

In Their Own Words

Current
Mental Health Challenges
In Rhode Island

Mental Health Association
of Rhode Island

April 2017

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Dedication

This report is dedicated to the fond memory of two of the most outstanding advocates for mental health in Rhode Island over the last 40 years: Joseph Bevilacqua and Daniel McCarthy! Unbelievably, these two close colleagues died 8 days apart in February 2017. Dr. Bevilacqua was the charismatic Director of the Rhode Island Department of Mental Health, Retardation & Hospitals (MHRH) from 1975 to 1981. He ably led the deinstitutionalization movement in Rhode Island. During this same period of time at MHRH, Dan McCarthy was responsible for the development of community mental health service in Rhode Island; and was nationally recognized for the Assertive Community Treatment Program (ACT) which he fostered in conjunction with the local Community Mental Health Centers. In their retirement, both of these gentlemen volunteered to serve for a substantial period of time on the Board of Directors of the Mental Health Association of Rhode Island (MHARI) reflecting their true personal dedication to the improvement of mental health in Rhode Island. MHARI will sorely miss these two great guys! They were both exceptional in their mental health leadership, commitment, and comradery!

J. Clement Cicilline
President, Board of Directors
Mental Health Association of Rhode Island

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INTRODUCTION

In the Fall of 2016, the Rhode Island Senate Health & Human Services Committee chaired by Senator Joshua Miller held a series of five hearings on the status of mental health services in Rhode Island. These hearings taken together represent a fairly rare event in Rhode Island in terms of their singular focus on mental health and in terms of the large number of knowledgeable individuals (over 40) who provided public testimony concerning the serious mental issues impacting Rhode Island today. In February 2017, the Senate Health & Human Services Committee produced a report entitled: Mental Health Hearings & Recommendations. This Report contains 11 overarching recommendations and 36 specific recommendations for improving mental health in Rhode Island. Thus, the Senate report is a milestone in Rhode Island mental health planning & policy development in terms of both its breadth and specificity. Accordingly, the Mental Health Association of Rhode Island (MHARI) wishes to sincerely thank Senator Joshua Miller for his continuing leadership for the improvement of mental health in our state.

This MHARI report which follows, In Their Own Words: Current Mental Health Challenges In Rhode Island, is based on the written testimony received by the Senate Health & Human Services Committee in the hearings noted above. This MHARI report is intended to complement and supplement the Senate report noted above by excerpting selected testimony to highlight the identified problems and potential solutions which were contained in the written testimony which was submitted. The complete written testimony submitted to the Senate is incorporated in the Addendum section of the Senate report.

Ruth Feder

Executive Director, Mental Health Association of Rhode Island

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Rhode Island Senate Mental Health Hearings
Selected Highlights (bold emphasis added)
Mental Health Association of Rhode Island

1. IDENTIFIED PROBLEMS

a. Mental Health Status

- “These studies are important because we now understand that **Adverse Childhood Experiences** or childhood trauma are a root cause of poor mental and physical health outcomes and early death. And typically, once we understand the cause of something we can prevent it, screen for it, and treat it. Unfortunately, even armed with this knowledge, we have not made significant progress in how we prevent, screen for and treat adverse childhood experiences. In Rhode Island, one in five (19.0%) children ages six to 17 has a diagnosable mental health problem and one in 10 (9.8%) has significant functional impairment. 34% of Rhode Island children who needed mental health treatment or counseling in the previous year did not receive it. Rhode Island has the sixth highest rate in the nation (14.34%) for youth attempting suicide.” **20**

- “Our mission is to support individuals and families in their efforts to meet economic, social and emotional challenges and enhance their well-being. Woonsocket is home to the highest rate of substantiated cases of child abuse and neglect in the state, including emotional, physical and sexual abuse. Our clients are among the most impoverished in Rhode Island. These two factors contribute to PTSD, anxiety, depression, and other mental health disorders. At least 50% of the people that we serve have co-occurring substance use disorders, a common maladaptive strategy utilized by individuals struggling to cope with complex trauma. Combined, these issues contribute to **pervasive problems that cut across all major life domains**: relationships, education/employment, housing, legal, and medical. The chronic stress of trauma and poverty contribute to poor

health, limiting not only people's level of functioning, but their life expectancy, due to serious medical conditions, such as COPD, hypertension, heart disease, HIV/AIDS, hepatitis, and much more." **15**

- "There is an average of one **suicide** every 3 days in Rhode Island. For youth age 24 and under, the number is 1 every 25 days." **17**
- "15-20% of all ACI inmates have **severe, persistent mental illness** (SPMI). There are roughly 3000 inmates at the ACI at any given time." **22**
- From 1999-2010, the **suicide** rate in the United States population among males was 19.4 per 100,000, compared to 4.9 per 100,000 in females. Based on the most recent data available, in fiscal year 2009, the suicide rate among male Veteran VA users was 38.3 per 10,000, compared to 12.8 per 100,000 in females." **21**

b. Mental Health Services Financing

- "Over the past 11 months the state's infrastructure for the delivery of community based mental health services has been weakened. Community based organizations that have been the safety net for persons with severe and persistent mental illness have struggled to make payroll due to inconsistent payment and at times overly complex and different claiming systems by Managed Care Organizations. While improvement in payments has occurred, due in part to intensive advocacy and engaged legislators, **the system remains fragile and not sustainable using the current funding methodology**. The State of Rhode Island needs to take responsibility for assuring its providers of community based services are appropriately funded and paid on time." **1**
- "I have some concerns with the significant budget cuts DCYF has received in recent years and resulted in financial issues for the provider community. It is critical that the provider community receive adequate resources to assist the state in preventing placements and supporting community based

services. **There has been consistent erosion in provider funding and service quality relative to existing community based and residential programming in recent years.** Budgets have been cut relative to preventative services. The State of Rhode Island lacks a fair, systematic rate setting process across its service continuum that assesses the real cost of providing service.” **23**

- “We’ve witnessed recent ***closures of adolescent Substance Abuse residential treatment facilities*** due to low reimbursement rates from the state.” **12**
- “However what we have seen are a significant number of these individuals with an insurance plan unable to access these badly needed services. The **unaffordable co-pays and high deductibles prevent access.**” **11**
- “**Community based health services in general do not rank high on the reimbursement list.**” **7**
- “**Plans do not cover education and prevention services.**” **8**

c. Mental Health Services Delivery

- “Currently we have no common vision amongst state agencies and **no agreed upon plans** as to what prevention, interventional and treatment services should be delivered to these age groups.” **11**
- “We know that **only about 40% of those with diagnosable mental health conditions get care**, and of those who do, a majority are served in non-specialty settings.” **10**
- “**Rhode Island lacks intermediate level services. Rhode Island lacks ancillary services. The public and private behavioral health service systems are largely disconnected.** It is difficult to provide people continuity when they move between systems.” **8**

- “We’ve witnessed over the last few years, actually since the **Substance Abuse Residential programs went in plan and covered by the insurance providers, a significant drop in lengths of stay**. Before the residential programs went in plan, the average length of stay was four months. It has now shrunk to about two to three weeks.” **11**
- “We simply are not well suited to provide a therapeutic environment for psychiatrically ill patients. In addition, this care is costly, reportedly costing an estimated \$2,264 for an average emergency department boarding in 2012. All of the emergency department medical directors felt that the boarding of behavioral health patients in their departments significantly reduced their **emergency department** throughout and all identified this as an impediment to their Department’s ability respond to a disaster. In addition, there was agreement **this was not the optimal place to care for these patients and they would be better served in another environment.**” **19**
- “I am increasingly alarmed by the lack of care for Rhode Island residents with Psychiatric Illness. As a state, we seem to be returning to the age where those with such illnesses are without any rights and are routinely institutionalized. Sadly, not locked in attics or asylums, but in our **very overburdened homeless shelters and jails.**” **16**
- “Psychiatric patients wait hour and hours for an evaluation. Patients who are not homicidal or suicidal are mostly sent home, not because they are not severely ill or suffering, but because there is “no bed”. For those few who make it to a psychiatric-in-patient unit, **the “follow-up-care” is abysmal.**” **16**
- “**Lengthy wait times between release from prison and engagement in outpatient mental health treatment often leads to lapses in mental health treatment** for people re-entering the community following periods of

incarceration. Difficulty securing group home placement for appropriate individuals due to their charge history (ex. sex offenders, arsonists, assaultive behaviors), limited bed availability and lengthy waitlists, and inability to bring inmates for visits to the group homes to evaluate them for appropriateness prior to placement (which is often requested by the group homes). Cities and towns requiring homeless shelters to place capacities on the number of sex offenders that can be admitted into shelters at a time, ultimately leaving many of our (Serious & Persistent Mental Illness) populations truly homeless. Need to increase communication between community based providers and DOC (Department of Corrections) mental health providers to improve continuity of care and strengthen the services available to SPMI (Serious & Persistent Mental Illness) individuals that we serve.” 22

d. Mental Health Human Resources

- “The staff I work with are the most dedicated, caring, professional people I’ve ever met. And they’re doing it for \$11-\$13 an hour. Our staff worked to resuscitate the client and ensure others safety until the ambulance arrived. Clients have outbursts, make threats and sometimes hurt themselves in our buildings. Staff de-escalate, intervene and stabilize situations like these on a daily basis and then go back to their desks to enter careful notes to make sure every i is dotted and t is crossed to meet regs and to make sure we get reimbursed. **The majority of these have bachelor’s degrees, make \$11-\$13 an hour and haven’t received a raise in years.” 3**
- **“Unfortunately, most of our newly hired case managers leave within the first year due to the low wages that we are forced to pay. Some of these case managers that leave us go to work in retail or fast food for the same amount of money and much less stress and regulations to deal with.” 14**
- **“The vacancy rate for RN positions in the community mental health centers is very high.” 7**

- “A recent survey by the Association of American Medical Colleges found that 59% of psychiatrists are 55 or older. A study published in the journal JAMA Psychiatry found that only 55 percent of psychiatrists accepted private insurance, compared to 89 percent of other doctors. Likewise, the study found, 55 percent of psychiatrists accept patients covered by Medicare, compared to 86 percent of other doctors. **43 percent of psychiatrists accept Medicaid**, which provides coverage for low-income people, while 73 percent of other doctors do.” 5
- “Private psychiatrists (if you can find them) often refuse to take insurance payments because of the **low rates of reimbursement** and the high degree of micromanagement and paperwork.” 9
- “In Rhode Island, there is some evidence that **the dynamics of the psychiatric workforce are getting worse**. At the Butler Hospital Medical Staff, the leading factor for staff resignations is psychiatrists moving out of state – 39% of total resignations. **Reimbursement rates in Rhode Island are lower than in most surrounding states.**” 5
- One of the biggest challenges we face is a **lack of physician providers.**” 13
- “One critical problems affecting the supply of psychiatrists available to see patients in the community is the **trend away from psychiatrists accepting any kind of insurance.**” 5
- “The Eleanor Slater Hospital is licensed for 495 beds, but because of limitations on the numbers of physicians available to provide services to patients, we currently run a census of approximately 250. **The Eleanor Slater Hospital has had a longstanding problem with hiring of physicians, particularly psychiatrists**, which has reached a critical point in recent years. There are multiple reasons for this problem. One is that the only medical school in the state is private. Brown University School of Medicine admits few Rhode Islanders.” 12

- “BHDDH (Department of Behavioral Healthcare, Developmental Disabilities and Hospitals) put out an RFP and now has two physician recruitment companies who could look for psychiatrists, but until the physician contract is settled **we will not be able to recruit due to the low state salary for psychiatrists.**” 12
- Too often, however, practitioners are overworked and underpaid, **lack training in many of the evidence based practices**, and lack incentives to change. 4

2. IDENTIFIED SOLUTIONS

a. Mental Health Promotion and Illness Prevention

- “Considering that an average student spends about 1,200 hours a year in school, **wouldn’t it make sense for a school to be a priority for mental health services?**” 24
- “The two solutions that they believed were most important were **increasing the number of social workers and teacher training in schools.**” 24
- “As we move forward, there are several areas this committee may wish to explore:
 - First, implementing universal screening for Adverse Childhood Experiences (ACEs), mental health, and substance abuse in primary care.
 - Second, **training of childcare and school personnel in identifying children who have suffered (Adverse Childhood Experiences (ACEs) and in how to address the resulting behaviors.**
 - Third, educating parents and the public at large on the impact of Adverse Childhood Experiences (ACEs) on our children’s physical and mental health.” 20

- **“Remove barriers to preventive services that discourage individuals from participating in screenings and preventive initiatives.** Studies show that even small copayments and deductibles cause individuals to forego essential screenings and annual physicals which detect health problems before they become full blown conditions.” **4**
- “Like many of our members who have co-occurring substance use issues, Denise says: “It has supported me by helping me stay drug free....It’s a safe place to go help to keep me sober.” Howie credits the **Oasis** with keeping him out of the hospital. Of retirement age, he feels more comfortable at **Oasis**, where he is able to find understanding with his peers, than at a senior center. John values the **Oasis** as a source of “contact with peers”, “contact with resources”, and keeping him out of the criminal justice system. Paul says: I have been a very active participant of [**Oasis**] since...1999. On numerous occasions I have been rescued from the depths of depression. Their wholesome activities and therapeutic...sessions have shaped my recovery from a life-long battle with mental illness.” **2**

b. Mental Health Services Financing

- “It is my hope that the Senate will play a leadership role in moving the state’s funding of mental health services for vulnerable populations to one that is more rational, accounts for the true cost in service delivery and affords the retention of a workforce capable of meeting the needs of the people we serve. The state must adopt a **Prospective Payment System** for the delivery of community based mental health services for vulnerable populations (i.e. adults with severe and persistent mental illness and/or with serious mental illness, children and youth with severe emotional disorders etc.). Such a system should be similar to the **funding methodology employed with Federally Qualified Health Centers in Rhode Island**. This approach assures consistent, uninterrupted cash flow while also utilizing metrics to assess outcomes and promote program quality improvement. Service rate must be reassessed and should be based on the true costs in which to operate community based programs and support qualified personnel. The state’s lack of attention to the expenses incurred

by community based organizations and the cost of training and employing a workforce inevitably will result in diminished quality and care to the populations served. The Senate and House should be briefed by the BHDDH (Department of Behavioral Healthcare, Developmental Disabilities and Hospitals) personnel on its application to SAMHSA to fund **Certified Community Behavioral Health Clinics (CCBHC)**. This application proposes a particular Prospective Payment model that is population based.” **1**

- “Imagine if we could bundle all of what we spend on outpatient, inpatient, pharmacy, and primary care and put all this money in a single bucket and hold providers accountable for an agreed-upon set of quality and cost measures in exchange for flexibility in doing or creating the right service array. My strong belief is that we could see dramatically improved outcomes at the right cost. Until we can get to a true **bundled model**, we will be limited to painstakingly slow work to close service gaps and experiments whose scope is limited by the availability of whatever capital we can scrounge up.” **9**
- “Other complex barriers Care New England is working to address include changing insurance coverage and reimbursement rates. Our partnership with BlueCross BlueShield of Rhode Island in collaboration with Butler Hospital, The Providence Center and Continuum Behavioral Health to develop a program call **HealthPath** represents the nation’s first health home program for commercially insured and Medicare covered adults. Enrollees in the program are pre-approved for one year with the care team receiving bundled monthly payments to cover all services including psychiatry, case management, nursing, therapy, peer support, transportation, housing and employment placement assistance and coordination with primary care and other medical specialties as needed. What’s even more impressive is the team has created literal pathways for communication and coordination of the treatment plan.” **13**

- “Review the adequacy and variability of fee-for service rates for behavioral health services. **Incentivize moving away from fee-for-service to bundled rates, case rates, and other structures that reduce administrative complexity.** 5
- “Fourth, we need to **review access, coverage and reimbursement policies** as they relate to Adverse Childhood Experiences (ACEs) and mental health issues.” 20
- “Update Coverage for Mental Illness and Substance Abuse to make consistent with **federal parity** and Sections 27-38.2 for rate parity.” 8

c. Mental Health Services Delivery

- “We’re asking that going forward we work to establish a local prevention and treatment network of services to address these needs as defined in the **Truven Report.**” 11
- “One model that offers substantially improved outcomes is the **Certified Community Behavioral Health Clinic (CCBHC)** for which BHDDH (Department of Behavioral Healthcare, Developmental Disabilities and Hospitals) has recently submitted a planning grant. CCBHCs (Certified Community Behavioral Health Clinic) are person-centered and recovery-focused, dictating staffing patterns that incorporate qualified staff who are culturally competent to address specific areas of need across the lifespan, from early childhood to the elderly. Certain populations are identified as having unique needs, including individuals with severe and persistent mental illness, children/adolescents with serious emotional disturbance, those who have experienced trauma, those with substance use disorders, and veterans.” 15
- “EBCAP (East Bay Community Action Program) offers a **full cadre of enabling services** such as case management, WIC, heating assistance, food

- pantry services, housing assistance and support, means tested eligibility assessments and a host of other services which are critical in the delivery of a fully integrated patient centered care experience; however few, if any are reimbursed by the payers.” **6**
- “The success of our **Accountable Entities** in providing quality care and reducing cost is predicated on an integrative health strategy that treats the whole person and addresses the underlying issues of co-occurring primary health and behavioral health disorders.” **6**
- “The **Collaborative Care model** is supported by over 80 randomized controlled studies showing that it is more effective than usual care for common mental health conditions such as depression and anxiety. (See The Kennedy Forum, <http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-Behavioral Health FINAL 3.pdf>)” **10**
- “What our state needs is a concerted **planning process** that builds a comprehensive vision for a behavioral health system **as part of the larger healthcare system.**” **9**
- “To provide an example of how measurement-based care is used in public specialty care systems, let’s look at a new study sponsored by **Southwest Michigan Behavioral Health**, the public behavioral health plan covering eight counties in Michigan. That state’s Behavioral Health and Developmental Disabilities Administration now requires the use of some standardized tools across all of its service populations for programs providing specialty behavioral health services.” **10**
- “There was consensus that the medical clearance required prior to admission was not helpful in over 90% of the cases, excluding those with a

documented overdose. In other words, most medical directors felt these patients could be safely evaluated the vast majority of the time in a **more appropriate and potentially less costly environment**, just as has been proposed for the chronic intoxicants. There was also consensus that better access to outpatient services and better access to 7 day a week inpatient availability would significantly reduce this burden. There was also consensus that improved funding, that is truer mental health parity would presumably help expand access and improve the situation. It was hoped that in any redesign of the Healthcare System we would look to the **Alameda Model in California** which has largely bypassed emergency departments and essentially eliminated the holding problem at a lower overall cost.” **19**

- “Support mechanisms for people to be able to stay with their **primary care providers** when they move between the private and public sectors, or change commercial health plans.” **8**
- “Our programs include our **Crisis Hotline/Listening Line, Safe Place Grief Support, Youth and Teen Education and Community Education** including our Lifeline program at the Men’s Intake Center at the Rhode Island ACI (Adult Correctional Institution). Since our inception, more than 1,539 trained volunteers have answered more than 500,000+ calls and hosted more than 1,500 guests to our Safe Place grief support group. In 2015, the Samaritans hosted more than 92,789 website visitors.” **18**
- “The VA (Veterans Administration) program for suicide prevention is based on a **public health approach** which is an ongoing approach utilizing universal, selective, indicated strategies while recognizing that suicide prevention requires ready access to high quality Mental Health Services, supplemented by programs that address the risk of suicide directly.” **21**

- “Lastly we need to develop a reformed system model that is specifically **addresses the unique needs of adolescents and young adults**. These youth need a model that continues with what we have learned works in children’s mental health intervention; a systems frame including family, mentors, education and career in treatment while being unique developmentally.” **20**
- “The Annie E Casey foundation has illustrated the importance of **“homegrown” programs** to meet the needs of families where there is not a “stable” caretaker.” **23**
- “We have a serious issue with **sex trafficking in Rhode Island**. We need to develop appropriate programs.” **23**
- “My main concern is to help develop **support programs for these most difficult of families** to make sure that they can fully utilize all of the options that are available to them for both job training and medical support services.” **23**

d. Mental Health Human Resources

- “We desperately need your help so that we can continue to help others. Without **regular, dependable funding and stability**, we will be without staff. Without staff, we will be unable to maintain all the good we do for the community and the people in it.” **3**
- Explore strategies that would make **loan forgiveness and other incentives** available to community-based psychiatrists.” **5**

In Their Own Words
Selected Written Testimony

1. Benedict F. Lessing, Jr., MSW, Chief Executive Officer, Community Care Alliance
2. Jim McNulty, Executive Director, Mental Health Consumer Advocates of Rhode Island, Inc., and Charles Feldman, Chair, Mental Health Recovery Coalition of Rhode Island
3. Lori Ziegler Halt, Director of Human Resources, Community Care Alliance
4. Dr. Susan Storti, Administrator of the Opioid Treatment Program, Health Homes and Mental Health Policy, Substance Use and Mental Health Leadership Council of Rhode Island
5. Michael Silver, MD, Chief Medical Officer, The Providence Center, and Rhode Island Psychiatric Society
6. Dennis Roy, Chief Executive Officer, East Bay Community Action Program
7. Mary Dwyer, Psychiatric Nurse Specialist, Rhode Island State Nurses Association, and Community Care Alliance
8. Peter Oppenheimer, Ph.D., Chair, Rhode Island Primary Care Physician Corporation, Behavioral Health Committee
9. Dale Klatzker, President, The Providence Center
10. William Emmet, Mental Health Consultant

- 11.** David Spencer, President/Chief Executive Officer, The Substance Use and Mental Health Leadership Council of Rhode Island
- 12.** Elinore McCance-Katz, MD, PhD., Chief Medical Officer, Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals
- 13.** Lisa Shea, MD, Medical Director, Butler Hospital
- 14.** Marc Dubois, Hospital/Court Liaison/Case Manager, Community Care Alliance
- 15.** Michelle Taylor, Director of Outpatient Services at Community Care Alliance
- 16.** Mary Roth, RN, CTTS-M
- 17.** Deborah Garneau, Rhode Island Department of Health
- 18.** Denise Panichas, Executive Director, The Samaritans of Rhode Island
- 19.** Dr. Gary Bubly, Medical Director, Miriam Hospital Emergency Department, and Rhode Island Chapter of the American College of Emergency Physicians
- 20.** Margaret Holland McDuff, Chief Executive Officer, Family Services of Rhode Island

- 21.** Robert Swift, MD, Ph.D., Chief of Mental Health, Veterans Administration
New England Healthcare System

- 22.** A.T. Wall, Director, Rhode Island Department of Corrections

- 23.** Brother Michael Reis, MSW, President and Chief Executive Officer, Tides
Family Services

- 24.** Generation Citizen Students from Juanita Sanchez School