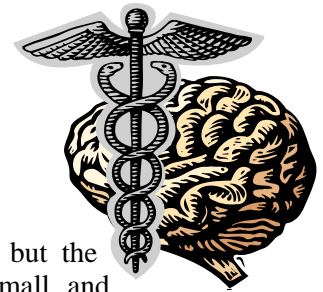


MENTAL HEALTH IN OREGON IN THE 1990's AND BEYOND



In Oregon, according to incidence statistics, about nine percent of adults over 18 (225,000) are severely and chronically mentally ill. Between 12 and 22 percent of Oregon children (105,000 to 194,000) are in need of mental health services. As a result of the League of Women Voters of Oregon's 1985-86 study of adult mental health in Oregon, League members agreed that individuals experiencing mental illness should be cared for, treated and supported in the least restrictive environment possible.

Changes in the 1990s

First, with the passage of the property tax rate limits in 1990, state-funded human services programs, such as mental health and developmental disabilities, have had to compete for funding with public education, other social services, public safety and transportation. At the same time a growing population has increased pressure on the mental health system, a major funding shortfall has occurred in the acute/crisis care area, which is experiencing tremendous client demand.

Secondly, the establishment of the Oregon Health Plan (OHP) in 1995 and the integration of mental health services into the rationed list of services (1996-97) have resulted in 85 percent of the Medicaid eligible persons being enrolled in managed care programs. There were approximately 287,000 adults and 231,000 children enrolled for 1999-2000. The OHP is a system of managed physical and mental health care which is permitted under a waiver of the federal Medicaid requirement. Mental health contractors are required to give an assessment and services to eligible citizens. Barriers to persons seeking services under the OHP are the stigma of admitting to a mental health problem and finding the right set of providers when there are multiple health issues. Major mental illnesses and those that are treatable according to the research literature are covered under OHP. There are several large provider corporations around the state which contract with the Mental Health and Developmental Disabilities Services Division (MHDDS) to provide mental health assessments and services. Eligible diagnoses under OHP are broader now than in the 1980s under the public mental health system.

For people not eligible for OHP (Medicaid), there is very narrow, limited access to mental health care. Some peo-

ple have insurance coverage, but the mental health benefits are small and capped. Those without insurance must depend on public mental health services at the local level (often unavailable in rural and isolated places) which are provided through county mental health programs funded partially by the state through federal block grant money (about \$4 million annually) from the Center for Mental Health Services. These services have not been adequate in the 1990s, particularly for children. This has led to incarceration for inappropriate public behavior, people "on the streets", and increased demands for early intervention and for more emergency care.

Thirdly, development of new community programs for formerly institutionalized clients has come about with the closure of Dammasch State Hospital (Wilsonville) and the Fairview Training Center for Developmentally Disabled (Salem) since 1995. It has been necessary to create housing, treatment services, case management and evaluation programs for over 500 persons with mental illness and over 300 developmentally disabled (DD) persons, each requiring an individualized plan. Two new wards were created at the State Hospital in Salem; a new state-of-the art 68-bed facility in Portland and two regional secure residential mental health facilities also were opened in the Portland metropolitan area; and a variety of residential options have been offered to both the mentally ill and the developmentally disabled in community settings.

Fifty percent of people with serious psychiatric disorders also have substance abuse problems; 70% of acute admissions to psychiatric care have a dual diagnosis.

Major Issues

Some issues critical to the stability of the mental health system are addressed below.

Dual Diagnosis

Dual diagnosis means a psychiatric disorder co-occurring with substance abuse/addiction. The statistics indicate the extent of the problem: 50% of people with serious psychiatric disorders also have substance abuse problems; 70% of acute admissions to psychiatric care have a dual diagnosis; 90% or more of the homeless with mental health problems also have a substance abuse problem. The inability of the mental health system to deal with dual diagnosis clients has created service gaps. For example, the lack of cross training for mental health and substance abuse professionals limits the ability to provide treatment.

Funding for treatment of mental illness and substance abuse is not integrated either at the state or local level. Caseworkers are being innovative in ways to provide dual diagnosis clients with one source of assistance for both problems, meshing the funds and the treatment. From only three county programs in 1987, the number has grown to 63 in 27 counties. Recognition is growing that every program (particularly residential care and programs for the homeless) should include dual diagnosis competency. A Dual Diagnosis Task Force completed its review in Spring 2000 and has made 40 recommendations in its report, some already implemented and some for the future.



Crisis/Acute Care

The MHDDS has had to go to the Legislature's Emergency Board (E-Board) for a budget "rebalance" during the interims in both the 1997-99 and the 1999-2001 bienniums to request funds to address the crisis in acute beds across Oregon. Eight years ago there were 2000 acute care cases annually. Currently, there are 6000 new admissions to the system each year. This has led to a 40 percent increase in the number of persons approved for transfer to long-term care in the state hospitals in the last two years although the admission criteria have not changed. The Oregon population is increasing and with it more people who have psychotic episodes. There has been some improvement in access because of the Oregon Health Plan and the encouragement of voluntary admissions. However, more community capacity and extended care capacity are needed. Having crisis beds in the community can prevent state hospital admissions most of the time, which saves local money for additional community treatment. Some 120 additional community beds have been opened since 1997, but the demand still exceeds the supply.

Parity

The issue of parity (equivalent benefits in insurance coverage for physical and mental illnesses) was discussed in both the 1997 and 1999 Oregon legislative sessions. The final version of the bill, passed in 1999, provided only for a 25 percent increase in the coverage for mental health related services. The Oregon Health Plan provides the uninsured poor with very good benefits. Employed persons with health care coverage, people who work for employers who are self-insured, and employed persons with no insurance have to be very sick in order to get some help. More than 30 states now require parity, and parity increases health insurance premiums from one to four percent, according to advocates and providers respectively. Oregon state employees do not have parity in their health insurance package, and with health

cost increases, it is not likely that the Legislature will require parity in mental health coverage.

Caregivers

There are between 5000 and 6000 staff members in state hospital and community programs around the state. The line staff in 24-hour facilities has the lowest pay. Small population counties in Eastern and Coastal Oregon have lower salaries and benefits than those in the Willamette Valley. As part of the closure of Fairview, caregivers for the developmental disabilities population were given a raise. During the 1997-1999 biennium, the wage for community care providers was raised \$1, at the rate of 25 cents every six months. Most work at or a little above the Oregon minimum wage of \$6.50 per hour. Mental health caregivers are not quite at parity with DD workers. The turnover rate of caregivers is in the range of 110 -115 percent per year.

Security checks of caregivers regarding previous criminal history are done by the MHDDS. Persons convicted of serious crimes will not be hired. Every caregiver is fingerprinted. Abuse and neglect in institutions by caregivers has been a greater problem than criminal history. County mental health departments receive help from the state to evaluate accusations of abuse, and every death is carefully investigated.

Language continues to be a problem. There are Spanish-speaking caregivers working with people who don't speak Spanish, and Spanish-speaking patients who need Spanish-speaking caregivers.

Corrections and Law Enforcement

Transportation of persons in mental crisis from a community setting to a state facility is usually provided by local law enforcement agencies - a time consuming responsibility. There are still many law enforcement personnel who do not understand mental illness. Mental health professionals believe improvement would be possible if jails had programs for mental health workers to meet with mentally ill inmates while they are still in jail to plan for housing, medications and employment. While some jails still have at least a nominal mental health component, most do not. At the state level, the Corrections Department has interest in having a mental health professional available for assessment and counseling, but funding is inadequate. The MHDDS received funding during this biennium to provide a quality assessment and a staff member to coordinate with Corrections in establishing a program for the mentally ill. Persons who are tried for committing a crime, but judged guilty except for insanity, serve their time in the Forensics Unit at the State Hospital. When the Psychiatric Security Re-

view Board determines a person is capable of living in the community, housing, supervision and treatment may be authorized.

Developmental Disability (DD) Wait Lists

Two problems plague the community programs for the developmentally disabled. The first, need for support for families who care for DD adults, has grown as more people were released from Fairview. Some three to four thousand clients are involved. Additional funding is needed to assist these families in providing 24-hour care. The second problem is the long wait list for DD students transitioning from the educational program, which goes through age 21, to some type of employment or work experience. Supported employment is a critical element for stability in the lives of DD clients. The wait list has exceeded 3000. The 1999 Staley agreement, which settled a suit against the state, is intended to reduce wait lists and improve the provision of services. There is a six-year phase-in of the agreement, with a total cost of approximately \$500 million through 2009. It will increase the availability of comprehensive services on a non-crisis basis, provide universal access to support services for all eligible individuals, and define an appropriate planning process and implementation procedures.

OHP Integration and Consumer Involvement

At the start of the Oregon Health Plan, services for the mentally ill were not available. The phase-in of 25 percent of the Medicaid eligible mentally ill started in 1995, and the managed care mental health programs through community providers have been available since 1998. One of the primary issues has been the extent to which mental health services consumers and their families can be involved with their treatment plans and the evaluation of the services received. As part of the contracts with the provider groups, the MHDDS has incorporated requirements that there be interaction between the providers and the families/consumers, usually through some type of panel, council or board which reviews procedures and opportunities. The division has established a Consumer Technical Assistance Office which oversees the interests of mental health services consumers and is directed by a consumer.

Fiscal Issues

Since 1981 the state has had responsibility for funding treatment for those persons unable to care for themselves or a danger to others. Other areas of mental illness are to be funded "subject to the availability of funds." The Leg-

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islature rarely funded even the priority area at more than 60 percent of the need. Many counties no longer budgeted for mental health programs, depending only on state dollars.

Over the last 10 years, state funding for mental health programs has increased, and new programs have been initiated, but because of the increase in population, there has never been enough to create the new housing and employment programs which consumers seek. Supported employment increased from 200 to 500 people, but many more seek work projects.

The division requested \$751,835,999 for 2001-2003, but the Governor's proposed budget for mental health community programs and institutions is \$726,878,227. It includes some increases to account for case load increase and inflation; however, it barely meets continuing the current services level, and it excludes any cost of living adjustment (COLA) for the continuing service level programs. It is difficult to compare the proposed budget to the 1999-2001 budget because the 1999 Legislature took dollars away from the state hospitals, and what appear to be additions this time are merely add-backs. Included in the proposed budget are 120 beds for the crisis/acute care system. Of major importance is the recognition by the Department of Administrative Services that the mental health services portion of the division has a caseload, so the forensics caseload (state hospital patients accused of crimes, those adjudicated, and those awaiting trial) will be funded. While funds for DD clients have usually been allocated as a lifetime entitlement, only very recently have funds for the severely and persistently mentally ill been allocated on the basis of long-term care needs.

The proposed budget includes \$380 million for the Oregon Health Plan (\$400 million requested) and continuing service levels for community treatment, the State Hospital and Eastern Oregon Psychiatric Hospital. In priority order, the division had presented several add-on packages. Of the 14-project list of new packages, four were included, including a 25-cents-per-hour salary increase for provider workers and children's mental health assessments and treatment. The entire add-on package totals \$13 million. The projected shortfall of \$700 million in the state's revenue makes full funding of the Governor's budget doubtful. The division's priority, not included in the proposed budget, was a Mental Health Safety Net comprehensive community system of mental health care for all persons in need, regardless of Medicaid enrollment.



The Olmstead Decision

An emerging issue for Oregon's mental health system in 1999 was the U.S. Supreme Court's Olmstead decision. This ruling held that a violation of the Americans With Disabilities Act (ADA) occurred when two women with developmental disabilities as well as psychiatric impairments were held in the restrictive environment of a Georgia state hospital when they could have been safely released to their preferred community living arrangements. In 2000, the MHDDS initiated a planning process to review the status of persons who have been determined to be ready for discharge by their treatment teams. The effect of the Olmstead decision over the next several years is anticipated to support the long-term state policy of moving persons to least restrictive community-based programs rather than to large institutional settings. In Oregon the estimated cost to implement the necessary arrangements is \$30 million.

Summary

The positive improvements in the mental health system since 1990 include the

- Oregon Health Plan with its mental health component,
- continuing commitment to a consumer-centered system,
- a less restrictive environment of treatment and support resulting from the closing of the institutions.

Continuing concerns into the next biennium and beyond are

- the need to develop an integrated system (e.g. dual diagnosis) that is locally planned, highly accountable to the state and provides coordinated care,
- improvement in access to the system particularly to eliminate the wait lists by increasing availability and breaking down barriers to service,
- one place in each community where priorities for treatment are set and a range of services are established to meet the needs.

Two groups which have been meeting for many months

are expected to present recommendations to the Legislature. The Governor's Mental Health Realignment Task Force has been examining the entire mental health system, and a Joint Interim Judiciary Committee has been looking at the procedures and policies around civil commitment. It is essential to follow the legislative process and to participate in the ongoing debate about the Oregon mental health system.

Sources

- 2001-03 MHDDS proposed budget. 2000
- Governor's Proposed Budget, 2001-1003. 2000
- The Oregon Health Plan. 2000
- Oregon Population and Special Population Estimates, Portland State University. 2000
- Dual Diagnosis Task Force Report. 2000
- Preliminary Report, Governor's Mental Health Realignment Task Force. 2000
- Adult Mental Health in Oregon. League of Women Voters of Oregon. 1986
- Supplement to 1987 Adult Mental Health in Oregon. League of Women Voters of Oregon. 1990
- Progress Report. Oregon Department of Human Services. 2000
- Information from: Deschutes, Curry, Umpqua, Clackamas and Douglas County Mental Health Programs

Interviews

- Barry Kast, MHDDS Director
- Madeline Olson, Mental Health Services Director
- James Toews, Developmental Disability Services Director
- Bob Nikkel, Mental Health Services Deputy Director
- Jeff Davis, Marion Mental Health Program Director

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