REPORT TO THE OREGON LEGISLATURE ON THE PROGRESS OF THE PLANNING FOR LOCAL MENTAL HEALTH SERVICES

Department of Human Services
Office of Mental Health and Addiction Services
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Introduction

House Bill 3024 that passed during the 2001 Oregon Legislature amended the Oregon Revised Statute 430 related to the planning for local mental health services. It requires Local Mental Health Authorities to develop a coordinated biennial service plan for their county or service district. The plan is submitted to the Department of Human Services, Office of Mental Health and Addiction Services. This statute requires the Department of Human Services to report to the Legislature on the planning progress. This report will provide an update on the local planning process, the statewide planning and performance measures.

Local Planning

In May 2003, the Office of Mental Health and Addiction Services (OMHAS) requested Local Mental Health Authorities (LMHAs) to submit a local mental health service plan for the 2005 – 2007 biennium. OMHAS provided LMHAs a guideline to assure that required elements were included in each plan. The timing of this request for local plans was adjusted to allow more time for the LMHAs to adequately plan for meeting the mental health needs of the county's population and to coordinate the plan with other stakeholders. In planning for the next biennium, the LMHAs were to ensure that local stakeholders were included in the development and review of the plans. This timing also allowed the local plans to inform the development of the Agency Requested Budget. Each local DHS Service Delivery Area Director was required to review and sign the plan.

Thirty-three local plans were submitted to the OMHAS for the 05-07 biennium. Thirty of the plans were from counties, two from service districts, and one was from a Native American Tribal Government.

Significant strengths were noted in Oregon's 2005-2007 local mental health plans. These included:

- ✓ A broad expansion of Evidence-Based Practices (EBP) in order to meet community needs and improve outcomes. Supported employment and supported education services for consumers with a serious mental illness is currently being implemented in Washington and Josephine counties. These

programs have demonstrated an increase in employment rates for consumers from 10% to 50%.

Other strengths in the planning process noted were:

- ✓ Involving stakeholders in the planning, including local law enforcement, child welfare, local hospitals and ambulance services, housing and vocational rehabilitation; and,
- ✓ Restructuring services after significant funding cuts.

These strengths will need to be built on as local planning continues.

In May 2004, a formal request went to the Local Mental Health Authorities (LMHAs) requesting an addendum to the local plans. This request centered on collaborative efforts to reduce the hospital utilization at Oregon State Hospital. Each community developed a Biennial Plan Amendment to rebuild local crisis and intensive case management services to assist in resolving the crisis of overcrowding at the state hospital. All CMHPs have approved plan amendments and OMHAS is closely monitoring the implementation of those plans.

Areas for improvement for the next planning cycle comprise:

- ✓ Increasing focus on meeting the mental health needs of older adults;
- ✓ Determining the ethnic, cultural and diversity needs of the local population and developing cultural competence in the workforce,
- ✓ Involving consumers throughout the planning process; and,
- ✓ Ongoing adoption and implementation of evidence-based practices as an avenue to improve quality services and outcomes.

Other coordinated community planning processes consistently inform the mental health planning processes. These include planning for community public safety, which emanates from the Local Public Safety Coordinating Council in each county. Housing and Community Services participates in several community planning processes. Services funded through Community Action Programs (CAP)s and related planning cover housing and HUD monies, the Community Development Block Grant programs, Homeless funds, rental assistance and more. CAP plans are completed on a biennial basis with required annual reports. Senate Bill 555 (1999 Session) established another local planning process that coordinates services to support children and families who are at risk.. This is planning process is administered through the Commission on Children and Families.

Statewide Planning and Initiatives

While OMHAS provides the guidance in the development of the local plans, the office incorporates input from the local plans into statewide planning efforts. This section will describe the ongoing planning process and three specific planning initiatives that have occurred this biennium.

The Mental Health Planning and Management Advisory Council is the mental health advisory board required by ORS 430. This planning council also meets the federal mental health block grant advisory council requirement. It provides guidance to the OMHAS Administrator in the areas of state planning, policy, and funding. One of its primary federally mandated functions is to provide oversight of the state mental health planning process for adults with serious mental illness and children with serious emotional disorders. The council is made up of 51% consumers, family members and advocates. Eight State agencies are federally mandated to have representation from Services to People with Disabilities, Seniors, Housing, Corrections, Youth Authority, Child Welfare, and Medicaid.

The following are four other significant initiatives that planned or started planning for the state public mental health system during this past biennium.

I. The Governor's Mental Health Task Force: This Task Force had broad representation from the Legislature, Higher Education, Law Enforcement, Association of Community Mental Health Program Directors, Consumer and Family groups and Oregon Psychiatric Association. It was established through Executive Order and given the mission 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 objectives, goals and outcomes based upon system-wide implementation of evidence-based practices; and
- Take into account the constraints of existing funding.

Public hearings were a critical component of the effectiveness of the Task Force. The Governor's Mental Health Task Force began their work in 2003 and completed it August of 2004. The final report to the Governor was issued September 2004. OMHAS staff are working on and tracking the progress of the implementation of recommendations in this report. The report made

recommendations in twelve areas ranging from possible Legislative action to collaborative work to improve training, access and treatment for people with mental illness who are in the criminal justice system. The full Task Force Report may be found on the web at http://www.oregon.gov/DHS/mentalhealth. Click on the Governor's Mental Health Task Force under the menu on the left hand side of the screen. The Implementation Action Plan is available on the site as well.

II. Evidence-Based Practices: The Community Mental Health System will adopt and implement evidence-based practices over the next four years (Senate Bill 267, 2003). The legislative mandate requires a certain percentage of total mental health treatment funding be directed to evidence-based practices. For the biennium beginning in July 2005, OMHAS must spend at least 25% of mental health treatment funds on evidence-based practices. The percentage increases from 25% to 50% in the 2007-09 biennium and caps at 75% in 2009-11.

Two workgroups were established to plan for the implementation of evidence based-practices: the Selection and Verification workgroup and the Adoption and Implementation workgroup. Broad representation in this planning process was instrumental in the efficacy and acceptance of the plan that was developed. Representatives in this planning process included those from Oregon's Higher Education system, local community providers, members of Oregon's ethnic minority communities, consumers, family of mental health consumers and experts in the field of mental health.

The Community Mental Health Programs (CMHPs) have been active in this planning process. The CMHPs have provided input into the state planning for implementing evidenced-based practices based on the local planning efforts. The CMHPs have also incorporated information from the statewide planning into their local planning process. The following is a sample of current evidenced-based practice projects occurring in Oregon counties.

- Supported employment: Supported employment and supported education are two evidence-based practices currently funded by the federal block grant and a Dartmouth University and Johnson and Johnson research study. Local sites implementing these pilot projects are Josephine and Washington Counties.
- Family psycho-education: OMHAS has contracted with the Oregon chapter of the National Alliance for the Mentally Ill (NAMI) to provide Family education and support for family members of adults with severe mental illness and children with serious emotional disorders. NAMI

provided 25 complete series of family psycho-education classes to family members.

- Consumer operated services: Oregon has received a Federal Real Choice System Change Grant that has been a significant force in promoting the development of consumer-operated services, specifically consumer run drop-in centers. During FY 04 there were 27 consumer run drop-in centers in Oregon communities.
- Support services: Personal Care Services are supportive services designed to assist the person with serious mental illness to live independently. These services may include housekeeping, grocery shopping, accompanying a consumer to the doctor or pharmacy. The need for the personal care services is assessed and authorized by the CMHP. The caregiver is paid a minimal hourly rate for up to 20 hours per month per consumer.
- Parent Management Training (PMT) refers to programs that train parents to manage their child's behavioral problems in the home and at school. In PMT, parent-child interactions are modified in ways that are designed to promote pro-social child behavior and to decrease antisocial or oppositional behavior.
- Wraparound (a treatment planning process model, not a treatment model). A wraparound approach allows for the provision of any service (traditional or nontraditional) that is specifically designed for individual youths and their families that enables them to achieve treatment goals and fulfill unmet needs. The Oregon's Children's Mental Health System Change Initiative will employ the wraparound planning process as a major tool in creating additional community-based services for children with serious emotional disorders. Professionals are also included as team members however; they should ideally make up no more than 50% of the team.
- Functional Family Therapy is a multi-systemic prevention program focusing on multiple domains and systems in which adolescents and their families live. Functional Family Therapy was mentioned several times in Oregon's local plans, which the CMHPs are beginning to implement. The program focuses on the treatment system with family functioning and individual functioning, and the therapist as major components.

Evidence-Based Practices facilitate the significant likelihood of meeting the following Oregon Benchmarks:

1. People are living as independently as possible.

2. People are able to support themselves and their families.
3. People are safe.
4. People are healthy.

III. The Children's Mental Health System Change Initiative: A Budget Note adopted by the Oregon Legislature in 2003 mandates the integration of children's mental health services, decreased reliance on institution-based care, increases in the availability of community-based services and requires family and community involvement at the policy, planning and child levels. Counties and regions have implemented local planning efforts to focus on the children's mental health system of care.

A broad state-level stakeholder-planning group was developed for the Initiative. The stakeholder group recommended six policy changes to OMHAS for consideration. The following policies were accepted:

- Level of Need Determination which outlines when children are eligible for intensive mental health treatment services.
- System Structure requires care coordination and the integration of services.
- Family Involvement mandates 51% family membership on local advisory committees to the Mental Health Organizations (MHOs).
- Workforce Development in Cultural Competence will facilitate a statewide needs assessment for culturally sensitive services and training to staff to achieve competence in providing these services.
- Data and Outcomes prescribes the measurement of outcomes achieved through the provision of services and the satisfaction of families with these services.
- Financing outlines the re-distribution of funding that has been based historically on the utilization and proximity to psychiatric residential and day treatment centers.

The Children's Mental Health System Change Initiative also involves other child and family related coordinating and system transformation efforts. The Criminal Justice Commission, Commission on Children and Families, Office of Mental Health and Addiction Services, Oregon Youth Authority, Public Health and local child welfare offices participate in a combined planning effort at the local level as envisioned by Senate Bill 555 from the 1999 Legislature. This effort covers services provided to a target population of children age 0 to 18.

These three planning initiative are relatively new and were not advanced far enough to fully influence the 2003-04 local planning for the Biennial Implementation Plans. The local plans are dynamic documents that are changed and adapted as statewide planning and actions progress.

IV. Oregon State Hospital Master Plan: This process was initiated by Legislative leadership due to concerns about the age, state of repair and suitability of the current buildings for treating patients with severe mental illness. Following approval of $120,000 funding for Phase I of the Plan by the November 2004 Emergency Board, the Department selected a national firm with experience in state hospital system planning. Phase I will provide an overview of the system needs, an analysis of the buildings and propose options for consideration by the 2005 Legislature. The Governor's Recommended Budget includes funding for Phase II of the plan which will be a more extensive, in depth review of system needs, a recommended role for the state hospital within the context of the system, and specific recommendations regarding size and components of a system including state hospital buildings.

This work includes and will continue to include broad stakeholder involvement and relies on previous Task Forces, Workgroups and planning documents as sources of information.

Data, Outcomes & Outputs

The Office of Mental Health and Addiction Services monitors and reports mental health prevalence data as required in ORS 430.640. OMHAS uses nationally recognized methods for determining prevalence rates. During FY 04 there were 2,665,710 adults residing in Oregon. The prevalence of severe mental illnesses for adult Oregonians is estimated to be 157,810. Of these, approximately fifty percent (75,706) are thought to experience a severe and persistent mental illness. During this same time period, there were 61,178 adults served in the CMHP system. Thirty-nine percent of the demand for public mental health services was met during FY 04.

There were 875,790 child residents in Oregon during FY 04. The prevalence of moderate emotional disorders for Oregonians ages 0 to 17 was estimated to be 105,095, which includes 7,357 children with severe emotional disorders. There

were 29,199 children accessing public mental health services during FY 04. This represented twenty-eight percent of the demand.

Investigation and commitment processes, determining with good cause whether an individual is an imminent danger to themselves or others, is a core responsibility of the community mental health programs. This is in line with the Oregon Benchmark of living safely.

The harm reduction effort is best facilitated at the local level. During CY 2003 there were 7,945 commitment investigations performed. Nine hundred and forty of these went to hearing to determine the risk to self or others. Of the persons that went to a hearing 747 were actually committed to the Department of Human Services due to being a danger to themselves or others. Approximately nine out of every ten persons investigated for civil commitment are diverted from civil commitment and served safely in the community.

Special Populations

The federal Center for Mental Health Services mandates that states engage in a planning process that requires broad agency, family and advocate involvement. Several areas are required to be addressed in the federal planning process. The Mental Health Planning and Management Advisory Council provides guidance to OMHAS in the planning process including consideration of needs related to specific special populations.

Racial and ethnic minorities: Of Oregon's total adult population, 14% are racial or ethnic minorities. Fourteen percent of the adults served by the public mental health system are also ethnic or racial minorities. Adult Native Americans & African Americans are slightly over represented in the population served. Hispanics are the most underserved (nearly 3 percentage points less than their representation in the total population). Adults of Asian descent are proportionately represented in the served population.

Native American and African American children are over represented in the served population (18 percentage points over their proportion of the total child population). Asian American and Hispanic children are under-represented in the served population. Overall percentages of racial and ethnic minority children are over-represented in the public mental health service system.

Homeless: Numbers of adults who are homeless and served in the public mental health system have dropped significantly during this biennium (by approximately 10% or 300 people). This is largely due to the cuts in Medicaid funding for mental health services to adults, i.e. the reduction in numbers eligible under OHP standard. Adults who are homeless have been the hardest hit by these cuts. The number of unaccompanied homeless youth being served through public mental health services has also dropped, perhaps for the same reasons.

Rural & frontier: Twenty-six counties in Oregon are considered rural, with 25% of Oregonians residing in these counties. Most Oregon communities have at least an outpatient mental health office with a part-time practitioner visiting that location. Rural Oregonians have difficulty accessing acute and extended psychiatric care and psychiatric evaluations. With the development of 'telemedicine' or videoconferencing capability the later service is becoming increasingly available.

Summary

As indicated in this report the local mental health authorities are complying with the planning requirements of ORS 430. This has been demonstrated in the submission of Biennial Implementation Plans. The CMHPs have continued to involve the local communities in the statewide planning initiatives. The state plans for the public mental health system with input from the local plans and the advice of the Planning Management and Advisory Council. The State will continue to monitor the implementation of the recommendations from the Governor's Mental Health Task Force Report. The state will implement evidence-based practices and the changes to the children's mental health system of care. OMHAS will continue to monitor existing performance indicators and develop performance indicators specific to monitoring system changes.