State of Oregon

Report to the Governor from the Mental Health Alignment Workgroup

Executive Summary

January 2001

Oregon will benefit from a well-functioning system where people have access to coordinated, comprehensive, caring and community-based medical and social supports for their mental health needs regardless of place of residence, age or income.

"Let Me Be Again"

Once I was striving to be treated equal because of my dark skin.
That was way back, before I went in.

Once I was treated as a credible person.
That was way back, before I went in.

I had hopes. I had dreams. I tried to live my life filled with pride, and self-esteem.
That was way back, before I went in.

Once I went in I became known as "mentally ill," gone was my name.
Gone were my dreams. Gone was my life. Gone was me. After I went in.

I am a "mental patient," perceived to be insane, violent and no longer able
to be credible in any way.
All that I say is doubted, and taken to be the rambling of an "insane person."

This is something neither of us would choose, I cannot stop it, and we all lose.
Because of me being in a mental hospital, which I did not choose.
No one would walk a foot in my shoes.

With each thump in my heart, inside I cry. I am not insane or violent.
Give me back my pride. Let me have my dignity again.
Mental illness is a destructive ride. Pain and indignities fill the inside.

I am not allowed to recover or to be a whole person again, because of where
I have been and my label "mentally ill."

Sometimes I feel I can take no more, because so many feel I will never be "cured."
I pray for myself and I pray for others.
I pray to the Lord to open some eyes.

I have depression, not insanity. I get angry, but never violently.
Severe depression can kill a person's life.
Being in a mental hospital takes away all your choices and your rights.
They think I have no judgement or insight.

Many nights I have cried in my pillow bitter tears of anger and pain, and to myself
I have whispered "the world is insensitive, and insane."
And I cry some more because of the shame.

I say let me be again, and have a real life. I am still able to do a lot of good.
Please let me have back my rights, my credibility, and pride.
I am not asking for a free ride. I have paid my dues.

I am filled with shame as I say "LET THE WORLD'S INHUMANITY AND INSANITY STOP!"

Written by Betty Turner, 1994
Consumer Member, MHAWG

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Values

Oregon's Mental Health System

- shall be consumer-centered, with the needs and preferences of the individual with a mental health disorder, his/her family and other support persons guiding the services that are provided.

- shall be community-based, with services, management and decision-making at the community level.

- shall be culturally competent with services that are responsive to race, gender, age, disability and ethnicity.

- shall provide access to comprehensive, 'round the clock' services that address the needs of individuals with mental health disorders.

- shall recognize and value that individuals, businesses, providers, government entities and others share responsibility for the mental health of Oregonians.

- shall balance the need for public safety with individual autonomy.

- shall affirm family members, providers and staff who care for those with mental health disorders.

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Executive Summary

Workgroup Recommendations

In Priority Order

Develop local biennial blueprint plans that use a multi-system team approach to coordinate and deliver services for children, families and adults. See page 79 of the full report for details.

Timeline: Begin Planning July 2001

Lead: Local Mental Health Authorities, Mental Health and Developmental Disability Services Division

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Establish equal benefits for mental health and physical health (parity). See page 108 of the full report for details.

Timeline: 2001 Legislative Session

Lead: Governor's Office and Legislature

Provide public mental health funds, including Oregon Health Plan, through a block grant for the purpose of implementing local plans and encourage Local Mental Health Authority to enter into "blended funding" agreements with state and providers. See page 108 of the full report for details.

Timeline: July 2003

Lead: Mental Health and Developmental Disability Services Division

Local Mental Health Authority and Local Public Safety Coordinating Councils shall work together to address the interface between law enforcement and mental health for both youth and adults. Results become part of the local blueprint plan. Corrections and Oregon Youth Authority (state) should work with local mental health to develop release plans. See page 91 of the full report for details.

Timeline: First phase begins July 2001

Lead: Department of Corrections, Local Mental Health Authorities, Criminal Justice Commission, Oregon Youth Authority and Public Safety Planning and Policy Council

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Create a seamless data system using an "information system guidance committee" inform the process. See page 118 of the full report for details.

Timeline: July 2001 - Committee, July 2003 - Begin implementation

Lead: Mental Health and Developmental Disability Services Division and Information and Resource Management Division of the Department of Administrative Services

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Simplify Oregon Health Plan enrollment process and eliminate periods of non-coverage. See page 109 of the full report for details.

Timeline: 2001 Session

Lead: Governor and Legislature

Develop or adopt statewide performance measures and allow for additional local measures. See page 116 of the full report for details.

Timeline: Begin July 2001. Complete February 2003.

Lead: Mental Health and Developmental Disability Services Division and Local Mental Health Authorities

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Establish a FHIAP-like subsidy program for the purchase of employer-based insurance, based on a basic benefit package. See page 110 of the full report for details.

Timeline: 2001 Session

Lead: Governor, Legislature and congressional delegation

Conduct a study and analysis of the needs of the mental health workforce. Delineate workforce needs and responsibilities according to a matrix. Identify core competencies and develop training across the system. See page 120 of the full report for details.

Timeline: July 2002 - study completed, July 2003 - rules revised, July 2003 - training begins, July 2003 - budgeted and developed

Lead: Department of Administrative Services, Department of Human Services, Mental Health and Developmental Disability Services Division, and Office of Alcohol and Drug Abuse Programs

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Form a consortium of public and private groups to provide public education. See page 122 of the full report for details.

Timeline: July 2001

Lead: Governor's Office

Governor and state agencies should make changes necessary to integrate administrative functions to support local service delivery. See page 119 of the full report for details.

Timeline: January 2001- directive to agencies, January 2003 - changes implemented

Lead: Governor, Department of Administrative Services, and agencies

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Establish an independent ombudsperson office. See page 123 of the full report for details.

Timeline: 2001 session for legislation, January 2003 for rules and processes

Lead: Governor and Legislature

For implementation purposes, transfer Dammasch Housing Trust Fund to Oregon Housing and Community Services Department to leverage and grow**.** See page 101 of the full report for details.

Timeline: After sale of Dammasch

Lead: Department of Human Services and Oregon Housing and Community Services Department

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Establish a developmentally appropriate screening tool for children and adolescents. See page 73 of the full report for details.

Timeline: Completed by January 2003

Lead: Mental Health and Developmental Disability Services Division

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Develop a state comprehensive plan consistent with Mental Health Alignment Workgroup values and guiding principles and derived from local plans. See page 120 of the full report for details.

Timeline: Completed July 2005

Lead: Mental Health and Developmental Disability Services Division

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Develop abuse/neglect and safety policy. See page 123 of the full report for details.

Timeline: Completed by July 2002

Lead: Mental Health and Developmental Disability Services Division

Develop standardized levels of care criteria linked to local plans. See page 84 of the full report for details.

Timeline: Completed by July 2002

Lead: Mental Health and Developmental Disability Services Division

Why Mental Health?

The hydraulic impact of mental health issues on other parts of the human resource, education and workforce systems is very clear, for both children and adults. For example, untreated mental health problems affect a significant number of the clients seen in state agencies, including:

The hydraulic impact of mental health issues on other parts of the human resource, education and workforce systems are very clear. . .

- 75 percent of those receiving public assistance;
- 66 percent of incarcerated adults;
- 48 percent of youth in community programs, but in the jurisdiction of the Oregon Youth Authority;
- 40 percent of those on the child protection case load; and
- 70 percent of youth incarcerated in a state institution.

These impacts are often the result of a lack of access to mental health services for large numbers of Oregon children and adults. Lack of access is compounded by the lack of a clear "mental health system" in Oregon, especially for children.

There is fragmentation in funding, risk, management of services at the state and local levels, and fragmentation in the responsibility for delivering necessary services in many communities. There is also fragmentation among state agencies, and between local, state and federal levels

of government. Finally, there continues to be some level of fragmentation between OHP and non-OHP mental health services.

In February 2000 Governor Kitzhaber appointed a Mental Health Alignment Work Group (MHAWG) and charged it with addressing these and other fundamental issues that create a disintegration of funding, services, and responsibility in Oregon's approach to mental health services for both children and adults.

Barriers to the Ideal System

Before achieving a more ideal mental health system, the Workgroup determined that Oregon must address and overcome a number of barriers. These barriers apply to mental health services for both children and adults.

Fragmented Approach

Oregon does not have a systematic approach for planning and providing public mental health services at state and local levels. This is especially true for children's mental health services. There is fragmentation in funding, risk, management of services at the state and local levels, and fragmentation in the responsibility for delivering necessary services in many communities. There is also fragmentation in the services funded by the MHDDSD. The fact that other DHS divisions and agencies fund mental health services for their clients outside the Oregon Health Plan (OHP) and outside the funding and oversight provided by the MHDDSD even further fragments the situation. There are approximately 13 state agencies or divisions providing funding for mental health services for their clients. Virtually none of these agencies have coordinated the delivery of mental health services for their clients with the others. The result is separate funding from the OHP for some residents, publicly funded safety net services for others, and no services for others. As a result, Oregon has a collection of autonomous programs,

managed by various state and local agencies, operating in a piecemeal fashion.

Further, the State lacks consistent standards for contractual and reporting agreements, client screening, assessment and placement, and payment for mental health services. Consequences for failing to meet contractual obligations are inconsistently enforced.

Oregon does not have a statewide-shared data system reporting on treatment availability, program performance and client outcomes. As a result, state agencies are unable to monitor potential duplication of services, or track client success and needs. This problem is compounded by federal confidentiality requirements, which often make it difficult to share relevant client information.

Inadequate Resources

Oregonians who do not have access to the OHP, including many with private insurance, often have limited or no mental health benefits. This leaves them to utilize whatever resources state or local communities can provide, including hospital emergency rooms or law enforcement. The cost of psychotropic medications covered by the OHP is growing at an unsustainable rate, and there is no mechanism in place to assure cost control. While state "safety net" funding was not intended to cover 100 percent of costs, dwindling local resources and increasing costs for private coverage have forced local community partners to reduce spending on mental health services. Local and private resources are currently inadequate to fill the existing gap between need and capacity. As a result, Oregon lacks the ability to meet the current need for mental health services, particularly for children and minority populations. Further, since local providers are often unable to pay competitive wages for staff, the quality and availability of service suffers.

Oregonians who do not have access to the OHP, including many with private insurance, often have no or substantially reduced mental health benefits.

According to an on going survey of the Residential Providers Association, 75% of staff in residential treatment programs turn over each year. On the other hand, the turnover rate for adult case managers (which are a significant portion of the community mental health outpatient workforce, and about half of whom have a masters degree) is relatively low according to surveys conducted by MHDDSD in 1994 and 2000.

Need for Additional Training

There is a need to develop a workforce of skilled and qualified treatment providers that includes the use of consumers in the delivery of services. In particular, there is a need for staff who are skilled in culturally appropriate services, services for the dually diagnosed, and those involved in the criminal justice system. Providers with expertise about the developmental stages of children and aging adults are also sorely needed. Finally, there is a need for more child psychiatrists, particularly in rural parts of the state.

Public Perception

There is a widespread lack of understanding and public misperception about mental health disorders along with the role of mental health treatment and services. A public information campaign could help all Oregonians understand that mental health disorders are community issues that affect everyone, and that treatment is available and effective.

Paucity of Services for Criminal Justice and Dually Diagnosed

Few programs exist for those who have co-occurring mental health and substance abuse disorders, yet an estimated 30 percent of Oregonians with mental health disorders are in need of dual diagnosis treatment. The criminal justice system has become a "default" mental health system for many of these people. The lack of services and fragmentation, coupled with the fear of persons with mental disorders, leaves law enforcement to

"deal with" these individuals. The criminal justice system is neither funded nor trained to help persons with a mental health disorder.

Lack of Continuity of Care and Social Supports

Because Oregon's mental health system is disjointed and overwhelmed, consumers and families do not always receive the most clinically appropriate service. Research shows that people with mental disorders are most likely to succeed when services are matched to their needs, and social supports (such as respite care for families whose children are affected by mental health disorders, or housing for adults) are provided. This means that Oregonians with a mental health disorder must have access to a range of treatment opportunities in addition to social supports. Further, for the most seriously ill, care based on medical necessity as required under the OHP does not recognize that recovery and rehabilitation are accomplished through a variety of means – many of which lie outside the traditional domain of health care. The current research literature indicates that housing and employment are central features of effective treatment and recovery. In particular, the following is needed:

. . . people with mental disorders are most likely to succeed when services are carefully matched to their needs, and social supports surround clinical treatment.

- A full range of treatment services, including prevention, early screening and assessment;

- Transitional services that assist criminal offenders with a mental health disorder to reintegrate into the community;

- Transitional services that ensure older adolescents with serious mental health disorders will receive appropriate services and supports as they leave the child and adolescent system;

- Employment opportunities for adults, and education services for children, that will help ensure independent and productive lives;

- A full range of housing opportunity, which impacts a consumer's ability to stay in recovery; and

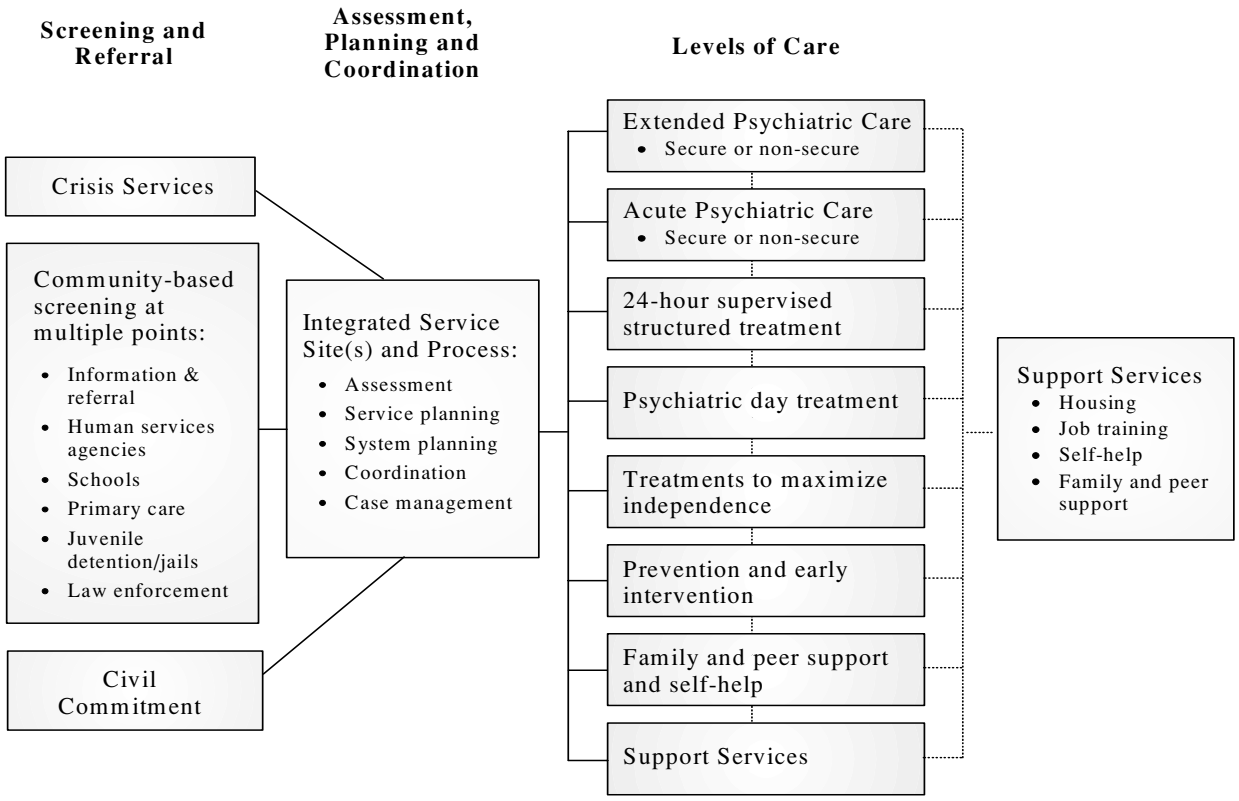
- Access to appropriate alcohol and other drug treatment to facilitate the highest level of recovery and self-sufficiency possible.

An Ideal Mental Health System for Oregon

A model or "ideal" mental health system was designed by the MHAWG. Components of the ideal system were identified to address the concerns and barriers outlined above. The ideal mental health system focuses on identifying mental health disorders or risks for mental health disorders as early in a person's life as possible and providing needed treatment and support as soon as possible. This means focusing on prevention and early intervention services, especially for children. The ideal system encompasses a range of services and supports, including screening, assessment and referral; a range of treatment options; appropriate connections to criminal justice and other systems where necessary; availability of critical social supports; a recovery orientation; and involvement of family members and other support persons. The relationship between components is illustrated on the following page.

The diagram also provides an illustration of how the recommendations will combine to form a more ideal mental health system for children, families and adults.

Figure 1
Ideal Mental Health System



Conclusion

The recommendations in this report, if implemented over time, will ensure the best possible outcomes for individuals with mental health disorders and for the state. These recommendations establish a clear vision, shared values, and consistent principles of operation. This report will move our state toward a mental health system that identifies mental health disorders as early in a person's life as possible and provides treatment and support as soon as possible. The recommendations contained in this report focus on prevention and early intervention, especially for children. They encompass a range of services and supports delivered in a comprehensive and coordinated manner, including screening, assessment and referral; a range of treatment options; appropriate connections to criminal justice and other systems where necessary; availability of critical social supports; a recovery orientation; and involvement of family members and other support persons.

Only a coordinated approach . . . will ensure any reduction in the sobering statistics associated with mental health disorders.

Only the coordinated approach recommended here, which recognizes, responds to and helps people recover and is supported by key infrastructure components, will ensure any reduction in the sobering statistics associated with mental health disorders.