Beverly J. Wright
Assistant Director

PHONE 503-761-7139 FAX 503-761-7917

e-mail: bev@serendipitycenter.org
school address: 14815 S.E. Division • Portland, OR 97236
mailing address: P.O. Box 33350 • Portland, OR 97292

Belinda Marier, MS
Executive Director

PHONE 503-761-7139 FAX 503-761-7917

e-mail: belindam@serendipitycenter.org
school address: 14815 S.E. Division • Portland, OR 97236
mailing address: P.O. Box 33350 • Portland, OR 97292

#1

SPEAKER SIGN UP CARDS

DATE 08-06-01

NAME LADDIE READ

ADDRESS

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health

GIVE TO BOARD CLERK

#2

SPEAKER SIGN UP CARDS

DATE 8-016-01

NAME Rosalie Peggy Hammond

ADDRESS 4181 SW Council Crest Dr
Portland, OR 97201

PHONE 503-222-5396

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Funding for Mental

GIVE TO BOARD CLERK Illness

#3

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME Ruth Ascher

ADDRESS

PHONE 777-3420

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Access to Services

GIVE TO BOARD CLERK

#4

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Caroline Hess "CAROLEENA"

ADDRESS _____

_____

PHONE 524-4678

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Contracts 1

GIVE TO BOARD CLERK

#5

SPEAKER SIGN UP CARDS

DATE August 6, 2001

NAME Scott M. Murray, M.D.

ADDRESS 3874 NE Alameda

Portland, OR

PHONE 503-659-7311

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Acute Care Resection

GIVE TO BOARD CLERK

#6

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME Ian Chisholm

ADDRESS 731 SW Salmon

Apt 615 Portland, OR

PHONE 222-5660

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health Advocacy

GIVE TO BOARD CLERK

#7

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Sandra Chisholm

ADDRESS Po Box 674

Trout Dale Or 97060

PHONE 666 6981

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC mental health advocacy

GIVE TO BOARD CLERK

#8

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME José Eduardo Rivera

ADDRESS 202 N Bridgeton Rd.
Portland, OR 97217

PHONE 503-283-2682

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MENTAL HEALTH

GIVE TO BOARD CLERK

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Latino Consumers

ADDRESS 1607 NE Killingsworth
Portland.

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

SPEAKER SIGN UP CARDS

DATE 8/4/01

NAME Consumers Youth Latino

ADDRESS 1607 NE Killingsworth
Portland, OR

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Latino Americans / Nina Alvarado

ADDRESS 1607 NE. Killingsworth
Portland, OR

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

SPEAKER SIGN UP CARDS

DATE 8/1/01

NAME Latino Consumer

ADDRESS 1607 NE. Killingsworth
Portland, OR

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

- Steve Lorea
  #11 ↑
- Nancy Robles
  #10 ↑
- #13 → Brenda Reyes
- #14 → Nalleli Ignacio
- #12 Maria Ignacio
- Leticia Zepeda
  #9 ↑

Latino Consumers

SPEAKER SIGN UP CARDS

DATE _____

NAME _____

ADDRESS _____

_____

PHONE _____

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC _____

GIVE TO BOARD CLERK

#15

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Jaron Martin

ADDRESS 2331 NE 47th
Ptld, OR 97213

PHONE (503) 287-9891

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

Health System

Legacy Health System
Project Network

2631 N. Mississippi
Portland, Oregon 97227
(503) 335-0855
(503) 335-8125 *Fax*
(503) 301-5172 *Pager*

Kathie L. Prieto, L.C.S.W.
Operations Manager
Project Network, Da Da Kidogo

#16

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Kathie Prieto

ADDRESS 683 NE Alexis Ct.
Hillsboro

PHONE (503) 525-2160

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health Redesign

GIVE TO BOARD CLERK

#17

SPEAKER SIGN UP CARDS

DATE 8-06-01 "BOWMAN"

NAME DEBORAH J BOUMANN

ADDRESS 714 S.E. BIDWELL

PORTLAND, OR. 97202

PHONE 503-239-0406

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MENTAL HEALTH ISSUES

GIVE TO BOARD CLERK

#18

SPEAKER SIGN UP CARDS

DATE Aug 6, 2001

NAME Chocka Guiden

ADDRESS 11630 SW Clay St
Portland, OR 97201

PHONE 503 291-6633

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health READ Corliss

GIVE TO BOARD CLERK the Keever Testimony

#19

SPEAKER SIGN UP CARDS

DATE 8-6-91

NAME DELORIS STORKE

ADDRESS 3032 SE 15th AVE

Portland 97202

PHONE 503-771-1668

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Health Care Crisis

GIVE TO BOARD CLERK

#20

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Adrienne Livingston, Black United Fund

ADDRESS 2828 NE Alberta St.

Portland, OR 97211

PHONE 503-282-7973

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Supporting culturally specific programs

GIVE TO BOARD CLERK

#21

SPEAKER SIGN UP CARDS

DATE 8/06/01

NAME Frances Sarna

ADDRESS 3635 SE 14th

PHONE (503) 236-0390

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Acute Care Crisis

GIVE TO BOARD CLERK

#22

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME Shura Young

ADDRESS 2727 SE 16th Av

Pld 97202

PHONE 503 232-5043

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Dual eligibles re: Budget

GIVE TO BOARD CLERK Report

#23

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Jackie Mercer

ADDRESS NARA

PHONE 503-621-0114

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#24 AFTER 7:00 PLEASE

SPEAKER SIGN UP CARDS

DATE 8/06/01

NAME KAY TORAN / SHIRLEY ROBERTS

ADDRESS 5010 NE 33rd

PORTLAND OR

PHONE (503) 249-1731

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MENTAL HEALTH

GIVE TO BOARD CLERK

#25

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME Linda Reilly

ADDRESS 3668 SE Cooper St.

PHONE (503) 774-1824

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Overall Plan

GIVE TO BOARD CLERK

F26

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Bob Head

ADDRESS 18288 SE 43rd Ave

Port 97215

PHONE 503-232-3849

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC ~~1-10 etc~~, MH

GIVE TO BOARD CLERK

#27

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME SHARON BJORTVEDT

ADDRESS 13115 SE FOSTER #43

PORTLAND, OR 97236

PHONE 503-761-8768

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#28

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME RAMON QUIROZ-SALTOS

ADDRESS 9229 N. CHASE AVE.
PORTLAND OR. 97217

PHONE 503-285-4197

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MH

GIVE TO BOARD CLERK

#29

SPEAKER SIGN UP CARDS

DATE 8-5-01

NAME Angie DeRouchie DeRouchie

ADDRESS PO Box 8842

PTL OR 97207

PHONE 503-228 3279

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC CCHROREGON@EARTHLINK.NET

GIVE TO BOARD CLERK

#30

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Carol Boos

ADDRESS 775 NE Lenerhurst Place

Port 97232

PHONE (503) 232-2714

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC 8.

GIVE TO BOARD CLERK

#31

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME James Buck

ADDRESS 362 SE 15th St

Gresham 97080

PHONE 503 618-2447

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health Planning

GIVE TO BOARD CLERK

#32

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Brenda Boggés

ADDRESS 1506 NE 65th

Portland 97213

PHONE 5032870489

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Benefits on acute Mental Health Services

GIVE TO BOARD CLERK

#33

SPEAKER SIGN UP CARDS

DATE 8/6

NAME Angela Steckly "Steckley"

ADDRESS 2793 SW Roswell

Pdx 97201

PHONE (503) 279-0256

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#34

SPEAKER SIGN UP CARDS

DATE 08/06/01

NAME Patricia Nicol Flemire

ADDRESS 2631 N Mississippi
Port, OR 97227

PHONE (503) 335 0855

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#35

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Gary Magnuson

ADDRESS 512 SW Shrills Ferry Rd
apt. 1110 Portland 97225

PHONE 503.203.8725

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health

GIVE TO BOARD CLERK

36

SPEAKER SIGN UP CARDS

DATE Aug 16 01

NAME Kebala Dorn

ADDRESS 2631 n. Mississippi

PHONE 335-0855

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#37

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Brenda Spearman

ADDRESS 1816 N.E. Sunior

PHONE (503) 247-2920

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#38

SPEAKER SIGN UP CARDS

DATE 08-06-01

NAME Veronica Howard

ADDRESS Project Network

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC mental health

GIVE TO BOARD CLERK

#39

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME Shalonda Jenkins

ADDRESS 2621 N. Mississippi
Portland, Ore 97227

PHONE 335-0855

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Mental Health

GIVE TO BOARD CLERK

#40

SPEAKER SIGN UP CARDS

DATE 8/06/01

NAME Lori Tiel

ADDRESS 2631 N. Mississippi
Portland, OR 97227

PHONE (503) 335-0855

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#41

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME SANDY HAYDEN

ADDRESS P.O. BOX 6623

PORTLAND OR 97228

PHONE (503) 274-9495

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#42

SPEAKER SIGN UP CARDS

DATE 9 8-6-01

NAME MAGGIE BENNINGTON, DAVIS, MD

ADDRESS _____

_____

PHONE SALEM HOSPITAL

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MENTAL HEALTH SYSTEM

GIVE TO BOARD CLERK

#43

SPEAKER SIGN UP CARDS

DATE Aug 6, 2001

NAME Estelle Sullivan

ADDRESS 1180 N.W. 4th St

Gresham OR 97030

PHONE 503-665-7988

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Public Hearing - Mental Health

GIVE TO BOARD CLERK

#44

SPEAKER SIGN UP CARDS

DATE 8-6-01

NAME AL TURNER, DO

ADDRESS TURNER

MEDICAL SOCIETY

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#45

SPEAKER SIGN UP CARDS

DATE Aug 6, 2001

NAME Mary Beth Collins

ADDRESS PSU/CAPS

P.O Box 751 Pdx 97207

PHONE 503 725-4423

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

#46

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Kevin Mesch

ADDRESS 1825 SW Vermont St. #14
Portland, OR 97219

PHONE (503) 245-1081

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC re-organization

GIVE TO BOARD CLERK

#47

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Rosemary Hutchinson

ADDRESS 7115 SE 16th

Portland, OR 97202

PHONE 503-233-1975

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC NAMI

GIVE TO BOARD CLERK

#48

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Stuart L. OKen, MD

ADDRESS Psychiatrist

Eugene

PHONE 503 224-1291

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Crisis Plans

GIVE TO BOARD CLERK

#49

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Gerald Hopfowl

ADDRESS 1734 NE Killingsworth
PDX 97211

PHONE (503) 287-1565

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC MCCI Mental Health

GIVE TO BOARD CLERK

#50

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Jan Lacy c/o Sandy

ADDRESS ~~4240 SD 5~~ Bunyans

PHONE

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Chance now!

GIVE TO BOARD CLERK

Did not speak

SPEAKER SIGN UP CARDS

DATE Aug 6 2001 BIG BACK

NAME Rebekah Blackwell

ADDRESS 4350 SE Milwaukie #4
Portland Ore. 97202

PHONE 503-232-5431

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC _____

GIVE TO BOARD CLERK

DID NOT SPEAK

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Gina Bendly

ADDRESS 2010 NW Kearney

Portland 97209

PHONE (971) 544-2351

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Native TX Issue

GIVE TO BOARD CLERK

DID NOT SPEAK

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Carlos Rivera

ADDRESS _____

_____

PHONE _____

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC _____

GIVE TO BOARD CLERK

Did not speak

SPEAKER SIGN UP CARDS

DATE 6/6/01

NAME Rusty H. Means

ADDRESS 1225 SE Belmont #319
Portland, Ore. 97214

PHONE (503) 236-3019

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC Board Mtg.

GIVE TO BOARD CLERK

Did not speak

SPEAKER SIGN UP CARDS

DATE 8/6/01

NAME Shannon Branch BRANCH

ADDRESS 2631 N. Mississippi

PHONE (503) 335-0X55

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

DO NOT SPEAK

SPEAKER SIGN UP CARDS

DATE 8-16-01

NAME Angela Megrant

ADDRESS 2631 N. Mississippi
Ptld OR 97227

PHONE 503-335-0855

SPEAKING ON AGENDA ITEM NUMBER OR TOPIC

GIVE TO BOARD CLERK

ANNOTATED MINUTES

Monday, August 6, 2001 - **6:00 PM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

PUBLIC HEARING

Chair Diane Linn convened the meeting at 6:05 p.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz, Lonnie Roberts and Maria Rojo de Steffey present.

PH-1 Public Hearing on Mental Health Acute Care Services and Budget. Testimony Limited to Three Minutes Per Person.

CHAIR LINN GREETED AUDIENCE AND PRESENTED BRIEF EXPLANANTION. VICE-CHAIR NAITO READ A LETTER OF SUPPORT FOR IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM FROM AVEL GORDLY. CHAIR LINN READ TESTIMONY IN SUPPORT FOR IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM FROM LADDIE READ, WITH EMPHASIS BY MR. READ. ROSALIE PEGGY HAMMOND TESTIMONY IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. RUTH ASCHER AND CAROLINA HESS TESTIMONY IN SUPPORT OF ACCESS FOR OTHER POPULATIONS; ADDRESSING LATINO LANGUAGE ISSUES; AND THE INCLUSION AND PARTICIPATION OF THOSE CONCERNED WITH ACCESS FOR MINORITY POPULATIONS INTO THE MENTAL HEALTH REDESIGN PROCESS DISCUSSIONS. SCOTT MURRAY TESTIMONY IN SUPPORT OF INCLUSION OF MORE CLINICAL INPUT IN PLAN; CONCERNS WITH LIMITED HOURS OF WALK IN CLINICS; AND THAT CLOSURE OF THE TRIAGE CENTER WILL RESULT IN MORE EMERGENCY ROOM VISITS AND HOSPITALIZATIONS. MENTAL HEALTH SERVICES CONSUMER IAN CHISHOLM AND

MOTHER OF TWO MENTAL HEALTH CONSUMER SONS, SANDRA CHISHOLM, TESTIMONY RELATING THEIR EXPERIENCES WITH THE MENTAL HEALTH SYSTEM AND IN SUPPORT OF IMPROVEMENTS. JOŚE EDUARDO RIVERA TESTIMONY IN SUPPORT OF LATINO COMMUNITY RECOMMENDATIONS. MENTAL HEALTH CONSUMER LETICIA ZEPEDA TESTIMONY RELATING HER EXPERIENCES WITH THE MENTAL HEALTH SYSTEM AND IN SUPPORT OF PROVIDING ACCESS TO MENTAL HEALTH AND OTHER SERVICES IN SPANISH. NANCY ROBLES, STEVE LARA, MARIA IGNACIO, BRENDA REYES AND NALLELI IGNACIO TESTIMONY IN SUPPORT OF MENTAL HEALTH AND OTHER SERVICES FOR LATINO CONSUMERS AND FAMILIES. MENTAL HEALTH SERVICES CONSUMER JARON MARTIN TESTIMONY RELATING HIS EXPERIENCES AND IN SUPPORT OF ADEQUATE FUNDING AND IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. KATHIE PRIETO TESTIMONY IN SUPPORT OF CULTURALLY SPECIFIC SERVICES AND ACCESS FOR AFRICAN-AMERICAN AND HISPANIC COMMUNITY, AND ADDRESSING OTHER DIVERSITY ISSUES, INCLUDING SERVICES FOR CHILDREN. DEBORAH BOUMANN TESTIMONY IN SUPPORT OF IMPROVEMENTS TO MENTAL HEALTH SERVICES AND FUNDING. CHOCKA GUIDEN OF PROJECT NETWORK READ LETTER FROM AFRICAN AMERICAN HEALTH COALITION CEO CORLISS MCKEEVER IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. DELORIS STORKE TESTIMONY IN SUPPORT OF IMPROVEMENTS TO MENTAL HEALTH SERVICES. ADRIENNE LIVINGSTON OF BLACK UNITED FUND TESTIMONY IN SUPPORT OF CULTURALLY SPECIFIC MENTAL HEALTH SERVICES AND PROGRAMS. FRANCES SARNA OF NAMI TESTIMONY IN SUPPORT OF CULTURALLY SPECIFIC MENTAL HEALTH

SERVICES AND PROGRAMS. MENTAL HEALTH CONSUMER SHURA YOUNG TESTIMONY IN SUPPORT OF IMPROVED ACCESS TO SERVICES AND MEDICARE PAID OUTPATIENT CARE. JACKIE MERCER OF NARA TESTIMONY URGING CONTINUED FUNDING TO SUPPORT OF ALCOHOL AND DRUG TREATMENT PROGRAM AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. SHIRLEY ROBERTS READ TESTIMONY FROM KAY TORAN IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. LINDA REILLY TESTIMONY IN SUPPORT OF SERVICES FOR CHILDREN WITH MENTAL ILLNESS AND/OR DEVELOPMENTAL DISORDERS AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. BOB HEAD TESTIMONY IN SUPPORT OF PLAN, AS LONG AS IT IS ADEQUATELY STAFFED. SHARON BJORTVEDT TESTIMONY IN SUPPORT OF PLAN. RAMON QUIROZ-SALTOS TESTIMONY REGARDING HIS CHILD WITH MENTAL ILLNESS AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. ANGIE DEROUCHIE TESTIMONY EXPRESSING CONCERN THAT PATIENTS ARE TREATED FOR MENTAL ILLNESS WITHOUT FIRST GETTING A MEDICAL DIAGNOSIS AND RECOMMENDATION IN SUPPORT OF GIVING PATIENTS A PHYSICAL HEALTH//MEDICAL EXAM PRIOR TO INCARCERATION AND/OR MENTAL HEALTH TREATMENT. PARENT OF MENTAL HEALTH CONSUMER CAROL BOOS TESTIMONY RELATING HER EXPERIENCES WITH THE MENTAL HEALTH SYSTEM AND IN SUPPORT OF IMPROVEMENT. GRESHAM BARLOW SUPERINTENDENT JAMES BUCK TESTIMONY EXPRESSING CONCERNS WITH PLAN AND IN SUPPORT OF MENTAL HEALTH SERVICES TO CHILDREN AND FAMILIES. MR. BUCK URGED COUNTY TO ALLOW STAKEHOLDERS MORE PARTICIPATION IN POLICY DECISIONS.

MENTAL HEALTH CONSUMER BRENDA BOGGES TESTIMONY RELATING HER EXPERIENCES, AND THOSE OF HER DAUGHTER, WHO IS A CAAPCARE CLIENT, AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. ANGELA STECKLY TESTIMONY IN SUPPORT OF MENTAL HEALTH SYSTEM CHANGES AND IMPROVEMENTS; URGING ALL INVOLVED TO RECOGNIZE THE URGENCY AND COOPERATE IN A MANNER THAT WILL BENEFIT CLIENTS AND THEIR FAMILIES. MENTAL HEALTH CONSUMER PATRICIA NICOL FLEMING TESTIMONY RELATING HER EXPERIENCES AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. COUNTY BEHAVIORAL HEALTH EMPLOYEE GARY MAGNUSON TESTIMONY IN SUPPORT OF MOVE TOWARD INTERVENTION AND PREVENTION, ADVISING MENTAL HEALTH SERVICES SHOULD NOT BE PRIVATIZED, AND THAT PROVIDERS SHOULD BE CHALLENGED TO FIND REDUNDANCIES AND COST SAVINGS IN THEIR BUDGETS. MENTAL HEALTH CONSUMERS KEBALA DORM AND BRENDA SPEARMAN TESTIMONY RELATING THEIR EXPERIENCES AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. CHAIR LINN EXPLANATION IN RESPONSE TO MS. SPEARMAN'S CONCERNS REGARDING CALLING 9-1-1 DURING A MENTAL HEALTH CRISIS. VERONICA HOWARD AND SHALONDA JENKINS TESTIMONY IN SUPPORT OF ETHNIC SPECIFIC MENTAL HEALTH SERVICES AND ADDITIONAL BLACK COUNSELORS IN THEIR COMMUNITY. LORI HILL TESTIMONY IN SUPPORT OF MENTAL HEALTH SERVICES FOR BABIES AND CHILDREN. MENTAL HEALTH CONSUMER AND FORMER DESIGN TEAM MEMBER SANDY HAYDEN TESTIMONY IN SUPPORT OF DESIGN TEAM RECOMMENDATIONS FOR IMPROVEMENTS TO THE MENTAL HEALTH

SYSTEM. MAGGIE BENNINGTON DAVIS TESTIMONY CONCERNING THE STATEWIDE CRISIS AND SHORTAGE OF PSYCHIATRIC HOSPITAL INPATIENT BEDS, ADVISING 20% OR MORE OF THOSE ADMITTED TO THE SALEM HOSPITAL ARE MULTNOMAH COUNTY RESIDENTS. MOTHER OF MENTAL HEALTH CONSUMER SON ESTELLE SULLIVAN TESTIMONY IN SUPPORT OF GAP PLAN TO ELIMINATE COSTS AND SERVE MORE FOLKS AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. AL TURNER OF THE MEDICAL SOCIETY TESTIMONY EXPRESSING CONCERN FOR THE PLAN. MARY BETH COLLINS TESTIMONY EXPRESSING CONCERN WITH GAP PLAN. MENTAL HEALTH CONSUMER KEVIN MESCH TESTIMONY IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM AND IN SUPPORT OF KEEPING THE CLIENT RUN DROP-IN CENTER OPEN. MOTHER OF MENTAL HEALTH CONSUMER DAUGHTER ROSEMARY HUTCHINSON TESTIMONY RELATING HER EXPERIENCES; IN SUPPORT OF NAMI; AND IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. PSYCHIATRIST STUART OKEN TESTIMONY EXPRESSING CONCERN THAT GAP PLAN NOT ADEQUATE. MENTAL HEALTH CONSUMER AND NARA MEMBER GERALD HOPTOWIT TESTIMONY IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM AND EXPRESSING PRAYERS AND COMPASSION FOR DECISION MAKERS. MOTHER OF MENTAL HEALTH CONSUMER JARON MARTIN, TESTIMONY IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM AND IN SUPPORT AND AGREEMENT WITH THE TESTIMONY OF HER SON, JARON, ANGELA STECKLY, LINDA REILLY AND OTHERS. MS. BUMPUS READ TESTMONY FROM JAN LACY IN SUPPORT OF IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM.

COMMISSIONER CRUZ ADVISED SHE CONTINUES TO LEARN, AND EXPRESSED APPRECIATION FOR THE FOLKS WHO CAME OUT TO SPEAK TONIGHT, AS WELL AS THE PROVIDERS AND COUNTY EMPLOYEES, AND STATED THAT SHE HAS MANY OF THE SAME CONCERNS, INCLUDING NOT INVOLVING ALL THE STAKEHOLDERS, BUT THAT SHE IS HOPEFUL AND OPTIMISTIC THAT CONSENSUS WILL BE REACHED. COMMISSIONER NAITO THANKED EVERYONE FOR COMING TOGETHER AS A COMMUNITY TO WORK ON A PROBLEM THAT CONCERNS US ALL. CHAIR LINN THANKED EVERYONE FOR COMING AND ADVISED THAT THE BOARD WILL BE VOTING ON THE PROPOSED RESOLUTION AND PLAN THIS THURSDAY.

There being no further business, the meeting was adjourned at 8:36 p.m.

Tuesday, August 7, 2001 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

Chair Diane Linn convened the meeting at 9:35 a.m., with Vice-Chair Lisa Naito, Commissioner and Maria Rojo de Steffey present, Commissioner Lonnie Roberts excused, and Commissioner Serena Cruz arriving at 9:37 a.m.

B-1 Metro Policy Advisory Committee Briefing. Presented by Lisa Naito, Andy Catugno, Jim Zehren and Invited Others.

COMMISSIONER LISA NAITO, DAVID BRAGDON, JIM ZEHREN, ANDY COTUGNO, MARK TURPEL AND TOM KLOSTER AND PRESENTATION AND RESPONSE TO BOARD QUESTIONS, DISCUSSION AND COMMENTS IN SUPPORT.

B-2 Presentation of the Presentation of the Federal Financial Participation Work Plan by the FFP Work Team, Including Discussion of Recommendations: a

Modified Relationship Between the State of Oregon and the County; Opportunities and Risks; and Specific Action Steps. Presented by FFP Work Team Members.

TOM FRONK, ELLIE HALL AND JOEL YOUNG PRESENTATION AND RESPONSE TO BOARD QUESTIONS, DISCUSSION AND COMMENTS IN SUPPORT.

The meeting was recessed at 11:05 a.m. and reconvened at 11:13 a.m.

B-3 Early Childhood Planning: Early Childhood Framework and Implementation of the Oregon Children's Plan. Presented by Lisa Naito, Pam Greenough, Monica Ford, Gina Mattioda and Wendy Lebow.

COMMISSIONER LISA NAITO ACKNOWLEDGED AND WELCOMED NEW COMMISSION ON CHILDREN, FAMILIES AND COMMUNITY DIRECTOR KATHY TURNER. WENDY LEBOW INTRODUCTIONS. PAM GREENOUGH, GINA MATTIODA AND WENDY LEBOW PRESENTATION AND RESPONSE TO BOARD QUESTIONS, DISCUSSION AND COMMENTS IN SUPPORT. ELANA EMLEN WAS INTRODUCED AS THE DESIGNATED COMMISSION ON CHILDREN, FAMILIES AND COMMUNITY STAFF TO TEAM. KATHY TURNER COMMENTS IN SUPPORT.

There being no further business, the meeting was adjourned at 11:40 a.m.

Thursday, August 9, 2001 - **9:00 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

Chair Diane Linn convened the meeting at 9:08 a.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz, Lonnie Roberts and Maria Rojo Steffey present.

CONSENT CALENDAR

UPON MOTION OF COMMISSIONER ROJO, SECONDED BY COMMISSIONER NAITO, THE CONSENT CALENDAR (ITEMS C-1 THROUGH C-5) WAS UNANIMOUSLY APPROVED.

NON-DEPARTMENTAL

C-1 Appointment of Katy Yen to the COMMUNITY HEALTH COUNCIL

C-2 Budget Modification NOND 01 Increasing General Fund Revenues and District 4 Expenditures by $1,800 to Cover the Costs of Operating a "Satellite" District 4 Office in Gresham

PUBLIC CONTRACT REVIEW BOARD

C-3 ORDER Authorizing an Exemption to Specify Schlage Brand Locks for All Newly Acquired County Buildings

ORDER 01-105.

C-4 ORDER Exempting from the Formal Competitive Bid Process the Contract with Raintree, Inc. for a Software Program, and Two Years' Maintenance until June 30, 2003

ORDER 01-106.

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES

C-5 ORDER Authorizing Designees of the Mental Health Program Director to Direct a Peace Officer to Take an Allegedly Mentally Ill Person into Custody

ORDER 01-107.

REGULAR AGENDA

AT THE REQUEST OF CHAIR LINN AND UPON MOTION OF COMMISSIONER NAITO, SECONDED BY COMMISSIONER ROBERTS, CONSIDERATION OF THE FOLLOWING ITEM WAS UNANIMOUSLY APPROVED.

DEPARTMENT OF SUSTAINABLE COMMUNITY DEVELOPMENT

UC-1 RESOLUTION Approving Grant of Easement to City of Portland, Oregon on County Real Property at 102nd Avenue and East Burnside Street for Public Street and Right of Way Purposes

COMMISSIONER NAITO MOVED AND COMMISSIONER ROBERTS SECONDED, APPROVAL OF UC-1. BOB OBERST EXPLANATION. COMMISSIONER NAITO COMMENTS IN APPRECIATION OF BOARD CONSIDERATION OF EASEMENT FOR CHILDRENS RECEIVING CENTER. RESOLUTION 01-108 UNANIMOUSLY ADOPTED.

PUBLIC COMMENT

Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.

NO ONE WISHED TO COMMENT.

DEPARTMENT OF SUPPORT SERVICES

R-1 Ratification of the 2001-2004 Collective Bargaining Agreement Between Multnomah County and the Multnomah County Deputy Sheriff's Association

COMMISSIONER NAITO MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-1. GAIL PARNELL EXPLANATION. COMMISSIONER ROJO MOVED AND COMMISSIONER NAITO SECONDED, CORRECTION TO ADDENDUM A ON PAGE 80. ADDENDUM UNANIMOUSLY APPROVED. SHERIFF DAN NOELLE COMMENTS IN SUPPORT AND APPRECIATION FOR BARGAINING TEAM. DAVID HADLEY COMMENTS IN SUPPORT OF MS. PARNELL AND HER STAFF. CHAIR LINN COMMENTS IN SUPPORT OF AGREEMENT. AGREEMENT UNANIMOUSLY APPROVED, AS AMENDED. BOARD, SHERIFF AND UNION REPRESENTATIVE SIGNED AGREEMENT.

NON-DEPARTMENTAL

R-2 RESOLUTION Authorizing Funds to Determine Whether to Proceed with Renovating the Multnomah County Courthouse

COMMISSIONER NAITO MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-2. FOLLOWING DISCUSSION, COMMISSIONER ROBERTS MOVED AND COMMISSIONER CRUZ SECONDED, TO CONTINUE R-2 FOR TWO WEEKS. COMMISSIONER NAITO EXPLANATION OF CONCERNS AND VARIOUS OPTIONS AND COMMENTS IN SUPPORT OF STUDY AND TWO WEEK CONTINUANCE. COMMISSIONER CRUZ COMMENTS IN SUPPORT OF COMMISSIONER NAITO'S LEADERSHIP AND THE OPPORTUNITY TO WORK ON TASK FORCE. COMMISSIONER NAITO ACKNOWLEDGED AND THANKED BOARD STAFF TERRI NAITO, MARY CARROLL AND CHARLOTTE COMITO FOR THEIR EFFORTS. CHAIR LINN COMMENTS IN SUPPORT AND APPRECIATION OF EFFORTS OF STAFF AND COMMISSIONERS NAITO AND CRUZ. COMMISSIONER ROBERTS COMMENTS IN SUPPORT OF COMMISSIONER NAITO'S EFFORTS. RESOLUTION UNANIMOUSLY CONTINUED TWO WEEKS, TO THURSDAY, AUGUST 23, 2001.

The meeting was recessed at 9:33 a.m. and reconvened at 9:40 a.m.

AT THE REQUEST OF CHAIR LINN AND UPON MOTION OF COMMISSIONER NAITO, SECONDED BY COMMISSIONER ROJO, CONSIDERATION OF THE FOLLOWING ITEM WAS UNANIMOUSLY APPROVED.

UC-2 RESOLUTION Providing Policy Direction for the Acute Care Crisis Action Plan (Phase I)

COMMISSIONER NAITO MOVED AND COMMISSIONER ROJO SECONDED, APPROVAL OF UC-2. CHAIR LINN EXPLANATION AND COMMENTS IN SUPPORT AND APPRECIATION FOR THE COLLABORATIVE EFFORTS OF EVERYONE WORKING ON THE ACUTE CARE CRISIS ACTION PLAN. JOHN BALL PRESENTATION, INCLUDING INFORMATION REGARDING THE CULTURAL COMPETENCY GROUP ESTABLISHED TO PROVIDE SYSTEM IMPROVEMENT RECOMMENDATIONS TO THE BOARD, AND INTRODUCTION OF ROBIN MACK, LOLENZO POE AND HANK BALDERRAMA. CULTURAL COMPETENCY COMMITTEE VOLUNTEER HANK BALDERRAMA OF THE STATE OF WASHINGTON, COMMENTS REGARDING INTENSE EFFORTS OF THE COMMITTEE YESTERDAY. COMMISSIONER NAITO COMMENTS IN SUPPORT AND APPRECIATION OF THE EFFORTS OF SUCH A DEDICATED GROUP, WITH SPECIAL THANKS TO ED BLACKBURN; AND EXPRESSED NEED FOR PROCESS TO WORK THROUGH PROBLEMS IN A COLLABORATIVE WAY; AND FIND WAYS TO PROVIDE MORE MENTAL HEALTH SERVICES FOR CHILDREN. COMMISSIONER ROBERTS COMMENTS IN SUPPORT OF CHAIR LINN'S PROPOSAL, ADVISING HE FEELS IT ADDRESSES MANY CONCERNS AND IS A POSITVE FIRST STEP. COMMISSIONER ROJO COMMENTS IN SUPPORT OF WORKING TOGETHER IN A NON-VIOLENT MANNER TO EFFECT CHANGES TO THE MENTAL HEALTH SYSTEM; IN APPRECIATION OF THE FOLKS WHO CAME AND TESTIFIED MONDAY NIGHT; AND IN APPRECIATION FOR THE WORK OF THE CULTURAL COMPETENCY COMMITTEE, INCLUDING JACKIE MERCER AND ROBIN MACK. IN RESPONSE TO QUESTIONS OF COMMISSIONER CRUZ, JOHN BALL ADVISED THAT THE SEPTEMBER 21ST BUDGET MODIFICATIONS WILL ADDRESS ALL BOARD

POLICIES AND WILL BE REFLECTED IN THE CURRENT DEPARTMENT OF COMMUNITY AND FAMILY SERVICES BUDGET. COMMISSIONER CRUZ COMMENTS IN SUPPORT AND IN APPRECIATION FOR THE EFFORTS OF MARY CARROLL, MARIE DAHLSTROM, THE BOARD AND COUNTY STAFF, CULTURAL COMPETENCY COMMITTEE AND ALL THE MENTAL HEALTH CLIENTS, FAMILIES AND STAKEHOLDERS WORKING TOWARD IMPROVEMENTS TO THE MENTAL HEALTH SYSTEM. COMMISSIONER NAITO EXTENDED SPECIAL THANKS TO LADDIE READ. RESOLUTION 01-109 UNANIMOUSLY ADOPTED.

R-3 Board Discussion and Consideration of Budget Approval Regarding Mental Health Services

COMMISSIONER NAITO MOVED AND COMMISSIONER ROBERTS SECONDED, APPROVAL OF R-3. CHAIR LINN, JOHN BALL, LOLENZO POE AND DAVE WARREN EXPLANATION, COMMENTS IN SUPPORT AND APPRECIATION FOR EFFORTS OF BUDGET OFFICE AND DEPARTMENT OF COMMUNITY AND FAMILY SERVICES STAFF. BUDGET UNANIMOUSLY APPROVED.

There being no further business, the meeting was adjourned at 10:25 a.m.

Thursday, August 9, 2001 - **3:00 PM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

Chair Diane Linn convened the meeting at 3:00 p.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz, Lonnie Roberts and Maria Rojo de Steffey present.

E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660(1) (d) for Labor Negotiator Consultation Concerning Labor Negotiations. Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session. No Final Decision will be made in the Executive Session. Presented by Gail Parnell and John Ball.

EXECUTIVE SESSION HELD.

There being no further business, the meeting was adjourned at 4:30 p.m.

BOARD CLERK FOR MULTNOMAH COUNTY, OREGON

Deborah L. Bogstad

Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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ANY QUESTIONS? CALL BOARD CLERK DEB BOGSTAD @ (503) 988-3277
Email: deborah.l.bogstad@co.multnomah.or.us

INDIVIDUALS WITH DISABILITIES PLEASE CALL THE BOARD CLERK AT (503) 988-3277, OR MULTNOMAH COUNTY TDD PHONE (503) 988-5040, FOR INFORMATION ON AVAILABLE SERVICES AND ACCESSIBILITY.

AUGUST 6, 7 & 9, 2001 BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

See Multnomah Community Television Live and Playback Schedule - Page 2

Monday, August 6, 2001 - **6:00 PM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

PUBLIC HEARING

PH-1 Public Hearing on Mental Health Acute Care Services and Budget. Testimony Limited to Three Minutes Per Person.

Monday's public hearing before the Multnomah County Board of Commissioners will be cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Monday, 6:00 PM, (LIVE) Channel 21
Friday, August 10 - 6:00 PM, Channel 30 East County Only
Wednesday, August 15 - 2:00 PM, Channel 21
Monday, August 20 - 2:00 PM, Channel 21
Wednesday, August 22 - 7:00 PM, Channel 30 East County Only

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30
Friday, 11:00 PM, Channel 30
Saturday, 10:00 AM, Channel 30 East County Only
Sunday, 11:00 AM, Channel 30

Produced through Multnomah Community Television
(503) 491-7636, ext. 333 for further info

Tuesday, August 7, 2001 - **9:30 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

B-1 Metro Policy Advisory Committee Briefing. Presented by Lisa Naito, Andy Catugno, Jim Zehren and Invited Others. 30 MINUTES REQUESTED.

B-2 Presentation of the Presentation of the Federal Financial Participation Work Plan by the FFP Work Team, Including Discussion of Recommendations: a Modified Relationship Between the State of Oregon and the County; Opportunities and Risks; and Specific Action Steps. Presented by FFP Work Team Members. 1 HOUR REQUESTED.

B-3 Early Childhood Planning: Early Childhood Framework and Implementation of the Oregon Children's Plan. Presented by Lisa Naito, Pam Greenough, Monica Ford, Gina Mattioda and Wendy Lebow. 30 MINUTES REQUESTED.

Thursday, August 9, 2001 - **9:00 AM**
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:00 AM
NON-DEPARTMENTAL

C-1 Appointment of Katy Yen to the COMMUNITY HEALTH COUNCIL

C-2 Budget Modification NOND 01 Increasing General Fund Revenues and District 4 Expenditures by $1,800 to Cover the Costs of Operating a "Satellite" District 4 Office in Gresham

PUBLIC CONTRACT REVIEW BOARD

C-3 ORDER Authorizing an Exemption to Specify Schlage Brand Locks for All Newly Acquired County Buildings

C-4 ORDER Exempting from the Formal Competitive Bid Process the Contract with Raintree, Inc. for a Software Program, and Two Years' Maintenance until June 30, 2003

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES

C-5 ORDER Authorizing Designees of the Mental Health Program Director to Direct a Peace Officer to Take an Allegedly Mentally Ill Person into Custody

REGULAR AGENDA - 9:00 AM

DEPARTMENT OF SUSTAINABLE COMMUNITY DEVELOPMENT

UC-1 RESOLUTION Approving Grant of Easement to City of Portland, Oregon on County Real Property at 102nd Avenue and East Burnside Street for Public Street and Right of Way Purposes

PUBLIC COMMENT - 9:00 AM

Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.

DEPARTMENT OF SUPPORT SERVICES - 9:00 AM

R-1 Ratification of the 2001-2004 Collective Bargaining Agreement Between Multnomah County and the Multnomah County Deputy Sheriff's Association

NON-DEPARTMENTAL - 9:10 AM

R-2 RESOLUTION Authorizing Funds to Determine Whether to Proceed with Renovating the Multnomah County Courthouse

R-3 Board Discussion and Consideration of Budget Approval Regarding Mental Health Services

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Thursday, August 9, 2001 - **3:00 PM**
Multnomah Building, Sixth Floor Commissioners Conference Room 635
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners Will Meet in Executive Session Pursuant to ORS 192.660(1) (d) for Labor Negotiator Consultation Concerning Labor Negotiations. Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session. No Final Decision will be made in the Executive Session. Presented by Gail Parnell and John Ball. 1 HOUR REQUESTED.

MEETING DATE: August 6, 2001
AGENDA NO: PH-1
ESTIMATED START TIME: 6:00 PM
LOCATION: Boardroom 100

(Above Space for Board Clerk's use only)

AGENDA PLACEMENT FORM

SUBJECT: Public Hearing on Mental Health Acute Care Services and Budget

BOARD BRIEFING: DATE REQUESTED:
REQUESTED BY:
AMOUNT OF TIME NEEDED:

REGULAR MEETING: DATE REQUESTED: Monday, August 6, 2001

AMOUNT OF TIME NEEDED: 2 hours

DEPARTMENT: Non-Departmental DIVISION: Chair's Office

CONTACT: John Ball TELEPHONE #: (503) 988-3958
BLDG/ROOM #: 503/600

PERSON(S) MAKING PRESENTATION: Chair Diane Linn

ACTION REQUESTED:

[X] INFORMATIONAL ONLY [ ] POLICY DIRECTION [ ] APPROVAL [ ] OTHER

SUGGESTED AGENDA TITLE:

Public Hearing on Mental Health Acute Care Services and Budget. Testimony Limited to Three Minutes Per Person

SIGNATURES REQUIRED:

ELECTED OFFICIAL: *Diane M. Linn*
(OR)
DEPARTMENT MANAGER:

01 AUG -1 PM 3:52
BOARD OF COUNTY COMMISSIONERS
MULTNOMAH COUNTY OREGON

ALL ACCOMPANYING DOCUMENTS MUST HAVE REQUIRED SIGNATURES

Any Questions: Call the Board Clerk @ (503) 988-3277 or email deborah.l.bogstad@co.multnomah.or.us

CRISIS SERVICES FOR RESIDENTS OF MULTNOMAH COUNTY

WHEN THE CRISIS TRIAGE CENTER CLOSES JULY 29TH AT MIDNIGHT

THE MULTNOMAH COUNTY HOTLINE NUMBER STAYS THE SAME

CENTRAL CRISIS PHONE NUMBER

503-215-7082

(24 HOURS DAILY)

Call this number for:

- Information about where to go
- Brief crisis ph one counseling

Call 911 for life-threatening emergencies

Watch for expanded hours, a fourth walk-in site, and mobile outreach starting September

URGENT WALK-IN SERVICES FOR ADULTS, CHILDREN, AND FAMILIES

You may go to any of the following places . You do not need an appointment

- Network Plaza (503-238-0705)
  2415 SE 43rd (43rd & Division-
  enter on Division at West entrance)
  Bus #4 Division, Exit 43rd & Division
  Hours: Mon-Fri from 1:00 p.m. to 9:00 p.m.
  Saturday from 1:00 p.m. to 4:00 p.m.
- Mt. Hood Gresham Office (503-661-5455)
  400 NE 7th, Gresham
  Hours: Mon-Fri 1:00 p.m. to 5:00 p.m.
  Max to Gresham Central Station. Walk south.
- Mt. Hood North Portland Office (503-251-1338)
  3113 N Lombard
  Hours: Mon-Fri 1:00 p.m. to 5:00 p.m.
  Bus #1 Greeley, Exit Lombard & Peninsula. Walk West.

MENTAL HEALTH CRISIS SERVICES FOR RESIDENTS OF MULTNOMAH COUNTY

WHEN THE CRISIS TRIAGE CENTER CLOSES AT MIDNIGHT ON JULY 29TH YOUR MULTNOMAH COUNTY CRISIS LINE WILL STAY THE SAME

CENTRAL CRISIS PHONE NUMBER

503-215-7082

(24 hours daily)

Call this number for:

- **Information About Where To Go**
- **Brief Crisis Phone Counseling**

Call here

CLINIC/PHONE	ADDRESS	HOURS	TRI-MET
NETWORK PLAZA **Phone: 503-238-0705**	2415 SE 43rd, Portland West entrance off Division	Mon-Fri. 1–9pm Sat. 1-4pm	#4 Division; exit bus at 43rd & Division
MT. HOOD GRESHAM **Phone: 503-661-5455**	400 NE 7th Gresham	Mon-Fri. 1-5pm	Max train to Gresham Central Station & walk South across the street
MT. HOOD NORTH PORTLAND **Phone: 503-251-1338**	3113 N Lombard Portland	Mon-Fri. 1-5pm	#1 Greeley; exit bus at Lombard & Peninsula. Walk West

Or walk In here

Watch for expanded hours, a fourth walk-in site, and mobile outreach in September 2001

Call 911 if you have a life-threatening emergency

Resolving the Multnomah County Acute Care Crisis

Proposed Action Plan - Phase I

August 6, 2001
Jim Gaynor, Director of Mental Health Redesign, Verity
Peter Davidson, MD, Chief Clinical Officer/Medical Director, Verity
Dale Jarvis, CPA, MCPP Healthcare Consulting, Inc.

TABLE OF CONTENTS

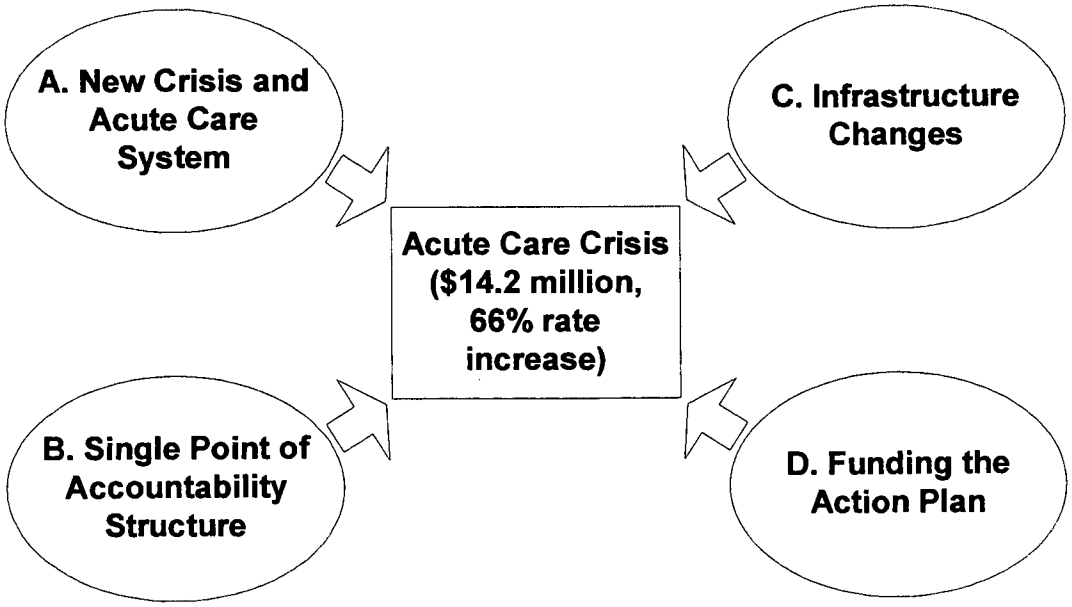
Executive Summary

In the fiscal year that just ended June 30, 2001 the average cost for an Oregon Health Plan acute inpatient bed day was $422.50. With the implementation of the new, per diem arrangement that goes into effect next month, this average rate will increase 66% to approximately $700 per day. Based on a thorough analysis of projected inpatient use, this represents a $4.2 million (43%) increase in inpatient costs from $9.9 million to $14.2 million. This increase is based on the assumption that, as the Crisis Triage Center closes August 1, 2001, new and more comprehensive inpatient alternatives will start being brought online and hospital admissions will begin to decline. If better management of inpatient does not occur during the fiscal year, Multnomah County will spend an additional $1 million or more on inpatient expenses (on top of the $4.2 million planned increase).

These rate increases mean that one out of every five mental health dollars (20%) will be spent on inpatient services. These figures do not include state hospital costs, which increase the inpatient percentage. These are the highest costs in the State of Oregon and the Pacific Northwest. For example, King County Washington (Seattle) spends 13.2% of their mental health funds on inpatient services.

Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The Phase I plan that is presented in this report is a 90-day first step towards resolving this crisis. It includes four areas of intensive activity that must be implemented immediately.



A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. Six action-steps must be taken to support the implementation of these services.

1. Access/Crisis Phone System
2. Urgent Walk-In Clinics
3. Mobile Crisis Teams
4. Secure Evaluation Facility
5. Acute Hospital Alternatives
6. Acute Care Coordination

B. Roll-Out of the Single Point of Accountability Philosophy and Structure

Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. Three action-steps must be taken to support the implementation of this philosophy and structure.

7. Single Point of Accountability Structure
8. Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool
9. Assignment of Existing and New Consumers

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important four are listed below.

10. Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool
11. Rapid Implementation of Raintree Systems Computer Software
12. System-Wide Performance Reporting System
13. Redeployment of Key DCFS Staff

D. Funding the Action Plan

The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $21,582,230. This includes $14,051,935 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently

allocated, the Crisis and Acute Care System is currently underfunded by $6,730,044. The following action steps must be taken to resolve this crisis.

14. Reallocation of New OHP System-Wide Funds
15. Transfer of the 3% OHP Incentive Pool
16. Inpatient Contract Negotiation
17. BHD/Verity Reorganization and Budget Adjustments
18. One-Time Use of Mental Health Reserves

Note: It is important to underscore that the consequences of not funding the crisis and acute care services listed in this report creates significant risks for the Multnomah County mental health consumers, the County and provider organizations. If one or more financial recommendations are considered unfeasible and not implemented, the difference should be appropriated from the County General Fund Contingency Pool.

Implications for Phase II

The 90-day Phase I must be followed immediately by Phase II that should run from days 91 – 365. During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes
- Reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

Introduction

Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The current system is fragmented, has the wrong incentives built-in, and perpetuates costly redundancies. This is neither cost effective nor clinically efficient. It also provides unnecessary impediments for consumers attempting to access the right care at the right time. Accordingly, system accountability suffers.

The solutions outlined in this plan:

- Lay the groundwork for the integrated consolidation of system providers, infrastructure, and the blending of funding streams wherever possible.
- Make strategic interventions in the crisis, and acute care, and outpatient systems in Phase I.
- Begin a process that will allow dollars to be freed up for reinvestment in service expansions and capacities that will result in easy access to the right care, delivered at the right time, for the right price.
- Allow us to move to Phase II where further system development will occur and unnecessary administrative overhead is identified and eliminated.

As old silos are replaced with a new seamless array of easily accessible services, true public-private partnerships based on risk as well as gain sharing will emerge. A new era of system accountability will be born that is much more self-regulating, consumer centered, and responsive.

Consumer choice will be enhanced by providing expanded service options that produce good consumer outcomes. Synergies will be achieved through ongoing horizontal and vertical integration initiatives resulting in systems of activities that are complementary, consistent, interdependent, and mutually reinforcing. The finite pool of system dollars will be managed for maximum effectiveness for the maximum amount of consumer gain. This will be achieved by blending funding streams into a single risk pool managed by the MHO. Performance based contracts will be executed and actively managed by continuous quality improvement specialists serving in responsive outcomes management roles. Likewise, County employed Acute Care Coordinators will serve in the capacity of "innovation stimulators" as well.

Providers will be increasingly self-regulated through performance based accountability contracting models that reward the generation of good consumer outcomes while also assuming the risk and responsibility associated with negative outcomes. Any remaining fee-for-service provider contracting will be aggressively managed. Consumers will no longer be "exiled" from treatment options for any reason. The MHO will be a proactive partner in the development and

deployment of productive and innovative systems of care that minimize risk and promote success. Reinvestment plans will be negotiated that result in increased risk reserves, employee compensation, and capacity building.

Background and Problem Statement

The problems in the mental health system are well known and have been well documented over the course of the past 2 years of redesign initiatives. These problems are interconnected and require an integrated approach to solutions. This section will identify the prioritized target issues most in need of immediate turnaround solutions.

ACUTE CARE CRISIS

Escalating Utilization

Multnomah County has an inpatient utilization rate that is more than twice that of the statewide average when adjusted per capita (bed days/month/1000 members). When Multnomah County's utilization data is removed from the statewide aggregate data, we exceed inpatient rates by a factor of almost four (19/1,000 vs. 5/1000). The major reason for this predicament is the lack of less costly and more clinically appropriate sub-acute and crisis response alternatives. It should be noted that risk often motivates the deployment of these types of service alternatives, yet this idea was never pursued by the partner hospitals under the risk partnership contractual arrangements over the past 2 years. Inpatient care should be targeted to stabilize individuals so that they can be more actively engaged in community based recovery oriented treatment. Instead, it is capable of consuming over a third of the total available system treatment resources if left uncontrolled.

Movement to Per Diem Inpatient Vendors

The inpatient providers in the process of severing their current risk contract with the County and return to individually negotiated per diem bed rates. This return to a fee-for-service relationship will result in a significant net increase in the cost of a bed day of an average of 66% over current rates. When factored in to present utilization rates, this could result in an annual inpatient cost of over $15,000,000. Suffice it to say that this development mandates a rapid utilization management solution to reverse this scenario.

Absence of Vital Crisis Response Service Continuums

The Crisis Triage Center (CTC) performed a vital system function but was nonetheless providing significantly fewer crisis response services than it agreed to perform in its proposal to the original RFP. Because of this, the CTC was a very expensive system component. The CTC's efficacy was severely compromised due to the lack of a strongly coordinated system of adjunct crisis services geared toward mitigating the inpatient risk with more appropriate and less costly alternatives. This most critical service element is the most glaring service gap in the current system.

OUTPATIENT DELIVERY SYSTEM

Fragmentation and Market Rivalry

Multiple providers delivering basically the same types of services while looking to protect and expand their historical market share does not drive good collaboration or true partnership. It does drive a lot of expensive window dressing and meeting time, which only resembles true collaborative partnership. Competition for scarce clinical resources across professional disciplines results in added ongoing recruitment costs that could be better spent by providing a more stable integrated workforce at higher wages. The providers could look to create seamlessly integrated niche specialties and clinical centers of excellence that would better benefit consumers and the system as a whole. Historically, there was little financial incentive to explore consolidated service delivery models in an environment of "co-opetition" (cooperation + competition).

Fee-for-Service Program Structure

The current outpatient reimbursement formula pays for services based 50% on encounter and 50% on case rates. This encourages the outpatient system to perform in much the same way as under fee-for-service models. However, under managed care, the case rate portion results in a net loss from those historical Medicaid fee-for-service revenues. Therefore, the outpatient system is experiencing much downside associated with risk while still operating the same way as before. This dual mismanagement rewards the system for focusing on those who are easiest to care for while neglecting the difficult client most likely to need more costly and intensive services. Currently, the outpatient system is financially encouraged to shift the care for difficult clients to hospitals rather then expend the overburdened clinical resources to provide alternatives to hospitalization.

Administrative Redundancy

The current multiple providers separately fund multiple administrative structures that are mirror operational components of one another. These redundancies come at a high cost to the system, whereas, if providers were consolidated, the savings would be reinvested in vital service and capacity expansion. The two major contracting networks (ABH and HSA) show some economies of scale, but they provide yet another layer of administrative overhead. Member organizations must reduce their individual administrative structures to offset the costs the networks charge back to the members.

Low Productivity

Despite feeling genuinely overburdened with huge caseloads and dramatically reduced fiscal reserves, the average time clinical staff spend in direct clinical encounters with consumers averages less than 50% across the system. Paperwork, meetings, lack of automated processes, and antiquated infrastructures are reasons given as to why more direct service time isn't being spent with consumers. Productivity should and can be increased significantly. Nationwide, successful provider organizations have found ways to work smarter, resulting in more effective and efficient clinical service models. Providers must also find ways to reduce their overhead costs. These changes will result in more time for clients and the ability to better meet the needs of the community. It is

also important to note that the MHO must be part of this solution by working to reduce unnecessary paperwork and non-value-added procedures to a minimum.

Access

Waiting times to access outpatient services are too long. Approximately twenty-five percent of all consumers accessing the inpatient system are not assigned to any outpatient provider. This results in a very expensive access system whose doorbell is, by proxy, a bad outcome (i.e. deterioration to the point of requiring an inpatient stay).

The providers, with a combination of poor productivity, greatly increased caseloads, and little incentive to successfully move clients from out the back door (i.e. successful recovery oriented treatment utilizing natural community systems of support), are in fact unwittingly contributing to their own burnout and failure. The bottleneck at the front door is experienced by the providers as being a direct result of a real lack of service capacity to meet the demand needs of clients wishing to access outpatient services. The reality is that as access to less expensive and most appropriate care is impeded at the outpatient level, more and more consumers are deteriorating to the point of having to access the inpatient system. This in turn bleeds more money out of the outpatient pools, which then results in more diminished outpatient capacity. This downward spiral must be reversed. The best way to achieve this is to provide adequate incentives to provide access on demand and to lower hospitalization

BUSINESS MODEL AND ORGANIZATIONAL STRUCTURE

Accountability Alignment

The single variable most responsible for the deterioration of the mental health system with the advent of capitated Medicaid funding is the adverse alignment of risk and reward across the system. Shared risk contracting, when properly aligned and aggressively managed, generates true partnerships and, most importantly, effective, expanded, and seamless clinical care continuums. This is the difference between managed care nightmares and good managed care being synonymous with good and timely clinical intervention. Good accountability-based contracting will result in the right care being delivered at the right time and for the right price. When done effectively, the consumer benefits enormously. Secondarily, so does everyone else.

Contract Compliance Management

The County's contracting and contract management processes are in need of major change. Multiple contracts with multiple terms and expiration dates that get changed, sometimes only verbally, are often signed several months after the services are being delivered. The ongoing management of performance metrics and other contract terms are frequently renegotiated in the direction of less value than the original terms. MHO staff will be focused on performance that generates good consumer outcomes. Contingencies must be considered and acted upon when, despite all efforts otherwise, contract agencies fail to meet necessary conditions specified in the contract.

Role Diffusion

The relationship between the MHO and the Behavioral Health Division (BHD) has been unclear in the past. Clear boundaries and relationships must be defined and operationalized to maximize accountability while maintaining the flexibility to continuously improve in mutually effective ways. As always, assuring that the right care is taking place at the right time and for the right price will be the ultimate yardstick against which any change is made and measured. Fiscal accountability between the two divisions must be reconciled accordingly.

Data Analysis and Infrastructure

Standardized reporting across specified outcomes management targets must be made available through sound database/data warehouse development and ongoing analytical processes that can optimize continuous quality improvement activities.

CONSUMER INVOLVEMENT

Advocacy versus Empowered Ownership

The consumer advocacy landscape in Multnomah County is very impressive. This is due to the inclusive process involvement by consumers throughout the redesign process. This is also due to the level of talent and commitment embodied in the advocacy community. It is time to take advantage of this underutilized resource. We need to provide a conducive platform that shifts the advocacy community away from a reactive mode towards more proactive involvement and ownership in making new solutions work. In this regard, consumers are most likely to become the true partners in crafting the solutions they so desperately deserve. Development of Ombudsman functions, expansion of the office for consumer affairs, and deployment of expanded peer support services will serve to enhance the continued proactive involvement in existing stakeholder forums. Additionally, inclusion as valued contributing members on contract provider Boards of Directors will serve to secure necessary governance representation as well.

Proposed Action Plan: Phase I

The Phase I plan presented below is a ***90-day first step*** towards resolving the acute care crisis in Multnomah County. It includes four areas of intensive activity that must be implemented immediately, including:

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives
B. Roll-Out of the Single Point of Accountability Philosophy and Structure
C. Infrastructure Changes to Support the Action Plan
D. Funding the Reconfigured System

These recommendations are based on a detailed financial and utilization analysis that examined all aspects of the Multnomah County Mental Health System including:

- Detailed review of outpatient **client and service delivery history** for Oregon Health Plan enrollees and indigent consumers;
- Comparisons of **how much service** was provided, in total, and per client at each outpatient provider organization
- Analysis of all Behavioral Health Division and Verity **provider contracts;**
- Examination of all federal, state and local **revenue sources** and funding restrictions;
- **Inpatient projections** based on several years of admissions, days and average length of stay data for all health plans operating in Multnomah County;
- Sophisticated **demand projections** for mobile crisis, urgent walk-in, secure evaluation facility and acute impatient alternative services;

Because of the severity of the financial and client safety crisis facing Multnomah County and the carefully built-in interdependencies of the eighteen strategies, ***all must be implemented within the next 90 days*** if the County hopes to prevent insolvency of the mental health system.

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. The following action-steps must be taken to support the implementation of these services.

1. **Access/Crisis Phone Service:** Multnomah County should immediately contract with the identified provider organization to implement a new Access/Crisis Phone Service, with a contract that runs through June 30, 2002. This service will consolidate similar services at Providence, Advanced Behavioral Health, Human Services Alliance, and some portion of Verity's Access Line into a single service. It will also add a Warm Line that is staffed by mental health consumers. This consolidation will allow for improved response time, better connection between phone workers and the outpatient system and reduction of duplication. Providence will continue to provide phone service between July 1 and September 30, 2001 as the new capacity is developed and brought online. *Annual Cost: $1,803,218.*

2. **Urgent Walk-In Clinics:** Multnomah County should immediately contract with the identified provider organizations to operate four, regional Urgent Walk-In Clinics, with contracts that runs through June 30, 2002. These Clinics will use a "no appointment necessary" approach and operate during the highest demand periods from 9:00 am to 5:00 pm Monday through Friday. Additionally, a centrally located walk in clinic will operate from 5:00 pm to 9:00 pm Monday through Friday and 1 to 4 pm on Saturday. This design will dramatically increase access to consumers and provide a more appropriate service delivery environment to individuals who have urgent, but not emergency needs. *Annual Cost: $1,084,821.*

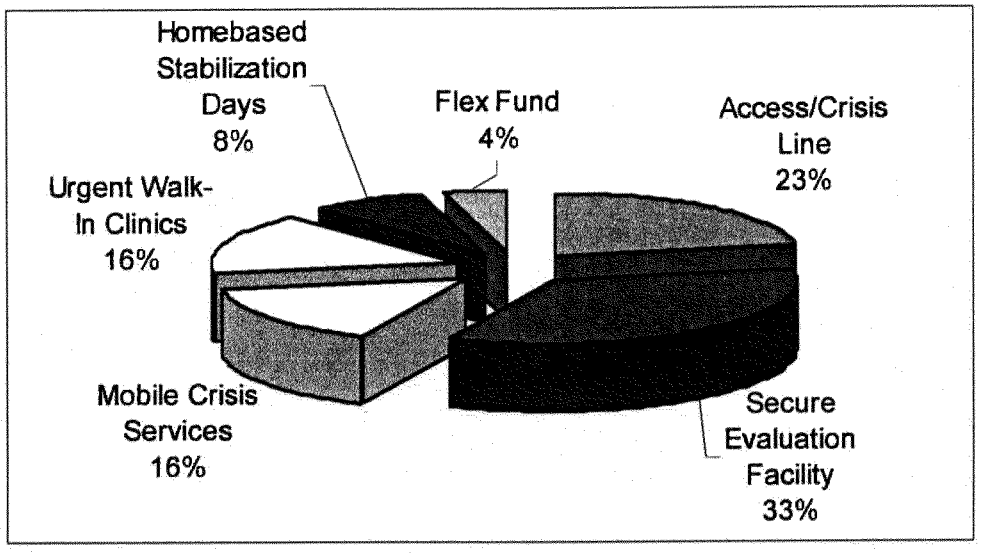
3. **Mobile Crisis Outreach Teams:** Multnomah County should immediately contract with the identified provider organization to operate Mobile Crisis Outreach Teams 24-hours per day, seven days per week, with a contract that runs through June 30, 2002. During hours of operation Mobile Outreach staff will be co-located at the four Urgent Walk-in clinical sites. During evenings and on Saturday, the Mobile Outreach Team will be co-located with the centrally located Urgent Walk-in clinic. *Annual Cost: $1,096,305.*

4. **Secure Evaluation Facility:** Multnomah County should immediately contract with the designated provider organizations to provide 23-Hour observation capacity for a period of assessment for those patients deemed to have the potential to rapidly regain functioning, and to facilitate their smooth reintegration into the community through optimal discharge planning. The contract is currently being negotiated and the final length of the contract along with other contract terms should be determined as part of that process. *Annual Cost: $2,388,949.*

5. **Acute Hospital Alternatives:** Multnomah County should immediately contract with designated provider organizations to provide additional alternatives to hospitalization capacity including Intensive Home-Based Stabilization services, Respite Beds, Sub-Acute Inpatient services, and "Flex Funds" to support other creative alternatives. The length of these contracts should be consistent with existing contracts that are in place for these types of services. *Annual Cost: $3,137,468.*

6. **Acute Care Coordination:** Multnomah County should immediately complete the development of the Acute Care Coordination Team. Members of this team will work with referring clinicians, discussing treatment options for clients in crisis in the context of the criteria for "medical appropriateness", assisting with referral to the least restrictive and most clinically appropriate care setting. *Annual Cost: Part of Verity's Budget.*

These six changes will result in a system that has many "right doors" and capacity that has been carefully designed to meet the needs of consumers in crisis. The chart on the following page illustrates how financial resources will be allocated to the newly designed crisis system. As the system stabilizes we expect that costs for the secure evaluation facility will decrease and those savings will be redirected towards non-urgent/emergent services.



B. Roll-Out of the Single Point of Accountability Philosophy and Structure

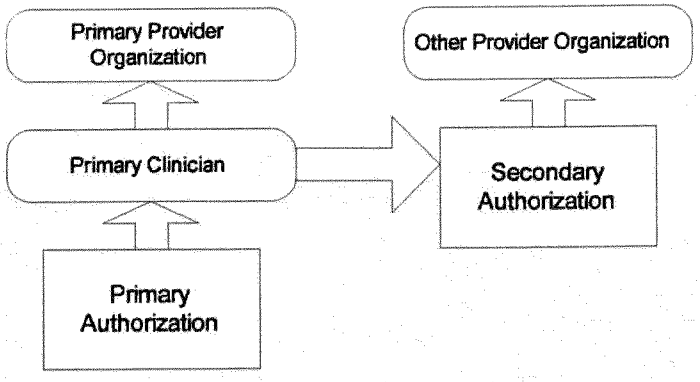
Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These circumstances result in the inability of crisis caregivers, including the police, to determine the most appropriate treatment setting for clients in crisis and often results in hospitalization that may have been unnecessary.

These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. This type of structure is critical to helping prevent crises before they occur. Furthermore, this model is an essential building block for implementing a recovery-oriented care delivery model.

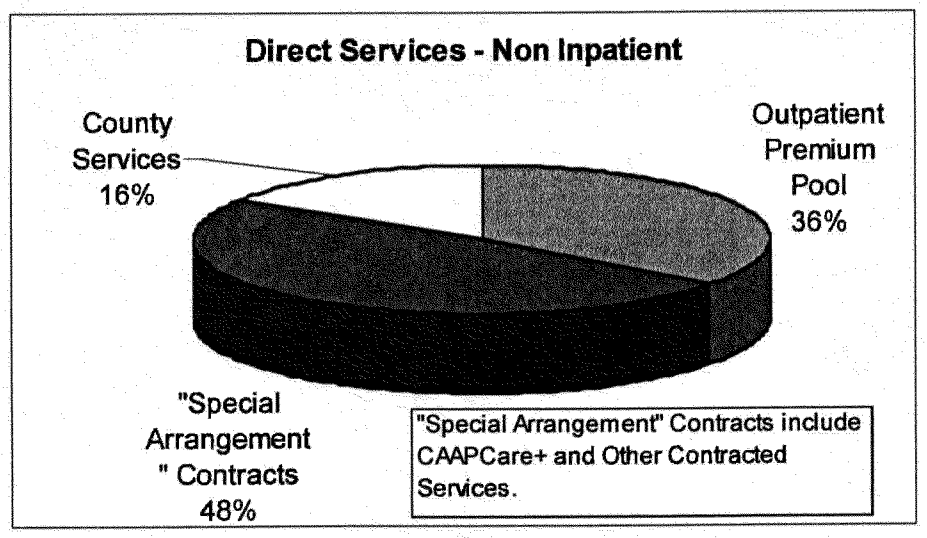
The following action-steps must be taken to support the implementation of this philosophy and structure.

7. **Single Point of Accountability Structure:** Multnomah County should revise all existing outpatient contracts to establish a Single Point of Accountability structure. Under this structure all mental health consumers whose care is financially supported by Multnomah County would be assigned to a Primary Provider Organization and a Primary Clinician through the issuance of an open-ended Primary Authorization. The Primary Clinician will be part of a Care Team (consisting of at least two individuals – the consumer and the Primary Clinician) whose jobs include treatment planning, service coordination, service delivery, and crisis planning and management. The Primary Authorization will "stay open" for as long as the client resides in Multnomah County or until/unless the consumer transfers to a different Primary Provider Organization, regardless of whether their case file is open or closed. Part of this system will include Secondary

Authorizations that support the purchase of evidence-based services or supports for special services not otherwise available from Care Team members who do not work at the Primary Provider Organization. *Annual Cost: Part of the Outpatient Contracts.*



8. **Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool:** The Single Point of Accountability Structure should be supported by a new payment mechanism that increases the flexibility of how monies can be used, provides financial incentives for proper management of the crisis and acute care system and holds providers accountable for poor outcomes. The mechanics of this model are described in Recommendation C10 below.



A financial model that supports the Action Plan is critical to successfully changing the behavior of the provider community. Currently only 41% of the existing funding for the Multnomah County Outpatient System is available for the Single Point of Accountability System – the funds that are in the OHP Outpatient Premium Pool. The other 59% is embedded in "Special Arrangement" Outpatient Provider Contracts (48%) and budgets for County-Staffed Services (11%). The Special Arrangement Contracts are funded through a myriad of case rates and fee

for service arrangements that use "old-style", commercial managed care arrangements that prevent more flexible and creative use of funds and are necessarily outside the Accountability and Incentive Structure. It addition, these contracts require over 20 full time equivalents of County Care Coordinators, whose salary costs alone are over $1.3 million per year.

Multnomah County should immediately convert the OHP Outpatient Premium and CAAPCare+ Outpatient Pools to the new Accountability/Incentive Pool. County staff should also immediately begin an Internal Audit and Performance Analysis of the Special Arrangement Outpatient Provider Contracts and County-Staffed Services to determine which services can be moved into the Accountability/Incentive Pool in Phase II. This analysis should be completed by 10/1/2001. *Annual Costs: Phase I $23,782,833; Impact of Phase II: To be determined.*

9. **Assignment of Existing and New Consumers:** Multnomah County should immediately begin a process to identify the Primary Provider Organization and Primary Clinician for all currently enrolled consumers. This will consist of using historical data in the Verity authorization database to complete a preliminary identification of Primary Provider Organizations. Providers will then review the computer reports, make corrections as needed and identify the Primary Clinician for each consumer. This information will be returned and entered to the County Information System.

   The County should also begin a process to rapidly assign all newly identified mental health consumers to a Primary Provider Organization and Primary Clinician. This will include the development of policies and procedures for all providers in the system. Crisis and Acute Care staff will be responsible for helping "hook" new consumers up with Outpatient Organizations. Outpatient Organizations will have clear guidelines for how and when to assign consumers who are new to their organizations. *Annual Cost: Part of the Existing DCFS IS Budget and Provider Outpatient Contracts.*

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important are listed below.

10. **Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool:** The funding design for the Accountability/ Incentive Funding Pool combines the OHP Outpatient Premium and CAAPCare+ Pools to create a funding stream to be used for OHP and indigent consumers in Multnomah County. Funds will be allocated based on the number of consumers for whom each provider organization becomes the Single Point of Responsibility. If Agency X has taken responsibility for 10% of the consumers they will receive 10% of the pool each month. In return for payment, organizations will be expected to provide all medically necessary outpatient services to their clients. In

addition, use of crisis and acute care services will be carefully tracked and provider organizations will be responsible for covering a portion of those expenses, up to a limit that will be defined by a financial risk corridor. If providers are able to properly manage their caseloads and lower the utilization of crisis and acute care services, incentive payments will be made to the organizations in the form of a rebate on under-spent Crisis and Acute Care System funds. The risk corridor will be designed so that no provider organizations will be threatened with catastrophic losses.

For the first year, smaller providers, who believe that they may not be able to manage under the new funding model, can select a Hold Harmless alternative where their crisis and acute care utilization will be monitored but funding accountability and incentives will not apply.

Multnomah County Board of Commissioners are requested to immediately approve the Outpatient Accountability/Incentive Funding Model and direct staff to develop the Policies and Procedures Manual that includes the detailed business rules for this model. Provider contracts must be revised so that the system can be phased in between July and September 2001, with full implementation beginning October 1, 2001. Later approval will delay these dates with substantial financial and system problems accruing. *Annual Costs per Action Step 8 above: Phase I $23,782,833; should increase to a minimum of $32,000,000 during Phase II with the roll-in of Specialized Arrangement Contracts.*

11. **Rapid Implementation of *Raintree Systems* Computer Software:** There are nine categories of County and Provider Organization staff that are necessary to support the reconfigured crisis and acute care alternatives. These include staff working with the 1) Call Center, 2) Mobile Crisis Teams, 3) Acute Care Coordination, 4) Urgent Walk-In Clinics, 5) Primary Provider Organizations, 6) Care Coordination, 7) Member Services, 8) Claims Processing, and 9) Quality Assurance. Together these groups require 34 different pieces of computer functionality to support their work. The functionality ranges from Client Lookup to Authorization Entry to Crisis Episode Tracking to Claims Processing.

    A rapid but thorough evaluation was made of existing County computer systems and "off the shelf" packages, covering the areas of Functionality, Architecture, Ease of Implementation, Flexibility, Performance, Security, Reporting, Cost and Vendor Reliability. After determining that existing County systems could not adequately support the 34 functions the Joint County-Contractor IT Workgroup narrowed the field down to two finalists, PH Tech, from Salem Oregon, and Raintree Systems from San Diego California. A final vendor scoring resulted in the recommendation to purchase and implement Raintree Systems.

    Because of the emergent need to implement a new solution within 90 days, Multnomah County should suspend normal contracting requirements and immediately contract with Raintree Systems and begin implementation of the new system within 14 days. The functionality of the system should be rolled out in

three phases, October 1, November 1, and December 1, 2001. Five Implementation Teams should be immediately assembled that will be made up of County and Provider Organization staff – Application Develop, Data Conversion, Infrastructure, Deployment, and Reporting. The rapid implementation project should be co-lead by a County and a Provider Organization staff person. *One Time Costs: $175,000.*

12. **System-Wide Performance Reporting System:** A great deal of effort went into gathering utilization and financial data from a variety of sources to support the development of the Action Plan. Unfortunately, there was a scarcity of standard reports that could be "pulled off the shelf" to support these efforts. Most available reports were ad hoc in nature, so that the system was operating in a relatively "data-free environment". As stakeholders of the mental health system already know, the Multnomah County mental health system can no longer operate under these conditions.

    Multnomah County should immediately begin the development of a System-Wide Performance Reporting System. The design of this system should be informed by key documents including the Utilization and Financial Modeling Tools that were used to support the Action Plan; Oregon Health Plan Mental Health Organization Agreement requirements; existing ad hoc and standard reports; the March 2001 Recommended Mental Health System Performance Measures authored by Jim Carlson, Seth Lyon and Theresa Posner; the 2001 American College of Mental Health Administrators' Proposed Consensus Set of Indicators for Behavioral Health; and the January 2001 State of Oregon Report to the Governor from the Mental Health Alignment Workgroup.

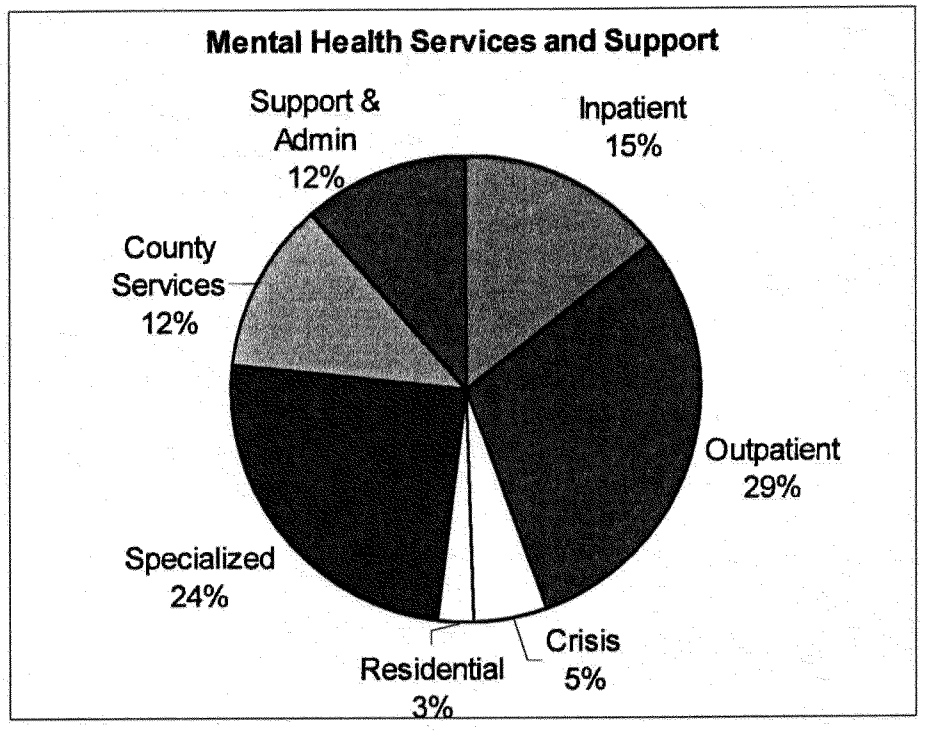
    These efforts should result in a set of regularly produced reports for key managers and stakeholders from the Multnomah Board of County Commissioners to Acute Care Coordinators to Primary Clinicians and their Supervisors that are produced daily, weekly, monthly and quarterly, based on need. The data in these reports should be used to build a "culture of measurement" within the Multnomah County Mental Health System, where meetings regularly include the analysis of data and all-important decisions are informed by this analysis. *One-Time Costs: $50,000.*

13. **Redeployment of Key DCFS Staff:** There are a number of activities that require the involvement of several DSFS staff members. This includes Acute Care Coordination, Accountability/Incentive System Policies and Procedures Development, Provider Contracting, assistance with bringing up the new Crisis and Acute Care Alternatives, Raintree Implementation, Performance Reporting System Development, further Financial and Budget Analysis, Stakeholder Communications, and more. Many DCFS staff have already been intensively involved in the planning activities that have resulted in this report. These efforts must now be followed by the development of a detailed Implementation Workplan and redeployment of DCFS staff to assist in these implementation activities. Multnomah County leadership should direct all DCFS management

and staff to actively participate in the implementation efforts, as needed. *Annual Cost: Part of the existing Verity Budget.*

D. Funding the Action Plan

The fiscal year 2002 DCFS Mental Health Budget is $68,769,348. These funds are allocated to several areas, as illustrated in the chart below.



The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $21,582,230. This includes $14,051,935 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently allocated, the Crisis and Acute Care System is currently underfunded by $6,730,044. The following action steps must be taken to resolve this crisis.

14. **Reallocation of New OHP System-Wide Funds:** Currently 16.7% of the OHP Premiums are allocated to a System-Wide Funds Pool. These monies are used to support the Crisis Triage Center and a number of Specialized Services such as Day Treatment, Dual Diagnosis Residential Support, Supported Classrooms and Fee-For-Service outpatient providers. In fiscal year 2001 just over $4.4 million was allocated to this pool, with $1.3 million spent on Crisis and Acute Care Alternatives and $3.1 million spent on Specialized Services. With the addition of a full year of Regence enrolled lives this $4.4 million has grown to $5.5 million.

    Multnomah County should use the Specialized Services funding levels as of the June 2001 as the basis for fiscal year 2002 funding and redirect the difference, $2.4 million, to fund the Crisis and Acute Care System. As the system stabilizes

and inpatient costs come down, additional funds should be redirected to the Outpatient Accountability/Incentive Pool. *Annual Amount: $2,386,980.*

15. **Transfer of the 3% OHP Incentive Pool:** Currently $998,980, which represents 3% of the OHP revenue, is allocated to a provider incentive pool. These funds should be earmarked for covering the costs of the crisis and acute care system. These monies would then, automatically become part of the Single Point of Accountability, accountability/incentive pool. *Annual Amount: $998,980.*

16. **Inpatient Contract Negotiation:** In fiscal year 2001 Multnomah County was paying an average of $864 per day for emergency-hold inpatient beds, including professional fees. This is significantly higher than rates paid for other Multnomah County inpatient bed days or the rates paid at other Oregon MHOs. These contracts should be renegotiated immediately, combining them with the inpatient contracts for OHP covered clients, to bring the average rate down to $700 per day. *Annual Savings: $365,757.*

17. **BHD/Verity Reorganization and Budget Adjustments:** Currently 11.52% of mental health dollars are spent on administration, or just under $8 million. At the same time the administrative functions are spread out over three reporting areas: Verity, the Behavioral Health Division, and the Department of Community and Family Services. This structure significantly impacts the ability of the 75+ full time equivalent administrative employees to effectively accomplish their work.

    It is possible to reorganize these administrative functions, consolidate duplicate activities, reduce costs and better support the management and operation of the Multnomah County mental health system through the implementation of the following changes.

    Admin Consolidation: Pull the system management activities including Care Coordination, Involuntary Commitment, Adult and Child Contract Management, and DCFS fiscal services out of their respective areas and into Verity. This would allow for the development of a fully functional, self-contained business enterprise with its own fiscal, contract and management capacities, all under "one roof".

    8% MHO Administrative Cap: If the costs of the consolidated system management activities are measured against the total revised budget for this area, including provider contracts, the administrative percentage is 9.4%. This compares with the following:

    - OMAP provides 8% to fully capitated health plans.
    - CareOregon is managed within their 8% rate.
    - The State MHDDSD Department provides 8% to MHOs for administration.
    - Clackamas MHO administration for FFY99/00 was 6.54%.
    - Mid-Valley Behavioral Care Network MHO administration for FFY99/00 was 7%.

- Accountable Behavioral Health Alliance MHO administration for FFY99/00 was 8%.

As part of this administrative consolidation, Verity should bring its administrative costs down to 8% of total contract and service expenditures. It is anticipated that this will require a reduction of approximately twelve FTEs. *Annual Savings: $988,902.*

12% Behavioral Health Administrative Cap: With the transfer of Care Coordination, Involuntary Commitment, Adult and Child Contract Management to Verity, the existing administrative costs for the Behavioral Health Division would total 16.5%. This budget should be reduced to 12%, which "better-sizes" the administrative staffing in relation to the new duties. It is anticipated that this will require a reduction of approximately four FTEs. *Annual Savings: $333,880.*

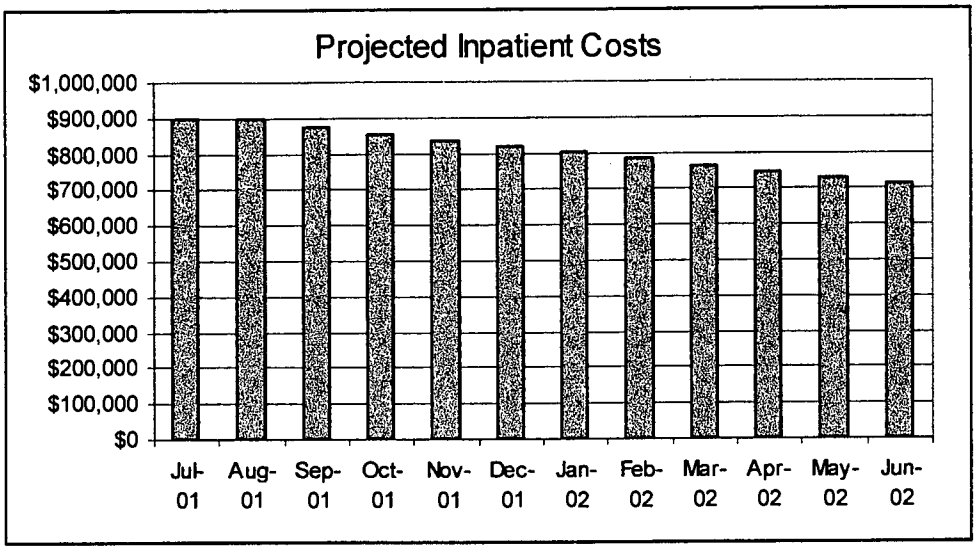
Local Administrative Dollars: Currently $2.1 million is received from the State to administer Mental Health, Alcohol & Drug and Developmental Disabilities. $805,640 is allocated directly to programs, of which only $111,054 is allocated to Mental Health. At the same time $1,310,870 is allocated to DCFS overhead departments. To support the administrative consolidation 30% of the $1.3 million of the Local Administration should be transferred to Mental Health to free up additional OHP and State General Funds to support the Crisis/Acute Care System costs. *Total Amount: $393,261.*

The four parts of this recommendation are interdependent in that shifting or responsibilities must be accompanied by shifting of funds and vise-a-versa. *Total Amount: $1,716,043.*

The four strategies identified in action-steps 14 – 17 represent a $5.47 million shift of funds to the Crisis and Acute Care System. This leaves a remaining shortfall of $1.26 million. After an exhaustive evaluation of all funding sources and programs it is readily apparent that additional cut or funding shifts could severely threaten the already fragile mental health system.

18. **One-Time User of Mental Health Reserves:** The main purpose of Mental Health Reserves is to cover emergencies that threaten the viability of the MHO. The current Acute Care Crisis constitutes such an emergency. Multnomah County should allocate $1.26 million of existing reserves to fund excess inpatient costs that are projected for fiscal year 2002.

    To prevent a similar shortfall in fiscal year 2003, inpatient expenditures must be reduced 21%. The funding model that was used to develop these recommendations assumes that these reductions will begin in September 2001, with the rollout of the Crisis and Acute Care Alternatives and Single Point of Accountability Structure and grow to a 21% savings by June 2002. The graph on the following page illustrates the required change in inpatient expenditures. *One-Time Costs: $1,262,284.*



Note: It is important to underscore that the consequences of not funding the crisis and acute care services listed in this report creates significant risks for the Multnomah County mental health consumers, the County and provider organizations. If one or more financial recommendations are considered unfeasible and not implemented, the difference should be appropriated from the County General Fund Contingency Pool.

What is not included in the Action Plan – Phase I

While stabilizing the crisis and acute care system is the immediate, mission-critical intervention to keep the mental health system solvent, there are a number of equally important parts of the system that need to be protected during the process. These includes:

- **Child and Family Service Funding:** Public mental health began as a system for adults with severe and persistent mental illness. Funding for children came later and in smaller quantities. Multnomah County has made substantial effort to address shortfalls in this area and design service delivery strategies that are relevant and successful for this population. It is important during an acute care crisis, which is substantially related to the adult population, that funding for child and family mental health services are protected and, to the degree possible, strengthened. This Action Plan has been specifically drafted to prevent reduction of service dollars for child and family services during Fiscal-Year 2002.
- **Multi-Cultural and Underserved Populations Funding:** Preliminary analysis of mental health utilization data, by ethnicity, illustrates that non-majority ethnic groups are significantly underserved in Multnomah County. Substantial efforts are underway to develop and strengthen cultural competency in Multnomah County and address under-service to non-majority ethic groups. This Action Plan has been designed to protect existing funding to organizations that specialize in serving multi-cultural and other underserved populations. The Single Point of Accountability structure is being proposed for these organizations on a "hold-harmless" basis, where multi-cultural providers will be identified as Primary Clinicians and receive continuing payments for their clients without the downside financial risk that will be embedded in the accountability/incentive structure.

- **County Mental Health Service Delivery:** Multnomah County staff in the Behavioral Health Division provide mental health services through their Child and Adolescent Treatment unit and School-Based programs. As the outpatient system begins to prepare for additional funding that will be freed up from a successful resolution to the acute crisis, these services need to be included in the analysis of what's available, what gaps exist, what changes in priorities are necessary to best meet the needs of consumers and family members. These efforts are not part of the Action Plan – Phase I.
- **Alcohol and Drug Services and Funding:** Services and funding for the county-supported alcohol and drug system are outside the scope of this Action Plan.

Important Notes about Cultural Competency and Consumer Involvement

The reader will note that there are no *specific* Acute Care Crisis action-steps addressing cultural competency and consumer involvement. Nonetheless, there are many *implicit* actions within the eighteen steps that relate to both.

It is imperative for Multnomah County to ensure that all services are designed with sensitivity and specialization for specific sub-populations including adults, children, older adults and ethnic and cultural communities. Staffing must consistently attend to cultural and special population considerations incorporating bicultural members, bilingual staff and sub-populations specialists into all staff teams. This is relevant for services that are developed during times of relative calm as well as times of crisis.

Design work has already begun towards producing data that will demonstrate how new services as well as existing ones address the needs of different populations; this is an important element of Action-Step 12, System-Wide Performance Reporting System. In addition, Appendix 3 – Detailed Acute Care Design, describes in greater detail how new services will be deployed in culturally appropriate ways.

Consumer Involvement must also be a characteristic that winds its way through all new and existing planning and service delivery activities. Development of the Single Point of Accountability Structure and Philosophy is a critical foundation step towards building a system of care that is based on placing the consumer at the center of the service delivery process.

The Clinical Design Workgroup was well represented with consumers, including a Consumer Involvement Subcommittee. This group has highlighted the need for a consumer-operated Warm Line, which is an important component of the new Access/Crisis Phone Service. Development of an Ombudsperson will occur within the existing Verity budget.

Work in moving these components of a well-functioning system forward will continue.

Implications for Phase II

When all of the eighteen Action-Steps in Phase I are implemented by September 30, 2001, the acute care crisis will have only begun to be resolved. There are numerous additional Action-Steps that should have been implemented as part of a Phase I. Because of the two-year delay in beginning detailed implementation work, this was not possible.

The 90-day Phase I must be followed immediately by Phase II that should begin at day 91. During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes
- Continued reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

It is only after this Phase II work is completed that the mental health system will be able to regain stability and begin to move away from financial insolvency.

Multnomah County Mental Health FY2002 Utilization/Financial Model
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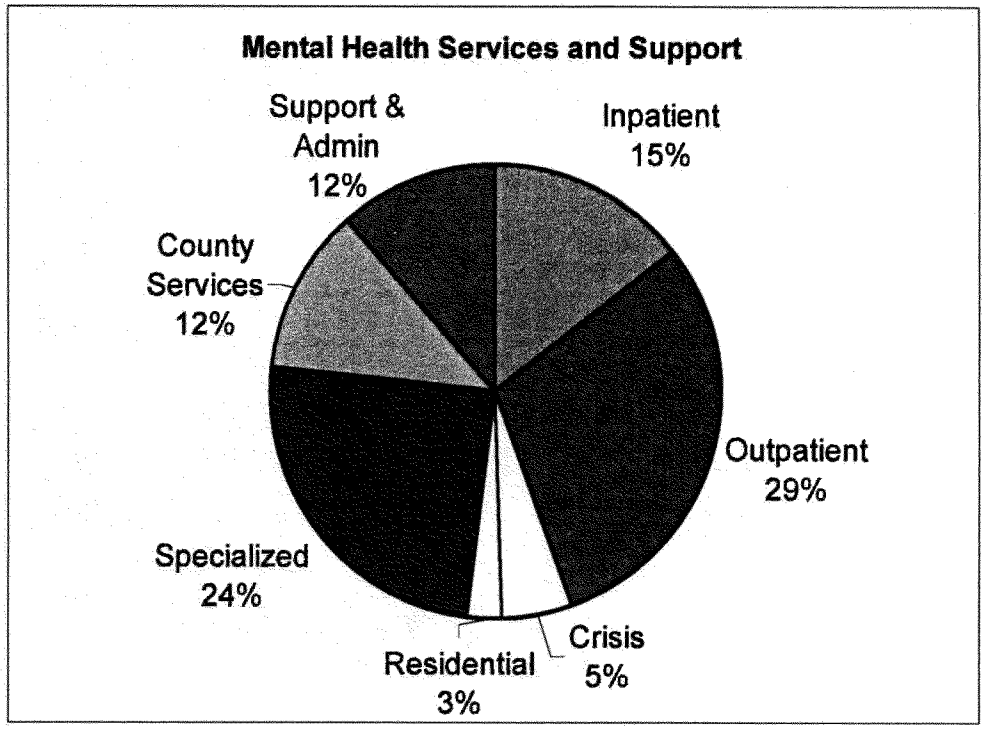
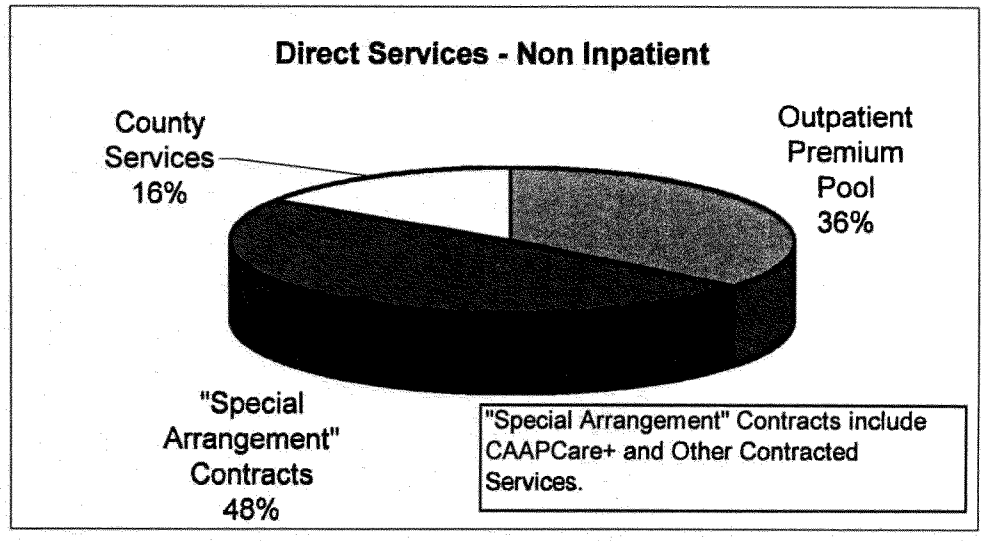
Multnomah County Behavioral Health -- FY2002 Adopted Budget Analysis

Program Area	*Total Budget*	*Ratio*
Indigent Inpatient Contracts	$2,358,798	3%
Subacute Inpatient Contracts	$1,129,249	2%
OHP Acute/Subacute Contracts	$6,519,466	9%
Inpatient Contracts Subtotal	$10,007,513	15%
Outpatient Premium Pool	$18,120,680	26%
CAAPCare+, Indigent Medications	$2,378,560	3%
Outpatient Contracts	$20,499,240	30%
Crisis System	$3,456,768	5%
Residential Contracts	$1,781,494	3%
Specialized Services	$17,035,959	25%
Other Contracted Services	$22,274,221	32%
County Treatment Services	$6,763,492	10%
Involuntary Committment	$1,299,459	2%
County Services Subtotal	$8,062,951	12%
Behavioral Health Administration	$1,453,811	2%
Care Coordination	$1,112,372	2%
Managed Care Administration	$5,359,240	8%
Support Services Subtotal	$7,925,423	12%
Total Mental Health	$68,769,348	100%
County A&D Services	$3,680,825	
A&D Contracts	$14,762,926	
Total A&D	$18,443,751	
Total Behavioral Health	$87,213,099	





Multnomah County Mental Health Crisis and Acute Care Shortfall Analysis

Section 1: Summary of Costs and Utilization

	FY2001 Costs	FY2001 Utilization	FY2002 Costs	FY2002 Utilization	FTEs/Units of Service/Comments
Crisis System					
A. Access/Crisis Line			$1,578,110	122,585	Incoming Calls
C. Secure Evaluation Facility			$2,388,949	2,450	Days
D. Mobile Crisis Services			$1,096,305	14,449	Service Hours
F. Urgent Walk-In Clinics			$1,084,821	10,800	Service Hours
K. Homebased Stabilization Days			$533,250	3,333	Verity Days
O. Warm Line			$225,108		6.00 FTEs
R. Flex Fund			$300,000		Dollars
Total Crisis System			**$7,206,543**		
Inpatient/Inpatient Alternative Services					
G. Sub-Acute Services	$1,461,600	4,176	$1,694,523	5,000	Verity Bed Days
H. Respite Services	$320,913	3,074	$609,696	4,357	Verity Bed Days
I. Voluntary Inpatient Services	$4,110,955	9,135	$6,915,834	9,880	Verity Bed Days
J. Involuntary Inpatient Services	$2,117,765	4,706	$2,819,809	4,028	Verity Bed Days
K. Indigent Inpatient Services	$1,925,338	1,562	$2,154,845	1,562	Mult. Co.-Responsible Bed Days
Total 24-Hour Services	**$9,936,572**	**22,653**	**$14,194,707**	**24,827**	Totals assume same number of total bed days for FY2002 with a shift from acute to sub-acute and respite
Acute Care Administration			**$156,750**		2.00 FTEs
New IT System Purchase, Customization, Implement			**$175,000**		Estimate of new Raintree Software and Implementation Costs
Additional Consultation			**$100,000**		Assume additional support will be required during fiscal year
Totals			**$21,833,000**		It is assumed that this level of expenditure will be needed to ramp up the new services, cover FY2002 costs, and pay for short-term alternatives, such as 1 month of CTC operations.

Section 2: Currently Available Funds

Indigent Inpatient Contracts	$2,700,000
OHP Inpatient Contracts	$7,448,000
Total Inpatient	**$10,148,000**
CTC Funds	$3,456,768
Sub-Acute Funding	$1,129,249
Total Crisis & Inpatient Alternative Funding	**$4,586,017**
Total Inpatient & Crisis Available Revenue	**$14,734,017**
Projected Excess(Shortfall)	**-$7,098,983**

Multnomah County Mental Health
Summary of Recommended Changes to Fund the Crisis/Acute Care System

#	Gain(Loss)	Change Impact	Description of Change	Category
Changes to the Adopted Budget				
0	($7,098,983)	$0	Starting Point: Projected Crisis/Acute Care Shortfall	N/A
1	($8,020,314)	($921,331)	Reduction in OHP Inpatient Premiums based on $4.7M overall reduction	Adjust shortfall
2	($8,856,488)	($836,174)	Decrease in available Indigent Inpatient Revenue	Adjust shortfall
3	($9,150,488)	($294,000)	Emergency Room recoveries during phase in period	Adjust shortfall
4	($9,372,773)	($222,285)	Correction of Sub-Acute Rates	Adjust shortfall
5	($8,660,172)	$712,601	Net Savings from Call Center Ramp Up	Adjust shortfall
6	($8,503,256)	$156,916	Net Savings from Mobile Crisis Ramp Up	Adjust shortfall
7	($8,536,869)	($33,613)	Net Savings from Urgent Walk-In Ramp Up	Adjust shortfall
8	($8,365,632)	$171,237	Net Savings from Secure Evaluation Facility Ramp Up	Adjust shortfall
9	($6,730,044)	$1,635,588	Reduction in Inpatient rates due to Medicare payments	Adjust shortfall
10	($4,343,063)	$2,386,980	Allocate Larger Portion of OHP System-Wide Funds	Recommendation
11	($3,344,083)	$998,980	Shifting of 3% Incentive Pool	Recommendation
12	($2,978,326)	$365,757	Revisions to Emergency Hold Days and Rates	Recommendation
13	($1,989,425)	$988,902	Reduction of Verity Administrative Costs	Recommendation
14	($1,655,545)	$333,880	Reduction of BHD Administrative Costs	Recommendation
15	($1,262,284)	$393,261	Transfer of State Local Mental Health Authority Funds	Recommendation
16	($1,262,284)	$0	Estimate of Reduction in Acute Inpatient Rates	Recommendation
17	$0	$1,262,284	One-Time Use of Reserves	Recommendation

Multnomah County Mental Health
Audit Trail of Recommended Changes to Fund the Crisis/Acute Care System
(based on evaluation by DCFS/Verity Staff, County Budget Office, Consultants, and Community Members)

					Cumulative	Notes
0 Starting Point: Crisis/Acute Care Shortfall					**-$7,098,983**	
1 Change in OHP PMPM Revenue						
	Enrollees	% Change	PMPM	Revenue		
Jul-01	68,556	0.00%	$ 39.738	$2,724,272		- New information has clarified that 85,000 enrollees per month
Aug-01	69,418	0.00%	$ 39.738	$2,758,526		were used to project OHP revenue. These figures are not
Sep-01	70,000	0.00%	$ 39.738	$2,781,653		correct. Current information shows that fewer enrollees have
Oct-01	70,000	0.00%	$ 39.738	$2,781,653		signed up with Verity.
Nov-01	70,000	0.00%	$ 39.738	$2,781,653		
Dec-01	70,000	0.00%	$ 39.738	$2,781,653		
Jan-02	70,000	0.00%	$ 39.738	$2,781,653		
Feb-02	70,000	0.00%	$ 39.738	$2,781,653		
Mar-02	70,000	0.00%	$ 39.738	$2,781,653		
Apr-02	70,000	0.00%	$ 39.738	$2,781,653		
May-02	70,000	0.00%	$ 39.738	$2,781,653		
Jun-02	70,000	0.00%	$ 39.738	$2,781,653		
Total				$33,299,333		
Original Estimate				$38,000,000		
Gain(Loss)				-$4,700,667		
Outpatient 48.7%				-$2,289,225		
System-wide 16.7%				-$785,011		
Incentive 3.0%				-$141,020		
Admin 12.0%				-$564,080		- Of the $4.7 million shortfall $921K has to be deducted
Decrease in Inpatient 19.6%				**-$921,331**	**-$8,020,314**	directly from the $7.4 million OHP Inpatient Revenue.
2 Corrections to Available Indigent Inpatient Revenue						
Original Indigent Inpatient Revenue						
Fund Source 24150 Passthrough				$500,000		- During the final budget revision the County General Fund
Fund Source MHS37 Passthrough				$800,000		Subsidy for Inpatient hospitalizations was decreased by
County General Fund Subsidy				$681,346		$341,202.
Fund Source MHS24				$718,654		
Total				$2,700,000		
Changes to Available Revenue						- It has been determined that $494,972 of State Pass through
Gen. Fund Subsidy Decrease: Approved to Adopted				-$341,202		funds cannot be used to subsidize the crisis and acute care
Decrease based on projected unused Passthrough				-$494,972		system.
Gain(Loss)				**-$836,174**	**-$8,856,488**	

Multnomah County Mental Health
Audit Trail of Recommended Changes to Fund the Crisis/Acute Care System
(based on evaluation by DCFS/Verity Staff, County Budget Office, Consultants, and Community Members)

		Cumulative	Notes
3 Emergency Room Reimbursement			
Estimated monthly days	105		- Assume 3.5 extra bed days per day for four months.
Average Cost per Day	$700		
Cost per month	$73,500		
# months	4		
Gain(Loss)	**-$294,000**	**-$9,150,488**	
4 Correction of Sub-Acute Rates			
Costs based on $350 per day for Subacute Services	$1,694,523		- Change of assumption of $350 per day to $400 per day.
Costs based on $400 per day for Subacute Services	$1,916,808		
Gain(Loss)	**-$222,285**	**-$9,372,773**	
5 Net Savings from Call Center Ramp Up			
Original budget	$1,578,110		
Added Providence Phase-In Costs	$195,000		- $65,000/month for 3 months
New Contractor Ramp-up Cost Savings	-$487,601		- Per attached schedule
Savings from Consolidating Existing Phone Services	-$420,000		- Per attached schedule
Revised First Year Budget	$865,509		
Gain(Loss)	**$712,601**	**-$6,273,192**	
6 Net Savings from Mobile Crisis Ramp Up			
Original budget	$1,096,305		
New Contractor Ramp-up Cost Savings	-$156,916		- Per attached schedule
Revised First Year Budget	$939,389		
Gain(Loss)	**$156,916**	**-$6,116,275**	
7 Net Savings from Urgent Walk-In Ramp Up			
Original budget	$1,084,821		
New Contractor Ramp-up Cost Savings	-$156,932		- Per attached schedule
Additional Medical Professional Costs	$190,546		- Per attached schedule
Revised First Year Budget	$1,118,434		
Gain(Loss)	**-$33,613**	**-$6,149,889**	

Multnomah County Mental Health
Audit Trail of Recommended Changes to Fund the Crisis/Acute Care System
(based on evaluation by DCFS/Verity Staff, County Budget Office, Consultants, and Community Members)

		Cumulative	Notes
8 Net Savings from Secure Evaluation Facility Ramp Up			
Original budget - Net Cost to Verity	$2,388,949		
Savings from 3 month delay in opening	-$597,237		
Payment of Remodel Costs	$330,000		
Payment of Startup Costs	$96,000		
Revised First Year Budget	$2,217,712		
Gain(Loss)	**$171,237**	**-$5,978,652**	
9 Medicare/Medicaid Copays			
Total # of Acute Care Days	13,908		- Preliminary assessment of how many inpatient days are for clients who have Medicare and Medicaid, where Medicare is the primary payor and Verity will only have to pay the copay.
% of Medicare Days	21.00%		
# of Medicare Days	2,921		
Original Cost Projection	$700		- Approximately 28% of OHP Inpatient days were for clients with Medicare and Medicaid coverage.
Average Copay for Medicare Days (20%)	$140		
Per Day Savings	$560		- 21% was selected as a conservative estimate of the number of days (75% of 28%).
Gain(Loss)	**$1,635,588**	**-$4,343,063**	
10 Allocate Larger Portion of OHP System-Wide Funds			
OPH System-wide 16.7% Revenue	$5,560,989		- This is a $785,011 reduction from original budget.
Projected Funding for FY2002	-$4,461,811		- Assumes no change over 4th Qtr 2001 costs.
Add-Back of Sub-Acute Portion of FY2002 Costs	$1,287,803		- Back out funds to transfer to Crisis/Acute Care Pool.
Gain(Loss) to Transfer to Crisis/Acute Care	**$2,386,980**	**-$6,985,793**	
11 Shifting of 3% Incentive Pool			
Projected OHP PMPM Revenue	$33,299,333		
3% Incentive used to cover Acute Care reserve	$998,980		
Gain(Loss)	**$998,980**	**-$3,344,083**	
12 Revisions to Emergency Hold Days and Rates			
Original E-Hold Costs	$1,349,817		
Reduction in E-Hold Days	-$134,982		- Assume a 10% reduction from 1,562 to 1,406.
Reduction in E-Hold Rates	-$230,775		- Negotiate rates to $700/day including professional fees. This requires a renegotiation of existing contracts.
Revised E-Hold Budget	$984,060		
Gain(Loss)	**$365,757**	**-$2,978,326**	

Multnomah County Mental Health
Audit Trail of Recommended Changes to Fund the Crisis/Acute Care System
(based on evaluation by DCFS/Verity Staff, County Budget Office, Consultants, and Community Members)

		Cumulative	Notes
13 Reduction of Verity Administrative Costs			
Current Admin Expense	$6,471,612		- Based on budget analysis of Verity budget with addition of
Current Admin Expense as a % of Total Exp	9.4%		QA/UR, Care Coordination, AMH/CMH Contracts, and
Admin Expense at 8%	$5,482,711		Involuntary Commitment
Admin. Reduction	$988,902		
Gain(Loss)	**$988,902**	**-$1,989,425**	- Savings based on reduction of admin to 8%
14 Reduction of BHD Administrative Costs			
Current Admin Expense	$1,218,349		- Based on budget analysis of BHD budget with transfer of
Current Admin Expense as a % of Total Exp	16.5%		QA/UR, Care Coordination, AMH/CMH Contracts, and
Admin Expense at 12%	$884,469		Involuntary Commitment to Verity
Admin. Reduction	$333,880		
Gain(Loss)	**$333,880**	**-$1,655,545**	- Savings based on reduction of admin to 12%

15 Transfer of State Local Mental Health Authority Funds

	Director's Office	Info Services	Human Resources	Operations & Support
Total LMHA Revenue	$356,083	$333,605	$121,353	$499,829
30% Transfer to Cover Direct LMHA Duties	$106,825	$100,082	$36,406	$149,949

Gain(Loss)	**$393,261**	**-$1,262,284**	- Currently $2.1 million is received from the State to administer Mental Health, Alcohol & Drug and Developmental Disabilities - $805,640 is allocated directly to programs and only $111,054 is allocated to Mental Health programs. - $1,310,870 is allocated to DCFS overhead departments. - The recommendation transfers 30% of the $1.3 million to Mental Health to free up additional OHP and State General Funds to support the Crisis/Acute Care System costs.

16 Estimate of Reduction in Acute Inpatient Rates			
Costs based on $700 per day for Acute Services	$11,525,431		- What-if scenario analysis if better rates were negotiated
Costs based on $650 per day for Acute Services	$10,759,688		for voluntary OHP, involuntary OHP and emergency hold
Potential Savings	$765,743		days. This would bring the deficit closer to zero.
Gain(Loss)	**$0**	**-$1,262,284**	
17 One-Time Use of Reserves			
Estimated Current Reserves	$2,491,771		- As of 7/1/2001; includes repayment of redesign costs and
One-Time use of Reserves	-$1,262,284		system-wide OHP pool.
Remaining Reserves	$1,229,487		
Gain(Loss)	**$1,262,284**	**$0**	

Multnomah Co. Behavioral Health
Administrative Restructuring and Reductions Analysis

Section 1: Reorganization of Activities along Functional Lines

					Reorganization Proposal				
		Existing	FY2002	FY2002	New	Services - BHD		Sys. Mgmt. - Verity	
Area	Type of Service	Division	FTEs	Budget	Category	FTEs	Budget	FTEs	Budget
Div Admin	Admin of BHD Svcs and Contracts	BHD	10.30	$1,125,439	Services	10.30	$1,125,439		
Div Admin Contracts	Primarily Consulting Contracts	BHD	-	$431,478	Services	-	$431,478		
Children's Treatment Services	Mental Health Direct Service	BHD	66.72	$5,720,748	Services	66.72	$5,720,748		
Addiction Services Admin	A&D Admin & Direct Services	BHD	6.70	$559,433	Services	6.70	$559,433		
A&D A&R	A&D Services	BHD	35.96	$2,662,621	Services	35.96	$2,662,621		
A&D Contracts	A&D Direct Service Contracts	BHD	-	$14,866,237	Services	-	$14,866,237		
RDI	A&D Services	BHD	4.00	$355,460	Services	4.00	$355,460		
Managed Care	System Oversight	Verity	34.75	$44,660,346	Sys. Mgmt.			34.75	$44,660,346
QA/UR	System Oversight	Verity	5.10	$439,143	Sys. Mgmt.			5.10	$439,143
CRC	Special Services Contracts	BHD	-	$2,296,698	Sys. Mgmt.			-	$2,296,698
Involuntary Commit Program	Statutory Services	BHD	15.00	$1,299,459	Sys. Mgmt.			15.00	$1,299,459
Care Coord Services	System Oversight	BHD	13.50	$1,112,372	Sys. Mgmt.			13.50	$1,112,372
AMH Contracts	Mental Health Direct Service Contracts	BHD	-	$9,310,272	Sys. Mgmt.			-	$9,310,272
CMH Contracts	Mental Health Direct Service Contracts	BHD	-	$1,274,024	Sys. Mgmt.			-	$1,274,024
Operations & Support Services	DCFS Support Services	DCFS	7.50	$579,220	Allocated	2.24	$173,008	5.26	$406,212
Information Systems	DCFS Support Services	DCFS	4.25	$520,148	Allocated	1.27	$155,364	2.98	$364,785
Totals			203.78	$87,213,099		127.19	$26,049,788	76.59	$61,163,311

Note: This section describes a restructuring model that allows for the reduction of Administrative Overhead to 8% and supports a fully functional, self-contained business enterprise with its own fiscal, contract and IS capacity.

Multnomah Co. Behavioral Health
Administrative Restructuring and Reductions Analysis

	A&D Services Admin $	Mental Hlth Services Admin $	Mental Hlth Sys. Mgmt. Admin $	Total Mental Hlth Admin $
Section 2: Cost Reduction Data				
Total Expenses	$18,679,213	$7,370,576	$61,163,311	$68,533,886
Administrative Expenses				
Div Admin		$1,139,807		$1,139,807
Div Admin Contracts		$5,508		$5,508
Children's Treatment Services		$73,034		$73,034
Addiction Services Admin	$566,575			$0
A&D A&R	$33,992			$0
A&D Contracts	$189,789			$0
RDI	$4,538			$0
Managed Care			$4,719,255	$4,719,255
QA/UR			$444,750	$444,750
CRC			$29,321	$29,321
Involuntary Commit Program			$16,589	$16,589
Care Coord Services			$1,126,573	$1,126,573
AMH Contracts			$118,859	$118,859
CMH Contracts			$16,265	$16,265
Totals	$794,894	$1,218,349	$6,471,612	$7,689,962
Percent of Total Expense	4.3%	16.5%	9.4%	11.2%
Administrative Reductions				
Goal Admin Percentage	**N/A**	**12.0%**	**8.0%**	**N/A**
Goal Admin Calculation		$884,469	$5,482,711	$6,367,180
Goal Admin. Reduction		**-$333,880**	**-$988,902**	**-$1,322,782**

Note: - This section lists the administrative expenses that directly reside in each service area or have been allocated to those areas.

Notes: - OMAP provides 8% to fully capitated health plans for administration.
- CareOregon is managed within their 8% rate.
- The State MHDDSD Department provides 8% to MHOs for administration.
- CAAPCare/Verity MHO administrative costs for Federal Fiscal Year 1999/2000 was 12%
- Clackamas MHO administration for FFY99/00 was 6.54%.
- Mid-Valley Behavioral Care Network MHO administration for FFY99/00 was 7%.
- Accountable Behavioral Health Alliance MHO administration for FFY99/00 was 8%.

Multnomah Co. Behavioral Health
Administrative Restructuring and Reductions Analysis

	Mental Hlth Services Admin $	Mental Hlth Sys. Mgmt. Admin $	Total Admin $
Section 3: Cost Reduction Recommendation			
Impact Estimates			
% Reduction Achievable in FY2002	100.0%	100.0%	N/A
Scenario A - Admin Reduction	**-$333,880**	**-$988,902**	**-$1,322,782**
Materials & Supplies % of Comp + M&S	37%	54%	
"Reducibility" Ratio of Materials & Supplies	50%	50%	
Materials & Supplies Reduction	**-$61,993**	**-$266,143**	**-$328,136**
Balance (Reductions from Staffing)	**-$271,887**	**-$722,759**	**-$994,645**
Average Compensation per FTE	$68,690	$61,899	
Estimated FTE Reduction	**(3.96)**	**(11.68)**	**(15.63)**
Existing FTEs	78.77	76.59	155.37
FTE Reduction %	5.0%	15.2%	10.1%

Note: - Assume that only a partial reduction in Materials and Supplies will be able to be made.

Multnomah County Mental Health
Acute Care Scenario Viewer

Scenario: Version 8/5/01
Fiscal Year: FY2002

Section 4A: Access/Crisis Phone Center

Cost Analysis	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-June FTEs	Rate	1st Yr Amount	Ongoing Amount	Savings
Clinician FTEs	0.00	0.00	0.00	5.82	23.28	23.28	23.28	$35,000			
Manager FTEs	0.00	0.00	1.00	1.00	1.00	1.00	1.00	$45,000			
Support Staff FTEs	0.00	0.00	0.00	0.50	1.00	1.00	1.50	$28,000			
Subtotal FTEs	0.00	0.00	1.00	7.32	25.28	25.28	25.78				
Clinician Salaries	$0	$0	$0	$16,975	$67,900	$67,900	$407,442	$2,917	$560,217	$814,885	$254,667
Manager Salaries	$0	$0	$3,750	$3,750	$3,750	$3,750	$22,500	$3,750	$37,500	$45,000	$7,500
Support Staff Salaries	$0	$0	$0	$1,167	$2,333	$2,333	$21,000	$2,333	$26,833	$42,000	$15,167
Subtotal Salaries	$0	$0	$3,750	$21,892	$73,983	$73,983	$450,942		$624,551	$901,885	$277,334
Protocol 10 PM - 8 AM Costs	**$0**	**$0**	**$0**	**$0**	**$7,500**	**$7,500**	**$45,000**		$60,000	**$90,000**	$30,000
Benefits/Payroll Taxes								25%	$156,138	$225,471	$69,334
Other Exp. as % of Comp.								40%	$249,820	$360,754	$110,934
Total Cost									**$1,090,509**	**$1,578,110**	**$487,601**
Providence Call Center Costs	**$65,000**	**$65,000**	**$65,000**	**$0**	**$0**	**$0**	**$0**		$195,000	**$0**	-$195,000
Total First Year Costs									**$1,285,509**		

Cost Offset of Existing Phone Staffing	FTEs	Rate *		
Mt. Hood	4.00	$55,000	-$146,667	-$220,000
Unity	5.00	$53,000	-$176,667	-$265,000
Network Behavioral Health	2.50	$58,000	-$96,667	-$145,000
Total Offset	11.50		**-$420,000**	-$630,000

Rate * Note: This is a fully loaded rate: salary, benefits, payroll taxes, other expenses.

Net Additional Cost for Crisis/Acute Care System	**$865,509**	**$948,110**
Cost per Month		**$79,009**
Current Cost per Month		**$65,000**
Difference		**$14,009**

Section 4D: Mobile Crisis Services

Cost Analysis	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-June FTEs	Rate	1st Yr Amount	Ongoing Amount	Savings
Clinician FTEs	0.00	5.67	17.22	17.22	17.22	17.22	17.22	$35,000		$602,622	
Manager FTEs	0.00	1.00	1.00	1.00	1.00	1.00	1.00	$45,000		$45,000	
Support Staff FTEs	0.00	0.25	1.00	1.00	1.00	1.00	1.50	$28,000		$42,000	
Subtotal Staff	0.00	6.92	19.22	19.22	19.22	19.22	19.72			$689,622	$34,975
Clinician Salaries	$0	$16,538	$50,225	$50,225	$50,225	$50,225	$301,311	$2,917	$518,749	$602,622	$83,874
Manager Salaries	$0	$3,750	$3,750	$3,750	$3,750	$3,750	$22,500	$3,750	$41,250	$45,000	$3,750
Support Staff Salaries	$0	$583	$2,333	$2,333	$2,333	$2,333	$21,000	$2,333	$30,917	$42,000	$11,083
Subtotal Salaries	$0	$20,871	$56,308	$56,308	$56,308	$56,308	$344,811		$590,915	$689,622	$98,707
Benefits/Payroll Taxes								25%	$147,729	$172,406	$24,677
Other Exp. as % of Comp.								40%	$236,366	$275,849	$39,483
Total Cost									**$975,010**	**$1,137,877**	**$162,866**

	Services	% Insured	Pmt Rate			
Revenue Projections	2,598	20%	$80	$35,621	$41,571	-$5,950
Other Revenue as a % of Total Expense	3.7%					
Net Cost to Verity				**$939,389**	**$1,096,305**	**$156,916**

Section F: Urgent Walk-In Clinics

	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-June FTEs	Rate	1st Yr Amount	Ongoing Amount	Savings
Scheduled QMHPs	0.00	5.00	7.74	7.74	7.74	7.74	7.74	$35,000			
QMHP Float	0.00	0.00	1.00	1.00	1.00	1.00	1.00	$35,000			
LMP - MD Contracted	0.00	1.23	1.95	1.95	1.95	1.95	1.95	$208,000			
LMP - ARNP Contracted	0.00	0.35	0.65	0.65	0.65	0.65	0.65	$72,800			
Manager	1.00	0.50	1.00	1.00	1.00	1.00	1.00	$45,000			
Support Staff	0.00	2.00	2.00	2.00	2.00	2.00	2.00	$28,000			
Subtotal FTEs	1.00	9.08	14.34	14.34	14.34	14.34	14.34				
Scheduled QMHPs	$0	$14,583	$22,575	$22,575	$22,575	$22,575	$135,489	$2,917	$240,372	$270,978	$30,606
QMHP Float	$0	$0	$2,917	$2,917	$2,917	$2,917	$17,500	$2,917	$29,167	$35,000	$5,833
LMP - MD Contracted	$0	$21,233	$33,800	$33,800	$33,800	$33,800	$202,800	$17,333	$359,233	$405,600	$46,367
LMP - ARNP Contracted	$0	$2,123	$3,943	$3,943	$3,943	$3,943	$23,660	$6,067	$41,557	$47,320	$5,763
Manager	$3,750	$1,875	$3,750	$3,750	$3,750	$3,750	$22,500	$3,750	$43,125	$45,000	$1,875
Support Staff	$0	$4,667	$4,667	$4,667	$4,667	$4,667	$28,000	$2,333	$51,333	$56,000	$4,667
Subtotal Salaries	$3,750	$44,482	$71,652	$71,652	$71,652	$71,652	$429,949	$35,317	$764,787	$859,898	$95,111
Child Psychiatrist Consultation									$25,000	$25,000	$0
Benefits/Payroll Taxes								25%	$191,197	$214,974	$23,778
Other Exp. as % of Comp.								40%	$305,915	$343,959	$38,044
Total Cost									**$1,286,899**	**$1,443,831**	**$156,932**

	Svc Hrs	% Insured	Pmt Rate		
Revenue Projections	10,800	35%	$50	$168,465	$189,008
Other Revenue as a % of Total Expense	13.1%				
Net Cost to Verity				**$1,118,434**	**$1,254,823**
Original Net Cost to Verity				$1,084,821	$1,084,821
Net Increase in Medical Costs due to shift from Nurse Practitioner to MD				$165,546	$145,002
Addition of Child Psychiatrist Consultation				$25,000	$25,000
Net Additional Costs				**$190,546**	**$170,002**

Multnomah County
Department of Community and Family Services
FY2002 Local Mental Health Authority Budget Analysis

	Director's Office	Information Services	Human Resources	Operations & Support	Develop. Disabilities	Behavioral Health	Verity	Community Programs	Total
Expenses - Approved Budget									
Personal Services	$1,661,849	$0	$427,237	$2,498,767	$5,346,972	$9,917,830	$2,150,998	$3,675,607	$25,679,260
Contractual Services	$1,826,412	$0	$25,087	$257,572	$69,313,702	$27,384,351	$45,509,528	$24,468,765	$168,785,417
Materials and Supplies	$709,614	$2,228,849	$170,570	$743,150	$2,107,227	$3,195,693	$968,262	$1,449,648	$11,573,013
Capital Outlay	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$4,197,875	$2,228,849	$622,894	$3,499,489	$76,767,901	$40,497,874	$48,628,788	$29,594,020	$206,037,690
Excess(Deficit)	-$280,764	-$318,946	-$1	-$459,225	-$93,841	-$6,471,596	-$1,229,686	-$9,680,931	-$18,534,990
Local Admin Analysis									
Director's Office	$237,924								$237,924
Planning & Development	$118,159								$118,159
Business Services Management				$37,833					$37,833
Information Services		$333,605							$333,605
Human Resources			$121,353						$121,353
OSS Division Management				$48,999					$48,999
OSS Administrative Services				$64,624					$64,624
OSS Financial Services				$164,112					$164,112
OSS Contracts				$116,416					$116,416
OSS Data Management				$67,845					$67,845
DD Division Management					$397,718				$397,718
Office of Addiction Services						$93,694			$93,694
A&D A&R						$203,174			$203,174
Care Coordination Services							$86,706		$86,706
Verity Managed Care Administration							$24,348		$24,348
Totals	$356,083	$333,605	$121,353	$499,829	$397,718	$296,868	$111,054	$0	$2,116,510
Percent of Total Budget	8.48%	14.97%	19.48%	14.28%	0.52%	0.73%	0.23%		1.03%
Transfer of Local Admin to MHO/LMHA									
30% Transfer of DCFS Funds	-$106,825	-$100,082	-$36,406	-$149,949			$393,261		$0
Balance of Local Admin	$249,258	$233,524	$84,947	$349,880	$397,718	$296,868	$504,315	$0	$2,116,510
Revised Percent of Total Budget	5.94%	10.48%	13.64%	10.00%	0.52%	0.73%	1.04%		1.03%

Multnomah County Mental Health OHP System-wide Pool

Oct 99 & Forward Model

Note: Figures in italics are projected

Month of Service	CTC	CTC RESPITE	Dual Diag/Res Support	Day Treatment	'High End Children'	Sub Acute Residential	Subtotal	Lag	Total (with Lag)	Supported Classrooms	Theraputic & Stabilization Classrooms	IOP CARE CO ORDINATION	SOAP / RAPP	CRISIS HOT LINE	Total Expenses
	BA Codes	*EEC10/PROVX*	*PROJNET*		*Auth Mc2**	*ECC10*									
Oct-99	$10,280	$20,149	$2,042	$15,518	$53,391	$103,725	$205,105	100.0%	$205,105	$14,777	$89,926	$0	$14,425	$0	$324,233
Nov-99	$12,649	$29,030	$4,416	$18,640	$43,057	$122,776	$230,567	100.0%	$230,567	$15,564	$85,104	$0	$13,577	$0	$344,812
Dec-99	$10,669	$19,691	$3,339	$17,156	$45,463	$129,909	$226,226	100.0%	$226,226	$15,151	$88,469	$0	$14,541	$0	$344,387
Jan-00	$12,296	$21,229	$1,230	$17,393	$48,395	$132,275	$232,819	100.0%	$232,819	$16,490	$96,100	$0	$19,388	$0	$364,797
Feb-00	$14,013	$29,235	$1,769	$18,323	$53,271	$135,127	$251,738	100.0%	$251,738	$24,624	$93,768	$0	$24,055	$0	$394,185
Mar-00	$12,552	$20,026	$2,040	$20,950	$51,502	$128,316	$235,386	100.0%	$235,386	$27,102	$92,506	$0	$19,285	$0	$374,279
Apr-00	$11,660	$18,477	$2,791	$15,303	$56,425	$160,327	$264,983	100.0%	$264,983	$28,728	$94,067	$0	$19,065	$0	$406,843
May-00	$15,764	$8,254	$4,256	$15,784	$65,479	$136,489	$246,026	100.0%	$246,026	$30,149	$90,713	$0	$20,410	$0	$387,298
Jun-00	$13,657	$4,572	$3,360	$21,068	$62,947	$80,095	$185,699	99.9%	$185,885	$28,497	$82,450	$0	$19,208	$0	$316,040
Jul-00	$13,568	$0	$1,848	$18,535	$53,070	$71,105	$158,127	99.8%	$158,444	$24,367	$73,914	$0	$16,980	$0	$273,705
Aug-00	$16,732	$0	$4,382	$13,968	$57,489	$86,906	$179,477	99.5%	$180,379	$24,780	$43,669	$0	$17,900	$0	$266,728
Sep-00	$14,099	$0	$2,127	$11,403	$46,766	$83,419	$157,813	98.7%	$159,892	$26,019	$108,259	$0	$18,360	$1,936	$314,466
Oct-00	$13,666	$0	$4,825	$16,520	$46,697	$81,629	$163,337	97.6%	$167,354	$27,774	$110,013	$18,755	$21,968	$2,255	$348,119
Nov-00	$13,046	$0	$4,991	$17,774	$42,990	$119,915	$198,715	96.7%	$205,496	$30,149	$101,560	$20,770	$22,040	$0	$380,015
Dec-00	$9,841	$0	$4,500	$10,544	$38,056	$98,914	$161,854	96.5%	$167,724	$30,252	$103,150	$19,220	$22,004	$0	$342,350
Jan-01	$14,210	$0	$6,867	$4,450	$40,808	$99,958	$166,293	93.5%	$177,853	$41,507	$136,148	$18,290	$17,940	$1,650	$393,388
Feb-01	$14,483	$0	$6,082	$11,762	$33,898	$103,664	$169,889	88.9%	$191,101	*$35,000*	$134,177	$16,895	$19,351	$2,079	$398,603
Mar-01	$15,214	$0	$8,909	$11,601	$34,910	$110,041	$180,674	75.8%	$238,357	*$35,000*	$131,571	$16,898	$22,540	$1,661	$446,027
Apr-01	$12,426	$0	$6,550	$6,959	$23,400	$119,117	$168,452	pmpm	$196,106	*$35,000*	$136,917	*$20,000*	*$20,000*	$4,191	$412,214
May-01	$105	$0	$0	$276	$1,091	$33,509	$34,981	pmpm	$194,228	*$35,000*	*$130,000*	*$20,000*	*$20,000*	$11,000	$410,228
	$250,931	$170,663	$76,323	$283,926	$899,106	$2,137,214	$3,818,162		$4,115,670	$545,930	$2,022,481	$150,828	$383,037	$24,772	$7,242,718
7/00-5/01 Total	$137,390	$0	$51,080	$123,791	$419,176	$1,008,176	$1,739,613		$2,036,935	$344,848	$1,209,378	$150,828	$219,083	$24,772	$3,985,844
Annual Lag Ratio	$160,872	$0	$59,810	$144,949	$490,818	$1,180,486	$2,036,935		117.09%	$344,848	$1,209,378	$150,828	$219,083	$24,772	$3,985,844
Monthly Average	$14,625	$0	$5,437	$13,177	$44,620	$107,317	$185,176			$31,350	$109,943	$13,712	$19,917	$2,252	$362,349
FY2002 Ratio	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%				100.00%	118.24%	145.86%	100.00%	0.00%	
Projected Mo. $	$0	$0	$5,437	$13,177	$44,620	$107,317	$170,551			$31,350	$130,000	$20,000	$19,917	$0	$371,818
FY2002 Total	$0	$0	$65,247	$158,126	$535,438	$1,287,803	$2,046,614			$376,198	$1,560,000	$240,000	$239,000	$0	$4,461,811
Crisis Exp to Tx						-$1,287,803	-$1,287,803								-$1,287,803
FY2002 Net	**$0**	**$0**	**$65,247**	**$158,126**	**$535,438**	**$0**	**$758,811**			**$376,198**	**$1,560,000**	**$240,000**	**$239,000**	**$0**	**$3,174,008**
OHP Revenue															$5,560,989
Savings															$2,386,980

Green shading = Provided by Keith Mitchell in DCFS

Yellow shading = Developed by Dale Jarvis

BOGSTAD Deborah L

From: JARVIS Dale
Sent: Tuesday, August 07, 2001 2:32 PM
To: BALL John; CARROLL Mary P; CRUZ Serena M; DAVIDSON Peter J; GAYNOR Jim G; TINKLE Kathy M; LINN Diane M; NAITO Lisa H; RAKOWITZ John A; ROBERTS Lonnie J; ROJO DE STEFFEY Maria; SPONSLER Thomas; LEAR Wendy R; BOGSTAD Deborah L
Subject: Additional Financial Information

Attached please find the second set of information that Commissioners Naito and Cruz requested from our meeting yesterday. This spreadsheet contains two reports:
1) A summary of Crisis and Acute Care Revenue and Expense
2) A draft cost comparison of a county versus contracted operated Access/Call Center

The questions raised by Commissioners Naito and Cruz yester regarding what should be on the table for Thursday were crucial in helping frame the summary of Crisis and Acute Care Revenue and Expense. In short, the report says the following:

Existing Budgeted Revenue for Crisis and Acute Care Services:	$13,464,281	
Projected Inpatient Costs:	$14,051,935	
Shortfall before any funds are allocated for Crisis Services		-$587,654
Crisis Services First Year Costs (net of ramp up savings)		$6,335,790
Shortfall		-$6,923,444

In other words, available revenues are completely absorbed by inpatient costs before we spend a dollar on crisis services. It is this gap that we are attempting to address.

Short Term Model.xls (40 KB)

Multnomah County Mental Health
Summary of Crisis and Acute Care Revenue and Expense
(prior to implementation of recommendations)

SECTION 1: REVENUE

Program	Category	Fund Source	Fund Source Name	Amount
AMH Contracts	Indigent Inpatient	76010	County General Fund Subsidy	$340,144
Managed Care	Indigent Inpatient	24150	Mental Health Hospital Beds	$500,000
AMH Contracts	Indigent Inpatient	MHS 24	Regional Acute Psychiatric Inpatient Facilities	$718,654
AMH Contracts	Indigent Inpatient	MHS 37	Regional Acute Psychiatric Inpatient Facilities; non Mg Care folks	$800,000
Subtotal				**$2,358,798**
Managed Care	Subacute	82024	MHS24	$684,430
Managed Care	Subacute	82024	MHS24 carryover	$444,819
Subtotal				**$1,129,249**
Managed Care	Inpatient Premium	26030	TXIX Medicaid FQHC	$6,519,466
Subtotal				**$6,519,466**
TOTAL INPATIENT CONTRACTS				**$10,007,513**
AMH Contracts	Crisis	76010	County General Fund Subsidy	$250,385
AMH Contracts	Crisis	MHS 24	Regional Acute Psychiatric Inpatient Facilities	$709,404
AMH Contracts	Crisis	MHS 25	Community Crisis Svcs for Adults & Children	$2,496,979
TOTAL CRISIS TRIAGE FUNDING				**$3,456,768**
TOTAL BUDGETED INPATIENT AND CRISIS FUNDING				**$13,464,281**

SECTION 2: PROJECTED INPATIENT EXPENSE

Service Category	Days	Description	Amount
Sub-Acute Services	5,000	Verity Bed Days	$1,916,808
Respite Services	4,357	Verity Bed Days	$609,696
Voluntary Inpatient Services	9,880	Verity Bed Days	$6,915,834
Involuntary Inpatient Services	4,028	Verity Bed Days	$2,819,809
Indigent Inpatient Services	1,406	Mult. Co.-Responsible Bed Days	$1,789,788
TOTAL INPATIENT SERVICES	**24,671**	**Total Days**	**$14,051,935**
GAIN/LOSS PRIOR TO FUNDING CRISIS SERVICES			**-$587,654**

SECTION 3: PROJECTED CRISIS EXPENSES

Service Category	Units	Description	Amount
Access/Crisis Line	122,585	Incoming Calls	$1,578,110
Secure Evaluation Facility	2,450	Days	$2,388,949
Mobile Crisis Services	14,449	Service Hours	$1,096,305
Urgent Walk-In Clinics	10,800	Service Hours	$1,254,823
Homebased Stabilization Days	3,333	Verity Days	$533,250
Warm Line	6	FTEs	$225,108
Flex Fund		Dollars	$300,000
TOTAL CRISIS SERVICE COSTS - FULL YEAR			**$7,376,545**
Less Ramp-Up Savings			
Net Savings from Call Center Ramp Up			-$712,601
Net Savings from Mobile Crisis Ramp Up			-$156,916
Net Savings from Secure Evaluation Facility Ramp Up			-$171,237
NET FIRST YEAR SERVICE COSTS			**$6,335,790**
SHORTFALL			**-$6,923,444**

Multnomah County Mental Health
Comparison of County versus Contracted
Crisis/Access Phone System

	County	Contracted	Difference	Difference %
FTEs				
Clinicians	23.28	23.28	-	0%
Manager	1.00	1.00	-	0%
Support Staff	1.50	1.50	-	0%
Subtotal	25.78	25.78	-	0%
Rate (including benefits and taxes)				
Clinicians	$67,337	$43,750	$23,587	35%
Manager	$82,544	$56,250	$26,294	32%
Support Staff	$41,824	$35,000	$6,824	16%
Compensation				
Clinicians	$1,567,767	$1,018,606	$549,160	35%
Manager	$82,544	$56,250	$26,294	32%
Support Staff	$62,736	$52,500	$10,236	16%
Subtotal	$1,713,046	$1,127,356	$585,690	34%
Protocol 10 PM - 8 AM Costs	$90,000	$90,000	$0	0%
Other Exp. as % of Comp.	23.60%	40.00%		
Indirect Rate	15.88%	0.00%		
Total Other Rate	39.48%	40.00%		
Total Other Expense	$676,311	$450,942	$225,368	33%
TOTAL COST	$2,479,357	$1,668,299	$811,058	33%

NOTE: These figures do not include startup costs. This information is forthcoming.

Multnomah County Mental Health
Comparison of County versus Contracted
Crisis/Access Phone System

SECTION 2: BASIS FOR COUNTY COMPENSATION CALCULATIONS

BH - Child & Adolescent Treatment	63,312.34	1.00	6365	MEN HTH CNSL	63,312.34
BH - Child & Adolescent Treatment	65,124.81	1.00	6365	MEN HTH CNSL	65,124.81
BH - Child & Adolescent Treatment	71,123.23	1.00	6365	MEN HTH CNSL	71,123.23
BH - Child & Adolescent Treatment	35,498.85	0.50	6365	MEN HTH CNSL	70,997.70
BH - Child & Adolescent Treatment	14,316.97	0.20	6365	MEN HTH CNSL	71,584.85
BH - Child & Adolescent Treatment	71,218.69	1.00	6365	MEN HTH CNSL	71,218.69
BH - Child & Adolescent Treatment	45,972.14	0.70	6365	MEN HTH CNSL	65,674.49
BH - Child & Adolescent Treatment	70,244.46	1.00	6365	MEN HTH CNSL	70,244.46
BH - Child & Adolescent Treatment	33,715.15	0.50	6365	MEN HTH CNSL	67,430.30
BH - Child & Adolescent Treatment	51,441.55	0.80	6365	MEN HTH CNSL	64,301.94
BH - Child & Adolescent Treatment	65,706.74	1.00	6365	MEN HTH CNSL	65,706.74
BH - Child & Adolescent Treatment	68,599.37	1.00	6365	MEN HTH CNSL	68,599.37
BH - Child & Adolescent Treatment	70,537.38	1.00	6365	MEN HTH CNSL	70,537.38
BH - Child & Adolescent Treatment	31,148.13	0.50	6365	MEN HTH CNSL	62,296.26
BH - Child & Adolescent Treatment	68,769.37	1.00	6365	MEN HTH CNSL	68,769.37
BH - Child & Adolescent Treatment	61,133.87	1.00	6365	MEN HTH CNSL	61,133.87
BH - Child & Adolescent Treatment	68,400.60	1.00	6365	MEN HTH CNSL	68,400.60
BH - Child & Adolescent Treatment	70,932.31	1.00	6365	MEN HTH CNSL	70,932.31
BH - Child & Adolescent Treatment	65,674.04	1.00	6365	MEN HTH CNSL	65,674.04
BH - Child & Adolescent Treatment	69,878.30	1.00	6365	MEN HTH CNSL	69,878.30
BH - Child & Adolescent Treatment	##########	3.20	6365	MEN HTH CNSL	61,133.87
				AVERAGE	67,336.90

BH - Child & Adolescent Treatment	39,921.99	0.50	9008	CFS SUPR	79,843.98
BH - Child & Adolescent Treatment	75,541.95	1.00	9008	CFS SUPR	75,541.95
BH - Child & Adolescent Treatment	80,750.52	1.00	9008	CFS SUPR	80,750.52
BH - Child & Adolescent Treatment	94,040.67	1.00	9745	CFS ADMIN	94,040.67
				AVERAGE	82,544.28

BH - Child & Adolescent Treatment	42,289.75	1.00	6001	OA 2	42,289.75
BH - Child & Adolescent Treatment	12,576.05	0.35	6001	OA 2	35,931.57
BH - Child & Adolescent Treatment	47,249.86	1.00	6002	OA SR	47,249.86
					41,823.73

July 19, 2001

Handout

Resolving the Multnomah County Acute Care Crisis

Proposed Action Plan - Phase I

July 18, 2001
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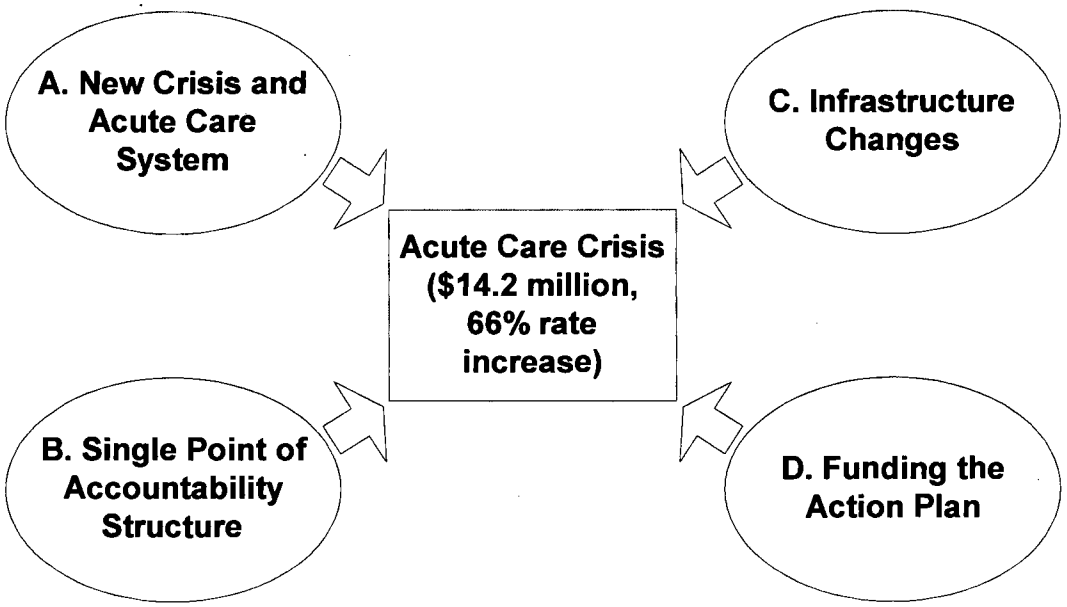
Executive Summary

In the fiscal year that just ended June 30, 2001 the average cost for an Oregon Health Plan acute inpatient bed day was $422.50. With the implementation of the new, per diem arrangement that goes into effect next month, this average rate will increase 66% to approximately $700 per day. Based on a thorough analysis of projected inpatient use, this represents a $4.2 million (43%) increase in inpatient costs from $9.9 million to $14.2 million. This increase is based on the assumption that, as the Crisis Triage Center closes August 1, 2001, new and more comprehensive inpatient alternatives will start being brought online and hospital admissions will begin to decline. If better management of inpatient does not occur during the fiscal year, Multnomah County will spend an additional $1 million or more on inpatient expenses (on top of the $4.2 million planned increase).

These rate increases mean that one out of every five mental health dollars (20%) will be spent on inpatient services. These figures do not include state hospital costs, which increase the inpatient percentage. These are the highest costs in the State of Oregon and the Pacific Northwest. For example, King County Washington (Seattle) spends 13.2% of their mental health funds on inpatient services.

Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The Phase I plan that is presented in this report is a 90-day first step towards resolving this crisis. It includes four areas of intensive activity that must be implemented immediately.



A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. Six action-steps must be taken to support the implementation of these services.

1. Access/Crisis Phone System
2. Urgent Walk-In Clinics
3. Mobile Crisis Teams
4. Secure Evaluation Facility
5. Acute Hospital Alternatives
6. Acute Care Coordination

B. Roll-Out of the Single Point of Accountability Philosophy and Structure

Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. Three action-steps must be taken to support the implementation of this philosophy and structure.

7. Single Point of Accountability Structure
8. Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool
9. Assignment of Existing and New Consumers

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important four are listed below.

10. Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool
11. Rapid Implementation of Raintree Systems Computer Software
12. System-Wide Performance Reporting System
13. Redeployment of Key DCFS Staff

D. Funding the Action Plan

The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $21,833,000. This includes $14,194,707 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently

allocated, the Crisis and Acute Care System is currently underfunded by $7,098,983. The following five action steps must be taken to resolve this crisis.

14. Allocation of Yet-To-Be Programmed Redesign Funds
15. Reallocation of New OHP System-Wide Funds
16. Recovery of FY2001 Carryover Remitted to the County General Fund
17. Staffing Position Freeze/Recovery
18. BHD/Verity Budget Reduction
19. One-Time Use of Mental Health Reserves

Implications for Phase II

The 90-day Phase I must be followed immediately by Phase II that should run from days 91 – 365. During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes
- Reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

Introduction

Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The current system is fragmented, has the wrong incentives built-in, and perpetuates costly redundancies. This is neither cost effective nor clinically efficient. It also provides unnecessary impediments for consumers attempting to access the right care at the right time. Accordingly, system accountability suffers.

The solutions outlined in this plan:

- Lay the groundwork for the integrated consolidation of system providers, infrastructure, and the blending of funding streams wherever possible.
- Make strategic interventions in the crisis, and acute care, and outpatient systems in Phase I.
- Begin a process that will allow dollars to be freed up for reinvestment in service expansions and capacities that will result in easy access to the right care, delivered at the right time, for the right price.
- Allow us to move to Phase II where further system development will occur and unnecessary administrative overhead is identified and eliminated.

As old silos are replaced with a new seamless array of easily accessible services, true public-private partnerships based on risk as well as gain sharing will emerge. A new era of system accountability will be born that is much more self-regulating, consumer centered, and responsive.

Consumer choice will be enhanced by providing expanded service options that produce good consumer outcomes. Synergies will be achieved through ongoing horizontal and vertical integration initiatives resulting in systems of activities that are complementary, consistent, interdependent, and mutually reinforcing. The finite pool of system dollars will be managed for maximum effectiveness for the maximum amount of consumer gain. This will be achieved by blending funding streams into a single risk pool managed by the MHO. Performance based contracts will be executed and actively managed by continuous quality improvement specialists serving in responsive outcomes management roles. Likewise, County employed Acute Care Coordinators will serve in the capacity of "innovation stimulators" as well.

Providers will be increasingly self-regulated through performance based accountability contracting models that reward the generation of good consumer outcomes while also assuming the risk and responsibility associated with negative outcomes. Any remaining fee-for-service provider contracting will be aggressively managed. Consumers will no longer be "exiled" from treatment options for any reason. The MHO will be a proactive partner in the development and

deployment of productive and innovative systems of care that minimize risk and promote success. Reinvestment plans will be negotiated that result in increased risk reserves, employee compensation, and capacity building.

Background and Problem Statement

The problems in the mental health system are well known and have been well documented over the course of the past 2 years of redesign initiatives. These problems are interconnected and require an integrated approach to solutions. This section will identify the prioritized target issues most in need of immediate turnaround solutions.

ACUTE CARE CRISIS

Escalating Utilization

Multnomah County has an inpatient utilization rate that is more than twice that of the statewide average when adjusted per capita (bed days/month/1000 members). When Multnomah County's utilization data is removed from the statewide aggregate data, we exceed inpatient rates by a factor of almost four (19/1,000 vs. 5/1000). The major reason for this predicament is the lack of less costly and more clinically appropriate sub-acute and crisis response alternatives. It should be noted that risk often motivates the deployment of these types of service alternatives, yet this idea was never pursued by the partner hospitals under the risk partnership contractual arrangements over the past 2 years. Inpatient care should be targeted to stabilize individuals so that they can be more actively engaged in community based recovery oriented treatment. Instead, it is capable of consuming over a third of the total available system treatment resources if left uncontrolled.

Movement to Per Diem Inpatient Vendors

The inpatient providers in the process of severing their current risk contract with the County and return to individually negotiated per diem bed rates. This return to a fee-for-service relationship will result in a significant net increase in the cost of a bed day of an average of 66% over current rates. When factored in to present utilization rates, this could result in an annual inpatient cost of over $15,000,000. Suffice it to say that this development mandates a rapid utilization management solution to reverse this scenario.

Absence of Vital Crisis Response Service Continuums

The Crisis Triage Center (CTC) performed a vital system function but was nonetheless providing significantly fewer crisis response services than it agreed to perform in its proposal to the original RFP. Because of this, the CTC was a very expensive system component. The CTC's efficacy was severely compromised due to the lack of a strongly coordinated system of adjunct crisis services geared toward mitigating the inpatient risk with more appropriate and less costly alternatives. This most critical service element is the most glaring service gap in the current system.

OUTPATIENT DELIVERY SYSTEM

Fragmentation and Market Rivalry

Multiple providers delivering basically the same types of services while looking to protect and expand their historical market share does not drive good collaboration or true partnership. It does drive a lot of expensive window dressing and meeting time, which only resembles true collaborative partnership. Competition for scarce clinical resources across professional disciplines results in added ongoing recruitment costs that could be better spent by providing a more stable integrated workforce at higher wages. The providers could look to create seamlessly integrated niche specialties and clinical centers of excellence that would better benefit consumers and the system as a whole. Historically, there was little financial incentive to explore consolidated service delivery models in an environment of "co-opetition" (cooperation + competition).

Fee-for-Service Program Structure

The current outpatient reimbursement formula pays for services based 50% on encounter and 50% on case rates. This encourages the outpatient system to perform in much the same way as under fee-for-service models. However, under managed care, the case rate portion results in a net loss from those historical Medicaid fee-for-service revenues. Therefore, the outpatient system is experiencing much downside associated with risk while still operating the same way as before. This dual mismanagement rewards the system for focusing on those who are easiest to care for while neglecting the difficult client most likely to need more costly and intensive services. Currently, the outpatient system is financially encouraged to shift the care for difficult clients to hospitals rather then expend the overburdened clinical resources to provide alternatives to hospitalization.

Administrative Redundancy

The current multiple providers separately fund multiple administrative structures that are mirror operational components of one another. These redundancies come at a high cost to the system, whereas, if providers were consolidated, the savings would be reinvested in vital service and capacity expansion. The two major contracting networks (ABH and HSA) show some economies of scale, but they provide yet another layer of administrative overhead. Member organizations must reduce their individual administrative structures to offset the costs the networks charge back to the members.

Low Productivity

Despite feeling genuinely overburdened with huge caseloads and dramatically reduced fiscal reserves, the average time clinical staff spend in direct clinical encounters with consumers averages less than 50% across the system. Paperwork, meetings, lack of automated processes, and antiquated infrastructures are reasons given as to why more direct service time isn't being spent with consumers. Productivity should and can be increased significantly. Nationwide, successful provider organizations have found ways to work smarter, resulting in more effective and efficient clinical service models. Providers must also find ways to reduce their overhead costs. These changes will result in more time for clients and the ability to better meet the needs of the community. It is

also important to note that the MHO must be part of this solution by working to reduce unnecessary paperwork and non-value-added procedures to a minimum.

Access

Waiting times to access outpatient services are too long. Approximately twenty-five percent of all consumers accessing the inpatient system are not assigned to any outpatient provider. This results in a very expensive access system whose doorbell is, by proxy, a bad outcome (i.e. deterioration to the point of requiring an inpatient stay).

The providers, with a combination of poor productivity, greatly increased caseloads, and little incentive to successfully move clients from out the back door (i.e. successful recovery oriented treatment utilizing natural community systems of support), are in fact unwittingly contributing to their own burnout and failure. The bottleneck at the front door is experienced by the providers as being a direct result of a real lack of service capacity to meet the demand needs of clients wishing to access outpatient services. The reality is that as access to less expensive and most appropriate care is impeded at the outpatient level, more and more consumers are deteriorating to the point of having to access the inpatient system. This in turn bleeds more money out of the outpatient pools, which then results in more diminished outpatient capacity. This downward spiral must be reversed. The best way to achieve this is to provide adequate incentives to provide access on demand and to lower hospitalization

BUSINESS MODEL AND ORGANIZATIONAL STRUCTURE

Accountability Alignment

The single variable most responsible for the deterioration of the mental health system with the advent of capitated Medicaid funding is the adverse alignment of risk and reward across the system. Shared risk contracting, when properly aligned and aggressively managed, generates true partnerships and, most importantly, effective, expanded, and seamless clinical care continuums. This is the difference between managed care nightmares and good managed care being synonymous with good and timely clinical intervention. Good accountability-based contracting will result in the right care being delivered at the right time and for the right price. When done effectively, the consumer benefits enormously. Secondarily, so does everyone else.

Contract Compliance Management

The County's contracting and contract management processes are in need of major change. Multiple contracts with multiple terms and expiration dates that get changed, sometimes only verbally, are often signed several months after the services are being delivered. The ongoing management of performance metrics and other contract terms are frequently renegotiated in the direction of less value than the original terms. MHO staff will be focused on performance that generates good consumer outcomes. Contingencies must be considered and acted upon when, despite all efforts otherwise, contract agencies fail to meet necessary conditions specified in the contract.

Role Diffusion

The relationship between the MHO and the Behavioral Health Division (BHD) has been unclear in the past. Clear boundaries and relationships must be defined and operationalized to maximize accountability while maintaining the flexibility to continuously improve in mutually effective ways. As always, assuring that the right care is taking place at the right time and for the right price will be the ultimate yardstick against which any change is made and measured. Fiscal accountability between the two divisions must be reconciled accordingly.

Data Analysis and Infrastructure

Standardized reporting across specified outcomes management targets must be made available through sound database/data warehouse development and ongoing analytical processes that can optimize continuous quality improvement activities.

CONSUMER INVOLVEMENT

Advocacy versus Empowered Ownership

The consumer advocacy landscape in Multnomah County is very impressive. This is due to the inclusive process involvement by consumers throughout the redesign process. This is also due to the level of talent and commitment embodied in the advocacy community. It is time to take advantage of this underutilized resource. We need to provide a conducive platform that shifts the advocacy community away from a reactive mode towards more proactive involvement and ownership in making new solutions work. In this regard, consumers are most likely to become the true partners in crafting the solutions they so desperately deserve. Development of Ombudsman functions, expansion of the office for consumer affairs, and deployment of expanded peer support services will serve to enhance the continued proactive involvement in existing stakeholder forums. Additionally, inclusion as valued contributing members on contract provider Boards of Directors will serve to secure necessary governance representation as well.

Proposed Action Plan: Phase I

The Phase I plan presented below is a ***90-day first step*** towards resolving the acute care crisis in Multnomah County. It includes four areas of intensive activity that must be implemented immediately, including:

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives
B. Roll-Out of the Single Point of Accountability Philosophy and Structure
C. Infrastructure Changes to Support the Action Plan
D. Funding the Reconfigured System

These recommendations are based on a detailed financial and utilization analysis that examined all aspects of the Multnomah County Mental Health System including:

- Detailed review of outpatient **client and service delivery history** for Oregon Health Plan enrollees and indigent consumers;
- Comparisons of **how much service** was provided, in total, and per client at each outpatient provider organization
- Analysis of all Behavioral Health Division and Verity **provider contracts**;
- Examination of all federal, state and local **revenue sources** and funding restrictions;
- **Inpatient projections** based on several years of admissions, days and average length of stay data for all health plans operating in Multnomah County;
- Sophisticated **demand projections** for mobile crisis, urgent walk-in, secure evaluation facility and acute impatient alternative services;

Because of the severity of the financial and client safety crisis facing Multnomah County and the carefully built-in interdependencies of the nineteen strategies, ***all must be implemented within the next 90 days*** if the County hopes to prevent insolvency of the mental health system.

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. The following action-steps must be taken to support the implementation of these services.

1. **Access/Crisis Phone Service:** Multnomah County should immediately contract with the identified provider organization to implement a new Access/Crisis Phone Service, with the contract retroactive to July 1, 2001 to support startup. This service will consolidate similar services at Providence, Advanced Behavioral Health, Human Services Alliance, and some portion of Verity's Access Line into a single service. It will also add a Warm Line that is staffed by mental health consumers. This consolidation will allow for improved response time, better connection between phone workers and the outpatient system and reduction of duplication. Providence will continue to provide phone service between July 1

and September 30, 2001 as the new capacity is developed and brought online. *Annual Cost: $1,803,218.*

2. **Urgent Walk-In Clinics:** Multnomah County should immediately contract with the identified provider organizations to operate four, regional Urgent Walk-In Clinics. The contracts should be made retroactive to July 1, 2001. These Clinics will use a "no appointment necessary" approach and operate during the highest demand periods from 9:00 am to 5:00 pm Monday through Friday. Additionally, a centrally located walk in clinic will operate from 5:00 pm to 9:00 pm Monday through Friday and 1 to 4 pm on Saturday. This design will dramatically increase access to consumers and provide a more appropriate service delivery environment to individuals who have urgent, but not emergency needs. *Annual Cost: $1,084,821.*

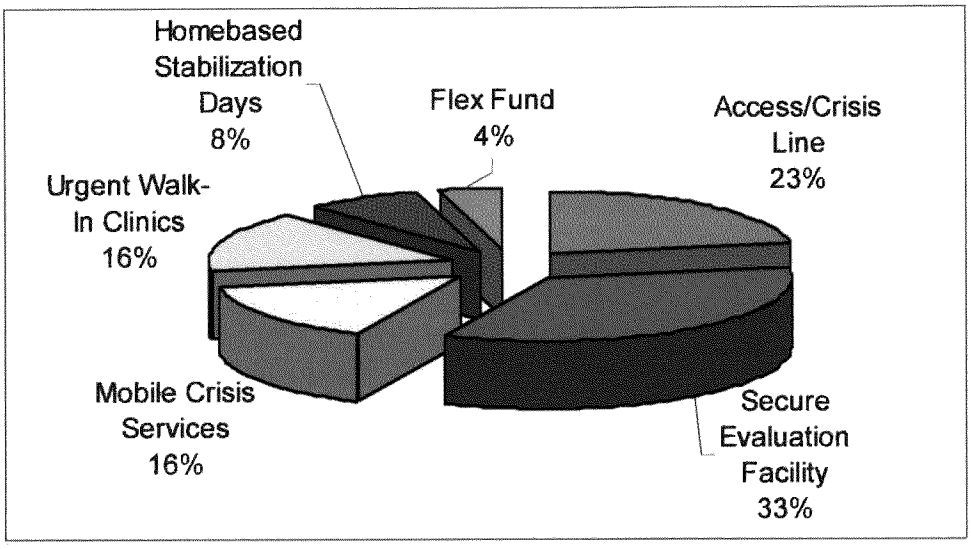
3. **Mobile Crisis Outreach Teams:** Multnomah County should immediately contract with the identified provider organization to operate Mobile Crisis Outreach Teams 24-hours per day, seven days per week. The contract should be made retroactive to July 1, 2001. During hours of operation Mobile Outreach staff will be co-located at the four Urgent Walk-in clinical sites. During evenings and on Saturday, the Mobile Outreach Team will be co-located with the centrally located Urgent Walk-in clinic. *Annual Cost: $1,096,305.*

4. **Secure Evaluation Facility:** Multnomah County should immediately contract with the designated provider organizations to provide 23-Hour observation capacity for a period of assessment for those patients deemed to have the potential to rapidly regain functioning, and to facilitate their smooth reintegration into the community through optimal discharge planning. *Annual Cost: $2,388,949.*

5. **Acute Hospital Alternatives:** Multnomah County should immediately contract with designated provider organizations to provide alternatives to hospitalization including Intensive Home-Based Stabilization services, Respite Beds, Sub-Acute Inpatient services, and "Flex Funds" to support other creative alternatives. *Annual Cost: $3,137,468.*

6. **Acute Care Coordination:** Multnomah County should immediately complete the development of the Acute Care Coordination Team. Members of this team will work with referring clinicians, discussing treatment options for clients in crisis in the context of the criteria for "medical appropriateness", assisting with referral to the least restrictive and most clinically appropriate care setting. *Annual Cost: Part of Verity's Budget.*

These six changes will result in a system that has many "right doors" and capacity that has been carefully designed to meet the needs of consumers in crisis. The chart on the following page illustrates how financial resources will be allocated to the newly designed crisis system. As the system stabilizes we expect that costs for the secure evaluation facility will decrease and those savings will be redirected towards non-urgent/emergent services.



B. Roll-Out of the Single Point of Accountability Philosophy and Structure

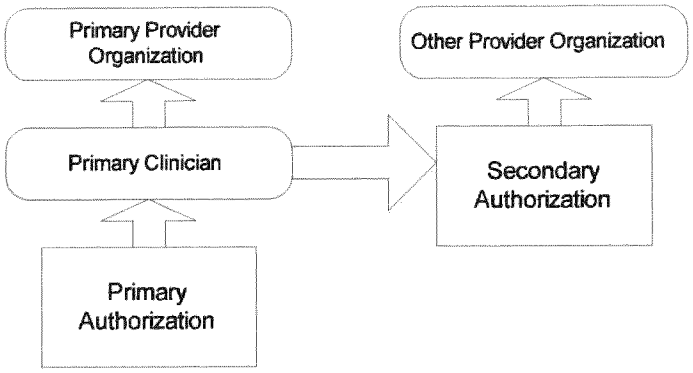
Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These circumstances result in the inability of crisis caregivers, including the police, to determine the most appropriate treatment setting for clients in crisis and often results in hospitalization that may have been unnecessary.

These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. This type of structure is critical to helping prevent crises before they occur. Furthermore, this model is an essential building block for implementing a recovery-oriented care delivery model.

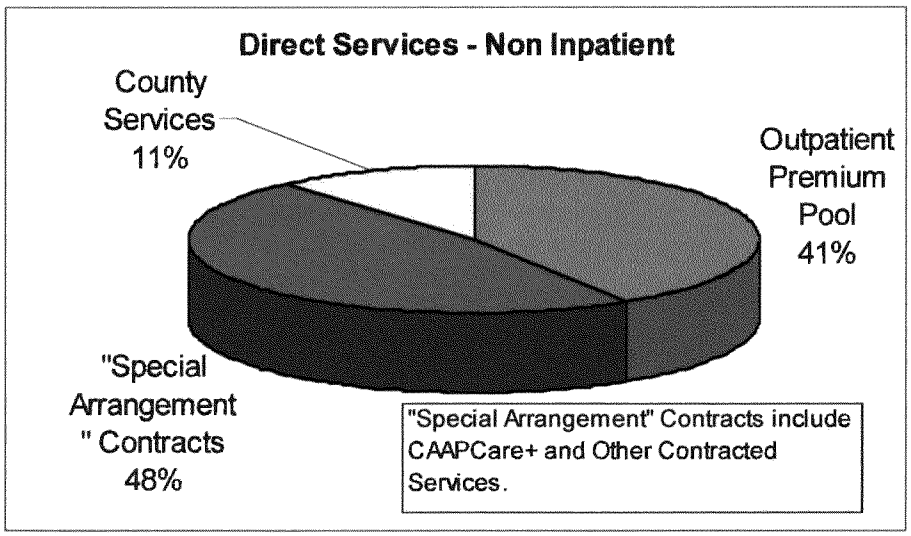
The following action-steps must be taken to support the implementation of this philosophy and structure.

7. **Single Point of Accountability Structure:** Multnomah County should revise all existing outpatient contracts to establish a Single Point of Accountability structure. Under this structure all mental health consumers whose care is financially supported by Multnomah County would be assigned to a Primary Provider Organization and a Primary Clinician through the issuance of an open-ended Primary Authorization. The Primary Clinician will be part of a Care Team (consisting of at least two individuals – the consumer and the Primary Clinician) whose jobs include treatment planning, service coordination, service delivery, and crisis planning and management. The Primary Authorization will "stay open" for as long as the client resides in Multnomah County or until/unless the consumer transfers to a different Primary Provider Organization, regardless of whether their case file is open or closed. Part of this system will include Secondary

Authorizations that support the purchase of evidence-based services or supports for special services not otherwise available from Care Team members who do not work at the Primary Provider Organization. *Annual Cost: Part of the Outpatient Contracts.*



8. **Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool:** The Single Point of Accountability Structure should be supported by a new payment mechanism that increases the flexibility of how monies can be used, provides financial incentives for proper management of the crisis and acute care system and holds providers accountable for poor outcomes. The mechanics of this model are described in Section C. below.



A financial model that supports the Action Plan is critical to successfully changing the behavior of the provider community. Currently only 41% of the existing funding for the Multnomah County Outpatient System is available for the Single Point of Accountability System – the funds that are in the OHP Outpatient Premium Pool. The other 59% is embedded in "Special Arrangement" Outpatient Provider Contracts (48%) and budgets for County-Staffed Services (11%). The

Special Arrangement Contracts are funded through a myriad of case rates and fee for service arrangements that use "old-style", commercial managed care arrangements that prevent more flexible and creative use of funds and are necessarily outside the Accountability and Incentive Structure. It addition, these contracts require over 20 full time equivalents of County Care Coordinators, whose salary costs alone are over $1.3 million per year.

Multnomah County should immediately convert the OHP Outpatient Premium and CAAPCare+ Outpatient Pools to the new Accountability/Incentive Pool. County staff should also immediately begin an Internal Audit and Performance Analysis of the Special Arrangement Outpatient Provider Contracts and County-Staffed Services to determine which services can be moved into the Accountability/Incentive Pool in Phase II. This analysis should be completed by 10/1/2001. *Annual Costs: Phase I $23,782,833; should increase to a minimum of $32,000,000 during Phase II with the roll-in of Specialized Arrangement Contracts.*

9. **Assignment of Existing and New Consumers:** Multnomah County should immediately begin a process to identify the Primary Provider Organization and Primary Clinician for all currently enrolled consumers. This will consist of using historical data in the Verity authorization database to complete a preliminary identification of Primary Provider Organizations. Providers will then review the computer reports, make corrections as needed and identify the Primary Clinician for each consumer. This information will be returned and entered to the County Information System.

   The County should also begin a process to rapidly assign all newly identified mental health consumers to a Primary Provider Organization and Primary Clinician. This will include the development of policies and procedures for all providers in the system. Crisis and Acute Care staff will be responsible for helping "hook" new consumers up with Outpatient Organizations. Outpatient Organizations will have clear guidelines for how and when to assign consumers who are new to their organizations. *Annual Cost: Part of the Existing DCFS IS Budget and Provider Outpatient Contracts.*

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important are listed below.

10. **Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool:** The funding design for the Accountability/ Incentive Funding Pool combines the OHP Outpatient Premium and CAAPCare+ Pools to create a funding stream to be used for OHP and indigent consumers in Multnomah County. Funds will be allocated based on the number of consumers for whom each provider organization becomes the Single Point of Responsibility. If Agency X has taken responsibility for 10% of the consumers they will receive

10% of the pool each month. In return for payment, organizations will be expected to provide all medically necessary outpatient services to their clients. In addition, use of crisis and acute care services will be carefully tracked and provider organizations will be responsible for covering a portion of those expenses, up to a limit that will be defined by a financial risk corridor. If providers are able to properly manage their caseloads and lower the utilization of crisis and acute care services, incentive payments will be made to the organizations in the form of a rebate on under-spent Crisis and Acute Care System funds. The risk corridor will be designed so that no provider organizations will be threatened with catastrophic losses.

For the first year, smaller providers, who believe that they may not be able to manage under the new funding model, can select a Hold Harmless alternative where their crisis and acute care utilization will be monitored but funding accountability and incentives will not apply.

Multnomah County Board of Commissioners are requested to immediately approve the Outpatient Accountability/Incentive Funding Model and direct staff to develop the Policies and Procedures Manual that includes the detailed business rules for this model. Provider contracts must be revised so that the system can be phased in between July and September 2001, with full implementation beginning October 1, 2001. Later approval will delay these dates with substantial financial and system problems accruing. *Annual Costs per Action Step 8 above: Phase I $23,782,833; should increase to a minimum of $32,000,000 during Phase II with the roll-in of Specialized Arrangement Contracts.*

11. **Rapid Implementation of *Raintree Systems* Computer Software:** There are nine categories of County and Provider Organization staff that are necessary to support the reconfigured crisis and acute care alternatives. These include staff working with the 1) Call Center, 2) Mobile Crisis Teams, 3) Acute Care Coordination, 4) Urgent Walk-In Clinics, 5) Primary Provider Organizations, 6) Care Coordination, 7) Member Services, 8) Claims Processing, and 9) Quality Assurance. Together these groups require 34 different pieces of computer functionality to support their work. The functionality ranges from Client Lookup to Authorization Entry to Crisis Episode Tracking to Claims Processing.

    A rapid but thorough evaluation was made of existing County computer systems and "off the shelf" packages, covering the areas of Functionality, Architecture, Ease of Implementation, Flexibility, Performance, Security, Reporting, Cost and Vendor Reliability. After determining that existing County systems could not adequately support the 34 functions the Joint County-Contractor IT Workgroup narrowed the field down to two finalists, PH Tech, from Salem Oregon, and Raintree Systems from San Diego California. A final vendor scoring resulted in the recommendation to purchase and implement Raintree Systems.

    Because of the emergent need to implement a new solution within 90 days, Multnomah County should suspend normal contracting requirements and

immediately contract with Raintree Systems and begin implementation of the new system within 14 days. The functionality of the system should be rolled out in three phases, October 1, November 1, and December 1, 2001. Five Implementation Teams should be immediately assembled that will be made up of County and Provider Organization staff – Application Develop, Data Conversion, Infrastructure, Deployment, and Reporting. The rapid implementation project should be co-lead by a County and a Provider Organization staff person. *One Time Costs: $175,000.*

12. **System-Wide Performance Reporting System:** A great deal of effort went into gathering utilization and financial data from a variety of sources to support the development of the Action Plan. Unfortunately, there was a scarcity of standard reports that could be "pulled off the shelf" to support these efforts. Most available reports were ad hoc in nature, so that the system was operating in a relatively "data-free environment". As stakeholders of the mental health system already know, the Multnomah County mental health system can no longer operate under these conditions.

    Multnomah County should immediately begin the development of a System-Wide Performance Reporting System. The design of this system should be informed by key documents including the Utilization and Financial Modeling Tools that were used to support the Action Plan; Oregon Health Plan Mental Health Organization Agreement requirements; existing ad hoc and standard reports; the March 2001 Recommended Mental Health System Performance Measures authored by Jim Carlson, Seth Lyon and Theresa Posner; the 2001 American College of Mental Health Administrators' Proposed Consensus Set of Indicators for Behavioral Health; and the January 2001 State of Oregon Report to the Governor from the Mental Health Alignment Workgroup.

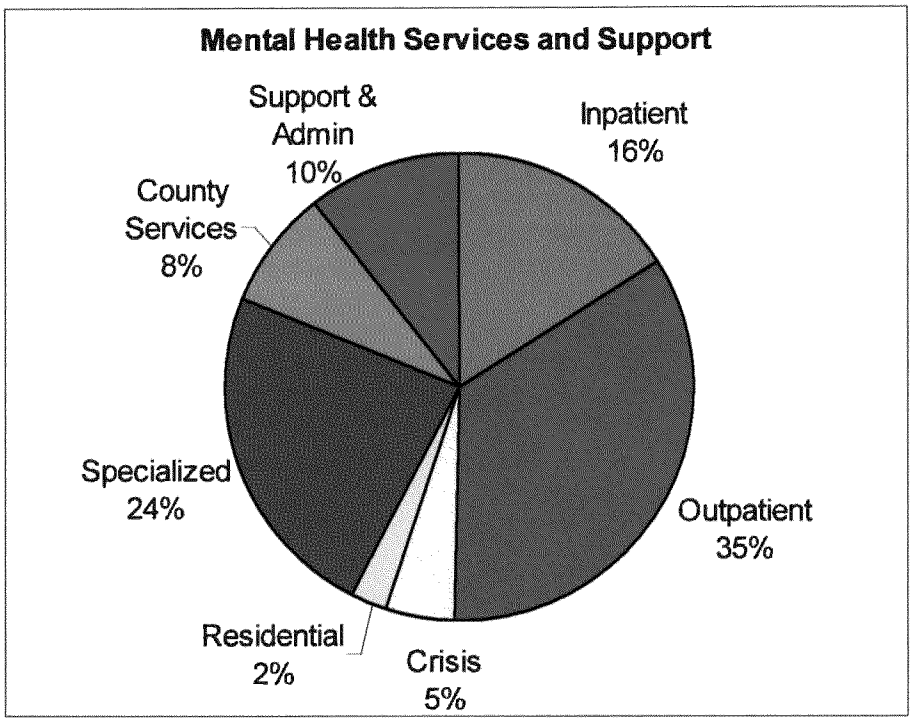
    These efforts should result in a set of regularly produced reports for key managers and stakeholders from the Multnomah Board of County Commissioners to Acute Care Coordinators to Primary Clinicians and their Supervisors that are produced daily, weekly, monthly and quarterly, based on need. The data in these reports should be used to build a "culture of measurement" within the Multnomah County Mental Health System, where meetings regularly include the analysis of data and all-important decisions are informed by this analysis. *One-Time Costs: $50,000.*

13. **Redeployment of Key DCFS Staff:** There are a number of activities that require the involvement of several DSFS staff members. This includes Acute Care Coordination, Accountability/Incentive System Policies and Procedures Development, Provider Contracting, assistance with bringing up the new Crisis and Acute Care Alternatives, Raintree Implementation, Performance Reporting System Development, further Financial and Budget Analysis, Stakeholder Communications, and more. Many DCFS staff have already been intensively involved in the planning activities that have resulted in this report. These efforts must now be followed by the development of a detailed Implementation Workplan and redeployment of DCFS staff to assist in these implementation

activities. Multnomah County leadership should direct all DCFS management and staff to actively participate in the implementation efforts, as needed. *Annual Cost: Part of the existing Verity Budget.*

D. Funding the Action Plan

The fiscal year 2002 DCFS Mental Health Budget is $71,379,128. These funds are allocated to several areas, as illustrated in the chart below.



The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $21,833,000. This includes $14,194,707 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently allocated, the Crisis and Acute Care System is currently underfunded by $7,098,983. The following action steps must be taken to resolve this crisis.

14. **Allocation of Yet-To-Be Programmed Redesign Funds:** The current FY2001 Budget includes $1,482,572 of revenues that were set aside to be used to support the redesign. Multnomah County should reprogram this entire amount to fund the Crisis and Acute Care System. *Annual Costs: $1,482,572.*

15. **Reallocation of New OHP System-Wide Funds:** Currently 16.7% of the OHP Premiums are allocated to a System-Wide Funds Pool. These monies are used to support the Crisis Triage Center and a number of Specialized Services such as Day Treatment, Dual Diagnosis Residential Support, Supported Classrooms and Fee-For-Service outpatient providers. In fiscal year 2001 just over $4 million was allocated to this pool, with $1.4 million spent on Crisis and Acute Care Alternatives and $2.6 million spent on Specialized Services. With the addition of a full year of Regence enrolled lives this $4 million has grown to $6.3 million.

Multnomah County should freeze the Specialized Services funding at the $2.6 million level for fiscal year 2002, redirect $2.7 million of the difference (75%) to fund the Crisis and Acute Care System, and add the remaining 25% ($1 million) to the Outpatient Accountability/Incentive Pool. As the system stabilizes and inpatient costs come down, additional funds should be redirected to the Outpatient Accountability/Incentive Pool. *Annual Costs: $3,708,072.*

16. **Recovery of FY2001 Carryover Remitted to the County General Fund:** Currently it appears that there may be between $200,000 and $500,000 of fiscal year 2001 Behavioral Health funds that were not spent, not reserved as Carryover Funding for fiscal year 2002, but instead earmarked for return to the County General Fund. Multnomah Board of County Commissioners should direct County Fiscal Staff to determine the actual, final amount of these funds and reprogram them as one-time Carryover Funds to support the Crisis and Acute Care System for fiscal year 2002. *Annual Costs: $200,000.*

17. **Staffing Position Freeze/Recovery:** Currently Verity has 5 open positions out of a total 34.75 budgeted FTEs. Not filling these positions and reprogramming these funds to the Crisis and Acute Care System would total approximately $325,000. It is anticipated that the redesigned Verity organizational structure that will be created in Phase II will be able to adequately fulfill its MHO functions with 29.75 FTEs. Multnomah County should immediately implement this strategy. *Annual Costs: $325,000.*

18. **BHD/Verity Budget Reduction:** The fiscal year 2002 mental health direct services and support budgets for the Behavioral Health Division and Verity totals $13,167,839. Of this figure $7,300,410 is earmarked for Division Administration, Care Coordination, Managed Care Administration and County Overhead. These administrative and support costs represent 10% of the total mental health budget. In other communities these costs range between 4% and 6%. Multnomah Board of County Commissioners should direct DCFS management to immediately reduce expenses for the current fiscal year by 5%. Additional analysis of these costs should occur during Phase II. *Annual Costs: $658,392.*

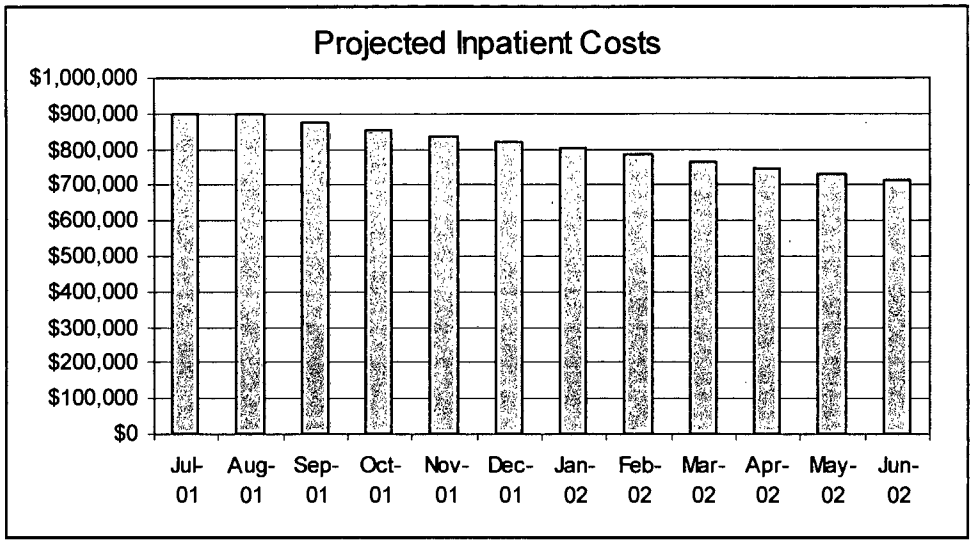
The five strategies identified in action-steps 14 – 18 represent a $5.44 million shift of funds to the Crisis and Acute Care System. This leaves a remaining shortfall of $1.65 million. These figures are shown in greater detail in the table on the following page.

Proposed Strategies for Covering Shortfall

A.Net Shortfall	**-$7,098,983**
B.Funding Strategies	
1Allocate Unbudgeted Redesign Funds	
Unbudgeted Amount	**$1,482,572**
2Allocate a Larger Portion of MHO System-Wide Funds	
MHO System-wide Funds	$6,346,000
less Specialized portion of system-wide	-$2,637,928
Net MHO System-wide Funds	$3,708,072
Additional to allocate to Shortfall	75%
Additional to allocate to Shortfall	**$2,781,054**
3Recover FY2001Carryover, not yet budgeted	
Estimate of unrecovered Carryover	**$200,000**
4Staffing Position Freeze/Recovery	
Freeze of Verity Open Positions	**$325,000**
5BHD/Verity Mental Health Budget Reductions	
5% Budget Reduction of BHD and Verity Budgets	**$658,392**
Subtotal Savings	**$5,447,018**
Shortfall Balance	**-$1,651,966**
C.Use of Reserves	
6Use of Mental Health Reserves	
Total Reserves	$2,491,771
One-time use of Reserves	$1,651,966
Remaining Reserves	**$839,805**
Shortfall Balance	**$0**

19. **One-Time User of Mental Health Reserves:** The main purpose of Mental Health Reserves is to cover emergencies that threaten the viability of the MHO. The current Acute Care Crisis constitutes such an emergency. Multnomah County should allocate $1.6 million of existing reserves to fund excess inpatient costs that are projected for fiscal year 2002. When added to the $200,000 carryover from action-step 16, this represents $1.8 million of one-time spending.

    To prevent a similar shortfall in fiscal year 2003, inpatient expenditures must be reduced 21%. The funding model that was used to develop these recommendations assumes that these reductions will begin in September 2001, with the rollout of the Crisis and Acute Care Alternatives and Single Point of Accountability Structure and grow to a 21% savings by June 2002. The graph on the following page illustrates the required change in inpatient expenditures. *One-Time Costs: $1,851,966.*



Important Notes about Cultural Competency and Consumer Involvement

The reader will note that there are no *specific* Acute Care Crisis action-steps addressing cultural competency and consumer involvement. Nonetheless, there are many *implicit* actions within the nineteen steps that relate to both.

It is imperative for Multnomah County to ensure that all services are designed with sensitivity and specialization for specific sub-populations including adults, children, older adults and ethnic and cultural communities. Staffing must consistently attend to cultural and special population considerations incorporating bicultural members, bilingual staff and sub-populations specialists into all staff teams. This is relevant for services that are developed during times of relative calm as well as times of crisis.

Design work has already begun towards producing data that will demonstrate how new services as well as existing ones address the needs of different populations; this is an important element of Action-Step 12, System-Wide Performance Reporting System. In addition, Appendix 3 – Detailed Acute Care Design, describes in greater detail how new services will be deployed in culturally appropriate ways.

Consumer Involvement must also be a characteristic that winds its way through all new and existing planning and service delivery activities. Development of the Single Point of Accountability Structure and Philosophy is a critical foundation step towards building a system of care that is based on placing the consumer at the center of the service delivery process.

The Clinical Design Workgroup was well represented with consumers, including a Consumer Involvement Subcommittee. This group has highlighted the need for a consumer-operated Warm Line, which is an important component of the new Access/Crisis Phone Service. Development of an Ombudsperson will occur within the existing Verity budget.

Work in moving these components of a well-functioning system forward will continue.

Implications for Phase II

When all of the nineteen Action-Steps in Phase I are implemented by September 30, 2001, the acute care crisis will have only begun to be resolved. There are numerous additional Action-Steps that should have been implemented as part of a Phase I. Because of the two-year delay in beginning detailed implementation work, this was not possible.

The 90-day Phase I must be followed immediately by Phase II that should run from days 91 – 365 (October 1, 2001 – June 30, 2002). During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes
- Reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

It is only after this Phase II work is completed that the mental health system will be able to regain stability and begin to move away from financial insolvency.

Appendix 1 - VERITY
Integrated Behavioral Healthcare Systems
Core Values

1. Customer Service

- Consumers are always the primary (i.e. most important) customers.
- We exist solely to serve consumers with the right care, delivered at the right time, for the right cost.
- The most important employees in the system are those providing direct services that result in good client outcomes; everything else is overhead.
- Necessary overhead is defined as those activities that add value to the delivery of effective direct services to the consumer.
- We recognize that there exist multiple internal and external customers involved in constant service transactions geared to best serve consumers.
- A customer is anybody receiving goods or services in exchange for reward.
- Anybody who can better serve our customers deserves the business of doing so. The converse is also true.

2. Accountability

- We employ fact-based decision making utilizing evidence based standards of care to ensure best practices.
- Outcome/results driven measurement systems and methods will be adopted to generate publicly posted status reports along with performance profiling.
- Performance based contracting will be actively managed.
- Sharing risk will increase the likelihood of mutually beneficial partnerships.
- Robust information technology infrastructure will be employed in recognition of the degree to which: "Excellent care management is dependent upon excellent information management"
- We seek to increase leadership and decrease micro-management processes.

3. Quality

- Quality is that which meets or exceeds the customer's needs and reasonable expectations at a cost that represents value to them.
- "Good enough"....isn't. Excellence is the enemy of the mediocre and vice versa. Quality service is not an average service. Who would prefer to be operated on by an average surgeon?
- The customer defines quality.
- Quality is not an abstraction; it is a measurable and manageable business practice. Continuous quality improvement is our core management philosophy and business strategy.
- Quality is about passion and pride. Scarcity of resources demand innovation.
- Higher quality costs less, not more.

1. Integrity

- We will recognize and embrace the moral high ground.
- Say what we mean and mean what we say, then do what we say we are going to do. We must "walk the talk."
- Utilizing dignity and respect, conflicts will be resolved in a collegial and professional manner.
- Acknowledge honest mistakes and recognize problems as opportunities for improvement. A problem is the gap between the existing situation and a better situation.
- Honest straightforwardness is recognized as a key element of any successful transaction.
- Accepting responsibility while building our response-ability is the desired way to replacing blame, cynicism, and excuses with results that work. Find remedy, not fault.
- We will foster productive labor-management partnerships that are consumer focused.
- Trust is built through proactive versus reactive activity.
- To not see a problem is in itself a problem. However, the worst thing a person can do is to ignore or cover up a problem.

Appendix 2 – Resolution 00-161

Resolution 00-161	
Type:	Resolution, Order or Proclamation
Date:	09/28/2000
Number:	00-161
Title:	ADOPTING A VISION STATEMENT FOR A CONSUMER AND FAMILY CENTERED MENTAL HEALTH SYSTEM
Text:	BEFORE THE BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON RESOLUTION NO. 00-161 Adopting a Vision Statement for a Consumer and Family Centered Mental Health System The Multnomah County Board of Commissioners Finds: A. On May 4, 2000 the Board of County Commissioners adopted Resolution No. 00-063 creating a Mental Health Design Team " to work with county, state, and community personnel to develop short and long term action plans to improve County mental health services." B. The Design Team has determined that an underlying vision and a unifying philosophy is needed to guide system design efforts. This vision and philosophy should apply to services for adults, children and adolescents at all levels of care. C. The Design Team has recommended that the Board of County Commissioners adopt the vision statement expressed in a " Consumer and Family Centered Mental Health System" . The Multnomah County Board of Commissioners Resolves: 1. The values and principles described in the attached document " Consumer and Family Centered Mental Health System" will provide the underlying vision and unifying philosophy for the mental health system in Multnomah County.

2. County Departments that provide mental health services will distribute this document to all employees and to appropriate contractors, advisory board members and other partners.

3. County Departments that directly provide mental health services will incorporate these values and principles into those services to the fullest extent possible.

4. County Departments that contract for mental health services will include these values and principles in all relevant contracts and will insure that these values and principles are incorporated into the services delivered through those contracts.

5. The Department of Community and Family services will provide leadership in the collaborative development of a training program to increase system-wide understanding of these values and principles. Planning and implementation of this training program will include consumers, members of their support teams, families and providers.

6. The County will work with community advocates and organizations to encourage State and Federal policy makers to develop and fund programs which are consistent with this vision statement.

ADOPTED this 28th day of September 2000.

BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON

Beverly Stein, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY FOR MULTNOMAH COUNTY, OREGON

By Thomas Sponsler, County Attorney

A Consumer and Family Centered Mental Health System For Multnomah County

This document expresses the underlying vision and unifying philosophy that will guide the design and operation of public mental health services in Multnomah County. Consumers receiving mental health services (including adults, adolescents, children and families as appropriate) are at the center of the mental health system. The system is organized and operated to meet their needs. While there may be resource constraints the ultimate goal of the system is to improve the lives of those receiving mental health services.

The services for children, adolescents and their families will focus on a developmental model of intervention and on age and developmentally appropriate outcomes for children within the contexts of their individual family situations. The services for adults will be recovery-oriented with a focus on developing natural systems of support and self-determination. Within the adult and children service systems there may be different providers, programs and types of services but common values and principles will anchor and unify all mental health services.

Our vision for mental health services has three sections: attitudes and values; the service system; and accountability and management.

A. The attitudes and values of the mental health system support and encourage consumers to achieve their full potential.

1. Everyone receiving services in the Multnomah County Mental Health System is supported and encouraged to reach his or her full potential. Consumers are supported by attitudes and services that communicate hope, focus on strengths, nurture recovery, promote optimal development and support achievement of goals. Respect and dignity will be embraced throughout the County' s caring and flexible system.

2. The services provided by the mental health system in Multnomah County are individualized, and in the case of children, child-centered and family-focused. The needs, goals and preferences of consumers dictate the types and mix of services provided.

3. The mental health system is community based, with the location of services and decision-making resting at the community (i.e. local) level.

4. Agencies, programs, services and staff are culturally competent; that is, sensitive and responsive to all the elements of consumers' identities, including but not limited to age, ethnicity, race, religion, gender, sexual orientation, disability and culture.

5. Adult consumers may choose to identify friends, family members or others to participate in planning for their care and service delivery. The families and/or surrogate families of children receiving mental health services are full participants in all aspects of the planning and delivery of services.

6. Mental health services for children and adolescents will be guided by the best interests of the child or adolescent. Services will support, assist and strengthen the family system. This may include identifying and addressing changes needed to better support the child' s optimal development.

B. It is the goal of the mental health system to work toward the provision of a wide range of services that support recovery and optimal human development.

1. Services for adults maximize the opportunity for self-sufficiency, autonomy and a self-directed practice of recovery. Services for children reflect the " System of Care " principles. Services and models for adults and children will evolve in response to consumer needs and evidence-based changes in best practices.

2. Services are provided in the least restrictive setting that is clinically appropriate and meets consumers' needs. Services to achieve stabilization and recovery at lower levels of care are prioritized so that they are available when needed,

	thereby reducing utilization of higher levels of care such as crisis services and hospitalization. Services are organized to avoid inappropriate use of the criminal and juvenile justice systems as a substitute for mental health care. 3. Every person receiving mental health services has access to competent diagnosis and an appropriate and affordable menu of treatment. Access to and coordination with competent, comprehensive physical health care is arranged. 4. Every consumer is assured of having a prompt and clinically appropriate response to his or her crisis and acute care needs. 5. Adult consumers have access to a range of safe, affordable housing options and the support services needed to successfully retain their housing over time. 6. Every person receiving mental health services has access to suitable employment, training and/or education services in order to reach his or her full potential for independence and contribution to society. 7. Every person receiving mental health services has access to a network of natural supports including transportation and affordable social, cultural, physical and recreational and/or faith-based activities that promote integration into the community, optimal development and recovery. 8. Competent care management services are provided based on need. Case managers insure that multiple services are delivered in a coordinated and therapeutic manner and that consumers can navigate smoothly through the system. 9. Services from multiple agencies including the education, criminal justice, juvenile justice, child-welfare, health and chemical dependency systems are coordinated and/or integrated to better serve consumers. 10. In order to support prevention and effective treatment, the mental health system provides consultation to other health and social service providers.

	11. Mental health services include outreach and education in order to increase early identification and intervention and to increase appropriate continuation in care, leading to earlier recovery. 12. Consumers and families are able to access services easily. They are offered at convenient and accessible locations and times. 13. Services include consumers as providers and include opportunities for peer support and self-help. Services for children include opportunities for family peer support. C. The mental health system is publicly accountable and well managed. 1. In order to be truly accountable the mental health system is organized with clear lines of responsibility and authority. The policy, planning, resource allocation and evaluation functions are centralized and consolidated and/or coordinated. 2. Consumers, providers, families and a wide range of stakeholders are involved in policy development, program planning, service delivery and evaluation for the mental health system. 3. The mental health system is publicly accountable for the resources that have been entrusted to it. Service delivery systems are integrated administratively to eliminate expensive fragmentation and duplication. Financial risk and incentives are utilized as tools to achieve system goals. 4. At all levels, the system is accountable for service delivery and outcomes. Clear, quantifiable measures are established to show efficiency and effectiveness. These measures include consumer satisfaction and improving the quality of life for people receiving services. The system uses data to monitor costs and outcomes and to improve quality and access. 5. A centralized data system is structured to increase coordination across service

	systems and provide the demographic, financial, service and outcome data necessary for system reporting, management and accountability. 6. The mental health system supports a positive working environment for its providers and staff. Competitive salaries and benefits, training and education and reasonable workloads reduce turnover and support the provision of high quality services and positive interactions with consumers 7. The system vigorously pursues new resources and partnerships that will help to meet the mental health needs of County residents. The system is expert at blending funds from a variety of sources to meet consumer needs. 8. Advocacy for the needs and rights of those with mental health disabilities is an important component of system management. Stigma and discrimination make recovery more difficult. Education and advocacy is carried out in order to increase understanding and support for consumers and families and their needs. 9. Critical incidents are investigated and, where appropriate, result in corrective action. A fair and consistent process exists to respond to grievances and complaints.

Appendix 3 – Detailed Acute Care Design

Policy Issues

The following plan for addressing the service needs of the acute care system is a specific response to the mandates of Multnomah County Board of County Commissioners Resolution, "Providing Policy Direction for a Restructured Mental Health System", adopted by the Board of County Commissioners on September 28, 2000. The following specific portions of the mandate are clearly addressed in this proposal:

- "manage risk in such a way as to provide incentives that reward the attainment of positive outcomes, including reduced hospital stays, coordinated care, and other goals consistent with the vision adopted by the County"
- "work with provider organizations to reduce hospitalizations, develop an integrated provider network that will improve coordination of care, reduce administrative expenses, increase access to care, promote sharing of information technology and increase capacity for risk bearing or risk sharing"
- "reduce hospital utilization by implementing a range of mid-level services including housing, intensive case management and respite beds"
- "Agencies, programs, services and staff are culturally competent; that is, sensitive and responsive to all the elements of consumer's identities, including but not limited to age, ethnicity, race, religion, gender, sexual orientation, disability and culture."

Additionally, this proposal effectively implements the values of a Consumer and Family Centered, Recovery-Oriented Mental Health System of Care by increasing emphasis in service delivery to naturally-occurring, community based support systems, engaging consumers as service providers and incorporating peer support and self-help, working with consumer's strengths in the least restrictive and most normal environments appropriate, providing a broader array of service options to achieve stabilization and recovery at lower levels of care, improving access and outreach, particularly to traditionally underserved populations and coordinating and integrating services to facilitate smooth transitions among different systems of care.

Creating an Accountable System

This proposal assumes a business plan that maps a transition to accountability-based contracts with the provider system. This will insure a system where providers are responsible for the outcomes produced over the full "life" of the consumer's involvement anywhere in the system. This requires continually providing proactive access to effective treatment. Positive clinical outcomes are incentivized and financial accountability clearly lies with providers as the consequence of inadequate or ineffective services. Ultimately, funds now spent on crisis and hospital services will become available for reinvestment in community based clinical care delivery. Most importantly, this business model provides incentives to work with people who can or will not avail themselves of necessary treatment and who are at the greatest risk.

This business model also creates strong incentives to integrate care with allied agencies including primary care, community justice, public health, aging, alcohol and drug, the various services for children and families and many others given that the risk lies with the entity regardless of where the service is last delivered. This model begins to drive together disparate sections of the service system for joint planning and integration. These incentives do not exist under either the current or a traditional fee for service models.

Performance Measurement

An effective acute care system is driven by accountability to positive outcomes that can be measured. A comprehensive Quality Improvement plan will be developed to support this design. This Quality Improvement plan will ensure there is a direct relationship between: 1.) The therapeutic goals described in the consumer's treatment plan, 2.) The standards and goals established in the Quality Improvement Plan, and 3.) Contractual performance requirements and incentives established with the County and State. Important quality indicators under consideration include admissions and bed days per 1000 members, stakeholder, family and consumer satisfaction data, access data, adverse incident rates, complaint rates, standardized clinical outcome measurement tools, provider financial health, and proportion of dollars spent on administrative costs vs. direct-care costs. A single quality process for the entire system will reduce multiple and redundant layers of data collection and analysis and the associated expense.

Crisis Services Overview

The service components of this proposal are consistent with the recommendations to the Multnomah County Design Team by the Crisis System and Community-Based Intervention work groups. These groups' recommendations include 24 hour crisis services that are integrated into the CMHC service delivery system, a crisis treatment center physically located in or next to an ER, a centralized access/crisis phone line; consumer warm line availability; use of trained consumer peer counselors as natural supports, community-based, decentralized urgent care services; an increase in mobile response; a strengthening of the bridge between mental health crisis services and outpatient services that supports continuity of care and discourages fragmentation; and the development of enhanced resources for alternatives to hospitalization including respite and sub-acute care. In their final report, the Work Group states, "The difficulties the CTC has encountered relate directly to significant gaps in service along the entire continuum of mental health care. We have created a system where the only place a consumer can seek immediate therapeutic services is the CTC or emergency room" and "...an effective crisis system must consist of more than simply a good emergent care facility"

The solution to the high utilization of inpatient services involves four critical design principles. First, the logical strong alignment of a crisis response system within the outpatient provider system with capacity for proactive and preventative interventions, an enhanced set of alternatives to hospitalization, and an expanded role for the use of peer supports. Secondly, a system of Acute Care Coordination, as a crucial component of a crisis response system, which involves the consistent application of criteria for hospitalization including the exploration of potential effective alternatives coupled with the means to mobilize those resources. Thirdly, as discussed earlier, a business plan with aligned incentives for provider accountability. Finally, services must be designed with sensitivity and specialization for specific sub-populations including

adults, children, older adults and ethnic and cultural communities. Staffing must consistently attend to cultural and special population considerations incorporating bicultural members, bilingual staff and sub-populations specialists into all staff teams.

Service elements included in this proposal are:

- **Telephone Access**, a centralized 24 Hour, 7 days per week telephone access to routine, urgent and crisis care
- **Community-Based Urgent Walk-In Clinics**, a "no appointment necessary" approach to care during days, evenings and weekends
- **Mobile Crisis Outreach Capacity**, available 24 hour 7 days-a week
- **Alternatives to Hospitalization**, including sub-acute, temporary/emergency housing, flexible funding, and respite care
- **Secure Evaluation Facility**, for consumers who present a danger to themselves or others, who are so gravely disabled as to be incapable of being safely cared for safely in the community
- **Care Coordination,** ensuring that services are appropriately matched to consumer's needs.
- **Transportation** appropriate to the level of acuity of the client
- **Intensive Community Support** services which operate county wide within the outpatient provider system and include peer run drop-in sites, and expanded supports to natural systems of care.

Using these methods, most crisis intervention can and should be community-based. Secure, facility-based assessment capacity is included in the plan as well and will continue to be needed for some emergent and urgent care as a last resort.

Crisis Service Flow: The service flow design proposed here is consistent with the following operating principles:

- Early Identification and pro-active and preventative care
- Community-based versus facility-based interventions
- Efficient use of resources and cost-effectiveness
- Meeting consumer's needs with minimum of intrusiveness
- No wrong door to accessing service
- Maximizing natural, community-based supports
- Minimal authorization /utilization management procedures based on shared accountability/risk
- Centralization of services when more effective or cost-efficient with most direct service delivery decentralized
- Services tailored to the specialized needs of consumer sub-populations including children and families, older adults, and cultural groups.

The attached schematic flow chart describes the proposed system. A well-designed acute care system recognizes that anyone can make the determination that a mental health crisis may exist and begins with the first call. Police, family members, emergency departments, or allied agency personnel identify a perceived urgent or emergent need. These requests are de facto triaged by

four groups of clinicians: 1.) Out-stationed staff in a face-to face evaluation of the client in jails, primary care offices, AFS, SCF or other allied agency settings; 2.) Centralized 24 hour, 7 days per week phone access/crisis staff when a phone request for service occurs; 3.) Urgent Walk-In clinic staff; and finally, 4.) The active treatment team of a client in service, particularly Intensive Community Service teams supporting clients identified as in need of intensive services to avoid hospitalization. All these staff are empowered and trained to determine whether an actual mental health crisis exists, and authorize services as appropriate, or whether the problem may be medical, housing, placement, social, or a chemical dependency issue. These non-mental health dilemmas are triaged to the appropriate agency or community resource with assertive linking to assure appropriate follow up.

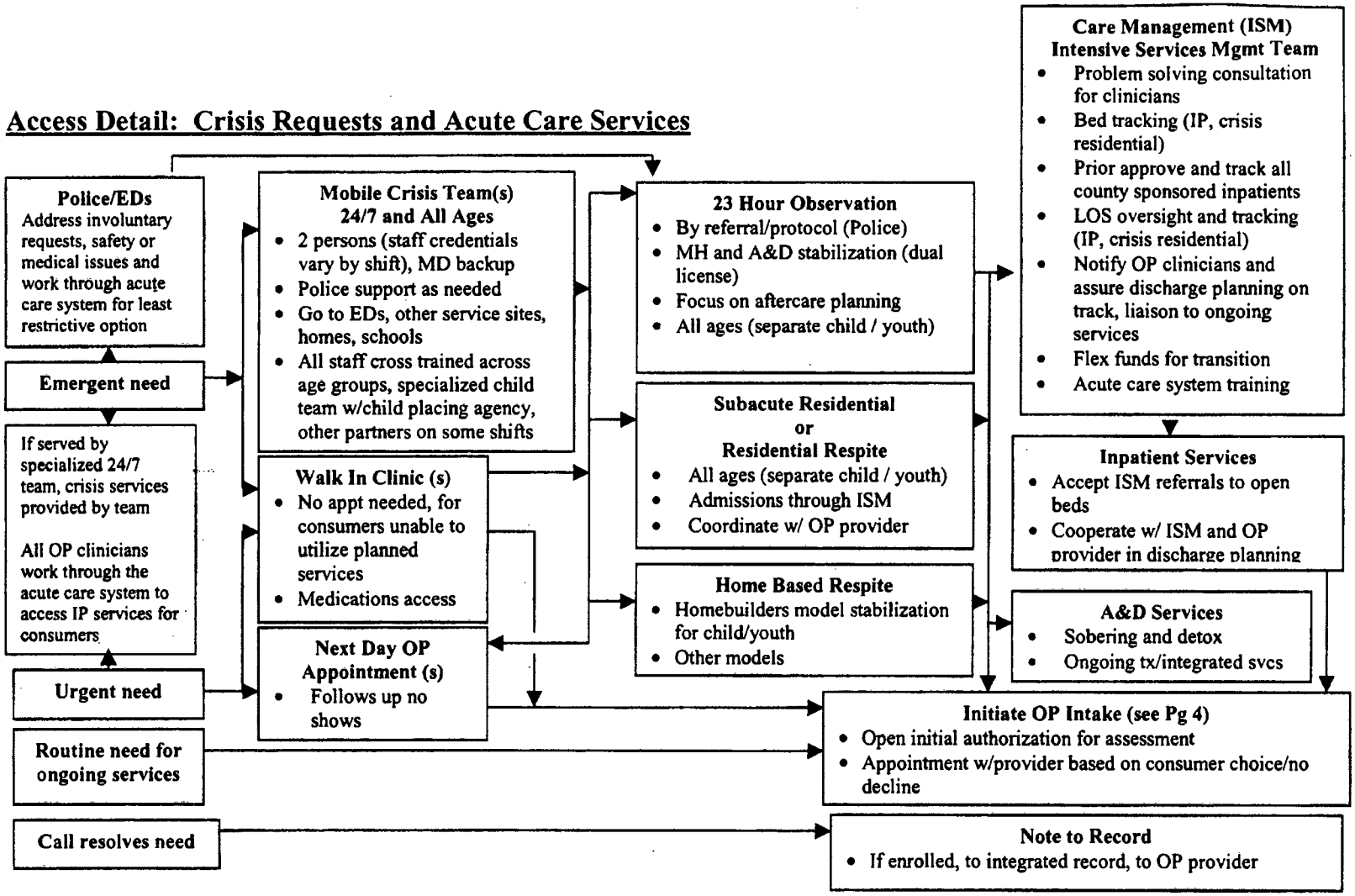
In the case of a mental health crisis requiring active intervention several options are available including dispatch of a mobile crisis outreach team; assessment in a secure facility; referral to appropriate alternatives to hospitalization including sub-acute residential or respite care; or finally, inpatient services. It is expected that all consumers assessed as in crisis will be provided a face to face evaluation through an existing provider, the mobile crisis team, or within the secure evaluation facility.

Phone access staff are co-located with care management staff who will provide acute care coordination functions. This co-location results in efficiencies in communication and staffing making best use of overlapping roles such as tracking of inpatient, sub-acute, emergency housing and respite beds; length of stay oversight and tracking; discharge planning follow-up and pre-authorization of inpatient care.

Critical to the effective functioning of this system is an interagency coordinating team to include mental health crisis providers, inpatient providers, police, emergency department representation, sub-acute providers, DCFS staff, and other partner agencies.

Finally, the entire system must be linked together with an information system that will support providing quality, timely and cost effective services to consumers. We must provide a robust and reliable common infrastructure capable of supporting a new behavioral health information system and accessible at multiple sites via web-based technology to include clinical, utilization and fiscal data. A data warehouse will allow us to create a "Culture of Measurement" where data is turned into knowledge and used to make all key decisions. Clinical data, accessible to all components of the acute care system, will inform intervention decisions at all levels. Cooperation and collaboration with the DCFS will be critical to this data system's operation.

Access Detail: Crisis Requests and Acute Care Services



Service Description

Centralized 24 Hour, 7 days per Week Telephone Routine, Urgent and Crisis Phone Access.

Staffed 24 hours a day, seven days a week by Qualified Mental Health Professional staff, a single 800 number phone access line will serve as a primary entry point for routine, urgent and crisis requests for service. It will be co-located with Care Management staff allowing this centralized group to be in the unique position of monitoring the pulse of the system at all times, prioritizing the allocation of intervention resources, and tracking bed availability all from a single location. All callers will be assessed for acuity and the appropriate level of intervention to achieve a positive outcome in the least restrictive or intrusive manner. Routine appointment scheduling capability will also be available.

Child and family and older adult specialists will be integrated into the phone team. Cross training regarding adult, SPMI, older adult, and child/ family issues will occur on an ongoing basis. Similarly, training in culturally specific interventions and recruiting of ethnic minority, bicultural and bilingual staff will occur. Recruitment of staff who speak other languages will be prioritized. The phone staff will also have access to back-up child/family and older adult specialist consultation, translator service and cultural group representatives.

Appropriate actions, which may be taken from lowest level response to highest level response, include:

- Providing information and referral to community agencies
- Scheduling routine intake within appropriate outpatient program.
- Referral to a Consumer Warm Line for lower acuity telephone support needs
- Providing Qualified Mental Health Professional phone counseling to stabilize urgent concerns
- Referral to Community Urgent Walk-In Clinics
- Linking with responsible treatment team or Intensive Community Service Teams for enrolled clients
- Dispatching transportation options to assist client in reaching a facility for evaluation
- Accessing emergency housing
- Dispatching Mobile Crisis Team for community-based evaluations
- Facilitating sub-acute or respite admission
- Arranging for potentially dangerous clients to be seen at the Secure Evaluation Facility for face-to-face assessments.
- Accessing police or medical emergency response
- Facilitating hospital admissions if appropriate

The phone staff work with police, emergency departments, providers and partner agencies to locate the most appropriate resource to respond to the consumer's need. They will have access to a database to schedule appointments after hours and on weekends, as well as being able to

refer consumers to urgent and routine walk-in clinics. In situations where the caller is assessed to need an alternative to hospitalization, the crisis staff will be able to assist in accessing these resources. In the routine access role, phone staff will primarily focus on brief assessment, triage for eligibility and urgency of need, authorize initial assessment, prepare consumer for next steps, offer choice of providers/sites, enter and track request for service via database, make appointment for assessment or refer to walk-in clinic. If assessment not required, clinician will refer to alternative services such as consumer run "sanctuaries", agency sponsored support/education groups or community resources.

The Phone Access line is expected to receive in the range of 300 to 350 calls per 24-hour period. The phones will be staffed at all times with a call management system that will appropriately flow calls by acuity. Special features of the phone system will include caller identification, multiple intake lines, call forwarding, direct transfer to outside agencies, power failure back-up system, and language interpretation.

The Phone Access line is ideally co-located with care coordination services. There will be cross training of staff to perform multiple functions to maximize responsiveness and flexibility of staffing patterns. Qualified Mental Health Professional level clinicians will fill all phone triage and crisis functions with cross training in care management (alternatives to hospitalization, authorization of services, flexible funding, etc.)

Community-Based Urgent Walk-In Clinics

Re-establishing decentralized community provider-based urgent/crisis capacity was strongly supported by the Design Team Crisis System and Community-Based Intervention Workgroups in their final recommendations. Four "no appointment necessary" urgent walk-in clinics located in North Portland, Downtown, close in Eastside and the Rockwood/Gresham area will be implemented. These clinics will be staffed by Qualified Mental Health Professionals and will also have Licensed Medical Professional coverage for urgent medication evaluations. They will operate during regular business hours Monday through Friday. An evening and Saturday urgent walk-in clinic will also be established and will operate from 5:00 till 9 PM Monday through Friday and from 1-4 on Saturday. Staffing for all walk-in clinics will include a Qualified Mental Health Professional and a Licensed Medical Professional (MD, PMHNP or PA). Sample and stock medications will be available in addition to prescriber services. Follow-up prescriptions and referred to a pharmacy will also be provided.

This resource (along with appropriate transportation for clients, as needed) will be offered in all cases where it is clinically appropriate, and safety issues do not require a police response. Services provided will include evaluation, supportive counseling, and medication evaluation. Referrals may come from self-referral (walk-in), the Mobile Outreach Team, Emergency Departments, the phone access line, hospitals, police, etc. The urgent care clinic staff may also refer to the Secure Evaluation Facility.

Child and Family Urgent Care: Utilization of clinic-based urgent service options is not the preferred option for children and families. Instead, preserving continuity of care by utilizing existing treatment teams to provide urgent care for active service clients will be a practice principle for all sub-populations, especially children. Further, Mobile Outreach, provided in the

natural context and most comfortable setting for the family, is often the preferred option for intervening with children and families and will be discussed in more detail in the next section. However, the urgent walk-in clinics described above will be made available to children and families for urgent service needs when other options are not available, are not appropriate, or when the family chooses to access them. These clinics will provide a warm and inviting, family-friendly, atmosphere and will incorporate child and family clinical expertise and child prescribing capacity.

Older Adult Urgent Care: Urgent care response for older adults requires a highly skilled assessment component in order to accurately diagnose, consider over-lapping medical issues and suggest key interventions for older persons and their caregivers. In addition, all interventions require an age sensitive response designed to build trust and rapport with older persons who are often hesitant to seek psychiatric help.

Services offered in a crisis situation will be coordinated within available natural and professional support systems, including key family members, caregivers and involved staff from Aging and Disabled Services (ADS) (including the ADS 24 hour help-line staff)and Older Adult Services within the outpatient provider system. The need for tight coordination with current cooperating providers through the Gatekeeper Program (community based volunteer case identifiers) and the inter-agency Multi-Disciplinary Team; a well coordinated team of senior service providers: including health, mental health and social services; will be key to successful intervention with this population.

Follow-up services provided to the older adult and their support system after an acute episode are key to continued crisis stabilization, and will likely include follow-up in multiple areas, such as physical safety and health, social contact, capacity assessment, addiction treatment and continuing mental health intervention.

Qualified Mental Health Professionals with geriatric expertise will train Urgent Care staff regarding key assessment, diagnostic and approach techniques key to successful geriatric mental health treatment, as well as familiarizing crisis staff with the array of Senior services accessible to older adults through Oregon Project Independence and the Oregon Health Plan. A Geriatric Psychiatric Mental Health Nurse Practitioner and a Geriatric Psychiatrist will also be available for consultation on an as-needed basis.

Mobile Crisis Outreach Capacity 24 hour 7 Days-a Week

Rebuilding Mobile Outreach follows the principle that the most effective crisis intervention service often occurs within the natural system of support of the client. The Team will provide face-to-face assessment, brief resolution-oriented crisis intervention, environmental/systems interventions, disposition to appropriate alternatives to hospitalization and linkage to appropriate community resources for individuals, children and families. Family involvement, consultation with schools or other involved agencies, or mobilizing potential natural helping supports in the client's environment will increase the speed with which a crisis is resolved in a manner which is the least intrusive and restrictive to the client. Interventions aimed at relieving situational stressors, for example a housing crisis, can often be the singly most effective intervention in

resolving a crisis. Mobile outreach staff must be community resource specialists and must constantly update their knowledge of housing, meal, clothing and social service resources in the community.

Facilitating access to inpatient care including authorization to perform Director's Custody holds will also be the team's role. Police and Emergency Department requests will be highly prioritized. The Mobile Outreach Team will operate on a "no-refusal" basis for outreach requests from Police, Emergency Rooms and Hooper Detox. Finally, linking clients with ongoing outpatient services is part of any effective outcome in a crisis situation.

The Following assumptions provide a conceptual framework and philosophy for the Mobile Outreach Team:

- The least restrictive, most effective clinical intervention will always be used in responding to requests for urgent or crisis services.

- All services provided will be provided in a culturally competent and sensitive manner, utilizing community-based services and supports (bicultural and bilingual staff, interpreters, natural systems of support, etc.) whenever available.

- Mobile Outreach response will be considered as just one potential response to service requests.

- It is not practical in designing a crisis response system, to distinguish between enrolled and non-enrolled clients, nor should the issue of adequate coverage be a factor in providing urgent and crisis services. Urgent services must be provided to all Multnomah County residents requesting such services.

- Non-Multnomah County residents seeking urgent mental health assistance within Multnomah County will be assisted in accessing appropriate services within their County. Multnomah County should take a leadership role in establishing a Regional Operating Agreement with neighboring County Mental Health Authority entities to establish defined roles and procedures in relation to acute care.

- All clients who are being involuntarily assessed for dangerousness or grave disability (on a hold, transported by police) will be taken to the Secure Evaluation Facility, regardless of residency.

Psychiatric consultation will be available to the Mobile Outreach Team via the on-call psychiatrist staffing the Secure Evaluation Facility. The use of Licensed Medical Professional time as a component of urgent/crisis services has been closely studied with the conclusion that having a Licensed Medical Professional as one of the mobile crisis responders is not the most effective use of their time, as prescribing in the field is unlikely. Instead, Licensed Medical Professional skills would be better spent providing medical consultation to the crisis system along with increasing the availability of walk-in prescriber time at the clinics.

All staffing levels will be sensitive to high demand periods. The need for mobile response teams during business hours should be significantly decreased with the introduction of the additional services described above. However, we expect a need for a Mobile Outreach response capacity during business hours, especially in regard to police and emergency department support. Additionally, timely response to community requests for urgent services must be available, if we are to effectively divert clients seeking services at emergency departments to a more appropriate and less restrictive level of care. The decision as to whether to dispatch one staff or two will be made by the Phone staff or Acute Care Coordinator and will depend upon the nature of the call and the need for police back up. In cases where police back up is required, or where the request has been made by a facility that provides on-site security (i.e., hospital ED), only one staff person will be dispatched. In cases where police back up is determined to be unnecessary, two staff will be dispatched.

Mobile Outreach staff will be available for the following responsibilities:

- Availability for outreach response
- Phone consultation with emergency departments and police
- Outreach to emergency departments and police to consult, assess, and provide alternatives to hospitalization as appropriate
- Back-up for walk-in/crisis clients at the clinics
- Follow-up on crisis calls from prior shifts

During regular business hours Mobile Outreach staff will be co-located at the four Urgent Walk-in clinical sites. During evenings and on Saturday, the Mobile Outreach Team will be co-located with the centrally located Urgent Walk-in clinic and, ideally, the Care Management and Telephone Access services. Evening Mobile Outreach staff can provide back-up support to the Care Management and Phone Access teams when they are not needed for crisis calls. During the lowest demand periods at night and during weekends, Mobile Outreach will be staffed on an on-call basis. Timely response to after-hours requests for mobile response will be emphasized with a performance benchmark of 30 minutes from the time the dispatch occurs.

Child and Family Mobile Outreach: A mobile response is optimal when the appropriate goal is to intervene within the natural context and most comfortable setting for the client. This is particularly true of families and children whose needs are not well served through facility-based crisis intervention. Therefore, Mobile Outreach will be the response of choice for children in crisis. For children and families, stabilization in the home or other natural setting is the most efficient and effective way of achieving quick stabilization and diverting from more restrictive forms of care.

It is expensive and unnecessary to operate independent adult and child/ family Mobile Outreach Teams. Therefore, the mobile outreach team will serve both adults and children/families. Team makeup will include Child and Family specialists who can take the lead in relevant clinical situations and training in family systems interventions will occur on an ongoing basis. Consultation expertise to include child and family specialization will also be available, coordinated with the consultation resources available to the Phone Access Line and Urgent

Walk-in clinics. As the system evolves, we may explore establishing child and family-specific mobile crisis teams for targeted, high use time periods.

It will be crucial to collaborate with Services to Children and Families in resolving many outreach service requests and coordination with case workers to seek alternatives to hospitalization and to resolve placement issues will occur whenever indicated. A process will begin immediately to begin to develop operating agreements which will define policy and procedures in these areas as well as explore blended funding opportunities.

Older Adult Mobile Outreach: Mobile outreach will be particularly key in serving hard to reach seniors that are often isolated with an acute mental health crisis. In 1997, Older Adult Behavioral Crisis Services, a mobile outreach model, was developed at Mt. Hood CMHC to respond to a high number of psychiatric hospitalizations of older persons. Fueling this development was interest in early intervention to prevent hospitalization, and acknowledgement that the trauma of hospitalization of older persons and the high cost of inpatient stays should not be supported as the most viable option for care in a crisis when help could be provided in the community. Outcomes showed significant financial savings with community care averaging $1,620 per crisis episode, versus $3,230 for the average hospital stay per similar crisis. Clinical outcomes included a substantial reduction in frequency of symptoms, severity of symptoms, GAF scores and caregiver distress.

This model illustrates the success of a mobile outreach approach, with geriatric specialization, for older persons. As for urgent walk-in, QMHP staff with geriatric expertise will be available to provide consultation and training to Mobile Outreach staff regarding assessment activities such as medical rule-outs, assessment of persons with dementia, the unique suicide profile of older persons, linkage with the Aging Services system, medication guidelines for prescribers, and consultation with family and caregivers. A Psychiatric Mental Health Nurse Practitioner and a Psychiatrist with geriatric expertise will also be available for consultation.

Alternatives to Hospitalization

Many factors besides acute mental illness contribute to the overuse of the acute care system in Multnomah County. The lack of a suitable and integrated community crisis response contributes to this and is addressed in previous sections of this proposal. Another major factor in over-reliance on in-patient care is the lack of access to alternatives to hospitalization in the community. The following resources are either in place and slated for expansion under this proposal or are proposed for rapid development to address the acute care crisis safely and effectively.

Our operating assumption is that naturally occurring supports will be explored and used first or in conjunction with the alternatives described below after consultation with an acute care coordinator.

Housing: Approximately 30% of the consumers referred to the Hospital Alternatives Pilot Project were homeless at the time of referral. Another 9% were being evicted or in unstable or highly unsuitable housing. Obviously, housing is a serious risk factor affecting the safety and well-being of consumers with mental illness, as well as a major contributing factor in long

lengths of stay and repeat hospitalizations. The Housing Outreach Team, composed of QMHP and QMHA level staff, will continue as a centralized program to respond quickly to emergency housing needs of consumers. The program offers outreach to consumers, families, landlords, and partner agencies such as Aging Services and the Housing Authority. The goals are to prevent eviction, stabilize housing, provide appropriate emergency housing referrals, and establish wraparound services aimed toward maintaining housing financed by flexible funding pools. Short-term case management to engage and link the consumer with other needed services is another important element of this model. The Housing Outreach Team works with the consumer and involved parties toward a solution of the immediate housing problem such as referral to emergency housing, as well as exploring longer term interventions such as offering the consumer money management services. The team will work closely with the Intensive Community Services team, the Mobile Outreach Team, and the Acute Care Coordinators. The Housing Outreach Team will also work with the agency-based housing specialists to develop longer-term housing goals and specialized knowledge and skill in finding, developing, and locating funding for permanent housing.

Intensive Home-Based Services: Intensive Home Based Stabilization services are flexible services tailored to the consumer's needs with a goal of resolving a crisis within the clients natural system, home or community. Their purpose is to provide the level of service which will allow the consumer to remain in a home or community-based setting. This alternative is generally short-term, but components of the service, provided less frequently and intensively, could continue for a time after the acute episode if appropriate.

The philosophy of Intensive Home Based service is to temporarily fill gaps in abilities and functioning in a flexible manner, while building skills and recovery wherever there is potential. Service is provided for several hours a day up to 24 hours in a crisis situation. The providers of this service include para-professionals, cultural group representatives and/or consumer peers with training and supervision by mental health professionals; personal care assistants; and medical staff such as LPN's or RN's. The program will hire and train these consumers, community members, family members, and paraprofessionals, developing a flexible pool of primarily part-time staff with a variety of skills, abilities, cultures and languages. These individuals can assist with providing supervision of activities of daily living, transportation, monitoring nutrition or medication, providing support, accessing resources, or providing skills training, all while the consumer remains in the home or community setting.

Additionally, Metropolitan Family Service (MFS), an established local social service agency which subcontracts with mental health agencies to provide a variety of services, will be available to provide more complicated levels of need. This agency has two primary programs applicable to the adult and older adult populations: The **Health at Home** program provides trained staff for homemaking, personal care, respite, and skill training for the consumer and family members or care-givers. Nursing care management, a RN level function, will assess all medications and their use, and work closely with the physician to set up a program which a CNA can implement to provide medication management. The **Help at Home** program is a non-medical community based service for adults, children, and families. Paraprofessional staff provide a variety of skill building, respite, mentoring, and other community based services as needed. All MFS staff work with the philosophy of assisting the consumer in recovery by helping them learn to do the

activities for themselves. If this is not possible, they attempt to locate a family member, a friend, a landlord, or someone else they can train for ongoing assistance. There are also times when the consumer is more chronically unable to function in some areas and the service may be extended for a longer period of time to allow them to live as independently as possible.

If the consumer is enrolled in Intensive Community Support, it is assumed that the ICS clinician will provide some of the above services. However, due to the time demands and scheduling challenges of full-time salaried clinical staff, the flexible pool of part-time "on-demand" services adds responsiveness and diversity when a crisis occurs and intensive service needs to be implemented quickly.

Respite: Community based respite is a safe, structured alternative to hospitalization or a step-down from inpatient or sub-acute care. Respite facilities are staffed 24/7 with mental health and/or residential service staff. They provide room, board, personal care housekeeping, medication management, and other services typical of a residential care facility. The mental health staff provides support, consultation, crisis intervention, and case management. There are currently 10 community respite beds at 3 locations. We plan to make additional beds available quickly. These crisis respite beds are currently occupied at a rate of 96%. We plan to extend hours of admission to respite until 9PM on weekdays and during the day on Saturday and Sunday.

Respite can also be provided to in-home caregivers who are fatigued and might initiate a hospitalization or for consumers who need temporary in-home care to monitor mental status and self-care. This will be provided by finding and hiring a neighbor or friend of the consumer's choice, or hiring an in-home support service with flexible funding. This alternative is a good choice when the consumer needs more than a few hours a day and less than 24/7 support.

Sub-Acute: Ryles Center is currently the adult sub-acute facility. The MHO will work with Ryles and the MHO to expand the hours of admission to include evenings and weekends. Ryles is also potentially able to expand another 10 beds. This represents about a 70% increase in sub-acute capacity.

Flexible Funding: The Acute Care Coordinators and the Intensive Community Services teams will have access to flexible funding to pay for alternatives to hospitalization. The funds can be used for a wide variety of purposes including temporary housing, assisting with basic needs, transportation, legal fees, incentives, engaging natural support systems such as landlords or neighbors to assist consumers, etc. The funds will be authorized and managed centrally, but can be accessed rapidly with minimal bureaucracy.

Child and Family Alternatives to Hospitalization: Community-based services for both known and unknown families will always be utilized first in assisting children and families. Maintaining the child within an existing home environment and system of care while providing the least-intrusive intervention and stabilization is the treatment of choice. Reducing the number of changes in treatment providers and placements is a guiding principle in designing the child's individualized plan of care. Family involvement is paramount and incorporated in every area of

the system of care. Family input and choice of services are integral parts of the child's individualized plan of care.

The services described here offer alternatives to psychiatric hospitalization. **Flexible Funding** and **Intensive Home-Based Services** are generally considered the first line response. Facility-based services will only be considered after home-based interventions are ruled out. These services are targeted to avert inpatient psychiatric hospital treatment, not to resolve longer-term placement difficulties. It is not expected that Oregon Health Plan outpatient funding will be used to pay the cost of residential services, but rather to resolve a mental health or behavioral crisis that would otherwise result in an inpatient psychiatric stay. Some of these services already exist in the community, others are near implementation, and others can be sub-contracted with community partners.

Existing partnerships, particularly between the Multnomah County child and adolescent mental health system and SOSCF, provide a foundation for both blended services and blended funding. Coordination of care and blended funding strategies are critical to support the child and adolescent acute care system. Without this coordination of services and funding, the development of the proposed range of crisis respite and sub-acute services specifically tailored to the developmental and treatment needs of children is not possible. Additionally, the Multnomah County system has an extensive history of collaborative planning and pooling resources with SOSCF, local school districts, and juvenile justice to fund components of our local system of care for SED children and youth. We plan to put considerable effort to expanding and fortifying these partnerships.

All of these services will be accessed via the **Acute Care Coordination** system. Parents, community partners, and mental health providers access the Acute Care Coordinator via the centralized phone system staffed by qualified mental health professionals. Once it is determined that the child cannot be treated safely or effectively in outpatient care, he or she is referred to the appropriate services. To ensure continuity of care, linking with **Intensive Community Support Services (ICS),** described in a later section of this proposal, will insure that children are followed, during and after their involvement in the acute care system. ICS staff or other outpatient providers will participate in the facilitation of post-discharge services and continuous coordination of care.

Flexible Funding: A generous flexible funding pool will be established to support the purchase of wrap around services, including child care services for parents, in home respite, arranging access to appropriate medical care for the child, transportation, academic supports, and involvement in positive youth and family activities. The ability to provide funds to make a motel room available for a night or provide cab fare can often serve as a powerful tool to resolve a crisis. Flexible funds will allow Acute Care Managers to provide the necessary flexible funding to help children and families access the necessary services they need for enhancing their strengths or empowering them to meet their needs.

Intensive Home-Based Services: Intensive Home-based services are designed as a time limited effort targeted to stabilize a crisis which offers children, teenagers, and parents support in their homes from well-trained professional staff. Services can include around-the-clock crisis

management, problem-solving, consultation, skill building, case management and client support services. The staff providing the services are on-call 24 hours a day/ 7 days per week to assist in de-escalating crises for the children and families in the community and to assist in the prevention of more intensive crisis services. Access to flexible funds and services are also available. These services are provided until the crisis is stabilized, but are generally not more than 2 weeks in length. Follow-up outpatient services are begun prior to the termination of Intensive Home-Based Services.

Intensive skill building is provided by paraprofessional staff. The skill builder can work with the family on a range of issues, including helping the family find practical solutions to barriers to accessing services. For example, many families are struggling with basic needs, therefore have no energy to address mental health issues. Assisting the family with accessing services to address these needs, such as the food bank, housing agencies, or other resources, can often resolve the crisis as ell as remove barriers to accessing continuing mental health service. Skills trainers can walk the family through the process, and accompany them to services at first, if needed. Paraprofessional sill trainers work as a team with Mental Health Professional staff, supporting the work of the Mental Health Professional by helping the family practice what was learned in family therapy. For example skill trainers can assist the family with utilizing behavior charts, maintaining a safe and clean household, etc.

Intensive Home-Based services differ from Intensive Community Support Services for Children in that they are expected to be provided as an emergent response to a crisis for families who are not currently in outpatient treatment or who are not assigned to an intensive level of care within the outpatient continuum of services. They are generally provided on a more short-term basis than ICS and should only remain in place until appropriate services within the outpatient continuum of services have been established.

Children's Alternative Placements to Hospitalization

1. Crisis Respite

- **Out of Home Respite Care for Children:** We are exploring a number of options for this level of care within existing programs that we believe can be developed or expanded quickly. These resources should serve as a mental health/behavioral intervention to resolve a crisis rather than as a potential solution to a placement problem. The length of stay is short-term, often 2 to 3 days, following the principle of return to a home environment as rapidly as possible:
- **Respite provided in Shelter Care settings:** Shelter care can provide 24 hour care of children in crisis by professional staff in home-like environments. Case managers within shelter care programs will work closely with Intensive Case Managers, outpatient mental health providers and community partners to insure continuity of care. Estimated cost per bed day is approximately $180.
- **Respite provided in Therapeutic Out-of-Home Care Settings:** Professionally trained and fully certified families and individuals provide therapeutically structured and nurturing setting for children. Outpatient services will be established and may continue during stay. The available outpatient treatment services can include Intensive Case Management, individual and family therapy, psychiatric evaluation, and medication management, skill building, and 24-hour crisis intervention services. Length of stay and package of services are

determined by client need and community need. The projected cost of this service is $160 per day. This rate includes the cost of the placement only and does not include the additional costs of mental health services.

2. Intensive Evaluation and Stabilization

- We plan to create options for intensive evaluation and stabilization services to a wide age range for boys and girls. An intensive evaluation and stabilization option may be appropriate with a high-acuity mental health/behavioral presentation but without the need for the level of medical intervention available in a hospital setting. Children placed within this level of care will require a length of stay to stabilize their psychiatric condition and to establish and integrate family and community resources.

  Intensive Evaluation and Stabilization services are defined as a non-hospital level of psychiatric assessment, evaluation, and short-term treatment in a staff or facility secure program. The main emphasis of the services is to provide a safe environment to rapidly stabilize a child's behavioral and psychiatric functioning. A comprehensive assessment of the child's mental health functioning and recommendations for continued treatment is provided to assist the family in the next step of treatment and support of the child. The purpose of the child's stay is to obtain a complete evaluation of current functioning, stabilization of the psychiatric crisis, recommendations for ongoing care, and skills for a safe transition to the next level of care. The average length of stay is 7-14 days.

  Available services include psychiatric assessment, psychological evaluation, medical screening, neurological screening, family assessment, social functioning, assessment, and educational assessment. The child's treatment team coordinates services through an individual plan of care. The service implementation and staffing ratios follow state regulatory guidelines. The exclusionary criteria for this level of care include children who are medically unstable or who require the use of mechanical restraints.

  The projected cost of this service is $325 a day.

3. Sub-Acute Treatment Option for Children

We plan to expand existing options for Sub-Acute care to a wider population in terms of age and gender. A Sub-Acute option may be appropriate with a high-acuity mental health/behavioral presentation but without the need for the level of medical intervention available in a hospital setting. The Sub-Acute program is an alternative to psychiatric hospitalization for clients who present an imminent risk to themselves or others. While in Sub-Acute services, children have access to 24-hour on-site nursing care, consultation with a physician 24 hours a day, individual, group and family therapy conducted by a Master's level therapist. Youth receive assessments consisting of psychiatric, mental health, nursing, and education. The average length of stay is 24 hours-7 days. Estimated cost per bed day is approximately $400. To date, the cost of the service has been shared with Services to Children and Families. The service implementation and staffing ratios follow the state regulatory guidelines. The exclusionary criteria for this level of care include children who are medically unstable or who require the use of mechanical restraints.

Older Adult Alternatives to Hospitalization:

The Acute Care Coordinators will facilitate referrals to existing resources. Older Adults often have a particularly high need for structured settings to provide safety and health care for co-existing physical health needs that often precipitate the onset of serious mental health disorders, particularly dementia and related conditions. The use of Nursing Home beds for clients with significant functional needs is an option for some older persons following acute episodes, however, placement is not recommended without adequate assessment and follow-up by the mental health system. PASRR Level II screenings as well as outreach counseling services can be employed in order to assure that an older person is not "dumped" into a senior care facility without adequate assessment and attention for key mental health needs. Similarly, Adult Foster Homes and Residential Care facilities offer care, and should be complimented by sufficient mental health treatment to assure continued stabilization.

Respite services have been successfully provided to older persons whose placements are at risk. Services provided by specially trained C.N.A.'s has proven to be effective in reducing distressing (and often destructive) behavioral episodes, and reducing the stress level of caregivers.

Other services may be provided in any manner that is clinically indicated; from peer counseling to gero-psychiatric work-ups, according to the level of need required to assure the goal of stabilization.

Secure Evaluation Facility

This service will be provided through a contract with Woodland Park Hospital. The program will be sited in a ward adjacent to the Emergency Department thus effecting potential efficiencies in staffing and cost. In high-demand times, any hospital staff can be called in to assist. A percentage of staff are already working on the in-patient psychiatric units, so would be able to fill in when necessary.

This will NOT be an open facility, that is, available for walk- in clients. The rationale for the closed secure facility is threefold. First, experience with "walk-in" secure facilities has shown that mixing of all populations and levels of risk/dangerousness is difficult to manage. The lower risk consumers, young children, and older adults are exposed to potential vicarious trauma and are often subjected to long wait times due to the need to triage and treat the highest risk consumers first. Staff must try to serve a wide variety of needs compromising their ability to attend to some of the more subtle crises. Secondly, staffing and maintaining capacity for urgent walk-in traffic at the same time as having 24/7 capacity for up to 3 secure police holds is very expensive. It represents a single model of urgent/emergent care that does not lend itself to a continuum of community-based, least restrictive alternatives as are outlined in this proposal. The secure, hospital based facility is a necessary part of this continuum, but its purpose is for use in cases where a police or crisis triage decision is made after exploring risk and other alternatives for consumers who cannot be better and more safely served in another community setting. Thirdly, the current CTC's experience is that an open, hospital-based facility acts as a magnet for the provision of convenient routine care, provided at extremely high cost.

Demand for Secure Evaluation Facility service is therefore expected to be considerably lower than in the current CTC model. Referrals for secure evaluation and stabilization will come from police, the mobile outreach team, or from the 24 hour crisis/access line staff who have determined that the consumer needs this level of care and cannot be better served by the community-based urgent clinics or mobile outreach.

Initiating this service design successfully will require that the development of other service element system enhancements, especially the community-based urgent walk in clinics, will need to occur first and become established prior to implementing the "no open door" secure evaluation facility.

The purpose of 23-Hour observation capacity is to provide the least restrictive treatment alternative for clients by providing for a period of assessment for those patients deemed to have the potential to rapidly regain functioning, and to facilitate their smooth reintegration into the community by providing optimal discharge planning. Consumers who cannot be safely and effectively evaluated in a less restrictive setting are referred or brought by police or secure transport. The facility will be primarily used for adult and older adolescent consumers. Though never a first choice, the facility should be available to be used by older adults if necessary, and will utilize specialized approaches and protocols for this sub-population, including phone consultation with geriatric specialty staff.

The space at Woodland Park Hospital will include secure hold rooms and observation rooms for extended evaluation and stabilization. The facility will be a pleasant, spacious environment that is not over-stimulating. Staffing patterns will reflect a multi-disciplinary approach as well as blending of in-patient staff and staff from the community to better integrate levels of care and to ensure communication and continuity of care.

Older Adult Secure Evaluation

Older Adults with need for 23 - hour observation would be screened by clinicians in consultation with on-call geriatric mental health specialists who will determine if there is a need for a geriatric psychiatric bed in the facility. Provisions for medical rule-outs through use of key lab work will be completed upon admission to the observation facility.

Care Coordination

Care Coordination will operate collaboratively between Verity and the Provider Organizations. Two aspects of this collaboration must be coordinated. The first area involves information management, billing reconciliation, and eligibility determination. Verity's role should include the development and operation of an OHP prime number based information system. This care coordination capacity will tell authorized users about a client's eligibility status and who is responsible for their care in addition to the having the demographic and clinical information associated with the data fields required by OMAP for encounter submission. Ultimately, this will lead to the development of a web-based care-coordination and clinical record capacity.

The second area is clinical, that of Acute Care Coordination. This material is covered in ***Appendix 4: Acute Care coordination Plan.***

Transportation

Mountain Retreat Secured Transport has a history of providing this service in the metropolitan area for many years. They are quite experienced with transporting adults and children and adolescents in distress and possess the appropriate liability coverage and consent procedures to perform this service for individuals on a commitment status. Mountain Retreat can also bill Medicaid (via a subcontract with Tri-Met) for eligible persons.

Intensive Community Support Services

Intensive Community Support services provide a unique array of outreach services in the community for people with severe and persistent mental illness. Intensive Community Support will typically be made up of a multidisciplinary teams of six and ten members, and will include consumers, as well as members of underserved communities in areas where this is an issue. Teams will be assigned a consulting Licensed Medical Professional and may contain specialists in child/family work, addiction treatment, housing, or other specific competencies. These teams will be developed within the provider agencies through the re-allocation of existing outpatient resources to the development of these teams.

All services by ICS teams are provided in the community – at home, in shelters, in public places – on the street if necessary. Services are intensive, but short in duration – the goal is stabilization and not continuous care. Once an ICS client is stabilized and able to make use of conventional office-based services and other peer and naturally occurring community supports, ICS services can be withdrawn.

These community-based services are critical elements to achieving recovery goals such as establishing and maintaining housing, employment, or improving social and familial circumstances. Services are oriented toward clients who may have histories of high service utilization or treatment failure. The approach to care taken by Intensive Community Support staff must be to make themselves helpful and useful from the consumer's perspective so that they are attracted to use the services of staff. This is in contrast to more historically traditional approaches of the treatment plan being developed by staff and imposed on the consumer.

This proposal has addressed the importance of access to services and the coordination and integration of care as a part of the solution to the acute care crisis. However outpatient services themselves must also be more effective, and Intensive Community Services are a crucial part of working for the recovery of those who are unable to access the services supplied in clinics.

This model has similarities to the techniques associated with assertive community treatment, wraparound, system of care and even community policing models. A proactive and preventative approach is taken versus a reactive, problem-solving approach. The idea is rather than waiting for something bad to happen and rushing to fix it, Intensive Community Support staff are chosen by consumers and families for the services they recognize as necessary. Contact may be occasional or frequent according to functional capacity.

These services are made available primarily during the day but can be accessed after hours for crisis situations, preserving continuity of care. Typically, team members rotate on-call after hours.

Intensive Community Support Services for Children and Families:
Intensive Community Support teams for children and families consist of clinicians who are Qualified Mental Health Professionals with training and experience in child and family mental health. Qualified Mental Health Associates, skills trainers and mentors also function as a part of the ICS teams. The ICS team works primarily with children and families who have intensive mental health needs, have difficulty participating in traditional office-based services, and have involvement with multiple systems which need integration and coordination.

Initially, the ICS clinician does a thorough needs assessment, which involves consulting with the family and all providers involved. This is usually accomplished through a variety of modalities, including initial assessment with the family, phone consults, review of records and synthesizing of this information. An initial Plan of Care meeting is held to identify strengths of the child and family as well as treatment goals and objectives. These goals are monitored and adjusted as needed.

ICS clinicians take the lead in forming multi-disciplinary treatment teams, which include the child's family, mental health providers, schools, SOSCF, Juvenile Justice, DD, providers of specialty and flexible services, and other and community and natural support systems. The ICS clinician initiates and facilitates planning meetings with all parties, cooperatively develops and implements the services outlined in the plan of care, and connects children and families to appropriate services. ICS clinicians also participate in the transition of clients from higher levels to lower levels of care, and facilitate admission to higher levels of care when appropriate.

The ICS clinician serves as the central point of information regarding a child's services and progress. He or she provides clinical leadership for the team, always looking at the entire system of care for the child and family. He or she is responsible for facilitating communication among the team members, and arranges team meetings as needed to assist with this process. In addition, the ICS clinician assists the team with defining roles and responsibilities and setting timelines for tasks to be accomplished. The ICS clinician is also the clinical liaison with the multiple children's funding sources and partners with them for the best use of resources.

ICS clinicians typically provide adjunctive services to traditional out patient services and wrap around services. However, they do provide direct service, including assessment, crisis management and stabilization, out reach and community based interventions (i.e. at the child's home or school). They can be the primary mental health provider if the child is primarily receiving community based, wrap around services as opposed to more traditional services. ICS clinicians also provide advocacy for the child and family with other systems that are involved with the family (e.g. school, AFS, SOSCF). They also have the flexibility to "do whatever it takes" to assist the family with overcoming barriers to utilizing treatment. For example, the ICS clinician can attend social service appointments with the family and assist with referrals and services related to basic needs. The ICS team and providers follow the child, to provide continuity of care for the child as much as possible.

Lengths of stay will vary considerably as this is a highly individualized service. However, the ultimate goal of ICS is to build competencies within the child, the family, and the surrounding

support system to allow for a step-down from ICS into the strengthened natural support system as soon as appropriate. A family strengths focus, rather than a focus on the child's problems in isolation, guides all interventions. Toward this end, ICS clinicians locate and develop community resources. They can access flex funds for a variety of purposes, such as respite or community based activities. They also screen, hire and supervise community based therapeutic mentors and skill builders. When this service is contracted through another agency or a specialty provider in the community, the ICS clinician provides clinical oversight. Finally, ICS clinicians are available after hours to intervene in crises that arise with their clients. All carry pagers and rotate after-hours on-call.

Appendix 4: Acute Care Coordination Plan

Care Coordination
Verity will operate a 24/7 'Acute Care Coordinator' (ACC) capability. Upon contact from any referral source considering acute care or a length of stay extension, the ACC together with the referring clinician(s), will discuss treatment options in the context of the criteria for "medical appropriateness", listed below. Hospitalization of OHP and general fund eligibles (members) may occur without consulting the ACC. But only a pre-authorization by the ACC can guarantee Verity's payment for these services.

Clinical Philosophy of Acute Care: The core of all discussion concerning treatment options, including hospitalization, should be the best clinical outcome, not cost. The best clinical intervention is the one most likely to promote healthy functioning within a client's natural system of support. In general, hospital resources should be used only for those who can not be treated as safely or effectively as outpatients.

The Acute Care Coordinator will review the individual clinical circumstances of each case with referring sources. The emphasis of these discussions will always have to do with what is best for the consumer, not simply whether all possible outpatient possibilities have been tried and exhausted. The issue of safety is well articulated in the minds of most clinicians. There are laws and regulations pertaining to the involuntary detention of persons who are a danger to themselves or others or who are gravely disabled due to a mental disorder. When involuntary treatment criteria are met, a mentally ill person will usually be hospitalized and the "resource management" issue will be moot.

There are, however, times when safe alternatives to hospitalization do exist. The issue of the relative effectiveness of inpatient versus outpatient treatment is where potential problems arise. These problems have many variables and require a simultaneous consideration of many priorities. Cost should only be a consideration when equally safe and effective outpatient treatment is available. There are times, however when treatment is as likely to be as effective (or ineffective) in the hospital as in an outpatient setting.

Another issue is the relative intrusiveness and the restrictive nature of a given treatment plan. The disruption of a person's natural support system, the damage to their self-esteem, their relationships and so on must all be balanced in the decision whether to hospitalize. If people can be safely treated in their natural surroundings, in their homes and communities, then this is the preferred option.

Psychiatric admission is not ususally appropriate for a medically fragile patient or as an initial intervention for an elderly person with a sudden change in behavior or mental status. Medical work-up and stabilization must always come first in these clinical situations. This is because an acute change in mental status in this population very often is a result of a medical problem.

There are other clinical circumstances when the rapidity of effective treatment in an inpatient setting will far outweigh considerations of cost and intrusiveness. It does not make sense to keep

someone in the community when, due to their illness, they are destroying or burning-out their natural system of supports, when it is an option to rapidly stabilize and discharge them from a more restrictive (acute care) setting. These natural support systems are priceless resources that need to be cared for and nurtured. They will make the difference between lifelong mental health center dependency and successful individual functioning in the community.

The Role of the Acute Care Coordinator: The referring source or clinician will need to:

- Ensure that clinical criteria (below) for psychiatric hospitalization are met.
- Explore alternatives to hospitalization and be prepared to discuss why hospitalization is the only alternative, or is the best alternative given clinical circumstances.
- Obtain enough clinical knowledge of the case to be able to present the case to the Acute Care Coordinator.
- Call and present the case to the ACC. Using a standard format for these presentations greatly facilitates communication.
- The ACC will go over the case with the referring source. Alternatives to hospitalization will be explored and may be ruled in or out. Further information may be requested prior to any decision.
- A guarantee of payment (called "pre-authorization") for a specific number of acute care days may or may not be agreed upon. If the client is assigned to a "risk" bearing provider agency, the final decision with regard to acute care authorization will remain with the clinician(s) of the provider agency and not the ACC.
- If funding is pre-authorized for inpatient treatment, the referring worker should notify hospital admissions personnel for further arrangements.
- If the case is not pre-authorized, the ACC will be available, upon request, to aid in alternate treatment plans and arrangements, in collaboration with referring clinician or agency.
- Any hospital may refuse to admit a pre-authorized case. If this occurs, the ACC will be responsible for working with the referral source until an adequate placement is obtained.

It is always the clinician who has actual contact with the case that must make the final determination with regard to hospitalization. If the referral source continues to believe that hospitalization is necessary, they may pre-authorize payment from their own budgets to the hospital. If this decision is made, then the ACC will continue to help to arrange hospitalization in the usual manner. In this case, where there is disagreement between the ACC and the referral source as to the medical necessity of the admission, the cost of the hospitalization is borne by the referring agency, including the hospital itself if the hospital is the referring agency.

Acute Care costs accrued under these circumstances will be paid if an appeal process is undertaken according to OHP rules and there is a determination that the acute care delivered did meet emergency definitions and/or clinical criteria for medical appropriateness.

Clinical Criteria for Hospitalization: In order for an inpatient treatment course to be funded, the admission must be "medically appropriate". The definitions/criteria for psychiatric inpatient medical appropriateness are as follows:

1. A mental disorder must be the primary cause of the signs and symptoms that make inpatient treatment necessary.

2. Medical cause(s) of mental or behavioral symptoms must be ruled out or be very unlikely given the clinical circumstances. The following special populations must have a medical clearance performed by a licensed medical practitioner prior to any consideration of inpatient psychiatric care:
   - People over age 65 with the recent onset of behavioral symptoms or an acute change in mental status.
   - Medically fragile/complex persons of any age.
   - People who are residents of nursing homes or congregate care facilities.
   - People being referred from emergency rooms or hospitals.

3. Intoxication must be ruled out as the primary cause of the signs and symptoms that make hospitalization necessary.

4. Acute inpatient treatment must be likely to be effective for stabilization and/or improvement of the signs and symptoms produced by the mental disorder.

5. Outpatient alternatives must be demonstrated to be less likely to be effective, more likely to be intrusive, unavailable or too dangerous.

In the case of a request for the extension of an inpatient stay, the treatment must be *active*, defined by HCFA as: aggressive, consistent implementation of a program of individualized treatment services which has been specifically designed to facilitate discharge to a less restrictive setting as rapidly as possible.

Multnomah County Mental Health Crisis and Acute Care Financing Plan

Section 1: Summary of Costs and Utilization

	FY2001 Costs	FY2001 Utilization	FY2002 Costs	FY2002 Utilization	FTEs/Units of Service/Comments
Crisis System					
A. Access/Crisis Line			$1,578,110	122,585	Incoming Calls
C. Secure Evaluation Facility			$2,388,949	2,450	Days
D. Mobile Crisis Services			$1,096,305	14,449	Service Hours
F. Urgent Walk-In Clinics			$1,084,821	10,800	Service Hours
K. Homebased Stabilization Days			$533,250	3,333	Verity Days
O. Warm Line			$225,108		6.00 FTEs
R. Flex Fund			$300,000		Dollars
Total Crisis System			**$7,206,543**		
Inpatient/Inpatient Alternative Services					
G. Sub-Acute Services	$1,461,600	4,176	$1,694,523	5,000	Verity Bed Days
H. Respite Services	$320,913	3,074	$609,696	4,357	Verity Bed Days
I. Voluntary Inpatient Services	$4,110,955	9,135	$6,915,834	9,880	Verity Bed Days
J. Involuntary Inpatient Services	$2,117,765	4,706	$2,819,809	4,028	Verity Bed Days
K. Indigent Inpatient Services	$1,925,338	1,562	$2,154,845	1,562	Mult. Co.-Responsible Bed Days
Total 24-Hour Services	**$9,936,572**	**22,653**	**$14,194,707**	**24,827**	Totals assume same number of total bed days for FY2002 with a shift from acute to sub-acute and respite
Acute Care Administration			**$156,750**		2.00 FTEs
New IT System Purchase, Customization, Implement			**$175,000**		Estimate of new Raintree Software and Implementation Costs
Additional Consultation			**$100,000**		Assume additional support will be required during fiscal year
Totals			**$21,833,000**		It is assumed that this level of expenditure will be needed to ramp up the new services, cover FY2002 costs, and pay for short-term alternatives, such as 1 month of CTC operations.

Section 2: Currently Available Funds

Indigent Inpatient Contracts	$2,700,000
OHP Inpatient Contracts	$7,448,000
Total Inpatient	**$10,148,000**
CTC Funds	$3,456,768
Sub-Acute Funding	$1,129,249
Total Crisis & Inpatient Alternative Funding	**$4,586,017**
Total Inpatient & Crisis Available Revenue	**$14,734,017**
Projected Excess(Shortfall)	**-$7,098,983**

Multnomah County Mental Health Crisis and Acute Care Financing Plan

Strategies	FY2002	Comments
Proposed Strategies for Covering Shortfall		
A. Net Shortfall	**-$7,098,983**	
B. Funding Strategies		
1 Allocate Unbudgeted Redesign Funds		
Unbudgeted Amount	**$1,482,572**	Funds were designated for use during redesign
2 Allocate a Larger Portion of MHO System-Wide Funds		
MHO System-wide Funds	$6,346,000	Per FY2002 Budget
less Specialized portion of system-wide	-$2,637,928	Includes:Day Treatment, High End Children, Supported Classrooms, Therapeutic & Stabilization Classrooms, IOP Care Coordination, SOAP/RAPP
Net MHO System-wide Funds	$3,708,072	
Additional to allocate to Shortfall	75%	Remaining additional funds should be transferred to Outpatient Pool
Additional to allocate to Shortfall	**$2,781,054**	
3 Recover FY2001Carryover, not yet budgeted		
Estimate of unrecovered Carryover	**$200,000**	Unknown; Board has currently designated that these funds should be shifted back into county general fund; **(one-time expenditure)**
4 Staffing Position Freeze/Recovery		
Freeze of Verity Open Positions	**$325,000**	Preliminary Estimate of 5 positions
5 BHD/Verity Mental Health Budget Reductions		
5% Budget Reduction of BHD and Verity Budgets	**$658,392**	Includes County-Provided Mental Health Services and Admin/Support Costs
Subtotal Savings	**$5,447,018**	
Shortfall Balance	**-$1,651,966**	
C. Use of Reserves		
6 Use of Mental Health Reserves		
Total Reserves	$2,491,771	As of 7/1/2001; includes repayment of redesign costs and System-wide Pool
One-time use of Reserves	$1,651,966	**(one-time expenditure)**
Remaining Reserves	**$839,805**	
Shortfall Balance	**$0**	
Total One-Time Expenditures	**$1,851,966**	These funds are not available in future years; Crisis and Acute Care costs must be reduced by this amount prior to the end of Fiscal Year 2002. This amounts to a 21% reduction in acute care bed day utilization. This model assumes that these reductions will occur between September 2001 and

Multnomah County Mental Health Crisis and Acute Care Financing Plan

June 2002. This also yields a savings of $1,081,856 in FY2002.

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 1: Population Statistics

	FY2000	FY2002	Comments
Multnomah County Population			
Verity OHP Members	53,113	66,705	FY2000 monthly average and April 2001 for FY2002
Other Residents	607,373	593,781	Difference between OHP and Total Population
Total Population (per 2000 US Census)	660,486	660,486	per the 2000 US Census
OHP Members			
Children	24,523	30,799	FY2000 monthly average; FY2002 based on FY2000 ratios
Adults	23,122	29,038	"
Older Adults	5,469	6,868	"
Total	53,113	66,705	

Section 2: Summary of Costs and Utilization

	FY2000 Costs	FY2000 Utilization	FY2002 Costs	FY2002 Utilization	Units of Service
Crisis System					
A. Access/Crisis Line			$1,578,110	122,585	Incoming Calls
C. Secure Evaluation Facility			$2,388,949	2,450	Days
D. Mobile Crisis Services			$1,096,305	14,449	Service Hours
F. Urgent Walk-In Clinics			$1,084,821	10,800	Service Hours
L. Homebased Stabilization Days			$533,250	3,333	Verity Days
O. Warm Line			$225,108	6.00	FTEs
R. Flex Fund			$300,000		Dollars
T. Transportation			$0		
Total Crisis System			**$7,206,543**		
Inpatient/Inpatient Alternative Services					
G. Sub-Acute Services	$1,461,600	4,176	$1,694,523	5,000	Verity Bed Days
H. Respite Services	$320,913	3,074	$609,696	4,357	Verity Bed Days
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J. Involuntary Inpatient Services	$2,117,765	4,706	$2,819,809	4,028	Verity Bed Days
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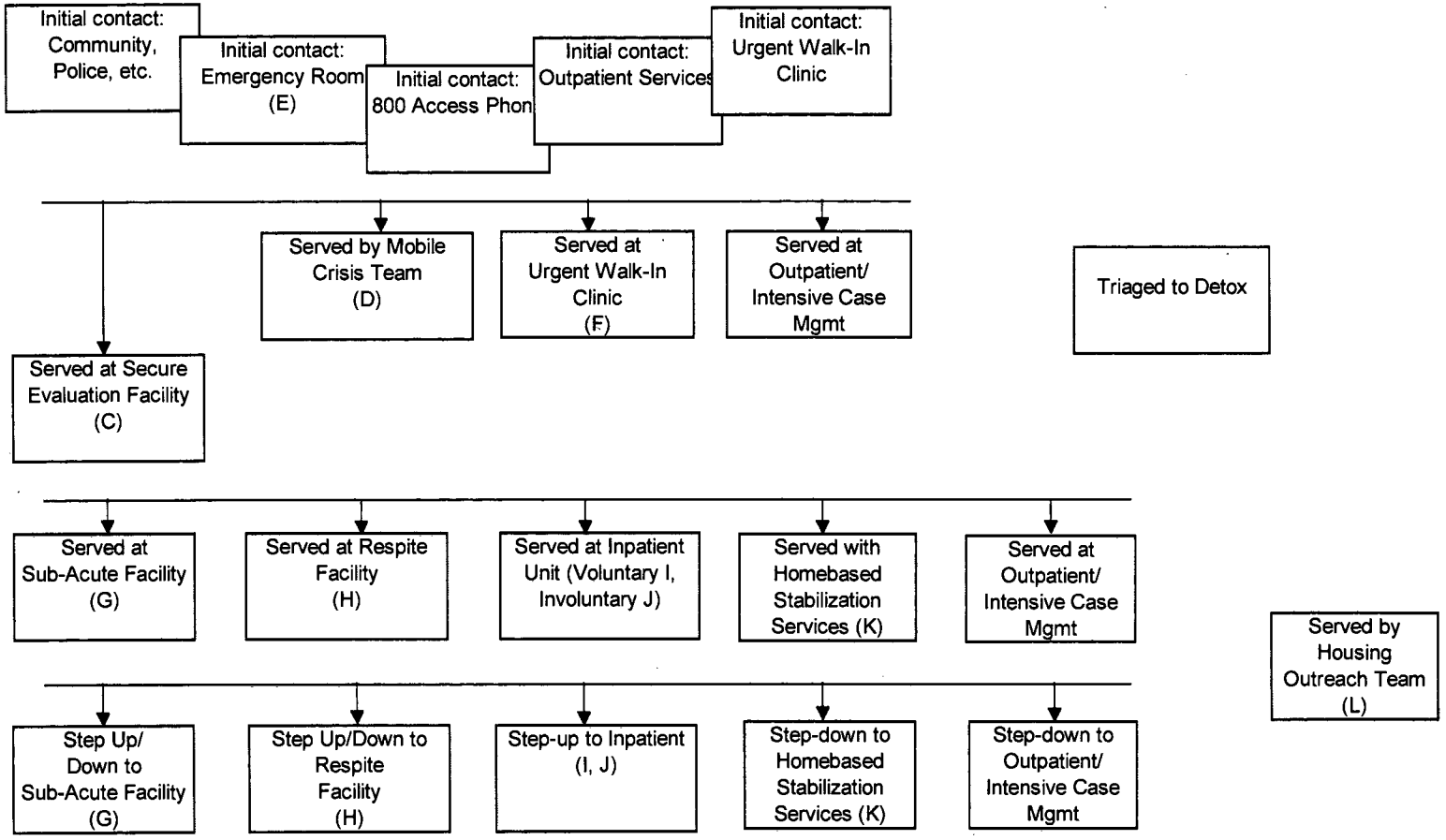
Total 24-Hour Services	**$9,936,572**	**22,653**	**$14,194,707**	**24,827**	
Acute Care Administration			**$156,750**	2.00	FTEs
Totals			**$21,558,000**		

Section 3: Acute Care Flowthrough Design



Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4A: Access/Crisis Phone Center

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Incoming Calls							
Info/Referral/Access Center Calls	95,210				95,210		Incoming I&R/Access calls based on 150/day Al
Crisis Calls	27,375				27,375		25/day Network, 50/day Mt Hood, 55/day Verity,
Total Incoming Calls	122,585	0	0	0	122,585		16/day after hours calls to N/MH/U, 50 (of 125/c
							total) Crisis Line calls x 5 days/week, 52 wks/yr
I&R/Access Calls/Day	366	0	0	0	366		Incoming Crisis calls based on 75 (of 125/day tc
Crisis Calls/Day	75	0	0	0	75		Crisis Line call x 7 days/wk, 52 wks/yr.
Total Calls/Day	441	0	0	0	441		
2 Ratio of Incoming to Outgoing Calls							
Info/Referral/Access Center Calls	0.00	0.75	0.75	0.75	0.75		Assume 1/2 rate of Crisis
Crisis Calls	0.00	2.00	2.00	2.00	2.00		Based on Elinor Hall repo
3 Number of Outgoing Calls/Year							
I&R/Access Calls/Day	0	0	0	0	71,408		
Crisis Calls/Day	0	0	0	0	54,750		
Total Calls/Day	0	0	0	0	126,158		
4 Length of Incoming Calls (minutes)							
Info/Referral/Access Center Calls	0	5	5	5	5		Assume 1/2 rate of Crisis
Crisis Calls	0	10	10	10	10	10	Based on Elinor Hall repo
5 Length of Outgoing Calls (minutes)							
Info/Referral/Access Center Calls	0.0	3.5	3.5	3.5	3.5		Assume 1/2 rate of Crisis
Crisis Calls	0.0	7.0	7.0	7.0	7.0	7.0	Based on NSRSN analysi
6 Total Call Hours per Year (Incoming and Outgoing)							
Info/Referral/Access Center Calls	0	0	0	0	12,100		
Crisis Calls	0	0	0	0	10,950		
Total Hours	0	0	0	0	23,050		
7 FTE Demand Analysis							
Hours per FTE per Year		990	990	990	990	990	40 hrs/wk x 45 wks/yr x 5
FTE Requirements		0.00	0.00	0.00	23.28		productivity

8 Cost Analysis	FTEs	Rate	Amount
Clinicians	23.28	$35,000	$814,885
Manager	1.00	$45,000	$45,000
Support Staff	1.50	$28,000	$42,000
Subtotal			$901,885
Protocol 10 PM - 8 AM Costs			$90,000
Benefits/Payroll Taxes		25%	$225,471
Other Exp. as % of Comp.		40%	$360,754
Total Cost to Verity			**$1,578,110**
Cost per Month			**$131,509**

Multnomah County Mental Health
Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4B: Individuals in Crisis Analysis

	FY2000 Child	FY2000 Adult	FY2000 Older Ad	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
# Receiving Crisis Services	**1,492**	**8,107**	**182**	9,781	**1,716**	**10,323**	**209**	12,248		CTC, included only Multnomah Clients; In 1999
Adjustments				0				0		2.5% of svcs were to Older Adults; in 2000 17%
Total Receiving Crisis Services	1,492	8,107	182	9,781	1,716	10,323	209	12,248		svcs were to youth under 18. These percents applied to 9,781 episodes in 2000. Added 100(
										additional from N/MH/U walk ins, all to adult. A
% Triaged to Secure Eval Facility	**100%**	**100%**	**100%**		**20%**	**20%**	**20%**			assume that volume will go up 15% with increa
% Triaged to Mobile Crisis Team	**2%**	**2%**	**2%**		**25%**	**20%**	**50%**			access options.
% Triaged to Urgent Walk-In Clinics	**0%**	**0%**	**0%**		**55%**	**60%**	**30%**			
Total %	102%	102%	102%		100%	100%	100%			
# Triaged to Secure Eval Facility	1,492	8,107	182	9,781	343	2,065	42	2,450		Note that SEF is a level of care, children will be
# Triaged to Mobile Crisis Team	30	162	4	196	429	2,065	105	2,598		served in setting separate from adults. Assume
# Triaged to Urgent Walk-In Clinics	0	0	0	0	944	6,194	63	7,200		remaining crisis services will be split between
	0	0	0	0	0	0	0	0		Mobile Crisis and Urgent Walk-In Clinics.
	0	0	0	0	0	0	0	0		
Total	1,522	8,269	186	9,977	1,716	10,323	209	12,248		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4C: Secure Evaluation Facility Services/Dispositions

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Number Served	9,781	343	2,065	42	2,450		FY2000 = Util at CTC
Average Length of Stay (ALOS)		1.00	1.00	1.00			This is a 23 hour facility
Days of Service		343	2,065	42	2,450		
2 Dispositions							
# discharged to Sub-Acute Beds		17	206	4	228		
# discharged to Respite Beds		14	83	2	98		
# transferred to V-tary Inpatient		55	330	7	392		
# trans. to Involuntary Inpatient		26	310	6	342		
# discharged to Homebased Stab.		17	103	6	127		
# discharged to OP Svcs/Community		214	1,032	17	1,264		
Total		343	2,065	42	2,450		
% discharged to Sub-Acute Beds		5%	10%	10%		28%	Benchmark dispositions from Maricopa County Urgent Care Center during CY2000. The UCCs there include a walk in clinic function, which is separate in this proposed approach.
% discharged to Respite Beds		4%	4%	4%		2%	
% transferred to V-tary Inpatient		16%	16%	16%		2%	
% trans. to Involuntary Inpatient		7.5%	15%	15%		12%	
% discharged to Homebased Stab.		5%	5%	15%		1%	
% discharged to Non-Acute Svcs array		63%	50%	40%		55%	
Total (must equal 100%)		100%	100%	100%			

3 Capacity Analysis	Beds	Bed Days	
Secure Hold Room	4	1,460	
23 Hour Observation	6	2,190	
Total Capacity	10	3,650	
Demand - Bed Days - Adults		2,106	Total SEF, less child bed
% Utilization		58%	
Demand - Bed Days - Child		343	Assume purchased elsew

4 Cost Analysis	Method					
Adult Bed Capacity Purchase	Yes			3,650		Per Capacity Analysis
Adult Utilization-Based Purchase	No			2,106		Per Demand Analysis
Cost per Bed Day				$785	$300	Per Maricopa County
Total Adult Cost				$2,866,080		
Child Bed Days				343		
Cost per Bed Day				$350	$300	Per Maricopa County
Total Child Cost				$120,106		
Total Cost				**$2,986,186**		
Multnomah OHP Patients		%	60%	$1,791,712		Hall: CTC - 38.3% Medic
Multnomah County Responsible Self Pay Patients		%	20%	$597,237		Hall: CTC - 15.8% self-pa
Patients with Other Payors		%	20%	$597,237		Hall: Projected 61% for SI
Net Cost to Verity			100%	**$2,388,949**		
Cost per Month				**$199,079**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4D: Mobile Crisis Services

		FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services								
Number Field Encounters		196	429	2,065	105	2,598		
% Svcs = hr. length:	2.00		65%	65%	65%		65%	Based on NSRSN analysi
% Svcs = hr. length:	3.00		25%	25%	25%		25%	Based on NSRSN analysi
% Svcs = hr. length:	4.00		10%	10%	10%		10%	Based on NSRSN analysi
			100%	100%	100%			
Hrs of Svcs - hr. length:	2.00		558	2,684	136	3,378		Transportation of consum
Hrs of Svcs - hr. length:	3.00		322	1,548	78	1,949		to be arranged, not by tea
Hrs of Svcs - hr. length:	4.00		172	826	42	1,039		
Total Hours of Client Service			1,051	5,058	256	6,366		
Travel Time/Encounter			322	1,548	78	1,949		.75/hr. travel time per enc
Outreach: # Staff	1		0%	25%	50%			Plus commitment staff &
Outreach: # Staff	2		100%	75%	50%			"
			100%	100%	100%			
ED/Detox Encounters						2,789		ED visits, 1 person, 1.75 h including travel time
Total Staff Hours			2,424	8,852	385	14,449		
2 Dispositions								
# triaged to Sub-Acute Beds			17	83	4	104		
# triaged to Respite Beds			17	83	4	104		
# triaged to V-tary Inpatient			21	103	5	130		
# triaged to Involuntary Inpatient			34	165	8	208		
# triaged to Homebased Stab.			21	103	5	130		
# triaged to OP Svcs/Community			317	1,528	77	1,923		
Total			429	2,065	105	2,598		
% triaged to Sub-Acute Beds			4%	4%	4%		1%	Benchmark adult dispositions from Maricopa County Mobile Crisis during CY2000.
% triaged to Respite Beds			4%	4%	4%		3%	
% triaged to V-tary Inpatient			5%	5%	5%		3%	
% triaged to Involuntary Inpatient			8%	8%	8%		3%	
% triaged to Homebased Stab.			5%	5%	5%		1%	
% triaged to OP Svcs/Community			74%	74%	74%		89%	
Total (must equal 100%)			100%	100%	100%	(Some % of IP admits will flow through the SEF)		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
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Section 4D: Mobile Crisis Services (continued)

3 Staffing/Capacity	FY2002 Teams	FY2002 Staff/Team	FY2002 Hrs/Wk	FY2002 Yr. Hrs	FY2002 # On-Call	FY2002 Days/wk	FY2002 Days/yr	FY2002 Benchmark	Comments
M-F 8am-2pm	5	1	200	10,400	0	0	0		Teams work 8 hour shifts; 4 teams work out of the Urgent Walk-In Clinics M-F 8-4; 2 teams work M-F 1-10; 2 teams w
M-F 2pm-10pm	5	1	200	10,400	0	0	0		a 4hr shift on Saturday, rest of service is provided by on-call
M-Th 10pm-8am	1	2	80	4,160	0	0	0		coverage.
Sa-Su 8am-10pm	1	2	56	2,912	0	0	0		
Sa-Su 10pm-8am	1	2	60	3,120	0	0	0		
Total Capacity			596	30,992		0	0		
Capacity-Based FTEs				17.22				1,800	40 hrs/wk x 45 wks/yr
Demand - hours				14,449					
% Utilization				47%					

4 Cost Analysis	FTEs	Rate	Amount
Clinicians	17.22	$35,000	$602,622
Manager	1.00	$45,000	$45,000
Support Staff	1.50	$28,000	$42,000
Subtotal Staff			$689,622
Benefits/Payroll Taxes		25%	$172,406
Other Exp. as % of Comp.		40%	$275,849

On Call Costs	Hrs/Shift	Shifts	Rate	
Weeknight shift costs		0	$75.00	$0
Weekend shift costs		0	$125.00	$0
Service Costs	4.00	0	$15.00	$0
				$0
Total Cost				$1,137,877

	Services	% Insured	Pmt Rate		
Revenue Projections	2,598	20%	$80	$41,571	Hall: assumed 50% insur rate; Jarvis: assume or bill open card clients
Net Cost to Verity				$1,096,305	

Multnomah County Mental Health Acute Care Utilization/Financial Model

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Section 4E: Emergency Department Services

	FY2000 Child	FY2000 Adult	FY2000 Older Ad	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services										FY 2000 based on 2,500 PPMC ED Psych Visit
Number Served	723	3,421	106	4,250	542	2,566	80	3,188		1999 and 1,750 Adventist Medical Center ED P:
										Visits in 2000. Assume 25% reduction in FY20(
2 Dispositions										
# triaged to Sub-Acute Beds					11	51	2	64		
# triaged to Respite Beds					11	51	2	64		
# triaged to V-tary Inpatient					163	770	24	956		
# triaged to Involuntary Inpatient					0	0	0	0		
# triaged to Homebased Stab.					27	128	4	159		
# triaged to OP Svcs/Community					331	1,565	48	1,944		
Total					542	2,566	80	3,188		half of these will have mobile team on site
% triaged to Sub-Acute Beds					2%	2%	2%			
% triaged to Respite Beds					2%	2%	2%			
% triaged to V-tary Inpatient					30.0%	30.0%	30.0%		36%	based on CTC data analy:
% triaged to Involuntary Inpatient					0%	0%	0%			
% triaged to Homebased Stab.					5%	5%	5%			
% triaged to OP Svcs/Community					61%	61%	61%			
Total (must equal 100%)					100%	100%	100%			

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section F: Urgent Walk-In Clinics

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Number Served	0	944	6,194	63	7,200		
Avg Service Hours		1.50	1.50	1.50			
Avg # of Visits		1.00	1.00	1.00			
Total Service Hours		1,416	9,291	94	10,800		
2 Dispositions							
# triaged to Sub-Acute Beds		19	124	1	144		
# triaged to Respite Beds		19	124	1	144		
# triaged to V-tary Inpatient		85	557	6	648		
# triaged to Involuntary Inpatient		0	0	0	0		
# triaged to Homebased Stab.		47	310	3	360		
# triaged to OP Svcs/Community		774	5,079	51	5,904		
Total		944	6,194	63	7,200		
% triaged to Sub-Acute Beds		2%	2%	2%			
% triaged to Respite Beds		2%	2%	2%			
% triaged to V-tary Inpatient		9%	9%	9%			
% triaged to Involuntary Inpatient		0%	0%	0%			
% triaged to Homebased Stab.		5%	5%	5%			
% triaged to OP Svcs/Community		82%	82%	82%			
Total (must equal 100%)		100%	100%	100%			

3 Staffing/Capacity	1/2 day Clinics	Staff/Clinic	Hrs/Wk	Yr. Hrs	FTEs	Benchmark	Comments
M-F 8am-5pm	40	1	160	8,320			Based on 4 regional Walk-In Clinics providing 2 - 1/2 day clinic sessions per day, 5 c
M-F 1-5pm	15	1	60	3,120			per week M-F (4 x 2 x 5 = 40 clinic sessions/wk), plus 1 evening clinic per week M-F
M-F 5pm-9pm	10	1	40	2,080			plus 1 Saturday clinic (1-4pm).
Weekend	1	2	8	416			
Total Capacity			268	13,936	7.74	1,800	40 hrs/wk x 45 wks/yr
Demand - hours				10,800	6.00	1,800	40 hrs/wk x 45 wks/yr
% Utilization				78%			

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
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Section F: Urgent Walk-In Clinics (continued)

4 Cost Analysis	Method					
Capacity FTE Purchase	Yes				7.74	Per #3 above
Utilization-Based FTE Purchase	No				6.00	"
			FTEs	**Rate**	**Amount**	
Scheduled QMHPs			7.74	**$35,000**	$270,978	
QMHP Float			**1.00**	**$35,000**	$35,000	
LMP - MD Contracted			**1.30**	**$208,000**	$270,400	
LMP - ARNP Contracted			**1.30**	**$72,800**	$94,640	
Manager			**1.00**	**$45,000**	$45,000	Supervises all sites
Support Staff			**2.00**	**$28,000**	$56,000	Portions of FTEs at 4 clin
Subtotal					$772,018	
Benefits/Payroll Taxes				**25%**	$193,004	
Other Exp. as % of Comp.				**40%**	$308,807	
Total Cost					**$1,273,829**	
		Svc Hrs	**% Insured**	**Pmt Rate**		Insured = open card, Med
Revenue Projections		10,800	**35%**	**$50**	$189,008	self-pay and private insur
Net Cost to Verity					**$1,084,821**	

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4G: Sub-Acute Beds

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Admits from Secure Eval Facil		17	206	4	228		
Admits from Mobile Crisis		17	83	4	104		
Admits from Emergency Depts		11	51	2	64		
Admits from Urgent Walk-In Clin		19	124	1	144		
Admits from Respite Beds		1	6	0	7		
Admits from Voluntary Inpatient		3	18	0	22		
Admits from Involuntary Inpatient		1	5	0	6		
Total Admissions	0	69	494	12	575		
Verity OHP Admissions	0	60	430	10	500		
Average Length of Stay (ALOS)	**14.00**	**10.00**	**10.00**	**10.00**			
Days of Service	**4,800**	691	4,937	120	5,747		
Verity OHP Days	4,176	601	4,295	104	5,000		
2 Dispositions							
# discharged to Respite Beds		0	25	1	25		
# discharged to V-tary Inpatient		3	25	1	29		
# discharged to Involuntary Inpatient		3	25	1	29		
# discharged to Homebased Stab.		3	25	1	29		
# discharged to OP Svcs/Community		59	395	10	463		
Total		69	494	12	575		
% discharged to Respite Beds		**0%**	**5%**	**5%**			
% discharged to V-tary Inpatient		**5%**	**5%**	**5%**			
% discharged to Involuntary Inpatient		**5%**	**5%**	**5%**			
% discharged to Homebased Stab.		**5%**	**5%**	**5%**			
% discharged to Non-Acute Svcs array		85%	80%	80%			
Total (must equal 100%)		100%	100%	100%			

3 Capacity Analysis	Beds	Bed Days	Utilization	
Ryles Center Existing	**14**	5,110	5110	Assume Ryles Subacute
Ryles Enhanced Respite	**10**	3,650	637	Ryles, "enhanced respite"
		0		No other new sub-acute r
		0		
Total Capacity	24	8,760		
Demand - Bed Days		5,747	5,747	
% Utilization		66%		

4 Cost Analysis							
Bed Days	4,800	691	4,937	120	5,747		Per above
Average Cost per Day	**$350.00**	**$338.92**	**$338.92**	**$338.92**			Based on Sub-Acute @ $
Total Cost	**$1,680,000**	**$234,028**	**$1,673,173**	**$40,526**	**$1,947,727**		Enhanced @ $250
Multnomah OHP Patients	$1,461,600	%	**87%**		$1,694,523		
Patients with Other Payors	$218,400	%	**13%**		$253,205		
Net Cost to Verity	**$1,461,600**		**100%**		**$1,694,523**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4H: Respite Beds

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Admits from Secure Eval Facil		14	83	2	98		
Admits from Mobile Crisis		17	83	4	104		
Admits from Emergency Depts		11	51	2	64		
Admits from Urgent Walk-In Clin		19	124	1	144		
Admits from Sub-Acute Beds		0	25	1	25		
Admits from Voluntary Inpatient		33	182	4	219		
Admits from Involuntary Inpatient		7	53	2	61		
Total Admissions	0	101	600	15	715		
Verity OHP Admissions	0	88	522	13	622		
Average Length of Stay (ALOS)	**14.00**	**7.00**	**7.00**	**7.00**			
Days of Service	3,533	705	4,197	106	5,008		
Verity OHP Days	3,074	613	3,651	92	4,357		
2 Dispositions							
# discharged to Sub-Acute Beds	0	1	6	0	7		
# discharged to V-tary Inpatient	0	5	30	1	36		
# discharged to Involuntary Inpatient	0	5	30	1	36		
# discharged to Homebased Stab.	0	5	30	1	36		
# discharged to OP Svcs/Community	0	85	504	13	601		
Total	0	101	600	15	715		
% discharged to Sub-Acute Beds		**1%**	**1%**	**1%**			
% discharged to V-tary Inpatient		**5%**	**5%**	**5%**			
% discharged to Involuntary Inpatient		**5%**	**5%**	**5%**			
% discharged to Homebased Stab.		**5%**	**5%**	**5%**			
% discharged to Non-Acute Svcs array		84%	84%	84%			
Total (must equal 100%)		100%	100%	100%			

3 Capacity Analysis	Beds	Bed Days		
Existing Beds	**11**	4,015	**3,533**	estimated occupancy at 88%
New - Identified	**5**	1,825		5 new beds at Ryles
New - Unidentified	**0**	0		
		0		
Total Capacity	16	5,840		
Demand - Bed Days		5,008		
% Utilization		86%		

4 Cost Analysis							
Bed Days	3,074	705	4,197	106	5,008		Per Section H
Average Cost per Day	**$120.00**	**$139.94**	**$139.94**	**$139.94**			Per historical rates adjust
Total Cost	**$368,866**	**$98,644**	**$587,283**	**$14,873**	**$700,800**		Capacity to Per Diem
Multnomah OHP Patients	$320,913	%	**87%**		$609,696		Hall: CTC - 38.3% Medic
Patients with Other Payors	$47,953	%	**13%**		$91,104		
Net Cost to Verity	**$320,913**		**100%**		**$609,696**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4I: Voluntary Inpatient Services

	FY2001 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Admits from Secure Eval Facil	0	55	330	7	392		
Admits from Mobile Crisis	0	21	103	5	130		
Admits from Emergency Depts	0	163	770	24	956		King Co. ALOS:
Admits from Urgent Walk-In Clin	0	85	557	6	648		7.8 Adult Voluntary
Admits from Sub-Acute Beds	0	3	25	1	29		10.9 Youth Voluntary
Admits from Respite Beds	0	5	30	1	36		16.2 Adult Involuntary
Admits from Involuntary Inpatient	0	0	0	0	0		17.2 Youth Involuntary
Total Admissions	0	332	1,815	43	2,191		
Verity OHP Admissions	**1,114**	183	998	24	1,205		
Average Length of Stay (ALOS)	**8.20**	**8.20**	**8.20**	**8.20**			Note: there are conflicting
Days of Service	16,610	2,726	14,886	351	17,963		figures for FY2001; the fi
Verity OHP Days	9,135	1,499	8,187	193	9,880		uses balances to the payr
2 Dispositions							
# discharged to Sub-Acute Beds	0	3	18	0	22		
# discharged to Respite Beds	0	33	182	4	219		
# discharged to Involuntary Inpatient	0	0	0	0	0		
# discharged to Homebased Stab.	0	10	54	1	66		
# discharged to OP Svcs/Community	0	286	1,561	37	1,884		
Total	0	332	1,815	43	2,191		
% discharged to Sub-Acute Beds		**1%**	**1%**	**1%**		**1%**	Benchmark dispositions
% discharged to Respite Beds		**10%**	**10%**	**10%**		**18%**	from Maricopa County
% discharged to Involuntary Inpatient		**0%**	**0%**	**0%**		**0%**	Inpatient Services during
% discharged to Homebased Stab.		**3%**	**3%**	**3%**		**3%**	CY2000.
% discharged to Non-Acute Svcs array		86%	86%	86%		**78%**	
Total (must equal 100%)		100%	100%	100%			
4 Cost Analysis							
Bed Days	16,610	2,726	14,886	351	17,963		Per above
Average Cost per Day	**$450.00**	**$700.00**	**$700.00**	**$700.00**			Estimate
Total Cost	**$7,474,464**	**$1,908,251**	**########**	**$245,605**	**$12,574,244**		
Multnomah OHP Patients	$4,110,955	%	**55%**		$6,915,834		Hall: CTC - 38.3% Medic
Patients with Other Payors	$3,363,509	%	**45%**		$5,658,410		
Net Cost to Verity	**$4,110,955**		**100%**		**$6,915,834**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 4J: Involuntary Inpatient Services

	FY2001 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
1 Services							
Admits from Secure Eval Facil		26	310	6	342		King Co. ALOS:
Admits from Mobile Crisis		34	165	8	208		7.8 Adult Voluntary
Admits from Emergency Depts		0	0	0	0		10.9 Youth Voluntary
Admits from Urgent Walk-In Clin		0	0	0	0		16.2 Adult Involuntary
Admits from Sub-Acute Beds		3	25	1	29		17.2 Youth Involuntary
Admits from Respite Beds		5	30	1	36		
Admits from Voluntary Inpatient		0	0	0	0		
Total Admissions	0	69	530	16	614		
Verity OHP Admissions	**574**	55	424	13	491		
Average Length of Stay (ALOS)	**8.20**	**8.20**	**8.20**	**8.20**			Note: there are conflicting
Days of Service	5,883	562	4,342	131	5,035		figures for FY2001; the fi
Verity OHP Days	4,706	450	3,474	105	4,028		uses balances to the payr
2 Dispositions							
# discharged to Sub-Acute Beds	0	1	5	0	6		
# discharged to Respite Beds	0	7	53	2	61		
# discharged to Voluntary Inpatient	0	0	0	0	0		
# discharged to Homebased Stab.	0	2	16	0	18		
# discharged to OP Svcs/Community	0	59	455	14	528		
Total	0	69	530	16	614		
% discharged to Sub-Acute Beds		**1%**	**1%**	**1%**		**1%**	Benchmark dispositions
% discharged to Respite Beds		**10%**	**10%**	**10%**		**18%**	from Maricopa County
% discharged to Voluntary Inpatient		**0%**	**0%**	**0%**		**0%**	Inpatient Services during
% discharged to Homebased Stab.		**3%**	**3%**	**3%**		**3%**	CY2000.
% discharged to Non-Acute Svcs array		86%	86%	86%		**78%**	
Total (must equal 100%)		100%	100%	100%			
4 Cost Analysis							
Bed Days	5,883	562	4,342	131	5,035		Per above
Average Cost per Day	**$450.00**	**$700.00**	**$700.00**	**$700.00**			Estimate
Total Cost	**$2,647,206**	**$393,424**	**$3,039,452**	**$91,886**	**$3,524,762**		
Multnomah OHP Patients	$2,117,765	%	**80%**		$2,819,809		Hall: CTC - 38.3% Medic
Patients with Other Payors	$529,441	%	**20%**		$704,952		
Net Cost to Verity	**$2,117,765**		**100%**		**$2,819,809**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
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Section 4K: Indigent Inpatient Services

	FY2001 Total	FY2002 % Change	FY2002 Total	Benchmark	Comments
1 Services					
Emergency Hold Days	1,562	0%	1,562		
4 Cost Analysis					
Emergency Hold Cost per Day	$651.30		$730.31		
Emergency Hold Cost	$1,017,331		$1,140,744		
Emergency Hold Professional Fees	$190,066	10%	$209,073		
Total Emergency Holds	**$1,207,397**		**$1,349,817**		
State Hospital Wait List Costs	$717,942	12.13%	$805,028		
Total Indigent Inpatient Costs	**$1,925,338**		**$2,154,845**		

Section 4L: Homebased Stabilization Services

	FY2000 Total	FY2002 Child	FY2002 Adult	FY2002 Older Ad	FY2002 Total	Benchmark	Comments
Cases from Secure Eval Facil	0	17	103	6	127		
Cases from Mobile Crisis	0	21	103	5	130		
Cases from Emergency Depts	0	27	128	4	159		
Cases from Urgent Walk-In Clin	0	47	310	3	360		
Cases from Sub-Acute Beds	0	3	25	1	29		
Cases from Respite Beds	0	5	30	1	36		
Cases from Voluntary Inpatient	0	10	54	1	66		
Cases from Involuntary Inpatient	0	2	16	0	18		
Total Cases	0	133	769	22	925		
Verity OHP Cases		60	346	10	416		
Average Length of Stay (ALOS)	0.00	14.00	7.00	7.00			
Days of Service	0	1,868	5,386	152	7,406		
Verity OHP Days		841	2,424	69	3,333		
4 Cost Analysis							
Homebased Stab. Days	0	1,868	5,386	152	7,406		Per Section J
Average Cost per Day		$80.00	$80.00	$80.00			Estimate
Total Cost	**$0**	**$149,430**	**$430,891**	**$12,178**	**$592,500**		
Multnomah OHP Patients		%	45%		$266,625		Hall: CTC - 38.3% Medic
Multnomah County Responsible Self Pay Patients		%	45%		$266,625		Hall: CTC - 15.8% self-pa
Patients with Other Payors		%	10%		$59,250		Hall: Projected 61% for S
Net Cost to Verity			**100%**		**$533,250**		

Multnomah County Mental Health Acute Care Utilization/Financial Model

Scenario: Version 7/14/01
Fiscal Year: FY2002

Section 5: Ancillary Services

	FY2002 Total	Benchmark	Comments
L. Housing Outreach Team			
FTEs			Funded in OP system
Fully Loaded Cost/FTE			
Total Cost	$0		
M. Care Management			
FTEs	**17.00**		12 FTEs in ASO budget
Fully Loaded Cost/FTE	**$69,435**		Add 5 FTEs for 24/7 SEF
Total Cost	$1,180,395		Add commitment invest h
N. Intensive Community Support			
FTEs			
Fully Loaded Cost/FTE			Funded in OP system
Total Cost	$0		
O. Warm Line			
FTEs	**6.00**		San Diego budget
Fully Loaded Cost/FTE	**$37,518**		
Total Cost	$225,108		
P. Outstationed Staff			
FTEs			To be added when
Fully Loaded Cost/FTE			at full risk
Total Cost	$0		
Q. Flex Fund	**$300,000**		
R. Geriatric Consultation	**$28,600**		10 hrs/wk QMHP; 2 hrs/w

Section 6: Other Services

S. Acute System Manager	**FTEs**	**Rate**	**Amount**	**Benchmark**	**Comments**
Manager	**1.00**	**$65,000**	$65,000		
Support Staff	**1.00**	**$30,000**	$30,000		
Subtotal	2.00		$95,000		
Benefits/Payroll Taxes		**25%**	$23,750		
Other Exp. as % of Comp.		**40%**	$38,000		
Total Cost			**$156,750**		

Incoming I&R/Access calls based on 150/day ABH, 25/day Network, 50/day Mt Hood, 55/day Verity, 16/day after hours calls to N/MH/U, 50 (of 125/day total) Crisis Line calls x 5 days/week, 52 wks/yr. Incoming Crisis calls based on 75 (of 125/day total) Crisis Line call x 7 days/wk, 52 wks/yr.

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55%

CTC, included only Multnomah Clients; In 1999 2.5% of svcs were to Older Adults; in 2000 17% of svcs were to youth under 18. These percents applied to 9,781 episodes in 2000. Added 1000 additional from N/MH/U walk ins, all to adult. Also assume that volume will go up 15% with increased access options.

Note that SEF is a level of care, children will be served in setting separate from adults. Assume remaining crisis services will be split between Mobile Crisis and Urgent Walk-In Clinics.

Benchmark dispositions from Maricopa County Urgent Care Center during CY2000. The UCCs there include a walk in clinic function, which is separate in this proposed approach.

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hrs

Benchmark adult dispositions from Maricopa County Mobile Crisis during CY2000.

Teams work 8 hour shifts; 4 teams work out of the Urgent Walk-In Clinics M-F 8-4; 2 teams work M-F 1-10; 2 teams work a 4hr shift on Saturday, rest of service is provided by on-call coverage.

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FY 2000 based on 2,500 PPMC ED Psych Visits in 1999 and 1,750 Adventist Medical Center ED Psych Visits in 2000. Assume 25% reduction in FY2002.

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Based on 4 regional Walk-In Clinics providing 2 - 1/2 day clinic sessions per day, 5 days per week M-F (4 x 2 x 5 = 40 clinic sessions/wk), plus 1 evening clinic per week M-F, plus 1 Saturday clinic (1-4pm).

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King Co. ALOS:
7.8 Adult Voluntary
10.9 Youth Voluntary
16.2 Adult Involuntary
17.2 Youth Involuntary

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Benchmark dispositions from Maricopa County Inpatient Services during CY2000.

:aid/OHP

King Co. ALOS:
7.8 Adult Voluntary
10.9 Youth Voluntary
16.2 Adult Involuntary
17.2 Youth Involuntary

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Benchmark dispositions from Maricopa County Inpatient Services during CY2000.

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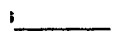
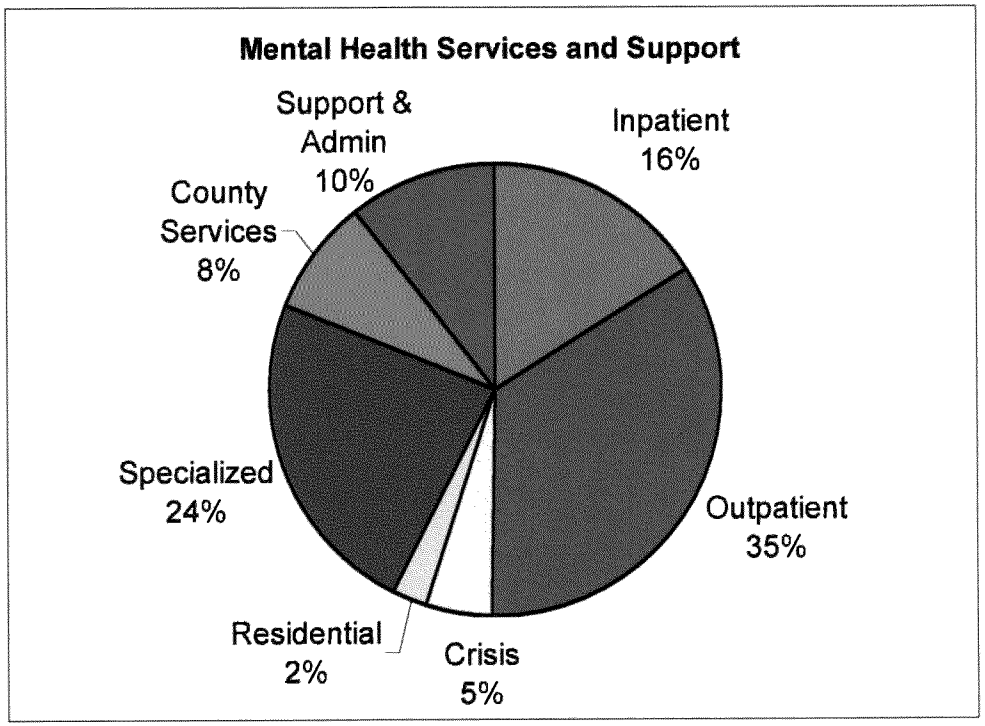
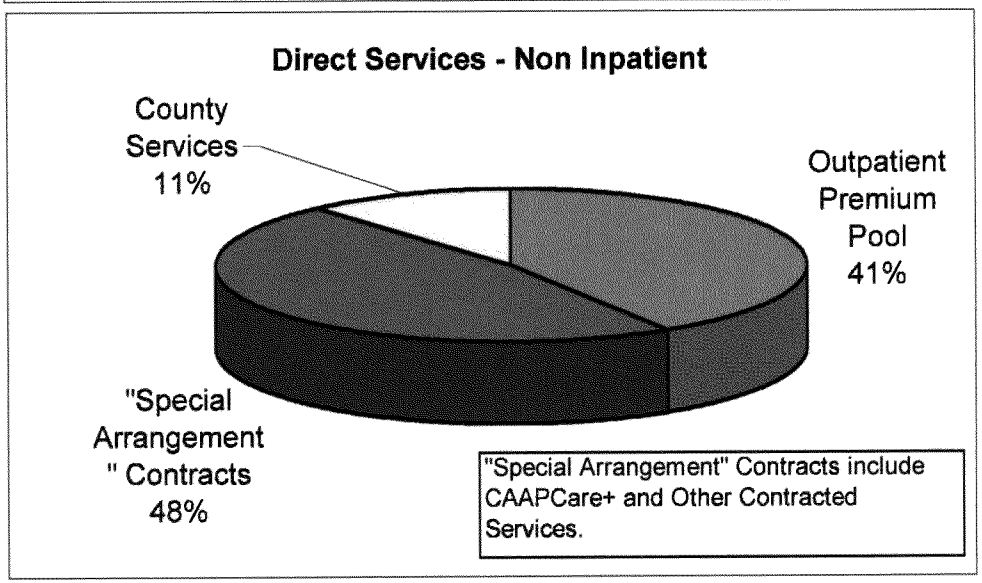


Multnomah County Behavioral Health -- FY2002 Approved Budget Analysis

Program Area	*Total Budget*	*Ratio*
Indigent Inpatient Contracts	$2,700,000	4%
Subacute Inpatient Contracts	$1,129,249	2%
OHP Acute/Subacute Contracts	$7,448,000	10%
Inpatient Contracts Subtotal	$11,277,249	16%
Outpatient Premium Pool	$21,128,572	30%
CAAPCare+, Indigent Medications	$2,654,261	4%
Outpatient Contracts	$23,782,833	33%
Crisis System	$3,456,768	5%
Residential Contracts	$1,622,692	2%
Specialized Services	$16,589,175	23%
Other Contracted Services	$21,668,635	30%
County Treatment Services	$4,725,301	7%
Involuntary Committment	$1,142,127	2%
County Services Subtotal	$5,867,428	8%
Behavioral Health Administration	$3,401,120	5%
Care Coordination	$1,738,148	2%
Managed Care Administration	$2,161,143	3%
Support Services Subtotal	$7,300,410	10%
Unbudgeted prior to Redesign	$1,482,572	2%
Total Mental Health	$71,379,128	100%
County A&D Services	$3,108,593	
A&D Contracts	$14,638,940	
Total A&D	$17,747,533	
Total Behavioral Health	$89,126,661	





AVEL L. GORDLY
State Senator
DISTRICT 10
MULTNOMAH COUNTY

REPLY TO ADDRESS INDICATED:
☐ 900 Court St NE S-302
Salem, OR 97301
☐ 2009-B NE 16th Ave.
Portland, OR 97212

OREGON STATE SENATE
SALEM, OREGON
97301

2001 COMMITTEES:
Vice-Chair:
Business, Labor and Economic Development
Member:
Education

1999 COMMITTEES:
Member:
Education
Ways and Means
Education Subcommittee
Vice-Chair:
Trade and Economic Development

1997 COMMITTEES:
Member:
Ways and Means
Public Safety Subcommittee
Crime and Corrections
Trade and Economic Development

Good evening Commissioners. I am unavailable this evening, and have asked my friend and colleague County Commissioner Lisa Naito to read my testimony into the record.

I am State Senator Avel Gordly representing portions of northeast and southeast Portland. I served on the Governor's Mental Health Alignment Work Group. I am co-chair of the Governor's Racial and Ethnic Health Task Force working to eliminate health disparities and barriers to access for all Oregonians. I am a mother of an adult child with a mental illness. I will say that to date, I and my family have still received no information about alternatives to Crisis Triage.

I have previously written to you about my concerns about the redesign plan. Given recent events including the closure of Providence's Crisis Triage, I feel the need to once again speak with you regarding the redesign of mental health services in Multnomah County. I recognize the tremendous challenge that the redesign presents, and hope in providing this feedback to you to assist you in meeting this challenge.

1. **Commitment to and support of cultural competence needs to be explicit and trustworthy.** In my oversight role for the Cultural Competence Committee, I am concerned about the lack of formal acknowledgement of the work completed to date by the committee, work that had been lacking in the year-long discussion and development of the redesign plan until recently. Of greater concern to me is the attempted establishment of a second cultural competence committee. Such a duplicative committee undermines the work of this committee, and suggest a lack of support for the positions and concerns that have been developed by the committee. The Cultural Competence Committee's work is vital to the overall success of the redesign for all of Multnomah County's communities and consumers. This is a committee and a process that must be heard, not controlled and silenced.

2. **Even the appearance of impropriety undermines the credibility, and possible success, of the redesign to the public, communities of interest, and consumers.** Increasingly, I am hearing consumer and provider concerns that raise the appearance of impropriety regarding the County's role in the redesign process. Questions about dual relationships and ulterior motives have surfaced given the employment history of key staff, authorship of the plan, and the appearance that members of the proposed Bridge Northwest are plan providers. Impropriety, or the appearance of impropriety, cannot be dismissed as personality clashes, self interested agendas, or anti-reform. This is not about personalities. This is about accountability to the County's citizens, about services and support to mental health consumers, and about families such as mine struggling daily to support their family member with a mental illness. The integrity of an inclusive, constructive process is needed here.

3. **Contracting and civil rights regulations should not be circumvented.** There are questions and concerns from a number of corners regarding County contracting practices under the redesign plan.

4. **Cultural competence and inclusion needs to be integrated into the plan and decision making, not continued as an add-on.** The lack of key decision makers who are reflective of communities of color and special populations has been compounded by the lack of inclusion in the planning process. Further, your key executives' styles have not supported or facilitated the work of the Cultural Competence Committee.

Dale Jarvis' presentation spoke specifically to the lack of data relevant to culturally diverse and special populations impact on making informed and reasoned decision making regarding the GAP plan budgeting. This simply underscores the importance and value of both the Cultural Competence Committee and culturally specific providers, and the need to adequately support their work.

5. **It is the consensus of the Cultural Competence Committee that implementation of the Phase I Plan will lay a flawed foundation that will ultimately undermine and restrict existing culturally specific programs.** There are strategies and risk designs that will allow for the survival and expansion of these programs.

Phase II has not been publicly distributed yet but is already being talked about. Community stakeholders have not been consulted. The Cultural Competence Committee has not been consulted. This continued lack of communication and consultation, built on the flawed foundation of Phase I, further compounds the distrust with community, countywide, and state partners. While the situation is urgent, an inclusive, constructive process is critical to our

collective success in redesigning culturally competent, quality mental health services for all of Multnomah County.

I conclude by reiterating that the Cultural Competence Committee and the communities that they represent look forward to working with you to craft solutions that will address both their needs and those of the larger community. As you know, I will be away, however, I will continue to be in contact with Robin Mack, staff to the committee, and ask that you work with her on these issues.

I have been going to the Network Behavioral clinics lately and so far I have been pretty impressed with them. They seem to handle themselves well. I feel that they are putting their money to good use and I would like to see more clinics open up like it. I think we need more therapists and counselors, especially on the weekends. They did have one incident where a guy grabbed the hose at the sink and hosed down the counselor. He handled it well. One guy [client] even called me names. He was trying to irritate everyone.

I hope that the board members try to visit the clinics nearest them. They have three so far. Contact me if you need the addresses.

Laddie Read

MENTAL HEALTH CRISIS SERVICES FOR RESIDENTS OF MULTNOMAH COUNTY

THE CRISIS TRIAGE CENTER CLOSES AT MIDNIGHT ON JULY 29, 2001. HERE'S WHAT TO DO STARTING AUGUST 1.

CENTRAL CRISIS PHONE NUMBER

503-215-7082

(Open 24 hours daily/ 7 days per week)

Call this number for:

- **Information About Where To Go**
- **Brief crisis phone counseling**

Call Here

URGENT WALK-IN CLINICS FOR ADULTS, FAMILIES, TEENS, AND CHILDREN

You may go to any of the following places. You do not need an appointment:

- **Network Plaza** (503-238-0705)
  2415 SE 43rd (43rd & Division–Enter at West Entrance off Division)
  Hours: Monday to Friday from 1:00 pm to 9:00 pm
  Saturday from 1:00 pm to 4:00 pm
  Bus #4 Division, exit 43rd & Division

- **Mt. Hood Gresham Office** (503-661-5455)
  400 NE 7th, Gresham
  Hours: Monday to Friday from 1:00 pm to 4:00 pm
  Max to Gresham TC. Walk South 1-2 blocks

- **Mt. Hood North Portland Office** (503-251-1338)
  3113 N. Lombard
  Hours: Monday to Friday from 1:00 pm to 4:00 pm
  Bus #1 Greeley, exit Lombard & Peninsular. Walk West.

Or walk in here

Call 911 if you have a life-threatening emergency

Watch for expanded hours, a fourth walk-in site, and mobile outreach in September 2001

ATTENTION: JOHN BALL AND DIANE LINN — PLEASE PROVIDE COPIES FOR THE OTHER COMMISSIONERS.

8/6/2001

SPEAKER #5

COMMENTS FROM SCOTT MURRAY, M.D.

PSYCHIATRIST IN PRACTICE AT ADVENTIST MEDICAL CENTER

I AM CONCERNED ABOUT THE APPARENT LACK OF CLINICAL INPUT IN THE FORMULATION OF THIS PLAN. I FEAR THERE IS A GROSS UNDERESTIMATE OF WHAT WILL LIKELY BE THE REALITY OF EMERGENCY ROOM VISITS AND HOSPITALIZATIONS.

PSYCHIATRIC CRISIS VISITS TO THE AMC-ER HAVE INCREASED FROM AN AVERAGE OF 5 TO 9 PER DAY. (SINCE CTC CLOSED) UTILIZATION IS LIKELY TO INCREASE DRAMATICALLY. LAST WEEK, MULTNOMAH COUNTY HAD 85 HOSPITAL HOLDS — AN ALL-TIME HIGH.

CTC PROVIDED CRITICAL MEDICAL ASSESSMENTS AND INTERVENTIONS UNAVAILABLE IN MOBILE CRISIS OUTREACH OR IN WALK-IN CLINICS. LAB TESTING FOR DRUG SCREENING OR METABOLIC PROBLEMS AND ACUTE MEDICATION INTERVENTIONS TO STABILIZE A CRISIS ARE UNLIKELY TO BE AVAILABLE IN MOBILE SETTINGS OR WALK-IN CLINICS. HOW WOULD THESE TEAMS DEAL WITH MULTIPLE SIMULTANEOUS CRISES (SAY, AT 2 A.M.)?

CTC PARTICULARLY DECREASED DEMANDS ON LOCAL ER'S, PROVIDING THE CAPACITY TO PROVIDE A SAFE HOLDING ENVIRONMENT TO ASSESS ONE'S SAFETY. MEDICAL ER'S MAY BE MORE QUICK TO PLACE PEOPLE ON HOLDS, DUE TO A LACK OF SPACE, TIME, AND PERSONNEL NEEDED FOR OFTEN LENGTHY ASSESSMENTS. THERE IS NO APPARENT PROVISION FOR THE SAFETY OF THESE PEOPLE IN CRISIS (PARTICULARLY IN A MOBILE SETTING) OR OF THE PEOPLE PROVIDING THE INTERVENTIONS. THERE IS NOTHING THAT ADDRESSES DRUG AND ALCOHOL INTOXICATION, WHICH OFTEN PRECIPITATES A CRISIS.

THANKS.

Speaker # 7

Testimony of Sandra Chisholm
August 6, 2001

In 1980, my oldest son Robert was arrested for breaking into a pop machine while he was with two friends. They were drinking beer. He was sentenced to a work farm and walked off and came home. He was sentenced to 10 years for escape. He was sentenced to Shelton Prison. And then McNeil and then Walla Walla. He had his first psychotic break a week after going to prison and was psychotic for the 10 years he was incarcerated. The last 3 years he was diagnosed as schizophrenic.

In 1994, my youngest son Ian became ill at age 13. I was only able to get a diagnosis through Kaiser by getting a court order. He was diagnosed as schizoaffective.

It was several years before Robert was given the right medication and housing. He is now stable, alcohol and drug free and attends day treatment at David's Harp through Mt. Hood MentalHealth. Ian graduated with honors, is now in Americorp and living in his own apartment.

Diagnosis, medication and treatment. Is this too much to ask? The reason that my sons arestable and alive is because I have been employed as a counselor, educator and mental health professional for the past 30 years. I've pulled in every favor an individual could ever ask.

My exprience has been one that I would never wish on anyone. Who could imagine that a person could spend 10 years in prison, most of that time in solitary confinement, because of mental illness. What disease would require that a mother needs a court order to get a diagnoisis?

TESTIMONY READ BY SPEAKER #18 CHOCKA GUIDEN

August 1, 2001

Dear ~~Commissioner~~ Chair Linn: And the Board of Multnomah County Commissioners,

I am writing as the President/CEO of the African American Health Coalition, a non-profit organization committed to improving the health and wellness of African Americans through health education, advocacy, and research. Good health is a goal that spans across cultural boundaries and is an important factor in increasing the quality of life for all. Unfortunately, for many African Americans, striving for good health is complicated by racism and cultural differences, and further discouraged by a lack of access to quality health care, culturally specific information, and support to make healthy lifestyle choices. Total health must begin with a sound sense of mental health. As an organization with a mission to improve the overall health of African Americans we recognize the need to establish an effective and efficient system of mental health care for all residents of Multnomah County.

To recognize the increasing need of addressing mental health the AAHC developed Blues Day, a Mental Health Summit, in collaboration with PCC-Cascade Campus and Eli Lilly, on October 17, to begin our 6th Annual Wellness Week. I am fully aware of the disparities in health care that exist in Multnomah County and as a member of the Governor's Racial and Ethnic Health Care Task Force I have worked towards the identification of strategies to eliminate these disparities. It is incumbent upon Multnomah County to work towards eliminating barriers in internal and external access to care for diverse racial and ethnic communities of Multnomah County with the goal of eliminating disparities in health. A commitment to culturally specific services for communities of color is required and desired to reduce the health disparity.

Current plans for the mental health redesign seek not to redress these disparities but to jeopardize the foundation of the existing programs that serve these vulnerable communities by unfair and discriminatory practices. These programs were developed because of the need not only for culturally specific, but also culturally competent services. It has been well demonstrated nationally and locally that culturally specific services are the most effective strategy for successful intervention.

I am available to participate in the development of this plan as CEO of the African American Health Coalition and/or as a private practice therapist on contract with service to children and families.

Sincerely,

Corliss McKeever, MSW
President/CEO
African American Health Coalition

SPEAKER # 22

Multnomah County
Mental Health Public Comment - Shura Young

August 6, 2001

In the financial report given by Dale Jarvis in last Wednesday's Coordinating Council meeting, it was suggested that the expenditures for FFS outpatient providers be phased down with a resultant reduction of individual FFS counseling services.

In Multnomah County there are nearly 4500 consumers, including myself, who have Medicare primary insurance and Medicaid (OHP) secondary, called "dual-eligible." With Medicare+ Medicaid a consumer can see a private practice psychotherapist who accepts Medicare payment. Medicare insurance will pay 50% of Medicare allowable charges for mental health outpatient therapy. The balance - that is the 50% coinsurance - is then paid by Medicaid, either through a county mental health organization like Verity when the consumer is in managed care, or through OMAP directly when both provider and consumer are not in managed care. When a FFS provider can bill OMAP directly, the Medicaid 50% coinsurance amount doesn't appear to come through the County funding stream.

The State MHDDSD has recognized dual-eligible consumers' right to have a traditional Medicare provider. Concerning Verity's stated policy in March on dual-eligibles, Anita Miller of the MHD wrote: "I would recommend that the statement (in Verity's policy) be changed to include the Medicare beneficiary's right to choose a traditional Medicare provider, since in this case the dual-eligible still has the right to access services from any mental health provider who can bill Medicare." For clarification, in this method FFS providers would bill Verity for the 50% coinsurance, not OMAP directly.

In December last year, Anita Miller said, "From the Division perspective we don't want to penalize providers who are willing to see Medicare eligible patients [by not paying the Medicaid coinsurance]. We have an access problem as it is without limiting the number of providers that are available to us..."

People in the redesign process have said that the agencies ideally will provide the variety and quality of treatment services that meet the needs of all consumers, including dual-eligibles. I was a client at Network BH for 3 years with its therapy limitations, and though my therapist was good (and he's left the OHP system), the only way I've been able to get expert help in special areas has been to have a private practice Medicare therapist, go to non-OHP specialized support groups, and pay out-of-pocket from my $550 a month disability income for services not available in OHP agencies. These are treatment needs which the agencies will probably never provide.

In a system that wants to provide less costly outpatient services to avoid more costly crisis services, consumers should have the option of accessing FFS outpatient professionals if this treatment choice works best for them. Now this option may be phased down. I want all of you to make sure that dual-eligibles, like myself, have access to the greater range of providers available to us through our Medicare insurance. And I would make a guess that if a non-managed care Medicare provider with an OMAP FFS billing number bills OMAP directly, the 50% Medicaid coinsurance payment may actually be less than 50%.

Thank you.

Hi, my name is Heidi Crane. Here is my testimony. I have bipolar and have been seeking treatment for two and half years. I first got treatment through the Crisis Triage Center. They thought that it would be best for me to go to the respite for a little rest. From there I started my trek through the Multnomah County mental health system. I started Day treatment at Providence and lived in their assisted living apartment, then was forced to move after only nine months of treatment. I had to move into an assisted living arrangement, where I took care of an handicapped lady. I had not gotten stable in my medication and still suffered consistently in rapid cycling. I went once into St. Vincent's for depression and suicidal ideation. I also started St. Vincent's Day treatment program. They started to help me get stable on my medication, but I had to leave the temporary respite home. Through the stress of my daily life I was still having terrible symptoms and was put back into the hospital, but this time into Providence Portland Hospital. For my lack of housing I had to stay in this hospital for three weeks. While in this hospital I was put on Lithium, which later on I would find out that I was unable to process it without getting toxic. I was then sent to live in a group home. After a long hard fight I finally was able to get stable on medication. I had to leave the county to get proper treatment. I am currently living on my own and going to personal therapy. I am also learning

how to take care of myself and how to control the reaction I have to stressful situation. I would like to see there be more drop in centers for us.

Thank you for you time.

BOGSTAD Deborah L Speaker 29

From: CCHR Oregon [cchroregon@earthlink.net]
Sent: Thursday, August 09, 2001 11:50 AM
To: BOGSTAD Deborah L
Subject: Re: my testimony

Deborah, Here it is:

My name is Angie DeRouchie and I'm here today representing the Citizens Commission on Human Rights (CCHR) of Oregon. CCHR is an international network of chapters that has been investigating and exposing psychiatric violations of human rights since its founding in 1969.

First of all, I just want to say that I have at least 10 or 20 hours of stuff I'd like to say to you. I'm very nervous because I know I've got only 1 or 2 MINUTES to say it, to try and convey the import of our message.

Having said that, I'll just get straight to the point: there is one major flaw in what's being called the "mental health system", and it is the fact that you are contracting with an industry that has no definition for "mental illness", cannot tell you what causes it, cannot tell you how to cure it, and can't even conceive of someone becoming mentally healthy. That industry is called psychiatry.

This is exemplified in this quote from psychiatrist Norman Sartorius, president of the World Psychiatric Association 1996-1999: "The time when psychiatrists considered that they could cure the mentally ill is gone. In the future the mentally ill have to learn to live with their illness." Psychiatry has gone from bleeding and the rack, through lobotomies and straight jackets, and now to drugs. They've received an ever-increasing pot of money from governments. Still, they cannot produce a mentally healthy person. In fact, we see dramatic increases in school and workplace shootings, senseless violence and suicides. The best the psychiatrist can hope to do is to keep a person drugged into some sort of submissive state.

Why doesn't psychiatry work?

As with all seemingly complex problems, the answer is very simple: they are not, in many cases, treating people for what's really wrong with them.

You may have been told that mental illnesses are actual diseases. The truth is, there is no biological basis for "mental illness." You can't "catch" depression. There is no mysterious brain germ or bacteria.

We are told they are chemical imbalances of the brain, yet there isn't even a method to test brain chemicals.

Every day hundreds of people, with no prior comprehensive testing, are incarcerated against their will, restrained to a bed, and forcibly injected with powerful drugs. They have commited no crime.

The homeless and low income are the most seriously abused. The nature of being homeless is often enough to get a person label "schizophrenic". True, many homeless people act crazy...so do I when I don't eat all day.

The point is: there are literally hundreds of legitimate medical diseases that cause people to be chronically depressed, upset, psychotic and in other ways non-optimum in their behavior. The psychiatrist has tried to convince us these manifestations are "incurable mental illnesses."

Imagine for a moment what it is like to be told you have an unknown illness of your brain, you will never know what it really is, what caused it, and you will never be able to get rid of it. You have to take drugs that cause you severe side effects (often brain damage) for the rest of your life. Now imagine being properly tested and told that what you really suffer from is a brain tumor, anemia, liver failure, endocrine system failure or worse, that has gone

untreated because no psychiatrist bothered to test you for it.

What's the ultimate solution/next step: Multnomah County right now has the ideal opportunity. You've shut down the Crisis Triage Center, a brave commendable and move toward a saner, more humane system. Mejia Poot was not an isolated case; if I had another couple of hours, I would relay to you truly heart breaking stories of people being labeled "dangerous to self and others" because of a mental health worker's judgment of their behavior. Once labeled, they had very little recourse. They're taken away, drugged, then hauled into court where they're supposed to make some kind of sense in their drugged state.

Now you need to go the next step: you need to find out how many other Mejia Poots are there? How many anemics, epileptics, people with brain tumors or liver failure are sitting in psych beds, or are under out patient commitments? The county might even be able to recoup some of the funds paid to these institutions for what was essentially fraud: billing the County for treatment of unsubstantiated diagnoses.

As it rebuilds the mental health system, the County should take the psychiatrist out of the equation. Rebuild with wards and centers where a person in a crises or psychotic condition can be placed without the accompanying violence. Once placed, the person can receive real food, real sleep and real medical care and treatment.

The County would certainly save precious mental health dollars by putting a medical team together to replace the CTC. These doctors (naturopathic physicians have the most sophisticated testing models that I've personally seen) would be able to detect and treat the physically ill with finite medical treatment, giving the person a chance to become actually well.

Citizens Commission on Human Rights of Oregon

PO Box 8842

Portland OR 97207

503-228-3279

www.cchr.org

cchroregon@earthlink.net

For documentation on this subject: http://alternativementalhealth.com

http://.mindfreedom.org

8/9/2001

Speaker #35

Questions and Comments for the Board, by Gary Magnuson

1. (Action Step 8) County staff members provide or arrange for the provision of early intervention, education, safety net, or other community based services for children and their families that are not available through traditional mental health agencies, regardless of their nonprofit or for profit status. Why are these effective, "value-added" programs being thrown into the stew pot called the Single Point of Accountability Pool? These programs should not be privatized by giving the General Fund dollars that support these services to a monolithic nonprofit agency or to a limited liability (for profit) corporation. These services reside in the County precisely because they serve client populations that require expensive, labor-intensive services that cannot be efficiently provided in a managed care environment.

2. The "Proposed Action Plan-Phase 1" includes statements that I believe are inaccurate. On page 16, lines 4-6 it claims, "...these contracts require over 20 full time equivalents of County Care Coordinators, whose salary costs alone are over $1.3 million per year." First of all, we do not have 20 FTE of County Care Coordinators, so I have no idea how the author came up with that number. Secondly, $1.3 million divided by 20 is $65,000, which is a manager's salary, not a Care Coordinator's salary, which falls in the low to mid 40's range.

3. (Action Step 13) Before any County staff are "redeployed" careful consideration should be given to the services they are currently providing, especially if "redeployment" would have a negative impact on the clients being served, causing destabilization or dislocation.

4. The Task Force and the Design Team both gave a strong recommendation to contract directly with the providers, eliminating the administrative costs of the networks. Why is so much energy being spent in creating an "uber-network"? How will our customers benefit from this additional layer of administration?

5. I do not believe it is in the best interest of our clients to put all our eggs in one basket. If all the money for specialized services is commingled with the Outpatient Premium Pool the Single Point of Accountability Structure will diminish the capacity of our smaller community based providers to remain viable. If we truly value consumer choice we must maintain the independent ability of County staff to facilitate the provision of services by the most appropriate, culturally sensitive agency or provider.

6. It is imperative that we preserve the proper distinction between the MHO and the Local Mental Health Authority services provided by the Behavioral Health Division. I am specifically thinking of the Involuntary Commitment Investigators and the Trial Visit Monitors. It would be folly, especially in a managed care environment, for the entity paying for the hospital bed to also provide the legal and client advocacy functions of these highly specialized positions.

"Creating a Caring Voice for Mental Health"

SANDY HAYDEN

(503) 274-9495 ▪ bn791@scn.org
P.O. Box 6623 ▪ Portland, OR 97228

SPEAKER # 41

August 6, 2001
Multnomah County Public Hearing
Testimony of Sandy Hayden; P.O. Box 6623; Portland, OR 97228

Hi -- to all the Commissioners, and to everyone who has taken the time to be here today.

I'm Sandy Hayden, a mental health consumer/advocate, a former member of the Multnomah County Mental Health Task Force, a former member of the Multnomah County Mental Health Design Team, and a current very-concerned citizen of Multnomah County.

I prefer to ad-lib, but this time, I'm delivering a prepared text. I want my words to be part of the written record for today.

On September 28th of last year, the Board of County Commissioners passed Resolution Number 00-161, "Adopting a Vision Statement for a Consumer and Family Centered Mental Health System." It says in part, "While there may be resource constraints the ultimate goal of the system is to improve the lives of those receiving mental health services."

Without re-hashing the past few years of our County's mental health crisis, my belief is that we have an opportunity, this week, to point our resources in a new and positive direction. What I mean by "resources" is a combination of physical facilities, employed personnel, volunteers, mental health consumers who are or could be receiving services, and our County's citizenry, as a whole.

The County Resolution also states, "The needs, goals and preferences of consumers dictate the types and mix of services provided." Later on in the Resolution it says, "Services to achieve stabilization and recovery at lower levels of care are prioritized so that they are available when needed, thereby reducing utilization of higher levels of care such as crisis services and hospitalization."

Phase One, the Gap Plan, and whatever name it may go by, begins to address these issues. However, direct input by consumers into the writing of the Plan, into being invited to a stakeholders meeting by the Mental Health Executive Team to discuss the Plan, is still abundantly lacking. That's why I'm here testifying today.

I have three points to make to improve the odds of the Action Plan working:

1) Mental health consumers need their voices heard as primary stakeholders, and must be invited to the table each and every time a decision is to be made;

2) In the "Roll-Out of the Single Point of Accountability Philosophy and Structure" on page 14, where "all mental health consumers" are "assigned" to a specific provider in a specific clinic, stop the crucial mistake before it happens. Locking consumers, even temporarily, into a no-choice setting is counter

to the intent of the County's adopted Resolution, but more importantly, it is counter to the culture of mental health consumers. Consumers need choice.

Hold the providers accountable to the consumers. Don't hold consumers hostage to the providers.

Flexibility within the system is the only way the County can succeed.

3) The budget needs to include an ongoing evaluation component that encompasses: a) Encounter Data, AND, b) Outcome Data.

Besides asking and answering, "What did we do, for how many?" we also need to ask and answer, "How effective was the service, what else can we add, and what else needs to be changed?"

I'm specifically requesting that within the budget, a one-page quick-assessment instrument be devised and implemented to confidentially provide feedback from the consumers' point of view, to immediately and continually monitor the County's mental health system.

Within 10 days of receiving a service, each consumer must be given the opportunity to fill out this quick-assessment form. If it's mailed, then provide a perforation to remove the portion of the sheet that has identifiers, such as a name and address. It could easily be a letter-sized sheet of paper that can be refolded and taped, with the postage pre-paid.

Simple? Yes. Cost effective? Yes. Will it happen? I hope the answer to that will also be: Yes.

Whatever the overall budget will be, please keep flexibility of funds as a central feature. And please keep mental health consumers at the top of your priority list of people who are capable of making our mental health system work, and work well.

Thank you!

SPEAKER #50

Statement and Testimony in favor of establishing and executing reform to Mental Health Services of Multnomah County.

Family member, Jan Lacy

My concern is with the comprehensive development of a mental health program in this county that will deal not only with the immediate crisis, but will educate, communicate, provide resources and reliable services to consumers and family members in need. That refers to all of us, not just the ones who qualify for Oregon Health Plan.

Two years ago when my son developed Schizoaffective Disorder, I did not have a clue who to turn to when I discovered that his insurance only covered three days in the hospital. His doctors were suggesting a week at the very minimum. Wouldn't it have been helpful if my county health office had a brochure or promoted information readily available that gave me support, or possible resources to turn to? No one suggested I contact the county as a resource of support and services. Alone, I struggled to discover what I needed to do from day to day to insure my son's safety at school and home.

Recently, it was suggested to me by another parent from Texas, that since my son was graduating from high school this past spring, I should have a transition plan lined up for him and know the services available to him through federal, state and county governments. Upon calling Multnomah County, Child and Family Services, I was sent on a wild goose chase when I requested to be connected to someone who could inform me about services and programs in mental health for transitioning adolescents. Several people tried very hard to figure out who or what I should be connected to, but finally in frustration referred me to Developmental Disabilities. I got to leave a message there for a case manager to call me back. The next day I assisted other county employees and we tried to figure out if there was an answer to my question. Developmental Disabilities could not help me because my son did not have a low IQ. They did suggest another phone call or two, and eventually I networked my way to an organization called *Verity.* I understand that there is a book of resources that I can come to the office and read in order to gather more information regarding resources.

I know that in order to organize and develop a more citizen friendly system that the crisis and redevelopment plan must begin <u>now</u>. With more delays our children's futures are put in jeopardy. This county and the school districts within its borders need to provide services in a simple and direct manner that will address the needs of consumers and families experiencing the already stressful conditions of mental health diseases.

Thank You for your time.

Oregon
John A. Kitzhaber, M.D., Governor

Department of Human Resources
Vocational Rehabilitation Division
North Portland Branch Office
4744 N. Interstate Avenue
Portland, Oregon 97217
Voice/TTY (503) 280-6940
FAX (503) 280-6960

August 6, 2001

Chair Diane Linn and Commissioners,

I want to bring to your attention the needs and concerns of individuals with disabilities seeking mental health services. I am particularly concerned about the needs of those who are deaf and hearing impaired.

The mental health system as it currently exists and as it may exist, given the redesign efforts, does not meet the needs of individuals who are deaf. There is no capacity to in the system to meet the needs of this population given their cultural and language issues.

As I understand it, the Oregon Health Plan reimburses less than half of the going rate for sign language interpreters. Programs are left to pay the other half. We have consistently seen issues for our consumers in accessing services on a timely basis. We have found ourselves in an adversarial role with programs as we educate them about their role and responsibilities under the ADA.

While interpreters address the language barrier, there remain issues in understanding and dealing with cultural issues. A lack of understanding regarding cultural and developmental issues as it relates to individuals with deafness impacts the provision of appropriate and effective mental health services.

My experience is that programs are minimally compliant with the physical access issues under the ADA and that staff lack awareness and knowledge of the kinds of issues our consumers present with. We share, I believe with the public in general, frustrations in quickly accessing services for individuals in crisis and in need for ongoing assistance.

For those with the most severe psychiatric disabilities, I would note that the County's support for the IPS+ Project has made a significant

difference. I am concerned that in order to fund Phase One activities that funding to this project will be cut.

It is my hope that the redesign efforts with begin the work needed to insure access for individuals with disabilities. In doing so I hope that sufficient dollars are budgeted to support the work.

Sincerely,

Stephaine Parrish Taylor

Stephaine Parrish Taylor
Branch Manager

Testimony for County Mental Health Redesign – August 6, 2001

By Dean M. Coffey, M.A.

Mr. Coffey is employed by Providence Health System as a crisis telephone counselor on the Multnomah County Crisis Line and is a doctoral student in clinical psychology at George Fox University.

A noted psychiatrist of the twentieth century defined mental health as the ability to love and work. Applying this definition to the current mental health challenges faced by Multnomah County, every person in the county becomes a stakeholder of sorts in the promotion of mental health. The discussion of the state of affairs in Multnomah County has focused on mental illness rather than mental health. In other words, how can we get the most effective treatment delivered in the most effective way to meet the needs of the largest number of people suffering from mental illness? This does not necessarily promote mental health. It promotes treatment for mental illness.

Important to consider is the possibility that our efforts are actually promoting mental illness in the county. It is well known among mental health professionals that a person may generate a crisis as a dysfunctional way to communicate needs, feelings or conflicts. When the only available treatment for mental illness after 5 p.m. is called the "crisis" center or the "emergency" room, many people learn very quickly that the way to get service is to have a crisis or an emergency.

I would like to suggest a broader vision for the county's efforts in which mental health dollars are invested to promote the ability to love and work. What I am proposing is a new partnership among community interests to promote mental health; a philosophical shift away from the medical model of treatment for mental illness to a more holistic bio-psycho-social approach.

I am suggesting the provision of incentives to promote the ability to love and work through this new partnership. This partnership could provide a "benefits package" to reward those in compliance with early treatment. This benefits package could include:

1. Health club memberships which the county pays a negotiated price for free use by persons who are active in treatment. Research has shown that regular, moderate exercise is as effective as anti-depressant medication in the treatment of depression.
2. Access to "apprenticeships" in which the disabled work alongside a journeyman mentor in companies who agree to pay half the apprentice's wages and the county pays the other half.
3. Eligibility for some extra nice quality housing after demonstrating treatment compliance of so many months.
4. Provision of not only therapy, but also quality social activities funded by community businesses and the county.

Incentives promoting mental health should also be provided to hospitals operating psychiatric units by measuring success in terms of empty mental health beds and rewarding hospitals for shorter patient stays. This could be done by requiring all hospitals receiving public funds to train staff and implement a Solution-Focused Brief Therapy model of treatment. This model has been shown to reduce the length of costly hospital stays.

Volunteer respite homes could be developed (possibly as part of the faith-based initiatives program) where a brief length of stay is negotiated up front with the client and the county pays a religious provider a nominal amount rather than a medical provider a large amount for a costly hospital stay.

Mental health professionals could also participate in this partnership by eliminating costly office space by offering weekly in-home therapy with compensation for car expenses and provision of cell phones and laptop computers.

Even the media could participate by reporting about the current redesign of the mental health delivery system as an opportunity for the community to join together to do something innovative rather than reporting it as a crisis, transition, or "the August problem." It is time that we as a community embrace

those who are challenged in the area of loving and working and share our resources to promote lasting mental health rather than the expensive and shortsighted Band-Aid of crisis treatment for mental illness.

Note:
Phone: 503-434-6787
Email: coffeyd@macnet.com

BOGSTAD Deborah L

From: SNEDECOR Scott P
Sent: Monday, August 06, 2001 12:45 PM
To: BOGSTAD Deborah L
Subject: RE: Monday Evening Public Hearing

Please just say they are members of a local self help group that operates in conjunction with a community mental health program.

-----Original Message-----
From: BOGSTAD Deborah L
Sent: Monday, August 06, 2001 11:53 AM
To: SNEDECOR Scott P
Subject: RE: Monday Evening Public Hearing

Thanks so much - would it be correct to say these folks are clients of the New Mezz Connection? Or do you want me to use the term "mental health consumer"? Thanks Scott!

Deb Bogstad, Board Clerk
Multnomah County Chair's Office
501 SE Hawthorne Boulevard, Suite 600
Portland, Oregon 97214-3587
(503) 988-3277
http://www.co.multnomah.or.us/cc

-----Original Message-----
From: SNEDECOR Scott P
Sent: Monday, August 06, 2001 11:46 AM
To: BOGSTAD Deborah L
Subject: RE: Monday Evening Public Hearing

The people whose testimony I gave you this morning are available through:

The New Mezz Connection
Unity Downtown Portland
412 SW 12th Ave
Portland, OR 97205

HELLO My Name iS Michael Harris and Im a mental Health Consumer one thing I've noticed is there wasn't a clear Spokeperson out there for the Consumer I hadn't until recently heard a voice on our behalf, Jim Gaynor, and Wayne miya are in the fore front for Our Consumer rights. They have brought to our attention our needs can be addressed and acted on. Ive been a part of Unity Since Feb 2000 being homeless and Suffering from a mental illness felt Unbearable. Unity has given me hope that there can be a place for the Mentally handicapped Person. I have Self respect for myself and a purpose in my Life. Programs like Unity are of the up most importance. Closing programs dosent address the problems of mental Health. We need things to do to improve our Lives and make them worth living.

Michael Harris

mentally handicap Shouldn't mean you have no Life. People See mentally ill as inferior not worth the trouble. There has to be a alterative to housing people in "Crazy houses." We need assitance and Guidance to Live with our inperfections in the eyes of Mentally Sound people. I'm pleased with the directions Mental Health is headed Addressing the Tough problem. What do you do in emgercency, is there any help out there? The foremeationed Jim and Wayne are in the forefront of this battle with a voice Some one out there will listen and respond to Our needs

Margaret Minor

I like to see more at the
~~Mentelhelth~~ Mentral helth*
it has help me a Great Deal.
here I have ~~Dis~~ Depression
and it has ~~help~~ help me in a lot
of ways here at* Mentral Helth
I Want to keep Coming here
to work here at Mentral helth*
it makes me feel very good
and ~~help~~ helps me to meet new
Pepole and to Be togather
its helps me not to Be onley
at the Mintral Helth Center
Please Keep it open on weeks
days and Weekends

Sing By
Margaret L Minor

* New Mezz

7/31/05

Testiomony of Tom Wittick

I have spent over half my Life as psyc Survior. Spent Five years at Mt Hood care center, Been to Dammish

I moved up to Portland after years in hare county. I worked with Oregon advacy center, support colation, and worked For a year at SaFehaven, worked with Homeless mental ILLiness.

Personaly I had break by being in a cult the Labor Committee Battle to Be my real self out in Fighting the dargerous parts of Command Voice's Lead to Parnoid Schizophrenia.

Now I have grown By work with mezz connection, staFF at Unity west. By peer advocate and running Schizophrenia Support Groups.

Thomas E. "2" Wittick

Testimony by David Bolins
for Multnomah BCC
Aug 6 Hearing 2001

I was 51 y/o when I first came to m h services west. My problem was bipolar, secondary injuries with plates & pins in my ankle & ~~plate~~ injury to my arm & a head injury from a car accident. The whole structure of m h s w (Unity) and The Mezz (The New Mezz Connection, Inc) helped me immeasureably. Without it, I'd be lost. My job, the people around me, Jan Swett, Lorraine, I'm on the Board of Directors for the New Mezz Connection, and am the new kitchen Manager. Jan Swett is a full time consumer staff staff Person. She helps me on my job. she trains me.

David Bolins

Testimony for Multco BCC
Hearing
Aug. 6, 2001

I think we need more jobs for people who are handicapped, to work 2-3 hours a day. They should be paid minimum wage. The public should be aware that there are mental patients downtown, and maybe the county could find ways to help people learn how not to be scared of us. It has happened to me several times that when some body found out I was a mental patient, they walked away me.

Dan W. Brannan

~~By Anonymous~~ D.W.B.

D O C U M E N T I N G

PSYCHIATRY

A HUMAN RIGHTS ABUSE AND GLOBAL FAILURE

PRESENTED BY THE CITIZENS COMMISSION ON HUMAN RIGHTS

•

International Watchdog for Mental Health

THROUGH

psychiatry's

STIGMATIZING LABELS,

EASY-SEIZURE COMMITMENT LAWS

AND OFTEN BRUTAL,

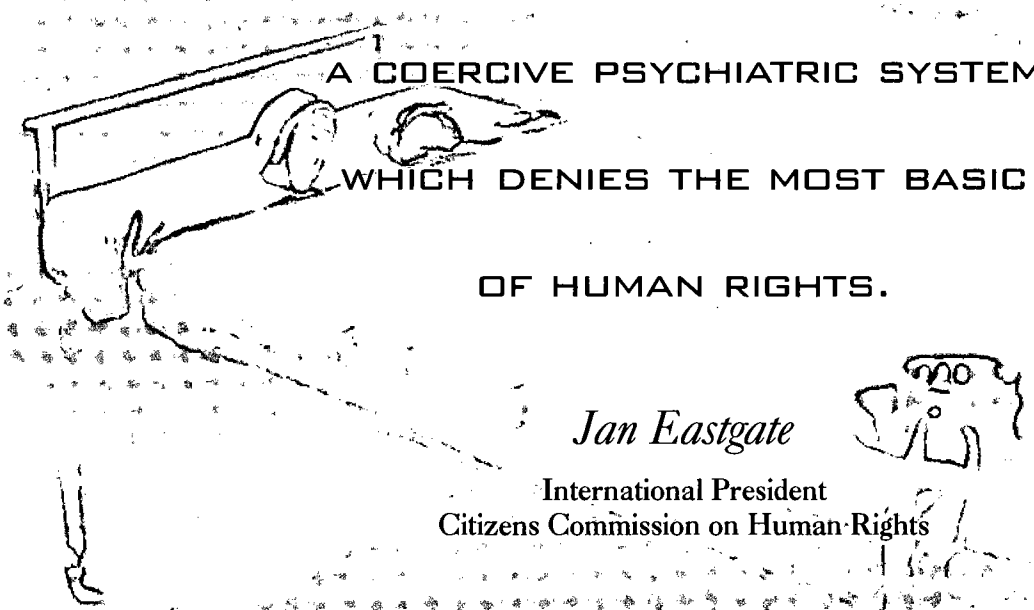
DEPERSONALIZING "TREATMENTS,"

THOUSANDS NEEDLESSLY FALL INTO

A COERCIVE PSYCHIATRIC SYSTEM

WHICH DENIES THE MOST BASIC

OF HUMAN RIGHTS.



Jan Eastgate

International President
Citizens Commission on Human Rights

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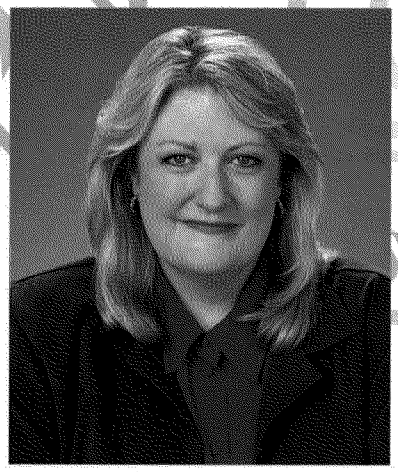
THE NEED FOR A MEN



Human rights can be defined as freedom from false accusations, brutality and punishment without offense.

In 1994, psychiatrist Norman Sartorius, president of the World Psychiatric Association (1996-99), declared at a meeting of a congress of the Association of European Psychiatrists, "The time when psychiatrists considered that they could cure the mentally ill is gone. In the future the mentally ill have to learn to live with their illness."[1]

Considering Sartorius's ranking as one of the leading figures in international psychiatry today, it seems logical to conclude then that mental problems are incurable, and that the afflicted are condemned to lifelong suffering.

Actually, this is not correct, and thankfully so, for how depressing to think that man is destined never to fully understand himself and life. To see this, however, requires some concept of what an ideal situation in mental healing would be.

Consider the following basic criteria for the creation of mental *health*:

1. Effective mental healing technology and treatments which improve and strengthen individuals and thereby society, by restoring individuals to personal strength, ability, competence, confidence, stability, responsibility and spiritual well-being.

2. Highly trained, ethical practitioners who are committed primarily to their patient's and patient's family's well being, and who can and do deliver what they promise.

3. Mental healing delivered in a calm atmosphere characterized by tolerance, safety, security and respect for people's rights.

From individuals to governments, far too many assume that this is mental healing today. The reality, however, is that it bears no resemblance to mental healing under psychiatry.

In 1969, the Citizens Commission on Human Rights (CCHR) was established to investigate and expose

oduction

TAL HEALTH VOICE

psychiatric violations of human rights and to clean up the field of mental healing.

After 30 years of fully documented experience dealing with psychiatry, it can be confidently said that in the absence of a watchdog group such as CCHR, the true depth of psychiatry's abuse only becomes visible to mankind when it reaches the hellish proportions of contemporary tragedies like the Nazi Holocaust, Russia's political Gulags, South Africa's apartheid or the Bosnian-Kosovo conflicts. Even then, however, few see the trail of psychiatric dogma which precipitated these horrors.

Human rights can be defined as freedom from false accusations, brutality and punishment without offense. The United Nations Declaration of Human Rights lists the right to be free from "torture, cruel, inhuman or degrading treatment or punishment," to enjoy "equal protection of the law" and not to be subjected to "arbitrary arrest" and "detention."

Through psychiatry's stigmatizing labels, false explanations, easy-seizure laws, brutal, depersonalizing "treatments" and deadening, mind-altering drugs, thousands needlessly fall into psychiatry's coercive system every day all over the world. It is a system which exemplifies human rights abuse.

An involuntary patient has less rights than a criminal and less legal protections, even though no law has been broken. Psychiatrists ordering parents to put their children on drugs assure us of a deepening drug culture; children as young as one year old are now being prescribed mind-altering drugs. Psychiatric patients can be readily observed to be in a submissive and emotionless state—no joys, no sorrows, just obedient and dull.

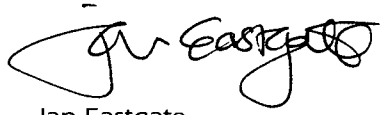
These are psychiatry's high points. This is *not* mental healing. This does not produce mental *health*. Yet this *is* psychiatry today.

Meanwhile, psychiatry today is also attempting to export itself globally. Lacking any scientific system of measuring mental phenomena, psychiatric sources yet artfully report that five out of the ten leading causes of disability worldwide are mental problems. Major depression is similarly ranked fifth in the ten leading causes of the global disease burden, and projected to be second by the year 2020.

Sartorius is correct. Psychiatry *can't* and never could cure mental problems. A true science can predict and attain uniform results through its technology. Psychiatry is not a science. Factually, it is an unmitigated and verifiable failure, as this booklet reveals.

As psychiatry today increasingly operates above the law and at the cost of individual well-being and lives, it requires constant alertness and vigilance to preserve true human rights, and even life itself. Psychiatry, therefore, is no more than a global menace, and a roadblock to real progress in the field of mental healing and the mind. At present 130 chapters strong in 31 countries, CCHR proudly continues its watchdog role, now more vital than ever. The work is no less than a fight for the dignity and decency of man. With your help, the job will most certainly get done.

Sincerely,



Jan Eastgate
International President

By the Citizens Commission on Human Rights

mental health declaration OF HUMAN RIGHTS

All great organizations set forth codes by which they align their purposes and activities. The Mental Health Declaration of Human Rights articulates the guiding principles of CCHR and the standards against which human rights violations by psychiatry are relentlessly investigated and exposed.

A. No person shall be given psychiatric or psychological treatment against his or her will.

B. No person, man, woman or child, may be denied his or her personal liberty by reason of mental illness, so-called, without a fair jury trial by laymen and with proper legal representation.

C. No person shall be admitted to or held in a psychiatric institution, hospital or facility because of their religious, political or cultural beliefs and practices.

D. Any patient has: 1. The right to be treated with dignity as a human being;

2. The right to hospital amenities without distinction as to race, color, sex, language, religion, political opinion, social origin or status by right of birth or property.

3. The right to have a thorough, physical and clinical examination by a competent registered general practitioner of one's choice, to ensure that one's mental condition is not caused by any undetected and untreated physical illness, injury or defect, and the right to seek a second medical opinion of one's choice.

4. The right to fully equipped medical facilities and appropriately trained medical staff in hospitals, so that competent physical, clinical examinations can be performed.

5. The right to choose the kind or type of therapy to be employed, and the right to discuss this with a general practitioner, healer or minister of one's choice.

6. The right to have all the side effects of any offered treatment made clear and understandable to the patient, in written form and in the patient's native language.

7. The right to accept or refuse treatment but in particular, the right to refuse sterilization, electroshock treatment, insulin shock, lobotomy (or any other psychosurgical brain operation), aversion therapy, narcotherapy, deep sleep therapy and any drugs producing unwanted side effects.

8. The right to make official complaints, without reprisal, to an independent board which is composed of non-psychiatric personnel, lawyers and lay people. Complaints may encompass any torturous, cruel, inhuman or degrading treatment or punishment

PREFACE

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received while under psychiatric care.

9. The right to have private counsel with a legal advisor and to take legal action.

10. The right to discharge oneself at any time and to be discharged without restriction, having committed no offense.

11. The right to manage one's own property and affairs with a legal advisor, if necessary, or if deemed incompetent by a court of law, to have a State appointed executor to manage such until one is adjudicated competent. Such executor is accountable to the patient's next of kin, or legal advisor or guardian.

12. The right to see and possess one's hospital records and to take legal action with regard to any false information contained therein which may be damaging to one's reputation.

13. The right to take criminal action, with the full assistance of law enforcement agents, against any psychiatrist, psychologist or hospital staff for any abuse, false imprisonment, assault from treatment, sexual abuse or rape, or any violation of mental health or other law. And the right to a mental health law that does not indemnify or modify the penalties for criminal, abusive or negligent treatment of patients committed by any psychiatrist, psychologist or hospital staff.

14. The right to sue psychiatrists, their associations and colleges, the institution, or staff for unlawful detention, false reports, or damaging treatment.

15. The right to work or to refuse to work, and the right to receive just compensation on a pay-scale comparable to union or state/national wages for similar work, for any work performed while hospitalized.

16. The right to education or training so as to enable one to better earn a living when discharged, the right of choice over what kind of education or training is received.

17. The right to receive visitors and a minister of one's own faith.

18. The right to make and receive telephone calls and the right to privacy with regard to all personal correspondence to and from anyone.

19. The right to freely associate or not with any group or person in a psychiatric institution, hospital or facility.

20. The right to a safe environment without having in the environment, persons placed there for criminal reasons.

21. The right to be with others of one's own age group.

22. The right to wear personal clothing, to have personal effects and to have a secure place in which to keep them.

23. The right to daily physical exercise in the open.

24. The right to a proper diet and nutrition and to three meals a day.

25. The right to hygienic conditions and non-overcrowded facilities, and to sufficient, undisturbed leisure and rest.

Psychiatry is "the single most destructive force that has affected ... society within the last 50 years."

— Thomas Szasz, M.D.
Professor Emeritus of Psychiatry, 1994

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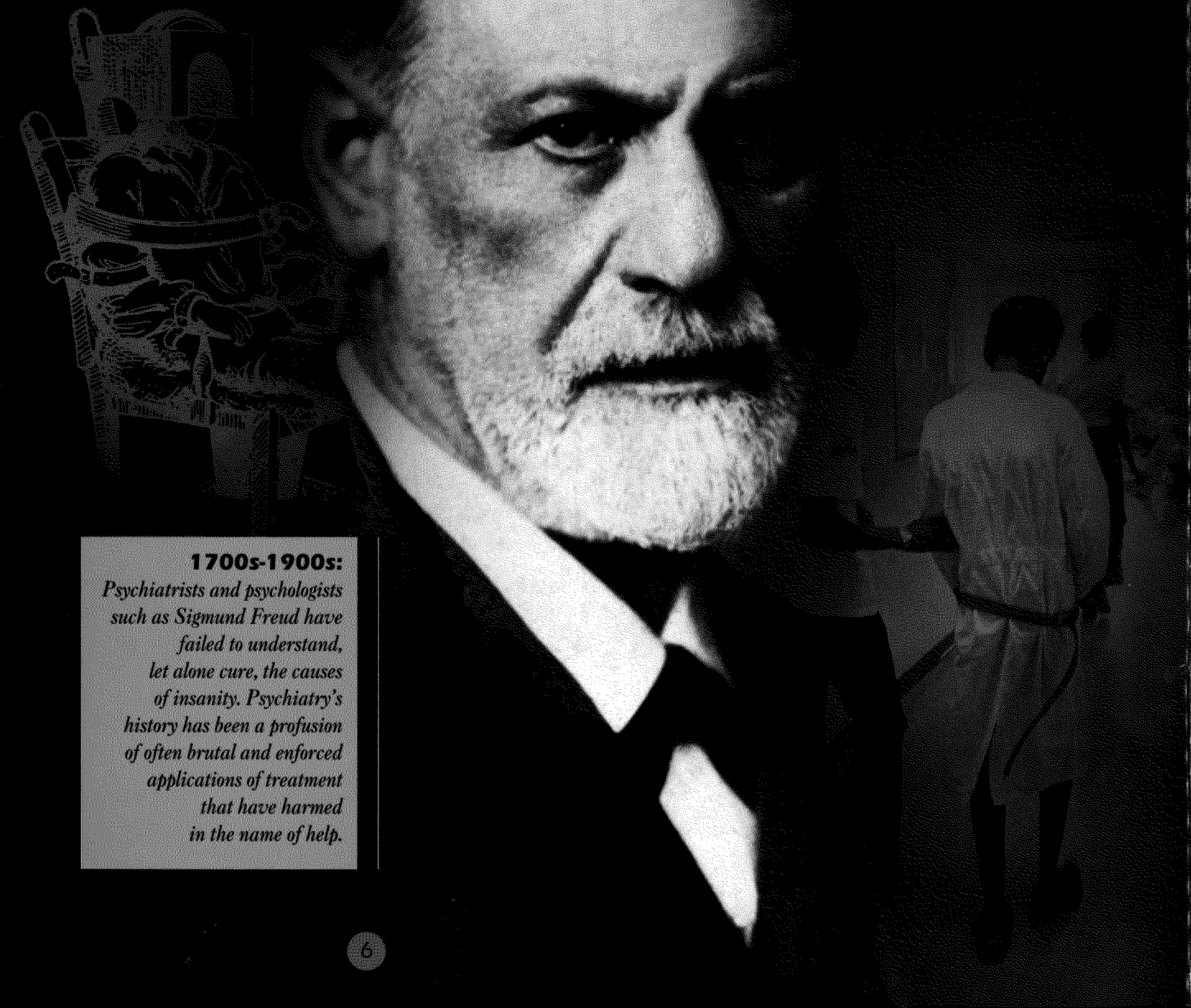


1700s-1900s:
Psychiatrists and psychologists such as Sigmund Freud have failed to understand, let alone cure, the causes of insanity. Psychiatry's history has been a profusion of often brutal and enforced applications of treatment that have harmed in the name of help.

CHAPTER 1

ychiatry

RY OF FAILURE

The origin of psychiatry is not, as it would have us believe, medicine, therapy or any other even faintly scientific endeavor. Its original purpose was not even to cure mental affliction.

First emerging during the French Revolution in pursuit of the notion that a science might be developed to *control* whole populations, the mental healing "sciences" gained momentum during the warmongering reign of Germany's "Iron Chancellor," Otto von Bismarck, in the late 1800s. Their real core motivation and character have not changed since these early days.

Specifically, in 1879, as dictatorial and dogmatic as his political sponsors, psychologist Professor Wilhelm Wundt of Leipzig University in Germany, declared that there was no soul and that man was simply a higher level animal which could be controlled using "science."[2]

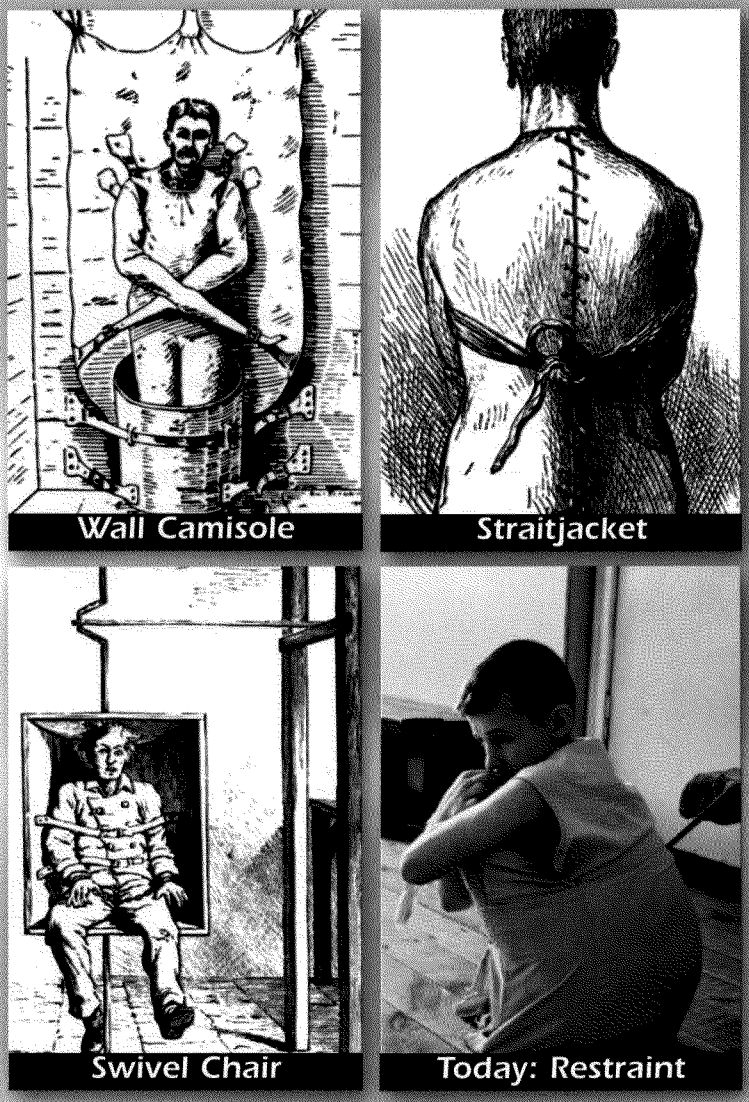
Always at odds with the concept of spirituality, redefining the mind in "biological" terms was the major challenge remaining to psychiatry in wrenching mental healing away from religion. Initially supervising the unwanted insane within asylums, psychiatry eventually adopted the tenet that insanity is a physical disease. While this still remains unproven to this day, psychiatry's "treatments" ever since have continued to use different applications of *force* to overwhelm individuals mentally and physically, whether insane or not.

These have included whipping, flogging, the application of ants, scabies and stinging nettles, surgical removal or cauterizing (burning) of the clitoris and removing a woman's ovaries. Masturbation, once considered a mental illness, was treated by circumcision and cauterizing the spine and genitals.[3]

By the turn of the 20th century, psychiatrists had failed utterly to understand, let alone cure, the causes of insanity. Psychiatry's history to date had been a profusion of brutal experimental applications, which no self-respecting medical professional would dare call treatments. In fact, as author Edward Shorter states in *A History of Psychiatry,* they continued to have "a rather poor reputation among their medical colleagues as the dull and the second rate."[4]

Psychotherapy Augments Biopsychiatry

Sigmund Freud's legacy, psychotherapy, provided competition for the physical disease model. Psychoanalysis essentially espoused that the cause of mental disorder was the "suppression of the sexual instinct in childhood" which "blocked a progressive, adult living of life."



"TREATMENT" THEN AND NOW: ***Historically, psychiatry's treatment methods have nullified and controlled the individual by violence and force. Today, children are still placed in straitjackets and shackled to beds.***

Today, Freud's theories are seen as flawed. According to psychology professor Frank Sulloway, author of *Freud: Biologist of the Mind*, "Freud was wrong in almost every important respect."[5]

Meanwhile biopsychiatry's fixation with physical experimentation continued. Within a five year period in the 1930s, insulin coma, metrazol shock, electroshock and lobotomies were widely prescribed by psychiatrists worldwide.[6] While all caused physical damage to the patient, none ever effected a cure.

The Political Power Play Of Post-WWII Psychiatry

By far the biggest boost to psychiatry's credibility and fortunes came with the close of World War II, when its main interest switched from the asylum to the community. In 1946, the United States psychiatric research body, National Institute of Mental Health (NIMH), was established with psychiatrist Dr. Robert Felix as its first director. Felix shamelessly defined psychiatry's latest and most lucrative strategy—community mental health—which aimed at fostering "the prevention of mental illness."[7] He urged colleagues to become involved with "education, social work, industry, the churches, recreation, the courts," so that "mental health services" would be "fully integrated into, and a regular and continuing part of, the total social environment."[8]

"Promising more than could reasonably be delivered became a way of life" for leaders in psychiatry, according to authors Foley and Sharfstein. "The extravagant claims of enthusiasts—that new treatments were highly effective, that all future potential victims of mental illness and their families would be spared the suffering, that great economies of money would soon be realized—were allowed to pass unchallenged by the professional side of the professional-political leadership."[9]

The community mental health push created an international wave of expanded mental health care which sharply accelerated after the discovery of tranquilizing (antipsychotic) drugs.[10] Reinforcing this was the passage of the 1963 Community Mental Health Centers Act which implemented "deinstitutionalization"—the emptying of state psychiatric hospitals that sent drugged patients homeless into the streets. According to Dr. Thomas Szasz, professor emeritus of psychiatry, "The insane person could now be controlled with a chemical, instead of a mechanical, straitjacket: The restraint could be put *in* him, instead of *on* him."[11]

A 1974 study by Franklin Chu and Sharland Trotter of NIMH and the Community Mental Health Center program found that it only recapitulated the problems it was supposed to solve.[12] And a 1991

"Through strong, painful impressions we capture the patient's attention, accustom him to unconditional obedience, and indelibly imprint in his heart the feeling of necessity. The will of his superior must be such a firm, immutable law for him that he will no more resist it than he would rebel against the elements."

— Johann Christian Reil
(who first coined the word psychiatry) 1810

New York Times article called deinstitutionalization "a cruel embarrassment, a reform gone terribly wrong."[13] Underpinning its failure was psychiatry's reliance upon mind-altering drugs.

Today psychiatry is almost unilaterally fixated on using drugs as the "treatment" for mental problems. Its press-button, quick-fix mentality is now also heavily reflected in community attitudes towards drugs. In 2000, psychiatrist Joseph Glenmullen warned that these drugs are being prescribed for a "burgeoning list of 'conditions,'" including everyday life, and that this is "often one of the first clues that one is looking at a general mood brightener that provides a quick fix."[14]

According to psychiatrist and author David Kaiser, "biological psychiatry" is "an ideology" in "its most pernicious form."[15] Propagating this ideology are the mental disorders sections of *The International Classification of Diseases (ICD)* and the American Psychiatric Association's (APA) *Diagnostic & Statistical Manual for Mental Disorders (DSM)*. Kaiser says, "This is essentially a pseudoscientific enterprise that grew out of modern psychiatry's desire to emulate modern medical science...."[16]

COMMUNITY MENTAL HEALTH PROGRAM FAILURE: *In 1963, the United States psychiatric research body, National Institute of Mental Health (NIMH), under psychiatrist Robert Felix (above), implemented a Community Mental Health program which relied heavily on the use of mind-altering psychiatric drugs. Spawning an international trend, it sent drugged patients homeless and incapable into the streets. After more than $47 billion spent on it between 1969 and 1994 alone, the program is an abject failure.*

The DSM/ICD-10 psychiatric diagnoses lack scientific validity. "This is essentially a pseudoscientific enterprise that grew out of modern psychiatry's desire to emulate modern medical science...."

— David Kaiser, psychiatrist and author, 1996

DSM – Diagnostic Fraud

Arrived at by what psychiatrists call "consensus," which in reality is no more scientific or sophisticated than a vote of insider hands, the *DSM-IV* contains a record 374 so-called mental disorders; *ICD-10* is based on the *DSM*. In his book *Blaming The Brain*, biopsychologist Elliot S. Valenstein says: "*DSM-IV* is not an exciting document. It is purely descriptive and presents no new scientific insights or any theories about what causes the many mental disorders it lists."[17]

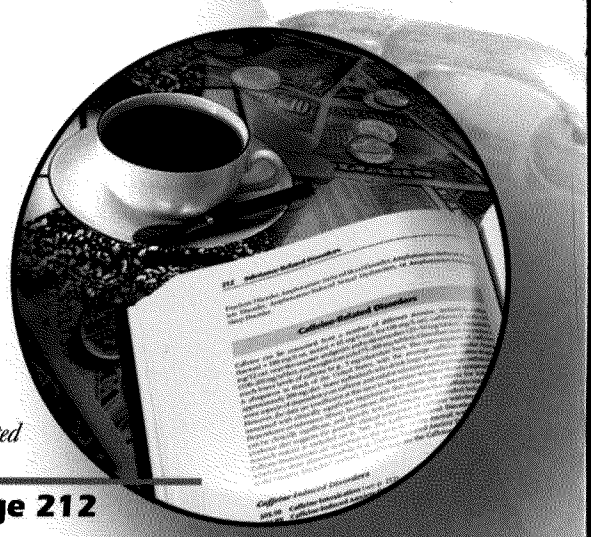
Margaret Hagen, author of *Whores Of The Court*, summarily dismisses the *DSM*: "Given their farcical 'empirical' procedures for arriving at new disorders with their associated symptoms lists, where does the American Psychiatric Association get off claiming a scientific, research-based foundation for its diagnostic manual? This is nothing more than science by decree. They say it is science, so it is."[18]

Because of the *DSM*, many resident psychiatrists no longer spend time talking to their patients. In a 1986 speech, Morton Reiser, a psychiatrist affiliated with Yale University School of Medicine, said that once students had done their *DSM* "inventory" and "had identified target symptoms for psychopharmacology, the diagnostic workup and meaningful communication stopped....Most of these residents could and would have learned more about a stranger sitting next to them for an hour on an airplane trip than they had learned in these formal psychiatric interviews."[19]

Decade of the Brain

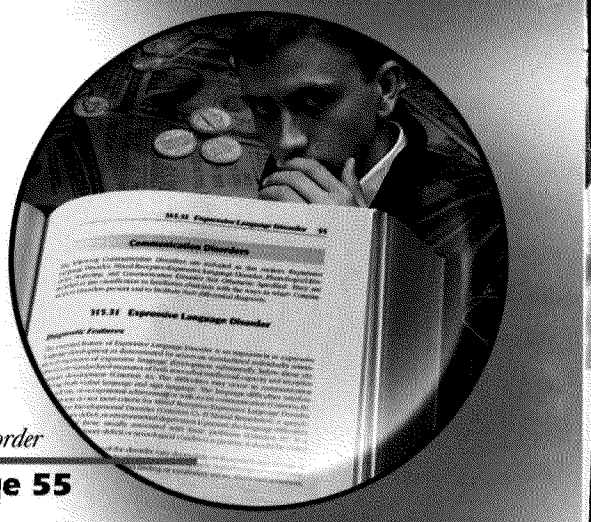
Flanking the rapid development of the *DSM*, Lewis Judd, director of NIMH from 1987 to 1990, created the biopsychiatric marketing strategy, "Decade of the Brain," which was signed into United States law by Presidential Proclamation on July 17, 1990. Since then, terms like "treatable brain disorder," "no-fault brain" disease, "chemical imbalance" and campaign slogans such as "mental illness is just as real as physical illness" have become part of mental healing parlance at all levels. The ruse succeeded in grouping legitimate brain disorders such as Alzheimer's, spinal cord injury and stroke, with the illegitimate "depression" and "schizophrenia."

Before the decade was out, however, psychiatry suffered a storm of criticism and defection within its ranks. Loren Mosher



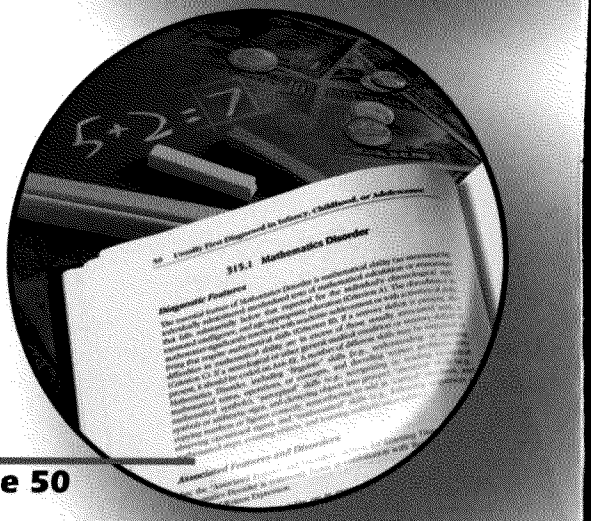
Caffeine-Related Disorder

DSM Page 212



Expressive Language Disorder

DSM Page 55



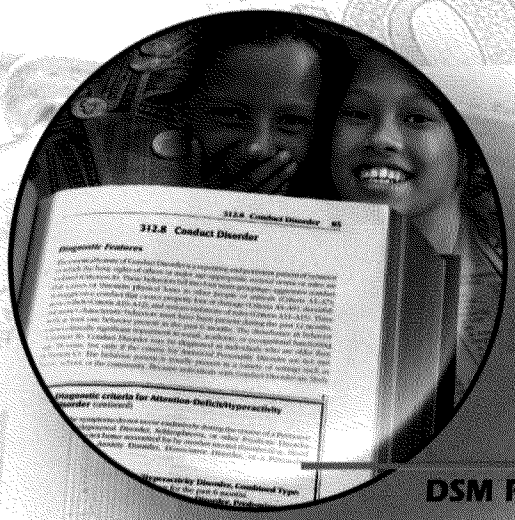
Mathematics Disorders

DSM Page 50

In his book *Blaming The Brain*, biopsychologist Elliot S. Valenstein says: "DSM-IV is not an exciting document. It is purely descriptive and presents no new scientific insights or any theories about what causes the many mental disorders it lists."

was a former NIMH researcher and a 30-year member of the APA before he resigned in 1998 stating, "Biologically based brain diseases are convenient for families and practitioners alike." He added, "*It is no fault insurance against responsibility.* We are just helplessly caught up in a swirl of brain pathology for which no one, except DNA, is responsible....The fact that there is no evidence confirming brain disease attribution is, at this point irrelevant."[20]

According to Valenstein, "Contrary to what is claimed, no biochemical, anatomical, or functional signs have been found that reliably distinguish the brains of mental patients." He also states that the "theories are held on to not only because there is nothing else to take their place, but also because they are useful in promoting drug treatment." In his view, "all of the impressive knowledge of neuropharmacology has not really brought us closer to understanding the origin of mental disorders...people with mental disorders may be encouraged when they are told that the prescribed drugs will do for them just what insulin does for a diabetic, but the analogy is certainly not justified."[21]

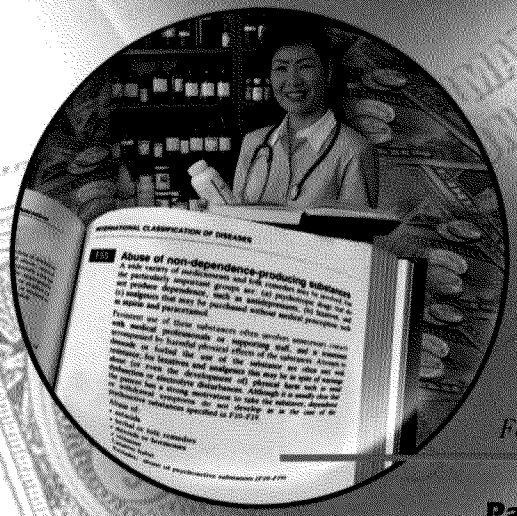


Conduct Disorder

DSM Page 85

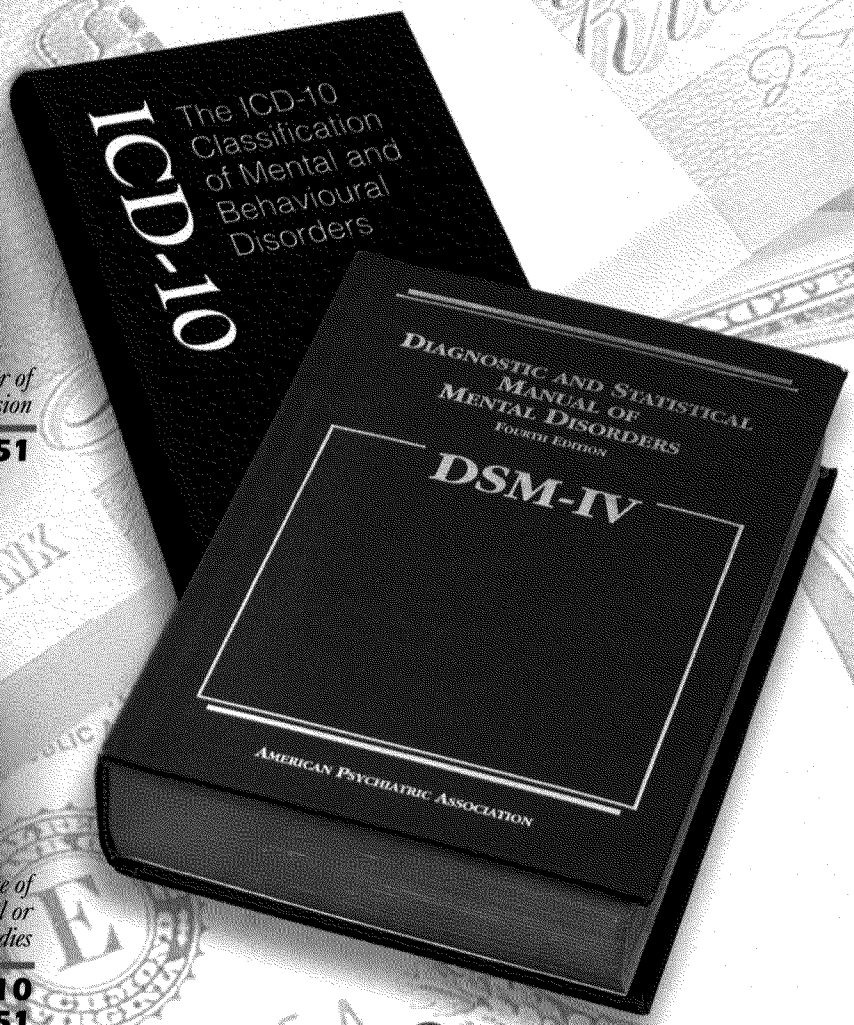
Disorder of Written Expression

DSM Page 51



Abuse of Herbal or Folk Remedies

ICD-10 Page 351



"Decade of the Brain"

In 1990, flanking the rapid development of the DSM and Community Mental Health Centers (CMHCs), NIMH created the biopsychiatric marketing strategy, "Decade of the Brain." Catching on internationally, it promoted terms like "no-fault brain" disease and "chemical imbalance," relegating life's joys and problems to being caused by nothing more than the brain. Elliot S. Valenstein says that "no biochemical, anatomical or functional signs have been found that reliably distinguish the brains of mental patients." And "people with mental disorders may be encouraged when they are told that the prescribed drugs will do for them just what insulin does for a diabetic, but the analogy is certainly not justified."

The "Global Disease" Spreads

While the 1950s saw psychiatry begin to target the general community, psychiatry's emphasis today is global. With the 1990s development of the Composite International Diagnostic Interview (CIDI) by NIMH and Dr. Norman Sartorius of the World Health Organization (WHO), whole national populations are now being surveyed to determine and compare types and levels of so-called mental disability.[22]

Commonplace among early CIDI surveys are statements like, "major depression [is] the number one disease in the world today in terms of global burden in the age range 15-44, with a number of other mental disorders filling out the top ten list of conditions," and "...no other class of diseases comes close to mental disorders...."[23] Based on the scientifically discredited *DSM-IV* and *ICD-10*, however, the CIDI will eventually earn the same "junk science" reputation.

Additionally, Dr. Thomas Szasz says that the designation "disease" can *only* be justified when the cause can be related to a demonstrable anatomical lesion, infection, or some other physiological defect.[24] As there is no such evidence for any mental disorder, the term *disease* is a misnomer; in fact, it is fraudulent.

Psychiatry's diagnoses deliberately stigmatize and pathologize normal, everyday life, creating the false impression that mental disorder is everywhere and burdensome. As Shorter states, "Psychiatrists have an obvious *self-interest* in pathologizing human behavior...."[25]

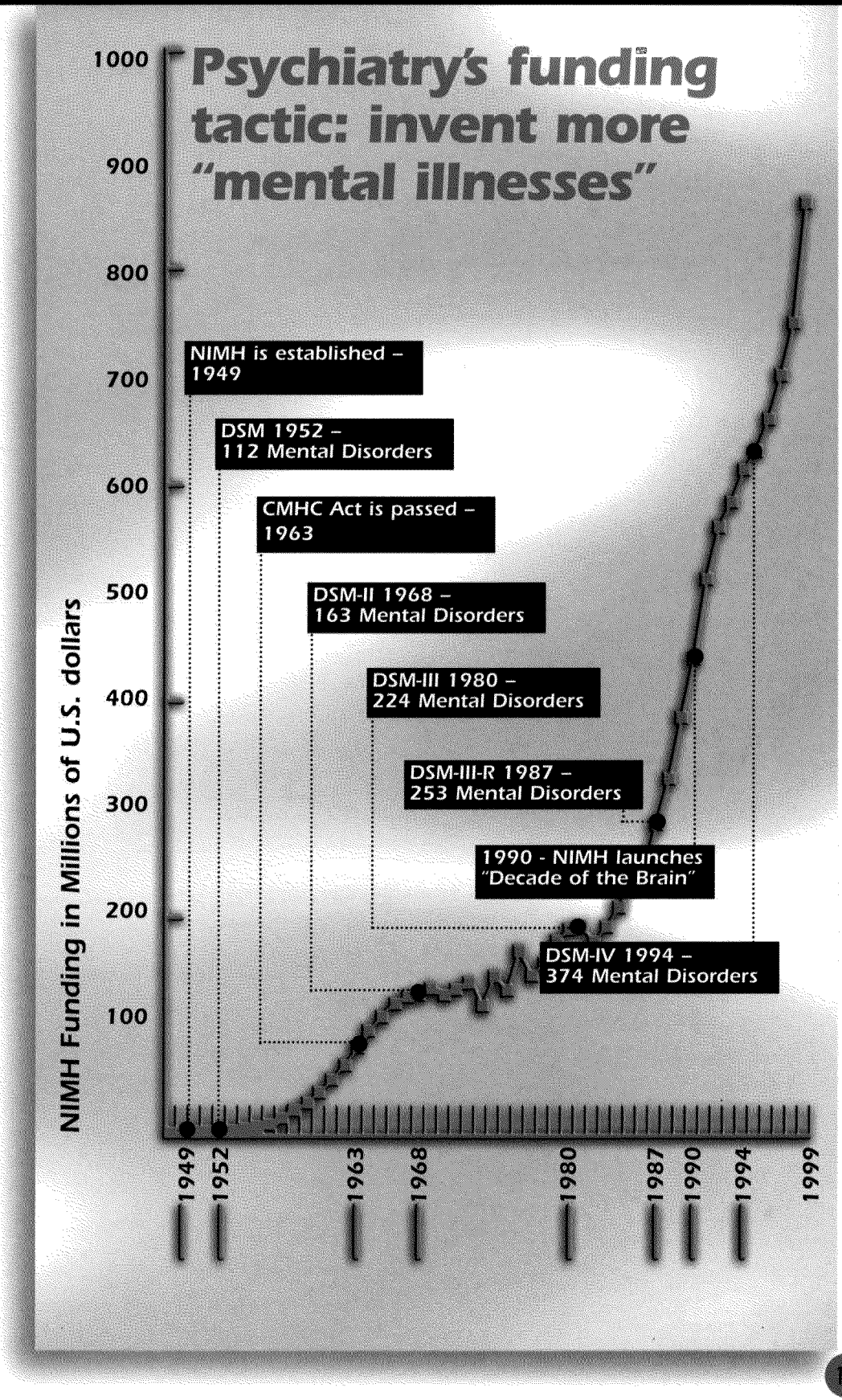
After 150 years, psychiatry still has absolutely no understanding of, or cure for, insanity or mental problems. It has never scientifically isolated any root cause of mental problems, has no proof whatsoever to back its claim of a biological or genetic cause of mental "illness," has no understanding of how psychoactive drugs, electroshock or lobotomies affect the mind, has zero ability to predict human behavior or prevent the onset of mental problems, and has no valid clue on what constitutes good mental health or how to create it.

Kaiser states that "in general, biologic psychiatry has not delivered on its grandiose and utopian claims." Meanwhile, patients have been subjected to "years of medication trials which have done nothing except reify [materialized] in them an identity as a chronic patient with a bad brain. This identification as a biologically-impaired patient is one of the most destructive effects of biologic psychiatry. At the level of the individual patients this means a growing number of over-diagnosed, overmedicated and disarticulated people less able to define and control their own identities and lives...."[26]

Built upon a foundation of lies and deceptions, psychiatry's eventual failure is predictable. But at what cost? Only by understanding the true character and costs of psychiatric intrusion up to now, will individuals, communities and nations be able to predict and avoid another century of tragic consequences from psychiatry's menacing incompetence.

"Research has yet to identify specific biological causes for any of these [mental] disorders.... Mental disorders are classified on the basis of symptoms because there are as yet no biological markers or laboratory tests for them."

— U.S. Congress Office of Technology Assessment Report, 1992



With the dual tactics of psychiatrists inventing more and more mental illnesses for inclusion in their *Diagnostic & Statistical Manual for Mental Disorders (DSM)*, and initiating expansion campaigns to increase market penetration — such as the 1963 Community Mental Health Centers Act and the 1990 "Decade of the Brain" — the U.S. National Institute for Mental Health (NIMH) has garnered millions in government appropriations — with no measurable benefit to society.

"Most appreciated are the [CCHR] efforts, through various public forums and media, to inform the public of such critical issues as abusive psychiatric drugging, electroshock therapy and psychosurgery."

— Bruce Garberding, Director
Washington Protection and Advocacy System, 1988

the "then" VALUE OF

Italian psychiatrist Ugo Cerletti (far right) and Portuguese psychiatrist Egas Moniz (right) are considered the "fathers" of electroshock and psychosurgery respectively.

CHAPTER 2

apeutic"

PAIN

"This is a crime against the spirit. This is a rape against the soul."

— Dianna Loper
Founder, Association of Electroshock Survivors
1995

If human rights include freedom from brutality and cruel, inhuman or degrading treatment, then there is no doubt that contemporary psychiatry's major "treatment" fixations are no more than human rights abuses.

The three main treatments used by psychiatrists today—psychosurgery, electroshock treatment (ECT) and psychoactive drugs—rely on overwhelming the individual for their "effectiveness." As they never address the *causes* of "mental illness"—a cause is something that psychiatry has never come close to discovering—these treatments do not "cure" the individual's troubles. Their action is to interfere, in a hit-and-miss way, with the individual's current physical, emotional and thought processes. When the treatment "works," it commonly means the problem or its manifestations are chemically or mechanically suppressed; the trouble with this is that, to varying degrees, so is the patient and his awareness of life. Meanwhile, the underlying problem remains, and in due course, the individual will find himself less able to cope with life than before.

Psychosurgery: "Murder of the Mind"

Sylvia suffered depression. From the age of 18 she was given electroshock, then drugs and counseling. None of them worked. She was then given a leucotomy (leuco: "white"; tomos: "cut") brain operation, also known as psychosurgery. Sylvia later wrote to thank her psychiatrist for having "saved my life." Five years later, her depression returned in full force, the "dreaded shock treatments resumed and continued obliterating her memory until doctors said she could not have any more shocks." Today she lives in a nursing home.[27]

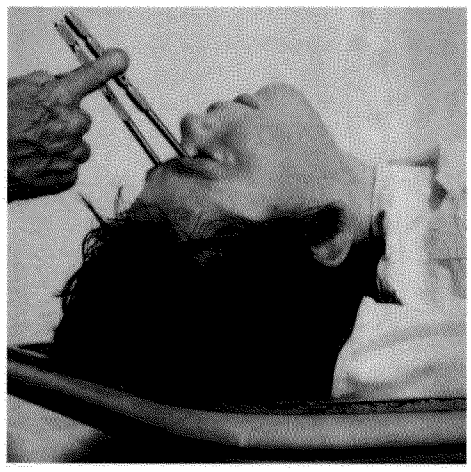
It was 1935 that marked the true birth of psychosurgery when Egas Moniz, a Portuguese psychiatrist, conceived of leucotomy operations which destroyed the brain in the same way as you would "core an apple." American psychiatrist Walter Freeman gave leucotomy a new name — frontal lobotomy.

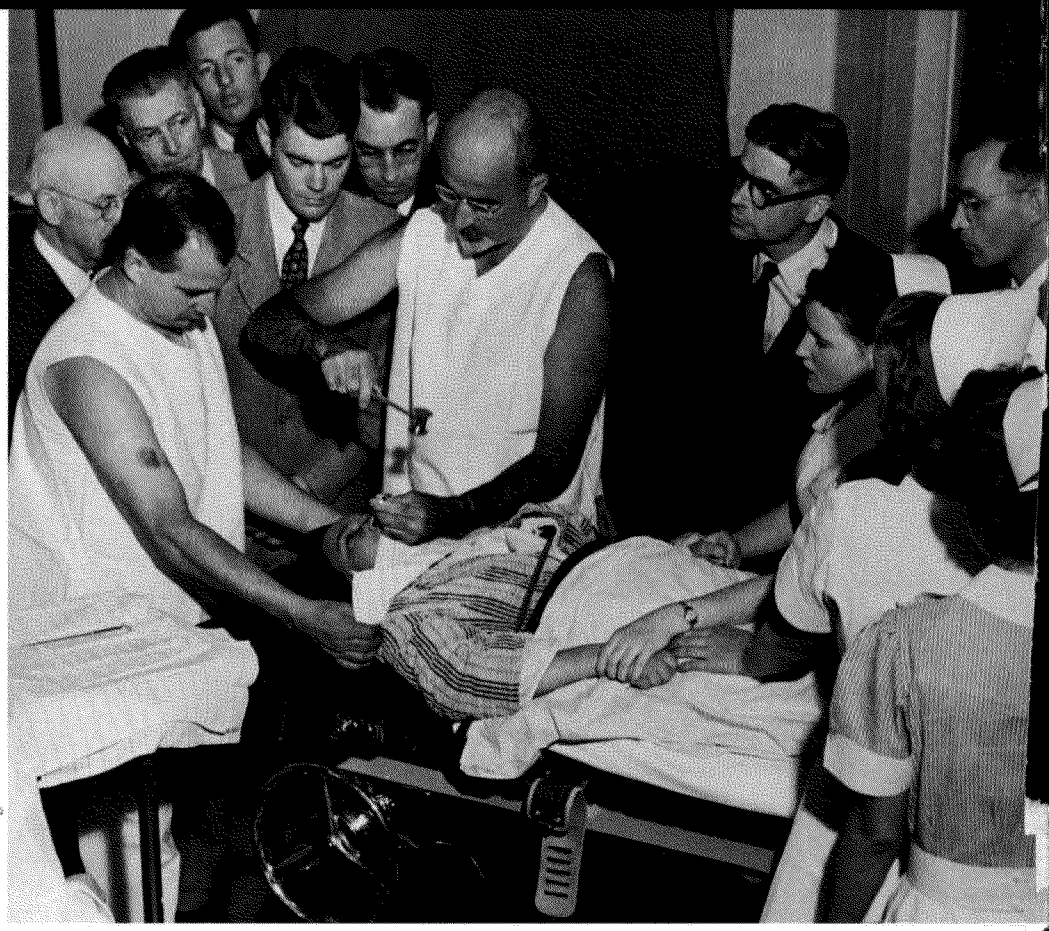
"I found the CCHR to be sincerely concerned and dedicated in their campaign to increase basic human rights for the mentally ill....Their concern for individual patients in an area which many neglect, reflects a genuine humanitarian endeavor and they are hereby acknowledged...."

— The Hon. Peter Duncan
Minister of Health, South Australia, 1979

A barbarous act, it involved inserting an ice-pick like instrument beneath the eyelid and driving it through the eye socket bone into the brain using a surgical mallet. Movement of the instrument severed the fibers of the frontal brain lobes, causing irreversible brain damage.

Today, under the newly-sanitized name of "neurosurgery" for mental





PSYCHOSURGERY BRUTALITY: ***American psychiatrist Walter Freeman (above) developed the frontal lobotomy, a barbarous act which used electric shock as an anesthetic before plunging an ice-pick like instrument beneath the eyelid and, using a surgical mallet, driving it through the eye socket bone and into the brain. Movement of the instrument severed the fibers of the frontal brain lobes, causing irreversible brain damage.***

disorders (NMD), psychosurgery advocates such as the Scottish Health Secretary propose that lobotomies—performed by burning out the frontal lobes—be used on patients without their consent.[28] While in Russia between 1997 and 1999, Dr. Sviatoslav Medvedec, director of St. Petersburg's Institute of the Human Brain, admitted to overseeing more than 100 psychosurgery operations given mainly to teenagers for drug addiction. "I think the West is too cautious about neurosurgery because of the obsession with human rights...," he said.[29]

But where psychosurgery was once indiscriminately performed without patient consent, today it has largely fallen into disuse. In 1977, CCHR worked with patients' rights groups and the United States Congressional Black Caucus to introduce a federal law prohibiting psychosurgery on prisoners in federally-funded institutions.[30] By 1980, it was no longer used in prisons or mental institutions without consent.[31]

In Australia in 1977, CCHR brought about a New South Wales (NSW) government inquiry into psychosurgery.[32] As of 1999, psychosurgery was no longer performed in NSW, and in Victoria, the only Australian state that still performs psychosurgery, only eight operations had been approved in the decade of 1987 to 1997.[33]

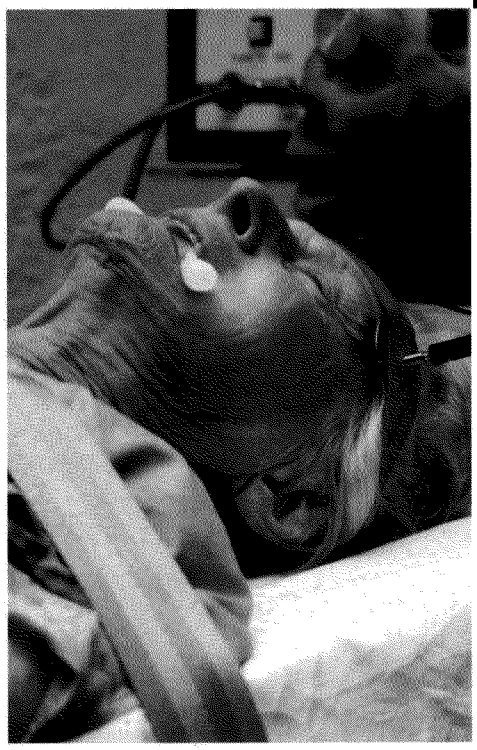
CCHR Norway worked with patients' rights activist Mary Lehne in 1996 to secure thousands of dollars in government compensation for the country's 500 surviving lobotomy victims.[34]

In a 1997 article in *Discover*, neurosurgeon Frank Vertosick commented, "Finding a paper extolling the virtues of psychosurgery in today's medical literature is rather like finding one advocating bloodletting."[35] He equated it to repairing a "computer with a chain saw."

Electroshock Treatment: Electrical Torture

Electroshock "treatment" (Electro-Convulsive Therapy or ECT) pioneer, Ugo Cerletti, an Italian psychiatrist, was inspired by watching slaughterhouse operators using electric shock to send pigs into epileptic convulsions prior to slitting their throats. ECT for humans creates a similar severe grand mal convulsion of long duration through the application of 180 to 460 volts across the brain.

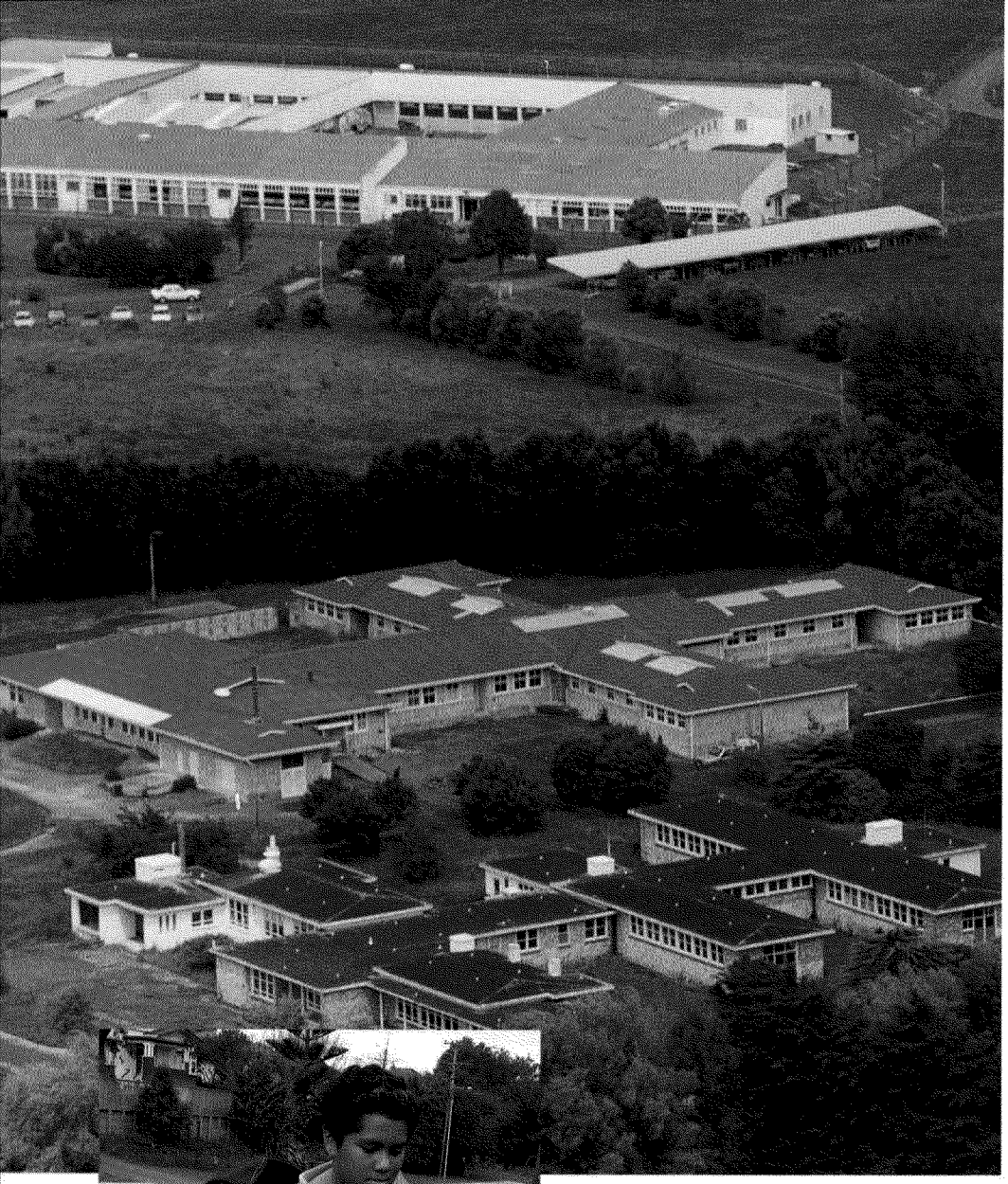
While some psychiatrists still deny that electroshock causes irreversible brain damage and memory loss, neurologists and anesthesiologists emphatically disagree. Studies between 1979 and 1991 reveal abnormal neurological signs following electroshock, as well as brain atrophy (shrinkage), and enlarged ventricles.[36] A Mayo clinic study of 34 persons over the age of 85 who were subjected to ECT documented that 79% suffered treatment complications, including a 32% incidence of confusion and delirium, while 18% had serious heart arrhythmias during treatment disrelated to their age.[37]

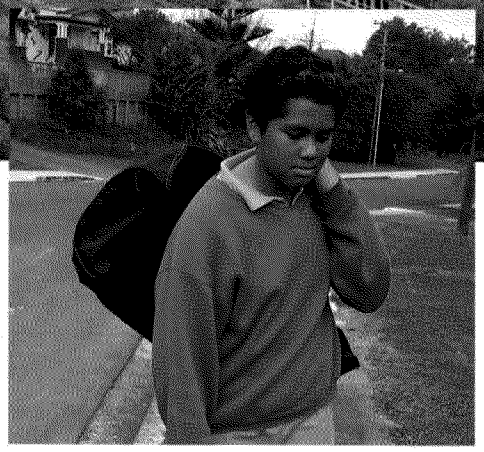


BANNING ELECTROSHOCK TREATMENT: ***With Texas legislators (and CCHR Texas Director Jerry Boswell, rear right), the Texas governor signed the most innovative ECT law, prohibiting ECT on children under 16 and implementing mandatory reporting on ECT usage, side effects and deaths. In 1999, the region of Piemonte in Italy banned ECT use on children, pregnant women and the elderly.***

The dangers and failure of ECT have been documented in numerous studies. However, because of psychiatry's litany of lies about ECT's "safety and efficacy," it has fallen to CCHR and scores of victims to ensure that people are fully informed about its risks.

In 1976, CCHR helped secure a ban in California on the use of electroshock and psychosurgery on children under the age of 12. The legislation became a model law,





CHILDREN IN PERIL: ***In 1976, CCHR members obtained a magisterial inquiry into the use of ECT without anesthetic on children as a form of behavior modification and punishment in New Zealand's Lake Alice psychiatric hospital. The damaging practice was stopped. Lake Alice is now shut down. In 1997, former Lake Alice victims began suing over the long term damage alleged from the treatment.***

adopted in substance by legislatures across the United States and overseas.

In September 1993, through CCHR's work, Texas passed the most restricting law to date, raising the lower age limit for ECT to 16 years of age, and forcing psychiatrists to warn their patients *in writing* of the potential for ECT to cause death and/or permanent memory loss. Along with other constraints, psychiatrists must furnish autopsy reports on any deaths within 14 days of ECT administration. At least 16 psychiatric facilities subsequently stopped using electroshock in Texas.

In 1999 in Italy, the birthplace of ECT, the Parliament of Piemonte responded to CCHR's information by unanimously voting to ban the use of ECT on children, the elderly and pregnant women.[38]

Lake Alice, New Zealand — A Child's Worst Nightmare

"The psychiatrist was the one who twiddled the knobs that sent the current into my head....It was incredibly painful. I was terrified because I couldn't see. My vision was gone. Instead there were black and white wavy lines, like the test pattern on the TV....It was a reign of terror...you did what you were told—or else they injected you with a drug or gave you ECT."[39]

12-year-old electroshock victim
1997

In 1976, CCHR members in New Zealand discovered a special adolescent psychiatric unit in Lake Alice Hospital, where children were given ECT as behavior modification, punishment and control. Electric shock was applied to their legs and arms, often without anesthetic.[40] Through CCHR's persistence, a magisterial inquiry followed, the damaging practice was stopped, the "shock ward" was closed, and the psychiatrist in charge resigned. Lake Alice was subsequently shut down.

Since 1997, more than 90 former Lake Alice victims have come forward and a $32 million civil claim was filed against the government and the psychiatrist involved, alleging torture, sexual abuse, unlawful confinement, false imprisonment, assault and negligence.[41]

PSYCHOTROPIC DRUG PUSHING

"What's happening in the training of psychiatrists and in the quality of a psychiatrist is that they have become drug pushers. They have got an array of drugs that they keep changing, adding, taking away, adjusting, with really no good rationale...."[42]

— Walter Afield, Psychiatrist, 1994

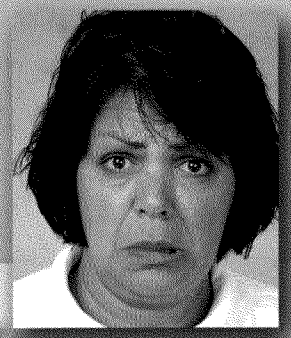
While barbiturates and anti-depressants were used in the 1920s and 1930s, major tranquilizers in the 1950s enabled psychiatry to empty patients from institutions. A leading psychiatric researcher described the drugs as "a pharmacological substitute for lobotomy."[43] As a result of psychiatry's community push however, millions of people today are "bathed" in drugs "24 hours a day," to the point that the nervous system doesn't know how to cope without the "constant presence of the drug."[44] In other words, addiction.

Generally, psychiatrists continue to ignore the evidence of dangerous side-effects, including the iatrogenic (physician-induced) condition called Tardive Dyskinesia—irreversible and uncontrollable twitching of the extremities and facial muscles. "We will not know what side effects the newer drugs will have until they have been in use for a sufficient period of time," warns Valenstein, adding that, "the possibility of serious and permanent side effects from prolonged treatment cannot be discounted."[45]

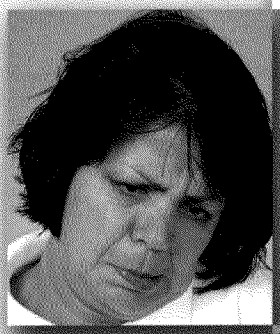
CCHR has successfully worked to obtain informed consent for psychiatric drugs.[46] In 1983, the Massachusetts Supreme Judicial Court ruled that involuntarily committed patients had the right to refuse psychotropic drugs unless deemed mentally incompetent by a court—not by the arbitrary opinion of a psychiatrist.[47] Thereafter a series of suits established the right to refuse treatment in other states across the country.[48]

In the late 1980s, CCHR Australia exposed patients being subjected to 30 times the recommended dose of psychiatric drugs in the psychiatric Ward 10B of Townsville Hospital. In a letter to a colleague, the psychiatric registrar Dr. Bevan Cant, boasted: "In emergencies we offer [a major tranquilizer]; if refused, we stand several staff around and re-offer. If again refused, it is 'grab and jab.'"[49]

After CCHR's continual exposure of psychiatric drug abuse and campaigning for better recording of drug information in medical records, the 1991 United Nations statements of rights for the Protection of Persons with Mental Illness, Principle10, specifies that all prescribed medication data shall be recorded in a patient's records and psychiatric drugs shall never be administered as a "punishment or for the convenience of others."[50]

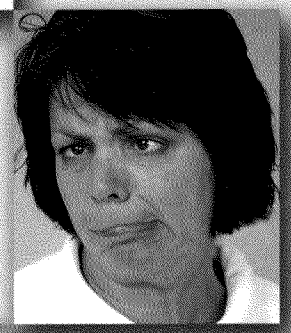


"Tardive dyskinesia" and "tardive dystonia" are permanent conditions caused by psychiatric drugs.



Tardive means "late-appearing," dyskinesia means "abnormal movement of muscles" and dystonia means "abnormal tension in muscles."

In these conditions, the muscles of the face and body contort and spasm involuntarily.



These effects occur in more than 20% of those given major tranquilizers.

TRAGIC SIDE EFFECTS:
Users of psychiatric drugs are rarely informed that they could suffer crippling facial and body spasms as a permanent side effect of many psychotropic drugs. However, in psychiatric newsletters and journals, psychiatrists readily admit to the devastating nerve damage their drugs cause.

"The campaign by CCHR in relation to Chelmsford and to obtain a Royal Commission was the most sustained and thorough exercise in whistleblowing, investigatory reporting and public interest work in the history of this country—bar none!"

— Patrick Griffin, Australian Lawyer
1994

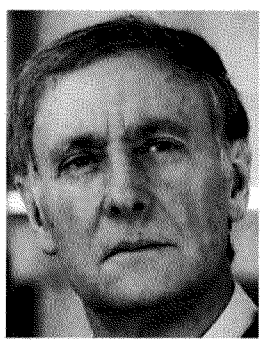
The Deep Sleep Patients Didn't Wake From

The thin 13-year-old girl lay naked, strapped to a hospital bed. Just after midnight a psychiatrist entered the ward and moments later her body, rudely awakened from a drug-induced coma, thrust violently upward as a bolt of electricity surged through it. It happened ten times in two weeks—without anesthetic, without her consent and without her parent's knowledge. Eventually, she was discharged with brain damage. She was one of the lucky ones. She survived.[51] Craig, 13, didn't. Admitted for a "short rest," Craig didn't have a "psychiatric" condition. He was blind. Four months later, he was dead.[52]

More than 1,100 people were subjected to Deep Sleep Treatment (DST: also known as continuous narcosis and sleep therapy) in Chelmsford private psychiatric hospital in Sydney, Australia between 1963 and 1979. DST kept patients in a drugged comatose state for two to three weeks during which the person was battered daily with electroshock. It was given without anesthetic, often without the consent or knowledge of the patient. Nearly all of the patients suffered complications including deep vein thrombosis (blood clots), pleurisy, pneumonia and brain damage; 48 people died.

Due to the work of Barry Hart, a former Chelmsford patient, and the bulldog determination of CCHR, DST was eventually banned. Their work resulted in award-winning TV exposes, thousands of newspaper reports, and eventually justice. Between 1988 and 1990, the New South Wales government held a Royal Commission Inquiry into DST, ultimately recommending major legislative reforms.

Medical complaints bodies with ombudsman status, were established to investigate and prosecute complaints about psychiatrists, psychologists and other health professionals. Moreover, several hundred of the Chelmsford victims were compensated. Similar successes were achieved by CCHR in New Zealand.



VICTIMS' BATTLE FOR JUSTICE: ***More than 1,100 citizens were subjected to Deep Sleep Therapy (DST) in Sydney, Australia. The 2- to 3-week drug-induced coma with daily electroshock killed 48 people before it was banned in 1983. Even after its ban, DST psychiatrists continued practicing, sparking a five-year battle for justice. In 1986, CCHR and actor and DST victim Barry Hart (above) helped form the Chelmsford Victims Action Group (left) which achieved a Royal Commission government inquiry into DST that led to legislative reforms in Australia and New Zealand. In 2000, Hart filed a complaint about his experiences to the United Nations.***

Telegraph Mirror

SYDNEY, Saturday, February 29, 1992

Deep sleep man wins $½m

A FORMER patient of Chelmsford Private Hospital has been awarded $585,186 dam-

By JENNIFER

The West Australian

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Chelmsford: horror of the living dead

Royal commissioner Justice J. P. Slattery's 12-volume, 4000-page report into deep sleep therapy at Sydney's Chelmsford Hospital was released yesterday.

JOHN COLMEER and JERRY PRATLEY report on the sordid affairs that were carried on under the direction of Dr Harry Bailey.

The Sydney Morning Herald

Saturday, July 6, 1991

to first deep-sleep

o win justice

"You can't put a price on pain and suffering"

PAGE 16 DAILY MIRROR, Friday, December 21, 1990

EVIL DOC 'KILLED 200 PATIENTS'

By MARK DOWDNEY

MAD doctor Harry Bailey was blamed yesterday for killing more than 200 patients.

Another 977 were brain-damaged by his terrifying electro shock treatment in a private mental hospital.

Twelve were given ... treatment, kept many of the deaths secret so he could continue experiments.

The full horror of Sydney's hospital of death was revealed when an official inquiry called for criminal charges against three of his colleagues.

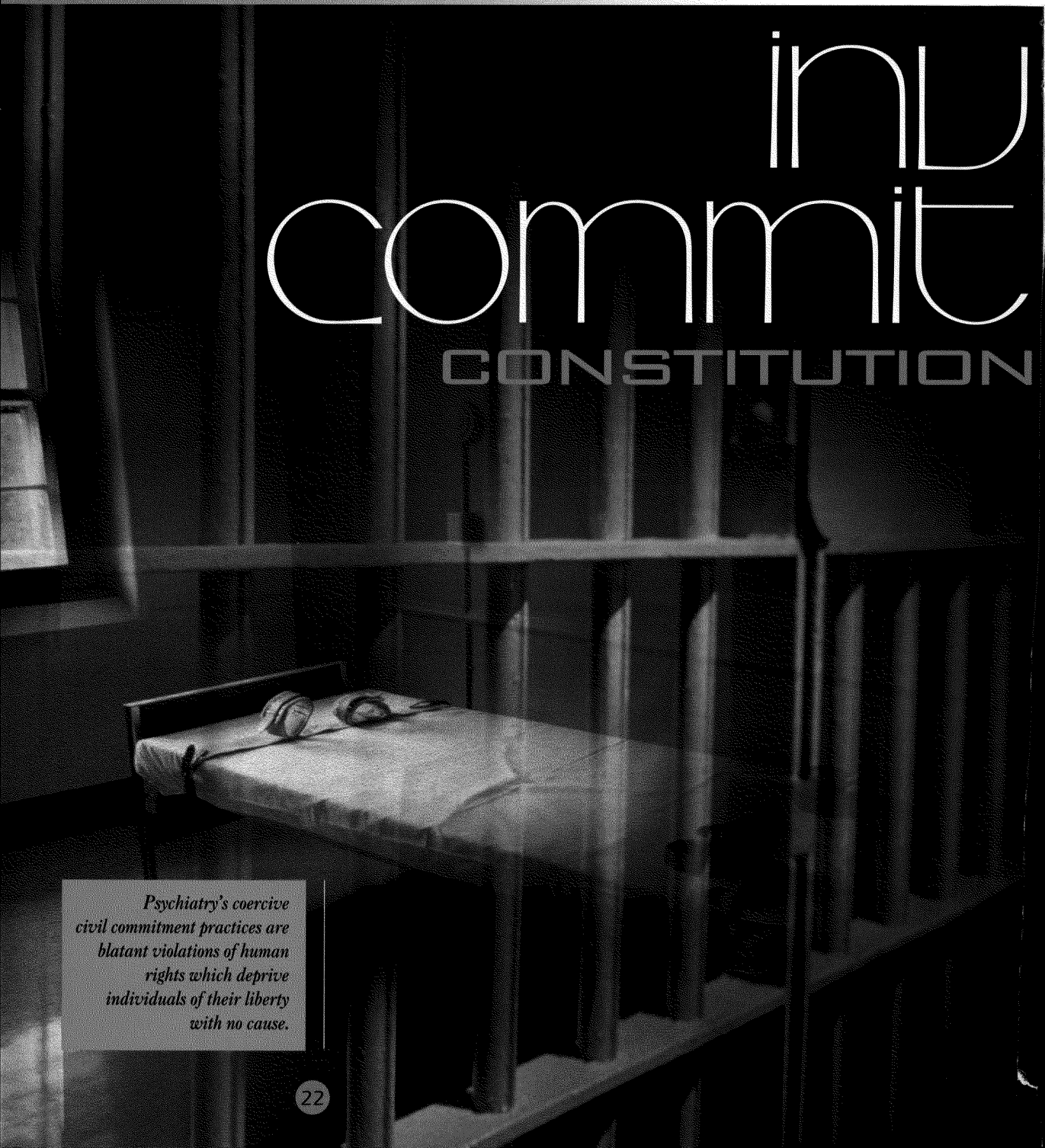
It said the doctors must have known what Bailey described as a "daily" ... was doing. A judge's report revealed ... patients died from ... Sleep Ther-

JUSTICE AND COMPENSATION: *For more than a decade, CCHR spearheaded a campaign for "justice and compensation" for DST victims. CCHR President Jan Eastgate (above) worked with government officials including Pat Rogan and John Hatton (top) for inquests into patient harm and deaths. A 1988-90 Royal Commission Government Inquiry resulted in a 12-volume report with recommendations for reforms. Since then, hundreds of Chelmsford victims have been compensated.*

Civil commitment "entails far greater deprivation of rights than does incarceration in prison, a penalty carefully circumscribed by constitutional guarantees and judicial safeguards."[53]

— Thomas Szasz, M.D.
Professor Emeritus of Psychiatry, 1984

my commit CONSTITUTION



Psychiatry's coercive civil commitment practices are blatant violations of human rights which deprive individuals of their liberty with no cause.

CHAPTER 3

oluntary ment

AL DESTRUCTION

Human rights include equal protection of the law, as well as freedom from arbitrary arrest and detention. Psychiatry's coercive civil commitment practices are therefore no less than flagrant violations of basic human rights.

In 1969, Hungarian refugee Victor Gyory was committed to Haverford State Hospital in Philadelphia, stripped naked, held in isolation against his will and forced to undergo electroshock. He was refused the right to an attorney and denied the right to refuse treatment. CCHR obtained the aid of Hungarian born Dr. Thomas Szasz, who found that Gyory had been diagnosed as "schizophrenic with paranoid tendencies" for one simple reason—his inability to speak English. Chief counsel for CCHR prepared to take Gyory's case to court to test the constitutionality of Pennsylvania's law, at which point the hospital director discharged Gyory.[54]

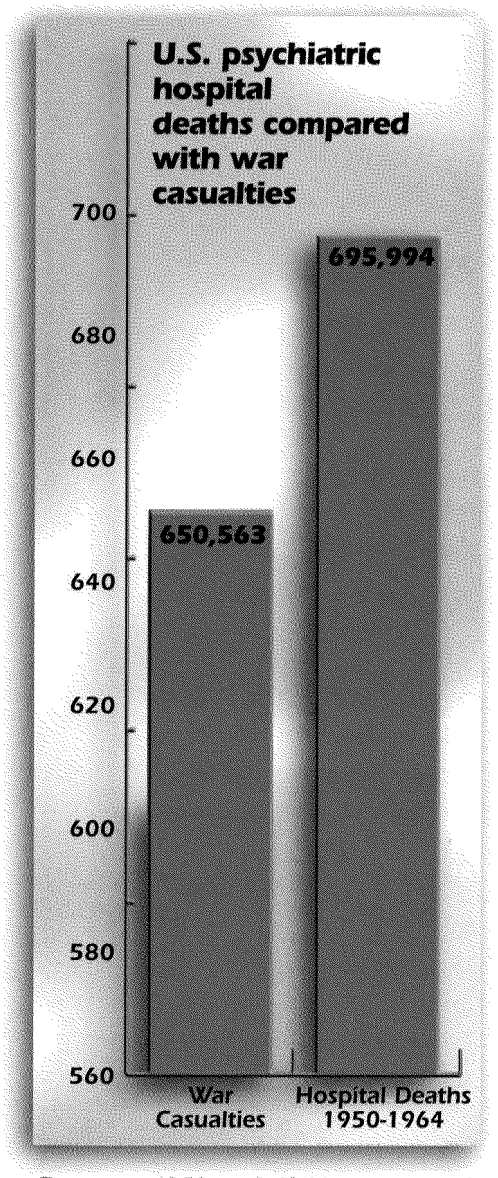
Mental health involuntary commitment laws, inspired and lobbied for by psychiatrists, are frequently used by them—even today—to violate the most basic of individual human rights and civil liberties. Internationally exposing the unconstitutionality, discrimination and human rights violations inherent in psychiatry's "easy seizure" laws has been one of CCHR's most important missions. Many mental health laws around the world introduced legal safeguards and protections against arbitrary psychiatric incarceration.

In Australia in the 1980s, legislation mandated that people in any commitment proceeding be provided legal representation at the cost of the state with the right to appeal and call witnesses in their support. Furthermore, people can no longer be committed based on their *religious, cultural or political beliefs and practices.*

In 1980, a federal court in California ruled that involuntarily committed persons had the right to refuse treatment.[55] In 1993, Texas added criminal penalties for wrongful commitment; offending psychiatrists could face up to two years in jail.

Through Freedom of Information, CCHR France obtained a study in 1985—which the Ministry of Health and Inspector General for Social Affairs sought to keep hidden—revealing that 44.4% of persons in psychiatric hospitals were there without proper reason and of these, 45% had no "mental disorder."[56]

In 1994, CCHR Hungary helped a 17-year-old boy who was incarcerated and electroshocked because he had refused to leave his mother's place of work when told she was not there. CCHR helped stop the ECT and secured his release. The same year, CCHR Denmark helped secure the release of a man who had been forcibly held in a psychiatric institution, restrained by belts and threatened with being drugged against his will. The National Appeal Board confirmed the decision of the Patients Complaints Board that the psychiatrists' actions were illegal.[57]



Between 1950 and 1964, more people died in U.S. federal, state and county psychiatric hospitals than the number of Americans killed in 10 wars combined, including WWI and II, Vietnam and the Gulf War.

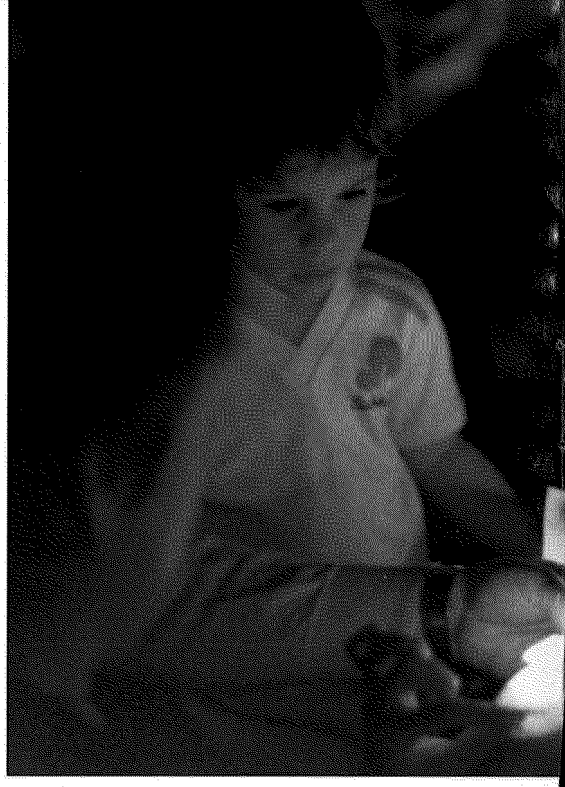
Psychiatry's Death Toll

Being denied basic human rights and protections is not necessarily the only loss that a patient risks, once he or she becomes enmeshed in psychiatry's coercive system. The patient's life itself may also be at risk.

Between 1950 and 1964, more people died in United States federal, state and county psychiatric hospitals than the number of Americans killed in the Revolutionary War, the War of 1812, the Mexican War, the Civil War, the Spanish-American War, World Wars I and II, the Korean War, Vietnam and the Persian Gulf War combined. In fact, between 1950 and 1990, the total number of psychiatric inpatient deaths exceeded the same cumulative number of war casualties by at least 70%.[58]

It may be stating the obvious to a non-psychiatrist that treatment is not supposed to kill a patient, or that a patient should not die in the course of treatment, yet this is what happens virtually every day through psychiatric drugs, restraints, brutality, assault and neglect.

In the 1970s, CCHR provided evidence and witnesses to document 100 unexplained deaths in California's Camarillo and Metropolitan State hospitals. One 36-year-old man was found dead upside down in bed where he had been shackled with



DEATHS IN PSYCHIATRIC HOSPITALS EXPOSED: ***CCHR's research and investigation has led to media exposure of the high fatality rate in psychiatric institutions. Above, a candlelight vigil mourning children killed by restraining measures.***

leather restraints. A grandmother was found dead in a hospital closet two weeks after the staff informed the family that she was missing. Inquests led to legislative reforms, giving the medical board access to patient files for future investigations.

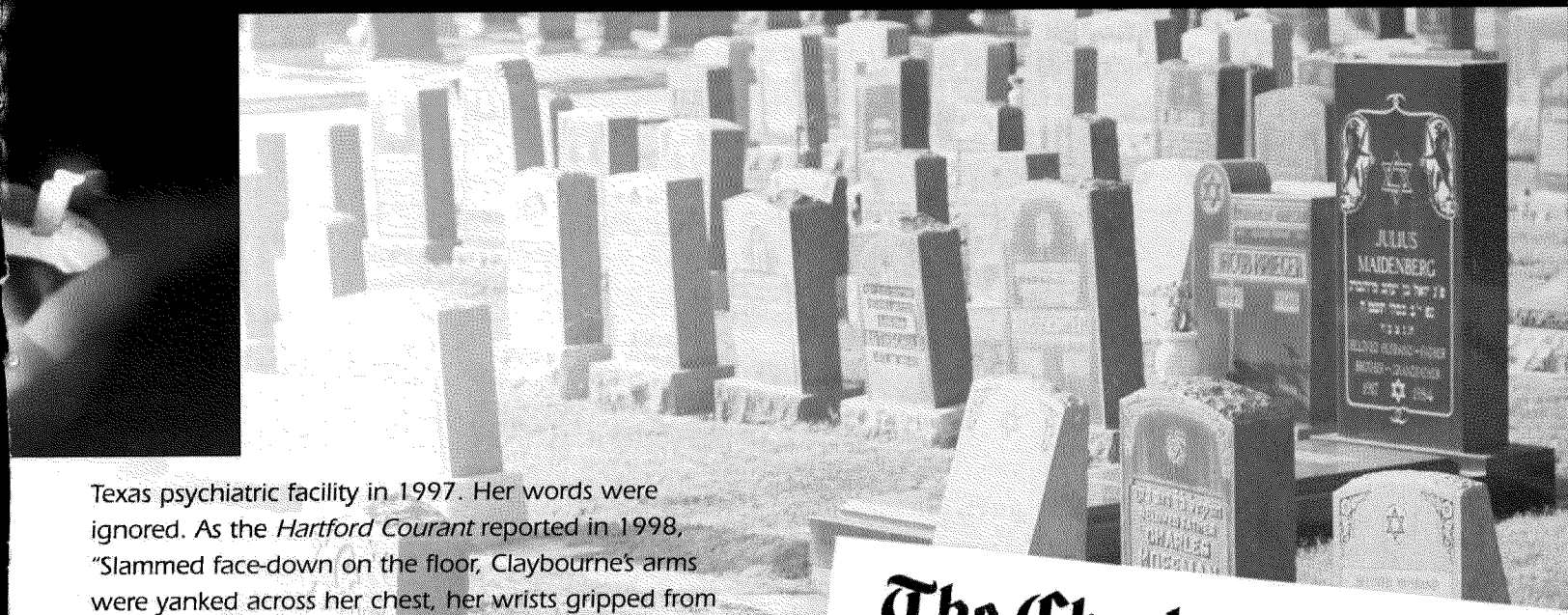
Scandal rocked Japan between 1994 and 1998, after the discovery that private psychiatric hospitals were forcibly incarcerating and illegally restraining elderly patients. In 2000, regulations went into effect prohibiting the use of physical restraints on the elderly, except in emergencies.[59]

Also in 2000, CCHR helped expose the shocking number of deaths at Graylands state psychiatric hospital in Western Australia, resulting in a coroner's investigation. The proportion of suicides to admissions of Graylands patients had trebled in the previous 12 years.[60]

"I can't breathe," 16-year-old Roshelle Claybourne pleaded in a

"To the everlasting credit of these stalwart citizens [CCHR]...the light has been focused on the evil doings inside these institutions...."

— National Health Federation Bulletin, 1977



Texas psychiatric facility in 1997. Her words were ignored. As the *Hartford Courant* reported in 1998, "Slammed face-down on the floor, Claybourne's arms were yanked across her chest, her wrists gripped from behind by a mental health aide." She was forcibly drugged, became suddenly still, blood trickled from the corner of her mouth as she lost control of her bodily functions. Her limp body was rolled into a blanket and dumped in a seclusion room. No one watched her die.[61]

In 1998 and 1999, working with legislators and media, including Fox Files, CCHR exposed the grisly truth that up to 150 restraint deaths occur each year in the United States. Thirteen of the deaths over a two-year period were of teenagers and children; the youngest was 6 years old.[62]

In 1999, the Clinton administration adopted federal regulations prohibiting the use of physical and chemical restraints to coerce or discipline psychiatric patients. The regulation also ordered a "national reporting system" to be implemented and for government funding to be cut to any facility that did not abide by the regulations.[63]

"Efforts by organizations like CCHR are vital if we are to succeed in returning our schools to places of learning. This can only be done by eliminating unworkable psychiatric or psychological curriculums and questionnaires."

— Mrs. Patti Johnson, Member
Colorado State Board of Education, 2000

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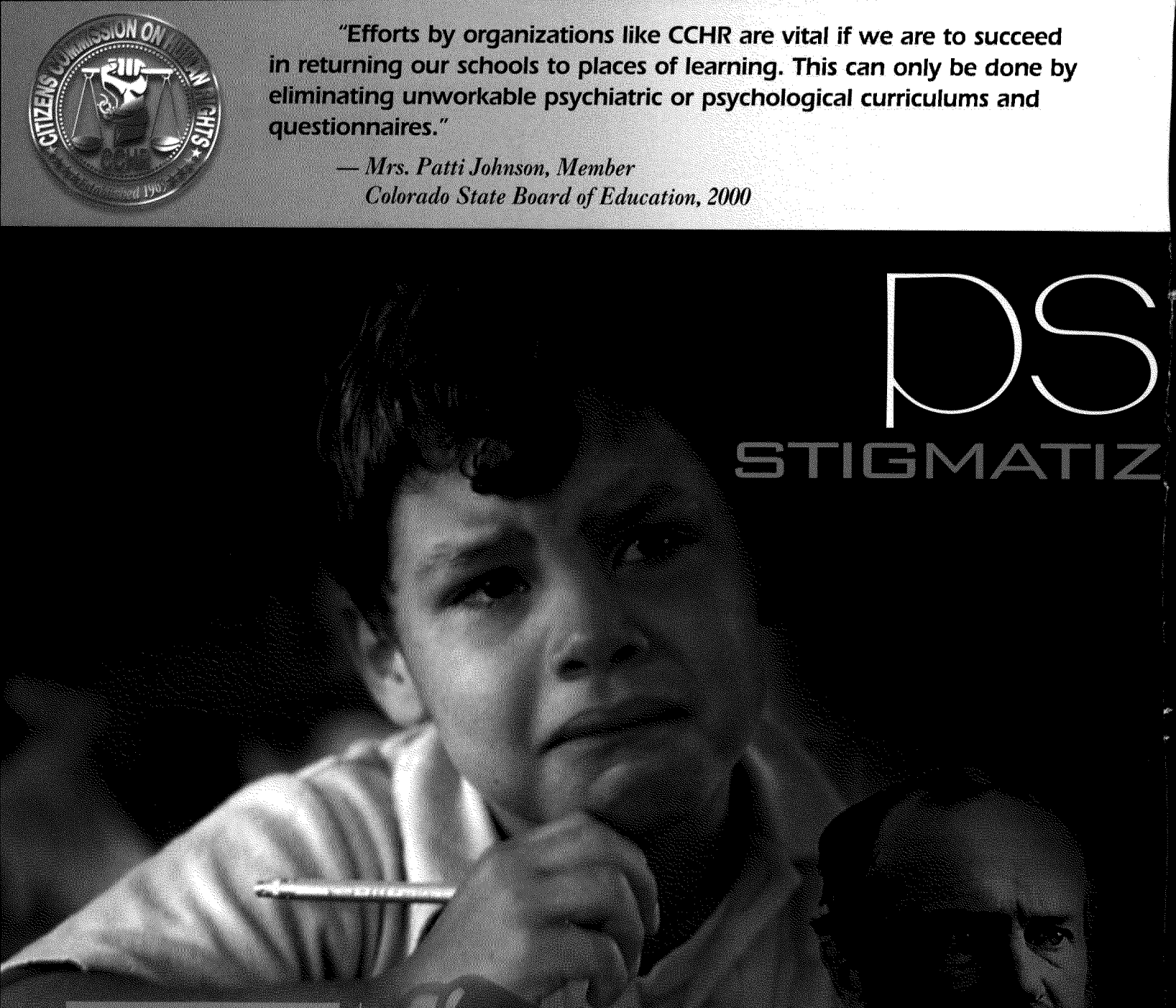
STIGMATIZ



William James (right), often referred to as "the father of modern psychology," laid the ground work for the introduction of psychology into the field of education. In doing so, he opened the doors to today's infiltration by psychologists and psychiatrists diagnosing millions of normal children as defiant, disordered and "hyperactive" and subject to harmful "treatment."

...tion-Deficit and Disruptive Behavior Disorder

Attention-Deficit/Hyperactivity Disorder

...stic Features

...ential feature of Attention-Deficit/Hyperactivity Disorder is a ...
...tion and/or hyperactivity-impulsivity that is more frequent and ...
...observed in individuals at a comparable level of developmen...
...active-impulsive or inattentive symptoms that cause impairment ...
...ier before age 7 years, although many individuals are diagnos...
...have been present for a number of years (Criterion B). Some ...
...toms must be present in at least two settings (e.g., at ...
...C). There must be clear evidence of ...
...al, academic, or occupational ...
...occur exclusively during ...
...ental disorder ...

CHAPTER 4

ychiatry

ES AND HARMS CHILDREN

"Clearly, this business of treating minds—particularly this big business of treating young minds—has not policed itself, and has no incentive to put a stop to the kinds of fraudulent and unethical practices that are going on."

— U.S. Representative Patricia Schroeder
Chair, House Select Committee
on Children, Youth and Families, 1992

Today at least six million American children are diagnosed with some form of psychiatric disorder requiring medication. Under criteria voted on by the APA, *any* child can be diagnosed as having "Attention Deficit Disorder" (ADD) or "Attention Deficit Hyperactivity Disorder" (ADHD). The criteria for "ADHD" consists of 18 points, including "has difficulty playing quietly," "often talks excessively" and "often loses things."

In 1987, ADHD was added to the APA's *Diagnostic & Statistical Manual for Mental Disorders* (*DSM*). Within a year, the diagnosis had been given to 500,000 American children. By 1997, it had reached 4.4 million.[64]

Dr. Fred A. Baughman Jr., a pediatric neurologist and Fellow of the American Academy of Neurology, says ADHD and other childhood psychiatric disorders and "learning disabilities" are "inventions, contrivances" and "100% fraud."[65] He says that the psychiatric tag of ADHD deceives parents into believing that their children have a mental disorder which requires heavy drugs.

The problem is not limited to the United States. The number of stimulant drug prescriptions given British children shot from 3,500 in 1993 to 126,000 in 1998.[66] No small wonder that in 1996, the United Nations International Narcotics Control Board (INCB) asked authorities to investigate this child-drugging problem.[67]

CCHR brings psychiatry's abuse of children to public notice by testifying before legislative hearings, holding workshops for legislators and holding its own public hearings.

Parents have repeatedly testified about being threatened with their child's removal from school unless the child is taking some form of psychiatric drug.

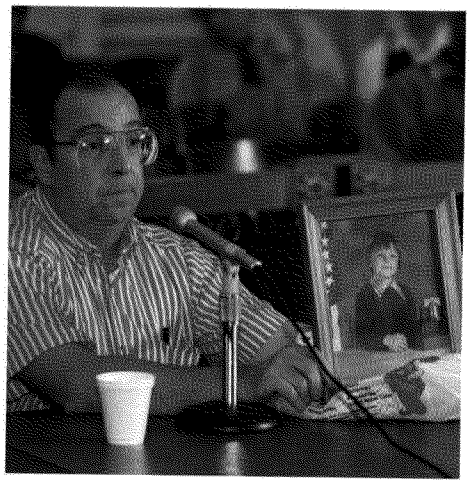
In February 2000, a study published in the *Journal of the American Medical Association* revealed the number of American children between two and four years of age who had been given psychiatric drugs had soared 50% between 1991 and 1995.[68] Responding to the scandal, the White House announced a major effort would be taken to reverse this sharp increase.[69]

The announcement came within five months of a precedent-setting Resolution passed by the Colorado State Board of Education calling on teachers to use academic rather than drug solutions for behavior, attention and learning difficulties in the classroom.[70]

On April 17, 2000, the Green Party of Soermland County in Sweden passed a motion calling for all health and medical personnel to be educated on alternative, natural methods of treating children who display hyperactive behavior.[71]

On the same day, members of the Council of Europe signed a motion regarding "Ending the misdiagnosing of children"—specifically naming ADD/ADHD as "underpinning [a] wave of drug abuse" in the United States, which wasn't welcomed in Europe. The motion called for a study on the diagnosing of ADHD and to establish possible legal measures to "curtail the abuse of psychiatric drugs by children."[72]

And on June 15, 2000, in Switzerland, the socialist party of the state of Luzern asked the Luzern council to investigate the number of children placed on psychotropic drugs and whether parents were being properly informed of the drugs' damaging side effects.[73]



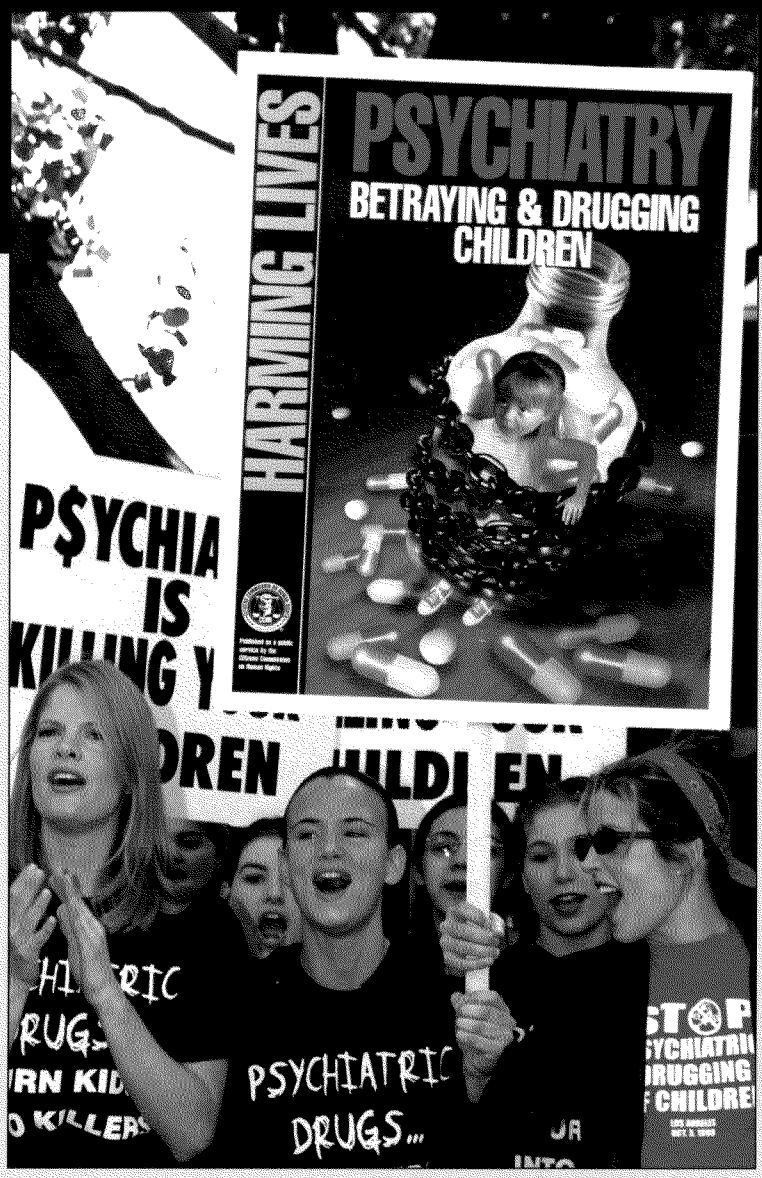
PARENTS TESTIFY AT HEARINGS: *At CCHR hearings on labeling and drugging children, parents have testified to being threatened with their child's removal from school unless they agreed to put the child on psychiatric drugs. Fred Erlich (bottom left) with photo of his son, told the hearing panel that his son committed suicide after psychiatric treatment.*

PUBLIC HEARINGS: *In Pennsylvania, a panel of experts chaired by CCHR U.S. President Bruce Wiseman (center) presented a report of findings on psychiatric child abuse in schools.*

"By identifying psychiatry as the root cause of our nation's problems (illiteracy, drug abuse, teen pregnancies and crime, etc.), CCHR is the leader in exposing the hoax."

— Shelly Uscinski
School Board Member, New Hampshire, 1997

RESOLUTIONS PROTECT RIGHTS: *CCHR raises public awareness of psychiatry's abuse of children by testifying before legislative hearings and holding educational workshops. In 1999, the Colorado State Board of Education, led by member Patti Johnson (below left), passed a resolution calling for academic rather than drug solutions to classroom learning and behavioral problems. This was followed by a similar resolution from the National Caucus of Black State Legislators, spearheaded by Pennsylvania State Representative LeAnna Washington (below right).*



CCHR organizes marches and demonstrations on important issues such as protection of children from psychiatric abuse, often supported by international celebrities.

STATE OF COLORADO

COLORADO STATE BOARD OF EDUCATION
201 East Colfax Avenue
Denver, CO 80203
(303) 866-6617

COLORADO STATE BOARD OF EDUCATION

Revised January 12, 1999

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Cathy Stanford
1st Congressional District

RESOLUTION: PROMOTING THE USE OF ACADEMIC SOLUTIONS TO RESOLVE PROBLEMS WITH BEHAVIOR, ATTENTION, AND LEARNING

WHEREAS, the Colorado State Board of Education is constitutionally charged with the general supervision of K-12 public education; and

WHEREAS, the Colorado State Board of Education dedicates itself to increasing academic achievement levels for all students; and

WHEREAS, the responsibility of school personnel is to ensure student achievement; and

WHEREAS, only medical personnel can recommend the use of prescription medication; and

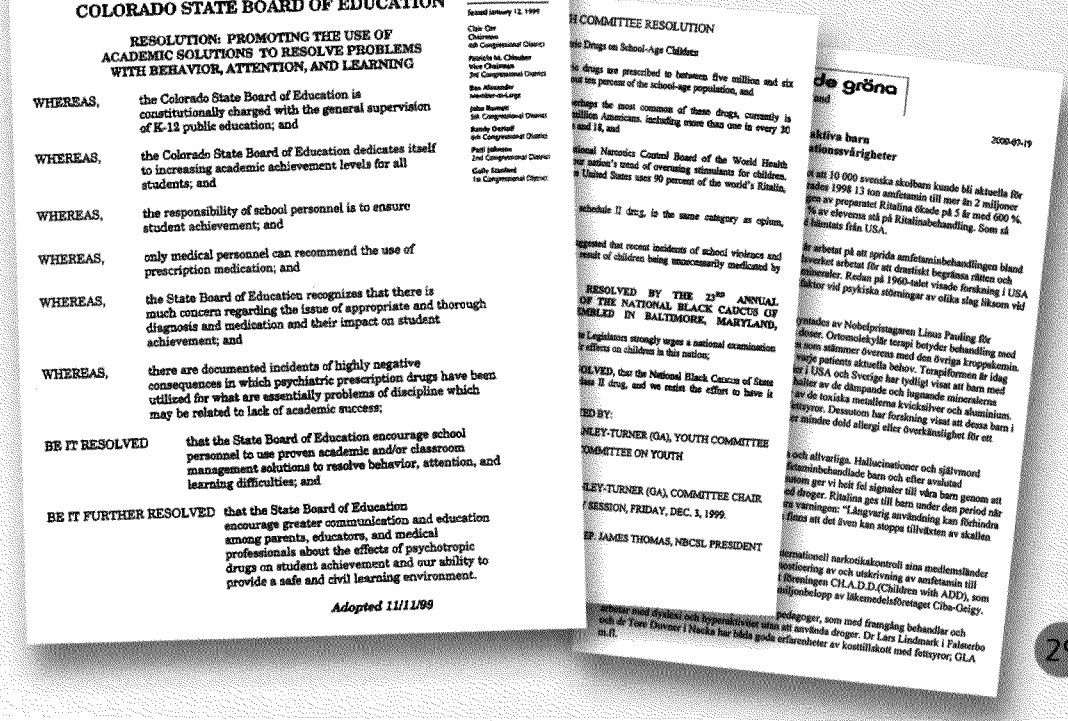
WHEREAS, the State Board of Education recognizes that there is much concern regarding the issue of appropriate and thorough diagnosis and medication and their impact on student achievement; and

WHEREAS, there are documented incidents of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success;

BE IT RESOLVED that the State Board of Education encourage school personnel to use proven academic and/or classroom management solutions to resolve behavior, attention, and learning difficulties; and

BE IT FURTHER RESOLVED that the State Board of Education encourage greater communication and education among parents, educators, and medical professionals about the effects of psychotropic drugs on student achievement and our ability to provide a safe and civil learning environment.

Adopted 11/11/99


H COMMITTEE RESOLUTION

ic Drugs on School-Age Children

ic drugs are prescribed to between five million and six
our ten percent of the school-age population, and

erhaps the most common of these drugs, currently is
million Americans, including more than one in every 20
and 18, and

ational Narcotics Control Board of the World Health
ior nation's trend of overusing stimulants for children,
e United States uses 90 percent of the world's Ritalin,

schedule II drug, is the same category as opium,

ggested that recent incidents of school violence and
result of children being unnecessarily medicated by

RESOLVED BY THE 23RD ANNUAL
OF THE NATIONAL BLACK CAUCUS OF
EMBLED IN BALTIMORE, MARYLAND,

e Legislators strongly urges a national examination
r effects on children in this nation;

OLVED, that the National Black Caucus of State
ssess II drug, and we resist the effort to have it

ED BY:

ONLEY-TURNER (GA), YOUTH COMMITTEE

OMMITTEE ON YOUTH

LEY-TURNER (GA), COMMITTEE CHAIR

SESSION, FRIDAY, DEC. 3, 1999.

EP. JAMES THOMAS, NBCSL PRESIDENT

de gröna

aktiva barn
tionssvårigheter

2000-07-19

t att 30 000 svenska skolbarn kunde bli aktuella för
ades 1998 13 ton amfetamin till mer än 2 miljoner
gen av preparatet Ritalina ökade på 5 år med 600 %.
% av eleverna stå på Ritalinbehandling. Som så
ämtats från USA.

r arbetat på att sprida amfetaminbehandlingen bland
verket arbetat för att drastiskt begränsa rätten och
mineraler. Redan på 1960-talet visade forskning i USA
faktor vid psykiska störningar av olika slag liksom vid

rtades av Nobelpristagaren Linus Pauling för
droger. Ortomolekylär terapi betyder behandling med
som stämmer överens med den övriga kroppskemin.
varje patients aktuella behov. Terapiformen är idag
i USA och Sverige har tydligt visat att barn med
haller av de därpunde och ingående mineralerna
av de toxiska metallerna kvicksilver och aluminium.
ttsyror. Dessutom har forskning visat att dessa barn i
er mindre dold allergi eller överkänslighet för ett

och allvarliga. Hallucinationer och självmord
fetaminbehandlade barn och efter avslutad
utom ger vi bekymmer till våra barn genom att
ed droger. Ritalina ges till barn under den period när
ra varningen: "Långvarig användning kan förhindra
finns att det även kan stoppa tillväxten av skallen

ternationell narkotikakontroll sina medlemsländer
ostisering av och utskrivning av amfetamin till
föreningen CHADD.(Children with ADD), som
miljonbelopp av läkemedelsföretaget Ciba-Geigy.

arbetar med dyslexi och hyperaktivitet utan att använda droger. Dr Lars Lindmark i Falsterbo
och dr Tore Dawzer i Nacka har båda goda erfarenheter av kostutskott med fettsyror; GLA
m.fl.

INTERNATIONAL TREND: *Resolutions calling for an end to psychiatric drugging of children as a false and harmful solution to learning and behavioral problems are an international trend, from the Colorado State Board of Education; National Caucus of Black State Legislators; the Green Party of Soermland County, Sweden; the socialist party in Switzerland.*

"I do appreciate from my whole heart [CCHR's] plan to openly discuss and to be active against abuse of human rights by psychiatry....It is important that these [abuses] are pointed out and all that is possible needs to be done to stop these crimes."

— Simon Wiesenthal, internationally renowned Nazi hunter, 1979

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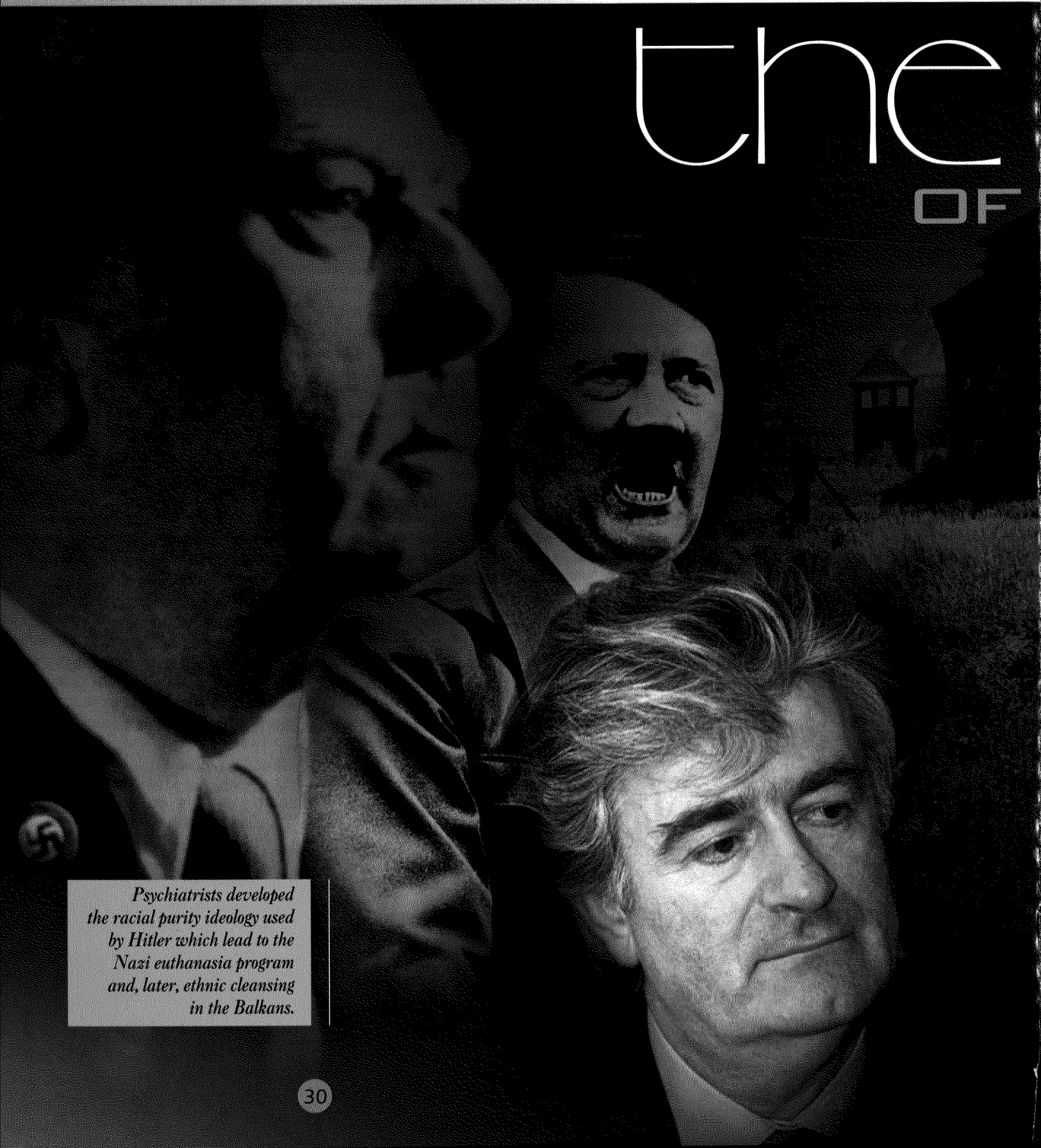


Psychiatrists developed the racial purity ideology used by Hitler which lead to the Nazi euthanasia program and, later, ethnic cleansing in the Balkans.

CHAPTER 5

POLITICS

PSYCHIATRY

"Only through the Führer did our dream of over 30 years, that of applying racial hygiene to society, become a reality."

— Ernst Rüdin,
Professor of Psychiatry Commissioner,
German Society for Racial Hygiene, 1940s

It is cold, hard fact that psychiatry spawned the ideology which fired Hitler's mania, turned the Nazis into mass murderers, and created the Holocaust. German psychiatrists violated the core moral principles of the medical profession and the Hippocratic Oath in devising the "scientific" justification for euthanasia before World War II. In 1920, Alfred Hoche, a professor of psychiatry, and Karl Binding, a jurist, published Permission to Destroy Life Unworthy of Life, equating killing as a "healing treatment."[74] They advocated the outright killing of mental defectives, stating that, "For the idiots...the continuation of life for society as well as for the person himself has no value."[75]

In April 1940, psychiatrists established the euthanasia program known as "T4"; between 1939 and 1944, nearly 300,000 "mentally defective" persons met their deaths at the hands of psychiatrists.[76] In 1941, experienced psychiatrists from T4 were sent to the concentration camps to establish their liquidation program as the model for the mass extermination of Jews, Gypsies, Poles and others.

Only a minority of those psychiatrists responsible for the Nazi killing program were ever prosecuted during the Nuremberg Trials or otherwise. Most returned to comfortable practice in the new German republic.[78] Only four psychiatrists were executed or sentenced to prison. This was in part due to the influence of Austrian born psychiatrist Leo T. Alexander, who assisted War Crime Tribunal prosecutors. According to a 1996 paper entitled "Medical Ethics at Nuremberg: The Nazi Doctors and the Hippocratic Oath," Alexander wanted the psychiatric profession protected to ensure it regained "the respect and leadership" he believed it deserved.[79]

In 1974, when the Commission for Violations of Psychiatry against Human Rights (CCHR Germany) was formed, it embarked upon the courageous path of finding and exposing Nazi psychiatrists still practicing in Germany and Austria.

Psychiatry and the Holocaust

Psychiatrists must be examined "....as providers and refiners of the ideological and intellectual foundations for race theory and medical killing...."

— Ernest Hunter, psychiatrist
"Dimensions of Medical and Psychiatric Responsibility in the Third Reich," 1993

1895: German psychiatrist Alfred Ploetz published his theories about race inferiority in the book, *The Fitness of Our Race and the Protection of the Weak*. In 1909, Ploetz founded the German Society for Racial Hygiene. Ploetz's theory was that destroying unworthy life was "purely a healing treatment."

Early 1900s: German psychiatrist Edwin Katzen-Ellenbogen drafted a law allowing sterilization of epileptics, criminals and incurably insane for the state of New Jersey, USA. Sterilization was adopted throughout the U.S. and other countries.

1920: Psychiatrist Alfred Hoch's book, *Permission to Destroy Life Unworthy of Life* demanded euthanasia be conducted on "mental defectives."

1921: *Human Genetics and Racial Hygiene* by Erwin Bauer, Eugen Fischer and Fritz Lenz, was published. These three books formed the "scientific" basis for the Nazi racial purity program.

1924: Hitler's *Mein Kampf* declared racial purity the mission of the German people.

1933: Psychiatrist Ernst Rüdin's Sterilization Law was passed; among the "hereditarily sick" were the feebleminded, hereditarily blind and deaf, physically handicapped and hereditary alcoholics. Hereditary Health Courts were established to make decisions on sterilization. Rüdin was also a co-founder with Alfred Ploetz of The Society for Racial Hygiene.

1933: The Nuremberg Laws prohibited marriage and sexual contact between Jews and non-Jews.

1934 - 1945: Up to 350,000 people were forcibly sterilized in Germany.

1939: Hitler's euthanasia decree was signed the same day Hitler invaded Poland; the first euthanasia used a handicapped child. The program was organized exactly as outlined in Hoche's book.

1940: First "gassing test" was conducted at Brandenburg institution; 18-20 people were exterminated while psychiatrists and staff watched.

1941: Hadamar psychiatric institution celebrated the killing of its 10,000th mental patient. Psychiatrists and staff who participated were given a bottle of beer.

1940: The "T4" psychiatric euthanasia program began with psychiatrist Werner Heyde as medical director; mental patients were transferred from institutions to extermination camps. 300,000 "mental defectives" were killed over the next four years.

1941: "T4" psychiatrists established their killing machine in the concentration camps to kill Jews, Poles and others; more than 6 million people were exterminated.

In 1978, Nazi psychiatrist Heinrich Gross was found working in the largest psychiatric facility in Austria and acting as a "court expert." Gross was forced to resign his position when CCHR reported his involvement in "mercy killings" during WWII. In April 2000, he was to be tried for his complicity in the murders of nine handicapped children during the war; however, at the time of writing, the case was suspended based on psychiatric testimony claiming Gross suffered from "dementia."[80]

In 1980, CCHR and allied individuals forced the resignation of a former SS doctor, Heinrich Harrer, from the organizing committee of a "World Conference on Psychiatry." During the war, Harrer had injected pig brain fluid into the brains of human beings in the bizarre belief that it could "improve their intelligence." Additionally, in 1997, CCHR Switzerland exposed how the face of the 1,000 Swiss Franc bill was adorned by one of the founders of the ideology that spawned Nazism—Swiss psychiatrist August Forel.[81] Eight months later, Forel's face was removed from the currency.

After 20 years of in-depth research, CCHR helped write and publish *Psychiatrists: The Men Behind Hitler*, a book that prompted the President of the German Society of Psychiatrists to write to the Minister of Interior asking for his help to silence CCHR. CCHR increased its efforts and in August 1999, the German Society of Psychiatrists publicly admitted psychiatrists had been "active in and primarily responsible for the different euthanasia organizations."[82]

Sterilization: A Contemptuous Crime Of Denial

In the early 1900s, psychiatrist Edwin Katzen-Ellenbogen, later convicted of World War II war crimes committed as a doctor at the infamous Buchenwald concentration camp, drafted a law allowing sterilization of epileptics, criminals and incurably insane in New Jersey.[83] Twenty-two other American states enacted similar laws.

Sweden shortly followed suit in 1934 and by 1976, 60,000 people were diagnosed as "genetically inferior" and sterilized, including teenage girls from poor families.[84] In Canada, psychiatrists claimed that two-thirds of mental illness was inherited and sterilization was the only feasible solution.[85] Over a five-decade period, sterilization of 4,728 people was authorized by the province of Alberta alone.[86]

Sterilization victims and CCHR independently campaigned for compensation and as usual, governments have paid dearly for their alliance with psychiatry. In 1998 and 1999, both Sweden and Alberta agreed to compensate survivors of involuntary sterilization.[87]

Apartheid: Child Of Psychiatric Eugenics

In 1976, CCHR exposed psychiatric "slave labor" camps in South Africa where thousands of blacks were imprisoned in former mining camps.

1946: Nuremberg Trials—Only four out of dozens of Nazi psychiatrists were prosecuted; most escaped justice, others returned to psychiatric practice after the war. Assisting the Nuremberg prosecutors was Austrian born psychiatrist Leo T. Alexander who wanted psychiatry's reputation protected.

Post War: British psychiatrist John Rawlings Rees and U.S. psychiatrist Frank Fremont Smith met with German Professor of Psychiatry Werner Villinger, a proponent of racial hygiene and consultant to the Nazi "T4" program. German psychiatrists were put in charge of caring for war-ravaged people and determining their degree of "psychic damage." In 1990, the president of the German Society of Psychiatrists and Neurologists, Johannes Meyer-Lindenberg, said victims "had to encounter the very people who once inflicted their tortures" and "the grim phrase the 'second road to sacrifice' was coined."

1995: CCHR released the book, *Psychiatrists: The Men Behind Hitler*, exposing psychiatry's creation of the Nazi killing program and causing an uproar with the German Society of Psychiatrists (DGPPN).

1999: DGPPN publicly admitted in a Hamburg exhibition that psychiatry was responsible for the ideology behind euthanasia and for managing and carrying out the killing program.

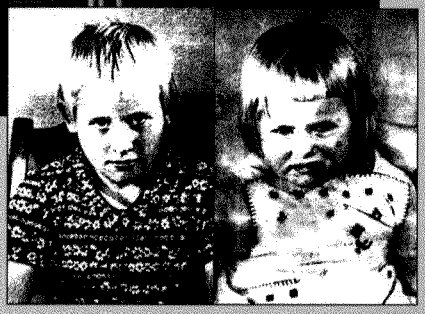
The inmates were forced to labor for private companies and were treated so atrociously that media, decades later, dubbed it "mental genocide."

CCHR referred its evidence to the United Nations, which led to the camps being investigated by the World Health Organization (WHO) in 1977. WHO's 1983 report concluded that, "in no other medical field in South Africa, is the contempt of the person cultivated by racism more concisely portrayed than in psychiatry."[68]

However, psychiatric and psychological groups were not mere passengers under apartheid; they designed, built and navigated the apartheid ship. South Africa's Prime Minister, Hendrick Verwoerd, a psychologist, had studied in German universities in the 1920s when these institutions were energetically forwarding race betterment theories.

When apartheid ended in 1994, CCHR presented submissions to the government on the atrocities committed against blacks in psychiatric institutions. A Health Ministry inquiry into malpractice and racism in psychiatric hospitals found gross patient

BEATING THE GAS CHAMBERS



1938: Elvira and sister, Lisa.

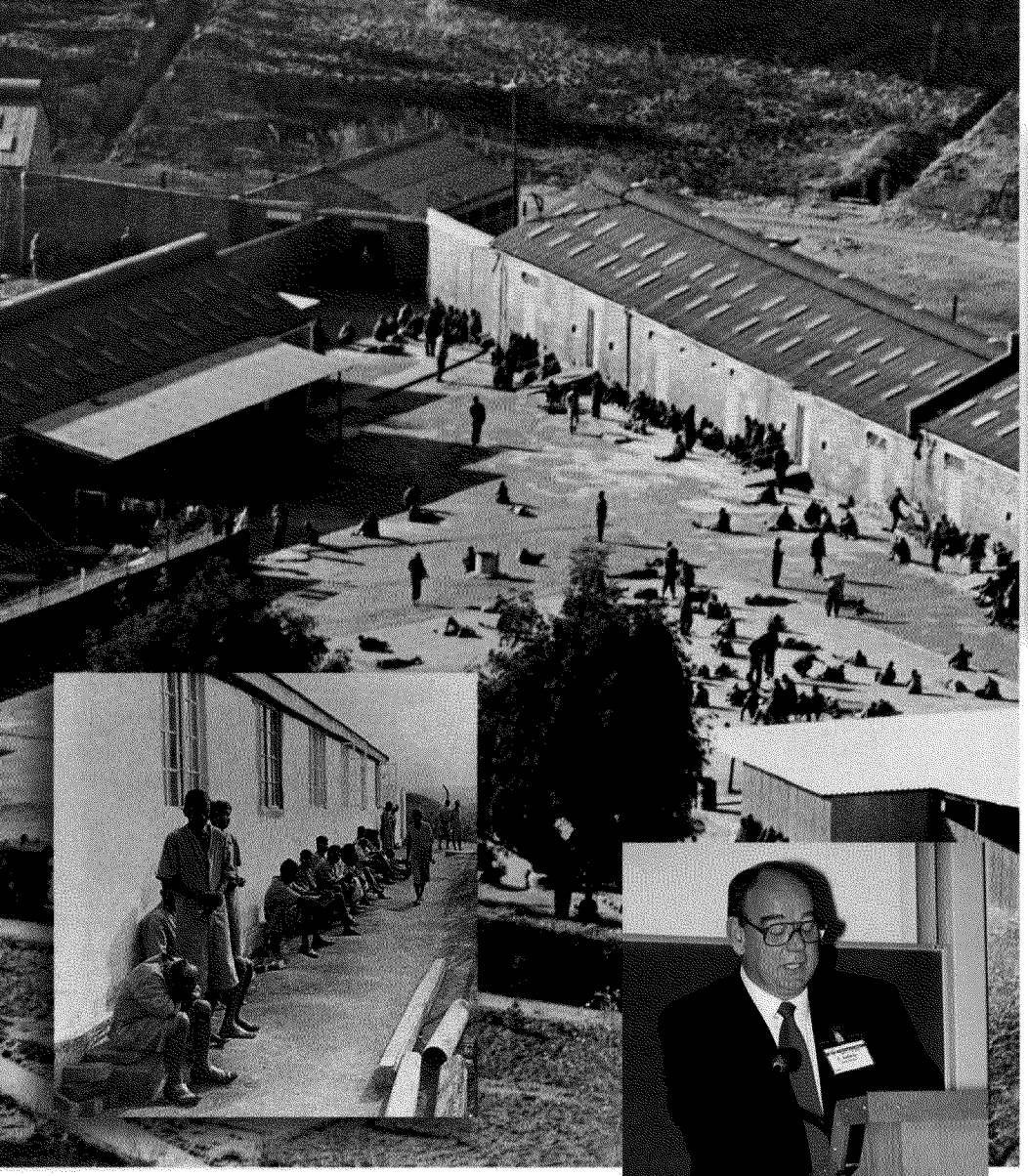
"I want to also thank you for your interest and your sympathy for my message, and for the vital actions of the staff of CCHR. Throughout my journey to seek justice and to restore the human dignity deprived myself and [my sister] Lisa, I have met many honest and helpful people. You count among them. If people who strive for good and for freedom would unite and be watchful, and get others to be alert, then this horror can never happen again."

— Mrs. Elvira Manthey Holocaust Survivor, 2000

In September 1938, at the age of 7, Elvira and her 3-year-old sister, Lisa, were labeled a "public danger, congenitally feebleminded, abnormal, hereditarily diseased and ineducable" and incarcerated in a psychiatric institution under Germany's Hereditary Act. On August 26, 1940, Lisa was murdered in the gas chambers. Elvira escaped, but it was not until after the Berlin Wall fell, through access to their medical records, that Elvira discovered the lie about her "genetic disability." The discovery inspired a 12-year fight to have the false report retracted.

Mrs. Manthey helped get the German Government to enact legislation in 1998 that officially canceled all judgments by the Hereditary Health Courts, which had ordered sterilizations and transfers of the "hereditarily diseased" to psychiatric and other institutions. A major human rights achievement, it unfortunately did not apply to Elvira and Lisa. They were not sent to the institution by the courts but by an independent psychiatrist.

In August 1999, Elvira requested help from the German Society of Psychiatrists to have her stigmatizing records returned to her. The following year, she sought assistance from the World Psychiatric Association (WPA). Niether organization would help her. The fraudulent psychiatric diagnosis remains on her record today. Her fight for justice continues, with CCHR's assistance.



PSYCHIATRIC SLAVE CAMP DISCLOSURE: *CCHR International Commissioner Lawrence Anthony presented evidence of South African psychiatry's apartheid human rights abuses to the World Psychiatric Association World Congress in 1999. CCHR also presented evidence to the South African Truth and Reconciliation Commission.*

Hendrik Verwoerd
First apartheid Prime Minister

ARCHITECT OF APARTHEID: *Psychiatry and psychology designed, manned, navigated and advised the apartheid ship. First apartheid Prime Minister, Hendrik Verwoerd (above), was a psychologist who studied in Germany's nationalist universities in the 1920s. Tens of thousands of black South Africans were kept in abandoned mining compounds and abused by psychiatrists—all exposed by CCHR.*

abuse, falsified death certificates and general mistreatment of patients. Innocent children, "whose only offense is merely being ill are made to bear conditions from which we protect even the worst criminals in society," the report stated.[89]

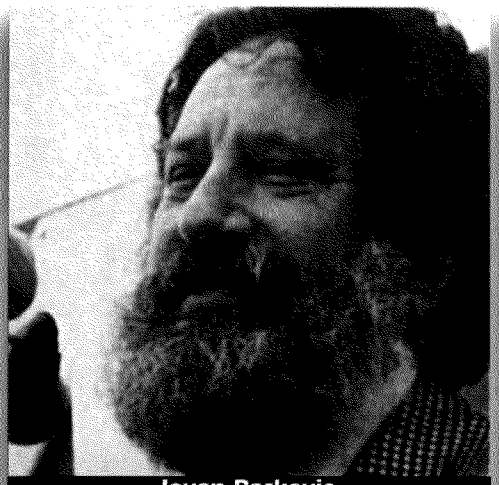
In 1997, CCHR presented oral and written testimony to the South African Truth and Reconciliation Commission about apartheid crimes committed by both psychiatrists and psychologists. The Psychological Society of South Africa finally admitted that psychological studies had aimed at discrediting blacks as intellectually inferior and, in 1998, called for legislation to scrap all racist psychological tests.[90]

"It is a joy to work with CCHR and it is my fervent hope that we succeed in keeping the flame of freedom burning brightly for our children and our children's children so that some day we have a real future, without psychiatry," said Dr. Patience Koloko, national president of the Traditional Healers Association of South Africa, who attended the conference.

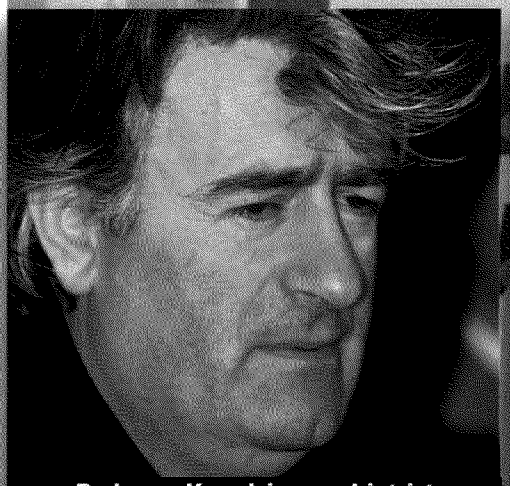
Bosnia & Kosovo: On The Trail Of Psychiatric Genocide

Addressing the United Nations in 1994, Bijedic Mustafa, Ambassador, Permanent Mission of the Republic of Bosnia and Herzegovina, stated, "The only weapon we have in this war is truth, and you have helped us a lot by digging up evidence and spreading information on what's happening in Bosnia and Herzegovina on all possible lines internationally."

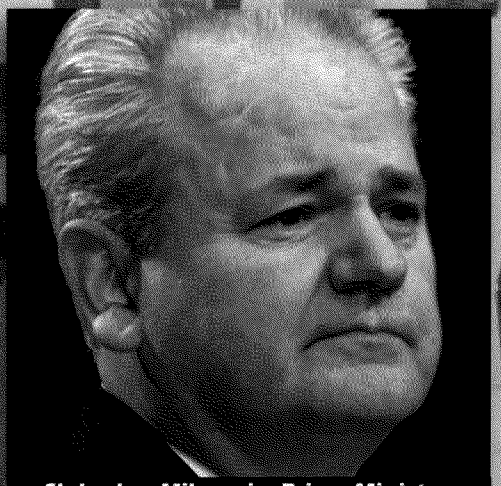
In 1999, the world looked on in horror at the chilling "ethnic cleansing" conducted in Kosovo and earlier, in



Jovan Raskovic, psychiatrist and author of genocide



Radovan Karadzic, psychiatrist & Raskovic patient



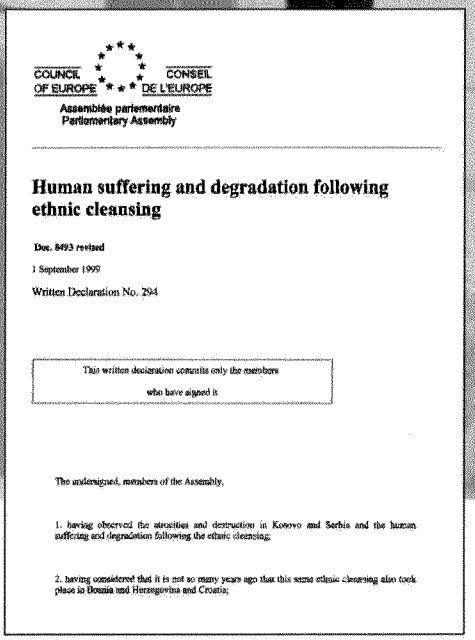
Slobodan Milosevic, Prime Minister, former patient of Karadzic

PERPETRATORS OF BALKAN CONFLICT: ***Psychiatrist Jovan Raskovic inspired racial and religious genocide in Bosnia. He and his patient, psychiatrist Radovan Karadzic, allowed the mass torture, rape and murder of the innocent. Prime Minister Slobodan Milosevic, a former Karadzic patient, then perpetrated and financed ethnic cleansing in Kosovo.***

Bosnia. However, very few are aware that this contemporary genocide was driven by the exact same psychiatric ideology that inspired Nazi Germany. In fact, psychiatrists also directed this latest bloodbath.

CCHR France investigations revealed that psychiatrist Jovan Raskovic was the architect of the genocidal program. In 1991, he appointed his devoted student of ten years, Sarajevo psychiatrist Radovan Karadzic, to lead his Serbian Democratic Party. The following year, CCHR presented its findings in a compelling submission to the WPA, the World Health Organization, and the Bosnia War Crimes Tribunal. In June 1993, CCHR also delivered a letter to the United Nations Secretary General, Boutros Boutros-Ghali, demanding that those responsible for the deaths in the former Yugoslavia be prosecuted.

In September 1999, members of the Council of Europe signed a resolution which recognized psychiatrists Karadzic and Raskovic as the architects of ethnic cleansing in Kosovo and Serbia. Prime Minister Slobodan Milosevic—a former Karadzic patient—perpetrated and financed the ethnic cleansing in Kosovo. The resolution invited everyone to "study the material that has been put together and researched by the French chapter of the Citizens Commission on Human Rights (an organization established by the Church of Scientology in 1969 to expose the abuse of human rights by psychiatry)."[91]



COUNCIL OF EUROPE — CONSEIL DE L'EUROPE

Assemblée parlementaire
Parliamentary Assembly

Human suffering and degradation following ethnic cleansing

Doc. 8493 revised

1 September 1999

Written Declaration No. 294

This written declaration commits only the members who have signed it

The undersigned, members of the Assembly,

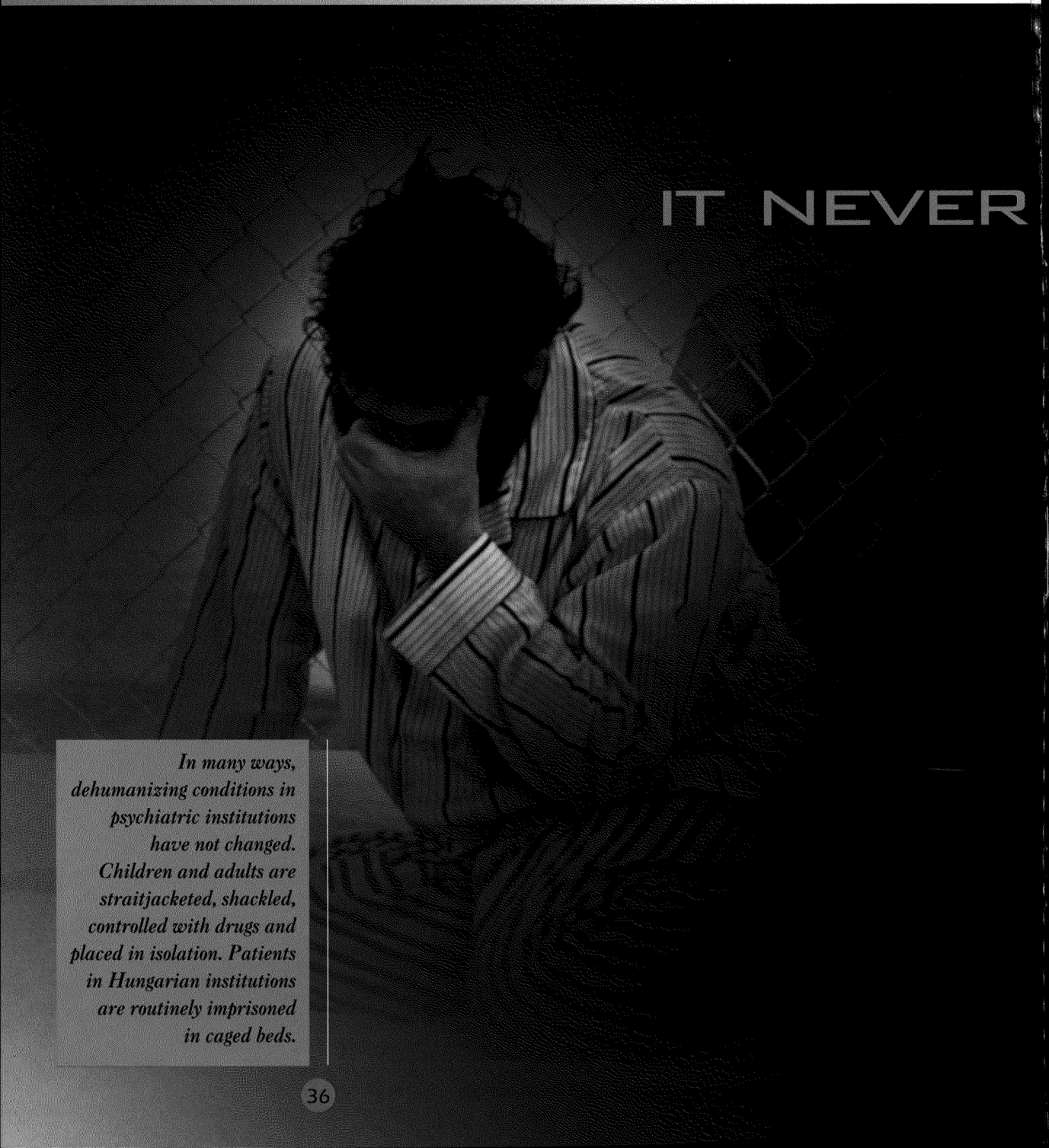
1. having observed the atrocities and destruction in Kosovo and Serbia and the human suffering and degradation following the ethnic cleansing;

2. having considered that it is not so many years ago that this same ethnic cleansing also took place in Bosnia and Herzegovina and Croatia;

RESOLUTION 1999: ***Members of the Council of Europe signed a resolution recognizing psychiatrists Karadzic and Raskovic as the architects of ethnic cleansing in Kosovo and Serbia. It recommended members study CCHR's material on this issue.***

"Hundreds of thousands of people were deprived of their honor, work, family and place of living" and were "deprived of their rights without cause" during the punitive Soviet political-psychiatry regime.

— Anatoli Prokopenko
author of Insane Psychiatry, *1998*



In many ways, dehumanizing conditions in psychiatric institutions have not changed. Children and adults are straitjacketed, shackled, controlled with drugs and placed in isolation. Patients in Hungarian institutions are routinely imprisoned in caged beds.

CHAPTER 6

"bedLam"

LEFT

"If they are not mad when they go into these cursed Houses, they are soon made so by the barbarous Usage they there suffer....Is it not enough to make anyone mad to be suddenly clapped up, stripped, whipped, ill fed, and worse used? To have no Reason assigned for such Treatment, no Crime alleged, or Accusers to confront?"[92]

— Daniel Defoe
English novelist, writing about the conditions in asylums in the 1700s

In the eighteenth and nineteenth centuries, social outcasts were labeled mentally ill, and if they were not tortured at the stake, they were imprisoned in the most squalid conditions. As authors Franz G. Alexander, M.D., and Sheldon T. Selesnick tell us, "Should they survive the filthy conditions, the abominable food, the isolation and darkness, and the brutality of their keepers, the patients of Bedlam [in England] were entitled to treatment," including bloodletting and various "so-called harmless tortures."[93]

According to Dr. Jean Garrabe, president of the World Psychiatric Association International Jubilee Congress held in Paris in June 2000, "...conditions for helping the mentally ill have changed radically."[94] Dr. Garrabe could not be more wrong. Indisputable evidence attests that "Bedlam" is indeed alive and happening, and not just in England.

It has been left to CCHR and other human rights groups to investigate and expose such modern-day atrocities.

Italy's Concentration Camp Asylums

In April 1991, accompanied by government officials and media, CCHR conducted a raid on a psychiatric facility in Italy. Patients were found naked, living like animals and locked in rooms with peeling walls, old stained tables and chairs. Beds were covered with human feces and urine. It was not an isolated incident.

Over the next five years, successive raids carried out on Italy's forgotten asylums located thousands of patients housed in similar sordid conditions.

"The asylums that I saw are concentration camps. ... We cannot separate the tree from the fruit it produces and we have to judge the system by its fruits. What I have seen of psychiatry cannot bring me to any other conclusion. ...Together with all the good people of CCHR Italy, we did a good job...[we have] shown to the people...that such horrors exist and that we have to put an end to it," observed Senator Edo Ronchi in 1994, after participating in one of the raids.

In 1996, a government resolution ordered 97 asylums closed and sold, the proceeds to be used to find alternative accommodations and humane care for the thousands of inmates. Stiff penalties for noncompliance were included.[95]

Inhuman and degrading conditions exist in psychiatric institutions in countries around the world, including Italy, Hungary, Russia, and Mexico. No matter how rich or poor the country, psychiatrists have found ways to exploit both patients and governments.

Today these horrifically neglected people have been restored their dignity — relocated, taught to read and write, to work and care for themselves for the first time in their lives.

In 1996, during the 50th anniversary of the Italian Republic, the Mayor of Garbagnate presented CCHR with a medal for its humanitarian service to citizens.[96]

Greece And Hungary: Shackled And Caged

In Athens, Greece, the Ntaou Pendeli psychiatric institution kept children in cold, barren wards with mentally handicapped adults, often lying naked in their own feces and urine. One child was found shackled to a bed by the ankle. Children witnessed horrors such as the rape of other children by psychiatric nurses. CCHR worked with a national television show to expose this, and in 1995, the offending psychiatric ward was shut down.

In Hungary, patients are confined in a cage-like bed as punishment for "misbehavior" such as getting up in the night or taking food from the refrigerator.[97] Left to defecate in bed pans spilling over onto the sheets, patients suffered from bed sores and life-threatening infections.[98]

Thanasis Legas, speaking at CCHR's Human Rights Award event on behalf of Mikas Triatafylopoulos of Sky TV (who helped expose pyschiatric abuses in Greece) acknowledged CCHR's work saying, "[We] congratulate [CCHR] on your touchingly, altruistic interest in the disabled of this planet...."

South America's Tragic Forgotten

Establishing South American offices in 1996, CCHR works with legislators, parents, teachers and celebrities in Mexico, Colombia, Costa Rica, Puerto Rico, Argentina and Venezuela.

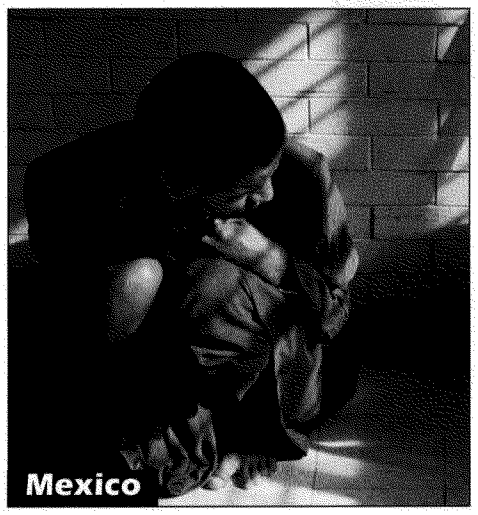
One such person is Colombian actress Margalida Castro, who wrote a book about the brutality and drug abuse she witnessed while incarcerated in psychiatric institutions.

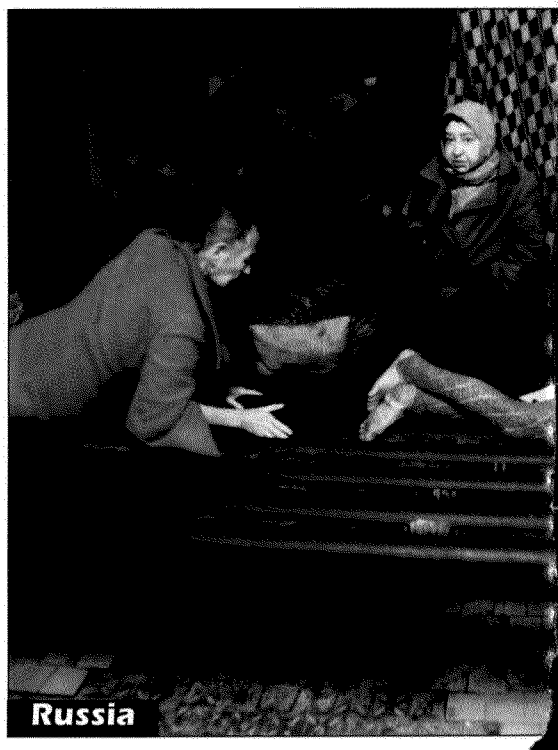
Working closely with CCHR, she gratefully acknowledged their work in her book: "My biggest thanks to CCHR for the material provided to me from which I extracted documented information that I considered needed to complete this testimony of life....This non-profit organization is the hope that is strengthened every day for the 'mentally ill people' who carry their pain and are not accepted by society."

In Mexico in 1999, CCHR worked with journalists to expose shocking abuses in the country's psychiatric asylums. On January 16, 2000, *The New York Times* also ran an expose on these conditions: patients incarcerated for as long as 30 years; one nurse watching over 110 male patients; inmates herded together, milling about or huddled together for warmth, naked in 45-degree temperatures; only two towels for use by 98 women.[99]

Doctors estimate as many as 80% could be discharged.


Italy


Mexico


Russia

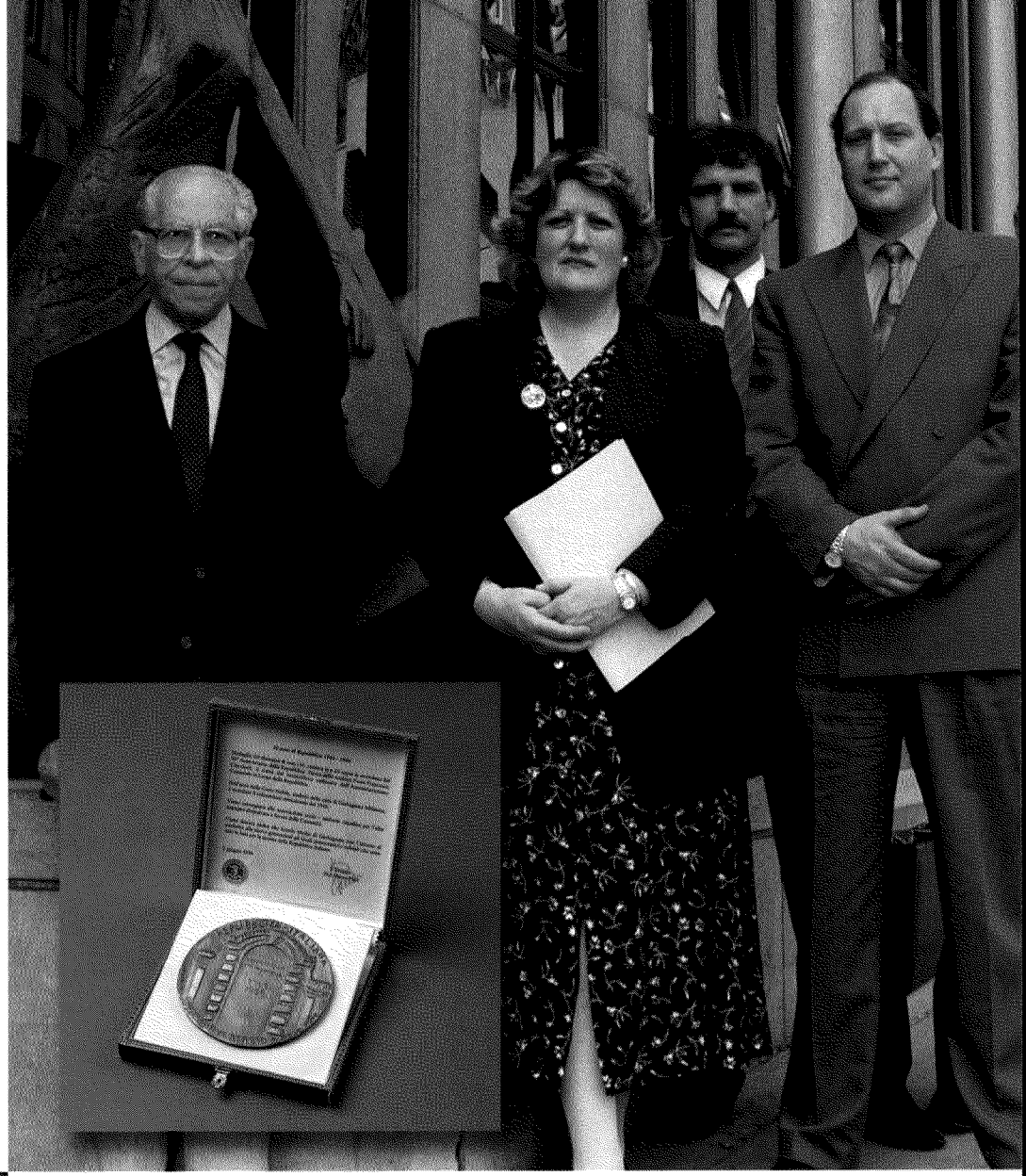
Russian Psychiatry's Abysmal Human Rights Record

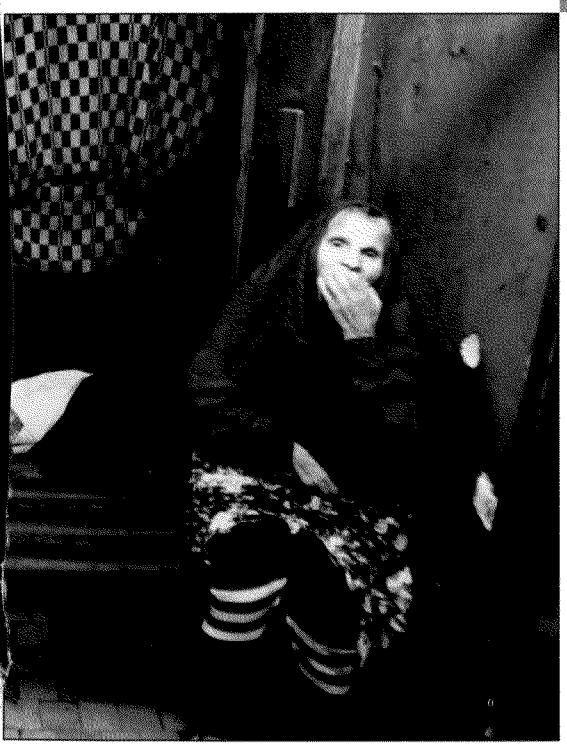
Russian psychiatrists gave the Soviets the justification for wrongly incarcerating 40 million citizens in psychiatric gulags, inventing the term "sluggish schizophrenia" to describe political dissidents. Symptoms were a severe case of "inflexibility of convictions" or "nervous exhaustion brought on by [their] search for justice," camouflaged by "normal behavior."[100]

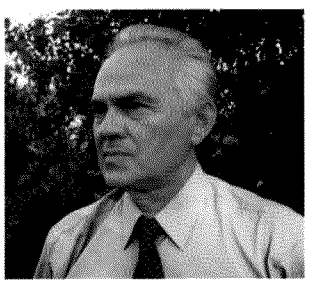
In a 1999 press conference in Moscow, CCHR joined author Anatoli Prokopenko to support his demand for the notorious Serbskii Institute to release its confidential records of psychiatric involvement in the political suppression of Russians. He called for the medical rehabilitation and restoration of rights of Soviet dissidents still languishing in psychiatric facilities.

According to Dr. Yuri Savenko, President of the Independent Psychiatric Association, "The leaders of the [psychiatric] profession are virtually the same people as those who misused psychiatry for political purposes in the '60's and '70's."[101]

CCHR has also exposed shocking conditions in Russia's orphanages, where at least 600,000 children are incarcerated in institutions that one doctor referred to as "death camps."[102] A panel of "experts," including psychiatrists and psychologists *diagnose* them as "imbeciles" and "ineducatable"—no matter what their condition. Some are neglected to the point of death. Others are beaten, locked in freezing rooms for days at a time, and can be abused physically and sexually.[103]







1999: ***CCHR supported Russia's renowned historian, archivist and author of*** **Insane Psychiatry,** ***Anatoli Prokopenko, in his call for all Soviet psychiatric records to be made public and for the "medical rehabilitation" of Soviet dissidents imprisoned in psychiatric "gulags."***

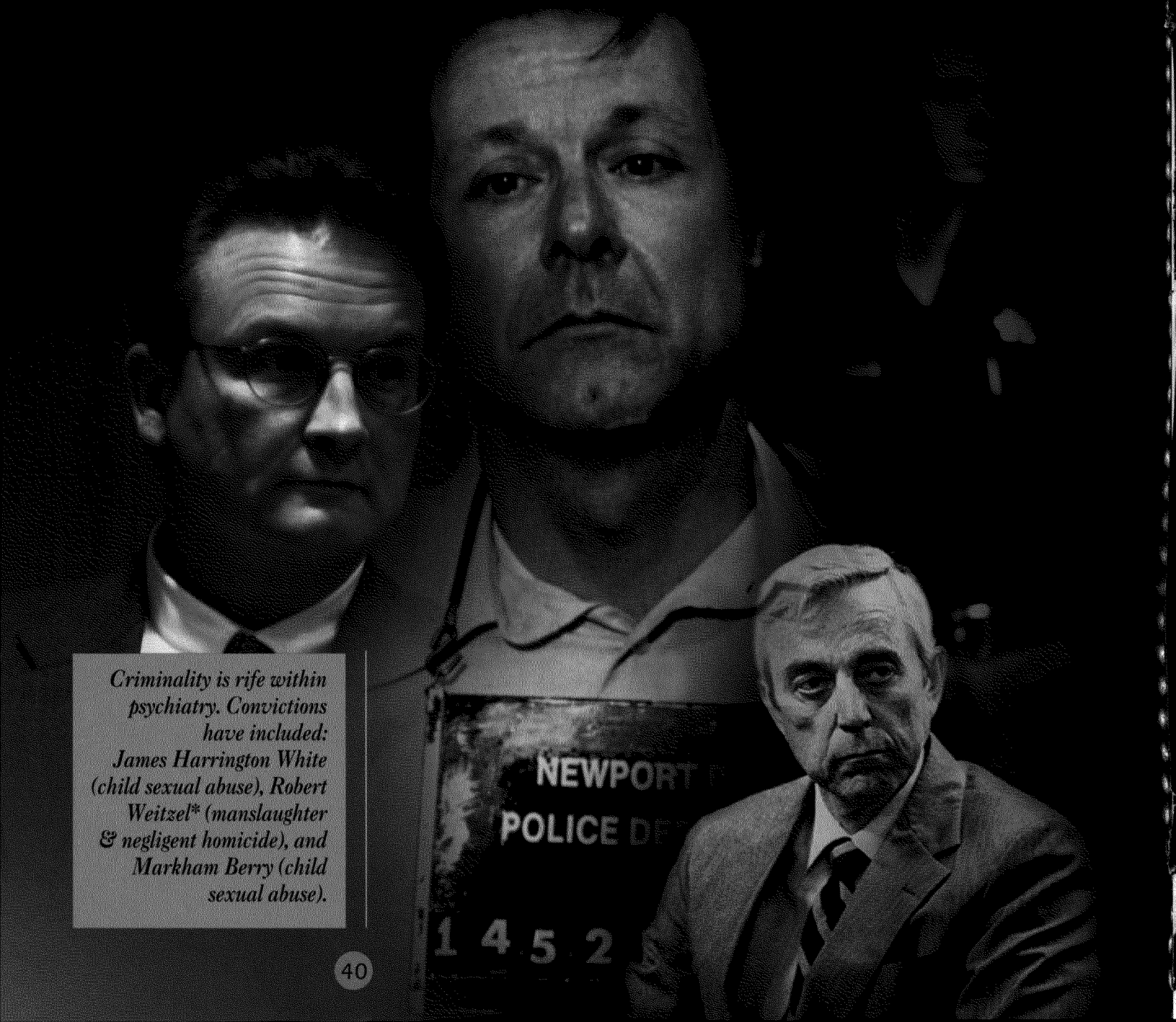
1996: ***CCHR co-founder Dr. Thomas Szasz (above left) with CCHR representatives, taking evidence of psychiatric abuses in Europe to the Council of Europe and other European bodies. Inset: Award presented to CCHR Italy by the Mayor of Garbagnate for its humanitarian service to the community.***

"I ... commend your organization and the individuals involved in assisting me in the criminal prosecution of a psychiatrist... [CCHR's] efforts were of a superior quality and greatly assisted me."

— Detective Mike Morrison
Newport Beach Police Department, 1991

psychiat

PUTTING



Criminality is rife within psychiatry. Convictions have included: James Harrington White (child sexual abuse), Robert Weitzel (manslaughter & negligent homicide), and Markham Berry (child sexual abuse).*

CHAPTER 7

ric crime

PATIENTS AT RISK

"I am sure it would be sensible to restrict as much as possible the work of these gentlemen [psychiatrists], who are capable of doing an immense amount of harm with what may easily degenerate into charlatanry."

— Sir Winston Churchill, 1942

Ethical practitioners are an essential component of the overall success of any profession. Organizational psychiatry, however, has always been reluctant to deal with its members' ethics. So much so that in 1996, the WPA's ethics code, *The Declaration of Madrid*, effectively renounced any responsibility, by saying that "Ethical behavior is based on the psychiatrist's individual own sense of responsibility" and "their judgment in determining what is correct and appropriate conduct." "External standards and influences such as professional codes" or "the rule of law by themselves will not guarantee the ethical practice of medicine," it claims. By psychiatry's default, it has fallen to CCHR to act as watchdog over psychiatrists' conduct and practices, and to be an advocate for patients.

Since 1989, CCHR has worked intensively to bring criminal psychiatrists to justice, and to assist patients who have been criminally abused to report the abuse to the proper authorities. CCHR's own database of mental health practitioners who were under criminal investigation between 1990 and 2000, reveals that 814 psychiatrists, psychologists, psychotherapists and psychiatric employees have been prosecuted—more than one arrested and/or charged *every* week. This doesn't include all the crimes reported to law enforcement agencies around the world. Taking nearly 400 convictions alone, the combined jail sentence is over 2,700 years, with more than $581 million paid in criminal fines, restitution and penalties.

Crimes include rape, possession of child pornography, drug dealing, murder, attempted murder, assault, stalking, child abuse, theft and weapons violations; 53% of the crimes were for health care fraud; 26% were for sexual crimes.

Dr. Wulf Aschoff, child psychiatrist and former head of Germany's Albert-Schweitzer clinic, was charged in 1999 for photographing and videoing naked children and playing with their genitals. Aschoff claimed this therapy helped his patients to "get a more intense feeling for their body." With his medical license revoked, he committed suicide two days before his criminal trial.[104]

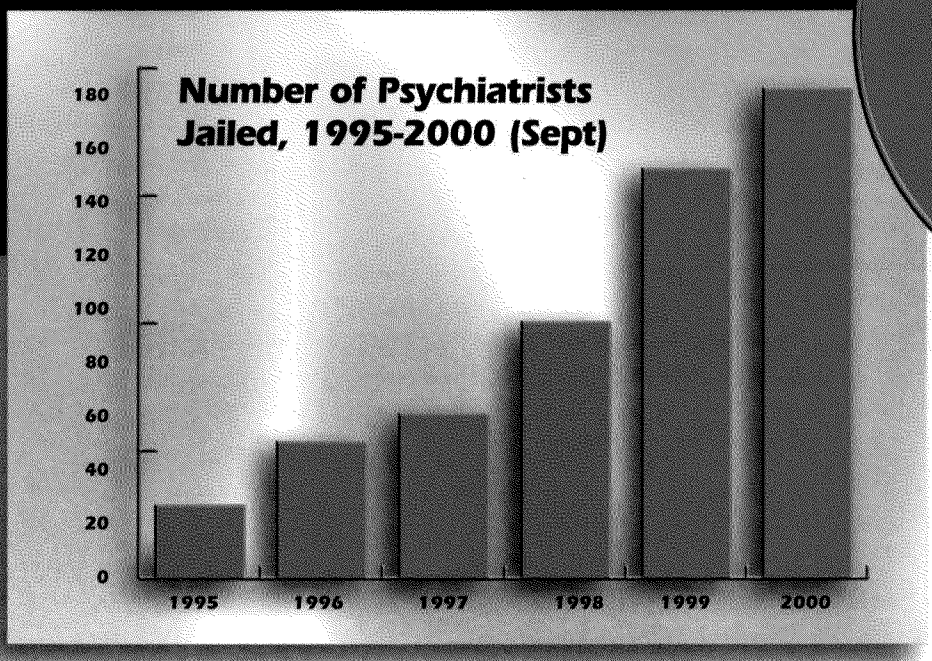
In July 2000, Utah psychiatrist Robert Weitzel was convicted on two counts of manslaughter and three counts of negligent homicide over the deaths of five elderly patients that he had "blasted" with anti-psychotic drugs until near death, and then gave lethal doses of morphine.[105]

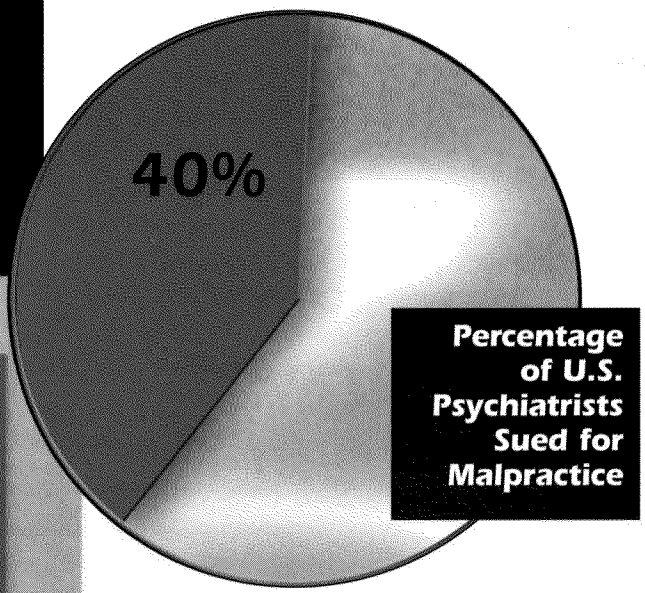
CRIMINAL CONVICTIONS: (1) Roderick Doyle Motum: Australian psychiatrist convicted in January 2000 of shooting a male prostitute. (2) Carl Lichtman: New Jersey psychologist pleaded guilty to defrauding 36 insurance carriers of $3.5 million for therapy sessions that never took place. In 1996, he was ordered to pay insurance companies $2.8 million and $200,000 to the state. (3) John Orpin: Canadian psychiatrist was convicted and jailed for 6 years in 1998 for sexually assaulting female patients during bizarre hypnotic therapy sessions. Earlier convicted for defrauding the Canadian government health insurance plan. (4) Antonio DeGuzman: In 1998, the Massachusetts adolescent psychiatrist was sentenced to 3 to 4 years prison with 15 years probation for fondling three young male patients.

On May 18, 2000, Robert Bruce Craft, a child psychologist, was sentenced to 20 years in prison and 20 years probation for 100 counts of felony sexual exploitation of a minor and child molestation. Craft had worked for the Georgia Department of Family and Children's Services, treating abused and emotionally disturbed children.[106]

Psychiatrists are also high malpractice risks. According to psychiatrist Sander Breiner, in the *Psychiatric Times*, nearly 40% of psychiatrists are sued for malpractice in the United States. He partly attributes this to the problem of patients' and psychiatrists' fantasies about each other, with psychiatrists' number one fantasy being, "I will be able to 'cure' my patient."[107]

CCHR has campaigned aggressively for legislation to protect persons from psychiatrists who sexually abuse their patients. More than 20 psychiatric rape laws, regulations or amendments to criminal laws have been passed to date, making it a criminal offense for any psychiatrist, psychologist or psychotherapist to have any form of sexual relationship with a patient. This includes 17 American states, Australia, Canada, Germany and Sweden.





PSYCHIATRISTS JAILED: The number of psychiatrists jailed for crimes and reported to CCHR International has soared. A sample of 400 convictions yielded a combined jail sentence of over 2,700 years, with more than $581 million paid in criminal fines, restitution and penalties.
In the United States, 40% of psychiatrists are sued for malpractice in the course of their career.

Psychiatry's Insurance Fraud

In 1991, CCHR conducted extensive investigations into psychiatric fraud in the United States, receiving hundreds of calls from people who had been defrauded in the private psychiatric insurance arena. Across the United States, individuals with good insurance benefits had been locked up and detained in psychiatric facilities until their insurance had been exhausted. As soon as the insurance ended, so did the previously diagnosed "mental illness"; the person was suddenly declared well and discharged.[108] Psychiatric institutions had hired "bounty hunters" to kidnap people in order to hold them against their will and milk their insurance dry. Details of the abuses found were given to law enforcement agencies.

CCHR Texas, in particular, relentlessly challenged the abuses they found and successfully worked for laws to help eliminate this type of fraud. In 1991, Texas Senator Mike Moncrief convened a series of hearings into the issue, stating, "We're the first state to turn the rock over, and it's frightening to see what's crawling out from underneath."[109]

On August 26, 1993, five government bodies, including the Federal Bureau of Investigation, the Defense Criminal Investigative Service, and the Internal Revenue Service, staged raids in 17 cities of the corporate offices and hospital facilities of a major private hospital chain, National Medical Enterprises (NME).[110] In 1994, because of psychiatry's abuses, NME pleaded guilty to government charges of Medicare insurance fraud and conspiracy and paid a record fine of $379 million.[111]

In Japan in 1998, the discovery that private psychiatric hospitals were committing widespread fraud and inflating the numbers of doctors and nurses in facilities to obtain more money from the government, led to conviction and jailing of psychiatrists.[112]

On December 1, 1998, police raided three private psychiatric hospitals in Ticino, Switzerland, arresting renowned psychiatrist Dr. Renzo Realini for fraud and falsifying documents.[113] Records showed Realini had been billing 30-hour days.[114]

In the wake of United States federal fraud investigations, on February 16, 2000, Charter Behavioral Health Services, the largest private psychiatric hospital chain in the United States, announced it was $100 million in debt and filed for bankruptcy.[115]

RAID ON PSYCHIATRIC FRAUD: On August 26, 1993, five government bodies, including the FBI, raided the corporate offices and hospital facilities of a major U.S. private hospital chain, National Medical Enterprises (NME). In 1994, because of psychiatry's abuses and fraud, NME paid a record fine of $379 million.


THE SANTA FE
NEW MEXICAN
SATURDAY
OCTOBER 16, 1999
State criticizes Charter
Heights treatm
The New York Times
WEDNESDAY, JUNE 29, 1994
THE WALL STREET JOURNAL.
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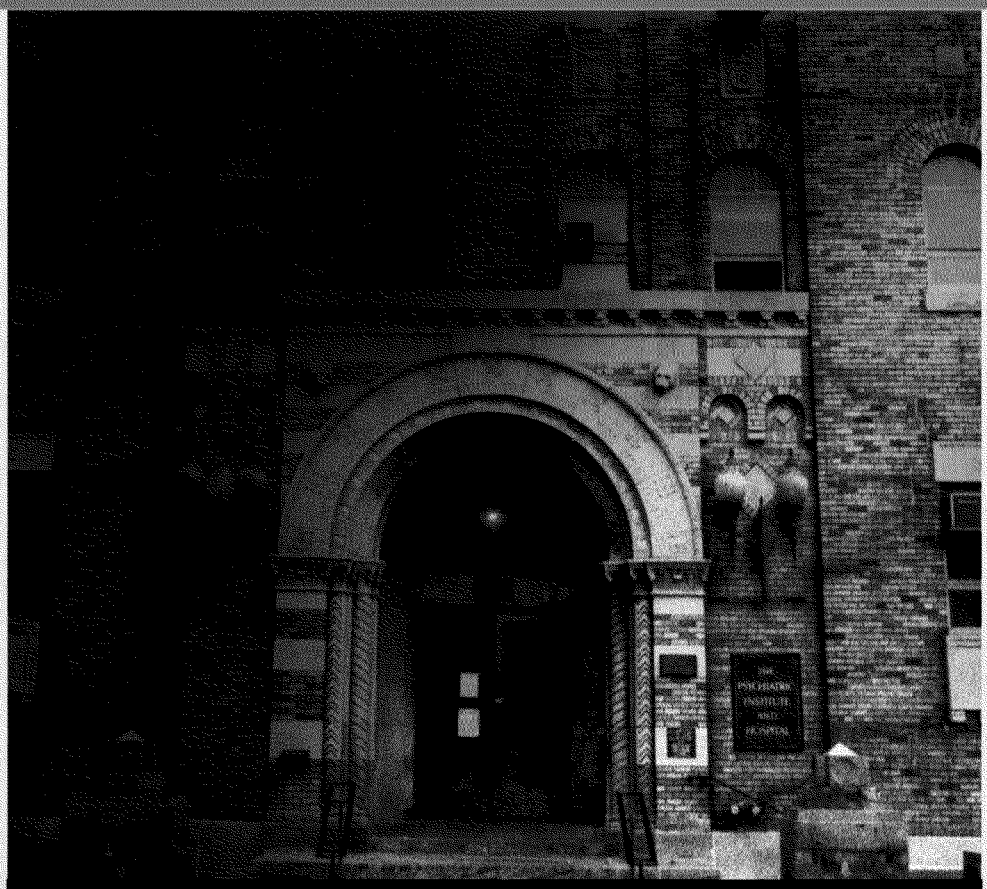
FRIDAY, AUGUST 27, 1993
WHITE OAK, MARYLAND
National Medical Facilities Raided By U.S. Agents
National Medical Sites Raided Nationwide By Fede
The Atlanta Journal-Constitution
FRIDAY, JAN. 28, 2000
rter closing 33 sites
ides Macon, Augusta, Athens hospitals
Los Angeles Times
NME to Settle Fraud Case by
The New

* In September 2000, Dr. Weitzel received 15 years in prison. At the time of printing, he was appealing his sentence.

PSYCHIATRIC "EXPERTS": CREATE DEGRADATION, NOT REHABILITATION



A close inspection of their disastrous results reveals internationally that psychiatrists and their facilities should not be in charge of drug and criminal rehabilitation.

"We should start holding the [criminal justice] system accountable. If two out of three Toyotas broke down within a year of coming out of the factory, Toyota would be out of business. But if two out of three kids coming out of juvenile institutions re-offend, we build bigger juvenile institutions."[116]

Vincent Schiraldi, Founder, Center on Juvenile and Criminal Justice, San Francisco, 1995.

Psychiatry once promised to cure so-called mental illness. Today, in spite of record levels of mental health expenditure, their statistics claim to measure burgeoning mental illness. Psychiatry also promised to end crime. Today, in spite of record expenditures, the United States prison system alone is bursting at the seams, as individual prisons are forced to operate beyond their mandated capacity. Since 1980, the United States prison population has more than tripled.

Working hard behind this scene is the psychiatrist, dispensing everything from his pernicious "insanity defense" in our courts—thereby helping dangerous criminals escape justice—to his mind-numbing drugs within the prisons. His achievement is a recidivism rate of around 80%.[117] Of course, with high rates of inmate illiteracy and drug abuse, it is reasonable to assume that educational psychiatry was on the scene years before the inmate committed any crime, busily "helping" children with an earlier promise to improve education—with, of all things, addictive, mind-numbing drugs. Chances are, too, that after his school years, the inmate was "helped" by a psychiatrist who promised to rid the world of drug addiction.

A close inspection of their disastrous results reveals that psychiatrists are the last people who should be in charge of improving literacy or drug and criminal rehabilitation. Quite aside from statistics showing a cataclysmic failure on their part, psychiatrists personally have a higher drug addiction rate than the general population, commit suicide at twice the rate of, and divorce more than other physicians. They also have the dubious distinction of laws specifically designed to curtail their tendency to commit sex crimes against those in their charge.[118] A 1992 study of Medicaid and Medicare insurance fraud in the United States showed psychiatry to have the worst track record of all medical disciplines.[119]

Psychiatry's ideas on rehabilitation are quackery to say the least. Consider its "remedies" for drug addiction, especially substituting methadone for heroin. Does it seem logical to treat heroin addiction with another drug which is just as addictive, if not more so, than heroin? Between 1985 and 1998, United States national drug control funding for drug abuse treatment increased by 380%—from $625 million in 1985 to $3 billion in 1998.[120] In the United States, in 2000, there are 810,000 heroin addicts, up from 500,000 in 1989.[121]

In the wake of their drug rehabilitation failures, psychiatry has now redefined drug addiction as a "treatable brain disease." In other words, it's conveniently "incurable" and requires massive additional funds for "research" and to maintain

treatment for the addiction.[122] While that approach is soaking up more money for negative results, psychiatry plows ahead with another justification for failure, "harm reduction"—the idea that "drug abuse is a human right and that the only compassionate response is to make it safer to be an addict."[123]

According to psychiatrist Sally Satel, "Harm reduction holds that drug abuse is inevitable, so society should try to minimize the damage done to addicts by drugs (disease, overdose) and to society by addicts (crime, health care costs)....But since harm reduction makes no demands on addicts, it consigns them to their addiction, aiming only to allow them to destroy themselves in relative 'safety'—and at taxpayers' expense."[124]

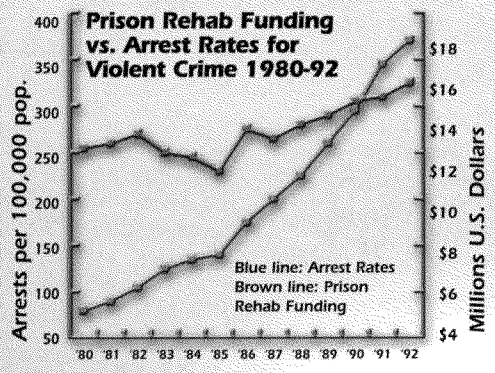
Once the facts are known, psychiatrists are entirely predictable. They promise to end our problems in return for money and control, and then they fail to deliver; in fact they make things measurably worse. They then invent new ways to promise to end our bigger problems in return for more money and control, again fail to deliver, and make things worse. They then invent more new ways to promise to end our bigger problems in return for more money and control, *ad infinitum.*

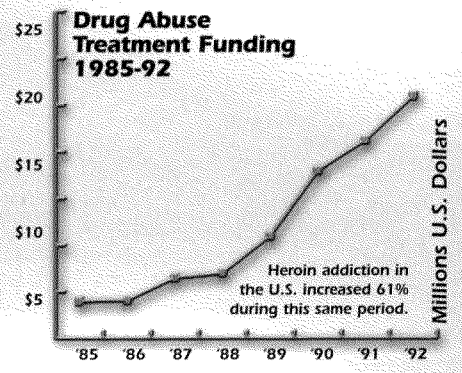
An individual seeing and realizing this for himself or herself will find the confounding problems and contradictions of today's society much less perplexing. CCHR is dedicated not only to doing something effective about psychiatric degradation, but doing everything possible to help others do something about it as well.

In spite of record levels of expenditure for mental health, criminal and drug rehabilitation, psychiatry's statistics for all these areas are worsening, showing an abject failure and waste of taxpayers' funds.

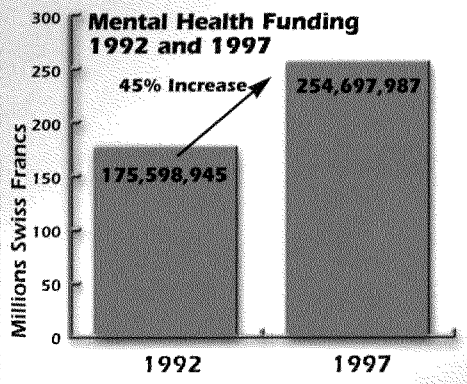
Mental health funding results: CRIME AND DRUG ABUSE SOAR

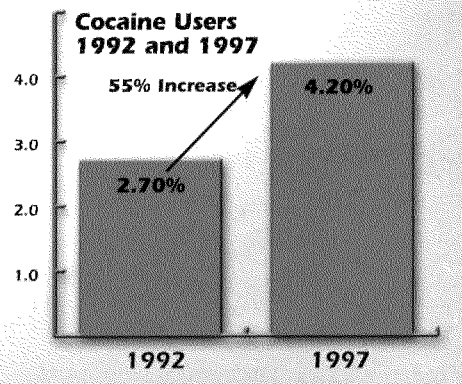
United States



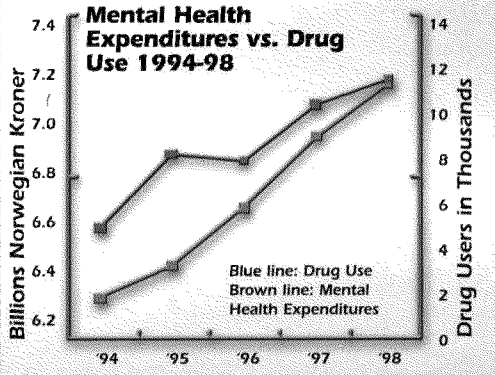


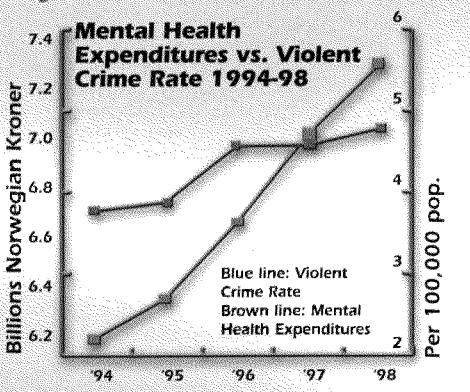
Switzerland



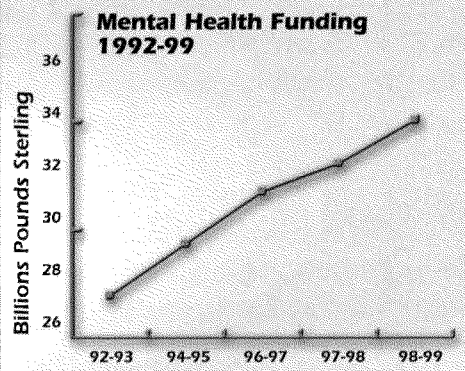


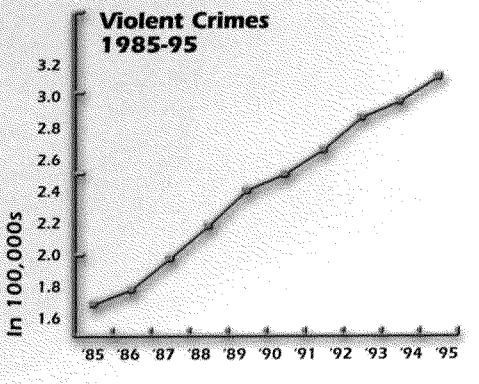
Norway





United Kingdom





secur human

ACHIEVING MENTAL

"The main task of CCHR has been to achieve reform in the field of mental health and the preservation of the rights of individuals under the Universal Declaration of Human Rights. CCHR has been responsible for many great reforms. At least 30 bills [now more than 100] throughout the world, which would otherwise have inhibited even more the rights of patients, or would have given psychiatry the power to commit minority groups and individuals against their will, have been defeated by CCHR actions."

— Erica-Irene Daes, Special Rapporteur
In her report to the United Nations
Human Rights Commission, 1986

Without the protection of basic human rights, there can only be diminished mental health. With this inherent contradiction in psychiatry itself, it has fallen to outside groups to protect those who are victimized by psychiatry's inhumanity. To that end, in 1969 CCHR penned a Declaration of Human Rights for "mental patients" and also worked to have a Bill of Rights introduced on an international level. In 1986, CCHR reported to the United Nations Human Rights Commission Rapporteur about securing human rights in the field of mental health. In 1991, the United Nations General Assembly adopted a statement of rights entitled "The Protection of Persons with Mental Illness and the Improvement of Mental Health Care." The principles adopted included patients' rights to refuse treatments, and when treated, that they shall not be denied basic human and civil rights and shall be protected from sexual and other forms of exploitation.

Long an advocate for non-psychiatric medical evaluation of people with mental problems, CCHR

ing rights

HEALTH

in 1982 campaigned for Senate Bill 929 in California, which established a pilot project to provide medical evaluation of people in public psychiatric hospitals. CCHR was represented on the advisory committee established to oversee the pilot.[125] The findings, published in 1989 in *Archives of General Psychiatry*, found that 39% of the more than 500 patients studied had an active, important physical disease which had been unknown to the mental health professionals.[126] Undiagnosed and untreated physical conditions can manifest as "psychiatric" symptoms.

Consider the massive number of children and adults being diagnosed as "hyperactive." Yet in the course of evaluating seriously troubled adolescents, D. Lonsdale and R. Schamberger identified 20 teens whose hostility, irritability, impulsiveness and aggression stemmed from borderline deficiencies of the B-vitamin thiamin. When their diets were supplemented, their behavior improved markedly. According to Dr. Joseph Beasley in *The Betrayal of Health*, these teenagers showed a typical "pattern of skipping breakfast, snacking on junk foods, and drinking many cans of soda a day...neither the teenagers nor their parents ever thought that the symptoms might be related to their diet."[127]

The late Dr. Sydney Walker, a renowned American psychiatrist, said that thousands of children put on psychiatric drugs are simply "smart." "They're hyper, not because their brains don't work right, but because they spend most of the day waiting for slower students to catch up with them. These students are bored to tears, and people who are bored fidget, wiggle, scratch, stretch, and (especially if they are boys) start looking for ways to get into trouble."[128]

Psychiatrist Joseph Glenmullen says that "most people can overcome the obstacles of leading satisfying lifestyles through the help of more natural alternatives that treat our whole selves," including "physical, intellectual, and emotional."[129]

Institutions should be turned into safe havens where people will voluntarily seek help without fear of indefinite incarceration. If admitted, they need a quiet environment, nutrition, good food, rest and exercise. Counseling from their priest or minister and spending time with friends will then help. Such institutions also should be well fitted with medical diagnostic equipment.

With proper medical—not psychiatric—screening, a majority of people brought to institutions could avoid the life of mind-altering drugs and destitution that psychiatry delivers. People could be properly treated medically and lead healthier, happier lives.

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MEN AND WOMEN OF SPEAK OUT

CCHR has the tremendous good fortune to work with like-minded individuals in its efforts to clean up the field of mental health. These are people of personal courage who, by virtue of their integrity and willingness to take a stand, have withstood attack and held their ground for what they knew was right. Each year, CCHR International presents human rights awards to such individuals. These have included legislators, educators, doctors, journalists, attorneys and authors.

JANICE HILL

2000 Recipient

Janice Hill is the founder of "Overload Network" in Scotland, a network for parents which educates them on the stigmatization of psychiatric diagnoses and drugs given children. Between 1992 and 2000, she has serviced the requests and concerns of more than 28,000 parents and professionals.

"CCHR is a sane prescription for what ails our children, our schools and our communities. It's a no-nonsense, say-it-the-way-that-it-is, type of group. I hope that every parent and teacher will continue to have access to CCHR's outstanding up-to-date factual data. I also hope that every parent and teacher takes CCHR's superb advice to heart. Do not allow harmful psychiatric diagnoses, treatments and drugs to ruin another child's life, another child's future."

NURSE REUBINA NUKUNA

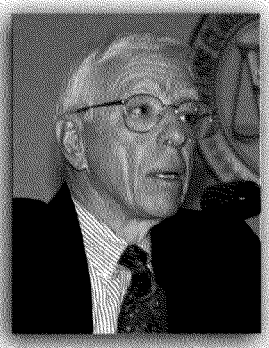
1997 Recipient

Ms. Reubina Nukuna is a courageous nurse who worked in one of South Africa's most notorious private psychiatric hospitals in a tireless effort to improve the conditions, often encountering considerable opposition. She saw neglected patients, including children, die after being denied proper medical care, which when reported to authorities, fell on deaf ears. Linking up with the media and CCHR, she helped cause a government investigation.

"I consider myself fortunate to have found a home in CCHR, to be among people who know exactly how I feel [and] as strongly about violations of the rights of these patients as I do....I would like to ask all of you to use your influence to spread the message of CCHR's crusade to further the rights of the mentally ill persons."

DR. FRED BAUGHMAN, JR.

1997 Recipient



Dr. Fred Baughman, Jr., is an outspoken critic of psychiatry's wrongful diagnosing of children. He has scientifically documented how "Attention Deficit Hyperactivity

rights ds COURAGE

Disorder" (ADHD) is a fraudulent diagnosis, not a medical disease.

"The victimization of children, leaving them illiterate and not educable, is criminal. I share your outrage and I am happy to have CCHR as an ally to try and bring sanity back to the education system and to the treatment of our children."

BEV EAKMAN

1999 Recipient

Beverly Eakman is the co-founder of the U.S. National Education Consortium and author of the compelling best sellers, *Educating for the New World Order* and *Cloning of the American Mind: Eradicating Morals Through Education*. She has exposed how psychology and psychiatry have failed governments, teachers, parents and, more importantly, children.

"[CCHR's] response, like mine, was to make each issue, each hearing, each rally, harder-hitting than the last. And in doing so, some surprising, high-profile people, like former Congresswoman Pat Schroeder, suddenly sat up and took a second look at what was being subsidized in the name of 'mental health.'"

SENATOR MIKE MONCRIEF

1994 Recipient

Texas State Senator Mike Moncrief was chairman of the interim committee that exposed patient abuse and massive fraud in psychiatric facilities in Texas. He testified before Congress on this issue and personally helped pass comprehensive mental health reform legislation in Texas.

"As long as we have a system that lends itself to greed, that lends itself to being more concerned about the bottom line of a financial statement of a provider than it does to the quality of care delivered in that institution, we have potential for being taken advantage of. Congratulations to the Commission....I am deeply appreciative of your honoring me for basically doing the right thing for the right reason."

CHRISTINE HAHN

1999 Recipient

Christine Hahn is an investigative journalist who received the 1999 Canadian Community Newspaper Association award for Outstanding Reporter Initiative for her series of articles exposing psychiatric fraud in a Texas facility called Tangram. Here, Canadian and other patients with "acquired brain injury" were body slammed into furniture by staff, thrown to the floor, restrained and pulled by the hair. Several staff were indicted on charges of assaulting a disabled person, and civil suits resulted in settlements for the victims of this abuse.

"The issue of abusive restraints is now front and center in the media, thanks to the persistence of CCHR staff — the best partners any journalist could have. I truly believe that evil thrives where good men do nothing. I want to thank CCHR for not allowing evil to thrive."

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MAKING HUMAN RIG

"In my experience, CCHR is the only organization that is playing hardball against psychiatric fraud and abuse. It was the first to seriously spearhead a movement against it. It has steadfastly insisted on the individual's constitutional right to freedom of conscience. It has worked tirelessly to protect the right of all parents to direct the education and upbringing of their children. I salute CCHR for its incredible persistence."

— Beverly Eakman
Co-founder, U.S. National Education Consortium, and Author, 1999

While its watchdog role has grown proportionately with psychiatry's assault on mainstream society, CCHR also realizes that education is a vital part of any initiative to reverse the tailspin that appears to have gripped so much of society today. As these pages show, CCHR takes this responsibility very seriously.

Through the broad dissemination of CCHR's internet site, books, thousands of newsletters, free booklets and pamphlets, more and more patients, families, professionals, lawmakers and countless others are becoming educated on the truth about psychiatry, and that effective action can and should be taken.

CCHR's booklets show the impact of psychiatry on racism, education, women, justice, morals, the elderly, religion, arts and even the very minds of man.

ATTACKING SCHOOLS, CHURCHES, COURTS AND MEDICINE

In 1940, psychiatry's goals were defined by John Rawlings Rees, a British psychiatrist and co-founder of the World Federation for Mental Health, who stated: "We must aim to make [psychiatry] permeate every educational activity in our national life....[W]e have made a useful attack upon a number of professions. The two easiest of them naturally are the teaching profession and the Church; the two most difficult are law and medicine."[130]

CCHR published several booklets showing the drastic effects of Rees' plans: *Psychiatry: Education's Ruin* and *Psychiatry: Betraying and Drugging Children,* document the impact of psychiatric and psychological curricula in education, including plummeting educational standards and the destruction of morals; *Creating Evil: Psychiatry Destroying Religion,* exposes psychiatry's infiltration of churches and the disastrous results for religion; *Creating Crime: Psychiatry Eradicating Justice,* shows how the "insanity defense" has redefined the guilty as victims. Like hired guns, psychiatrists provide testimony in courts to the highest bidder, subverting the only tool society has to protect itself and survive. *Psychiatry Committing Fraud* explores the rising incidence of psychiatric health-insurance fraud and how psychiatrists have sullied the good name of medicine.

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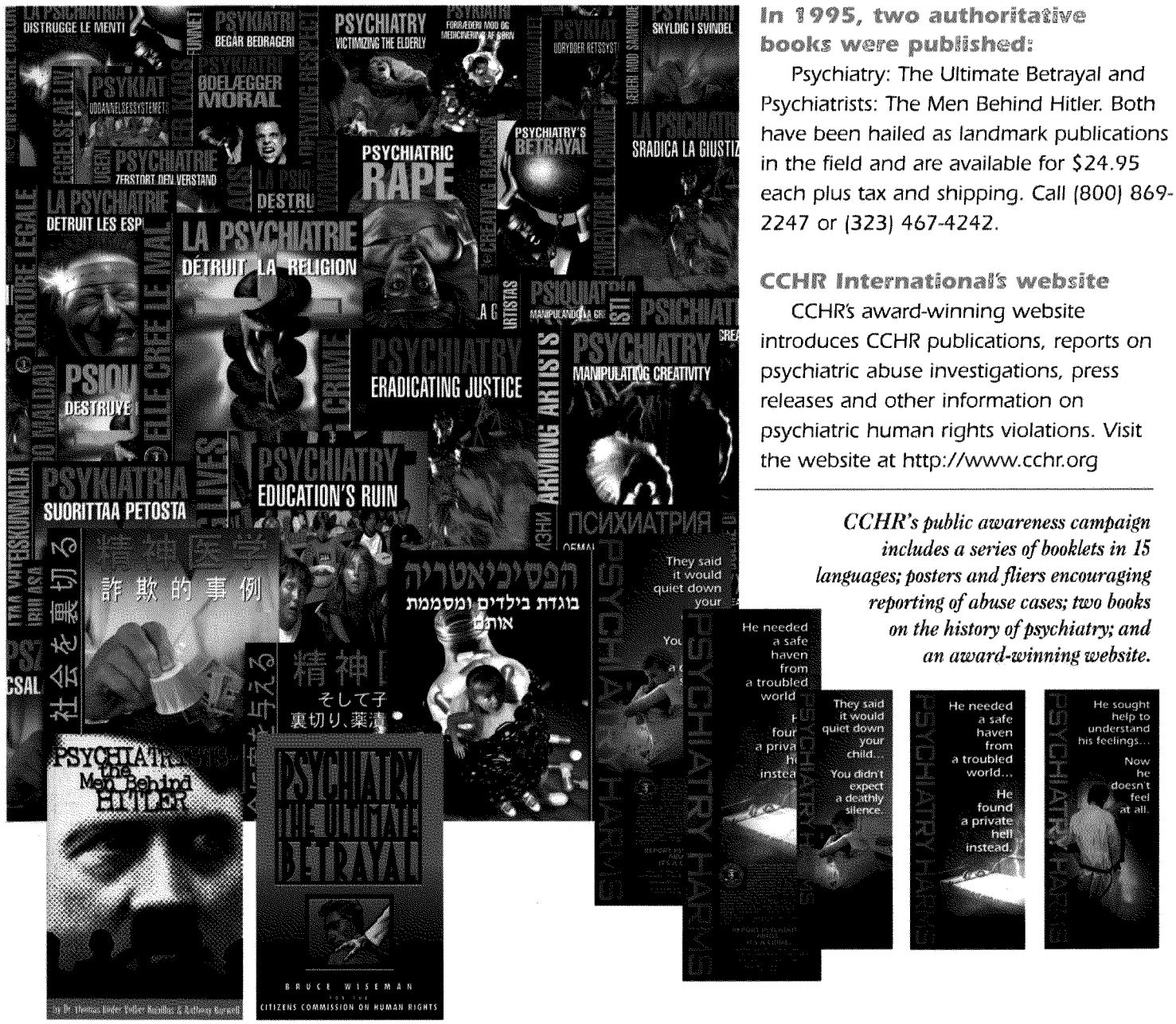

In 1995, two authoritative books were published:

Psychiatry: The Ultimate Betrayal and Psychiatrists: The Men Behind Hitler. Both have been hailed as landmark publications in the field and are available for $24.95 each plus tax and shipping. Call (800) 869-2247 or (323) 467-4242.

CCHR International's website

CCHR's award-winning website introduces CCHR publications, reports on psychiatric abuse investigations, press releases and other information on psychiatric human rights violations. Visit the website at http://www.cchr.org

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CCHR's public awareness campaign includes a series of booklets in 15 languages; posters and fliers encouraging reporting of abuse cases; two books on the history of psychiatry; and an award-winning website.

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Psychiatrists and psychologists should be required to sign a Mental Health Practice Code that legally binds them to certain standards of practice before they can be employed in government-run or subsidized hospitals or for their services to be eligible for health insurance coverage.

I hereby subscribe to the following code of ethics and practice and swear to abide by it at all times.

1. To support the Constitution of the government of my country.

2. To refuse to practice brainwashing upon any citizen.

3. To actively prevent the harmful use of psychological and psychiatric programs in schools and universities.

4. To use my knowledge and skill only to the proven benefit of individuals and groups.

5. To engage in no conspiracy to commit or treat persons for purely self-interested or political reasons.

6. To refuse to protect criminals by supporting questionable pleas of insanity at trials.

7. To discourage all violence against the mentally ill.

8. To refuse to use, advocate or experiment with methods of "therapy" upon patients which might bring about incapacitating physical injury to the patient's brain tissue or body.

9. To refuse to force or cause to have forced practices or treatment on my patients.

10. To refuse to contribute money, dues or my services to organizations which knowingly carry out scientific research programs that may impede the health or liberty of an individual or cause unnecessary suffering or physical or mental damage.

11. To refute propaganda to the effect that IQ cannot be improved or that IQ is congenital, inherited or race related.

12. To refuse to accept for counseling or assistance, and to refuse to accept money from any patient or group I feel I cannot honestly help and to offer no solution or cure I cannot accomplish.

13. To refuse to advertise beyond the display of my professional card and capabilities.

14. To refer to competent medical treatment ills which demand medical

ETHICS

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attention. Prior to engaging in any treatment, to rule out physical or medical origin for a patient's apparent affliction or difficulty by thorough examination by one or more non-psychiatric physicians and, in the event that such physical illness or condition is detected, to allow competent non psychiatric medical treatment as the first resort to addressing such difficulties.

15. To render good treatment, sound training and good discipline to those students or people entrusted to my care.

16. To refuse to interfere with the lives of my patients beyond actual treatment.

17. To refuse to enter into or engage in any sexual contact, interaction or relationship with my patients or to permit sexual liberties or violations of my patients, and to report any incident of a professional colleague that I know to have engaged in such criminal conduct.

18. To hold in confidence the secrets of my patients.

19. To accept as fellow psychiatrists and psychologists only psychiatrists and psychologists adhering to this code and to speak no word of criticism in public of them.

20. To hold that my patients have the right to equal recognition everywhere as a person before the law and are entitled without discrimination to equal protection before the law.

21. To refuse to allow my patients to be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

22. To refuse to determine a patient's condition on the basis of race, color, sex, religious or political beliefs or opinion.

23. To refuse to impede my patients' right to practice and express their religious or political beliefs.

24. To refuse to allow any patient to be subjected to arbitrary arrest or detention in any psychiatric facility.

25. To refuse to use physical and/or chemical restraints on children.

26. To refuse to practice euthanasia.

I make this declaration knowing the above to be true.

_____

Practitioner's Name

_____

Witness

_____

_____

_____

Address

On this date: (day)_____ (month)_____ in the year _____

THE CITIZENS COMMISSION ON HUMAN RIGHTS

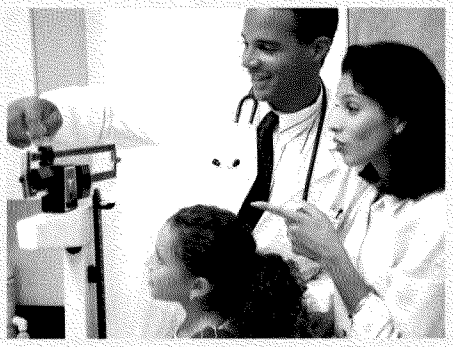
When CCHR began in 1969, it entered a world almost wholly ignorant of the nature, extent and effects of psychiatric practice and control. It was a world in which none of the suffering millions had any voice at all. CCHR became that voice.

Established by the Church of Scientology as an independent body to investigate and expose psychiatric violations of human rights, CCHR is cleaning up the field of mental healing.

CCHR's co-founder is Dr. Thomas Szasz, Professor of Psychiatry Emeritus and internationally renowned author. CCHR is now an international organization with more than 130 chapters in 31 countries.

Achieving its purposes began as a veritable David and Goliath struggle. A guiding strength to CCHR was humanitarian and founder of Scientology, L. Ron Hubbard, who in 1969 stated that "human rights must be made a fact, not an idealistic dream." To that end, CCHR has brought its message to the doorsteps of national and state legislatures, the United Nations, international councils, patients' rights groups and people and organizations from all walks of life. Its powerful voice is now heard around the world.

CCHR is proud of the reforms it has brought about in its efforts to make human rights a fact. Today, prosecutions of psychiatrists, psychologists and mental health workers are commonplace. Many countries and states have now mandated informed consent for psychiatric treatment, along with the right to legal representation, advocacy, recourse and compensation for patients.



The Commission includes a board of advisors, composed of doctors, lawyers, educators and human rights representatives. CCHR strongly supports competent, non-psychiatric medical care.

The Commission includes a board of advisors known as Commissioners, which includes doctors, artists, lawyers, educators and civil and human rights representatives. While CCHR does not provide medical or legal advice, it advocates thorough medical screening to discount physical illness before transferring any individual to psychiatric hands.

Since 1969, CCHR's work has saved the lives of millions and prevented needless suffering for millions more around the world. Its work will only be complete when the beacon of human dignity shines clear in *all* corners of the globe and psychiatry is held to account for the fraudulent practice it is.

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Los Angeles, CA 90028, USA
323 467 4242
800 869 2247

Or contact your nearest CCHR office:
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Toshima-Ku
170-0004 Tokyo
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CP 06760, Mexico D.F.
Mexico
52 5 56 44778

CCHR Norway
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Menneskerettighets
Kommisjon
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Youngstorget
0028 Oslo
Norway

CCHR Commonwealth of Independent States
c/o Hubbard Humanitarian Center
31, Prospekt Budennogo
105275 Moscow
Russia, CIS
709 526 70100

CCHR Sweden
Kommittén for Mänskliga Rättigheter
Johan Enbergs väg 36
171 61 Solna
Sweden
46 8 838 518

Endnotes

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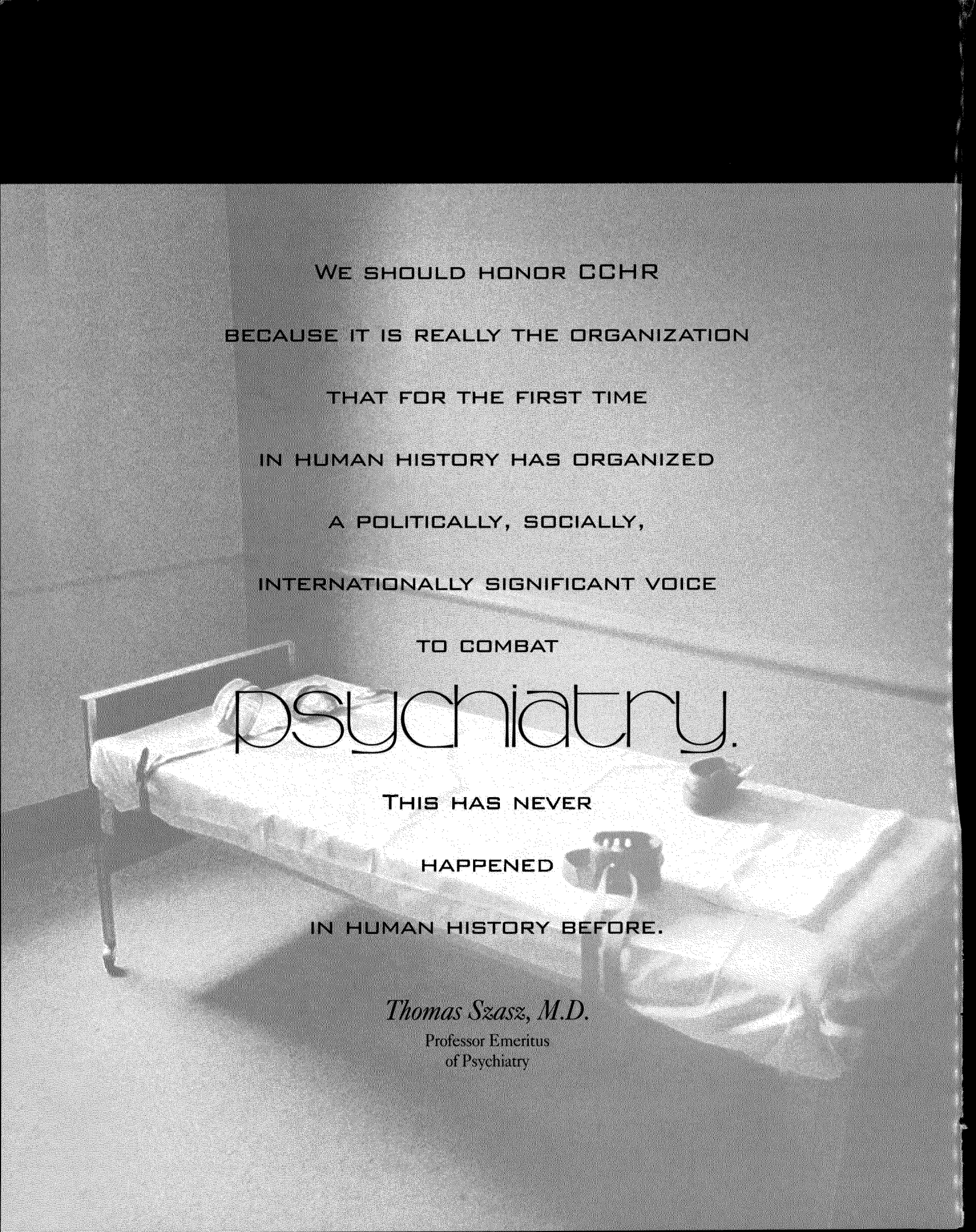
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