

**This public comment was provided by Empower Oregon which is a project of SEIU Local 503. Included is panel testimony from our forum on January 17<sup>th</sup> in Portland and Eugene as well as feedback from breakout sessions at the same forum on what should be kept, avoided, and added to mental health and addictions services in transformation.**

**If you have any questions please call Penny Ruff at 503-539-7108 or [ruffp@seiu503.org](mailto:ruffp@seiu503.org).**

## **Chalaina Connors**

*Chalaina Connors is a child abuse interviewer at CARES NW. She worked previously at the Morrison Child and Family Services, and prior to that worked at the Domestic Violence Resource Center. She holds a Master's degree in counseling psychology from Pacific University. She became a Licensed Professional Counselor for the State of Oregon in March of last year. She has been a volunteer with DanceSafe since 1999 and currently runs the Portland Chapter.*

I've been working community mental health for the past five years. In that amount of I've seen a huge shift in the availability of funds, and the expectations for caseloads. This does not work. When therapists are forced to take on more than what is ethically appropriate. It effects the quality of services we can offer our clients and ultimately our clients suffer. For example when you're expected to take on at least six or seven hours a day of seeing clients how can you expect to be fully present for every one of those. I knew working in community mental health was tough work but our clients definitely need therapists who are experienced and not over worked so they can do the best job they can for their clients in the highest need.

I know the need is greater than the number qualified professionals that help but we need ways to reach more clients rather than the services we can bill for. I know that funding is not readily available and each year we get told of new and issues related to keeping agencies afloat. But I really feel that one of the services to be cut last should be the health and welfare of our children and people in general. If we can't be around to help our children become healthy individuals then who will be and what will the future hold.

Something beneficial for therapists would be having support from management. If we're not given appropriate feedback on the work we are doing with our clients this can be very discouraging. When we here nothing but the numbers it takes to keep the agency afloat we may lose sight of the good work we are doing and the lives that we are changing for the better. It also makes me sad to see the amount of turnover that takes place at community mental health agencies. I think that it is caused by the lack of support, pay, and the apathy about what kind of work this is. I know each year it feels like the normal cost of pay for a masters level therapist keeps dropping which makes it really difficult to appreciate the work that we do let alone paying off the cost of our student loans when the cost of higher education keeps skyrocketing each year as well.

Now I would like to talk about paperwork. I understand that documentation is very important. Luckily many agencies are switching to electronic medical records and I think this is absolutely wonderful and way more efficient and less time consuming. But I think that in some cases the programs that are designed to be more efficient can be very redundant and keep repeating some of the information that seems unnecessary. For example in an assessment for a new client is very important to gather all of the history information including previous diagnosis, family history, social/economic history, all kinds of medial relevance. But every year we are expected to do a reassessment and the program is designed to transfer a lot of the information over but sometimes with the programs you have to repeat a lot of the

information because it actually doesn't save what you did prior and so it is very redundant. It doesn't make sense to go through all these arbitrary steps to get things signed off for example.

For our yearly assessments we have to get them signed off by a psychiatrist and sometimes it can take months to track them down. Initially when we switched to electronic medical records a lot of the psychiatrists were unwilling to make the switch which created a lot of extra work and then it is the responsibility of the therapist to get it signed off because it shows up on our chart as not being completed which can be frustrating.

I don't think there is any quick solution but I feel that with more support from management and good feedback we can continue to provide the quality care we need to. Our clients ultimately need to be the number one focus in mind when we make changes because when we lose valuable clinicians because of budget cuts which creates more work for the remaining clinicians. This can lead to burnout and losing them as well. Of course if we had more funding and could hire more people, this would lower the burden on everyone and provide more balance for all.

## **Patricia Kennedy**

*Patricia Kennedy is a Family Advocate who lives in SE Portland. She has spent over 20 years caring for two children with mental health issues. Her oldest son, now 25, was diagnosed as a child with Asperger Syndrome, a form of Autism, and Obsessive-Compulsive Disorder. He is now living in a residential facility in Portland, recovering from a series of acute psychotic breaks triggered by the suicide of his brother, Patricia's youngest son, who died at age 20 after losing his struggle against severe depression and drug abuse.*

Whenever I'm asked to think about how mental health services can be improved, my head starts to spin. I think about how my son was confined for days in a Portland Emergency Room on two occasions last year, once for 3 days, once for 5 days, waiting for a bed in a psychiatric unit to open up somewhere in the city. I think about how that would never happen to someone experiencing an acute physical illness.

I start to remember how my son once called the County Crisis Line because he realized he was becoming psychotic again, but didn't want to be hospitalized for a third time. He was told to call his caseworker. Well, it was after 5 pm on a Friday afternoon and she was long gone. He then went to an ER, asking if there was any place he could go just to talk with somebody. He was told there was a clinic in SE, but he didn't have the right insurance to go there. Recalling that day, I still feel anger over the way the Crisis Line passed my son off and how the ER got it wrong about which kinds of insurance that clinic in SE accepts.

I think about the time my son went to see a doctor about chronic back pain. Upon learning my son was on several medications, the doctor demanded "What do you take all this medication for?" When my son replied that he was there for his back pain and that he didn't want to talk about the reason for the meds, the doctor said "I can tell you why you take them. It's because you're Bi-Polar." When my son countered that he was not diagnosed with Bi-Polar Disorder, the doctor said "If you're not going to be honest you can just leave right now." And so, my son, left.

I start to recall how my son was cut with a knife by a man who was beating up a social worker at his residence. I think back to the first thing he said to me when I got to the hospital: "Nobody was doing anything. They just kept yelling 'Stop'. I had to help her." And so, I think how odd it is that, according to the social worker my son saved, staff is trained in CPR, but not in how to approach, engage and subdue. I think about the staff turnover and all the shift changes at my son's residence and how unsettling it is for him and the other residents there with paranoia.

A few weeks ago I went to an input session for consumers and family advocates on health care transformation at Multnomah County's Mental Health & Addiction Services Division. Here are some of the things that were mentioned

- Timely access to care and services
- Emphasis should be on preventive care
- Providers and staff need to be knowledgeable about insurance coverage, how the system works, where care is available and what resources are available.
- Increased communication through Electronic Health Records, but with more safeguards to assure that the records can only be accessed on a "need to know" basis.
- Providers need to be educated not to dismiss problems or downplay symptoms as due to someone's psychiatric diagnosis or addiction
- Primary care physicians need to know their limitations regarding mental health and addictions
- Peer support specialists need to be legitimate members of the team to help people with mental illness and with addictions engage in their own care and to coordinate services and help establish trust with providers and staff.
- Food, housing, safety and transportation are necessary for healthy outcomes

Thank you so much for listening.

## **Saige Gracie**

*Saige Gracie is a Senior Clinician at an Outpatient Program of Comprehensive Options for Drug Addiction aka CODA. She has nearly 10 years in social services caring for adolescents, elders, high risk homeless youth, and dual diagnosis populations. She is a member of SEIU Local 503's Board of Directors*

So I figure the first thing we do when we look at a job we want to maybe be employed with, is the job description and say to ourselves that of the following criteria I think I can do that I think I can work these hours and provide these services and then you jump in and see how it goes. So what a job asks of us after three months is are you engaged how is this going, are you exhausted yet? The thing I am built for is providing social welfare to our population. About ten years ago when I was 18 or so I started volunteering with these groups that provide basic services like consoling and peer support and I think that stuck with me, still trying to figure out why that is. When I turned 25 or so I was an assistant supervisor on a dual diagnoses unit with teenage girls with severe mental illness and drug addiction. It was a lock down unit that required not only group and individual therapy but hands on redirection. I was there for about two years and it was probably an experience that will be with me for the rest of my life. There were time at that facility that went really well and there were times at that facility that

reminded me there is a world of change that needs to happen in this community Portland, Oregon, United States and a couple of them draw back to the original concept of the job description.

At no point do I recall having to look at a job description at that facility and think to myself I was going to have to find co-workers crying in the bathroom, at no point did I think to myself I was going to watch a systematic decline of a unit that was designed for therapy fall because of the pay scaled being so drastically different, at no point did I think to myself I would have to watch the only foundation the children ever had come out from underneath them because of funding cuts and budget cuts and the loss of belief and faith in a system that was set up to support them, at no point did I think I signed up to watch the decline in faith in the next generation that will follow me that will possibly provide absolutely essential elder services for myself. When we create a structure for social services ideally we would create a structure that we can sustain. Then, the situation that we have right now is that we have created a structure that we haven't funded, haven't set expectations for, and that we've watched suffer. So not only do we have the population of social workers who are stressed and traumatized but we have the outcome of that which is the population who relies on those services that's traumatized, that's disabled whether it be physically or emotionally and further traumatized by the decline of that consistency. If anything is to change for these services it is for them to be properly funded, create reasonable expectation for the social workers who provide these services and to put in the job description that at any point if you feel you can't provide these services this is exactly what we plan to do to support you because you are essential. At no point was that provided to me but we knew where to find it and it was from one another, these are the things not happening right now.

## **Dylan Ritchie**

*Dylan Ritchie is a self-pay consumer of Mental Health services in Portland, Oregon. He studied Public Health and Community Development at Portland State University, graduating in 2010. He has worked in many social services jobs dealing with issues affecting the LGBTQ spectrum and other economic and social minorities. He is currently a working artist at a local shoe repair shop and uninsured.*

So what I am going to do is go over a very long and extensive history very quickly, I think you can keep up. I struggled with mental health issues pretty much my entire life; I have had PTSD my entire life. I had both parents try to kill me and that kind of leaves a mark on you. By fourteen I was fairly suicidal and began my decline and you would say entry into services but I didn't have services I had foster care. I emancipated myself when I was sixteen, I went to school full time, and I worked full time and I had no health insurance, I had never taken a psych med besides what my doctor gave me which is what my abusive mother told him to give me and that was it until I was nineteen.

Then I worked for the county for about a year before I had a full on psychotic break and lost my job, a month before I was union. I left that job and that town to come to Portland and go to school to study what I love which is social justice and public health and access. I was in my senior year at Portland state university when I had my next psychotic break. I thought fourteen was bad because I was in a coma in a bathtub for a week and I thought that was bad but this time I was much more together and much more adult and it was much more terrifying. I fortunately had school health insurance because I was a

fulltime student and an employee of the college but there are some interesting intricacies in how that insurance worked. I was getting my psychiatric services and medication through the student health center but as soon as I entered a hospital because I was suicidal there was really no other resource to go to at that point I lost my psychiatric coverage at my school. I have it in my documentation because I couldn't believe my psychiatrist telling me I couldn't see him even though I was there just about to finish school, I was a 3.9 student, he told me that any student who was dependent on health insurance who had any issue that jeopardized their full time attendance it was unethical for them to treat me because I could drop out at any minute and then I wouldn't have coverage. So in the meantime I didn't have any coverage and was attending school full time and began to spiral into large large amounts of medical debt that I am still dealing with. I had \$100,000 worth of bills that I either had written off to charity or have entered into a bankruptcy. I'm twenty-six years old, I pretty much can't work because of the damage that happened to my brain when I tried to commit suicide that year I had the last psychotic break. That year I spent about a year in the hospital and I went back to school but finished at a pretty slow pace and by the time I got out with my degree and that forty grand in debt I had a lot of memory issues and a lot of stress responses and a market change in personality I had to deal with on top of entering the job market. So I went to live with my step dad for a year in a place where there was no mental health coverage and literally have gone years of my life with absolutely no treatment. I have severe depression with psychotic breaks and I have PTSD. I make about \$400 a month and with that \$400 I am supposed to house myself, transport myself, pay for medication, somewhere in there see a counselor and then try to find a psychiatrist that will see me, usually I end up in the hospital first. The last time I needed care because I was having a psychotic break, I know I'm having them because I hallucinate; I was on a waiting list to see a psychiatrist, actually a psychiatric nurse practitioner since they are a little bit more affordable. If I was over thirty I wouldn't have qualified for the waiting list, I was in the hospital before they could see me; I was released from the hospital the day of my appointment so I could see them. I can't afford a counselor, I am fortunate to have my medication through Outside In right now and I'm trying to build a future, I don't have health insurance, access is one of the biggest issues I face. I've applied for OHP, I'm on that waiting list too. I've worked with the Department of Aging and Disabilities, I'm not old enough, I don't have a kid, and I work just enough that I am "not disabled." I fight with social security, I filled bankruptcy paperwork, and I work almost forty hours per week just trying to put my life together hoping I don't have another psychotic break.

## **Dr. Tobias Ryan**

*Dr. Tobias Ryan is a licensed clinical psychologist in independent practice. He practices across the lifespan, working with children, adults, couples and families. Dr Ryan has been practicing since 2007, when he graduated from Pacific University, and is a former clinician at Morrison Child and Family Services.*

I'm really to be here especially because my journey with beginning trying to do some advocacy work with mental health really began with people I was exposed to in graduate school who told me that to provide really inclusive and competent services you have to get out of your office and go see what communities are doing in general to take care of problems outside of your office. I was encouraged to

do that and I started to do that and one of the first events I attended was in this room and I was ready to talk about paperwork, lack of support for clinicians and what I heard from people utilizing services or seeking services was that they couldn't get access and I heard that over and over again, this is a big room and it was a big circle and I heard that from person after person. I went home wondering how did this system evolve where here I am where I was actually chastised is one of my graduate course when I said I wanted to work part-time, pro-bono, for children who weren't receiving services anywhere else and the professor told me I had naïve and unrealistic expectations for how the world worked. I then went into the mental health field and I here this around the circle where I feel I was supposed to learn about what goes on outside of my office and people are saying they can't get into your office, just getting into your office would be nice but just getting access to you on a regular basis, what's wrong with that. I started to ask how we could evolve a system that makes it harder and harder for me to get access to people who need therapy or treatment and yet at the same time makes it harder and harder for people who want treatment to get access to providers. I don't think there's any shortage of providers, there was a group of people for instance who graduated with me in 2007 and there were 40-45 of them, that's 45 new doctors spread out into the world and there were concerns that they may be flooding the market because so many of them were graduating at the time.

So there's no shortage of providers so where's the disconnect? I think the disconnect the disconnect happens when we are emphasizing systems of administrations which are going to on the one hand were promised hold providers accountable for treatment they provide so they don't end up scamming on services and over billing and overcharging and at the same time managing the care of the other people so they don't remain in services and don't want to get better. I find over and over again that this viewpoint that admin is what's needed in order to be sure the providers don't abuse the system and consumers don't rely on the system overly just gets reinforced over and over again. There was this panel in Portland where we talked about the new CCO system and we came to this big group and one of the questions we were asked to address as tables was, what's the responsibility of consumers to get healthy? I'm just like I don't even want to answer this question I feel that there is this bias towards people who are like need to take charge of their treatment and get control and if they don't we are going to move on to the people who actually want to get better. So this system in the middle or this administrative system which I think is trying to keep me accountable and make sure my clients don't overly rely on me, really is what is creating more and more barriers for me.

So I'll give you a couple of concrete examples of this the first one is this week I do some work under Medicare in an assisted living facility for people who go into theses assisted living facilities and they stay in their rooms and they don't exit and then they become irritable and they yell at staff and they don't want their medication and then they start talking about just wanting to die, I wonder why I don't I die. My oldest client who is 95 continually asking me in session, why am I still alive? Why do keep going? And I remind him that he know all of this music and all of this history and all of these stories and he says oh yeah, there are still good things. I have to call the insurance company for clients on a regular basis and tell them and social isolation is detrimental to their health and I have to explain that I spent 45mins on the phone in one of my two days there doing just that. Just to get an authorization to keep working with a client who was I was already not getting paid for services because the authorization for services

expired. So that's an example of the administrative system blocking us out. She want me to come see her, I want to come see her, that's why I went to school, and I can't get to her because the system in the middle says call us first and tell us why you need to see her and then we'll give you ten weeks to see her and then after that you need to call us again.

So that's my first concrete example, my second concrete example is that I actually Morrison Child and family Services because I felt that the way the services were being provided was not actually responsive to children's actual needs. I had a conversation with a series of supervisors who told me that children didn't have the same expected levels of confidentiality that adults do so that they can be able to tell adults whatever the children said in session and I shouldn't have the expectation for that to be guarded. I decided I would leave for that reason. When I went into my own practice OHP sent me a twenty page document to fill out, in my practice where I don't have any benefits and need to make money to survive and buy food. When I finally sent in this form I went through this series of phone calls to get access to OHP clients. They told me I had been approve through this twenty page packet solely to give 1hr assessment session 1 time to people on OHP who were waiting for services. That's it, I could not see them on a regular basis, could not form relationships with them, I was supposed to asses them and turn in a report and that was it. That was the OHP contract I had just spent hours on the phone for.

My third example of this comes from this week when I have set aside time to prepare for session in my individual practice because this was something I was unable to do at Morrison child and Family Services because I needed to see patients all the time. So I set aside about 6hrs to do that, look over my cases see what's working look at the researching coming out. So I had this 6hrs last week and I used 5.5hrs of it on the phone with Insurance companies filling out HIPPA forms online, were talking about electronic medical records, this is supposed to make things streamlined and fast. There's is a 5 digit code called a payer ID that has been ruining my life for the last month, but the payer ID is different for all different types of people so I call the insurance company and they say I need to go through the local system and I call the local system and ask why aren't you guys approving this and they are like you have the wrong ID, client ID?, no org ID, what is that? So I spent 5hrs complete forms for 8 patients, help me out, 8 patients! So this middle system is not only making me accountable, it is not only keeping people from relying overly on the system it is keeping, its keeping people from getting into the system then it's keeping people from getting into the system and staying in the system because there is a strong desire on my part to do less and work more directly with people who coincidentally have enough money to pay their bill by themselves without the insurance company.

So I start to wonder if this is a consumer protection issue, why are there people who need the services not able to say, I am ready to authorize my doctor for 10 sessions and we'll see how my treatment is going after that. I don't like my diagnosis so I'm going to authorize this other doctor. But the people I work with don't have those kinds of power in choosing their own services. If I were going to change anything I would allow doctors to say you know you're wrong were going to do it this way, insurance company. And I would let patients say, you know I don't think my doctor is doing me wrong and we're going to keep with that with the co-pay I was promised with my plan. The co-pay is not difficult for me and I want this person added to my network so I get access to the co-pay I was promised when I signed up for this plan. Because as an out of network provider in a community where they are not accepting

new providers, the out of network cost is significantly higher than the co-pay they were promised when they got benefits at the job they were hired at or when they purchased this policy for themselves. Thank you very much for your time and attention.

## Breakout Feedback:

### Add

- More early crisis intervention
- Presumptive eligibility for Medicaid
- A nest egg or funding stream for paying for services when early crisis intervention is not covered by OHP/Medicaid – get people the services they need, worry about the funding later, saves money in the long run
- Residential services
- Better coordination of services
- Better access to care before need is acute
- Need to keep funding in system and add more
- Beer/liquor tax to fund A&D treatment
- Better access to community care after hospitalization
- Better crisis services
- Need to serve more people in the community
- Must share information between providers
- No wrong door to access care
- Better services available in rural communities
- Include preventative care – EASA (Early Assessment and Support Team) in Multnomah County as model
- Higher expectation for outcomes
- More peer support services
- More access to therapy, not just drugs
- Mental Health component to Addictions Centers/treatment
- Merge Mental Health and Addictions treatment
- Client centered treatment
- Encourage clients/patients own initiative
- Incentives to get off medications
- All providers for a single individual should communicate for the patients best treatment
- More community based services in poor neighborhoods
- Adequate pay for direct care staff – consistent with private providers
- Better working conditions for direct care staff – adequate paid time to meet administrative needs and to provide services – with appropriate support
- Electronic records that are compatible across public and private agencies
- Equal access to services for people on OHP
- Access to more prescribers for medications
- Make education and training for clinicians free or cheap in exchange for community work
- Centralized clearing house for medical records

- Consumer “smart cards” medical records
- More training/introduction for PCAs helping clients with mental health needs
- Additional pay with training
- Concentrated system for training prior to doing the work
- Coordinated trainings around the state for residential treatment
- More communication among different treatment settings
- Transparency with allocation of funding related to care provided
- More utilization of PCAs for activities of daily living and collaboration with case managers
- Utilize front line staff experience for better understanding of client conditions
- Utilize and create a treatment guide/mentor position to assist clients moving through the system
- Use our community services more often
- A more fluid spectrum of mental health treatments up and down the scale. Allocation transition between the case settings happen more early
- Transparency of info about client care
- Availability of opiate bridge drugs
- Treat the whole person
- Use housing services as a metric for CCOs
- Have strict accountability for services
- Use a series of risk issues to judge client health
- Use self-reporting from consumers in metrics
- Consumers should have individual choice
- Utilize peer specialists
- Have a “walk in their shoes” day for providers and OHPB members so they can see the difficulties in accessing services
- More simple forms
- More public forums

## **Avoid**

- Making people have to access needed care at many different locations or organization
- Care being cost prohibitive
- Capitalizing services that are really needed
- Spending all our money on in-patient treatment
- Just diagnosis and drugs are not enough – real treatment must be available
- Don’t let the CCO set the rules
- Too high case loads or not enough time with patients
- Bureaucracy has too many layers
- Don’t turn people away, EVER
- Unequal services, treatment centers should not be separated from medical care

- Unequal prioritization of medical models
- Providers expected to give services beyond scope of their education or training
- Insurance companies making choices about medications
- Provider centered treatment
- Administrative costs of over 10% of funding
- Staff shortages that prevent consumers accessing services
- Underpayment of direct care providers
- Making so much paperwork or administrative oversight that consumers do not receive the services they need
- Electronic records that are bean-counter based and not direct care provider based
- Losing the consumer in the system
- Closer/more accessible services
- Hospital ER care, bigger problem in poorer areas
- Income disparities in services
- OHP recipients looked at as “lucky” to get experiences
- 8 or 6 session limit not based on client need
- Paperwork prioritized over services
- Too much time trying to find services
- High administrative costs
- Time not allowed for paperwork and preparation
- Stigma
- Confusing medical records
- Profit driven services
- CCO has to provide a full continuum of care
- Worker burnout/wage-theft
- Cooking the books for metrics
- Relying on patient independence
- Obstacles to training options for providers of mental health services
- Change for change’s sake
- Not following through on residential care setting inspections
- Mental health services in isolation

## Keep

- Services available in community, which is cheaper than hospitalization
- Accountability of providers
- Electronic medical records/shared access to info

- Basic concept of CCO has some appeal: brings together treatment team centralizes care and resources
- Centralization of AMH and physical health records
- Caring, thoughtful, well trained direct care providers
- Accountability for direct care providers and administrators to provide care consistent with their ethical principles
- Not for profit status of providers
- Individual based treatment to meet the unique needs of each clients
- Maintain parity between mental health services and physical health care
- Peer supports are good but should be good jobs
- Access to housing to keep people stable
- Keep recovery mentors
- Need to keep county mental health services available to public
- Keep democratic control
- Social model for mental health – like case management, housing, support groups, social work.
- Peer support groups
- A community approach
- Open communication to county case managers and mental health providers
- At least current coverage elvels
- DHS case managers