The following annual report from King County, Washington, home of the city of Seattle, shows how psychiatric drug treatment does not lead to recovery. Of over 9300 patients treated by the county in 2002, only 5 individuals recovered. The report for 2001 is similar

KING COUNTY DEPARTMENT OF COMMUNITY AND HUMAN SERVICES

Mental Health, Chemical Abuse and Dependency Services Division

King County Ordinance #13974
Second Annual Report: Recovery Model

BACKGROUND

The Metropolitan King County Council passed Ordinance # 13974 on October 16, 2000. This ordinance is designed to promote recovery as an achievable outcome for adult consumers of the publicly funded mental health system in King County. The ordinance recognized that recovery is both a treatment philosophy and a process characterized by consumers moving toward participation in age-appropriate roles, including living independently, working, and having less dependence on the mental health system.

The ordinance required the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) to submit:

A report in April 2001 that described steps the Division would take in redirecting the system toward recovery outcomes A written annual report to the Council that describes the performance of the mental health system toward achieving recovery outcomes, with calendar year 2001 as the evaluation baseline period.

This report addresses the second requirement.

REPORTING REQUIREMENTS

The ordinance stipulates the population MHCADSD is expected to evaluate on an annual basis. The population of interest is consumers who:

Received outpatient benefits or residential services during the previous calendar year
Were aged 21-59 years during the reporting period Completed at least one benefit period during calendar year 01/01/2002 - 12/31/2002

The ordinance provides definitions of "recovery categories". These definitions are:

Dependence and dependent: experiences significant disability, is not employable, is served the MH system, has a Global Assessment of Functioning (GAF) score of 50 or below. Less dependence and less dependent: some disability, progress toward recovery, improved self-esteem, enhanced quality of life, a GAF score between 51 and 80 Recovered: Ø is engaged in volunteer work, or pursuing educational or vocational activities, or employed full or part-time, or engaged in other culturally appropriate activities, and Ø lives in independent or supported housing, and Ø is discharged or receiving infrequent maintenance services, and Ø has a GAF score of 81 or above

OUTCOMES AND ANALYSIS

In addition to evaluating consumers' recovery status, the ordinance requires MHCADSD to specifically evaluate certain outcome measures. These outcomes, which are central to principles of recovery and indicate involvement in adult life roles, are:

· Level of functioning
· Employment
· Housing

MHCADSD was able to use the existing consumer database when measuring performance on these outcomes.

The ordinance includes a set of six questions that must be responded to in the annual evaluation of recovery outcome performance. This section provides an analysis of outcomes achieved from outpatient benefits during 2002. Although the 2001 report included an analysis of outcomes achieved from long-term Rehabilitation (LTR) benefits, we are removing that analysis from this report. During 2002 an LTR benefit, unlike outpatient benefits, did not include a specified term or requirements for benefit renewal. This benefit serves some of our most severely mentally ill consumers, many of whom were discharged from institutions. Most consumers served with an LTR benefit receive this level of care for an extended period of time, so there is insufficient outcome data from which to draw valid conclusions.

Outcomes: The definitions and perameters described in the ordinance were used to develop a database that includes information on 9,302 adults who completed a tier benefit during calendar year 2002. There is an increase of 1,471 people in this year's data set from the previous year, because there are more people enrolled in the outpatient system and overall data quality has improved. The table and charts that follow respond to each of the questions found in ordinance language.

Table 1 responds to questions 1-4

Table 1. Change in Recovery Status for people served with outpatient tier benefits

Ending Recovery Category
Starting Recovery Category Dependent Less Dependent Recovered Total
Dependent 6,433 573 1 7,009
Less Dependent 561 1730 4 2,295
Total 6,994 2303 5 9,302

Question 1 asks: How many consumers at the beginning of their benefit period were categorized as dependent, or less dependent. Of the 9,302 consumers:
· 7,009 (75%) began their benefit as dependent
· 2,295 (25%) began their benefit as less dependent

Question 2 asks: How many consumers at the end of their benefit period were categorized as: dependent, less dependent, recovered and receiving maintenance level of services, recovered and discharged, or left services for another reason. Of the 9,302 consumers:
· 6,994 (75%) ended their benefit as dependent
· 2,303 (25%) ended their benefit as less dependent
· 5 (< 1%) ended their benefit as recovered

3,009 consumers left services. Of these:
· 1,955 (65%) were dependent at exit
· 1,048 (35%) were less dependent at exit
· 5 (< 1%) were "recovered" at exit

Question 3 asks: By "recovery category", how many consumers progressed, regressed, or remained unchanged.

7,009 clients began their benefit period as dependent. Of these:
· 6,433 (92%) remained dependent at the end of their benefit
· 573 (8%) progressed to less dependent
· 1 (< 1%) progressed to recovered

2,295 clients began their benefit period as less dependent. Of these:
· 561 (24%) regressed
· 1,730 (75%) remained unchanged
· 4 (< 1%) progressed to recovered

Overall, of the 9,304 consumers:
· 561 (6%) regressed
· 8,163 (88%) remained unchanged
· 580 (6%) progressed

Question 4 asks: For those consumers who changed, what was the extent of progression or regression (by recovery category)?

Of the 7,009 consumers who began their benefit as dependent:
· 573 (25%) improved by one recovery category
· 1 (< 1%) improved by two recovery categories

Of the 2,295 consumers who began their benefit as less dependent
· 4 (< 1%) improved by one recovery category (recovered)

Question 5 asks: What percent of consumers have improved housing compared to the beginning of their benefit period? Note: the category labeled "All Diagnosis" is inclusive of all consumers.

1,944 consumers had the potential to improve (i.e., did not begin their benefit with the

residential status of "independent" housing - the highest housing "level"). Of these:

· 18% (n = 74) of the consumers with a diagnosis of schizophrenia improved their housing status during the course of their benefit
· 28% (n = 115) of those diagnosed with depression improved
· 23% (n= 9) of those diagnosed with dysthymia improved
· 28% (n = 86) of those diagnosed with bipolar disorder improved

As an overview, 22% of all individuals with potential to enhance their residential status showed improvement by the end of their benefit, regardless of diagnosis.

Question 6 asks: What percent of consumers have improved daily activities compared to the beginning of their benefit period?

5,417 consumers had the potential to improve (i.e. did not start their benefit with the highest level of activity status). Of these: ·
28% (n = 1,090) of the consumers diagnosed with schizophrenia had improved activity status
· 28% (n = 1,301) of the consumers diagnosed with depression improved
· 26% (n = 204) of the consumers diagnosed with dysthmia improved
· 28% (n = 936) of the consumers diagnosed with bipolar disorder improved

As an overview, 28% of all consumers with potential to improve their activity status showed improvement by the end of their benefit, regardless of diagnosis.

While few consumers reached the status of recovered, many more did demonstrate progress toward recovery. Of the 9,272 consumers included in this report:
· 5% (n = 427) improved their residential status
· 16% (n = 1,501) improved their activity status
· 29% (n = 2,998) have an improved GAF score, OR and improved residential status, OR an improved activity status. Each of these elements is used to provide the composite definition of "recovered" in the ordinance.

Conversely, 22% had a decline in their GAF score, OR a decreased residential status, OR a decrease in their activity status. It is not clear whether improvement or deterioration in the outcome measures relate to the cyclical nature of mental illness, treatment effect, or other factors.

DISCUSSION

Consumer impairment: The funding for mental health services in King County is primarily established by the state legislature. The legislature has decreased the level of funding to King County in the last two sessions, which will result in a $50 million reduction over a six year period. Reductions of this magnitude have necessitated modifications to the mental health system, including reducing access to people without Medicaid benefits. In addition, the State Mental Health Division is closing wards at the state hospital, resulting in clients returning to the community who are more impaired than in the past. The mental health system is also reaching out to persons being released from jails and prisons who need treatment for mental illness. Each of these factors suggests King County is serving clients who have a number of characteristics that create considerable challenges for the outpatient system.

Data considerations: This report provides recovery status information about a portion of individuals who received publicly funded mental health services in King County. Overall, 33,246 individuals were served by the King County mental health system during 2002. (See

Attachment 2) Ordinance # 12974 specifically required information about individuals who completed a benefit during the previous calendar year. Report criteria, therefore, exclude certain individuals from the analysis of outpatient benefits. These individuals are:

· persons younger than 21 and older than 59 years of age
· persons who received "carve-out" , crisis, or inpatient services only
· persons who did not complete a benefit
· persons for whom incomplete or invalid data was submitted regarding their housing and/or activity status

Diagnostic considerations: Ordinance # 13974 required outcome reporting about consumers with specified diagnoses (schizophrenia, depression, dysthymia, and bipolar disorder). In 2002, approximately two-thirds of consumers were classified with these diagnoses. Details about diagnostic classifications used for this report are available upon request.

Proportion of consumers residing in independent housing: Our analysis revealed a large portion of consumers residing in independent housing (7,384, or 72%, at the beginning of their tier benefit, and 7,883, or 77%, at the end). This means that only 2,892 of the consumers analyzed for this report had the potential to improve their housing. However, there are mitigating factors to consider:
· Consumers may choose to live independently to avoid the rules, expense, or social closeness required of persons residing in supervised living situations.
· Some group living situations will not admit low functioning persons with problematic behaviors and/or histories.
· Although people may be categorized in the data set as "independent", in fact they may be receiving significant support from their family, treatment providers, and other community members, which can help an otherwise low-functioning person to live on his/her own.
· A count of consumers living in various residential "levels" does not address whether the consumers are satisfied or successful in maintaining their housing.

Implementation of the "Recovery Model": Although challenged by numerous factors, MHCADSD, providers, and consumers have made inroads toward reshaping attitudes and beliefs about the potential for consumers to recover from mental illness. Three specific initiatives are described below:

Recovery Conference: In September 2002, MHCADSD sponsored a conference: "Creating a Culture of Recovery" in partnership with the Greater Seattle Chapter of the Washington Advocates for the Mentally Ill and United Behavioral Health. Over 200 consumers, advocates, providers, administrators and public officials attended the full day conference. Workshops included discussions on establishing a definition for recovery; consumer and family responsibilities; voices of recovery (consumer lead panel in which consumers shared their own recovery stories); recovery in the delivery of services; and innovations and commitment to recovery for organizations and systems.

Vocational Services: In recognizing that employment is one of the pillars of recovery for people with mental illness, MHCADSD dedicated funds in 2002 to support the development of vocational programming. A vocational services plan for clients enrolled in the King County Mental Health Plan was developed. The plan incorporated significant input from consumers and other stakeholders, including vocational services staff working in mental health agencies and other vocational experts, and includes the following elements:
· A reorientation of the MHCADSD mission statement to emphasize the value of vocational services and the commitment to support clients in their pursuit of employment
· Education of all parties regarding mental illness and work, including clients, line staff, medical staff, and management
· Development of policies and procedures to support vocational services
· Assurances that vocational services will be based upon evidence-based practice

· Development of Regional Employment Services and Placement Centers (RESPC) to provide a full array of supported employment services, including motivational enhancement groups, long term employment supports and peer support activities.
· Application to the Department of Vocational Resources for Innovation and Expansion start-up funds for the centers described above

Vocational initiatives planned for 2003 include issuing a Request for Proposal (RFP) and a subsequent contract for establishment of the RESPCs, and developing a system-wide educational process that builds on the Recovery Conference and focuses on employment and mental illness.

Residential Services and Supports: The MHCADSD reviewed its residential services policy during 2002. This process was informed by two studies that were completed during the summer and fall of 2002:
1. The residential services study focused on the licensed residential facilities funded by the MHCADSD and the supported living programs serving MHCADSD clients. The purpose of the study was to identify the skills and supports clients need in order to live in supported (non facility-based) housing.
2. The second study analyzed the readiness of consumers to move from facility-based to more normative housing including options featuring greater independence, and found that 30% of people residing in facilities appeared to be ready to move to less restrictive housing.

In December of 2002 the MHCADSD drafted a statement of policy intent for residential services. The new policy is based on maximizing client independence, meeting each client's individualized needs, assuring informed client choice, providing services that support clients in their recovery, and funding flexibility. In a significant departure from the previous residential policy, the MHCADSD will gradually shift resources away from facility-based housing and develop an increasing number and variety of supported housing programs. Funding for over 300 residential beds will be phased out over the next three to five years and redirected to services that support consumers to live in independent housing. National evidence based research and local findings indicate that most clients want to live on their own (with supports) in normative housing and that supported housing models result in more positive outcomes for clients than highly structured group housing models.

Housing initiatives planned for 2003 include working with stakeholders to implement the new housing policy.

CONCLUSIONS

Ultimately the success of a recovery-based model of care can only be assured through full commitment and participation by all stakeholders. Each must embody the belief that persons with mental illness can and will recover if necessary individualized supports are available to them. Although the publicly funded mental health system in King County - and across the United States - is stressed due to reductions in budgets that fund mental health services, the system must still strive to build a culture focused on principles of recovery. Over the past year MHCADSD has worked to build the foundation for a recovery model through the initiatives described above. The level of participation and support from stakeholders clearly shows that this is a shared vision and effort.

health health care practitioners. It is also not intended to diagnose or prescribe treatment for any illness or disorder. Anyone already undergoing physician-prescribed therapy should seek the advice of his or her doctor before reducing the dosage or stopping such treatment.

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