A Safety Net in Peril:

The State of Public Mental Health in the Quad-Cities

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A Statement of the Quad-City Community Mental Health Initiative

The Quad-Cities mental health care system is in crisis. Long fragile and insufficient, it is now in serious peril. This crisis is underscored by the daily struggle to survive that faces many of our neighbors suffering from chronic and serious mental illness.

Mental illness is ruinous, pervasive and real. Ten percent of children and twenty-five percent of adults in America struggle with mental illness, causing significant daily functional impairment.

Mental illness is treatable. Between seventy and ninety percent of individuals with mental illness experience "significant reduction" in symptoms and improved quality of life after receiving pharmacological and psychosocial treatment and support. Yet, less than one-third of adults and half of children with mental illness receive mental health services.

The solution to this crisis is within our reach. We need to educate ourselves and come to agreement on what the safety net for the mentally ill needs to be.

Severe budget cuts are occurring at a time when services are more critical than ever. These budget cuts exacerbate a downward vortex that has a significant detrimental impact on the sickest and poorest in the greater Quad-Cities region.

The challenge to leaders in the Quad-Cities is to find local solutions to this national crisis. While we desperately need change at the state and federal level, we cannot wait for their solutions alone. The mentally ill are our friends, our family and even us. Fixing this problem is a critical component in building a healthier Quad-Cities.

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The Quad-Cities mental health care system is in crisis. Long fragile and insufficient, it is now in serious peril. This crisis is underscored by the daily struggle to survive faced by those most chronically and severely mentally ill.

Mental illness is ruinous, pervasive and real.

- 10% of children and 25% of adults in America struggle with mental illness, causing significant daily functional impairment.
- Four of the ten leading causes of disability in the US are mental disorders.
- 31% of homeless adults have both a mental illness and an addiction disorder.
- Adults living with mental illness die 25 years earlier than other Americans.

Mental illness is treatable.

- Between 70% and 90% of individuals with mental illness experience "significant reduction" in symptoms and improved quality of life after receiving pharmacological and psychosocial treatment and support.
- Less than 1/3 of adults and 1/2 of children with mental illness receive mental health services.

Mental health services benefit the entire community.

- Reduction in health care costs, such as emergency room visits, hospitalizations and readmits to the hospital.
- Reduction in criminal justice costs, such as such as police interventions, court time and jail usage.
- Reduction of pressure on the health care, social service and education systems.
- Community impacts such as quality of life, public safety and family life.

The mentally ill are our friends, our family and even us.

The solution to this Quad-City crisis is within our reach if we educate ourselves and come to agreement on what the safety net for the mentally ill needs to be. Severe budget cuts are occurring at a time when services are more critical than ever. The budget cuts exacerbate a downward vortex that has a significant detrimental impact on the sickest and poorest in the greater Quad-Cities region.

Mental illness is ruinous, pervasive and real. 10% of children and 25% of adults in America struggle with mental illness, causing significant daily functional impairment.

As Michael J. Fitzpatrick, Executive Director of the National Alliance on Mental Illness, states, "Almost every state, county, and local government is facing large deficits and cutting public services across the board. State Medicaid programs are being squeezed.

"The budgets of state mental health agencies are being slashed. We know from experience that states often respond to fiscal crises by reducing mental health budgets. As a result, the status of each state system may already be falling below the levels documented in this report.

"The challenge to our leaders across America today is to find the vision, the political will, and the funding to hold the line; to allow state mental health care systems to continue to move forward and build momentum for change."

History: How we got here

More than 50 years ago, events occurred that promised to make a lasting and positive impact on the treatment of the mentally ill in America and in the Quad-Cities. In 1963, President John F. Kennedy signed the Community Mental Health Act into law.

In the 1950s and early 1960s, mental health institutions were still crowded and treatment was often inhumane, but modern science had developed new and exciting medications that helped moderate serious mental illness and new programming concepts were on the horizon. With the creation of Federal Comprehensive Community Mental Health Centers (CCMHCs) in 1963, the real possibility that many persons who had been caged in institutions for years could return to their home community became a reality that would allow them to live more independently but concurrently be able to depend on the "safety net" of the newly developed CCMHCs. On a national basis, the number of institutionalized mentally ill people in the US dropped from 560,000 in 1963 to 130,000 by 1980.

The number of serious mentally ill has now increased to a staggering 20 percent of the prison population.

However, as the population shifted into local communities, the support needed to maintain them in community settings was slow to follow. As a result we began to see the incidence of mental illness increase in the jail and prison population. In the 1970s, it was estimated that 5% of the jail and prison inmates were seriously mentally ill. According to E. Fuller Torrey, a psychiatrist who founded the Treatment Advocacy

Center, the number of serious mentally ill has now increased to a staggering 20 percent of the prison population.

In a Treatment Advocacy Center blog, Marvin Ross states, "Shortly after this de-hospitalization, the number of mentally ill in the criminal system began to expand in Canada, the U.S., and in much of the industrialized world."

Between 1955 and 1994, the rate of mental health institution beds in the U.S. per 100,000 decreased from 339 to 29. The money from the hospital sector needed to provide community support for those discharged either did not get to the patient's community or was insufficient. Those patients discharged to the community or new patients needing service could not receive it. They were often on the street and running afoul of the criminal justice system.

At the same time, it became more difficult for doctors to hospitalize patients who needed it or to keep them there long enough to bring about meaningful improvements. Laws designed to safeguard the rights of patients resulted in patients not being able to enjoy **the right to be well.**

As institutional beds reduced in number, more responsibility was placed on the local community to secure them. While the community mental health centers have proven to be cost-effective in providing high-quality outpatient care and community services, the need for inpatient care has gone largely unmet.

The consequence of all this is that more and more of those with mental illness are not receiving care or are winding up in correctional facilities where they may or may not receive care. High quality, local community mental health centers have proven to provide a more cost effective and successful model in treating these patients.

As Dr. Rosalie Greenberg, a noted author and child and adolescent clinical psychiatrist, writes in the *HuffPost Healthy Living*, December 2012:

"Our poor handling of mentally ill youth as they enter adulthood is a sad comment on our society. People with mental disorders are not a voting block or disenfranchised group who hold special appeal to our politicians. We hear people, especially during election years, talk about children being our future, but the reality is that our young people -- especially those living with a mental disorder -- lack monetary and therefore political power. When it's time for budget cuts, their needs are quickly ignored or forgotten in exchange for what are deemed more "crucial" (i.e., politically important) issues.

Our poor handling of mentally ill youth as they enter adulthood is a sad comment on our society.

"It is time for all of us to step up to the plate and be actively involved. It is our mandate as a free society to recognize our responsibility to take better care of our future generations if we want America to continue to exist as a country proud of its morals and ethics -- a place where the American dream still holds promise for all of our children."

The Community Mental Health Act was actualized in the Quad-Cities with the creation of the Robert Young Center for Community Mental Health in Rock Island and Mercer Counties; and the creation of the Vera French Community Mental Health Center in Scott County. A new life was on the horizon for thousands of seriously mentally ill citizens in the greater Quad-Cities.

Comprehensive Community Mental Health Center (CCMHC) services included: Inpatient Psychiatric Services, Outpatient Services, Consultation and Educational Services, Emergency Services and Partial Hospital Services. These services were provided by the newly formed Robert Young Community Mental Health Center and Vera French Community Mental Health Center in collaboration with their hospital partners, Mercy and Franciscan Hospitals, now Genesis and UnityPoint Health-Trinity.

Throughout the 1970's and 1980's, thousands of local residents were transferred from mental health institutions such as the East Moline State Hospital and the Mental Health Institutes in Mt. Pleasant and Independence, Iowa, and returned to their original homes, apartments or a variety of newly developed residential settings. They received important community support services and medication management from the CCMHCs. The support services in the local community were the only way this new concept called "deinstitutionalization" could possibly work. Patients required ongoing, consistent contact with their provider – the CCMHC. This "safety net" was the critical component to make this national movement a success. It was a program that

promised a new dignity for the returning patient and was equally less costly to fund than institutions. It was important that a significant portion of the dollars funding the institutional care "follow the patient" to their community care. Coupled with eight years of federal funding, the formula for success was set. The funding did not pass through State Departments of Mental Health because it was believed that individual States had an inconsistent and spotty performance record in caring for the mentally ill, so the Department of Health, Education and Welfare contracted directly with local coalitions who were willing to establish CCMHCs. The purpose of the eight year declining funding cycle for the CCMHCs was to seed the start-up of the Community Mental Health Centers with the expectation they would develop local and state funding. This is what led to the successful creation in 1976 of the Rock Island County Mental Health Board that assessed property tax to support the Community Mental Health Center, ARC, and Substance Abuse Services in Rock Island County.

Often, service providers do not serve the severe and persistent mentally ill.

In the Quad-Cities, the Robert Young and Vera French Centers provided these safety net services. The Robert Young Community Mental Health Center was developed within the Franciscan Health System (now UnityPoint Health-Trinity) and the Vera French Center was established as a free standing center but on the grounds of Mercy Hospital (now Genesis). In 1975, an amendment was made to the original Community Mental Health Centers Act that allowed the CCMHCs to develop further services including: Specialized Services for Children and Elderly, as well as Alcohol and Drug Abuse Services, Transitional Housing Services, Consultation to Courts, and specialized follow up care for the severe and persistent mentally ill (frequently referred to as "aftercare").

In 1980, when President Ronald Reagan was elected, he chose to return control of these programs to the states. As a result, direct funding from the federal government to the individual local CCMHCs was replaced with Block Grant funding to the states, thus giving

control of local funding to the State Department of Mental Health. This was a damaging blow to many CCMHCs across America. It opened the door to a proliferation of competition at the local level to seek these block grant funds in competition with the CCMHCs. Often, the service providers competing for these funds did not serve the severe and persistent mentally ill, thus eroding even further access to the critical help these individuals needed for survival. And often, the block grants did not follow these mentally ill patients to their local communities. For example, in Illinois, the State Department of Mental Health apportioned a disproportionate share of these federal funds to the Chicago area. In Iowa, there was no state Department of Mental Health, but a newly created division within the Department of Human Services.

As the late 1970s through the 1990s unfolded, a number of original CCMHC staff departed the CCMHCs and spun off into private practices, developed new agencies or modified the missions of existing agencies to provide services for persons with mild to moderate behavioral disorders. Early on, many of these new "spin offs" tended to focus on persons with commercial insurance. Then, as managed care proliferated in the behavioral health sector, commercial insurance became scarcer, so many of the behavioral health agencies sought the local and State funds originally intended for the patients served by the community mental health centers. Because they were not adequately equipped to treat the severely mentally ill, said agencies tended to remain focused on the patient with mild to moderate difficulty. These services are necessary and desirable, but

as the agencies who were not CCMHCs further competed for local and state funding, the erosion of the public funds necessary for the treatment of the most severely mentally ill continued. The net result of so many organizations striving to feed at the trough of public funding heated up the local competition for those grant dollars. The publicly funded services for the sickest and poorest were squarely in the cross hairs for State political target practice.

As the States of Illinois and Iowa have continued to close state mental institutions, a smaller portion of the funding saved by the closures has followed the patient into her or his community (in this instance, Rock Island, Scott and Mercer Counties). Simultaneously, Illinois and Iowa departments that fund mental health and substance abuse services continue to severely reduce the funding allocated for these patients. From 2009 to 2012, Illinois has cut more than $187 million or 31.7% from the Illinois mental health budget (according to a report by the National Alliance on Mental Illness). Illinois ranked #3 for the most aggressive funding cuts of the 29 states that reduced their mental health budgets in that period. Only two states cut more during this period. In 2013, Iowa Governor Terry Branstad vetoed $13 million in transition funds meant to improve the delivery and access to mental health services.

As the States of Illinois and Iowa have continued to close State Mental Institutions, a smaller portion of the funding saved by the closures has followed the patient into her or his community.

Conclusion

Several months ago, a group of Quad-City health care organizations that provide the vast majority of these safety net services for the sickest and poorest of our communities convened a task force to discuss this critical situation and make recommendations for a cohesive community response. The organizations included the Robert Young Center, Vera French Center, Community Health Care, Genesis Health System, UnityPoint Health-Trinity and the National Alliance on Mental Illness of the Greater Mississippi Valley (NAMI).

This group – the Community Mental Health Initiative – has engaged in a process that defined the strengths, weaknesses, opportunities and threats of the existing service array in the greater Quad-Cities (see Appendices). It is now in the process of defining strategies and developing action steps to improve the mental health care of the Quad-City region. This report is the first step in that process.

It is clear that the States of Illinois and Iowa are largely disenfranchising from subsidizing treatment and medication management for the sickest and poorest citizens. The erosion of mental health care has occurred and it has brought us to this moment of crisis. The needs of the sickest and the poorest of our community are not being met. It is time for the local Quad-City community to recognize this crisis. If our state and federal governments will not or cannot fund the community mental health model, it is time for our local community to step up our efforts.

A.) Planning Assumptions:

- Robert Young, Vera French, UnityPoint Health-Trinity, Genesis and Community Health Care take persons with the most severe cases of mental illness in the Quad-Cities. They are the core providers for the sickest and poorest in community.
- The agencies in the Community Mental Health Initiative are the "unrecognized safety net" in this community. Without this group, the core of the mental health providers would be absent.
- There is little commitment from local funding bodies to fund these core community mental health services. Robert Young is the second lowest funded agency by the United Way. Vera French is not funded by United Way at all.
- The focus of this group of public mental health providers is to combine our efforts with a greater focus on the sickest and poorest.
- We are mandated (in Illinois and Iowa) as the local core agencies to provide mental health services. The safety net is disappearing for many folks with serious mental illness, especially adults. Children go home to parents who are symptomatic. There is a large gap between child and adult services.
- Three to four years ago, we were treating every patient. We can no longer treat every patient. We are serving people with fewer hours, fewer services – not turning them away.
- NAMI can help with the education, peer to peer, family to family. A lot of people are affected by mental illness but don't know where the resources are.
- As mental health funding continues to decrease, crime, public safety and family crisis issues will rise.
- We need to develop more community support for the real hard work of mental health, not just services for the patient with mild to moderate behavioral disturbance.
- Our focus is on comprehensive community mental health; not just for adults, not just for children, but for the community as a whole. This includes inpatient psychiatry, primary care, residential care and behavioral health integration.

B.) Strengths of Local Community Mental Health Services

- The two biggest strengths are Vera French and Robert Young. Each is recognized for its services. Each Center has a reputation for high quality and a variety of services.
- There are two health care systems (Genesis and UnityPoint Health-Trinity) providing quality behavioral health care, but the systems are different. Robert Young Center is based in a health system (Trinity) as a fully vertical and horizontal model of integration, versus Vera French Center and Genesis Health System, which are free-standing systems of care.
- Community Health Care is a valuable community-wide asset and partners with the Community Mental Health Centers.
- There is a wide array of services, including the classic CCMHC Service Array:
    - Inpatient Psychiatric Services
    - Outpatient Services
    - Partial Hospitalization Services
    - Consultation & Education Services
    - 24/7 Emergency Services
    - Specialized Services for Children
    - Specialized Services for Seniors
    - Transitional Housing Services
    - Aftercare Services
    - Screening for Courts & Other Services
    - Services for Alcohol Treatment
    - Services for Drug Abuse Treatment
    - Community Support Services for severely mentally ill individuals
    - Transportation Services
    - School-Based Services
    - Telepsychiatry
    - Integration of primary and behavioral health services
    - Residential services

- There is a good degree of collaboration, as evidenced by CHC, Genesis, UnityPoint Health-Trinity, Vera French, Robert Young and NAMI coming together into this Community Mental Health Initiative. There is a high degree of collaboration, high level of trust and integrity.
- What we do is measurable, tangible. We are able to show that we are needed and are making a difference (e.g. Balanced Scorecard, Detailed Outcome Data from the Title XX Donated Fund Initiative).
- Police departments and legal system are supportive.

C.) Weaknesses of Local Community Mental Health Services

- Significant variation between Rock Island and Scott Counties (e.g. funding sources).
- Funding is connected to everything and increasingly dictates the services array. This is an ongoing struggle that will not go away anytime soon.
- We need more qualified professionals in the mental health arena, particularly psychiatrists.
- We need "community psychiatrists"– those willing to work with the sickest and poorest. Too many psychiatrists choose to work in private practice and accept only those patients with the more lucrative, private-pay health insurance.
- Genesis almost closed its inpatient services due to lack of inpatient psychiatrists.
- Mobile crisis intervention existed but was cut in Scott County. RYC has mobile crisis intervention and telepsychiatry in local hospital Emergency Departments.
- Serious lack of funding in Quad-City area for indigent care.
- Lack of community knowledge on how to access both at Vera French, Robert Young. Patients still have difficulty accessing mental health care, particularly psychiatric services.
- It takes all resources to offset unfunded cost of low-income care.
- Large and growing number of uninsured adults (working poor) and the lack of public funding for full reimbursement for this population.
- We get better reimbursement for children, but we can do more for adults. It must be balanced.
- We are not as visible to community as we need to be.
- Seniors not being adequately served. Lack of geriatric psychiatrist.

- Increasingly, more and more physicians are depending on hospitalists and preferring to work solely in an outpatient practice. This makes it difficult to staff inpatient psychiatric services.
- Emergency rooms seeing more and higher severity of mental illness. Trinity's ED has three times the national average of psychiatric patients in their ED. We are seeing an increase in combative and violent patients.
- Transition from children to adult system is tough.
- Long delays in getting a patient from Emergency Department (ED) to psychiatric unit. Can't get them into a psych unit. It could be hours before finding a bed. Throughput is a quality issue – from one department to another, e.g. ED to Psychiatric units.
- Workforce shortage, especially for LISW/LCSW social workers. We are in a major growth mode via bi-directional integration efforts. Medicare will only reimburse for social workers who are licensed as LCSW/LISW. Neither the Licensed Clinical Professional Counselor nor the Licensed Mental Health Counselor can be reimbursed through the Medicare system.

D.) Opportunities for Local Community Mental Health Services

- Affordable Care Act is increasing insurability.
- Iowa will expand into the 5-county region. Iowa is unique, with funds allocated county by county.
- Innovations Care Coordination project is a significant grant opportunity but the risk is spending more money than the organization saves.
- Scott County: Genesis has made changes having hospitalists running behavioral unit.
- More stability at Genesis: Previously, doctors worked at Vera French and psych unit at Genesis at same time.
- Integration of primary and behavioral health care.
- Grant potential expands with collaborative efforts.
- Robert Young Center has 11 telepsychiatry sites and this can and should be grown.
- Inpatient programs: Need for child/adolescent beds and elderly, adult geriatrics beds.
- Physicians – especially surgeons, cardiologists, anesthesiologists and primary care physicians – want more access to mental health.

- Primary care managers can be taught to make the distinction and understand the association between physical and psychological concerns.

E.) Threats or Obstacles for Local Community Mental Health Services

- Affordable Care Act focuses too much on bricks and mortar, existing communities, not operational support.
- States are moving out of providing safety net. Subsidization will rest with the local community and the ability to expand Medicaid. County and local jails will continue to see more of the mentally ill, particularly young males.
- States are disenfranchising from mental health, closing all but a few institutions, and then, community will be the victim of the backlash. We are experiencing de-institutionalization without a safety net.
- It is unknown and unseen how many indigent mentally ill people there are in QCA as many of them seem to be "invisible."
- Too many resources are being allocated to the mild and moderate behavioral disorder population. The outcomes are unclear, but it looks nice, particularly in the schools. Kids generate more community/public sympathy than adults.
- We anticipate reduced state money for existing CMHC programs. Any new funds will most likely be designated only for new programs – not current ones that are already under-funded.
- Without Medicaid there is a limited service package, however crisis intervention services are unlimited, never allowing patients to stabilize in treatment.
- We need more balance between the uninsured, Medicaid, Medicare and private-pay patients.
- Medicaid-funded patients are higher no-show, and self-pay (uninsured) patients have an even lower attendance rate for treatment.
- There remains a stigma of mental illness among many in the community, including some specialists in the medical profession.
- The community concept is vastly different than that of actual community mental health system. There is a perception of what community mental health looks like, and there is the reality of what community mental health providers know to be true.

- Legal ramifications of commitments post discharge with court ordered outpatient treatment programs.
- Now that capital improvements have been made, Community Health Care has more overhead, more space and not enough operational funding.
- The homeless population's transient nature causes challenges in accessing services and treatment. They are a small portion of un-insured but more severe and complex.
- Many non-psychiatric physicians indicate that taking care of medications for the severe and persistent mentally ill is beyond what they are capable of doing safely and doing well.
- Primary care physicians will speak to "integration," and claim it is not part of their practice, but they medicate for general depression and anxiety.
- Iowa will pay for dementia, Illinois will not.
- Intra-state issues slow the system down (Iowa). Could be from 200 miles from here. Looking for a bed, they are traveling from great distances which are a drain on the system. Hard to get people back to their original home. Medicare brings people in an acute situation to Genesis…bus tickets to get them home.
- Intra-state issues with taking patients outside the area (Iowa). Taxing on the hospital that has to take the person and give a bed when it might be needed locally before the out-of-town patient arrives.
- Overall, medical studies show there are enough psychiatrists per population but there is a shortage of those who will take Medicaid or take indigent patients.
- Very few psychiatrists desire to work inpatient psychiatry. Severe shortage of those who will work with Medicaid and community mental health as well as work in the hospital.

Hubert Humphrey once said, "The moral test of government is how the government treats …the sick, the needy and the handicapped." At this point, we are not living up to this measure. In the words of E. Fuller Torrey, M.D. an advocate of mental health, "It is time to try again."


Community
Health Care, Inc.


GENESIS


NAMI
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Trinity


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VERA FRENCH