State of Oregon

Report to the Governor
from the
Mental Health Alignment Workgroup

January 2001

"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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Mental Health Alignment Work Group
Report and Recommendations

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Tables and Figures

Executive Summary

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.

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.

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 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 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 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 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" to inform the process. See page 118 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 for details.

Timeline: 2001 Session

Lead: Governor and Legislature

Develop or adopt statewide performance measures and allow for additional local measures**.** See page 116 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 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 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

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

Timeline: Completed July 2005

Lead: Mental Health and Developmental Disability Services Division

Develop abuse/neglect and safety policy**.** See page 123 for details.

Timeline: Completed by July 2002

Lead: Mental Health and Developmental Disability Services Division

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Develop standardized levels of care criteria linked to local plans. See page 84 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 are very clear. . .

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:

- 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 percent 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 there are an estimated 66,000 Oregonians 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, people with mental disorders 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.

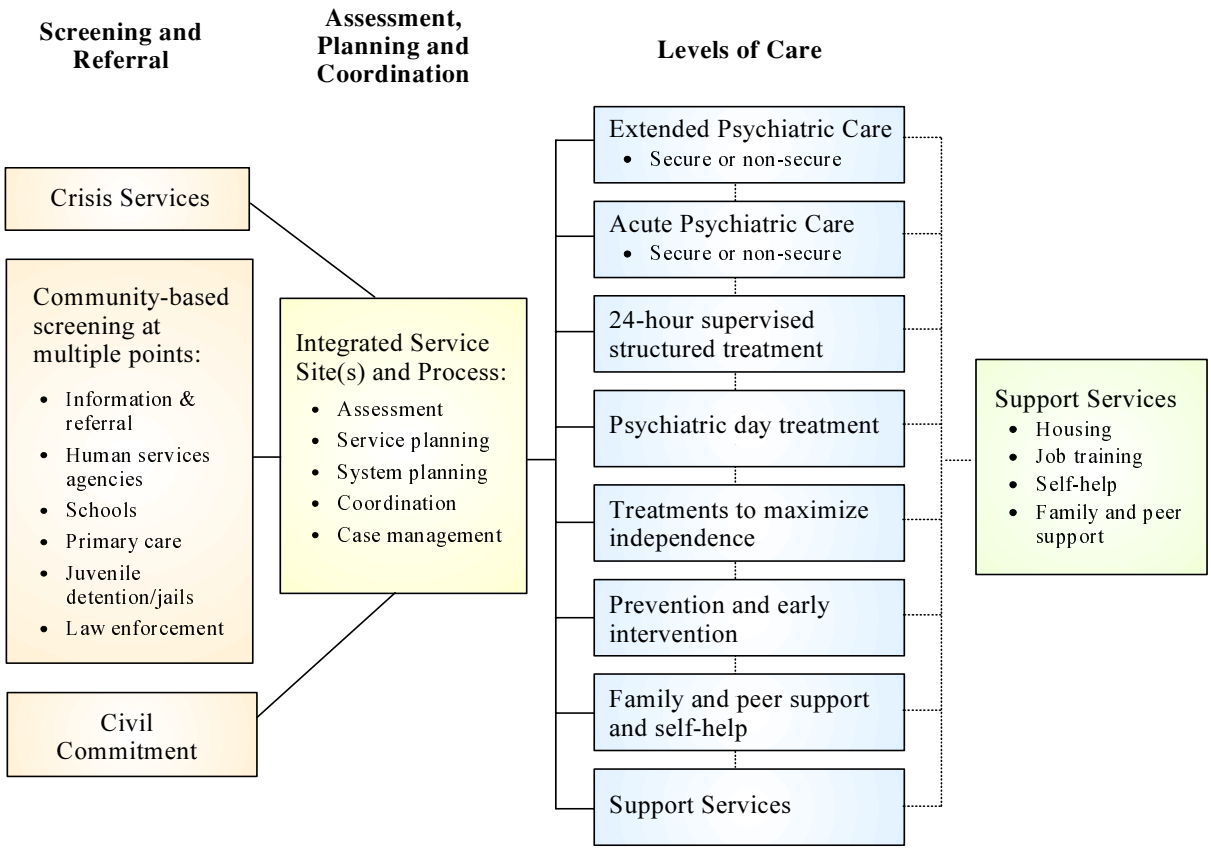
- A full range of treatment services, including prevention, early screening and assessment;
- Transitional services that assist older adolescents and adults with chronic mental health disorders and long hospital stays to reintegrate into the community;
- Transitional services that assist criminal offenders 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.

Introduction

Oregon Strategy for Social Support

In the spring of 1996, Governor John Kitzhaber developed a concept of governance named the *Human Investment Framework*. The goal of the Framework is:

> "*…to empower Oregonians to be as independent, productive and self-sufficient as possible*."

This framework set the goal and tone for Oregon's approach to investing in its people. It said that our approach would be one of shared investments—among state, local and community, public and private partners. It said that Oregon's approach would recognize the inter-connected relationship between education, workforce development and social supports. That is, in order for children to be successful in school, and for adults to be successful at finding and maintaining employment, certain social supports must be present in their lives.

...Oregon's approach would recognize the inter-connected relationship between education, workforce development and social supports.

Next in 1996, the Governor appointed a special Social Support Investment Work Group (SSIWG) to define the critical social supports necessary to ensure successful attainment of education and workforce goals. This work group delivered its report to the Governor in April 1997. The SSIWG identified the social supports core to education and workforce success, defined where state government has a primary responsibility, outlined the most appropriate manner for the state to fulfill its responsibility, and identified strategic opportunities for investment to ensure optimum availability of core social supports. This became known as the Oregon Strategy for Social Support.[1]

Next, the Governor invited representatives from a wide variety of stakeholders: state and local agencies, family members, consumers and other key community partners, to participate in a Mental Health Alignment Work Group. This body was charged with analyzing gaps and redundancies in existing mental health treatment and services in Oregon. It was to recommend the most efficient means of coordinating and delivering mental

health services in Oregon with a particular focus on state-funded services.

This, the report of the Mental Health Alignment Workgroup (MHAWG), fulfills the Governor's directive to analyze and propose necessary realignment of mental health services in Oregon as part of the Oregon Strategy for Social Support.

Why Mental Health?

Through the work of the SSIWG, the hydraulic impact of mental health issues on other parts of the human resource, education and workforce development systems became 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:

- 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,[2] and
- 70 percent of youth incarcerated in a state juvenile correctional institution.[3]

Lack of access is compounded by the lack of a clear "mental health system" in Oregon...

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 in the services funded by the MHDDSD, especially in relationship to the Oregon Health Plan (OHP) and high-intensity services, and the delivery of these services at the Oregon State Hospital and in community mental health programs. Other Department of Human Services (DHS) divisions and agencies that fund mental health services for their clients outside the OHP and outside the funding and oversight provided by MHDDSD even further fragment funding and

service delivery. 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 funded mental health services for their clients with the others.

The MHAWG was charged to address these and other fundamental issues creating a disintegration of funding, services, and responsibility in Oregon's approach to mental health services for both children and adults.

Acknowledgments

The MHAWG would like to acknowledge the consumers and family members who graciously volunteered their time and travel to participate in the MHAWG and who courageously told their personal stories and challenged the stories of the system.

Work Group members also extend a special thanks to the citizens and community members who participated in the community forums. Their hard work and insight was critical to the development of this report.

Madeline Olson and staff at the Department of Human Services, Mental Health and Developmental Disability Services Division generously responded to countless inquiries for data, charts and historical documents. Their efforts made the work of the MHAWG possible. And special thanks is extended to Joan Wan who patiently formatted this report.

... consumers and family members ...courageously told their personal stories and challenged the stories of the system.

The National Technical Assistance Center for Children's Mental Health deserves thanks for their support of the MHAWG and its process beginning in December 1999 with the "Policy Academy" and throughout this effort.

The MHAWG members would like to thank Suzie Willard because without her organizational logistics and stellar staffing skills, regular meetings and this report would not have been possible.

The MHAWG members thank Mark Gibson for his leadership as chair. Finally, MHAWG members would like to thank Pam Curtis whose facilitation skills and thoughtful leadership fostered creative and productive work.

Background

History of Mental Health in Oregon[4]

Mental health disorders in Oregon first entered the realm of public policy... in 1843, 16 years before statehood.

Mental health disorders in Oregon first entered the realm of public policy with the establishment of the Oregon Territorial government in 1843, 16 years before statehood. The provisional government formed at Champoeg adopted laws and appropriated $500 "for purposes of defraying expenses of keeping lunatic or insane persons in Oregon". Probate courts were to direct the county sheriff to summon "a jury of twelve intelligent and impartial men" to investigate whether a person was "insane." If this jury so determined, the person with a mental health disorder would be appointed a trio of guardians to sell his or her property and dispose of the proceeds to pay for the person's care.

Guardians were to ensure that the person received care at their own charge and were to ensure that the "unfortunate" receive "relief as paupers and be maintained under the care of the overseers of the poor." The guardians also had responsibility for safekeeping and maintenance of the person with a mental health disorder and his or her family. Finally, if there were not sufficient resources, the county was required to pay for these supports out of the county treasury.

Further modifications came quickly. In 1844, the following year, another state law was passed which specified that a person with a mental health disorder should be "let out publicly…to the lowest bidder, to be boarded and clothed for one year…". By 1850, there were five such persons identified in a state population of 13,294. Counties soon appealed for state funds, which were granted in 1855 and then taken away in 1856 when another law passed that repealed the 1855 law.

For some this marked the beginning of confusion over roles and responsibilities between the state and counties over the care of the persons with a mental health disorder. For others, it launched counties as the backbone of the mental health system in Oregon. Discussions continue to this day regarding the capacity of counties to provide local care for persons with mental health disorders.

By 1861, a physician, Dr. J. C. Hawthorne opened a private institution in Portland to care for persons with mental health disorders. In the fall of 1862, Dr. Hawthorne was the only respondent when the governor was required to identify suitable persons to care for persons with mental health disorders and to provide them with medical treatment.

The state contracted with Dr. Hawthorne initially to care for 12 patients in the fall of 1862. By the spring of 1863, the population of the institution had already increased to 28 patients. As the population of Oregon increased over the next 15 years, so too did the size and census of Dr. Hawthorne's "Oregon Insane Hospital." In 1866 there were 77 patients; in 1870 there were 111; in 1874 there were 194. By 1877, the costs of caring for these patients took up 52 percent of the total state budget!

By 1877, the costs of caring for these patients took up 52 percent of the total state budget!

Dr. Hawthorne's thinking about early intervention and the likelihood of recovery bears quotation today. In his report to the governor in 1878, he stated:

> *"The percentage of the recoveries of the past two years shows an increase over that exhibited in my last report. This result is attributable to the condition of the patients when admitted, the form of insanity being acute in a greater number of cases. It is a fact which the experience of all engaged in the treatment of this class of patients shows, that judicious treatment in the early stages of the disease is, in a majority of cases, attended with success, while but a small proportion are restored to reason where a considerable period of time has elapsed before the patient has been put under systematic hospital treatment."*

The population of persons in need of mental health care and treatment continued to grow steadily until the legislature decided to open its own state-operated facility in 1883, at which time 370 persons with mental health disorders were transferred from the private Portland facility to a public facility in Salem.

The Oregon State Insane Asylum grew by leaps and bounds. Only 25 years after it opened, there were more than 1,500 patients. By 1901, the county courts were committing so many patients that many families objected saying that they could and would care for their relative with a mental health disorder through private resources. In 1913, 325 patients were transferred east to Pendleton where the state had built and opened a second state hospital. Families were enabled to care for their relatives with mental health disorders during periods of stability by the passage of legislation in 1917 that allowed for persons to be released temporarily under "parole."

As more was learned about mental health disorders and new treatment concepts gained acceptance, the Oregon State Insane Asylum's name was changed to Oregon State Hospital in 1907. Greater differentiation between types of mental disorders led to the recognition that a separate facility was needed for persons who had mental retardation or developmental disabilities. For this purpose, Fairview Home was established in 1908.

During the first 60 years of Oregon's history, there were no separate mental health facilities for children.

During the first 60 years of Oregon's history, there were no separate mental health facilities for children. Little information is available about the fate of children with mental health disorders during this time. Most likely children with severe mental health disorders were in state hospitals with adults, but it is also likely that most children with emotional, behavioral and mental health disorders were not recognized as such and instead labeled as conduct problems. These children were probably kept at home and not treated, or placed in orphanages along with other children who were difficult to place or care for. Estimates are that only 30 percent of children in orphanages at this time were actually orphaned. Many were crippled, mentally retarded, or came from poor or single parent homes.

In 1915 Dr. DeBusk, a professor of education and clinical psychology at the University of Oregon began to give lectures across the state on topics of "mental hygiene". Over the next 10 years, Dr. DeBusk received referrals, from schools, of "problem children" and he encouraged the development of school psychologists and school social workers that would be trained to deal with the social and emotional development of children.

Built on the experiences and vision of Clifford Beers, who founded the National Mental Hygiene Association in 1909, the mental hygiene movement in Oregon grew in the 1920s. There was great interest in the prevention and treatment of mental health disorders during this period. Activities included a 1921 mental hygiene survey in Multnomah County, a study section about child development for parents, and establishment of parent-teacher groups concerned with healthy child development.

The Child Guidance movement in the U.S. began with pilot projects funded in 1922 (prototypes of child guidance clinics) and 1925 (social work in schools). The first child guidance clinics were concerned with delinquency and conduct problems. In 1932, the University of Oregon Medical School at Doernbecher opened the first Child Guidance Clinic in Oregon. The purpose was to correlate medical, psychological and social phases of childhood problems. This work involved a multi-disciplinary team consisting of a psychiatrist, psychologist and social worker. During the 1930s the theme of "benefit to the state" of child mental health services was apparent with an emphasis on cost saving through preventive psychiatry. At the first Oregon Conference on Child Health and Protection in 1932, reference was made to the prevention of mental health disorders as one of the "most promising means of reducing public expense".

At the first Oregon Conference on Child Health and Protection in 1932, reference was made to the prevention of mental health disorders as one of the "most promising means of reducing public expense".

During the 1940s the focus of Child Guidance Clinics shifted away from preventing delinquency to addressing mental health disorders directly. As a result of recommendations from a survey of mental health needs for children, conducted by the Council of Social Agencies in Portland, the first community child guidance clinic was opened in 1944 to treat mental health disorders. This clinic, now known as the Morrison Center (for its first director, Carl Morrison) provided consultation, diagnosis, treatment and public education.

The perpetual struggle for sufficient capacity and resources for mental health services is illustrated by the continued inability of funded services to keep up with demand. Between 1920 and 1940, the Legislature approved funding for an average annual increase of 28 patients at the state hospital. The actual average annual increase was 50 patients. By 1942, the state hospital census had reached 2,622. Around 1958, the state hospital

The perpetual struggle for sufficient capacity and resources for mental health services is illustrated by the continued inability of funded services to keep up with demand.

census peaked at over 5,000. The current state hospital census is just under 700 occupying 725 beds. In early 2000, twenty-one Oregon adults and children are waiting in acute settings to move to the Oregon State Hospital. There are a total of 66 persons waiting to move from the three state hospitals to community placements, and approximately 20 who are in community-based enhanced levels of care who are waiting to move to lower levels of community care.

The passage of the Federal Mental Health Law in 1946 made federal funds available for mental health services. In Oregon, most of these funds were used to stimulate services for children. The Public Health Department was designated as the authority for dispensing these funds. By 1948 there was a full time psychiatrist who directed traveling clinics serving eight population centers. As community capacity grew, at least 6 counties had active mental health clinical programs for children by 1950. The traveling clinics were discontinued in 1953. In the 10 years between 1953 and 1962, 11 additional local child guidance clinics were developed.

The Board of Control, which traditionally oversaw state institutions, reports from the period of the 1950s and 1960s indicate that many patients at the state hospital were beginning to show improvement as a result of the new psychotropic drugs, such as Thorazine. The rate of discharge in state hospital populations nationally for a 40-year period beginning in the late 1950s was 83 percent; for Oregon it was 81 percent. At the same time, new admissions were also increasing in numbers, a trend that continues to this day with Oregon's community-based acute psychiatric hospital system. If the state hospital census had continued to increase at the 1958 level, Oregon would have needed nearly 9,000 state hospital beds by 1994 at a cost of $767 million per year for state hospitals alone[5]. In 2000 the Oregon State Hospital has about 725 beds.

In the late 1950s, then Governor Mark Hatfield recognized the need for greater attention to the needs for local mental health services. In 1959 the Governor's State Committee on Children and Youth recommended continued emphasis on the education of non-psychiatric people working with children, the establishment of a school of social work, the development of outpatient facilities for diagnosis and treatment of mentally and

emotionally disturbed children at the state hospitals, and the immediate and thorough study of the mental health problems of children. Until this time, nearly all state supported mental health care took place in the two state institutions.

The Mental Health Division of the Department of Human Services was established in 1961 to collaborate with county governments to promote the development of a system of community mental health programs. At the time the Mental Health Division was formed, the public mental health system in Oregon consisted of three state hospitals, two training centers, 11 child guidance clinics, and one alcohol outpatient clinic. The Division, as directed by ORS 430, set about building a network of locally directed community mental health services and to upgrade institutional care and treatment. While federal legislation in the 1960s provided funds for establishing Community Mental Health Programs (CMHPs), Oregon took little advantage of this opportunity and only a few such projects were developed. The areas in which such CMHPs were established included Eastern Oregon, Lane County, Jackson County, Clackamas County, and several in Multnomah County by the 1970s. Most community mental health programs were developed without federal funds using the state's 50-50 matching formula of state and local funds. By the early 1970s, there were a total of 27 CMHPs and 17 contract programs serving all 36 Oregon counties.

The Mental Health Division of the Department of Human Services was established... to collaborate with county governments to promote the development of a system of community mental health programs.

During the period between 1964 and 1970 a number of important documents addressing children's mental health were produced. The first state mental health plan was published in 1966. The plan provided a comparison of adult and children's mental health services, noting that 77 percent of manpower resources were devoted to adults. A study of children's welfare needs in Oregon was published as the *Greenleigh Report*. This report found that only half of the children needing psychiatric services were receiving them. Four recommendations were made:

- 24-hour intensive care should be made available;
- develop a therapeutic foster care program;

- develop special classes; and
- separate state hospital facilities for children.

The 1967 Legislature authorized the Mental Health Division to set up a two-year pilot program to provide services for emotionally disturbed children and to conduct research to determine the nature and extent of services required. The pilot program was terminated in 1970 due to budgetary deficits in the Mental Health Division.

In 1972, six Day and Residential Treatment Services (DARTS) programs were established as non-profit agencies for children with mental health disorders. The state Executive Department made a decision that these facilities should not be state-operated, and contracts were issued using state funds. However, in 1976, the Oregon State Hospital opened the Child and Adolescent Treatment Services (CATS) program as the inpatient backup support for the DARTS programs.

Further systemic and financing refinements took place in 1973 with Oregon's Community Mental Health Programs Act, which set up three regions for tying together state hospitals and community programs. It also established the structure which is currently administered by the Department of Human Services in three program categories in two divisions—Alcohol and Drug (A&D), Mental and Emotional Disturbances (MED), and Mental Retardation and Developmental Disabilities (MR/DD). This act further divided funding into two major categories—first, a continuation of the 50-50 mix for outpatient services, aftercare, training, consultation and education, and prevention services. Second, the act provided for the state to fully fund "alternatives to state hospitalization" which included 24-hour emergency care, day and night treatment services, local housing resources, and inpatient care in community hospitals.

These and other efforts eventually led to the establishment of community mental health services in all of Oregon's 36 counties. These programs have increasingly offered a variety of mental health services from aftercare to day treatment to children's outpatient services.

In 1981 the legislature required that an emphasis be placed on severe and persistent mental illness and established a priority system for access to publicly funded mental health services.

In 1981 the legislature required that an emphasis be placed on severe and persistent mental illness and established a priority system for access to publicly funded mental health services. The emphasis was heavily on adults. This resulted in significant changes to the mental health system, away from prevention, and many believe a de-emphasis on children's mental health services.

Medicaid fee-for-service funding gradually increased from the early 1980s through the mid-1990s, until it became the primary funding mechanism for a range of public mental health services for adults.

In 1990, states were mandated to implement the requirements of federal law by providing medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including mental health for all Medicaid eligible children. The same year, Multnomah County Legal Aid filed a lawsuit to ensure access to mental health services for all children eligible for Medicaid. The resolution of this action brought new funds to provide mental health services for children.

Two key initiatives have driven the Oregon public mental health system since 1990. First is the implementation of the 1988 Governor's Task Force on Inpatient Psychiatric Services Report. The passage of Ballot Measure 5 in 1992 prevented the full implementation of this report. The closure of Dammasch State Hospital was the most dramatic example of Oregon's attempt to deal with the financial realities of fewer state General Funds for the support of state hospitals.

Second, the Oregon Health Plan has been implemented using a capitated, managed care financing model for a portion of Medicaid services to an expanded pool of Oregon children and adults. Assuming adequate funding levels, children and adults eligible for Medicaid with treatable mental health disorders are now assured of preventive care and earlier intervention.

Mental Health Disorders and Mental Health Today

This report was prepared sometime after the release in 1999 of the first U.S. Surgeon General's Report on Mental Health, and during a time of increased advances in understanding the functioning of the brain, as well as our knowledge about the central role mental health plays in overall wellness. We have come to understand that mental and physical health cannot be separated. Good mental health enables individuals to be productive, independent members of our communities, and to cope with adversity while pursuing goals of education, work, leisure and relationships.

This report involves both children and adult mental health.

Nature and Occurrence of Mental Health Disorders

The term "mental health disorder" refers to conditions of altered thinking, mood and/or behavior associated with impaired functioning or distress. Mental health disorders affect at least one in every five adult Americans[6], translating to an estimated 504,161 Oregon adults. One in ten American children and adolescents suffer from mental disorders severe enough to cause some level of impairment, this would be an estimated 88,148 Oregon children and adolescents.[7] Approximately 30 percent of people with mental health disorders, also experience a co-occurring substance abuse disorder (known as dual diagnosis)[8]. It is estimated that up to 75 percent of persons living in long-term residential facilities due to frailty, impairment or chronic disease suffer mental health problems as well.[9]

Mental health disorders are dynamic in their occurrence, and reflect a person's genetic, environmental, biological, social and psychological experience. The brain interacts and responds (both in structure and in function) as circumstance change across all stages of life, so that the expression of a mental health disorder can change dramatically over a person's life span. In contrast to many physical illnesses, relatively few mental health disorders have a steady course. Instead, the symptoms associated with some mental health disorders occur in cycles, which may result in a gradual deterioration over time.

Mental health disorders occur in people of all social classes, all ages and all backgrounds. However, certain groups are more

Mental health disorders occur in people of all social classes, all ages and all backgrounds.

likely to experience mental health disorders than others are because of greater exposure to risk factors. These factors include physical problems, intellectual disability, low birth weight, family history of mental health disorder or substance abuse, poverty, caregiver separation or abuse/neglect. Due to changing demographics, mental health disorders among senior citizens will become an even more significant issue in the near future particularly among those receiving long term residential care. Dementia, depression and schizophrenia all present special problems for this age group.[10]

We are able to estimate the prevalence of serious mental health disorders in adults and serious emotional disturbance in children, as well as the need for treatment. Table 1 and Table 2 present estimates of prevalence of mental health disorders in Oregon and the demand for services by fiscal year from 1989 through 1999. Based on the distribution of Oregon's population as determined by annual updates to the 1990 census, the prevalence of serious mental health disorders statewide among adults is estimated to be 5.9 percent. In addition, the statewide estimate for adults with serious and persistent mental illness (SPMI) (analogous to a chronic disease) is 2.84 percent.

It is further estimated that 12-22 percent of children in Oregon are in need of mental health services. Oregon uses a prevalence rate of 12 percent to estimate the needs of the general population of children. Twenty-two percent is used for Medicaid eligible children because the risk factors associated with poverty increase the likelihood of mental health problems. 7 percent of all Oregon children requiring services are believed to have disorders of a severe and persistent nature. While 68 percent of Oregon children have private health insurance, most of these same children will also need publicly funded services if they have severe and persistent disorders because of the limits of their private insurance coverage.

Table 1

Oregon Adult Population and Special Population Estimates

	State Fiscal Year									
	1990-91	**1991-92**	**1992-93**	**1993-94**	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**1998-99**	**1999-00**
Population	2,126,652	2,171,034	2,210,132	2,225,278	2,285,317	2,323,637	2,362,617	2,393,047	2,481,340	2,520,805
Prevalence (SMI)	126,166	128,874	131,100	133,819	135,550	137,641	139,897	141,668	146,895	149,232
Prevalence (SPMI)	59,546	60,789	61,884	63,148	63,989	65,062	66,153	66,981	70,470	71,591
Medicaid Eligibles	120,097	160,272	187,150	200,573	317,169	332,299	288,336	289,978	310,733	308,341
Percent	5.6 %	7.4 %	8.5 %	8.9 %	13.9 %	14.3 %	12.2 %	12.1 %	12.5 %	12.2%
Enrolled in OHP managed care				76,815	209,137	267,137	273,721	259,361	271,616	267,572
Percent of eligibles				38 %	66 %	80 %	95 %	89 %	87 %	87%
Demand for Public Mental Health	57,907	59,015	59,991	61,118	66,820	67,716	68,628	68,170	71,085	71,924
Adults served in MH system	29,477	33,356	35,601	37,773	43,096	45,213	48,137	52,769	56,259	59,692
Percent of demand	51 %	57 %	59 %	62 %	64 %	67 %	70 %	77.4 %	79%	83%

Data Sources:

Population- Center for Population Research and Census, Portland State University
All other data Produced by the Budget and Operations Unit, Oregon Office of Mental Health Services

Table 2

Oregon Child and Adolescent Population and Special Population Estimates

	1990-91	**1991-92**	**1992-93**	**1993-94**	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**1998-99**	**1999-00**
Population	720,347	758,966	768,868	782,722	796,683	808,363	818,383	823,953	866,330	881,479
Prevalence (Moderate)	86,442	91,076	92,264	93,927	95,602	97,004	98,206	98,874	103,960	105,777
Prevalence (Severe & Persistent)	6,051	6,375	6,458	6,575	6,692	6,790	6,874	6,920	7,277	7,404
Medicaid Eligibles	107,249	148,935	184,666	207,806	245,166	255,941	239,513	221,112	248,246	252,633
Percent	14.9 %	19.6 %	24.0 %	26.5 %	30.8 %	31.7 %	29.3 %	26.8 %	28.7 %	28.7%
Enrolled in OHP managed care				79,585	161,659	205,753	210,823	196,271	223,880	231,300
Percent of eligibles				38 %	66 %	80 %	88 %	89 %	90 %	92%
Demand for Public Mental Health	27,661	29,144	29,254	30,057	30,593	41,383	39,544	35,432	39,146	39,836
Children served in MH system	12,610	16,734	21,233	23,815	25,498	26,750	28,192	23,932	24,451	27,938
Percent of demand	46 %	57 %	72 %	79 %	83 %	86 %	71 %	68 %	62%	70%

Due to welfare reform, actual numbers of children eligible for Medicaid declined in the late 90s but has increased for the last two years. This decline in eligibles results in fewer children accessing the publicly funded mental health system.

Data Sources:

Population- Center for Population Research and Census, Portland State University
All other data Produced by the Budget and Operations Unit, Oregon Office of Mental Health Services

Table 3

Ethnic Diversity of the Oregon Population

This table shows the ethnic diversity of the Oregon population and those served in public mental health system during fiscal year 1999-2000.

Adults	White	Native American	Hispanic	Black	Asian	Total
Adult Population	2,222,442	37,013	144,259	40,925	76,166	2,520,805
Percent of Total	88.2%	1.5 %	5.7%	1.6 %	3.0 %	
Number Receiving Mental Health Services	50,318	1,222	2,059	1,914	1,488	57,001
Percent of Total	88.3%	2.1%	3.6%	3.4%	2.6%	
Percent of Ethnic Group Receiving Mental Health Services	2.3%	3.3%	1.4%	4.7%	2.0%	2.3%
Children						
Child Population	731,628	8,815	88,148	17,630	35,259	881,479
Percent of Total	83.0%	1.0 %	10.0%	2.0 %	4.0%	
Number Receiving Mental Health Services	22,246	857	2,171	1,579	295	27,148
Percent of Total	81.9%	3.2%	8.0%	5.8%	1.1 %	
Percent of Ethnic Group Receiving Mental Health Services	3.0%	9.7%	2.5%	9.0%	.8%	3.1%

Note: Clients with unknown ethnicity have been excluded. For this reason, total adults and children served do not equal the figures presented in other sections of this report.

Produced by the Budget and Operations Unit, Oregon Office of Mental Health Services

Perceptions of Mental Health Disorder

Despite an increasing understanding of mental health disorders and their role in the lives of our citizens and communities, we still collectively stigmatize persons with mental health disorders. This is manifested by fear, avoidance and stereotyping. Moreover, much of what we think we know about people diagnosed with a mental health disorder has simply been wrong.

Since the 1950s, representative samples of citizens across the United States have been surveyed about their attitudes about mental illness. To permit comparisons over time, several surveys have asked the same questions. [11, 12] These surveys reveal that although we have increased our understanding of mental illness our understanding has not decreased the stigma of those with a mental health disorder.

While we have learned to distinguish mental illness from common worry, and that mental illness is a mix of biological factors, social and psychological stress and other factors, we have mistakenly increased our belief in the last 50 years that mental illness is frequently accompanied by violent behavior. [13] In reality the overall risk of violence from people with mental health disorders is very low. Recent research suggests that the same number of violent acts will be committed by a randomly selected group of persons with no mental health disorder as by a randomly selected group of people with a diagnosis of a mental health disorder. The popular mistaken perceptions of risk are closest to reality when looking at risk from persons with a dual diagnosis (a mental health disorder as well as a substance abuse disorder) and who are not actively involved in treatment. Even here, the greatest risk is not violence to a stranger, but to family members or other persons close to the perpetrator.[14] The stigma surrounding mental health disorders discourages people from seeking help. Approximately two-thirds of all people with a mental illness do not seek treatment.[15] This stigma also affects our willingness to pay for treatment. While studies show a great public willingness to pay for treatment or increased insurance coverage for individuals with mental health disorders, the motivation to do so declines as people realize that higher taxes might be necessary. [16]

The stigma surrounding mental health disorders discourages people from seeking help. Approximately two-thirds of all people with a mental illness do not seek treatment. This stigma also affects our willingness to pay for treatment.

For these reasons, and in order to help change the stereotype, this report refers to "mentally ill persons" as "persons with a mental health disorder", except when using specific references. The MHAWG recognizes that consumers use a variety of terms to refer to their mental health disorder or status. The MHAWG honors the wishes of consumers, but has chosen one term for the sake of consistency and reader ease.

Cost of Mental Health Disorders

Mental health disorders together account for more than 15 percent of the overall burden of disease from *all* causes--including slightly more than the burden associated with all forms of cancer. According to a study of the Global Burden of Disease by the World Health Organization, the World Bank and Harvard University,[17] mental illness leads cancer in the burden of disease, and is second only to cardiovascular disease (Table 4). In this same study, the burden of major depression alone was second only to heart disease.

Table 4
Disability Adjusted Life Year by Disorder

	Percent of Total DALYs*
All Cardiovascular conditions	18.6
All mental illnesses	15.4
All malignant diseases	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic diseases	2.8
All drug use	1.5

**DALY (Disability Adjusted Life Year) is a measure that expresses years of life lost due to premature death and years lived with a disability of specified severity and duration.*

...mental illness leads cancer in the burden of disease, and is second only to cardiovascular disease.

In 1996 the treatment of mental illness, substance abuse and Alzheimer's Disease cost our nation $99 billion. Direct costs for mental illness alone totaled $69 billion. In 1990, indirect costs for mental disorders alone totaled $79 billion.[18]

According to the National Foundation for Brain Research, the estimated annual cost associated with each person diagnosed with Schizophrenia is $7,700 – totaling approximately $246 million per year for the 31,950 Oregonians estimated to have the disorder.

Mental health disorders also have significant impacts on family members and care givers. Many studies have suggested that the presence of a child or adult with a mental health disorder has a significant impact and cost to the family, particularly for the primary care giver. Research findings indicate that there is social isolation, lack of awareness of services, poor service delivery and psychiatric disorders among many parents of children with a mental health disorder. The mental health of parents, especially mothers, of children and adults with psychiatric disabilities is often severely affected by the care-giving process. Parents of children with mental health disorders experience more worries and depression, a lower sense of competence in handling their child's problems, and higher use of mental health services for their own needs. These findings increase the longer the child has been part of the mental health system.[19] Research has also shown that stress among families of children with a mental health disorder is notably associated with the severity of the child's disorder and the lack of coordination among service providers. Stress reduction for family members is associated with high levels of empowerment and spiritual support.[20]

For children, the family is the primary context where mental health problems emerge and are manifested. Families play an important role in bringing children to treatment. Family members and caregivers are important in making and following through on treatment decisions and in supporting gains made in treatment. The strain on family members, therefore, has important implications for children's use of and success in

mental health treatment. Research has found a connection between level of caregiver stress and how children use mental health services. Reports of caregiver stress are associated with increased children's use of inpatient hospitalization and extended day treatment services. Lower caregiver stress is associated with community-based and outpatient treatment environments for the child. As a result, the reduction of family and caregiver stress is important to the success of community-based mental health services.

Treatment of Mental Health Disorders

There are a variety of well-documented, proven treatments for most mental health disorders. These can be divided into three broad categories:

- psychopharmacological treatment (medications or drugs);
- psychological treatment (such as therapy or counseling); and
- social supports (such as housing and employment).

Current clinical practice ... has produced higher rates of recovery for all major psychiatric disabilities than those produced by cardiology in the fight against heart disease.

These are most often effective when they are combined. However, with the most severe and persistent mental health disorders (such as schizophrenia) psychological treatment without medication is usually ineffective.

Current clinical practice in psychiatry has produced higher rates of recovery for all major psychiatric disabilities than those produced by cardiology in the fight against heart disease.[21] This is despite the considerable resources, research and technology devoted to heart disease. Even schizophrenia, long considered to be the most severe and debilitating of all mental health disorders, now shows a greater recovery rate than heart disease. [22]

It is also clear from research and experience that social supports, such as housing or employment, have a significant impact on the ability of a person with a mental health disorder to attain and maintain a state of recovery. For example, Bennett (1998) found that social supports improve the likelihood that clients will complete treatment and remain in a relative state of recovery.

About 10 percent of Americans seek mental health treatment services from the mental health field in any one year, with another 5 percent seeking help from social service agencies, schools, religious organizations or self-help groups.[23]

Yet, serious gaps and disparities exist between those who need services and those who receive services. Gaps also exist between effective treatment and what is actually provided, particularly when it comes to treatment that is available and sensitive to the needs of racial and ethnic minorities. Culturally appropriate treatment has been designed, but is not widely available. There is a need for culturally competent professionals and providers.

Some successful preventive strategies are emerging. They have developed slowly because for most mental health disorders, their cause (or etiology) is not yet completely understood. Nevertheless preventive strategies have been shown to be effective in reducing the incidence or impact of risk factors for mental health disorders (such as low birth weight, substance abuse, poverty, abuse/neglect, etc.).

Need for Treatment

Oregon bases the demand for publicly supported mental health services on three categories of citizens:

- people eligible for Medicaid (OHP);
- the uninsured; and
- the privately insured population whose mental health coverage falls short of their treatment needs.

The MHDDSD estimates that 220,823 Oregon adults and 113,181 children will need mental health treatment each year. Of these, 71,924 adults and 39,836 children are likely to seek or "demand" state supported service each year, due to income, lack of insurance coverage or inadequate insurance coverage. State supported services are able to accommodate 83 percent of the demand for adult services, and only 70 percent for children's services.

All persons eligible for Medicaid and uninsured persons requiring mental health services depend primarily on the public system for treatment. It is assumed that privately insured individuals who depend on the public system to supplement their private mental health benefit do so because they have an illness of a persistent or chronic nature, and their private insurance does not cover needed treatment. Available information suggests that 32 percent of adult Oregonians with a mental health disorder, who receive treatment, obtain it in private settings. The remainder (68 percent) is expected to use the public system.[24] The Office of Mental Health Services estimates that 12,232 Oregon adults are in need of public mental health services, but are not receiving them (See Table 1).

...12,232 Oregon adults are in need of public mental health services, but are not receiving them [and] 11,898 Oregon children are in need of public mental health services, but not receiving them.

It is estimated that 28.7 percent of Oregon children are Medicaid eligible, and that 91.5 percent of those (or 231,300) are enrolled in the Oregon Health Plan. This means that 26.2 percent of Oregon children can receive needed services through the OHP. Sixty-eight percent of children have private health insurance, which has some level of mental health coverage. Six point two percent of Oregon children are uninsured with no mental health coverage. The demand for publicly supported mental health treatment is estimated using the prevalence of serious emotional disturbance in the child and adolescent population that has either no insurance, or is covered by the Oregon Health Plan. This estimate does not include children whose private insurance does not adequately provide treatment for their mental health diagnosis. Using this method, 11,898 Oregon children are in need of public mental health services, but not receiving them (See Table 2).

There is a consensus among professionals and consumers alike, that Oregon does not have sufficient quality mental health treatment especially treatment that is culturally sensitive and age appropriate.

Financing Treatment for Mental Health Disorders

Private Sector

Historically, financial barriers to mental health treatment are attributed to a variety of economic forces as well as public concern. This has resulted in varying and inconsistent resource allocation for financing mental health treatment. Over the last decade, mental health and substance abuse (behavioral health) benefits have declined significantly in employer-sponsored insurance coverage, dropping from 6.1 percent of health care value in 1988 to 3.1 percent in 1997. Nearly half of private plans place limits on outpatient visits. Between 1988 and 1997 these limits decreased from 50 to 20 outpatient visits annually. The annual value of mental health and substance abuse benefits from employer sponsored insurance coverage declined from $152 to less than $70 over 10 years, based on 1997 dollars[25] (Table 5).

Table 5
Behavioral Health Care Costs

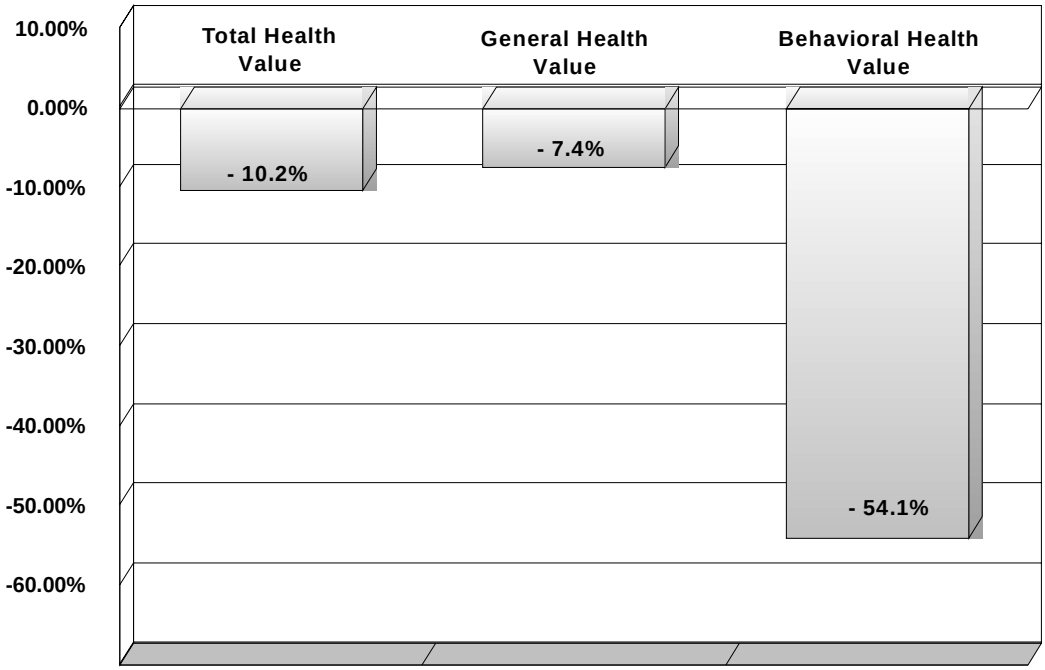
Behavioral Healthcare Costs as a Percent of Total Healthcare Benefits Costs
(All Values are in 1997 Dollars)

Year	Total Value	General Health Value	Behavioral Health Value	Behavioral Health as a Percent of Total
1988	$2,478.41	$2,326.87	$151.64	6.1%
1989	$2,480.72	$2,336.19	$144.53	5.8%
1990	$2,455.41	$2,320.35	$135.08	5.5%
1991	$2,443.19	$2,316.14	$127.05	5.2%
1992	$2,423.81	$2,305.08	$118.73	4.9%
1993	$2,374.23	$2,268.61	$105.62	4.4%
1994	$2,338.48	$2,243.74	$94.74	4.1%
1995	$2,292.30	$2,207.50	$84.81	3.7%
1996	$2,237.59	$2,161.66	$75.93	3.4%
1997	$2,225.21	$2,155.60	$69.61	3.1%
% Change 1988-1997	-10.2%	-7.4%	-54.1%	

Source: The Hay Group, 1998

Figure 2 shows the decline in health benefit value between 1988 and 1997. While both general health and behavioral health values declined, the decline in behavioral health was a dramatic 54.1 percent compared to a 7.4 percent decline in value of general health coverage.

Figure 2
Decline in Health Benefit Value
From 1988 to 1997
(in 1997 Dollars)



Source: The Hay Group, 1998

Spending for mental health and substance abuse benefits in the private sector has shown a growth rate significantly below that for all health care between 1987 and 1997. Consequently, the public sector has had to pick up an increasingly larger fraction of the total cost for mental health and substance abuse treatment[26] (Table 6 and Figure 3).

Table 6
Percent of Average Annual Growth in Spending
1987-1997

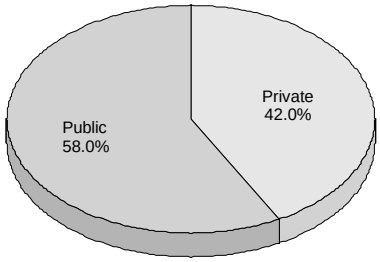
Growth in Spending on Mental Health and Substance Abuse Lagged Behind Total Health Care Spending

Source of Payment	MH/SA	Personal health/government public health
Private, total	6.1	7.2
Client out of pocket	5.6	4.9
Private insurance	6.9	8.6
Other private	2.8	7.6
Public, total	7.4	9.5
Medicare	11.7	10.0
Medicaid	9.9	12.2
Other federal	5.2	5.5
Other state/local	4.3	6.0
Total	**6.8**	**8.2**

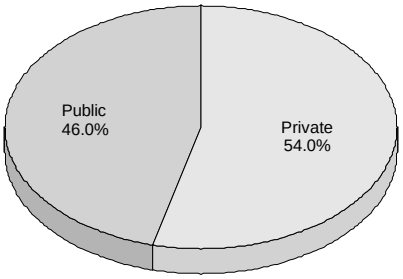
Source: CMHS, CSAT (MEDSTAT 2000)

Figure 3
Public and Private Funding
for Mental Health and Substance Abuse
1997

Funding for mental health and substance abuse is predominantly public. All health funding is predominantly private in 1997.



Mental Health/Substance Abuse
($82.2 billion)



All Health
($1,057.5 billion)

Prescription drugs account for a substantial portion of the growth, rising from 7 percent to 13 percent from 1987 to 1997 of mental health costs with an average annual growth rate of 12.6 percent, due in part to more effective and more expensive pharmaceuticals.

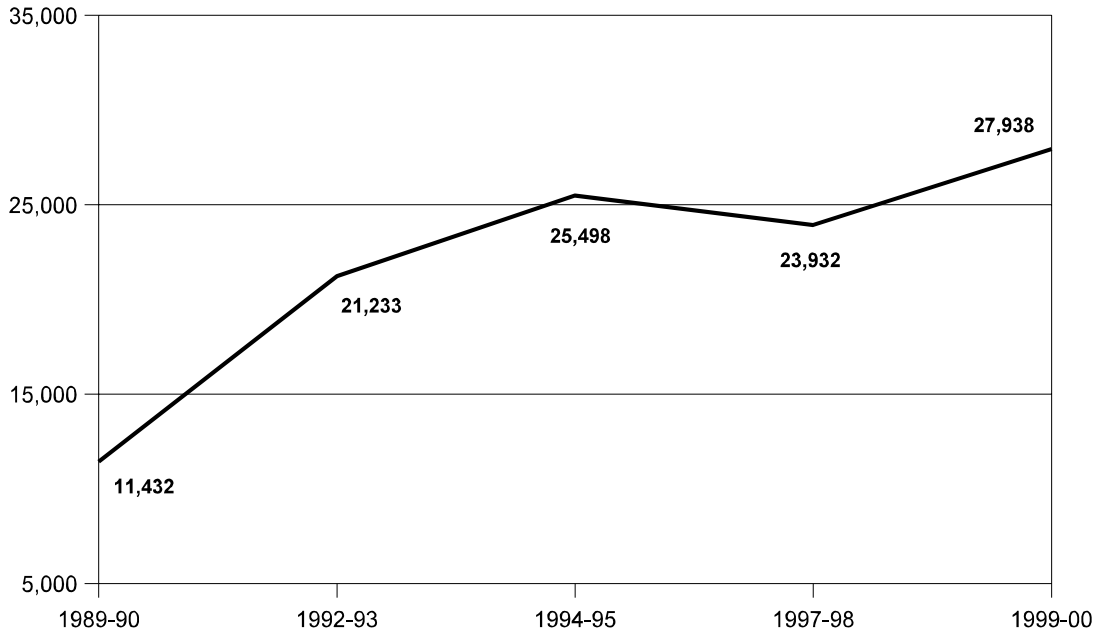
Oregon Health Plan and the Public System

...the OHP has been the single greatest factor in increasing access to needed mental health care in recent history.

In recent years, the dynamics of insurance financing have become a significant issue in mental health. Managed care has ushered in cost containment policies across the nation. In Oregon, the OHP has been the single greatest factor in increasing access to needed mental health care in recent history. Treatment for diagnosed, significant mental health disorders is currently covered by the OHP, and services have increased from

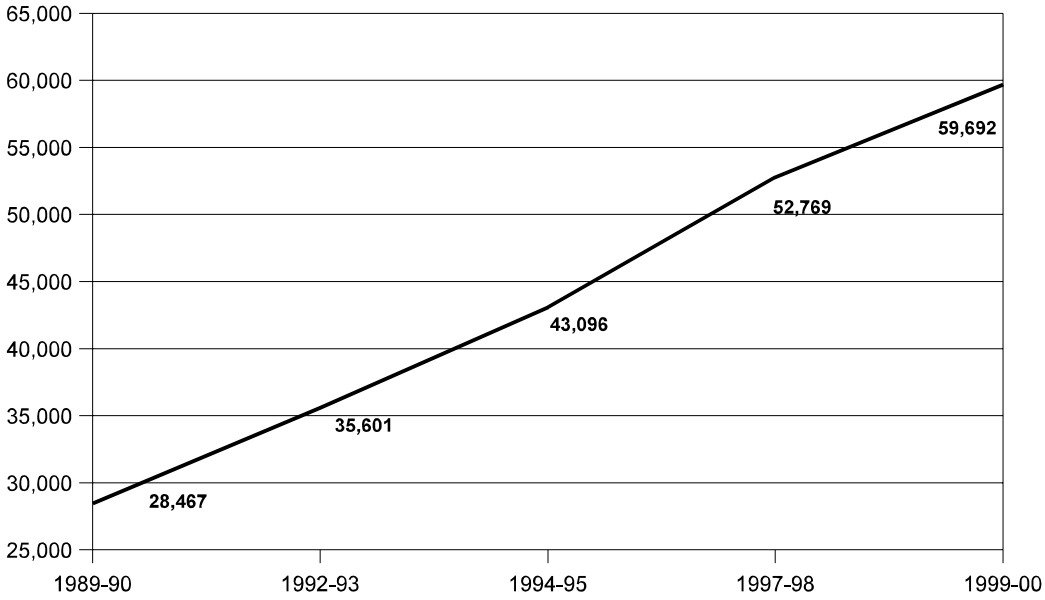
a short list to a broad menu of treatment options. Access to care has increased and more Oregonians in need of mental health treatment are being served than a decade ago. Between 1989 and 2000 the number of children and adults served by the public mental health system more than doubled (Figures 4 & 5). The mental health benefits under the Oregon Health Plan equals or exceeds most public or private plans in the nation.

Figure 4
Children Served in the Public Mental Health System Between 1989 and 2000



Source: MH Services block Grant Application FY 2001

Figure 5
Adults Served in the Public Mental Health System Between 1989 and 2000



Source: MH Service Block Grant Application FY 2001

Oregonians who do not have access to the Oregon Health Plan, including those who have private insurance, often have no or substantially reduced mental health benefits...

Nevertheless, problems remain. Oregonians who do not have access to the Oregon Health Plan, including those who have private insurance, often have no or substantially reduced mental health benefits – leaving them without care, or falling into whatever safety net state and local governments can provide. The price of psychotropic medications is growing at an unsustainable rate, and there is as yet no mechanism in place to assure cost control. The psychiatric needs of new eligibles in the Oregon Health Plan were largely unknown prior to the integration of mental health benefits into the Plan. The population served by the OHP has a higher incidence and severity of mental health disorders than a similar cohort of commercially insured Oregonians. Finally, for persons with the most serious mental health disorders, care based on medical

necessity (as required by OHP regulations) does not recognize that recovery and rehabilitation are accomplished or enhanced through a variety of means – many of which lie outside the traditional domain of medical care (including education and school-based services and social supports such as housing and employment).

National expenditures for treatment of mental health was $73.4 billion in 1997, $3 billion less than the previous year.[27] Mental health and substance abuse expenditures represented 7.8 percent of the one trillion dollars spent on all healthcare in the U.S. in 1997, down from 8.8 percent in 1987. In addition, expenditures on mental health care and substance abuse grew more slowly than spending for health care. Health care spending grew by 5.0 percent on the average between 1987 and 1997, while mental health and substance abuse spending grew by 3.7 percent annually.[28]

State spending on mental health services, for both community-based and OHP services, grew 64 percent from 1990 to 1999 – due primarily to the Oregon Health Plan. However, the percent of state spending on community mental health programs compared to state institutions increased by 47 percent from 39.2 percent of mental health spending in 1990 to 74 percent in 1999. Total spending on mental health services in 1998-1999 totaled 293,747,605.[29]

...Oregon ranked 18th in the nation in per capita spending for mental health services in 1997.

According to a 1998 report from the federal Substance Abuse and Mental Health Services Administration, Oregon ranked 18th in the nation in per capita spending for mental health services in 1997.

To fully fund needed services for the 11,898 Oregon children and 12,232 adults who need public mental health services; an additional $139,685,346 for children and $90,625,665 for adults is needed – for a grand total of $230,311,011.[30] These estimates are based on the cost of providing a full array of services to meet the need (See Table 7). If the additional unserved people received the average intensity of services currently provided, costs would be less.

Table 7

Office of Mental Health Services
Estimated Cost to Finance Unmet Need
Prepared January 4, 2000

PART 1

Adult Mental Health Services

Number of Adults in Need of
Public Mental Health Services
but not receiving **12,232**

Services Needed by these Adults:

	% Needing Service	Number of Adults	Cost Per for	Unit Cost	Total Annual
Assessments	100%	12,232	$ 100 assess.	1 assess.	$ 1,223,200
Outpatient (including medicines)	85%	10,397	$ 2,500 year	1 year	$ 25,993,000
Crisis/commitment	25%	3,058	$ 650 epis.	1.5 epis	$ 2,981,550
Secure Residential	1%	122	$ 181 day	365 days	$ 8,081,071
24 hour Residential	5%	612	$ 150 day	365 days	$ 33,485,100
Supportive Housing	25%	3,058	$ 1,000 year	1 year	$ 3,058,000
Employment/Education	25%	3,058	$ 1,000 year	1 year	$ 3,058,000
Acute Inpatient/Subacute	10%	1,223	$ 750 day	10 days	$ 9,174,000
Inpatient Long-Term	0.1%	12	$ 400 day	365 days	$ 1,785,872
Extended Care	0.1%	12	$ 400 day	365 days	$ 1,785,872
Total Costs for Adults					$ 90,625,665

PART 2

Child and Adolescent Mental Health Services

Number of children in need of public mental health services but not receiving **11,898**

Services Needed by these Children:

	% Needing Service	Number of Children	Cost Per	Units for	Total Annual Cost
Assessment	100%	11,898	$150 episode	1 Episode	$ 1,784,700
Outpatient	85%	10,113	$2,324 year	1 year	$ 23,498,550
Crisis	10%	1,190	$650 episode	1.5 episodes	$ 1,160,055
Acute Inpatient/Subacute	1%	119	$800 day	8 days	$ 761,472
Mid to Long-Term Hospitalization	1%	119	$400 day	180 days	$ 8,566,560
Residential Services with Behavioral Rehabilitation	5%	595	$126 day	365 days	$ 27,378,993
Treatment Foster Care	5%	595	$30 day	365 days	$ 6,514,155
Treatment Group Home	3%	357	$30 day	365 days	$ 3,908,493
Secure Assessment and Evaluation	5%	595	$306 day	30 days	$ 5,458,505
Psychiatric Residential Treatment	3%	357	$280 day	365 days	$ 36,479,268
Day Treatment	7%	833	$126 day	230 days	$ 24,174,594
Total Costs for Children and Adolescents					$139,685,346

Grand Total Cost to Finance Unmet Need **$230,311,011**

Notes:

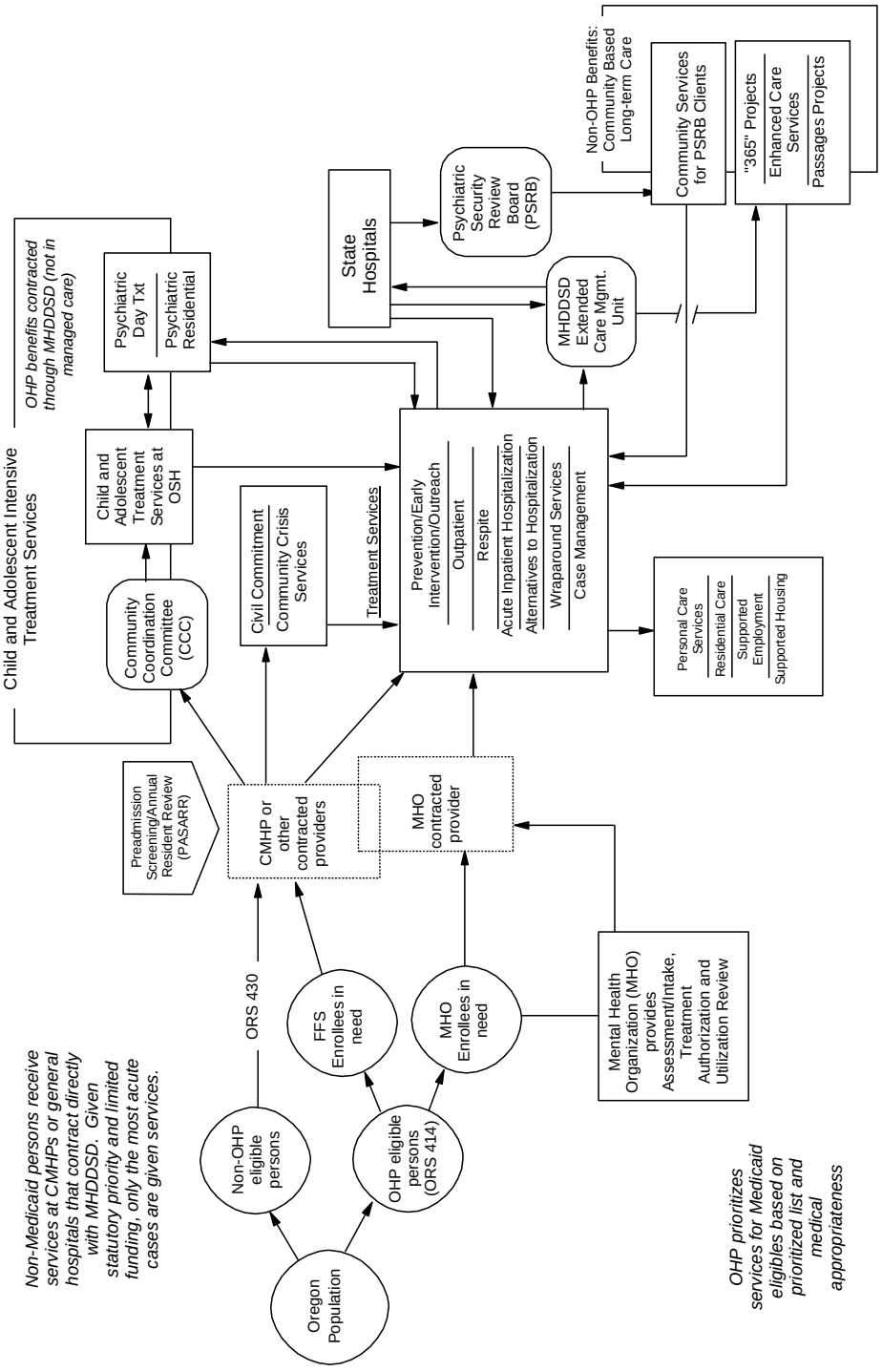
Child and Adolescent service arrays are based on suggested models developed through the federal Child and Adolescent Services System Project.

Numbers in need of public mental health services are calculated using data from Oregon's 2000-2001 Block Grant. Specifically, the number who received services is subtracted from the number who demand public mental health services.

Systems Approach

Research findings that identify problems and suggest treatment approaches, and to some extent suggest means to prevent mental health disorders, are outpacing the capability of the service system to provide mental health care to those who need it. Mental health services in Oregon are delivered by a complex array of agencies and organizations (housing, health, education, criminal justice, senior services, families, non-profit providers and child welfare, to name a few). As a result, mental health care is often organizationally and financially fragmented, creating barriers to access and successful treatment. Figure 6 only depicts the mental health delivery system in Oregon that is financed by the State Mental Health and Developmental Disability Services Division. Due to its history of funding and service delivery, it is fragmented in and of itself. The mental health services funded by another twelve state agencies/divisions are not depicted in Figure 6.

Figure 6
Access to Mental Health Services



Role of Trauma

The prevalence and effects of mental health disorders, especially trauma, are underlying issues that cut across many agencies. The need for a coordinated and systemic approach to identifying and preventing trauma, and providing needed mental health services is highlighted by the following findings:

- Over one million U.S. teenagers currently suffer from Post Traumatic Stress Disorder (PTSD).[31] Using national population estimates, this translates to over 200,000 Oregon teens.

- Domestic violence is the leading cause of injury to women between the ages of 15 and 44.[32]

- Sexual and physical abuse are in the histories of 92 percent of homeless women and 81 percent of non-homeless women living in poverty.[33]

- Severely abused and victimized women have more persistent and prevalent medical problems such as chronic pelvic and other pain, gastrointestinal disorders, headaches and psychogenic seizures.[34]

- Among rape victims, 92 percent show symptoms of Post Traumatic Stress Disorder (PTSD) within 1-2 weeks following the crime.[35]

- A diagnosis of PTSD is predictive of a five-fold increase in the probability of alcohol abuse and dependency.[36] Among veterans with PTSD, 75 percent also meet the criteria for alcohol dependence.

- Up to 80 percent of psychiatric inpatients have consistently been found to have histories of severe trauma and at least 15 percent meet diagnostic criteria for PTSD.[37]

The long term psychological, social and neurobiological effects of violence, abuse, severe neglect and retraumatization are pervasive, highly disabling and cross many local and state

agencies—and cross the whole life span. Only a coordinated approach that recognizes responds to, and helps people recover will ensure any reduction in these sobering statistics.

Recovery

Families and consumers have become increasingly recognized as essential partners in the delivery of mental health services for children and adults. The nationwide campaign "Nothing About Us, Without Us", promoted by national consumer groups and the National Alliance for the Mentally Ill (NAMI) illustrates the advocacy role consumers and family members have in shaping mental health policy. The goals of this advocacy include decreasing stigma, encouraging self-help, dignity and a focus on recovery, drawing attention to special needs of individuals with mental health disorders, promoting research, and ensuring that services are responsive to the needs of different consumers and their families.

Families and consumers have become increasingly recognized as essential partners in the delivery of mental health services for children and adults.

The concept of "recovery" advocated by consumer organizations and advocates is increasingly and substantively supported by research on rehabilitation and treatment. Until the 1970s the prevailing view among most mental health professionals was that mental health disorders got worse over time, and eventually caused permanent problems in most areas of functioning. This conclusion was based on observations of long-term psychiatric patients who were held for long periods of time (even decades) in hospital settings that fostered near total dependence, and eliminated almost all consumer choice. This stereotype began to erode as former patients were discharged into community settings with adequate treatment and social supports.

Many of these former patients exceeded the expectations of the professionals. A 25-year longitudinal study of patients discharged from Vermont psychiatric hospitals found that 50-66 percent had achieved considerable improvement or recovered, in contrast to diagnostic statements that predicted poor outcomes for the same patients. Although a variety of outcomes were reported, the most positive outcomes were for

those who had obtained community-based services and social supports they needed.[38]

The concept of recovery from mental illness is based on the notion that with the right combination of treatment and social supports, people can learn to manage their illness, sometimes to the point where symptoms and functional deficits disappear. As recovery progresses, the individual becomes more independent and better adjusted to community life while simultaneously reducing reliance on the mental health system. Movement toward recovery produces a greater sense of dignity, self-determination and empowerment. Individuals who achieve stability and a state of recovery often are good role models for others who are learning to deal with mental health disorders. The earlier that mental health disorders are identified and addressed, the less difficult it may be to manage a state of recovery.

Primary care settings and the schools can be principal sources for early identification of mental health disorders. However, doctors are busy and trained staff is limited. Connections between mental health professionals and medical and educational settings are fragmented at best.

Role of Culture and Ethnicity

Culturally appropriate practices must be an integral part of the design, implementation and ongoing operation of any system of mental health services.

One of the most difficult system problems to overcome is the lack of culturally and ethnically appropriate mental health services. The Surgeon General's report states "The U.S. mental health system has not been very responsive to the needs of racial and ethnic minorities". Cultural and ethnic minorities are disproportionately represented in lower socioeconomic groups. Research has shown that lower socioeconomic status, income, education and occupation are strongly associated with increased risk for psychiatric disabilities. Culturally appropriate practices must be an integral part of the design, implementation and ongoing operation of any system of mental health services.

Culturally appropriate services cannot be a separate or special area of focus. It must be included in every aspect of the development and operation of the mental health system. To achieve a culturally competent systems approach to mental health care, all levels will need to make a dedicated and concerted effort.

The multiple problems associated with mental health disorders require a "systems approach" provided at a community level...

It is clear that the care of adults and children with serious and persistent mental health disorders cannot be accomplished solely by the health care delivery system. The multiple problems associated with mental health disorders require a "systems approach" provided at a community level, in which multiple organizations from many disciplines work in an organized and collaborative manner to deliver culturally appropriate services with a focus toward recovery and social supports. Research shows promising results for both the person with a mental health disorder and mental health service entities with this approach.

Work Group Process

Governor John Kitzhaber established the Mental Health Alignment Work Group (MHAWG) in January 2000 to recommend strategies to better align state mental health services for Oregon children and adults, both within the traditional mental health system, and among state and local partners. Members of the work group were carefully selected to represent the breadth and depth of interest in the issue of mental health and mental health disorders in Oregon. Ten percent of the members appointed are or were mental health consumers. An additional 10 percent are parents of children who are previous or current mental health service recipients. Appendix 1 lists the members on the Work Group and their affiliation.

The Governor charged the Mental Health Alignment Work Group with the following:

The Charge

> *Recommend how best to align existing programs, policies and resources into a statewide mental health system for children and adults. Recommend steps that need to be taken to fully implement such a system.*

Policy Directive

- The system must ensure a basic level of support statewide.

- The system must be consistent with The Oregon Strategy for Social Support, including principles and role of state government.

- The system, at all levels, must be held accountable for client outcomes and efficient use of resources.

- State dollars must be used to ensure that a basic level of supports is available to all Oregonians of similar risk.

- Findings and recommendations must be quantifiable.

- More money is the easiest of answers. Recommendations must address systemic problems first.

Focus

At a minimum, the following issues must be addressed:

- Limits of the mental health system,

- Housing and other long-term community supports,

- Corrections (juvenile and adult) as a default mental health system,

- Mental health integration into the Oregon Health Plan (including role of public and private sector),

- Disparity between adult and children's mental health, and

- Approach with a responsibility for dual diagnosis clients.

The Work Group met two or three days per month from February 2000 through December 2000 to accomplish its charge. The Work Group was chaired by Mark Gibson, policy advisory to Governor Kitzhaber, facilitated by Pam Curtis and staffed by Suzie Willard, also of the Governor's Office.

The Work Group established a work plan (refer to Appendix 2) and a three-phase strategy to complete their work. First, the group studied the history and current state of mental health disorders and mental health services in Oregon. Second, they developed a model or "ideal" mental health system for Oregon, based on this historical context and the needs of Oregonians. And, finally, the Work Group developed specific recommendations to change, improve, and realign existing services, strategies and funding in order to implement a more

ideal system over time. The recommendations contained in this report are intended as a road map for improving mental health services in Oregon. When in place, they will improve the cost effectiveness and quality of mental health care for more Oregonians, and ensure our citizens with mental health disorders have the greatest opportunity for independent and productive lives.

The recommendations contained in this report are intended as a road map for improving mental health services in Oregon.

The MHAWG received testimony from experts, stakeholders, consumers and family members regarding mental health treatment, efficacy, financing and emerging issues. (See Appendix 3 for a list of speakers.) They also gathered input from over 750 Oregonians through 38 community forums, regarding the "ideal" system, and the steps necessary to put that system in place. (See Appendix 4 for a list of Community Forums.) Appendix 5 outlines the key concerns and recommendations made at these community forums.

The Ideal Mental Health System: Findings and Recommendations

Barriers to the Ideal System

Before achieving an 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 the 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. Other DHS divisions and agencies that fund mental health services for their clients outside the OHP and outside the funding and oversight provided by the MHDDSD even further fragment the situation. There are approximately thirteen 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 available for others. As a result, Oregon has a collection of autonomous programs, managed by various state and local agencies, operating in a piecemeal fashion. Figure 6 illustrates the current flow of mental health services in Oregon.

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 also 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 and state confidentiality requirements, which often make it difficult to share relevant client information.

Inadequate Resources

Oregonians who do not have access to the Oregon Health Plan, including many with private insurance, often have no or substantially reduced mental health benefits. This leaves them without care utilizing whatever resources state or local communities can provide, including hospital emergency rooms, or law enforcement. The cost of psychotropic medications within 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 these 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.

According to an on going survey of the Residential Providers Association, 75 percent of staff in residential treatment programs turnover 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 relative 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 delivering 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

Both participants in the community forums and Work Group members took special note of the lack of understanding and public misperceptions about mental health disorders which leads to other problems in the mental health system. Along with mental health treatment and services, a public information campaign could help all Oregonians understand that mental health disorders are a community issue that affects everyone -- and that treatment is available and effective.

Paucity of Services for Criminal Justice and Dually Diagnosed

Few programs exist for consumers who have co-occurring mental health and substance abuse disorders, yet there are 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, people with mental disorders 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 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:

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

- Transitional services that assist older adolescents and adults with chronic mental health disorders and long hospital stays to reintegrate into the community;

- 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.

Components of the Ideal System

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 in this report.

The ideal mental health system has a clear vision, shared values, and functions under consistent principles of operation.

The following are the recommended vision, values and principles for a new mental health system in Oregon.

The ideal mental health system has a clear vision, shared values, and functions under consistent principles of operation.

Vision

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.

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.

Guiding Principles

1. Individuals with mental health disorders should be served by caring and empathetic individuals—with services and supports designed to stabilize their disorder and to maximize independence, dignity, self-worth and recovery.

2. The state and other governments should define clear, consistent standards and require accountability for mental health services.

3. Regional, county and community services should have flexibility in services and funding to maximize effectiveness and individual outcomes.

4. Individuals with mental health disorders, their families, and other support persons should be full participants in policy setting, planning, delivery and evaluation of services.

5. Individuals with mental health disorders should receive services that address the whole person by linking agencies and programs, and integrating the planning and delivery of services and supports.

6. Mental health needs should be identified at the earliest point possible and at the youngest age possible in order to increase the likelihood of positive outcomes.

7. The entire mental health system should reflect a caring, comprehensive approach that provides services in an appropriate, least restrictive setting.

8. Successful client outcomes should drive the services and linkages of the system.

9. Individuals with mental health disorders, their families, and other support persons should be full participants with practicing clinicians and line workers.

10. Oregon communities should work to maximize the potential of individuals with mental health disorders to be as independent and productive as possible.

11. Providers, communities, government, individuals with mental health disorders, and their families should promote public education about psychiatric disorders and treatment in order to de-stigmatize mental illness.

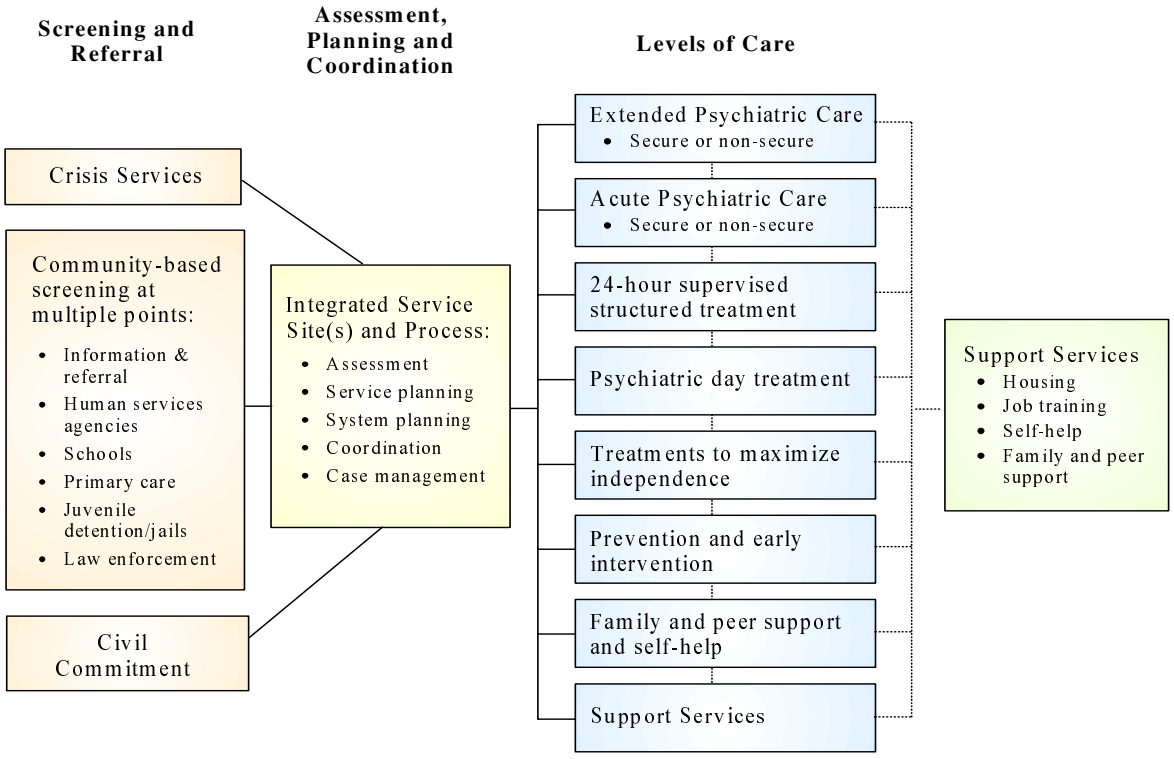
12. The mental health system should safeguard human dignity, minimize coercion and maximize self-determination of individuals with mental health disorders.

As articulated above, the ideal mental health system focuses on identifying 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 ideal system also includes the infrastructure, financing and insurance coverage necessary to support the availability of needed services.

The relationship between these components is illustrated by Figure 7.

Figure 7
Ideal Mental Health System



The ideal mental health system should be accountable for measurable results to its clients, funders, stakeholders and the citizens of Oregon.

The ideal mental health system should be accountable for measurable results to its clients, funders, stakeholders and the citizens of Oregon. The MHAWG identified four long-term goals and twenty-two intermediate outcomes to measure success in putting an ideal mental health system in place for Oregon. Unless otherwise noted, these goals are applicable to children, families and adults.

Goals

1. Create continuity of insurance coverage for Oregonians of all income levels.

2. Provide appropriate treatment as defined by best clinical practices which links treatment with the appropriate social supports required for best clinical outcomes.

3. Ensure a mental health system that is accountable to consumers, families and tax payers for delivery of high quality, timely, cost effective services.

4. Provide timely access to all levels of care, including a broad range of social supports, for all Oregon children, families and adults, based on level of need.

Outcomes

1. Increase the number of Oregonians who have adequate mental health coverage as part of their insurance.

2. Increase the number of insurers (including OHP) who require best practices in provider contracts and monitor compliance with best practices.

3. Increase the number of consumers and families satisfied with treatment and connected to needed social supports.

4. Increase the number of consumers and families who are treated with dignity and respect.

5. Increase the functionality and self-sufficiency of persons with mental health disorders.

6. Create results-oriented performance measures for each part of the mental health system.

7. Create an independent, accessible grievance process.

8. Increase the number of organizations in each county that are doing preliminary and early mental health screening.

9. Increase the number of organizations involved in referral, planning, funding and treatment services and supports for children and families.

10. Increase the percentage of families involved in transition planning between levels of care.

11. Increase the number of children who receive services close to home.

12. Increase the percentage of families who can successfully keep their children with mental health needs at home.

13. Decrease the percentage of youth with identified mental health needs that enter the juvenile justice system.

14. Increase the capacity of all levels of care, with priority given to those which serve people with the most severe or acute mental health disorders.

15. Decrease the average length of time in each county between referral and first service contact.

16. Increase the number and rate of consumers and families reporting involvement and choice in their treatment and support plans.

17. Increase the number and rate of affordable housing units per county focused on individuals with mental health disorders.

18. Increase the percentage and number of individuals with mental health disorders who have access to educational training and/or vocational rehabilitation services.

19. Increase the number and percent of communities with consumer-operated peer support programs (such as drop in centers).

20. Decrease the number of Oregonians who believe those with mental health disorders pose a public safety threat.

21. Increase the percent of incarcerated people with mental health disorders, who are connected with local mental health treatment within 5 days of leaving the correctional facility.

22. Reduce staff turnover.

The following were identified as necessary service and infrastructure components in order to achieve the goals and outcomes of an ideal mental health system for Oregon.

Service Components

Multiple Points of Screening

There should be multiple points where potential mental health concerns can be identified as early and soon as possible. The individual can then be referred to a more in-depth mental health assessment if necessary.

Multiple Points of Entry

Individuals with mental health disorders, and their families should have many ways to access mental health services. There should be "no wrong door".

Integrated Service Teams

Mental health disorders do not occur in isolation of other needs. A team that represents mental health services and other social supports, should work with the individual with a mental health disorder, his/her family and other support persons to ensure that supports are available when needed. These supports should be delivered in a seamless fashion.

Single Care Plan/Care Coordinator

Even though a team may work with the individual and his/her family, one single person should coordinate the efforts of the team and ensure that needed services are delivered. The individual and his/her family needs one person to count on to look out for their interests.

Cross-Training Across Disciplines

Service providers outside the mental health system need to be trained to understand the dynamics of mental health disorders, how to recognize them early and what to do. Likewise, mental health workers need to be trained in the dynamics of other disciplines (such as substance abuse or developmental disorders) so they can more appropriately care for individuals who have dual issues.

Integrated Transition

As individuals leave the mental health system, or as they transition between mental health and other related systems, their in and out movement should be as smooth as possible. The disconnected ends of separate systems should be woven together.

Local Determination

Because local communities are different, there should be flexibility in how each of the system components (above) is developed from community to community.

Infrastructure Components

Outcomes-Based Funding

Public funds (both insurance related and community related) should be tied to outcomes. Providers and provider organizations who do not show fiscal responsibility and who are not able to show good service outcomes should not continue to receive public funds.

Pooled and Flexible Funding

Resources and funding to support individuals with mental health disorders should be flexible enough to meet their needs. The state should "pool" or combine resources, rather than deliver such funding to the local level in separate funding streams with strings attached for each fund.

Insurance Coverage

There should be adequate insurance coverage to provide treatment to individuals with mental health disorders. Oregon should ensure parity (equal benefits) for physical and mental health care by statutorily establishing a basic health care benefits package for private insurance based on the OHP prioritized list. These benefits should apply to group and individual coverage, and include prevention, early screening and assessment, early identification and early intervention in mental health needs.

Statewide Grievance Process and Abuse/Neglect Policy

There should be a statewide grievance process so that individuals with mental illness, their families and other support persons have an opportunity to complain and a method for correcting injustices in the system. The grievance process should include attention to allegations of abuse/neglect.

Integrated Local Planning

The state should ask communities to develop one plan that integrates local services (such as mental health, substance abuse, corrections/law enforcement and prevention).

Integrated State Administrative Functions

The state should support integrated local planning and services by integrating state administrative functions. The following functions should be integrated: data and record keeping requirements, funding, outcome reporting, planning, intake, and so on.

Performance Measures

There should be a minimum set of performance measures both for services and for the system as a whole. Local communities or providers should be allowed to add additional performance measures, but there should be a consistent statewide standard set of measures.

A Plan for Workforce Development and Support

A plan should be developed to ensure that workers in the mental health system are adequately trained, supported and valued. Workers should have the opportunity and responsibility to continually improve their skills.

Statewide Data System

There should be a statewide data system for mental health, capable of tracking provider and community performance. It should also provide linkages to other related systems (such as public safety and substance abuse) in order to support integrated services. As required by federal law confidentiality should be safeguarded.

Uniform Data

All providers of mental health services who receive public funds, should be required to report some basic and consistent data. Without it, there is no way to track performance and measure successful outcomes.

Articulated Roles and Responsibilities

The mental health system should clearly articulate the roles and responsibilities of state government, local government and providers in caring for and supporting Oregonians with mental health disorders.

Findings and Recommendations

The recommendations that follow are for improvements in the mental health system for children, families, and adults. These recommendations emphasize early identification and providing help as soon as possible. They also stress the critical need for infrastructure and financing improvements in order for service enhancements to be effective. While each recommendation lists a "lead implementer" they are dependent on the involvement of a broad array of stakeholders to put each proposal into place. The recommendations are divided into sections addressing screening, treatment, links with criminal justice, social supports, financing/insurance, and infrastructure.

Screening, Assessment and Referral

Mental health disorders can be progressive, especially in children, and they are often cyclical. The most effective way to "treat" a mental health disorder is to prevent it from happening in the first place. Where this is not possible, and often it is not, the next best strategy is to "catch it early". This requires early screening, assessment and referral.

A growing number of staff in the criminal justice, education and human service fields are recognizing the need for formal identification and referral to mental health services for their clients.

A screen is a brief (5-10 minute) review of indicators that show potential need for a more thorough assessment for potential mental health disorders. Screening should be done in a consistent manner through use of a screening tool that has been tested for reliability and validity.

If a screen shows indicators of a mental health concern, a referral should be made for a diagnostic assessment to determine the true existence and nature of any mental health disorder. Protocols and resources need to be identified and supported by referral agreements between referring sites and local assessment/treatment providers. Assessments should be conducted as part of an integrated process to plan and deliver needed services.

Findings

Oregon does not have a coordinated screening system for identifying mental health problems, nor is there a standardized screening tool. Screening protocols need to be instituted at natural "touch points" which are often linked to mental health, such as primary care offices and medical care facilities, schools, criminal justice systems, alcohol and drug treatment agencies, health/human/social service agencies, and senior centers.

An inventory of state agencies reveals that:

- Services to Children and Families (SCF) does not conduct a formal or consistent mental health screen on all of its clients.

- OYA screens all youth coming into their institutions, although a consistent tool is not used.

- A mental health screening tool has been developed, tested and validated for use in Oregon county juvenile departments. However, the tool is seldom used and universal screening for mental health issues does not occur.

- Alcohol and drug treatment providers do not consistently screen clients for mental health concerns. The state Office of Alcohol and Drug Abuse Programs does not require a screen for funded services and clients.

- Primary health care is an important access to treatment for mental health services. OHP providers are required to screen at least 75 percent of patients for mental health problems. However, there is no mechanism in place to ensure or enforce that screening occurs.

- DHS's Health Division provides funds to county health departments. Those who provide primary care and/or case management also provide mental health screening of the patients they see. However, there is no consistent tool used, nor is there a consistent referral for assessment and treatment.

- AFS may screen some clients. However, this is not consistent and there has been some question as to the appropriateness of the tool.

Need for Screening and Referral

State agencies with large numbers of "high risk" clients should routinely screen those clients for mental health concerns upon initial contact. In particular DHS divisions and programs, the Department of Corrections and the Oregon Youth Authority should routinely screen new clients. The Department of Education should work with local schools to screen students who show early signs of concern.

The following data reflect clients who have documented mental health needs. They illustrate the need for mental health screening and referral to appropriate services:

- 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,[39] and
- 70 percent of youth incarcerated in a state juvenile correctional institution.[40]

Recommendation

Screening

The state should establish a series of developmentally appropriate screening tools for use for all children and adolescents and provide training and oversight in the use of the tool. Each mental health agency must provide an assessment after a referral comes to them from a screening, as identified in the local blueprint plan.

Recommended Timeline:

- January 2002; July 2002 training begins

Recommended Lead Implementer:

- Mental Health and Developmental Disability Services Division

Indicators of Success:

- Increase the number of organizations in each county that are doing preliminary and early mental health screening.

- Decrease the average length of time in each county between referral and first service contact.

Treatment

There are a variety of well-documented, proven treatments for most mental health disorders for both children and adults.

There are a variety of well-documented, proven treatments for most mental health disorders for both children and adults. These can be divided into three broad categories that are most effective when they are combined:

- psychopharmacological treatment (medications or drugs),
- psychological treatment (such as therapy or counseling), and
- social supports (such as housing and employment).

Currently, mental health services are thought of in traditional terms – largely focused on treatment and the locus of treatment. But the definition needs to be expanded to include prevention and the basic supports people need to live and thrive in their own community (including housing, employment, education, and primary health care). The definition also needs to include both professionals and non-professionals and result in a decrease in the stigma associated with mental health disorders.

This is particularly true of co-occurring mental health and substance abuse disorders. Consumers with co-occurring disorders are increasingly the rule rather than the exception. Research and practice have shown that consumers with co-occurring disorders do not get better when they are treated in a disintegrated fashion.

Findings

An inventory of state agencies revealed the following mental health services and programs:

- The Oregon Commission on Children and Families (OCCF) funds Relief Nurseries in three counties to provide therapeutic preschool and other services to high-risk children who are six weeks to six years of age and their parents. OCCF operates the Healthy Start Program in half of Oregon's counties. This program includes a social-risk screening at-birth for first born children. They also provide several flexible funding streams to counties for services to strengthen family relationships and parent-child bond.

- The Oregon Department of Education provides educational services for state contracted mental health programs. They also oversee special education programs in each school district for children who have severe emotional disturbances.

- The Office of Medical Assistance Programs at DHS administers Oregon Health Plan assistance for persons meeting OHP and Medicaid requirements.

- MHDDSD is the primary provider and funder of mental health treatment services for children and adults outside the OHP. MHDDSD provides funding and oversight for a range of local mental health services for low income Oregonians who do not qualify for the OHP or who have exhausted their private insurance coverage. The Division manages and contracts for mental health services provided to OHP members. The Division also operates two state hospitals (Oregon State Hospital with campuses in Salem and Portland and Eastern Oregon Psychiatric Center in Pendleton) for persons with the most severe mental health disorders.

- The Oregon State Police operate a Juvenile Firesetter Intervention Program designed to reduce firesetting behavior among at-risk youth. Their Criminal Justice Services Division oversees the use of federal Byrne funds targeted toward reducing violent crime and associated behaviors.

- Services to Children and Families (SCF) at DHS uses available funds to develop individual service plans for children in their care, including mental health services. SCF also purchases residential care and other mental health services from community providers as needed.

- The Health Division of DHS provides funding for eleven school based health centers to provide youth with integrated services, including mental health care. The Health Division also coordinates strategies to prevent and reduce suicide attempts in Oregon youth, ages 10-24.

- The OYA provides community placement settings for youth offenders returning to the community. Often these services include mental health treatment. The OYA also provides some mental health services to youth incarcerated in all seven of their facilities.

- The Department of Corrections provides mental health treatment for some adult inmates with serious mental health or alcohol/drug problems.

- The Office of Alcohol and Drug Abuse Programs provides limited funding for enhanced services for individuals with co-occurring disorders (mental health and substance abuse).

- The Senior and Disabled Services Division provides assistance to elderly and disabled persons with serious disabilities with a focus on activities of daily living. Where a mental health disorder interferes with these activities, the Division may provide assistance.

- A study on seriously mentally ill adults and children in Seattle, King County found[41]:

  › teens who abused drugs were four times as likely to have been incarcerated,

  › adults who abused both drugs and alcohol were over twice as likely to have been hospitalized,

› adults who abused both drugs and alcohol were over five times as likely to have been incarcerated,

› older adults who abused both drugs and alcohol were over six times as likely to have been hospitalized,

› 90 percent of the mentally ill offenders released by the Washington Department of Corrections have a co-occurring alcohol and/or drug problem,

› without integrated services, individuals with co-occurring disorders continued to cycle repeatedly through the most expensive publicly funded resources in the system: hospitals, jails and detox centers,

› substance abuse is one of only two co-factors that correlates significantly to increased utilization of hospitals and jails. The second variable is homelessness, and

› provision of integrated services led to a reduction in rates of hospitalization and incarceration.

...without integrated services, individuals with co-occurring disorders continued to cycle repeatedly through the most expensive publicly funded resources in the system: hospitals, jails and detox centers.

Need and Cost for Treatment

Oregon bases the demand for publicly supported mental health services on three categories of citizens:

- people eligible for Medicaid (Oregon Health Plan);

- the uninsured; and

- the privately insured population whose mental health coverage falls short of their treatment needs.

Table 1 illustrates the need for mental health treatment in the general population of Oregonians.

The MHDDSD estimates that 220,823 Oregon adults and 113,181 children will need mental health treatment each year. Of these, 71,924 adults and 39,836 children are likely to seek or

"demand" state supported service each year, due to income, lack of insurance coverage or inadequate insurance coverage. State supported services are able to accommodate 83 percent of the demand for adult services and only 70 percent for children's services.

Available information suggests that 32 percent of adult Oregonians with a mental health disorder, who receive treatment, obtain it in private settings. The remainder (68 percent) are expected to use the public system.[42] The Office of Mental Health Services estimates that 12,232 Oregon adults are in need of public mental health services, but are not receiving them.

It is estimated that 28.7 percent of Oregon children are Medicaid eligible, and that 91.5 percent of those eligible (or 231,300) are enrolled in the Oregon Health Plan. This means that 25.8 percent of Oregon children can receive needed services through the OHP. 68 percent of children have private health insurance, which may have some level of mental health coverage. Most often, this is the minimum required by law. Some private health insurance does not include coverage for any mental health care. 6.2 percent of Oregon children are uninsured with no mental health coverage. Using this method, 11,898 Oregon children are in need of public mental health services, but not receiving it.

To fully fund needed services for the 11,898 Oregon children and 12,232 adults who need public mental health services; an additional $139,685,346 for children and $90,625,665 for adults is needed – for a grand total of $230,311,011.[43]

The Oregon Youth Authority estimates that 6 percent of youth committed to close custody institutions are in need of psychiatric residential treatment. The Oregon Department of Corrections estimates that 17 percent of male inmates and 40 percent of female inmates have a serious mental health disorder, not including those who need short-term crisis services.

Recommendations

Develop local blueprint plans

Amend existing planning requirements to ensure each county local mental health authority, or locally determined region, creates a comprehensive biennial blueprint plan for the local delivery of mental health services for children, families and adults consistent with the recommendations, values, vision and principles of the MHAWG.

Services in the plan

- Each county shall plan and be accountable for a seamless continuum of care based on level of need and intensity including: 24-hour Crisis Services; Extended Psychiatric Care, Secure or non-secure; Acute Psychiatric Care, Secure and non-secure; 24-hour Supervised Structured Treatment; Psychiatric Day Treatment; Treatments to maximize independence; Family and Peer Support and Self-help; Support Services; Prevention and Early Intervention; transition between levels of care; and dual diagnosis services.

- Local plans should address the coordination and accountability for all levels of care. This should include access to state hospital beds.

- Services should maximize resources to clients, and minimize administrative expenses.

- The plan should include approaches to provide supported employment and other vocational opportunities for persons with mental health disorders.

- The plan should assure an integrated triage process to determine the most appropriate provider among the range of locally qualified providers.

- Local plans should describe how referral for mental health needs will be made.

- Each plan should describe how housing needs are addressed.

- Local plans should describe the process for discharge and transition planning from each level of care and between systems.

- Local plans should arrange for peer support services such as drop in centers, which include paid peer staffing.

- Transportation supports should be an integral part of the plan.

Services guarantees

Counties should demonstrate integrated systems and administrative functions that will support integrated service delivery described above.

Services described in the plan should:

- address the values, vision and principles of the MHAWG,

- treat children and families as close to their home as possible,

- ensure delivery of culturally appropriate and competent services;

- ensure children and adults with mental health needs receive mental health services from providers appropriate to deliver those services. Families not otherwise a part of SCF or OYA should receive mental health services from the LMHA as indicated in the local plan. Resources should follow the individual for those services,

- be delivered via an integrated service delivery system with integrated service sites or processes and integrated service teams,

- ensure consumer choice among the range of qualified providers in the community,

- be distributed geographically,

- involve consumers, families, clinicians, children and schools in treatment as appropriate,

- maximize early identification and early intervention,

- ensure appropriate transition planning between providers and systems, especially between children and adult mental health services,

- be based on clients' ability to pay,

- ensure collaborative service delivery,

- use age-appropriate, research-based quality indicators,

- use best practice innovations, and

- be delivered using a community-based, multi-system team approach.

Planning process should:

- coordinate with state budget decision-making in each state budget cycle and other planning processes,

- involve consumers, advocates, families, a full range of providers, schools and other stakeholders in the community,

- require shared responsibility for funding the plan implementation,

- conduct a population-based needs assessment, including range of needs and range of care needed to meet needs,

- review county populations in order to identify ethnic, cultural and diversity needs, and

- describe anticipated outcomes, how outcomes will be monitored and what actions in the plan will meet outcomes. Outcomes should be linked to established statewide performance measures.

Coordination for:

- education needs of children and adults and with service delivery and funding,

- social supports with mental health services,

- school involvement with children's services,

- interface with law enforcement,

- integration with physical health care at a clinical and consumer level, and

- transportation services – resources – especially the statewide transportation coordination project.

State role

- The State in consultation with local mental health authorities shall develop guidelines for the development of local blueprint plans, including integrated service sites, expected outcomes, incentives to reduce use of state hospitals and mechanisms for local sharing of risk for state hospitalization.

- The State shall work with counties to provide incentives for community-based care whenever appropriate while at the same time safeguarding adequate statewide capacity.

- The State shall provide technical assistance and information throughout the planning process to counties on federal and state requirements.

- The State shall provide incentives to counties for enhanced/increased vocational placements for adults.

Recommended Timeline:

- July 2001 - produce initial statewide guidelines for a planning.
- January 2002 - initial plans due.
- July 2002 - final planning guidelines released.
- January 2003 - implementation begins.
- July 2003 - final plans due.
- January 2005 - full implementation.

Recommended Lead Implementers:

- Local Mental Health Authorities
- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:

- Increase the number of organizations involved in referral, planning, funding and treating services and supports for children and families.
- Increase the number of children who receive services close to home.
- Increase the capacity of all levels of care, with priority given to those with the most severe or acute mental health disorders.
- Increase the number of consumers and families connected to needed social supports.
- Increase the number and rate of consumers and families reporting involvement and choice in their treatment and support plans.
- Increase the number and percent of communities with consumer-operated peer support programs (such as drop in centers).
- Increase the number and rate of affordable housing units per county focused on individuals with mental health disorders.
- Increase the percentage and number of individuals with mental health disorders who have access to educational training and/or vocational rehabilitation services.

Develop criteria for levels of care

The State should develop standardized level of care criteria and implementation protocols, including protocols for strength-based assessment and case planning. These should be linked to requirements for local blueprint plans.

Recommended Timeline:
- March 2002

Recommended Lead Implementer:
- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:
- Increase the capacity of all levels of care, with priority given to persons with the most severe or acute mental health disorders.
- Increase the number of consumers and families satisfied with treatment and connection to needed social supports.
- Increase the number of consumers and families who are treated with dignity and respect.
- Increase the functionality and self-sufficiency of persons with mental health disorders.
- Increase the percentage of families who can successfully keep their children with mental health needs at home.
- Increase the number and rate of consumers and families reporting involvement and choice in their treatment and support plans.
- Increase the functionality and self-sufficiency of persons with mental health disorders.

Connections to Criminal Justice Systems

In 1992 the National Alliance for the Mentally Ill (NAMI) and the Public Citizen's Health Research Group released a report, entitled *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*. The report revealed alarmingly high numbers of people with schizophrenia, bipolar disorder and other severe mental disorders incarcerated in jails across the country. The vast majority of their offenses were minor breaches of the law directly related to symptoms of untreated mental disorders (breaches such as trespassing, disorderly conduct, etc.).

...over a quarter of a million mentally ill offenders were incarcerated in the nation's prisons and jails.

In 1998, the United States Department of Justice reported that over a quarter of a million mentally ill offenders were incarcerated in the nation's prisons and jails. The Department also reported that mentally ill offenders were more likely to be homeless and chronically unemployed. Further, it suggested that the increase of mentally ill offenders in corrections facilities may be as a result of deinstitutionalization of psychiatric facilities, reduced levels of public defenders and the lack of low-income housing and mental health care.

Although police agencies and criminal justice professionals recognize the problems posed by people with mental illness in jails, they often lack adequate training, procedures and resources to divert people with severe mental health disorders into community-based treatment programs. At the release of the NAMI report less than 5 percent of jails had procedures in place to divert petty offenders with severe mental health disorders into treatment programs. Further, due to the lack of available treatment services, 29 percent of jails reported incarcerating people with severe mental health disorders without filing any charge.

Most correctional facilities do not have qualified mental health professionals available to identify inmates with a mental health disorder, nor do they have the resources necessary to appropriately respond to the needs of these individuals. As a result, the response to an inmate with a severe mental health disorder is often to place them in isolation or physical restraints – which actually can make symptoms worse in many cases.

The lack of appropriate treatment and services in the criminal justice system can have serious costs. Suicide is the leading cause of death in our nation's jails. A 1995 study found that people with a treatable mental illness committed 95 percent of all jail suicides, and that 75 percent communicated their intent in advance. [44]

Jails and prisons are becoming default mental hospitals. And, without qualified mental health professionals in these settings, or without suitable community-based alternatives, persons with severe mental health disorders and those who work in the criminal justice system are being put at greater risk.

The 1990s saw a dramatic expansion of secure custody in Oregon's criminal justice system for both youth and adults. At the same time, Oregon began reducing capacity in the state hospital and long-term care institutions for adults and children with mental health disorders. These moves mirrored national trends to incarcerate offenders and provide mental health services less expensively in the community. To illustrate these trends, in the six years from 1993 to 1999, the number of offenders in Oregon Youth Authority custody transferred to the Oregon State Hospital for services dropped dramatically to almost half, while the total capacity of the OYA system more than doubled. As a result, staff at the OYA report larger numbers of youth with severe mental health disorders inappropriately housed in their facilities.

Findings

- The U.S. Department of Justice reports that 16 percent of all inmates in state and federal jails nationwide have a severe mental illness.

- Statewide an average of 18 percent of local jail populations in Oregon have a mental illness. Many of these inmates also have a co-occurring substance abuse disorder.

- Eighty percent of incarcerated Oregon adults have an alcohol or other drug problem.

- The Oregon Department of Corrections (DOC) has 10,000 inmates. Seventeen percent of male inmates and 40 percent of female inmates have a serious mental health disorder, not including those who need short-term crisis services.

- A study of inmates in the Marion County Jail found that 17 percent of inmates are mentally ill. Key findings from this study include:

    › mentally ill inmates were jailed 23 percent more often than other offenders,

- mentally ill inmates serve an average of four months, compared with an average of three months for other offenders,

- mentally ill inmates committed 17 percent more offenses,

- 73 percent of mentally ill inmates were diagnosed with a severe and persistent mental illness, disability or disorder requiring medication. About 75 percent of this population were on psychotropic medication while in jail,

- women inmates with mental illness spent less time in jail than men, committed fewer offenses and were more likely to be taking more medications,

- inmates with mental illness were older and often white women. The average age was 34,

- 66 percent of mentally ill inmates released are noncompliant with the terms of their probation,

- more than 25 percent of mentally ill inmates released have returned to jail on a new violation,

- more than 66 percent of mentally ill released inmates don't take their medication,

- more than 25 percent of inmates with mental illness are homeless or in temporary housing, and

- almost 75 percent of mentally ill inmates who are released do not participate in community mental health treatment.

- OYA facilities provide a basic level of psychiatric care, however the level of mental health need is too great to manage or treat effectively with these basic services. A study by the OYA on the mental health needs of its offenders revealed the following:[45]

Six percent of the total number of youth held in OYA facilities meet the criteria for placement in a juvenile psychiatric residential center in Oregon.

› Six percent of the total number of youth held in OYA facilities (or 60 youth) meet the criteria for placement in a juvenile psychiatric residential center in Oregon.

› While only 9 percent of the OYA population are females, 21.6 percent of the youth needing psychiatric residential care are girls.

› Youth aged 15-16 years are most represented among those needing psychiatric residential care at 48.3 percent. This is a significantly higher percentage than is represented in OYA facilities overall (28 percent). The percentage of 12-14 year old youth needing psychiatric residential care is also disproportionately higher (16.6 percent) based upon their representation in the overall OYA population.

› The vast majority of the OYA youth needing psychiatric residential care were sent to state custody through local juvenile departments (91.6 percent).

› More than one-third of the youth needing psychiatric residential care were committed to the OYA for a Class A misdemeanor crime as the most serious offense. Less than one-fifth were committed for Class A felonies.

› All of the OYA youth needing psychiatric residential care have had extensive contact with the mental health system in their communities prior to commitment to the youth corrections system. Unfortunately they all also experienced numerous treatment failures and unsuccessful discharges.

› All of these youth had significant dysfunction in their homes, with frequent alcohol and other drug abuse by their parents and siblings.

› Almost half of the youth needing psychiatric residential care (45 percent) were too disturbed to benefit from corrections treatment programs without significant and intensive mental health services.

- As of 1992, less than 5 percent of the nation's jails had procedures in place to divert petty offenders with severe mental illnesses into community treatment programs.

- Twenty-nine percent of jails nationwide report incarcerating people with severe mental illnesses without filing any criminal charge, due to the lack of available community services.

- Suicide is the leading cause of death in our nation's jails. A 1995 study found that people with a treatable psychiatric illness committed 95 percent of all jail suicides. The same study reported that 75 percent communicated their intent beforehand.

- The most common deficiencies in the corrections system related to mental illness include:

    › There is minimal training for corrections officers on mental health and substance abuse issues.

    › Most jails do not have specific accommodations for mentally ill inmates. If anything, they are housed in medical units for inmates who require significant medical attention, or in isolation cells.

    › There is a lack of a release plan for transition into the community.

    › Parole and probation officers often are not aware that their clients have mental illnesses.

The lack of treatment for mental health disorders results in law enforcement involvement with the people who have these disorders, and a vicious cycle appears to begin. County juvenile departments commit low level offenders to the state juvenile correction facilities because of the lack of mental health treatment available, or their lack of capacity to address the needs of these offenders. State correctional facilities, likewise do not have the resources or capacity to treat these offenders, so they often do not get the help they need. The problem continues to worsen, because by the time offenders reach the adult system, a

significantly greater percentage of them have a diagnosed serious mental health disorder (6 percent of offenders in state juvenile corrections facilities, compared with 18 percent of adults).

Need and Cost for Mental Health/Public Safety

[Oregon] DOC reports that...21 percent of all male inmates, and the female inmate caseload to 50 percent of all female inmates...[have an acute or serious mental health disorder.]

As outlined above, The Oregon DOC has 10,000 inmates. The DOC reports that 17 percent of male inmates and 40 percent of female inmates have a serious mental health disorder, not including those who need short-term crisis services. Adding in short-term crisis services (such as suicide prevention) brings male inmate mental health caseload to 21 percent of all male inmates, and the female inmate caseload to 50 percent of all female inmates. Six percent of the total number of youth held in OYA facilities meet the criteria for placement in a juvenile psychiatric residential center in Oregon. These youth are generally younger, female, committed by county juvenile departments, and committed for lower-level offenses.

The costs to the criminal justice system from the incarceration of individuals with mental health disorders are enormous. This is illustrated by the case of a female offender diagnosed with schizoid affective disorder, conduct disorder, polysubstance abuse disorder and borderline personality traits. She was committed to the OYA by a local juvenile department for menacing and harassment. The following costs were born by the state agency over 10 ½ months:

- 6 psychiatric hospitalizations during her stay at OYA, 19 suicide attempts, 6 visits to the emergency room for self-destructive behavior costing the OYA $3,121.60 (not including hospital costs),

- $400 per month medication costs,

- $96,750 in one-to-one staffing due to suicidal tendencies and other destructive behavior,

- Costs for the following treatment sessions: 564 individual therapy sessions; 52 sessions with a psychiatrist; 5 documented consultations with a psychologist; 39 physician visits; and 312 assessments and interventions by a registered nurse.

The MHDDSD conservatively estimates that 15 percent (or $136.2 million) of the 1999-2000 annual budget will be spent on public safety services for acute care, community crisis services (for both children and adults), the Psychiatric Security Review Board, the State Hospital and extended care. This estimate does not include most of the services which prevent people from becoming a threat to themselves, others or property. It also does not include costs borne by local law enforcement and public safety agencies. If these costs were included, the estimate would be significantly greater.

Recommendations

Local interface between mental health and public safety

For the purpose of ensuring that people with mental health disorders receive needed care and are diverted from the criminal justice system as appropriate, and to provide continuity of services as persons with mental health disorders leave the corrections system, amend necessary ORS to direct each local mental health authority and the local public safety coordinating council to jointly develop a coordinated plan, as part of the local mental health blueprint plan for both children and adults. Specifically:

- Develop and implement a plan for training law enforcement officers on all shifts to recognize and interact with persons with mental health disorders and their families, with the purpose of diverting them from the criminal justice system.

- Develop, with local hospitals, voluntary locked facilities for crisis treatment and follow up in lieu of custodial arrests (using King County model).

- For those that are arrested, develop and implement a plan for sharing of daily jail custody roster (and the identity of other persons of concern) with the county mental health authority or integrated service site. Appropriate services must then be offered.

- Plan for and implement appropriate voluntary diversion programs, such as mental health and drug courts, to provide an alternative for persons with mental health disorders in the justice system.

- Develop and implement a plan to make available mental health services -- including housing –– prior to and upon release from custody of all persons with mental illness.

Recommended Timeline:
- January 2002

Recommended Lead Implementers:
- Local judges
- Department of Corrections
- Local Mental Health Authority
- Criminal Justice Commission
- Oregon Youth Authority
- Public Safety Policy and Planning Council
- County juvenile departments

Indicators of Success:
- Decrease the percentage of youth with identified mental health needs that enter the juvenile justice system.

- Increase the number and rate of consumers and families reporting involvement and choice in their treatment and support plans.

- Decrease the number of Oregonians who believe those with mental health disorders pose a public safety threat.

- Increase the percent of incarcerated people with mental health disorders, who are connected with local mental health treatment within five days of leaving the correctional facility.

- Reduce staff turnover.

State level transitions

Require LMHA and DOC and/or OYA to jointly develop appropriate release plans, including housing for people with mental health disorders, for the purpose of providing continuity of services as persons with mental health disorders leave the corrections system.

Recommended Timeline:
- January 2002

Recommended Lead Implementers:
- Department of Corrections
- Oregon Youth Authority
- Criminal Justice Commission
- Public Safety Policy and Planning Council
- Local Mental Health Authority
- Local judges
- County juvenile departments

Indicators of Success:
- Increase the percentage of families involved in transition planning between levels of care.

- Increase the number of children who receive services close to home.

- Increase the number and rate of affordable housing units per county focused on individuals with mental health disorders.

- Decrease the number of Oregonians who believe those with mental health disorders pose a public safety threat.

- Increase the percent of people with mental health disorders, who are incarcerated, that are connected with local mental health treatment within 5 days of leaving the correctional facility.

Social Supports: Housing and Employment

The concept of recovery from mental illness is based on the notion that with the right combination of treatment, social supports, and links to natural systems of support, people can learn to manage their illness, sometimes to the point where symptoms and functional deficits disappear. As recovery progresses, the individual becomes more independent and better adjusted to community life while simultaneously reducing reliance on the mental health system.

It is clear from research and experience that social supports, such as housing or employment, have a significant impact on the ability of a person with a mental health disorder to attain and maintain a state of recovery. Bennett (1998) found that social supports improve the likelihood that clients will complete treatment and remain in a relative state of recovery. Key social supports in his study included housing and employment/vocational training.

...social supports, such as housing or employment, have a significant impact on the ability of a person with a mental health disorder to attain and maintain a state of recovery.

In 1983, Oregon was one of the first states to develop a funding mechanism for actively supporting mental health consumers in independent apartments and shared homes. These supported housing services enable many local mental health programs to hire staff to help consumers find and maintain independent community housing. Today's residential services for people with mental health disorders include both longer-term and short-term options. The long-term options can be categorized as supported housing, structured residential programs and specialized residential services.

Housing is considered "affordable" when a household pays no more than 30 percent of household income for rent (including utilities). Accessing affordable housing is a challenge for persons with mental health disorders. A typical consumer who receives Supplemental Security Income (SSI) (or $512 per

month in 2000) would pay $569 (or 111 percent of income) to rent a modest one-bedroom apartment in Portland or $371 (72 percent of income) in rural Oregon. This income level places them below the federal poverty level and makes it difficult to afford decent housing at market-based rents.

People with mental health disorders are often among the poorest of the poor. They often resort to the least costly housing options, which are likely to be substandard. Because of these very low incomes and the high costs of rental housing, and because rents continue to increase more rapidly than income levels, subsidized housing is a much needed resource. Both public housing authorities and private owners (including nonprofit agencies) provide various forms of subsidized housing.

Research and model programs in Oregon have shown that most consumers of mental health treatment would like to be employed, and in fact, more than 60 percent of people with severe and persistent mental health disorders are capable of finding and maintaining competitive employment with some assistance. Standard principles of rehabilitation, the consumer movement, and certain treatment approaches have contributed to the development of six core principles for employment of persons with mental health disorders[46]:

...more than 60 percent of people with severe and persistent mental health disorders are capable of finding and maintaining competitive employment with some assistance.

1. competitive employment should be a goal,
2. there should be a quick and rapid job search,
3. mental health and vocational rehabilitation services should be integrated, not separate,
4. consumer preferences should be respected,
5. assessment should be continuous and comprehensive, and
6. support is time-unlimited.

Persons with mental health disorders tend to have lower tolerance levels for stress. The stress induced by inadequate or substandard

shelter or lack of employment, and the lower income that results, exacerbates mental health disorders and increases the need for mental health services. With assistance from family, friends, mental health workers, and other social supports, most people with mental health disorders can live comfortably and successfully in their home communities. Some will need additional services or specialized care through structured residential programs.

Findings

- An estimated 6,000-8,000 Oregonians with mental health disorders spend some time without housing each year.

- A total of 2,054 persons enrolled in state-funded mental health services in FY 1998-99 had living arrangements coded in the state data system as "none or transient with no address". This represents 1,953 adults and 101 children and adolescents.

- In FY 2000 Marion County, which uses federal funds to provide outreach services, reported serving 1,915 homeless persons with mental illness. In Multnomah County, where the same funds support a transitional housing program and provide emergency housing assistance, 2,306 persons were served.

- The Oregon Supportive Housing Evaluation Project looked at supportive housing for persons with serious mental health disorders in Clackamas, Lane, Multnomah and Washington counties. The study found that the 961 persons receiving services had been housed continuously for an average of three years. But, 30 percent had experienced homelessness in the past five years. Of the first 103 persons enrolled in the study, 66 percent reported being homeless at some time in their life, with the duration averaging 6-12 months.

- In 1999 Deschutes County determined that 176 mental health consumers were homeless and living on the streets.

- Locations that have experienced extreme population growth (such as Bend) have extremely tight housing markets. The resulting lack of affordable housing appears to be related to an increase in homelessness among persons with mental health disorders in those communities.

- The 1996 National Survey of Homeless Assistance Providers and Clients found that 17 percent of homeless clients had mental health problems. An additional 22 percent had mental health problems in addition to alcohol or other drug abuse problems.

- An estimated 5-7 percent of homeless persons with mental health disorders require psychiatric hospitalization. Most can live in the community, however, if they have supportive, affordable housing options.

- MHDDSD has developed a housing policy for Oregonians with mental health disorders (See Appendix 6)

- In 1999, the Oregon Legislature passed a bill requiring the proceeds from the sale of Dammasch State Hospital to be put into a housing trust fund and the interest used to develop and fund housing options for persons with mental health disorders.

- More than 60 percent of people with severe and persistent mental health disorders are capable of finding and maintaining competitive employment with some assistance.

- There are proven, research-based models for employment for persons with mental health disorders.

- These models have successfully reduced hospitalization by 50 percent, increased consumer satisfaction and residential stability.

Employment for persons with mental health disorders has been proven to reduce dependence on the mental health system, and is more cost effective than most other community and inpatient treatment models for adults.

- Employment for persons with mental health disorders has been proven to reduce dependence on the mental health system, and is more cost effective than most other community and inpatient treatment models for adults.

Need and Cost for Housing and Employment Supports

The majority of the 49,000 persons with serious mental health disorders in Oregon live in existing community housing. It is estimated that 10,322 mental health consumers need some level of support in their living environment, and 27,549 need subsidized rent.[47] Because so many of these people rely on public sources for their income (such as SSI), an estimated 75 percent would benefit from rent subsidies in order to obtain decent, affordable housing. Currently, resources are available to meet about one-third of this need. The chart below outlines housing needs for persons with mental health disorders, by county.

Table 8

Housing Needs Data for Adults with Psychiatric Disabilities

(Prepared 9/99)

	Total Adult Population 1998	Prevalence of Psychiatric disorders = 1-3% of General Adult Population	# Served w/State $ 1998-99	# Served Who Need Subsidized Rent	# Served Who Need Special Housing Program
Baker	12,423	124 to 373	195	146	55
Benton	61,116	611 to 1,833	469	352	132
Clackamas	242,415	2,424 to 7,272	1,742	1,307	490
Clatsop	25,453	255 to 764	721	541	203
Columbia	31,154	312 to 935	224	168	63
Coos	48,644	486 to 1,459	1,259	944	354
Crook	12,169	122 to 365	99	74	28
Curry	18,607	186 to 558	399	299	112
Deschutes	77,349	773 to 2,320	732	549	206
Douglas	74,512	745 to 2,235	1,746	1,310	491
Grant	5,709	57 to 171	52	39	15
Harney	5,425	54 to 163	27	20	8
Jackson	129,272	1,293 to 3,878	2,200	1,650	18
Jefferson	12,408	124 to 372	282	212	79
Josephine	54,902	549 to 1,647	1,092	819	307
Klamath	46,129	461 to 1,384	984	738	277
Lake	5,407	54 to 162	126	95	35
Lane	241,149	2,411 to 7,234	4,511	3,383	1,268
Lincoln	32,531	325 to 976	828	621	233
Linn	75,691	757 to 2,271	586	440	165
Malheur	20,056	201 to 602	520	390	146
Marion	198,542	1,985 to 5,956	3,299	2,474	927
HR/Was/Sh	32,834	328 to 985	705	529	198
Mor/Wh/Gil	8,973	90 to 269	22	17	6
Multnomah	487,960	4,880 to 14,639	10,469	7,852	2,942
Polk	44,027	440 to 1,321	208	156	58
Tillamook	18,383	184 to 551	394	296	111
Umatilla	48,333	483 to 1,450	587	440	165
Union	18,675	187 to 560	158	119	44

	Total Adult Population 1998	Prevalence of Psychiatric disorders = 1-3% of General Adult Population	# Served w/State $ 1998-99	# Served Who Need Subsidized Rent	# Served Who Need Special Housing Program
Wallowa	5,392	54 to 162	108	81	30
Washington	288,189	2,882 to 8,646	1,688	1,266	474
Yamhill	59,142	591 to 1,774	300	225	84
Oregon	2,442,971	24,430 to 73,289	36,732	27,549	10,322

Notes:

(1) Population estimates are for 1998 (adult age 18+ population) per Center for Population Research and Census, Portland State University.

(2) Hood River, Wasco and Sherman counties are combined due to service arrangement covering the three counties.

(3) Morrow, Wheeler and Gilliam counties are combined due to service arrangement covering the three counties.

(4) The number served in 1998 includes adults with chronic and severe mental illness receiving state-funded services of any kind unduplicated within counties between July 1, 1998 and June 30, 1999 (MHDDSD data report, 9/99).

(5) The number served in need of subsidized rent is estimated at 75 percent based on living situation and income level data.

(6) The number served in need of a specialized housing program is estimated based on the 1988 MHDDSD Residential Task Force Report, adjusted for population growth. Special housing programs include Residential Treatment Facilities and Homes, Adult Foster Care, Supported Housing, and other programs providing both affordable housing and support services.

(7) This report was compiled by the State Office of Mental Health Services, Oregon MHDDSD. To obtain additional local information, contact the local mental health service provider (number can be obtained by calling 503-945-9700).

Recommendations

Dammasch Housing Trust Fund

For implementation purposes, transfer Dammasch Housing Trust Fund to the Oregon Housing and Community Services Department (OHCSD). OHCSD should leverage other resources to expand availability of affordable housing for persons with mental disorders (this would not supplant existing OMHS Housing Trust Fund).

Recommended Timeline:
- After sale of Dammasch

Recommended Lead Implementers:
- Department of Human Services
- Oregon Housing and Community Services Department

Indicators of Success:
- Increase the number and rate of affordable housing units per county focused on individuals with mental health disorders.

Local housing plans

Require that Local Blueprint Plans include an identification of housing needs for persons with mental health disorders, and steps that will be taken to address those needs. Ensure that housing issues are also addressed in the transition from criminal justice institutions to community settings. (See Treatment recommendations.)

Recommended Timeline:
- October 2001

Recommended Lead Implementer:
- County Mental Health Authority

Indicators of Success:
- Increase the number and rate of affordable housing units per county focused on individuals with mental health disorders.

Employment and vocational training

Ensure that Local Blueprint Plans include a section on providing employment training and vocational services to persons with mental health disorders, as a part of treatment services, where appropriate. (See Treatment recommendations.)

Recommended Timeline:
- July 2002

Recommended Lead Implementer:
- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:
- Increase the percentage and number of individuals with mental health disorders who have access to educational training and/or vocational rehabilitation services.

Oregon Health Plan and Insurance

The OHP has been the single greatest factor in increasing access to needed mental health care in recent history. Treatment for diagnosed, significant mental health disorders is currently covered by the OHP, and services have increased from a short list to a broad menu of treatment options. The mental health benefits under the OHP equals or exceeds most public or private plans in the nation. Yet, for persons with the most serious mental health disorders, care based on medical necessity (as required by OHP regulations) does not recognize that recovery and rehabilitation are accomplished or enhanced through a variety of means – many of which lie outside the traditional domain of medical care (including education and school-based services and social supports such as housing and employment).

The OHP has been the single greatest factor in increasing access to needed mental health care in recent history.

There is a varying and inconsistent resource allocation for financing mental health treatment with private resources. Over the last decade, mental health benefits have declined significantly in employer sponsored insurance coverage. Spending for mental health and substance abuse benefits in the private sector has shown a growth rate significantly below that for all health care between 1987 and 1997. Consequently, the public sector has had to pick up an increasingly larger fraction

of the total cost for mental health and substance abuse treatment. Prescription drugs account for a substantial portion of the growth.

A report issued by a coalition of eight professional associations, including the American Academy of Pediatrics, American Association of Child and Adolescent Psychiatry and the National Association of Pediatric Nurse Practitioners, recommended that parity be established between medical health services and mental/behavioral health services and substance abuse services.[48] In a statement issued in September of 2000, the coalition asserts that attempts to restrain costs have decreased the availability of children's mental health services to the point that without the private commitment to increased resources "current and future needs will not be met". The report found that a decline in children's mental health care is occurring at a time when primary care doctors are identifying 7 percent to 18 percent more psychosocial problems in children than twenty years ago – and when there is increasing evidence of the effectiveness of mental health services.

President Clinton signed the Mental Health Parity Act in 1996. This Act amended the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act. The Act only applies if the employer's insurance plans have defined mental health benefits in dollar amounts that are different than the dollar aggregate lifetime limits and annual limits for other services. Employer plans that use "durational" limits (e.g. specified days) different from those applied to other medical services are not affected by the federal law. To date, twenty-six states have enacted some type of parity legislation. Oregon is not included in this group.

...Oregon has required mental health and substance abuse benefits to be included in group health insurance since the early 1980s.

However, Oregon has required mental health and substance abuse benefits to be included in group health insurance since the early 1980s. The impetus for the coverage requirement was an interim review of adolescent substance abuse needs. However, legislative deliberations led to rewriting of all mental health and substance abuse benefit requirements. This also was the period during which new emphasis was placed on outpatient and residential treatment in order to better control costs. Consequently, Oregon statute makes explicit reference to cost

containment, utilization review, and specific medical circumstances defining reimbursement for services. Rather than establishing lifetime limits, Oregon statute requires certain mental health and chemical dependency benefits every two years. (Refer to Appendix 7 for detail.)

Findings

- Over the last decade, mental health and substance abuse benefits have declined in employer sponsored insurance coverage from 6.1 percent of health care value in 1988 to 3.1 percent in 1997.

- Nearly half of private plans place limits on outpatient visits. Between 1988 and 1997 these limits decreased from 50 to 20 outpatient visits annually. The situation has been more restrictive in Oregon due to a low level of outpatient coverage required by state statute.

- The annual value of mental health benefits from employer sponsored insurance coverage declined from $152 to less than $70 over 10 years (based on 1997 dollars).

- Between 1989 and 2000 the number of children and adults served by the public mental health system in Oregon more than doubled under the OHP. Yet, there are still an estimated 12,232 Oregon adults and 11,898 Oregon children in need of public mental health services.

- While the OHP has substantially increased access to mental health care for low income Oregonians, the state has created a disparate mental health system. Oregonians who do not have access to the OHP, including those who have private insurance, often have no or substantially reduced mental health benefits – leaving them without care, or falling into whatever safety net the resources of the state and local governments can provide.

- The price of psychotropic medications is growing at an unsustainable rate, and there is no mechanism in place to assure cost control.

- The capitation system provided for in the OHP has provided many communities, particularly rural and sub-urban areas of Oregon with the opportunity for flexibility and innovation in providing mental health care. This is especially true for prevention services with children, and connections to schools.

- The managed care model has worked well in most counties.

- The lack of integration between OHP and non-OHP services has further fragmented an already disconnected series of mental health services.

- In 1996 the federal government passed a mandate for parity. The federal law only requires that dollar limits for coverage of mental health cannot be lower than dollar limits for other services. Federal law allows exclusion if states and carriers adopt durational limits.

- Oregon allows dollar and durational limits so long as they are actuarially equivalent. All carriers in Oregon currently have durational mental health limits—which exempts them from the federal mandate. (See Appendix 7 for insurance limits in Oregon Statute.)

Cost estimates differ but fall in a range of 1 percent to 4 percent cost increase for parity.

- Oregon Statute provides the following mental health limits: $13,000/2 years for adults and $15,000/2 years for children.

- The concept of "parity" is different than what Oregon has in place currently. Parity refers to equal benefit levels between physical and mental health care.

- Cost estimates differ but fall in a range of 1 percent to 4 percent cost increase for parity. Benefits of parity fall both within and outside the health system. Therefore carriers don't have the same incentives as others to reach for parity.

- There has been a 30 percent increase from 1987 to 1997 in public spending on mental health services.

- Public polls in Oregon show broad support for parity regardless of income or party affiliation. Seventy percent of

Oregonians are in favor of parity, and 75 percent of Oregonians would be willing to help bear the costs of parity.

- Seventy percent of Oregonians support parity even if it would cost their employer more money.

- Nationally, only 42 percent of costs for mental health and substance abuse treatment are covered by insurance.

- Office of Medical Assistance Programs (OMAP) contracted with Price Waterhouse Coopers for an actuarial analysis on parity where beneficiaries participate in cost sharing. The outcome was a 1.2 percent market impact on employers.

- Health care costs are increasing in double digits. The average cost is $200/empoyee/month for insurance.

- Employers have asked for limits on coverage. In response to rising costs due to parity mandates, employers report they will either drop benefits and ask employees to pick up more costs themselves, or drop family coverage.

- Employers are concerned about profit margins keeping up with costs. Adjustments are made accordingly when profits do not keep up with costs and health care coverage for employees is one place where adjustments are taken.

- Twenty-six states have enacted some type of mental health parity legislation. Appendix 8 summarizes each state's legislation, and outlines the provisions of each law.

Need and Cost for Oregon Health Plan and Private Insurance

Oregon bases the demand for publicly supported mental health services on three categories of citizens:

1. people eligible for Medicaid (OHP),
2. the uninsured, and

3. the privately insured population whose mental health coverage falls short of their treatment needs.

All persons eligible for Medicaid and uninsured persons requiring mental health services depend primarily on the public system for treatment. It is assumed that privately insured individuals who depend on the public system to supplement their private mental health benefit do so because they have an illness of a persistent or chronic nature, or because their private insurance does not cover needed treatment. Available information suggests that 32 percent of adult Oregonians with a mental health disorder, who receive treatment obtain it in private settings. The remainder (68 percent) are expected to use the public system. The OMHS estimates that 12,232 Oregon adults are in need of public mental health services, but are not receiving them.

It is estimated that 28.7 percent of Oregon children are Medicaid eligible, and that 91.5 percent of those (or 231,300) are enrolled in the OHP. This means that 26.2 percent of Oregon children can receive needed services through the OHP. Sixty-eight percent of children have private health insurance, which has some level of mental health coverage. 6.2 percent of Oregon children are uninsured with no mental health coverage. The demand for publicly supported mental health treatment is estimated using the prevalence of serious mental health disorder in the child and adolescent population that has either no insurance, or is covered by the OHP. This estimate does not include children whose private insurance does not adequately provide treatment for their mental health diagnosis. Using this method, 11,898 Oregon children are in need of public mental health services, but not receiving it.

To fully fund needed services for the 11,898 Oregon children and 12,232 adults who need public mental health services, an additional $139,685,346 for children and $90,625,665 for adults is needed – for a grand total of $230,311,011 in public funds. (See Table 7 on pages 45 and 46). This estimate does not include individuals who have inadequate mental health coverage under their private insurance.

Recommendations

Parity

Establish parity (equal benefits) for physical and mental health care.

Establish parity (equal benefits) for physical and mental health care. Statutorily establish a basic health care benefits package for private insurance based on the OHP prioritized list, with the Legislature drawing the line to establish extent of benefits. Replace statutory insurance coverage requirements that deal with treatment and diagnosis with basic benefits package based on the prioritized list.

- Basic benefits apply to group and individual coverage
- Prevention, early screening and assessment, early identification and early intervention for mental health needs are included

Recommended Timeline:
- 2001 Legislative Session

Recommended Lead Implementers:
- Legislature
- Governor's Office

Indicators of Success:
- Increase the number of Oregonians who have adequate mental health coverage as part of their insurance.

Blended funding and block grants

State-funded mental health services, including OHP, shall be administered through block grants to county mental health authorities to help fund local blueprint plans and services. Funding should be based on local needs and outcomes, and sufficient to maintain quality consistent with the range of services in the local blueprint plan. OHP benefits to Oregonians eligible for Medicaid should be based on a prioritized list, at HCFA approved levels.

Direct state agencies to allow and encourage a local mental health authority or regional organization under Chapter 190 to

enter into blended funding agreements with the state and/or providers. These agreements shall hold the organizations accountable for meeting performance standards in the expenditure of those funds.

Recommended Timeline:

- June 2002

Recommended Lead Implementer:

- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:

- Create results oriented performance measures for each part of the mental health system.

- Increase the number of organizations involved in referral, planning, funding and treatment services and supports for children and families.

- Increase the capacity of all levels of care, with priority given to those which serve the most severe or acute mental health disorders

<u>Simplify OHP enrollment</u>

Simplify OHP enrollment and re-enrollment processes to eliminate periods of non-coverage for both children and adults.

- Suspend, not eliminate, eligibility during incarceration and long-term hospitalization.

- MHDDSD and OMAP should reconcile differences in timing in enrollment between physical and mental health coverage.

- Provide coverage for one-year, eliminate six month reapplication process, as well as monthly issuance of OHP cards.

- Voluntary co-pay requirements for "new eligible" with some income and circumstantial exceptions and with no corresponding reduction in cap rates.

- Allocate resources for eligibility and enrollment.

- Allow eligibility determination of incarcerated individuals prior to release so that eligibility can be in place at release from incarceration.

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- For those not previously enrolled, direct Adult and Family Services Division (AFS) to accept and process applications for the OHP from inmates 90 days prior to their release date (or as soon as possible for individuals serving less than 90 days) with actual coverage to begin immediately upon release. OMAP may accept the address of the probation/parole authority as the permanent address of the inmate to be released.

Recommended Timeline:
- 2001 Legislative Session

Recommended Lead Implementer:
- Governor's Office
- Legislature

Indicators of Success:
- Increase the number of Oregonians who have adequate mental health coverage as part of their insurance.

<u>Subsidy for employer-based insurance</u>

For Oregonians with incomes between 100 percent and 200 percent of the federal poverty level, establish a FHIAP-like subsidy program that includes a subsidy (tax credit or tax deduction if such methods appear more feasible) for purchase of employer based health insurance based on the basic benefit package. Both employer and employee should contribute, with employee contribution scale based on income. Seek waiver(s) from HCFA to allow federal matching funds to be used on basic benefit package.

Recommended Timeline:
- 2001 Legislative Session

Recommended Lead Implementer:
- Governor's Office
- Legislature
- Congressional Delegation

Indicators of Success:
- Increase the number of Oregonians who have adequate mental health coverage as part of their insurance.

Infrastructure and the Mental Health System

Oregonians with mental health needs should find mental health treatment and supports as convenient and easy to access as any service or product they consume. The path to care should be clear and user-friendly. It should reduce, not increase, stigma. And resources should fit the individual and be provided without unnecessary delay.

Unfortunately, the infrastructure of mental health services in Oregon is ill-suited to supporting high quality, timely and cost effective services. A suitable mental health infrastructure should support the treatment system rather than constrain the use of best practices. Key infrastructure functions include:

2. the articulation of system goals and desired outcomes,

3. data and management systems to monitor and modify program approaches,

4. coordinated local and state planning,

5. administrative mechanisms which promote integrated services,

6. strategies to assure that services are responsive to the cultural needs of all racial and ethnic groups, and

7. workforce training which assures that staff have the requisite skills to make the system work.

Contributing to the difficulties in establishing a sound infrastructure is the fact that 13 different Oregon state agencies -- with responsibilities for housing, health, education, criminal justice, senior services, families, child welfare, and more -- have been identified as providing or contributing some type of mental health treatment for their clients.

To date, these 13 different state agencies have not achieved an overall agreement about how these services should be delivered or coordinated. The current infrastructure does not support an individual transitioning between service agencies. Care may not be continued in exactly the way it is needed and when it is needed. The funding for continued services is not integrated. Each funding source pays for a different type of treatment for a different type of client. As a result mental health care is often organizationally and financially fragmented, creating barriers to access and successful treatment. The reasons for this are many: categories of funding which do not fit well with other categories, multiple funding and administrative sources, conflicting priorities and standards, and poorly articulated goals and expectations toward which publicly funded mental health services should be focused. Put simply, there are many infrastructure barriers to effective and efficient treatment and not enough clarity about what Oregon's efforts to provide mental health services are trying to accomplish.

Perhaps none of these issues can be resolved without significant attention being directed toward the cultural negativity surrounding mental health disorders. Despite an increase in the knowledge of mental disorders in the United States, stigma keeps people from seeking help early enough. And at the social and public level, stigma obscures clear thinking about whether public funds should be made available--in spite of now massive evidence of the effectiveness of certain types of (though not all) mental health treatments. The 1999 Surgeon General's report points out that this is not just a matter of public education, since the public now knows more about mental illnesses than 30 years ago. It has to do with attitude changes, which are known to be

the product of both information and contact with real people in recovery. A sound infrastructure for mental health services must take into consideration the continued challenge of public education.

Another barrier and challenge for an improved infrastructure is that of racial and ethnic sensitivity in the organization and delivery of mental health services. The Surgeon General's report states, "The U. S. mental health system has not been very responsive to the needs of racial and ethnic minorities." Cultural and ethnic minorities are disproportionately represented in lower socioeconomic groups. Research has shown that lower socioeconomic status, income, education and occupation are strongly associated with increased risk for psychiatric disabilities. Culturally appropriate practices must be an integral part of the design, implementation and ongoing operation of any system of mental health services.

Although mental health disorders are not primary causes of other social policy concerns (such as poverty, criminal activity, child abuse, alcohol and drug abuse) the mental disorders greatly complicate the successful resolution of the other social policy concerns. The term "hydraulic" is useful in understanding the interconnectedness of mental health services and these significant social policy concerns. "Hydraulic" suggests that when pressure is applied in one place, the effects are transferred or felt somewhere else. This principle works in either direction--ignoring one set of problems makes another set worse; and conversely, resolving one set of problems either reduces the need for assistance in other areas or allows the assistance to be more effective. Therefore, earlier and easier access to mental health services will reduce pressures on just about every other social burden of concern to the state. Of course, later and more inaccessible services simply add to the burden of every other social agency.

Only a coordinated approach that recognizes, responds to, and helps people recover—and that is supported by key infrastructure components—will ensure any reduction in the sobering statistics associated with mental health disorders. Any effort to improve mental health infrastructure must include

Any effort to improve mental health infrastructure must include consumers and families as equal partners.

consumers and families as equal partners. Oregon currently does not have the necessary infrastructure components—such as data systems, consistent criteria for care, worker training and grievance procedures—to support an efficient and effective system of mental health care. Investment in needed infrastructure is a necessary foundation for quality mental health services. It will ultimately result in decreased recidivism and reduced utilization of more intensive services. It will ensure the most cost-effective use of state, local and private resources. And it will create the opportunity for collaborative approaches that cross traditional boundaries of state and local agencies.

Findings

- Thirteen different state agencies provide or contribute to some type of mental health treatment for their clients.

- Mental health disorders have a broad hydraulic impact on many other issues and agencies. For example, untreated mental health problems affect a significant number of the clients seen in state agencies, including:

  › 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,[49] and
  › 70 percent of youth incarcerated in a state juvenile correctional institution.[50]

- Funding, programs and administration are fragmented among agencies providing mental health treatment. This does not serve clients well, and is not an efficient use of resources.

- Consumers and families often lack an orientation to mental health services, what is offered and how to access services. In addition, there is not a consistent and accessible grievance process that is independent of the organizations providing services.

- While consumer run programs and support networks for family members exist in some communities, they are not consistently available and there is inadequate support for them. Yet, these services and supports are critical to successful outcomes for individuals with mental health disorders.

- There is significant concern about the state of mental health services in Multnomah County. Funding, service and organizational fragmentation seems to be exacerbated in this county.

- Oregon has an inadequate data system to track system accountability and outcomes for client services. Local mental health organizations seem especially interested in infrastructure support for data collection and accountability.

- Mental health and alcohol and drug organizations share a large number of clients. Yet, these clients must go through separate but similar processes to receive services in each system.

- Local communities report difficulty in working with the state and federal governments to remove barriers to collaboration.

- State agencies do not consistently hold contractors accountable for producing results and records in a timely manner.

- There is a lack of fiscal, administrative and service coordination among DHS divisions, resulting in increased fragmentation and paperwork at the local level and the lack of ability to adequately track funding and outcomes at the state level.

- Direct line service providers have significantly lower wages resulting in high turnover among staff.

- There are no consistent outcomes or performance indicators measured across mental health services.

- The DHS has accepted and plans to implement the recommendations of a "Dual Diagnosis" task force. These recommendations include a framework for targeting services, common administrative tools, guidelines for performance-based contracts, training standards, improved services for children and adolescents, review of cultural competency standards, development of collaborative policies and programs with the criminal justice system, and identification of gaps and deficiencies.

- With the exception of Asian-Americans, most racial minorities are disproportionately represented in the population receiving public mental health services compared to their representation in the general population. (Refer to Table 3 on page 31).

- According to an ongoing survey of the Residential Providers Association, 75 percent of staff in residential treatment programs turnover each year.

- 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.

Recommendations

Performance measures

State MHDDSD should develop or adopt nationally recognized system-level performance measures linked to Oregon Benchmarks for state-level monitoring and reporting for both children and adults. The domains to be covered shall at least include access, quality/appropriateness, outcomes, structure/plan management, prevention, education/outreach, and integration.

- The state should cause the Local Mental Health Authority (LMHA) to develop an area-wide quality improvement plan for all state-funded services including relative performance

measures from the statewide framework and others locally derived. The LMHA should monitor the results of the performance measure through a local Quality Improvement Committee composed of broadly representative stakeholders.

- A state level Quality Improvement Committee, comprised of broadly representative stakeholders with a majority of consumers and family members, should monitor the performance and effectiveness of the local Quality Improvement Committees and the system performance measures as a whole, and report annually to LMHAs, the MHDDSD, the Governor, all stakeholders and the public.

- Implement a process by which local mental health authorities certify that performance standards specified in state-county, MHO-state agreements and local plans are met or exceeded, including meaningful input from advisory committees.

- The state shall develop graduated sanctions in the event LMHA performance is unacceptable and fails to improve over a reasonable time.

Recommended Timeline:
- July 2002

Recommended Lead Implementers:
- Mental Health and Developmental Disability Services Division, Department of Human Services
- Local Mental Health Authority

Indicators of Success:
- Create results oriented performance measures for each part of the mental health system.

- Increase the number of insurers (including OHP) who require best practices in provider contracts and monitor compliance with best practices.

Data system

Create a seamless data system with the characteristics listed below. Form an adequately funded and staffed "information system guidance committee" to create the plan, including cost estimates.

- Common data elements and documents across state, county and provider,

- connectivity to other related state and local systems, including physical health,

- up-to-date and timely information,

- consistent instrumentation,

- incorporate, integrate and align with current statewide efforts,

- include demographics, data collection protocols, performance measure information,

- aggregate data and report to locals, Legislature and Governor,

- broad stakeholder involvement,

- sharing social service, mental health and criminal justice data with strictly controlled access and confidentiality,

- eliminate duplicate entries, and

- timely performance data from the state to local mental health authorities regarding their performance.

Recommended Timeline:
- July 2001 formation of a guidance committee
- July 2002 implement plan

Recommended Lead Implementers:
- Information and Resource Management Division, Department of Administrative Services
- Department of Human Services Office of Information Systems
- Private Sector
- High Tech Partners

Indicators of Success:
- Create results oriented performance measures for each part of the mental health system.

Administrative integration

When local mental health services are funded or provided in conjunction with other related services (such as substance abuse, education, corrections, etc.) the following administrative functions should be integrated. To accomplish this, the Governor should propose legislation and direct the following state agencies -- DHS, OYA, ODE, and DOC-- to recommend statutory changes and make necessary administrative changes.

- Single site visits
- Single client records which satisfy multi-agency requirements
- Unified billing codes (HIPAA)
- Unified paperwork to document required activities

Recommended Timeline:
- One month after adoption of order to agencies
- January 2003 implement changes

Recommended Lead Implementers:
- Governor's Office
- Department of Administrative Services
- State agencies

Indicators of Success:
- Create results oriented performance measures for each part of the mental health system.

- Decrease the average length of time in each county between referral and first service contact.

State comprehensive plan

The State shall develop a comprehensive state mental health plan that is consistent with the vision, goals and recommendations of the MHAWG and derived from the needs identified in local plans.

Recommended Timeline:
- July 2005

Recommended Lead Implementer:
- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:
- Create results oriented performance measures for each part of the mental health system.

- Increase the number of organizations involved in referral, planning, funding and treating services and supports for children and families.

- Increase the capacity of all levels of care, with priority given to those which serve the most severe or acute mental health disorders.

Workforce needs

Convene a group of stakeholders to identify a set of core mental health and cultural competencies and develop training curriculum to be used across systems, including cross training of direct service providers in dual diagnosis. The stakeholders will determine the need to revise statutes and administrative rules to require certain credentials for those who provide mental health services for children and adults.

The core competencies should include:

- skills in interagency collaboration at the state and local levels,

- skills in working as part of interdisciplinary teams at the care planning level,

- leadership and supervision skills in mental health agencies, and

- an understanding of and adherence to mental health service ethics.

To support and develop a high quality workforce, the state should:

- ensure the delivery of joint mental health/alcohol and drug training,

- ensure that culturally and linguistically competent and qualified staff provide services,

- conduct a comprehensive study and analysis of the needs of the mental health workforce,

- allocate new resources for the recruitment, retention and remuneration of the mental health workforce, based on results of the study, and

- review needs for mental health services for children and adults, then broaden current statutes and administrative rules to allow for delineation and assignment of workforce responsibilities based on a matrix which correlates service, competency and experience and formal preparation.

Recommended Timeline:

- January 2002 construct matrix

- January 2003 conduct study, revise rules based on matrix

- January 2004 training across systems

- January 2005 budget

Recommended Lead Implementers:
- Department of Administrative Services

- Mental Health and Developmental Disability Services Division, Department of Human Services

- Office of Alcohol and Drug Abuse Programs, Department of Human Services

Indicators of Success:
- Increase the number of insurers (including OHP) who require best practices in provider contracts and monitor compliance with best practices.

- Increase the number of consumers and families satisfied with treatment and connection to needed social supports.

- Create results oriented performance measures for each part of the mental health system.

- Reduce staff turnover.

<u>Public education</u>

The Governor should form a consortium of public and private groups who provide public education in Oregon to develop and implement an education and outreach strategy to remove from public perception the stigma associated with mental health disorders. This should include a "social marketing" approach that leverages private and community support.

Recommended Timeline:
- Six months after adoption

Recommended Lead Implementer:
- Governor's Office

Indicators of Success:

- Decrease the number of Oregonians who believe those with mental health disorders pose a public safety threat.

Ombudsperson office

Establish an independent, adequately funded mental health ombudsperson office for children and adult mental health issues. The office should have statutory authority to collect information and publish reports. The ombuds shall develop local points of access to ombuds services and shall conduct appropriate public education. An advisory committee broadly representative of all stakeholders should guide implementation of the recommendation.

Recommended Timeline:

- 2001 Legislative Session
- 2003 for rules and processes

Recommended Lead Implementers:

- Governor's Office
- Legislature

Indicators of Success:

- Increase the number of consumers and families who are treated with dignity and respect.

- Create an independent, accessible grievance process.

Abuse/neglect and safety

Building on existing statutes, develop a comprehensive abuse/neglect and safety policy applicable to all service levels for adults and children, which includes the following:

- train and certify users at all levels,

- delineation of state, law enforcement, county, and allied agency roles and responsibilities,

- requirements and protocols for complete, meaningful independent written investigations,

- timelines for completion of investigations and implementation of corrective action,

- specification of reportable incidents and thresholds for automatic investigation,

- requirement of root cause analysis of incidents,

- provisions to balance openness and confidentiality, and

- provision for limited liability shield, conditioned on provider response leading to corrective action (but nonetheless holding providers accountable).

Recommended Timeline:
- July 2002

Recommended Lead Implementer:
- Mental Health and Developmental Disability Services Division, Department of Human Services

Indicators of Success:
- Increase the number of consumers and families who are treated with dignity and respect.

- Create an independent, accessible grievance process.

Timeline for Recommendations

Particularly for the infrastructure and system-related recommendations, there is a logical and appropriate sequence for implementation. Some recommendations will naturally need to be implemented prior to the others. The MHAWG recommends implementing the recommendations according to the schedule shown on Table 9.

Table 9

Mental Health Alignment Workgroup
Timeline for Priority Recommendations

Recommendation	Jan 2001	July 2001	Jan 2002	July 2002	Jan 2003	July 2003	Jan 2004	July 2004	Jan 2005	July 2005
Legislative Action										
Establish an independent ombudsperson office Legislation *(begin)* Rules and processes *(complete)*	X				X					
Establish equal benefits for mental health and physical health (parity) *(begin)*	X									
Simplify OHP enrollment process and eliminate periods of non-coverage *(begin)*	X									
Establish a FHIAP-like subsidy program for purchase of employer-based insurance, based on a basic benefit package *(begin)*	X									
For implementation purposes, transfer Dammasch Housing Trust Fund to OHCSD to leverage and grow *(begin)*	X									
Local Biennial Blueprint Plan *(begin)*	X									
Planning										
Local Biennial Blueprint Plan State guidelines *(completed)* Plans due *(partial completion)* Partial implementation begins *(begin)* Expanded plan guidelines *(complete)* Expanded plans due *(completed)* Full implementation *(begin)*		X	X		X	X	X		X	
LMHA and Local Public Safety Coordinating Council shall work together to address the interface between law enforcement and mental health. Becomes a part of the local blueprint plan. Corrections (state) to work with local mental health to develop release plans. First phase *(begin)* Second phase, expanded guidelines *(complete)*		X			X					

Recommendation	Jan 2001	July 2001	Jan 2002	July 2002	Jan 2003	July 2003	Jan 2004	July 2004	Jan 2005	July 2005
Recommendation										
Develop or adopt statewide performance measures and allow for additional local measures. Needs to coordinate with data system work Start work *(begin)* Distribute with Feb 03 expanded guidelines *(complete)*		X			X					
Develop standardized levels of care criteria linked to local plans *(complete)*				X						
Provide public mental health funds, including OHP, through a block grant for the purpose of implementing local plans, and encourage LMHA to enter into "blended funding" agreements with state and providers. (OHP waiver amendment may be needed) *(begin)*						X				
Develop a state comprehensive plan consistent with MHAWG and derived from local plans *(complete)*										X
Administrative										
Governor and state agencies to make changes necessary to integrate administrative functions to support local service delivery. Governor directive *(begin)* Agencies to implement *(complete)*	X				X					
Create a seamless data system using an "information system guidance committee" to inform the process. Create committee *(begin)* 2003 Legislature for first phase funds *(begin implementation)*		X			X					
Develop or adopt statewide performance measures and allow for additional local measures. Needs to coordinate with data system work. Start work *(begin)* Distribute with Feb 03 expanded guidelines *(complete)*		X			X					
Establish a developmentally appropriate screening tool for children and adolescents. *(complete)*					X					

Recommendation	Jan 2001	July 2001	Jan 2002	July 2002	Jan 2003	July 2003	Jan 2004	July 2004	Jan 2005	July 2005
Provide public mental health funds, including OHP, through a block grant for the purpose of implementing local plans, and encourage LMHA to enter into "blended funding" agreements with state and providers (OHP waiver amendment) *(begin)*						X				

Education

Form a consortium of public and private groups to provide public education *(begin)*		X								
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 systems. Study *(complete)* Rules revision *(complete)* Training *(begin)* Budget *(complete)*				X		X X X				
Develop abuse/neglect and safety policy. *(complete)*				X						

Conclusion

The recommendations contained in this report, implemented over time, will enable Oregon to create a more ideal mental health system for children, families and adults and will ensure the best possible outcomes for those individuals 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 focuses on identifying mental health disorders as early in a person's life as possible and providing needed 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 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.

Appendices

Appendix 1

Mental Health Alignment Work Group
Membership Roster
and Their Representation

Carolyne Adams
Consumers

Mariana Bornholdt
Governor's Commission on Senior Services

Doris Cameron-Minard Ed.D
NAMI-Oregon

Jan Campbell
Oregon Disabilities Commission

Bob Cattoche
Local school district mental health coordinator

Phillip D. Chadsey
NAMI-Oregon

Phil Cox
Oregon Youth Authority

Pam Curtis
Facilitator

Daniel Eslinger, PMHNP
Private Medical

Gary Field
Department of Corrections

Kevin Fitts
Consumers

Jan Friedman
Citizens/Advocates

Barbara Friesen
University/Researcher

Bill Garrard
Association of Oregon Counties

Virginia Garrison
Consumers

Mark Gibson
Chair
Governor's Office

Senator Avel Gordly
Legislators

Judge Dennis Graves
Judges

Allen Hunt
Community non-profit & providers

Steve Johnson
Oregon Department of Education

Sharron Kelley
Association of Oregon Counties

Representative Jeff Kruse
Legislators

Don Leslie, President
NAMI-Lane County

Robert Lieberman
Provider

Robert C. Luther, M.D
Oregon Psychiatric Assn.

Scott Manchester
Office of Health Plan Policy and Research

Scott McKay
Association of Oregon Counties

Donna Middleton
Oregon Commission on Children and Families

Kim Miller
Housing provider

Richard Miller
Tribal Governments

Bobby Mink
Department of Human Services

George Naughton
Dept. of Administrative Services, Budget and Management

Sheriff John O'Brien
Sheriffs Association

Madeline Olson
Mental Health & Developmental Disability Services Division

Dale Penn
District Attorney Association

Connie Powell
Private Medical

Linda Reilly
Family members, parents

Rob Roy
Community non-profit & providers

Jim Russell
Executive Manager Managed Care Organizations

Callie Schlippert
Family members, parents

Mickey Serice
State Office of Services to Children and Families

Peter Shepherd, Special Counsel
Department of Justice

Gary Smith
Local Mental Health Directors

Kathy Spear
Office of Alcohol and Drug Abuse Programs

Barney Speight
Fully Capitated Health Plan

Georgia Stewart
Juvenile Directors Association

Lt. Robert W. Sundstrom
Oregon State Police

Cheryl Thorp
Association of Oregon Counties

Betty Turner
Consumers

Gustavo Wilson
Oregon Housing and Community Services Department

Janet Yu
Consumers

Norma Zabransky
Family members, parents

Appendix 2

Governor's Mental Health Alignment Work Group
DRAFT Work Plan

Mark Gibson, Chair
Pam Curtis, Facilitator

February 2-4

- Introductions
- Introduction to the Oregon Strategy for Social Support
- Purpose and Scope of Mental Health Alignment Work Group
- Review Tasks/Work Plan
- Set Ground Rules & Principles for working together
- Review History of Mental Health Services in Oregon
- Review ORS related to mental health
- Presentations on mental health services and findings:
  - › DHS Mental Health and Developmental Disability Services Division
  - › Oregon Health Plan
  - › Public Safety Review Board
  - › Surgeon General's Report
  - › The Oregonian
  - › Presentations on previous and existing mental health task forces
  - › Margaret Carter Task Force on Mental Health
  - › OHP Task Force on Mental Health
  - › Legislative Interim task forces
    - Review state agency mental health services
    - Identify issues
    - Homework assignment

March 16-17

- Introductions
- Review principles and groundrules
- Recap February meeting
- Report on homework assignment
- Presentation on "special focus" task forces
  - › Adjudicated Youth
  - › A&D Treatment Alignment
  - › DHS community forums
  - › Homework assignment

April 19-21

- Introductions
- Review work plan, principles and ground rules

- Recap March meeting
- Complete homework assignment
- Presentation on "special focus" task forces
- Dual Diagnosis
- Complete work on goals. Link to Oregon Benchmarks
- Outline principles for the "ideal system", considering
  - › Public & private roles
  - › Principles from SSIWG
  - › Integration with workforce and schools
  - › Local partners
  - › Etc.
    - Identify key system components
    - Identify goals and indicators for ideal mental health system
- Plan for regional meetings or focus groups
- Homework assignment

May 18-19

- Introductions
- Review work plan, principles and ground rules
- Recap April meeting
- Complete homework assignment
- Report from focus groups
- Adjustments to the work based on focus groups
- Presentations on model services

June 8-9

- Introductions
- Review work plan, principles and ground rules
- Recap May meeting
- Report from focus groups
- Complete homework assignment
- Identify areas for "re-tooling"
- Compare ideal system to current services matrix
- Homework assignment

July 19-21

- Introductions
- Review workplan, principles and groundrules
- Recap June meeting
- Complete homework assignment
- Homework assignment

August

(no meeting)

September 21-22

- Introductions
- Review workplan, principles and groundrules
- Recap July meeting
- Begin development of a recommendations to address:
  - Re-tool areas
  - Gaps
  - Barriers
  - Local, family and consumer involvement
  - Shifting state roles
  - Coordination
  - Other
- Complete homework assignment
- Continue recommendations and memo budget development
- Plan for community forums

October 19-20

- Introductions
- Review work plan, principles and ground rules
- Recap September meeting
- Presentation on upcoming budget scenario
- Complete homework assignment
- Review information from community meetings
- Complete recommendations

November 8-10

- Introductions
- Review work plan, principles and ground rules
- Recap October meeting
- Finishing touches on recommendations from each sub-committee
- Review all recommendations and prioritize them
- Complete homework assignment

December 14

- Finalize the work group report to the Governor
- Implementation planning
- **Celebrate!**

Appendix 3

Key Speakers before the Mental Health Alignment Work Group

February Meeting

- Bob Nikkel, Deputy Assistant Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services
- Madeline Olson, Assistant Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services
- Barry Kast, Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services
- Scott Manchester, Special Projects, Office of Health Plan Policy and Research
- Elsa Porter, Chair, Multnomah County Mental Health Task Force
- Mick McCracken, Staff, Multnomah County Mental Health Task Force
- Sandy Hayden, Member, Multnomah County Mental Health Task Force
- Michele Roberts, Reporter, The Oregonian
- Mark Larabee, Reporter, The Oregonian
- Karen Smith, Staff, Senate Majority Office
- Anne Tweedt, Bristol Myers Squibb

March Meeting

- Troy Simms, Consumer, Portland
- Drake Ewbank, Consumer, Eugene
- Nancy Hugo, Consumer, Corvallis
- Dr. Ron Heinz, adult treatment, Oregon State Hospital
- Dr. Michael Duran, child/adolescent treatment, Oregon State Hospital
- Bob Nikkel, Deputy Assistant Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services
- Brian Florip, Community Programs Manager, Oregon Youth Authority
- Stan Mendenhall, Juvenile Department Director, Columbia County
- Gwen Grams, Manager for Planning, Evaluation, Research and Technology Unit, Office of Alcohol and Drug Abuse Programs, Department of Human Services
- Steve Broich, Family member, Corvallis
- Kenneth (Skip) Klarquist, Family member, Portland
- Rebecca Eichhorn, Family member, Newberg
- Audrey K. Harris, Family member, Lane County

April Meeting

- Pat Risser, Consumer
- Dave Romprey, Consumer
- Cecelia Vergaretti, Staff, Mental Health Association of Oregon
- Barbara Bolstad, Clackamas County Education Service District
- Michael Taylor, Clackamas County Mental Health Department

- Diane Hensley, Bend-LaPine School District
- Donna Pearson, Bend-LaPine School District
- Judi Edwards, Linn-Benton-Lincoln Education Service District
- Stephen Alexander, Oregon Department of Education
- Elsa Porter, Chair, Multnomah County Mental Health Task Force
- Mike McCracken, Staff, Multnomah County Mental Health Task Force
- Madeline Olson, Assistant Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services
- Barbara Cimaglio, Administrator, Office of Alcohol and Drug Abuse Programs, Department of Human Services
- Barry Kast, Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services

May Meeting

- Rachel Post, IPS+ Program
- Jeff Krolick, IPS+ Program
- Robert Roy, Director, Trillium Family Services
- Janet Bardossi, Program Manager, RITS,
- Laurie Ellett, Program Coordinator, RITS,
- Dr. Peter Davidson, Greater Oregon Behavioral Healthcare, Inc.
- Jane Alm, Office of Medical Assistance Programs, Department of Human Services
- Kyleen Gower, Mental Health and Developmental Disability Services Division, Department of Human Services
- Michael Stickler, Mental Health and Developmental Disability Services Division, Department of Human Services
- Jim Russell, Mid-Valley Behavioral Care Network

June Meeting

- Lolenzo Poe, Director, Multnomah County Department of Community and Family Services
- Gina Mattioda, Director, Office of Public Affairs
- Janice Gratten, Clinical Director, Multnomah County Behavioral Services
- Denise Chuckovich, Deputy Director, Multnomah County Department of Community and Family Services
- Gary Smith, Director, Deschutes County Mental Health Department
- Jim Russell, Director, Mid-Valley Behavioral Care Network
- Sharon Guidera, Director, Mid-Columbia Center for Living
- Melinda Mowery, Director, Clackamas County Mental Health Department
- Chris Johnson, Director, Yamhill County Health and Human Services
- Patty Chamberlain, Oregon Social Learning Center
- Officer Ed Riddell, CIT Coordinator, Portland Police Bureau
- Barney Speight, Kaiser Permanente
- Dr. Keith Griffin, Associate Medical Director, Kaiser Permanente Mental Health Program
- Magnus Lakovics, Providence Health Plan
- Cindy Bowling, Blue Cross Blue Shield of Oregon

- Jay Roberts, LCSW, Blue Cross Blue Shield of Oregon
- Barry Kast, Administrator, Mental Health and Developmental Disability Services Division, Department of Human Services

July Meeting

- Joel Ario, Deputy Insurance Commissioner, Department of Consumer and Business Services
- Scott Gallant, Oregon Medical Association
- Ross Dwinell, President, Western Benefits, Inc.
- Holly Echo Hawk Solie, Senior Consultant, Nation Indian Child Welfare Association

September Meeting

- David Wertheimer, Consultant and former Service and System Integration Administrator, King County Department of Community and Human Services

October Meeting

- Theresa McHugh, State Budget Director, Department of Administrative Services

Appendix 4

Spring 2000 Mental Health Community Forums

Date	Target group	Locale	Convener
April 27th	Community Mental Health Program Directors	Kah-Nee-Ta	Chris Johnson
April 28th	Physicians		Connie Powell
May 8th	MHDDSD staff	Salem	Madeline Olson
May 10th	Oregon Indian Commission on Addictions	Red Lion in Eugene	Richard Miller
May 11th	Alcohol and Drug Program Directors Association of Oregon (ADAPDAO)	Annual retreat in Yachats	Kathy Spear
May 11th	Mental Health Organizations	Salem area	Jim Russell
May 11th	Law enforcement, sheriffs, chiefs, district attorneys, deputy district attorneys, others	Justice Building, West Salem	John O'Brien, Peter Shepherd, and Dale Penn
May 13th	NAMI Board, NAMI affiliates in Marion County	2620 Greenway Drive NE, Salem	Doris Cameron-Minard
May 15th	North and Southern Region School Personnel and Parents		Bob Cattoche and Steve Johnson
May 15th	Polk County Mental Health, public forum, mental health coalition (consumer based group)		Mariana Bornholdt
May 15th	Nonprofit community providers	Network Behavioral HealthCare Portland	Allen Hunt
May 16th	CASAs, CRBs, Foster Parent Assn., regional SCF consultants	OCCF Conf. Rm. Salem	Mickey Serice

Date	Target group	Locale	Convener
May 17th	Family Support Teams	Quarterly meeting in Keizer	Kathy Spear
May 17th	Juvenile Directors	Sisters area	Georgia Stewart
May 18th	Oregon Health Council (not public)	Clackamas Com. College, Wilsonville	Scott Manchester
May 22nd	State juvenile corrections	Rogue Valley Youth Center Grants Pass	Phil Cox
May 23rd	Consumers and advocates in Metro Area	Oregon Advocacy Center, Portland	Jan Friedman
May 24th	Jackson County	Jackson County Courthouse	Dr. Bob Luther, Kathy Ingram, and Ron Gardner
May 25th	Oregon Family Support Network	Adolescent Day Treatment Ctr. Oregon City	Callie Schlippert
May 31st	Consumers and providers in Josephine County	Anne Basker Auditorium Grants Pass	Kim Miller and Bob Lieberman
Late May	Wasco County government, AOC, constituents	The Dalles	Commissioner Scott McKay
Late May	Researchers, evaluators	Internet-based	Barbara Friesen
June 1st	NAMI Board, NAMI affiliates in Yamhill County	625 N Gallaway, McMinnville	Doris Cameron-Minard
June 6th	NAMI Board, NAMI affiliates in Clackamas County	Oregon City Evangelical Church, Oregon City	Doris Cameron-Minard
June 2nd and 9th	Community Action Agencies, Community Development Corporations and housing providers	Hood River	Gustavo Wilson

Date	Target group	Locale	Convener
June 12th	Clinicians, case managers, providers	Network Behavioral HealthCare Portland	Allen Hunt
June 20th	Douglas County constituents	Douglas County Library	Representative Jeff Kruse
June 22nd	NAMI Board, NAMI affiliates in Multnomah County	Multnomah County Library, Portland	Doris Cameron-Minard
Mid-June	Consumers and providers in Umatilla County		Daniel Eslinger
June	Governor's Commission on Senior Services, Long Term Care Ombudsmen	Salem	Mariana Bornholdt
June	Curry County population	Gold Beach	Commissioner Cheryl Thorp
Late June	Alcohol and drug providers and public safety organizations	Portland	Commissioner Sharron Kelley

Fall 2000 Mental Health Community Forums

Date	Target group	Locale	Convener
August 11th	Governor's Commission on Senior Services	Roth's - West Salem	Mariana Bornholdt
August 21st	Mental Health Director's Association		Gary Smith
August 23rd	Consumers and family members	Adolescent Day Treatment Center in Oregon	Callie Schlippert
August 25th	Long-Term Care Advisory Committee	Village East Office Complex, Salem	Mariana Bornholdt

Date	Target group	Locale	Convener
August 30th	Child welfare partners	SCF Salem	Mickey Serice
September 7th	OYA Executive Policy Council	OYA Salem	Phil Cox
September 11th	Portland Metro community mental health providers	Multnomah County Library, Portland	Allen Hunt and Rob Roy
September 14th	Mental health organizations	Sun River	Jim Russell
September 25th	Portland Metro community mental health providers	Multnomah County Library, Portland	Allen Hunt and Rob Roy
September 25th	Klamath County constituents	Courthouse Klamath Falls	Klamath County Mental Health
September 28th	Consumers, ex-patients, survivors and advocates	Oregon Advocacy Center, Portland	Jan Friedman and Betty Turner
September 29th	Local law enforcement		John O'Brien, Dale Penn, and Pete Shepherd
September	MHDDSD staff		Madeline Olson
September	Oregon Health Council, Mental Health Sub-committee of Health Services Commission		Scott Manchester
September	Mental Health Organizations		Jim Russell
Late September	Oregon Medical Association		Connie Powell
Early October	NAMI-Multnomah County	Portland	Phil Chadsey
October 4th	ADAPDAO members		Kathy Spear
October 4th	Consumers, providers, family members and other interested parties	Head Start Conference Rm, Pendleton	Norma Zabransky and Daniel Eslinger

Date	Target group	Locale	Convener
October	Douglas County system	Roseburg	Representative Jeff Kruse
October	Consumers, Providers, Advocates in Medford/Grants Pass area	Grants Pass	Carlyne Adams, Kim Miller and Bob Lieberman
October	Oregon Family Support Network, NAMI		Linda Reilly and Doris Cameron-Minard
October	Klamath County system, NAMI	Klamath Falls	Commissioner Bill Garrard

Appendix 5

Summary of Spring Community Forums

The summary reflects 24 community forums hosted by 29 work group members. 522 people attended these forums. Targeted audiences ranged from community at-large, to consumers, family members, medical providers, stakeholders and providers of mental health services. Because of the broad range of target audiences, and numbers of people attending, many specific issues were raised. This Executive Summary outlines those issues that were raised by participants at least three forums. The Summary of community forums contains an outline of all comments made.

Key Concerns and Findings

Infrastructure related:

- Agencies don't hold contractors accountable for producing results and records in a timely manner.
- Services should be blended and integrated.
- Lack of fiscal, administrative and service coordination among DHS divisions.
- Lack of caring, empathetic care-givers/providers.
- High turnover among staff and case managers.
- Low wage scale for private providers (20-30% below public agencies).
- Need to track where/how resources are spent. They are currently inefficient.
- Mental illness has a broad hydraulic impact.
- The system is complex and not functioning well.
- Excessive paperwork required by DHS.
- The current system promotes fragmentation.
- Mental health system in Multnomah County is in crisis.

OHP/Insurance related:

- Agency staff and consumers do not know what coverage is available and how to access what is available.

- There is inadequate support for safety net clinics.

- Resource incentives are not aligned with the best interest of the patient.

- OHP is seriously underfunded. Resources for mental health treatment have been reduced.

- Mental health benefit package is inadequate to prevent escalation in the system.

- When the state allows 30% to be taken for administration and management at the local level, it takes away from the clinical level and promotes additional layers in the HMO.

- Large gap between those who qualify for OHP and those who can pay for treatment.

- Lack of parity with physical health coverage.

- Lack of parity creates a cost shift to the public system.

Children related:

- Local options for respite care and residential services are lacking.

- Crisis and acute care, and secure residential treatment are not available statewide.

- Resources are woefully inadequate in children's mental health – and a disparity exists with adult mental health.

- MR/DD children with mental illness are underserved.

- Families should be participating in treatment, but information and services are often not available. Managed care is not "family friendly".

- Lack of attention to early intervention.

- Lack of child psychiatrists and trained child care workers.

Adult related:

- Local options for respite and residential care are lacking.

- Lack of acute care beds drives up law enforcement costs, and backs up waiting lists for the state hospital.

- Jails are not staffed to treat mentally ill.

- Lack of coordination/integration between mental health and alcohol and drug is harmful to consumers.

Community Supports related:

- More housing is needed – especially variety and intensity of housing settings.
- More information is needed to decrease the stigma of mental illness.

Other Findings:

- Mental health system is a "default" system.

Key Recommendations

Infrastructure related:

- Systematic training for caregivers, case managers, PCPs and corrections employees.
- Establish consistent standards for care, including community settings. Follow up with inspections to ensure standards are met.
- Put information about providers and their success rates on a centralized website.
- Hold providers accountable for outcomes.
- Tie reimbursement to outcomes.
- Develop a good, centralized data system – with adequate confidentiality and data across all levels of the system.
- Develop a release of information form across all human services settings, or another mechanism that will allow easy information sharing.
- Combine the administration of OADAP and MHDDSD.
- Do not combine OADAP and MHDDSD. Integrate services, but not administration.
- Conduct research to determine, then require, best practices.
- Consolidate and integrate funding silos.
- Resources should follow the consumer/family, NOT the program or provider.

- Pool resources for children's behavioral-social problems (such as substance abuse, child welfare, education, etc.)

OHP/Insurance related:

- Standardize payer rules or go to a single payer system.

- Integrate funding to decrease fragmentation. Establish incentives to integrate funds of counties and providers and/or physical, mental and A&D.

- Decrease cost of pharmaceuticals. Can this be done through group purchasing?

- Increase private insurance coverage (parity).

- Tie reimbursement to outcomes.

- Establish universal healthcare.

Children related:

- Adapt to the needs of the child/family by providing services in their world, rather than a "clinical model" or adult model.

- Provide a comprehensive assessment for all children and families entering into an agency's service, then offer all services recommended.

- Assign a single coordinator to work with each child/family to advocate for services and get needs met. This coordinator should follow the family/child wherever they go in the system.

- Integrate and support families at all levels of MH services.

- Increase access to Therapeutic Foster Care and training for foster parents.

- Address the needs of homeless youth.

- Integrate services and develop partnerships.

- Invest more in prevention and early intervention – including community activities for kids.

- Emphasize prevention.

- Pool resources for children's behavioral-social problems (such as substance abuse, child welfare, education, etc.)

- Ensure a variety of therapeutic approaches and settings.

- Develop a secure mental health forensics unit for chronically ill adjudicated youth that pose a significant public safety risk.

- Support school-based mental health services, and include early identification.

- Resources should follow the child, not the provider.

Adult related:

- Integrate and support families at all levels of MH services.

- Train corrections staff to be skilled and competent in dealing with people with mental illness.

- Establish consumer activity centers and peer counseling services.

- Apply research on treatment efficacy. Encourage and support what works best.

- Resources should follow the child, not the provider.

- Provide comprehensive and integrated services.

- Integrate A&D and mental health treatment, funding, administrative rules and paperwork.

- Coordinate and integrate efforts of multi-agency families. Take a holistic approach, not just symptom management.

Community Supports related:

- Create more community-based housing with a range of housing types in every community, including drug-free.

- Establish employment supports.

- Public education campaign is critical to de-stigmatizing mental illness (and it should be ongoing).

- Ensure community supports include multiple levels of support, including recreation and social connections (think holistically).

- Integrate housing with employment services and other supports.

- Provide transportation in rural areas.

- Support consumer-based services.

Overall:

- Limit/focus the number of recommendations so they are doable and we can be successful in achieving lasting change.

- Do not look to Multnomah County as a model for the state.

Summary of Fall Community Forums

Fifteen Community Forums were held between August and October. They were hosted by seventeen Work Group Members and attended by 271 consumers, family members, professionals and citizens. The Summary below outlines those recommendations that were common in at least three (or 20%) of the community forums.

Infrastructure:

- Conduct a community education campaign that involves parents, consumers and professionals. Use TV/media. The goal of the campaign should be to end discrimination and understand mental illness.

- Provide incentives to increase the number of child psychiatrists.

- Integrate mental health and chemical dependency services aggressively and speedily at both the state and local levels. Create one full service behavioral health contract for locals, and provide incentives for integration.

- De-categorize state funding – especially mental health, alcohol and drug and OHP.

- Integrate funding for the state hospital into the capitation mix – making MHOs responsible for higher levels of service.

- Expand who can provide services under public and commercial health plans to include legitimate, qualified mental health providers such as LPCs.

- Increase funding for mental health services to address gaps in client services, and to reduce ethical dilemmas by providers.

- Increase ability to share information across service systems (adjust confidentiality regulations as needed to enable sharing).

- Capitate all funds in the public system and use managed care principles to operate one system.

- Reduce paperwork requirements, and ensure that all paperwork is up-to-date.

OHP/Insurance:

- Reduce paperwork requirements, and ensure that all paperwork is up-to-date.

- De-categorize state funding, especially mental health, alcohol & drug and OHP.

- Expand who can provide services under public and commercial health plans to include legitimate, qualified mental health providers such as LPCs.

- Build in incentives to cover social supports. The reliance on CPT codes for funding puts everything into a medical model. Uncoded services need to be captured and tracked by the data system. This is particularly a problem for adolescent care because CPT does not capture services needed by youth.

- Decrease the number of layers of administration created and allowed under OHP. Is value added by *every* layer?

- Address the lack of coordination between physical and mental health – especially in Eastern Oregon.

- Capitate all funds in the public system and use managed care principles to operate one system. Integrate funding for state hospital into the mix, making MCO's responsible for higher levels of service.

- Establish full parity including access to services and to resolve problems (especially important for schizophrenia, bi-polar, depression, anxiety, ADD and children).

Children**:**

- Need state and local plan for children's mental health (but consolidate planning groups).

- Use juvenile detention centers as a point of entry, and improve mental health services in detention.

- Children should not be treated at the state hospital campus in Salem, especially those 13 and younger. Either enhance current provider system to meet the younger children's needs or design similar community-based alternatives to OSH. Convert OSH child and adolescent unit to community-based treatment services. Services for children should always be in their home community, and in natural settings whenever possible (such as home or school).

- Provide incentives to increase the number of child psychiatrists.

- Tighten the transitions between types of care, and ensure they are integrated.

Adult/Community Service:

- Establish a housing safety net—especially for homeless and jail transitional. Coordinate with other agencies.

- Establish a range of employment options.

- Establish mental health courts or diversion programs.

- Integrate funding for the state hospital into the capitation mix – making MHOs responsible for higher levels of service.

- Establish a range of employment options.

- Establish mental health courts, or diversion programs.

Other**:**

- Address the crisis in Multnomah County – use Clackamas County as a model.

- The redesign of the statewide mental health system needs to come from the top. The Governor should give clear direction and make this a clear message. He should also hold accountable those who are working on the redesign.

Appendix 6

Department of Human Services
Mental Health and Developmental Disability Services Division
Office of Mental Health Services

Oregon Housing Policy for Mental Health Consumers

The Oregon Mental Health and Developmental Disability Services Division views safe, affordable and decent housing as a basic human need. Persons with psychiatric disabilities in the state of Oregon will have access to and support in maintaining residential stability. Insufficient housing options currently exist for persons with psychiatric disabilities. Hence, planning must take place that identifies areas of greatest need and alternative. Local mental health service providers and others who participate in housing persons with psychiatric disabilities will do so consistent with the following guidelines.

Consumer Centered

- Consumers will have opportunities to make individualized housing choices based on a range of affordable housing options.

- Housing will be affordable based upon an analysis of consumer incomes.

- Housing will promote individual dignity and ensure exercise of rights.

- Consumers will have a voice in decision-making. Consumer preferences and satisfaction with respect to accommodations and support services will be the basis of planning efforts.

- Planning efforts will include an analysis of local housing needs as identified by mental health consumers, advocates and service providers.

Access to Housing

- The Division will strive to preserve existing housing stock for persons with psychiatric disabilities as well as promote and cultivate new housing development. Division-sponsored housing development will have a guarantee of long-term affordability.

- Local MH service providers will work with local housing providers to increase affordable housing opportunities for consumers.

- MH service providers and advocates will promote increased housing opportunities through involvement in planning processes (e.g. HUD consolidated plans, homeless services plans, housing authority plans).

- Where a shortage of adequate, affordable housing exists in a community, resources will be employed to develop new low cost housing and support services.

- Technical assistance and other support will be available to insure a cost-effective and timely development process.

- Development and operating revenues will be effectively employed to maximize availability of housing opportunities and enhance the delivery of support services.

- Housing will be integrated throughout the community and maintained in a manner that promotes community acceptance.

- The size and design of any housing or special residential facility will be consistent with other dwellings in the neighborhood. Residents will have ready access to transportation and community amenities.

- Mental health service providers and consumers will pursue optimal public relations with neighbors.

Mental Health Support Services

- Discretionary, responsive and flexible resources will be developed to ensure maximum consumer success in the most integrated settings.

- Services will be delivered in a culturally competent manner and reflect the diversity among consumers throughout Oregon.

- Services will be adapted for consumers based upon their individual capabilities and needs.

- Service providers and managers will be well-trained and effective.

- Alcohol and drug-free housing settings will be available to support those consumers in recovery from substance abuse.

(Developed in 1999 by the Office of Mental Health Services, Oregon MHDDSD wit input from stakeholders)

Appendix 7

SB 1331
Estimated Durational Limits
As interpreted by one Health Insurer
(Benefits per 24 month period)

	Adults		*Children/Adolescents*
		Chemical Dependency	
Traditional Plan	13 days	Inpatient	27 days
	19 days	Residential	26 days
	25 visits	Outpatient	36 visits
HMO Plan	14 days	Inpatient	32 days
	21 days	Residential	30 days
	27 visits	Outpatient	39 visits
		Mental Health	
Traditional Plan	15 days	Inpatient	16 days
	17 days	Residential	20 days
	34 visits	Outpatient	34 visits
HMO Plan	16 days	Inpatient	17 days
	19 days	Residential	21 days
	36 visits	Outpatient	36 visits

Prepared by the Office of Mental Health Services 07/10/00

Senate Bill 1331

Raises benefit limitations for group health insurance policy coverage of mental health and chemical dependency

Adults		Children/Adolescents
	Dual Diagnosis	
$13,125	Overall Minimum	$15,625
$5,000	Inpatient	$7,500
$1,250	Residential	$3,125
$2,500	Outpatient	$2,500
	Chemical Dependency	
$8,125	Overall Minimum	$13,125
$5,625	Inpatient	$5,000
$4,375	Residential	$3,750
$1,875	Outpatient	$2,500
	Mental Health	
$10,625	Overall Minimum	$13,125
$5,000	Inpatient	$7,500
$1,250	Residential	$3,125
$2,500	Outpatient	$2,500

- Benefits renew in full on the first day of the 25th month of coverage following the first use of services, or on the first day following two consecutive contract years.

- Insurers or health care service contractors may establish durational limits[51] which are actuarially equivalent to the benefits required as long as the same range of treatment settings is made available.

- SB 1331 increased coverage through amendment to ORS 743.556 and applies to policies of insurance issued or renewed on or after July 1, 2000.

Appendix 8

State Parity Legislation

Many states mandate that mental health, substance abuse, and chemical dependency benefits are provided (i.e., Oregon) or are available (mandatory offering) in insurance policies; however only states that have passed "parity" laws are included in this chart.

State	Enacted	Provisions of the Law
Arizona	1997	Mirrors federal law; this law affects group insurance policies with a small employer exemption (50 or fewer employees) or cost increase of 1% or more. No substance abuse or chemical dependency parity.
Arkansas	1997	Provides for equal coverage of mental illness and developmental disorders; excludes state employees, companies with less than 50 employees, and companies that anticipate a cost increase of more than 1.5 percent. No substance abuse or chemical dependency parity.
California	1999	Disability insurance group policies that cover hospital, medical, and surgical expenses which offer coverage for brain disorders must also offer coverage for the treatment of schizophrenia, schizoaffective disorder, bipolar disorder and delusional depression, and pervasive developmental disorder. Coverage for these mental disorders shall be subject to the same terms and conditions applied to the treatment of other brain disorders. An insurer may reserve the right to confirm diagnoses and to review the appropriateness of specific treatment plans as to medical necessity. No substance abuse or chemical dependency parity.
Colorado	1997	Provides for coverage of schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder that is no less extensive than the coverage provided for other physical illnesses. No substance abuse or chemical dependency parity.
Connecticut	1999	Expands coverage provided in the 1997 law. Requires group and individual policies to provide benefits for the diagnosis and treatment of "mental or nervous conditions" defined as mental disorders recognized by the most recent edition of the DSM (Diagnostic and Statistics Manual). The bill excludes coverage for mental retardation; learning, motor skills, communication, and caffeine-related disorders; relational problems; and other conditions that may be the focus of clinical attention that are not otherwise defined as mental disorders in the DSM. The law also includes coverage for substance abuse disorders in the DSM.
	1997	Provides for coverage of schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, panic disorder and pervasive developmental disorder and autism that is equal to coverage provided for medical or surgical conditions.

State	Enacted	Provisions of the Law
Delaware	1998	Requires health insurers to provide coverage for biologically-based mental illnesses, including schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, anorexia and bulimia, under the same terms and conditions of coverage offered for physical illnesses. No substance abuse or chemical dependency parity.
Georgia	1998	Requires small employers (2-50 employees) that choose to provide mental health benefits provide equal lifetime and annual caps for mental health benefits as is offered for other physical illnesses, and provide the same dollar limits, deductibles, coinsurance factors; requires larger employers (51+ employees) that choose to provide mental health benefits must provide equal lifetime and annual caps for mental health benefits as is provided for other physical illnesses, and provide the same dollar limits, deductibles, coinsurance factors; employer groups of 51+ employees who choose to provide mental health benefits cannot impose separate outpatient and visits limits on the treatment of mental illnesses; mental illnesses cover all brain disorders listed in the DSM-IV. Coverage also applies to substance abuse and chemical dependency.
Hawaii	1999	Prohibits insurers from imposing rates, terms, or conditions, including service limits and financial requirements, on "serious mental illness" benefits if similar restrictions are not applied to services for other medical or surgical conditions. Exempts employer groups with 25 or fewer employees and establishes a mental health insurance task force to study the financial and social implications of mandated equal mental health and substance abuse coverage. Law defines "serious mental illness." Annual covered benefit may not be less than 30 days of inpatient care and 30 outpatient visits. For alcohol and drug dependence benefits, the insurer may limit the number of treatment episodes.
Indiana	1999	Amends the 1997 law. Group and individual insurance agreements, HMO contacts and contracts for state employees' health insurance may not permit treatment limitations or financial requirements on the coverage of services for mental illness if similar limitations or requirements are not imposed on the coverage of services for other conditions. Coverage of services for mental illness does not include services for the treatment of substance abuse or chemical dependency treatment. Insurers are not required to offer mental health benefits. Applies to employers with more than 50 full-time employees. Exempts legal business entities that document that compliance with this law has increased the annual premiums or rates of its health services policy or plan by more than four percent.
	1997	Mirrors federal law; no substance abuse; also includes full parity in coverage for mental health for all state employees.

State	Enacted	Provisions of the Law
Louisiana	1999	Requires group insurance policies to include benefits for the treatment of severe mental illness under the same circumstances and conditions as for all other diagnoses, illnesses or accidents. "Severe mental illness" is defined to include the following illnesses: schizophrenia, or schizoaffective disorder, bipolar disorder, pervasive development disorder or autism, panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia/bulimia, Asperger's Disorder, intermittent explosive disorder, posttraumatic stress disorder, psychosis, and Rett's Disorder and Tourette's Disorder in children under 17 years of age. No substance abuse or chemical dependency parity.
Maine	1995	Provides for coverage of schizophrenia, bipolar disorder, pervasive development disorder, or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder in group contracts that is no less extensive than medical treatment for physical illnesses; no substance abuse; excludes group of 20 or fewer employees.
	1993	Raised minimum benefits to $100,000 lifetime, 60 days annual inpatient, $2,000 outpatient. Other terms same as 1995 measure (see above).
Maryland	1994	Law applies to individual and group coverage. Insurers and HMOs are prohibited from discriminating against any person with mental illness, emotional disorder, or drug abuse or alcohol abuse by failing to provide treatment or diagnosis equal to physical illnesses.
Minnesota	1995	Requires cost of inpatient and outpatient mental health and chemical dependency services to be not greater or more restrictive than those for outpatient and inpatient medical services. Applies to all health plans that provide coverage for mental health or chemical dependency services.
Missouri	1999	If any of the following disorders are covered by a health insurance policy, than all of the listed illnesses must be covered: schizophrenic disorders and paranoid states; major depression, bipolar disorder, and other affective psychoses; obsessive-compulsive disorder, port-traumatic stress disorder and other major anxiety disorders; early childhood psychoses, an other disorders first diagnosed in childhood or adolescence; alcohol and drug abuse; and anorexia nervosa, bulimia and other severe eating disorders; and senile organic psychotic conditions. The law applies to group health insurers, including group or individual contracts issued by an HMO. Insurers who demonstrate that compliance with this law over 24 consecutive months has increased premium costs by 2% may be granted a waiver from the law. No substance abuse or chemical dependency parity.
	1997	Covers all disorders in DSM-IV in managed care plans only equal to physical illnesses; part of large managed-care regulatory measure.

State	Enacted	Provisions of the Law
Montana	1999	Insurers must provide a level of benefits for the necessary care and treatment of severe mental illness that is no less favorable than that level provided for other physical illness. "Severe mental illness" includes schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive compulsive disorder, and autism. Benefits for treatment of severe mental illness may be subject to managed care provisions. No substance abuse or chemical dependency parity.
Nebraska	1999	Group health insurance plans that provide coverage for treatment of mental health conditions (other than alcohol or substance abuse) may not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for serious mental illness than for a physical health condition. Prior to 1/1/02, "serious mental illness" is defined as schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression and obsessive compulsive disorder. After 1/1/02, "serious mental illness" will mean any mental health condition that current medical science affirms caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Plan covering employer groups of less than 15 employees are excluded. No substance abuse or chemical dependency parity.
New Hampshire	1994	Provides for coverage of schizophrenia, schizoaffective disorder, bipolar disorder, paranoia, and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive development disorder or autism no less extensive than coverage for physical illnesses; applies only to group and HMOs regardless of size. No substance abuse or chemical dependency parity.
New Jersey	1999	Requires insurers to provide coverage for biologically based mental illness under the same terms and conditions as provided for any other sickness. "Biologically based mental illness" means a mental or nervous condition that is cause by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder of autism. No substance abuse or chemical dependency parity.
New Mexico	1998	This law requires parity in group insurance policies, with different exemptions for small and large employers. "Mental health benefits" is defined to mean mental health benefits as described in the group health plan or group health insurance offered in connection with the plan. Substance abuse or gambling addiction is not included.

State	Enacted	Provisions of the Law
North Carolina	1997	Amends the State Employees Health Plan to include benefits for the treatment of chemical dependency.
	1991	(State employees only) Requires non-discriminatory coverage of mental health services in state government employee health contracts.
Oklahoma	1999	Health benefit plans, excluding individual plans and plans for a small employer, must provide benefits for treatment of severe mental illness. Large group opt out, if a 2% premium increase results. Benefits must be equal to and subject to the same preauthorization and utilization review mechanisms and other terms and conditions as benefits for treatment of all other physical diseases and disorders. "Severe mental illness" includes schizophrenia, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder and schizoaffective disorder. No substance abuse or chemical dependency parity.
Rhode Island	1999	Amends the 1994 parity law. Moves enforcement authority to the Deparment of Health, and provides that any subscriber who is denied benefits under the 1994 law may appeal in accordance with the rules and regulations of the Department of Health. No substance abuse or chemical dependency parity.
	1994	Provides for coverage of "serious mental illness" that current medical science affirms is caused by a biological disorder of the brain and substantially limits life activities.
South Dakota	1999	Clarifies the term "biologically based mental illness" to mean schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive compulsive disorder. No substance abuse or chemical dependency parity.
	1998	Provides coverage for the treatment and diagnosis of biologically based mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, with the same dollar limits, deductibles, coinsurance factors and restrictions as for other covered illnesses.
Texas	1997	Covers schizophrenia, paranoia and other psychotic disorders, bipolar disorder, major depressive disorder, schizoaffective disorder, pervasive developmental disorder, obsessive-compulsive disorder, and depression in childhood and adolescence; exempts businesses with fewer than 50 employees; 60 outpatient visits and 45 inpatient days annually. No substance abuse or chemical dependency parity.
	1991	(Public employees only) Covers all public state and local employees and all teacher and university system employees. This plan covers schizophrenia, schizoaffective disorder, bipolar disorder and major depression.

State	Enacted	Provisions of the Law
Vermont	1997	Requires coverage for any condition or disorder involving mental illness or alcohol or substance abuse; comprehensive coverage for deductibles and out-of-pocket expenses. Applies to group and individual markets.
Virginia	1999	State health care plans, health insurers, health services plans and HMOs must provide coverage for "biologically based mental illnesses" which may not be different or separate from coverage for any other illness, condition or disorder. Biologically based mental illness is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits a person's functioning such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention-deficit hyperactivity disorder, autism, and drug and alcohol addiction. Policies, contracts or plans issued to employers with 25 or fewer employees are exempt from the requirements.

(National Alliance for the Mentally Ill, Communications, State Mental Illness Parity Laws, June 1998) (American Psychiatric Association, State of the States: Parity Laws, September, 1999) (Health Insurance Association of America; Summary of State Mental Health Parity Laws, March, 2000) (National Conference of State Legislatures-Health Policy Tracking Service; Full Parity, Mandated Benefit and Mandated Offering Laws: 50 State Profile)

Characteristics of the State Mental Health "Parity" Legislation

State	Individual Health Plans Exempt	Small Employer Health Plans Exempt	Limited to Serious or Biologically Based Illnesses	Does Not Cover Substance Abuse/ Chemical Dependency	Applies Only if Plan/ Employer Offers Benefit	Cost Increase Exemption
Alabama	*(No state parity law but mandates offering of alcohol treatment).*					
Alaska*	*(No state parity law but mandates offering of alcoholism and drug abuse benefits for small groups, and mandates alcoholism and drug abuse benefits for larger groups.)*					
Arizona (1)*	✓	✓		✓	✓	✓
Arkansas (1)*	✓	✓		✓		✓
California (1)			✓	✓		
Colorado (1)	✓		✓	✓		
Connecticut						
Delaware*			✓	✓		
Florida*	*(No state parity law but mandates offering of mental health benefits and offering of substance abuse benefits.)*					
Georgia	*(No state parity law but mandates offering of teratment for mental disorders including stubstance abuse.)*					
Hawaii (2)		✓	✓	✓		
Idaho	Not available					
Illinois	*(No state parity law but mandates offering of mental health benefits and mandates alcoholism benefits.)*					
Indiana*		✓		✓	✓	✓
Iowa	Not available					
Kansas*	*(No state parity law but mandates mental health benefits and mandates alcoholism and drug abuse benefits.)*					
Kentucky	*(No state parity law but mandates offering of mental health and offering of alcoholism benefits.)*					
Louisiana(1)*	✓		✓	✓		
Maine (2)	✓	✓	✓	✓		
Maryland		✓				
Massachusetts	*(No state parity law but mandates mental health benefits and mandates alcoholism benefits.)*					
Michigan	*(No state parity law but mandates offering of inpatient substance abuse treatment and mandates substance abuse benefits for other levels.)*					
Minnesota	✓	✓				
Mississippi	*(No state parity law but mandates offering of mental health benefits and mandates alcoholism benefits.)*					
Missouri	HMOs only		✓		✓	✓
Montana(2)*			✓	✓		
Nebraska (1)	✓	✓	✓	✓	✓	
Nevada (2)*		✓	✓	✓		✓
New Hampshire	✓		✓	✓		
New Jersey (2)			✓	✓		

State	Individual Health Plans Exempt	Small Employer Health Plans Exempt	Limited to Serious or Biologically Based Illnesses	Does Not Cover Substance Abuse/ Chemical Dependency	Applies Only if Plan/ Employer Offers Benefit	Cost Increase Exemption
New York	*(No state parity law but mandates offering of mental health and offering of alcoholism and drug abuse benefits.)*					
North Carolina (1)*			State employees only	State employees only		
North Dakota	*(No state parity law but mandates mental health benefits and mandates alcoholism and alcoholism and drug addiction benefits.)*					
Ohio	*(No state parity law but requires parity for plan that offer mental health and mandates alcoholism benefits.)*					
Oklahoma	✓	✓	✓	✓		✓
Oregon	*(No state parity law but mandates mental health benefits and mandates alocholism and chemical dependency bnefits.)*					
Pennsylvania	✓	✓	✓	✓		
Rhode Island (2)			✓	✓		
South Carolina*	*(No state parity law but mandates offering of mental health benefits including substance abuse benefits.)*					
South Dakota (1)			✓	✓		
Tennessee* (1)	✓	✓		✓		✓
Texas (1&2)	✓	✓	✓	✓		
Utah	*(No state parity law but mandates offering of alcohol and drug dependency treatment.)*					
Vermont						
Virginia (2)		✓	✓	✓		
Washington	*(No state parity law but mandates offering of mental health and mandates chemical dependency benefits.)*					
West Virginia (1)*				✓	✓	✓
Wisconsin	Not available					
Wyoming	Not available					

*Has adopted legislation to conform with the federal Mental Health Parity Act of 1996

1. Also mandates offering of alcohol and/or substance abuse treatment.
2. Also mandates alcoholism and/or substance abuse treatment benefits.

Note: A number of states require certain minimum benefit levels for mental health and substance abuse (e.g., minimum annual inpatient and outpatient treatment days) when benefits are mandated, or required to be offered.

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