Behavioral Health Town Halls

Gary Halvorson, Oregon State Archives

2015 REPORT

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Oregon Health Authority

Executive summary

The Oregon Health Authority, in partnership with State Senator Sara Gelser, heard from approximately 550 consumers and family members over the course of seven Town Hall meetings across the state. Systemic challenges and holistic supports are the two main themes that emerged from these candid conversations. Systemic challenges include barriers to services, limited service array, poor service coordination, poorly trained service providers, and administrative complexity. Holistic supports include housing, employment, and transportation – what every person needs to be successful.

In short, we heard there are not enough services and supports to meet the needs of Oregonians. There is a provider shortage resulting in long wait times to see a prescriber. There are not enough specialty services for children. Emergency department (ED) experiences are often unpleasant. Service integration is insufficient to ensure that cross-agency and inter-agency communication happens. Housing, employment, and transportation are in short supply. We heard stories from family members who care deeply about their loved ones and struggle tirelessly every day to get the help their loved ones need. Consumers do not receive the quality, coordinated care and support they deserve.

We also heard that people are relieved that they finally have insurance coverage and are hopeful that recovery is now possible. Adult consumers who have access to services and providers are generally satisfied.

Regarding holistic supports, many people remarked that peer support and supported employment programs are working well. Accordingly, we heard requests for expanding these programs. Transportation and decent jobs remain an issue in rural and frontier Oregon; and safe, affordable housing is an issue throughout the state.

We have made significant gains in the past few years, as the data is just beginning to show. However, we still have work to do. It is important that we stay the course and continue to make strategic investments in programs that deliver results. The input provided by 550 consumers and family members will help chart the strategy behind these system investments.

Project purpose and hosts

State Senator Sara Gelser and OHA Director Lynne Saxton traveled across Oregon in the fall and early winter of 2015 to hear the experiences of consumers and their families who need access to behavioral health services.

As hosts for these town hall meetings, they wanted to ensure that the voices of the actual consumers of behavioral health services and their families were captured.

They wanted to create a welcoming environment at these meetings and encouraged participants to be open and candid about their experiences.

Meeting participants were invited to join focused topic tables if they desired: Children and Adolescents, Adults, Older Adults, Young Adults in Transition, Family and Friends, and other tables set up at meetings upon request.

Meeting design process and facilitation

OHA contracted with Oregon Consensus to provide neutral meeting design and facilitation. Cherie Shanteau-Wheeler from Triangle Associates, Inc., was selected to serve as the events facilitator for the OHA Behavioral Town Hall meetings throughout the state. OHA staff provided additional meeting support.

Table facilitators, many of whom were peers, led individual table conversations and acted as table scribes for participants. All table notes were synthesized and summarized by the event facilitator in this final report and the supporting OHA Town Hall meeting summaries.

How the questions were framed for the meetings

Consumers were asked these three questions at the town halls:

1. What's the best thing in your life right now? What is the biggest challenge?
2. What has been the experience for you or your family in accessing or receiving behavioral health services (including mental health and addictions services) in Oregon?
3. What works well for you and your family in the current behavioral health system (including mental health and addictions services)?

These questions were designed to stimulate open conversations and input about the real-life challenges that Oregon's behavioral health consumers are experiencing,

for them to share the important stories that otherwise go unheard, and to provide other consumers and interested parties with important insights and share resources they have discovered.

Oregon prevalence data

The table shows the prevalence of behavioral health challenges faced by various age groups in Oregon.

Measures	Numbers in thousands				
Illicit Drugs	Ages 12+	12-17	18-25	26+	18+
Past month illicit drug use	462	37	108	318	426
Past year marijuana use	649	53	157	439	596
Past month marijuana use	415	30	103	282	385
Past month illicit drug use excluding marijuana	120	11	28	81	109
Past year cocaine use	67	2	25	39	65
Past year nonmedical prescription pain reliever use	159	15	38	105	143
Drug dependence (includes marijuana)	69	6	24	39	63
Drug dependence or abuse including marijuana	99	13	32	54	86
Needing but not receiving treatment for drug use	89	12	30	48	78
Alcohol					
Past month alcohol use	1913	38	260	1615	1875
Past month binge alcohol use	740	22	164	555	719
Perception of risk from binge alcohol use	1235	97	116	1022	1138
Past month underage alcohol use (12-20 year olds)	117	NA	NA	NA	NA
Past month underage binge alcohol use (12-20 year olds)	75	NA	NA	NA	NA
Alcohol dependence	107	3	25	79	104
Alcohol dependence or abuse	233	10	56	167	223
Needing but not receiving treatment for alcohol use	217	9	53	155	208
Mental Health					
Past year major depressive episode	NA	43	48	205	252
Past year serious mental illness	NA	NA	22	123	145
Past year any mental illness	NA	NA	102	590	692
Had serious thoughts of suicide in the past year	NA	NA	34	104	138

(Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Drug Use and Health (NSDUH) 2013-2014)

Town hall meetings

- Klamath Falls – September 23 ~ 98 attendees
- La Grande – October 2 ~ 77 attendees
- Bend – October 7 ~ 55 attendees
- Astoria – November 4 ~ 77 attendees
- Albany – November 9 ~ 156 attendees
- Portland – November 20 (2 sessions) ~ 195 total attendees
- Virtual session – December 14 ~ 32 participants

A total of 613 people attended – approximately 550 of whom were consumers of behavioral health services. The rest were providers.

Meeting locations throughout the state

Note: the Salem event was a tele-townhall, with participation available statewide.

What we heard – two themes emerged

Each of the town hall meetings had its own unique set of participants, stories and perspectives. Differing geographic locations also had an impact on consumer experiences. Two themes, however, consistently emerged from **all** the town hall meetings: systemic challenges and holistic supports.

1. Systemic challenges
    a. Need for improved access to services
    b. Lack of certain services
    c. Lack of coordination among providers, schools, police, etc.
    d. Administrative complexity

2. Holistic supports needed
    a. Housing
    b. Employment
    c. Transportation

Theme 1: Systemic challenges

1.1 Improved access to services

"I am begging for help for my son – I ask for a provider (state, county, city, non-profit) to stand up and provide at least an intervention!"

Here are some of the common systemic barriers consumers said they encountered in trying to access services:

- Not sick enough
    - People must be acute to get help
    - Danger of suicide before receiving services
    - Often only alternatives are the emergency room and jail
- Long wait times
    - It can take months to get a diagnosis
    - No medications given until diagnosis established
    - No therapy even though medications are being taken
- Lack of consistency
    - Constantly changing therapists/providers
    - Inconsistent services and follow-through
    - Poorer quality services and consumer treatment occurring due to overloaded staff

Suggestions from participants

- Focus on crisis prevention
- Ensure that program definitions for "crisis" are consistent
- Improve or add a customer service approach
- Provide clear, **easy to understand** information and resources, preferably in a "one stop shop" format
- Provide support: client advocates, peers, support groups

1.2 Lack of availability of important resources and services

Beds in treatment facilities

"I lived for four days in the emergency room before getting a therapeutic bed."

Missing specialties

"County Behavioral Health is our only choice for medication prescription and counseling services, yet they don't have counselors that are trained in the areas where our children truly need help."

Auxiliary services

"We need a crisis hotline with trained people that can listen and de-escalate the situation. I was advised to lock myself in the bedroom or to hang up because they have no one to help."

Suggestions from participants

- Use telemedicine and other updated technical resources for rural areas.
- Add resources: a warm line, more beds, respite care, structured programs for children, etc.
- Provide high quality training (not just videos) for providers, consumers, families (e.g., cognitive skills, trauma, life skills, etc.)

Existing and developing resources

Services are indeed lacking and unevenly available from community to community. However, in many cases these services do exist or are being developed as part of ongoing initiatives. This suggests a need for better outreach and communication by OHA.

Here are a few of the existing resources currently available and those under development:

Auxiliary services: Oregon has a **statewide crisis line** – Lines for Life – which took 54,128 calls during 2015, and referred thousands of Oregonians to alcohol, drug, and mental health treatment services. In 2015, Lines for Life enhanced its statewide suicide prevention campaign by increasing its expertise in working with suicidal youth and veterans. They increased the number of veteran volunteers by 50

percent. The Youth Line activity more than doubled from 2014 to 2015: It saw 2,205 calls and 1,829 texts (up from 1,201 and 593 in 2014). In addition, Community Mental Health Providers also have crisis lines that field a number of calls and are responsible for an array of crisis services provided at the county level.

Oregon also has a **Warm Line** that operates 14 hours a day, seven days a week, with at least one operator on the line during those hours for a total of 98 operating hours per week. In calendar year 2015, they answered a total of 15,021 calls and saved the state an estimated $1 million by diverting individuals away from hospital emergency departments. The Warm Line does not have sufficient funding to increase staff or operating hours at this time, and it missed a total of 15,248 calls during the same period, either due hold times or staff not available. Of the 15,428 missed calls, nearly 1,000 were from outside of Oregon. The Warm Line does not accept out-of-state calls at this time.

Telemedicine: Telehealth Alliance of Oregon has started compiling an inventory of telehealth services available in Oregon. Once fully populated, it will provide a portal searchable by geographic area and specialty. In addition, the Oregon Health & Science University (OHSU) Project ECHO connects primary care providers with OHSU specialists for live, weekly video teleconferences. These one-hour virtual clinics give primary care physicians real-time reviews of complex cases. OHSU specialists provide written treatment recommendations.

Lastly, as a result of the new investments in mental health, OHA partnered with OHSU to create the Oregon Psychiatric Access Line about Kids – OPAL-K, a program that allows primary care providers statewide to call a child psychiatrist in Portland to consult on medication management and treatment options. In the past 18 months, 1,132 providers have registered, 779 cases have been consulted on, and an online care guide has been downloaded 12,000 times.

Resources: The 2015 Legislature provided OHA with $28 million in additional funding for programs in the areas of crisis, crisis respite, jail diversion, peer supports, sobering centers, and rental assistance. In addition, OHA is working in partnership with Oregon Housing and Community Services to fund $20 million in new housing development for people with behavioral health concerns, including respite.

Training – we need a multipronged approach to improving training for all health practitioners. Trauma Informed Oregon (TIO) has curriculums for clinicians, agencies and organizations, schools, and families. TIO is a result of the 2013 new investments in behavioral health – it was established as a Center of Excellence in partnership with PSU, OHSU, and Oregon Pediatric Society (OPS).

1.3 Failure to coordinate among agencies

This is a critical issue. We must integrate and coordinate information and resources instead of having **emergency rooms, schools,** and the **police and judicial system** working at odds with the mental health system. A functional system will provide people with accurate information, consistent resources, and training.

Here are some of the comments we received on this topic:

- *"The court system's response to behavioral health-related issues was to order a veteran with PTSD to go to anger management class, which did not address the diagnosis!"*
- *"Out of 65 children I have fostered, only one teacher was able to support one child who had ADHD."*
- *"There's a lack of mental health knowledge in the emergency room."*
- *"We have a family advocate to help with IEP, but there are no services in the school and no local community services to be referred to."*

Schools and behavioral health

What we know is that today's youth are struggling. The 2014 Student Wellness Survey was administered to 6th, 8th, and 11th graders across the state. It found that statewide, 31 percent of 11th graders reported having at least one adverse childhood experience (ACE); 54.2 percent had one, two or three ACEs: divorce, living with someone with alcohol or drug problem, experiencing hunger, embarrassment due to dirty clothes, abuse, etc.

In addition, 9.2 percent of 6th, 8th, and 11th graders reported psychological distress that might need further assessment; 37.2 percent reported having low Positive Youth Development scores (emotional, mental, physical health; feelings of competence; self-confidence; support of a caring adult in school; and service to the community); and 23.7 percent reported symptoms of depression within the past 12 months.

Lastly, 14.4 percent of these young people reported attempting suicide in the past 12 months.

These statistics tell us what our school system needs to cope with students' behavioral health issues:

- Well-trained staff who are trauma-informed, understand foster children, and know how to respond to mental health issues overall, through more management and treatment and less punishment.
- Services and resources available at school:
    - Behavioral health counselors
    - Appropriate handling of medications
    - Teachers who more consistently provide individualized education plans (IEPs)
- Coordination with family and therapists:
    - Parents and teachers act as allies to understand children's behavioral health needs
    - Provide support groups for teachers

Oregon is working toward these goals. We have 76 school-based health centers across the state, 75 of which have behavioral health providers on site. (One school in Josephine County doesn't have on-site services, but the others in that school district do). Trauma-informed schools is a great idea – the 2016 legislature passed HB 4002 which funds a few trauma-informed school pilot projects to help address chronic absenteeism. Advocates intend this to be the beginning of statewide programing.

We know that unaddressed trauma can lead to negative behavior patterns and a downward spiral. If we can intervene with youth BEFORE they commit a crime, lives change. According to the Oregon Youth Authority (OYA) Bio-psychosocial Summary from 2014, their kids report an 89 percent mental health disorder rate among females and 70 percent among males, along with substance abuse or dependence at 71 percent for females and 63 percent for males. It is also important to note that these kids have higher than average "adverse childhood experiences" or ACEs: 79 percent of girls and 64 percent of boys report their parents used alcohol or drugs; 45 percent of females and 14 percent of males were sexually abused.

Police/judicial system and behavioral health

Here are some of the comments we received on this topic:

- *"Difficulties accessing services for mental health issues cause recidivism in incarceration and the cycle of incarceration causes mental health issues to get worse."*
- *"It took being arrested to receive services."*

- *"There is an over-reliance on jails to park the mentally ill."*
- *"If there is more than one mental health crisis there isn't anybody to help — the local law enforcement agency has to intervene."*

Town hall participants identified the need for:

- Law enforcement training in behavioral health and how to recognize mental health issues;
- Better communication among the legal and court system, including District Attorney's office and the behavioral health system;
- Special treatment programs:
    - Use Mental Health Court to reduce the number of individuals being inappropriately incarcerated
    - Provide community treatment for those in juvenile justice system who will grow to be adults needing treatment
    - Use more than the old model of parole-mandated treatment

We know that the criminalization of the mentally ill is a problem. We see it every day in our "aid and assist" population at Oregon State Hospital (OSH). These are individuals who have committed a crime and cannot aid and assist their attorney in their defense. From December 15, 2015, to January 2016, this group at OSH has grown from 150 to 204 patients. And 40 percent of these patients committed misdemeanors, such as littering, as their highest offense.

We are working to add services to the community and to train our law enforcement partners in crisis intervention and the Sequential Intercept Model (opportunities to intercept folks at various points to keep them out of jail). In fact, on January 20, 2016, we held a large summit for law enforcement on this very topic.

We know there is a better way. The law now requires courts to work with local mental health providers to provide community services before sending an individual to the Oregon State Hospital. In addition, we currently have 18 mental health courts in the state and 28 of 36 counties have a drug court. It would be wonderful to see more.

Emergency Rooms and behavioral health

Here are some of the comments we received on this topic:

- *"I was brought into the ER for help and they did not know how to handle it and called the police."*
- *"The ER is not friendly to us or our kids."*

- *"ERs are poorly equipped to deal with mental health crisis (for example, patients need a separate place after triage)."*
- *We need advocates for people in mental health crisis — for example, in ER rooms where there are excessive wait times."*

We heard repeatedly that hospital emergency departments are not equipped to handle behavioral health crises. In response, the 2015 legislature directed OHA to collect and analyze data regarding emergency department boarding of mentally ill patients. We have contracted with Oregon State University so as to provide an independent analysis of the data and will have a full report available on this topic later in 2016.

We do know that among the Coordinated Care Organizations (CCOs), we have a 72.7 percent follow-up rate within seven days of a hospital inpatient visit related to behavioral health and an 88.7 percent rate of follow-up within 30 days. In addition, we are working with hospitals to implement a "warm hand-off" for patients leaving the hospital and transitioning to outpatient care.

Some suggestions from participants

- Have good advocates available
- Have good training for everyone
- Have whole integrated teams including a case manager, wraparound services, etc.

The National Alliance on Mental Illness (NAMI), Mental Health America and other advocacy groups are willing to help. Mental health first aid is an excellent training tool, available to everyone, usually for free, across the state. The CCOs' purpose in life is to produce good outcomes for patients by managing care through prevention and early intervention. In addition, wraparound services are available for children who are involved in multiple systems – foster care and behavioral health; Assertive Community Treatment (ACT) is available for adults with complex needs.

1.4 Administrative challenges

Town hall participants told us that they see administrative challenges as a major barrier to behavioral health services.

- *"The system sees clients as just a file, not as a person who is loved and valued by their family."*
- *"I had to allow my son to be given a bipolar diagnosis in order to get services when he wasn't bipolar."*

People said that the system values its own provisions and rules over the needs of consumers. The barriers they identified included:

- Red tape
- Arbitrariness
- Rationing
- Being driven by billing codes, not by real needs

Another systemic problem is coverage gaps.

- Levels of coverage are location-dependent, varying from one community or provider to another.
- Consumers fear or have experienced falling out of the system or through "cracks" in the system.

Finally, the system is composed of independent "silos" that don't communicate with each other. Challenges related to siloing include:

- Lack of service and resource integration — e.g., physical vs. mental health
- Dual diagnosis challenges

Here are some of the things consumers and their advocates told us:

- "We need available advocates that can help us straddle the chasms in the system."
- "They split my treatment into 'procedures' for insurance purposes turning a one visit operation into a multi-day adventure."
- "I hope and pray that the 30 visits for therapy per year under the Oregon Health Plan (OHP) will be enough."
- "We need an outcomes based system that recovers people and their lives, yet you support exclusion and deficit-based treatments and give all the resources to clinical elements that only measure adherence to procedures without accountability to results."

Consumers say they want a system of peers, family and friends, and client advocates that directly supports them. An outcome-based system with built-in accountability would create a vastly improved consumer- and people-focused behavioral health system in Oregon.

Peer support in Oregon

Oregon already has a strong system of peer support and is continually working to improve it. Our system currently has 237 peer support specialists and 418 certified recovery mentors.

Peers help consumers and their advocates maintain hope by teaching them valuable skills they've learned through similar life experiences. Peers can assist the consumer by:

- Getting information to help with informed decision making
- Navigating through multiple systems
- Helping them engage with providers in developing a treatment plan that reflects the consumer's goals
- Talking with providers about best practices

The Oregon Health Plan, the public behavioral health system and the Veterans Administration are quickly learning the value of services provided from one peer to another. The private insurance world, meanwhile, uses peer services to a far lesser degree, mostly in acute care and crisis services settings such as emergency departments.

Theme 2: Holistic support needed

We know that every person needs a reason to get out of bed in the morning – employment is crucial to success. Oregon has 30 supported employment programs throughout the state and one more in development.

Consumer comments highlighted three specific types of support that a holistic system would include:

Housing:

"Help getting a safe, clean and sober housing environment."

Jobs:

"Support for training and finding jobs."

Transportation:

"Help getting to work and appointments and transportation for emergencies."

Supporting independence

Participants said independence is one of the things they value most as they seek recovery for themselves or their loved ones:

- *"A recovery plan needs to be a shared plan – not just a provider plan. It works when we are meaningfully involved in shaping our plan."*
- *"The broken system has allowed for development of more self-advocacy."*
- *"Lack of transitional services keeps people in the mental health system longer (e.g. transitional house and connecting people to employment options.)."*

Some of the elements participants identified that go into client independence are

- Supportive family and friends
- Peers and support groups
- Special training in independent living
- Self-directed care
- Step-down transitions
- Self-advocacy

Oxford Houses are a great example of what works. With 172 locations throughout Oregon, Oxford provides clean and sober living for six to 15 individuals per house. There are houses specifically for men, women, and women with children. They are

low-cost and democratically run. Consequently, they are effective and provide a sense of independence with support for the clients they serve.

Part 3. Topic-focused tables

The town halls all included breakout sessions we called topic-focused tables for discussion, which provided input on these behavioral health topics:

- Adults
- Children and adolescents
- Young adults in transition
- Older adults
- Family and friends
- Other topics including transgender and multicultural services

Adults

General comments:

> *"There aren't enough resources for adults without insurance."*
>
> *"There is not enough wraparound in the adult system."*

Topics that rose to the top of this discussion were stigma, training, and care quality.

- Bias, stigma, and dehumanization are real challenges to success
- Quality training (e.g., self-management skills) helps us become independent
- Higher-quality treatment and care are essential to well-being

Peer-delivered services are a focal point in addressing stigma and helping people learn better self-management skills. The Oregon Health Authority actively works to increase roles for peers working in provider agencies and in peer-run organizations and programs. Peer-delivered services decrease stigma, especially internalized stigma, and help people enhance their skills to meet the challenges of day-to-day living. In addition, peer services within peer-run organizations and programs can help fill service gaps because they're often available to individuals who do not have insurance.

Children and adolescents

The top issues identified at these tables were challenges facing foster children and families, shortage of child psychiatrists, and insurance coverage challenges.

Challenges for foster children and families: We have wraparound services available in every CCO, which help kids involved in multiple systems.

Child psychiatrists: We have only 70 psychiatrists with a child subspecialty in the state – 64 of which are in urban areas, according to the Population Research Center, College of Urban and Public Affairs for Portland State University. Marion, Benton, and Lane counties, which are considered urban by the OHSU Office of Rural Health, all have five. Frontier counties, as well as Deschutes, Yamhill, Linn, Douglas, Curry, Jefferson, Lincoln, Tillamook and others have none. This urban-rural divide is why OPAL-K is a strategic resource.

Insurance coverage challenges: We heard overwhelmingly that people are finally enrolled in insurance. The challenge is that having a child with multiple diagnoses (autism, developmentally disabled, mental health) creates difficulty figuring out which program pays. Other concerns:

- OHP doesn't cover all conditions that need to be addressed;
- Child that's "too young to get a diagnosis" for insurance purposes but needs services;
- Being "forced into a diagnosis" to get coverage even for young children;
- Insurance not paying for testing that doctor said child needed;
- Insurance requirement for diagnosis first means medications are given before counseling;
- Being locked into a system with providers who are not skilled in the needs of children.

Young adults in transition

What youth tell us: "*When you grow up in the system, you get dropped at 18, and can't get services – you show up again in the correctional system.*"

What happens when you turn 18? Participants told us:

- "*Unable to navigate the system and find no help!*"
- "*Get disrespected, burned out, and often drop out!*"
- "*Discover the system isn't set up to transition us and isn't set up for parental involvement!*"

Older adults

Nearly 16 percent of Oregonians are 65 years or older. Some of the needs they identify are:

- Help with in-home services and access to day treatment
- Training to learn new ways of dealing with things
- Help deal with loneliness

The 2015 Older Adult Behavioral Health Investment (OABHI) provided 24 older adult behavioral health specialists across Oregon and one statewide coordinator at OHA.

The specialists have three functions:

1. Promote collaboration and coordination among multiple sectors that touch the lives of older adults with behavioral health issues;

2. Complex case consultation, facilitating care transitions, and promotion of best practices; and

3. Workforce development and capacity building through training and raising community awareness by increasing the mental health literacy regarding the behavioral health needs of older adults and promotion of wellness.

Family and friends

- Families need education about mental and behavioral health and also about self-care;
- Families need to be part of the team making decisions and they also need help addressing coverage challenges (private vs. Oregon Health Plan);
- Families need support from peers and peer partners, family support specialists, and intervention specialists, and they need to receive counseling for extended family.

Other table topics

Transgender issues:

- Need for residential treatment for transgender youth;
- Need for credible providers - the system assumes authority of the provider as a given without credibility of experience with transgender issues.

Multicultural and racial issues:

- Need for culturally specific services for refugees;
- Need for enough provider diversity and help finding them;
- Need for more culturally competent providers.

"The challenge is finding providers who really understand cultural diversity and are able to work with issues such as racial trauma, historical trauma, multigenerational poverty and trauma."

Part 4. Unique differences among Oregon's regions

Many of the issues in Oregon's rural communities are the same as they are in other areas of the state – however, geographic location changes the emphasis on the issue. For example, transportation challenges in rural Oregon doesn't mean it's hard to get a bus – it may mean that *there is no bus system* and necessary tests, services, or providers may be more than a two-hour drive away.

Rural and frontier areas:

- 14 percent of Oregonians live in a rural area.
- 2 percent live in a frontier area.

What we heard from participants:

- We need more qualified practitioners
- *"We need more services in rural areas – family practitioners are not the right choice. It took us 2 years to find someone who could help our child!"*
- We need more consistent quality services
- *"Services/resources vary by county – I shouldn't have to move to get services and they should be consistent."*
- Acute care hospitalization may not be available
- *"We had a nine-hour wait in the ER for the only county crisis worker."*
- It is very difficult to get around

"It's a three-hour bus ride from Warrenton to Astoria. Coming to appointments from outlying areas is difficult."

Urban areas:

- 84 percent of Oregonians live in an urban area

Living in an urban area with a large, diverse population may provide more options for transportation and other resources, but it also presents other challenges.

What we heard from participants:

- Competition for beds and specialized services can be fierce;
- Provider turnover within systems can be substantial and handoffs can be abrupt and unsettling;
- Cross-cultural issues and concerns, racial issues, LGBT issues and others are seen more frequently in larger communities and require special resources;
- More people in the system may mean a less personalized approach to customer service and care.

Highlights of consumer recommendations

Integration of health services

The consumer input from the town hall meetings strongly supports integration of physical, oral, and behavioral health services for the overall health of Oregonians.

Service equity

Continuums of care from providers and sectors are provided for various Oregon populations – however, these continuums, their coherency and scope of services vary widely throughout the state. Consumer input supports more consistency in behavioral health services and care throughout Oregon.

Improve communication and coordination

Consumers pointed to a number of challenges with system arbitrariness as well as lack of communication and follow-through. Consumers support improving bureaucratic processes to provide for real human needs and the elimination of "silos" that help perpetuate ongoing communication and coordination challenges.

Quality of care and customer service

Consumers are concerned about the quality of behavioral health care they receive and the lack of access they have to those services. Their input supports improving service quality and availability, including natural support systems and holistic programs.

Acknowledgments

The open, candid input asked for and received from consumers at the Oregon Behavioral Health Town Hall Meetings provides critical insights into areas

consumers feel need attention and improvement. And at every meeting, the participants were appreciative of the opportunity to speak out and were encouraged about the potential for behavioral health system improvement that takes their input into account.

Budget note

A budget note in HB 5507 (2015) directed the Oregon Health Authority to engage in this process. The language read:

The Oregon Health Authority shall conduct a minimum of five community meetings in a variety of geographic locations across the state. The goal of the community meetings is to capture, understand, and report to the Legislature on the experience of children, adolescents, and adults experiencing mental illness and their ability to access timely and appropriate medical, mental health and human services to support their success in the community. The meetings shall not be restricted to publicly financed services or individuals eligible for public benefits. The focus will be on the entirety of the Oregon mental health system, both public and private. Issues to be considered should include but not be limited to:

- Access to child and adolescent services
- Boarding in hospital emergency rooms
- Access to housing, addiction, and recovery services
- Family support services
- Waiting periods for services
- Workforce capacity
- Affordability for non-covered individuals to access mental health services
- Coordination between behavioral health and physical health services

The Oregon Health Authority shall consult and coordinate with stakeholders to plan and conduct the community meetings. The Oregon Health Authority is expected to report progress and findings to the appropriate legislative committees and the 2016 Legislature.

Event facilitator

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