Mental Health Priorities & Concerns

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Why do Mental Health Services Matter?

Mental illness affects 1 in 5 people each year, with anxiety and depression as the most common disorders. Substance use is often a co-occurring issue. Mental health disorders often go undetected or untreated, which can worsen symptoms and outcomes and lead to more costly forms of care. **Severe and persistent mental illnesses, such as bipolar disorder or schizophrenia, often affect an individual's ability to hold a job, complete an education, or afford housing.** Without appropriate treatment, people can cycle in and out of hospitals, shelters, and prisons. These issues also have a significant long-term impact on the individual's family.

Behavioral health disorders (mental illness or substance use) are the leading cause of hospitalization in CT for ages 5 through 44 as well as for men ages 45-64, accounting for more than one quarter of inpatient and emergency visits. More than half of people in prisons have a behavioral health disorder.

To address the complicated issues and far-reaching effects of mental illness, **a continuum of services is necessary:** mental health promotion; early detection screenings; therapy in community, residential, and hospital settings; access to psychiatric medications; peer support programs; and related wraparound services such as supportive housing, supported employment, and supported education for those most affected. Case management services are critical.

"In a budget crisis, the primary area to protect is basic needs! In behavioral health, that translates to protecting case management as a primary concern."

Impact of Budget Cuts in our Communities

The 2015-16 rescissions and cuts affected our communities in multiple ways. Not only were there cuts to state-funded agencies (DMHAS, DCF, DSS) and to state-supported behavioral health providers, but hospitals, municipalities, school-based health centers, youth services bureaus, court-supported services, and other programs that are also a part of the service system experienced budget reductions. **Overall, the system began to shrink**, **with reductions at multiple agencies often affecting the same populations.**

- **Southwestern CT lost 2 critical levels of care due to state cuts:** The only Transitional Residential Programs (TRPs) in the region were closed, for a loss of 20 beds in Bridgeport and 9 in Norwalk. TRP served as a medium-term residential program that diverted people with serious mental illness from hospitalization and from homelessness; no comparable program remains. Kids in Crisis lost its state-funded emergency beds, leaving no youth shelter beds south of New Haven.
- In July 2016, SWRMHB and the Regional Action Councils surveyed DMHAS-funded behavioral health providers about the impact of the budget cuts. Of 17 responding agencies in southwestern CT, **4 had eliminated programs, 3 had reduced program hours, 3 had laid staff off, and 3 reported a hiring freeze. As a result, 11 agencies reported an increase in caseload, 6 increased their client waitlists, and 4 had had to turn clients away.**
- **More changes have occurred since then.** A few examples: A Community Support Program in Stamford had to reduce its capacity from 150 clients to 50; a supported employment program in the region lost 45 client slots; a specialized program in Bridgeport lost 2 beds for intensive residential rehab services for people with co-occurring substance dependence and psychiatric disorders; and a couple of after-school programs for children were closed.

The impact can be seen throughout the community as demand outpaces supply. One hospital now has a waitlist of 100 people in need of outpatient services. A community provider is getting 25 new calls a day from people seeking help and unable to get an appointment. Children's agencies report increasingly long wait lists for high-need children who need immediate care, yet are unable to expand their workforce to meet the demand. An agency that provides mental health and substance use services reports that it now takes 6-8 weeks to get a client in need into inpatient care, as compared with 4 weeks one year ago.

Municipal social services departments note an **increase in anxiety** in all ages, from youth to seniors, affecting school focus in students and executive functioning in seniors. As local papers are reporting, **suicide is now the leading cause of death in children** ages 10-14 (ahead of motor vehicle accidents). In small towns where schools do not have social workers, districts increasingly refer family issues related to child attendance, behaviors, mood and anxiety to the town social worker. When municipal budgets cannot accommodate the increase in social work hours, the clients cannot be seen as frequently as needed.

2016-2018 Regional Priorities for Southwest CT

❶ **Outpatient Services** - Key issues include insufficient access to prescribers (psychiatrists and APRNs), cost barriers (insurance copays & reimbursements, providers who don't participate), timeliness of access, and the need for specialized mental health services, addiction services, and transitional/intermediate care.

- A recent SWRMHB survey found that more than half of psychiatrists don't accept any form of insurance and the vast majority of these also do not offer a sliding-fee scale.
- With costs ranging from $75-$325 for a medication management visit (usually monthly or quarterly) and from $60-$150 per therapy session (which may be needed weekly), out-of-pocket treatment is unaffordable for most people. Many clients who have privately insurance still cannot afford the high deductibles or co-pays associated with their treatment.

❷ **Workforce –** There is a shortage of providers, especially prescribers, bilingual providers, and those with expertise in children and adolescents, hoarding, and other specialized services. Providers are unequally distributed across the nonprofit, state and private sectors: because state funding for nonprofits has not kept up with cost-of-living increases, nonprofits cannot provide competitive salaries to experienced workers, who often seek employment elsewhere. As a result, it can be the least experienced workers who work with the most vulnerable populations.

- A recent SWRMHB survey found a ratio of 62 clients per Social Worker in Southwestern CT—significantly higher than the identified national ratios of 40:1-50:1.
- Nationally, a shortage of 90,000 psychiatrists is expected by the year 2025.
- Trained "peers," or people in recovery, are an underutilized yet very effective resource. CT has up to 900 trained Recovery Support Specialists who are not a part of the behavioral health workforce.

❸ **Inpatient Services –**Consumers and providers all report challenges in obtaining hospital admissions when needed. 90% of psychiatric beds in CT are filled every night, and 90% of Emergency Department doctors cite "boarding" of patients with mental illness for lack of inpatient beds. Inpatient stays are seen as too limited, with a need for longer-term treatment (psychiatric and substance use treatment) as well as crisis beds. Discharges are hard due to a lack of intermediate and residential care facilities.

- Between 2010-2014, CT hospitals saw a 31% increase in behavioral health hospitalizations, yet CT lost 126 psych beds between 2010-2016.

An Opportunity for Legislators to Support Needed Reforms

As the state's budget crisis continues and creates changes in the service system, insurance reform and other legislation could remove barriers to care (both for consumers and providers) and also help address the workforce issue by supporting use of peers and incentivizing doctors to enter the field of psychiatry.

❶ **Insurance reforms** such as streamlining paperwork, creating a standardized online formulary, increasing reimbursement rates to providers, and covering effective detection and intervention services could help improve service delivery:

- The mental health parity law should be better implemented (as proposed in the Mental Health Reform Act). Insurance providers often authorize inadequate levels of care, especially inpatient stays. Consumers cite multiple barriers, such as having to resubmit paperwork repeatedly. Providers often have to call frequently to advocate for their clients.
- Reforms could target the low reimbursement rates and procedural hurdles—such as paperwork and prior authorizations—listed by providers as reasons for not accepting insurance. (In Wilton, only 7% of providers expressed an interest in learning about participating on insurance panels.)
    - A local children's agency can no longer afford to offer psychological evaluations to the general public because both private and HUSKY reimbursement rates are too low. Private insurance companies reimburse at rates 38% lower than Medicaid, not even coming close to covering the true cost of services.
    - Insurance coverage is not uniform. One company may authorize 8 counseling sessions while another authorizes 30 for the same diagnosis.
- Essential and highly effective services, such as case management and DBT, should be covered. Screenings are only covered when administered by certain workers, despite need for early intervention and suicide prevention.
- If services provided by "peers" were made reimbursable (as in 31 states), peers could be better integrated into the system.

❷ To address **workforce issues,** a task force should look at: expanding scope of practice for different providers, incentivizing doctors to enter the field of psychiatry and providers to work in the public & nonprofit sectors, and prioritizing & reimbursing peer services.