

Blueprints for an Effective Mental Health System in Washington State

Executive Summary

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EXECUTIVE SUMMARY

In the early spring of 2000, in part inspired by the ongoing Joint Legislative Audit Review Committee's (JLARC) mental health study, the Washington Community Mental Health Council and NAMI Washington (National Alliance for the Mentally Ill) began a joint process to review and distill national and state experience into a set of guiding principles and recommendations for an effective state mental health/mental illness treatment system. The Council and NAMI members worked proactively and collaboratively to incorporate the views and priorities of system consumers, their family members, and stakeholders at all levels. The product of this collaboration is contained within the document, *Blueprints for an Effective Mental Health System in Washington State*. This document was developed with the following objectives in mind:

1. To incorporate national perspectives and best practices from other states and regions.
2. To reflect our conviction that there is no single "right answer" as to structure – that various systemic structures may or may not work well depending upon how adequately they are supported by core processes, functions, funding, and clarity about roles and responsibilities.
3. To build conclusions on data. Where useful data are not yet available, point out what data are needed.
4. To recognize that good mental health is integral to the total well-being of an individual and that the mental health system is an integral part of the total health care system. Effective mental health care is best provided across systems and contexts of care.
5. To appreciate that, unlike emotional or behavioral "problems," mental illness is a disease and therefore, to incorporate the fact that neurology, biology, and the chemistry of brain science is crucial to the provision of state-of-the-art treatment for illnesses such as schizophrenia, major depression, bipolar disorder, autism, ADHD, ADD and others.
6. To outline a process that helps all parties – consumers, family members, stakeholders, legislators, and others – develop a common language and common "view of the world," thus facilitating future joint problem solving and strategy implementation.

SHORT OF THE GOAL

The Washington State public mental health system has undergone very substantive changes in the last ten years. For some consumers and families, much is working better now than it was a decade ago. Yet, there are still major aspects of the system that are not responding to the needs of

either individuals who are ill or their communities. The present system does not extend to all who have mental illness the possibilities of REHABILITATION, RECOVERY AND REINTEGRATION derived from new discoveries in brain research and continual improvements in state-of-the-art treatment. Nor have the promise and legislative intent of SB5400 been fulfilled. Foremost among the shortcomings in the mental health system are:

- The Washington State public health system is significantly underfunded. Not all residents who need services from the public system can access them or obtain services in needed amounts.
- Consumers cannot receive the same treatment for the same illness in different parts of the state because benefit packages vary by Regional Support Network (RSN) and sometimes by counties within an RSN.
- Consumers who temporarily or periodically lose their Medicaid eligibility may find that they cannot get the same services, even though they have the same (or greater) need as when they were eligible for Medicaid. Similarly, those consumers who are not eligible for Medicaid but have limited or no private-sector mental health benefits, may not be able to access services in the Washington public mental health system.
- In many regions, there are increasing numbers of people with devastating mental illnesses, young and old, who are unserved or underserved by the public mental health system. Too often they end up, inappropriately, in other state or local systems that were never intended to meet the needs of people with serious mental illnesses and are ill equipped to do so.
- Funding formulas do not ensure that dollars follow consumers if they move from one region of the state to another. The formulas are based on fee-for-service era data that are a decade out-of-date and make it impossible to ensure equitable treatment across the state.
- Too much of the money allocated for mental health services is spent before it gets to the service level, reducing the total dollars for care available for Washington's consumers.
- Standard, relevant data are not universally available to support decision making, funding, and system improvement.
- Lack of a system-wide quality improvement process prevents the spread of best practices (clinical and management) across RSNs, depriving adult consumers and children and their families of advancements in care.
- Lack of system-wide outcome measures and core performance indicators make it nearly impossible to know how we are doing as a state system, by region, or by provider, despite the extensive system-wide data requirements for RSNs and providers.

HISTORY POINTS THE WAY

A review of the evolution of the Washington State public mental health system, points to key contributors to both the successes and the deficits of the current system. As one of the pioneers in Medicaid managed mental health care, Washington built a system without the benefit of the experience of other states. Strong values emphasizing local control of service delivery and the expectation of reduction in bureaucracy and unnecessary administrative costs inadvertently led to the creation of a patchwork quilt “non-system” with inequities in benefit design, duplicative data collection, reporting of data that are not analyzed or used, and administrative requirements that differ from region to region.

Using Medicaid data to establish capitation rates for each region, while providing limited support for treatment of non-Medicaid-eligible persons through other funding sources, unintentionally led to a two-tiered, segregated public system. Medicaid-eligible persons receive priority for services based not on considerations of the severity of their illnesses, but on Medicaid guidelines and each individual's ability to negotiate the Medicaid and Social Security application processes. Social and legislative changes, including welfare reform, have led to shifts in eligibility and consequently, funding levels in various areas of the state. Yet over the same time period, known in research circles as "the decade of the brain," a growing knowledge base of science and best practice in serving mentally ill children, adults and elders has changed the prospects of significant recovery for the most seriously ill and the nature of service delivery and demand for services.

FINANCING

According to a study recently released by the Bazelon Center for Mental Health Law using FY 1997 data from *Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 1997*, the national average *per capita* (total state and local dollars/ total population) funding by state mental health agencies was \$64.31. The range was from a low of \$22.91 (Tennessee) to \$336.50 (District of Columbia).¹ When analyzed in terms of constant dollars (adjusted for inflation), the average state appropriations dropped 7 percent between 1990 and 1997. State spending on mental health services (as a proportion of all state spending) declined from 2.12% in 1990 to 1.81% in 1997.²

A recent report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) shows consistent declining trends. While the private sector has been reducing its proportionate share of behavioral health funding and cost-shifting to the public sector, the public sector's support of mental health services has also declined in constant dollars.

Washington State was reported in the Bazelon study with a 1997 *per capita* funding level of \$78.74. It was one of the states that showed a constant dollar incremental increase from 1990 to 1997. However, it was during this time period that substantial funding for both boarding home care and Medicaid community inpatient care was transferred from elsewhere in the overall state budget into the MHD budget, confounding the analysis regarding the effect of inflation. In point of fact, the funding levels in Washington State have not kept pace with either population growth or inflation.

According to an analysis of prevalence developed for and included within this document, the *per capita* funding level in Washington State should be \$124.45 in order to address the documented service needs of the population and reduce utilization of alternative systems such as corrections. In 1998/99, the cost per client for outpatient and residential services was \$2,269; all costs per

¹ *Under Court Order: What the Community Integration Mandate Means for People with Mental Illnesses: The Supreme Court Ruling in OLMSTEAD v. L.C.*, Bazelon Center for Mental Health Law. Washington, D.C., October 1999. Table 1.

² *Ibid.* p. 20.

client (including community inpatient and state hospital) were \$3,228. This analysis projects that if funding levels were proportionate to the need for services, the cost per client for outpatient and residential services would be \$4,012; all costs per client (including community inpatient and state hospital) would be \$5,371.

ALIGNING ROLES, FUNCTIONS, CONTROL, AUTHORITY, AND ACCOUNTABILITY WITHIN THE STATE'S STRUCTURAL DESIGN

In the decade since Washington implemented SB5400, much has been learned nationally about what works in managed care, and specifically, in managed public mental health care. Clarity about roles, functions, control, authority, and accountability at all levels of the system can decrease unnecessary duplication, freeing resources for direct services to recovering consumers and their families. This document outlines best practices in organizing those elements.

THE SIGNERS OF THIS DOCUMENT CALL FOR WASHINGTON STATE TO IMPLEMENT THE FOLLOWING PRINCIPLES AND RECOMMENDATIONS:

GUIDING PRINCIPLES³ TO BE INCORPORATED INTO A RESTRUCTURED STATE MENTAL HEALTH/MENTAL ILLNESS TREATMENT SYSTEM:

1. A DIGITAL-ERA DATA SYSTEM: OPEN-ACCESS, UNIQUE AND SECURE PARTICIPANT IDENTIFIERS, AND STANDARDIZED LANGUAGE

Good decisions are based on fast access to accurate and reliable information. Simplification, standardization and accessibility are important characteristics of a data system in the digital age. Privacy is a major concern, but can be protected by assigning unique identifiers and erecting access barriers to an individual's information. Language and definitions need to be consistent.

³ *Six Guiding Principles on which to Design a "State of the Art" Mental Health System*, adopted by the Board of Directors of NAMI Washington on August 5, 2000. The full text of the *Six Guiding Principles* document appears in Appendix D of *Blueprints for an Effective Mental Health System in Washington State*.

2. "STATE OF THE ART" REHABILITATION, RECOVERY AND REINTEGRATION SYSTEM — THE 3 R'S

REHABILITATION, RECOVERY AND REINTEGRATION must be the goals of treatment. Increasingly, people can and do recover from serious mental illness, becoming for the first time or returning as useful members of society and taxpaying citizens. Successful treatment for elders results in better quality of life and independence rather than deterioration and expensive nursing home care. The rapid unfolding of scientific knowledge about what works for rehabilitation and recovery demands a service and support system that is attuned to progressive techniques. Moreover, the system must quickly incorporate research and scientific discoveries into standard practice and both consumers and providers must be encouraged to try new medications and new methods of recovering what has been compromised by disease.

3. PEER AND PROFESSIONAL INTEGRATION

The integration of recovering “peers” and trained professionals in the business of outreach, rehabilitation, and support of adults with serious mental illnesses promises improved access, participation, outcomes, and greater efficiency. Staff will be better able to meet the needs of all participants if they come from backgrounds that include both the knowledge and wisdom derived from formal education as well as that distilled from the intimate experience of having a mental illness. Collaborating with “peer” colleagues will help educate and sensitize professionals to the more subtle aspects of these illnesses and to the processes of decompensation (relapse) and recovery. Employing more peer staff members can be accomplished at less cost than adding more academically qualified colleagues. A similar partnership between care givers of young children who suffer from neurobiological brain disorders, recovering young adults who themselves were children at time of onset of their illnesses, and traditional professionals holds similar promises for children and their families.

4. EARLY DISCOVERY/INTERVENTION

Screening in order to detect early mental illnesses among children, adolescents and young adults, and other particularly vulnerable groups of people is imperative. Professional screening for possible brain disorders, on referrals initiated by experienced classroom teachers who have had training to recognize early behavioral symptoms of biological brain disorders, for example, would discover many early childhood cases of schizophrenia, bipolar disorder, major depression, OCD, etc. Carried through high schools and universities, such efforts would help to discover, at the earliest stages, serious mental illnesses which typically begin to assert themselves in early to late adolescence. Early recognition is also a critical element in avoiding one of the leading causes of death among children from 11 to 21, suicide.

5. RECONSIDER VOLUNTARY TREATMENT PLANS AND CONCEPTS OF INVOLUNTARY TREATMENT

Lack of insight on the part of a “patient” who believes that he or she is not ill is a most intractable complication. It is difficult to treat someone who believes that nothing is wrong. Today, we know that the major problem of “non-compliance,” particularly with medication

therapy, derives sometimes from the experience of the adverse side effects, particularly prevalent in older medications. But, very often “non-compliance” is occasioned by the ill person’s lack of awareness of their illness or of their need for treatment. Treatment plans, therefore, must be made more attractive to such individuals and maximize consistent treatment cooperation and adherence among those so affected.

6. FULL FUNDING, OPEN ENROLLMENT, AND QUALITY IMPROVEMENT APPROACH TO SYSTEM EVALUATION

To be effective, treatment requires ready access to quality medications, continuing education about the course of one’s illness, relentless involvement by the patient, informed rehabilitative therapy, sometimes aggressive outreach and support (see Peer and Professional Integration #3 above), and all of the other supports necessary for recovery from a very devastating illness. Often, professional practitioners and recovering consumers of treatment know what is needed and what to do; but they require a full complement of resources, time for intimate and stable relationships for hard work, and easy open enrollment for all those needing treatment, beginning with the earliest symptoms of illness.

System evaluation should begin with monitoring the results of what happens between a participant and a provider and how well those results match with his or her treatment plan. Accountability should begin with measurement of aggregated consumer outcomes and extend to analysis of correlations with various treatment modalities, medications correlated with diagnosis, etc. And such data should feed quality improvement by being readily available for use by providers, advocates, managers, legislators, and the public.

RECOMMENDATIONS FOR RESTRUCTURING THE WASHINGTON MENTAL HEALTH/MENTAL ILLNESS TREATMENT SYSTEM INTO AN EFFICIENT AND EFFECTIVE SINGLE SYSTEM:

RECOMMENDATION 1: BUILD FUNDING FOR THE WASHINGTON PUBLIC MENTAL HEALTH SYSTEM TO A LEVEL THAT ASSURES THAT ALL RESIDENTS CAN OBTAIN THE SERVICES THEY NEED

The gross underfunding of the public mental health system must be confronted. It will likely take more than a single legislative session or biennium to close the gap on the shortfall but work on a long-term strategy to raise the statewide funding level must begin. The methodology that generated the prevalence, needs and costs data in the *Blueprints* document provides a tool for projecting future funding needs. This tool, as revised and refined along the way, can guide a process over the course of coming budget periods to build funding to a level that assures that every resident has access to the appropriate level of mental health services from the public system.

RECOMMENDATION 2: GIVE ALL CONSUMERS OF THE PUBLIC MENTAL HEALTH SYSTEM ACCESS TO A COMPREHENSIVE, STANDARDIZED BENEFIT PACKAGE.

This recommendation is meant to provide a foundation of services for all consumers in Washington, regardless of where they live, or how their RSN has organized to meet the needs of its local citizens. A standard foundation for care can and should exist side-by-side with localized planning and individualized service delivery for consumers. This standardized benefit package is not proposed as a reduction in services, but as a platform upon which creative, innovative, and more effective treatment decisions can be built. The standardized benefit package must incorporate a sufficient array of services to meet the medically necessary needs in the designated priority populations.

RECOMMENDATION 3: CONSISTENTLY DELIVER STATE-OF-THE-ART SERVICES AND SUPPORTS, WHICH ARE BUILT ON NATIONAL AND LOCAL BEST PRACTICES, CURRENT RESEARCH, AND CONSUMER/ADVOCATE PARTICIPATION.

In addition to a standardized benefit package that can be accessed by all consumers in the public system, the actual services must be the very best possible. Services must incorporate the most current, most efficient and respectful approaches available to treating mental illness in the public sector. The best research, the brightest conceptual approaches, the strongest clinical and system leadership, and the practices that have yielded the best results need to forge the public mental health system. Those superlatives need to be present in all services, for all consumers, at all levels of the system. Washington’s citizens deserve the best. Setting high goals for quality of services can only strengthen the commitment and the skill of all involved in the public mental health system.

RECOMMENDATION 4: RESTRUCTURE THE FINANCING SYSTEM FOR THE WASHINGTON STATE PUBLIC MENTAL HEALTH SYSTEM SO THAT CONSUMERS MAY ACCESS THE STANDARDIZED BENEFIT PACKAGE REGARDLESS OF MEDICAID ELIGIBILITY.

As outlined earlier, Washington currently has a two-tiered mental health system based on whether or not a person is eligible for Medicaid. The two tiers receive dramatically different levels of service. Restructuring the financing system is a major tool to eliminate the tiered system, while providing the opportunity to use more current approaches to funding public mental health services.

RECOMMENDATION 5: CLARIFY AND ALIGN ROLES AND FUNCTIONS AT ALL STRUCTURAL LEVELS OF THE SYSTEM, REDUCING DUPLICATION AND REPLICATION OF TASKS AND EFFORT.

There are currently three structural levels in the Washington State mental health system. Each has a primary role that should be clarified and “owned.” The State Mental Health Division has the primary role as state mental health authority. The RSN has the primary role of managed care entity or intermediary. The providers (including the state hospitals) have the primary role of service delivery. The counties sometimes become a fourth level by performing contracting and/or monitoring functions within the overview of the managed care entity. (When a county functions

as a service deliverer, it is not a fourth level, but part of the provider level.) Within each role, there are multiple functions and tasks.

RECOMMENDATION 6: IMPLEMENT A SYSTEM-WIDE QUALITY IMPROVEMENT SYSTEM, REDUCING COMPLIANCE-ORIENTED ACTIVITIES, AND INTRODUCING SYSTEM-WIDE PERFORMANCE INDICATORS.

A system-wide quality improvement system is a necessity to help what is currently working well intact while other parts of the system are retooled to address the needs outlined in this document. More than any other goal, this one will require strong political commitment from both the executive and legislative branches, along with vigorous leadership from the Mental Health Division. Public reaction to system glitches is usually to want “heads to roll” and to ask “why weren’t there more rules?” Operational errors must be distinguished from those events – such as abuse or fraud – which can never be tolerated. Implementing a quality improvement approach in the public sector requires a political commitment to reframe glitches and non-critical events as opportunities for improvement and learning. There must be the political will (at all levels of the system, not just from elected officials) to craft clearly defined, consistently applied performance standards, and to hold all levels of the system accountable both for meeting those standards, and for developing strategies to improve upon them.

RECOMMENDATION 7: MOVE TOWARD A STATE-OF-THE ART, STATEWIDE DATA SYSTEM

Washington must take giant leaps forward in its ability to manage data in order to achieve all the goals outlined in this document. State-of-the-art systems can reduce the paperwork burdens at all levels of the system, and provide critical data to manage, evaluate, and improve care for those children, adults and elders who need services. An investment in a state-of-the-art, statewide data system will become an investment in moving more resources into service delivery. This document calls for bold action and commitment to develop creative strategies to help Washington State become a national role model for the data system.

OTHER OPPORTUNITIES

Although not the central focus of *Blueprints*, there are many other opportunities for reducing the consequences of untreated mental illness. These include:

- Parity in insurance coverage and benefits
- Providing Crisis Intervention Training to all officers of the law
- Developing a full array of appropriate housing and residential options
- Increasing the number of triage centers, mental health courts, and co-occurring disorder treatment programs to reduce the ongoing criminalization of mental illness
- Adopting “Ticket to Work” legislation to assure health care coverage for those who are recovering from their illness to pursue education and jobs

CONCLUSION

The fundamental goal that stands behind this document’s creation is to obtain and maintain a “state-of-the-art” mental health/mental illness treatment system -- one recognized by continued

improvement in service outcomes for children, adults and older adults who need public mental health/mental illness treatment in Washington State. Realization of this goal will mean constant improvement in the quality of life for every mentally ill child, adult and elder in every community across Washington, ultimately achieving the best possible outcomes -- RECOVERY, REHABILITATION AND REINTEGRATION -- for each person whose illness brings them into the system.