be unfit to proceed.

**3. Transfer To a More Restrictive Setting:**

Women who are admitted to 50J under 161.370 are not transferred to a more restrictive setting as they are maximum custody status. Women on 50J who are under the PSRB can be transferred to the other two units in FPS that provide services to female patients (50I and 41A). PSRB women who are not maximum custody can transfer to 41A. Men who are on 50J under 161.370 may be transferred to 50H or 48C, both of which provide services to male 161.370 patients.

**4. Transfer to a Less Restrictive Setting:**

Persons who are psychiatrically stable, have had good behavioral control, pose a low risk to the community, and would benefit from transfer to a specialty program and/or less secure environment, or to a program with greater opportunities for learning and practicing more independent living skills.

**5. Discharge Criteria:**

- Persons under PSRB jurisdiction who are no longer mentally ill or no longer present a substantial danger to others will be recommended to the Risk Review Board and the PSRB for discharge.
- Persons for whom existing court or PSRB jurisdiction has expired and who do not meet criteria for civil commitment will be recommended to the Forensic Disposition Board for discharge.
- Persons under ORS 161.370 who are determined as fit to proceed shall be discharged to the responsible jurisdiction.
- Persons who are no longer in need of intensive evaluation or acute psychiatric or behavioral management and no longer pose a high risk for escape or unauthorized leave and potential harm to the community may be referred to less restrictive coed treatment and transition units.
- Persons recommended for conditional release or discharge will have an understanding of the signs and symptoms of their illness, a personal relapse prevention plan, and a detailed plan for follow-up treatment and supervision in the community.

**E. EDUCATION SERVICES**

Educational services are provided at 50 Building Treatment Mall under contract with Willamette Education Services District for those persons admitted between ages 18 and 22, and who meet the criteria set forth in Public Law 94-142, handicapped education. Adult basic education is available at the Treatment Mall for those persons whose baseline assessment determines a need. All patients have access to the computers in the Computer Lab or the patient computers on the unit. Pre-GED and GED coursework is available to all patients.

**F. STAFFING PLAN AND PROCEDURE FOR SUPERVISION**

- 1. Unit 50J is staffed as follows: FTE**
- |                                 |      |
|---------------------------------|------|
| Unit Director                   | 1.0  |
| Physician Specialist            | 1.0  |
| Psychologist                    | 1.0  |
| Social Worker                   | 1.0  |
| Recreation Therapist            | 1.0  |
| Mental Health Specialist        | 1.0  |
| Mental Health Supervising Nurse | 1.0  |
| Mental Health Registered Nurse  | 2.0  |
| MH Therapist II                 | 2.0  |
| MH Therapist I                  | 10.0 |
| MH Therapy Technician           | 11.0 |

**(Unit 50J is staffing continued)**

MHT Coordinator 1.0  
MHT Shift Coordinator 1.0  
Unit Clerk .5  
Recreation Assistant .5

**2. Minimum Staffing:**

The following chart identifies the minimum staffing per shift.

Day and Swing shifts: 5 direct care nursing staff, one of which must be an RN.

Night shift: 3 direct care nursing staff, 1 of which must be an RN.

The Unit Director or the Mental Health Supervising RN reviews the patient census and acuity to determine if additional staff are needed beyond the minimum, or if staffing can be decreased in response to a change in patient acuity.

**3. Procedure For Supervision:**

Position	Administrative Supervision	Administrative Supervisor	Clinical Supervision	Clinical Supervisor
Unit Director	Individual meetings as needed; weekly supervision	Associate Program Director		
Staff Physician	Individual meetings as needed	Program Director	Individual meetings as needed; monthly supervision	Clinical Director or Chief Medical Officer
Clinical Psychologist	Individual meetings as needed; biweekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	FPS Psychologist 2 Clinical Supervisor (MD)
Social Worker	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	FPS Supervising Social Worker Clinical Supervisor (MD)
Mental Health Specialist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Unit Psychologist Clinical Supervisor (MD)
Rehabilitation Therapist	Individual meetings as needed; weekly supervision	Unit Director	Biweekly supervision of group & individual treatment services	Discipline Director Clinical Supervisor (MD)
MH Supervising Nurse	Individual meetings as needed; weekly supervision	Unit Director		Assoc. Director of Nursing

**Procedure For Supervision (cont.)**

Position	Administrative Supervision	Administrative Supervisor	Clinical Supervision	Clinical Supervisor
MH Registered Nurse	Individual meetings as needed; weekly supervision	MHSRN	Weekly meetings; daily contact and individual meetings as needed. Weekly sessions focused on milieu management and TCP interventions.	MHSRN  Clinical Supervisor
MH Therapy Coordinator	Individual meetings as needed; daily supervision	MHSRN	Daily supervision for CNA/CMA related assignments. Weekly sessions focused on milieu management and TCP interventions.	PhD, MH Specialist, LCSW, or UD
Mental Health Therapist 2	Individual meetings as needed; daily direct observation	MHSRN	Daily supervision for CNA/CMA related assignments. Weekly supervision of case monitor activities; weekly group supervision for skill building or psychoeducational groups/classes. Monthly individual supervision.	PhD, MH Specialist, LCSW, or UD
Mental Health Therapist 1	Individual meetings as needed; weekly group supervision.	MHSRN	Daily supervision for CNA/CMA related assignments. Direct observation of skill building or psychoeducational and treatment groups. Weekly sessions focused on milieu management and TCP interventions.	PhD, MH Specialist, LCSW, or UD

Clinical Supervision is provided as necessary resources are available.

## **G. PATIENT MANAGEMENT**

Patients on Unit 50J live in a medium security setting within a secure perimeter. Access to off-unit treatment activities is based on an assessment of the patients' ability to manage their behavior and benefit from treatment. Some patients attend Dual Diagnosis Anonymous weekly, which is a staff facilitated treatment group that is provided in the Treatment Mall.

Patients who are under the jurisdiction of the PSRB may be granted privileges through the Forensic Disposition Board for a variety of privileges ranging from travel within the secure perimeter to conditional release planning or movement outside the secure perimeter without restraints. Patients admitted under ORS 161.365 or 161.370 have a legal detainer and are not eligible for privileges outside the secure perimeter without Security Transport Restraints.

## **H. PHYSICAL ENVIRONMENT**

Unit 50J is located on the top floor of Eola Hall. It was completely remodeled in 1992 and offers an environment for psychosocial rehabilitation and psychiatric treatment. Unit 50J has its own dayroom, recreation room, patient treatment room, and laundry. The kitchen and dining room are shared with the adjoining Unit, 50I. The unit has 17 single rooms and 9 double rooms, plus wide hallways with skylights, which enhance the attractiveness of the unit. Additional areas for treatment are available within the secure perimeter in the Eola Community Center and on Unit 50B. The Unit has access to three secure yards, a swimming pool, recreation center, canteen, and gymnasium. Approved visitors may visit in the Visitors Center.

## **I. UNIT SCHEDULE**

All patient activities are posted on an easily identified Activity Schedule board for patients to read. Each patient has a regularly scheduled IDT in which his or her treatment plan is reviewed. Patient-centered treatment planning methods have been implemented in IDTs.

Unit staffs overlap shifts 5 times per week to communicate information on the therapeutic milieu. Unit staff meetings are held twice per week to discuss overall operation of the unit and significant patient care issues. Patients are awakened between 6:30 and 7:00 a.m. Those patients who take morning medications receive these before the morning Bend and Stretch exercises. The patient's daily schedule is reviewed and affirmations are shared by and with patients. Patients are offered the opportunity to go outside each day. Patients have Personal Time each day at 2:00 to 3:00 p.m., during which time they may sleep if they so choose. The psychologist, social worker, and recreation therapist each work at least one evening each week to extend services to patients.



# Oregon

Theodore R. Kulongoski, Governor

## Department of Human Services

Oregon State Hospital  
2600 Center Street NE  
Salem, OR 97301-2682  
(503) 945-2800 (Voice)  
(503) 945-2996 (TTY)  
Fax (503) 945-2807

June 25, 2010

To Whom It May Concern:

Attached are two documents outlining coordination of discharge services with the Fitness to Proceed Pilot Projects in Lane, Marion, and Multnomah County for patients admitted to Oregon State Hospital pursuant to Statute 161.370. All patients admitted to Oregon State Hospital under this Statute are admitted from a County Circuit Court to obtain fitness to proceed with adjudication of criminal charges. The Fitness to Proceed Pilot Projects began in 2007 via funding from the Oregon Department of Addictions and Mental Health. The objective of the Pilot Projects served to decrease institutionalization of patients deemed 'unfit' to proceed with criminal charges. Interventions within each County's Pilot Project included implementation of at least one County liaison position to collaborate with Oregon State Hospital. Collaboration between Oregon State Hospital and the County liaison's resulted in an increased coordination of aftercare for patients previously residing within the respective counties.

The two attached documents highlight the process of collaboration. The first document, **Fitness to Proceed Aftercare Coordination**, provides a narrative of Oregon State Hospital Social Work Department's ongoing collaboration with the Fitness to Proceed Pilot Projects to coordinate patients' aftercare following discharge from Oregon State Hospital. The document references the **Fitness to Proceed/.370 Program Referral form** which serves to coordinate County liaisons' interventions in conjunction with those of Oregon State Hospital's Social Work Department.

The **Fitness to Proceed/.370 Program Referral** form was developed by the Oregon State Hospital's Social Work Department. The Department reviewed the form with Medical Records in the past. It has been utilized since May 2008, last updated September 2008.

Please contact me at 503-932-8299 if I can be of further assistance.

Sincerely,

Sharon A. Murphy, LCSW  
Supervising Social Worker  
Oregon State Hospital  
[Sharon.A.Murphy@state.or.us](mailto:Sharon.A.Murphy@state.or.us)

cc: Rebecca Curtis, Rick Varnum, Len Ray



**Department of Human Services**  
*Health Services*  
*Office of Mental Health and Addiction Services*  
500 Summer Street NE E86  
Salem, OR 97301-1118  
**Voice (503) 945-5763**  
**FAX (503) 378-8467**

August 15, 2005

## **Psychiatric Security Review Board Risk Assessment**

### **PSRB Community Risk Assessment: Rationale**

It is commonly believed that there is no way to predict the risk of recidivism with regard to criminal behavior. Yet we face a paradox in view of the fact that we are charged with making exactly this sort of decision when we choose to recommend some PSRB patients for less restrictive services and not others. Up to now, there has been little if any directed clinical information delivered to the PSRB Board that would help them in this the most important exercise of their statutory authority.

Even in the absence of this information, there has been a remarkable rate of success measured in terms of the PSRB mandate of public safety. But now there is the perception in policy circles that the decision making process may be too restrictive. In other words, it may be that more people might move through the system without compromising public safety if the Board had fact based clinical opinions to support its decision making process with regard to both risk assessment and mitigation.

It is true that the only strong predictors of future criminal behavior for those with antisocial personality disorder are the age of onset and the type and frequency of previous criminal behavior. For those whose criminal behavior is judged to have been the result of a mental disorder however, it is obvious that there are a variety of factors which can exacerbate and mitigate risk for future criminal behavior. The risk of recidivism is not a steady state and in some cases can depend heavily on the type and intensity of clinical intervention.

Unfortunately, the current system does not have a method by which individual cases can be analyzed for the risk they present to the community with and without certain kinds of interventions. That is the purpose of the PSRB Community Risk Assessment (CRA) summary. It is designed to assemble all of the information that

should be. For example, when writing a CRA, “vocational experience” should not be listed. It is better to describe the specifics of what kind of job(s), duration, results, etc.

#### Section Four:

This is a paragraph that describes the interventions that can be made by the human service system that could diminish the risk exacerbating and enhance the mitigating factors listed above. These interventions may be evidenced based clinical programming as well as highly individual events, such as involving certain relatives in daily structure. In addition to clinical interventions that bear on risk mitigation, environmental interventions such as housing or encouraging contact with certain programs, meetings, etc. should be listed.

Some listed risk factors may not be able to be mitigated or augmented by any intervention. But when possible, the format of any recommended interventions should be organized so as to show the clear relationship between the listed intervention and the two lists in Section three. More specifically, the interventions should be directly referenced to each of the listed risk exacerbating and risk mitigating factors with which the clinician believes the intervention will help.

#### Section Five:

Create a paragraph that synthesizes all of the information above so as to support your choice of one of the five points on a scale of risk for re-offense from minimal to extreme. This paragraph may describe a risk score that varies depending upon whether or not the interventions listed in Section Four are implemented.

- Numeric data from instruments validated for use in predicting risk of recidivism in relevant clinical populations.

**PSRB CRA Sample List of Risk Mitigating factors:**

Note: This list of examples is not all-inclusive and many of the items overlap. It is intended solely as a reminder of certain kinds of examples of what to consider when assessing risk of re-hospitalization.

- Demonstrated ability to live independently
- Highly social
- Intact and supportive family of origin
- Able to think carefully before acting
- No substance abuse history
- No criminal behavior
- Availability of residential services
- Good relationship with outpatient treatment team
- Understands own illness
- Vocational skills
- Vocational experience
- History of prosocial behavior
- In general, the logical opposite of any of the items list as risk exacerbators may be considered risk mitigaters and if present, should be listed.

**Exhibit E**  
**PSRB Specific OAR's**

**309-032-1540**

**Program Specific Service Standards**

(4) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board: Services and supports must include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(a) Providers of PSRB and JPSRB services acting through the designated Qualified Person, must submit reports to the PSRB or JPSRB as follows:

(A) Orders for Evaluation: For individuals under the jurisdiction of the PSRB or the JPSRB, providers must take the following action upon receipt of an Order for Evaluation:

(i) Within 15 days of receipt of the Order, schedule an interview with the individual for the purpose of initiating or conducting the evaluation;

(ii) Appoint a QMHP to conduct the evaluation and to provide an evaluation report to the PSRB or JPSRB;

(iii) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB or JPSRB responding to the questions asked in the Order for Evaluation; and

(iv) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the person designated to serve as the individual's Qualified Person, who must be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

(B) Monthly reports consistent with PSRB or JPSRB reporting requirements as specified in the Conditional Release Order that summarize the individual's adherence to Conditional Release requirements and general progress; and

(C) Interim reports, including immediate reports by phone, if necessary, to ensure the public or individual's safety including:

(i) At the time of any significant change in the individual's health, legal, employment or other status which may affect compliance with Conditional Release orders;

(ii) Upon noting major symptoms requiring psychiatric stabilization or hospitalization;

(iii) Upon noting any other major change in the individual's ISSP;

(iv) Upon learning of any violations of the Conditional Release Order; and

(v) At any other time when, in the opinion of the Qualified Person, such an interim report is needed to assist the individual.

## Exhibit E

(1) If the Board finds the person may be controlled in the community and a verified conditional release plan is approved by the Board, the Board may order the person placed on conditional release.

(2) If the Board finds the person could be controlled in the community but no conditional release plan has been approved by the Board, the Board may order the person committed but find the person appropriate for conditional release pending submission of a conditional release plan. The Board shall specify what conditions the plan should include and may approve the conditional release plan submitted by the staff of the hospital, by the patient or someone on the patient's behalf at an administrative hearing.

(3) If a verified conditional release plan has not been approved and the conditions need further examination and approval of the Board, the Board may commit the patient, find the patient appropriate for conditional release or continue the hearing.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.336

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95

**859-070-0015**

### **Elements of Conditional Release Order**

The Board shall consider any or all of the following elements of a conditional release plan and determine which are appropriate and necessary to insure the safety of the public:

(1) Housing: Housing must be available for the patient. The Board may require 24-hour supervised housing, a supervised group home, foster care, housing with relatives or independent housing.

(2) Mental health treatment: Mental health treatment must be available in the community. The Board-approved provider of the treatment must have had an opportunity to evaluate the patient and the proposed conditional release plan and to be heard before the Board. The provider must have agreed to provide the necessary mental health treatment to the patient. The treatment may include: individual counseling, group counseling, home visits, prescription of medication or any other treatment recommended by the provider(s) and approved by the Board.

(3) Reporting responsibility: An individual must be available to be designated by the Board as having primary reporting responsibility and must have agreed to:

(a) Notify the Board in writing of the patient's progress at least once a month;

(b) Notify the Board promptly of any grounds for revocation under OAR 859-080-0010;

(c) Notify the Board promptly of any significant changes in the implementation of the conditional release plan;

(d) Coordinate and monitor all elements of the conditional release plan.

# Adult Mental Health Community Residential Capacity By Facility Type and City

Data Source: Licensing Database and ECMU Database

Addictions and Mental Health Division  
June 24, 2010

## **Definitions of Acronyms**

### Facility Types:

AFH:	Adult Foster Homes
RTF:	Residential Treatment Facility
RTH:	Residential Treatment Homes
SRTF:	Secure Residential Treatment Facility
ICM:	Intensive Case Management
SH:	Supported Housing

## ENHANCED CARE SERVICES AND RESOURCES

**Service Description:** Enhanced Care programs provide specialized services to individuals residing in Senior's and People with Disabilities (SPD) licensed facilities that have also been diagnosed with severe and persistent mental illness. Services are provided in Intensive Care Facilities and Residential Care facilities. Enhanced Care Outreach Services (ECOS) are provided to individuals in a variety of settings including independent living. The following is a list of facilities and providers that comprise the Enhanced Care System

### COOS COUNTY

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Services: Enhanced Care Outreach Services (ECOS)

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Agency: **Coos County Mental Health** (541) 756-2020 x 528  
1975 McPherson Street (541) 756-8982 - Fax  
Coos Bay, OR 97459

**David Geels, Program Manager** (541) 756-2020 x 508  
[David.geels@mh.co.coos.or.us](mailto:David.geels@mh.co.coos.or.us)

**Louise Cackowski, Coordinator** (541) 756-2020 x 548  
[louise.cackowski@mh.co.coos.or.us](mailto:louise.cackowski@mh.co.coos.or.us)

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### DESCHUTES COUNTY

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Services: Enhanced Care Outreach Services (ECOS)

---

Agency: **Deschutes County Mental Health Dept.** (541) 322-7500  
2577 NE Courtney Drive (541) 322-7565 - Fax  
Bend, OR 97701

**Kathy Drew, Manager** (541) 322-7557

**Tim Malone, Program Supervisor** (541) 385-1746  
[timmm@co.deschutes.or.us](mailto:timmm@co.deschutes.or.us) (541) 388-6617 - Fax

**Therese Poncy, Program Coordinator**  
[theresep@co.deschutes.or.us](mailto:theresep@co.deschutes.or.us) (541) 385-1746

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Figure 1. The effect of the concentration of the solution on the adsorption of the dye. The concentration of the solution was 0.001, 0.002, 0.003, 0.004, 0.005, 0.006, 0.007, 0.008, 0.009, 0.01, 0.012, 0.014, 0.016, 0.018, 0.02, 0.022, 0.024, 0.026, 0.028, 0.03, 0.032, 0.034, 0.036, 0.038, 0.04, 0.042, 0.044, 0.046, 0.048, 0.05, 0.052, 0.054, 0.056, 0.058, 0.06, 0.062, 0.064, 0.066, 0.068, 0.07, 0.072, 0.074, 0.076, 0.078, 0.08, 0.082, 0.084, 0.086, 0.088, 0.09, 0.092, 0.094, 0.096, 0.098, 0.1, 0.12, 0.14, 0.16, 0.18, 0.2, 0.22, 0.24, 0.26, 0.28, 0.3, 0.32, 0.34, 0.36, 0.38, 0.4, 0.42, 0.44, 0.46, 0.48, 0.5, 0.52, 0.54, 0.56, 0.58, 0.6, 0.62, 0.64, 0.66, 0.68, 0.7, 0.72, 0.74, 0.76, 0.78, 0.8, 0.82, 0.84, 0.86, 0.88, 0.9, 0.92, 0.94, 0.96, 0.98, 1.0. The concentration of the solution was 0.001, 0.002, 0.003, 0.004, 0.005, 0.006, 0.007, 0.008, 0.009, 0.01, 0.012, 0.014, 0.016, 0.018, 0.02, 0.022, 0.024, 0.026, 0.028, 0.03, 0.032, 0.034, 0.036, 0.038, 0.04, 0.042, 0.044, 0.046, 0.048, 0.05, 0.052, 0.054, 0.056, 0.058, 0.06, 0.062, 0.064, 0.066, 0.068, 0.07, 0.072, 0.074, 0.076, 0.078, 0.08, 0.082, 0.084, 0.086, 0.088, 0.09, 0.092, 0.094, 0.096, 0.098, 0.1, 0.12, 0.14, 0.16, 0.18, 0.2, 0.22, 0.24, 0.26, 0.28, 0.3, 0.32, 0.34, 0.36, 0.38, 0.4, 0.42, 0.44, 0.46, 0.48, 0.5, 0.52, 0.54, 0.56, 0.58, 0.6, 0.62, 0.64, 0.66, 0.68, 0.7, 0.72, 0.74, 0.76, 0.78, 0.8, 0.82, 0.84, 0.86, 0.88, 0.9, 0.92, 0.94, 0.96, 0.98, 1.0.

Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group (CG) and the experimental group (EG). The CG was divided into two subgroups: the control group (CG) and the control group (CG). The EG was divided into two subgroups: the experimental group (EG) and the experimental group (EG). The subjects were divided into two groups: the control group (CG) and the experimental group (EG). The CG was divided into two subgroups: the control group (CG) and the control group (CG). The EG was divided into two subgroups: the experimental group (EG) and the experimental group (EG).

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[illegible][illegible]

Facility: **West Wind Enhanced Care** (541) 857-0700  
3130 Juanipero Way (541) 857-2887 - Fax  
Medford, OR 97504

**Dan Gregory, Owner/Administrator**  
[westwindenhancedcare@yahoo.com](mailto:westwindenhancedcare@yahoo.com)

**Rachel Mills, Assistant Administrator**  
[Rachet66@yahoo.com](mailto:Rachet66@yahoo.com)

**Jolene White, Executive Director**  
[jhermant@yahoo.com](mailto:jhermant@yahoo.com)

**Susan Potap, RN**  
[westwindenhancedcare@yahoo.com](mailto:westwindenhancedcare@yahoo.com)

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MH Agency: **Jackson Co. Health and Human Services** (541) 774-8201  
1005 E. Main St. (541) 774-7979 - Fax  
Medford, OR 97504-7459

**Becky Martin, Program Director** (541) 774-8201

**LouAnn Edwards, Program Coordinator** (541) 774-7957  
[edwardla@jacksoncounty.org](mailto:edwardla@jacksoncounty.org)

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## LANE COUNTY

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Services: Enhanced Care Residential Care Services at Gateway Living  
Enhanced Care Outreach Services (ECOS)

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Facility: **Gateway Living** (541) 744-5642  
622 N. Cloverleaf Loop (541) 744-5647 - Fax  
Springfield, OR 97477

**Mark Kinkade, Director of Operations** (541) 744-9817  
[mkinkade@gatewayliving.com](mailto:mkinkade@gatewayliving.com)

**Shari Miller, RN** (541) 232-6850 - Cell  
[smiller@gatewayliving.com](mailto:smiller@gatewayliving.com)

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MH Agency:	<b>Cascadia Behavioral Healthcare</b>	
	<b>Madelyn Antinucci, Program Director</b>	(541) 744-9627
	<b>PO Box 71518</b>	(503) 686-1944 - Cell
	<b>Eugene, OR 97401</b>	
	<a href="mailto:madelyn.antinucci@cascadiabhc.org">madelyn.antinucci@cascadiabhc.org</a>	(541) 736-3990 - MH office
		(541) 736-7279 - MH fax

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## MARION COUNTY

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Services:	Enhanced Care Services at Benedictine Nursing Center Enhanced Care Outreach Services (ECOS)
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Facility:	<b>Providence Benedictine Nursing Center</b>	(503) 845-6841
	540 South Main Street	(503) 845-9229 - Fax
	Mt. Angel, OR 97362	
	<b>Emily Dazey, Administrator</b>	(503) 845-6841
	<a href="mailto:Emily.dazey@providence.org">Emily.dazey@providence.org</a>	
	<b>Debra Panther, RCM</b>	(503) 845-2753
	<a href="mailto:Debra.panther@providence.org">Debra.panther@providence.org</a>	

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MH Agency:	<b>Marion County Mental Health</b>	(503) 588-5351
	<b>Geriatric and Enhanced Care Services</b>	(503) 585-4919 - Fax
	3180 Center St. NE	
	Salem, OR 97301	
	<b>Katherine Stone, Program Director</b>	(503) 361- 2616
	<a href="mailto:kstone@co.marion.or.us">kstone@co.marion.or.us</a>	(503) 585-4908 - Fax
	<b>Eric Janoe, QMHP</b>	
	<a href="mailto:ejanoe@co.marion.or.us">ejanoe@co.marion.or.us</a>	(503) 845-6524
		(503) 845-2707 - Fax
	<b>Amber Donaldson, ECOS Coordinator</b>	
	<a href="mailto:adonaldson@co.marion.or.us">adonaldson@co.marion.or.us</a>	(503) 361-2747

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## MULTNOMAH COUNTY

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Services:	Enhanced Care Services at Healthcare at Foster Creek Enhanced Care Residential Care Services at Premier Living Enhanced Care Residential Care Services at Riverside Enhanced Care Outreach Services (ECOS)
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Facility:	<b>Premier Living</b>	(503) 762-3413
	5120 SE 118 <sup>th</sup>	(503) 762-3428 - Fax

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Portland, OR 97266

**Pooneh Entezari, owner**  
[pentezari@aol.com](mailto:pentezari@aol.com)

(503) 309-6202  
(360) 883-0106 - Cell

**Jennifer Schnitzer, Director of Operations**  
[Jenwhitell@hotmail.com](mailto:Jenwhitell@hotmail.com)

(541) 601-7228 - Cell

**Emily Buntin, Administrator**  
[jeepgirl@juno.com](mailto:jeepgirl@juno.com)

(503) 762-3413

Facility:

**Riverside**  
33500 NE Halsey  
Wood Village, Oregon 97060

(503) 328-9246  
(503) 328-9285 - Fax

**Pooneh Entezari, owner**  
[pentezari@aol.com](mailto:pentezari@aol.com)

(503) 309-6202  
(360) 883-0106 - Cell

**Jennifer Schnitzer**  
[Jenwhitell@hotmail.com](mailto:Jenwhitell@hotmail.com)

(541) 601-7228 - Cell

**Jennifer Ostrick, Administrator**  
[Lyno21@hotmail.com](mailto:Lyno21@hotmail.com)

(503) 328-9246

**Rick Beers, RN**  
[beersRN@gmail.com](mailto:beersRN@gmail.com)

Facility:

**Healthcare @ Foster Creek**  
**6003 SE 136<sup>th</sup>**  
Portland, OR 97236

(503-)761-1155  
(503)-761-1142 - Fax

**John Wakeman, Administrator**  
[administrator@healthcareatfostercreek.com](mailto:administrator@healthcareatfostercreek.com)

(503) 761-1155 X 202

**Ann Wakeman, DNS consultant**  
[annwakeman@yahoo.com](mailto:annwakeman@yahoo.com)

(503) 760-1727 x 204  
(971) 235-4825 - Cell

**Carol Rinard, Resident Care Manager**

(503) 760-1727 X 200

**Linda Pickering, Management Co**  
[lm\\_pickering@yahoo.com](mailto:lm_pickering@yahoo.com)

503-761-1155

**Renita Armstrong, DNS**

MH Agency:	<b>Cascadia Behavioral Healthcare</b> 10373 NE Hancock, Ste 200 Portland, OR 97220	(503) 253-6754 (503) 261-6393 - Fax
	<b>Greg Borders, Cascadia Director</b> <a href="mailto:Greg.borders@cascadiabhc.org">Greg.borders@cascadiabhc.org</a>	(503) 872-0186 (503) 887-8597 - Cell
	<b>Terri-Lynn McDonald, Program Supervisor</b> <b><u>Premier Living</u></b> , Enhanced Care Services <a href="mailto:terri-lynn.mcdonald@cascadiabhc.org">terri-lynn.mcdonald@cascadiabhc.org</a>	(503) 762-3435 (925) 989-1885 - Cell (503) 762-3431 - MH
	<b>Harry Shanks, Program Supervisor</b> <b><u>Riverside Living</u></b> , Enhanced Care Services	(503) 512-7605 (503) 512-7503 office
	<b>Laura Heller, Enhanced Care Outreach Services (<u>ECOS</u>) Coordinator</b> <a href="mailto:laura.heller@cascadiabhc.org">laura.heller@cascadiabhc.org</a>	(503) 261-6178 (503) 969-2096 - Cell (503) 261-6393 - Fax
	<b>Wade Belknap, Program Supervisor</b> <b><u>Healthcare @ Foster Creek (HCFC)</u></b> , Enhanced Care Services <a href="mailto:wadeb@cascadiabhc.org">wadeb@cascadiabhc.org</a>	(503) 954-2119 (503) 998-9721 - Cell (503) 206-6668 - Fax
	<b>Anna Dyar, Program Manager</b>	(503) 954-1706 (503) 899-9957 - Cell

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## POLK COUNTY

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Services:           Enhanced Care Outreach Services (ECOS)

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MH Agency: (Contractor)	<b>Polk County Mental Health</b> 182 SW Academy, Rm. 304 Dallas, OR 97338	(503) 623-9289 (503) 623-7560 - Fax
	<b>Geoff Heatherington, Director</b>	(503) 623-9289
	<b>Judith Morehead, ECS/ECOS Supervisor</b> <a href="mailto:Morehead.judith@co.polk.or.us">Morehead.judith@co.polk.or.us</a>	(503) 623-1886 x 436 (503) 910-6259 - Cell
	<b>Joselyn Salaz, QMHP</b> <a href="mailto:Salaz.joselyn@co.polk.or.us">Salaz.joselyn@co.polk.or.us</a>	(503) 623-1886 x 161 (503) 623-5581 (503) 623-7560 - Fax
	<b>Donna Errand-Olsen</b>	(503) 623-1886 x 166

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## UNION COUNTY

Services: Enhanced Care Services at Evergreen Vista Health Center  
Enhanced Care Outreach Services (ECOS)

Facility:	<b>Vista Specialty Care</b> 103 Adams Avenue La Grande, OR 97850	(541) 963-4184 (541) 963-0479 - Fax
	<b>Jack Sanofsky, Executive Director</b>	
	<b>Michael McCoy, Interim Administrator</b> <u>Ed057@ehcmail.com</u>	(541) 963-4184
	<b>Kathy Mallory, RCM</b> <u>RCM057@ehcmail.com</u>	(541) 963-4184
	<b>Colleen Clark, DNS</b> <u>Dns057@ehcmail.com</u>	(541) 963-4184

MH Agency: **Center for Human Development** (541) 962-8845  
2301 Cove Ave (541) 963-5272 - Fax  
La Grande, OR 97850

**Dwight Dill, Mental Health Director** (541) 962-8845  
[ddill@chdinc.org](mailto:ddill@chdinc.org)

**Dayneen Koopman, Coordinator** Call cell first  
[dkoopman@chdinc.org](mailto:dkoopman@chdinc.org) (541) 910-7211 - Cell  
(541) 962-8885 -Office

**WASHINGTON COUNTY**

Services: Enhanced Care Services at Forest Grove Rehab and Care Center  
Enhanced Care Outreach Services (ECOS)

Facilities:	<b>Forest Grove Rehab and Care Center</b> 3900 Pacific Avenue Forest Grove, OR 97116	(503) 359-0449 (503) 357-8086 - Fax
	<b>Gail Brockway, Administrator</b> <a href="mailto:gbrockway@prestigecare.com">gbrockway@prestigecare.com</a>	
	<b>Jennifer Lawrence, Director of Social Work</b> <a href="mailto:jlawrence@prestigecare.com">jlawrence@prestigecare.com</a>	(503) 616-5014 (503) 906-3914 - Fax
	<b>Dorothy Yargus, RCM</b> <a href="mailto:dyargus@prestigecare.com">dyargus@prestigecare.com</a>	(503) 359-0449
MH Agency:	<b>Lifeworks, NW</b> 14255 SW Brigadoon Court Beaverton, OR 97005	(503) 641-1475 (503) 641-8548 - Fax
	<b>Ellen Willis-Conger, Older Adult Services Program Coordinator</b> <a href="mailto:ellenw@lifeworksnw.org">ellenw@lifeworksnw.org</a>	(503) 641-1475 x 3816 (503) 799-1972 - Cell
	<b>Shannon Bullock, Program Coordinator</b> <a href="mailto:shannonb@lifeworksnw.org">shannonb@lifeworksnw.org</a>	(503) 616-5023 (971) 235-2294 - Cell (503) 357-0707 - Fax
MH Contractor:	Washington County MED Services Team 155 N. First Avenue, Hillsboro, OR 97124 <b>John Fryer, Supervisor</b> <b>Rebecca Clare</b>	(503) 846-4736 (503) 846-4415

## YAMHILL COUNTY

Services:	Enhanced Care Residential Care Services at Harmony Living, Inc. Enhanced Care Outreach Services (ECOS)	
Facility:	<b>Harmony Living, Inc.</b> 1535 SW Shirley Ann Dr. Mc Minnville, OR 97128	(503) 472-9997 (503) 472-9986 - Fax
	<b>Jennifer Schnitzer, Director of Operations</b> <a href="mailto:JenWhitell@hotmail.com">JenWhitell@hotmail.com</a>	(503) 472-9603 (541) 601-7228 - Cell
	<b>Julie Olds, Administrator</b> <a href="mailto:joldsharmony@yahoo.com">joldsharmony@yahoo.com</a>	(503) 472-9997
	<b>Dina Crown, RN</b> <a href="mailto:DinaCrown@hotmail.com">DinaCrown@hotmail.com</a>	(503) 472-9997

MH Agency: **Yamhill County Mental Health Program** (503) 434-7523  
627 N Evans (503) 434-9846 - Fax  
Mc Minnville, OR 97128

**Krisan Pendleton, Program Manager** (503) 472-4022  
[pendletk@co.yamhill.or.us](mailto:pendletk@co.yamhill.or.us)

**Pam Judd, Program Coordinator** (503) 472-9999  
[juddp@co.yamhill.or.us](mailto:juddp@co.yamhill.or.us)

**Chad Cox, Enhanced Care Outreach Services** (971) 241-4794  
1535 SW Shirley Ann Dr  
McMinnville, OR 97128  
[coxco@co.yamhill.or.us](mailto:coxco@co.yamhill.or.us)

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# STATEWIDE ENHANCED CARE SERVICES-BY COUNTY

Coos County  
**Coos County Mental Health**  
 5 Enhanced Care Outreach Services (ECOS) slots\*

Deschutes County  
**Deschutes County Mental Health**  
 6 ECOS Slots\*

Hood River County  
 Mid Columbia Center for Living at  
**Hood River Care Center**  
 11 nursing facility beds  
 5 ECOS slots\*

Jackson County  
**Jackson County Mental Health at West Wind Enhanced Care Facility**  
 16 residential beds  
 3 ECOS slots\*

Lane County  
 Cascadia Behavioral Healthcare at  
**Gateway Living**  
 15 residential beds  
 9 ECOS slots\*

Marion County  
**Marion County Mental Health at Providence Benedictine Nursing Center**  
 16 nursing facility beds  
 5 ECOS slots\*

Multnomah County  
**Cascadia Behavioral Healthcare at Premier Living & Riverside Living & Healthcare at Foster Creek**  
 16 residential beds & 16 residential beds & 14 nursing facility beds  
 16 ECOS slots\*

Polk County  
**Polk County Mental Health**  
 11 ECOS slots\*

Umatilla County  
**Lifeways Umatilla Inc.**  
 2 ECOS slots\*

Union County  
 Center for Human Development at  
**Evergreen Vista**  
 10 nursing facility beds  
 6 ECOS slots\*

Washington County  
**Lifeworks, NW at Camelot Care Center**  
 10 nursing facility beds  
 16 ECOS slots\*

Yamhill County  
**Yamhill County Mental Health at Harmony Living**  
 16 residential beds  
 4 ECOS slots\*

\* Enhanced Care Outreach Services (ECOS) are comprehensive mental health treatment services provided to enhanced-care eligible individuals residing in SPD-licensed facilities in the community.

## TOTALS

61 Nursing facility beds in 5 NFs  
 79 Residential Beds in 5 RCFs  
 88 ECOS slots in 12 counties

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Total ECS capacity

Amber Care 1  
17745 S.W. Marty Lane  
Aloha, OR 97006  
Owner: Stubblefield, Velma Lynn  
503-259-3371  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Azalea House #3  
20055 S.W. Johnson Street  
Aloha, OR 97006  
Sherry Petrey  
Owner: Gunter, Lori  
503-848-7779  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

CornerStone Care  
19600 S.W. Stacey Street  
Aloha, OR 97006  
Owner: Henneman, Lisa M. and Franklin, Danny L.  
503-649-6287  
Contact:  
503-649-6287  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Azalea House  
4620 S.W. 202nd Avenue  
Aloha, OR 97007  
Owner: Gunter, Lori  
503-352-5946  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Huskies Home  
6968 S.W. 179th  
Aloha, OR 97007  
Owner: Side-By-Side Adult Care Homes, L.L.C.  
503-649-9451  
Contact: Sunami Bjornson  
503-551-9988  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Smith Residence  
275 Myer Creek Road  
Ashland, OR 97520  
Owner: Smith, Timothy and Rebekah  
541-482-3573  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Filbert Home  
4905 S.W. Filbert Avenue  
Beaverton, OR 97005  
Owner: Side-By-Side Adult Care Homes, L.L.C.  
503-626-1050  
Contact: Sunami Bjornson  
503-551-9988  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Virgie's Adult Foster Home  
210 S.W. 150th Avenue  
Beaverton, OR 97006  
Owner: Flores, Virginia R.  
503-626-9617  
Contact:  
503-626-9617  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Breitenbush Adult Foster Home  
924 S.E. Breitenbush Lane  
Bend, OR 97702  
Owner: McClaskey, Deborah K.  
541-318-0623  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Golden Eagle Care Home, Inc.  
20782 St. George Court  
Bend, OR 97702  
Owner: Wyland, Scott and Frenette, Michelle  
541-317-0130  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Hemlock Home  
712 Hemlock Avenue  
Central Point, OR 97502  
Bill Brickley  
Owner: Esselstrom/Thomas, Inc.  
Contact: Johnnetta Esselstrom and Christie Thomas  
541-773-3389  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Leiter Adult Foster Home  
1225 Triangle Drive  
Central Point, OR 97502  
Owner: Leiter, Dorothy  
541-664-7954  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Beginning W.E.L.L.  
15651 S.E. McKinley Avenue  
Clackamas, OR 97015  
Owner: Silaev, Leah  
503-657-0549  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 2 Community: 3

Stepping Stone  
1150 Michigan  
Coos Bay, OR 97420  
Owner: Johnson, Alison  
541-404-5577  
Contact:  
541-267-0620  
Facility Type: AFH Capacity: 5  
PSRB: 5 ECMU: Community:

Tender Heart AFC, L.L.C.  
1068 Crocker Street  
Coos Bay, OR 97420  
Richard Cunningham  
Owner: Gray, Laura  
541-290-8308  
Contact: Laura Gray, Owner  
541-290-8308  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Bohemia Residential Community  
1115 W. Main Street  
Cottage Grove, OR 97424  
Cynthia Pratt  
Owner: South Lane Mental Health  
541-942-2217  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 4 Community: 1

Isman Foster Home #1  
425 N. 9th Street  
Cottage Grove, OR 97424  
Sharie Romane  
Owner: Isman, Kerry  
541-942-5307  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Isman Foster Home #2  
323 N. 9th Street  
Cottage Grove, OR 97424  
Arne Sansom  
Owner: Isman, Harvey and Kerry  
541-942-8400  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Thornton House  
33117 Lloyd Avenue  
Cottage Grove, OR 97424  
Owner: Owens, Linda and Phillip  
541-942-4212  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Triple Rainbow Adult Foster Home  
16525 Oakdale Road  
Dallas, OR 97338  
Owner: Grauer, Eugene  
503-623-3881  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Sifford's Adult Foster Home  
713 Ferry Street  
Dayton, OR 97114  
Owner: Berry, Laurie  
503-864-3563  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Robins' Nest  
220 N.W. First Street  
Dundee, OR 97115  
Nadja Plath  
Owner: Plath, Tanja  
503-538-9559  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Gateway House  
925 Arcadia Drive  
Eugene, OR 97401  
Owner: Hewett, Karen  
541-912-8838  
Contact:  
541-912-8838  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Green Meadows  
4389 Fergus  
Eugene, OR 97402  
Charlene Hughes  
Owner: Price, Kavitha P.  
541-505-8824  
Contact:  
541-505-8824  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Linda Egge's Foster Home  
1310 Jay Street  
Eugene, OR 97402  
Owner: Egge-Swearingen, Linda and Swearingen,  
Richard  
541-689-9443  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Matt Chiapuzio Foster Home #1  
1345 Hayes Street  
Eugene, OR 97402  
Kathy Easton  
Owner: Chiapuzio, Matt  
541-686-3155  
Contact:  
541-914-5357  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Rosebay House  
2561 Rosebay Street  
Eugene, OR 97402  
Kim Torkelson  
Owner: Howard, Terry  
541-688-4709  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Campbell Home  
598 Park Avenue  
Eugene, OR 97404  
Owner: Campbell, Elizabeth  
541-461-3389  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Nantucket House  
752 Nantucket Avenue  
Eugene, OR 97404  
Owner: Bilyeu, Karen  
541-912-1014  
Contact:  
541-688-5074  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Summer Lane Adult Foster Home  
2745 Summer Lane  
Eugene, OR 97404  
Owner: Fish, Russell  
541-688-3364  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Trueblood Home  
292 Foxglove Avenue  
Eugene, OR 97404  
Owner: Trueblood, Diana  
541-461-8743

Contact:  
Facility Type: AFH Capacity: 3  
PSRB: ECMU: Community: 3

Ellen's Home  
4459 Larkwood Street  
Eugene, OR 97405  
Owner: Chiapuzio, Ellen  
541-686-3155  
Contact:  
541-686-3155  
Facility Type: AFH Capacity: 3  
PSRB: ECMU: Community: 3

Ellen's Place  
1325 Hayes Street  
Eugene, OR 97405  
Ken Black  
Owner: Chiapuzio, Ellen  
541-345-4222  
Contact:  
541-914-5355  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Fillmore Lane Foster Home  
3323 Fillmore Street  
Eugene, OR 97405  
Owner: Clamb, L.L.C.  
541-345-8223  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Matt Chiapuzio Foster Home #2  
4007 Brae Burn  
Eugene, OR 97405  
Owner: Chiapuzio, John M.  
541-513-7703 (Matt cell)  
Contact:  
541-914-5357  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Moon Meadow Farm  
33823 Seavey Loop  
Eugene, OR 97405  
Owner: Ravenwood, Minx E.  
541-747-9970  
Contact:  
541-747-9970  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Nancy Kay Hibbs Foster Home  
118 N. Main  
Falls City, OR 97344  
Owner: Hibbs, Nancy Kay  
503-787-3114  
Contact:  
Facility Type: AFH Capacity: 2  
PSRB: ECMU: Community: 2

Serenity Place AFH  
17461 Quail Court  
Gladstone, OR 97027  
Owner: Connelly, John and Cynthia  
503-653-9761  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: 2 Community: 2

Ray's Place  
1840 Foothill Blvd.  
Grants Pass, OR 97526  
Owner: Ray, Susan and Martin  
541-955-1896  
Contact:  
541-955-1896  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Breeze Hill Foster Care  
1864 Allen Creek Road  
Grants Pass, OR 97527  
Cathy Milne-Ware  
Owner: Bender, Lynette  
541-474-1422  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Dieter's Place  
1693 Redwood Avenue  
Grants Pass, OR 97527  
Owner: Kanehl, Dieter  
541-659-8809  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

River Haven  
1300 Daisy Lane  
Grants Pass, OR 97527  
Owner: Jewkes, Eric T.  
541-944-9143  
Contact:  
541-226-2203  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

610 N.E. 23rd Place  
Gresham, OR 97030  
Owner: Colleen Tubania  
503-669-0360

Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Rockin' D Adult Foster Care  
32755 W. Walls Road  
Hermiston, OR 97838  
Owner: Walker, Douglas E.  
541-567-1562

Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Liberty House  
141 N. Milwaukie  
Hines, OR 97738  
Joann Sandell  
Owner: Harney Behavioral Health  
541-573-1800  
Contact: Chris Siegner, Director  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Koufax Lane Adult Foster Home  
6681 Koufax Lane N.E.  
Keizer, OR 97303  
Owner: Ingram, Jean Marie  
503-585-5962  
Contact:  
503-585-5962  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Monson Foster Care  
6413 Harlan Drive  
Klamath Falls, OR 97603  
Owner: Monson, Carol  
541-884-5579  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Precious Moments with the Hubbles  
2624 Patterson Street  
Klamath Falls, OR 97603  
Owner: Hubble, James and Merrienne  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Tyra Justice Adult Foster Home  
1750 Carlson Drive  
Klamath Falls, OR 97603  
Owner: Justice, Tyra  
541-331-2106  
Contact:  
541-331-2106  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

D & D Adult Care Home  
5995 Carman Drive  
Lake Oswego, OR 97035  
Owner: Covaciu, Daniel  
503-675-0192  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Smiles  
27529 Siuslaw River Road  
Lorane, OR 97451  
Owner: Siebel, Nicole and Miles, Cathryn  
541-767-9810  
Contact:  
541-521-2274  
Facility Type: AFH Capacity: 2  
PSRB: ECMU: Community: 2

Isle of the Tropics AFH  
2405 Stearns Way  
Medford, OR 97501  
Owner: Jones, Michael G.  
541-773-2095  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

King-Stewart  
911 King Street  
Medford, OR 97501  
Lisa Zurligen  
Owner: Smith, Timothy and Rebekah  
541-773-9493  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Lighthouse Foster Care  
3256 Madrona Lane  
Medford, OR 97501  
Owner: O Connor, Loni and Ampolini, Cathleen  
541-608-2765  
Contact:  
541-941-9071  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Marshall House  
875 Marshall Avenue  
Medford, OR 97501  
Owner: Thomas, Christie and Esslestrom, Johnnetta  
541-773-6803  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

McGinnis Adult Foster Home  
120 Newtown Street  
Medford, OR 97501  
Owner: McGinnis, Diane  
541-779-3197  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

402 Piccadilly #2  
402 Piccadilly Circle  
Medford, OR 97504  
Richie L. Gomez  
Owner: Von Strahl, Paul and Shanee  
541-772-4299  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

408 Piccadilly Circle  
408 Piccadilly Circle  
Medford, OR 97504  
Tamara Nash  
Owner: Von Strahl, Paul and Shanee  
541-732-0651  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

A Fresh Start  
1441 Oleander Street  
Medford, OR 97504  
Tillie Riggs  
Owner: Puckett, Patricia Lee  
541-772-0345  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

A New Beginning  
1449 Oleander Street  
Medford, OR 97504  
Katherine Barrett  
Owner: Puckett, Patricia Lee  
541-772-0345  
Contact:  
541-858-2729  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Amarylis Adult Foster Home  
3291 Ford Drive  
Medford, OR 97504  
Owner: Tan, Lie F.  
541-772-6428  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Cherry Lane Adult Foster Home  
3580 Cherry Lane  
Medford, OR 97504  
Joseph Horsley  
Owner: Tan, Lie F.  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Friendly Safe Havens, L.L.C.  
3264 Ford Drive  
Medford, OR 97504  
Owner: Tan, Lie H.  
541-779-0676  
Contact:  
541-779-0676  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Oakwood Haven Adult Foster Home  
315 N. Phoenix Road  
Medford, OR 97504  
Dexter Patmon  
Owner: Whitney, David and Susan  
Contact:  
541-778-3552  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Psallein Guest Home  
3082 Springbrook Road  
Medford, OR 97504  
Owner: Monzo, Cynthia  
541-858-9071  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Ross Lane Adult Foster Home  
683 and 685 N. Ross Lane  
Medford, OR 97504  
Diane Trenholme  
Owner: Jackson County Health & Human Services  
541-776-7355  
Contact: Lorna Anderson, Administrator  
Facility Type: AFH Capacity: 5  
PSRB: 0 ECMU: 3 Community: 2

Sunrise  
349 Sunrise Avenue  
Medford, OR 97504  
Owner: Von Strahl, Paul and Shanee  
541-732-0651  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Sunrise Foster Home  
887 Sunrise Avenue  
Medford, OR 97504  
Owner: Wiegman, Marites  
541-282-9850  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Ash Ct., L.L.C.  
12372 S.E. King Road  
Milwaukie, OR 97222  
Jeanette Fanning  
Owner: Schoenborn, Rhonda L. and Ruonavaara, Lacy  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

New Foundation Adult Foster Care  
294 Whitman Street  
Monmouth, OR 97361  
Matthew Beltz  
Owner: Engdahl, Justin  
503-838-6261  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Bridgeview Adult Foster Home  
2230 Maine Court  
North Bend, OR 97459  
Owner: Tramel, Janis  
541-751-1177  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Liberty Oaks Adult Foster Facility  
3133 Oak Street  
North Bend, OR 97459  
Kathy Crick  
Owner: Tichota, Melanie  
541-267-2255  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Burgess Adult Foster Home, Inc.  
775 N.W. Park Blvd.  
Ontario, OR 97914  
Dolores Teves  
Owner: Burgess Adult Foster Homes, Inc.  
541-881-8673  
Contact: Ralph and Mary Lee Burgess  
Facility Type: AFH Capacity: 5  
PSRB: 5 ECMU: Community:

Burgess Foster Home #1  
2568 S.W. 1st Avenue  
Ontario, OR 97914  
Owner: Burgess Adult Foster Homes, Inc.  
541-889-3691  
Contact: Ralph and Mary Lee Burgess  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Nancy's Adult Foster Care  
287 N. Oregon  
Ontario, OR 97914  
Owner: Armstrong, Nancy  
541-889-3081  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Spanish Villa Foster Home  
1518 W. Idaho Avenue  
Ontario, OR 97914  
Owner: Daudt, Kim Lien T. and Garrett R.  
Contact:  
541-889-9145  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Woodlawn Care  
161 Woodlawn Court  
Oregon City, OR 97045  
Patricia Drebin  
Owner: Shineovich, Sondra  
503-650-2681  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Ohana House  
3685 S.W. Marshall Court  
Pendleton, OR 97801  
Owner: Kraxberger, Kellie J.  
541-276-0465  
Contact:  
541-276-0465  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Werner Foster Care, L.L.C. #1  
85820 Parkway Road  
Pleasant Hill, OR 97455  
Owner: Green, Robin and Bradley  
541-747-1572  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Werner Foster Care, L.L.C. #2  
85820 Parkway Road  
Pleasant Hill, OR 97455  
Owner: Green, Robin and Bradley  
541-747-1572  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

5220 N.E. Roselawn Street  
Portland, OR 97218  
Owner: Valerie McConaughy  
503-284-1514  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

5316 N.E. 48th Avenue  
Portland, OR 97218  
Owner: Eva Miles  
503-281-3034  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Tara House  
13229 S.W. 64th Avenue  
Portland, OR 97219  
Susan Dodge  
Owner: Schoenborn, Rhonda L. and Ruonavaara, Lacy  
503-968-8854  
Contact:  
503-968-8854  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Providence Portland Medical Center: Women's Home  
10726 N.E. Glisan (5228 N.E. Hoyt)  
Portland, OR 97220  
Owner: Larry Betcher  
503-215-6474  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Paradise Adult Foster Care  
1356 S.E. 172nd Avenue  
Portland, OR 97233  
Owner: Christina Ellis  
503-760-8052  
Contact:  
Facility Type: AFH Capacity: 1  
PSRB: ECMU: Community: 1

5604 N.E. 11th  
Portland, OR 97211  
Owner: Lillian Brewster  
503-281-3558  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Providence Portland Medical Center: Men's Home  
1616 N.E. 74th (5228 N.E. Hoyt)  
Portland, OR 97213  
Owner: Larry Betcher  
503-215-6474  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Delia Dima #1  
8510 S.W. 20th Avenue  
Portland, OR 97219  
Owner: Delia Dima  
503-245-5126  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Delia Dima #2  
8520 S.W. 20th Avenue  
Portland, OR 97219  
Owner: Delia Dima  
503-245-5126  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

2220 S.E. 174th Avenue  
Portland, OR 97233  
Owner: Ana Maria Rivera  
503-761-4006  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Art's Foster Home  
6550 S.E. 13st Avenue  
Portland, OR 97236  
Owner: Arthur C. Tolentino  
503-762-5099  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

2334 N.E. 10th Avenue  
Portland, OR 97212  
Owner: Mattie Mullen  
503-287-6306  
Contact:  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Bell Dera AFC  
1435 N.W. Almira Street  
Roseburg, OR 97470  
Ken Mandera  
Owner: Bellinger, Pearl L.  
541-817-6231  
Contact:  
541-817-6231  
Facility Type: AFH Capacity: 4  
PSRB: ECMU: Community: 4

Elizabeth Stanton Foster Home  
524 N.E. Jackson Street  
Roseburg, OR 97470  
Owner: Stanton, Elizabeth  
541-672-9816  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Lorraine's Care Home  
2068 Burdette Drive  
Roseburg, OR 97470  
Owner: Crabtree, Lorraine  
541-679-9128  
Contact:  
Facility Type: AFH Capacity: 2  
PSRB: ECMU: Community: 2

Neely's Adult Foster Care  
1234 S.E. Court Avenue  
Roseburg, OR 97470  
Owner: Neely, Miriam  
541-957-1234  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Neely's Adult Foster Home Pitzer  
267 S.E. Pitzer Street  
Roseburg, OR 97470  
Brian Neely  
Owner: Neely, Miriam  
541-957-1234  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Devenberg Care Home  
3220 Felina Avenue N.E.  
Salem, OR 97301  
Chris Hall  
Owner: Devenberg, Robert  
503-581-3998  
Contact:  
503-931-4010  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Star House Adult Foster Home  
4075 32nd Place N.E.  
Salem, OR 97301  
Marie A. Mays-Nash  
Owner: Murdock Adult Foster Homes, Inc.  
503-363-1008  
Contact:  
503-363-1008  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Teton Lodge  
894 Teton Court S.E.  
Salem, OR 97301  
Barbara Jacob  
Owner: Devenberg, Robert  
503-931-4010  
Contact:  
503-931-4010  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Dukes Adult Foster Care Home  
4267 Cloudview Drive S.  
Salem, OR 97302  
Jody Terando  
Owner: Duke, James and Shantel  
503-589-3103  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

James Duke's Adult Foster Home  
540 Juneau Drive S.  
Salem, OR 97302  
Jessica Beard  
Owner: Duke, James and Shantel  
503-689-1967  
Contact:  
503-689-1967  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Dee Dee Services #1  
953 Burly Hill Drive N.W.  
Salem, OR 97304  
James Hendon  
Owner: Brown-Simmons, Darlene  
503-393-2520  
Contact:  
503-428-8886  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Heise Adult Foster Home  
1276 Lottie Lane N.W.  
Salem, OR 97304  
Randy Jackson  
Owner: Heise, Jeff and Katie  
503 371 6538 (TTY)  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Fisher Road II  
2255 Fisher Road N.E.  
Salem, OR 97305  
Owner: Gibson, Connie, John and Dana  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Gibson Adult Foster Care I  
2245 Fisher Road N.E.  
Salem, OR 97305  
Owner: Gibson, Connie and Dana  
Contact:  
503-581-0136  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Gibson Adult Foster Care II  
2255 Fisher Road N.E.  
Salem, OR 97305  
Lee Crafford  
Owner: Connie Gibson and Lilian Crafford  
503-580-3291  
Contact:  
503-990-6072  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Happy House #1  
4900 Happy Drive N.E.  
Salem, OR 97305  
Dan Redwine  
Owner: Murdock Adult Foster Homes, Inc.  
503-393-8647  
Contact:  
503-363-1008  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Jennifer's Adult Foster Home  
4241 Windflower Court N.E.  
Salem, OR 97305  
Brian David Jones  
Owner: Murdock, Jennifer  
503-390-5388  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: 5 ECMU: Community:

Mike's Adult Foster Home #3  
4259 Prairie Star Court  
Salem, OR 97305  
Patricia McCall  
Owner: Murdock, Mike  
503-365-8988  
Contact:  
503-409-5010  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Wheat House #3  
4235 Wheat Court N.E.  
Salem, OR 97305  
Margaret Caissey  
Owner: Murdock Adult Foster Homes, Inc.  
503-463-9845  
Contact:  
503-363-9845  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Garden Terrace  
5148 Lone Oak Road S.E.  
Salem, OR 97306  
Owner: Hartnell, Jan  
503-588-3390  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Mike's Adult Foster Home #2  
664 Valleywood Drive S.E.  
Salem, OR 97306  
John Paul Morin  
Owner: Murdock, Mike  
503-581-4892  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Heise Adult Foster Home, L.L.C.  
1276 Lottie Lane N.W.  
Salem, OR 97304  
Randy Jackson  
Owner: Heise, Jeff  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Emily's Care Home  
1129 R Street  
Springfield, OR 97477  
Christopher Polf  
Owner: Nelapudi, Leela  
541-726-4780  
Contact:  
541-228-8327

Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Eldorado Valley Care  
137 N. 51st Street  
Springfield, OR 97477  
Owner: Nelapudi, Nitin R.  
541-726-4780  
Contact:  
541-726-2704  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Blue Gryphon Light House  
880 N. 42nd Street  
Springfield, OR 97478  
Owner: Turnbull, Flora  
541-579-4259  
Contact:  
541-579-4259  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: Community: 5

Our House  
124 Forrest Park  
St. Helens, OR 97051  
Lana Ames  
Owner: Columbia Community Mental Health  
503-397-5211  
Contact: Juli Knapp, Residential Specialist  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

D' Immaculate  
8595 S.W. Pinebrook Drive  
Tigard, OR 97224  
Owner: Nepomuceno, Joel V.  
503-925-4570  
Contact:  
503-925-4570  
Facility Type: AFH Capacity: 2  
PSRB: ECMU: Community: 2

Stewart House  
2411 9th Street  
Tillamook, OR 97141  
Luana Russell  
Owner: Stewart, Jan  
503-842-1259  
Contact:  
Facility Type: AFH Capacity: 5  
PSRB: ECMU: 5 Community:

Lifeworks North West  
400 N.E. 7th Avenue  
Gresham, OR 97030  
Owner:  
Contact: Kevin Mahon  
503-661-5455  
Facility Type: ICM Capacity: 8  
PSRB: ECMU: 8 Community:

TRC - ACT  
4101 N.E. Division Street  
Gresham, OR 97030  
Owner:  
Contact: Multnomah County  
Facility Type: ICM Capacity: 50  
PSRB: ECMU: 50 Community:

TRC - ACT Phase 2  
Gresham, OR 97030  
Owner:  
Contact: Multnomah County  
Facility Type: ICM Capacity: 20  
PSRB: ECMU: 20 Community:

CODA - various independent apartments  
Portland, OR  
Owner:  
Contact: Carolyn Mounts  
503-252-3304 ext. 14  
Facility Type: ICM Capacity: 5  
PSRB: 5 ECMU: Community:

Cascadia - various independent apartments  
Portland, OR 97206  
Owner:  
Contact: Bonnie Lambert  
503-238-0705 ext. 228  
Facility Type: ICM Capacity: 10  
PSRB: 10 ECMU: Community:

Jackson Co Individual Rehab  
Owner:  
Contact: JoAnn Almanza  
541-744-7862  
Facility Type: ICM Capacity: 1  
PSRB: ECMU: 1 Community:

Springer House  
1106 S.W. Broadway  
Albany, OR 97321  
Kathy Wujcik  
Owner: Linn County Mental Health  
541-967-8634  
Contact: Frank Moore, Director, Linn County Mental  
Health  
Facility Type: RTF Capacity: 7  
PSRB: 1 ECMU: Community: 6

Edwards House  
4180 S.W. 185th Avenue  
Aloha, OR 97007  
Ann Valdez  
Owner: Sequoia Mental Health Services, Inc.  
503-649-4925  
Contact: Terry Brown, Residential Manager  
Facility Type: RTF Capacity: 15  
PSRB: ECMU: Community: 15

Columbia River Ranch  
70362 Kunze Road  
Boardman, OR 97818  
Todd Siex  
Owner: ColumbiaCare Services, Inc.  
541-481-3233  
Contact: Bob Beckett  
541-858-8170  
Facility Type: RTF Capacity: 12  
PSRB: ECMU: 11 Community: 1

Coos Crisis Resolution Center  
1885 Thompson Road  
Coos Bay, OR 97420  
Katherine Parker  
Owner: ColumbiaCare Services, Inc.  
541-266-8480  
Contact: Robert Beckett, President  
541-956-6081  
Facility Type: RTF Capacity: 6  
PSRB: ECMU: Community: 6

Connell House  
117 N. 29th  
Cornelius, OR 97113  
Karen Tarvin  
Owner: Luke-Dorf, Inc.  
503-726-3690  
Contact: Stephanie Peacock, Res. Operations  
Coordinator  
503-726-3690  
Facility Type: RTF Capacity: 12  
PSRB: 8 ECMU: Community:

Janus House  
606 S.W. 5th  
Corvallis, OR 97333  
Bill McClenaghan  
Owner: Mental Health Association of Benton County  
541-753-9219  
Contact: Bill McClenaghan  
Facility Type: RTF Capacity: 13  
PSRB: 1 ECMU: Community: 12

Fir Hill Group Home, L.L.C.  
1487 Main Street  
Dallas, OR 97338  
Pamela Wood  
Owner: Fir Hill Group Home, L.L.C.  
503-623-4230  
Contact: Rodney Proaps  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: Community: 12

Pioneer Guest Home, Inc.  
101 E. Main  
Enterprise, OR 97828  
Randall Roddey  
Owner: Snoozy, Elden  
541-426-4222  
Contact:  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: 6 Community: 10

Royal Avenue Program  
780 Highway 99 North  
Eugene, OR 97401  
R. Dean Schlecht  
Owner: ShelterCare  
541-461-2845  
Contact: Susan Ban, Executive Director  
Facility Type: RTF Capacity: 24  
PSRB: ECMU: Community: 24

Alder Street Residence  
1774 Alder Street  
Eugene, OR 97402  
Denise Schadeegg  
Owner: Halfway House Services, Inc.  
541-683-7532  
Contact: Denise Schadeegg  
Facility Type: RTF Capacity: 8  
PSRB: ECMU: Community: 8

William Ware Residence  
910 Jefferson  
Eugene, OR 97402  
Kerrie Bishop  
Owner: Halfway House Services, Inc.  
541-686-8438  
Contact: Denise Schadeegg, Program Manager  
541-686-8438  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Driftwood Lodge  
29413 Russell Street  
Gold Beach, OR 97444  
Cathy Klamroth  
Owner: ColumbiaCare Services, Inc.  
541-247-6566  
Contact: Robert Beckett, Executive Director  
541-858-8170  
Facility Type: RTF Capacity: 8  
PSRB: ECMU: 8 Community:

Carnahan Court  
1644 Carnahan Court  
Grants Pass, OR 97527  
Ron Winfrey  
Owner: Options for Southern Oregon, Inc.  
541-474-5498  
Contact: Marilane Jorgenson  
541-476-2373  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: 10 Community:

Hoodview  
1610 W. Powell Boulevard  
Gresham, OR 97030  
Shannan Mays  
Owner: Sistere, Inc.  
503-665-5193  
Contact: Dennis Murphy, Owner  
503-774-1365  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Wallula Place  
801 N.W. Wallula  
Gresham, OR 97030  
Jeff Barker  
Owner: Luke-Dorf, Inc.  
503-726-3802  
Contact: Elizabeth Adami, Residential Program  
Manager  
503-726-3706  
Facility Type: RTF Capacity: 15  
PSRB: ECMU: Community: 15

Cognitive Enrichment Concepts, L.L.C.  
1307 S.E. 4th Street  
Gresham, OR 97080  
Rick St.Clair  
Owner: Scott, Debra  
503-516-7363  
Contact: Debra Scott  
Facility Type: RTF Capacity: 11  
PSRB: ECMU: 11 Community:

Glynn Terrace  
360 S.W. 6th  
Gresham, OR 97080  
Amber Lewis  
Owner: Luke-Dorf, Inc.  
503-726-3806  
Contact: Stephanie Peacock, Residential Operations  
Coorr.  
Facility Type: RTF Capacity: 15  
PSRB: 15 ECMU: Community:

Independence Place  
120 S. Roanoke  
Hines, OR 97738  
Salene Green  
Owner: Harney Behavioral Health  
541-573-1780  
Contact: Chris Siegner  
541-573-8376  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: 9 Community: 1

Parkside Living Center  
1525 S.W. Shirley Ann Drive  
McMinnville, OR 97128  
Holly Smith  
Owner: Parkside Living, Inc.  
503-472-9603  
Contact: Pooney Entazari, Owner  
503-285-7648  
Facility Type: RTF Capacity: 16  
PSRB: 2 ECMU: 14 Community:

Harmony House  
11458 S.E. McEachron Street  
Milwaukie, OR 97222  
Corey Baird  
Owner: NW Mental Health Management Services, Inc.  
503-794-2928  
Contact: Jennifer McFee  
503-655-6674  
Facility Type: RTF Capacity: 6  
PSRB: ECMU: 6 Community:

King Road/64th Avenue L.L.C.  
4199 S.E. King Road  
Milwaukie, OR 97222  
April Dye  
Owner: 64th Avenue L.L.C.  
503-968-8854  
Contact: Rhonda Schoenborn  
503-803-9404  
Facility Type: RTF Capacity: 6  
PSRB: 3 ECMU: 3 Community:

Roethe Manor  
5230 S.E. Roethe Road  
Milwaukie, OR 97267  
Shirley Chambers  
Owner: NW Mental Health Management Services, Inc.  
503-642-9092  
Contact: Jennifer McFee  
503-655-6674  
Facility Type: RTF Capacity: 13  
PSRB: ECMU: Community: 13

Leland House  
18980 S. Leland Road  
Oregon City, OR 97045  
Jade Bourbonnais  
Owner: NW Mental Health Management Services, Inc.  
503-650-8605  
Contact: Jennifer McFee, Program Director  
Facility Type: RTF Capacity: 11  
PSRB: ECMU: 10 Community: 1

Pearl Street  
304 Pearl Street  
Oregon City, OR 97045  
Julie Jabobs  
Owner: NW Mental Health Management Services, Inc.  
503-657-9889  
Contact: Jennifer McFee  
Facility Type: RTF Capacity: 13  
PSRB: ECMU: 6 Community: 7

Andrea Place  
7621 N. Portsmouth Avenue  
Portland, OR 97203  
Roberta Green  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-240-7599  
Contact: Kathy Prenevost, Program Manager  
503-872-0123  
Facility Type: RTF Capacity: 15  
PSRB: ECMU: 15 Community:

70th Street Respite  
3909 S.E. 70th Street  
Portland, OR 97206  
Scott Bolen  
Owner: Cascadia Behavioral Healthcare, Inc.  
541-777-2278  
Contact: Mike Nomina, Program Manager  
503-238-0705  
Facility Type: RTF Capacity: 12  
PSRB: ECMU: Community: 12

Nadine's Place  
2270 S.E. 39th Street  
Portland, OR 97206  
Chris Goforth  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-963-8337  
Contact: Kathy Prenevost, Program Manager  
503-889-2550  
Facility Type: RTF Capacity: 9  
PSRB: ECMU: 6 Community: 3

Pisgah Home Colony  
7511 S.E. Henry Street  
Portland, OR 97206  
Cordelia Kolar  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-771-6061  
Contact: Silas Halloran-Steiner, Program Manager  
503-238-0705  
Facility Type: RTF Capacity: 16  
PSRB: 6 ECMU: 10 Community:

Glisan Street House  
2375 N.W. Glisan Street  
Portland, OR 97210  
Barrett Crosby  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-243-2236  
Contact: Neal Rotman  
503-889-2550  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: 10 Community:

Cameron Care, Inc.-Garfield  
3626 N.E. Garfield  
Portland, OR 97212  
Andrew Sperry  
Owner: Cameron, Gaye, Corey and Geraldine  
503-249-6998  
Contact: Gaye, Corey and Geraldine Cameron  
Facility Type: RTF Capacity: 14  
PSRB: ECMU: Community: 14

8041 Recovery House  
8041 E. Burnside  
Portland, OR 97215  
Joe Pense  
Owner: CODA, Inc.  
503-252-3304  
Contact: Margaret Thiele, Deputy Director  
503-236-2290  
Facility Type: RTF Capacity: 7  
PSRB: ECMU: 7 Community:

McCarthy Place  
945-949 N.E. 165th  
Portland, OR 97230  
Deb Rice  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-408-8100  
Contact: Kathy Prenevost, Program Manager  
503-889-2550  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: 10 Community:

Rita May Manor  
13541 S.E. Market  
Portland, OR 97233  
Jerry Allen  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-258-9734  
Contact: Kathy Prenevost, Program Manager  
503-889-2550  
Facility Type: RTF Capacity: 8  
PSRB: ECMU: 7 Community: 1

Cameron Care, Inc.-Boise  
12657 S.E. Boise  
Portland, OR 97236  
Roberta Green  
Owner: Cameron, Gaye, Corey and Geraldine  
503-761-6065  
Contact: Gaye, Corey and Geraldine Cameron  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Cameron Care, Inc.-Powell  
14309 S.E. Powell Blvd.  
Portland, OR 97236  
Roberta Green  
Owner: Cameron, Gaye and Corey  
503-761-0381  
Contact: Gaye and Corey Cameron  
Facility Type: RTF Capacity: 15  
PSRB: ECMU: Community: 15

Columbia Rose  
12511 S.E. Raymond Street  
Portland, OR 97236  
Sheryl Peterson  
Owner: ColumbiaCare Services, Inc.  
503-761-2580  
Contact: Robert Beckett, President  
541-858-8170  
Facility Type: RTF Capacity: 9  
PSRB: ECMU: 9 Community:

Willamette Rose  
12505 S.E. Raymond Street  
Portland, OR 97236  
Sheryl Peterson  
Owner: ColumbiaCare Services, Inc.  
503-760-8300  
Contact: Robert Beckett, President  
Facility Type: RTF Capacity: 9  
PSRB: ECMU: 9 Community:

Horizon House  
2435 Greenway Drive N.E.  
Salem, OR 97301  
Jackie Hadley  
Owner: Marion County Health Department  
503-362-5918  
Contact: Scott Richards, Clinical Supervisor  
503-361-2642  
Facility Type: RTF Capacity: 8  
PSRB: ECMU: 8 Community:

Oregon State Hospital - Cottages 5 and 6  
2430 and 2440 Greenway Drive N.E.  
Salem, OR 97301-2682  
Dana Petre-Miller  
Owner: Oregon State Hospital  
Contact: Dusty Charter, RN, Quality Improvement  
Specialist  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Royvonne House  
1240 Royvonne Street S.E.  
Salem, OR 97302  
Karen Liudahl  
Owner: Carroll's GroupCare Home, Inc.  
503-362-2605  
Contact: Neil Carroll  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Carrolls Group Care Home, Inc.  
293 14th Street S.E.  
Salem, OR 97309  
Neil Carroll  
Owner: Carroll, Neil  
503-399-0189  
Contact: Neil Carroll  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: Community: 16

Oregon State Hospital - Cottages 1 and 2  
2465 and 2445 Midway Court N.E.  
Salem, OR 97310  
Dusty Charters, R.N.  
Owner: Oregon State Hospital  
Contact:  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: Community: 16

Oregon State Hospital - Cottages 7 and 8  
2460 and 2470 Greenway Drive N.E.  
Salem, OR 97310  
Dusty Charters, R.N.  
Owner: Oregon State Hospital  
Contact:  
Facility Type: RTF Capacity: 10  
PSRB: ECMU: Community: 10

Gateway 2 Community Living  
620 N. Cloverleaf Loop  
Springfield, OR 97477  
Tammi Morton  
Owner: Gateway Assisted Living, Inc.  
541-501-0061  
Contact: Mark A. Kinkade  
541-744-9817  
Facility Type: RTF Capacity: 13  
PSRB: 4 ECMU: 9 Community:

Rainrock Treatment Center, L.L.C. (Private Pay Only)  
41496 McKenzie Highway  
Springfield, OR 97478  
Anthony Laughlin  
Owner: Rainrock Treatment Center, L.L.C.  
541-896-9300  
Contact:  
541-896-9300  
Facility Type: RTF Capacity: 11  
PSRB: ECMU: Community: 11

Alternative  
105 3rd Street  
St. Helens, OR 97051  
Linda Pritchett  
Owner: Columbia Community Mental Health  
503-397-6900x13  
Contact:  
Facility Type: RTF Capacity: 9  
PSRB: 8 ECMU: Community: 1

Cornerstone  
271 Columbia Boulevard  
St. Helens, OR 97051  
Juli Knapp  
Owner: Columbia Community Mental Health  
503-397-0391  
Contact: Juli Phelps, Administrator  
503-397-5211  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: 15 Community: 1

Creskside Residential Treatment Facility  
1021 W. 9th Street  
The Dalles, OR 97058  
William Byers  
Owner: ColumbiaCare Services, Inc.  
541-298-1920  
Contact: Bob Beckett, President  
541-858-8170  
Facility Type: RTF Capacity: 12  
PSRB: ECMU: 9 Community: 3

Sandvig House  
10313 S.W. 69th Avenue  
Tigard, OR 97223  
Chris Judson  
Owner: Luke-Dorf, Inc.  
503-246-5493  
Contact: Elizabeth Adami, Residential Program  
Manager  
503-726-3706  
Facility Type: RTF Capacity: 16  
PSRB: ECMU: Community: 16

Wallowa River House  
601 Whiskey Creek Road  
Wallowa, OR 97885  
Scott Colony  
Owner: Wallowa Valley Center for Wellness, Inc.  
Contact: Stephen Kliewer, D.Min., Director  
541-426-4524  
Facility Type: RTF Capacity: 11  
PSRB: ECMU: 11 Community:

Young Adult Program - Trillium  
729 S.W. 7th  
Albany, OR 97321  
Matt Holland  
Owner: Trillium Family Services, Inc.  
541-758-5926  
Contact: Mark McIntyre  
541-758-5926  
Facility Type: RTH Capacity: 4  
PSRB: ECMU: Community: 4

Casa Rio  
4472 Del Rio Place S.E.  
Albany, OR 97322  
Layne Wright  
Owner: Shangri-La Corp.  
503-581-1732  
Contact: Karen Rutledge  
503-581-1732  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Old Oak RTH  
1206 Old Oak Place  
Albany, OR 97322  
Layne Anderson-Winchester  
Owner: Shangri-La Corp.  
503-581-1732  
Contact: Karen Rutledge  
503-581-1732 X 321  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Myrtlewood House  
20695 S.W. Kinnaman  
Aloha, OR 97007  
Elizabeth Martin  
Owner: Sequoia Mental Health Services, Inc.  
503-591-8371  
Contact: Terry Brown, Residential Manager  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Matthews House  
10120 S.W. Cynthia  
Beaverton, OR 97005  
Kimberly Galindo  
Owner: Luke-Dorf, Inc.  
503-520-1895  
Contact: Stephanie Peacock, Residential Operations  
Coord.  
503-726-3708  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Haven House Treatment Center Corp.  
13565 S.W. Singletree Drive  
Beaverton, OR 97008  
Sara Hergic  
Owner: Lacandazo, Julieta  
503-267-8012  
Contact:  
503-267-8012  
Facility Type: RTH Capacity: 2  
PSRB: ECMU: 2 Community:

Hosmer House  
3316 N.E. Cruise Loop  
Bend, OR 97701  
Dan Cochran  
Owner: National Mentor Services, L.L.C.  
541-647-1269  
Contact: Jay Herzog  
503-258-2440  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Sequoia Creek RTH  
884 N.W. Chipmunk Place  
Corvallis, OR 97330  
Anthony Sorce  
Owner: Shangri-La Corp.  
503-581-1732  
Contact: Karen Rutledge  
503-581-1732  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Linden Lane  
1085 Linden Lane  
Dallas, OR 97338  
J.C. Engdahl  
Owner: New Foundations, L.L.C.  
503-831-3082  
Contact:  
503-581-3082  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Danebo  
2140 N. Danebo  
Eugene, OR 97402  
LaJeana Boss  
Owner: Shangri-La Corp.  
503-581-1732  
Contact: Karen Rutledge  
503-581-1732  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Myers Road  
2015 Myers Road  
Eugene, OR 97404  
Karen Rutledge  
Owner: Shangri-La Corp.  
Contact:  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: Community: 5

Portland Avenue  
1035 A and B Portland Avenue  
Gladstone, OR 97027  
Matthew Wright  
Owner: NW Mental Health Management Services, Inc.  
Contact: Jennifer McFee, Program Director  
503-655-6674  
Facility Type: RTH Capacity: 4  
PSRB: ECMU: 4 Community:

Court House  
1555 S.W. 1st Court  
Gresham, OR 97030  
Shannan Mays  
Owner: Murphy, Dennis  
Contact:  
503-665-5193  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: Community: 5

Homestreet Bridges  
510 S. First Avenue  
Hillsboro, OR 97123  
Carmen Garcia  
Owner: Sequioa Mental Health Services, Inc.  
503-693-1464  
Contact: Terry Brown, Residential Program Manager  
503-640-4959X22  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: Community: 5

Adams Lane RTH  
2614 Adams Lane S.E.  
Jefferson, OR 97352  
Tammy Montgomery  
Owner: Shangri-La Corp.  
503-581-1732  
Contact:  
503-581-1732  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Joseph House  
301 E. Seventh  
Joseph, OR 97828  
Hannah Hillock  
Owner: Wallowa Valley Center for Wellness, Inc.  
541-422-1068  
Contact: Diana Jannuzzi  
541-426-4524  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Chinook House  
714 Lost Lane  
Keizer, OR 97303  
Heather Knudson  
Owner: Knudsen, Heather and Stevens, Chad  
541-760-7851  
Contact: Heather Knudsen  
541-908-4124  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

PCL RTH  
1376 N.E. Ridgeview  
Monmouth, OR 97361  
Marty Mierau  
Owner: PCL  
503-838-2403  
Contact:  
503-838-2403  
Facility Type: RTH Capacity: 1  
PSRB: ECMU: Community: 1

Benton Place  
168 S.E. 10th Street  
Newport, OR 97365  
J. Jasmine  
Owner: Shangri-La Corp.  
541-574-0086  
Contact: Sandy Post, Program Director  
Facility Type: RTH Capacity: 5  
PSRB: 3 ECMU: 2 Community:

Cedar Bay  
1592 N. Monroe Street  
North Bend, OR 97459  
David McDaniel  
Owner: ColumbiaCare Services, Inc.  
541-290-3535  
Contact: Stacy Beaumont, Administrative Program  
Manager  
541-660-5696  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Mosaic Young Adult Transition Program  
996 South End Road  
Oregon City, OR 97045  
Sommer Wolcott  
Owner: Christie School DBA ChiristieCare  
Contact: Linda Fanning, Program Development  
Manager  
503-675-2259  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: Community: 5

Mossy Meadows  
20025 Mossy Meadows Avenue  
Oregon City, OR 97045  
Sheryl Peterson  
Owner: ColumbiaCare Services, Inc.  
Contact: Stacy Beaumont, Admin Services Director  
541-858-8170  
Facility Type: RTH Capacity: 2  
PSRB: ECMU: 2 Community:

Hilltop House  
37 N.E. Mt. Hebron Drive  
Pendleton, OR 97801  
Mary Ward  
Owner: Lifeways, Inc.  
541-276-0810X347  
Contact: Elizabeth Pearson, Program Manager  
541-276-0810X347  
Facility Type: RTH Capacity: 5  
PSRB: 2 ECMU: 3 Community:

75th Home  
4729 S.E. 75th  
Portland, OR 97206  
Erica Bartleson  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-788-1680  
Contact: Silas Halloran-Steiner  
503-228-7134x4214  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Overton House  
2270 N.W. Overton  
Portland, OR 97210  
Mark Flathman  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-241-6051  
Contact: Silas Halloran-Steiner  
503-238-0705  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

23rd Avenue  
1232 N.W. 23rd Avenue  
Portland, OR 97212  
Renee Boak  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-227-3450  
Contact: Sillas Halloran-Steiner, Program Manager  
503-238-0705  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Buena Vista Home  
326 S.E. 76th Avenue  
Portland, OR 97214  
Chad Ernest  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-255-3198  
Contact:  
503-889-2551  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Hazelwood House  
10714 N.E. Glisan  
Portland, OR 97220  
Cammy Bentz  
Owner: LifeWorks Northwest  
503-256-2453/503-252-5670  
Contact: Connie Dunkle-Weyrauch  
503-645-3581 ext.2354  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Horizon House  
10638 N.E. Glisan  
Portland, OR 97220  
Scott Fitzwater  
Owner: LifeWorks Northwest  
503-617-3827  
Contact: Phyllis Maynard  
503-617-3827  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Centennial Resident Treatment Home  
15208 S.E. Tibbetts  
Portland, OR 97236  
Robert Bailey  
Owner: ColumbiaCare Services, Inc.  
503-760-959  
Contact: Stacy Beaumont  
541-858-8170  
Facility Type: RTH Capacity: 2  
PSRB: ECMU: 2 Community:

Estuesta House  
6449 S.E. 128th Avenue  
Portland, OR 97236  
Will Alarid  
Owner: Luke-Dorf, Inc.  
503-726-3796  
Contact: Elizabeth Adami, Residential Program  
Manager  
503-726-3706  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: Community: 5

Rolfson House-North  
15606 S.E. Division  
Portland, OR 97236  
Ryan Bair  
Owner: CODA, Inc.  
503-239-8400X216  
Contact: Margaret Thiele, Deputy Executive Director  
503-239-8400X216  
Facility Type: RTH Capacity: 4  
PSRB: 4 ECMU: Community:

Rolfson House-South  
15602 S.E. Division  
Portland, OR 97236  
Ryan Bair  
Owner: CODA, Inc.  
503-239-8400X216  
Contact: Margaret Thiele, Deputy Executive Director  
503-239-8400X216  
Facility Type: RTH Capacity: 4  
PSRB: 4 ECMU: Community:

Valeo  
15308 S.E. Division Street  
Portland, OR 97236  
Will Alarid  
Owner: Luke-Dorf, Inc.  
Contact: Stephanie Peacock-Residential Program  
Coordinator  
503-726-3706  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Eldorado  
7405 S.E. 84th Avenue  
Portland, OR 97266  
Tina Green  
Owner: National Mentor Services, L.L.C.  
503-771-1675  
Contact: Rondi Grace, Owner  
503-258-2440 X 144  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Via Verde  
545 24th Place N.E.  
Salem, OR 97301  
Anthony Sorce  
Owner: Shangri-La Corp.  
503-581-1732  
Contact: Karen Rutledge, Director  
503-581-1732  
Facility Type: RTH Capacity: 5  
PSRB: 5 ECMU: Community:

Christopher House  
11990 S.W. 121st Street  
Tigard, OR 97223  
Kimberly Galindo  
Owner: Luke-Dorf, Inc.  
503-726-3770  
Contact: Stephanie Peacock, Residential Operations  
Manager  
503-726-3706  
Facility Type: RTH Capacity: 5  
PSRB: 2 ECMU: 3 Community:

Meusch House  
10335 S.W. View Terrace  
Tigard, OR 97223  
Chris Judson  
Owner: Luke-Dorf, Inc.  
503-726-3780  
Contact: Stephanie Peacock, Residential Operations  
Coord.  
971-222-6625  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Fieldstone  
29120 S.W. San Remo Court  
Wilsonville, OR 97070  
Sheryl Peterson  
Owner: ColumbiaCare Services, Inc.  
Contact: Stacy Beaumont, Administrative Services  
Director  
541-858-8170  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

HearthStone  
29549 S.W. Villebois Drive  
Wilsonville, OR 97070  
Shelly Horne  
Owner: NW Mental Health Management Services, Inc.  
503-427-0172  
Contact: Jennifer McFee, Program Director  
503-655-6674  
Facility Type: RTH Capacity: 5  
PSRB: ECMU: 5 Community:

Laurel Hill Center  
2145 Centennial Plaza  
Eugene, OR 97401  
Owner:  
Contact: Shawn Murphy  
541-485-6340  
Facility Type: SH Capacity: 10  
PSRB: ECMU: 10 Community:

Laurel Hill Center Phase 1 & 2  
2145 Centennial Plaza  
Eugene, OR 97401  
Owner:  
Contact: Shawn Murphy  
541-485-6340  
Facility Type: SH Capacity: 20  
PSRB: ECMU: 20 Community:

Hawthorne Apt.  
2988 Oak Street  
Eugene, OR 97405  
Owner:  
Contact: Lane Shelter Care  
541-343-4070  
Facility Type: SH Capacity: 4  
PSRB: ECMU: 4 Community:

Crater Lake  
1005 E. Main Street, Bldg. D  
Medford, OR 97504  
Owner:  
Contact: Jackson County  
541-774-8035  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

Quince  
3820 S.E. 26th  
Portland, OR 97202  
Owner:  
Contact: Bonnie Lambert  
503-719-4776  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

Rosewood  
7003 S.E. Woodstock  
Portland, OR 97206  
Owner:  
Contact: Bonnie Lambert  
503-771-2271  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

INSTAR  
5417 N.E. 25th Avenue  
Portland, OR 97211  
Owner:  
Contact: Kai Harris  
503-282-6707  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

Halsey  
6631 N.E. Halsey Street  
Portland, OR 97213  
Owner:  
Contact: Larry Betcher  
503-253-0613  
Facility Type: SH Capacity: 13  
PSRB: ECMU: 13 Community:

Sandy Apts.  
11401 N.E. Sandy Blvd.  
Portland, OR 97220  
Owner:  
Contact: Luke-Dorf, Inc.  
503-597-3928  
Facility Type: SH Capacity: 10  
PSRB: 5 ECMU: 5 Community:

Alberta Plaza  
501-521 N.E. Alberta Street  
Portland, OR 97221  
Owner:  
Contact: Royce Bolin  
503-750-4978  
Facility Type: SH Capacity: 22  
PSRB: ECMU: 22 Community:

Stepping Stone  
2440 Greenway Drive  
Salem, OR 97301  
Owner:  
Contact: Bill Turtollotte  
503-361-2642  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

15th Street Apts  
215 S. 15th Street  
St. Helens, OR 97051  
Owner:  
Contact: Linda Pritchett  
503-397-4493 ext 109  
Facility Type: SH Capacity: 4  
PSRB: ECMU: 4 Community:

Rain Garden  
29197 S.W. Orleans Avenue  
Wilsonville, OR 97070  
Owner:  
Contact: Cathy Polinsky  
503-722-6515  
Facility Type: SH Capacity: 29  
PSRB: ECMU: 20 Community: 9

4th Avenue Housing  
1076 N.W. 4th Avenue  
Ontario, OR 97914  
Owner:  
Contact: Alice Mills  
541-889-5438  
Facility Type: SH Capacity: 5  
PSRB: ECMU: 5 Community:

Brookside Center  
10180 S.E. Sunnyside Road  
Clackamas, OR 97015  
Melinda Howard  
Owner: Kaiser Foundation Hospitals  
510-271-2603  
Contact: Margaret Wise  
503-571-1999  
Facility Type: SRTF Capacity: 40  
PSRB: ECMU: Community: 40

Garden Place  
3692 Hickory  
Eugene, OR 97401  
Robin Tiedeman, M.S.W.  
Owner: ShelterCare  
541-284-7800  
Contact: Susan Ban, Executive Director  
541-686-1262  
Facility Type: SRTF Capacity: 12  
PSRB: ECMU: 12 Community:

Heeran Center  
2222 Coburg Road  
Eugene, OR 97401  
Paulette Montplaisir  
Owner: ShelterCare  
541-465-3323  
Contact: Susan Ban, Executive Director  
Facility Type: SRTF Capacity: 16  
PSRB: 3 ECMU: 11 Community: 2

Fairview Firs  
1945 N.E. 205th Avenue  
Fairview, OR 97024  
Louis Brothers  
Owner: ColumbiaCare Services, Inc.  
541-858-8170  
Contact: Stacy Beaumont, Administrative Program  
Manager  
541-858-8170  
Facility Type: SRTF Capacity: 4  
PSRB: ECMU: 4 Community:

Hugo Hills Residential Treatment Facility  
900 Hitching Post Road  
Grants Pass, OR 97526  
Jillana Tappan  
Owner: Options for Southern Oregon, Inc.  
541-474-5380  
Contact: Marilane Jorgenson  
Facility Type: SRTF Capacity: 16  
PSRB: ECMU: 16 Community:

Crisis Resolution Center  
320 S.W. Ramsey  
Grants Pass, OR 97527  
Marilane Jorgenson  
Owner: Options for Southern Oregon, Inc.  
541-474-5363  
Contact: Marilane Jorgenson  
541-476-2373  
Facility Type: SRTF Capacity: 15  
PSRB: ECMU: Community: 15

Ramsey Place  
324 S.W. Ramsey  
Grants Pass, OR 97527  
Shelly Uhrig  
Owner: Options for Southern Oregon, Inc.  
541-474-5350  
Contact: Marilane Jorgenson  
541-476-2373  
Facility Type: SRTF Capacity: 11  
PSRB: ECMU: 11 Community:

Three Bridges  
711 S.W. Ramsey Avenue  
Grants Pass, OR 97527  
Michelle Richardson  
Owner: SOASTC  
541-479-5901  
Contact: Robert Lieberman  
541-956-4943  
Facility Type: SRTF Capacity: 12  
PSRB: ECMU: Community: 12

Telecare Recovery Center @ Gresham  
4101 N.E. Division Street  
Gresham, OR 97030  
Kevin McChesney  
Owner: Telecare Mental Health Services of Oregon,  
Inc.  
503-666-6575  
Contact: Kevin McChesney, Regional Operations  
Director  
Facility Type: SRTF Capacity: 16  
PSRB: ECMU: 16 Community:

Lakeview Heights  
68982 Willow Creek Road  
Heppner, OR 97836  
Matt Bergstrom  
Owner: Community Counseling Solutions  
Contact: Kimberly Lindsay  
541-676-9161  
Facility Type: SRTF Capacity: 10  
PSRB: ECMU: 8 Community: 2

Phoenix Place  
725 Washburn Way  
Klamath Falls, OR 97603  
Robert Leep  
Owner: Klamath County Mental Health  
541-273-1999  
Contact:  
541-273-1999  
Facility Type: SRTF Capacity: 16  
PSRB: ECMU: 9 Community: 7

Hazel Center  
1911 Hazel Street  
Medford, OR 97501  
Gordon Norman  
Owner: Jackson County Health & Human Services  
541-734-3952  
Contact:  
541-774-8201  
Facility Type: SRTF Capacity: 16  
PSRB: 8 ECMU: 8 Community:

Johnson Creek  
2808 S.E. Balfour  
Milwaukie, OR 97222  
H. Andrew Axer  
Owner: ColumbiaCare Services, Inc.  
503-830-7286  
Contact:  
503-659-2575  
Facility Type: SRTF Capacity: 8  
PSRB: 8 ECMU: Community:

Pendleton Cottages  
2585 Westgate Drive  
Pendleton, OR 97801  
Jenny Peters  
Owner: State of Oregon  
Contact: Darcy Strahan  
503-945-6185  
Facility Type: SRTF Capacity: 16  
PSRB: 16 ECMU: Community:

Telecare 72nd Avenue Recovery Center  
7759 S.E. 72nd Avenue  
Portland, OR 97206  
Jan Clay  
Owner: Telecare Mental Health Services of Oregon,  
Inc.  
503-788-4500  
Contact: Kevin McChesney, Regional Operations  
Director  
503-666-6575  
Facility Type: SRTF Capacity: 16  
PSRB: ECMU: 16 Community:

Arbor Place  
2330 N.E. Siskiyou Street  
Portland, OR 97212  
Wade Belknap  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-528-0757  
Contact:  
503-889-2551  
Facility Type: SRTF Capacity: 16  
PSRB: 1 ECMU: 15 Community:

Barbara Roberts House-East  
5023 N.E. Killingsworth Street  
Portland, OR 97218  
Sandy Wilborn  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-528-0757  
Contact:  
503-889-2551  
Facility Type: SRTF Capacity: 5  
PSRB: ECMU: 4 Community:

Barbara Roberts House-West  
5009 N.E. Killingsworth Street  
Portland, OR 97218  
Sandy Wilborn  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-528-0757  
Contact:  
503-889-2551  
Facility Type: SRTF Capacity: 5  
PSRB: ECMU: 4 Community:

Faulkner Place  
13317 S.E. Powell Blvd.  
Portland, OR 97236  
Lark Roe  
Owner: Cascadia Behavioral Healthcare, Inc.  
503-760-9606  
Contact: Neil Rotman  
Facility Type: SRTF Capacity: 15  
PSRB: 1 ECMU: 14 Community:

Summit South  
622 S. 57th Place  
Springfield, OR 97478  
Cheri Rushing  
Owner: ElderHealth & Living Corp.  
541-747-4858  
Contact: Rhonda Cobiskey, Chief Operations Officer  
541-747-4858  
Facility Type: SRTF Capacity: 5  
PSRB: ECMU: 5 Community:

McNary Place  
290 Willamette Avenue  
Umatilla, OR 97882  
Tim Mahoney  
Owner: Lifeways, Inc.  
541-922-0880  
Contact: Greg Schneider  
541-889-9167  
Facility Type: SRTF Capacity: 16  
PSRB: 10 ECMU: 2 Community: 4

Telecare Recovery Center @ Woodburn  
1605 E. Lincoln Road  
Woodburn, OR 97071  
Jim Sechrist  
Owner: Telecare Mental Health Services of Oregon,  
Inc.  
503-982-9300  
Contact: Kevin McChesney, Regional Operations  
Director  
503-319-6142  
Facility Type: SRTF Capacity: 15  
PSRB: 15 ECMU: Community:





Type	Contact Person	Name of Home	Address	Phone #	E-Mail Address	County	P	Bed	O	Be	Status
AFH	P & S Von Strahl	Von Strahl	408 Piccadilly Circle, Medford, OR 97504	541-732-0651	None Listed	Jackson	0	1	EST		
AFH	Lie-F- Tan	Amaryllis AFH	3291 Ford Drive, Medford, OR 97504	541-245-6515	None Listed	Jackson	0	1	EST		
AFH	Diane McGinnis	McGinnis AFH	120 Newtown St. Medford, OR 97501	541-779-3197	None Listed	Jackson	0	1	EST		
AFH	Susan & Martin Ray	Ray's Place	1840 Foothill Blvd., Grants Pass, OR 97526	541-955-1896	None Listed	Josephine	0	1	EST		
AFH	Ralph and Mary Lee Burgess	Burgess AFH #2	775 NW Park Blvd., Ontario, OR 97914	541-881-8673	maryleeburgess@cableone.net	Malheur	5	0	EST		
AFH	Mike Murdock	Mikes AFH #2	664 Valleywood Dr. SE, Salem, OR 97302	503-581-4892	None Listed	Marion	0	2	EST		
AFH	Shantel & James Duke	Dukes AFH	4267 Cloudview Drive S., Salem, OR 97302	503-999-8059	None Listed	Marion	0	1	EST		
AFH	Violet & Ernest Murdock	Wheat House #3	4235 Wheat Court NE, Salem, OR 97305	503-463-9845	None Listed	Marion	0	1	EST		
AFH	Mike Murdock	Mikes AFH #1	960 Downs Street South, Salem, OR 97302	503-365-8988	None Listed	Marion	0	2	EST		
AFH	Jennifer Murdock	Jennifer M. AFH	4241 Windflower Ct. NE Salem, OR 97305	503-390-5388	jennifermurdock1@yahoo.com	Marion	5	0	EST		
AFH	Larry Betcher	Providence Mens	1616 NE 74th, Portland, OR 97213	503-253-6909	Lawrence.Betcher@providence.org	Multnomah	4	0	EST		
AFH	Larry Betcher	Providence Womens	10726 NE Glisan, Portland, OR 97220	503-256-1645	Lawrence.Betcher@providence.org	Multnomah	5	0	EST		
						Total AFH	19	10			
RTF	Bill McLenaghan	Janus House	606 SW 5th, Corvallis, OR 97223	541-753-9219	jannusmha@peak.org	Benton	1	0	EST		
RTF	Rhonda Schoenborn	King Road	4199 SE King Rd. Milwkie, OR 97222	503-786-3830	kingroadtr@yahoo.com	Clackamas	3	0	EST		
RTF	Ben Weaver	Alternatives	105 3rd Street, St. Helens, OR 97051	503-397-6900	benw@ccmhl.com	Columbia	8	0	EST		
RTF	Robert Leep/County	Phoenix Place	705 Washburn Way, Klamath Falls, OR 97603	541-882-4471	bleep@co.klamath.or.us	Klamath	0	1	EST		
RTF	Cascadia- Joan Kehoe	Gateway Living 2	611 N. Cloverleaf Loop, Eugene, OR 97477	541-501-0061	Joan.kehoe@cascadiabhc.org	Lane	4	0	NEW		
RTF	Kerri Bishop	William Ware	910 Jefferson, Eugene, OR 97402	541-686-8438	wwr-hhs@comcast.net	Lane	0	2	EST		
RTF	Denise Schnadegg	Alder St.	1774 Alder St., Eugene, OR 97402	541-683-7532	None Listed	Lane	0	2	EST		
RTF	Kathy Wujick	Springer	1106 SW Broadway, Albany, OR 97321	541-967-8634	kwuycik@comcast.net	Linn	1	0	EST		
RTF	Cascadia- Cordelia Kolar	Pisgah Home Colony	7511 SE Henry St. Portland, OR 97206	503-771-6061	cordelia.kolar@cascadiabhc.org	Multnomah	6	0	EST		
RTF	L-D Inc.- Amber Lewis	Glynn Terrace	360 SW 6th, Gresham, OR 97080	503-726-3806	Alewis@like-dorf.org	Multnomah	15	0	EST		
RTF	L-D, Inc.- Katrina Bennett	Connell House	117 N 29th Ave, Cornelius, OR 97113	503-597-3900	kbenneitt@luke-dorf.org	Washington	8	0	NEW		
RTF	Jenny White	Parkside	1535 SW Shirley Ann Dr. McMinville, OR 971	503-472-9603	jennywhite1@hotmail.com	Yamhill	2	0	EST		
						Total RTF	48	5			

Type	Contact Person	Name of Home	Address	Phone #	E-Mail Address	County	P Bed	O Bed	Status
RTH	David McDaniel	Cedar Bay RTH	1592 N. Monroe ST. North Bend, OR 97459	541-756-2048	dmcDaniel@columbiacare.org	Coos	5		0 EST
RTH	Dan Choocrane	Hosmer House	3316 Cruise Loop, Bend, OR 97702	541-647-1269	dan.cochrane@thementorNetwork.com	Deschutes	5		0 New
RTH	Shangri-la- J. Jasmine	Benton Place	168 SE 10th. St. Newport, OR 97365	541-574-0086	jasmine@shangrilacorp.org	Lincoln	3		0 EST
RTH	Shangri-la-Anthony Source	Via Verde	2435 Greenway Dr. Salem, OR 97301	503-361-2642	anthony@shangrilacorp.org	Marion	5		0 EST
RTH	Cascadia-Lashawn DeGrate	23rd	1232 NW 23rd. Ave. Portland, OR 97210	503-552-5133	Lashawn.degrate@cascadiabh.org	Multnomah	5		0 EST
RTH	Cascadia- George Strider	75th	4729 75th Portland, OR 97206	503-788-1680	George.strider@cascadiabh.org	Multnomah	5		0 EST
RTH	Cascadia- Chad Ernest	Buena Vista	326 SE 76th Ave, Portland, OR 97215	503-402-8109	Chad.ernest@cascadiabh.org	Multnomah	5		0 EST
RTH	Cascadia- Mark Flathman	Overton	2270 NW Overton, Portland, OR 97210	503-241-6051	Mark.Flathman@cascadiabh.org	Multnomah	5		0 EST
RTH	Luke-Dorf- Will Alarid	Valeo	15380 Division St, Portland, OR	503-726-3706	walarid@luke-dorf.org	Multnomah	5		0 EST
RTH	CODA- Michael Jones	Rolfson South	15602 SE Division, St. Portland, OR	503-762-2530	Michaeljones@codaine.org	Multnomah	4		0 EST
RTH	CODA- Michael Jones	Rolfson North	15606 SE Division St, Portland, OR	503-760-7314	Michaeljones@codaine.org	Multnomah	4		0 EST
RTH	Mentor- Joe Dominguez	Eldorado	7405 SE 8th Avenue, Prid, OR 97266	503-771-1645	Joe.Dominguez@TheMentorNetwork.org	Multnomah	5		0 EST
RTH	Lifeways- Steve Jensen	Hilltop House	37 NE Mt. Hebron Drive, Pendleton, OR 97801	541-276-1126	None Listed	Umatilla	2		0 EST
RTH	Luke Dorf- Katrina Bennett	Matthews House	10120 SW Cynthia, Beaverton, OR 97005	503-726-3786	kbennett@luke-dorf.org	Washington	5		0 EST
RTH	Luke Dorf-Katrina Bennett	Christophher House	11990 SW 21st Tigard, OR 97223	503-726-3786	kbennett@luke-dorf.org	Washington	2		0 EST
						Total RTH	65		0
SH	Linda Pritchett	15th St. Apts.	215 S 15th St. Helens, OR	503-397-4493 x109	lindap@ecmh.com	Columbia	4		0 NEW
SH	Jackson County	Crater Lake	1005 East Main Street,Building D, Medford, 975	541-774-8035	StocumRM@jacksoncounty.org	Jackson	5		0 EST
SH	Lane Shelter Care	Hawthorne Apt	2988 Oak Street, Eugene, OR 97405	541-343-4070	None Listed	Lane	4		0 EST
SH	Alice Mills	4th Avenue House	1076 NW 4th Ave., Ontario 97914	541-889-5438	amills@lifeways.org	Malheur	5		0 EST
SH/A&B	Bill Turfollotte	Stepping Stone	2440 Greenway Dr. Salem, OR 97301	503-361-2642	BTurfollotte@co.marion.or.us	Marion	5		0 EST
SH	Cascadia	Quince	3820 SE 26th, Portland, OR 97202	503-719-4776	bonnie.lambert@cascadiabh.org	Mult.	5		0 EST
SH	Cascadia	Rosewood	7003 SE Woodstock, Portland , OR 97206	503-771-2271	bonnie.lambert@cascadiabh.org	Mult.	5		0 EST
SH	Larry Betcher	Halsey	6631 NE Halsey Street, Portland, OR 97213	503-253-0613	Lawrence.Betcher@providence.org	Mult.	13		0 EST
SH	Luke-Dorf, Inc.	Sandy Apts.	11401 NE Sandy Blvd. Portland, OR 97220	503-597-3928	edanehey@luke-dorf.org	Mult.	5		0 NEW
ICM	Bonnie Lambert	Cascadia	Various- Independent Apartments	503-238-0705 x 228	bonnie.lambert@cascadiabh.org	Mult.	10		0 EST
ICM	Carolyn Mounts	CODA	Various- Independent Apartments	503-252-3304 x14	CarolynMounts@codaine.org	Mult.	5		0 EST
						Total SH	66		0

Type	Contact Person	Name of Home	Address	Phone #	E-Mail Address	County	P Bed	O Bed	Status
SRTF	Andrew Axer	Johnson Creek	2808 SE Balfour St. Milwaukie, OR	503-830-7286	aaxer@columbiacare.org	Clackamas	8	0	NEW
SRTF	Gordon Norman	Hazel Center	1911 Hazel Street, Medford, OR 97501	541-734-3950	normang@jacksoncounty.org	Jackson	8	0	EST
SRTF	Paulette Montplaisir	Heeran Center	2222 Coburg Rd. Eugene, OR 97401	541-465-3323	paulmont@sheltercare.org	Lane	3	0	EST
SRTF	Jim Sechrist	Telecare	1605 E. Lincoln Road, Woodburn, OR 97071	503-982-9300	jsechrist@telecarecorp.com	Marion	15	0	EST
SRTF	Scott Tucker	Arbor	2330 NE Siskiyou Street, Portland, OR 97212	503-528-0757	scott.tucker@cascadiabhc.org	Mult	1	0	EST
SRTF	Lark Roe	Faulkner	13317 SE Powell Blvd. Portland, OR 97236	503-760-9606	jark.roe@cascadiabhc.org	Mult	1	0	EST
SRTF	Tim Mahoney	McNary Place	290 Williamette, Umatilla, OR 97882	541-922-0880	tmahoney@lifeways.org	Umatilla	10	0	EST
SRTF	Jenny Peters	Pendleton Cottages	2585 Westgate Dr. Pendleton, OR 97801	541-276-0295	jenny.peters@state.or.us	Umatilla	16	0	EST
Total SRTF							62	0	
Total							260	30	

Permanent PSRB Bed to be refilled by PSRB Resident  
Occupied Bed to be refilled by County, ECMU or PSRB Resident



**Addictions and Mental Health Division-  
Residential Definitions 3/24/2006**

<b>Type Facility</b>	<b>Capacity</b>	<b>Staffing</b>	<b>Description</b>
<b>Supportive Housing (SH)</b>	Site Specific	Varied staffing per site.	Supported independent living and other minimally structured settings; generally unlicensed.
-Site-specific supported housing (SSH)		On-site and outreach.	Apts., rooms, and/or homes designated for persons with mental illness & sponsored by MH agency.
-Integrated supported housing (ISH)		Outreach in community.	Affordable apts. and/or shared homes in the open housing market with access to support services.
-Transitional Housing (TH)		On-site and outreach.	A housing program that provides on-site support for up to 2 yr. for transitioning to community living.
-Room and Board (R+B)		No staffing on-site.	Shelter and meals provided in exchange for payment.
-Safe Haven (SH)		On-site and outreach.	Residential program providing "low demand" supports for people who were formerly homeless.
<b>Intensive Case Management (ICM)</b>	Individual CM 1-10 ratio	Team Support- ACT Like Model	Individual Treatment in Supportive Housing Model Case Management, Supported Employment/Education, A&D treatment, Nursing and Psychiatric Support
<b>Adult Foster Home (AFH)</b>	up to 5	Provider and an approved caregiver for occasional respite. 24 hour care, with provider awake until 11pm.	Adult Foster Homes are licensed by the Addictions and Mental Health Division, or by the Seniors and People with Disabilities Division. Services provided include training or assistance with personal care and activities of daily living, supervision of medications and/or behavior, crisis prevention, and management of diet and health care. Adult Foster Homes testing and Certification of Completion is required for staff. Adult Foster Homes are inspected annually and a yearly license is issued if in compliance.
<b>Residential Treatment Home (RTH)</b>	up to 5	24 Hour Awake Staff  Minimum Staff Required: * .5 Administrator One Direct Care Staff per 8 hour shift.	A program licensed by the Addictions and Mental Health Division to serve 5 or fewer adults with mental illness. Services include medication monitoring, daily living skill training, and supportive services. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance
<b>Residential Treatment Facility (RTF)</b>	6 to 16	24 Hour Awake Staff  Minimum Staff Required: * .5 Administrator One Direct Care Staff per 8 hour shift.	A program licensed by the Addictions and Mental Health Division to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance
<b>Secure Residential Facility (SRTF)</b>	6 to 16	24 Hour Awake Staff  Minimum Staff Required: * .5 Administrator Two Direct Care Staff and an RN per 8 hour shift	A locked residential treatment facility licensed by the Addictions and Mental Health Division to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring, and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance.

\* More staff may be required to insure safety for clients and staff.  
This is negotiated at the time of program development and is facility specific.

Oregon SE Supervisors All Contacts List

Alice Mills  
Lifeways (Malheur Co.)  
702 Sunset Drive  
Ontario, Oregon 97914  
[amills@lifeways.org](mailto:amills@lifeways.org)  
541-823-9043

Craig Hinrichs  
Abacus Programs (Yamhill Co.)  
627 NE Evans ST  
McMinnville, OR 97128  
[hinrichc@co.yamhill.or.us](mailto:hinrichc@co.yamhill.or.us)  
(503) 434-7468

Pam McCollum  
Marion County Adult Behavioral Health (Marion Co.)  
3180 Center St NE  
Salem, OR 97301  
[pmccollum@co.marion.or.us](mailto:pmccollum@co.marion.or.us)  
503-361-2675.

ZoeAnn Northcutt  
Options for Southern Oregon (Josephine Co.)  
1181 Ramsey Ave  
Grants Pass, OR 97527  
[znorthcutt@optionsonline.org](mailto:znorthcutt@optionsonline.org)  
541-476-2373

Tom Stagg  
Central City Concern  
2 NW 2<sup>nd</sup> Ave  
Portland, OR 97209  
[tstagg@centralcityconcern.org](mailto:tstagg@centralcityconcern.org)  
503-226-7387

Sarah Haefele  
Deschutes County Mental Health (Deschutes Co.)  
1128 NW Harriman

Bend, Oregon 97701  
[Sarah\\_Haefele@co.deschutes.or.us](mailto:Sarah_Haefele@co.deschutes.or.us)  
541.330.4639

Miho Shimba  
LifeWorks NW  
971 SE Walnut St. (Washington Co)  
Hillsboro, OR 97123  
[mihos@lifeworksnw.org](mailto:mihos@lifeworksnw.org)  
503-640-5297

Angela Harman, PsyD  
Sequoia Mental Health Services, Inc.  
13575 SW Millikan Way  
Beaverton, OR 97005  
[aharman@sequoiamhs.org](mailto:aharman@sequoiamhs.org)  
503-591-9280 x206

Bob Molesworth  
Crook County Mental Health/ Lutheran Community Services (Crook Co)  
203 N Court St.  
Prineville, OR 97754  
[bmolesworth@lcsnw.org](mailto:bmolesworth@lcsnw.org)  
(541)447-7441

Patrick Tilcock  
c/o Laurel Hill Center (Lane Co.)  
2145 Centennial Plaza  
Eugene, OR 97401  
[patrick@laurel.org](mailto:patrick@laurel.org)  
541-984-3106

Robert Rogers  
[rrogers@sheltercare.org](mailto:rrogers@sheltercare.org)  
Deborah Holloway  
[dholloway@sheltercare.org](mailto:dholloway@sheltercare.org)  
541-868-3328  
Shelter Care (Lane Co)  
P. O. Box 23338  
Eugene, OR 97402  
Street Address: 1790 West 11th Suite 290, Eugene, OR 97402

541-686-1262

Cathy Pennington  
Working Wonders of Coos County  
PO Box 1013  
North Bend, OR 97459  
[cathamaran@hotmail.com](mailto:cathamaran@hotmail.com)  
541-756-2057

Allison Holloway  
Luke-Dorf (Washington Co)  
10313 SW 69<sup>th</sup>  
Tigard, OR 97223.  
[aholloway@luke-dorf.org](mailto:aholloway@luke-dorf.org)  
503-726-3836

Al Barton, MS, LPC  
Mid-Columbia Center for Living  
1610 Woods Ct., Hood River, OR, 97031  
[al.barton@mccfl.org](mailto:al.barton@mccfl.org)  
541-386-2620

Janet Stevely  
Columbia Care  
3587 Heathrow Way  
Medford, OR 97504  
541-488-6495  
[janet@ashlandhome.net](mailto:janet@ashlandhome.net)

Bruce Mack, Business Services Coordinator  
Community Solutions for Clackamas County  
Villebois Community Housing  
Working for Independence Program  
146 Molalla Avenue Oregon City, OR 97045  
Phone - (503) 502-2346 Fax - (503) 723-4979  
[BruceMac@co.clackamas.or.us](mailto:BruceMac@co.clackamas.or.us)

**SE Trainers**

Crystal McMahon  
1215 SW G St.  
Grants Pass, OR 97526  
[cmcmahon@optionsonline.org](mailto:cmcmahon@optionsonline.org)  
541-472-5852  
541-621-8875 cell

Jeff Krolick  
1215 SW G St  
Grants Pass, OR 97526  
[jkrolick@optionsonline.org](mailto:jkrolick@optionsonline.org)  
541-472-5853

Sandy Reese  
8770 SW Scoffins St  
Tigard, OR 97223  
[sandyr@lifeworksnw.org](mailto:sandyr@lifeworksnw.org)  
503-684-1424 x 1226  
503-422-9227 cell

**Portland State University**

Peer Support Coordinator: Rollin Shelton [sheltonr@pdx.edu](mailto:sheltonr@pdx.edu) 503-725-8097  
Research: Heidi Herinckx: [herinch@pdx.edu](mailto:herinch@pdx.edu) 503-725-5958  
Research: Elisabeth Winter [wintere@pdx.edu](mailto:wintere@pdx.edu) 503-725-8719 phone  
503-725-4180 fax

**State of Oregon**

Darcy Strahan [darcy.strahan@state.or.us](mailto:darcy.strahan@state.or.us) 503-945-9722  
Marisha Johnson [marisha.l.johnson@state.or.us](mailto:marisha.l.johnson@state.or.us) 503-947-5544

**Supported Education Trainer**

Karen Unger [kvungeror@comcast.net](mailto:kvungeror@comcast.net)  
503 232 7085  
cell 503 709 9720.

**SE links**

<http://dms.dartmouth.edu/dsec/>

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/>

[http://www.rri.pdx.edu/or\\_excellence\\_center.php](http://www.rri.pdx.edu/or_excellence_center.php)



# Additions and Mental Health Division Mental Health Managed Care Organizations (MHOs) Service Areas As of March 23, 2010

**ABHA (pink)**  
Benton  
Crook  
Lincoln  
Deschutes  
Jefferson  
Klamath -  
(only zip  
97731, 97733,  
97737 & 97739)

**Clackamas (yellow)**  
Clackamas  
Sherman  
Hood River  
Wasco

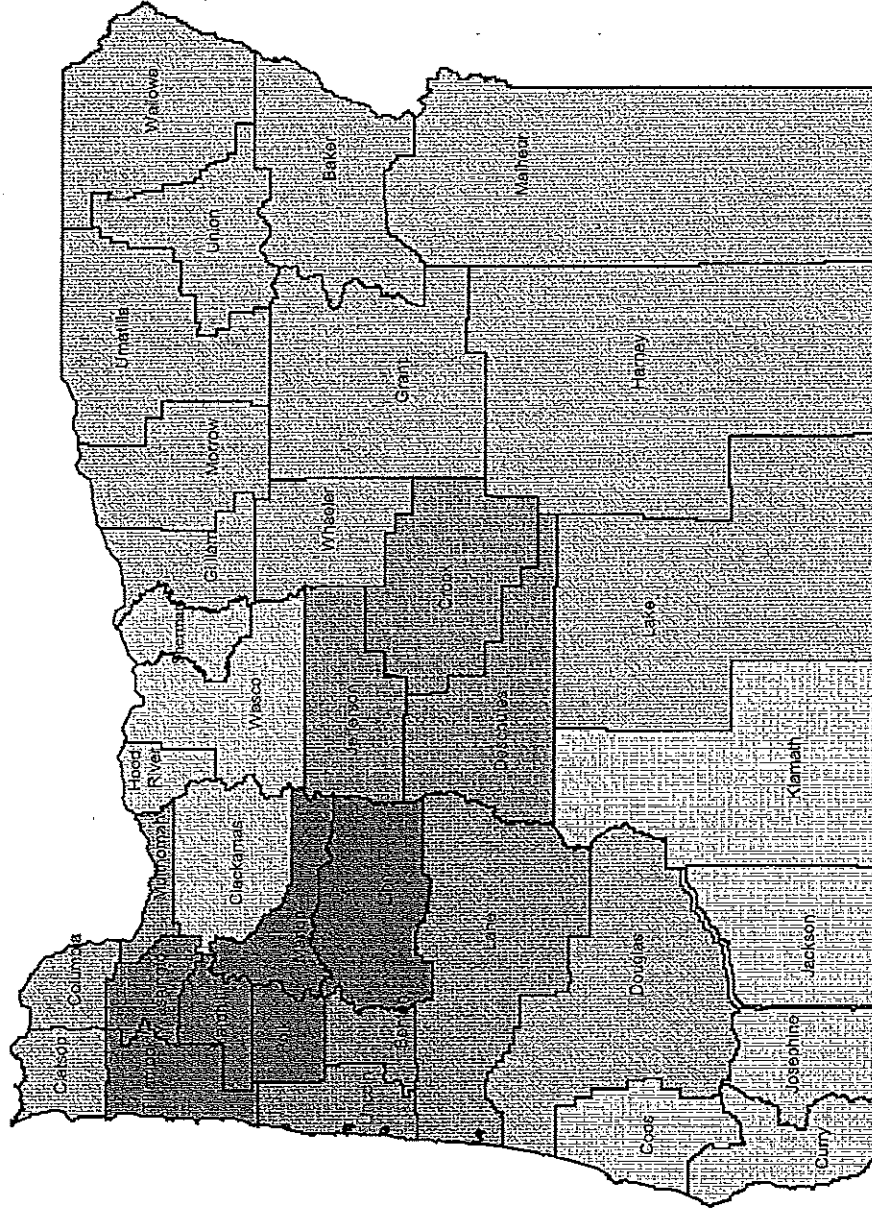
**Family Care  
(yellow, gold, blue)**  
Clackamas  
Washington  
Multnomah

**GOBHI (tan)**  
Gilliam  
Lake  
Malheur  
Umatilla  
Harney  
Wheeler  
Morrow  
Baker  
Clatsop  
Columbia  
Grant  
Wallowa  
Douglas  
Union  
Jackson  
Josephine  
Klamath-  
(except zip  
97731, 97733  
97737 & 97739)

**JBH (green)**  
Coos  
Curry

**LaneCare (blue)**  
Lane  
MVBCN (aqua)  
Linn  
Marion  
Yamhill  
Polk  
Tillamook

**Washington (lime)**  
Washington  
THA (lime)  
Washington  
Verity (gold)  
Multnomah





## Benefit packages

*General Rules 410-120-1160 through  
410-120-1230; OHP Rule 410-141-0480*

Oregon Health Plan (OHP) clients receive coverage for health care services based on their benefit package(s). Coverage is different for each package. Clients are assigned to benefit packages based on their program eligibility.

The "Benefit Plan" field on the MMIS Recipient Information panel displays the client's most current benefit package. The packages that indicate DHS medical eligibility are:

- ♦ BMH – OHP Plus
- ♦ BMD – OHP with Limited Drug
- ♦ BMM – QMB + OHP with Limited Drug
- ♦ BMP – OHP Supplemental
- ♦ KIT – OHP Standard
- ♦ MED – Qualified Medicare Beneficiary (QMB)
- ♦ CWM – Citizen/Alien-Waived Emergency Medical (CAWEM)
- ♦ CWX – CAWEM Prenatal

## Who receives OHP benefits

Clients who receive medical benefits through the Department of Human Services (DHS) are assigned to these benefit packages.

Children who receive Healthy KidsConnect subsidy payments through the Office of Private Health Partnerships **do not qualify** for OHP benefits. Therefore, they are not in MMIS and do not receive OHP benefits.

## What's covered

*OHP Rule 410-141-0480*

The Oregon Health Services Commission (HSC) developed a list of medical conditions and treatments, organized in order of effectiveness. Currently, covered services are lines 1-502 on the Prioritized List of Health Services.

This list is updated in October and April each year, and in January every two years. The Benefit Plan and HSC Prioritized List Inquiry panel in the MMIS Reference Subsystem (go to Reference-->HSC) provides HSC coverage information for specific dates of service.

To determine DMAP coverage of a specific health care service, there are two questions to consider:

- ♦ Does the client's benefit package cover the service? Pages 3-8 of this guide provide an overview of the services covered by each benefit package; they do not list all covered services or limitations. Refer to the OARs cited above for more specific information.
- ♦ Does the Prioritized List rank the service (treatment) "above the line" (lines 1-502) for the client's reported medical condition?

## OHP Plus

## BMH

OHP Plus covers most medical, dental, mental health and chemical dependency services.

Preventive services	<ul style="list-style-type: none"> <li>♦ Maternity and newborn care</li> <li>♦ Well-child exams and immunizations</li> <li>♦ Routine physical exams and immunizations</li> <li>♦ Maternity case management, including nutritional counseling</li> </ul>
Diagnostic services	<ul style="list-style-type: none"> <li>♦ Medical examinations to tell what is wrong, even if the treatment for the condition is not covered</li> <li>♦ Laboratory, X-ray and other appropriate testing</li> </ul>
Family planning services and supplies	Including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations
Medical and surgical care	<p>Medically appropriate treatments for conditions expected to get better with treatment. Includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>♦ Appendicitis</li> <li>♦ Infections</li> <li>♦ Ear Infections</li> <li>♦ Broken bones</li> <li>♦ Pneumonia</li> <li>♦ Eye diseases</li> <li>♦ Cancer</li> <li>♦ Stomach ulcers</li> <li>♦ Diabetes</li> <li>♦ Asthma</li> <li>♦ Kidney stones</li> <li>♦ Epilepsy</li> <li>♦ Burns</li> <li>♦ Rheumatic fever</li> <li>♦ Head injuries</li> <li>♦ Heart disease</li> </ul>
Medically appropriate ancillary services	<p>When provided as part of treatment for covered medical conditions.</p> <ul style="list-style-type: none"> <li>♦ Hospital care, including emergency care</li> <li>♦ Home health services</li> <li>♦ Private duty nursing</li> <li>♦ Physical and occupational therapy evaluations and treatment</li> <li>♦ Speech and language therapy evaluations and treatment</li> <li>♦ Medical equipment and supplies</li> <li>♦ Prescription drugs and some over-the-counter drugs</li> <li>♦ Limited vision services for medical/emergent reasons</li> <li>♦ Hearing services including exams, evaluations, treatment, materials and fitting for hearing aids</li> <li>♦ Transportation to health care for clients who have no other transportation available to them, including ambulance and other methods of transport</li> </ul>

Other services	<ul style="list-style-type: none"> <li>♦ Dental services, including cleanings, fillings, and extractions</li> <li>♦ Outpatient chemical dependency services</li> <li>♦ Comfort care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services</li> <li>♦ Mental health services</li> </ul>
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For children under age 21, OHP Plus also covers the following benefits:

Services to improve vision	<ul style="list-style-type: none"> <li>♦ Exams to prescribe glasses or contacts</li> <li>♦ Fittings for glasses or contacts</li> <li>♦ Glasses or contacts</li> </ul>										
Other dental services	<table border="0"> <tr> <td>♦ Crowns</td><td>♦ Apically positioned flap</td></tr> <tr> <td>♦ Root canals</td><td>♦ Osseous surgery</td></tr> <tr> <td>♦ Apexification/recalcification procedures</td><td>♦ Surgical revision procedure</td></tr> <tr> <td>♦ Gingival flap procedures</td><td>♦ Alveoplasty</td></tr> <tr> <td></td><td>♦ Office visit for observation</td></tr> </table>	♦ Crowns	♦ Apically positioned flap	♦ Root canals	♦ Osseous surgery	♦ Apexification/recalcification procedures	♦ Surgical revision procedure	♦ Gingival flap procedures	♦ Alveoplasty		♦ Office visit for observation
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♦ Root canals	♦ Osseous surgery										
♦ Apexification/recalcification procedures	♦ Surgical revision procedure										
♦ Gingival flap procedures	♦ Alveoplasty										
	♦ Office visit for observation										

### OHP with Limited Drug

**BMD**

OHP with Limited Drug covers the same medical, dental and mental health services as OHP Plus. However, OHP with Limited Drug does not cover drugs already covered by Medicare Part D.

### QMB + OHP with Limited Drug

**BMM**

This benefit package covers the same services as OHP with Limited Drug. It also provides the benefits described in the QMB benefit package section.

### OHP Plus - Supplemental

**BMP**

This benefit package covers certain dental and vision services only for pregnant adults who receive OHP Plus benefits through the BMH, BMD and BMM packages.

Services to improve vision	<ul style="list-style-type: none"> <li>♦ Exams to prescribe glasses or contacts</li> <li>♦ Fittings for glasses or contacts</li> <li>♦ Glasses or contacts</li> </ul>										
Other dental services	<table border="0"> <tr> <td>♦ Crowns</td><td>♦ Apically positioned flap</td></tr> <tr> <td>♦ Root canals</td><td>♦ Osseous surgery</td></tr> <tr> <td>♦ Apexification/recalcification procedures</td><td>♦ Surgical revision procedure</td></tr> <tr> <td>♦ Gingival flap procedures</td><td>♦ Alveoplasty</td></tr> <tr> <td></td><td>♦ Office visit for observation</td></tr> </table>	♦ Crowns	♦ Apically positioned flap	♦ Root canals	♦ Osseous surgery	♦ Apexification/recalcification procedures	♦ Surgical revision procedure	♦ Gingival flap procedures	♦ Alveoplasty		♦ Office visit for observation
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♦ Root canals	♦ Osseous surgery										
♦ Apexification/recalcification procedures	♦ Surgical revision procedure										
♦ Gingival flap procedures	♦ Alveoplasty										
	♦ Office visit for observation										

## OHP Standard

## KIT

This benefit package is similar to private insurance with premiums and benefit limitations.

Emergency services	<ul style="list-style-type: none"> <li>♦ Ambulance</li> <li>♦ Limited emergency dental services (<i>e.g.</i>, acute infection or abscess, severe tooth pain, tooth re-implantation and extraction of symptomatic teeth)</li> </ul>
Durable medical equipment and supplies	<p>Limited to:</p> <ul style="list-style-type: none"> <li>♦ Respiratory equipment (<i>e.g.</i>, CPAP, BiPAP)</li> <li>♦ Oxygen equipment (<i>e.g.</i>, concentrators and humidifiers)</li> <li>♦ Ventilators</li> <li>♦ Suction pumps</li> <li>♦ Tracheostomy supplies</li> <li>♦ Urology and ostomy supplies</li> <li>♦ Diabetic supplies (including blood glucose monitors)</li> </ul>
Limited hospital benefit	<p>Includes:</p> <ul style="list-style-type: none"> <li>♦ Evaluation, lab, x-ray and other procedures to determine diagnosis</li> <li>♦ Hospital treatment for urgent/emergent services</li> <li>♦ Inpatient and outpatient hospital treatment for diagnoses listed in the Limited Hospital Benefit code list.</li> </ul>
Other services	<ul style="list-style-type: none"> <li>♦ Outpatient mental health</li> <li>♦ Outpatient chemical dependency services</li> <li>♦ Physician services</li> <li>♦ Hospice services</li> <li>♦ Prescription drugs</li> <li>♦ Laboratory and x-ray services</li> </ul>

The following services are **not covered** by OHP Standard:

- ♦ Acupuncture, except for treatment of chemical dependency
- ♦ Chiropractic and osteopathic manipulation
- ♦ Nutritional supplements taken by mouth
- ♦ Hospital services that are not for urgent or emergency care
- ♦ Therapy services (occupational, physical, and speech therapy)
- ♦ Private duty nursing and home health care
- ♦ Dental routine services (*e.g.*, teeth cleaning, orthodontia, fillings)
- ♦ Hearing aids and exams for hearing aids
- ♦ Non-ambulance medical transportation
- ♦ Vision exams, materials, correction and therapy

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## **QMB**

## **MED**

The QMB benefit package pays for Medicare premiums, copayments and deductibles for services covered by Medicare. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB-only coverage for deductible and co-insurance amounts for services covered by Medicare (except for Medicare Part D prescriptions). However, providers may bill these clients for services that are not covered by Medicare, and for Medicare Part D prescriptions.

Clients with **only** the QMB benefit package cannot be enrolled in managed care plans.

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## **CAWEM - Citizen/Alien-Waived Emergency Medical**

## **CWM**

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women are considered an emergency. Clients on the CAWEM benefit package do not pay premiums or copayments and cannot be enrolled in managed care plans.

Services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance are **not covered** for clients on the CAWEM benefit plan.

The following list is not all-inclusive but can be used as an illustration to identify services that are **NOT** covered for clients on the CAWEM benefit plan:

- ♦ Administrative medical examinations and reports
- ♦ Chemotherapy
- ♦ Dental services provided outside an emergency room/hospital setting
- ♦ Dialysis
- ♦ Family planning and sterilization
- ♦ Home health services
- ♦ Hospice
- ♦ Medical equipment and supplies
- ♦ Non-emergency medical transportation
- ♦ Outpatient drugs or over-the-counter products
- ♦ Pre-natal and postpartum care
- ♦ Private duty nursing
- ♦ Preventative care
- ♦ Transplants or transplant related services
- ♦ Therapy services
- ♦ Rehabilitation services

## CAWEM Plus

CWX

For as long as she is pregnant, a CAWEM woman living in Deschutes, Multnomah, Benton, Clackamas, Hood River, or Jackson county may receive most of the covered services an OHP Plus client receive, and all OHP Plus - Supplemental benefits, through the CAWEM Plus benefit package.

The CAWEM Plus benefit **does not cover** the following OHP Plus benefits:

- ♦ Abortions;
- ♦ Death with dignity;
- ♦ Hospice care; or
- ♦ Sterilization.

When she is no longer pregnant, she retains CAWEM Plus eligibility for two months before redetermination, but DMAP will reimburse only for the following services:

- ♦ Hospital claims related to the delivery of the child through discharge;
- ♦ Post-partum services only if provided in a bundled rate; and
- ♦ Emergency services.

CAWEM Plus clients are eligible for services anywhere in the state and are not enrolled in managed care.

## What's not covered

*OHP Rule 410-141-0500*

Services for conditions that the Health Services Commission ranks of lower priority are generally not covered. The HSC's report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the client's benefit package(s).

## Non-covered conditions

Treatments for the following conditions are **not covered**, unless there is another complicating diagnosis:

Conditions which tend to get better on their own	Examples include:
	<ul style="list-style-type: none"><li>♦ Measles</li><li>♦ Infectious mononucleosis</li><li>♦ Mumps</li><li>♦ Viral sore throat</li><li>♦ Dizziness</li><li>♦ Viral hepatitis</li><li>♦ Benign cyst in the eye</li><li>♦ Minor bump on the head</li><li>♦ Non-vaginal warts</li></ul>

Conditions where a "home" treatment is effective	Home treatments include applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include: <ul style="list-style-type: none"><li>♦ Canker sores</li><li>♦ Corns/calluses</li><li>♦ Sunburn</li><li>♦ Diaper rash</li><li>♦ Food poisoning</li><li>♦ Sprains</li></ul>
Cosmetic conditions	Examples include: <ul style="list-style-type: none"><li>♦ Benign skin tumors</li><li>♦ Cosmetic surgery</li><li>♦ Removal of scars</li></ul>
Conditions where treatment is not generally effective	Examples include: <ul style="list-style-type: none"><li>♦ Some back surgery</li><li>♦ TMJ surgery</li><li>♦ Some transplants</li></ul>

### Non-covered services

Other non-covered services regardless of condition include, but are not limited to:

- ♦ Circumcision (routine)
- ♦ Weight loss programs
- ♦ Infertility services

## Cost-sharing requirements

OAR 410-120-1230

This page does not list all requirements or exceptions.

### OHP Plus requirements

### BMM, BMH and BMD

Copayments	<ul style="list-style-type: none"> <li>♦ \$0 for preferred generic prescription drugs, preferred brand-name drugs, and non-preferred generics costing less than \$10</li> <li>♦ \$1 for non-preferred generic prescription drugs costing more than \$10</li> <li>♦ \$3 for all other non-preferred brand-name drugs</li> <li>♦ \$3 for outpatient office visits (such as office visits to see a doctor, dentist or other health care provider).</li> </ul> <p>Copayments are not required for these services:</p> <ul style="list-style-type: none"> <li>♦ Family planning services and supplies</li> <li>♦ Emergency services, as defined in OAR 410-120-0000</li> <li>♦ Prescription drugs ordered through DMAP's home delivery (mail order) vendor</li> <li>♦ Services covered by the client's managed care plan</li> </ul> <p>Copayments are not required for these clients:</p> <ul style="list-style-type: none"> <li>♦ Clients in managed care plans (for services covered by the plan)</li> <li>♦ Pregnant women</li> <li>♦ Children under age 19</li> <li>♦ American Indians/Alaska Natives</li> <li>♦ Clients who are eligible for benefits through Indian Health Services</li> <li>♦ Clients who are receiving services under the Home and Community Based waiver and Developmental Disability waiver</li> <li>♦ Clients who are in a hospital as an inpatient, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)</li> </ul>
Premiums	None

### OHP Standard requirements

### KIT

Copayments	None
Premiums	<ul style="list-style-type: none"> <li>♦ Premiums are charged per member/per month</li> <li>♦ Clients must pay all required premiums before their coverage can be renewed for another enrollment period</li> </ul> <p>The following clients are not required to pay premiums:</p> <ul style="list-style-type: none"> <li>♦ American Indians/Alaska Natives</li> <li>♦ Clients with income of 10 percent or less of the Federal Poverty Level</li> <li>♦ Clients who are eligible for benefits through Indian Health Services</li> </ul>

State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Mental Health Organization: 15 May 2010

County Name	ASHA	Checkmate	Family Care	30841	Latina	AVBCN	Advocate	WVH Co	MHO Enrolled	FES	TOTAL Enrolled	Enrollment %	County %
Baker	2	2		2138									
Benton	5,298				4	28	109	2	2	234	2,378	90.2%	0.6%
Clackamas	5	22,296	5,448		2		8	507	195	5,354	647	6.031	88.3%
Clatsop				3,977						28,462	3,337	31,799	83.5%
Columbia			9	5,201		1		2	23	3,878	445	4,423	88.9%
Coos						3	3			5,244	634	5,878	89.2%
Cook	2,878			11	9,472			1		9,490	1,024	10,514	90.3%
Curry							2			2,683	304	2,987	88.8%
Deschutes	15,795	6		5	2,441					2,441	229	2,670	81.4%
Douglas	1				4			1		15,812	1,648	17,460	90.5%
Gilliam		1		14,381	9	1	2			14,704	1,903	16,607	88.5%
Grant										1	192	193	0.5%
Haney	3	2		785						785	97	882	89.0%
Hood River	1	2,738	1	915		1				922	111	1,033	88.3%
Jackson	3	1		6	26,098	1	3		1	2,744	225	2,969	82.4%
Jefferson	3,507			1						26,113	2,721	28,834	90.8%
Josephine	1	1		3	13,749	6	4		1	3,508	509	4,017	87.3%
Klamath	145		3	5	9,462					13,768	1,220	14,988	91.9%
Lake				983						9,616	1,048	10,664	90.2%
Lane	28	1		13	15	41,589	2			985	83	1,068	92.2%
Lincoln	6,455	4				3	1			41,648	4,374	46,022	90.5%
Linn	145	1			144	16,091	2			5,464	587	7,051	91.7%
Malheur				5,339	3					16,384	1,834	18,218	88.8%
Marion	3	307	50	6	3	2	48,637	6	2	5,342	602	5,944	88.9%
Morrow				1,500						48,916	4,805	53,721	91.1%
Multnomah	6	841	11,156	13	10	5	43	77,867	50	1,500	182	1,682	88.7%
Polk	18			1			8,606			89,791	8,871	98,662	91.2%
Sherman		190								8,624	949	9,573	90.1%
Tillamook				7			2,778			190	18	208	91.3%
Umatilla	1			10,422						2,785	213	2,998	92.8%
Union				3,220						10,423	1,283	11,716	93.0%
Wallowa				730						3,221	385	3,607	89.3%
Wasco	9	3,408								730	74	804	90.8%
Washington	2	116	2,855	10	5	1	104	448	40,283	3,416	385	3,801	88.8%
Wheeler				177						43,825	4,241	48,066	91.2%
Yamhill	2	11	2	3	4	1	11,713	6	43	1,771	15	1,922	92.2%
Unknown										11,785	1,230	13,015	90.8%
MHO Total	34,047	29,724	19,524	50,165	51,283	41,789	88,010	78,856	40,603	444,001	46,819	490,820	80.5%
Percentage of Enrolled	7.7%	6.7%	4.4%	11.3%	13.6%	9.4%	19.8%	17.8%	6.1%	100.0%			100.0%

\*1 Includes Medicaid recipients eligible for OHP Plus or Standard benefits.  
 Medicaid recipients excluded from these counts include recipients eligible under the following classes: QB, QS, NP, CW, and BC.  
 see: [www.dhs.state.or.us/healthplan/data\\_public/enrollment/pop-eligibility.pdf](http://www.dhs.state.or.us/healthplan/data_public/enrollment/pop-eligibility.pdf) for an explanation of DMAP eligibility codes

State of Oregon, Division of Medical Assistance Programs, 500 Summer Street NE, Salem, OR 97301-1016  
 Source: DMAP DSSURS data warehouse; DataLoad = 6/7/2010



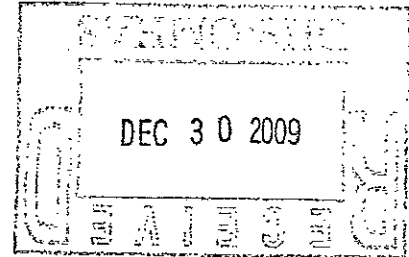
4

## ABHA Notice Of Subcontracted Work and Subcontractor List

December 30, 2009

ABHA has subcontracted to the following entities the services described below:

1. Benton, Lincoln, Jefferson and Deschutes Counties; Lutheran Family Services
  - a. Outpatient services
  - b. Utilization management of outpatient services
  - c. Level 1 grievances
2. ProtoCall
  - a. 24 X 7 Telephone based access and crisis services
3. PhTech
  - a. Claims payment
  - b. Encounter data submission



Note: final authority and oversight, as well as the development of standards and policies governing the administration of the services listed above are ABHA's responsibility.

Addresses, phone numbers etc for each delegated entity are listed below

<b>Benton County Mental Health</b> 530 NW 27 <sup>th</sup> Street Corvallis, OR 07330 Phone: 541-766-6835	<b>BestCare Treatment Services (Jefferson County)</b> 676 Negus Way NE PO Box 1710 Redmond, OR 97756 Phone: 541-904-9577
<b>Lutheran Community Services Northwest (Crook County)</b> 203N Court Street Prineville, OR 97754 Phone: 541-447-7441	<b>Lincoln County Health &amp; Human Services</b> 36 NW Nye Street Newport, OR 97365 Phone: 541-265-4179
<b>Deschutes County Mental Health</b> 2577 NE Courtney Drive Bend, OR 97701 Phone: 541-322-7500	<b>PhTech</b> 3993 Fairview Industrial Drive SE Salem, OR 97302
	<b>ProtoCall</b> 621 SW Alder Street, Suite 400 Portland, OR 97205 Phone: 503-256-6703



### Schedule 9 – Subcontracted Activities

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

**Contractor subcontracts** the following activities.(Please assign an item number to each activity):

1. Client notices
2. Credentialing
3. CPMS reporting
4. Consumer Complaints / Quarterly submission of Grievance Logs
5. Encounter data submission
6. Financial reporting
7. Fraud & Abuse detection and prevention
8. Oregon Patient Resident Care System
9. Quality improvement program
10. Third party resource information

Subcontracted Activity – Insert all item numbers that apply to each Agency	Name of Administrator or Executive Director	Agency Name	Contact Information- Address, Phone Number
2, 3, 4, 7, 8, 9	Chris Krenk	Albertina Kerr Centers	424 NE 22 <sup>nd</sup> Ave Portland OR 97323 503-262-0176
2, 7, 10	Mark Spiro MD	California Emergency Physicians Medical Group	2100 Powell St Ste 900 Emeryville CA 94608 510-350-2693
2, 7, 8, 10	Kevin Vernier	CareMark Behavioral Health	305 NE 102 <sup>nd</sup> Portland OR 97220 503-251-6266
2, 3, 4, 7, 8, 9	Derald Walker PhD	Cascadia Behavioral Healthcare	847 NE 19 <sup>th</sup> Ave Ste 100 Portland OR 97232 503-238-0769
2, 3, 4, 7, 8, 9	Mary Stone Smith	Catholic Community Services of SW Washington	5410 N 44 <sup>th</sup> St Tacoma WA 98407-3799 503-517-8663
2, 7 – 10	Shanti Carter	Cedar Hills Hospital	10300 SW Eastridge St Portland OR 97201 503-260-7809
2, 3, 4, 7, 8, 9	Lynn Saxton	ChristieCare	PO Box 368 Marylhurst OR 97036 503-635-3416
2, 3, 4, 7, 8, 9	Robert Beckett	Columbia Care Services Inc	3587 Heathrow Way Medford OR 97504 541-858-8170

2, 3, 4, 7, 8, 9	Carrie Howell	Dungarvin Oregon Inc	7320 SW Hunziker Rd Ste 101 Portland OR 97223 503-624-0205
2, 3, 4, 7, 8, 9	Mary Calderon LCSW Linda Estergard LCSW Patricia Finley PhD Stefani Shaver, LCSW	Lake Oswego Counseling Center	3990 Collins Way #202 Lake Oswego OR 97035 503-675-2830
2, 3, 4, 7, 8, 9	Mary Monnat	LifeWorks Northwest	14600 NW Cornell Rd Portland OR 97229 503-645-3581
2, 3, 4, 7, 8, 9	Robert Nestaas	Lutheran Community Services	605 SE 39 <sup>th</sup> Ave Portland OR 97229 503-231-7480
1 – 7, 9	Sharon Guidera	Mid-Columbia Center for Living *	419 E 7 <sup>th</sup> St The Dalles OR 97058 541-296-5452
2, 3, 4, 7, 8, 9	Ivan Frasier	Mid-Columbia Child and Family Center	3221 West 10 <sup>th</sup> St The Dalles OR 97058 541-298-5104
2, 3, 4, 7, 8, 9	Tia Gay Stecher	Morrison Child and Family Services	9911 SE Mt Scott Blvd Portland OR 97266 503-233-4359
2, 3, 4, 7, 8, 9	Rath Ben	OHSU Intercultural Psychiatric Program	3633 SE 35 <sup>th</sup> Pl Portland OR 97202 503-494-4222
4, 7, 10	Lori Olson	Olson PMHNP, Lori	4511 SE Hawthorne Ste 215 Portland OR 97215 503-224-6446
2, 3, 4, 7, 8, 9	Steve Allen PhD	Options Counseling Services	1255 Pearl St #102 Eugene OR 97401 541-687-6983
2, 3, 4, 7, 8, 9	Soonie Kim PhD	Portland DBT Program	5200 SW Macadam Ave Ste 580 Portland OR 97239 503-231-7854
2, 7 – 10	Shelly Handkins	Providence Health & Services	1235 NE 47 <sup>th</sup> Ave Ste 260 Portland OR 97213 503-215-3039
2, 7 – 10	Steve Jaspersen	Samaritan Mental Health (Good Samaritan Hospital – Corvallis)	3509 NW Samaritan Dr Corvallis OR 97330 541-768-5235
2, 3, 4, 7, 8, 9	Kim Scott	Trillium Family Services	3415 SE Powell Blvd Portland OR 97202 503-234-9591
4, 7, 10	Ed Green MD	Well Health Center	4037 NE Tillamook Portland OR 97212 503-736-3307

2, 3, 4, 7, 8, 9	Daryl Quick PhD	Western Psychological & Counseling Services	5415 SE Milwaukie Portland OR 97202 503-828-8718
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## Schedule 9 – Subcontracted Activities

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

Contractor subcontracts the following activities. (Please assign an item number to each activity):

1. After Hours Member Services
2. Credentialing
3. Encounter Data Submission
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Subcontracted Activity -- Insert all item numbers that apply to each Agency.	Name of Administrator or Executive Director	Agency Name	Contact Information- Address, Phone Number
1	Karl Brimmer	Multnomah County	503-988-3371
2	Derald Walker	Cascadia	503-238-0769
2	Mary Monnat	Lifeworks NW	503-645-9010
2	Daryl Quick	Western Psychological	503-233-5405
2	Tia Gray-Stecher	Morrison Child & Family Services	503-258-4200
3	Dean Hill	Payer Connection	503-820-8803

see attached

Subcontracted Activity - Insert all item numbers that apply to each agency	Name of Administrator or Executive Director	Agency Name	Contact Information- Address, Phone Number
1	Karl Brimmer	Multnomah County	503-988-3371
2	Derald Walker	Cascadia	503-238-0769
2	Mary Monnat	LifeWorks NW	503-645-9010
2	Daryl Quick	Western Psychological	503-233-5405
2	Tia Gray-Stecher	Morrison Family Service	503-258-4200
2	Janell McCloud	Clackamas County	503-722-6577
2	Janet Brandt/Ed Blackburn	Central City Concern	503-200-3889
2	Chris Larsen	CHRISTIECARE	503-675-2224
2	Doug Crandall	Catholic Community Services	253-759-9544
2	Chris Krenk	Albitina Kerr	503-2554205
2	Richard Blum	Trillium Family Service	541-758-5927
3	Dean Hill	Payor Connection	503-820-3803
2	Dr. Morin	Lutheran Family Services	503-231-7480
2	Linda Drebin	NARA	503-224-1044
2	Lucrecia Suarez	Conexiones	503-235-8057
2	Patricia Findly	Lake Oswego Counseling	503-675-2830

\* 2 FamilyCare  
credentials prescribers

## **Subcontractor List 2010**

**Center for Human Development, Inc.**  
(Union County)  
Dwight Dill, Director  
1100 K. Avenue  
La Grande, OR 97850  
Ph: 541-962-8800; Fax: 541-963-5272

**Clatsop Behavioral Healthcare**  
(Clatsop County)  
Nancy V. Winters, Director  
#10 Sixth Street, Suite 103  
Astoria, OR 97103  
Ph: (503) 325-5722; Fax: (503) 325-8483

**Columbia Community Mental Health**  
(Columbia County)  
Roland Migchielsen, Director  
58646 McNulty Way  
St. Helens, OR 97051  
Ph: (503) 397-5211; Fax: (503) 397-5373

**Community Counseling Solutions**  
(Grant County)  
Kimberly Lindsay, Director  
528 E. Main Street – Ste. W  
John Day, OR 97845  
Ph: 541-575-1466; Fax: 541-575-1411

**Harney Behavioral Health**  
(Harney County)  
Chris Siegner, Director  
348 West Adams  
Burns, OR 97720  
Ph: 541-573-8376; Fax: 541-573-8378

**Lake County Mental Health Center**  
(Lake County)  
Chris Siegner, Director  
215 North G Street  
Lakeview, OR 97630  
Ph: (541) 947-6021 Fax: (541)947-6020

**Lifeways, Inc.**  
(Malheur County)  
Greg Schneider, Director  
702 Sunset Drive  
Ontario, OR 97914,  
Ph: 541-889-9167; Fax: 541-889-7873

**Community Counseling Solutions**  
(Morrow/Wheeler/Gilliam Counties)  
Kimberly Lindsay, Director  
PO Box 469  
120 S. Main, 2nd Floor  
Heppner, OR 97836  
Ph: 541-676-9161; Fax 541-676-5662

**Mt. Valley Mental Health Programs, Inc.**  
(Baker County)  
Vicki Long, Director  
PO Box 649  
2200 Fourth Street  
Baker City, OR 97814  
Ph: 541-523-3646; Fax: 541-523-7602

**Lifeways, Inc.**  
(Umatilla County)  
Greg Schneider, Director  
331 SE 2<sup>nd</sup> Street  
Pendleton, OR 97801  
Ph: 541-276-6207; Fax: 541-278-5419

**Wallowa Valley Mental Health Center**  
(Wallowa County)  
Stephen Kliewer, Director  
PO Box 268  
207 SW First Street  
Enterprise, OR 97828  
Ph: 541-426-4524; Fax: 541-426-3035

**Douglas Co. Mental Health**  
(Douglas County)  
Janet Holland, Director  
621 W. Madrone St  
Roseburg, OR 97470  
Ph: 541-440-3532; Fax: 541-426-3035



### **Schedule 9 – Subcontracted Activities**

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

**Contractor subcontracts** the following activities.(Please assign an item number to each activity):

#### **Clinical Functions:**

1. Delivery of services consistent with contract and JBH policies and procedures.
2. Delivery of Outpatient Services (Children & Adults)
3. Participation in all ISA services all defined by ISA.
4. Pre-authorization of Acute and Sub-Acute Care (Children and Adults)
5. Level of Care Determination (Children and Adults)
6. Completion Cons certificate of need for children needing residential placement.
7. Authorization of Mental Health Services for children in BRS placements in coordination with Child Welfare
8. Provision of 24-hour per day, 7-days-a-week Crisis Services and Respite Services
9. Community Care Coordination Committee participation
10. Participation in Child-Family Team meetings, determination of levels of need, and placement
11. Administration and reporting on all clinical tools that assist in level of need or level of care determination.
12. Prevention Education and Outreach (PEO) service (service delivery, tracking, reporting to JBH and State)
13. Identification and Coordination of Care for Members with Special Healthcare needs
14. Insurance and Reporting of Access to services within MHO contract guidelines.
15. Assurance of Native American or Alaska Native provider selection for Native American or Alaska Native members.
16. Health Education to members to include identification of tobacco use and referral for tobacco cessation.
17. Clinical Record Keeping in the Individual Service Record consistent with ISSR, OAR and JBH policy requirements.
18. Critical Incident Identification, Tracking and Reporting to State and JBH.

#### **Administrative Functions:**

1. Personnel Documentation according to ISSR standards & JBH policy
2. Training and Supervision of Staff according to ISSR standards & JBH policy
3. Non-Employee Documentation for interns, contractors and volunteers according to ISSR standards & JBH policy
4. Development and Implementation of Service Delivery Policies
5. CPMS and other data collection
6. Provision of copies and OHP Member orientation on enrollee rights and responsibilities,

- Mental Health Declarations, Advanced Directives and the Grievance/Appeal system. Including provision in each non-English language that is prevalent in the Contractor's Service Area.
7. Provider & staff orientation and education (including cultural competency, consumer rights, grievance and appeal system, fraud, waste & abuse system)
  8. Accommodations to staff with moral or personal obligations and responsibility
  9. Policies and Procedures to allow for accommodations for members to have freedom of choice for providers
  10. Financial Records pertinent to covered services delivered and capitation received in accordance with GAAP standards.
  11. Monitoring, evaluating and improving the quality and appropriateness of Covered Services provided to OHP Members and participation in JBH quality improvement activities and PIP's.
  12. Encounter Data collection and submission through PH-Tech
  13. Internal Fraud, Waste and Abuse monitoring and reporting to JBH and AMH.
  14. Management of Grievance and Appeals and delivery and reporting of Notice of Actions according to JBH policy.
  15. Yearly reviews and reports to JBH for services to members that are subcontracted in order to verify that all services are provided in accordance to MHO contract, JBH policies and procedures and list of delegated activities summary.

<b>Subcontracted Activity – Insert all item numbers that apply to each Agency.</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
Clinical 1-18 Administrative 1-15	Ginger Swan	Coos County Mental Health	1975 McPherson, North Bend, Oregon 97459 541-756-2020, ext. 528 <a href="mailto:ginger.swan@mh.co.coos.or.us">ginger.swan@mh.co.coos.or.us</a>
Clinical 1-18 Administrative 1-15	Jan Kaplan	Curry County Mental Health	29821 Colvin St Gold Beach, OR 97444 (541) 247-4082 <a href="mailto:kaplanj@co.curry.or.us">kaplanj@co.curry.or.us</a> )
Clinical 1-18 Administrative 1-15	Maureen Graham	Jackson County Mental Health	1005 East Main Street Medford, OR 97504 Phone: (541) 774-8201 <a href="mailto:GrahamME@jacksoncounty.org">GrahamME@jacksoncounty.org</a>

Clinical 1-18 Administrative 1-15	Ann Lynn	Klamath County Mental Health	3314 Vandenberg Road Klamath Falls, OR 97603 Phone: 541 882-7291 <a href="mailto:alynn@co.klamath.or.us">alynn@co.klamath.or.us</a>
Clinical 1-18 Administrative 1-15	Kim Miller	Options for Southern Oregon	1215 SW "G" Street Grants Pass, OR 97526 Voice/TTY: (541)-476-2373 <a href="mailto:kmiller@optionsonline.org">kmiller@optionsonline.org</a>



**Schedule 9 – LaneCare Subcontracted Activities**

LaneCare Subcontracts the following activities.

1. Mental Health Services
2. Credentialing of QMHA and QMHP
3. Lane County contract compliance
4. Claims Payment
5. Encounter Data Submission
6. Distribution of member handbook
7. Performance report generation
8. Portions of complaint and grievance resolution. LaneCare provides oversight and monitoring and retains responsibility for the final adjudication of member grievances and appeals.

<b>Subcontracted Activity Insert all numbers that apply to each agency</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
3,4,5,6,7	Dean Andretta	Performance Health Technology (PH Tech)	200 Hawthorne Avenue Suite A-102 Salem, OR 97301 503-371-7701
1,2,3,8	David Mikula	Center for Family Development	1258 High Street Eugene, OR. 97401 541-342-8437
1,2,3,8	Bill Wellard	The Child Center	3995 Marcola Road Springfield, OR. 97477 541-726-1465
1,2,3,8	Marshall Peter	Direction Service Counseling Center	576 Olive Street Suite 307 Eugene, OR. 97401 541-344-7303

<b>Subcontracted Activity Insert all numbers that apply to each agency</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1,2,3,8	Al Levine	Lane County Behavioral Health Services	2411 Martin Luther King Jr. Blvd. Eugene, OR. 97401 541-682-3708 (Adult Program) 541-682-7575 (Child Program)
1,2,3,8	Susan Ban	Shelter Care	Administrative Office PO Box 23338 1790 W, 11 <sup>th</sup> Avenue Suite 290 Eugene, OR. 97401 541-686-1262
1,2,3,8	Mary Alice Johnson	Laurel Hill Center	2145 Centennial Loop Eugene, OR. 97401-2421 541-485-6340
1,2,3,8	Chris Rubin	Looking Glass	Counseling Center 20 E. 13 <sup>th</sup> Avenue Eugene, OR. 97401 541-484-4428
1,2,3,8	Steve Allen	Options Counseling Service of Oregon	1255 Pearl Street Eugene, OR. 97401 541-687-6983
1,2,3,8		Oregon Psychiatric Partners	3203 Willamette Street Eugene, OR. 97405 541-726-9912
1,2,3,8	Peter Sprenglemeyer	OSLC Community Programs	315 W. Broadway Avenue Eugene, OR. 97401 541-743-4340

<b>Subcontracted Activity Insert all numbers that apply to each agency</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1,2,3,8	Terry Stimac	PeaceHealth Behavioral Health Services	1162 Willamette Street Eugene, OR. 97401 541-687-6096
1,2,3,8	Margie Malsch	PeaceHealth Counseling Service	1525 12 <sup>th</sup> Street #22 Florence, OR. 97439 541-902-0408
1,2,3,8	Sheri De Silva	Relief Nursery	1720 W. 25 <sup>th</sup> Avenue Eugene, OR. 97405 541-343-9706
1,2,3,8	David Ziegler	Jasper Mountain Center	37875 Jasper-Lowell Rd. Jasper, OR. 97438 541-747-1235
1,2,3,8	Tom Wheeler	South Lane Mental Health	410 N. 9 <sup>th</sup> Street Cottage Grove, OR. 97424 541-942-2850
1,2,3,8	Lucy Zammarelli	Willamette Family Mental Health Services	687 Cheshire Eugene, OR. 97402 541-343-2993
1,2,3,8		Willamette Valley Psychiatric Medicine	132 E. Broadway Suite 825 Eugene, OR. 97401 541-344-5363
1,2,3,8	Chuck Gerard	White Bird Clinic	323 E. 12 <sup>th</sup> Ave. Eugene, OR 97401 541-342-8255

<b>Subcontracted Activity Insert all numbers that apply to each agency</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1,2,3,8	Dale Smith	Sacred Heart Medical Center	1255 Hillyard Street Eugene, OR. 97401 541-686-7058
1,2,3,8		Good Samaritan Regional Medical Center	3600 Northwest Samaritan Dr Corvallis, OR 97330 541-768-5223
1,2,3,8		Salem Hospital	890 Oak Street SE Salem, OR 97301 503-561-5200
1,2,3,8		AscendHealth Corp. Cedar Hills Hospital	10300 SW Eastridge St. Portland, OR 97225 503-944-5000
1,2,3,8		Cascade HealthCare Community Hospital	2500 Northeast Neff Rd Bend, OR 97701-6015 541-706-7717
1,2,3,8	Kim Scott	Trillium Family Services	3415 SE Powell Blvd Portland, OR. 97202-3396 503-234-9591
1,2,3,8	Lynne Saxton	ChristieCare	2507 Christie Drive Marylhurst, OR. 97036 503-635-3416
1,2,3,8	Dave Ziegler	SAFE Center	89124 Marcola Road Springfield, OR. 97478 541-741-7402

<b>Subcontracted Activity Insert all numbers that apply to each agency</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1,2,3,8		Morrison Children's Services	2408 SW Halsey Troutdale, OR 97060 503-665-0157



**Schedule 9 – Subcontracted Activities**

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

**Contractor subcontracts** the following activities. (Please assign an item number to each activity):

1. Credentialing of individual practitioners (including search of excluded provider databases)
2. Initial response to complaints
3. Education of staff on MVBCN fraud, waste and abuse prevention requirements
4. Quality improvement program (required in coordination with DHS required MVBCN plan)
5. Communication of member rights and responsibilities
6. Grievance system requirements including providing Notices of Action
7. Utilization management and authorization of services
8. Selection of outpatient providers recommended to MVBCN
9. Assurance of accessibility of services

<b>Subcontracted Activity – Insert all item numbers that apply to each Agency.</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1, 2, 3, 4, 5, 6	Tim Murphy	Bridgeway	P.O. Box 17818 Salem, OR 97305 ☎(503) 363-2021
1, 2, 3, 4, 5, 6	James Seymour	Catholic Community Services	P.O. Box 20400 Keizer, OR 97307 ☎(503) 390-2600
1, 2, 3, 4, 5, 6	Lona O'Dell	Easter Seals Children's Therapy Center	P.O. Box 5193 Salem, OR 97304 ☎(503) 370-8990
1, 2, 3, 4, 5, 6, 7, 8, 9	Frank Moore	Linn County Department of Health Services*	P.O. Box 100 Albany, OR 97321 ☎(541) 967-3866
1, 2, 3, 4, 5, 6	Jordan Robinson	Lutheran Community Services Northwest	617 NE Davis St McMinnville, OR 97128 ☎(503) 472-4020

1, 2, 3, 4, 5, 6, 7, 8, 9	Rod Calkins	Marion County Health Department*	3180 Center St. NE, Rm. 2100 Salem, OR 97301 ☎(503) 588-5357
1, 2, 3, 4, 5, 6	Tim Markwell	New Perspectives Center for Counseling and Therapy	1675 Winter St. NE Salem, OR 97303 ☎(503) 585-0351
1, 2, 3, 4, 5, 6	Paul Logan	Northwest Human Services	681 Center St. NE Salem, OR 97301 ☎(503) 588-5828
1, 2, 3, 4, 5, 6	Steve Allan	Options Counseling Services of Oregon, Inc.	3000 Market St. NE, Ste. 530 Salem, OR 97301 ☎(503) 390-5637
1, 2, 3, 4, 5, 6, 7, 8, 9	Geoff Heatherington	Polk County Human Services*	182 SW Academy St., Ste. 310 Dallas, OR 97338 ☎(503) 623-9317
1, 2, 3, 4, 5, 6, 7, 8, 9	Frank Hanna- Williams	Tillamook Family Counseling Center*	906 Main St. Tillamook, OR 97141 ☎(503) 842-8201
1, 2, 3, 4, 5, 6	Kathy Boyle	Valley Mental Health / Salem Psychiatric Associates	821 Saginaw St. S. Salem, OR 97302 ☎(503) 362-1999
1, 2, 3, 4, 5, 6, 7, 8, 9	Chris Johnson	Yamhill County Health and Human Services*	627 NE Evans McMinnville, OR 97128 ☎(503) 434-7523
1, 2, 3	Medical Director	Adventist Medical Center	10123 SE Market St. Portland, Oregon 97216 ☎(503) 257-2500
1, 2, 3	Dr. Michael May	Good Samaritan Hospital Regional Mental Health Program	3600 NW Samaritan Dr. Corvallis, OR 97330 ☎(541) 757-5235
1, 2, 3	Medical Director	Legacy Emanuel Hospital	2801 N Gantenbein Ave. Portland, Oregon 97227 ☎(503) 413-2200
1, 2, 3	Medical Director	Legacy Good Samaritan Hospital	1015 NW 22nd Avenue Portland, Oregon 97210 ☎(503) 413-7711
1, 2, 3	Medical Director	Providence St. Vincent Medical Center	9205 SW Barnes Road Portland, Oregon 97225 ☎(503) 216-1234

1, 2, 3	Medical Director	Providence Portland Medical Center	4805 NE Glisan Street Portland, Oregon 97213 ☎(503) 215-1111
1, 2, 3	Dr. Robert Wolf	Salem Hospital Psychiatric Medicine Center	P.O. Box 14001 Salem, OR 97309 ☎(503) 561-5255
1, 2, 3	Medical Director or Robin Henderson	St. Charles Hospital Cascade Healthcare Community	2500 NE Neff Road Bend, OR 97701 ☎(541) 706-2791
1, 2, 3, 4	Christopher J. Krenk	Albertina Kerr Centers	424 NE 22nd Ave. Portland, OR 97232 ☎(503) 408-5019
1, 2, 3, 4	Ray Falgout	Christian Community Placement Center	4890 32nd Ave. SE Salem, OR 97317 ☎(503) 588-5647
1, 2, 3, 4	Lynne Saxton	ChristieCare	P.O. Box 368 Marylhurst, OR 97036 ☎(503) 675-2207
1, 2, 3, 4	Larry Tang	Polk Adolescent Day Treatment Center, Inc.	2200 E. Ellendale Dallas, OR 97338 ☎(503) 623-5588
1, 2, 3, 4	Hope Shaw	Polk, Yamhill and Marion Child Treatment Services, Inc.	460 Greenwood Rd. S. Independence, OR 97351 ☎(503) 838-6431
1, 2, 3, 4	Kim Scott	Trillium Family Services	3415 SE Powell Blvd. Portland, OR 97202 ☎(503) 234-9591





# MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES  
MENTAL HEALTH & ADDICTION SERVICES DIVISION  
VERITY Integrated Behavioral Healthcare Systems  
421 SW OAK STREET, SUITE 520  
PORTLAND, OREGON 97204  
503-988-5464 FAX 503-988-5870  
TDD (503) 988-5866

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January 21, 2010

Kellie Skenandore  
Department of Human Services  
Addictions & Mental Health Division  
500 Summer Street NE E86  
Salem, OR 97301-1118

RE: List of Delegated Activities

Dear Ms. Skenandore,

As required in the 2010 MHO Agreement, Exhibit D, please see attached schedule 9 outlining VERITY Integrated Behavioral Healthcare Systems' delegated activity to the following contractor:

1) Third Party Administrative services for data management and benefits administration:

Performance Health Technology (PHTech)  
3993 Fairview Industrial Drive SE  
Salem, OR 97302  
503.362.2818  
President: Michael Rohwer

Please contact me at (503) 988-5464 x83371 if you have any questions or concerns.

Sincerely,

Karl Brimner  
Division Director  
Mental Health and Addiction Services Division  
Multnomah County

**Schedule 9 – Subcontracted Activities  
MHO 2010 AGREEMENT**

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

**VERTII INTEGRATED BEHAVIORAL HEALTHCARE SYSTEMS** subcontracts the following activities. (Please assign an item number to each activity):

1. Third Party Administration services
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

<b>Subcontracted Activity – Insert all item numbers that apply to each Agency.</b>	<b>Name of Administrator or Executive Director</b>	<b>Agency Name</b>	<b>Contact Information- Address, Phone Number</b>
1	President: Michael Rohwer	Performance Health Technology (PHTech)	3993 Fairview Industrial Drive SE Salem, OR 97302 503.362.2818

### Schedule 9 – Subcontracted Activities

On the effective date of this Contract, Contractor shall notify AMH, in writing of activities to be subcontracted and the entities performing such subcontracted activities. Contractor shall provide a list which shall include the subcontractor, address, phone number, email address, name of executive director and activities to be performed. Place an asterisk (\*) by those agencies who are at-risk, subcapitated entities. Contractor shall notify AMH in writing of changes to this list within thirty (30) calendar days of such change.

**Contractor subcontracts** the following activities.(Please assign an item number to each activity):

1. Third Party Administrator functions to Performance Health Technology, DBA PHTech. These functions include claims processing and payment, and encounter data submission.\_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Subcontracted Activity – Insert all item numbers that apply to each Agency.	Name of Administrator or Executive Director	Agency Name	Contact Information- Address, Phone Number
1.	Michael Rohwer, M.D.	PhTech	200 Hawthorne Ave. SE, SuiteA-102, Salem, OR 97301, (503-362-2818.



# County PSRB Contacts

Updated 4/12/2010

<i>Agency</i>	<i>PSRB Contact</i>
<b>BAKER</b> –Jen Yturriondobeitia, Executive Director Mountain Valley Mental Health Programs P.O Box 649 Baker City, OR 97814 Main <b>541- 523-3646 x108</b> Fax: <b>541-523-7602</b> <a href="mailto:jeny@mvmhp.org">jeny@mvmhp.org</a>	<p>Jen Yturriondobeitia <a href="mailto:jeny@mvmhp.org">jeny@mvmhp.org</a></p>
<b>BENTON</b> - Mitch Anderson, Director Benton County Health Department c/o Kairos 530 Northwest 27 <sup>th</sup> St. Corvallis, OR 97330 Main <b>541-766-6844</b> Fax: <b>541-766-6186</b> <a href="mailto:Mitchell.C.Anderson@co.benton.or.us">Mitchell.C.Anderson@co.benton.or.us</a>	<p>Jeanne Nelson, Program Mgr. E-Mail: <a href="mailto:jeanne.nelson@co.benton.or.us">jeanne.nelson@co.benton.or.us</a> <b>(541) 766-6620</b></p> <p>Claudia Lee, Contract &amp; Budget Analyst <b>(541) 766-6244</b></p>
<b>CLACKAMAS</b> – Cindy Becker, Director Clackamas County Mental Health Public Services Bldg-3 <sup>rd</sup> Floor 2051 Kaen Rd., Ste 398 Oregon City, OR 97045 Shuttle Main <b>503-742-5300</b> Director: <b>503-742-5310</b> Fax-Adm <b>503-742-5301</b> Fax-Dir: <b>503-742-5311</b> David Dischner- <b>503-742-5345</b> or <b>503-929-2245</b> Fax- <b>503-228-1145</b> Sherry Mackey <b>503-742-5930</b> or cell <b>503-919-0094</b> <a href="mailto:cbecker@co.clackamas.or.us">cbecker@co.clackamas.or.us</a>	<p>Martha Spiers: <b>503-557-5833</b> E-mail: <a href="mailto:marthas@co.clackamas.or.us">marthas@co.clackamas.or.us</a> Olivia Smith, Contracts: <b>503-534-5328</b> E-Mail: <a href="mailto:OliviaS@co.clackamas.or.us">OliviaS@co.clackamas.or.us</a> Brian Dwigans, <b>503-722-6625</b> <a href="mailto:BrianDwi@co.clackamas.or.us">BrianDwi@co.clackamas.or.us</a></p>
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<p><b>Luke-Dorf, Inc.</b> Phone: 503-726-3690 Fax: 503-620-0399 11895 Greenburg Rd. Tigard, OR 97223</p>	<p>Howard Spanbock Phone: <b>503-726-3690 x3700</b> Cell: <b>503-516-8143</b> E-Mail: <a href="mailto:hspanbock@luke-dorf.org">hspanbock@luke-dorf.org</a> John Trinh <b>503-726-3690 x3702</b> Cell: <b>503-740-5618</b> E-Mail: <a href="mailto:jtrinh@luke-dorf.org">jtrinh@luke-dorf.org</a></p>
<p><b>YAMHILL – Chris Johnson, Director</b> Yamhill County Mental Health Program 627 N. Evans Mail for Director: 412 NE Ford St. McMinnville, OR 97128 Main <b>503- 434-7523</b> Fax: <b>503-434-9846</b></p>	<p>Leonard Wootton: <b>503-434-7523</b> E-Mail: <a href="mailto:lwootton@co.yamhill.or.us">lwootton@co.yamhill.or.us</a> Parkside- Chad Cox: <b>503-472-4055</b> E-mail: <a href="mailto:coxco@co.yamhill.or.us">coxco@co.yamhill.or.us</a> Premier Living- ECPC Krisan Pendleton: <b>503-472-4022</b> E-Mail: <a href="mailto:pendletk@co.yamhill.or.us">pendletk@co.yamhill.or.us</a></p>

# County PSRB Contacts

Updated 4/12/2010

<p><u><a href="mailto:Johnsonc@co.yamhill.or.us">Johnsonc@co.yamhill.or.us</a></u></p>	
<p><b>HOOD RIVER, WASCO, SHERMAN –</b>          Sharon Guidera, Exec. Director          Mid Columbia Center for Living          419 E. 7<sup>th</sup> St., Ste 207          The Dalles, OR 97058          Main <b>541-386-2620 (HR) or 541-296-5452 (The Dalles)</b>          Fax: <b>541-386-6075 (HR) or 541-296-9418 (The Dalles)</b>  <u><a href="mailto:Sharon.guidera@mccfl.org">Sharon.guidera@mccfl.org</a></u></p>	<p>Al Barton          541-386-2620  <u><a href="mailto:Al.Barton@mccfl.org">Al.Barton@mccfl.org</a></u></p>
<p><b>Telecare- Woodburn Recovery Center – Marion County</b>          Jim Sechrist, Administrator          503-982-9300  <u><a href="mailto:jsechrist@telecarecorp.com">jsechrist@telecarecorp.com</a></u>          Debby Kettle, Clinical  <u><a href="mailto:dkettle@telecarecorp.com">dkettle@telecarecorp.com</a></u></p>	<p><b>Hazel Center SRTF- Jackson County</b>          Gordon Norman, Administrator: <b>541-734-3952</b>  <u><a href="mailto:normang@jacksoncounty.org">normang@jacksoncounty.org</a></u>          Leslie Wegs: <b>541-734-3954</b>  <u><a href="mailto:wegsla@jacksoncounty.org">wegsla@jacksoncounty.org</a></u>          Toni K. Marrin:  <u><a href="mailto:marrintk@jacksoncounty.org">marrintk@jacksoncounty.org</a></u></p>
<p><b>Lifeways Org. Facilities</b>  <b>McNary SRTF- Umatilla County</b>          Tim Mahoney, Administrator 541-922-0880  <u><a href="mailto:tmahoney@lifeways.org">tmahoney@lifeways.org</a></u>          Liz Pearson  <u><a href="mailto:lpearson@lifeways.org">lpearson@lifeways.org</a></u>          Todd McJunkin  <u><a href="mailto:tmcjunkin@lifeways.org">tmcjunkin@lifeways.org</a></u>  <b>Hiltop RTH</b>          Steve Jensen, Administrator 541-276-1126  <u><a href="mailto:Sjensen@lifeways.org">Sjensen@lifeways.org</a></u></p>	<p><b>Heeran Center SRTF- Jackson County</b>          Paulette Montplaiser, Administrator          541-465-3323  <u><a href="mailto:paulmont@sheltercare.org">paulmont@sheltercare.org</a></u></p> <p><b>Cascadia Facilites- Lane County</b>  <b>Gateway Living 2 RTF</b>          Joan Kehoe, <b>541-736-3990</b>  <u><a href="mailto:Joan.kehoe@cascadiabhc.org">Joan.kehoe@cascadiabhc.org</a></u>          Madelyn Antinucci : 503-686-1944  <u><a href="mailto:madelyn.antinucci@cascadiabhc.org">madelyn.antinucci@cascadiabhc.org</a></u></p>

# County PSRB Contacts

Updated 4/12/2010

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<p><b>Luke-Dorf- Washington County</b>  <b>Connell House RTF</b>  Karen Tarvin: Service Coordinator/ Administrator  503-597-3900  <a href="mailto:ktarvin@luke-dorf.org">ktarvin@luke-dorf.org</a>  Katrina Bennett, Clinical Coordinator  <a href="mailto:kbennett@luke-dorf.org">kbennett@luke-dorf.org</a></p>	<p><b>The Mentor Network</b>  <b>Hosmer House- Deschutes County</b>  Dan Cochrane, Administrator: 541-647-1269  <a href="mailto:dan.cochrane@thementornetwork.com">dan.cochrane@thementornetwork.com</a>  <b>ElDorado- Multnomah County</b>  Joe Dominguez, Administrator 503-771-1645  <a href="mailto:Joe.dominguez@thementornetwork.com">Joe.dominguez@thementornetwork.com</a></p>
<p><b>Shangri-La Facilities</b>  Jennifer McIntosh  <a href="mailto:jenifer@shangrilacorp.net">jenifer@shangrilacorp.net</a>  <b>Buena Vista RTH- Marion County</b>  Anthony Sorce, Administrator 503-361-2642  <a href="mailto:anthony@shangrilacorp.org">anthony@shangrilacorp.org</a>  <b>Benton Place- Lincoln County</b>  J. Jasmine, Administrator 541-574-0086  <a href="mailto:jasmine@shangrilacorp.org">jasmine@shangrilacorp.org</a></p>	<p><b>DDA of Oregon</b>  Corbett Monica,  <a href="mailto:corbettmonica@yahoo.com">corbettmonica@yahoo.com</a></p>



## DHS medical assistance program codes

\*The BMP benefit only applies to pregnant adults receiving BMH, BMM or BMD benefits.

Code	Program Title	Case Descriptor	Benefit package							
			BMH	BMM	BMD	BMP	KIT	CWM	CWX	QMB
1, A 1	Aid to the Aged	Various; see SPD Staff Tools	X	X	X					
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	X							
V2	Refugee Assistance		X			*				
3, B3	Aid to the Blind	Various; see SPD Staff Tools	X	X	X	*				
4, D4	Aid to the Disabled	Various; see SPD Staff Tools	X	X	X	*				
19, 62	DHS Foster Care		X							
C5	Substitute/Adoptive Care	SAC, SCP, SFC	X							
GA (CSD)	Non-title XIX Foster Care		X							
5	OSIPM-PRS	Various; see SPD Staff Tools	X		X	*				
P2	Qualified Medicare Beneficiary (QMB)	QMB								X
P2, M5, 2, 82	OHP Medical	OP0, OP6, OPP	X			*				
	OHP Medical	OPU					X			
	Breast and Cervical Cancer Program	BCP	X			*				
	Children's Health Insurance Program (CHIP)	CHP	X							
	Extended Medical Program	EXT	X			*				
Any Program	CAWEM	CWM						X		
	CAWEM Plus	CWX							X	
	QMB + Any Program	QMM		X						



## Assertive Community Treatment (ACT)

Information on the following practice can be found at:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

If you would like more information on this practice, contact Greta Coe at [greta.l.coe@state.or.us](mailto:greta.l.coe@state.or.us) or 503-945-6187.

Assertive  
Community  
Treatment (ACT)  
Number of Providers  
in County  
Implementing this  
Practice

Benton 1  
Columbia 1  
Josephine 1  
Klamath 2  
Lane 1  
Linn 1  
Malheur 1  
Wallowa 1  
Wasco 1

## ASSERTIVE COMMUNITY TREATMENT (ACT)

### BENTON COUNTY

Benton County Health Department  
530 NW 27th St  
Corvallis  
Program Contact: Mitch Anderson  
Phone: (541) 766-6805

### COLUMBIA COUNTY

Columbia Community Mental Health

58646 McNulty Way  
St. Helens  
Program Contact: Linda Pritchett  
Phone: (503) 397-5211

#### JOSEPHINE COUNTY

Options for Southern Oregon  
1215 SW G St  
Grants Pass  
Program Contact: Jeff Krolick  
Phone: (541) 476-2373

#### KLAMATH COUNTY

Klamath County Mental Health  
3314 Vandenberg Rd  
Klamath Falls  
Program Contact: Tamara Rose  
Phone: (541) 883-7291

Klamath County Mental Health-PSRB  
3314 Vandenberg Rd  
Klamath Falls  
Program Contact: Dannielle Brown  
Phone: (541) 882-7291

#### LANE COUNTY

South Lane Mental Health  
410 North 9th  
Cottage Grove  
Program Contact: Tom Wheeler  
Phone: (541) 942-2850

## LINN COUNTY

Linn County Mental Health Services  
PO Box 100  
Albany  
Program Contact: Sandy Minta, Psy.D.  
Phone: (541) 924-6916

## MALHEUR COUNTY

Lifeways -Malheur  
702 Sunset Dr  
Ontario  
Program Contact: Ray Millar  
Phone: (541) 823-9012

## WALLOWA COUNTY

Wallowa Valley Center for Wellness  
207 SW First  
Enterprise  
Program Contact: Stephen Kliewer, D.Min.  
Phone: (541) 426-4524

## WASCO COUNTY

Mid-Columbia Center for Living  
419 E 7th St  
The Dalles  
Program Contact: Rodney McDowell, LCSW  
Phone: (541) 296-5452



June 17, 2010

RE: Response to The Department of Justice pertaining to the CRIPA investigation of the Oregon State hospital

Question #9

A variety of peer-operated services are available through the county mental health system. The Federal Block Grant administered by AMH supports peer delivered services in four sites across the state:

Peer Wellness Program  
Benton County Health Department  
530 NW 27<sup>th</sup> Street  
Corvallis, OR. 97330

Peer wellness coaching, peer operated wellness programs, training, community education. Serves PSRB and non-PSRB individuals.

Union Drop-in Center  
106 NW F. Street  
PMB 56

Grants Pass, OR. 97526  
Drop-in Center services, peer support groups, consumer education. Serves PSRB and non-PSRB individuals

Lane Independent Living association  
99 West 10<sup>th</sup> Ave. #117  
Eugene, OR. 97401

Drop-in Center services, peer support groups, consumer education, serves PSRB and non-PSRB individuals

Silver Sage Drop-in Center c/o Lifeways Behavioral Health  
702 Sunset Dr.  
Ontario, OR. 97914

Drop-in Center services, advocacy services, local mental health advisory activities. Serves PSRB and non-PSRB individuals

Also available are services provided through:

NAMI Oregon  
3550 SE Woodward St.  
Portland, OR. 97202

State-wide advocacy  
State-wide advocacy, peer leadership training, peer support groups. Serves PSRB and non-PSRB individuals

Mid-Valley Behavioral Care Network  
1660 Oak St. SE, Suite 230  
Salem, OR. 97301

Proposed project start date: 7/1/2010

The project goal is to promote community integration, linkage with peer support programs, and recovery through a joint effort with the region's mental health organization and community mental health services.

David Romprey Warm line  
401 Fourth St.  
Human Services Building  
Fossil, OR. 97830

The warm line is state-wide program designed and provided by individuals who have or have had challenges with mental health issues and are able to offer support to individuals with mental health challenges. Serves PSRB and non-PSRB individuals.

CODA (5 individuals served)

Individuals live in fair market housing with intensive case management services provide twice daily in their home or community. Participating individuals have the expectation that they will be involved in work, school or volunteer activities as well as treatment and self help activities.

CODA

Carolyn Mounts, 503-252-3304 x14  
[CarolynMounts@codainc.org](mailto:CarolynMounts@codainc.org)

Dual Diagnosis Anonymous (DDA) is a peer support group based on an authorized version of the 12 steps of Alcoholics Anonymous plus and additional 5 steps that focus on Dual Diagnosis (mental illness and substance abuse). DDA's unique 12 steps Plus 5 Program offers hope for achieving the promise of recovery.

Cascadia  
Bonnie Lambert, 503-238-0705 x 228  
[bonnie.lambert@cascadiabhc.org](mailto:bonnie.lambert@cascadiabhc.org)

# DOJ Information Request 6/9/2010

## 10.a

Non-PSRB Patients (as of 6/15/10)	
0-89 days	405
90-179 days	239
180-364 days	152
1-2 yrs	73
2-3 yrs	29
3-4 yrs	19
4-5 yrs	11
5-10 yrs	17
10-15 yrs	6
15+ yrs	10

961

All PSRB Patients (as of 6/15/10)	Class A Felony	Class B Felony	Class C Felony	Class A Misd	Class B Misd	Unknown
0-89 days	21	5	6	3	0	1
90-179 days	28	12	4	10	2	0
180-364 days	61	15	14	25	7	0
1-2 yrs	100	50	24	13	12	0
2-3 yrs	97	47	22	23	4	1
3-4 yrs	68	34	16	12	2	0
4-5 yrs	37	13	7	14	3	0
5-10 yrs	64	38	17	5	0	4
10-15 yrs	15	12	3	0	0	0
15+ yrs	11	8	3	0	0	0
	502	234	116	108	33	1
						10

**US DOJ Document Request June 2010**  
**Response to 10.b**  
**Conditional Release List Breakdown**

Request for Cond Release	
0-89 days	10
90-179 days	9
180-364 days	22
1-2 yrs	39
2-3 yrs	30
3-4 yrs	20
4-5 yrs	9
5-10 yrs	15
10-15 yrs	3
15+ yrs	2
Unknown	1
Total	160

US DOJ Document Request June 2010  
Response to 10.b  
Ready to Place List Breakdown

Ready to Place Patients	
0-89 days	121
90-179 days	55
180-364 days	30
1-2 yrs	22
2-3 yrs	10
3-4 yrs	5
4-5 yrs	3
5-10 yrs	5
10-15 yrs	1
15+ yrs	3
Unknown	1
Total	256

Question 10-c

The number of individuals currently on Ready-to-Place (RTP) lists:

**OSH-Portland: Total RTP = 17**

<90 days = 14

<180 days = 2

>2 years = 1

**OSH-Salem: Total RTP = 9**

<90 days = 8

< 1 year = 1

**EBRC – Salem and Portland Campuses: Total = 14**

<90 days = 2

<180 days = 2

<1 year = 1

1-2 years = 3

>2 years = 6

**Blue Mountain Recovery Center: Total = 25**

<90 days = 21

<180 days = 3

>2 years = 1

**Total: 65**

### **DOJ Request Question 10.d**

The hospital does not assess, collect or track whether patients are housed within a less restrictive unit within the hospital. The hospital units do not have official "restriction" standards or levels from which we could assess, track, or monitor placement. Patient placement is based on a number of factors that include consideration of appropriate placement based on patient need, but also includes (but is not limited to) factors such as hospital and unit census, incoming admissions, acuity, and additional staffing and patient factors.

## **DOJ Request 10.e**

### **Ready to Place Status**

There were 267 individuals that were on the ready to place status since 1/1/2009 to the present

Of those, there have been 28 individuals that had their status on the list withdrawn.

LOS of Patient's Previous Admission (as of 6/15/10)	
90-179 days	51
180-364 days	40
1-2 yrs	23
2-3 yrs	12
3-4 yrs	8
4-5 yrs	0
5-10 yrs	1
10-15 yrs	3
15+ yrs	0

\* Review included all patients admitted  
since 1/1/2009

Patient Placement at Discharge  
1/1/09 to 6/15/10

Discharge Facility	# Placed
Acute or Sub-Acute Psychiatric Facility	57
Community Based Mental/Addiction Service Provider	47
Developmental Disabilities Services	1
Eastern Oregon Training Center	7
Family/Friend	33
Federal Correctional Institution	1
Jail (City/County) *	388
Mental Health Organization	1
Other	2
Other Community Agency	174
Parole (County/State/Federal)	3
Police/Sheriff (Local/State)	2
Primary Care Provider, Specialist, or Other Physical Health Provider	7
Private Professional	23
Psychiatric Security Review Board	43
Self	38
Senior Services Division	1
State Correctional Institution	6
State Psychiatric Facility	4
Unknown/None	18
<b>Total</b>	<b>856</b>
* Primarily our Aid and Assist Population	