

**Oregon Department of Human Services
Community Services Workgroup Report**

*A Complement to the Master Plan Phase II Report
on the Replacement of the Oregon State Hospital*

Version II, March 2009

Introduction

The State Hospital Master Plan Phase II Report released in February 2006 recommended significant investment in community mental health services in Oregon. The report stated, “Without the enhanced community programming, demand for Oregon State Hospital (OSH) beds will substantially exceed projections of size and cost.”

To address in more detail the need for community mental health services, the Addictions and Mental Health Division (AMH) convened the Oregon State Hospital Master Plan Community Services Workgroup (CSWG) in September 2006. Over the succeeding months, the CSWG received extensive input into the types of services needed, especially for those services that prevent individuals from needing more expensive and intensive services. The report provided a narrative description of each type of service, systematic estimates of the need for and costs of these services, and a timeline for implementing the services. The CSWG issued its report, including comprehensive program and financial recommendations in February 2007.

Update on 2007 recommendations

The Oregon Legislature provided an additional \$20.9 million in general fund for adult-focused community mental health services. This initial investment was a first step in improving Oregon’s mental health system. However, the amount provided was only 1/6 the amount recommended by the Community Services Workgroup. The funding was released to local Community Mental Health Programs (CMHPs) in late 2007 and early 2008.

The following are examples of how local communities utilized funds to develop and/or enhance services:

- **Crisis and Acute Care Services**
 - Development of programs to assist in the diversion of clients from hospital level of care.
 - Development of respite beds.

- **Jail Diversion**
 - Implementation of mental health courts and other programs that enhance the relationship of the mental health care system with law enforcement and county jails.

- **Supported Employment**
 - Funding for 440 indigent clients, who for various reasons were not able to be part of the Oregon Health Plan.
- **Early Assessment and Support Alliance (EASA)**
 - Program staff trained, and programs are in the early phases of implementation.
 - Approximately 180 additional non-Medicaid youth, age 16-24, and their families are being served.
- **Case Management**
 - Enhancement of existing services to improve quality of services for clients.

Current Status

In 2008, AMH reconvened the CSWG to update the original report as Oregon moves forward on building the new state hospitals. The 2008 CSWG agreed with the philosophy and recommendations in the 2007 report. The CSWG continued to stress that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. The significant difference in this report is that the CSWG no longer defines front-end and back-end services. The CSWG recommends that the system should be seen as a continuum of services that individuals may need to access at different points in their lives, as they manage their illness and progress in their recovery.

The CSWG issues this revised report as an addendum to the previous year's report, in order to inform the Department of Human Services (DHS)/AMH, the Governor, and the Legislature on the continuum of services required to complement the replacement of the state hospital facilities and to assure the new hospitals' success.

The CSWG acknowledges that the realities of available funding will influence the decisions made in response to this report. The CSWG recognizes that there are not yet sufficient numbers of qualified mental health professionals and other trained staff to fully implement the recommendations in the immediate future. However, the community system must be fully funded and functional by 2015. This allows both funding and staff development to occur over the next three biennia.

Regardless of funding realities, this revised report needs to be seen in its entirety. The components of the system are interconnected and interdependent. An array of services must be available that support individuals in recovery by allowing them to access services that meet their needs and desires. These services must be available regardless of the individual's location. Funding must be sufficient to develop sustainable programs throughout the state, and not to be so small that there is no way to create and maintain the programs and services.

Values

As has been articulated in previous reports and recommendations, community mental health services must be developed with values that support and empower individual recovery. The following statements, adapted from the Governor's 2004 Mental Health Task Force Report, summarize the values that drive the recommendations in this report.

- Recovery is a journey of personal healing and transformation, and is the goal of all mental health services.
- Treatment and supports must be consumer-directed.
- Services provided by persons who are recovering from mental health problems serve an invaluable role in supporting other people in recovery.
- Services must be available in communities where people live.
- Services must be evidenced-based.
- Safe and affordable housing is key to recovery.
- Services must be culturally and age specific.
- Services must recognize the effects of and support recovery from trauma.
- An effective mental health system coordinates and collaborates with the broader system of community services.

Determining the level of unmet need in Oregon

The prevalence rate for severe mental illness among adults in Oregon is 5.4 percent, which translates into 154,867 individuals in Oregon.¹ Some of these individuals are served in the public system while others receive services through the private sector.

¹ Based on estimates from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

A national research report states that approximately one-third of individuals with a serious mental illness are uninsured.² The same report states that under-insurance, even in states with parity, is a large barrier to accessing mental health services. Therefore, these rates under-report the number of individuals needing publicly funded services.

Extrapolating this data to Oregon, approximately 27,609 persons with a mental illness are currently uninsured and not receiving services in Oregon. Due to the nature of mental illness, with people fluctuating in their level of need during different stages of their illness, this report estimates that approximately 21,000 additional individuals need publicly funded mental health services at some time during a biennium.

These recommendations also assume a three percent population growth per biennium. All funding for services described in this report are General Fund dollars. This report assumes that new funding invested in one biennium will be included in the department's Essential Budget Level for the following biennium, so funding identified for each biennium is new funding.

Another category of unmet need is for the individuals who are not able to fully access services. They may be receiving some services through community programs. However, due to funding restrictions, regional differences, lack of treatment providers or other barriers, these individuals cannot obtain the full array of services they need. At this time, AMH cannot determine this level of unmet need. Still, the CSWG believes that the recommendations and assumptions specified in this report under represent the true need in our communities.

Traditional funding and targeted programmatic funding silos do not serve the best interest of the individuals we need to serve. Services must be seen as an array of options that allow people to access appropriate services depending on their individual need and desires. Local communities should be encouraged to develop innovative services that meet the needs of their communities and the people they serve.

² Coverage for All: Inclusion of Mental Illness and Substance use Disorders in State Healthcare Reform Initiatives
June 8th, 2008, NAMI

Recommendations for community services

Services needed in an effective community mental health system are outlined in these recommendations. In addition to identifying new services, the expansion of current services to meet the unmet needs is outlined. The costs for this expansion are stated in terms of additional funds needed each biennium from 2009-2011 through 2013 - 2015. Actual funding estimates are attached in Appendix A.

The recommendations are encompassed in the following categories:

- Expand early intervention and prevention services;
- Increase the availability of crisis services;
- Ensure access to acute care and alternative services;
- Increase the availability of case management services;
- Provide access to medications and medication management services;
- Develop supported employment and supported education services;
- Decrease criminal justice involvement with the correct treatment and services;
- Treat co-occurring disorders;
- Reduce health disparities through wellness;
- Increase safe, affordable and permanent housing;
- Institute culturally appropriate mental health services;
- Create services and programs for elders and young adults;
- Invest in peer-delivered and trauma informed services;
- Develop appropriate residential capacity; and
- Ensure proper oversight of the mental health service delivery system.

Recommendations details

Early intervention and prevention services

Overview

Early intervention and prevention services provide the best opportunity for ensuring an individual's long-term recovery. These services focus on early identification, support and mental health treatment for the individual, including supports for the family as well. Educating individuals regarding their illnesses and assisting them in developing skills to manage their symptoms are key components of the services.

Recommendations

All newly identified individuals should have access to early assessment and support. The state needs to invest enough resources to provide a complete range of services to this population.

Assumptions

Based on epidemiological research, the statewide need for services is estimated to be 360 new clients and their families per year. About 270 persons per year would require services funded by General Fund monies. The average length of service would be 24 months.

Crisis services

Overview

Crisis services at the community level are critical. Mobile Crisis Outreach Services provide crisis intervention in the community, at the location of need. Mobile crisis outreach increases the opportunity of stabilization in a client's community and not in the hospital. Crisis respite services provide a place in the community to stabilize a crisis, avoiding unnecessary hospitalization.

Recommendations

Oregonians should have access to appropriate crisis services in every community. The particular services would vary depending upon the specific needs in each community. The state should provide guidance on a core set of services.

Assumptions

To accurately determine the unmet need for crisis services can be difficult. Individuals without ongoing supports often bounce in and out of crisis. The Mental Health Alignment Workgroup (MHAWG) estimated that 25% of those not receiving ongoing services will need crisis services.³ CSWG believes this is still a valid starting point.

Acute care and alternative services

Overview

Acute care hospitals serve as an entry point to the public mental health system and play a vital role in the continuum of care. Unfortunately, due to lack of funding, limited number of mental health professionals and expertise, acute in-patient psychiatric services are limited to just a few hospitals. Access in community hospitals for Psychiatric Hold Rooms (for short term involuntary care) and sub-

³ Report to the Governor from the Mental Health Alignment Work Group; January 2001.

acute residential programs are also limited. Access issues are compounded in rural areas due to the considerable distance from hospitals with psychiatric units.

Recommendation

Acute care hospitals must be adequately compensated for the services they provide. Aside from the challenges facing hospital acute care service, options need to be expanded to provide sub-acute care when appropriate. This opportunity provides less expensive care options for patients who do not need hospital level of care, as well as providing a “step down” level of care for people leaving the hospital. Special consideration must also be given to the challenges in rural communities.

Assumptions

In calendar year 2007, AMH served 5873 adults in acute care;⁴ local hospitals have estimated that this is only 50% of the need. The existence of significant administrative burdens, financial losses for community hospitals and the shortage of state-owned psychiatric beds have contributed to the closure of hospital acute care beds. It is likely that if these issues are not addressed additional acute care beds will close, placing increased pressure on other parts of the system.

Case management services

Overview

Case management services are provided to persons in and out of a clinic setting. As part of the continuum of care, these services provide the linkage to services and supports. Case managers help individuals stay in their local communities and provide the additional supports for successful community reintegration after stays in the state hospitals.

Recommendation

Case managers play a critical role in an individual’s recovery by linking them to treatment services, community services and naturally occurring supports. Individuals needing ongoing mental health services and supports should have regular access to case managers. Every person leaving the state hospital should also have access to case management services. The level of case management services should be determined based on each individual’s specific needs.

⁴ Oregon Patient Resident Care System.

Assumptions

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to case management services.

Approximately 15 percent of persons with a serious mental illness require Assertive Community Treatment (ACT) level of service.

Access to Medications and Medication Management

Overview

For many persons with a serious mental illness medications are essential to healthy living in the community. However, for individuals without medical coverage, medications are too expensive to obtain. Accessing the medical professionals who can prescribe medications and monitor reactions is also problematic for individuals without medical coverage.

Recommendation

Community mental health programs need funding to cover the cost of medications for persons who have a gap in medical coverage and do not qualify for medication scholarship programs. Medication funding and access to licensed medical professionals who can assess and prescribe medications are a necessity.

Assumption

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to medications subsidized by the state.

Supported employment and education

Overview

Ensuring access for persons with a serious mental illness to evidenced based services that place and support them in competitive employment or education that leads to employment is necessary for continued recovery. As part of the continuum of care, supported employment and supported education assist clients in becoming productive community members and improves quality of life.

Recommendation

Oregon is a leader in the development of both supported employment and supported education. Supported employment is an evidence-based practice that has proven results. Supported education is a promising best practice. These services are currently only available in select Oregon counties; however, they should be available to all individuals who want them.

Assumptions

Studies estimate that 70 percent of persons with a serious mental illness express a desire to work. This means that more than 14,000 individuals may need supported employment or supported education services. Because studies have not been conclusive regarding the optimum length of supported employment services, this report assumes that 25 percent of those not receiving services should have supported employment or education services.

Reducing criminal justice involvement

Overview

In 2005 AMH and the Oregon Jail Managers Association survey reported nine percent of inmates have severe mental illness and the Oregon Sheriffs Jail Command Council reports 20 percent of their inmates have a mental illness. Jail systems are ill equipped to handle inmates with mental illnesses. When incarcerated, individuals with mental illness deteriorate quickly due to lack of treatment services. Reducing criminal justice involvement includes: jail diversion services, mental health courts and re-entry programs, all of which help individuals successfully manage their illness while they are in prison or jail, and develop a plan for when they return to their community.

Recommendation

As a result of inadequate resources for non-Medicaid eligible individuals, law enforcement has had to accept a far more central role in handling mental health crises in the community than it should have to assume. Services need to be in place to divert people with a serious mental illness from the criminal justice system, providing immediate services when a person is released from a local jail. These services are not widely available in every Oregon county.

Assumptions

According to the survey referenced above, the average number of daily jail bookings in Oregon is 540, which means that about 100 people with a serious mental illness are booked every day. Assuming that some of the bookings are repeat offenders, and some individuals can be served in traditional ACT programs, approximately 1,030 non-Medicaid eligible people per year will need forensic intensive case management services. Every county needs enhanced liaisons with local law enforcement.

Co-occurring disorder services

Overview

Individuals with Co-occurring Disorders (COD) are more likely to be homeless and die at the average age of 43.9 years compared to 74.9 for the rest of the population. COD is defined as a person with both a severe psychological disorder and a substance abuse disorder. Treatment for persons with a co-occurring disorder is most effective when addiction and mental health services are integrated.

Recommendation

Communities need access to specialized COD services. The system needs a standardized and universal screening protocol for all persons enrolling in mental health and addictions services. Addictions and mental health providers and physical health care providers must be trained to use these screening tools. Communities throughout Oregon have also identified detox for people with COD services as a high priority. Beds are particularly needed to serve the indigent population, which is growing as a result of the economic downturn.

Assumptions

Research indicates that the prevalence of co-occurring disorders in the population of adults accessing community-based mental health services averages between 20-30 percent, with outlying variables being age and mental health diagnosis.⁵ Washington State prevalence data note that 27 percent of individuals entering state treatment programs have a COD.⁶

Focusing on wellness

Overview

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die almost 25 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council.

⁵ Rush, B. & Koegel, C.J. (2008). Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System. *Canadian Journal of Psychiatry*; 53 (12): 810-821. **Note:** Research conducted in the United States.

⁶ Washington State Department of Social and Health Services; Division of Alcohol and Substance Abuse. (2008). *Abuse Trends in Washington State*.

Recommendation

Oregon must develop and support a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. Coordinated care for people accessing publicly funded health services will maximize early intervention for mental health and substance abuse issues. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions.

AMH should build on current activities within the Wellness Initiative. This should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.

Assumption

In the study referenced above, DHS gathered data on 527,564 persons who were treated for substance abuse, mental health problems or both, between 1996 and 2005, and matched with death records from 1999 to 2005. The data showed that people with mental illness die much younger than others in their age cohort. Based on these numbers, an important tool to adequately address this level of disparity is for Oregon to develop a wellness model focused on people with mental illness.

Housing that is safe, affordable and permanent

Overview

Stable housing is an essential element for anyone living with mental illness. Unfortunately many individuals become homeless, or lack safe and affordable housing. The stability of safe, permanent housing plays a vital role in an individual's recovery.

Recommendations

To help individuals locate and remain in safe, affordable and permanent housing, there needs to be:

- Appropriate transitional housing,
- Supportive housing options, and
- Rental assistance.

Additional funding is critical to the ongoing ability of the system to provide stable and affordable housing for individuals with mental illness. While developing additional facilities and providing supported housing are critical, rental assistance plays a vital role in keeping individuals in safe and stable environments. In

combination, supportive housing and rental assistance provide critical alternatives to group homes and other structured facilities.

Assumption

A 2005 state survey conducted by AMH found that more than 12,861 people were in immediate need of affordable housing, that over 2,500 needed supportive or structured housing, and that an estimated 3,000 adults with mental illness were homeless at the time of the survey.

Institute culturally appropriate mental health services

Overview

Oregon population is mostly Caucasian with a growing percentage of population being Hispanic, African American, Native American, Asian, and other ethnic populations. AMH data indicate that African Americans and American Indians/Alaska Natives tend to be represented in outpatient services at rates higher than their rates in the general population while Asian and Hispanic populations are served at lower rates.

Recommendation and Assumptions

The mental health system needs to provide culturally competent mental health services. The state and community mental health programs must provide culturally competent services. This requirement must go beyond the current requirement that information be provided to potential consumers, family members and others in a multi-lingual format.

AMH should develop outreach and intervention tailored to communities and populations by providing resources to pay for culturally-specific positions. These positions would function as project *promotores de salud* or community mental health workers to act as links between communities and the mental health care system, organizing their communities to achieve better mental health.

AMH should also continue efforts to reach African-Americans. Services should be delivered close to where individuals live, in settings that these individuals are willing to attend. Services could be modeled after many of the peer-programs that have proven successful.

Age specific services

Overview

Two populations of Oregonians require specific attention in the development of mental health resources due to barriers preventing their access to the mental health

system. These are youth, ages 16 to 24, and older adults, age 65 and over.

According to AMH's 2009 Report to the Oregon Legislature on Planning for Mental Health Services, almost every county noted a gap in mental health services for its older adult population.

Transition age youth and young adults are difficult to engage in services. They often do not understand how to access benefits. They do not have access to professionals who can help them navigate into adult services. The system has not developed the appropriate tools to be relevant to this age cohort. Additionally, the children's delivery system and the adult delivery system speak different languages and there is little connection and interface between the two distinct system. Currently, service rates drop by 80 percent for these youth and young adults.

Recommendation

CMHPs should have specialized staff that can help coordinate services and develop the capacity needed to serve these youths and older adults.

Assumptions

According to US census data, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Oregon needs to position itself to provide more services for this age cohort.

More than 34,000 children under the age of 17 receive mental health services. Since 80 percent drop from services, often entering the adult system much more impaired, Oregon is missing the opportunity to help more than 27,000 youths transition to adulthood smoothly and with the resources that they need.

Peer delivered services

Overview

Research is mounting that demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people that have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

An excellent example of peer-supported services is the establishment of Dual Diagnosis Anonymous of Oregon, Inc. (DDA). DDA conducts meetings throughout Oregon that are based on the 12 Steps of Alcoholics Anonymous plus 5 steps that focus on dual disorders of substance abuse and mental illness. In less than 3 years, DDA has grown to over 2,500 people attending meetings with more than 90 groups in 24 counties. As another example, the David Romprey Oregon Warm Line, staffed by peers, is a valuable companion to the delivery system.

Recommendation and Assumptions

Peer delivered services can and should be included in all the categories described above. For example, ACT services are enhanced when the team includes a peer counselor or case manager, and peers can provide support even in acute care settings. As the mental health services are funded and directed to the CMHPs, peer-delivered services should be incorporated into the development of services.

Contractual oversight

The community mental health system in Oregon relies on a strong partnership between AMH and CMHPs. Nearly all of the community mental health services are contracted through the CMHPs. Frequently when mental health service funding is enhanced, the CMHPs are expected to implement additional services without consideration of the costs associated with the administration of those services. Proper administration ensures that the planning, development, and delivery of mental health services occur with regulatory assurance and quality.

Residential Programs

Overview

Community residential programs provide a stepping-stone for people leaving the state hospital. The State Hospital Master Plan Phase II Report emphasizes the importance of a strong residential system as part of an effective mental health system. The report states, "...availability and access to these programs (*community residential*) are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community."⁷ The table below demonstrates the needed residential services by region between 2005 and 2030.

⁷ Oregon State Hospital Master Plan Phase II Report.

Community Residential Bed Need by Region⁸

Region	2005 ^a		2011b		2030b	
	Civil	Forensic	Civil	Forensic	Civil	Forensic
North Willamette Valley	749	118	865	233	996	365
South Willamette/Central Coast	356	27	380	51	430	101
North Coast	22	8	38	24	41	28
Southern Oregon	281	11	292	25	318	52
Central Oregon	29	7	67	45	87	66
Eastern Oregon	116	5	119	9	129	20
TOTAL	1,553	176	1,761	387	2,001	632

a Actual distribution of beds in 2005

b Assumes 50% civil and 50% forensic development

AMH developed 283 community placements in the 2005-2007 biennium and is projected to develop 299 in the 2007-2009 biennium. If funding for mandatory caseload growth is continued as part of the department’s base budget, AMH has determined that the need for community residential placements can be met with projected budget. AMH will plan future development to address current disparities in residential bed distribution. Special attention will need to be paid to the Central Oregon region, as it is the region that is most in need for residential development.

Further considerations

The CSWG identified additional issues but did not make specific recommendations for funding. The following warrant consideration as “front end” services are implemented:

Transportation

Mental health services need to be accessible to all who need them. While a majority of the population is located in areas with a public transportation system, many counties and municipalities have limited or non-existent public transportation. Distances to mental health services are significant in the rural areas. These issues need to be addressed as communities plan mental health services.

⁸ Ibid.

Rural costs

Another concern for rural communities is delivering mental health services on a much smaller scale. This often increases the cost of those services. CMHPs should work closely with AMH to assure the cost of rural services is considered as new funding is allocated. Additionally, rural communities should be encouraged to partner across traditional county lines. Regionalization could provide a mechanism to maximize resources.

Improved information system infrastructure

Effective planning for mental health services and effective monitoring of outcomes require information systems that can produce timely meaningful data. Electronic medical records would improve the coordination of individuals care across the system. Funding for the replacement state hospital facilities includes some funding for the Behavioral Health Improvement Project (B-HIP) to replace the hospital components of the archaic data systems upon which the mental health system relies. It is critical that the community services portion of the new data system also be funded.

Funding disparities

Each community or regional system of care in our State must have enough resources to fund a set of core services and supports. The Oregon State Hospital Master Plan will not be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate unless every region is funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area.

Our current system has great disparity in the level and type of state investment in our regions and communities. Historical precedent, insufficient funding of behavioral health care, significant cuts in indigent and Oregon Health Plan funds in recent years, extraordinary population growth in a handful of counties and an inability to fully address disparity all contribute to the current unmet need. AMH should work with the CMHPs as plans for the allocation of new funds are determined. AMH and the CMHPs have agreed that the use of the Kessler Prevalence Formula⁹ would guide future allocations of new funds.

⁹ Epidemiological estimate of how common a condition is within a population over a certain period of time.

Conclusion

The Oregon State Hospital Master Plan Phase II Report focuses on the replacement of hospital facilities. However, the number of patients to be served and the costs associated with building and running the new facilities, are predicated on a significant enhancement of the community mental health system. Without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

This report serves as an addendum to the 2007 report, informing the Governor, the Legislature and DHS what community-based services are needed to support the new state hospitals.