

Legislative Training on the Public Mental Health System

January 7, 2003

10:30 am – 12:00 noon

Hearing Room A

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Introduction

- “The inescapable presence of the mentally ill has always raised important issues. What is society’s obligation to them? What is the most effective way of meeting their varied needs? Should the protection of the public take precedence over the human needs of the mentally ill?”

Gerald N. Grob in The Mad Among Us: A History of the Care of America’s Mentally Ill, 1994

Early American Responses

- Before the American Revolution, care of persons with mental illness remained a family responsibility
- Colonial codes required local communities to assure the safety and well-being of their inhabitants
- 1641: First legal code contained references to “distracted” persons

Care arrangements before 1843

- Families
- Almshouses
- Poorhouses
- Asylums
- Hospitals
- Prisons and jails

Hospital Treatment Modalities

- Mild cathartics and warm baths
- Sedatives (camphor and opium)
- Funnel feeding
- Blood-letting
- Recreation and employment
- Solitary confinement and restraining devices

Early Oregon arrangements

- 1843 Provisional government formed at Champeog adopted laws and appropriated \$500 to defray expenses
- Probate courts directed to determine disposition of persons
- Used “a jury of twelve intelligent and impartial men” to investigate whether a person was “insane”
- If so, a trio of guardians appointed
- County responsible for paying cost of care

County and State tensions

- 1855: Counties' appeal for territorial funds granted
- 1856: Territorial funds revoked
- Marks the beginning of counties as the backbone of the mental health system
- Tensions continue to the present day between the state and county over their roles in caring for persons with mental illness

Oregon's first psychiatric hospital

- 1861: Dr. J.C. Hawthorne opened first private hospital in Portland
- 1862: Dr. Hawthorne was the only respondent to the Governor's solicitation for contract to care for 12 patients
- 1863: Population of institution more than doubled to 28 patients

Growth in state institution population

- 1862 12
 - 1863 28
 - 1866 77
 - 1870 111
 - 1874 194
- Mental health share of Oregon's 1877 state budget: **52%**

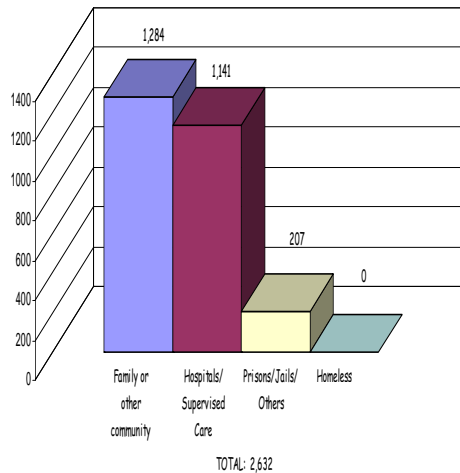
Development of State Hospitals

- Grew from the several private hospitals developed between 1820s and 1840s
- Dorothea Dix led movement to make public asylums the foundation of public policy between 1840s and 1860s
- First state hospital in US: Worcester, Massachusetts, 1833
- Expansion continued for over a century

Massachusetts 1854

Jarvis study

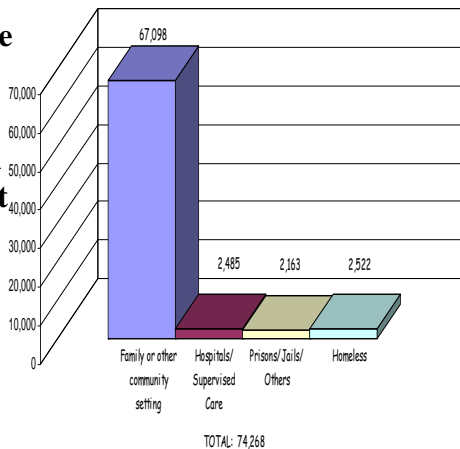
- Leading state in care of persons with mental illness, especially with hospitals
- Complete survey of all persons identified as mentally ill
- Reliance on hospitals, families, and city poorhouses
- Considerable use of jails

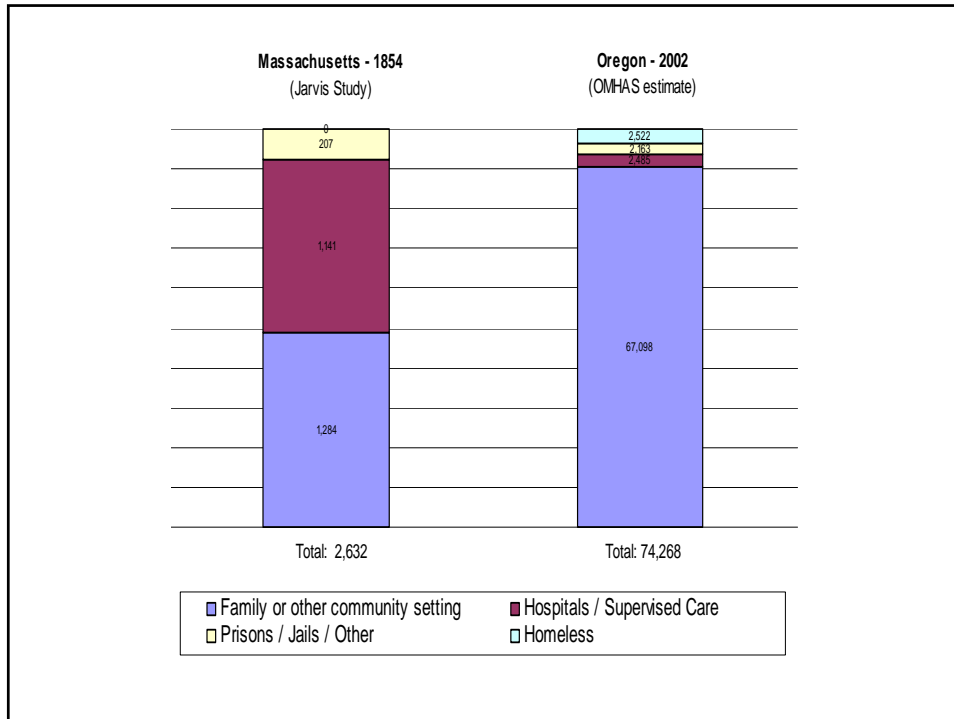


Oregon 2002

OMHAS Estimates

- **Budgeted 25% for State Hospital; 75% for Community**
- **Much more reliance on family and independent living**
- **Homelessness**
- **Still too many persons with mental illness in prisons and local jails**





Federal role in mental health care

- State and local responsibilities upheld by federal action and inaction
- 1854: President Franklin Pierce vetoed bill passed by both federal legislative bodies which would have established federal land grant resources to support state hospitals
- Nearly 100 years passed before federal government re-entered the mental health arena

Federal mental health initiatives

- 1930: Division of Mental Hygiene in US Public Health Service
- Operated heroin addiction programs but not mental health programs
- 1946: Passage of National Mental Health Act
- 1949: Establishment of the National Institute of Mental Health
- 1963 and 1965: Community Mental Health Centers Acts

Decline of State Hospitals

- State hospitals expanded rapidly during period of rapid population growth and opening of western states
- At turn of 20th century, shift in state hospital populations toward older adults
- Depression and World War II led to an awareness of increasing neglect

Psychiatry in post WWII

- In 1940, 2/3 of psychiatrists still worked in state institutions
- WWII focused attention on the mental health needs of “normal” populations rather than persons with serious and persistent mental illness
- Public health approach and psychotherapy dominated post WWII psychiatry

Rise of the community mental health centers

- Kennedy administration reviewed needs of persons with mental retardation and mental illness
- Led to passage of two Community Mental Health Center (CMHC) acts by federal government
- Funded development of facilities and declining grants for services

CMHCs disconnected from state hospitals

- CMHCs took a more public health and psychotherapy direction and ignored the needs of persons with severe disorders
- Meanwhile, improved drug treatment, increasing costs, and establishment of Social Security Income (SSI) depopulated the state hospitals in the late 1950s and 1960s
- Oregon's state hospital population peaked at about 5,000 in late 1950s

1980s-1990s

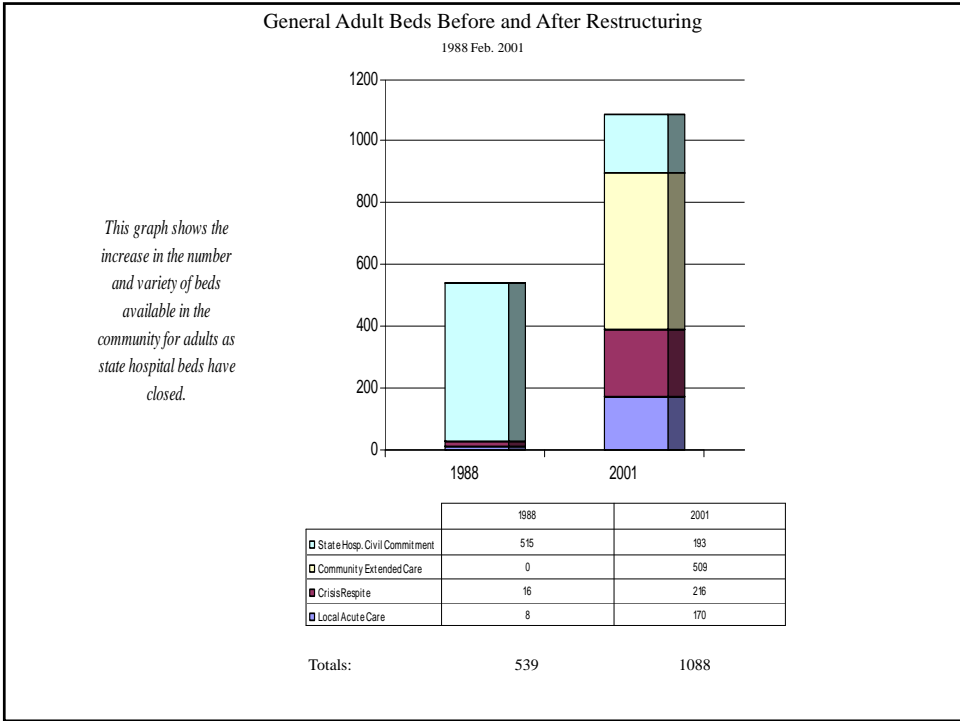
- Beginning of community support projects encouraged by National Institute of Mental Health (NIMH)
- Increased awareness of the impact of alcohol and drug abuse by persons with mental illness
- Rising costs of housing
- Homelessness and incarceration

Developments in Oregon 1990-present

- Training programs slow to catch up with research base
- Property tax limitation measure in the early 1990s forced increased reliance on federal funds for community-based services
- Oregon developed many model programs and approaches including the extended care system and Oregon Health Plan

Issues for the 21st Century in Oregon

- More mentally ill people in jails and prison despite dramatic increase in access to acute hospitalization
- Need to implement more Evidence-Based Practices
- Balance community needs with budget realities
- Balance needs for public safety and civil rights
- Achieve more cost effective methods for long-term care
- Respond to changing Oregon demographics
- Improved state/county/regional coordination



What is Mental Illness?

Psychotic disorders such as:

- Schizophrenia
- Major depression
- Bipolar disorder
- Attention deficit/hyperactivity disorder

Other disorder caused by trauma, including:

- War
- Abuse as a child or adult
- Response to a disaster

Treatment

These disorders can be disabling, but are treatable:

- People do better when the illness is identified and treated early
- Medications reduce symptoms
- Counseling helps people cope with symptoms
- Supports provide the ability to live independently
- Treatment for children should involve families, schools and others as soon as possible

Who Needs Public Mental Health Treatment?

Children and Adolescents Who

- Are poor and covered by the Oregon Health Plan or the State Child Health Insurance Program, or
- Have mental or emotional disturbances and are at risk of:
 - Removal from their homes, or
 - Developing more severe or persistent mental or emotional disorders, or
 - Hospitalization.

Adults Who

- Are poor and covered by the Oregon Health Plan, or
- Have major mental illness, and
 - Have severe symptoms such as delusions, hallucinations, unmanageable emotional highs and lows, or inappropriate social behavior, or
 - Are unable to meet their basic needs and/or are dangerous to themselves or others, or
- Have been found guilty of a crime except for insanity and placed under the jurisdiction of the Psychiatric Security Review Board.

How is Treatment Provided in Oregon?

In the community:

- 32 community mental health programs represent 36 counties
- Confederated Tribes of Warm Springs
- 9 mental health organizations manage service in 36 counties for people covered by the Oregon Health Plan
- 19 private agencies provide services statewide
- 23 community hospitals

In two State Hospitals at three locations:

- Oregon State Hospital – Portland Campus (68 beds)
- Oregon State Hospital – Salem Campus (604 beds)
- Eastern Oregon Psychiatric Center – Pendleton (60 beds)

Through Community Partnerships:

- County mental health programs
- Local schools
- Local law enforcement agencies
- Local alcohol and drug programs
- Area Agencies on Aging

State Level Partnerships:

- Housing and Community Services Department
- Oregon Youth Authority
- Local branches of:
 - Children, Adults and Families
 - Seniors and People with Disabilities
 - Vocational Rehabilitation Services

Department of Human Services
 Health Services
 Office of Mental Health and Addiction Services
 DHS Funded Public Mental Health System in Oregon

Type	System of Care	Funding Stream				Service Provider			
		OHP		NonOHP		County	MHO	Provider	State
		MHO	FFS	GF	XIX				
Less than 24hr	Prevention/Early intervention	☐	☐				☐	☐	
	Outpatient	☐	☐	☐		☐	☐		
	Case management	☐	☐	☐		☐	☐		
	Prescribing/monitoring medication	☐	☐	☐		☐	☐		
	Supports necessary to work/school	☐	☐	☐		☐	☐		
	Therapy (individual/group/family)	☐	☐	☐		☐	☐		
24hr	Youth Day Treatment	☐	☐	☐		☐		☐	
	Acute Care	☐	☐	☐		☐	☐		
	Adult Residential			☐		☐			
	Youth Psychiatric Residential		☐					☐	
	State Hospital			☐	☐				☐

OHP = Oregon Health Plan
 MHO = Mental Health Organizations - Manage services under the OHP
 FFS = Fee-for-Service reimbursement
 XIX = Medicaid - not part of OHP

October 16, 2002

Funding for the System

Legislatively Approved funding includes:

- Funds directed to the community, primarily through the counties, via a Financial Assistance Agreement or Contracts for noncounty providers.
- Funds directed to the state hospitals to pay for the intensive, long term services provided to people who are civilly or criminally committed to the state for care and custody.

- Funds directed to the mental health Oregon Health Plan Budget, for conditions covered by the Health Plan and the associated medically appropriate services. Most of these are contracted with managed-care Mental Health Organizations and are prepaid on a per member per month basis. The rest are paid as reimbursements for services delivered to people eligible for Medicaid but not enrolled in managed care.
- The Budget for the mental health system, including the state hospitals and the Oregon Health Plan is approximately \$1,157,263,560 of which \$534,112,517, or 46.2%, is General Fund.

Role of Federal Policy

- People with mental disorders excluded from Medicaid coverage
- Served in state hospitals which were denied Medicaid payment and labeled Institutions for Mental Disease
- No federal entitlement for adults with mental illness to receive Medicaid covered services
- States were prohibited from developing Home and Community Based Waivers for adults with mental illness

- Later, states were permitted to cover people younger than age 21 and older than age 64 in state hospitals
- The federal Medicaid program for children has an institutional bias and results in children and adolescents being eligible for Medicaid reimbursed services in institutional settings, but not when they return to their families in the community

Role of State Policy

- Throughout the mid 1980s, Oregon pursued opportunities to replace state General Fund with programs reimbursed by Medicaid for eligible persons
- Obtain federal Medicaid funds for allowable state hospital programs
- Maximize Medicaid in the community mental health system
- Allowed the system to serve people and make legislatively required reductions
- Providers learned to bill fee-for-service to Medicaid, costs for adults exceeded the Legislatively Approved Budget

- The Legislature reduced flexible General Fund (GF) from community programs to match the growth in federal Medicaid reimbursements
- By the latter half of the 1990s, several counties had lost all or nearly all of the GF needed to provide outpatient services to non-Medicaid eligible adults

In response to the fiscal crisis of the mid-1990s:

- The state closed state hospital wards, funded with GF and created community-based services which captured federal Medicaid for persons who are disabled due to mental illness and had previously been served in state hospitals for years

- For each state hospital bed closed, approximately 1.8 community beds were opened
- A system that relies on federal Medicaid funds and is limited in who may be served
- Only 5.7% of the C & A system was available to serve children with serious emotional disorders who were not Medicaid eligible
- For the adults **without** Medicaid eligibility, only 6.9% of the system was funded to provide services for them
- Across all funding sources and all components of the system in FY 2001-02, 71,135 adults received services and 29,024 children and adolescents received services; 100,159 Oregonians with mental disorders received publicly funded mental health services last fiscal year

State – County Relationship

- Oregon Revised Statute, Chapter 430, sets the requirements for the relationship between the state and the counties for mental health services. It is a partnership with the state providing the primary funding for the local system and with the county responsible for planning the local delivery system, delivering treatment services directly or through subcontractors and assuring the coordination at the local level.

The County Role

- Local Mental Health Authority – County commissioners appoint the community mental health director.
- System Planning – which has changed with the passage last session of HB 3024.
- Historically, planning was limited to the services funded by the state.
- Now the planning must include a full system of care (spelled out in ORS 430.630), the steps for moving in that direction, outcomes to be achieved, and a broad array of stakeholders must be included.

- This expanded responsibility came with new funding reserved in the emergency fund. There was up to \$1.0 million for planning and \$6.5 million for services. As of the 5th Special Session, \$750,000 in planning funds have been distributed to the counties and \$1.2 million remains for services, contingent on the outcome of the January 28, 2003 special election on a temporary tax increase.

- In accordance with Statute and subject to the availability of funding, the counties are to assure the provision of essential services. These include screening and evaluation to determine a person's need for services; crisis stabilization, hospital holds and investigations related to the civil commitment process, vocational and social services, case management, psychiatric care in state and community hospitals, residential services, and therapy.

- Locally, counties are the major focus of mental health information and advocacy, required to be involved with Local Public Safety Planning Councils and Commission on Children and Families for planning, and numerous other bodies. County mental health may be the first contact with the public system for many families in crisis.

The State Role

- Seek funding from the Legislative Assembly through the state budget process, seek funding from federal and other grant opportunities.
- As a result of HB3024, the state will develop a statewide mental health plan based on the county plans. This will be presented to the 2003 Legislature. In the following biennia, the state will report progress made on implementing the plan.

- Training and technical assistance to the counties to improve the quality of the services delivered and to make available the latest practices in the field.
- Standard Setting – It is the state’s responsibility to develop necessary administrative rules, policies, procedures and guidelines to assist the counties in their responsibilities and to assure the health and safety of the vulnerable people treated in the public mental health system.
- State staff conduct reviews and inspections of counties and the subcontract providers on a periodic basis to assure the health and safety of clients and the quality of the services delivered at the local level. These result in the certification or licensure of counties and providers.

Challenges

- There are a number of challenges facing the system, in addition to the obvious ones created by the current fiscal situation in the state.
- Work Force Development/Retention – Training in new practices that are determined to be more effective, training to deal with the changing population in Oregon – greater numbers of ethnic minorities, non-English speakers, an aging population.

- Evidence-Based Practices – The mental health field nationally has reached a place where there is research evidence that makes clear that certain practices are more likely to yield better client outcomes than others. There is much work to be done to move the administrative infrastructure and the workforce in a direction that supports the use of these practices, e.g. integrated services to clients with co-occurring mental illness and substance abuse disorders supported employment, and assertive case management.

- Recovery Focus – There are new best practices in treating psychotic disorders that suggest the earliest identification, work with the family, support of the young adult's social, academic and work development leads to less disability and less long-term reliance on the public system. Doing this while supporting older persons disabled as a result of years of mental illness and institutionalization is a major challenge.
- Demands for services beyond the budgeted capacity in the system strains local communities, leads to people with mental illness being incarcerated for minor crimes, leads to school failure for children.

- Increased Accountability – Moving the system from one that delivers outputs, i.e. numbers of persons treated to one that delivers outcomes is in process in Oregon. This is complicated by the economic situation, the obsolescence of much of the computer technology used by the state and the counties and the need to select outcomes that are closely related to the services delivered rather than large system outcomes.