Report to The Governor and Legislature

September 2004

A BLUEPRINT FOR ACTION

Governor's Mental Health Task Force

STATE OF OREGON

Executive Summary

The 2004 Governor's Mental Health Task Force has prepared a full report which identifies systemic problems in Oregon's public mental health system, makes additional findings, and offers numerous recommendations for improvement. While every one of the recommendations listed in the full report is critical, this Summary focuses on the 10 recommendations identified as priority items for the Governor, the Legislature and state agencies in 2005-07. These priority areas were identified based on the charge from the Governor in the Executive Order creating the Task Force, focusing on systemic problems the Task Force identified (see pages 7-11) and relating to recommendations to improve communication and coordination between the State and community providers of mental health services, including the criminal justice system.

2005 Legislative Session

1. The Legislature should pass legislation requiring private insurers to provide parity coverage for mental health and substance abuse services provided to consumers voluntarily.

2. The Legislature should appropriate sufficient funds to permit the orderly restructuring of Oregon State Hospital and the construction and operation of community facilities to support populations of individuals who will no longer be hospitalized.

3. The Legislature should expand the Oregon Prescription Drug Program established in ORS Chapter 414 (SB 875).

Interface between the State and Community Mental Health Providers

1. The State will complete and implement a business plan to reinvent the Oregon State Hospital in Salem as a "focus of excellence facility."

2. The State will implement programs which provide funding and incentives to counties and community providers to achieve community-based System of Care services.

3. Local mental health authorities with support from OMHAS will continue to accept increasing responsibility for assisting individuals to leave acute care and State hospitals, including individuals subject to PSRB jurisdiction.

Criminal Justice System

1. The State and local mental health authorities will develop and offer training for courts, district attorneys, defenders, correction officers and police (i) to identify and properly respond to persons with mental illness and (ii) to understand and use community mental health and substance abuse programs.

2. OMHAS will work with counties (individually or regionally) to create 24/7 acute care crisis centers to permit individuals to be diverted prior to arrest and to receive individuals upon diversion from jail or court.

3. The Superintendent of the Oregon State Hospital and Executive Director of the PSRB will continue their effort to better communicate and collaborate and will together with Local Mental Health Authorities create a rolling three-year plan for the construction and operation of community facilities to serve the individuals under the jurisdiction of the PSRB.

4. The Department of Corrections and Sheriffs operating local jails will implement administratively the recommendations of the Bazelon Center for pre-release planning, to the extent possible without additional legislation.

Funding

Consistent with its charge, the Task Force took into account existing funding restraints when developing its recommendations. However, the Task Force did conclude as part of its identification of System Problems facing Oregon's public mental health system that the system is significantly under-funded. The impact of this under-funding is compounded by the effects of cuts in other State services needed by people with mental illness who are poor. Accordingly, the Taskforce recognizes that some recommendations can be accomplished without additional resources. Others would require resources that may not be available given fiscal realities for 2005-07 and will impact the degree to which some recommendations can be fully implemented.

Table of Contents

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REPORT TO THE GOVERNOR AND LEGISLATURE

September 23, 2004

GOVERNOR'S MENTAL HEALTH TASK FORCE

INTRODUCTION

By Executive Order dated October 8, 2003, Governor Kulongoski appointed a Task Force of 21 members (one of whom subsequently withdrew), including four legislators, to address specific issues related to the delivery of mental health services to Oregonians. A copy of the Executive Order is Appendix A

In summary, the Executive Order asked the Task Force to:

- Describe key problems in Oregon's public mental health system;
- Recommend ways to improve communication and coordination between the State and community providers of mental health services, including the criminal justice system;
- Consider regionalization as a strategy to improve efficiency and effectiveness;
- Identify measurable objectives, goals and outcomes based upon system-wide implementation of evidence-based practices; and
- Take into account the constraints of existing funding.

The Task Force was charged to complete its work during 2004 and to prepare a report for consideration by the Governor and the Legislature. The Task Force determined to complete its work and this report on or before October 1, 2004, in order to permit consideration of our recommendations as part of the Governor's budget and by the legislative caucuses prior to the start of the 2005 Legislative Session.

This report builds upon the legal and policy principles established in ORS Chapter 430. It also builds on work done and values established by a 1988 Governor's Commission on Inpatient Psychiatric Services and by the Mental Health Alignment Work Group (MHAWG) that completed its work in 2000. This report also reflects the values and principles set out in the June 2003 report of the The President's New Freedom Commission on Mental Health.

A critical concern to all members of the Task Force was the underlying and ongoing problem of stigma associated with mental illness and serious emotional disturbances. The Task Force recognizes that all of the problems, findings, and recommendations described in this report

are impacted by the ongoing negative effects of stigma. The Task Force was unanimous in endorsing the work taking place on many fronts to reduce and eliminate stigma. The Commissions and Work Groups that have preceded the current Governor's Mental Health Task Force contain recommendations and action steps that must continue in order to provide ample opportunity for the present report to achieve its intended maximum results.

In this report, we first describe ten Systemic Problems in Oregon's public mental health system. We then summarize the core values and principles that must be met for any kind of sensible mental health system in these times. We then make specific findings and recommendations that respond to the charge given to us in the Executive Order.

Of necessity, this report focuses on mental health services provided by the State and local governments, either directly or by contract. We acknowledge that many people receive mental health services from private providers, sometimes, but not always, with the benefit of insurance. The public system is directly and indirectly affected by the workings of the private mental health system, and we discuss that to some extent in this report. However, we do not otherwise address the private system.

The Executive Order asks the Task Force to address children's mental health issues. At the same time, a separate group, called the Oregon's Children's Budget Note Work Group, was created to address reforms in the children's mental health system. The Children's Work Group effort is underway. The Task Force believes that the State can and must do a better job meeting the mental health needs of children. We make specific recommendations for improvements in the children's mental health system that we believe to be congruent with the thinking of the Children's Work Group, but we acknowledge that the Children's Work Group effort will not be concluded until after publication of this report.

The members of the Task Force are honored to have been invited to this project and trust that our report will be helpful to the Governor, members of the Legislature, and all other stakeholders in our collective effort to enable all persons with mental illness to live successful and productive lives in our communities. We thank all of those who supported our work.

SYSTEMIC PROBLEMS IN THE PUBLIC MENTAL HEALTH SYSTEM

The public mental health system in Oregon has serious problems, some of which are problems throughout health care. The Task Force refers to these as Systemic Problems. These Systemic Problems are well known in the mental health community and have been addressed by prior Task Forces and Commissions.

Like most states, Oregon's public mental health system is composed of a number of state and local agencies, all of which have varying degrees of responsibility for the administration and delivery of mental health services (See Appendix B). The diversity of missions and risks for each of these agencies makes the creation of an integrated public mental health system a major challenge for all states, including Oregon.

Even though there are many talented individuals working in the public mental health system who are aware of and addressing these Systemic Problems, the problems persist and – indeed – some have worsened over time. These Systemic Problems can be addressed and the mental health system made stronger, but only with sustained and committed leadership from the Governor and the Legislature, and then only with the sustained and committed participation of other players, including county mental health departments and service organizations, non-governmental service providers, employers, insurers, and – perhaps most importantly – the people who receive mental health services. In later sections of this report, the Task Force makes many recommendations for organization and management changes that address these Systemic Problems.

The President's New Freedom Commission reports that, in any given year, 5% to 7% of adults have a serious mental illness. A somewhat larger percentage of children - 7% to 9% - have a serious emotional disturbance. This means that in Oregon, in any given year, more than 175,000 adults 18 and older and more than 75,000 children under age 18 need some kind of mental health services. Some fraction of these individuals receive services from the private system. Others receive services from the public system. But in Oregon, many individuals receive no services at all, and in recent years, the number of people who do not receive needed services has increased, rather than decreased.

Mental illness ranks first among illnesses that cause disability in the United States, Canada and Western Europe, and presumably therefore, also in Oregon.

When we neglect mental illness, the financial and social costs to each individual, his or her family, and society are extraordinary and incalculable.

If we address mental illness with wisdom and compassion, and if we value the recovery of individuals, we can change lives and reduce costs: both the direct costs of care and the indirect costs which flow inevitably from failure.

In 2004, the key Systemic Problems facing the public mental health system in Oregon include:

1. **The system is significantly under-funded**. The impact of this under-funding is compounded by the effects of cuts in other State services needed by people with mental illness who are poor. For example, the reductions in support for affordable housing and General Assistance have increased the probability that people will be homeless. The elimination of the Medically Needy program for most adults has resulted in the loss of both medications and treatment for many persons with major mental illness. While this Task Force makes many recommendations that can be implemented without substantial additional funding, no one should pretend that our public mental health system will become what it can and should be without additional funding. We must also assure that all Oregonians have equitable access to local public mental health services.

2. **There is a need for greater clarification of the role of the Oregon Health Plan (OHP) managed care Mental Health Organizations (MHOs) and the statutory**

responsibilities of Local Mental Health Authorities (LMHA). While MHOs accept financial risk and contractual responsibility for many federally-driven contract requirements, LMHAs remain responsible for providing a coordinated set of services as the local level. These local services and supports are funded by a complex mixture of state and federal funding, only about half of which are Medicaid managed care capitated funds. The roles and responsibilities for MHOs and LMHAs are not yet integrated in a manner that will assure the development of a local System of Care.

3. **The State's administration and funding of mental health services is not well coordinated or commonly managed**. The State has historically shifted responsibility for serving persons with mental illness to counties and other community providers, without providing stable or sufficient funding for communities to provide services. Although Oregon policy is to deliver mental health services through community structures, the funding for this system must necessarily come from the State in order to produce a comprehensive and accountable system. There is essentially no statewide effort to integrate mental health services with traditional medical care, with public health initiatives, or with other social services. For example, mental health services are administered and funded by both the Office of Mental Health and Addiction Services (OMHAS), and the Office of Medical Assistance Programs (OMAP). This pattern repeats itself in county governments and among non-governmental service providers, with the result that there is not enough coordination of services and insufficient overall accountability for outcomes.

4. **Too many persons with mental illness are in prisons and jails**. The number of Oregonians with mental illnesses who are in county jails and State prisons has increased dramatically to approximately 16-20% of all inmates. Youth with mental disorders in state juvenile corrections facilities exceeds 60%. More people with mental illness are incarcerated than are being cared for in psychiatric hospitals. Most of these people could and should be in community treatment programs receiving integrated mental health and substance abuse services.

5. **There are far too few community resources, particularly housing, for persons with mental illness**. Based on a year 2000 survey, the Department of Human Services estimates that Oregon needs at least 14,713 *additional* affordable housing units, of which at least 2,567 require support services, such as case monitoring, residential management, and food service. Until we have sufficient housing and community resources, the State will continue to spend money in the wrong places and fail to achieve reasonable outcomes.

6. **The failure to plan for, invest in, and maintain adequate community resources causes gridlock in the entire public mental health system**. This is particularly true in the most expensive parts of the system: community acute care hospital beds, the Forensic Treatment Program at Oregon State Hospital and the Recovery Units (extended care for persons who are civilly committed) in all three State hospital programs. Too many individuals remain in community hospitals and the State

hospitals much longer than necessary because there is no place for them to go. Many people who could be better served in a State hospital wait in acute care hospitals, at greater cost. Some people who need to be hospitalized wait for unacceptable periods of time in emergency departments, or must be transported long distances because their local hospitals are full, in each case at significant and unnecessary cost. The forensic units are crowded beyond design capacity, and there is a backlog of at least 60 individuals who have been approved by the Psychiatric Security Review Board (PSRB) for discharge to community facilities which are not being developed rapidly enough to meet demand and for which there is not sufficient long-term planning. Hospitals serve an important role, but when we misuse them, we spend more money than we should, and we do not meet the needs of individuals or society.

7. **The emphasis on acute care and incarceration means that the public mental health system does not consistently emphasize early intervention and prevention, especially with children**. We spend proportionately less on children's mental health than on adult mental health. We do not reliably and consistently provide a System of Care (a term which is defined below) to adults, to children, or to the families of adults and children with mental health issues. This crisis intervention emphasis also means that Oregon has not been proactive enough in preventing suicide, especially among children, youth, and older adults.

8. **Oregon is among a handful of states that does not require significant parity of private insurance coverage for mental health conditions**. This failure has two major consequences: first, it results in a substantial shift of costs from the private sector to the public sector. Second, it means that families who are otherwise insured, but required to cover mental health treatment costs from their own pockets, fall into poverty needlessly and at great cost to society, far exceeding the costs of treatment.

9. **The mental health system, like most other parts of health care, does not take advantage of modern information systems**. The lack of investment in and use of modern technology means that there is much duplication of activity and services, it is difficult to coordinate care and services among various providers, it is not easy to measure performance or even establish performance benchmarks, and there is too much opportunity for errors and omissions. The State should be a leader in building a common health care information system, with mental health providers being key participants.

10. **There is not sufficient statewide effort to integrate mental health services with addiction services, traditional medical care, public health initiatives or other social services**. This means that there is often little coordination of services for individuals whose needs are multi-dimensional, with the result that services to such individuals are hit and miss and almost certainly more costly. A particular concern is that lack of service integration creates barriers to accessing mental health services for individuals whose families or ethnic cultures hold mental illness and treatment with great stigma.

The Task Force urges the Governor and the 2005 Legislature to take all steps possible to begin to address these Systemic Problems and to transform the public mental health system in ways which will provide better services and outcomes to individuals, their families and society. In later sections of this report, we propose concrete steps that will begin systemic change and improvement.

VALUES AND PRINCIPLES

Chapter 430 of Oregon Revised Statutes sets important policy goals for mental health services in Oregon. Predecessor task forces have clarified those goals and suggested ways to achieve them. The President's New Freedom Commission has established the same basic goals for mental health services nationally. These goals are best expressed as a statement of values and principles.

Here are key values and principles for any responsible mental health system:

- Mental illness is treatable, often at low direct cost.
- Recovery is possible and is the goal of all mental health services. Recovery means that individuals with mental illness have control over their own lives and are able to have a meaningful role in their families and communities.
- Services are driven by the strengths and needs of consumers and their families, rather than by funding silos or the organization of service agencies.
- Services are cultural and age-specific, and delivered with respect for the integrity and dignity of consumers.
- Services are available in the communities where people live.
- Services are preventative and offered as early as possible.
- Services reflect evidence-based practices.
- Services are holistic and respond to a person's universe of strengths and needs.
- High quality services, including medications, are available without regard to ability to pay.
- For individuals who are dangerous to themselves or others, services must reflect public safety concerns, but always with the goal of returning these individuals to full participation in community life**.**
- Recovery from mental illness also requires recovery from substance abuse and physical illness, if present. Thus, coordination and integration of services is essential.
- Outcomes can be measured, both in terms of individual recovery and improved population health. In public health terms, the most important outcome is that a substantial number of individuals achieve recovery and function effectively as productive members of society.
- People who use or have used public mental health services in Oregon and their families are key stakeholders and must be included in meaningful ways

at all state and local levels in decision-making and service provision. Meaningful inclusion goes beyond mere tokenism.

Later in this report, we refer to these concepts as Values and Principles.

FINDINGS

The Task Force heard testimony and received documentation on a wide range of issues. Based on that information, and the personal knowledge and experience of the Task Force members, the Task Force makes the following findings:

1. The Task Force finds that a System of Care for individuals and families affected by mental illness and addiction achieves positive outcomes and is cost effective. This is well-recognized by people who use mental health services and providers in Oregon, and there are excellent examples of programs that are built on System of Care principles. However, Oregon has not adequately embraced or adopted the System of Care approach, and there is more fragmentation than necessary in Oregon's approach to children, juveniles, adults and older adults. The term "System of Care," as used in this report, describes an approach which responds to all of the strengths and needs of persons who need mental health services and their families in the communities where they live, incorporating all or most of the following characteristics:

    a. Services promote prevention and recovery, and respect persons as individuals.

    b. Services are readily available and include outreach services such as assertive community treatment, school clinics, and services provided in senior centers.

    c. There is integration of primary care, mental health, and substance abuse services.

    d. The community has the capability and culture to routinely divert people with mental illness from the criminal justice system to appropriate community resources.

    e. The community has and supports adequate housing and community support facilities, including vocational training and employment opportunities, for persons with mental illness.

    f. Services are age and culturally relevant.

    g. The community proactively seeks to identify and help individuals of all ages who are prone to suicide and self-injury.

h. The community accepts responsibility for assisting individuals to return to the community from acute care and forensic hospitalizations.

i. Service providers are accountable for outcomes, both individual and societal, including clear lines of accountability for case management and financial responsibility for continuity of care.

2. In spite of the Systemic Problems we identify above, there are many success stories and dedicated people who are working to achieve the Values and Principles and to implement Systems of Care in communities. The Task Force finds that the State must identify, reinforce and support worthwhile efforts now underway, address the Systemic Problems to the extent possible within funding constraints, and remove barriers that interfere with innovation and achievement of the Values and Principles. The State, by regulation and policy, should not create new barriers or derail existing quality initiatives.

3. The Task Force became acutely aware of the need for and challenges in assigning increased accountability in a public system where many, if not the majority, of mental health services are delivered outside the administration of the state Office of Mental Health and Addiction Services. Ultimately, state and local governments must explore more effective methods of coordinating, funding, and integrating mental health and addiction interventions that take place in state as well as local corrections and juvenile justice settings; schools; child welfare and return-to work programs; senior and disability service settings including nursing homes; private insurance; primary health care; pharmaceutical resources; and finally, federal programs such as Medicaid and Medicare.

4. Oregon statutes and public policy provide for community-based services to persons with mental illness **(***see generally* ORS Chapter 430**)**. The Task Force finds that a community-based system is sound public policy and, in any event, this is not the time to change to a State-operated system. However, the State must provide consistent, predictable and stable funding to communities to achieve the policy, service and accountability goals that are essential.

5. The Task Force finds that regionalization of services can, in many cases, achieve either or both economies of scale and better outcomes for a diverse and sometimes transient population. Community-based mental health services are necessarily local, and regionalization is most likely to succeed when it is developed with support and input at the local level and implemented in support of local efforts. Accordingly, the Task Force finds that regionalization should be encouraged, but not mandated. There is no single organizational model which could or should be implemented throughout the State, given the range of population density, the strengths of local organizations and people, and local cultural differences.

6. There are some important local and regional efforts underway which demonstrate the potential for excellence from programs which provide a System of Care and which

build upon regional opportunities. Appendix C describes several important local and regional initiatives currently underway in a regional program and a single county program. It is not intended, however, to be a complete list of all noteworthy programs.

7. There is substantial research and practice that establish evidence-based practices. Consistent with the passage of SB 267, OMHAS has been developing definitions of acceptable evidence-based practices and guidelines that can be implemented throughout the public mental health system, and that effort should continue. Examples of such practices include integrated treatment for co-occurring mental health and addiction conditions; certain specialized therapies such as cognitive behavioral therapy and dialectical behavioral therapy, as well as medication algorithms and family psycho-education. In addition, peer operated services and supports show significant potential to achieve standing as an accepted evidence-based practice. OMHAS must facilitate a prompt evaluation of peer-operated services so as to determine their utility as an evidence-based practice. Incorporating evidence-based practices into a "System of Care" achieves the best public health and individual outcomes, and best reflects the Values and Principles identified by the Task Force.

8. Systematic implementation of a System of Care and evidence-based practices throughout State and community mental health services will lead to a reduction, over time, in the demand for high-cost clinical services, hospitalization, and criminal justice services for persons with mental illness. Systems of Care are stronger when the participants embrace and practice the Values and Principles we identify in this report. A System of Care is not the same as evidence-based practices, but works best if the services reflect evidence-based practices, including, for example, medication algorithms, the use of effective clinical techniques, and recovery-oriented services with substantial individual choice and participation. The costs of a System of Care are manageable, the use of evidence-based practices is cost effective, and the investment in these techniques will be returned by a reduction of long-term human and clinical costs, including acute care, institutional care, school failure, unemployment, homelessness, and incarceration.

9. The fragmentation of funding, service delivery, and accountability is a major problem throughout the mental health system, but especially so for children and adolescents who need intensive mental health services. Presently, children's services are provided under a separate system of contracts and agencies, are generally not integrated with other community mental health services, and are not uniformly available throughout the State. The Children's Work Group is proposing major changes to the organization and delivery of children's mental health services, including the creation of additional community, home-based, and family-centered services. These proposals must be implemented as rapidly as possible to the extent that they are consistent with the recommendations of this Task Force.

10. There is an administrative and financing disconnect between the criminal justice system and the mental health system, such that no one is truly accountable for services or outcomes to individuals who are incarcerated or at risk of incarceration.

For example, neither courts nor district attorneys (who determine most sentencing as part of plea bargaining) are fiscally responsible or accountable for the costs of diversion, hospitalization, or incarceration. The PSRB influences but does not direct or control the availability or location of housing and community services for individuals ready for discharge from Oregon State Hospital. The State does not provide systematic funding for community services that might reduce criminal activity, prevent recidivism, or support diversion.

11. In order to implement the Values and Principles, there must be both adequate funding and significant cultural change among all providers and funding agencies, together with recognition by the Governor and Legislature that such change is both possible and essential. The Task Force acknowledges that this cultural change is underway in some parts of the public mental health system and is being driven forward by the leadership of the Department of Human Services and by community leadership too numerous to single out. Nevertheless, there is much to be done and many pockets where the status quo is most comfortable. Some areas where cultural change is most urgently important include acceptance of recovery as a goal, adoption of evidence-based practices, recognition of ethnic and language differences, implementation of age-specific services, and de-institutionalization of care, including even forensic services.

12. Many, perhaps most, persons with mental illness in the criminal justice system have a co-occurring substance abuse issue. We can successfully divert many individuals with mental illness from the criminal justice system by providing appropriate and timely community services, especially for individuals with co-occurring disorders. Those services, provided widely and effectively, are cheaper than the costs of arrest, arraignment and incarceration. Too many individuals are arrested and then retained in the criminal justice system because of the absence of community resources and also because of historic differences between law enforcement and social service cultures that have fostered a lack of cooperation among players.

13. In a state of over three and one half million people, there is a continuing necessity for acute care and forensic mental hospital facilities, and such facilities, as a practical matter, must be funded directly or indirectly by the State as needed. However, the Oregon State Hospital's Salem facility is too crowded, requires considerable human and financial resources, and houses people who could be better served in communities using a System of Care approach. Moreover, the gridlock that is part of the System Problems described earlier in this report can only be unlocked with significant changes in both the admission and discharge protocols at Oregon State Hospital.

14. The OMHAS Administrator and Hospital Superintendent have told the Task Force that they are making and intend to make more significant changes in the mission and focus of the Oregon State Hospital to be substantially implemented no later than July 1, 2007. The Task Force anticipates that these changes will be generally reflective of the Values and Principles. In order to accomplish this goal, the Governor and Legislature must provide appropriate assurances and funding for the creation and

longevity of community resources to provide services to the now-hospitalized population. The present staff of Oregon State Hospital can provide valuable services in communities, as State employees or otherwise as may be appropriate. Except to provide secure treatment and housing for individuals who pose an ongoing significant danger to society or to themselves, the Task Force believes that the State should not operate a large centralized mental hospital, but should invest directly and indirectly in community facilities.

15. Eastern Oregon State Hospital and the Portland campus of Oregon State Hospital serve important populations and should be maintained as public institutions, but perhaps with a changing focus to reflect changes at Oregon State Hospital in Salem, the development of additional community resources, and the changing demographics of the counties east of the Cascades.

16. In some Oregon communities, there are major efforts underway to integrate mental health services with physical health and substance abuse services. These efforts provide models of good practice that must be built upon throughout the State. In general, however, there is little or no integration of health services with each other or with other parts of a System of Care.

17. In some Oregon communities, law enforcement officers have been well trained to recognize and deal appropriately with mentally ill individuals. One example is Crisis Intervention Team (CIT) training. This kind of training, and periodic retraining, is important and should be mandatory for all police officers, corrections officers, and other law enforcement officials.

18. Individuals and families whose mental health and substance abuse needs are not met by the private sector turn to the public sector for assistance. Oregon's existing statutory mandate for limited mental health benefits in private sector insurance coverage compares badly to "parity" legislation in most other states. Too many Oregonians with mental illness themselves or in their families lose insurance coverage and then financial well-being, with the result that their costs of mental health services and often other social services fall onto the public sector. Actuarial experience in other states suggests that the incremental direct cost of insurance parity is materially less than the social costs incurred by the absence of appropriate insurance requirements.

19. Oregon lacks a comprehensive and fully coordinated strategy for suicide prevention, especially for youth, but also for adults, and especially older adults. The Task Force supports the current efforts of the State's Offices of Public Health to be more integrated with other mental health and addiction services.

20. All initiatives for improving mental health services (and health services generally) must recognize and plan for the changing demographics of our State, including a rapid increase in the number of senior citizens and the growing cultural diversity of our State. Business as usual is not sustainable.

21. Psychotropic medications are effective for many individuals. Access to affordable medication is an essential part of recovery for many people and the failure to provide appropriate medication can have potentially catastrophic costs for individuals, their families and society. The expense of pharmaceuticals can be reduced both by bulk purchasing and by prescribing patterns that are evidence-based. The Task Force is concerned that medications be prescribed carefully, having due regard for age, ethnic, gender and physical differences. The Task Force believes that approaches must continue to be developed to support rational and effective prescribing practices and that both OHMAS and OMAP must take a lead role in achieving this objective.

22. As in all health professions, Oregon faces a serious shortage of trained workers to provide mental health services. This shortage is particularly severe for staff who are from communities of color, as well as who are bilingual and bicultural. The psychiatric nursing shortage and the lack of sufficiently trained physicians in rural areas are also serious problems in Oregon. In addition, many mental health workers do not earn living-wage jobs, resulting in high turnover, difficulty in recruiting, and sometimes quality and safety problems. As we move to a System of Care approach, the workforce needs to include not only traditional mental health providers such as psychiatrists, but also people with a variety of community skills. In many cases, individuals in recovery from mental illness or substance abuse can be valuable and important members of this new workforce. Workforce training, for professional skills and cultural competency, is a matter of urgency. Fair, living wage jobs are essential for both providers and consumers.

23. Oregon's mental health and addiction system must take into account the needs of seniors and people with disabilities. Seniors and people with disabilities are among the most likely Oregonians to experience serious mental health problems such as depression, anxiety, and abuse of alcohol and drugs. Seniors face changes in relationships, physical and health care decline, and financial troubles. Nationally, 15-25% of adults over 65 can be expected to have mental health problems requiring intervention. People with disabilities also face serious adjustments and mobility problems and experience higher levels of anger and depression, yet are less likely to seek help due to fear of a double stigma. Suicide is often the consequence of ignoring, minimizing or misdiagnosing serious mental health impairments. While seniors represent only 13.7% of the population, they account for at least 25-30% of all successful suicides. Suicide rates for persons with disabilities are also very high.

24. Mental health services, especially in the public sector, are not adequately funded, with the consequences that individuals and family needs for help go unmet and society bears the costs and consequences in other ways. As we move to a System of Care approach, we can hope for better outcomes and for cost savings, but we cannot meet the reasonable needs of our society without additional investment.

RECOMMENDATIONS

The Task Force has a number of recommendations. All of the recommendations reflect the Values and Principles we have identified and the findings we have made. We make these recommendations with full knowledge of the State's current fiscal situation. The Task Force believes that the State and other stakeholders must begin to implement our recommendations at any level of public funding, in order to address the Systemic Problems we have identified. We believe that additional public funding will be rewarded in reasonable time by better outcomes and reduced costs to society and perhaps also to the State. We organize our recommendations by category, with the result that there is some apparent duplication. We make these recommendations as measurable objectives, goals and outcomes, in keeping with the Governor's Executive Order.

A. Legislative Recommendations.

1. The 2005 Legislature should adopt legislation requiring private insurers to provide parity coverage for mental illness and substance abuse services provided to consumers voluntarily. The Task Force believes that "comprehensive parity" should be the goal. If that goal is not achievable in a single legislative session, then the Task Force recommends that Oregon adopt a "biological parity" form of legislation, based on one or more such forms of such legislation now in effect in 19 states but, in any case, including coverage for clinical depression which is a primary precursor of suicide. Any form of parity legislation must recognize the importance of providing adequate mental health services to children, without bankrupting their parents or forcing families onto welfare or to abandon their children. Appendix D is a summary of parity legislation in various forms now in effect in 44 states.

2. In furtherance of Recommendation A.1, the Governor, Speaker of the House, and Senate President should immediately convene a working group of stakeholders, including people and their families who use mental health and addiction services to negotiate and agree on the essential terms of parity legislation during the fall of 2004 to be introduced in the 2005 Legislative Session.

3. The 2005 Legislature and future legislative assemblies should appropriate sufficient funds to OMHAS to permit the orderly restructuring of Oregon State Hospital during the 2005-07 biennium and beyond, including sufficient funds to permit OMHAS, directly or indirectly by contract, to provide for the construction and operation of community facilities to support the population of individuals who will no longer be hospitalized. Appendix E, prepared by OMHAS, shows projected costs and timelines to achieve a restructured State Hospital of 700, 500, 300 or 100 beds. **(**Please refer to Recommendation B.1 with respect to the proposed reinvention of Oregon State Hospital.**)**

4. The 2005 Legislature should adopt legislation to require that people with mental illness and/or substance abuse who are in OYA youth correctional facilities, prison, and jail inmates receive pre-discharge planning and qualification for

disability and Medicaid benefits. Discharging such individuals without provision for immediate financial support is to virtually assure relapse and recidivism. To a substantial extent, the costs of these benefits are borne or shared by the federal government. Several counties, to the extent permitted by state law, are developing such programs in local jails, with increasingly successful outcomes to date. Appendix F is a form of model legislation proposed by the Bazelon Center to accomplish the objectives of this recommendation. Key points of the Bazelon proposal include: (i) suspending, rather than terminating, benefits during incarceration, thus making possible speedy restoration of federal benefits upon discharge; (ii) pre-discharge planning and qualification for benefits; (iii) pre-release agreements with Social Security; (iv) bridge programs; and (v) medication supplies and case management services on release.

5. The 2005 Legislature should amend SB 875, now codified in ORS Chapter 414, to extend the benefits of bulk purchasing of psychotropic medications to all individuals, regardless of age, and to providers who are non-governmental organizations providing services. It is in the public interest to make such medications available generally and widely at the lowest possible cost to people who need these medications and payers.

6. The 2005 Legislature should adopt legislative changes which will improve the efficiency of siting community-based housing that, operated in accordance with federal Fair Housing Laws, will support a System of Care approach throughout the State and will provide sufficient community housing to relieve the hospital gridlock we identify as Systemic Problem number six.

7. The 2005 Legislature should implement funding and protocols for the statewide adoption of electronic health and prescription transactions and records, including, but not limited to, mental health services. The legislative protocols should provide that sensitive records are confidential and subject to the control of patients. (The Governor has directed the Oregon Health Policy Commission and particularly its Quality Work Group, to address this issue.)

8. The 2005 Legislature should adopt legislation to require a mental health evaluation prior to a court committing a defendant to the Psychiatric Security Review Board.

B. Recommendations Related to the Interface Between the State and Community Mental Health Providers.

1. OMHAS must finish and implement a business plan to reinvent Oregon State Hospital in Salem as a "focus of excellence" facility to serve those individuals who cannot effectively or safely be served in a community setting and to develop appropriate supporting programs in Portland and Pendleton. This business plan should be finished during the fall of 2004 and implementation should begin immediately with available funds and resources, including community resources. This reinvention should be fully concluded by June 30, 2007, if not sooner.

2. The Governor should direct the Director of the Department of Human Services to create a plan for a unified and seamless approach to State funding and support of mental health services, including all possible integration with other health services and housing, to support a System of Care model. The Task Force urges special attention to the issue of simplifying and streamlining the functions of Local Mental Health Authorities and the Mental Health Organizations.

3. OMHAS, with existing and additional funding, must continue to provide State support for community programs and facilities, including funding for caseload growth and additional support to permit Local Mental Health Authorities to assume responsibility for individuals now in the State hospitals who are ready for discharge. OMHAS should implement, by policy, contract, and regulation if necessary, programs which provide funding and incentives to counties and community providers to achieve the following:

    a. Community-based System of Care services, described above, with measurable outcomes and coordination of services by local government agencies, non-profit and for-profit providers (including community gate-keeping responsibility for services currently delivered or authorized by State employees.

    b. Services that reflect people's needs and are recovery oriented.

    c. Housing and support services as appropriate.

    d. Residential facilities of not more than 16 beds.

    e. Specially designed treatment facilities as required for persons under the jurisdiction of the PSRB and individuals diverted from the criminal justice system

4. OMHAS and the Local Mental Health Authorities, typically counties, must – assuming adequate and sustainable State funding and in partnership with each other:

    a. Promote and implement a System of Care for children, adults, and older adults that honors the strengths, needs and dignity of individuals.

    b. Routinely divert persons from incarceration and hospitalization so that care and support for these individuals take place in community settings that are most natural and least restrictive.

    c. Accept increasing responsibility for assisting individuals to leave acute care and State hospitals, including individuals subject to PSRB jurisdiction.

d. Take full advantage of the State's prescription drug purchasing arrangements now in place under ORS Chapter 414 and any expansion of such opportunities.

e. Develop and maintain collaborative and transparent relationships with non-profit providers, including acute care hospitals, mental health organizations, and residential operators.

f. Integrate primary care, mental health, and addictions services.

C. Recommendations Related to the Criminal Justice System.

1. The State, by education and policy initiatives, must promote cultural recognition that recovery is an appropriate public safety goal best achieved in a community setting for most individuals and that a System of Care approach costs less than incarceration, produces more resilient individuals, and reduces recidivism. The Task Force recommends that OMHAS and the Department of Corrections develop a joint strategy to achieve this recommendation.

2. The State and Local Mental Health Authorities must train and retrain courts, district attorneys, defenders, corrections officers and police in all counties (i) to identify and properly respond to persons with mental illness and (ii) to understand and use community mental health and substance abuse programs.

3. Every county or region should have a 24/7 acute care crisis center, with State, local or federal funding as necessary, and potentially including funding from the corrections systems, to permit individuals, where appropriate, to be diverted prior to arrest and to receive individuals upon diversion from jail or court. There must be a standardized screening mechanism established in all correctional and juvenile justice settings to identify those individuals with mental illness or serious emotional disturbance. Police should make all reasonable efforts to divert individuals into such programs at the first encounter. Neither jails, emergency rooms, nor juvenile detention centers should be asked to be primary mental health providers.

4. The Chief Justice should ensure that judicial education programs include training for judges in mental health and substance abuse issues so that Mental Health or Treatment Courts are implemented where feasible. It is critical that funding for courts and treatment be included in the design and implementation of Mental Health or Treatment Courts.

5. The Governor and Legislature should assure that judicial, corrections and parole budgets provide incentives for early diversion, certainly prior to conviction wherever possible, taking public safety into account. The prospect of recovery is higher if an individual is diverted prior to conviction, because of the incentive to avoid a criminal record. This recommendation reflects the earlier finding that there are financial disconnects in the criminal justice system such that decision makers are neither aware of nor responsible for all of the costs of their decisions.

6. All correctional institutions and Local Mental Health Authorities must implement purchasing policies that benefit from bulk purchasing of pharmaceuticals by the State.

7. The State must provide and continue over time to provide adequate funds to build and operate community facilities as necessary to house individuals under the jurisdiction of the PSRB, as part of a goal to reduce the census of the State Hospital, both immediately and over time. Housing and treating individuals in community facilities will over time cost less and produce better outcomes, including reduced recidivism.

8. The present procedures for processing "aid and assist" and "restoration to competency" cases are time-consuming, expensive, and a burden to an already over-taxed Oregon State Hospital. The OMHAS Administrator and State Hospital Superintendent must include as part of their business plan for the State Hospital new protocols by which those services can be provided in various locations throughout the State with the objective of completing such services more efficiently and with uniform standards of evaluation.

9. The Superintendent of Oregon State Hospital and the Executive Director of the PSRB must continue their newly organized effort to improve communications between their agencies, develop shared treatment and discharge plans, and provide for the least restrictive community-based service wherever possible. OMHAS and PSRB need to have a rolling three-year plan for the build out and operation of community facilities to serve the individuals under the jurisdiction of the PSRB, and Local Mental Health Authorities must participate in planning to serve the needs of persons who are under the jurisdiction of the PSRB.

10. The Department of Corrections, OMHAS, the PSRB, and representatives of local law enforcement and mental health authorities must evaluate the possibility of creating a single forensic mental health facility to house and provide integrated services to individuals who cannot safely be treated in community settings.

11. The Department of Corrections and Sheriffs operating local jails should implement administratively the recommendations of the Bazelon Center for pre-release planning, to the extent possible without additional legislation. See Finding 1.d and Appendix F.

D. Recommendations Related to Workforce Training and Compensation.

1. The State must promote workforce training programs in the Oregon University System, the community college system, private colleges and private universities, public schools, and the vocational education system. The State should also promote continuing education, such that treatment teams maintain the skills for and conform to current evidence-based practices. See Appendix G, Proposed Recommendation on Behavioral Health Workforce Development.

2. The best incentive for an adequately trained and stable work force is to provide living wages and benefits to employees. The State must take all reasonable steps to provide adequate funding to pay providers fairly.

3. The State must develop an action plan to assure the development of work force resources for serving communities and persons of color in the next ten years. This work force action plan should focus on recruitment of persons from the major racial and ethnic groups in Oregon, and assure adequate numbers of well-trained bilingual and bicultural staff for the fastest growing ethnic group in Oregon, persons of Hispanic descent.

E. Recommendations Related to Regional Services.

1. Consistent with ORS 430, the State must encourage regionalization of mental health and substance abuse services where there is strong local support for such initiatives and where there is a reasonable prospect of cost-savings or better outcomes.

2. The Legislature should not mandate regional service delivery, but should consider providing incentives for regionalization.

3. Given the importance of achieving statewide implementation of a System of Care approach and culture, the energy and resources required for regionalization may be better spent in simplifying the administrative and financial organization of State services and developing integrated care services locally.

F. Recommendations Related to Integration of Care.

1. Integration of care for mental illness, substance abuse and physical health services is an essential part of a System of Care, particularly for those individuals who are uninsured or who are covered by Medicaid, Medicare or other public programs and for families with children who have serious emotional disturbances. The State must actively promote the development of integrated care delivery systems throughout the State. Integration of services, particularly as part of a System of Care, will reduce the recycling of individuals through various parts of the health care system and the juvenile and criminal justice systems. It will also allow for early intervention where possible, thus avoiding increased disability and cost.

2. The Public Employees Benefit Board (PEBB) is promoting integration of care for services to State employees. OMHAS, OMAP and other State agencies should coordinate their efforts with PEBB, to assure that the State is pursuing a common strategy for the development of integrated healthcare delivery systems.

G. Recommendations Related to Suicide Prevention.

1. The suicide prevention programs of the Offices of Public Health must develop a seamless working relationship with all State and community partners, so that the

best practices of suicide prevention can be implemented consistently throughout all State mental health programs.

2. The State should fund, and Local Mental Health Authorities should accept leadership to provide, comprehensive intervention and suicide prevention services in the schools and in places where senior citizens live and congregate, in recognition of the high rates of suicide among adolescents and senior citizens.

3. Parity legislation must include coverage for clinical depression, a primary precursor of suicide.

H. Recommendations Related to Evidence-Based Practices, Outcome Measurement, and Housing.

1. To achieve widespread implementation of evidence-based practices will require seed money, training and cultural change. The State must provide all of these resources and the leadership to see that evidence-based practices are implemented. At the very least, OMHAS must be provided with funding for pilot projects to validate various evidence-based practices and to demonstrate how they can be effectively implemented throughout Oregon.

2. There are developing tools for outcome measurement beyond the expertise of this Task Force to evaluate. OMHAS must make such tools available to all Local Mental Health Authorities and community providers, as well as OMHAS operated programs, OMAP, the PEBB and other State entities which purchase or influence mental health and addiction services.

3. One of the important uses of outcome measurements is to encourage constant process and outcome improvement. To that end, the data gathered from outcome measurement must be open and readily available to persons who use mental health services, the general public, and the Legislature, as well as to providers and regulators.

4. The state Office of Housing and Community Services and the Department of Human Services, Office of Mental Health and Addiction Services must use every means available to continue their partnership to develop specialized housing to match the needs of people with mental disorders.

I. Recommendations Related to Child and Adolescent Services.

The following recommendations reflect this Task Force's best understanding of the directions and recommendations of the Children's Work Group and are intended to support and further those recommendations:

1. OMHAS must integrate all intensive mental health services for children and adolescents through the Mental Health Organizations (MHOs). These services currently include: psychiatric day treatment, psychiatric residential treatment, therapeutic foster care, longer term treatment for adolescents at the Oregon State

Hospital, and the Secure Children's Intensive Program. The purpose of this integration is to provide the resources to local mental health authorities to create locally operated systems of care that are strengthened by family involvement, not only in treatment planning, but in system design, oversight, quality improvement and governance.

2. OMHAS must require and promote the development of local family-driven flexible and wraparound services. The purpose is to decrease either the numbers of children who are treated in institutional-like settings or decrease the amount of time children receive treatment in such settings.

3. OMHAS must hold the MHOs and the local mental health authorities accountable for changing local delivery systems, improving the quality of services available to children and their families, and expending all resources made available for treatment of children and their families for that treatment.

4. OMHAS must integrate the few resources that are available to serve children who are not eligible for Medicaid and the OHP into the local Systems of Care.

5. OMHAS must advocate for additional resources in order to begin to fund, at an adequate level, a full system of mental health care including prevention and early intervention services for all Oregon children and families who must rely on the public mental health system.

6. School-based clinics must provide a full-range of mental health intervention and suicide prevention services

7. School personnel, including teachers, counselors, administrators, and clinic personnel must be trained and retrained to recognize symptoms of serious emotional disturbance and alcohol or other drug problems that lead to suicidal behavior and to intervene appropriately.

J. Recommendations Related to Older Adults.

1. The Legislature and the Department of Human Services should work toward developing comprehensive mental health and addiction services for seniors and persons with disabilities. These services must include counseling, peer supports, community education, mental health and substance use screening within long term care facilities, increased involvement of primary care physicians in senior mental health and addiction through consultation services, on-site services, and geriatric mental health assessment tools geared to evaluate older patients.

2. There must be more flexible managed health care and long term care insurance coverage that provides for geriatric mental health and addiction treatment. These services must be carried out through a coordinated service and program approach within the senior and disability system as well as mental health and addictions systems.

K. Recommendations Related to Funding.

1. Although the Executive Order directs the Task Force to take existing funding constraints into account, and we have done so, we would be derelict in our duty if we did not recommend that the 2005 Legislature appropriate funds at a minimum sufficient to fund the recommendations we have made in sections A through I of this report. In addition, the Office of Mental Health and Addictions Services must develop a plan to move toward an equitable distribution of resources in the 2005-07 biennium and beyond.

2. The enactment of reasonable parity legislation will directly and indirectly reduce the caseloads and costs of the public mental health system, as well as other public social services.

3. Consistent with changes made as a result of the passage of HB 3024, OMHAS must prepare and provide to the Governor and the Legislature at least annually a rolling three-year business plan showing the opportunities for implementation of System of Care services throughout the State. The plan should forecast the direct costs of such services, how such costs might reasonably be borne by the State and by local mental health authorities, and how the investment in such programs will benefit society in terms of improved outcomes, better human productivity, and lower social costs.

L. Recommendation Related to Implementation

The Governor should designate the Oregon Health Policy Commission as the keeper of this report. OMHAS, together with other key implementers of these recommendations, shall report at least annually to the Commission on progress made toward implementation of the recommendations contained herein.

CONCLUSIONS

The Task Force offers the following concluding thoughts:

- The social and individual costs of neglecting mental illness far exceed the direct costs of providing services to people with mental illness and their families.
- The Systemic Problems of the State's public mental health system are well-documented over many years, at least since 1988. Regardless of the skill and commitment of individuals throughout the State, we will continue to experience these problems until we agree to rebuild our mental health system – and indeed, our entire health care system – to meet the reasonable needs of our growing and aging population. To continue to defer discussion of financing is to assure that the problems will grow and become more expensive in future years.

- There is widespread recognition that the System of Care approach, promoting recovery of individuals in the communities where they live, and combined with evidence-based practices, results in the best public health outcomes at lowest cost to society, particularly when combined with evidence-based practices.
- We ask that the State embrace and support the Values and Principles we have identified in this report and provide legislative, policy and financial support for the recommendations we have made.

Respectfully,

Jonathan Ater, Co-Chair	Erinn Kelley-Siel, Co-Chair
Todd Anderson	Doris Cameron-Minard, Ed.D.
Senator Margaret Carter	Heather Crow Martinez
Representative Bill Garrard	Susan Godschalx, Ph.D.
Sharon Guidera	Cliff Johannsen, Ph.D.
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Timothy Murphy	Michael Reaves, M.D.
Rollin Shelton	Sharon Smith
Representative Carolyn Tomei	Raymond Tricker, Ph.D.
Robert E. Nikkel	Senator Jackie Winters

APPENDICES

A - Executive Order

B - An Inclusive Map of Oregon's Public Mental Health System

C - Examples of Successful Local and Regional Programs

D - Summary of Parity Legislation in Various States

E - Costs and Timelines for State Hospital Restructure

F - Bazelon Center Model Legislation

G - Proposed Recommendation on Behavioral Health Workforce Development

H - Invited Presentations and Public Testimony Presenters

I - Acronym Guide