MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

REPORT 00-8

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REPORT DIGEST

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MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

The public mental health system in Washington spends almost $1 billion per biennium and serves approximately 106,000 people per year. The system is administered by the Mental Health Division (MHD), of the Department of Social and Health Services (DSHS), which also operates the two state mental hospitals. The MHD contracts with 14 county-operated Regional Support Networks (RSNs) for the provision of community-based mental health services and allocates federal and state funding to the RSNs. The RSNs administer mental health services at the local level and contract with private and public providers of community mental health services.

This study was required by the Legislature via a proviso in JLARC's 1999-01 Biennial Budget. The Legislature required JLARC to conduct a broad review of the performance of the public mental health system to include:

- An analysis of the roles and responsibilities of the MHD, RSNs, and community mental health providers.
- An analysis of funding of the RSNs through contracts let by the MHD.
- An analysis of service levels, outcomes, and costs for RSNs.
- An analysis of contracts between RSNs and community mental health providers.
- Recommendations for modifying the basis on which RSNs and community mental health providers are funded.

MAJOR FINDINGS

1. There are problems with coordination of services between the MHD and other DSHS divisions including the Developmental Disabilities Division (DDD), Division of Alcohol and Substance Abuse (DASA), the Aging and Adult Services Administration (AASA), and between the state mental hospitals and the RSNs.
2. The MHD has made efforts to streamline burdensome activities to promote system accountability. However, these accountability activities are focused on processes of service, rather than on outcomes of service. There is almost no information collected on a statewide basis on client or system outcomes.
3. The fiscal, client, and service data collected by the MHD to promote system accountability are not consistently reported by providers and RSNs.
4. Because of the inconsistencies in the reporting of fiscal, client, and service data, comparisons of the *efficiency* of services provided by RSNs and providers are suspect. Because of the lack of statewide outcome data, comparisons of the *effectiveness* of services provided by RSNs and providers are impossible.

5. The MHD's method of providing capitated funding to RSNs under a managed care approach creates incentives for RSNs to provide services in a cost-efficient manner. However, there are wide disparities in the amount of resources allocated to the RSNs. These resources include funding for community mental health services as well as the allocation of state hospital beds among the RSNs. The disparity in resources is not associated with differences in the prevalence of mental illness, the severity of the clients served, or geographic cost differences among RSNs.
6. The disparity in funding to RSNs leads to disparities in the amount of service provided to clients. Higher-funded RSNs have higher expenditures per client served than lower-funded RSNs.
7. There are wide differences in how RSNs operate. Some RSNs pass on almost all of their funding to community mental health providers and exert relatively little oversight over their providers. Other RSNs spend considerably more money at the RSN level and provide more oversight over their providers. However, without information on client or system outcomes, whether one approach is more effective than another is impossible to determine.

CONCLUSIONS AND RECOMMENDATIONS

Due to the decentralized administration of community mental health services, the MHD's role is limited to statewide planning and policy direction, system oversight, allocation of resources to RSNs, and operation of the state hospitals. We believe the MHD has been taking appropriate steps to improve the system, for example, by instituting a capitated method for allocating resources and by streamlining its activities to promote system accountability. However, we believe further improvements are needed to better coordinate services for clients, to ensure resources are allocated equitably among the RSNs, and to promote accountability by measuring the outcomes of service, rather than the processes of service. The report includes 14 recommendations intended to achieve the following:

- Improve the coordination of services between the MHD and other DSHS divisions, and improve the coordination of state hospital discharge planning between the state hospitals and the RSNs.
- Improve the consistency of fiscal, client, and service data collected by the MHD.
- Further streamline and eliminate process-oriented accountability activities to be replaced with a system for measuring client and system outcomes.
- Change the resource allocation methodology to simplify the methodology, provide further incentives for the provision of services in a cost-effective manner, and improve the consistency of services to clients around the state.
- Promote the identification of best practices among providers and RSNs in order to facilitate the cost-effectiveness of the public mental health system.

<u>COMMITTEE ADDENDUM</u>

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Services and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.