

**AOCMHP ANALYSIS OF PCG REPORT ON OREGON ADULT MENTAL HEALTH SYSTEM
MARCH 3, 2009**

OVERVIEW: In February of 2008 the Oregon State Legislative Assembly directed the Oregon Department of Human Services (DHS) to conduct an assessment and evaluation of the adult community mental health care component of the state's mental health care delivery system and appropriated money for that purpose. The result is a 168 page report dated November 2008. It makes 12 recommendations for improvements and restructuring of the community mental health system.

The PCG Report findings ascribe national leadership in a number of areas to Oregon's adult system including:*

Use of community mental health programs in Oregon is higher than the national average while hospitalization and admission rates are markedly lower than national averages. (p.7 and p.56)

Oregon's community programs are national leaders in implementing evidence-based practices in spite of receiving no additional funding (p. 11) and "evidence-based practices have been widely accepted and implemented across the state." (p. 13)

"This program [supported education]...together with more than 40 other approved mental health EBPs (evidence-based practices) places Oregon on the leading edge of the national initiative to implement consumer-driven, community-based EBP treatments to individuals in need." (p.30)

"...compared to other states, more individuals in Oregon are being served in the community instead of in hospitals." (p.58) "...if it is assumed that individuals have in fact been referred to appropriate sources for treatment services, then this pattern would indicate that Oregon is doing better than other states in providing non-institutional, more community-focused treatment." (pp.58-59)

Figure 4.2 "Comparison of Oregon to the United States" shows that the penetration rate for Oregon community based programs is 50% higher than the average in the United States as a whole; it shows that Oregon is 33% less likely to use the state hospital; and that Oregon's state hospitalization rate is one-half that of the rest of the country's (*In spite of Oregon's heavy use of the "Guilty Except for Insanity" defense compared to other states with similar PSRB systems*). (p.59)

***See pages 5-7 for list of additional PCG attributes to Community Mental Health.**

Recommendations:

PCG Recommendation #1: Oregon should establish a regional approach and contract with regional authorities for the delivery of mental health care services. The regional entity would be responsible for both Medicaid and non-Medicaid services. (*...A regionalized approach could be implemented using the existing MHO structure as the template for regionalization. Make statutory changes that either establish regional mental health authorities to replace existing local mental health authorities including the transfer of responsibilities or require the LMHAs to designate a regional authority to serve their populations*).

AOCMHP supports the development of “bottom up” regional strategies but not “top down” regionalization. PCG’s analysis of the data concludes that Oregon’s Mental Health System is performing beyond what one would expect with the resources available. We believe this is due to the County Local Mental Health Authority (LMHA) role and our current system’s ability to strike a balance between responsiveness to unique local needs and our history of pursuing the efficiencies of consolidation and collaborative initiatives, when appropriate.

Opportunities for regionalization have been pursued by LMHAs where consolidation or cooperative management of resources has proved to be cost-effective, more efficient, manage financial risk more effectively and most importantly, improve access and quality of the services to the individuals we serve.

The Mental Health Organizations (MHOs) are an excellent example of counties pursuing regionalization in localities where it was desirable. Other successful regional efforts, such as acute care regional initiatives, have also been pursued and have been highly successful.

There are also effective examples of administering Medicaid and non-Medicaid funding in a single regional organizational structure. This is currently done in Washington, Clackamas, and Multnomah Counties where the counties act both as the MHO and the Local Mental Health Authority/CMHC. We believe that other localities may elect to pursue similar models when advisable.

AOCMHP supports a “bottom up” rather than “top down” approach to regionalization in order to insure that a balance is struck between the need to lower costs and achieve administrative simplification and the need for local responsiveness and adaptability. With a “bottom up” approach, regionalized initiatives can be pursued in such a way that local community investment in planning and shaping the local system of care is assured.

AOCMHP strongly opposes statutory changes to shift the Local Mental Health Authority role away from County Board of Commissioners. Counties are uniquely positioned to serve in this role. Our Boards of Commissioners are elected officials accountable to their constituents and responsible for the health, welfare, and safety of their citizens and the livability of their region. Counties make significant contributions of local funds, \$17 million in 2008 and millions more in in-kind contributions of real estate, personnel support, and other resources, to support mental health services. Their responsibility in the areas of community corrections, juvenile justice, law

enforcement, jails, and public health mean that they are uniquely invested in a well-operated system of mental health services.

Finally, an imposed regional approach would not change the fact that the system is terribly under-resourced. We believe this is the absolute core of the inadequacies of our current system. Without recognizing this fact and addressing it, we will simply achieve a reorganized, under-funded mental health system.

PCG Recommendation #2: The emphasis in mental health program and funding priorities must be on increasing access to and strengthening community supports, including prevention and early engagement.

AOCMHP agrees with this recommendation. The 2007 legislature recognized this as well and put additional dollars in early intervention services (EAST-type programs) and acknowledged the Community Services Workgroup Report (March 13, 2007) as the blueprint to build additional capacity.

PCG Recommendation #3: Oregon needs to define the System of Care model that it is committed to implementing.

While AOCMHP believes that Oregon has a defined System of Care detailed in the Community Services Workgroup Report (March 13, 2007), A Blueprint for Action (September 2004), and the Mental Health Alignment Workgroup Report (January 2001) it is clear that the System of Care model has never fully been implemented or funded.

PCG Recommendation #4: Coordination of efforts among the DHS, the Criminal Justice System, the Department of Corrections, and Public Safety needs to be strengthened at the state and local levels.

AOCMHP agrees with this recommendation.

PCG Recommendation #5: The mental health needs of underserved populations should receive more attention (*especially seniors, people with disabilities and cultural and ethnic groups*).

AOCMHP agrees with this recommendation.

PCG Recommendation #6: DHS should interface with the reintegration efforts of the Oregon National Guard and the US Veterans' Administration in meeting the needs of returning veterans.

AOCMHP agrees with this recommendation.

PCG Recommendation #7: Funding for housing and supportive employment and education programs for individuals with mental illness needs to be increased.

AOCMHP agrees with this recommendation.

PCG Recommendation #8: The availability of community residential treatment programs needs to be increased.

AOCMHP agrees with this recommendation. Development of intensive supported housing models needs to be explored as an alternative to the more costly traditional residential treatment.

PCG Recommendation #9: The integration of physical and behavioral health needs increased emphasis.

AOCMHP agrees with this recommendation.

Over 100 integration projects are now in operation in nearly every county. Only 3 counties remain who do not have operational programs to address this with various subpopulations and those counties are moving forward with planning initiatives to get locally designed projects off the ground. Six counties formed their own FQHCs and DHS has designated a high level Special Assistant position to ensure the implementation of a systematic plan to achieve full integration.

PCG Recommendation #10: AMH needs additional funding in order to take the lead in creating greater accountability and transparency within the mental health care delivery system.

AOCMHP agrees with recommendation #10. While PCG identifies exemplary performance of the grass roots development of community mental health services at the local level there are 20 years of studies underscoring continuous levels of underfunding the community part of the system. This recommendation could introduce the kind of uniformity that could reduce the development of cost effective community alternatives that as the report notes “provides variety of services at relatively reasonable costs compared to other systems around the country.” It is precisely the bottom up grass roots development of community mental health initiatives that “places Oregon on the leading edge of the national initiative to implement consumer-driven, community-based EBP treatments to individuals in need.” DHS is currently undergoing a costly transformational process in an attempt to increase its own responsiveness and creativity that is already present in the community mental health system.

DHS has old data systems that are incapable of providing real time data about programs and services. We would welcome a modern data system that could ensure accountable and transparent outcomes and results available to the public.

PCG Recommendation #11: DHS needs to develop a data management system that provides accurate, timely, and insightful information in order to make informed management decisions.

AOCMHP agrees with this recommendation.

PCG Recommendation #12: The program to promote evidence based practices in mental health services should be reviewed.

AOCMHP agrees with this recommendation and is participating in AMH's steering committee that is currently reviewing Evidence Based Practice (EBP) policies and practices.

Additional Points:

- The report somehow completely missed the development of dual diagnosis programs in Oregon community mental health system over the past decade. The AMH website has posted a directory of well over 120 such programs; and in addition to that, Oregon's peer-delivered service initiative, Dual Diagnosis Anonymous has 350 groups meeting each month with well over 3,000 contacts occurring monthly as well. At least 5 more groups are in the formation stage and include projects within the walls of state hospitals and Department of Corrections institutions as well so that transition planning for dually diagnosed persons can have more meaning as people move to less restrictive settings. CMHPs provide the venues for most of these community-based meetings.
- The report makes it more difficult to discern Oregon's true rank in funding mental health services by using two different figures. First it refers to Oregon ranking 15th in per capita funding nationwide; later in a footnote, it shows that Oregon was ranked 40th by the National Alliance for Mental Illness. These two figures are not explained in enough detail for the reader to grasp which one makes more sense.
- Careful readers will reasonably have concerns about the fact that there are several allegations, without any evidence submitted, about the "transparency" issue. Transparency perceptions are always going to be present in a stressed and stressful environment; but CMHPs provide public reports to county commissioners on a regular basis; reports on their compliance with regulations are available by requesting them from AMH or the county of interest. AOCMHP will also gladly assist with gaining access to any information other than client information protected by federal and state laws. A number of reports are available in PDF and other formats on the AOCMHP website. (www.aocmhp.org)

***INNOVATION:**

Strong local efforts to address the shortage of safe and affordable housing (p.4); community partners, including many counties, have created such housing for over 1,200 adults since 1989. (p.54)

In spite of funding limitations, 18 counties offer supported employment services with 39% of the 646 adults receiving this services obtaining competitive employment. (p. 30)

The local biennial implementation plans address the full continuum of service needs, subject to available funding, including 24 hour-crisis services; secure and non-secure extended psychiatric care; secure and non-secure acute psychiatric care; 24-hour supervised structured treatment; psychiatric day treatment; treatments that maximize client independence; family and peer support and self-help services; support services; prevention and early intervention services; transition assistance between levels of care; dual diagnosis (i.e. alcohol/drug and mental health) services; access to placement in state-funded psychiatric hospital beds; pre-commitment and civil commitment in accordance with ORS chapter 426; and outreach to older adults at locations appropriate for making contact with older adults, including senior centers, long term care facilities and personal residences. (p.31)

Several counties, notably Multnomah and Deschutes, have “recognized reputations for providing mental health programs for adults; and there has been a concerted effort since 2003-04 to focus on older adult suicide prevention. (p.74)

Community programs implement a number of programs focused on earlier intervention for transition aged youth; these include the Early Psychosis Projects now operational to approximately half of the youth and their families in Oregon who experience a first psychotic illness episode. (pp.119-120)

***COORDINATION OF CARE**

Joint programming with Seniors and People with Disabilities (SPD) for enhanced care community placements. (p.8)

Figure 3.4 (beginning on p. 37) displays a comparison between a large and small county that indicates that virtually all of these and several other services are offered, either in a single or where feasible in multiple locations. (pp.37-39)

AMH has been working more closely with community partners to ensure a more orderly discharge to lower and less restrictive levels of care. (p.42)

Blue Mountain Recovery Center has as its goal, “...recovery and reintegration into the community...at the forefront of care.” (p. 42) The community programs, in partnership with the state, operate the services in the community to persons under the jurisdiction of the Psychiatric Security Review Board (PSRB). The recidivism rate of these individuals is 2.2% compared to the Department of Corrections rate of 31.4%. (p.45)

***ACCOUNTABILITY**

Estimates of the types and costs of services needed are consistent with previously unmet needs for prevention, case management, crisis and acute care services, housing and employment, and jail diversion programs. (p.7)

Counties appropriate \$17 million annually for adult mental health programs as Local Mental Health Authorities. (p.9)

AMH conducts on-site quality reviews of the CMHPs every 3 years. (p.11)

AMH has produced a Work Plan to identify system performance indicators and benchmarks against which these indicators are compared; it also publishes an Oregon Health Plan Utilization and Enrollment Report so that enrollment, service and hospitalization data can be monitored; it contracts with a private independent review organization for External Quality Review; and it reports to the federal government on National Outcome Measures. (p. 11)

Most CMHPs of any size have developed their own performance measurement systems to enforce quality standards for their local contractors. (p.11)

Oregon's adult community mental health system provides a variety of services at comparatively reasonable costs compared to other systems around the country. (p.13)

There are currently reporting systems in place that track and monitor the quality of services provided through community-based programs. (p.13)

The Community Services Workgroup Report provides “an excellent analysis of the investments that need to be made in the community mental health system.” (p.15)

The role of the Local Mental Health Authority is spelled out in statute and results in the creation, updating, review and approval of county mental health plans so that a comprehensive system can be developed for both Medicaid and non-Medicaid eligible persons utilizing funding from counties, tribes, the state and federal governments. (p.29)

“A review of surveys distributed by AMH finds a high level of satisfaction with services received by individuals over the age of 65.” (p.74)

Figure 5.21: “Administrative Expenses Related to Adults Mental Health Services” shows that counties get 2% for administering the entire range of expected services compared to 3% for the state hospitals and 8% for the MHOs. (p.121)

“AMH reports on National Outcomes Measures (NOMS)...This results in Oregon statistics being comparable with statistics from other states.” (p.122)

Both the county financial assistance agreements and the regional MHO contracts contain highly detailed requirements that are listed in the report and to which CMHPs providers and MHOs are accountable. (pp.125-126)

“AMH conducts on-site inspections of the CMHPs every three years. There are review teams that inspect all aspects of the CMHPs operations. The results of the inspections are provided to the CMHPs and a corrective action plan is developed.” (p.129)

