U.S. Department of Justice
Civil Rights Division

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Special Litigation Section - PHB
950 Pennsylvania Ave, NW
Washington DC 20530

January 24, 2014

VIA FIRST CLASS MAIL

John Dunbar
Attorney in Charge, Special Litigation Unit
Oregon Department of Justice
1515 S.W. Fifth Avenue, Suite 400
Portland, OR 97201

Re: January Meeting with State Officials regarding Oregon's Mental Healthcare System

Dear Mr. Dunbar:

This letter is in follow-up to our meeting with state officials on January 8-9, 2014 concerning our investigation of Oregon's mental healthcare system pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, as interpreted in Olmstead v. L.C., 527 U.S. 581 (1999).

We are very encouraged by the commitments made by the state during the meeting and impressed by the vision and leadership of Pam Martin, the new Director of the Addictions and Mental Health Division of the Oregon Health Authority. Ms. Martin's plans and proposals outlined during our meeting appear to be a promising use of recent increased funding provided by the state legislature to build the array of community-based services to serve Oregonians with mental illness in the most integrated settings appropriate for each individual's needs. Many of these proposals the Department heard about for the first time in our January meeting. It behooves state officials to keep us up-to-date on proposals regarding community mental health care, even if the proposals are in draft form, or may not be fully realized, so that they may be considered in our analysis of the state's system. In order for us to provide guidance and support as a collaborative partner in assisting Oregon in reaching a truly integrated system of community-based mental health care, we would like to engage in at least quarterly conversations with AMH, and to be provided copies of proposals in advance of their implementation, so that we may provide the most timely guidance possible.

In this letter, we summarize many of the commitments made by the state during our January meeting. If these commitments are carried through, Oregon will lay the foundations to address the concerns raised in our investigation and in our Interim Report released on January 2, 2014.

The state's proposals, discussed below, are a long overdue first step in addressing the gaps in Oregon's community-based system, that the Department and the state now agree exist: (1) lack of an adequate array of crisis services throughout the state; (2) lack of adequate supported housing choices for individuals with severe and persistent mental illness (SPMI); (3) lack of quality intensive supports and services (such as Assertive Community Treatment teams and intensive case management) throughout the state's population centers for persons with SPMI; (4) lack of adequate supported employment services for persons with SPMI; (5) lack of adequate peer support services throughout the system of care; and (6) Oregon's reliance upon restrictive and expensive institutional-based care and treatment of persons with mental illness.

As previously discussed, in the letter to the state last April from U.S. Attorney Amanda Marshall, our November 9, 2012 agreement matrix provides the state a "blue print" for the array of evidence-based and cost effective community based mental health services necessary to address these gaps. This array includes: (1) crisis services, such as mobile crisis teams, crisis walk in centers, crisis drop off centers, and crisis apartments; (2) supports and services, such as Assertive Community Treatment teams, intensive case management, peer support, and supported employment; (3) increased early intervention services; (4) supported housing; (5) quality management; and (6) Medicaid maximization. These services are critical for not only providing care in the most integrated setting, but also for providing services in the most cost effective manner. Furthermore, stakeholders across the board -- from consumers to law enforcement -- agree that investment in these critical community-based services will help keep people stable in their homes and their communities and out of crisis and segregated institutionalization.

Furthermore, as Oregon moves forward, the state, counties, and Coordinated Care Organizations (CCOs) must all act as partners in addressing the gaps in community-based services. The unaddressed gap in crisis services in Portland, for example, shows why this partnership is critical. Between July 1, 2012 and June 30, 2013, Portland police officers made 1,138 transports (of 955 different individuals) to emergency rooms, where the individuals were placed on some type of mental health hold. In that same time period, Portland police officers only transported 50 individuals to other locations, where the individuals were served without the need for a mental health hold. There is no disagreement that treating an individual with mental illness or in a mental health crisis in an emergency room is the most expensive form of treatment and one that also runs the increased risk of institutionalization and does not provide the services necessary for prevention of future crises. Portland and the United States emphasized in their Settlement Agreement concerning police practices the need for coordination between the state, CCOs, county, and local hospitals as partners to establish one or more drop-off centers for first responders and public walk-in centers for individuals with addictions and/or behavioral health service needs.[1] The United States expected that these drop-off and walk-in centers would be established by mid-2013. However, not one center in Portland has been established or funded by the state, county, or CCO. While the United States is aware that City leadership has attempted to convey to the local CCOs and hospitals this expectation by the United States, the responsibility

[1] See Proposed Settlement Agreement, paragraphs 88-89, publically available at http://www.justice.gov/crt/about/spl/documents/ppb_proposedsettle_12-17-12.pdf

to make this happen rests on the partners responsible for mental health services – the state, counties, and CCOs.

The following plans and proposals from the Addictions and Mental Health Division are first steps in addressing the gaps, and we look forward to continuing our discussion with AMH regarding these proposals. In the near future, as we also discussed, we will agree upon the systemic changes these proposals and others must show in order to comply with federal law requiring states to serve individuals with mental illness in the most integrated setting appropriate for their needs:

- **Crisis**: Grant applications totaling over $6.2M approved for 12 counties throughout the state's populations centers for increasing crisis services, including mobile crisis response and crisis respite services in order to avoid hospitalization or incarceration. The state is also undergoing a utility review of the fragmented county-based crisis hot-line system and expects to provide a report to us in July 2014.

- **Assertive Community Treatment (ACT) Teams**[2]: Request for proposals pending for the funding of three additional ACT teams and one forensic ACT team. Additionally, state officials plan to conduct fidelity reviews this year of the current ACT teams. State officials are also scheduled to meet with the Oregon Supported Employment Center for Excellence early this year to discuss the current status of ACT teams in Oregon. Providing for ACT services is also embedded within the state's contracts with the Coordinated Care Organizations (CCO).

- **Supported Housing**: AMH, in collaboration with Lifeways, Inc., is contracting with Cascade Property Management to conduct a "housing inventory" of all available independent housing options available to individuals with mental illness. AMH intends to use the inventory to inform targeted planning of Supported and Supportive Housing development. The state expects the inventory report by the end of this month. AMH is also working on a memorandum of understanding with the National Alliance on Mental Illness regarding construction of affordable housing options.

- **Peer Support**: Oregon recently published regulations regarding peer support specialists, which should provide an increase in the peer-delivered services. AMH expressed an interest in playing a role in providing training and certification for such services.

- **Adult Mental Health Initiative (AMHI)**: While AMHI is not a new program, the state explained that the focus on this program is shifting to emphasize community placements and transitioning from the state hospital directly to supported housing. Furthermore, in

[2] Although the data provided by the State throughout 2013 showed that Oregon had 41 ACT teams, during our January meeting, AMH officials informed us that Oregon has 16 ACT teams, and that they are in the process of determining the status of each team's fidelity to evidence-based standards. We expect further information from the state regarding ACT team status in early February.

2014, the CCO contracts provide a higher incentive for CCOs to become financially responsible for individuals under their plan who are placed in the state hospital.

- **Data Collection**: In order to address the data accuracy concerns we raised in our Interim Report, the state has made several recommendations to ensure improving capturing more accurate data. The Department and the state are currently discussing these recommendations, as well as considering input received from community stakeholders.

- **Office of Consumer Affairs:** AMH recognizes that Oregon is only one of 10 states without an office of consumer affairs. AMH plans to fill two full time positions in March 2014 to address this gap at the state level.

Sincerely,

JUDY PRESTON
Deputy Chief
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Civil Rights Division

cc: S. Amanda Marshall, U.S. Attorney